

WORKING WITH REFUGEES, ASYLUM SEEKERS AND NEW MIGRANTS

**Best and Promising Practices: Guide for staff of mental health and addiction
services working with refugees, asylum seekers and new migrants in Aotearoa New Zealand**

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Te Pou
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FOREWORD

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It is a pleasure to write this foreword for the new Te Pou Guide relating to working with Refugees, Asylum Seekers and New Migrants.

Working effectively with all new migrants from culturally and linguistically diverse backgrounds, requires sensitivity, openness to learning, and a commitment to the practice of cross-culturally responsive skills and competencies. It is easy to assume that all refugees will have mental health problems or that such problems will become apparent immediately on arrival in New Zealand. Neither of these assumptions is true, but refugees and some new migrant groups are at higher than usual risk of presenting with mental health problems some time after settlement. Some of these problems are triggered by the resettlement experience itself, while others reflect past trauma. It is vital that health practitioners recognise this and can work sensitively with people from resettled refugee and migrant populations in health-promoting way.

Services provided to new settlers who have a refugee or related forced migration backgrounds have developed over time, but many mainstream mental health practitioners from a variety of helping agencies may never have met such a client or had the opportunity to explore the unique issues that relate specifically to this group of people. While the mental health needs of resettled refugees and new migrants are similar in some ways to those of any other client, key differences exist in understandings, in experiences of health systems, education, family, community, and in other social and personal areas. This means that mental health professionals may need to apply special attention and new skills if they are to help this group of clients achieve a sense of well-being in a country and society where many cultural values and practices are new to them.

This new Te Pou resource has been developed by a multi-disciplinary team of experienced senior practitioners from RASNZ, New Zealand's specialist refugee health agency, and provides important information about the kinds of issues that may arise when health professionals are engaging with resettled new migrants and refugees. For the new practitioner or the experienced clinician meeting clients from such backgrounds for the first time, this will prove a highly valuable guide and essential resource.

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EXECUTIVE SUMMARY

This resource guide is intended to provide a concise overview of relevant recent patterns of immigration to this country, and to cover some of the challenges and issues that may affect refugees, asylum seekers, and new migrants. The purpose is to offer a summary of some of the knowledge and skills required for a health practitioner to work in more culturally responsive ways to better meet client needs. A review of the domestic and international literature in relation to current best and promising practices is provided, along with some practical guidelines on working through interpreters, ways to better understand the unique needs of diverse clients, and practical tips that may be helpful to better and more effectively serve in the challenging and rewarding field of cross-cultural practice. A summary of the known current applications of various approaches are covered, including principles of engagement, talking therapies, kinaesthetic, collective and narrative approaches, as well as some of the issues related to medications. Working in the area of cross-cultural international health can be highly rewarding and challenging. The aim is to assist migrants and refugees to overcome obstacles and enhance resettlement success. There are constant opportunities to learn about new cultures and concepts of mental health and different customs and ways of life. With an attitude of sincerity, openness, flexibility and a willingness to learn, a practitioner may gain experience and develop confidence to be effective in providing help for people from a wide variety of countries, cultures, backgrounds and needs.

SECTION ONE-

INTRODUCTION

RELEVANT PRACTICE GENERAL GUIDELINES

This general resource applies to a health practitioner's work in relation to refugees, asylum seekers and new migrants from culturally and linguistically diverse (CALD) backgrounds, and particularly those affected by forced migration or related experiences which may impact their resettlement in Aotearoa New Zealand.

Potential roles for health practitioners in this area are in assessment and treatment of new migrants, refugees or asylum seekers affected by trauma or post-settlement general or mental health issues, assessment reports to the Immigration and Protection Tribunal regarding asylum claims, or in client advocacy in relation to case matters being managed by Immigration New Zealand, or other relevant government departments.

It is well beyond the scope of this resource to address the specific unique cultural aspects of the highly diverse former refugees, new migrants, and ethnic minority communities, or to provide a comprehensive detailed guide to all aspects of mental health related these populations. The purpose of this resource is to provide an overview of key issues, considerations, and to cover some international practice guidelines and protocols which may assist a health practitioner to understand and work more effectively with a client or patient from a refugee, asylum or migrant background.

RELEVANT LEGISLATIVE AND PRACTICE CONTEXT

The relevant domestic practice context includes the Immigration and Protection Tribunal, Immigration New Zealand (INZ), the Department of Labour, Department of Internal Affairs, Ministry of Social Development, and the Health Practitioners Act, 2004. The relevant national legislation pertaining to migrants and refugees is the Immigration Act, 2009, and in international law the 1951 UN Convention Relating to the Status of Refugees, the 1967, Protocol Relating to the Status of Refugees, the International Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment 1984, the Universal Declaration of Human Rights, Article 14.1, the Immigration Advisers Licensing Act, 2007 and the New Zealand Human Rights Act, 2001. The central purposes of the Immigration Act 2009 are to regulate border control and immigration policy and practice, to insure New Zealand complies with international conventions relating to human rights and refugees, and for provisions governing visas, residency and citizenship.

Purpose and Target Audience

This document assumes that readers are familiar with the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services as described in the Ministry of Health *Let's get real* framework. The *Let's get real* framework is explicit in stating the expectations for people who work in mental health and addiction services irrespective of their role, discipline or position in an organisation. Further information on *Let's get real* is discussed in Section Two – Principles of Engagement.

Working in a helping role with new migrants arriving from refugee or forced migration backgrounds presents among the most unique, challenging, and potentially rewarding professional experiences for any health practitioner. This document is intended as a general resource for practitioners such as psychologists, nurses, social workers, medical doctors, community workers, psychiatrists, physiotherapists, occupational therapists, or others in the mainstream health or social services who may be called upon in a professional or helping role for working with someone from a refugee or migrant background.

The purpose of this resource is to provide a health practitioner with an introduction and basic understanding of the special characteristics and needs of new migrants, as well as a succinct overview of some practical skills required for work with a person from with a background of forced migration. Typically people from such backgrounds may have a history of profound trauma caused by war, dislocation, flight, detention, torture, or grief from loss on a scale seldom experienced by people living in comfortable Western societies. People from former refugee backgrounds must also learn a new language, overcome obstacles and adapt to a very different ways of living in the process of starting new lives.

This resource is intended as an initial reference guideline and is not a substitute for specialist training, experience or supervised practice. Further resources for both specialist training and detailed information are included in the reference and links sections.

International Migration

International migration increased substantially during the late 20th century and currently continues to accelerate at historically unprecedented levels (UN, 2009). It is presently estimated that over 200 million people or approximately 3% of the world population have migrated from the place of their birth to a new country (IOM, 2008). The United Nations High Commissioner for Refugees (UNHCR 2008) presently confirms 16 million refugees and asylum seekers forcibly uprooted by war, repression or persecution out of 42 million internally displaced persons of concern. Polls have estimated that over 700 million people would like to migrate to a new country if there was opportunity to do so (Gallup, 2008).

Aotearoa New Zealand, at over 20%, has one of the highest proportional rates of foreign born populations in the world (Statistics New Zealand, 2001), comparable with Canada and Australia (IOM, 2008). The largest proportion of the 45,000 annual migrants in recent years has originated from the Pacific Islands, UK and Asia (Statistics New Zealand, 2001 and 2006).

People may migrate for a variety of complex personal, family, social, educational, cultural, political or economic reasons, generally in pursuit of hopes for a better life. Push factors may include poverty, deprivation, persecution, overcrowding, natural disasters such as earthquakes, drought, or more recently the impacts of climate change (IOM, 2008). Pull factors often include

economic betterment, job opportunity, education, family reunification, relationships, environment, climate, personal freedom, or lifestyle options.

Moving to a new country involves major changes and challenges such as disruption to familiar patterns, leaving behind family, friends and support networks, and exposure to new experiences and problems. The challenges are particularly greater if the move is to a country with major cultural and linguistic differences from the point of origin. There are considerable legal barriers to migration and stringent international border control practices restricting it. Generally, only the most skilled or affluent migrants are readily accepted for residency in developed countries (IOM, 2008). Politics have increasingly become intertwined with immigration policy in many countries due to contemporary societal concerns with national security, terrorism and issues around cultural diversity and tolerance (IOM, 2008).

Natural and social barriers to immigration can also prove formidable. Departing migrants often leave behind everything familiar: family, friends, support network, customs and culture. When they arrive in a new adopted country there are many challenges including finding work, accommodation, adaptation to new laws, new cultural norms, language or accent issues, possible discrimination or other exclusionary behaviour towards them and their family.

Abbott (1997) describes some key reasons why migrant and refugee mental health needs are particularly important to consider:

- Migrants constitute a large and growing proportion of the national population
- They come from culturally and linguistically diverse (CALD) backgrounds and have needs that may well not be adequately met by existing mono-cultural or bicultural health and human services.
- They are likely to include subgroups at high risk of mental illness or dysfunction due to pre and post migration stresses and challenges

New Migrants in Aotearoa New Zealand and Mental Health

Given that Aotearoa New Zealand is significantly a nation of migrants, the experiences of migration in relation to mental health and adaptation are important to consider and better understand. All new arrivals, whether short term visitors, students or migrants must adapt to a different environment and society. Shifting to a new place of residence involves losses, disruption to familiar life patterns and exposure to new experiences and challenges. There are yet more challenges involved in crossing national boundaries or entry to a place of new language and different culture. All of this involves an ongoing process requiring a capacity to adjust and adapt.

Sluzki (1986) (1992) describes a continuum in the process of migration broken down into discrete steps: (1) preparatory stage; (2) act of migration; (3) period of overcompensation; (4) period of de-compensation; and (5) trans-generational phenomena. Each step has distinctive characteristics, triggers different types of personal and family coping mechanisms, and unchains different types of responses.

Following a literature review, Abbott (1997) concluded that it remains unclear whether migrants generally are more at risk than locals for major mental health disorders. Albee (1984) proposed a model that includes a balance between both adverse life circumstances or contributors to risk and

protective and adaptive factors relevant to resiliency in new migrant individuals, families and communities.

Wong (1992) reported on South Auckland Pacific and Chinese admissions to in-patient psychiatric units. His study found that acute admission rates for Pacific and European New Zealanders were similar (1.5 per 1000), that Māori rates were almost double (2.8 per 1000) and that the Chinese rate was considerably lower (0.6 per 1000). Wong also calculated rates for community mental health service consultations. European New Zealander and Māori rates were similar at 6.4 and 6.1 per 1000 respectively. Pacific and Asian rates were much lower at 2.3 and 1.6 respectively.

Abbott (1997) observed in a review of the literature and in reference to Albee (1984) that the following factors appear to have been most strongly and consistently linked to elevated rates of mental health problems among new migrants generally:

- **traumatic experiences or prolonged stress prior to migration**
- **separation from family and community**
- **isolation from people of similar ethnic/cultural background**
- **inability or difficulty to speak the language/languages of the host country**
- **unemployment and underemployment**
- **drop in socioeconomic status**
- **negative public attitudes towards, and rejection of, immigrants and refugees generally and/or some (ethnic) groups specifically**
- **being a child without parents or with seriously disrupted formal education**
- **being adolescent or of advanced age at the time of migration**
- **being a woman from a culture in which gender roles and values differ from the host country.**

Although stresses and challenges of adjustment in migration may be considerable, they do not necessarily lead to mental health disorders. Stillman, McKenzi and Gibson (2009) reported an experimental approach in which Tongan migrants to New Zealand were compared in those who remained at home. They found in this recent study that migration actually appeared to lead to improvements in mental health, particularly for women and those with a history of poor mental health.

Boyle, Kulu, Cooke, Gayle, and Mulder (2006) found, however, that in a cross-national demographic comparison of the impact of family migration, women's employment status declined and that marriage or relationship stability was adversely affected with increased rates of separation or divorce.

Abbott (1997) and Pernice and Brook (1994) noted that maintaining close links with existing ethnic migrant communities can promote wellbeing and reduce the risk of pathology. Yet Krupinski (1981) earlier argued this may be counter-productive in the longer term and particularly detrimental to children and adolescents. Abbott (1997 page 257) further observed, however, that: "while different rates of acculturation among family members over time can result in conflict, it is still unclear whether those second generation migrants who maintain stronger links with their ethnic group in a new culture are at greater risk of mental illness," (Jayasuriya et al 1994). Such views are based on assumptions that maintaining one's own culture and

integration within the new host society are mutually exclusive, and as Abbott (1997) observes, they are not. Many migrants and refugees value and pursue both, and there is evidence that maintenance of original culture balanced with acculturation in the new settlement country are associated with greater positive adaptation and lower levels of mental health problems (Williams and Berry 1991; Cheung 1995; Liev 1995).

Pernice, Trlin, Henderson, North, and Skinner (2009) reported on a longitudinal study of 107 skilled migrants to New Zealand from China, India and South Africa applying demographic and employment data, and through testing within a structured mental health questionnaire. Initial interviews took place after the new migrants had been resident for an average of five months with follow-up annually for two years. The results indicated stress and moderately poor health indicators in the first two years irrespective of employment status, but thereafter, mental health slightly improved, as did employment rates. There were no substantial mental health differences found among the three diverse groups.

Although the challenges for newcomers can certainly be quite demanding and stressful, particularly in the early stages, it remains unclear if this may tend to lead or contribute to mental health problems for a significant proportion of migrants generally. There is very clear evidence, however, that migrants from refugee and related forced-departure backgrounds are at higher risk for some specific mental health issues and difficulties in resettlement.

In New Zealand, Cheung and Spears reported on the mental health of adult Cambodian refugees resident in Dunedin (Cheung 1994, 1995; Cheung and Spears 1994, 1995). The majority had experienced severe, multiple trauma in Cambodia, including torture. The prevalence of psychological disorder was 15.7 percent, and was compared with the general adult population of Dunedin. However, an additional 12.1 percent of the sample was diagnosed as suffering from PTSD. Older adults had a higher prevalence of PTSD and GHQ-defined (General Health Questionnaire) mental health disorder. Despite this, only one person reported using psychiatric services during the previous year. Risk factors included being widowed, experiencing major life events during the past twelve months, and having experienced chronic post-migration stressors, a poor individual coping style and weak social supports.

Due to the special and often high and complex needs of those coming from forced migration or refugee backgrounds, a large proportion of the present resource is necessarily devoted to those unique issues. At the same time, the following information on cultural competencies, working with interpreters, therapeutic approaches, and managing issues arising will equally apply to all new migrants, particularly those from culturally and linguistically diverse CALD backgrounds.

