The contemporary refugee crisis: an overview of mental health challenges

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There has been an unprecedented upsurge in the number of refugees worldwide, the majority being located in low-income countries with limited resources in mental health care. This paper considers contemporary issues in the refugee mental health field, including developments in research, conceptual models, social and psychological interventions, and policy. Prevalence data yielded by cross-sectional epidemiological studies do not allow a clear distinction to be made between situational forms of distress and frank mental disorder, a shortcoming that may be addressed by longitudinal studies. An evolving ecological model of research focuses on the dynamic inter-relationship of past traumatic experiences, ongoing daily stressors and the background disruptions of core psychosocial systems, the scope extending beyond the individual to the conjugal couple and the family. Although brief, structured psychotherapies administered by lay counsellors have been shown to be effective in the short term for a range of traumatic stress responses, questions remain whether these interventions can be sustained in low-resource settings and whether they meet the needs of complex cases. In the ideal circumstance, a comprehensive array of programs should be provided, including social and psychotherapeutic interventions, generic mental health services, rehabilitation, and special programs for vulnerable groups. Sustainability of services, ensuring best practice, evidence-based approaches, and promoting equity of access must remain the goals of future developments, a daunting challenge given that most refugees reside in settings where skills and resources in mental health care are in shortest supply.

Key words: Refugees, displacement, asylum seekers, ecological models, trauma, stress, mental health, post-traumatic stress disorder, depression, social interventions, brief psychotherapy

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The upsurge in the number of refugees over recent years is unprecedented in the modern world. If current trends continue, one in a hundred persons will be a refugee in the near future[1]. At present, responsibility for mental health support to refugees is shared by a network of agencies, including the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO), government and non-for profit organizations, mainstream mental health and specialist refugee services and voluntary organizations. Yet, the ineluctable reality is that most refugees with mental health problems will never receive appropriate services.

The chief reason for this is the scarcity and inequitable distribution of services, but other factors contribute to the situation, including difficulties in coordinating national and international efforts, barriers to accessing care even when services are available, and persisting stigma associated with being both a refugee and mentally ill[2]. Notwithstanding, advances have been made in research, theory, policy and models of treatment. Importantly, there is evidence of growing convergence in these areas, a consensus that is likely to gradually build to the more effective use of scarce resources to achieve better mental health outcomes for this population.

The present paper focuses on issues of general concern amongst adult refugees. The reader is referred to the specialized literature on vulnerable sub-populations (child soldiers, unaccompanied minors, children and youth, single or widowed women) and specific geographical situations around the world[3-7].

THE SCALE OF THE PROBLEM

The United Nations estimate that over 65 million persons worldwide are currently displaced by war, armed conflict or persecution. In total, 16.5 million fall under the mandate of the UNHCR. Although the flow has slowed somewhat, 3.2 million persons were displaced in 2016 alone, the leading source countries being Syria and South Sudan[1]. More than 80% of refugees are displaced internally or have fled across national border to neighbouring countries, the majority being located in low- and lower middle-income countries.

Half of the world's refugees remain in "protracted situations", unstable and insecure locations, most commonly in dense urban areas, but also in refugee camps. For example, 314,000 persons remain displaced from Darfur in Eastern Chad, and more than a million Somalis live as displaced persons in Kenya, Ethiopia, Djibouti and Yemen. Dadaab, a vast refugee camp in Kenya, houses families that have been sequestrated in this remote and insecure location for more than three generations.

In 2016, Europe confronted the largest single inflow of refugees since the World War II, with over a million Syrians and others from the Middle East entering the region[1]. Oscillations in public opinion and government policies resulted at times in chaotic responses in which authorities attempted to halt or divert the influx, indicating the lack of preparedness of even advanced nations to deal with this humanitarian crisis.

To place the European situation in perspective, a total of 13 million Syrians have been displaced by the war, the majority to

neighbouring countries. Lebanon, a small country of 4.5 million persons, now accommodates as many Syrian refugees as the whole of Europe[1,8]. The wars in the Middle East also tend to overshadow lesser known refugee crises around the world, for example in West Papua, Myanmar and Western Sahara[9-14].

