Refugees and mental wellbeing. A call for community approaches in Aotearoa New Zealand

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Abstract

Purpose – *The purpose of this paper is to examine community based, trauma informed to support refugee mental health and wellbeing, recognising that refugee status is met through forced displacement in which refugees have experience of personal human rights abuses and have survived atrocities in which family and community have been lost.*

Design/methodology/approach – *A co-production approach was taken to review existing literature and policy to produce a position statement on how to better meet the needs of people who experience mental distress who are refugees. The co-production was between refugee and mental health researchers and refugee representatives.*

Findings – *Understanding the mental health needs of refugees has conventionally focused on incidence of mental illness such as post-traumatic stress disorder and depression. If mental health and illness are understood as a continuum, diagnosis of mental illness indicates a significant problem, and furthermore access to services is predicated on risks associated with mental illness. When accessing mental health services, refugees have an added issue in a lack of communication availability and recognition of the trauma that they have survived.*

Originality/value – *In this paper, a different position is advocated, that understanding the mental health of refugees can be framed more effectively as a process of recovery from trauma that emerges during resettlement, and over a long period of time before people are able to talk about the trauma they experienced. Community-based responses that enable recovery from trauma are more readily able to meet the mental health and wellbeing needs of refugee communities.*

Keywords *Refugees, Mental health, Aotearoa New Zealand, Wellbeing, Trauma, Community approach*

Paper type *Research paper*

(Information about the authors can be found at the end of this article.)

Introduction – the context

Linked to the trauma caused by forced migration, refugees unsurprisingly have higher levels of diagnosable mental illness and face challenges accessing services. People who have survived war and forced migration are more likely than the general population to experience trauma which can continue for many years (Barbui *et al.*, 2022; Bogic *et al.*, 2015). This article is concerned with the question of what approaches best meet the wellbeing needs of refugee communities, if we consider that trauma recovery improves wellbeing. In Aotearoa New Zealand, there is a dearth of research locally to understand whether and how mental health needs are recognised and acted upon. This article originated in a question about how the needs of refugee communities are met in Aotearoa which raised a question of how best to meet the needs of these communities. The team of community members and researchers identified this broader question about how support the wellbeing of refugees.

Globally, forcibly displaced people are at unprecedented numbers due to increased war, persecution and climate change. At the end of 2022, there were an estimated 108.4 million forcibly displaced people worldwide, of whom 35.3 million are refugees and 5.4 million are asylum seekers (United Nations High Commissioner for Refugees (UNHCR), n.d.). Resettlement is one of the permanent or durable solutions for displaced people who are forced to migrate (UNHCR, n.d.), alongside reunification with origin country. Aotearoa New Zealand draws on a humanitarian framework to welcome refugees via three pathways, which are the quota programme which takes up to 1,500 people annually, refugee family support category (RFSC), up to 600 people annually and the refugee and protection pathway which has taken an average of 106 asylum seekers per year since 2012 (Immigration New Zealand, 2023a). The newly introduced Community Organisation Refugee Sponsorship (CORS) pilot programme offers an avenue for community organisations to sponsor and support the resettlement of a modest number of refugees annually (Immigration New Zealand, 2023b).