Refugees in Aotearoa New Zealand

DEFINING REFUGEES

New Zealand is a signatory to the 1951 United Nations Convention Relating to the Status of Refugees (HRC, 2009) provides the following (and frequently-quoted) universal definition of a refugee as a person who:

owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of [their] nationality and is unable, or owing to such fear, is unwilling to

avail [themselves] of the protection of that country; or who, not having a nationality and being outside the country of [their] former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (UNHCR, 2009)

The UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment was signed by New Zealand on 14 January 1986 and ratified on 10 December 1989 (HRC, 2009).

The United Nations High Commissioner for Refugees (UNHCR) is charged with the responsibility of overseeing international conventions providing for protection of refugees. New Zealand fulfils its international humanitarian obligations through its UN Quota Refugee Programme that is administered by Immigration New Zealand, a part of the Department of Labour. Aotearoa New Zealand is one of ten countries that formally accept a quota, including Canada, United States, Finland, Netherlands, Sweden, Denmark, Norway, Sweden and most recently, Japan (UNHCR, 2009). New Zealand's quota acceptance now ranks fifth, equal with Canada (UNHCR, 2009), and particularly includes a large proportion of high protection, medical, disability, and special needs cases, including survivors of torture.

Immigration New Zealand (INZ 2003) defines three legal categories related specifically to refugees:

1. *Quota Refugees*: those determined overseas by UNHCR to be refugees and accepted for resettlement in New Zealand (approximately 1000 per year);
2. *Asylum Seekers*: persons who enter New Zealand through legal or illegal means (such as false travel documents) and who declare asylum at the border or upon arrival in New Zealand;
3. *Convention Refugees*: asylum seekers who have had their claims proved and are eligible as refugees for permanent residency pursuant to determination by the Immigration and Protection Tribunal, pursuant to criteria of the 1951 UN Convention.

NUMBERS AND CHARACTERISTICS OF REFUGEES IN AOTEAROA NEW ZEALAND

Approximately 1,500 new refugees from highly diverse nationalities are resettled in Aotearoa New Zealand each year and over 40,000 people from refugee backgrounds have been settled in this country (NZIS, 2004). New Zealand accepts 750 UN quota refugees annually and allocates only 300 places for family reunification cases. The annual number of asylum claims varies widely and further details are included in a following section of this publication. Some of the largest collective numbers of refugees have arrived in recent years from Vietnam, Cambodia, Kosovo, Afghanistan, Iraq, Myanmar (Burma), Sudan, and Ethiopia. There are communities of former refugees from Burundi, Congo, Columbia, Sri Lanka, Rwanda, and Nepal also resettled throughout New Zealand.

It should be particularly noted that New Zealand accepts within its annual quota a large proportion of UNHCR "high protection" cases, and particularly medically disabled people, vulnerable women and children (INZ, 2004), as well as survivors of torture and trauma. UNHCR "high protection" categories include people considered especially immediately vulnerable or at-risk in refugee camps or transit countries. Because of this humanitarian

principle on which the quota composition is based, the particular needs of the people arriving are likely to be high and complex.

NATIONAL REFUGEE RESETTLEMENT CENTRE IN AUCKLAND AND HEALTH SERVICES

Quota refugees arrive for assessment and orientation at the national Mangere Refugee Resettlement Centre (MRRC) and are approved for permanent residency status from the time of their arrival under provisions of the Immigration Act. It should be noted that from the time a refugee steps off the aeroplane and onto the tarmac of the Auckland International airport, they are no longer a refugee, but a permanent New Zealand resident with all the rights and responsibilities which come with their new nationality.

The MRRC provides an internationally unique assessment and orientation service where all Quota refugees come initially for assessment and orientation. Immigration New Zealand (INZ), Auckland Public Health Service (ARPHS), (medical assessment and treatment) RASNZ - Refugees As Survivors New Zealand (mental health assessment and treatment), Refugee Services Aotearoa NZ (social work and volunteer settlement support), Red Cross, and AUT University (ESOL and education) operate collaboratively on a single 10 acre campus to provide a range of services in a “one-stop-shop” approach during the first six weeks of arrival. From the MRRC the former refugees are resettled around the country in Auckland, Hamilton, Wellington, Palmerston North, Nelson, and Christchurch. The only specialist refugee mental health services are in Auckland (RASNZ), Wellington (RAS Wellington) and Christchurch (Christchurch Resettlement Services).

Common Health Issues for Refugees

MEDICAL ASSESSMENT AND HEALTH NEEDS UPON ARRIVAL

A recurring theme reported is the difficulty that culturally and linguistically diverse (CALD) clients in New Zealand have in accessing health services (Scragg & Maitra, 2005, Mortensen, 2009). Aotearoa New Zealand has advanced in responding to bi-cultural health service development partnership with Māori and more recently has developed responsive services for Pacific peoples (Love and Waitoki, 2007). There are few specialist services available, and the large increases in numbers of migrants and refugees from most diverse cultures in Asia, the Middle East, and Africa has meant that mainstream health services have needed to respond as a result to become more accessible through workforce development and training.

The leading principal study of refugee health status was carried out by McLeod and Reeve (2005) of the Auckland Regional Public Health Service at the National Mangere Refugee Resettlement Centre and involved 2992 incoming quota settlers who were screened and treated during over a 10 year period. Infectious diseases screened and treated included tuberculosis, intestinal parasites and a small number of refugees infected with HIV; non-infectious conditions included iron and Vitamin D deficiency. Most of the illnesses are caused by parasitic or bacterial infection in contaminated water, unhygienic conditions, or malnutrition in camps or during transition. Virtually every refugee screened required some major or minor intervention. There were 349 cases of female genital mutilation (FGM) reported. FGM is an important and very sensitive area of inquiry in the initial assessment phase of resettlement.

Severe permanent physical damage, scarring and disability as a result of torture, war injury, landmines or major traumatic wounds during flight have been widely reported in refugee populations (Gavgan and Brodyaga, 1998), (UNHCR, 1996), Holtan (1992), as well as exposure to disease. A large proportion of female refugees, particularly from some African countries, are often survivors of systemic rape and mass sexual violence (Hynes and Cardozo, 2004). Refugee and internally displaced girls and women are particularly vulnerable to gender-based violence during armed conflict, civil war, ethnic genocide, or inside camps and detention centres.

Physical disability from injury, effects of torture, severe dental damage and abscess, or disease acquired in flight or in refugee camps or detainment centres can be expected to present with high prevalence in refugee populations and can have profound impacts on mental health, recovery, and resettlement outcomes. There are also a number of people who have pre-existing disability conditions. Because of both language and cultural barriers, former refugees often have great difficulty in accessing primary health services, or in knowing how to utilise the Australian (Lamb and Smith 2009) and New Zealand health care systems (Scragg & Maitra, 2005, Mortensen, 2009).

AGE ESTIMATION IN CHILDREN AND YOUNG PEOPLE

Age is taken for granted in the developed world and most Kiwis know their birth date. In relation to refugee children, many arrive with no birth certificate or any form of documentation regarding date or place of birth. For many refugees, an accurate age is not known and this has implications for developmental milestones, medical care (such as vaccinations), education and future legal considerations such as driver's license. It is possible to estimate approximate ages through non-intrusive assessment, which may include mandible (lower jaw) growth rates and general dental measurement (Benson and Williams, 2008).

THE UNIQUE SITUATION AND NEEDS OF REFUGEES

The international literature clearly indicates that health and mental health are thematic and major issues for refugee populations. This is, in part, a result of post-resettlement stressors, many of which are experienced by any migrant individual or group (Abbott, 1997; Jackson, 2006; Keyes, 2000). Cultural transition is also now acknowledged as a process with its own psychological burdens (Pumariega, Rothe & Pumariega, 2005), which include:

- linguistic barriers (Abbott, 1997; Tribe, 1999);
- adjustment to a new culture (Pumariega, Rothe & Pumariega, 2005; Tribe, 1999);
- attempting to maintain one's own culture (Abbott, 1997; Pumariega, Rothe & Pumariega, 2005; Watters, 2001);
- institutional and social racism, affecting access to education and employment, and impacting on the enjoyment of everyday activities (Abbott, 1997; Watters, 2001).

Within the UN legal definition there are fundamental points that indicate how refugees differ in substantive ways from those who voluntarily migrate – refugees are likely to have suffered persecution, and they are *unable* to return to the place they have known as home. These two factors result in a number of specific differences between refugees and migrants, which are summarised in Table 1.

Table 1

Table 1. Refugees and migrants: what's the difference?	
Refugees	Migrants
No options	Many options
Escape/danger/risk	Plan ahead
No travel documents	Travel documents
No possessions	Possessions
Secretly leave	Say farewell
No contacts/visits	Can visit home again
Unlikely to return	Free to return

These fundamental differences mean that refugees are likely to experience stressors that relate specifically to their status *as* refugees. These stressors emerge from their experiences prior to flight from their country of origin, events during the time of transition, and the process of resettlement in the host country (Keyes, 2000), and include (but are not limited to):

- **experiences of marginalisation, persecution and/or torture in the country of origin;**
- **often long-term residence in harsh conditions inside refugee camps, or in a 'transitional' state in the initial country of refuge;**
- **forced separation from community, friends and family members, and often uncertainty as to the location and status of family members;**
- **a lack of control over futures and destiny;**
- **social perceptions of 'refugees';**
- **inability to return to the country regarded as 'home'.**

Moreover, refugees do not necessarily resemble the more 'typical' sufferers of PTSD, as the stressors faced by refugees are often numerous and sustained, from traumatic events in the country origin through high levels of uncertainty during transition to the issues involved in resettlement (Porter & Haslam, 2005). Rather than one discrete traumatic incident, refugees must cope with all or most of the events discussed below, often moving directly from one environment of extreme stress to another with no time to recover.

DEPARTURE AND TRANSITION



*Harsh conditions
in the setting of a
refugee camp in
Pakistan on the
Afghanistan
border region*

*Photo by co-
author 2006*

Image 1

Refugees usually have no opportunity to plan their departure from their country of origin, and may have fled for their lives, with little thought of, or control over, their destination (Abbott, 1997; Tribe, 1999; 2002). The travel itself can be physically and psychologically traumatic (Pumariaga, Rothe & Pumariaga, 2005), with some refugees being at constant risk of apprehension or violence, and having little certainty as to what awaits them at their immediate destination (Tribe, 1999). The need to care for children or elderly or infirm family members may exacerbate these stressors.

The time between a refugee fleeing their country of origin and arriving at their eventual place of resettlement can be lengthy. This transitional period is marked by extreme levels of uncertainty on the part of the individual about the future of themselves and their families, which may include a very real fear that they will be returned to the country from which they have fled. This is also a period of continual interviewing by a range of authorities, with extremely high stakes attached to the outcomes of these interviews (Abbott, 1997).

In addition to these obvious stressors, the place/s occupied during this time of transition, particularly in the case of refugee camps, may be extremely hostile, “with shifting populations and little, if any, personal space” (Tribe, 2002, p. 241) – contexts in which a refugee may live for years. Refugee camps are almost universally extremely poorly resourced, and residents often experience a multitude of health problems resulting from poor sanitation, quickly spread diseases, malnutrition, and other factors (Abbott, 1997; Kang, Kahler & Tesar, 1998; New Zealand Immigration Service, 2004). Furthermore, the camps are often sites of high levels of (often violent) criminal activity including sexual violence (Kang, Kahler & Tesar, 1998; Pumariaga, Rothe & Pumariaga, 2005). While these impacts of these experiences are more immediately physical, they are also likely to be psychological stressors.

Mental Health Issues

PREVALENCE OF MENTAL HEALTH ISSUES IN REFUGEE POPULATIONS

Among refugees as a population, there is a relatively high prevalence rate of serious mental health problems. An overview of the international literature shows a high incidence of refugees settled in western host societies having been diagnosed with post-traumatic stress disorder (PTSD), but

also with major depression, anxiety disorders, and frequent co-morbidity (Fazel, Wheeler & Danesh, 2005). While major depression prevalence may be only slightly higher in comparison to the general population, PTSD may be up to ten times higher among refugee populations (Fazel, Wheeler & Danish, 2005).

Most larger scale general population studies of refugees have focused on PTSD and depression, possibly because of the relative ease of applying standardised self-report measures. A small sample of the international reports on the prevalence of PTSD and depression among refugees yields the following reports:

- Of 534 Bosnian refugees, 39% reported scores supporting a diagnosis of depression and 26% PTSD (Mollica, McInnes, Sarajlić, Lavelle, Sarajlić & Massagli, 1999).
- In 993 Cambodian refugees, corresponding rates of depression at 68% and PTSD at 37% were reported (Mollica, McInnes & Poole, 1998).
- A study of 842 refugees from Kosovo yielded estimates of prevalence rates of just under half with PTSD, and approximately 20% with a major depressive disorder (Turner, Bowie, Dunn, Shapo & Yule, 2003).
- A Norwegian clinical sample study of 231 consecutive outpatient refugees further confirmed evidence of refugees constituting a population at high risk for mental disorders, finding that 46.6% suffered PTSD, while the GAF (DSMIV) mean score for the patients was 57.3 (Lavik, Hauff, Skrondal & Solberg, 1996).

Interview-based studies tend to present somewhat lower but still consistent rates of PTSD and depression. For example, in the United Kingdom, van Velsen & Grost-Unsworth (1996) completed an interview survey of a mixed group of refugees reporting 35% with major depressive disorder and 52% with PTSD (although it should be noted that this was in a group referred for psychiatric assessment).

Timing and post-resettlement adjustment problems in the new host country are factors which require much further study, and which may contribute substantially to risk for mental illness in refugees. In an Australian sample of Tamil refugees, Steel et al. (1999) reported that pre-settlement factors accounted for 20% and post-migration factors for 14% of the variance in symptoms. PTSD and depression, often co-morbid, appear to have complex relationships with pre-resettlement trauma and post-resettlement social and adjustment difficulties (Gorst-Unsworth & Goldenberg, 1998). There are also studies investigating and confirming the prevalence, type and severity of psychological distress and mental health disorders in child and adolescent refugees (Westermeyer, 1991; Hodes, 2000). Symptoms and effects may be persistent and impacts long-term and intergenerational (Westermeyer, 1991; Hodes, 2000). Kinzie, Sack, Angell, Clarke & Ben (1989) carried out a three-year follow-up study of 46 young Cambodian refugees traumatised as children. At six years after the initial study, 38% were found to still suffer PTSD and 14% depression. Furthermore, the established link between parental mental health disorders and childhood adjustment problems would appear to be as relevant for refugees as for other groups (Garmezzy & Masten, 1994; Lukman & Bach-Mortensen, 1995; Montgomery, 1998).

