

Working with refugee young people: a nurse's perspective

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KEY WORDS

Refugees; young people; acculturation; mental health; support systems; resettlement

ABSTRACT

Objective

To improve the health outcome of young people from a refugee background through sharing nursing experiences and processes that can be used to effectively address young people's health related problems.

Setting

Primary Health Care.

Subjects

Newly arrived young people between the ages of 12-24 years from a refugee background.

Primary argument

There is evidence that a young person's personal responses to history of torture and trauma, displacement, loss and interruption to family life; intertwined with adolescent uncertainty may lead to particular challenges. All young people require nurses and clinicians with the knowledge and skills to address their health problems. However this particularly vulnerable group also require health professionals that can approach these young people and their families in a manner that is culturally and professionally acceptable. This paper seeks to share some of the experiences gained while working with adolescents and youths from refugee backgrounds including common health issues raised by young people, their families and communities. In addition it will suggest some processes that are being used to address health issues. This includes setting up a health initiative that seeks to address health issues in a familiar supportive environment that is acceptable to the young people their families and communities.

Conclusion

Refugee young people are a special group of people with different needs when compared to adults from a refugee background. It is very important for nurses to identify these needs and know how to identify the problems young people from a refugee background face. As clinicians it is very important to be aware of the issues facing refugee young people and the best way to approach young people so they feel welcome. Working with refugee young people requires patience and relationship building. It is very important to treat refugee young people as individuals and to involve the young people and their families in the treatment and problem solving as much as possible in order to get the best result.

INTRODUCTION

Refugee young people in Australia enter the country through the humanitarian program and may have experienced and/or witnessed traumatic events such as war and armed conflicts (Carlson et al 2012; Bond et al 2007). Young people comprise 12% of the refugee population who arrived in Australia between 2012-2013 (Department of Immigration and Citizenship 2013). Some of these young people enter Australia unaccompanied and some with their families. Common health problems for refugee young people are different from the health problems for the general population (Griffiths et al 2003) due to exposure to various traumatic experiences including mass murder, rape, extreme deprivation and torture (Aptekar 2004 pp377-410; Grizenko 2002). The common health problems for refugee young people include: post-traumatic stress disorder (PTSD) (Jefferson 1999; Cunningham and Silove 1993 pp751-762); infectious diseases, poor nutrition, dental problems, undiagnosed chronic conditions and physical trauma (Burnett and Peel 2001; Gavagan and Brodyaga 1998). Their vulnerability increases when faced with barriers associated with migration such as language and culture. Refugee young people require culturally appropriate and trauma sensitive services. The host community's policies and practices have a large impact on the health outcomes of young refugees during the resettlement period (Bhabha and Schmidt 2008; Silove et al 2000). Nurses are often the main health contact for these young people. It is vital that nurses working with refugee young people are equipped with knowledge and skills to deliver quality effective care. Although there are a few guidelines written on working with refugees for example Foundation House (2012), these are mainly directed towards medical practitioners. There is very limited material for nurses working with refugee young people. This lack of professional support and guidance may put the nurse looking after young people at risk of burnout and developing secondary trauma (Griffiths et al 2003). However it is very difficult to have a manual that suits all refugee young people taking into consideration the diversity of the refugee communities and cultures even for those from the same country. It is also important to note there are limited studies about refugee young people in Australia as most of the information used is from the international community (Cameron et al 2011). This paper seeks to share some of the experiences and problem solving techniques that have been helpful across cultures in trying to help improve the refugee young people's health outcomes and improve the relationship between the health personnel and young people.

MAIN HEALTH RELATED PROBLEMS IDENTIFIED

Psychological trauma

It is very important to note that psychological trauma for young people from a refugee background may happen before migration, while in transit or during the resettlement period. It is acknowledged that there are a lot of changes that happen naturally during the adolescent stage of development due to hormonal changes and changes in the anatomical structure of the brain (Paus et al 2008); however these changes can be disturbed by trauma that happens during adolescent and teenage years. Studies such as Brough et al (2003) and Fazel et al (2009) proved that although young people are resilient they are at risk of psychological issues even after resettlement. Before migration, a lot of young people experience and witness war; murders; bomb explosions; rape or sexual violence and a lot of torture and trauma inflicted to them or their relatives (Bean et al 2006; Sourander 1998; Felsman et al 1990). Despite surviving these atrocities some adolescents may not want their psychological issues addressed. A lot of young people though admitting to history of torture and trauma often just want to forget about it and move on (Halcon et al 2004). During transit young people face numerous issues in a foreign country where resources are often very limited; there is uncertainty about their final destination and they are often required to learn a new language. After arrival into the country of resettlement, young people find it very difficult to adjust; learn the new language and catch up academically. During resettlement

