Introduction

Mental health problems affect one in five youth today, according to several research estimates (Bourget and Chenier, 2007; Jorm et al, 2008; Wile Schwartz, 2009). Effective treatments are available; however, research indicates that less than half of those with a mental health problem access mental health services (Pinto-Foltz et al, 2011; Marcus and Westra, 2012). Of those who seek treatment, scholars link factors such as lack of information, accessibility and mental illness stigma to premature termination (Pinto-Foltz et al, 2011). Thus, as a group, young people have a high rate of unmet mental healthcare needs.

Mental healthcare needs, however, are even more urgent for refugee youth and those who have experienced forced migration. The world is currently facing a global refugee crisis. The United Nations High Commissioner for Refugees (UNHCR) estimates that there are over 16 million refugees worldwide (UNHCR, 2016), and more than half that population is under the age of 18. Researchers have found that traumatic experiences in their home countries, the stress of forced migration and the challenges of relocation are associated with higher rates of mental health problems among refugee youth as compared to non-refugee youth (Colucci et al, 2015). Healthcare and education professionals have been advocating for an increased focus on culturally relevant mental health education and interventions that are specifically tailored for refugee and immigrant youth (Whitley et al, 2013). Moreover, mental health practitioners and researchers have recommended that teachers, counsellors and other adults who work with youth acquire the knowledge and skills to support them to seek help for mental and emotional difficulties (Pinfold et al, 2005).

A frequently cited reason for youth not seeking help for mental health problems is that they lack mental health literacy (MHL) – they may not have sufficient knowledge to identify mental health symptoms and/or they may not know how to access mental health support and treatment (Jorm et al, 2008; Marcus and Westra, 2012). For refugee and immigrant youth who may have recent war or other trauma experiences, family losses, language difficulties, resettlement challenges and other stressors, there are often additional barriers to help-seeking, such as discrimination.
and stigma, problems with treatment access and lack of cultural safety. To improve mental health outcomes for refugee youth, culturally and contextually appropriate strategies and resources to increase MHL are needed. Although the potential negative impacts of forced migration are clear, it is important to note that refugee youth also have significant strengths, resilience, courage and community support – these positive factors can mitigate harmful effects and provide a base for positive growth and adaptation (Tedeschi and Calhoun, 2004).

In this chapter, a cultural approach is suggested as an essential element in programmes and strategies addressing refugee youth MHL. First, we present a snapshot of youth mental health figures. Next, we discuss MHL, youth MHL and MHL for refugee youth. We then present education and training considerations, including the Mental Health First Aid (MHFA) approach, and briefly discuss several successful resources and programmes. The chapter concludes with suggestions and implications for practice and research.

Youth mental health

Approximately 20 per cent of adolescents and young adults aged 15 to 24 in North America and other OECD (Organisation for Economic Co-operation and Development) countries have reported a mental health and/or substance abuse problem (Marcus and Westra, 2012). Depression and anxiety are the most common problems, with girls often reporting higher rates than boys. Conduct disorders, attention deficit hyperactivity disorders, psychoses and substance use disorders are less frequent but on the increase (Chalmers et al, 2014).

Although the incidence of mental health problems among the general youth population is of concern, the incidence among refugee youth is particularly urgent. This situation underscores the need for treatment and prevention programmes and strategies to address mental health and mental illness among refugee youth. A focus on improving MHL for both youth and adults who work with youth represents an important step to achieving this goal.

Schools are the only institutions that touch the lives of all adolescents: ‘schools have evolved into community “hubs” offering services and programmes to families within the school community’ (Freeman, 2013, p 1). Schools are significant contributors to the acculturation of refugee youth, particularly in mental health areas such as psychosocial and emotional development (Quinlan et al, 2015). School personnel can all contribute to MHL.

Definitions of mental health literacy

MHL is a relatively recent concept, a more specific aspect of the broader notion of health literacy. The first widely accepted definition of MHL – ‘mental health literacy comprises the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems’ – was proposed by the Australian psychiatrist Anthony Jorm and several colleagues (Jorm et al, 1997,
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A lack of MHL negatively affects understanding, recognition and treatment seeking for mental illnesses. Moreover, the stigma associated with mental illness has been identified as a major barrier to help-seeking (Marcus and Westra, 2012). Jorm et al (2008) argued that improving MHL among professionals and the public should be a key strategy for improving mental health overall.

