A REVIEW OF THE INTERNATIONAL LITERATURE ON REFUGEE MENTAL HEALTH PRACTICES

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ABSTRACT

This article is a summary of the literature review for the Refugee Mental Health Practices study. The goal of the study is to fill the gap in empirical research on services that are available for refugees to Canada which supports their mental health, emotional wellbeing, resiliency and recovery. The review is organized according to themes relating to three levels: the individual (refugees); the level of social systems (medical care and service provision), and policy-level decision-making.

ACKNOWLEDGEMENTS:

The Refugee Mental Health Practices study was funded by Citizenship and Immigration Canada.

Since 2000, Canada has supported the resettlement of approximately 7,500 refugees annually. With the introduction of the Immigrant and Refugee Protection Act, *IRPA*, in 2002, the criteria for eligibility for government-assisted resettlement softened to give greater consideration of refugees' needs. With less emphasis being placed on their ability to integrate quickly, "many refugees now have different settlement needs that include special requirements arising from years of trauma or torture followed by years in camps" (Pressé & Thomson, 2007).

The mental health of refugees has received more attention in the academic literature than have studies of refugee economic integration, social identity or adaptation (Ryan, Dooley, & Benson, 2008). While there is some existing data on the mental health concerns and needs of refugees, there is a greater gap in empirical research on mental health services for refugees in Canada (Yu, Ouellet, & Warmington, 2007). This article is a brief summary of a literature review from the Refugee Mental Health Practices study, a project which seeks to fill this gap in empirical research[i]. The review is organized according to themes relating to three levels: the individual (refugees); the level of social systems (medical care and service provision), and policy-level decision-making.

REFUGEE-LEVEL THEMES

EXPLANATORY MODELS

Recent work has sought to understand how refugees and other ethno-minority groups conceptualize and express emotional distress and how these cultural conceptions may differ from the Western medical perspective or vocabulary. Studies have sought to understand the gaps between clients and mental health services, and how differences may be bridged. Arthur Kleinman's concept of *explanatory models* [EMs] is heavily invoked in this literature. Explanatory models are "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. …The study of the interaction between practitioner EMs and patient EMs offers a more precise analysis of problems in clinical communication" (Kleinman, 1980). Mental health professionals who work with refugee clients must be aware of differences in explanatory models, that is, notions of cause, course and treatment for mental distress.

CONCEPTUAL MODELS OF HEALTH AND CARE

The Western or *biomedical* model of health care is understood to be one where the client, as an individual, seeks professional care. The professional may have no other relationship with the client than that of diagnosis and treatment, and the relationship is unidirectional: the patient changes, while the medical practitioner goes about her or

his work. It is important to bear in mind that the biomedical explanation of health and illness, which is common to Canadian and many other medical professionals in the Western tradition, is itself an explanatory model, one which may not be comprehensible to all clients, particularly refugees who are also ethno-cultural minorities (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006).

In many traditional cultures, the model of care emphasizes the connection of self and one's community, with a preference for social forms of intervention when mental health support is needed. The interconnectedness of self and society is taken to be axiomatic; therefore, responsibility for care of the individual rests with the family or community. *Psycho-social* or *social-ecological* models of health care are conceptual frameworks for understanding the health of individuals within society and include social determinants of mental health, such as income, social support, employment, housing, and education (Public Health Agency of Canada, 2005; World Health Organisation, 2001).

Among Southeast Asian refugees, the most important factors contributing to positive mental health in the post-migration period were being in a stable, significant personal relationship, and having stable employment (Beiser, 1999). Having ethnic or ethnic-like community supported mental wellbeing initially, but was not necessarily supportive in the long term. An interactional model is put forth to explain the more complex relationships between an individual and social resources that contribute to mental health (Beiser, 1999).

TRAUMA DISCOURSE

Many refugee mental health studies have sought to determine the prevalence of Post Traumatic Stress Disorder (PTSD) and other mental illnesses. Meta analyses of research findings on the extent of trauma and emotional distress and associated social factors in specific refugee populations is presented in Table 1.

Concern has been expressed about the lack of culturally sensitive diagnostic tools used in academic studies (Keyes, 2000). Moreover, the application of the concept of PTSD to refugees and other marginalized communities has been challenged for pathologizing individual responses to events which often have a social and political origin (Bracken, Giller, & Summerfield, 1995; Burstow, 2005; Friedman & Jaranson, 1994).

While medical care for acute mental disorders should be available upon resettlement, refugees' psycho-social needs must also be addressed. As Porter and Haslam (2005) suggest, humanitarian efforts to improve the post-migration social and material experiences of refugees would likely have a positive influence on mental health outcomes.