OSCILLATIONS IN PUBLIC PERCEPTIONS AND NATIONAL POLICIES

Throughout history, recipient societies have responded in ambivalent ways to refugees, at times greeting them as heroes, and at others as interlopers who threaten the peace, integrity, cultural identity and economic stability of the host country[15].

The policies applied to refugees by host countries are crucial to the mental health of that population. The United Nations Refugee Convention (1951) and later Protocol (1967) ushered in a progressive era in the international response to this problem. The essential principles established by these instruments include: a) that persons with "a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" have an inalienable right to seek asylum in signatory countries; b) that refugees are protected from *refoulement* or forced return to places of danger in their homeland; and c) that host countries have a responsibility to provide "favourable" conditions for refugees, including, *inter alia*, the right to work, to freedom of association and movement, and to appropriate services.

The Convention proved effective in the early decades following the World War II, when refugee flows were small, newcomers were mainly of European origin, and recipient societies resonated positively with their reasons for fleeing, usually based on their opposition to the ideology of totalitarian regimes in the countries of origin. The popular campaign against torture in the 1970s further strengthened public compassion for survivors who in most instances were refugees.

The large exodus of Southeast Asian refugees in the 1970s and 1980s created a new challenge for the Convention[16], but after a period of inertia and dissension, leading Western nations finally accepted most of the displaced persons for resettlement. Nevertheless, the crisis underscored a pattern that has been repeated in Europe in contemporary times, that is, that the willingness of recipient countries to accept refugees is inversely related to the rate of influx and ethnic difference of the incoming group[17].

The distinction made in the 1980s onwards between asylum seekers (persons arriving without prior authorization) and "Convention" refugees (those granted residency visas prior to arrival[17]) further put to test the viability of existing international procedures. Australia implemented stringent policies of deterrence to asylum seekers, and other countries of Europe and North America instituted similar policies and practices[18-20]

The spirit of the Convention was further eroded by the phenomenon of terrorism. Several factors, including the ethnic and religious stereotyping of terrorists, increased communal resistance to immigration, the distinction between refugees and voluntary migrants becoming blurred in the process[21-24]. For all these reasons, although the Refugee Convention is still in force, there are unprecedented pressures to dilute if not to dismantle the key provisions for protecting the rights of refugees, irrespective of their backgrounds or countries of origin[25].

EPIDEMIOLOGY OF MENTAL HEALTH PROBLEMS AMONGST REFUGEES

Prior to the 1970s, the field lacked robust scientific data detailing the nature, prevalence and determinants of mental health problems amongst refugees. Pioneering studies undertaken in the US, Canada, Norway and Southeast Asia identified what appeared to be substantial symptom levels of anxiety and depression amongst Indochinese refugees, but the absence of closely matched comparison groups limited interpretation of the findings.

The inclusion of post-traumatic stress disorder (PTSD) in the DSM-III set the stage for the modern era of research in the refugee field, the first studies being conducted amongst Southeast Asian refugees[26-28]. For example, a study conducted in a refugee camp for Cambodian survivors of the Khmer Rouge autogenocide found that half of respondents met threshold criteria for depression and 15% for PTSD[27].

In the following two decades, there was a burgeoning of epidemiological studies in the refugee mental health field, prompting two systematic reviews of the cumulative findings in 2005[30-32]. The first, which was limited to studies of refugees in Western countries, yielded an average prevalence of 9% for PTSD and 5% for depression, noting that lower rates were found amongst the larger, more rigorously conducted studies. These findings provided a corrective to the tendency to regard all refugees as "traumatized" and in need of counselling. The second review, based on studies that included comparison groups, showed that refugees had a modestly elevated risk (effect size of 0.41) of a range of adverse mental health outcomes. Factors associated with poor mental health amongst refugees included socio-demographic characteristics (being older, a woman, from rural background, well educated, and coming from a higher socio-economic status), and stressors in the post-displacement environment (living in institutions, restrictions in economic opportunities, being internally displaced or involuntarily repatriated, and coming from a country that remained in conflict).