The New Zealand Refugee Resettlement Strategy (RRS) was developed in 2012 and updated in 2023. The aim is for former refugees and their families to successfully settle, achieve their goals and thrive in Aotearoa (Immigration New Zealand, 2023c). The Strategy identifies feeling safe and well, having a sense of belonging and opportunities to fully participate as aspects of successful resettlement (Immigration New Zealand, 2023c). A common finding of research is that health services in Aotearoa are variably and unequally available to different refugee groups (Ferns *et al.*, 2022). Thus, a welcome addition to the 2023 Strategy is the inclusion of non-quota refugees (Immigration New Zealand, 2023c) including convention refugees and protected persons, those who entered via the CORS and RFSC pathways, and Afghan interpreters and evacuees resident visa holders (Immigration New Zealand, 2023c). The 2023 Refugee Resettlement Strategy operationalised five settlement outcomes: (i) participation and inclusion, (ii) health and wellbeing, (iii) housing, (iv) education, training and English language and (v) employment and self-sufficiency. The health and wellbeing pillar includes access to mental health services as one of three success indicators. The original 2012 success indicator for quota refugees still stands and states that a minimum requirement is one face-to-face visit at a mental health related appointment within the first 12 months after arrival. The New Zealand Refugee Resettlement dashboard indicates high engagement with general practitioner (GP) services with only 3%–4% of refugees not attending a GP appointment in the previous 12 months, and lower engagement with mental health services with 45% attending one face-to-face visit in 2018 (pre COVID-19 data) (Ministry of Business, Innovation and Employment, n.d.). More accurate and relevant indicators would help identify what support is required and the reality of lived experience of refugees in resettlement over time. Once a recognition of need is identified, the responsibility to provide competent knowledge and skills to enact policy and provide community-based support is required.

Resettlement is often a stressful period where people acclimatise to a new country while potentially simultaneously facing hostility and racism in host communities. International and local evidence consistently demonstrate that stress and discrimination at the interpersonal and/or systemic level, have detrimental effects on the wellbeing of minority groups, limiting access to support services (Stubbing *et al.*, 2023). The COVID-19 pandemic restrictions impacted the resettlement processes faced by refugee communities because of the time delay for contact with family members. Furthermore, the literature identifies challenges faced by refugee communities when accessing mental health services characterised by cultural insensitivities, barriers to access and a lack of adequate service provision (Byrow *et al.*, 2020). There is also a growing critical awareness of the limitations of Western-centric services (Bracken *et al.*, 2021) meeting the needs of refugee communities.

In 2022, we formed a cluster of researchers, lived experience refugees and service providers interested in improving the mental health and wellbeing among refugee background communities. With the goal of contributing to conversations and actions in this space, we collaboratively wrote this commentary drawing on international and national literature about the mental health needs among refugees and service delivery approaches to provide suggestions for improvement to better meet the needs of these communities. This commentary advocates for mental health provision in Aotearoa to draw from broader, more culturally encompassing theories of wellbeing and embed community partnership models to better support the needs of refugee background communities. This echoes recent calls for global action to improve the mental health of refugees through specific interventions at the family, community and society levels (Grasser, 2022).

Understanding the wellbeing and mental health needs of refugees

Mental illness and mental health are distinct but related concepts (Westerhof and Keyes, 2010). Mental illness is associated with the presence of psychopathologies as categorised in the diagnostic statistics manual or international classification system of disorders and illnesses. Mental health refers to flourishing or positive mental health. Westerhof and Keyes (2010) define three aspects that make up mental health which are *emotional wellbeing* – feelings of happiness and satisfaction with life, *psychological wellbeing* – positive individual functioning and *social wellbeing* – positive societal functioning in terms of being of social value (Westerhof and Keyes, 2010, p. 110). When viewed in this way a person may have a diagnosed mental illness but still have good mental health or conversely not have a diagnosed mental illness but experience illbeing. Conceptualising mental health related to emotional, psychological and social wellbeing aligns with the pillars of resettlement but not with the threshold access to mental health services which is guided by risk of harm to self or others. It also aligns with broader conceptualisations of wellbeing such as the capabilities approach (Nussbaum, 2011) that aims to provide solutions to inequities that result from global problems, such as war and human rights abuses.

