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The utilisation of mental health services by children and young people from a refugee background: a systematic literature review

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People from refugee background are known to be vulnerable to the development of mental health problems and to suicide because of the pre-migration events they have experienced and the difficulties associated with moving from their homeland to a usually different society. Concerns have been expressed that, in spite of this, young refugees' rates of contact with mental-health services are substantially lower than expected. This systematic literature review aimed to summarize what is known about the use of mental-health services by children and young people of refugee background and to identify factors that may constitute impediments to service use as well as factors that may facilitate access to and engagement with services. This article presents the main findings in relation to mental-health services utilization by children and young people of refugee background. An overview of literature on the general (i.e. adults or not-youth specific) refugee population has also been included to provide, where possible, a comparison between the former and the latter. A key finding of this review is that while countries of resettlement have introduced several policies and programs for refugee children and young people, these are based on very little evidence, thus more research is urged.

Keywords: refugee; young; youth; mental health service use; utilization; access; review

Introduction

Young people of refugee background[1] are at increased risk, compared with immigrant or Indigenous children and young people, for psychological symptoms and psychiatric disorders (Hodes, 2002a) because of forced migration, traumatic events and resettlement in unfamiliar environments (Hollifield, 2005). Reviews of prevalence studies (Davidson, Murray, & Schweitzer, 2008; Fazel, Wheeler, & Danesh, 2005; Gerritsen et al., 2004) show a wide range in reported prevalence rates of mental health disorders among people of refugee background, due to the heterogeneity (especially sample size) of the study population and the measurement instruments and process (e.g. interviewer non-native to the refugee's ethnic group versus native). The meta-analysis by Fazel and colleagues (2005) suggests that about 1 in 10 adult refugees in Western countries has PTSD, about 1 in 20 has major

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depression and about 1 in 25 has a generalized anxiety disorder, with the probability that there is a high levels of co-morbity. Although research is much more limited on children/youth, and rates of psychiatric disorders vary between studies, data reported in the meta-analysis suggest even higher prevalence rates in this population (Fazel et al., 2005). People of refugee background are also known to be at high risk of suicide (Baron, 2002; Harris & Maxwell, 2000; Nguyen, 1984; Vijayakumar & Jotheeswaran, 2010), although research is sparse.

Authors have consistently expressed concern that mental health services in receiving countries may be relatively underused by refugees (e.g., Michelson & Sclare, 2009), in terms of not accessing services or discontinuing engagement with such services. Children are identified as particularly at risk of suboptimal healthcare due to the impact of pre- and post-migration factors combined with the effect of resettlement stresses on parent's ability to care for their children (Davidson et al., 2004). In view of high risk of mental health problems among children and young people of refugee background and concerns around underutilization of mental health services and unmet needs, knowledge of factors that may constitute impediments to service use as well as factors that may facilitate appropriate access to services become of paramount importance. For this reason, we initiated this literature review as well as a research project on this topic (Colucci, Szwarc, Minas, Paxton, & Guerra, in preparation).

Methods

The objective of this literature review was to identify all published Australian and international studies concerning the utilisation of mental-health services among young people from a refugee background. The principal databases in psychology and psychiatry (PsycINFO, PubMed, Medline), nursing and allied health sciences (CINAHL), social sciences (Sociological Abstracts, International Bibliography of the Social Sciences) and other sciences (ISI: Web of Science) were searched from their inception (e.g., 1966 for Medline, 1960 for PsycINFO) to the latest publication available as for May 2011. Terms related to the concepts of mental-health services use and access and refugee population were generated by examining the terminology used in review papers and other relevant papers and by looking at databases' thesaurus to locate synonyms. The following terms were used for keywords and indexing:

(1) access or use or (health service) use or utilisation or utilization or referral *and*
(2) mental health or psychological health or depression or anxiety or schizophrenia or post-traumatic stress disorder (PTSD) or suicide *and*
(3) refugee (i.e., refugee or refugees).

The search was not limited by language, study design or age group. In addition to the database-based searches, reference lists of included studies and reviews were also searched for relevant studies. Experts in the field and corresponding authors were contacted to locate additional studies of relevance that had been published or had been accepted for publication.

Criteria for inclusion were that the manuscript was an original research paper published in a scientific journal or book, that it reported some data related to the topic of access or use of mental-health services[2] and that refugees represented one of

the samples in the study. Studies on refugees and other migrants were kept only when it was possible to extract findings specific for refugees.[3] An exception was for studies on refugees and asylum seekers, which were included even when only aggregated data (i.e., for the whole sample) were reported. However, these studies were excluded if the authors specified that the sample was made up solely of asylum seekers. The reason for excluding studies comprising only asylum seekers is that the access to services of this cohort is commonly determined by their legal status pending resolution of their application for recognition as a refugee. Publicly-funded services may simply be unavailable to asylum seekers who are permitted to remain in the country where they seek recognition as refugees only while their status is resolved, or who are residing in countries without legal authorisation. Privately-funded services are generally either very expensive or limited in scope.

All abstracts of potentially relevant papers were read and full texts were obtained of those that seemed to meet the inclusion criteria indicated above. At this stage, papers that reported data specific to children and/or young people (i.e., up to 25 years of age) were selected for review.