young people may feel the pressure of role changes within the family. These tensions may arise from their ability to quickly learn the new language resulting in the 'mini-parent' phenomena whereby they become the key negotiator/translator in the family helping with appointments, shopping and communication. A lot of young people with post trauma experiences have been missing out on getting help and later on these problems have been resurfacing mostly as behaviours (Brown et al 2006; Lloyd 2006). A mental health assessment for young people in the first few weeks after arrival often does not yield any positive results. It helps to let them settle first; form relationships; gain their trust; then do a mental health assessment when support systems are in place such a school, church, friends and the community. Linking them into health groups and main stream youth health services does help young people to interact with others and form relationships. When doing mental health assessments for refugee young people it is very important to note they may have a very low literacy level, even in their own language, or may be fluent in another language such as the language spoken in the country of asylum. Trauma experience varies depending on the country of origin and where the young person was while seeking asylum. For example; if young a young person was in a refugee camp the trauma experiences may be linked to lack of resources like clean water, healthy food, medications and clothing. Young people who were staying in their community may have witnessed death, bombs and shelling in the streets. One effective treatment approach is to focus on symptoms. As noted in a systematic review conducted by Gardiner and Walker (2010) and Perkonig et al (2005) adolescents may present with the following symptoms: learning and behavioural problems, poor appetite and sleep, psychosomatic symptoms, enuresis and encopresis as well as low self-esteem and guilt. For a more accurate assessment it is suggested to involve the family mostly because family experience has shown to have an impact on their children's mental health (Gardiner and Walker 2010). In the case of refugee young people, it is mainly exposure to war and trauma affecting both children and parents and their emotional response is usually interrelated (Panter-Brick et al 2009; Thabet et al 2008; Heptinstall et al 2004).

Vision and Hearing

Vision and hearing problems affect a third of young people from refugee backgrounds (World Vision 2009). The absence of good hearing and vision may affect resettlement and learning capabilities. Some of the reasons that increase the risk for refugee young people are: (WHO 2012; CDC 2012).

- poor nutrition such as deficiencies in vitamin A for vision and Iron for hearing;
- the effects of chronic ear /eye infections or infectious disease such as measles, mumps and rubella;
- noise from bombs and shelling; and
- Physical trauma to eyes and ears due to torture.

However, if you ask the young person whether they have any vision problems most of them will say no due to a number of reasons:

- not knowing that they have difficulties in hearing or seeing clearly;
- fear of the stigma attached to not being able to function normally;
- not sure what will happen to their refugee status if they are found to have health problems; and
- fear of the costs involved.

Parents and carers can be vital in answering some questions about the client's past medical history; however the medical history must never preclude the need to physically perform a screening test for both vision and hearing problems. The main thing is early detection of health issues as it is beneficial to both the consumers and the service providers; it saves costs and improves the outcome (Belli et al 2005).

Dental Problems

Dental problems are very common in newly arrived refugee young people. This may be attributed to poor health systems, lack of resources, lack of clean drinking water and nutritious food. Most young people have their dental health as a priority and will tell you about their dental problems, some will not be sure. Some young people will say no to treatment and dental problems due to fear of costs involved and previous bad experiences. As the vast majority of refugees are not covered by private health insurance it is very important that the young person is referred to public health services that bulk bill. Options such as dental vouchers and the school dental programs need to be discussed. The process needs to be explained to the young person and their family; ask the family for information regarding the young person's dental health as well as examine the mouth especially of school age young people.

Abnormal blood results

The most common abnormal blood results in refugee young people are: low vitamin D, strongyloides, hepatitis B, non-immunity to infectious diseases such as measles, and Rubella. The main thing is for the nurse to be able to identify the abnormal results and get appropriate treatment for the young person, for example attending to the catch up schedule for immunisations (NMHCR 2013). Referring to resources such as Foundation House (2012) can also be helpful.