SURVIVORS OF TORTURE

Because of the 'high protection' nature of the UN Quota composition that New Zealand accepts, a high proportion (sometimes up to 20%) of a given intake of 130-150 at Mangere National Refugee Centre may include survivors of torture. The torture may have been carried out by government agents, para-military groups, opposition parties, ethnic gangs during tribal conflict,

or “ethnic cleansing” operations by police, military, or other officials (UNHCR, 2009). Torture is used to create fear, destroy individuals and communities, and to suppress unwanted political or religious views. The survivor of torture often endures severe and prolonged physical and psychological trauma (Tribe, 2002).

Working with survivors of torture and trauma is a specialised area and dissociation is a risk in the early stages (Tribe 2002, Basalogu 2006). Generally, the approach must be slow, progressive and cautious (Campbell, 2007). Some survivors need and wish to ‘bear witness’ to what had been done to them and to tell their stories. Other clients may wish to avoid all discussion of it, even if manifesting intrusive symptoms consistent with PTSD. At all times, the wishes and needs of the client must be respected and the pace considered and adjusted.

THE ISTANBUL PROTOCOL

The Istanbul Protocol was a landmark step in recognising the importance of effective process in securing the rights of torture victims to rehabilitation, reparation and protection (UN OHCHR, 2004). In 2003 the UN Commission on Human Rights drew the attention of governments to the principles of the Istanbul Protocol as a useful tool in addressing and preventing torture. This international convention contains detailed procedures, and practical advice for medical, mental health and legal specialists on how to recognise and document evidence that may assist in legal process and in rehabilitation, and should be referenced and followed by practitioners (UN OHCHR, 2004).

ASYLUM SEEKERS

Work with asylum seekers can present some of the most complex and challenging situations for any mental health practitioner. Asylum seekers may arrive under extreme and desperate conditions such as through ‘people smugglers’ or with false and illegal documentation. The common negative view of asylum seekers as ‘queue jumpers’, all too often portrayed in the media and by politicians is an inaccurate and unfortunate stereotype for people often driven by desperation and extreme urgency to seek a place of safety. The reality is that only between 30% to 50% of asylum seekers will have their claims for refugee status approved as shown from the (INZ, 2009) (table 2) below:

Calender Year	Claims Lodged	Approved
2004	580	208
2005	348	209
2006	276	145
2007	248	113
2008	254	128
2009	319	93
TOTAL	2025	896

Table 2

The majority will eventually be deported to their last port of call, or back to their country of origin. In many cases this could include Iran, Ethiopia, Syria, Sri Lanka or other countries where their departure and unexplained absence alone could attract the attention and suspicion of authorities.

Most asylum seekers are housed in the community in Auckland, or in semi-secure detention at the national Refugee Reception Centre at Mangere. A few asylum seekers are sometimes held in secure detention at Mt Eden Prison if they are considered to be a potential security risk, or more commonly, if there are serious questions about their true identities.

The refugee claims process and its appeals can be lengthy and stressful for asylum seekers and may take up to 12 to 24 months or more in some cases. During this time, the claimant may experience depression, panic or issues such as extreme concern about family members left in dangerous circumstances in the country of origin. The claimant may be challenged regarding the veracity of their story by immigration officials, and the re-telling of personal stories may trigger symptoms during this period.

ROLE OF HEALTH PRACTITIONERS IN RELATION TO ASYLUM SEEKERS

The role of a practitioner in working with the asylum seeker can be challenging and complex. The initial role is often to provide anodyne or palliative support during the lengthy period when the refugee claim progresses through the appeals process. Lawyers acting for an asylum seeker may pressure a practitioner to provide evidence or give testimony to the Refugee Tribunal to support the claim. The practitioner must be clear about the role and seek supervision and guidance in the process of giving any evidence. In some cases, the practitioner may recommend that an independent opinion be sought, and remain in an exclusively therapeutic or supportive role (Tribe, 2002, Murray, Davidson & Schweitzer, 2008). In other instances, a practitioner may feel compelled to provide information, with informed consent of the client. The final determination made by the Tribunal will be based upon the 1951 Convention and whether the claimant is proved to have a “well-founded fear” that return to the country of origin will likely result in persecution, torture or harm.

In writing a report or in giving evidence before the Tribunal, similar protocols and practices related to the Criminal, Youth or Family Courts should be followed (2004 Code of Conduct for Expert Witnesses High Court Rules, Sch 4). A report must be supported by facts and objective observations, and its scope and limitations must be clearly stated from the outset (Murray, Davidson, Schweitzer, 2008, Tribe, 2002). The preparation of a brief by the lawyer acting for a client with specific questions may be helpful in preparing the framework for the assessment and report. Opinion about whether the presentation of a client is consistent with those typically seen in a victim of torture, trauma or persecution should be supported by assessment, case notes and relevant research literature (Campbell, 2007). Psychologists and psychiatrists should be duly cautious about becoming directly engaged in debate about the veracity of a client’s story, which will be supported by evidence put forward by the advocate and challenged by officials of Immigration New Zealand. The record of treatment, the reported personal history, the presentation of any symptoms of trauma, or mental health issues, known physical injuries, or medication will be relevant, as will references concerning traumatic memory and related factors.

Addiction Issues

ALCOHOL AND OTHER DRUGS



Photo above: Thousands of hectares of opium poppies growing in Afghanistan supply 90% of the world's heroin production
Image 2



Three month old refugee infant born addicted to heroin inside refugee camp in Waziristan, Pakistan – photos by co-author 2007
Image 3

Concurrent drug or alcohol dependence in refugee populations, particularly together with PTSD has been reported with frequency (Kozarić, Ljubin, & Grappe, 2000) over a period of time in the international literature (Johnson 1996) (Akerman, 1998).

In any culture, alcohol and other drug use and abuse will be affected by access, mores, peer behaviours, customs, and values. Coping responses to stress or adverse life conditions may affect consumption of alcohol and other drugs following severe trauma. This can lead to addiction in refugee camps or detainment centres, or subsequent to resettlement in a safe haven country. One of the authors witnessed severe and widespread heroin addiction on a massive scale among thousands of men, women and children inside refugee camps in Waziristan, Pakistan (see photo above).

Some cases of alcohol or other drug addiction may not have been detected or noted by UNHCR (United Nations High Commissioner for Refugees), IOM (International Organisation for Migration) case notes or by those involved in initial assessment in selection missions. The importance of both thorough assessment and education upon arrival in the host resettlement country is emphasised.

In refugees and migrants, alcohol and other drug abuse may be deeply hidden in the community due to religious or cultural prohibitions, and the associated shame, stigma and ostracising that may come with acknowledgement of addiction (Johnson 1996), (Simich, Hamilton, & Baya, 2006). This may be so for refugees from Muslim countries where alcohol use is banned or strongly discouraged, or for any group of new migrants who did not before have easy or affordable access to it as in a Western society such as New Zealand. In some cases, the widespread availability of alcohol and other drugs in a Western resettlement country may open the floodgates to abuse and addiction, which can also be aggravated by the breakdown of traditional and family cultural values in first and subsequent generations (Nemoto, Aoki, Huang, Morris, Nguyen, & Wong 1999).

In some instances, Western mental health and addiction services may encounter in refugee populations drug use that, in modern times, is rare or previously unknown such as opium, ghat or

betel abuse and dependency (Westermeyer , Lyfoung, & Neider, 1989), (Nemoto, Aoki, Huang, Morris, Nguyen, & Wong 1999).

Research into specialised treatment for refugee and migrant clients from CALD backgrounds indicates that an understanding of how stress is culturally expressed and managed, and of underlying attitudes toward substance use and abuse is important. Amadeo, Peou , Grigg-Saito, Berke , Pin-Riebe &, Jones (2004) reported in a two-year study on a demonstration addiction treatment service for Cambodian refugees that that a very controlled coping style is normative, including suppressing emotions, suffering silently, and acting pleasantly toward others regardless of one's true feelings. In Khmer culture, sadness is to be kept "within the heart" (Bromley& Sip, 2001, p. 329). Often, the act of *not expressing* feelings such as fear, anger, grief or hostility is associated with somatic problems (e.g., severe headache or stomach disorder), as a culturally acceptable response to stress.

Amadeo, et al, (2004) found from research and experience that these elements were most important in maximising intervention success:

- Use of a co-therapist clinical team to provide bilingual, bicultural counselling***
- Counselling carried out in native language***
- Education about addiction as a treatable and recoverable illness is needed for clients, their families, the community as a whole, and for refugee and immigrant human service staff***
- Treatment programmes must anticipate that a significant proportion of clients will be dually diagnosed***
- Due to the severe stigma of alcoholism and drug addiction, treatment programmes must be sited in non-stigmatizing settings***
- Immersion in traditional cultural practices, teachings and values plays an extremely important role in recovery***
- Clinicians used confrontation sparingly as a counselling method. Instead, they applied traditional Cambodian values of respect for family and community to increase client motivation for change. They explored the hopes and dreams that clients originally had about coming to a new country, and ways that clients were or were not able to fulfil those hopes and dreams in a new life***
- Exploration of ways clients had coped with stressful, painful, or dangerous situations in the past***
- Utilisation of a primarily nonverbal treatment such as acupuncture and traditional therapies should be considered as one key complementary element of a treatment programme***

Amadeo, Peou , Grigg-Saito, Berke , Pin-Riebe &, Jones (2004)

GAMBLING

It is also very important to insure that newly arriving refugees and migrants from ethnic or similar backgrounds have preventative education around the risks and serious pitfalls of gambling in Western resettlement countries. Petry, Armentano, Kuoch,, Norinth, & Smith (2003) found high prevalence rates of pathological gambling among 96 refugees from Laos, Cambodia and Vietnam,

and greater risk factors which included being male, divorced, and young. Problem gambling was also identified as an economic and settlement issue in a sample of Sudanese refugees in Canada (Simich, Hamilton, Baya, 2006).

In New Zealand, Tse, Wong, and Kim (2004) observed and reported anecdotal information about serious problem gambling among migrants of Asian origin, and with reference to refugees from Vietnam, Cambodia, Laos, and Myanmar Burma. They noted (2004) that gambling often provides migrants with temporary relief and escape from personal or resettlement problems. They also observed from clinical case practice (2004) how shame and cultural stigma (loss of face) prevents Asian problem gamblers and their families from seeking treatment until after serious loss and damage to lives had occurred.

Former refugees are at high risk for vulnerability to gambling problems for a range of reasons which include a history of trauma, and lack of boundaries in an unfamiliar environment where they are exposed to casinos, electronic poker machines, internet gambling, and a range of other stimuli that could be foreign, novel and enticing. Anecdotal reports in Auckland from Burmese Community Health Workers have indicated that some Burmese women who arrived as refugees had lost much of their family gold as a result of compulsive gambling in casinos. This had resulted in serious financial losses and family problems. The women had engaged in their home country in harmless forms of gambling games as a pastime for small stakes. They found the enticement of the lights and excitement of a gambling casino difficult to resist.

Since 2008 at the National Refugee Resettlement Centre at Mangere, RASNZ has provided group sessions for all incoming quota settlers in preventive health education through interpreters in relation to alcohol and drug issues and in regard to gambling in collaboration with the Problem Gambling Foundation. From these preventive education sessions in each intake, some individuals come forward for help with a problem, and all families are given information about where to go for assistance in the community.

New Migrants: Brief General Guidelines for Working With and Through Interpreters

Working with and through interpreters is a highly specialised skill to be developed through training, experience and supervision (Tribe & Ravel, 2002). The selection of the right interpreter for the needs of your client is paramount. Only NAATI (National Accreditation Authority for Training for Translators and Interpreters Australia) qualified or equivalent interpreters should be used wherever possible. Children should never be used for interpreting purposes and great caution should be applied if family members or unqualified community members are put forward for any role in interpreting (Tribe & Ravel, 2002).

Some researchers (Farooq, Fear & Oyboode 1992) have challenged the notion that psychological assessment and psychotherapy is generally possible through interpreters. Bot & Wadjenso (2004), Raval & Smith (2003) have highlighted how two fundamental cornerstones of practice: language and communication, are impacted by interpreter interaction. Translation and interpretation is not always exact, and errors may be made in omission, addition, or condensation. They also identified difficulties around precise translations for certain terms in some languages, and the unfamiliarity of the interpreter in the mental health context, or the ability to make sense of a clinician's questions or intent. Bot and Wadjenso (2004), however, have offered ways to

counter such difficulties such as introductory education in mental health, and in further training for understanding basic counselling terms and communication principles applied in therapy.

It is essential to first confirm with the client whether a particular interpreter is acceptable. The assumption that matching a client with an interpreter from his or her own community is necessarily the best option is sometimes proven wrong. In some cases, clients express strong reservations about an interpreter from a close-knit, small community. For example, Afghan clients speaking Dari may prefer to have an Iranian interpreter who speaks Farsi. The reasons for this relate to concerns about confidentiality in their community and embarrassment about discussing personal and private family matters with those connected with it. Gender considerations in relation to both the health practitioner and interpreter can be very important, particularly for CALD clients from Muslim or other traditional societies (Tribe & Ravel, 2002).

NAATI level trained and qualified interpreters are accountable for clear and specific ethical standards. Confidentiality is paramount and must be clearly and simply explained in the first session with a CALD client together in the presence of the interpreter. Interpreters are expected to convey everything that is said during a session accurately and precisely including remarks considered colloquial or vulgar. No additions, omissions or alterations are allowed. Interpreters must convey non-verbal cues such as hesitations, sarcasm, or authoritative commentary. If the interpreter does not know the meaning of a word or phrase, or does not understand a concept, they should stop and ask for clarification. It is imperative that interpreters interpret everything even if they think the content is nonsensical or irrelevant. Interpreters also need to consider any relevant cultural issues and advise the parties accordingly, including the health practitioner and the client.

Generally, the health practitioner should establish rapport and communicate directly with the client and avoid directing the interaction to or through the interpreter unless there is a need for a pause to clarify or seek further explication. The interpreter is there to act principally as tool for communication and should not be placed in any role of co-therapist or beyond pure interpreting or cultural advice. A skilled and experienced interpreter is a highly valued and necessary colleague essential to working with CALD clients. There should be a period of time for briefing between the practitioner and the interpreter prior to the session. During the pre-session briefing, the known facts of the case, background history and key presenting issues are covered. There should also be a post-session debriefing consultation between the practitioner and the interpreter to review the session and provide any cultural advice or suggestions which should be recorded in case notes.

