their place in a new environment (Bashir, 1993). Resolution of identity issues is an important aspect of mental health because of the relationship between the achievement of a satisfying identity and psychological functioning, development of self-concept, self-esteem and adjustment (Phinney, Lochner & Murphey, 1990). Literature on resilience suggests that a positive self-concept, a well-established feeling of self (Rutter, 1987), a sense of caring and connectedness (Resnick et al., 1993), and self-understanding (Beardslee & Podorefsky, 1988) may be protective factors in dealing with life challenges.

Phinney, Lochner and Murphey’s thesis is that ‘a commitment to an ethnic identity is an important component of the self-concept of minority youth and a factor that mediates the relation between minority status and adjustment’ (Phinney et al., 1990, p. 54). A number of authors have emphasised the role of ethnicity in identity development for immigrant young people (Phinney et al., 1990; Klimidis & Minas, 1995; Bashir, 1993; Lau, 1990). Ethnic identity is a dynamic process, changing in its intensity, importance and evaluation depending on the context (Rosenthal & Cichello, 1986). The family is an important context in the development of ethnic identity and the way it is valued (Rosenthal & Cichello, 1986). Several modes of coping with ethnic identity conflicts have been identified by Phinney et al. (1990). First, there is alienation/marginalisation: individuals accept the negative self-image presented by society, become alienated from their own culture, and do not adapt to the majority culture. Secondly we have assimilation: individuals attempt to become part of the dominant culture and do not maintain their ties with their ethnic culture. The third mode is withdrawal or separation: individuals emphasise their ethnic culture and withdraw from contact with the dominant group. The fourth involves integration/biculturalism: individuals retain their ethnic culture and adapt to the dominant culture by learning the necessary skills.

Rosenthal and Cichello (1986) found in a study of Italian young people that ‘Italian’ identity was less a predictor of social adjustment than perceived parental embeddedness in the ethnic community. This highlights the issue of the context in which ethnic identity is developed and the importance of the family in how identity issues are resolved. Kahn and Fua (1995) suggest that while young people who are caught between two cultures may be vulnerable, it is perhaps the young people whose parents are confused and unsure about ethnic identity who may be most vulnerable.

Goodenow and Espin (1993) suggest that for an adolescent immigrant the special problems in development of identity arise because they are carrying out developmental tasks in the context of a new culture and in the absence of the home culture’s ‘average, expectable environment’ (Goodenow & Espin, 1993, p. 174). The theme of the ‘expectable’ environment is also highlighted by Fabrier (1987) in the context of Australian high schools, where she discusses the lack of reinforcement for young people as the known social environment changes and the
McDermott summarises some of the stressors of identity development for young people who have migrated or do not share social norms developed by the dominant society.

Stress on the developing personality is directly proportional to the distance between the two cultural groups and to the degree of insistence on change. The highest stress is seen in those groups who have been uprooted and geographically transplanted to another culture and have lost traditional social supports ... Differences between conflicting values of the two cultures then become highlighted: group versus individual, extended versus nuclear family, interdependence versus independence, conformity versus competition, past versus future orientation, emphasis on age versus youth, harmony with nature versus conquest of nature, fatalism versus mastery of one's own fate, patience and modesty versus aggression and assertion, suppression versus expression of emotion (McDermott, 1991, p. 410).

Identity development in immigrant young people is also closely related to the process of acculturation. Goodenow and Espin (1993) suggest that for young people who are immigrants, the task of constructing an identity requires 'a realistic appraisal of both the new culture and the one left behind, the selective adoption of aspects of both cultures and, in many instances, an adequate mourning for what has been lost' (Goodenow & Espin, 1993, p. 176). Just as the experience of acculturation is experienced differently by different members of families and as a result of pre-migration, migration and post-migration factors, identity development also relates to how a young person adapts to their new social world. For example, Goodenow and Espin (1993) suggest that a too-rapid acculturation process — that is, one that rejects traditional cultural values and mores and adopts the values and artefacts of the new society — may result in the development of a 'false self', in which key aspects of personal history and background are disowned.

The question of differential levels of cultural affiliation between young people and their families, as an issue in relation to the development of identity for young people of NESB, has been raised by a number of authors both in research and in clinical reflection (for example, Bashir, 1993; Klimidis & Minas, 1995; Lau, 1990; Timimi, 1996). The key issues that emerge in relation to identity development include: the impact of negative attitudes towards the culture of origin and the corresponding impact on the development of a positive self-identity (Vasta, 1995; Phinney et al., 1990); the development of a generation gap between young people and their parents that affects communication and family functioning (Klimidis & Minas, 1995; Fabrier, 1987); young people assuming roles that were previously undertaken by their parents as their language and social skills develop more rapidly in the new country (Fabrier, 1987; Bashir, 1993); and differences between young
people and their parents in their affiliation to cultural values as young people become more affiliated to the values of the dominant culture (Klimidis, Minas & Ata, 1993).

**Experience in the broader community**

Some of the areas of the broader community identified in the literature that exert an impact on mental health and wellbeing of young people and their families include the provision of appropriate services (Morrissey et al., 1991) and social supports (Beiser et al., 1988), racism and discrimination, socioeconomic status, and the availability of employment, education and training opportunities.

The presence, or otherwise, of appropriate settlement, health and welfare services can affect how the transition to the new environment is made (Morrissey et al., 1991). It has been suggested that if young people and their families are not appropriately supported and reinforced in the new society, young people may suffer emotional or other related disorders later in life (Beiser et al., 1988). Fabrier (1987) highlights the key role of the responses of schools and other agencies to the needs of newly arrived migrant students.

The issue of racism and discrimination and its impact on young people particularly has been raised in the literature. Racism, lack of cultural understanding, and labelling of young people on the basis of colour or race may be contributors to low self-esteem and lack of adjustment in some immigrant young people (Beiser et al., 1988).

Racism and discrimination based on ethnicity or colour has been highlighted as a major issue for young people in Australia. A number of communities of NESB, particularly young people, have reported their experience of racism (Doan, 1995; Lyons, 1995).

Young people of NESB have noted racism, particularly in public spaces and in the relationship between themselves and the police (Lyons, 1995). For example, Indo-Chinese young people in Cabramatta in New South Wales have made a number of allegations about how they were treated by the police including:

- strip searches of men in public areas;
- strip searches of young women at the police station in the presence of male police officers;
- failure of police to return young people’s money or personal possessions after release;
- bashing of youth by police;
- racist verbal abuse;
- moving on, without reason, groups of young people (four or five) meeting or talking in public areas; and
- questioning without interpreters and adults present (Doan, 1995, p. 160).