The largest review of its kind, published in 2009, identified 181 surveys undertaken amongst 81,866 refugees and other conflict-affected populations from 40 countries[29]. The prevalences of PTSD and depression were similar, approximating 30%, although there was substantial heterogeneity in rates across studies. Exposure to torture and the total number of trauma events experienced emerged as the strongest predictors of PTSD and depression, respectively. Larger, more rigorously designed

studies yielded lower prevalence rates, reducing the estimate for PTSD to 15%, a finding broadly supported by a more recent review[33]. Even so, the PTSD prevalence greatly exceeds the estimate of 1.1% recorded across non-refugee populations in countries participating in the WHO World Mental Health Surveys[34].

The body of research focusing on asylum seekers served to highlight the impact of the post-migration environment on the mental health of displaced populations[35-43]. A growing number of studies in recipient countries found that imposed conditions of adversity, including prolonged detention, insecure residency status, challenging refugee determination procedures, restricted access to services, and lack of opportunities to work or study, combined in a way that compounded the effects of past traumas in exacerbating symptoms of PTSD and depression[29,36,39,44-48]. Yet, in spite of widespread concerns, these practices continue. As a corollary, mental health professionals keep on confronting ethical challenges when working within detention centre hierarchies, and practical questions persist regarding the effectiveness of offering counselling to persons forced to live under such restrictive conditions[49].

TRANSLATING EPIDEMIOLOGICAL DATA INTO POLICY AND PRACTICE

Translating epidemiological data into estimates of service needs requires careful consideration. As indicated, prevalence rates of common mental disorders such as depression and PTSD have shown wide variation across the body of refugee studies reported. Methodological factors are partly responsible, including transcultural measurement error, biases related to non-probabilistic sampling, and the use of screening measures which tend to overestimate the prevalence of disorder[50,51]. In addition, populations from some regions of the world (East Asia, Sub-Saharan Africa and the Pacific) tend to record lower symptom levels compared to high-income countries[52]. Failure to include indigenously derived measures that capture local expressions or idioms of distress also can lead to the under-enumeration of mental health problems[37,53].

Notwithstanding these sources of heterogeneity, substantive issues of a universal nature, such as the extent of exposure to torture, the severity and number of trauma events experienced, the socio-demographic characteristics of the population, the level of ecosocial threat that the community continues to face, and the nature and extent of post-migration stressors, all make a major contribution to the prevalence of disorders across populations. Given the variation in these substantive factors across contexts, it should not be surprising that prevalence rates of common symptoms of mental distress differ from one population to another.

The greatest obstacle in translating epidemiological data into service needs arises from the difficulty in differentiating, in cross-sectional surveys, between reactions which may be commensurate with the level of stress being encountered and frank mental disorder that risks becoming chronic and disabling, in part independent of the context[54]. Longitudinal studies assist to some extent in addressing this problem, in that they are capable of distinguishing between symptom trajectories that indicate recovery as opposed to chronicity, pathways that may be predicted to some extent by the profile of baseline risk and protective factors[55]. Short-term follow-up studies (1-3 years) may not distinguish these trajectories with any accuracy, particularly if the follow-up extends through a period of ongoing instability, for example, in the immediate post-displacement phase[56-59].

Only a small number of studies have followed up refugees for 10 years or longer, in all instances being limited to the measurement of general symptoms of anxiety and depression using screening instruments[57-60]. Broadly interpreted, these studies suggest a common pattern of outcome: most refugees continue to show low or no symptoms; a significant minority show a pattern of gradual recovery; and a small group remain chronic. This picture was supported by a large cross-sectional study using a retrospective quasi-longitudinal analysis[37]. A similar set of trajectories has been found in a six-year follow-up study amongst a post-conflict population in Timor-Leste[61]. This tripartite pattern of low or no symptoms, gradual recovery and chronicity, although tentative, has important implications from a public health perspective in judging which populations will benefit from programs of social reconstruction and which might require more intensive psychotherapeutic interventions, as discussed hereunder.