Cultural Worldviews of New Migrants: Cultural Safety and Competencies

The development for multicultural practice in Aotearoa New Zealand must be based upon the bi-cultural foundations of Te Tiriti O Waitangi (Love and Waitoki, 2007), and on principals of cultural safety and competence (Love and Seymour, 2007). The efforts and initiatives of health and social services in Aotearoa New Zealand to become more culturally responsive to Tiriti obligations to Mana Whenua, may have helped foster the development of better suited services for migrants from CALD backgrounds (Love and Waitoke, 2007). Specialist services by and for

Māori were initiated in the late 1980's, and more recently have been extended to migrants from Pacific Island and Asian origins.

Jackson (2006) observes that health practitioners working with clients from other cultures need a broad understanding of cultural difference if they are not to misperceive symptoms and misdiagnose illness. Practitioners need to be aware of the kinds of small differences in preferred patterns of communication, interaction, courtesy rules, and ways of showing agreement and disagreement within the practitioner-client relationship that are part of the normal behaviour of culturally and linguistically diverse clients. It is important that cultural differences be accepted and understood rather than judged to facilitate effective health treatment of refugees and migrants who have resettled in New Zealand (Jackson, 2006).

Although European New Zealand culture is principally based on an individualistic emphasis, Hofstede (1994) estimates that 80% of the cultures around the world are founded on collectivist principles. Cultural and linguistic competency is a set of congruent behaviours; attitudes and practices that come together in a system of care that enables effective work in cross-cultural situations (Pedersen, 1988, Hofstede, 1994). "Culture" refers to integrated patterns of human behaviour that include the history, language, thoughts communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, ability or social groups (Hofstede, 1994). A working definition of cultural competence is "having the awareness, knowledge, and skill, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds" (Love and Seymour, 2007).

Pedersen (1988), offer solutions for understanding cultural dimensions by isolating four cognitive components to cultural competency: (a) Awareness, (b) Attitude, (c) Knowledge, and (d) Skills. By contrast, cultural competency is not necessarily knowing everything about a particular culture, liking or agreeing with all aspects of another culture, or fluently speaking the language of that particular people or culture. A key part of the process of developing cultural competency is an objective self-awareness of one's own cultural heritage and values (Hofstede, 1994, Wing-Sue, 1998, 2001).

Where possible, a sound option may to refer to a specialist service for Pacific, Asian or Refugee services. Where this is not possible, the engagement of a cross-cultural advisor is a means for helping to achieve better understanding of client needs and appropriate practitioner responses. There are CALD training courses for health practitioners and a range of reference resources available from New Zealand and overseas sources for assisting practitioners in clinical case work (recommended resource list below).

Generally, clients from CALD backgrounds appreciate any sincere effort on the part of a health practitioner to acquire some basic understanding of something of their culture, simple greetings, protocols (such as handshakes, eye contact, or physical proximity) and willingness to learn and respond (Pedersen, 1988, Jackson, 2006). CALD clients are usually tolerant of cultural mistakes on the part of practitioners, and eager to work in partnership to develop a therapeutic relationship. Cultural competency also does *not* mean giving up one's own cultural values or professional principles in order to be culturally sensitive.

Informed consent to treatment, confidentiality and ethics of the helping relationship with a health practitioner are topics that may well be foreign and quite unfamiliar to a client from a CALD migrant or refugee background. To an extent, the concept of individual confidentiality may be something of a

Eurocentric construct (Summerfield, 2001) and the reasons for it and the adherence to other ethical guidelines must be given considerable extra attention and key emphasis in the first sessions of work with a CALD migrant or refugee client. For former refugees and asylum seekers, the issues of building trust with health practitioners or others viewed as authority figures, is a challenging key goal of even greater importance than with clients from mainstream backgrounds.

In relation to specific information about particular individual countries, cultures, languages, courtesies, special considerations, greetings and general information, New Zealand-published resources are available and included in the links section of this document.

National Evidence and Gaps in Knowledge and Evidence Base

There is very little New Zealand specific evaluation research that has been carried out on either settlement programmes for refugees and migrants in this country, or any mental health services or particular approaches. Much of the current knowledge has been based on the international literature and also published and practical experience with trans-Tasman links with long-established programmes in Victoria (Victorian Foundation) and New South Wales (STARRTS Centre). There are substantial gaps in the national evidence in relation to mental health generally and refugee and migrant issues specifically. A 2008 (Thorburn, David and Hagi) two year evaluation of a community-based specialist refugee mental health service in metropolitan Auckland is reported on the Te Pou website and is in process of publication.

International Evidence

There is some limited international evidence reported in specific overseas studies within particular groups of refugees, asylum seekers and migrants regarding the efficacy of a range of approaches. The detail of this summarised and presented in the following Section 3. It is important to bear in mind that refugee, asylum seekers and new migrants come from very linguistically and culturally diverse backgrounds and that methods described as effective with one group may not necessarily be applicable or generalised in the same way to others from different countries. At the same time, there is a growing body of evidence that some general principals and approaches and specific therapies are likely to enhance the prospects for improvement in mental health and resultant settlement outcomes.

SECTION TWO - PRINCIPLES OF ENGAGEMENT

General

Eileen Pittaway (2009) recommends a human rights rather than a needs-based approach for engaging and working with people from refugee and migrant backgrounds. Refugees and migrants arrive in New Zealand as permanent residents and immediately have all the same rights and responsibilities as anyone else, including access to employment opportunities, good housing, education and health services. Under the human rights principle, access to culturally responsive and effective health and social services is simply a requirement, and not a charitable option. It is, therefore, incumbent upon government departments, health boards, service providers, and particularly health practitioners, to both respond and to advocate for those rights.

A Wellington area refugee advocacy group, Changemakers (2009), has summarised a set of general principles for engaging with people from refugee or related backgrounds.

- Human rights are the basis for policy development and services.
- Our focus is on strengths, not weaknesses. People from refugee backgrounds bring with them knowledge and many skills that can be used
- A shared voice is a stronger voice.
- Trust and reciprocity are the basis of our relationships.
- Our goal/purpose for working together is clear and mutually agreed to.
- Our communication is open, honest and easy to understand.
- Our engagement is inclusive and fair to all parties involved.
- People with refugee backgrounds are involved in all stages of our work together – defining the issue, planning, implementation and evaluation.
- Information is accurate and timely.

There can be serious ethical issues arising in relation to placing traumatised refugees into settlement cities where there are no specialist health services to support them. Mainstream services are often not accessible, and some district health boards continue to apply the “3%” service rationing cut off where only the most florid or severe cases of presenting pathology are admitted for services. As the international literature has clearly and definitely shown, refugees and migrants from similar backgrounds frequently do not manifest symptoms or mental illnesses in the same ways as service users from Western cultural backgrounds. The failure of the mental health system to adequately address those issues has, in quite recent years, sometimes resulted in deeply tragic and very public incidents featuring in the news headlines.

Engagement – Assessment Issues

- *Assessment issues are likely to be complex and will require time, to gain understanding of the client, family, culture and context, with special attention to establishing trust and building rapport*
- *Mental health issues often do not manifest in refugees or migrants from CALD backgrounds in the same way as in mainstream Western populations, and this can frequently result in misdiagnosis and/or denial of services under mental health rationing policies within district health boards or public health services*
- *It is useful to apply a strengths-based approach, and wherever possible, and to engage the advice and assistance of a knowledgeable cross-cultural worker from a similar ethnic and linguistic background*
- *Confidentiality of written records is a very big concern to most refugees and migrants for reasons that may differ considerably from other service users. In many non-Western countries, the term 'confidential' may have no meaning in relation to official documents. For this reason, the taking of written notes, particularly during initial sessions can be extremely sensitive and will need to be thoroughly explored, explained, and possibly limited.*
- *Mental health issues may, in a number of cases, arise quite some time later after a person from a forced migration background reaches a place of safety and is progressing through the resettlement process*

ASSESSMENT AND TREATMENT SERVICES

A practitioner working in a mental health service may be referred a client from a refugee background who manifests severe distress and with special needs quite different from those encountered in mainstream practice. The refugee may have been a survivor of torture or profound trauma and may possibly not speak any English or have had any exposure to Western health care models or practices. The professional ethics and role of the psychologist remains the same as for any other client in the healing process, except there are special adaptations and responses required. Extra time and attention generally must be devoted to establishing rapport and building trust even beyond that in ordinary practice. Special attention must be given in relation to client rights such as consent to treatment, consent to release of referral information, in relation to the role of the psychologist, the process for complaints, and in relation to mutual goals and expected outcomes (Murray, Davidson & Schweitzer, 2008).

THE RESILIENCE OF PEOPLE FROM REFUGEE BACKGROUNDS

In spite of the fact that refugees may frequently have had experiences that could be expected to result in significant mental health issues, they have also often learnt how to survive and cope in situations of extreme difficulty (Pumariega, Rothe & Pumariega, 2005; von Buchwald, 1994). Concern about one's psychological state is a luxury that is seldom available to those fleeing a country in fear of their lives, or living in the environments that typify most refugee camps. As a result of this, together with specifically culturally bound understandings of 'mental health' (Jackson, 2006), refugees may be particularly reluctant to present as having mental health issues, but will rather point to social, economic or physical illness explanations for their distress (Summerfield, cited in Watters, 2001). Further, most refugees arrive in Aotearoa/New Zealand with little in the way of financial resources, and as a population have high rates of unemployment. They are thus subject to the stressors that are experienced by members of all lower socio-economic groups (Abbott, 1997; Pumariega, Rothe & Pumariega, 2005).

These include (but are not limited to):

- difficulties in covering basic needs;
- financial uncertainty;
- lack of sustained education;
- concern about the future of themselves and their families;
- dependency, sometimes inter-generational, on welfare agencies and charities, with related loss of dignity and control;
- feeling unable to contribute to one's own community and/or the wider society.

Refugees are thus likely to request relatively pragmatic solutions to personal problems, rather than psychological assistance. Practitioners working with refugees should not discount these pragmatic solutions as part of the provision of mental health services and an advocacy role may be required (Summerfield, 2001).

Porter and Haslam (2005) note that for many refugees, the provision of more generous material support on the part of host governments would result in significant improvements in mental health outcomes. While such support is beyond the means or remits of most (mental) health workers and agencies, recognition of the centrality of material security to the mental well-being of refugees suggests the potential efficacy of a holistic approach, one that requires a functional knowledge of the resources and services that may be available to assist refugees (Watters, 2001). The ability to provide such practical assistance is likely to impact on the willingness of refugees to then accept the provision of services more specifically targeted at mental health (Summerfield, 2002; Watters, 2001).

POST-TRAUMATIC STRESS DISORDER: WESTERN AND EUROCENTRIC CONCEPTS OF MENTAL HEALTH

There is international debate about the applicability and appropriateness of Western concepts (and current measures) for use with non-western populations (Miller et al., 2006; Terheggen et al., 2001). Murray, Davidson, and Schweitzer (2008) note the “applicability of PTSD, with its western ontology and values, is currently controversial,” (Bracken, Giller, & Summerfield, 1995; Kagee & Naidoo, 2004). They note that increasingly researchers recommend that mental health practitioners look beyond a narrow focus on PTSD and the victimisation of refugees (Muecke, 1992) in order to consider the broader context and other dimensions that are a part of the whole lives and experiences of people who, through circumstances, became refugees.

It is recommended that when assessing the needs of former refugees and migrants, health practitioners must move beyond rigid, limited categories of diagnostic pathology to consider the breadth and depth of the whole person, including a key focus on strengths, personal and cultural resources, and aspirations.

PRACTICAL SUPPORT IS IMPORTANT IN ADDRESSING MENTAL HEALTH CONCERNS

The need to provide practical support is also related to how refugees define ‘*successful resettlement*’. The concept of successful resettlement as an attainable goal is intertwined with good mental health.

Some key priority resettlement aims of many refugees

- 1. employment**
- 2. educational advancement**
- 3. retention of one’s own culture**
- 4. family reunification**
- 5. knowing one’s rights and duties in the host society**
- 6. language acquisition in the host country, and**
- 7. reduction of negative stereotyping and barriers**

The key importance of this dimension was clearly indicated in the two-year evaluation of the Auckland Regional Refugee Mobile Team (Thorburn, David, and Hagi 2009). Certain factors have been consistently

identified by refugees as markers of successful resettlement, regardless of cultural specificity (Valtonen, 2004):

The likelihood of refugees prioritising their immediate needs before considering things such as mental health issues also indicates the need for any refugee-specific mental health services to not be focused just on the initial weeks of the resettlement process, and suggests that the most effective delivery of mental health services to refugees may be some time after initial arrival in Aotearoa New Zealand, once the needs perceived by the refugee as more immediate, such as housing, financial support, education, and physical health, have been addressed (Watters, 2001).

As well as experiencing stressors unique to their situation, the ways in which refugees understand and utilise mental health services is likely to have some specific elements. All cross-cultural communications are marked by the potential for misunderstanding (Jackson, 2006; Kang, Kahler & Tesar, 1998), especially around complex issues such as mental health, where symptoms can be ill defined and inappropriate diagnoses may be made (Weinstein et al., 2000). For those from non-western cultures the concept of mental ill health may have particularly negative connotations (Jackson, 2006). Even in the absence of specifically negative connotations, the fact that different cultures simply have different understandings of what ‘mental health’ means, what symptoms are relevant, and how these might be appropriately treated must be taken into account (Guerin et al., 2004; Jackson, 2006; Kang, Kahler & Tesar, 1998; Keyes, 2000; Summerfield, 2001; Tribe, 1999; Weinstein et al., 2000).

There is frequently a general tendency for people from refugee backgrounds and traditional societies in Africa and Asia to express or manifest emotional distress in physical symptoms (Jackson, 2006, Tribe, 1999). In Western terminology this is often referred to as ‘somatising’ symptoms. For this reason, medical practitioners often first see a refugee and treat for physical symptoms, which may well have no apparent physiological basis. Specialist refugee mental health services such as RASNZ (Refugees As Survivors New Zealand) in Auckland and the Victorian Foundation in Melbourne often employ body therapists to work with refugees who present with physical pain as an entry point for complementary integrated psychological or medical services. As well as the factors which inflect all encounters between mental health practitioners and non-western clients, refugee histories may also be marked by experiences in which revelations of their beliefs and opinions, especially in an ‘interview’ context, have led to their persecution (Tribe, 2002).

