Best practices in refugee mental health

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ABSTRACT

Canada has a long history of accepting immigrants and refugees. These populations may have unique health care needs that the Canadian health care system must adequately address. Currently, there are numerous barriers to the treatment of refugee mental health concerns. These include cultural, language, financial, and systemic barriers. Best practices for treatment in this population include psychotherapies such as cognitive behavioural therapy and narrative exposure therapy, medications, and health promotion and psychosocial interventions. Physicians have previously advocated for improving health care for Canada's refugee population and medical schools are working to incorporate multicultural education into their curricula.

INTRODUCTION

Worldwide conflicts have led to an increase in the number of refugees in recent years. According to the United Nations High Commissioner for Refugees, by 2017 there were 25.4 million refugees worldwide.¹ The United Nations defines refugees as people who have been forced to leave their country of nationality due to fear of persecution.² Canada has a long history of accepting refugees from as far back as 1776, and in 2015 notably pledged to accept 25 000 refugees displaced after the conflict in Syria.^{3,4} In 2016, Canada welcomed 46 700 refugees primarily from Syria, Eritrea, Iraq, Congo, and Afghanistan.⁴

Having accepted a large number of refugees, Canada must now find a way to meet their diverse needs, including medical needs. Estimates of the prevalence of post-traumatic stress disorder (PTSD) and depression in refugees vary, but may be as high as 30%.⁵ However, the prevalence of these disorders differs between refugee populations, because rates of PTSD and depression are related to the particular traumas that refugees have experienced.⁵ These specific factors include exposure to torture, the severity of the trauma experience, and the person's post-displacement environment.⁵

In this paper, we will discuss barriers to treatment of refugee mental health concerns, specific recommendations for treatment in this population, and ways that physicians and medical students can advocate for improving refugee health care.

BARRIERS TO TREATMENT

Refugees are at much higher risk of having unmet health care needs compared to the general population of Canada. In a cross-sectional study of Syrian refugees conducted in 2016, 49% of refugees reported having unmet health care needs, compared to 11.2% of the general Canadian population.⁶

Cultural barriers. Stigma associated with mental health concerns is not a problem exclusive to Canada's refugee population; however, refugees may have unique reasons for feeling that mental health problems are stigmatized. Shannon et al. (2017) conducted focus groups in the United States with refugees from Burma, Bhutan, Somalia, and Ethiopia; these cultural groups are also represented among Canadian refugees.³ Their research found that a history of political repression, fear, a belief that "talking does not help", and avoiding symptoms were among the reasons that refugees were reluctant to discuss mental health, and were therefore less likely to seek mental health care.⁷ In addition, some patients may prefer a particular gender or ethnicity of care provider which cannot always be accommodated.⁸

Language barriers. Language barriers become critically important when related to mental health care. In many cases, health care institutions are unable or unwilling to provide formal translation services.⁹ Informal translation is then usually provided by the patient's friend or family member. The presence of this third person in the room with the provider and patient may lead to patient discomfort and concerns about whether confidentiality will be maintained.⁹ In addition, in smaller refugee communities, there are fewer translators available (formal or informal), which may lead to a perception that patient confidentiality will not be maintained due to the presence of dual relationships.⁹

Financial barriers. Most refugees are provided with coverage through the Interim Federal Health Program (IFHP) when they first arrive to Canada. However, many report difficulties registering for this program, and there is confusion among physicians' offices about who is eligible for the program.⁹ Some refugees have resorted to paying for their health care directly due to being unsure about their coverage.⁹

Systemic barriers. Refugees also cite general barriers to accessing health care that are common to all Canadians, including the availability of services and their cost.⁶ Even in communities which have dedicated refugee health centres, there may be a waiting list to access services.⁹

BEST PRACTICES IN TREATMENT AND MENTAL HEALTH PROMOTION

Evidence-based practices for supporting refugee mental wellness include the use of psychotherapies, medications, and psychosocial interventions.