A report into contact between young people and the police supports some of these allegations. This report found that NESB young people were more likely to be
searched by police, arrested by police and more likely to be injured in their contact with police than young people who described themselves as being of Australian cultural background (Maher, Dixon, Swift & Nguyen, 1997).

Stereotyping of ethnic communities is clearly related to how the police and other agencies approach providing services to young people of NESB. Cuneen suggests that ‘strong associations have been built up which stereotypically cast youth, ethnicity and crime together’ (Cuneen, 1995, p. 116). These associations have been given further credence in the community by media reporting that stereotypes young people, particularly young people of NESB, as being violent or dangerous and belonging to gangs (Cuneen, 1995).

Vasta argues that in Australia, despite the development of a ‘multicultural ambience’, young people from ethnic minorities have not achieved the same occupational status as their Anglo–Australian peers and many migrant students have been disadvantaged by their location in poorer, less resourced areas (Vasta, 1995, p. 63).

It is, however, important to note that low socioeconomic status of an ethnic community at one point in their migration history has the potential to change (Inglis, Elley & Manderson, 1992). In their study of educational attainment and the social and economic mobility of Turkish–Australian young people, Inglis, Elley and Manderson (1992) suggest that beliefs about disadvantage are often linked to prejudice: for example, the labelling of a community as one which uses an excessive proportion of welfare assistance.

Access to health services by people of NESB is another issue affecting the mental health of young people of NESB. A report on the impact of environment and income on health found that a range of barriers exist for people of NESB in achieving equitable health status with other members of the community (National Health Strategy, 1992). The problems identified in the report included the failure to address the lack of responsiveness of the system to people of NESB, cultural inappropriateness in how some health services are delivered, inadequacies in language services, and lack of attention to health promotion and illness prevention (National Health Strategy, 1992).

People of NESB have different patterns of mental health service utilisation compared to other people in New South Wales, suggesting issues in how services are provided and the care people of NESB receive within mental health services. A major study of mental health service utilisation among immigrants from NESB countries residing in New South Wales found that they have lower rates of hospitalisation for mental disorders than Australian-born residents (McDonald & Steel, 1997). This is consistent with earlier findings (McDonald, 1991; Ridout & Filis, 1992). The study also found that a much higher proportion of NESB psychiatric inpatients are involuntary (McDonald & Steel, 1997). While NESB immigrants have lowered rates of involuntary hospitalisation compared with the
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State average, the reduction is not as great for voluntary admissions. Thus the low rate of hospitalisation is primarily due to the exceptionally low rate of voluntary service use. NESB immigrants have also been found to have low rates of utilisation of community-based mental health services (McDonald & Steel, 1997).

Access and usage of health services continues to be a major issue for communities of NESB. For young people, there are implications in relation to how they may be able to access services when they need them, and to their family’s experience of accessing and using services.

Young people’s experience of the broader community provides the framework for how they respond to and negotiate their lives. The impact of the broader community, then, can be seen in how young people are treated by the community, their response to other members of the community, and in how they view themselves.

Young People from a Refugee Background and Mental Health

The literature addressing mental health issues for young people from refugee backgrounds encompasses longitudinal research into psychiatric and psychological issues, research with young people newly arrived in their country of resettlement, research with young people still living in countries of war and turmoil or living in refugee camps, clinical reflection based on long-term work with young people and their families, and reports of specific interventions with groups of young refugees. Research and other literature tends to focus on refugees by language or regional groupings. Much of the research on psychiatric and psychological issues has been conducted with clinical samples. The literature on the experience of young people has been conducted mostly with young people from Indo–China (Cambodia, Laos and Vietnam) and mostly in the USA. Information about the experiences of young people from other regions is beginning to emerge, for example in the former Yugoslavia (Weine, Becker, McGlashan, Vojvoda, Hartman & Robbins, 1995) and Afghanistan (Mghir, Freed, Raskin & Katon, 1995).

Literature on the experience of young people who have been refugees reflects the major movements and resettlements of peoples to major countries of asylum through the 1970s and 1980s, including the USA, Canada and Australia. Research tends to reflect the experience of ethnic groups who have arrived in those countries in the greatest numbers.

Some of the key issues raised in the literature include the psychiatric and psychological effect of refugee experiences, the impact of being a refugee on young people’s development and functioning, and the impact of the refugee experience on the family. A number of groups have been mentioned consistently in the literature as having particular vulnerabilities, including unaccompanied minors and young women.
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Young people describe the experience of being a refugee and resettling in a new country as an enormous change brought about by forces outside of their control, and raising feelings of sadness, loss, hope and ambivalence:

What does refugee mean to me? It means leaving everything behind you because you have to; no chance to go back, nowhere to go. You have no say about what will happen to you, where you’ll end up, if you are going to live or die.

We had to, and we did it. We left our homes and we headed for a new life. Coming closer to an unknown country which was for so long so far way from me and getting further way from my country. Many things went through my head. I had learnt everything about life, about friendship, work, love and hate, and now I have to start a new life. Is this what I really want? New homes, new friends, new school. Is it really that easy — coming in to a new, for me, unknown country ...

By the way, we hope that it will be better and that this new country will be as special to us as it is to those who were born here because they gave us the opportunity to get away from trouble which millions of other people are now in ... (Wallace, 1990).

Gong-Guy, Cravens and Patterson (1991) point out that the traumatic experience of becoming a refugee and the demands on refugees’ coping skills begin in the home country when conditions become intolerable to the point where imperatives force people to leave. It is a process often fraught with danger, taking place within the contexts of war, violence, invasion and political repression. The refugee experience includes the decision or imperative to flee, the experiences of departure and flight, reception at country of first asylum, time spent in refugee camps, and being ‘processed’ by various governments and agencies culminating finally, for some, in resettlement in a new country. Resettlement, as has been discussed in the experience of migrants, is a process that may take a lifetime.

For many refugees the departure and flight are undertaken in secret (Gong-Guy et al., 1991) with few, if any, opportunities to say farewell to family and friends or gather possessions. In addition, many families are split up before and during the period of flight, a time that can be highly traumatic and dangerous. Weine et al. describe ‘the nightmarish odyssey’ of Bosnian Muslims fleeing ‘ethnic-cleansing’ during the civil war:

Those who were not killed, or apprehended and sent to concentration camps, were forced to flee. Adolescents and children were often held briefly in detention camps, separated from their fathers (who were held in concentration camps), and then spent months fleeing from capture or being held in occupied territory along with their mothers (Weine et al., 1995, p. 1153).
In Afghanistan, ‘most Afghans escaped by walking across the mountains under threat of aerial bombardment’ (Mghir et al., 1995, p. 25). The trauma manifest in the treacherous voyages undertaken by boat by many Vietnamese refugees, including experiences of lack of food and water, rape and robbery by pirates and constant danger have also been discussed by a number of authors (for example, Lee, 1988; Williams & Westermeyer, 1983; and Tan, Krupinski & Chiu, 1986).