Results

Figure 1 presents the flow diagram for the selection of the included papers. Searches of electronic bibliographic databases, experts' advice and hand-searches of reference lists of included studies and other reviews yielded a total of 1028 references. One of the researchers (EC), in consultation with the research team, screened the papers on the basis of their titles and abstracts and, after discarding duplicates and applying the selection criteria described above, retrieved and read 171 full-text papers. Only 11 of the papers met the criteria for inclusion in the review, as agreed by the team.

All but one of the studies used a quantitative methodology consisting of structured questionnaire and/or scale ($n = 4$), clinical case notes or database ($n = 2$) or a combination of the two ($n = 3$). The other was a qualitative study based on focus-group discussions (de Anstiss & Ziaian, 2010). One study used a combination of quantitative and qualitative methods (Howard & Hodes, 2000). Participants in the study were generally children and young people, however in three instances their parents/caregivers and/or their teachers were also interviewed and, in one instance, only the mothers were the study's subjects (Thabet, El Gammal, & Vostanis, 2006). Only five studies (i.e., Ellis et al., 2010; Hodes, 2002b; Howard & Hodes, 2000; Michelson & Sclare, 2009; O'Shea, Hodes, Down, & Bramley, 2000) included children in the sample (i.e., younger than 12 years old). In three studies, participants were registered in an unaccompanied minors program and four studies used a clinical sample, that is, children and young people who attended a mental-health service/program.

The studies were all published between 2000 and 2010 and were mainly 'Western' countries – Norway ($n = 1$), the UK ($n = 4$), the Netherlands ($n = 1$), the USA ($n = 3$) and Australia ($n = 1$) – where refugees constitute a cultural and linguistic minority. The other was Gaza, where people of refugee background constitute the majority of the population.

Although the studies are small in number, they addressed several aspects of mental-health service utilization: from the kind of help sought by caregivers and/or the young person for mental health problems to pathways of referrals, typology of service received and drop-outs.

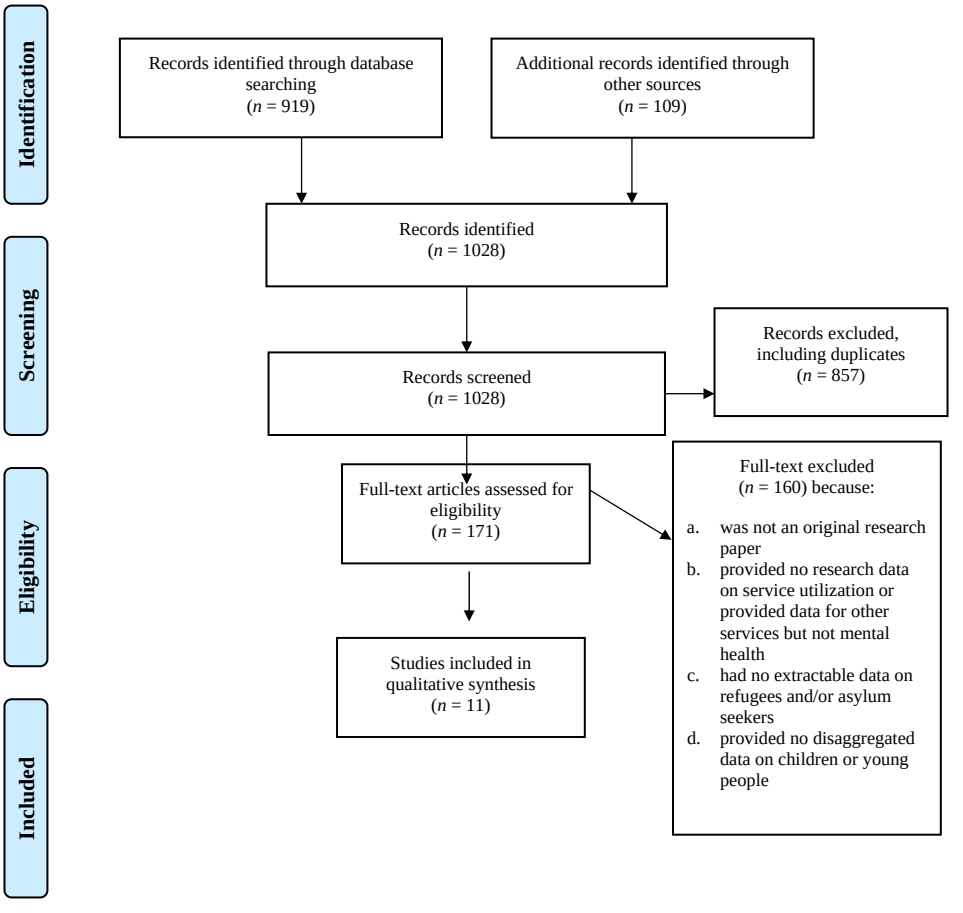

Figure 1. Selection flow diagram.

The key findings from these studies have been summarized in Table 1 and are discussed in the following section.

Discussion

The following section discusses the papers reviewed, divided by main topics of investigation, and presents an overview of non-youth-specific research on access to and utilization of mental-health services.