Estimating service needs also depends on a range of other factors, including help-seeking behaviour. Stigma, mistrust and lack of knowledge of services may limit the extent to which refugees access mental health services, even if available. Taking all factors into account, modelling based on the Global Burden of Disease Study has illustrated how large the gap is between the existing number of mental health professionals and the service needs of low-income countries and regions that have large populations exposed to mass conflict and displacement[62]. There is no realistic prospect, therefore, of formal mental health services, whether generic or specialized, meeting the mental health needs of refugees, noting that the majority reside in low-income countries. Creative solutions are thus necessary, including networking of all agencies to ensure the sharing of responsibility of care for refugees with mental disorder, and task-shifting, i.e., the transfer of skills to primary care and lay workers in order to undertake specific mental health interventions of various types under supervision.

BROADENING KNOWLEDGE OF MENTAL HEALTH OUTCOMES

Recent research in the refugee field has widened the scope of interest to disorders and reactions that extend beyond the conventional focus on PTSD and depression, and to a lesser

extent anxiety and somatic symptoms. There is a resurgence of interest in the construct of prolonged or complicated grief, given the importance of this reaction to refugees, the majority of whom have experienced multiple losses and separations in the context of gross human rights violations[63]. In addition, the long-debated category of complex PTSD, comprising elements of disrupted self-organization (negative self-concept, affective dysregulation, interpersonal difficulties) will be included for the first time in the forthcoming ICD-11[64], early evidence suggesting that the diagnosis can be identified amongst refugees.

There is also a growing body of studies documenting cases in which PTSD is associated with psychotic-like symptoms or frank psychosis amongst refugees and post-conflict populations[65-67]. Recognition of the prevalence and salience of these symptom constellations adds further complexity to the field, particularly in relation to the need to tailor interventions to individual patterns of comorbidity and disability.

TOWARDS AN ECOLOGICAL EPIDEMIOLOGY

The massive disruptions to family and social networks in the context of extreme human rights violations undermines the fundamental sense of coherence of refugees, many becoming isolated and losing trust in authority structures. Chronic anger is one potential outcome that has important social implications. For example, amongst West Papuan refugees, a constellation of mistrust, resentment and anger is embodied in an idiom of distress, *Sakit Hati*, literally meaning "sick heart"[68].

A focus on states of chronic and uncontrollable anger in survivors of extreme trauma creates an important bridge that links individual reactions to the stability of the family and the wider social network. A cycle of violence model posits that, in some instances, aggressive outbursts amongst survivors may be implicated in family conflict, generating a multiplier effect of mental health problems in intimate partners and potentially children, a cycle of violence that may have profound transgenerational effects[69]. Recent applications of multilevel statistical techniques allow examination of these transactional effects both within conjugal couples and families, thereby broadening the scope of epidemiology to increase its ecological and contextual significance[70,71].

CONCEPTUAL FRAMEWORKS

From a theoretical perspective, the formative period of the refugee mental health field (broadly the 1970s to 2000) was marked by spirited and at times divisive debates in relation to theory and models of intervention. Those adopting a critical, transcultural perspective questioned, and in the most extreme case rejected, the tendency by Western mental health professionals to transfer Western diagnostic categories such as PTSD and associated trauma-focused therapies to the culturally distinct environments in which most refugees live[72]. The chief ongoing division in the mainstream was between advocates of individualized, trauma-focused psychotherapeutic approaches and those arguing in favour of psychosocial models that focus on the community as a whole and that aim to promote self-directed recovery and build resilience.

Contemporary models address these issues by providing a comprehensive account of the refugee experience. Most adopt a multisystem, ecosocial framework, drawing on established models in the social sciences[73]. Within these broad frameworks, mental disorder is regarded as the endpoint of an imbalance in the multiplicity of countervailing environmental factors that impact on refugees rather than an expression of innate or intrapsychic problems at an individual level. In that sense, the distinction between normative and pathological responses is somewhat blurred and fluid, the vicissitudes of the ecological context determining the direction and extent to which individuals shift on a continuum of stress.