Acculturation

Acculturation is a process of adapting to a culture different from the person's culture of origin. This process is a known stressor and risk factor that can affect the health and behaviour of newly arrived refugees (Bhugra 2003; McKelvey et al 2002; Clark and Hofsess 1998, pp37-59). For example most parents fear for their children during acculturation because they are scared they might lose their customs and traditions especially for girls where, for example, chastity means a lot to refugee communities. On the contrary, this may be a barrier that can hinder the young person to access some services. Most young people from a refugee background do not wish to identify or be known as refugees. This is mostly because:

- whilst they acknowledge they are from a refugee background they are no longer refugees;
- there is a stigma attached to the word 'refugees' which is portrayed by the host communities; and
- young people want to be seen and treated like their counter parts in the main stream population.

Because of the above reasons, young people make a big effort to adapt to the new culture as soon as possible and will respond very well if not treated in isolation.

Support Systems

Support systems are very important for young refugees as they offer much needed support mostly during the resettlement period. This support is mainly offered by the school, friends, community and family. In a longitudinal study done by Correa-Velez et al (2010) they suggested that protective factors for young people include: how fast the young person can learn the new language, starting relationships with friends and community, supportive family and school.

COMMUNITY

The community is very important to both the young person and their family as culture religion and language plays an important role in the coping mechanism for young people (Cameron et al 2011). In a study done by Geltman and Cochran (2005) community integration was proven to improve health prognosis in refugee young people.

Health Initiative

School based clinic

Why school based refugee clinic?

In 2012 the New South Wales Refugee Health Service commenced a once a week refugee health clinic at a high school in south western Sydney. This clinic was commenced in recognition of the trust young people and their families had with the school environment and was underpinned by the following:

1. To safe guard the existing health policies on equity of health; cultural competence (NSW Multicultural Act 2000) and safeguard young people's wellbeing (NSW Youth Health Policy 2011-2016, 2010).
2. To adopt research recommendations from the Population Council (2009) and the NSW Research Report Access to Health Care among NSW adolescents' (2002).
3. The Australian health system is fragmented and there are many barriers to providing effective health care (Smith 2006; Tiong et al 2006) which makes the services hard for young people to access.
4. A large number of refugee young people had missed a lot of schooling due to war and conflicts and as a result find it difficult to miss a day of school for a health related appointments.
5. The need for a one stop shop for refugee young people where they can access a variety of services under one roof.
6. Young people feel respected in the school as they are likely to be the centre of attention, not only at school but from the community, and they are given opportunities to make choices on issues affecting their health; such as choosing the topic of discussion for a health education talk or asking for their consent to share information with their parents and teachers.

This initiative has been successful and well supported by the community because:

- school is involved which is the main support system for the young people;
- young people feel more relaxed and are happy to discuss issues like sexual abuse and trauma which is very difficult to do in a clinic environment;
- there is continuity of care and it is easy to follow up the young person where there are issues such as change of residential address and phone number; and
- Counselling and health promotion activities such as cooking classes are held at the school.

Making Referrals

Referring young people to services in the health system can be a daunting task. This is because our health system is often fragmented. Some specialist areas such as intellectual disability and physical disability can be difficult to access. Unlike most Australian children who are diagnosed at an early stage, clients come to the clinic as teenagers and without a diagnosis. It takes a lot of negotiation and hard work to refer such clients. Young people can be linked with the general practitioner. In some cases the young person may be uncomfortable with the family doctor discussing sexual health and women's health issues. It is important to link them with a youth friendly doctor so they feel free and comfortable to talk about their health concerns.

This issue has been addressed by nurses from the refugee health clinic visiting medical centres, explaining what services the clinic provides and seeking support and assistance from the general practitioners. This method has worked well to date.

CONCLUSION

Refugee young people are a vulnerable group that belong to families and communities. Their needs and the way nurses and clinicians approach and address these young people need to be specific and acceptable to them. Young people from a refugee background need to be treated as individuals who belong to a family not just as part of the family. They need to be consulted and have an informed choice on issues that affect their health just like main stream young people. As refugee nurses experiences in primary health nursing and experience gained through working with refugee young people is heavily relied on. It is crucial to note that nurses should continually develop the ability to practice cultural awareness so that they recognise personal cultural assumptions that may affect the way they approach refugee young people's health needs (Purnell and Paulanka 2008; Racher and Annis 2007). As noted by Brough et al (2003), there is lack of evidence based support when working with refugee young people even though there is a lot of information to support their vulnerability. There is need for more studies and research on effective ways to work with refugee young people that is appropriate and culturally acceptable.

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