

The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review

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Les déterminants sociaux de la santé mentale des réfugiés dans le contexte post-migratoire: une revue critique

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Abstract

With the global increase in the number of refugees and asylum seekers, mental health professionals have become more aware of the need to understand and respond to the mental health needs of forced migrants. This critical review summarizes the findings of recent systematic reviews and primary research on the impact of post-migration conditions on mental disorders and PTSD among refugees and asylum seekers. Historically, the focus of mental health research and interventions with these populations has been on the impact of pre-migration trauma. Pre-migration trauma does predict mental disorders and PTSD, but the post-migration context can be an equally powerful determinant of mental health. Moreover, post-migration factors may moderate the ability of refugees to recover from pre-migration trauma. The importance of post-migration stressors to refugee mental health suggests the need for therapeutic interventions with psychosocial elements that address the broader conditions of refugee and asylum seekers' lives. However, there are few studies of multimodal interventions with refugees, and even fewer with control conditions that allow for conclusions about their effectiveness. These findings are interpreted using a social determinants of health framework that connects the risk and protective factors in the material and social conditions of refugees' post-migration lives to broader social, economic and political factors.

Abrégé

Avec l'accroissement mondial du nombre de réfugiés et de demandeurs d'asile, les professionnels de la santé mentale ont pris conscience de la nécessité de comprendre les besoins de santé mentale des migrants forcés et d'y répondre. Cette revue critique résume les résultats des récentes revues systématiques et de la recherche primaire sur l'effet des conditions post-migratoires sur les troubles mentaux et le trouble de stress post-traumatique (TSPT) chez les réfugiés et les demandeurs d'asile. Historiquement, la recherche et les interventions en santé mentale auprès de ces populations ont porté sur l'impact du traumatisme pré-migratoire. Le traumatisme pré-migratoire prédit les troubles mentaux et le TSPT, mais le contexte post-migratoire peut être un déterminant aussi puissant de la santé mentale. En outre, les facteurs post-migratoires peuvent modérer la capacité des réfugiés de se rétablir du traumatisme pré-migratoire. L'importance des stressors post-migratoires pour la santé mentale des réfugiés suggère le besoin d'interventions thérapeutiques comportant des éléments psychosociaux qui abordent les conditions de vie élargies des réfugiés et des demandeurs d'asile. Toutefois, il y a peu d'études d'interventions multimodales avec des réfugiés, et encore moins d'études qui utilisent des conditions de contrôle qui permettent de conclure sur leur efficacité. Ces résultats sont interprétés à l'aide de déterminants sociaux du cadre de la santé qui relie les facteurs de risque et de protection des conditions de vie matérielles et sociales post-migratoires des réfugiés aux facteurs sociaux, économiques et politiques plus généraux.

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The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review

An unprecedented number of people are currently experiencing forcible displacement.¹ There were 65.6 million people forcibly displaced in 2016, the largest number ever recorded. Of these, 22.5 million were refugees, displaced across international boundaries. The 1951 Convention Related to the Status of Refugees defines refugees as people who have a well-founded fear of persecution due to their religion, race, political beliefs, nationality, membership in a social group or sexual identity, who cannot rely on their country of nationality to protect them.² Convention refugees are afforded unique rights and protections by the signatories of the Convention;³ although, the manner in which these rights are interpreted and implemented can be variable and can change with a shift in political will, resulting in very different conditions of asylum between countries and within countries over time.⁴

Few of the internationally displaced persons find permanent solutions. In 2016, 552,200 returned to their country of origin, whereas 23,000 naturalized in the country in which they sought asylum. Only 189,300 benefitted from a resettlement program, where refugees are screened and selected while in their country of asylum and resettled permanently into a third country.⁵ Moreover, whereas the average length of displacement has remained between 10 to 15 years over the last decade, the average length of displacement for those in protracted situations is now over 20 years.⁶ Most of the millions of refugees who are forcibly displaced will remain so for most of their lives; 80% of them in low-income countries.⁵