In a report to the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), Bourget and Chenier (2007, p 4) proposed a broader definition of MHL: ‘mental health literacy is the knowledge and skills that enable people to access, understand and apply information for mental health.’ This definition puts more emphasis on empowerment, an important concept in health promotion and health literacy. MHL involves more than providing information; it includes support for skill development and empowerment so people can make informed decisions and take effective action to promote positive mental health for themselves and others. Those with high levels of MHL are better able to identify mental health ‘strengths and needs in themselves and others, are better equipped and more empowered to seek appropriate supports, and report lower levels of mental health stigma’ (Potvin-Boucher and Malone, 2014, p 346). Bourget and Chenier’s (2007) approach to MHL guides this chapter and includes an emphasis on the key role of professionals and practitioners.

Youth MHL

Over the past two decades, many countries have sought to improve MHL (see Chapter 24, this volume); few, however, have explored MHL among youth, and even fewer have included refugee youth. In Australia, Reavley and Jorm (2011a, 2011b) conducted a computer-assisted national telephone survey focusing on MHL and stigma with 3,021 young people aged 15-25. Respondents were read one of six case vignettes portraying a young person (named John or Jenny) with depression or another mental disorder. They were then asked questions about MHL (for example, ‘What do you think is wrong with John/Jenny?’), stigma, exposure to mental disorders and beliefs about interventions. About 75 per cent recognised depression while about one-third recognised psychosis (for example, schizophrenia) and post-traumatic stress disorder (PTSD). Family members were named as the most likely source of help. Reavley and Jorm concluded that most young people’s MHL for recognising signs of depression was good, although it was much lower for other disorders. There was also a tendency to overgeneralise the term depression and considerable reluctance to endorse professional help-seeking for mental health problems, indicating that stigma continues to be a limiting factor. The authors recommended more MHL education and media information to promote increased mental health knowledge among youth and to reduce the stigma associated with mental health problems.

In a Canadian study, Marcus and Westra (2012) analysed the responses of 123 young adults aged 18 to 24 who were part of a computer-assisted MHL
telephone survey (n=1,004). The survey began with a short vignette of a person (named Robert or Mary) suffering from depression, anxiety or schizophrenia (psychosis). Participants were then asked questions about problem recognition, knowledge about mental illness, possible causes and management or treatment options. Marcus and Westra found no significant difference between younger and older adults in terms of rates of recognition and mental health knowledge, with higher rates of depression recognition (~80%) in contrast to anxiety or schizophrenia (~50%). However, young adults were significantly less in favour of accessing professional care (for example, a family doctor), less likely to view medications as helpful and marginally less likely to believe that psychotherapy could be helpful. These young adults, especially young men, reported more interest in managing mental health problems either on their own or with the support of friends or family. The authors recommended development of MHL interventions aimed at help-seeking behaviours, attitudes about treatment options and ‘alternative youth-friendly options for managing mental health problems’ (Marcus and Westra, 2012, p 10).

In the US, McCarthy and colleagues (2011) investigated adolescent MHL with a group of high school students (n=36) using vignettes depicting depression and suicidality. Teens were able to differentiate depressed from non-depressed vignettes and could identify (1) common symptoms of depression and (2) sources of help. The authors recommended including adolescents more actively when planning and providing mental health education or treatment services. They suggested additional research with culturally diverse groups since understanding of mental health risks, behaviours and help-seeking is affected by cultural values, beliefs and practices. As discussed in the next section, cultural factors are particularly salient for refugee youth.