An example of prevailing models includes Hobfoll's Conservation of Resources theory[74], which gives centrality to the effects of objective losses, and the shared meanings of these deprivations within each culture and context in determining mental health outcomes and resilience. From that perspective, resilience is regarded both as the capacity of the individual to withstand experiences of trauma and stress and as the capacity to remain vigorously engaged with life's tasks, principally, the pursuit of restoring resources that have been lost in times of adversity. The guiding assumption is that all humans have a natural drive to obtain, retain, foster and protect resources, defined widely to include a range of domains including the personal (health, well-being, positive sense of self), familial, and social (preservation of peace, capacity to work, access to facilities and services). Maintaining adequate resources is essential to fulfilling the task of self-regulation and a sense of control. The refugee situation typifies conditions in which there is a sudden and often massive loss of resources, the pattern of deprivation potentially compounding over time. Interventions should focus on providing the supportive environments that allow refugees (and other trauma survivors) to restore their resource base (personal, familial, social, material), a prerequisite for addressing mental health problems. The model offers the potential to make an objective assessment of the resource losses experienced by individuals and the community, the totality of the losses indicating the likely degree of mental distress that will be identified in the populations. Social interventions aimed at creating a supportive environment which facilitates the capacity of refugees to restore their lost resources will advance the overall aim of promoting resilience and mental health.

In their ecological model, Miller et al[75,76] give emphasis to the impact of daily stresses on the mental health of refugees and asylum seekers. The authors draw on data indicating that daily stressors partly or wholly mediate the effects of past war-related trauma in shaping mental health outcomes such as PTSD symptoms[77]. Examples of these stresses include living in unsafe environments, challenges in meeting basic survival needs

(inadequate access to food, water, shelter, health care); inability to pursue income-generating activities; and isolation from family and traditional social supports. Vulnerable groups – such as women exposed to gender-based violence, former child soldiers, unaccompanied and orphaned minors, and persons with physical and mental disabilities – all face exceptional levels of ongoing stress. Based on this conceptualization, the emphasis of interventions is on creating supportive social environments that reduce daily stressors rather than on providing individual psychotherapy focusing on past trauma experiences.

The Adaption and Development After Persecution and Trauma (ADAPT) model[78,79] identifies five core psychosocial pillars disrupted by conflict and displacement, that is, systems of safety and security, interpersonal bonds and networks, justice, roles and identities, and existential meaning and coherence. These pillars form the bedrock on which stable societies are grounded and on which civilians depend for their mental equilibrium. The refugee experience, which involves a sequence of adversity that traverses epochs of conflict, dislocation, flight, transition and resettlement, erodes the integrity of all five psychosocial systems, thereby weakening social structures and institutions and exerting deleterious effects on the mental health of individuals. Although the relationship is indirect, the erosion of each pillar can have broad representations in the symptom patterns identified in refugees. For example, the combination of traumatic loss and extreme injustice may result, via several intermediate pathways, in comorbid symptoms of complicated grief and explosive anger. The ADAPT framework has been used as a conceptual foundation for formulating and implementing a comprehensive refugee mental health program amongst Iraqi refugees in Syria[79]. In support of the model, a recent study showed that a measure of the ADAPT construct moderated the effects of past trauma and ongoing adversity in shaping PTSD symptoms[80]. The ADAPT model alerts clinicians and planners to the importance of understanding the overall social ecology of the refugee experience and contextualizes the array of interventions which may assist in repairing each pillar, thereby creating the context for promoting mental health recovery.

THE GLOBAL MENTAL HEALTH PERSPECTIVE

The refugee mental health field overlaps considerably with the larger movement of Global Mental Health, both focusing on the mental health needs of deprived populations from low-income countries (noting that one of several distinctions is the substantial number of refugees relocated to high-income countries, where they confront special conditions).