Utilization of mental-health services and unmet needs

Although research is sparse, the studies provide some evidence that children and young refugees underutilize mental-health services and that the need for mental-health care in this population is unmet (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006; Ellis et al., 2010). Vaage, Garlov, Hauff and Thomsen (2007) found no difference in level of service utilization among refugee and Norwegian-born children. The authors observed, however, that they expected more referrals from the

Table 1. Summary of findings.

Author(s), year	Sample(s)	Measures	Main findings
Bean et al. (2006)	Representative sample of 920 unaccompanied refugee minors (URM) residing in the Netherlands, their legal guardian and a teacher vs. control group of 1059 peers attending secondary and trade Dutch schools.	Adolescents: • Hopkins Symptom Checklist-37 for Adolescents (HSCL-37A) • Stressful Life Events (SLE) • Reactions of Adolescents to Traumatic Stress (RATS) • Mental Health Questionnaire for Adolescents Guardians: • Child Behavioural Checklist (CBCL); • Mental Health Questionnaire for Guardians. Teachers: • Teacher's Report Form (TRF); • -Mental Health Questionnaire for Teachers.	• 57.8% of the URM reported mental health care (MHC) need compared to 8.2% of Dutch adolescents. 18.1% of the guardians of the URM and 29.8% of their teachers reported a need for professional MHC for the URM in their care. • 11.7% of URM had been referred to MHC services by guardians. The variable with the highest odd ratio for referral by guardians was CBCL internalizing scores (AOR = 5.8, CI: 2.8–11.8, $p < .01$), i.e. guardians were more likely to refer URM when they considered their emotional distress to be elevated. • 12.7% of the URM had used a type of professional MHC compared to 16.1% of Dutch adolescents but 48.7% of the URM sample reported having an unmet MHC need compared to only 4.5% of the Dutch sample. • Reporting to have experienced 7 or more SLE's was the most robust predictor both of Self-perceived need (AOR = 1.8, CI: 1.2–2.6, $p < .001$) and Unmet need (AOR = 1.7, CI: 1.2–2.3, $p < .001$).

Table 1 (*Continued*)

Author(s), year	Sample(s)	Measures	Main findings
de Anstiss & Ziaian (2010)	A convenience and snowball sample of 85 refugee adolescents (aged 13–17 yrs) from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia and Sudan settled in South Australia	Semi-structured focus group discussions.	• Adolescents were much more likely to seek help for their psychosocial problems from their friends than from any other source due to a range of individual, cultural and service-related barriers. • Very few adolescents identified parents as a potential source of help, and even fewer identified mental health services.
Ellis et al. (2010)	• 114 Somali refugees between 11 and 20 years old enrolled through community agencies in US and their primary caregivers. • A subset of 14 adolescents participated also in semi-structured in-depth interviews and a subset of 23 in focus groups.	Adolescents: • Responses to Stress Questionnaire; • UCLA PTSD (Post Traumatic Stress Disorder) Index; • Depression Self-Rating Scale Parents/caregivers: • Modified version of Services Assessment for Children and Adolescents (SACA)	• The overall prevalence of formal help-seeking by parents for adolescents' emotional or behaviour problem was 6.7%. For parents of adolescents 'in need' (i.e. who scored above cut-off score for diagnosis of Depression or PTSD) this was 7.7%. • Overall 1.5% of total adolescents and 7.7% of those in need reported having sought formal help related to stress. • Both adolescents and their caregivers accessed more frequently other sources of help, such as religious, school personnel, community, family and friends. • Two primary, interrelated pathways of identifying and seeking help for mental health problems were described by Somali youth: one involved the community and the second the adolescents themselves. Several family, community and individual issues were reported as impacting upon this process.

Table 1 (*Continued*)

Author(s), year	Sample(s)	Measures	Main findings
Geltman et al., (2008)	304 Sudanese affiliated with the US URM Program who arrived in US between 2000 and 2001.	• Harvard Trauma Questionnaire (HTQ) • Child Health Questionnaire (CHQ) • Health services questionnaire (based on Health Care Access and Utilization section of the National Health Interview Survey, NHIS)	• Sudanese reported high rates of counselling (46%) but the majority (76%) reported seeking medical care for symptoms and complaints often associated with behavioural and emotional problems. • Sudanese with PTSD were no more likely to report having seen a counsellor than those without PTSD but were over twice as likely to have reported seeing any health professional for a behavioural or emotional problem (OR = 2.3, CI: 1.19–4.37).
Halcon et al., (2004)	Subset of participants ($n = 338$) 18–25-year-olds from a population-based survey of Somali and Oromo refugees conducted in 2000–2002 in Minnesota (US).	• Structured survey (RPS-1) consisting of 188 questions on trauma history, life situation and scales for physical, psychological and social problems • PTSD Checklist, Civilian version (PCL-C).	See 'doctor' and take medicine was indicated by a minority of participants (1.5% and 0.6%, respectively) as strategies to combat 'sadness'. The most frequent were praying (55.3%), sleeping (39.9%), reading (32.3%) and talking to friends (27.8%) while 3% chose 'Other'.
Hodes (2002b)	30 refugee children referred to a school-based mental health service in London, their teacher and family over a 4-year period.	Not fully specified in this article but this study is an extension of O'Shea et al. (2000, see below).	• Over a 4-year period, 30 children were referred to the service. 19 were offered family treatment sessions and 11-group intervention; 3 did not engage, 3 dropped out, 6 negotiated discharge without full recovery, 4 required referral to specialist child mental health services and 14 were considered recovered at discharge. • 15 of the children, the caregiver was regarded as having a mental health problem but only 2 were receiving some kind of psychiatric help.