**Refugee youth MHL**

A number of scholars and researchers assert that understanding and addressing mental health needs and MHL among refugee populations requires a cultural approach that recognises the ethnic, familial and national elements that influence how mental health problems and help-seeking are viewed. Colucci et al (2015) investigated facilitators and barriers to mental health service delivery in Australia for youth with refugee backgrounds. Analysis of focus groups and key informant interviews with 115 service providers identified eight key themes: cultural concepts of mental health, illness and treatment; service accessibility; trust; working with interpreters; engaging family and community; style and approach of mental health providers; advocacy; and continuity of care. The authors consulted with refugee young people; all emphasised the importance of obtaining the views and experiences of youth themselves, particularly when designing services and mental health programmes.

Rather than constituting a health crisis within an individual, Thira (2014) maintains that mental health problems should be seen as a *community crisis* with
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social, political and economic causes that call for a cultural approach. This approach recognizes the importance of diverse worldviews and values, family and kinship connections, the role of community, a holistic understanding of wellness that includes religion or spirituality and the intergenerational impacts of forced or asylum-seeking migration (Marshall et al, 2016).

Potvin-Boucher and Malone (2014) suggested three elements to be considered when promoting MHL with refugee youth. First, refugees come from a diverse array of cultures and ethnicities; although there may be commonalities, there are important differences of experience that warrant recognition. With regard to gender, for example, Guruge and Butt (2015) noted that more female than male refugee youth are diagnosed with mental health problems. Tastsoglou et al (2014) suggest that giving refugee women opportunities to share their stories could have a positive impact on societal awareness. There is also a need to address structural barriers that may segregate and devalue female refugees in schools, agencies and community settings (Marshall et al, 2016).

The second element is promoting refugee youth engagement in MHL. This includes fostering an understanding of cultural past and present that acknowledges strengths and overcoming obstacles; this can be a precursor to developing a sense of cultural identity (Potvin-Boucher and Malone, 2014). Cultural approaches emphasize experiential activities, community rituals and intergenerational social gatherings. Teachers, counsellors and mental health professionals can work with community members to help youth integrate traditional and host country ways. Mentoring and leadership activities can build teamwork and healthy relationships that foster a sense of belonging and self-esteem – key aspects of positive mental health. Opportunities to engage in art, singing and storytelling activities help develop skills while facilitating youth’s learning of culture and language (Lopes et al, 2012). Schools are often seen as the preferred setting for refugees to access mental health support (see, for example, Kutcher et al, 2016, p 156). School-based health clinics offer a timely and multisectoral approach to healthcare that includes physicians, nurses, substance use counsellors and social workers; these clinics can be co-located with other community resources such as language services and day care to provide refugee youth the best possible chance to develop MHL. Research indicates this coordinated approach is effective (Chiumento et al, 2011).

Facilitating youth empowerment to make healthy choices is the third element to consider. Potvin-Boucher and Malone (2014) maintain that respect is a key aspect for empowerment as well as the expectation that everyone takes responsibility for their actions. Encouraging youth to ask for help from peers and adult allies and viewing this as a sign of strength can address the problem of stigma or shame associated with needing and seeking help for mental health difficulties (Moses, 2010).

The above discussion has underscored the importance of culture, engagement and empowerment as the elements needed to promote and improve MHL among refugee youth. The next section focuses on how to foster MHL among the professionals who support these youth.
Enhancing professionals’ mental health literacy

Several principles and practices have been demonstrated to be effective for teachers, counsellors, mental health practitioners and other adult allies who wish to enhance their own MHL to work more effectively with refugee youth (Whitley et al, 2013). These include establishing cultural safety, implementing Mental Health First Aid practices and addressing stigma. In addition, concepts such as *post-traumatic growth* (Tedeschi and Calhoun, 2004) and the use of culturally appropriate mental health resources enhance professionals’ own MHL capacity as well as their intervention effectiveness.

*Cultural safety*

Cultural safety is essential to any discussion of refugee MHL; culturally safe practices recognise and respect the cultural identities of others and safely meet needs, expectations and rights (Brascoupe and Waters, 2009; Josewski, 2012). Although people understand mental health in culturally bound ways, this fact is not always acknowledged in mainstream mental health education and service delivery (Pinto-Foltz et al, 2011). Researchers have identified a number of help-seeking barriers among refugees (Colucci et al, 2015); these include access to services, misunderstandings due to cultural and language differences and the perception of stigma associated with mental illnesses (Chalmers et al, 2014). A lack of cultural safety is one explanation for this reluctance to seek help.