Recent years have also seen an increased number of asylum seekers, particularly in Europe. Asylum seekers are those who await formal recognition as refugees in order to be eligible for the protection afforded those with refugee status. In 2016, there were 2 million new claims made for asylum, 722,400 of them made in Germany alone.⁵ Asylum seekers are particularly vulnerable. While they await the review of their claim, asylum seekers often face restrictions on access to employment, housing, education and other normal conditions of residence. Increasingly, they face complete restrictions on their freedom in the form of detention, often in conditions that have been found to be degrading, punitive, and inhumane.^{7,8}

The recent large migration flows into Europe and Australia have increased attention to how to address the needs of refugees and asylum seekers, and resulted in greater demands for services appropriate to their needs, including health and mental health services. However, these influxes have also led to debates about who deserves protection and

what states' obligations are to provide it, to more restrictive refugee and asylum policies, and to a surge in anti-migrant and specifically anti-refugee and anti-Muslim sentiment.^{9,10} An Ipsos poll,¹¹ with 16,040 respondents in 22 countries found that 51% of respondents agreed somewhat or very much that most refugees entering their country were there for economic reasons or to take advantage of their welfare services. Similarly, a study conducted with 18,000 eligible voters across 15 European countries found that anti-Muslim bias was a key determinant of lower public support for refugees.⁹ Thus, at the same time that mental health services are becoming more sensitive to refugees' unique needs, forced migrants may be seeking asylum or settling into environments that are becoming less welcoming and more challenging at both the material and social levels. The goal of this review is to summarize the impact of these material and social conditions on refugee and asylum seeker mental health, and the effectiveness of multimodal mental health interventions that encompass these broader social determinants of health.

Predicting Mental Disorders among Refugees and Asylum Seekers

Exposure to violence and trauma, particularly repeated exposures and extreme violence such as torture, are associated with an increased risk for mental disorders, including post-traumatic stress disorder (PTSD).¹² Studies find that refugees have elevated rates of mood disorders, psychotic illness, and PTSD relative to non-migrant, resident populations.¹³ However, the rates of mental disorders vary widely from study to study. Systematic reviews of refugee mental health research note that large-scale studies with better methodology (e.g., random sampling) typically find lower rates of mental disorders among refugees than studies with smaller samples and weaker methods (e.g., self-report v. diagnostic interview), with methodology accounting for as much as 50% of the variance in reported rates.^{12,14,15} Higher quality studies find rates of PTSD and depression to be at or below 15%.¹² The research thus suggests that, although rates of mental disorders are higher in refugees and asylum seekers than among the general population, most are not suffering from mental disorders and most recover from the distress of their migratory experiences within 1 year of resettlement.^{15,16}

However, research also clearly indicates that refugees' mental health is highly influenced by the conditions that they live in post-migration.¹⁷ Different rates of mental disorders are observed in different countries. Those residing in refugee camps in low-income countries show the highest prevalence of anxiety and depression, reflecting the highly stressful conditions typically encountered in the camps. But rates also vary among high-income countries, and these differences

have also been tied to exposure to stressful events because of material and social conditions for refugees and asylum seekers there.^{14,18} The impact of exposure to these stressors may also be cumulative. An increased length of displacement is associated with poorer mental health outcomes,¹⁹ suggesting that the long-term mental health for refugees and asylum seekers may deteriorate because of resettlement into highly stressful settings. Consequently, those working in refugee mental health are calling for models that recognize and address post-migration conditions and the social determinants of refugee mental health.^{20,21}

The Social Determinants of Mental Health

It has been well established that physical and mental health are determined not only by biological factors but also by social ones. The risks for developing mental disorders and poorer mental health are greater for members of groups with less access to power, material resources and policy making as a result of broader social, political, and economic factors that sustain inequalities.^{22,23} The social determinants of health include material variables that are shaped by these broader social and policy forces, variables such as access to safe environments, adequate food and housing, high-quality health care, and appropriate employment. These material variables can have long-term and developmental effects in addition to the more obvious immediate risks. The social determinants of health also include interpersonal variables, like experiences of social exclusion, discrimination, and low social status. Both material and interpersonal social determinants influence health and mental health through psychological states such as stress, perceptions of control, and social networks, which in turn have effects through biological pathways including neuroendocrine, neuroimmune and epigenetic responses.^{24,25,26}