The horrific experiences of Cambodians fleeing the brutal genocidal regime of Pol Pot have also been documented extensively (for example Kinzie, Sack, Angell, Manson & Rath, 1986; Mollica, Donelan, Tor, Lavelle, Elias, Frankel, Bennett & Blendon, 1990b). Citizens of many other countries in recent times have had to flee in terrifying and brutal circumstances. However, there is limited literature in the mental health field that addresses the experiences of refugees from all continents.

The reception for refugees in a country of first asylum may be a hostile one. Although life may be protected, psychological threats such as coping with losses or abuses (such as rape and robbery) that occurred during departure and flight, basic living conditions in refugee camps and restricted movement continue (Gong-Guy et al., 1991). Where people are not granted resettlement, they face a future of uncertainty, the possibility of seeking further options for resettlement, the hopelessness of an open-ended period of camp life or the possibility of involuntary repatriation (Gong-Guy et al., 1991).

A study of health, mental health and social functioning of Khmer residents of Site Two, a refugee camp on the Thai–Cambodian border, found that both Khmer adults and children (aged 12 to 13 years) perceived themselves to have poor health status, experienced emotional distress, had experienced past massive trauma and recent traumatic events, and had many issues that could impair social functioning (Mollica, Donelan, Tor, Lavelle, Elias, Frankel, Bennett & Blendon, 1990a and 1990b). Mollica et al. described the refugee camp as having ‘oppressive social and political conditions’ (Mollica et al., 1990a, p. 11). They also noted the particular situation of young Khmers who have grown up in refugee camps: ‘many children who have known this camp as their only home, have had to socially and psychologically adapt to an abnormal and harsh environment’ (Mollica et al., 1990a, p. 11). The chronic stress that is associated with living in a refugee camp has been noted in the literature (Weine et al., 1995), in addition to the possibility of long-term physical and mental health effects of the experience on children and young people (Mollica et al., 1990b).

Felsman, Leong, Johnson and Felsman (1990) researched psychological distress among Vietnamese refugee adolescents, unaccompanied minors and young adults in the Refugee Processing Centre in the Philippines and the Philippine First Asylum Centre. They found high levels of depression and anxiety for the young adult group.
and high levels of anxiety for all three groups. All the groups studied scored poorly on self-reports of general health, with young adults and unaccompanied minors over-represented in the clinical range (Felsman, Leong, Johnson & Felsman, 1990).

For those refugees who are resettled, there are new challenges to face. Lee describes the transitions experienced by South-East Asian refugee adolescents:

As a unique group of youngsters, they are in tumultuous transitions. Many of them are faced with the difficult tasks of recovering from old wounds caused by the trauma of war, struggling with daily survival issues at home and in school, and establishing a new identity which is acceptable to their family members and to the host country (Lee, 1988, p. 167).

Weine et al. (1995) note the considerable resiliency of their sample group of twelve Bosnian young people who had lived in the USA for one year, as they undertook their resettlement tasks, such as learning English, whilst being still significantly affected by their recent traumatic experiences.

Clarke, Sack and Goff (1993) suggest that resettlement stress is a form of chronic strain, since it has a long duration. In research with Khmer adolescents, Clarke et al. (1993) found that resettlement stress and war trauma made significant contributions to symptoms of PTSD.

The refugee experience and mental health problems and disorders in young people

Research suggests that there are higher rates of symptoms and mental disorders in refugees, compared with the general population (Williams & Berry, 1991). Young people have been shown to experience both short-term and long-term mental health consequences as a result of their experiences.

The effect on mental health of being a refugee and living in a refugee camp was demonstrated with Khmer children (aged 12 to 13) by Mollica et al. (1990a, 1990b). The study found quantifiable impacts on mental health and general wellbeing from these experiences on both adolescents and adults. Other areas where refugee experiences impacted adversely were physical wellbeing and mobility, educational continuity, development of cultural identity and sense of safety (Mollica et al., 1990b). Also of note in the work on children was that parents underestimated the impact of the experiences on their children when compared with the children's self-report on a range of questions related to traumatic experiences and ongoing impacts (Mollica et al., 1990b).

Significant problems have been found with research and clinical instruments that measure symptoms and diagnoses, due to those instruments being developed for very different groups of subjects (such as Vietnam war veterans and adults) using different norms (Felsman et al., 1990). Other methodological problems in research
addressing the mental health problems of refugees has been the reliance on clinical samples, with a lack of community-based samples.

Refugee adolescents have been found to experience PTSD and other co-morbid conditions, such as major depressive disorder, depression and generalised anxiety (Clarke et al., 1993; Hubbard, Realmuto, Northwood & Masten, 1995; Mghir et al., 1995). Studies with Khmer adolescents have shown that while the intensity of symptoms of PTSD may change over time (Sack, Clarke & Seeley, 1995), PTSD endures in youth as well as adults (Sack, McSharry, Clarke, Kinney, Seeley & Lewinsohn, 1994). Delayed symptoms and the possibility of diagnoses of PTSD developing over time have also been raised in research, as young people who have experienced massive war trauma show high levels of adaptive behaviour initially after resettlement (Weine et al., 1995). Undiagnosed psychological problems have also been observed in adolescent and young adult Afghani refugees (Mghir et al., 1995).

In a study of adolescent and young adult Indo-Chinese refugees to Australia who arrived in Victoria between July and December 1981, Krupinski and Burrows (1986) reported a relationship between length of stay in Australia and rates of psychiatric morbidity. In the first interview, six months after arrival in Australia, a quarter of the adolescents and over a third of the young adults were diagnosed with definite or probable psychiatric disorders, the majority of which were anxiety or depressive disorders. At this time, the refugee group had higher levels of morbidity than the general population. Follow-up interviews at six, twelve and twenty-four months showed that definite and probable psychiatric diagnoses declined significantly over time and at twenty-four months the level of psychopathology in the refugee sample had dropped below comparative community samples. These results, however, must be taken with some caution because of relatively low retention rates in the study (60 per cent for adolescents and 51 per cent for young adults).