Political regimes have also been known to use tactics such as psychological torture as tools of oppression (Weinstein, 2000). Any therapies which involve a 'talking remedy' need to be approached with these possibilities in mind, particularly as this may mean that those with the greatest need (i.e. those who have suffered psychological and/or physical torture) may also be those most likely to avoid situations which resemble interviews/interrogations. At a more general level, the experiences of refugees may also have led to them no longer viewing the world "as a safe and benevolent place upon which they could have an impact" (Tribe, 2002, p. 243). This is likely to permeate all aspects of their mental health, and again impact on how they view mental health (or any) service providers.

CAUTION IN THE APPLICATION OF PSYCHOMETRICS

The application of psychometrics with migrant CALD clients generally and with refugees and asylum seekers particularly, should be approached with considerable caution. Some instruments that have been translated, applied and reported in the international literature include the General Health Questionnaire, the Harvard Trauma Questionnaire, and the Hopkins Symptom Checklist (Campbell, 2007, Murray, Davidson, Schweitzer, 2008). Generally, western psychometric instruments do not have relevant norms and in the translation of any instrument into a new language, there are precise technical protocols to follow (Murray, Davidson, Schweitzer, 2008, Tribe, 2003). In cases where the client reports a history of torture or head injury, referral for medical diagnostics such as MRI or for neuropsychological assessment may be necessary.

It can be a particularly traumatic event for both the asylum seeker and the health practitioner when a client loses the final appeal with resulting forced deportation, often with accompaniment by the Police. Psychologists or other staff members who witness this experience with a client can become quite distressed and debriefing and supervision, as well as self-care practices is important to emphasise. Equally, when an asylum seeker has the claim approved and becomes a Convention Refugee, there is often initial elation and celebration. Convention Refugees do not, however, receive the same level of support in settlement as Quota Refugees and the client may require follow-up support for the longer term. It also sometimes happens that the most productive therapeutic work begins to take place after the refugee status claim itself has been finally determined and resolved.

Involving Families

- *Family reunification, or lack of it, is often a vital, key issue for people from forced migrant backgrounds which can profoundly affect mental health and resettlement*
- *Family members may be missing, dead, or still remaining back in the country of origin or in a refugee camp, and be in danger and hardship*
- *People from CALD migrant backgrounds may frequently have a different understanding of 'family' which are extended beyond those from Western cultures*
- *Family reunification can contribute substantially to improvement in mental health, but may also bring challenges as well in some cases, particularly after long and traumatic separations*

FORCED SEPARATIONS AND ADVOCACY FOR FAMILY REUNIFICATION



Image 4

Because of the often chaotic contexts in which flight occurs, refugee families may become separated, with obvious mental health consequences for those concerned (Abbott, 1997; Kang, Kahler & Tesar, 1998; Tribe, 1999; 2002; Valtonen, 2004; Watters, 2001), particularly when married couples or parents and children are involved. While the mental health impacts of separation might be predictable in some cases, such as immediate family, in other instances potential problems might not be so clear to the western-oriented practitioner. For example, in some cultures, older members of the extended family, community leaders, or other members of the wider community may fulfil specific roles, such as advisor or ‘counsellor’. Separation from such significant individuals or social groups may leave refugees bereft of anyone to consult when emotionally troubled or experiencing family conflict (Guerin, Guerin, Diiriye & Yates, 2004; Tribe, 1999).

In other instances, families may not necessarily be separated, but may rather be forced to leave contexts in which they functioned well, to relocate to societies in which the norms surround family life may be considerably different, and often at odds with the refugee’s own cultural norms (Altinkaya & Omundsen, 1999; Samarasinghe & Arvidsson, 2002). While this may be the case for any migrant, for refugees the possibility of choosing to move to a society with comparatively similar cultural norms is not present.

Adjustments to changes in gender roles particularly can raise issues, as well as for parenting styles and practices. Family violence is an issue for people from all cultures in New Zealand and refugees and migrants are no exception. Information on New Zealand law and values is provided for all incoming quota refugees at the assessment and orientation phase at the national Mangere Refugee Resettlement Centre, as well as intervention and referral help for issues around family violence.

Advocacy in relation to family reunification matters is an important role that may often be needed in relation to assisting forced migrants. Help in locating missing family members in war zones or unsafe transit havens overseas can be provided through the Red Cross/Red Crescent, and this service link is offered onsite at the MRRC at Auckland. Many refugees may also ask for assistance in relation to understanding the process in applying for family reunification to Immigration New Zealand. Although health practitioners may provide a very important advocacy and support role, it is important to bear in mind that under the 2009 Immigration Practitioner Act, only licensed immigration consultants may legally provide formal immigration advice.

For asylum seekers or quota refugees, the advent of instant electronic global communications with family members through the internet or text messages has more recently led to a whole new set of issues. News from family members at home about extremely distressing ‘real-time’ events such as persecution, seizure of property, or detention can result in mental health crises for your clients in New Zealand many thousands of kilometres away.

Achieving family reunification can be a difficult, frustrating and very long procedural process for refugees to go through. There are occasions when children are reunited with family members after prolonged absences; and there is now a protocol (RASNZ, Refugee Services; INZ) recently developed to ensure that positive reunion is supported. If family reunification is not achieved, there can be issues of guilt, fear and grief that can affect both mental health and resettlement. When family reunification is finally achieved, this can often be a very joyous milestone experience. At the same time, depending upon the circumstances and length of separation, complex adjustment issues may arise in some instances. Family reunification is a very important topic that is currently being researched in much more depth in New Zealand.

Support of Community

COMMUNITY SUPPORT IS VITAL BUT MAY INVOLVE COMPLEX ISSUES



Travellers to distant countries or in foreign or unfamiliar environments will relate to how people naturally seek out and gravitate towards others who share the same language, nationality, religious or at least similar cultural backgrounds. Community support is as vitally important for refugees and migrants for all the same reasons as for other mainstream and minority populations in New Zealand society. Isolation in the resettlement phase is known to be a major contributor to mental health issues for both refugees and migrant (Basagolu 2006), (Andary, Stolk, and Klimidis 2003) (Abbott, 1997).

Refugee support agencies such as Refugee Settlement Services Aotearoa New Zealand (RS) engage lay volunteers in the community and social workers to offer practical assistance during the first six months such areas as organising housing, furniture, education and ESOL lessons. Some of the volunteers from mainstream society go on to form longer-term welcoming and supportive relationships that are very beneficial to resettling refugees. Acquiring a basic working knowledge of the language of a host country is a key milestone in the resettlement journey (Basagolu 2006) that can ease the challenges of adjustment. Typically, children and young people from arriving new migrant families will acquire language capability much faster than the adults, and thus may take on a de facto role of interpretation, which may lead to some family dynamics and intergenerational issues.

As well as making new friends from the mainstream host country society, it is also very important for refugees and new migrants to establish links within their own cultural and social groups to the extent possible. New migrants particularly can benefit from the experiences of those who have been long established in the new host country. Immigration New Zealand and agencies involved with planning and implementing refugee resettlement aim to try to locate new arrivals near

established ethnic communities of their own nationalities or cultures. This is not always possible due to practical constraints such as housing availability.

Considerations of placing people from the same nationality, same ethnic group, same tribal affiliation, same language, or similar political affiliation together can, however, involve some quite complex social issues. In some cases, people from the same country may have belonged to opposing and very hostile groups, some of whom may have been involved in war or persecution of the other. Although there are outstanding examples where reconciliation has occurred and people have set aside such histories in the new world of a resettlement country, it is not an easy or simple matter. The reality is that some people from refugee communities may be nearly as divided in the new country as they were in their nations of origin, and politics may affect the ability of a service user to seek and receive support from his or her own community (Andary, Stolk and Klimidis 2003).

There are also quite specific issues for people who have been 'warehoused' for long periods of time, (sometimes for generations) inside the pressure cooker environments of refugee camps (Basagolu 2006). Such refugees often arrive quite damaged both personally and in relation to dysfunctional family and social systems that had developed inside the camps. It may be necessary to consider resettlement of people from such experiences in new and separate areas.

Stigma About Mental Health in Refugee and Migrant Communities

Previous research has shown that people labeled with drug addiction are viewed as more blameworthy and dangerous compared to individuals labeled with mental illness who, in turn, are viewed more harshly than those with physical disabilities (Corrigan, Kuwabara & O'Shaughnessy 2009). Stigma in relation to mental illness has been long recognised as a hindrance to prevention and a barrier to early treatment in the mainstream Western literature, but over the past 25 years there is some evidence that public information campaigns are having an effect, and that changes in attitudes may have been in process of shifting in developed Western countries (Hinsaw and Stier 2008), (Bagley and King, 2005).

Yet in relation to new migrant and refugee groups stigma often remains entrenched. There are frequently other factors operating as well, such as very different beliefs about the origin and resolution of mental illness (Jackson, 2006) that can have profound effects upon the willingness to seek or receive help in a clinical health setting. Franks, Gawn, & Bowden (2007) found that many people in the migrant communities they studied appeared to have very different understandings of 'mental health' to those of the mental health service providers in the UK.

Jackson (2006) reported that traditional beliefs around mental health for many people coming from African, Asian or Middle Eastern origin countries are based on ideas very different from the concepts, assumptions and training of Western practitioners. Whereas Western health practitioners have been immersed in the empirical method, with disease models focusing primarily on neurochemistry, behavioural science, and underlying biological or psychological foundations, people from other cultures may have very different concepts of mind and body. Fate, spirits and curses (Jackson, 2006) may form alternative views of the origins and consequent

effective remedies for many people from traditional backgrounds in non-Western developing countries.

Palmer (2007) and Franks, Gawn, & Bowden (2007) found these common barriers to access for mental health services in migrant workers, refugees, and asylum seekers:

1. Mental health is not a priority (practical issues of survival take precedence)
2. Mental illness is defined as complete mental breakdown, or such as psychotic episode
3. Depression, anxiety or PTSD symptoms are not recognised or understood
4. Stigma about coming to a mental health service may mean an entire family is labelled as “cursed” or “crazy” and marriage prospects for children may be severely diminished
5. Mental illness is the result of fate or karma, and must be suffered
6. Services are not accessible, culturally responsive or seen as trustworthy

Both the literature and experience in this country indicates that stigma issues may be partially addressed by:

- Developing culturally responsive, specialist services for refugees and new migrants
- Locating mental health services in a ‘neutral’ context in the community such as at medical practices, shopping centres, or within more traditional treatments such as body therapy or related alternative practices
- Community education about the common effects of stress in migration, loneliness, depression, PTSD or other issues which may affect people who have experienced trauma which is designed and delivered by ethnic community health workers
- Talking about emotions and practical problems as a starting point rather than focusing on symptoms or pathology
- Ensuring that trust is built in the early stages and that migrant and refugee client ideas and concepts of mind and body are understood and worked with

Medication

This is not a systematic review of the literature. It is an overview of psychotropic medication as it applies to refugees and CALD migrants. It should be noted from the outset that there are real problems applying Western diagnostic concepts to non-Western populations and to assume that they are valid. Further, the evidence base for the efficacy treatment of refugees with psychotropic medication is very limited with respect to ‘Gold Standard’ research; Randomised Controlled Trials (RCT) and meta-analyses. In addition, extrapolating data from RCTs and meta-analyses in non-refugee populations is problematic given the unique situation for refugees and the social context in which they are treated (described in depth elsewhere in this document).

Given the morbidity of refugees in New Zealand as previously outlined, the focus of this overview is on the pharmacological treatment of what in a western paradigm would be termed Post Traumatic stress disorder (PTSD) and depression (MDD). Whilst anecdotally refugees do

respond to medications when referred to a RAS psychiatrist, the mainstay of which are SSRI (specific serotonin reuptake inhibitors) antidepressants, with or without augmentation with low dose atypical antipsychotic medications (AA); clearly most refugees have marked psychosocial need, at least some of which is unique for refugees and differs from that in other populations with PTSD and MDD. The responses that refugees have to medication have not been quantified, and cannot therefore, without additional research, be categorically pronounced as an effect resultant on medication that is independent of concomitant psychosocial interventions. Whilst it is the practise of psychiatrists working in this area to be relatively conservative with medications, especially with respect to refugees, it is observed that many do respond to medication; other disciplines regularly refer patients for psychiatric treatment with a specific request for medication.

PTSD

The evidence, as it exists for PTSD in non-refugee populations that might be of some guidance, stems primarily from research in war veterans and survivors of sexual assault. Drug treatment is poorly studied (Bazire 2009) even in these populations, but from the data ‘positive’ symptoms (e.g. nightmares, intrusive recollections and so forth) respond better to medications, than the ‘negative’ symptoms (e.g. social withdrawal, avoidance of exposure of cues that remind the sufferer of the traumatic event etc). Interestingly, chronic PTSD has a very poor response rate to placebo. SSRI medications have been shown to be effective, but long-term studies are limited. They have also been shown to have an improved effect, as opposed to placebo, for relapse prevention over a six to twelve month period. However, high doses of serotonergic drug for longer periods of time are deemed necessary as opposed to the treatment of ‘uncomplicated’ depression. Relapse rates and symptom recurrence is high if treatment is discontinued.

SSRI's

Meta-analysis (Stein et al 2000) provides definitive evidence for the efficacy of SSRI's for PTSD. In terms of the specific SSRI medications that have been studied, Sertraline has been relatively well studied, but is not Pharmac funded for use in New Zealand, and therefore is not discussed further here. Paroxetine has been shown (Marshall et al 2001) to be effective in both males and females with PTSD in a large double blind placebo controlled trial of over five hundred. It has also been shown to be effective in a number of open trials. There is a Randomised Controlled Trial of just over fifty adults where beneficial effect on dissociation is noted (Marshall et al 2007). Fluoxetine has been shown to be superior to placebo for PTSD in a randomised controlled double control placebo controlled trial of six-month duration (Mirtanyi et al 2002). It has also been shown to be effective in relapse prevention in open trials. Citalopram has a more limited evidence base and has been effective in various case reports. In this author's practise its use is disproportionate to its evidence base, given its relatively favourable side effect profile, especially when considering the propensity towards somatisation and difficulties with side effects that is encountered with certain refugee populations.

OTHER ANTIDEPRESSANT MEDICATIONS

Although the antidepressant Venlafaxine has a relatively robust evidence base in a randomised control of 329 (Davidson et al 2006), it is not available for posttraumatic stress disorder in New Zealand, although it is available for treatment resistant depression.