The post-migration social conditions of refugees and asylum seekers often place them at the lower end of the social gradient. As will be detailed below, this is partially due to the nature of forced migration, but is also a result of policies and public attitudes towards them, including their membership in groups that are stigmatized by the communities into which they migrate (e.g., as migrants, and/or as members of minority ethnic, racial, or religious groups). The result is often prolonged material deprivation, uncertainty, and social exclusion. Thus, many refugees and asylum seekers are at risk for poor mental health not only because of prior traumatic exposures, but also because of post-migration social determinants of health, and the impact of those determinants may increase over time. The variables that are consistently found to affect refugee and asylum seeker mental health are described below.

Income

Income has been found to be a particularly powerful determinant of health, and affects common mental health disorders in every age group, from young children through

adolescence into adulthood.^{25,27} Regardless of their original socio-economic background, refugees often leave behind most of their material possessions, including businesses, properties from which they derived livelihoods, savings, and even documentation demonstrating their qualification for their profession. Although some are able to bring resources with them, many cannot. As a result, many arrive in a situation of relative poverty, and can remain in a situation of poverty for many years.^{28,29} Several studies of refugee mental health have found a relationship between low socio-economic status and PTSD, distress, and/or depression.^{14,30} A meta-analysis of 59 studies comparing refugee mental health to that of resident populations revealed a clear linear relationship between refugees' mental health and measures of their economic opportunity, a composite construct including the right to work, access to employment, and socioeconomic status.¹³

Employment

Financial challenges are clearly linked to poor employment opportunities. The struggle to find adequate and appropriate employment, or even any employment, is a particularly common experience for refugees.^{31,35} Refugees can face greater employment challenges than voluntary migrants because the choice of whether, when, and where to migrate is much less under their control. As a result, they are less likely to arrive speaking the official language, which has consistently been found to be a major barrier to employment.^{31,36} They may also face greater challenges in having their credentials recognized, because they may not be able to produce documentation of their training. Although recognition of credentials and previous experience in a new country is a challenge shared by many migrants, one study in Canada showed that the challenges can be greater for refugees, who are more likely to be overqualified for their current employment.³⁷ Moreover, overqualification is associated with lower self-reported mental health, consistent with other research showing that unemployment affects mental health for reasons beyond economic well-being, having an impact on one's status and sense of self-worth.^{24,27}

Housing

Poverty is also strongly associated with inadequate housing. Inadequate housing can include overcrowding and safety risks, such as lead paint, hazardous electrical or structural elements. Overcrowding and inadequate housing have consistently been linked to poorer mental health outcomes in the general population.²⁷ Refugees tend to be resettled into poor-quality housing, struggle to afford the housing they have, and experience overcrowding, because of their financial constraints. Inadequate housing and financial difficulties, in addition to family separation, were the greatest sources of post-migration stress for refugees from the former Yugoslavia currently living in Germany, Italy, and the UK.³¹ Housing

challenges are further exacerbated by housing policies and practices that are particularly likely to affect refugees, such as requiring down payments or reference letters, and discrimination that effectively excludes them from better housing and safer neighbourhoods that have better services and amenities.^{28,32,33,34}

Language Skills and Interpretation

Language barriers also significantly affect refugee mental health in both qualitative and quantitative studies, and are a determinant of depression.^{14,38} Language skills are an issue in employment, as mentioned above, but fluency in the language of the country of asylum/settlement, or access to interpreters, has pervasive effects. The absence of qualified, professional interpreters emerges as a frequent issue in health settings, where it can have serious consequences for access to health care and treatment.^{39,40} Moreover, a lack of interpretation services is also a barrier to accessing, understanding, and navigating a range of social policies and legal conditions and can thus also limit refugee and asylum seekers' ability to advocate for their rights.⁴¹ The availability of interpretation services can be addressed through policies but, in some settings, there is a reluctance to use interpreters; studies have document under-utilization of available interpretation services by health care professional, suggesting a need for broader advocacy and education among service providers.^{34,42}