In a longitudinal study assessing the impact of trauma on Cambodian adolescents traumatised as children living under the Pol Pot regime and resettled in the USA, Sack, Clarke, Him, Dickason, Goff, Lanham and Kinzie (1993) found a relationship between PTSD and both past and recent stressors. In this non-clinical sample, the study found a demonstrable relationship between symptoms of PTSD and resettlement stress and stressful events. The research also found that PTSD symptoms persisted over the six-year period covered by the study, although their intensity diminished over time. Clinical depression, which was closely associated with PTSD symptoms at the initial study in 1984, slightly decreased after three years and at six years clinical depression almost disappeared among the subjects (Sack et al., 1994). The study highlights the enduring nature of PTSD in some groups, and shows strong relationships to both resettlement stress and recent stressful events suggesting that this diagnosis leaves one more vulnerable to the
experience of subsequent stress’ (Sack et al., 1993, p. 437). Depression (the major co-morbid condition with PTSD in this group) and PTSD followed different patterns over time, with depression resolving whilst PTSD symptoms fluctuated. Symptoms of PTSD in parents have been shown to continue over time (Sack et al., 1993). Further research with the same population of Khmer young people (Sack et al., 1995) showed a high level of social functioning in adolescents, combined with intermittent symptoms of PTSD.

In their study with 24 South-East Asian refugee adolescent patients with psychiatric diagnoses, Williams and Westermeyer (1983) found that most had some pre-morbid psychological impairment in their country of origin. However, after migration, their problems worsened and the most common presenting complaints were psychosis, suicide attempt, and school crises. The study noted that these problems happened in association with several other resettlement factors: loss of familiar surroundings and people; reduction in or even complete loss of their social network including family; new, often impossible expectation such as immediate fluency in English; adjusting to a new school system at a higher grade level (after no previous education or several years away from school); and exposure to American norms and values which were often the opposite of those previously learned in Asia. Williams and Westermeyer concluded that ‘[t]hese young people with previously marginal or tolerable adjustments became disturbed and disturbing to others’ (Williams & Westermeyer, 1983, p. 83).

In a study of young people living in Beirut during the war between Israel and Lebanon in the 1980s, Saigh (1985) found that, in relation to PTSD, there was a difference in impact between conflicts that were long, drawn-out and unresolved, and those that are settled within a shorter time period.

Richman (1993) makes the important point that a diagnosis of PTSD is not the only way to gauge a young person’s distress or the impact of violence on children and young people. The range of distress experienced by young people can be at a high level and interrupt personal and family functioning without being in the clinical range of PTSD.

**The refugee experience and the family**

The family is a key context in the life of young refugees, whether the family lives together, is separated on a temporary or permanent basis, or whether family members have been killed or have died in other circumstances (Bemak & Greenberg, 1994). Family stress and the strain of resettlement have been noted by a number of authors as a major factor in adjustment of refugee young people (Lee, 1988; Mghir et al., 1995; Hubbard et al., 1995).

Short- and long-term studies with young people support other, qualitative evidence (Wallace, 1990; Refugee Resettlement Working Group, 1994) that young people and their families continue, over time, to experience effects and stressors on
their mental health related to the refugee experience, all of which can be exacerbated by the resettlement process.

Issues noted in the literature include changes in family constellation after resettlement, the changes in relationships and roles within families, and the impact of parental distress and symptoms on young people. It is also noted in the literature that, despite the hardships experienced by many refugee families, many refugees endure and cope effectively in their new country without serious psychological problems (Lee, 1988).

Many young people who have been refugees arrive in their country of resettlement with different family constellations than those with which they had lived in their homeland. These family constellations may include a nuclear family with extended family networks (Tannenbaum, 1990), a female-headed single parent family (Williams & Westermeyer, 1983), siblings only, extended family group only, or just themselves (unaccompanied minors) (Williams & Westermeyer, 1983).

These differing family constellations reflect the effect of war, political repression and the dangerous experience of being a refugee. Parents, grandparents, siblings and extended family may have been lost or separated before flight, during the flight and departure, or in refugee camps. Young people may have witnessed the death, torture, injury, rape or humiliation of family members (Refugee Resettlement Working Group, 1994, Mollica et al., 1990b). They may also have been the only family member to escape (Lee, 1988). They may not know if other family members escaped. They may have been chosen by the family as the one member to escape (Gong-Guy et al., 1991).

Separation from family members has been suggested as a major factor causing depression and anxiety and impeding the adjustment processes of Vietnamese refugees (Nguyen, 1982, cited in Tannenbaum, 1990). Kinzie et al. (1986) found that the family had a role in mitigating psychiatric diagnoses in young Cambodian refugees in the USA. Those young people who lived with at least one member of their biological family were less likely to have a diagnosis of PTSD than those living with an American or Cambodian foster family.

Refugee experiences may have a massive impact on how families function in the short and long term: ‘[t]he combined exposure to organised violence and the stresses and demands of the exile, migration and resettlement process exert pressure on refugee families that may result in disrupted family dynamics characterised by disturbed relationships and roles’ (Refugee Resettlement Working Group, 1994, p. 64). In a discussion of family stress resulting from the trauma of war in South-East Asia, Lee (1988) suggests that emotions such as rage, aggression, despair, guilt and grief, may have been suppressed during the war and escape, only to be expressed after resettlement. Lee identifies some of the ways that adult family members may express these emotions, including
somatisation, nightmares, compulsive work, drug abuse and physical abuse of family members.

Parenting, as a key role in families, is one area that may be affected by the experience of being a refugee (Refugee Resettlement Working Group, 1994). It has been suggested that dealing with the consequences of exposure to traumatic experiences and the stress of resettlement may pose a drain on the emotional resources of refugee parents, which may have a deleterious effect on their ability to provide adequate parenting (Refugee Resettlement Working Group, 1994). Lee also suggests that many parents may be burdened by depression and emotional problems and as a result are ‘emotionally unavailable’ to their children (Lee, 1988, p. 173). As a result, adolescent children often feel an intense obligation to compensate for their parents’ helplessness and sorrow.

Some authors have noted that there may be conflict over role reversals in families as adolescents become competent in English before their parents and undertake a culture-broker role with the broader society, perhaps resulting in parental dependence and, at times, resentment (Lee, 1988; Bashir & Schwarz, 1988). For adolescents, their parents’ role may be undermined as the adolescent becomes more cognisant of the dominant society and begins to seek role models within that society. Instead of their parents becoming role models, or objects for competition and identification, parents may become objects of pity and shame (Lee, 1988).