The antidepressant Mirtazapine, which is also Pharmac funded in New Zealand for treatment resistant depression (but not PTSD), has an effect on some symptoms of PTSD and is well tolerated. It is ironical that there is in fact some specific evidence with respect to PTSD in refugees for Mirtazapine (Lewis 2002); in over three hundred patients in a Chicago based community link serving refugees Mirtazapine was reported to be particularly helpful in mitigating the pervasive sleep disturbance of PTSD and suppressing nightmare activity, (or in blocking the memory of the dream state upon waking). While exact figures were not available, it was estimated that seventy five percent reported improvement; a 'substantial minority' reporting the total absence of dreams related to traumatic events. Clearly this is a study that requires replication in a more rigorous evidence based format. It should be noted that evidence is available for the efficacy Mirtazapine at randomised control trial level in a study of a hundred Korean veterans with PTSD (Chung et al, 2004).

There are also various open labelled studies that look at the efficacy of Sodium Valporate, tricyclic antidepressants and a range of other treatments including Carbamazepine and Clonidine. These studies have not generally been replicated and are small numbered open labelled trials (Bazire 2009).

ANTIPSYCHOTIC MEDICATIONS

Atypical antipsychotic medications (AA) are generally not considered effective, but in a meta-analysis published (Pae et al 2008), pooled data from seven RCT's from a total of 192 patients (not refugees) with PTSD showed that the AA's Olanzapine and Risperidone may have a beneficial affect in the treatment of PTSD, in particular for intrusive phenomena of PTSD, but also for global PTSD symptoms. It was not possible to draw clear conclusions as to whether or not adding AA to the existing antidepressant treatment or monotherapy is superior. However, in New Zealand Olanzapine is only funded by Pharmac for treating psychosis of schizophrenia. The antipsychotic Quetiapine has demonstrated a number of encouraging signs of efficacy in open, non- placebo controlled trials; there is a similar level of evidence supporting efficacy of Aripiprazole. Interestingly, an eight-week randomised control double blind placebo trial of forty-seven patients who were randomly allocated either to Sertraline or Sertraline and Quetiapine showed a significant reduction in the later adjunct group (Ozdemir et Al, 2006).

DEPRESSION

In terms of the treatment for depression, meaning unipolar depression without psychosis, studies specifically for refugee populations are lacking; data has to be extrapolated from evidence from non-refugee populations. As described above, the unique situation for refugees and their psychosocial need argues for psychosocial interventions. Anecdotal and epidemiological evidence suggests that the depression is tied in with the complex psychosocial situation of the refugee, displaced people who have been homeless and stateless for long periods of time. Loss of relatives and trauma histories are common. Depression is commonly tied in with a history or trauma and associated with PTSD. Hence the treatment for depression in refugees is often intricately related to the treatment for PTSD. Treatment in Auckland most often occurs within the framework of cognitive behavioural therapy (CBT), eye movement desensitisation therapy (EMDR), which is consistent with the data from non-refugee populations showing that depression is more likely to respond to the combination of SSRI's and CBT.

SSRI antidepressants are first choice medications for depression given their safety in overdose and improved side effect profile. Citalopram is a well established first line antidepressant shown to be effective and well tolerated in a review of thirty randomised control trials demonstrating superiority to placebo (Hochstrasser et al 2001). Fluoxetine also has a clear evidence base in terms of its superiority to placebo as per RCTs, and has been shown to be superior to tricyclic antidepressants with significantly fewer dropouts in a meta-analysis of thirty trials (Bech et al 2000). The SSRI Paroxetine also available in New Zealand is widely used but has problems with respect to discontinuation effects due to its relatively short half-life.

Tricyclic antidepressants have been demonstrated to be clearly superior to placebo, but are used with caution given their propensity for cardiotoxicity and overdose (Shah et al 2001) and therefore generally not recommended as first line treatments. An ECG is recommended for prescribing them in those at risk of cardiovascular disease. Nortriptyline has the advantage of being mildly sedative relative to other tricyclics, with lower cardiotoxic potential, suitability for once daily administration and blood level monitoring can assist in optimising dosage. It is said that for treatment resistant depression forty percent may respond to Nortriptyline, although tolerability of the medication is an issue (Nierenberg 2003). Amitriptyline has been subject to a Cochrane systematic review that concluded that it is at least as effective as other antidepressants, but has a higher side effect profile (Guaiana et al 2007).

For Venlafaxine, a meta-analysis has proven that it may be more effective at higher doses than certain SSRI's and that it is as well tolerated (Smith et al British Journal of Psychiatry 2002) but in New Zealand it is pharmacy funded only when two other antidepressants have not succeeded. Mirtazapine, as it is a presynaptic alpha-II adreno-receptor inhibitor, reduces serotonergic side effects (headache sexual dysfunction nausea) and has been shown to be well tolerated and as effective as other antidepressants in severe depression (Versiani et al 2005) in a large double blind placebo controlled trial in two hundred and ninety seven patients. It is also only available in New Zealand when at least two other antidepressants have failed. Moclobemide, which is available, but commonly considered relatively ineffectual, has the evidential backing of a meta-analysis of studies of two thousand four hundred and sixteen patients showing it to be as good as tricyclic antidepressants and clearly superior to placebo.

It is beyond the scope of the ability of this to go in to details regarding various other drugs and combinations that are available and have been researched for treatment resistant depression. Strategies include Lithium and antidepressants, Mirtazapine with Venlafaxine or SSRI's.

NURSING PRACTICE IN MANAGEMENT OF MEDICATIONS

The management of medications in non-English speaking CALD patients and in people from refugee backgrounds requires special attention to detail and cultural sensitivities (Koehn & Sainola-Rodriguez 2005). It is necessary to go into considerably greater and sometimes repetitive detail in relation to informed consent and particularly to work together with the attending Psychiatrist or General Practitioner to closely monitor side-effects and re-emphasise dosage instructions. People from non-Western backgrounds may not have experience of psychotropic medication or understand its purpose or effects. Such patients may, for example, initially say that they understand a point when they do not actually do so. It is important to give extra time and attention to be assured that all information is properly understood and internalised. The highly accurate translation of information to the patient regarding the purpose and the details of prescribed medication is especially essential in the nursing management plan.

SUMMARY - MEDICATIONS

As described, there are very few evidence-based psychotropic medications that have been verified to be efficacious for the unique treatment challenges that face the clinician treating refugees. There is, however, a range of treatment options available, both psychotropic and psychological, for depression and posttraumatic stress disorder. This highlights the importance of optimising informed consent.

Refugees have often not had the benefit of choice, they have been at the mercy of circumstance, if not actively coerced, and many of their fundamental rights have been violated. Their wishes and needs have not been taken seriously by many charged with seeing to their welfare; or those that do, have had limited power. The clinician who utilises education as far as possible as a therapeutic tool, and gives the depressed and/or traumatised refugee the clearest sense possible of the range of choices available is wise. Such an approach can optimise the therapeutic alliance, foster a sense of empowerment and autonomy and engender respect. The demystification that results from thorough explanation has the added benefit of increased likelihood of treatment adherence, a sine qua non for treatment response.

Let's Get Real

Let's get real is a New Zealand Ministry of Health framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services. It is explicit in stating the expectations for people who work in mental health and addiction treatment services irrespective of their role, discipline or position in the organisational structure.

Respect

Service users are the focus of our practice. We respect the diversity of values of service users. The values of each service user and of their community are the starting point for all of our work.

There will be very great diversity among migrant and refugee service users. Focusing on service users from CALD backgrounds requires respect reflected not just in words, but also in action. This involves extending an effort to better understand the values, and unique characteristics and needs of those being served. This may mean acquiring additional training and in being prepared to extend ourselves in practice.

Human rights

We strive to uphold the human rights of service users and their families. Human rights include, but are not limited to, the right to autonomy and self-determination, the right to be free from coercion, the right to be treated in a non-discriminatory way, the right to informed consent, and the right to receive care and support that responds to the physical, psychological, spiritual, intellectual and cultural needs of the service user.

A human rights approach to serving clients from refugee and migrant backgrounds is increasingly being recognised as the foundation of sound cross-cultural practice. As health practitioners, our responsibility is to insure that people from refugee and migrant backgrounds receive the services and support they need in the way that makes sense and is effective for them. This is because they are entitled to good service as of right. For many refugees, this will be the first time they may realise that they do have rights, and that these will be upheld in their new adopted country. This

may mean that public and non-government health providers need to insure the availability of interpreters, cross-cultural support workers, and ongoing training and up-skilling for staff.

Service

We are committed to delivering an excellent service for all service users. This includes service user partnerships at all levels and phases of service delivery, including the choice of services available as well as the actual delivery of service.

Planning and delivering services for people from refugee and migrant backgrounds necessarily requires involving them in the process itself. “Nothing about us without us” is a theme of refugee and migrant advocacy groups, and resonates for many service users. Wherever possible, it is desirable to include and actively involve former refugees and migrants at every level, from board to staff to volunteers. It is also very important for employers to actively encourage and help former refugees to acquire training and qualifications that will lead to becoming professional health practitioners themselves.

Recovery

We believe and hope that every service user can live a full and meaningful life in the presence or absence of their mental illness and/or addiction. We also understand that recovery is not only related to the mental illness and/or addiction itself, but also to all of the losses associated with it.

For many refugees and migrants, the term “mental” itself has negative connotations. It may be helpful to reframe the services in general health terms, and particularly to explain and normalise the problems they are experiencing in relation to anyone who has survived such trauma and extreme experiences. It is important to provide education on trauma and mind health and to show how such reactions as they may be experiencing are both normal and definitely recoverable. A strengths-based approach, with a focus on small, practical steps, is often the best way to help set the course on a way forward to a new life. Sometimes it is also important to remember that in opening the pages on the chapter to a new life, it is also necessary to in some way close a previous chapter.

Communities

We value communities – the many places in which we all live, move and have our being – as pivotal resources for the effective delivery of services and support for service users and their families/whanau.

Individual therapy may be necessary and appropriate in many cases, but it is also important to bear in mind that many migrant and refugee service users have come from collective cultures. For this reason, it is very important to involve community members and support workers from their own cultural and linguistic backgrounds wherever possible. It is often essential that health practitioners seek consultation and support from specialist services and cultural advisors.

Relationships

We seek to foster positive and authentic relationships in all spheres of activity, including relationships with all people who work within mental health and addiction, wider communities, and service users and their families/whanau.

Networking is important in almost all spheres of health services, but is particularly so in relation to assisting people from refugee and migrant backgrounds. This may often involve developing and maintaining contacts in Work and Income New Zealand, Housing New Zealand, Immigration New Zealand, education providers and other government and non-governmental agencies. Refugee settlement support agencies such as Refugee Settlement Services Aotearoa New Zealand (RS) engage lay volunteers in the community and social workers to give support practical settlement in the first few months of settlement for quota refugees. It is important to also include leaders of the diverse communities being served in advice around service development, delivery, research and evaluation. Some of the best outcomes are achieved when former service users who have recovered and settled well later then go on to become engaged as providers themselves.

Dance of Harmony - Alyssa, Age 9
Country of Origin: Burma Myanmar
Image 6



SECTION 3 - TREATMENT AND THERAPIES



Examples of art therapy oil paintings by children from the Art Therapy Centre at the Mangere Refugee Resettlement Centre. Note how both paintings by two children from different countries portray very similar themes. There is a clear dividing line between the old life and representative images for a new one. In the second painting there are layers of barriers placed between the former memories and experiences and a present life in New Zealand. Images 6 & 7

Diagnosis and treatment of refugees in the mainstream Western context frequently proves problematic. Cultural constraints and expectations as well as symptom presentation may assume entirely different and separate meanings within the refugee culture of origin and attempts to clarify in order to gain a sense of the actual difficulties may result in a profound muddle. Diagnoses from a medical model may inspire pharmaceutical treatments and/or a number of interventions from a Western therapeutic perspective that are proven to be effective within western contexts, but indeed may have no effect at all with refugees. However they also can work very well indeed.

It is important to try to learn as much as possible about the client's home culture before treatment as well as the historical events that took place before the client had to leave their country. **Cultural consultation is therefore, the cornerstone of all treatment formulations/plans, as well as good assessment.** Even then the stated problems may elude the therapist and the cultural consultant and the "real" problems may not unfold for some time, so patience is advocated. Assessment may thus take time and unfold over many months and there may be a need to focus on more than one disorder. It is important not to confuse non-Western cultural beliefs and behaviours with psychopathology. Conversely psychopathology may be missed if there is credence given only to cultural explanations. (Andari et al, 2003, Ch 5) However, underlying biological responses support the theory that there may be cross-cultural commonalities in terms of treatment for symptomatic presentation (van der Kolk, 2005, 2006).

Language may be another barrier to effective assessment and treatment. Much of the treatment will involve the use of an interpreter unless the former refugee has extremely good English. A good knowledge of how to work effectively with an interpreter is important as well as training in working with people of other cultures, such as the CALD training. The use of children and other family members is not considered to be good practice.

The challenges of resettlement may supersede all attempts at “therapy” for months and sometimes years and the therapist may need to be a trustworthy person who is consistent for some time before anything else happens. Relationship, as always, is the key to therapeutic outcome as is the actual “art” of therapy. **It may be important to abandon traditional models of therapy and try to respond empirically to what is being presented.**

The effects of previous trauma and torture are often at the fore but the effects of forced migration and resettlement are also strong. **Presenting needs** may include disrupted sleep patterns, Posttraumatic Stress Disorder, depression, bereavement, loss, somatic complaints (often seen in medical practices), couple issues, domestic violence, problems with children and adolescents at home, marital issues, violence, issues specific to women and men, suicidal thoughts and actions, psychosis, substance misuse, chronic pain and head injuries, amongst other matters.

Key themes may include culture shock, acculturation needs, and unmet expectations in the new country, social role disruption, intergenerational conflicts, unemployment, family values, kinship disruption, insecurity/instability, practical needs, poverty, housing issues, and racism. Some refugees may come to the country with specialist health needs such as deafness, intellectual disability, damage to internal organs and limbs, HIV, congenital abnormalities and be moving through the health system – or be too frightened to do so, abandoning specialist appointment letters that are too hard to understand.

It is important to note that there may be some **strong and key protective factors** that assist therapy and hinder it if absent - such as resilience, contact with other family members and /or family reunification, social support links with local community groups, a strong religious or political ideology and a proactive problem-solving style. It is possible that the talking therapies may need to occur in conjunction with psychopharmacology in order to reduce the discomfort of intrusive symptoms (see Medication Section) as well as some non-talking therapies. Multi-modal support may need to be in place to deal with settlement issues in terms of extending social supports, community support work and cultural liaison.

Acknowledgement of the journey and survival is important – remember they got here! Remember the value of ensuring personal and physical well-being – food, shelter, warmth, safety, exercise and meaningful daily activities.