Table 1 (*Continued*)

Author(s), year	Sample(s)	Measures	Main findings
Howard & Hodes (2000)	30 refugee children and family, individually matched with 30 non refugee immigrant families and white British families who attended a department of Child and Adolescent Psychiatry in London in 1996–1997.	• Case notes from psychiatric interviews; • Children's global Assessment Scale (CGAS); • Espino's rating scales for assessment of exposure to violence.	• Refugees were more likely than controls to be referred by a non-medical source (e.g. school, social worker), ($\chi = 8.75$, $p = .01$) and were more likely to require an interpreter at the first appointment than immigrants ($\chi = 4.8$, $p = .03$). • There were no differences between groups in the proportion receiving assessment, kind of treatment or premature drop out (the proportion of each group being approx. one third).
Michelson & Sclare (2009)	49 unaccompanied minors (UAMs) and 29 accompanied minors who attended the Young Refugee Mental Health Project (UK) in 2002–2004.	Data from clinical database on socio-demographic characteristics, service use, psychological symptoms, psychosocial risk factors, and service provision.	• Significant differences in referral pathways, with UAM more likely to be referred from social agencies (58 versus 4%) and accompanied children more likely to be referred from GPs (7 versus 26%, $\chi = 21.24$, $p < .001$) and other health care providers. • UAM had higher rate of missed appointments at the clinic, failing to attend one in three scheduled sessions (33 versus 17% of accompanied minors, $t = -2.78$, $p < .01$). UAM also attended fewer total sessions during the course of treatment ($M = 8.47$ versus 15.17, $t = 3.03$, $p < .01$).

Table 1 (*Continued*)

Author(s), year	Sample(s)	Measures	Main findings
			• Despite having experienced more traumatic events (3.20 versus 1.83, $p < 01$) and manifesting higher rates of PTSD (85 versus 66%, $p < .05$), UAM did not receive more trauma-focused therapy. They were also less likely to receive cognitive therapy (19 versus 41%, $p < .05$), anxiety management (34 versus 62%, $p < .05$) and parent/carer training (16 versus 71%, $p < .001$) as well as less stabilization work addressing one or more basic social needs (p between $< .01$ and < 05).
O'Shea et al. (2000)	14 junior school pupils (7–11 years old) referred to a school-based mental health service in London, their teacher and family over a 2-year period.	Teachers: • Teacher proforma; • Strenght and difficulties questionnaire (SDQ). • Children and family: • Clinical interview.	• Of 90 refugee children within the school, 14 received referral to the service. • Of the 12 for whom complete data were available, the service was not taken up in two cases, two dropped out prematurely due to change of accommodation and in other two cases the parent disengaged after significant amount of treatment. • The mean number of appointments attended per child was 5.5 (*SD* 3.39, range 0–11).

Table 1 (*Continued*)

Author(s), year	Sample(s)	Measures	Main findings
Thabet et al. (2006)	249 randomly selected Palestinian families with children aged under 16 years living in a refugee camp in Gaza.	• Checklist exploring mother's perceptions of child mental health problems and services.	• 42.6% had knowledge of local child mental health services and 92.7% stated the need for such services. • 70% stated they would take the child to a primary care centre if concerned about any mental health problem listed in the checklist, 63.2% to a psychologist or psychiatrist, 52.4% a social worker and 4% for traditional Arab treatment. • Their preferred treatment was 'talking therapy' (psychotherapy, 84.7%), followed by medication (63.1%), reciting the Quraan (61%) and a traditional treatment (15.3%).
Vaage et al. (2007)	All ($n = 61$) refugee children who were referred to a Child Psychiatry Department in Norway during the period 1996–2000 matched with 61 Norwegian-born children admitted during the same period.	• Information on referral source, diagnoses and treatment as reported in the clinical case notes.	• The rates of referral or level of service utilization were proportional to the population (no statistically significant difference between samples). • Overall differences in referral rates among services, with significantly more Norwegian children referred from medical services, primary health care, child rehabilitation centre and paediatric department (65.6 versus 41%, $p = .005$).