There has been a tendency in the refugee field to limit interest in severe mental illnesses such as schizophrenia and related psychoses, bipolar disorder, melancholic forms of depression, drug and alcohol problems, and organic brain disorders. Persons with psychosis in particular are at risk of neglect, exploitation and abuse in acute humanitarian settings and other situations of mass displacement. During these periods, psychiatric hospitals and clinics often close, leaving patients without protection or medication.

The reality for psychiatrists and other mental health professionals working in clinics in Africa and other refugee situations is that a large proportion of the patients they consult manifest one or more of these forms of severe mental disorder. There is now compelling evidence that schizophrenia and other psychotic disorders are more prevalent amongst refugees resettled in high-income countries compared to other immigrants and host populations[81]. Therefore, the field of refugee mental health should include consideration of this subpopulation in mounting comprehensive programs of mental health care, an issue that is now more widely recognized and acknowledged in policy and planning exercises[82].

INTERVENTIONS

Brief psychotherapies

Counselling and psychotherapy remain the mainstay of treatment for common mental disorders – such as PTSD, depression and anxiety or combinations of these symptom profiles – in refugees. Most commonly, workers apply a flexible combination of supportive counselling and cognitive behavioural therapies. In spite of variability in the quality of existing studies, the overall evidence suggests that various forms of psychotherapy are relatively effective in ameliorating symptoms of PTSD, depression and anxiety[83].

Over the past two decades, a series of brief, structured, manualized psychotherapeutic packages have been devised for use amongst refugee and post-conflict populations. Most models draw on evidence from Western contexts supporting trauma-focused cognitive behavioural therapies[84]. The strengths of these newer programs include that: a) they can be adapted to local cultures; b) they allow rapid training of front-line personnel; and c) they facilitate task-shifting, that is, the transfer of skills from professionals such as psychologists to lay or community workers, a vital provision to allow uptake and dissemination in settings where there is a severe lack of mental health specialists. The time-limited nature and low cost of these interventions increase the potential for dissemination (or scalability) and for integrating the procedures within routine public health or community centre settings.

Most approaches use standard cognitive behavioural components including stress management, prolonged exposure, cognitive restructuring, behavioural strategies, and mindfulness or related de-arousal techniques. Increasingly, activation therapies are used for depression. The most widely tested method, narrative exposure therapy, draws on the principles of testimony therapy in tracing the person's chronological life course, embedding imaginal exposure to trauma memories in the natural course of this sequence[85]. A common elements treatment

approach is designed to accommodate common patterns of comorbidity, allowing the therapist flexibility in selecting modules (for example, for traumatic stress, depression, anxiety) to match the particular symptom constellation of each patient. Trials in several settings attest to the efficacy of this method[86]. More recently, the WHO has established a brief intervention, Problem Management Plus (PM+), drawing once again on the core principles and strategies of cognitive behavioural therapy. The first studies examining this method have yielded positive findings[87].

An important next step is to establish that these brief packaged interventions can be embedded in routine primary care services in low-income countries in a manner that is supported by local structures and hence sustainable. Apart from securing resources and the commitment of the hierarchy to these mental health initiatives, there is a major challenge in providing ongoing supervision and mentoring of workers, an essential provision to avert attrition of skills and motivation and to avoid burnout. The increasingly wide reach of the Internet and telecommunication systems improves opportunities to provide supervision from afar to remote locations where many refugee populations are located.

A further concern is whether brief or even extended interventions based on contemporary approaches to psychotherapy are effective for the significant minority of refugees with complex traumatic stress presentations. A controlled trial from Denmark[88] offering a comprehensive array of interventions (medical and psychiatric assessment and consultation, psychopharmacology, social worker assistance, and individualized psychotherapy) found no change in baseline high levels of PTSD symptoms over a one-year course of follow-up, and only modest reductions in symptoms of depression. The most likely reason is that the majority of participants came from the poor prognostic subpopulation provisionally identified in epidemiological studies. Participants had extensive exposure to torture and other forms of abuse; high rates of head injury, chronic pain and physical disability; a chronic pattern of persisting symptoms; and a history of failed response to past treatments. Most were socially isolated, marginalized and unemployed.