There is very little, if any, empirically validated treatment research available from New Zealand sources, although there are a number from other countries. A variety of therapeutic interventions have been assessed for their effectiveness at treating PTSD in refugee and non-refugee populations. Systematic reviews have compared the relative benefits of cognitive behaviour therapy (CBT), eye movement desensitization and reprocessing (EMDR), cognitive therapies, exposure therapies, narrative therapies, psychoeducation and relaxation techniques for PTSD in largely non-refugee populations (e.g. Mendes, 2008; F. Neuner, Onyut, P., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T., 2008; F. Neuner, Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T., 2004). CBT, cognitive therapy and exposure therapy were found to be equally successful at improving clinical symptoms and reducing drop-out (Mendes, 2008). Eye movement desensitization and reprocessing (EMDR) is another promising therapy but not enough research exists to conclude whether it is as effective as CBT or other therapies (Mendes, 2008). Biofeedback is another area that could be promising.

Some research has looked specifically at refugee populations when investigating treatment options for PTSD. These studies have noted clinical improvements from a range of therapies e.g. narrative exposure therapy, trauma counselling and CBT (e.g. Grey & Young, 2008; Devon et al., 2005; Hinton, 2004; F. Neuner, Onyut, P., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T., 2008; F. Neuner, Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T., 2004). For example, a randomised controlled trial of CBT noted significant improvements in PTSD symptoms, anxiety scores, culturally-associated physical symptoms for Cambodian refugee clients with PTSD and panic attack conditions relative to wait-list controls (Devon et al., 2005). A randomised controlled trial with African refugees noted that narrative exposure therapy was more effective at alleviating PTSD symptoms than supportive therapy or brief psychoeducation (F. Neuner, Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T., 2004). Paunovic & Ost (2001) compared CBT and exposure therapy in the treatment of PTSD in refugees, with large improvements on all measures and no difference between groups, results maintained at 6 month follow up.

Ehnholt et al (2005) had good results with school based CBT groups as did Barrett et al (2000) with young refugees. Ehnholt & Yule, W., (2006) have done a very good review of assessment and treatment of refugee children and adolescents who have experienced war-related trauma which is excellent and outlines a sound treatment approach which involves establishing safety and trust, trauma focussed therapy/treatment (CBT, testimonial psychotherapy, NET, EMDR, medication only as a back-stop) and reintegration. Michelson, D., & Sclare, I. (2009) compared treatment effectiveness for young refugees and unaccompanied minors (UAM), undertaking stabilization work (legal, housing assistance, various types of liaison with schools & social workers, leisure activities) and a variety of therapies (CBT, systemic, parent/carer training, psycho-education, anxiety management, grief-focused work, and trauma).

Culturally-adapted CBT can also be beneficial for refugee populations; however it is not known whether cultural-adaptation is superior to non-adapted CBT. Culturally adapted CBT was effective at improving symptoms of PTSD, depression, anxiety and physical symptoms associated with PTSD in these Vietnamese and Cambodian refugees (Hinton, 2004, 2005). Cultural adaption of this intervention included gathering cultural support and translation from Vietnamese and Cambodian social workers, inclusion of mindfulness relaxation techniques, and cultural imagery i.e. lotus flower as a metaphor (Hinton, 2004). Studies also indicate that lay counsellors can effectively provide narrative exposure therapy and trauma counselling therapy to refugee clients (Neuner F., Onyut, P.L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T., 2008) in developing countries, which are resource-poor. This may also be possible within ex-refugee communities in the country of settlement and has yet to be fully explored in New Zealand.

Most of the research acknowledges that a variety of approaches are helpful as seen below. A Community Psychology approach is also outlined as it embraces community based proactive macro methodologies and is prevention focused.

Traditional Therapies

Traditional therapies are not well documented and do vary from culture to culture and sometimes for religious beliefs. Many of the refugees may have sought and received some form of treatment prior to resettlement in New Zealand either in refugee camps or in the countries where they have been living temporarily. These treatments may have been Western in basis, traditional or through prayer and worship and often administered by traditional healers or by non-government organizations. The best option is to work alongside these beliefs as much as possible.

Somatizing symptoms may respond well to massage and other physical therapies, as many cultures are familiar with massage and may incorporate these into their treatment options. There is some anecdotal evidence that yoga has been effective in treating gender –based violence in Rwanda (Project Air, Deidre Summerbell).

Therapy	For Treatment of	Research Evidence	Expert Opinion
Acceptance and commitment therapy	No refugee specific research found		
Bibliotherapy	No refugee specific research found		
Cognitive behaviour therapy (CBT)	PTSD Depression Anxiety Psychosis Sleep disorders	<p>Grey N., Young K. (2008) Cognitive Behaviour Therapy with refugees and asylum seekers experiencing traumatic stress symptoms. <i>Behavioural and Cognitive Psychotherapy</i>, 36, 3 – 19</p> <p>Excellent clinical pathway discussion incorporating NET and testimony in CBT approach.</p> <p>Hinton, D.E., Chean D., Pich V., Safren S.A., Hofman S.G., Pollack M.H. (2005) A randomized controlled trial of cognitive behaviour therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: a cross-over design. <i>J. Trauma Stress</i>, 18(6): 617-29.</p> <ul style="list-style-type: none"> • Culturally adapted CBT for 20 in initial treatment & 20 in delayed treatment • Good improvement noted for PTSD & panic attacks improved. <p>Hinton, D.E., Pham T., Safren S.A., Otto M.W., Pollack M.H. (2004) CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. <i>J. Trauma Stress</i> 17(5), 429-433</p> <ul style="list-style-type: none"> • Culturally adapted CBT with 12 refugees with treatment-resistant PTSD and panic attacks • Significant improvements noted on HTQ, ASI, HSCL-25 anxiety & depression sub-scales, as well as improvement for panic attacks. <p>Barrett, P.M., Moore, A.F., Sonderegger, R. (2000). The FRIENDS program for young former-Yugoslavian refugees in Australia: A pilot study. <i>Behaviour Change</i>, 17(3), 124-133.</p> <ul style="list-style-type: none"> • Anxiety-reduction programme for 20 – a 10 wk program, once per wk. Mean age 16.6 • Treatment condition reported significantly lower internalizing symptoms <p>Ehnholt et al (2005). School based CBT group intervention for refugee children who have experienced war-related trauma. <i>Clin Child Psychol and Psychiatry</i>, 10(2), 235-250.</p> <ul style="list-style-type: none"> • 6 sessions group CBT, one per week • Wait list control group • 26 refugees or asylum seekers, aged 11-15 years • 15 CBT group and 11 wait list controls • CBT showed statistically significant, but clinically modest improvements post intervention • Significant improvements overall behavioural difficulties and emotional symptoms. • Control group did not show any improvements over the same period. • Follow-up only with 8 and no changes maintained at 2 months post intervention. <p>d'Ardenne, P., Ruaro, L., Cestari, L., Fakhoury, W., & Priebe, S. (2007). Does Interpreter-mediated CBT with traumatized refugee people work? A comparison of patient outcomes in East London. <i>Behavioural and Cognitive Psychotherapy</i>, 35(3), 293-301</p> <ul style="list-style-type: none"> • Retrospective study • Weekly or fortnightly, average 9 sessions 	<p>There is a large body of empirical evidence available to support CBT as being a very effective therapy for refugees, often in conjunction with other modalities – such as culturally adapted CBT and exposure therapy.</p>

		<ul style="list-style-type: none"> • 44 refugees requiring interpreters • 36 refugees not requiring interpreters • 48 non-refugee patients • All completed at least 2 of 3 pre/post assessments • Refugees with and without an interpreter did not differ in outcomes • Significant outcomes for all groups post treatment (IES, BDI) <p>Paunovic & Ost (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. <i>Behaviour Research and Therapy</i>, 39, 1183-1197.</p> <p>CBT and Exposure:</p> <ul style="list-style-type: none"> • 1 per week for 16-20 sessions • 60-120 minute sessions • 16 outpatients meeting DSM-IV criteria for PTSD • Assessment pre/post intervention and 6 month follow-up • CBT and E had large improvements on all measures and no difference between groups • Results maintained at 6 month follow-up • E led to a 48% reduction on PTSD symptoms, 49% generalized anxiety, and 54% depression • CBT led to 53% reduction PTSD symptoms, 50% generalized anxiety, 57% depression 	
Computerised cognitive behaviour therapy (CCBT)	PTSD Depression Anxiety Psychosis Sleep disorders	No refugee specific research found	
Counselling	PTSD Depression Anxiety Psychosis Sleep disorders	No refugee specific research found	This category is a bit vague – if some other techniques are used (CBT, NET, Exposure etc). Supportive therapy/counselling can be very useful but targeting symptoms is useful.
Narrative Exposure Therapy (NET)	PTSD Depression Anxiety Psychosis Sleep disorders	<p>Neuner, F., Onyut P. L., Ertl, V., Odenwald, M., Schauer, E., Elbert, T (2008) treatment of posttraumatic Stress Disorder by Lay trained Counselors in an African Refugee Settlement: A Randomised Controlled Trial <i>Journal of Consulting and Clinical Psychology Vol 76, No 4</i>, 686-694</p> <ul style="list-style-type: none"> • NET was compared with trauma counselling & a no-treatment monitoring group for PTSD by lay counsellors. • Both were shown to be effective but fewer dropped out of the NET programme possibly because of the value of the written testimony. <p>Onyut L.P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., Elbert, T (2005) Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: two case reports and a pilot study in an African refugee settlement. <i>BMC Psychiatry Feb 3</i>:5:7</p> <ul style="list-style-type: none"> • Using KIDNET, a child friendly version of NET, improvements maintained on 9-month follow-up. <p>Neuner, F., Schauer, M., Klaschik, C.Kurasaki U., & Elbert, T. (2005). A comparison of narrative exposure therapy, supportive counselling, and psychoeducation for treating Posttraumatic Stress Disorder in an African refugee settlement. <i>Journal of Counselling and Clinical Psychology</i>, 72, 579-587</p> <ul style="list-style-type: none"> • 29% survivors who received NET compared with 79% who had supportive counselling & 80% who received psycho-education meeting criteria for PTSD. 	NET has been particularly developed to treat the psychological sequelae of war, torture and organised violence. Integrates features of prolonged exposure. Very useful as part of treatment. There is a manual.

		Shauer, M., Neuner, F., & Elbert, T., (2005) <i>Narrative Exposure Therapy: A short term intervention for traumatic stress disorder after war, terror, or torture.</i> (2005) Cambridge, MA: Hogrefe & Huber	
Narrative therapy Testimonial Psychotherapy		Lustig, S.L., Weine S, M., Saxe, G.L., Beardslee, W.R. (2004) Testimonial psychotherapy for Adolescent Refugees: A Case Series. <i>Transcultural Psychiatry</i> , 41, 31-45 • Borrows from exposure & desensitisation, relaxation training & cognitive restructuring – also therapeutic relationship, ritual & narrative techniques. Manualised. Limited participants	Multi-modal therapy – depends upon the cultural acceptance of sharing personal stories
Cognitive Processing Therapy	PTSD Depression Anxiety Psychosis Sleep disorders	Schulz, P.M., Resick, P.A., Huber, L.C., Griffin, M.G., (2006) The effectiveness of Cognitive Processing Therapy for PTSD With Refugees in a Community Setting (2006) <i>Cognitive and Behavioral Practice</i> 13, 322 – 331. • 53 adults from different cultures, 28 with therapist speaking own language & 25 through an interpreter all improved significantly.	This CBT/ exposure-based treatment appears to have relevance to a number of cultural groups and can be effective with or without interpreters, taking the same amount of time. Some limitations to this study.
Group Therapy	PTSD Depression Anxiety Psychosis Sleep disorders	Evidence varied. No evidence that group exposure is useful as this may invoke uncontrolled emotions in some populations	Useful for social support – effective components appear to be mutual support & psychoeducation. Difficult to gain trust, working with more than 2 interpreters can be difficult, depending on subject matter.
Dialectical behaviour therapy (DBT)	Borderline personality disorder Severe and complex diagnoses	No refugee specific research found	
Family therapy	Marital problems Depression Child management	No refugee specific research found	Very useful to include family members in components of treatment. This is frequently used.
Interpersonal psychotherapy		No refugee specific research found	
Motivational interviewing		No refugee specific research found	Useful for substance abuse issues
Multisystemic therapy		No refugee specific research found	
Problem		No refugee specific research found	

solving therapy			
Psychotherapy		No refugee specific research found	
Psychotherapy with children	PTSD Depression Anxiety Grief	<p>Ehnholt, K.A. & Yule, W., (2006) Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma <i>Journal of Child Psychology and Psychiatry</i> 47:12 1197-1210</p> <ul style="list-style-type: none"> • Advocates for good assessment processes & holistic interventions, ie present & practical difficulties, as well as a future focus. • Phased model of intervention – establish safety & trust, trauma focused Tx (CBT, NET, testimonial psychotherapy, EMDR), & reintegration. 	Excellent article
Narrative Therapy	Experiences of Trauma & Torture; Anxiety; Stress; Depression; PTSD	<p>Angus, L. & McLeod, J. (2004). The Handbook of Narrative and Psychotherapy: Practice, Theory and Research. UK: Sage Publications</p> <p>Blackburn, P. (2005) Speaking the Unspeakable: bearing witness to the stories of political violence, war and terror. <i>International Journal of Narrative Therapy and Community Work</i>, 3&4:97-105.</p> <p>Blackburn, P. J. (2010) Creating space for preferred identities: Narrative practice conversations about gender and culture in the context of trauma All Other Info: <i>Journal of Family Therapy</i>, 32, 4-26.</p> <p>Boucher, M. (2009) Finding resiliency, standing tall: Exploring trauma, hardship, and healing with refugees. <i>The International Journal of Narrative Therapy and Community Work</i>, (4), 43-51.</p> <p>Denborough, D.(ed) (2006). Trauma: Narrative responses to traumatic experience. Dulwich Centre: Adelaide, Australia</p> <p>Denborough, D. (2005) A framework for receiving and documenting testimonies of trauma. <i>International Journal of Narrative Therapy and Community Work</i>, 3&4:34-42. Reprinted in Denborough, D. (ed) Trauma: Narrative responses to traumatic experience. Adelaide: Dulwich Centre Publications</p> <p>Fox, H. (2009). A good citizen: using narrative in contexts of trauma. <i>Context, Narrative Influences</i>, (105), 46-50, October 2009</p> <p>Marlowe, J. (2010) Beyond the discourse of trauma: Shifting the focus on Sudanese refugees. <i>Journal of Refugee Studies Advance Access</i>, published online on May 7, 2010, doi:10.1093/jrs/feq013</p> <p>Merscham, C. Restorying Trauma with Narrative Therapy: Using the Phantom Family. <i>The Family Journal</i>, Vol. 8, No. 3, 282-286 (2000)</p> <p>Sehwail, M. (2005) When the trauma is not past or 'post': Palestinian perspectives on responding to trauma and torture. Responding to continuing traumatic events. <i>International Journal of Narrative Therapy and Community Work</i>, 3&4:54-56.</p> <p>Shalif, Y. (2005) Responding to trauma and grief - family gathering, text and spiritual practice. <i>International Journal of Narrative Therapy and Community Work</i>, 3&4:43-47.</p> <p>White, M. (2004) 'Working with people who are suffering the consequences of multiple trauma: A narrative perspective.' <i>International Journal of Narrative Therapy and Community Work</i>, 1:45-76. Reprinted in Denborough, D. (ed) Trauma: Narrative responses to traumatic experience. Adelaide: Dulwich Centre Publications</p> <p>Yuen, Angel. Discovering Children's Responses to Trauma: A Response-based Narrative Practice [online]. <i>International Journal of Narrative Therapy & Community Work</i>, No. 4, 2007: 3-18. Availability: http://search.informit.com.au/documentSummary;dn=059632175830395;res=IELHEA > ISSN: 1446-5019. [cited 24 May 10].</p> <p>Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. <i>Lynette P. Vromans ;Robert D. Schweitzer Psychotherapy Research</i>, 1468-4381, First published on 19 March 2010</p>	<p>Narrative Therapy acknowledges that 'therapy' is not culturally resonant for the majority of Refugee communities. It also pays attention to the collective nature of trauma and the profound social suffering as the consequence of social injustice. Narrative therapy focuses on alternative discourses of resilience, hope and competence within reported experiences of trauma.</p>