Table 1 (*Continued*)

Author(s), year	Sample(s)	Measures	Main findings
			• The two groups did not differ in reasons for referral but more refugee children were diagnosed with psychosocial disorders ($p = 01$) and PTSD ($p = .03$). • Nevertheless, both groups made a similar use of service (in terms of numbers treated as in/outpatients, number of consultations and total consultation time).

refugee population, thus this study also suggests underutilization of services. Three of the studies (i.e., O'Shea et al. [2000], its follow-up paper by Hodes [2002b] and the work by Geltman, Grant-Knight, Ellis and Landgraf [2008]), at a first glance, seem to contradict the evidence for underutilization of services (although these were studies on clinical groups rather than population-study). The former showed an initial attendance rate of 12 out of 14 families referred to a school-based service over two years. However, of the 12 initially engaged, data was not completed for one family, three discontinued the service and the average number of appointments was 5.5 per child (with a range between 0 and 11 sessions), making the finding difficult to interpret (also because of the absence of comparison with another cohort or control group or a baseline measurement). Hodes (2002b) reported some additional data over a four-year period, with 14 out of the 30 children referred to the service considered recovered at discharge. Geltman, Grant-Knight, Ellis and Landgraf (2008) reported quite high levels of use of mental health counselling services with approximately half of the (non-clinical) sample accessing such services. However, as observed by the authors, this finding likely represents the efforts of the program the participants were engaged in to provide group psychosocial supports typically not available to most other refugees. The study also showed that Sudanese refugees with emotional or behavioural problems, including those with diagnosis of PTSD, sought and received care from non-mental health professionals such as primary-care physicians, emergency physicians and school nurses more than from mental health professionals. This finding may suggest, in spite of the efforts of the foster-care program, an overall lack of successful identification and treatment of young refugees in need of mental-health care. Also the studies by Ellis et al. (2010), de Anstiss and Ziaian (2010) and Halcon et al. (2004) indicated that young refugees might be more likely to access other sources of help such as friends, religious and school personnel. Although data is limited, it is worth noting that prayer was preferred as type of help over formal help both by parents (Ellis et al., 2010) and the young people (Ellis et al., 2010; Halcon et al., 2004). It might be interesting, on the other hand, to know that some of the young people in the study by Ellis et al. (2010) suggested that the younger generation of Somali refugees was more open to the idea of mental-health services compared to the older generation. This greater acceptability of services was also observed in an American study of second-generation Cambodians (Daley, 2005).

Two studies carried out in Australia (which were not included in the review because they were still unpublished at time of preparation of this manuscript) ratify the low rates of service utilization in children and adolescents of refugee background with depressive symptoms or emotional and behavioural problems (Ziaian, de Anstiss, Antoniou, Sawyer, & Baghurst, 2011; Ziaian, de Anstiss, Sawyer, Baghurst, & Antoniou, 2011).

This result is confirmed by the widespread underutilization of mental-health services consistently reported in several ethnic minority populations (see de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009). The literature review by Gulliver, Griffiths and Christensen (2010) found that between 18 and 34% of young people with high levels of anxiety or depression seek professional help, indicating an underutilization of services among youths in general, although the small research available on refugees collected in the current review shows even lower rates in this population.

Referrals and pathways to care

Several scholars have observed that child and young refugee's access to mental-health services is determined by key 'gateway providers' who influence decisions related to help-seeking as well as knowledge (or absence of it) of available services (see Ellis et al., 2010; Gulliver et al., 2010). The importance of key individuals and community in service utilization is confirmed by the studies reviewed. In particular, Ellis et al. (2010) observed that family, religious leaders, friends and schools, apart from being providers of help, are also identified as gateways to help. Bean et al. (2006) even showed that referrals to mental-health-care services do not appear to be driven by the reported needs of the young person, but by the need and emotional distress as observed and perceived by their guardians. The study by Vaage et al. (2007) indicated different pathways to care between refugees/migrants and children born in the country of resettlement[4] and that by Howard and Hodes (2000) between migrant and refugee children. However, Michelson and Sclare (2009) highlighted differences in referrals also within the refugee population: unaccompanied minors were more likely to be referred by social agencies, whereas accompanied children were generally referred by General Practitioners (GPs) and other health-care providers.

Pathways to care, including preferences and obstacles in accessing services located within or outside other systems, such as schools (see Ellis et al., 2010; Hodes, 2002b; O'Shea et al., 2000), among children and young people of refugee background are poorly understood. More research supporting provider partnership pathways (Ellis et al., 2010) as well as research showing what makes such partnerships successful or unsuccessful is required. This is even more important for young refugees who are psychiatrically admitted. A high level of cooperation between agencies, especially mental-health and social services, is frequently required to meet the complex needs of this group as observed by Hodes and Tolmac (2005).

Parents' perception of services

The only study of parents' perceptions of services was that by Thabet et al. (2006), which investigated perceptions of child mental-health problems and services among Palestinian mothers living in refugee camps in Gaza. Almost half of the parents had knowledge of child mental-health-care services and, overall, preferred Western over traditional types of treatments. The authors suggest that this unexpected finding may be explained by the participants' educational status as well as the presence in the locality under investigation of a community mental-health centre. It is likely that the proportion of mothers aware of such services would be lower in other areas of Gaza without such a service. Nevertheless, even mothers who were not aware of the local service acknowledged the need for such provision. Similar work to establish parents' views and expectations of child/youth mental health services is needed in non-Western as well as Western countries. As indicated by the authors of the study, this is one of the factors that should be considered in setting priorities and rationalizing service resources.

Barriers and facilitators

A selection of studies presented so far (in particular the work by Ellis et al. [2010]) presented some data relevant in regard to this topic, however only one article (de

Anstiss & Ziaian, 2010) explicitly looked at service-related barriers. The barriers noted in the study included 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.