The transgenerational effects of parental torture and trauma experiences have been raised by a number of authors (Weine et al., 1995; Mghir et al., 1995; Refugee Resettlement Working Group, 1994; Lee, 1988). In a study of PTSD across two generations of Cambodian refugees, Sack et al. (1995) found that PTSD tended to cluster in families. Mghir et al. (1995) found a strong correlation between their adolescent subjects’ symptoms and parent’s symptoms, particularly maternal distress.

Some authors have noted that secondary traumatisation of young people is a possibility, as they listen to their parents retell stories of trauma and torture. Weine et al. noted that in their study of adolescent survivors of ‘ethnic cleansing’ in Bosnia, at least in the first year, there was a distance between adolescents and their parents that reflected the dialectics of trauma: ‘the parents were burdened by the imperative to remember while the adolescents were more free to forget’ (Weine et al., 1995, p. 1158). Exacerbation of young people’s own trauma by interaction with traumatised parents and significant other adults in their family and community has also been raised (Rice, Rice & Dhamarak, 1993).

Kinzie et al. (1986) found that Cambodian adolescent survivors of the Pol Pot regime living in the USA experienced greater suffering than their caregivers realised. They found that despite their extreme past suffering, the young people performed relatively well in academic tasks; however, psychological symptoms
were clear in their behaviour. Consistent clues to their psychological disturbance were manifest in behaviour such as emotional withdrawal, daydreaming and non-participation in class.

**The refugee experience and impact on development and functioning**

Refugee experiences may take place before, during or after major life-transition stages. Weine et al. (1995) found that traumatisation, displacement and resettlement did not appear to put adolescent development on hold, although the experience may have been altered by adolescents' experiences of war trauma. Research is reasonably consistent in finding that young people who have been refugees often negotiate adolescent life-stage transitions and acculturation well, despite their traumatic experiences and even despite intermittent recurrence of symptoms of PTSD and emotional distress (Sack et al., 1995; Weine et al., 1995; Mghir et al., 1995).

Within an overall framework of a high level of functioning, however, some areas of development and functioning have been identified as being of concern in relation to young refugees. Identity development, intergenerational conflict, social isolation and schooling are issues identified in the literature in relation to development and functioning. Research, particularly of a longitudinal nature, is limited in this area and most of the literature that addresses these concerns is clinical and sociological reflection.

Some of the areas identified in the literature that may have an effect on the development of identity include childhood spent in refugee camps (Mollica et al., 1990b), involvement in political causes or wars as soldiers (Refugee Resettlement Working Group, 1994), physical and sexual abuse (Lee, 1988; Refugee Resettlement Working Group, 1994), loss of family role models or authority figures (Lee, 1988; Bemak & Greenberg, 1994), grief as a result of multiple losses (Tannenbaum, 1990; Refugee Resettlement Working Group, 1994; Lee, 1988; Bashir, 1993; Bashir & Schwarz, 1988), and participation in political or military struggles (Richman, 1993).

The issue of the torture of young people is generally not raised explicitly in the research literature; however, it seems that torture may be implicit in some of the experiences mentioned above. Also implicit is the effects on young people who bore witness to horrifying and deeply disturbing events. These events may include: summary execution of family or others adults or children known or unknown to them; combat; betrayal of one group in their community by another; betrayal of family members and neighbours; concentration or work camps; mass killings; mass graves; rape; death from disease, starvation and malnutrition; and death or injury of those with whom they were fleeing.

Research conducted in New South Wales at the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) with parents who are
survivors of organised violence found that 38 per cent of those parents were concerned about the effects on their children of exposure to organised violence (Refugee Resettlement Working Group, 1994).

Development of an integrated identity that encompasses their past experience, current reality, and possibilities for the future is a challenge for young refugees, after such severe interruptions to their life and developmental processes (Lee, 1988; Wallace, 1990; Refugee Resettlement Working Group, 1994). Weine et al. found a friction between a sense of hope for the future, even an excitement in the possibilities offered by the country of resettlement, and the traumatic nature of the past and associated grief and loss. ‘A sense of open horizon competed with the sense of an eroded future that is often seen in survivors of massive psychic trauma, a feeling experienced most intensely by those who remain separated from parents or who have lost parents’ (Weine et al., 1995, p. 1158).

Research suggests that refugee young people are often functioning at a high level within a short time of their resettlement (Mghir et al., 1995; Weine et al., 1995; Sack et al., 1994). However, the same research qualifies these findings with concerns raised about the future possibilities of mental health problems and adjustment problems. It has also been suggested that the traumatic memories and emotional distress of children and young people may be overlooked due to the overwhelming nature of resettlement (Refugee Resettlement Working Group, 1994) and because of their parents’ high levels of emotional distress (Refugee Resettlement Working Group, 1994). Lingering fear as a result of past experiences may also interrupt young people’s and their family’s functioning (Refugee Resettlement Working Group, 1994).

Tannenbaum (1990) notes that while the academic success of Vietnamese young people has been emphasised in the media, this success should not be mistaken necessarily for high levels of adjustment. She points out that evidence of emotional distress and social isolation must qualify any discussions on the adjustment of Vietnamese refugee adolescents. Intrusive memories of past events, and grief and loss are evident in this sample of writing from a young Vietnamese student:

My father was killed when I was five years old and my younger sister was two. I don’t know what his face looks like. I just saw him on the picture. However I love my father very much. I’m always upset to see someone who has both mother and father, I think they are very happy. I wish to have a father but I never have. Now I live with my older sister. My mother and younger sister are still in Vietnam. I miss them too much. I can’t sleep at night however I try. I’m thinking about them all day and when I have free time and all night too. It gives me headache. I can’t study. So I don’t want to go anywhere at this time. That’s a reason I don’t like to go out on the weekend (Tannenbaum, 1990, p. 44).
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Schools have an important role in relation to acculturation, language competence, and in connecting young people to wider social systems. Mental health problems experienced by young refugees may present at school, and the school response may be critical to whether appropriate assistance is rendered (Gong-guy et al., 1991; Williams & Westermeyer, 1983). Rice et al. (1993) suggest that generally, in Australian schools, there is a need for a deeper understanding of the life experiences of refugee young people and the impact of those experiences on their English language ability, self-concept and general school work.

Young refugees often experience serious discontinuities in schooling and this may affect their ability to cope with and adapt to school life (Rice et al., 1993). Young people who have received little or no education in their country of origin or in refugee camps may be placed in classes congruent with their age rather than their schooling history. As a result, they may be confronted with a significant educational disadvantage in comparison with their Australian-born and migrant classmates (Rice et al., 1993). Kinzie et al. (1986) described the typical childhood experiences of their 46 Cambodian adolescent subjects as beginning (primary) schooling in 1973, abrupt termination of schooling in 1975 and restarting schooling at high school in the USA in 1982. For these young people, a break of seven years in formal schooling was the norm.