Psychotherapies. Most evidence-based approaches to refugee psychotherapy include some combination of supportive counseling and elements of cognitive behavioural therapy (CBT).⁵ Many of these therapies are adapted to be delivered by front-line workers who may be more accessible to patients than psychologists or other

mental health professionals.⁵

Cognitive behavioural therapy. CBT is a technique that aims to teach patients to re-evaluate external events in a more adaptive way, compared to their previous coping strategies.¹⁰ CBT has mainly been trialed for refugees experiencing stress related to their migration, including PTSD.¹¹ Overall, CBT appears to be very effective in reducing patients' symptoms of PTSD and other forms of stress.¹¹

Specific modules, such as culturally adapted CBT (CA-CBT) have been modified to be more relevant to the unique situations of refugees. CA-CBT differs from traditional CBT in that it includes a modified approach to exposure, emphasizes somatic sensations, and addresses comorbid disorders such as anxiety and anger.¹⁰

Narrative exposure therapy. Narrative exposure therapy (NET) is another psychotherapeutic treatment that has produced positive results in children and adults diagnosed with PTSD. NET involves the patient chronologically exploring their life, including traumatic events, with the therapist in order to create a life narrative.^{5,12}

The actual psychotherapeutic modalities used to treat a specific mental disorder may not be delivered by a physician. However, physicians must still be aware of which therapies are evidence-based when making the decision to refer patients. Unfortunately, many of these psychotherapeutic techniques lack evidence from long-term follow-up.⁵ In addition, patients with more complicated illnesses may not be able to participate actively in psychotherapy, making this an ineffective treatment method for them.⁵

Medication recommendations. There is a lack of research regarding psychiatric medication specifically in refugee populations.⁵ If medication regimens are required to treat mental illness in refugees, physicians generally advise using the same medication regimens that are used in the general population.⁵ Commonly, selective serotonin reuptake inhibitors and tricyclic antidepressants are used to treat depression, PTSD, and anxiety disorders.⁵ However, the affordability of medications may be a barrier given that many refugees cite cost as a reason they are unable to access health care.⁶

Mental health promotion and psychosocial interventions. Refugee mental health may also be affected by the post-displacement environment, and social programs for refugees aim to treat this risk factor.⁵ One group intervention, sociotherapy, has been applied to several refugee populations.⁵ Sociotherapy involves a group discussion about personal and community issues in the presence of a trained facilitator. This intervention aims to increase connections between people and has been shown to improve mental health and community engagement.⁵

In Canada, the Centre for Addiction and Mental Health (CAMH) has laid out 13 best practices for refugee mental health promotion.¹³ These best practices highlight what communities must do in order to create an environment where refugees are able to seek and receive mental health treatment. CAMH recommends that all refugee mental health promotion programs aim to improve protective factors and protective determinants of health against mental illness.¹³ Protective factors include family cohesion, literacy, and adaptability, and protective determinants of health

include adequate medical services, housing conditions, and social support.¹³ CAMH also recommends attempting to reduce mental illness stigma within refugee communities, multidisciplinary collaboration, focusing on resilience, and ensuring that services are culturally appropriate.¹³

ADVOCACY FOR REFUGEE MENTAL HEALTH CARE

Physicians are well-placed to become advocates for refugee health. This was recently illustrated when the Canadian government made cuts to IFHP coverage in 2012. A group of Canadian physicians formed Canadian Doctors for Refugee Health Care. This advocacy group focused on repealing these cuts, and played a role in the reinstatement of coverage.¹⁴

Some authors have highlighted gaps in medical education with regards to the care of patients from different cultures.¹⁵ However, in recent years, medical schools have made efforts to teach their students cultural competency and social accountability. For example, the Association of Faculties of Medicine of Canada is working to ensure medical schools provide teaching about Indigenous health care.¹⁶ Culturally-competent care also includes trauma-informed care, where care providers are aware of the trauma and hardships faced by their patients.¹⁷ Recent research has shown that providers lack appropriate training to provide this trauma-informed care, which is another gap in medical education.¹⁸

In addition to advocating for changes to refugee health care, students and physicians can familiarize themselves with the IFHP. Across Canada, the program is administered by a third party provider. Physicians must register with Medavie Blue Cross and submit all claims for services provided under the IFHP through them.¹⁹ Some procedures and codes are automatically eligible for payment, however others require pre-approval.¹⁹ In addition, physicians should be aware that IFHP payments are often slower than Ontario Health Insurance Plan payments and reimbursement may be made at lower rates.⁹

CONCLUSION

It is clear that the trauma refugees may have faced before settling in Canada provides a significant stressor that contributes to the high rates of mental illness experienced by this population. In addition, once in Canada there are barriers that may prevent refugees from accessing care, leading to unmet health care needs.⁶ However, many refugees also display extraordinary resiliency that can be drawn on when planning mental health outreach and health promotion programs.¹³

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