The Asylum-Seeking Process

The asylum-seeking process is associated with numerous stressors and poorer mental health outcomes.¹⁶ Asylum seekers must typically await preliminary acceptance of their claims before accessing even temporary permission for employment. They may therefore spend months or even years without access to legal employment, and, for some asylum seekers, permanency may be a remote or even impossible outcome, leaving them particularly vulnerable.

Momartin and colleagues³⁵ detailed the impact of holding temporary visas among refugees in Australia, half of whom had been accepted and received permanent visas while overseas, whereas the other half had arrived as asylum seekers and received only temporary visas. Relative to those with permanent visas, most with temporary visas reported higher levels of stress because of the conditions of their visa and poorer post-migration conditions across multiple indicators (e.g., fear of being sent home, separation from families, and poor access to health care). Although PTSD, anxiety, depression, and general distress were predicted by post-migration living difficulties for all respondents, visa status was the strongest predictor of anxiety and depression, thus emphasizing the importance of stability and security in mental health. Here too, the effects may be complex and cumulative, with some research showing that the longer one awaits an asylum claim, the less likely one is to find employment.^{29,43}

Social Support and Social Isolation

Loneliness and isolation are common concerns in most studies of refugee mental health.³⁰ Social isolation is a particularly salient determinant of mental health among older adults in the general population, especially among women,²⁷ and for older refugees, who are particularly at risk for poor mental health.^{13,14} Language skills, discrimination, and poverty can contribute to social isolation, as can family separation, which is a common aspect of forced migration and related to policies of refugee reunification. Family separation is an important determinant of mental health,³⁶ listed as one of the primary causes of post-migration stress among refugees from the former Yugoslavia.³¹ Separation from family members may contribute to a lack of social support, which was found to predict depression in all 29 studies in a review of the mental health of refugees 5 or more years after displacement.¹⁴

Discrimination

Numerous studies suggest that the extent to which refugees feel welcomed or experience hostility has an impact on their mental health. Feeling accepted in one's country of settlement has had a significant impact on mood disorders among refugees from the former Yugoslavia.³¹ A large qualitative study with Colombian refugees in Ecuador found that regular experiences of discrimination and exclusion were associated with high levels of stress, anxiety and depression.⁴⁴ A longitudinal study with refugee youth in Australia found that experiences of discrimination were one of the main predictors of non-completion of secondary school.⁴⁵ A Canadian study found that refugee youth reported more internalizing disorders than did immigrant youth drawn from the same ethno-cultural groups but that differences between the groups' prevalence of internalizing disorders were no longer significant once refugee youths' greater experiences of post-migration trauma and discrimination were taken into account.⁴⁶

Psychosocial Interventions for Refugee Mental Health

There are few evaluations of mental health interventions for refugees, and most emphasize prior exposure to trauma rather than daily hassles, despite evidence that the stress of daily life post-migration is equally or even more important in determining mental health and, moreover, alters the impact of pre-migration trauma.^{19,47} For example, the aforementioned study comparing the long-term mental health of refugees from the former Yugoslavia found that the effect of traumatic war events on mood disorders decreased with time, but only for those with more positive post-migration conditions; this shows that the impact of pre-migration trauma on mental health may be dependent on the settlement context.³¹

The small number studies on mental health interventions with refugee populations have found that cognitive

behaviour therapy (CBT) and narrative exposure therapy are successful for reducing symptoms, particularly for PTSD, and especially when compared to wait-list controls. Their effectiveness for anxiety and depression is mixed at best, and the effects for PTSD are smaller for treatments compared with active control groups.^{48,49,50} The effectiveness of therapies for PTSD is more variable in refugee and asylum seekers than the general population.^{19,51} However, as noted above, these interventions typically involve trauma-focused therapies for pre-migration trauma. It is argued that the dominant focus on PTSD overlooks other aspects of refugees' mental health and well-being, such as family relationships or their sense of meaning.⁵⁰