Teachers' lack of knowledge about the life experiences of their students from a refugee background is problematic for young people when they present emotional distress or other problems connected with their refugee experiences (Rice et al., 1993). Gong-Guy et al. (1991) noted that where mental health problems arise in a school, for example, they may be exacerbated because of the environments in which they arise. Non-mental health professionals often become involved in assisting the young person without possessing the skills to assess numerous, multidimensional problems.

Problems that may arise in the school environment for young refugees include difficulties in concentration (Heperlin, 1991), learning difficulties (Gong-Guy et al., 1991), disruptive behaviour (Gong-Guy et al., 1991), depression (Gong-Guy et al., 1991) and language difficulties (Rice et al., 1993; Heperlin, 1991). Poor physical health as a result of previous experiences (such as malnutrition or injury) and somatic symptoms of distress may also affect school performance, preventing young people from attending regularly and participating to their best ability (Rice et al., 1993).

Young refugees may also have difficulties with social and cultural expectations in school (Heperlin, 1991). Unrealistic expectations of language and academic achievement have been noted (Williams & Westermeyer, 1983; Heperlin, 1991; Rice et al., 1993). Failure at school may result in a feeling of having failed the family and some young people may be burdened by a need to achieve due to family
expectations or ‘survivor guilt’ (Hepperlin, 1991). Family dynamics may also be problematic, where young people are experiencing conflict at home or additional pressure to achieve, or having to undertake additional tasks to assist the family financially (Lee, 1988).

**Vulnerable groups**

Young people who are resettled on their own, such as unaccompanied refugee minors, are a group which has been identified as experiencing particular disadvantage. The United Nations High Commissioner for Refugees identified unaccompanied refugee minors as the most vulnerable of refugee groups (UNHCR, 1989). Unaccompanied minors may be separated from their family or carers for many different reasons. The parents of some children may have been killed, be imprisoned or missing, and some children may have been sent away from a dangerous or potentially dangerous situation alone whilst their families remain behind (Refugee Resettlement Working Group, 1994).

Some children and young people separated from their families lived on the streets in their own country and in groups with other young people in refugee camps. In both of these situations young people may have become accustomed to harsh living conditions where they may have had to steal to obtain food and shelter. The transition from this way of life and these conditions to those in the country of resettlement is potentially vast and difficult (Refugee Resettlement Working Group, 1994).

Felsman et al. (1990) saw unaccompanied minors as a group under unique stress because ‘[f]or the first time, many are living apart from their families and are without any sanctioned adult guidance. Most are confronted with resettlement prospects that combine two factors most predictive of high stress, uncontrollability and unpredictability’ (Felsman et al., 1990, p. 1254). A report arising out of contact between unaccompanied children or adolescent refugees and mental health services found that these children and young people, identified in refugee camps as at risk, continued to be at risk after resettlement in the USA (Williams & Westermeyer, 1983).

Young adults who are outside the age limit for school and other services targeted at young people have been identified as a group with special needs. Felsman et al. (1990) found that young adults (17.5 to 20 years of age) faced a different set of challenges to the young people (13 to 17 years of age) in their sample group and had different support services available to them in the transition from refugee camp to resettlement, based on their age. The young adults’ age meant they would not be attending a public school in the USA and that they would not be entitled to the same support services as the refugee youth in their sample. This distinction meant that the young adults would need to find access to other services, not necessarily targeted to their needs.
In Australia, a distinction is made between detached and unattached minors who enter Australia. Detached minors have some family (however distant) to live with on arrival, and unattached minors are resettled on their own. As a result of this differentiation, services are provided differently to detached and unattached minors. However, service providers have suggested that all unaccompanied minors have the same needs on arrival (Refugee Resettlement Working Group, 1994). For example, although detached minors have a relative to live with initially upon arrival, family relationships often break down and the young person often becomes separated from their relatives (Wallace, 1990). These young people then require assistance with housing, income support and social services, which may not be available to them because of their detached minor status.

Australian research has found that accommodation options for young independent or unaccompanied minors are often unstable and unsuitable for study (Wallace, 1990). For young people who have settled with distant relatives, family problems may create difficulties in studying due to overcrowding or responsibility for household duties, or intergenerational conflict may prompt young people to leave the family home early. This in turn may have an impact on the ability to attend school regularly (Rice et al., 1993).

Young women have been highlighted in the literature as a vulnerable group (Refugee Resettlement Working Group, 1994). Young women’s experiences of, and vulnerability to, sexual assault and exploitation have been noted as a particular concern. One report suggests that one-third to two-thirds of refugee women and girls seeking treatment for the sequelae of torture report incidents of sexual violence (Chester & Nolan, 1992). Young women who have been refugees may continue to be at risk of sexual assault and exploitation after their resettlement (Refugee Resettlement Working Group, 1994). Experiences of sexual assault may also have an impact on a young woman’s resettlement experience if she is rejected by her family or community because she is viewed as having lost her virtue (Refugee Resettlement Working Group, 1994).

The possibilities of secondary traumatisation through hearing the trauma and torture stories of parents and older relatives have also been noted as an area of particular concern for some young women. Young women may be at increased risk because they tend to spend more time at home in the company of older relatives while undertaking home duties (Weine, 1995).

Young people who have been soldiers have also been identified as a group experiencing unique stressors (Refugee Resettlement Working Group, 1994; Richman, 1993). In addition to the other stressors related to being a young refugee, those who have been soldiers may have experienced further losses related to their political cause and their experiences in war (Refugee Resettlement Working Group, 1994). Some young people who have participated in political or military struggles may have difficulty adjusting to civilian life (Richman, 1993). The impact of
participating in, or perpetrating, violent acts may have long-term consequences on how young people cope with conflict resolution and family relationships, although the type of struggle and role that young people played within it will influence how much effect the experience has on a young person’s adjustment (Richman, 1993).

Conclusion

This chapter has approached the general topic of young people of NESB and mental health by investigating the mental health issues common to all young people and then trying to understand the differences or additional stressors that young people of NESB may experience in relation to mental health.

It can be concluded from this that young people in general, including young people of NESB, have serious needs in relation to mental health which are still not understood fully. While morbidity data show that young people have some of the highest rates of first onset of mental illness and other mental health problems, research about the genesis, experience, treatment and long-term effects of disorder and mental health problems are not prominent enough in Australian or international research.

