K4D | Knowledge, evidence and learning for development

Improving Mental Health among Refugee Women

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Question

What evidence is there to show that offering specific interventions (over and above mental health services provided through a national health system) can improve the mental health and wellbeing of refugee women?

The question refers principally to refugee women arriving via resettlement programmes or the asylum route to be resettled in developed high/middle income countries.

Contents

1. Summary

This review found very little evidence that is backed by robust evaluation to show that other specific interventions improve mental health for refugee women and promote their integration. Wide ranging reviews of evidence from Europe and other developed country contexts, document diverse community based psychosocial interventions but find only a minority of high-quality studies and generally weak methodological approaches (Slewa-Younan et al, 2018). Although many studies record an improvement in mental health the evidence base is low. Data was not systematically disaggregated by gender. Randomised control trials are not used and systematic evaluation of clinical outcomes is lacking (Priebe et al, 2016).

High absolute numbers of people with mental health conditions, from refugee, asylum seeker and migrant groups constitute a significant challenge to health care systems. Some good practices which may reduce barriers to mental health care and facilitate effective treatment are identified by the WHO Health Evidence Network report which considers the evidence on policies and interventions that improve mental healthcare for refugees and include: (Priebe et al, 2016: 13-18)

- Collaboration between mental healthcare, social services and the voluntary sector.
- Providing outreach services to inform and support refugees in accessing services.
- Coordination of different services within the health care system to ensure that refugees with mental health issues are correctly identified and signposted towards appropriate care
- Providing good information on entitlements to healthcare and available services both to people from refugee and asylum seeker groups and to professionals within the healthcare system.

There is also some recognition that interventions that recognise and foster the natural adaptive ways of communities' coping and allow the community to retain a sense of agency and self-respect are useful (Slobodin and de Jong, 2014). The tangible assessment of aspects that made their treatments acceptable and successful is gathered from a small sample of refugees settled in the US and treated for depression, anxiety or post-traumatic stress symptoms (Mitschke et al, 2017). This group clearly place value on peer led programmes where paraprofessionals are culturally and linguistically competent, empathetic and bring their own experience of life as a new refugee. Greater value is found from interventions structured for groups over individual counselling models and programmes are most useful where they can concurrently provide support for practical problems and needs.

There is limited reliable data for types of mental health interventions which actually work for refugee groups with some evidence for the efficacy of specialised cognitive behavioural therapy (CBT) where this incorporates cultural knowledge into standard CBT, and some positive evidence from narrative exposure therapy (NET) (Slobodin and de Jong, 2014). These authors conclude that there is not enough data to confirm or to refute other approaches such as group intervention, family intervention or multi-disciplinary approaches. To date most high quality research in the field of mental health interventions for refugees tends to be dominated by individual psychotherapy approaches set within clinical services models but these are not recent (Nickerson, A. 2011 & Patel, N., 2014 cited in Slewa-Younan et al, 2018:26)

Refugee women are a sizeable, heterogenous and growing group who face several integration challenges associated with poorer health and lower education. They are less successful in labour market outcomes when compared to refugee men, who are already disadvantaged in comparison with other migrant groups. Typically, employment has been regarded as the best

way to fast track social and economic integration of refugees (Banulescu-Bogdan, 2020) with work promoting self-esteem and mental health. For women who are less well educated, may have new children in the immediate period after settlement and other family responsibilities, they are likely to remain out of work and socially isolated for longer with pressure upon their sense of integration, mental wellbeing and knock on effects for their children and the rest of the family. Informal work adjacent activities, or community volunteering programmes often delivered by non-governmental organisations aim to strengthen social ties but are rarely systematically evaluated. Despite their apparent value and solid rationale for promoting women's integration there is limited data on what works (Banulescu-Bogdan, 2020).

Overall the literature describing direct mental health interventions and indirect community based psychosocial non-specialist interventions is wide ranging but there is a gap in robust evidence that would support specific approaches. There is a clear gap in linking interventions to mental health outcomes both immediately post programme and in the medium term given that rates of depression and difficulties in adapting to the new host country may occur for several years after the initial resettlement.