SOCIAL SUPPORT

Support networks are known to protect refugee mental health, and resettled refugees in Canada may engage in seemingly counter-intuitive secondary migration in order to be nearer to family and their own ethno-cultural community (Simich, 2003; Simich, Beiser, & Mawani, 2003). Qualitative data show that the affirmation of shared experiences through community-level support is a strong determinant of refugee wellbeing (Beiser, Simich, & Pandalangat, 2003; Simich et al., 2003). These findings corroborate epidemiological data showing that post-migration conditions matter to refugee mental health (Fazel et al., 2005; Porter & Haslam, 2005).

Refugee or ethno-cultural communities may not have the capacity to address acute mental illnesses

TABLE 1: Results of Meta-Analyses

REFERENCE	TOTAL ARTICLES	TOTAL REFUGEES	KEY FINDINGS AND CONCLUSIONS
Mental Health Status in Refugees: An Integrative Review of Current Research (Keyes, 2000)	n = 12	n =2,065	• At least one negative mental health state present in populations studied • Only one-third of studies used culturally sensitive measurement instruments • Psychological concerns *and* physical complaints present in all the studies that used culturally sensitive diagnostic tools
Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis (Porter & Haslam, 2005)	n= 56	n = 22,221 refugees and 45,073 non refugees	• Post-migration economic, social and housing conditions influenced mental health. • Worse outcomes experienced by refugees living in institutional accommodation and experiencing restricted economic opportunity. • Refugees who were older, more educated, female, had higher pre-displacement socioeconomic status and rural residence also had worse outcomes.
Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review (Fazel, Wheeler, & Danesh, 2005)	n=20	n= 6,743	• 9% to 11% of refugees resettled in Western countries were diagnosed with post-traumatic stress disorder (PTSD). • 4 % of resettled refugees experienced a generalized anxiety disorder, and about 5% suffered from major depression.

without the help of medical professionals, yet they may be well-equipped to support mental wellbeing and prevent emotional distress. Programs in Canada (Li, Koch, & Angelow, 2008) and in the United States (Weine et al., 2003) have sought to formally encourage social support through multi-family group-therapy types of programs. Some agencies match clients with volunteers in a befriending program or foster mutual supports groups with a goal of breaking down isolation (Canadian Centre for Victims of Torture, 2009). Many formal programs are offered through settlement and social service agencies, which do not often have the capacity to engage in evaluation and reporting of their activities. Therefore there is a need for more empirical research.

SYSTEMS-LEVEL THEMES

PROGRAM ACCESSIBILITY AND BARRIERS

Refugees face many barriers to accessing mental health services, both in Canada and internationally. In Canada, the challenge is in part due to the difficultly of finding culturally appropriate care and the lack of interpretation services in the health care system in general (Gagnon, 2002; Scheppers et al., 2006; White, 2008). Similar under-usage of health services has been found by ethnic minorities in other industrialized Western nations (Chow, Jaffee, & Snowden, 2003; Guerin, Abdi, & Geurin, 2003; Scheppers et al., 2006; Ten Have & Bijl, 1999). While mental health service providers in Canada are working to eliminate systems level barriers, perceptions of barriers may persist. Perceived accessibility of a service influences attitudes towards seeking help. If the perception of access to mental health services is improved through outreach programs, then more refugees and ethnocultural minorities may be encouraged to use services (Fung & Wong, 2007).

Ingleby (2009) puts forth three components to accessing services: entitlement to care (a question of legality and status), ease of accessibility, and the level of trust one has in a service and expectation of positive results (Ingleby, 2009). Scheppers and colleagues categorize barriers to services according to a three-level model of interaction: patient level, provider level, and system level (Scheppers et al., 2006). While differently directed, both models emphasize a dynamic and systemic understanding of access and barrier, rather than focusing on the individual in need of care.

MODELS OF SERVICE DELIVERY

A number of approaches and models of service delivery have been described. These include inductive models based on the qualitative input of clients and service providers, a model of a specific service or program being piloted, and broad approaches or schools of thought which influence service provision. Ingleby and Watters (2005) use the following groupings: mainstream health care approaches; multicultural health care approaches; sociological health care approaches; managed care, and service provision which has been influenced by the users' movement.