Engagement

We located only five articles that looked at what happens once children and young refugees do access services, and two of them (Hodes, 2002b; O'Shea et al., 2000) were part of the same study. One of studies (Howard & Hodes, 2000) showed that refugee children were more likely to require an interpreter at the first appointment than immigrants and that approximately a third of both samples discontinued the service prematurely. There is some evidence, however, that drop-out rates might be different within the refugee population. For instance, Michelson and Sclare (2009) found that unaccompanied minors had higher rate of missed appointments at the clinic and attended fewer total sessions.

The study by O'Shea et al. (2000) did not provide data on engagement but the authors stated that families once involved in the treatment remained engaged, even after transfer to the Child and Adolescent Mental Health Services venue. In a follow-up paper, Hodes (2002b) reported that 19 children were offered family treatment sessions and 11 group intervention and that 4 out of the 30 children referred to the service required referral to specialist child mental-health services. The study by Vaage et al. (2007) showed that refugee and Norwegian-born children made a similar use of services. The authors were surprised by this finding and speculated that the seeming lack of differentiation between the groups might reflect a shortcoming in recognizing the unique needs of refugee children. The possibility of services not being responsive to specific needs may be partially confirmed by the finding, in the study by Michelson and Sclare (2009), that unaccompanied minors, despite having experienced more traumatic events and manifested higher rates of PTSD, did not receive more trauma-focused therapy compared to accompanied minors and were also less likely to receive cognitive therapy, anxiety management and parent/carer training as well as less stabilization work addressing basic social needs.

A recent paper by Ellis, Miller, Baldwin and Abdi (2011) reports some promising preliminary findings (and therefore was not included in this review) on a mental-health intervention program for Somali youth that addresses barriers to engagement, which is likely to contribute to increased knowledge on this important topic.

Summary of the systematic literature review on children and young refugees

It is clear from the present systematic review that there is paucity of research on mental-health service utilization, including barriers and facilitators to access. The scarcity of studies has been criticized by a number of scholars included in this review (e.g. Bean et al., 2006; Hodes, 2002a; Michelson & Sclare, 2009) and is confirmed by two recent publications: de Anstiss and Ziaian (2010), who identified only two studies on refugee adolescent mental-health services utilization, and Gulliver et al., (2010), who found a total of 22 studies on perceived barriers and facilitators to mental-health help-seeking among adolescents or young adults. The systematic review by Gulliver et al. did not indicate how many of the already

small number of studies reviewed were on migrant and/or refugee populations and did not present data specifically for this group. The subject of service utilization is identified as a high priority in a recently developed research agenda by the authors of this review (see Colucci, Minas et al., 2011).

The next section will provide an overview of the literature about adults or not-youth-specific refugees providing, where possible, comparison with the findings observed among children/young people of refugee background.

Overview of research on adultlgeneral refugee population

As indicated earlier, while searching databases to identity papers relevant to this literature review, no age restriction was used in order to decrease the possibility of missing papers that were not specifically on children and/or youth but that still contained data on this population. Although the general literature was not the aim of this review, and it is therefore possible that a few additional papers on this broader topic might have not been retrieved, it appears that research on mental-health service utilization is scarce not just on children/youth but among the overall refugee population. We identified only 37 research papers, in addition to the 11 with specific data on children/young refugees, on this topic. This is a very limited number if we consider that the literature was searched worldwide and since time of inception of databases.

Utilization of mental-health services and unmet needs

The literature on adults and refugees in general also commonly reports the presence of unmet needs and underutilization of mental-health services (Bhui, Audini, Singh, Duffett, & Bhugra, 2006; Correa-Velez, Barnett, Gifford, & Sackey, 2011; Gerritsen et al., 2006; Hauff & Vaglum, 1997; McColl & Johnson, 2006; McCrone et al., 2005; Nguyen, 1984; Pham, 1986; Silove, Steel, Bauman, Chey, & McFarlane, 2007; Steel, Silove, Chey, Bauman, & Phan, 2005; Sypek, Clugston, & Phillips, 2008; Weine et al., 2000) and a significant number of people who discontinue attending services (Jamil et al., 2002). The study by Blair (2001) provided the concerning result that subjects most in need of mental-health treatment, such as those with diagnosis of PTSD, were those experiencing the most difficulty in accessing treatment. This is reminiscent of the findings that a lower variety of therapies were offered to unaccompanied minors, who manifested higher rates of PTSD, reported by Michelson and Sclare (2009).

The only research providing a finding in the opposite direction is by Marshall et al. (2006), who showed that Cambodian refugees with mental-health problems had high rates of mental-health care. However, the authors observed that this could in fact consist of non-professional care, thus the finding is inconclusive. Moreno, Piwowarczyk, LaMorte and Grodin (2006) reported that more than half of the patients offered psychological counselling by a torture rehabilitation centre accepted it, which they attributed to a strong-supportive role, heightened awareness of culture-related complaints and the practice in their centre for the primary-care provider to attend with the patient the first session. Toar, O'Brien and Fahey (2009) compared healthcare utilization between asylum seekers and refugees and found no difference in the use of mental-health services, whereas Gerritsen and colleagues (2006) and Portes, Kyle and Eaton (1992) found differences in self-reported use of mental-health services among refugees from different ethnic groups. We were unable to find any

study that compared asylum seekers and refugees or refugees from different ethnic background in the children/youth population.