2. Relevant evidence from meta-reviews

Firstly the most relevant evidence comes from an extensive Evidence Check commissioned to provide a summary of the best evidence with respect to effectiveness and appropriateness of community-based, psychosocial support specifically targeted for refugees and asylum seekers in Australia and comparable contexts (Slewa-Younan et al, 2018). This study finds diverse, community-based psychosocial support programmes targeting the mental health and wellbeing of refugee and asylum seeker populations, but such **programmes lack high quality evaluation and the evidence base for each intervention strategy is low.**

This evidence check surveyed recently published peer reviewed and grey literature from 2010-2018[1], to find *What community-based psychosocial support services specifically for refugees and asylum seekers have been effective in improving mental health and wellbeing?* The studies varied considerably in quality, with only 25% being of medium to high, or high quality. The literature reviewed in this evidence check showed gaps in the evidence arising from:

- Lack of quality evaluations
- Limited outcome measures
- Limited description of intervention
- Lack of consideration of the different sub-groups within the target population

The literature showed a wide diversity of strategies classed as psychosocial interventions or support, ranging from psychological therapies (administered individually or as part of a group), psycho-education, health literacy education, interpersonal skills, social and creative-based activities to support the expression of emotions and learning, and supportive practices for child development such as parenting programmes (Slewa-Younan et al, 2018:10).

[1] Published in English and deriving from Australia, UK, Canada, New Zealand, Germany, Sweden and the United States

Four categories of psychosocial support programmes were identified, commonly based on the therapeutic approach, with an exception of school-based programmes based on their setting. These were:

- Trauma informed psychotherapy programmes delivered with a group component
- Community-based psychoeducation and/or health programmes
- Physical activity and sports-based programmes
- Peer support and/or mentoring programmes

Overlooking the methodological constraints above, all the studies (with one low quality exception) find an improvement in mental health or wellbeing outcomes. Although the type of programmes vary, a focus on community or group based setting emerges as a strong consistent theme. "Community-based psychosocial supports are particularly relevant for refugee populations since refugee trauma is often characterised as collective trauma. This refers to the impact of the trauma not only on the individual refugee but also on their family and community. This can be manifested by family breakdowns, lack of trust among members, and changes in child rearing practices. At a macro level trauma can lead to communities becoming more dependent and passive, without leadership, mistrustful and suspicious." Therefore, collective or community-based supports are necessary methods that help refugees establish new social ties, since many former social ties may have been lost as a result of migration. (Slewa-Younan et al, 2018:10).

Secondly, a WHO Health Evidence Network report considers the evidence on policies and interventions that improve mental healthcare for refugees, asylum seekers and irregular migrants. This brings together research findings from a systematic review of available academic and grey literature where a part or all the population studied is found in at least one country of the WHO European Region. The report synthesises findings on the barriers encountered in accessing mental health care and suggests good practice for mental healthcare provision. Findings are qualified in noting that evaluations of initiatives to reduce barriers to care were based on the experience of health professionals and explored using qualitative or quantitative methods. So far, there have been **no reports of systematic evaluations of clinical outcomes or of experimental studies** (Priebe et al, 2016).

Nonetheless the high absolute numbers of people from these groups constitutes a significant challenge to health care systems which in many countries are underfunded and already under strain. The rates of psychotic, mood and substance use disorders in these (refugee, asylum seekers or irregular migrant) groups are generally like those found in the host country populations. An exception is post-traumatic stress disorder (PTSD), which is more common in refugees and asylum seekers (Priebe et al, 2016). The prevalence of depression in refugees is also higher than in the corresponding host country population after more than five years of resettlement. This has been linked to adverse post migratory socioeconomic conditions.

Barriers encountered by refugees, asylum seekers and irregular migrants in accessing mental health care include: (Priebe et al, 2016: 10-13)

- A lack of knowledge of the health care systems in the host country and of their health care entitlements
- Poor command of the language of the host country
- Belief systems and cultural expectations for healthcare that differ from those in the host country, and
- Lack of trust in professionals and authorities, aggravated by concerns over permanent settlement.

Good practices which *may* reduce barriers to mental health care and facilitate effective treatment, that were identified from this review include: (Priebe et al, 2016: 13-18).