Patients with these complex characteristics may not have the motivation, resilience or cognitive capacity to engage in exposure therapies or to implement the techniques of cognitive behavioural therapy which require active practice to be effective. Questions remain, therefore, as to the best strategies to assist these complex cases. It may be that more graduated rehabilitation approaches are needed to encourage what may be a slow recovery trajectory in this subpopulation.

Pharmacotherapies

There is a dearth of research focusing on specific psychopharmacological issues amongst refugee populations. Practitioners apply the same range of psychotropic medications used in routine psychiatric practice, although adjusting dosage according to ethno-pharmacological considerations.

In general, for common patterns of major depressive disorder, PTSD and anxiety disorders, the most commonly used medications are the first generation (tricyclic) drugs and, where available, the newer antidepressants (selective serotonin reuptake inhibitors, serotonin and noradrenaline reuptake inhibitors, and their variants), the latter recommended for PTSD by the WHO's Mental Health Gap Action Programme (mhGAP) guidelines[89]. In many low-income countries, first generation antipsychotic medications (haloperidol, chlorpromazine) are the only ones available for psychoses, although atypical antipsychotics, including clozapine, are becoming more widely available.

Difficulties are frequently encountered in humanitarian and acute refugee settings in ensuring continuity in the supply of medications. A further challenge is the provision of ongoing supervision and in-service training of nurses and other frontline community health workers who commonly oversee the use of psychotropic medications in low-income countries. There is a risk, therefore, that practices will be constrained to standard dosing and that side effects may receive inadequate attention.

Psychosocial interventions

As indicated, research findings are consistent with contemporary ecological models in demonstrating the powerful impact that ongoing social conditions exert on the mental health and psychosocial well-being of refugees. In addition to the effects of past trauma, refugees commonly confront important challenges and stressors in their new environments, including ongoing insecurity, restricted access to essential services (health, mental health, education), lack of opportunities for employment, and more generally, host society attitudes of racism and xenophobia. Death, disappearances and separations result in persisting grief and loss. The ongoing consequence of these losses is that refugees commonly lack the support of nuclear and extended families and other traditional networks, a profound challenge for communities with strong collectivist values. Even in intact families, relationships can be undermined by the cumulative effects of past trauma and ongoing stressors, resulting in conflict and, at worst, intimate partner violence[90].

Social programs for refugees have the potential to revive a sense of connectedness, re-establish social networks, and promote self-help activities. Strategies that foster community initiatives encourage a sense of control and engagement in the task of self-directed recovery, counteracting the inertia, dependency, and inter-group divisions that characterize many transitional refugee settings. There are compelling theoretical, economic, and strategic reasons, therefore, to give priority to social interventions in the array of strategies aimed at relieving distress and promoting well-being amongst refugees.

At the most general level, psychosocial programs focus on the population as a whole, examples being community-wide truth and reconciliation programs, income generation activities, and the development of participatory processes to foster democratic decision-making and self-governance. Practical programs include setting aside child friendly spaces, developing teams of refugee outreach volunteers to assist families confronting a range of economic or social problems, and establishing community centres where individuals can obtain assistance in relation to housing, other basic needs, education, and referral to other services[91-93].

Special populations or vulnerable groups such as former child soldiers and survivors of gender-based violence may require specifically designed programs. In some instances, however, social programs may have paradoxical effects. For example, participation in truth and reconciliation processes can improve community cohesion, but result in worsening of mental health. These findings reinforce the need for rigorous research to test both the benefits and disadvantages of various psychosocial programs.