Savin, Seymour, Littleford, Bettridge and Giese (2005) found that the 37% of the screened refugees who were offered mental-health referrals and followed-up were experiencing a higher level of suffering and symptoms compared to those who did not present for treatment. Although no similar study was identified for children/young refugees, as indicated previously the initiative to seek services was driven by the need and emotional distress as perceived by guardians rather than the reported needs of the young person in the study by Bean and colleagues (2006). This finding highlights that some factors that influence access to mental-health services are specific for children and young people and must be taken into consideration when working with these populations.

The study by Guerin, Abdi and Geurin (2003) showed a similar use of GPs and mental-health specialists for mental-health problems among Somali refugees, whereas a larger use of medical care was indicated among Sudanese unaccompanied minors in the study by Geltman and colleagues (2008). The study by Sypek et al. (2008), although not addressing specifically this topic, suggested that lack of access to appropriate mental-health services might be amplified among refugees living in rural areas. Drummond, Mizan, Brocx and Wright (2011) showed that although women of West African refugee background reported that they were as likely as other Australian women to approach a psychologist/counsellor for help with ongoing stress, the former were more likely to also seek help from members of their local community (religious leaders, traditional healers and elders). No study on children and young refugees compared use of services based on resettlement in rural versus urban areas, nor looked specifically at males and females.

Referrals, pathways to care and perception of services

Other topics addressed by the literature were satisfaction with mental-health services (Silove et al., 1997; Vandiver, Jordan, Keopraseuth, & Yu, 1995), pathways to care/referrals (Leavey, Guvenir, Haase-Casanovas, & Dein, 2007; Petric, 2001) and intervention models to improve access (Harris & Maxwell, 2000; Mucic, 2010; Roch, Pons, Squire, Anthoine-Milhomme, & Colliou, 2010; Weine et al., 2008). A few studies on pathways to care and models to improve access were also identified in the children/youth literature, although in this population guardians/parents and schools play a major role.

Barriers and facilitators

Although factors that influence the use of mental-health services among people of refugee background are scarcely understood, there is somewhat more research regarding barriers and facilitators to such use in the general literature than on children/youth. (i.e., Behnia, 2003; Blair, 2001; Drummond, et al., 2011; Guerin, Guerin, Diiriye, & Yates, 2004; McColl & Johnson, 2006; Misra, Connolly, & Majeed, 2006; Nguyen, 1984; Palmer, 2006; Pham, 1986; Vandiver et al., 1995; Warfa et al., 2006; Watters & Ingleby, 2004; Weine et al., 2000). Nevertheless, it must be noted that, in several of these studies, barriers and facilitators to accessing services were just one of the topics investigated or were the result of observations and speculations of the authors, rather than being directly researched.

Some of the barriers and facilitators highlighted in the non-youth-specific literature are similar to those identified by the only article currently available on young refugees (de Anstiss & Ziaian, 2010). The low priority placed on mental health by these participants also appeared an important factor in the former body of literature, which highlighted the need for practical solutions to social, legal and economic difficulties and hierarchy of such needs compared to health. De Anstiss and Ziaian (2010) observed that some of the participants in their study attributed mental-health problems to social rather than psychological aetiologies and to supernatural causes rather than psychopathology. Cultural explanations of mental illness and unfamiliarity (or incongruence) with the mental-health concept of the host country, and cultural mis-match in diagnosis, aetiology and treatment (including somatization of mental-health problems and use of traditional/spiritual healing) were all observed in the non-youth-specific literature. Poor mental health literacy and lack of knowledge of services available, as well as stigma and misconception towards mental illness and services, were also observed in both bodies of literature. Distrust of mental-health services and professionals was a central theme among the adolescents studied by de Anstiss and Ziaian (2010) and was also a key factor in the non-youth specific literature, which also highlighted the fear among people of refugee background of losing their job if they used such services or of being judged by the professional. The belief that services have low cross-cultural awareness and competency was also an important factor in the youth- and non-youth-specific literature. One of the findings from the study by de Anstiss and Ziaian (2010) was that the whole concept of seeking help for a personal-emotional problem from an unknown professional 'did not make sense' to many of the adolescent refugees they interviewed. A similar lack of understanding of benefits of 'talk therapies' and talking about problems with a stranger was observed in the body of non-youth-specific literature. The expectation that problems are kept inside the family was also present in both populations.