- Collaboration between mental healthcare, social services and the voluntary sector. Since the aim is to support social integration, good practice uses education, housing and employment initiatives to promote community relationships and social integration
- Providing outreach services to inform and support refugees in accessing services. NGOs are often well placed to reach beyond the mistrust of host country state organisations.
- Coordination of different services within the health care system to ensure that refugees with mental health issues are correctly identified and signposted towards appropriate care – such as from detention centres, primary care points and accident and emergency units
- Providing good information on entitlements to healthcare and available services both to people from refugee and asylum seeker groups and to professionals within the healthcare system. Alternative means of communicating this information such as video materials or presentations to groups have promoted discussion among peers of sensitive mental health issues and improved uptake
- Reducing language barriers by using native language speaking clinicians (via teleconferencing treatment sessions) and/or use of high-quality interpretation services to provide a better experience for the patient.

Finally, there is limited reliable data for types of mental health interventions which actually work for refugee groups. From a literature review of the research findings from mental health **interventions especially designed for traumatised asylum seekers and refugees** Slobodin and de Jong (2014) find some evidence to support the use of specialised cognitive behavioural therapy (CBT) among Southeast Asians where this incorporates cultural knowledge into standard CBT. Also, some positive evidence from narrative exposure therapy (NET) that acknowledges the narrative tradition common to many cultures and is specifically targeted at refugee populations for this reason. Studies from Germany have shown significant reduction in post-traumatic stress disorder among refugees and asylum seekers using NET (Slobodin and de Jong, 2014:19) but no decrease in depression or other associated disorders was found.

Although almost all studies reported positive outcomes in reporting trauma related symptoms, many of these are limited by methodological considerations such as small samples, no control group and a lack of randomisation. The authors conclude that there **is not enough data to confirm or to refute other approaches** such as group intervention, family intervention or multi-disciplinary approaches. Methodologically rigorous trials are needed in this field especially since the treatment of refugee populations has only recently been considered as a distinct area in mental health (de Jong and van Ommeron, 2002). Systemic interventions that recognise and foster the natural adaptive ways of communities' coping and allow the community to retain a sense of agency and self-respect are also encouraged. These can enhance positive adaptation to new circumstances in both individuals and groups (Slobodin and de Jong, 2014:23).

3. Small scale findings from refugees

The extensive literature reviews cited above illustrate a dilemma: qualitative review by programme participants is likely to show that while some support is better than none, and integration programmes are delivered with positive intent, these interventions are rarely

evaluated, the quality of studies is poor and mental health outcomes in the immediate aftermath of a programme, and more importantly in the medium to long term resettlement period, are unmeasured. In contrast a small-scale study conducted amongst 30 refugees (17 female) from five countries, who had received treatment for PTSD, depression or anxiety and were all resettled in the United States (Mitschke et al, 2017) provides tangible comment on aspects that made their treatments acceptable and successful.

The research was conducted by Cultural Ambassadors, natural leaders and refugees themselves who, with training, were able to conduct semi-structured interviews with group members in their native language. From these the common characteristics of effective mental health interventions were distilled. Major themes were the structure of the programme with emphasis on group support over individual focus. The camaraderie and sense of joint purpose derived from mental health support delivered in groups helped to reduce their social isolation and to progress to helping one another in practical ways and sharing knowledge and ideas. Being in a group with peers also helped refugees to feel empowered (Mitschke et al, 2017:594). Secondly programme content was important, with interventions that were able to vary and balance attention to mental health issues alongside practical needs more acceptable to a majority. Refugees are commonly focused on a wide range of needs to do with adjusting to life in a new country and being able to deal with these effectively is a major contributor to positive mental health. This relates to a view that given Maslow's hierarchy of needs, it is possible that mental health interventions should be preceded by interventions designed to foster a new sense of belonging (Berry, 2001 cited in Mitschke et al, 2017).

To this end, these refugees felt that supportive content as part of mental health programming should include (Mitschke et al, 2017:597):

- Help in navigating the health and social services systems and linkages
- Literacy and language as well as support with attaining host country citizenship (stability)
- A sense of place and connectedness to the natural environment, particularly when missing their home environment
- Advocacy and support in dealings with others (who may take advantage of their refugee status)
- Building a consistent relationship with a counsellor and trust, in order to effectively prioritise problems and needs
- Understanding law enforcement and gaining skills to deal with conflict in contacts with the judicial system.

This study reflects the value of group structure over individual counselling models. It also underscores the value of peer led programmes where paraprofessionals are culturally and linguistically competent, empathetic and bring their own experience of life as a new refugee. Such programmes seem likely to shorten the transition period, make it less traumatic and lead to successful integration outcomes.