Host countries play a critical role in determining mental health outcomes for refugees. In Aotearoa, research has highlighted that refugees have higher than population rates of post-traumatic stress disorder, anxiety and depression (Bloom and Udahemuka, 2014; Ferns *et al.*, 2022; Park *et al.*, 2022; Shrestha-Ranjit *et al.*, 2017). The experience of trauma at the point of forced migration can be reaffirmed through the pre-, during and post-migration journey (Cénat *et al.*, 2020). Resettlement is a potentially stressful time of adversity that can also contribute to mental health challenges. Resettlement is aided by access to health services and financial, social and practical resources, that decrease stress and support mental wellbeing (Feyissa *et al.*, 2022). Within refugee populations, ongoing unemployment, lack of stable housing, experiences of discrimination, visa uncertainty, familial separation and poor living conditions negatively impact wellbeing and increase the likelihood of developing significant distress (Byrow *et al.*, 2020; Hynie, 2018). For instance, Steel *et al.* (2002) investigated the connection between resettlement trauma and mental health among the Vietnamese refugee population in Australia. While high exposure to premigration trauma was the strongest predictor of current mental illness, the study also noted that factors such as employment status, household characteristics and English language proficiency were associated with mental illness (Steel *et al.*, 2002).

Intersectionality is a factor in how people respond to potentially distressing situations because that layer onto previous discriminations or harms that trauma. Lindert *et al.* (2016) identify the need for mental health responses that understand the impacts of human rights violations and "humiliation", for example the experience of humiliation through torture or sexual assault, as a precursor to the experience of trauma and poor

mental health. Given the challenges of gaining research participation and inaccuracy of medical records, research that engages refugee communities is particularly important to understand the extent of mental health challenges. Research that engaged communities found increased rates of post-traumatic stress disorder, depression and anxiety (Tonui, 2022), with associated higher rates of distress among women (Zheng *et al.*, 2022) and marginalised groups such as those belonging to lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI+) community. For refugees who identify as part of the LGBTQI+ community, trauma from persecution is a factor that contributes to poorer health outcomes with the added stress of disclosing transgender and/or sexual identities whilst facing the uncertainty of forced migration (Mulé, 2022). Women and older adults have increased risk of negative mental health outcomes following resettlement due to decreased opportunities for employment, language proficiency and adapting to the new culture and environment (Steel *et al.*, 2002).

Mental health service provision and refugee communities

Suboptimal access to mental health services among refugee populations remains (Mazumdar *et al.*, 2022; Zheng *et al.*, 2022) and inadequate provision of services to address the needs of refugees continues (Kanengoni-Nyatara *et al.*, 2023). Contextual factors pose barriers to addressing the mental health of refugee populations that include a lack of cultural awareness among service providers, lack of culturally diverse health professionals, limited professional and public knowledge about the refugee journey and limited access to interpreters (Jarvis and Kirmayer, 2023; Shrestha-Ranjit *et al.*, 2017). Conversations about trauma experienced by refugees amongst mental health professionals were commonly under prioritised (Sharif *et al.*, 2021).

In Aotearoa, services for mental health are primarily provided by statutory services and by non-governmental organisations and more diverse and trauma-informed provision responsive to multicultural communities has been called for (DeSouza, 2006). Statutory services have limited ability to provide first language therapists, and the threshold for service access is dependent on the person's level of need with priority given to people who are in medium to high needs. Non-governmental organisations can support refugee mental health, but are under-resourced and have limited capacity, resulting in limited geographical coverage and long waiting times. In primary care, limited mental health provision exists, but the complexity of trauma recovery is met with referrals to secondary services. Psychological treatments for trauma are available through Accident Compensation Corporation, but refugees do not meet criteria for access to services if the trauma happened outside of Aotearoa. More recently, psychiatry as an arm of colonisation has been highlighted (Bracken *et al.*, 2021) due to emphasis on a singular Western-centric understanding of mental health. Mental health services couched in a biomedical approach are not likely to adequately address the unique and complex challenges faced by refugee populations, hindering the delivery of appropriate care (Ellis *et al.*, 2019). The focus on predefined diagnostic criteria overlooks the social, political and historical factors that contribute to mental health challenges among refugee populations (Gopalkrishnan, 2018; Watters, 2001). Cultural practices that differ from that of the dominant culture are stigmatised or pathologised (Uba, 2003). Rejection of Western taxonomy of illness is framed as stigma, rather than an alternative perspective. This is a form of epistemic injustice (Fricker, 2007) as it denies the reality of the already marginalised culture.