Considering the impact of post-migration stressors, recommendations for practice suggest multi-modal approaches that include therapy along with assistance with practical issues.⁴⁹ This includes interventions with interdisciplinary team members who then provide different aspects of care, such as medication, psychotherapy, settlement and/or social counselling, or social support. Other recommendations are working beyond the individual and offering services to individuals, families and groups.⁴⁹ However, multi-modal studies that include components of settlement as well as therapy and/or medical care are both less frequent and less likely to include control groups, making their evaluation difficult.^{18,51} For example, in their recent review of PTSD treatment for refugees, Nickerson and colleagues identified only 4 multi-modal treatment studies. These studies were generally not successful in reducing symptoms of PTSD or other disorders, but none included control groups.⁴⁹

Van Wyk and Schweitzer⁵² reviewed 7 naturalistic mental health interventions for refugees, where treatment was provided in the context of an existing service and is thus assumed to be more ecologically valid. The existing services housing these interventions were largely specialist services for refugees that focused on torture or trauma. Interventions in these settings offered a range of different psychological approaches, including CBT, exposure therapy, psychodramatic treatment, and existential analysis, and usually also included both social and medical services. The interventions identified by van Wyk and Schweitzer generally showed decreases in symptoms, but the effects were inconsistent across the studies, samples were very different in terms of culture and past experiences, and, again, the studies lacked control groups and, usually, a sufficient description of the psychological services provided.

One recommendation has been for interventions that build collective identities and support networks that may also address the stigmatized labeling of refugees as passive and dependent¹⁸ but there is limited evidence about the effectiveness of this approach, largely due to study limitations.⁵⁰ Nonetheless, group-based interventions hold promise, as they could address both social isolation and advocating for the rights and material needs of refugees by allowing the communities and individual community members to organize and interact; this may also help to

change the post-migration conditions typical to these individuals.^{18,53}

Nickerson and colleagues⁴⁹ also note that addressing post-traumatic symptoms may help refugees to address other sources of stress in their lives. This highlights the complex and synergistic relationship between refugee mental health and the broader social context. It also points to the need for more longitudinal research, particularly research that identifies who might benefit most from psycho-social approaches and at what point in their settlement these might be most effective.¹⁷

Conclusions

Refugees are influenced by the same social determinants of mental health as the general population. However, the nature of the refugee migration experience, national and regional policies of deterrence and migration, and public attitudes towards refugees result in a greater likelihood of negative social conditions post-migration. Post-conflict conditions associated with the migration process, such as experiences of detention, extended insecure status, and restrictions on the ability to find employment and/or housing, can have a powerful impact on mental health. Despite the exposure to numerous risk factors, most refugees who have permanently resettled do not have mental disorders; rather, they show remarkably resiliency. But this resiliency can be undermined by their current conditions.

The focus on pre-migration trauma and serious mental disorders may be limiting our knowledge on how to best address other common mental health concerns, such as depression and anxiety, and issues of loss, family relationships, and identity. It may even have harmful effects. First, by defining refugee experiences in terms of trauma, we may be focusing the public's attention on discriminating between those who do and do not meet the definition of refugees, which can result in more negative attitudes to refugees overall.^{7,54} Second, the focus on trauma can obscure the impact of the conditions that refugees and asylum seekers reside in after leaving their countries of origin, and our need to address these conditions.^{17,30} Third, the focus on past trauma can increase compassion towards refugees as deserving of protection but also portrays them as a potential burden on the communities into which they settle, which may exacerbate the integration challenges they face by increasing stigma and reducing their perceived competence.⁹ Thus, although awareness of appropriate trauma-focused care is essential to refugees' health and well-being, we need to move beyond a focus on past trauma and explore current stressors and the efficacy and viability of holistic interventions that include the present lives of the whole person and their community.

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