4. Unmet need for mental health support

Refugee women are a sizeable and growing group. 45% of immigrants declaring to have arrived for reasons of international protection in the EU were women (EU Labour Force Survey, 2014). Globally, the share of women among those who obtain asylum is larger than their share among asylum seekers and the share of women among those obtaining international protection status has increased from 29% in 2015 to 38% in 2017 (Leibig & Tronstad, 2018). In the EU-28 in 2014,

one in four (26%) asylum applicants was a minor. While many of these accompany a parent there are increasing numbers[2] of unaccompanied minors travelling and arriving in groups with some evidence that girls are more affected by mental illness (Hebebrand et al, 2015).

Asylum seekers and refugees are **more likely to experience poor mental health than the local population** (Mental Health Foundation, 2016) including higher rates of depression, PTSD and other anxiety disorders. This increased vulnerability to mental health problems is linked to both pre-migration experiences, especially exposure to war trauma. The flight experience can in itself be traumatic or compound trauma for example via separation experiences, sexual abuse and trafficking including forced labour and sexual exploitation (Hebebrand et al, 2015). and the post-migration conditions that refugees often face, including separation from family, difficulties with asylum procedures or detention, unemployment and inadequate housing have negative impact on mental wellbeing (Mental Health Foundation, 2016).

There is some evidence that **mental illness among refugee minors** is higher than that of other minors although knowledge is limited and study methodologies are not consistent or always robust (Hebebrand et al, 2015). A survey of refugee minors in Germany found mental illness was observed in 13.7 % with females more frequently affected. This higher risk of females was also found in a review of 17 Canadian studies based on young Canadian refugees; and in Malmö, Sweden, unaccompanied minors, most of them males from Afghanistan, were shown to be overrepresented in psychiatric inpatient care where 3.4 % of unaccompanied minors in contrast to 0.26 % of other minors of the catchment area received inpatient treatment (Hebebrand et al, 2015). Triggers include pre-migration experiences, post-migration family and school environment, problems with group identity being excluded from host country peer groups or stigmatised by virtue of belonging to refugee groups, discrimination, and lack of equitable access to health care.

Refugees and asylum seekers have high mental health needs but under-utilise services in European host countries. Mental health and psychosocial support services (MHPSS) is recommended. These latter may usefully include basic psychosocial interventions such as child-friendly safe spaces, community activities, or low-intensity psychological interventions delivered by lay health care providers (Satinsky et al, 2019); as well as equitable access to a range of mental health services provided by a national health service. However, demand/need is not matched by adequate uptake and **robust evidence for the added value of community based psychosocial interventions is not found**.

A systematic review of the evidence on MHPSS service utilisation and access among refugees and asylum seekers in European Union Single Market countries finds inadequate MHPSS utilisation (Satinsky et al, 2019). Major barriers to accessing care included language, help-seeking behaviours, lack of awareness, stigma, and negative attitudes towards and by providers. Despite high mental health morbidity among refugees and asylum seekers, rates of MHPSS use were low. For example, only 20% of refugees with PTSD in the Netherlands accessed care. In Sweden, psychotropic drugs, antidepressants and neuroleptics were used less frequently among refugees than among the general population, despite higher rates of mental health problems

[2] For example, in Germany in 2013 6,584 (5,858 males) unaccompanied minors were taken into care by the youth welfare system in 2013; in 2015, the total number of unaccompanied minors to have entered the country exceeded 45,000 (Hebebrand et al, 2015).

among refugees who migrated from the Horn of Africa during the previous three years (Satinsky et al 2019: 854)

Studies conducted with child and adolescent populations found notable differences in engagement with care between accompanied minors (AM), unaccompanied minors (UAM) and children from the host countries. A study conducted in the UK found that UAMs were more likely than AMs to have experienced traumatic events prior to resettlement yet despite higher levels of subsequent PTSD, they attended fewer appointments and missed more treatment sessions than AMs (Satinsky et al, 2019: 854). Refugee children in Denmark had fewer first-time contacts with psychiatric services compared to Danish-born peers. In a study in Norway, Norwegian children were more likely than refugee children to be referred to MHPSS by medical services while refugee children were more likely to be referred by non-medical professionals, such as social workers, personnel working at asylum centres, or teachers. This underutilisation may be explained by cultural-specific barriers which need to be tackled to increase treatment demand as well as training of healthcare professionals to improve their understanding of refugee rights to access treatment and ability to provide this with empathy.