Currently in Canada, there is a focus on client-centred care, which should include refugees and ethno-cultural minorities. Ryan, Dooley and Benson (Ryan et al., 2008) advocate a *resource-based model*, in which resources are personal, material or social. Services premised on such a model would acknowledge that refugees are not passive victims of trauma; they are active survivors in a new environment which affects their mental health and adaptation as well (Birman et al., 2008; Birman & Tran, 2008) Services that capitalize on refugees' resources should be considered in future policy and programming decisions.

BRIDGING PRIMARY CARE AND MENTAL HEALTH

The importance of bridging primary care and mental health systems is underscored often by the World Health Organization (World Health Organisation and World Organization of Family Doctors (Wonca), 2008; World Health Organization, 2009). Upon arrival in Canada, refugees' primary health care needs often have not been met for many years, and it is through primary care that most refugees experience their first contact with the Canadian medical system. Mental health concerns are often raised in primary care settings, in the context of dealing with physical problems. Headaches, fatigue, difficulty sleeping, and difficulty breathing are physical complaints that may be expressions of psychological disturbances (Patel, 2002; Summerfield, 2005).

To increase capacity in primary care settings to better work with clients from diverse cultures, holistic, anthropological perspectives may aid in medical training and practice (Gozdziak, 2004; Kleinman, 1980). Some practitioners have promoted the need for recognizing the roles of spirituality (Collins, 2008; Mollica, Cui, McInnes, & Massagli, 2002) and the family (Stepakoff et al., 2006) in refugee mental health care. Given the barriers refugees and ethno-cultural minority groups face when accessing mental health services, some initiatives have sought to bridge services from multiple sectors, including mental health and social services, and to foster informal, community supports. Success has been demonstrated in programs that bridge gaps among services and build the internal capacity of agencies to better work with cultural minority clients (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Yeung et al., 2004).

POLICY-LEVEL THEMES

LACK OF POLICY

The World Health Organization's 2001 Annual Report, "Mental Health: New Understanding, New Hope," states that most countries do not have a national mental health policy. This statement applies to Canada, with different levels and breadth of service coverage across the country, compounded by a lack of policy to address the needs of low English/French proficiency clients (Abraham & Rahman, 2008). There has been movement towards filling this gap in recent years. The consultation activities of the new Mental Health Commission of Canada and publication of a discussion paper on Ontario's mental health care strategy (Ontario Ministry of Health and Long Term Care, 2009) are examples.

While mental health is a concern for all Canadians, refugees are especially vulnerable. They have experienced significant pre-migration stress and likely need services immediately upon entering Canada, yet they cannot be expected to know how to access those services. However, it is the post-migration conditions that potentially have the greatest moderating effect on refugee mental health and which the Canadian policy environment is most able to address. Current pre-settlement health screening practices in refugee camps are narrowly focused, and leave insufficient opportunity for mental health promotion and prevention (Gushulak & Williams, 2004).

MULTI-LEVEL GOVERNANCE

The Canadian context of health policy and programming is affected by the constitutional division of power of the federal and provincial governments. Health—including mental health—falls within the domains of the provinces and territories, and the transfer of federal health funds to the provinces and territories occurs when the latter have met the conditions of the federal Health Act. Thus, any discussion of pan-Canadian mental health policies is also a discussion of multi-level governance. In case studies of settlement programming and administration, the most successful cases are those in which all levels of government meaningfully work with local service providers, and where the later participate in the design and implementation of the programs (Leo & August, 2009; Leo & Enns, 2009). As noted above, economic opportunity and quality of housing are important predictors of emotional wellbeing in refugees. This is a strong argument for coordinating supports and services across traditionally separate sectors—in this case, housing, the labour market and health—when designing refugee resettlement policy and programming.

CONCLUSION

Current resettlement programs do not meet the mental health and wellbeing needs of Canada's newcomers, in particular refugees. Displaced people who have sought refuge in Canada face real challenges in obtaining culturally appropriate services for mental health problems that may not be understood well by medical practitioners. Given Canada's humanitarian commitment to refugee resettlement and the more acute needs of today's refugees, there is a need for culturally inclusive and appropriate mental health care practices for refugees. In particular, practices should be based on models which are more likely to be understood and accepted by clients from diverse cultural backgrounds, and which do not take the individual as the sole unit of care, but which included the family, the community, or the broader population. At the program or service level, more culturally competent care is needed. Programs may have no obvious institutional barriers, but because there has been little outreach to refugee and ethnic minority communities, the perception of accessibility needs to improve, as well as the quality of care. While some mental health service and settlement service providers are working to provide more comprehensive care at the local level, the lack of integration of sectors and services is most appropriately addressed at the provincial and national policy or systems level.

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FOOTNOTES

[1] The full review will be available with the final report, in spring of 2010.