Sociotherapy is one of the few well researched group psychosocial interventions[94], the primary focus being the fostering of connections between people. The method was developed in the post-genocidal context of Rwanda and has since been applied in other settings including amongst refugees[95]. Groups share and discuss daily problems ranging from interpersonal disputes, feelings of marginalization, and strategies to deal with gender-based violence and poverty at the community level. Trained facilitators create a safe therapeutic environment which nurtures trust, mutual care and community-wide respect. The restorative experience of participating in the group itself may assist in repairing disrupted social relationships, although in all groups of this kind there should be agreed limits to disclosure, for example, discussing and revealing specific instances of intimate partner violence is contraindicated in the group setting. In general, however, the process may foster supportive peer relationships that endure beyond the life of the group program. Preliminary research suggests that sociotherapy has the dual effect of increasing civic participation (and hence social capital) and improving participants' mental health[96,97].

Related models have been trialled, including use of multi-family interventions in which several families share experiences of traumatic stress and chronic adversity. The aim is to reduce isolation, create a sense of shared experiences and solidarity, and foster supportive connections. Preliminary findings indicate that such methods are effective in improving self-confidence, decreasing social isolation and increasing access to mental health services[98,99].

In relation to future developments, a stepped care model in which refugees first attend social programs which address general levels of distress, while at the same time those with more severe mental health problems are identified, offers an integrated approach to maximizing resources and a non-stigmatizing referral pathway to specialist services.

POLICY, LEADERSHIP AND COORDINATION

The pioneering phase of the refugee mental health field was driven by a high level of passion and commitment, in a context where program leaders and clinicians were working from a low knowledge base. The past two decades have witnessed a maturing of the field, an era when lead agencies (the United Nations, international non-governmental organizations, universities, amongst others) have established close working relationships that have allowed the gradual building of an international consensus on issues that previously were divisive.

The fruits of these endeavours include the formulation and wide adoption of influential policies and guidelines that assist the planning and implementation of programs, for example, the Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings and the SPHERE handbook[100,101]. A further major achievement has been the clinical guidelines produced by the WHO's mhGAP, especially the module focusing on emergencies[102,103]. In addition, United Nations agencies have produced and disseminated a range of assessment and monitoring tools to encourage standardization of assessments across programs around the globe[104]. There also have been important consensus building activities in relation to setting priorities for research[105].

TOWARDS THE FUTURE

As indicated, there are growing points of convergence across activities (research, development of conceptual frameworks and policies) in the refugee field, although tensions remain in some areas. For example, there is clearly a dysjuncture between the breadth and complexity of extant ecological models of mental health and the more limited assumptions underpinning the implementation of brief, symptom-focused packages of intervention that continue to be trialled in a range of refugee settings.

An important direction for research is to distinguish the needs of the various subpopulations of interest: those with distress reactions that are responsive to environmental factors, for whom broader social programs as well as more targeted non-clinical group interventions may be of assistance; those whose traumatic stress reactions are severe, disabling and unlikely to resolve spontaneously and who may benefit from brief structured psychotherapies; more complex trauma-related cases who may benefit from longer-term rehabilitation; the severely mentally ill who need an array of mainstream interventions; persons with drug and alcohol problems requiring specific attention; and special groups such as women exposed to domestic violence who may require a gender-sensitive approach to care.

In relation to advocacy, awareness-raising and embedding mental health programs within the existing institutional structure, the refugee field can learn a great deal from the general

field of Global Mental Health[106,107]. Without establishing a firm foothold for refugee mental health in existing primary care and other public health services, issues of sustainability will persist. Showing that treatments work under controlled research conditions is only the first step in ensuring that effective interventions actually reach the majority of populations in need.

A major challenge that the field confronts at a global level is that most refugee populations reside in locations where the resource base in mental health is extremely low. Theoretical debates aside, the reality is that, in these contexts, no single agency or program can provide for all the inter-related psychosocial and mental health needs of refugees. The success of the overall program will be gauged not by the accomplishments of one component but by the extent to which all contributors coordinate to establish the most comprehensive, inclusive, and integrated response, which includes networking of mental health agencies with social, community, and general health services.

Within the mix, the voice of the refugee communities is vital. Mental health cannot be conferred, it must be regained by the communities that have temporarily lost their equilibrium as a consequence of overwhelming circumstances.

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