5. Mental health, wellbeing and integration

Refugee women face several integration challenges associated with poorer health and lower education and are less successful in labour market outcomes when compared to refugee men, who are already disadvantaged in comparison with other migrant groups. Immigrants who have generally been educated in a different system and language face difficulties in validating their educational level and work experience and consequently often perform work that does not adequately reflect their education and experience. In over two thirds of OECD and EU countries, immigrant women have larger gaps with respect to employment vis-à-vis their native-born peers than immigrant men (Leibig & Tronstad, 2018). Refugee women have lower education levels compared with both other migrant women and refugee men. Refugee women are overrepresented among those lacking basic qualifications, take longer time to get established into the labour market compared with refugee men and when employed are frequently in part time work. Refugee women are at a triple disadvantage, as they must tackle the specific obstacles facing immigrants, refugees, and women at the same time.

Integration of refugee women tends to be crucial for the integration of refugees' children. OECD research (OECD, 2017) has shown that the integration of immigrant women is decisive for the integration outcomes of their children. Meaningful activity or employment is one factor contributing to mental health and wellbeing and the employment of immigrant mothers is linked to much better labour market outcomes for their children, particularly girls (Leibig & Tronstad, 2018).

There is a virtuous circle implicit with reinforcing links between mental health, wellbeing and successful integration into a new community and society. Good health enables greater social participation, engagement in education and subsequently employment. Being able to gain equal access to health and social services and the responsiveness of these to individual need is an important element of refugee integration in the host country. Leisure activities provide an opportunity to practice new language skills, establish social connections and learn about the culture of the host country thus promoting individual health and wellbeing. Establishing broader social connections with groups from other communities helps to build bridges between refugee

groups and to widen educational and employment opportunities. (Home Office Indicators of Integration framework, 2019).

It is in this context that other interventions such as provision of language classes; flexible childcare provision for refugee mothers attending language classes; availability of interpreters during interaction with health and social services providers; leisure, social and networking activities that build bridges between refugee groups from different cultural backgrounds and with host country communities; can all contribute to positive mental health. The needs of refugee women with small children must be fully accommodated by flexible arrangements regarding the timing and organisation of introduction activities. A peak in fertility shortly after arrival contributes to slower integration of some refugee women as women are quite likely to get pregnant the year after arrival. The uncertainty and insecurity refugees experience prior and during the process of flight makes them more reluctant to have children during this period (Leibig & Tronstad, 2018).

Typically, employment has been regarded as the best way to fast track social and economic integration of refugees (Banulescu-Bogdan, 2020) with work promoting self-esteem and mental health. So those illiterate, unskilled, elderly and female refugees who may find it difficult or slow to find appropriate work are at higher risk of social isolation. To address this governments have proposed or funded **'work adjacent' activities** such as informal craft or food related businesses; volunteering or **community service programmes**; and non-work programmes to build networks. These sorts of programmes designed to strengthen social ties can be resource intensive and since outcomes are rarely systematically evaluated it is hard to assess their efficacy. They tend to be small scale and informal, implemented by nongovernmental (NGO) groups or social enterprises and are seen as complementary to core, formal integration programmes. Clear standards and benchmarks for programmes focused on work, language instruction and civic integration are lacking. There is **limited data on what works** and this makes it difficult for Governments to justify spending limited public funds on such programmes (Banulescu-Bogdan, 2020:5). Despite this reality, Banulescu-Bogdan (2020:6) presents a strong rationale for the benefits of integration and dangers of social isolation, arguing that it is necessary to offer integration programmes long after the initial period of resettlement since for these women it may take many years to attain sufficient confidence, language and skills to attain a level of economic integration.

In particular two important innovations seem to improve access to services for refugee women (Banulescu-Bogdan (2020:13). These are:

- Providing free or subsidised childcare and coordinating child and parent programming so that especially mothers can take part in activities including language classes that reduce their social isolation, at times and in ways (including distance learning) that improve access
- Offering two generation or whole family programming to coordinate and sometimes combine services for adults and children that would otherwise have been offered in parallel. This usually means involving schools and local service providers to link refugee adults and their children in pre-school preparation, interactive literacy with parent and child, and providing services to the entire family

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