Literature dealing with young people in relation to mental health shows that they are a distinct population group with specific needs when it comes to mental health. Within the category of young people there are many different groups with more specific needs and issues. These include specific needs related to age and developmental stage, issues related to mental health status, the family constellation, social disadvantage, and other more specific areas of inquiry.

The mental health literature relating to children and young people emphasises the importance of identifying mental health problems or disorders as early as possible in order to provide the most appropriate style of intervention and to minimise the suffering the young person experiences. The suffering young people experience as a result of mental health problems and disorders is an underlying theme throughout the literature, particularly where the impact on young people’s lives is discussed. The impact of mental health problems on developmental processes, the development of social networks, school performance and attendance and overall personal achievement can be very serious and, without appropriate and timely intervention, has the potential to continue affecting the young person into adult life.

At the same time, young people are often exposed to a range of adverse environments that can have an impact on their mental health as a result of moving into a different life stage. The impact of these adverse environments (such as poverty, poor educational opportunities, family breakdown and violence) cannot be underestimated. The connection between poor mental health and adverse environments is often drawn in the literature. Where young people have been
consulted in research through focus groups or interviews, these connections are made even more strongly.

The issue of youth suicide stands out in the literature because of the clear relationship between mental illness and suicidal behaviour in young people. Research from Australia and overseas presents a compelling argument for investment in research in the mental health of young people.

A number of groups of young people have been identified in the literature as of particular concern in relation to mental health. These include young people who are homeless, young people who experience mental health problems or disorders, young people in custody, young people who have parents with a mental disorder, and young people who have attempted suicide. The young people in these groups are often extremely marginalised, may have limited access to mental health services, or feel mistrust towards systems such as the health system. The need for a co-ordinated approach to meet the range of health needs of these young people and keep them engaged in mental health services is a major issue that emerges in the literature.

Resilience and protective factors is an area of research showing promising directions for understanding how it is that adverse experiences impact differently on different young people. Research in this area has begun to draw more definite conclusions about what may develop resilience in a young person or protect them against the negative effects of adverse experiences. The evidence is sufficient for this to continue to be an important direction in mental health research and practice.

Young people of NESB have been understood in this chapter to be young people who potentially experience the mental health issues and problems identified as affecting all young people, but who may experience the impact of those issues and problems differently. Young people of NESB have been seen as potentially experiencing additional issues that may have an impact on their mental health. These differences and additional issues may relate to language and cultural background, migration experiences, or experiences in the broader community. This approach has been effective in focusing the review on those differences or additional stressors.

Most of the literature on young people of NESB and mental health issues focuses on the ‘additional’ stressors that may affect their mental health. Therefore it is difficult to draw conclusions about young NESB people’s experience of mental health issues that are identified as affecting all young people. Many of the major issues that arise in the literature on young people’s health lack a cross-cultural perspective or an acknowledgment of the impact of culture and ethnicity on health.

In particular, there is a lack of discussion about the impact of culture on such processes as life-stage transitions, or an acknowledgment that understandings of developmental processes are culturally located. The lack of a cross-cultural
perspective on adolescent development and life-stage transitions is particularly problematic because these concepts are so central in almost all research and literature on young people's health.

The absence of a cross-cultural perspective in research underpins a number of problems evident in the literature. These problems include the lack of a complex understanding of culture — both as it influences the direction and execution of research and in how it may affect the experiences of young people and their families. Another problem area is that research findings cannot necessarily be generalised for the whole population, meaning that additional research needs to be carried out. One area that stands out particularly in this respect is youth suicide, where there is a consistent lack of discussion of ethnicity in the research, particularly the Australian research. Even if ethnicity is found not to be a significant factor in youth suicide, this would nonetheless be a significant finding.

There are no conclusive results suggesting that young people of NESB have higher or lower rates of mental health morbidity than other young people. Therefore, this chapter has not followed a line of enquiry that suggests that young people of NESB suffer increased levels of morbidity that can be attributed to their language or cultural background or their migration experiences. Nor can this chapter draw conclusions about whether or not additional stressors that have been identified as impacting on young people of NESB (such as those related to migration, settlement, refugee experiences or racism) have an impact on the kinds of mental health morbidity they experience as a group. No conclusions can be drawn because such data do not appear to exist.

Equally, it is difficult to conclude that the experiences of some young people of NESB, such as those of migration and settlement, develop protective mechanisms and resilience in the face of adversity that make them less vulnerable to certain mental health problems or disorders. The lack of published research in this area is particularly disappointing.

Conclusions to be drawn from the literature about the mental health status and experiences of young people of NESB are limited due to a lack of research and data in this area. Ethnicity data are rarely drawn out as an area for scholarly study from population-based research with young people (which in itself is very limited). It seems that this lack of hard data on which to base information results in the drawing of conclusions that are often based on assumptions rather than hard data. For example, in policy documents young people of NESB are often noted as a group with special needs, although with very limited or no evidence as to why that is so. The situation seems to be that it is assumed there must be specific issues, but there is a lack of commitment to allocating the resources for finding out what those issues may be in any depth or detail.

However, in sketching the mental health issues that affect young people from NESB differently or additionally to those that affect other young people, this
chapter has found that while it is difficult to make any hard and fast conclusions, a complex picture emerges that invites more research and reflection. Here it can be said that where there are areas of concern to all young people, there are areas also of concern to young people of NESB. Such areas of concern would benefit from further research to draw out the differences and similarities between all young people and young people of NESB.

Taking an approach that understands the diversity of experiences and backgrounds of those included in the overall grouping ‘young people of NESB’ is crucial to gaining a true picture of their experiences. For example, the experiences of young people born in Australia of parents who were themselves born in Australia of migrant parents are very different to those of young people who have recently migrated to Australia. There are also major differences in the experiences of migrants and refugees and consequent mental health issues. Young people’s ethnicity raises different issues related to culture and mental health. Family relationships and the family constellation are also clearly important in understanding young people individually and in groups.

While the literature reviewed here focuses chiefly on migrant and refugee young people, this is not to suggest that young second- or subsequent-generation Australians do not have particular mental health issues that are additional or different to those of other young people. However, the experiences of young people who are second- or subsequent-generation Australian have not been examined in great detail in research. Nor have the experiences of subsequent generations of ‘minority’ young people been well documented in other parts of the world.