Cultural safety includes both process and outcome aspects (Josewski, 2012). As a *process*, cultural safety provides a critical lens to address the unequal power relations in education and health services delivered to refugee and other minority populations. Professionals need to become aware of how power and privilege operate in their relationships with youth. Furthermore, they need to discuss signs and symptoms of mental illness within a cultural context. Achieving the *outcome* of cultural safety involves adopting culturally sensitive and respectful attitudes and practices as well as making cultural adaptations to health education programmes (Brascoupe and Waters, 2009).

*Mental Health First Aid (MHFA) practices*

MHFA is based on the familiar practice of providing first aid in physical health situations and is defined as ‘the help provided to a person who appears to be developing a mental health problem or in a mental health crisis’ (Kitchener and Jorm, 2008, p 55). MHFA training includes the following: attitudes, knowledge and beliefs that help in recognising, managing and preventing mental illnesses; information about specific disorders; knowing how to find mental health information; understanding risk factors and causes; how to promote appropriate help-seeking; and learning about self-help strategies and what professional help is available (Ganshorn and Michaud, 2012).
Originally intended for a broad range of public audiences, specialised versions have subsequently been developed for educators, helping professionals, first responders, youth workers and cultural groups, including refugee adults and youth (Kanowski et al, 2009). Evaluation studies have consistently demonstrated that completion of MHFA training results in positive changes in MHL, knowledge and use of skills and decreases in mental health stigma (Kitchener and Jorm, 2008; Health Canada, 2012).

The action-oriented first aid aspect of MHFA is captured in the acronym ALGEE: Assess risk of suicide or harm, Listen non-judgmentally, Give reassurance and information, Encourage the person to get appropriate professional help, and Encourage self-help strategies. These five actions can be applied to diverse mental health problems, including depression and anxiety. They also have been adapted for use in schools and community settings (Health Canada, 2012).

Youth Mental Health First Aid (YMHFA) is a variation of the standard MHFA course that is specifically designed to improve the MHL of adult service providers who work with adolescents (Kelly et al, 2011). The YMHFA programme emphasises the importance of early intervention to minimise the impact of mental health problems. Evaluation of a YMHFA programme showed improvements in participants’ knowledge, attitudes and helping behaviours (Kelly et al, 2011). An adaptation of the programme was designed specifically for assisting refugee and Indigenous Australians (Kanowski et al, 2009). Historical, cultural and political forces affecting refugee mental health were recognised in the adaptation.

In a recent study by Chalmers et al (2014), a panel of youth mental health professionals reached consensus about culturally appropriate communication strategies for providing YMHFA to refugee adolescents. Several guidelines were recommended: incorporating cultural influences, using culturally appropriate communication, discussing options with youth and handling cultural challenges. Barriers to accessing service were identified, such as language, mobility, discrimination and shame. Empowering refugee adolescents to make informed choices about seeking mental health assistance was a strong theme among this diverse group of practitioners.

**Addressing stigma**

Myths about mental illness comprise a significant part of MHL (Jorm et al, 2008), leading to stigmatising beliefs and attitudes that result in discrimination. In spite of 50 years of research and recommendations to address the stigma of mental illness, it continues to be a major hurdle in the help-seeking process (Moses, 2010). Therefore, challenging the underlying myths of stigma is a significant component of promoting positive MHL. Professionals need to understand the multiple elements of stigma and to develop strategies to combat cultural and other stereotypes that undermine positive mental health attitudes (Health Canada, 2012).
**Post-traumatic growth**