Symptoms of mental illnesses and expressions of distress are historically and culturally located and understood differently among different cultural groups populations, and particularly those with refugee status (Hsu *et al.*, 2004). Every culture has nuanced perspectives on wellbeing, mental health and origins of distress and appropriate interventions, therefore service providers are required to adapt to promote recovery and

not to cause further distress or trauma (Gopalkrishnan, 2018; Vaka *et al.*, 2016). Moreover, mental health services rely on people presenting with Western-centric health literacy, and those who do not request help in this way may not be recognised as having mental health challenges (May *et al.*, 2013, Tonui, 2022). Refugees are generally wary of mental health services due to the risk of unwanted restrictions or treatments incompatible with their cultural and social beliefs systems, not wanting to use mental health services because of a lack of identification with diagnoses of mental illness (Kim *et al.*, 2023). Concerns about acceptability were balanced against affordability (May *et al.*, 2013). The lack of access and acceptable treatment options exacerbate disparities in access, treatment outcomes and overall satisfaction with mental health services (de Anstiss *et al.*, 2009).

Community approaches to supporting refugee mental health

Trauma recovery focuses on mental health needs related to the circumstances that refugees have survived, ongoing losses and the stressors of resettlement. Approaches that work best are human rights-informed, equity focused, localised community generated responses and solutions. Refugees need practical support to enable settlement. Non-governmental organisations provide the kinds of support and connection that enable refugees to cope as well as possible with significant stressors and is preventative. There is a need to design services that are well positioned and provisioned to meet the needs of refugee communities, are longer term to meet ongoing and emergent needs.

There is value in the power of peer support through shared experiences that enable people to connect, understand that they are not isolated in their experience and provide mutual beneficial and relevant support to each other. People often need space in which to understand their group experiences inform a broader understanding of responses that will help that community. For this to work, it needs to be embedded in the community to foster deep seated care and trust so that no further trauma is endured. A recent community development participatory approach to develop principles to underpin health service development highlighted shared community values, characteristics and experiences and using community leaders in all service delivery planning (Kanagaratnam *et al.*, 2022). Community generated responses identified preventative interventions that incorporated tools to help with stress, such as simple yet effective strategies like breathing techniques and reaffirmation of capabilities. Tonui's (2022) qualitative research was with Rwandan refugees in the USA, concluding that holistic, collaborative and integrative approaches are required for engagement to facilitate the practical and emotional support people require. Sharif *et al.* (2021) support that trauma informed care is essential for greater mental health outcomes and that assertive outreach which provides acute mental health care at home, effective in non-refugee populations, may be a more appropriate approach. Im and Swan (2022) designed an interprofessional collaborative training module that helped mental health workers share knowledge and build trust with refugee provider groups to develop knowledge about the refugee community and how stress and mental health challenges are expressed and what cultural responses are usual. This is particularly pertinent for refugee communities to address concerns about the framing of mental illness and potentially problematic treatment which significantly impact service utilisation and help seeking behaviours (Byrow *et al.*, 2020). Addressing the barriers to accessible, culturally safe mental health services for refugees would aid resettlement stress. Acceptable services are those informed by the needs of communities responsive through collegiate cross-agency support. In a review of refugee experiences and responses, Grasser (2022) issued a call for action for more global responses to improve the mental health of refugees; more preventative and treatment interventions at the familial and community level, with technological interventions, mind/body modalities and community focus holding much

promise. Bringing together practical and emotional support counters stress. To find solutions for self-determination and equity as the bedrock to addressing mental health disparities and sustainable long-term health outcomes in refugee communities it is imperative for service design and delivery to be co-produced with communities themselves.