The research that is available on the experiences of second- and subsequent-generation migrant young people generally focuses on family relationships and ethnic identity. There seems to be an assumption that young people of NESB generally experience more conflict in their families than other young people due to cultural differences and gaps that emerge between young people and their parents or older family members. There is also an assumption that young people of NESB are generally more likely to have a conflicted identity and other problems in identity development. These assumptions are not always supported by research. In order to understand the experiences of these young people, there is a need for further research and documentation of how families work and the cross-generational impact of migration. In order to understand any specific mental health issue a distinction needs to be made between ethnocentric assumptions about family relationships and conflict and genuine issues arising from families that lead to effects on young people’s mental health. Therefore there needs to be some reconceptualising in research about what issues are of particular importance to these young people.

The links between racism and discrimination and poor self-esteem and other mental health issues have also been made in some of the literature. However, very little research has been undertaken to explore the complex relationship between
racism and discrimination and mental health issues. A more complex analysis of the range of social and economic factors that may have an impact on young people of NESB is needed to provide the context for the impact of racism and discrimination on young people. Some of the literature that gives an insight into the experience of young people of NESB living in Australian society provides a context for why it is that they are targeted as subjects for community concern or negative stereotypes on account of their cultural or language background. This context includes understanding that there are other complex issues contributing to these problems, including social attitudes towards 'youth', gender and social class. While this literature review has not been able to explore these issues in great detail, the connections that are drawn in the literature invite further reflection about how experiences such as racism and discrimination intersect with other social attitudes to fuel community members' attitudes towards young people of NESB. A crucial research question that needs to be answered is how these complex social phenomena may affect the mental health of young people of NESB.

The question of culture has been addressed extensively in the mental health literature, in particular how culture affects ideas and beliefs about mental health, or how appropriate mental health care should be provided. However, there is very little discussion in the literature about what culture means to young people of NESB and how they develop their own understanding of culture. There is an assumption in the literature that culture is only an issue when cultural difference causes conflict. Another assumption is that where culture impacts on mental health, the 'problem' is the culture of the young person’s family, not necessarily that of the young person themselves.

Consulting young people’s personal narratives about their journey towards developing an understanding of their own culture yields a richer and more diverse picture of how culture and issues related to culture affect young people. However, it has not been in the scope of this literature review to explore personal narratives. As a result, possibly there is a false sense from the literature that culture is not a key issue for young people unless it is related to cultural conflict within families or between parents and outside agencies.

For young people of NESB who are migrants, the literature focuses on the impact of the migration experience, acculturation and acculturation stress and family dynamics. The many and diverse experiences that lead to young people and their families migrating to Australia have not been discussed at length in the literature. While this may seem tangential to mental health, the lack of a clear picture of young people’s pre-migration experiences undermines our understanding of young people’s adjustment processes and where points of conflict or concern may arise. The link between acculturation and acculturation stress or family conflict and mental health problems is more assumed than proven by research. There is also a real lack of information about the Australian context and how settlement services
that are provided here impact positively or negatively on how young people negotiate migration-related stressors.

In relation to refugees, there is a more substantial body of literature located within the mental health field that addresses mental health morbidity of young refugees. In particular, a number of long-term studies have provided insight into the changes in mental and psychological states of groups of refugees. Long-term information such as this is extremely valuable in tracking how young people’s needs change over time and the mental health issues that stay with them as they move through adolescence and young adulthood into their adult lives. These studies reveal a picture of fluctuating mental health status for some of the worst affected young refugees and the continuing influence of their refugee experiences on their later lives. Conversely, they also reveal an astonishing level of resilience and adjustment. Taken together, these conclusions hint at the level of complexity in long-term mental health issues for young refugees and suggest ways to build on the many strengths that young people who are refugees have gained and utilised as a result of their terrible experiences.

Other studies have been undertaken with clinical samples which, while valuable in revealing young people’s experience of mental health problems and disorder, give less insight into the general refugee youth population as a whole. However, where other information has not been available, information based on clinical samples may be used to be representative of other refugee young people and clearly this creates other problems for research and practice.

The focus of many studies, most of which have been conducted in the USA, is on PTSD morbidity. Some studies have examined PTSD in conjunction with adjustment, family changes and school adjustment. Conclusions about levels of PTSD in groups of refugee young people provide an important gauge of mental health morbidity resulting from past trauma. However, it has also been noted that there is a danger that other ways of experiencing or expressing distress resulting from refugee experiences may be less well understood or responded to because they do not fit the clinical picture of PTSD.

Another feature of the literature on refugee mental health is the contribution of those working with refugee young people outside of the mental health system, for example in schools or settlement services. These contributions, while generally more reflective than those based on research, provide insights into the experience of young refugees and their families as they attempt to rebuild their lives after shattering experiences. It is perhaps here, more than elsewhere in the literature, that one can gain a compassionate and complex understanding of how young refugees maintain and improve their mental health and wellbeing in the long term, usually under very trying circumstances. The difficult circumstances refugees face after their settlement in Australia becomes very apparent in this literature, as it deals with general social issues rather than mental health morbidity.
Deeper Dimensions – Culture, Youth and Mental Health

Information about mental health issues affecting young refugees in Australia is limited. The information that does exist focuses mainly on the Vietnamese and Cambodian refugee community. Some of the long-term issues confronted by these communities have been documented, in particular the experiences of detached and unattached minors. Clearly some Australian young people continue to experience the impact on their mental health as a result of their experiences in their country of origin, during their flight, and after their resettlement in Australia. However, these have not been generally documented in the realm of mental health. It is more likely for these issues to emerge in literature dealing with social issues such as youth crime, poverty, homelessness and juvenile detention. This suggests that mental health problems experienced by these young people may have been deflected away from the mental health system to other systems. It is difficult to draw distinctions between the social problems experienced by young people as a result of poverty and poor social support, and those arising from mental health problems. Again, research and reflection in this area seems to depend on assumptions in the face of a lack of information about mental health problems that are ongoing for these young people.

In the Australian context, more information is needed about the latest groups of young refugees arriving in this country, their experiences in the country of origin, their cultural and language backgrounds. In order to learn from Australia’s experiences with providing settlement, health and other services to young refugees, it is important to find ways to critically analyse how best to support young refugees and assist them to achieve optimal mental health over the long term.

By locating young people of NESB in the context of all young people, this review has sought to contextualise the experience of young people of NESB in Australia, whilst acknowledging the important differences wrought by culture and ethnicity. This approach seems to be appropriate, given that there is no research that suggests that ethnicity or culture alone are a major influence on mental health. Indeed, one of the most powerful themes emerging from the literature, both specific to young people of NESB and relating to all young people, was the social context of young people’s lives and the complexity of factors contributing to the experience of mental health.

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