Coined by Tedeschi and Calhoun (2004, p 228), *post-traumatic growth* refers to ‘the positive change that many people experience as the result of their struggle with highly stressful circumstances.’ It is important to differentiate this concept from resilience, which is the ability to ‘bounce back’ or return to normal levels of functioning following adversity (Tedeschi and Calhoun, 2004). In contrast, post–traumatic growth denotes a transcendent change ‘that goes beyond an ability to resist and not be damaged by highly stressful circumstances; it involves a movement beyond pretrauma levels of adaptation’ (2004, p 4). Viewed in this light, significant pain or suffering can lead to a positive and transformational change in functioning. Tedeschi and Calhoun (2004) propose three types of positive change associated with posttraumatic growth: (1) *changes in self-perception* – increased sense of personal strength, a change in priorities and life choices or an increased appreciation for life and one’s existence; (2) *interpersonal relationship growth* – an increased sense of closeness in significant relationships or with others who have experienced significant suffering or pain; and (3) *spiritual and existential growth* – developmental changes in spiritual beliefs or existential questions. This concept of post–traumatic growth seems particularly relevant for refugee populations.

**Resources to support refugee youth MHL**

There is a growing number of interventions and programmes that aim to reduce mental illness stigma and improve MHL among children and adolescents (Pinto-Foltz et al, 2011), including school-based curricula, knowledge-contact initiatives, multimedia tools, online resources and theatrical drama. Several examples are described below; all have cultural components, and a few have been developed specifically for refugee youth.

Visual resources have been used to promote health, MHL and wellness for refugee young people: graphic novels (similar to comic books), DVDs, posters and mobile phone apps. Multimedia and arts-based activities also offer refugee youth opportunities to work with and learn from other refugees and with host country youth (Schwarz and Crenshaw, 2011; Ferrari et al, 2015; Gavigan and Albright, 2015). Canadian research indicates that refugee youth are ‘likely to take advantage of such opportunities if they were offered’ (Edge et al, 2014). These activities are not only therapeutic for refugee youth (Quinlan et al, 2016); they can also raise self-confidence by increasing social connections with non-refugee peers (MacNevin, 2012). Such activities can also increase connections in the community (Correa-Velez et al, 2010), helping to integrate refugees into broader society. Participating in extracurricular and community activities that are not heavily language-based can help increase self-esteem, prevent social isolation, and build social networks (Stewart, 2014).

In Canada, the Healthy Aboriginal Network (2014) publishes graphic novels that address health and social issues. *Just a Story*, for example, is about mental
health stigma; another entitled *Lost Innocence* is about the impact of residential schools. These graphic novels can be used with individual youth in counselling and health service contexts as well as with groups in schools, cultural programmes and community organisations.

*Beyondblue* (2015) is a national initiative established in Australia in 2000 to address issues associated with depression, anxiety and related disorders. The *beyondblue* four-part message is Understand, Do Something, Help Someone, and Get Involved. The main website provides general information; there is a separate site for young people aged 12 to 25 called *youthbeyondblue* (nd). The user-friendly website offers a 24-hour helpline, online chats, information, apps, downloadable resources, videos and links to people’s stories.

The Pan-Canadian Joint Consortium for School Health (nd; see also Morrison and Peterson, 2015) has created a ‘Positive mental health toolkit’ to promote positive mental health perspectives and practices for youth in school contexts. The intent of the toolkit is to facilitate a process for engaging school and community strengths to support youth mental wellbeing. It is paired with a ‘Better practices’ document that includes information, activities and resources for all school levels.

An intervention entitled *In our own voice* (NAMI, nd) is designed to improve MHL and reduce stigma (Pinto-Foltz et al, 2011). Administered by NAMI in the US, this one-hour programme uses narrative storytelling, discussion and a video presentation. Initial evaluations of the intervention have demonstrated some improvements in MHL and reduction of stigma among adolescents and young adults (NAMI, nd).

**Fostering a climate for learning**

Developing a positive, engaging climate for learning is important when considering sensitive and emotion-focused topics such as refugee MHL (Westeman, 2010). In addition to culturally appropriate content, educators need to draw on their knowledge and skills regarding youth communication and learning. Adolescents look to teachers as knowledgeable adults they can trust. Using youth-friendly communication styles and avoiding assumptions can facilitate the discussion of mental health topics. Since youth today spend much of their time online, digital formats are a good way to engage their attention. A few suggestions are highlighted below.