In addition to the factors indicated above, the non-youth-specific literature also indicated other factors that impacted on the uptake of mental-health services, such as heavy reliance on and use of GPs; inappropriate expectations placed on service providers; pessimism (e.g. thinking that no one could help); focus of professionals on past (trauma experience) rather than in the present and the future; lack of understanding and possible fear of Western bureaucratic processes and inability to negotiate the health-care system; partnership and collaboration between agencies and service providers and continuity of care (including difficulties arising by high geographical mobility); acknowledgment of family, religious and community ties and working in collaboration with family and community (including the role of 'brokers', 'advocates', 'mediators' and 'gatekeepers' in accessing services); self-concept not oriented to illness and/or help-seeking; and sense of personal control. Economic factors such as costs (e.g. travel), language difficulties and translation/interpreting issues, gender issues, including gender-match, and issues surroundings appointments (such as booking system, missing appointments, time schedule, waiting period, transport difficulties) were also indicated as barriers to accessing and engaging with mental-health services. Finally, the need for a holistic approach to health and an advocacy role was contrasted with staff's lack of experience, training and/or time in recognizing and managing the complex needs and problems with which refugees present (advocacy role).

Many of the issues raised in the youth- and non-youth-specific literature, as well as some additional factors, were also highlighted in our research with service

providers (Colucci, Szwarc, Minas, Paxton, & Guerra, 2011) and during a round-table discussion between young people of refugee background and service providers, representatives of government departments and academics (Centre for Multicultural Youth, 2011).

Future directions

The dearth of studies on refugees' mental health services utilization hampers the ability of policy makers and service providers to assess the responsiveness of services to needs (Chow, Jaffee, & Choi, 1999). Not only there is very little refugee-specific, let alone child-specific, research in the area of help-seeking and service utilization but, as also observed by de Anstiss et al. (2009), most studies focus on specialist mental-health services and neglect the full range of service sectors and settings where mental-health-care is provided. Research is needed to shed light on rates and prevalence of service use, pathways to referrals and factors that act as barriers or facilitators to accessing and engaging with services.

Because of the overall scarcity of research available on barriers and facilitators to mental-health services among refugees, individuals and organizations who are trying to access this sort of information are left to resort to non-mental-health-specific (e.g., Cooke, Murray, Rice, Mulholland, & Skull, 2004; Omeri, Lennings, & Raymond, 2006; Sheikh-Mohammed, Macintyre, Wood, Leask, & Isaacs, 2006) and/or non-research-based literature (e.g., Woodland, Burgner, Paxton, & Zwi, 2010). Most barriers described in the available literature are plausible explanations for the underutilization of services but have not been formally researched or systematically reviewed (as criticized by Ellis et al., [2011]), even more so for barriers affecting refugee children and young people (de Anstiss et al., 2009). We have carried out a study addressing this essential but neglected area of research (Colucci, Szwarc et al., 2011). Similarly, literature on empirically-tested interventions developed for refugee youths is sparse (Hodes, 2002b; Lustig et al., 2004) and more needs to be done to understand the effectiveness of mental-health services for children and young refugees.

It is also important noting that although scholars have highlighted the importance of gender and gender roles in accessing health services (O'Mahony & Donnelly, 2010), the studies reviewed have generally overlooked these factors. Research is urged to shed light on how gender and gender roles might impact on mental-health service utilization among refugees.

Finally, although there is overall consensus that psychological problems are significantly more common in refugees than comparison groups, it must not be forgotten that the majority of child and adolescent refugees are able to cope well despite repeated and prolonged exposure to adverse events before, during and after migration (Beiser, 2009; Michelson & Sclare, 2009) and, paraphrasing Beiser (2009), do not become 'mental health casualties'. Thus, just as it is important to understand factors that might improve mental-health service utilization among this population, it is also important to understand which factors contribute to their resilience. This information would be useful also to design effective mental-health promotion programs and prevention strategies, as well as clarify whether low levels of use reflect identified and unidentified barriers to services utilization or rather reduced levels of need (as hypothesized, for instance, by Correa-Velez, Sundararajan, Brown, & Gifford 2007; Steel et al., 2005; Weine et al., 2000), or a combination of both factors.

Conclusion

This systematic literature review has been prepared with the goal of stimulating academics, policy makers and service providers to undertake and commission rigorous research to identify patterns and rates of mental-health service utilization and recognize and reduce the barriers to providing effective mental-health services to children and young people of refugee background.

The review identified only 11 studies on mental-health service utilization for children and young people of refugee background. Although more than 1000 manuscripts were browsed in the first phase of this literature search, it is possible that the search strategy may have not captured all of the relevant articles and it is also likely that more data on the topic is available in the grey and unpublished literature. Nevertheless, other scholars have also noted that the topic of mental-health services utilization, including barriers/facilitator to their access, is a seriously neglected area of investigation. This situation is puzzling, given the importance of the issues. Countries of resettlement, such as Australia, have introduced a variety of policies and programs for refugee children and young people but have very little robust evidence to guide these efforts (de Anstiss et al., 2009). Rectifying this situation is well overdue and should be a matter of priority.

Notes

1. For brevity, the terms 'people of refugee background' and 'refugees' will be used interchangeably throughout the article.
2. Because of the scarcity of relevant literature, we included manuscripts that were not looking specifically at the topic of mental health service utilization but reported some data on this topic.
3. An exception was made for Vaage et al. (2007) where the authors indicated that all or the great part of the sample consisted of refugees.
4. Countries of resettlement consider for permanent residence individuals and families living in countries where they have sought protection, after selection and referral by UNHCR. The status they provide ensures protection against *refoulement* and provides a resettled refugee and his/her family or dependents with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals (UNHCR, 2011).

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