Conclusion

Forced migration through conflict, persecution and displacement results in profound stress and distress, as would be expected in the face of extreme adversity. It is not just individuals that have these experiences, but families, communities, regions, cultures, ethnicities and countries are affected, and this makes trauma interconnected with time, place and people. Experiences are not geographically bound to one place, as the journey continues into new destinations with new societies and systems to navigate. Providing timely culturally safe and congruent care that helps with distress and trauma that takes into consideration these emotional and literal journeys is more relevant and acceptable when based within the communities in which it lives and co-produced with the people who are affected. Recent attention has increasingly turned to the experience of settlement and the systemic multifaceted needs and responses of people who seek refuge. The implementation of appropriate interventions requires not only policy and legislative shifts, but a re-framing of what is included when considering mental health and wellbeing.

Meeting the mental health needs of refugees depends on improving access to support through quality and appropriate services, while at the same time considering the broader social, political and economic determinants of health and wellbeing (Alegria *et al.*, 2018; Byrow *et al.*, 2020; Hynie, 2018). Thus, it is imperative that Aotearoa's future mental health policies and services adopt an integrated, multi-modal approach to the assessment, measurement and treatment of mental health and wellbeing for resettled refugees. As all resettled refugees should be entitled to receive mental health support and services, strategies and policies must be inclusive to all refugees irrespective of the pathway within which they entered Aotearoa. Addressing the gaps in mental health services for refugee populations requires more than a shift towards culturally sensitive approaches while continuing to provide Western-centric services. Instead, it requires a move towards co-designing and delivering services in partnership with refugee communities to recognise and respect diverse cultural understandings of mental health. Importantly, co-governance partnership models enable health providers to meet the health and social care needs of refugee communities through their obligations under Te Tiriti o Waitangi. Current and predicted population demographics and the contextual and sociocultural factors influencing mental health considerations among former refugees can help plan who is involved in those partnerships and the values that will underpin them. It is crucial to develop targeted interventions and policies that address the underlying factors contributing to refugee mental health disparities. Efforts should focus on reducing postmigration stressors through improved support for resettlement, cultural integration programmes and community engagement initiatives.

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Positionality statement. The team came together with various concerns about mental health being under-recognised and supported among refugee background communities. Tula Brannelly is Irish, a registered mental health nurse and social scientist who is originally from the UK and migrated to Aotearoa in 2006 and has an interest in the

experience of mental health service provision for marginalised groups. Anjali Bhatia is a public health researcher working in migrant youth mental health and health-care services in New Zealand. Arezoo Z Malihi, is a population health researcher. As a research fellow for the Centre for Asia Pacific Refugee Studies (CAPRS), she has been researching the resettlement trajectories of refugee groups in Aotearoa New Zealand, including the long-term mental health service utilisation of refugees compared with New Zealand resident population. Lucie Vanderpyl is a PhD candidate at Otago University in the Department of Psychology and a student in the Clinical Psychology Training Program. Her research and practice interests are in improving access to appropriate mental health-related services for refugee background individuals. Buster Brennan was an undergraduate student who received the summer studentship to look at the literature around refugees and mental health and has since graduated and is a registered nurse working in mental health. Leo Gonzalez Perez is a Spanish nurse working in Community Mental Health with an interest in migrant and refugee mental health. Fahima Saeid is CEO of New Settlers Family and Community Trust, and a counsellor who supports refugees affected by trauma. Eleanor Holroyd, is a New Zealand-born nurse anthropologist and co-Director of the AUT Migrant and Refugee Health Research Centre, who has been extensively involved in migrant research in Asia and the Pacific region. Nadia Charania is a public health researcher and a co-Director of the AUT Migrant and Refugee Health Research Centre. Her research programme focuses on reducing health inequities faced by migrant and refugee background communities.

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