Moses (2010) observed that mental health information and treatment-seeking among adolescents is significantly influenced by the opinions of peers and influential adults. Adolescents often prefer to discuss mental health issues with their peers, but may be reluctant because they anticipate negative responses and stigmatisation (Jorm et al, 2008). Because mental health beliefs and mental health stigma are grounded in social relationships and contexts, it is important to establish a climate of openness and acceptance in the classroom and other learning environments. In recent research with mental health practitioners who worked
with refugee youth (Marshall et al, 2016), acceptance, relationship building and trust were universally endorsed as essential for success.

Professionals need to adopt youth-friendly communication approaches when attempting to engage refugee youth. Westeman (2010) outlined an 11-step model of engagement for youth in mental health treatment that has been tested with rural and urban youth. It includes elements such as relationship building, choosing appropriate locations for conversation, sitting side by side with youth, acknowledging non-verbal expressions, being aware of belief systems and having access to a cultural consultant. Westeman acknowledged that particular or local contexts have specific values, expectations and practices; however, her model has universal elements that can be adapted or extended. Although developed for mental health practitioners, teachers can easily implement most of the steps.

Although each person’s context is, to some extent, unique, Chalmers et al (2014) found that helping professionals endorsed many of the same communication practices with refugee adolescents as with non-refugee adolescents. These practices include asking where they feel comfortable and safe to talk, taking time to build rapport and trust, being reliable and consistent, listening without interrupting, being genuine, talking calmly, having awareness of body language and offering possible courses of action. Many educators and helpers will possess knowledge and skills that are appropriate and adaptable for refugee youth, particularly if the youth are living in urban environments or away from traditional homelands. Moreover, as Chalmers and colleagues observed, those helping refugee youth should not be so focused on cultural awareness that they lose sight of the often universal emotional needs that are present.

Avoiding assumptions is another key point. Teachers and other professionals should consider the particular challenges that some refugee youth may be facing, such as problems due to discrimination, bullying, multiple deaths or losses among family and friends or anger related to past injustices (Chalmers et al, 2014). At the same time, it is equally important that helpers not assume that a young person is facing any or all of these problems. As a research participant in Chalmers et al’s study noted: ‘It is important to recognise historical factors that may lead to shame but essential that the first aider takes the adolescent on face value without pushing previous trauma upon them’ (2014, p 8). It is also important to look for strengths and signs of resilience in youth; this emphasises the positive aspects of MHL in contrast to a problem focus.

Digital formats should be considered as effective media when working with adolescents. Today’s youth spend significant time online: US figures suggest nine hours a day (Rideout, 2016). Youth are comfortable online and can easily keep pace with new technologies that enable the revitalisation of traditionally text-heavy materials into something they can access readily. Mental health information and resources can be transformed into digital visual formats such as graphic novels, videos and websites (for example, www.youthbeyondblue.org). The popularity of mobile phone apps, online chat services and e-counselling among youth attest to the importance of using these new technologies in efforts to enhance youth
MHL. Online formats can be more accessible and less threatening for hesitant help-seekers, especially if there are language barriers.

Conclusion

Many refugee adolescents and young adults will continue to forgo beneficial and potentially life-saving mental health treatment unless help-seeking barriers such as access, cultural context, stigma and lack of understanding are effectively addressed. A key strategy is to focus on adopting culturally relevant and culturally safe programmes and practices to improve MHL – among the youth themselves as well as among the professionals working with them. Schools, community youth programmes and youth-serving agencies can offer developmentally appropriate learning and skill-building environments in which the promotion of MHL should be a priority. A central consideration is how to actively engage and empower refugee youth in culturally safe ways. To date, there is little information or evidence published about how teachers and educational programmes can successfully foster MHL among refugee youth; more research and evaluation studies are needed.

As Potvin-Boucher and Malone assert: ‘Our youth are our future and our responsibility’ (2014, p 344). A cultural approach can foster MHL among refugee youth and supporting adults. In this chapter we noted several promising strategies, programmes and resources; most are readily adaptable to diverse environments, including schools. A culturally relevant and culturally safe approach to MHL will benefit refugee as well as non-refugee youth, and support them along the path of mental wellness.

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