Collective Narrative Practices	Experiences of Trauma & Torture; Anxiety; Stress; Depression; PTSD	<p>Denborough, D (2008) Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma. Adelaide: Dulwich Centre Publications</p> <p>Denborough, D., Freedman, J., & White, C. (2008) Strengthening resistance: The use of narrative practices in working with genocide survivors. Adelaide: Dulwich Centre Foundation.</p> <p>Denborough, D. Clinical Psychology, <i>Issue 17, September 2002</i>. Community song writing and narrative practice</p> <p>Ncube, N (2006) The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. International Journal of Narrative Therapy and Community Work 1:3-16</p> <p>Sliep, Y. (2005). 'A narrative theatre approach to working with communities affected by trauma, conflict and war.' International Journal of Narrative Therapy and Community Work, 2:47-52.</p>	The Dulwich Centre, Adelaide Australia has developed a range of narrative methodologies in collaboration with Refugees and other groups experiencing hardship. Practices are simple and easy to use in a range of community settings and include group work, collective documents, Tree of Life, Team of Life, River of Memory and Narrative Song writing.
Physical Therapy	Acute & chronic body pain Chronic fatigue PTSD Mood disorders (anxiety, depression, anger, poor concentration) Sleep problems	<p>Field, T., Morrow, C., Valdeon, C., Larson, S., Kuhn, C. & Schanberg, S. (1992). <i>Massage reduces anxiety in child and adolescent psychiatric patients</i>. Journal of the American Academy of Child and Adolescent Psychiatry, 31, pp 125-131. Compared with control group who viewed relaxing videotapes, massage subjects were less depressed and anxious and had lower saliva cortisol levels. In addition, nurses rated the subjects as being less anxious and more cooperative on the last day of the study, and night time sleep increased over this period. Finally, urinary cortisol and norepinephrine levels decreased, but only for the depressed subjects.</p> <p>Field, T., Seligman, S., Scafidi, F., & Schanberg, S. (1996a). <i>Alleviating posttraumatic stress in children following Hurricane Andrew</i>. Journal of Applied Developmental Psychology, 17, pp 37-50. Sixty 1st-5th graders who showed classroom behaviour problems following Hurricane Andrew were randomly assigned to a massage therapy or a video attention group. Subjects who received massage reported being happier and less anxious and had lower salivary cortisol levels after the therapy than the video subjects. The massage group showed more sustained changes as manifested by lower scores for anxiety, depression, and self-drawings. The massage therapy subjects were also observed to be more relaxed.</p> <p>Field, T., Ironson, G., Scafidi, F., Nawrocki, T., Goncalves, A., Burman, I., Pickens, J., Fox, N., Schanberg, S., & Kuhn, C. (1996b). <i>Massage therapy reduces anxiety and enhances EEG pattern of alertness and math computations</i>. International Journal of Neuroscience, 86, pp 197-205. Twenty-six adults were given a chair massage and 24 control group adults were asked to relax in the massage chair for 15 minutes, two times per week for five weeks. Results from different measures and analyses demonstrated that frontal delta power increased for both groups, suggesting relaxation; the massage group showed decreased alpha and beta power (suggesting enhanced alertness); the massage group increased in speed and accuracy on math computations, while the control group did not change; and at the end of the five week period depression scores were lower for both groups.</p> <p>Field, T., Kilmer, T., Hernandez-Reif, M. & Burman, I. (1996c) <i>Preschool Children's Sleep and Wake Behavior: Effects of Massage Therapy</i>. Early Child Development and Care, 120, pp 39-44. Preschool children received 20-minute massages twice a week for five weeks. The massaged children as compared to the children in the wait-list control group had better behaviour ratings on state, vocalization, activity and cooperation after the massage sessions on the first and last days of the study. Their behaviour was also rated more optimally by their teachers by the end of the study. Also, at the end of the 5 week period parents of the massaged children rated their children as having less touch aversion and being more extraverted. Finally, the massaged children had a shorter</p>	Physical therapy has been shown to be effective irrespective of culture or age. Few contraindications if client is willing. Most clients report at least some improvement in body or mind symptoms.

		<p>latency to naptime sleep by the end of the study.</p> <p>Field, T., Hernandez-Reif, M., Hart, S., Quintino, O., Drose, L., Field, T., Kuhn, C., & Schanberg, S (1997). <i>Effects of sexual abuse are lessened by massage therapy</i>. Journal of Bodywork and Movement Therapies, 1, pp 65-69. Women (mean age = 35 years) who had experienced sexual abuse, were given a 30-minute massage twice a week for 1 month. Immediately after the massage the women reported being less depressed and less anxious and their salivary cortisol levels decreased following the session. Over the 1-month treatment period the massage therapy group experienced a decrease in depression and in life event stress. Although the relaxation therapy control group also reported a decrease in anxiety and depression, their stress hormones did not change, and they reported an increasingly negative attitude toward touch.</p> <p>Field, T., Peck, M., Krugman, S., Tuchel, T., Schanberg, S., Kuhn, C., & Burman, I. (1998). <i>Burn injuries benefit from massage therapy</i>. Journal of Burn Care and Rehabilitation, 19, pp 241-244. Twenty-eight adult patients with burns were randomly assigned before debridement to either a massage therapy group or a standard treatment control group. State anxiety and cortisol levels decreased, and behaviour ratings of state, activity, vocalizations, and anxiety improved after the massage therapy sessions on the first and last days of treatment. Longer-term effects were also significantly greater for the massage therapy group. Although the underlying mechanisms are not known, these data suggest that debridement sessions were less painful after the massage therapy sessions due to a reduction in anxiety, and that the clinical course was probably enhanced as a result of a reduction in pain, anger, and depression.</p> <p>Hasson, D., Arnetz, B., Jelveus, L., & Edelstam, B. (2004). <i>A randomized clinical trial of the treatment effects of massage compared to relaxation tape recordings on diffuse long-term pain</i>. Journal of Psychotherapy & Psychosomatics, 73, pp 17-24. The purpose of this randomized clinical trial was to assess possible effects of massage as compared to listening to relaxation tapes on musculoskeletal pain. 129 patients suffering from long-term musculoskeletal pain were randomized to either a massage or relaxation group, and assessed before, during and after treatment. During treatment there was a significant improvement in self-rated health, mental energy, and muscle pain only in the massage group as compared to the relaxation group.</p>	
Eye Movement Desensitization and Reprocessing (EMDR)	PTSD Depression	<p>Carlson, J.G., Chemtob, C.M., Rusnak, K., & Hedlund, N.L (1996). Eye movement desensitization and reprocessing (EMDR) as treatment for combat PTSD. <i>Psychotherapy</i>, 33(1), 104-113.</p> <p>Carlson, J.G., Chemtob, C.M., Rusnak, K., Hedlund, N.L & Muraoka, M.Y. (1998). Eye movement desensitization and reprocessing for combat related posttraumatic stress disorder. <i>Journal of Traumatic Stress</i>, 11, 3-24.</p> <p>Daniels, N., Lipke, H., Richardson, R., & Silver, S. (1992, October). <i>Vietnam veterans' treatment programs using eye movement desensitization and reprocessing</i>. Symposium presented at the annual meeting of the International Society for Traumatic Stress Studies, Los Angeles.</p> <p>Lipke, H. (2000). <i>EMDR and psychotherapy integration</i>. Boca Raton, FL: CRC Press</p> <p>Silver, S.M., Brooks, A., & Obenchain, J (1995). Eye movement desensitization and reprocessing treatment of Vietnam war Veterans with PTSD; Comparative effects with biofeedback and relaxation training. <i>Journal of Traumatic stress</i>, 8, 337-342.</p> <p>White, G.D. (1998) Trauma treatment training for Bosnian and Croatian mental health workers. <i>American Journal of Orthopsychiatry</i>, 63, 58-62.</p> <p>Van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., et al. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. <i>Journal of Clinical Psychiatry</i>, 68(1), 37-46. EMDR intervention was more successful than pharmacotherapy in achieving reductions in PTSD and depression symptoms for, adult-onset trauma survivors. But for childhood-onset trauma patients, neither treatment</p>	<p>Treatment resistant combat veterans from Desert Storm, the Vietnam war, Korean War, and World War II showed distinct improvement in PTSD symptoms such as flashbacks, nightmares etc Although EMDR was initially developed to treat traumatic memories, there are lot of studies which have shown its effectiveness in treating other mental health disorders</p>

		produced complete symptom remission	
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Cognitive Behaviour Therapy

WHY THIS THERAPY IS USED

Mental health problems that it is useful for – as shown by research evidence, grey literature and expert opinion (best practice/promising practice)

Alcohol, drug, smoking and gambling issues, anxiety, depression, eating disorders, long-term illnesses, chronic pain, obsessive compulsive behaviour, phobias, post-traumatic stress disorder, self-harming, symptoms of bipolar disorder, symptoms of schizophrenia, eg. for psychosis. Families and couples can also benefit.

POTENTIAL ISSUES

Issues particularly important when working with older people that are specific to that therapy

Any particular cultural issues for Maori, Pacific, Asian and refugee/new migrant communities that are specific to that therapy

Although literacy is often useful for CBT – with children and others, pictorial representation can be used and is easily adapted into other languages. Take into account cultural beliefs – culturally adapted CBT is explained well in Hinton (2004, 2005).

REFERENCE MATERIAL

References or resources for practical manuals helpful when using the therapy **Standard CBT references as per other “Talking Therapy” manuals**

See “A Shattered World the Mental health Needs of Refugees and Newly Arrived Communities”, Ehntholt, K.A. & Yule, W., (2006) Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma for descriptions on how to integrate CBT with other therapies. One example is **Cognitive Processing Therapy (Resick, P.A., & Snicke, M.K. 1993; Schulz, P.M., Resick, P.A., Huber, L.C., Griffin, M.G., 2006)** has a manual but could be adapted as an amalgamation of CBT and exposure therapy.

TRAINING

Training available for the therapy in New Zealand is listed in detail in other Te Pou Guides.

LIMITATIONS

Limitations may relate to the cultural differences and understandings of cognitive processes, as well as literacy issues.

Narrative Therapy & Collaborative Narrative Practice

WHY THIS THERAPY IS USED

Narrative methodologies are being found beneficial across refugee and migrant communities because they do not require clients to understand or have skill in engaging with traditional western approaches to counselling. Narrative approaches focus on helping people identify and utilise existing skills, competencies, beliefs, values and abilities to address problems. Narrative therapy helps facilitate the telling and retelling stories in ways that acknowledge the personal, historical, social, cultural and political context of people's experiences. This is particularly useful for

refugee clients helping them contextualise their experiences of trauma as well as their coping skills and competences. Narrative approaches have been developed to be used with children, young people and adults. The narrative use of language, storytelling and metaphors is affective with refugee communities who are generally more familiar with 'storying' as a 'performative' method of personal and collective change and development.

POTENTIAL ISSUES

There is diversity in the field of narrative methodologies but generally narrative approaches are underpinned by postmodern or post structuralist ideas and have a common relationship with other discursive therapies and critical psychology. Although many narrative practitioners work with individuals, couples and families in similar ways to therapist from other modalities other narrative practitioner work with communities focused on developing collective practices often focused on social as well as individual change.

REFERENCE MATERIAL

Denborough, D. (ed) (2006). Trauma: Narrative responses to traumatic experience. Dulwich Centre: Adelaide, Australia

Denborough, D (2008) Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma. Adelaide: Dulwich Centre Publications

Morgan, A. (2000). What is Narrative Therapy: An easy to read introduction. Dulwich Centre Publications

White, M. (2004) 'Working with people who are suffering the consequences of multiple trauma: A narrative perspective.' International Journal of Narrative Therapy and Community Work, 1:45-76. Reprinted in Denborough, D. (ed) Trauma: Narrative responses to traumatic experience. Adelaide: Dulwich Centre Publications

TRAINING

Masters of Counselling – University of Waikato http://edlinked.soe.waikato.ac.nz/index.php?tier2_id=14

Postgraduate Diploma Discursive Therapies – Massey University <http://therapy.massey.ac.nz/>

Short Courses / Graduate Certificate – Dulwich Centre, Adelaide, Australia
<http://www.dulwichcentre.com.au/training-in-narrative-therapy.html#international-training-program>

LIMITATIONS

Some refugee clients may find it initially difficult to participate in collaborative conversation if their experience of 'treatment' has been to be given 'expert advice.' Some critics also suggest that a lack of confidence, intellectual capacity, or poor articulation skills hinder clients engaging in narrative approaches due to hindered self expression. However this appears to be a misunderstanding of the discursive opportunities narrative approaches offer even in situations where initial engagement is low. Research for evidence-based outcomes with Narrative approaches are increasingly being conducted and future publication of results will include significant studies using Narrative approaches with refugee communities (See Dulwich Centre – Research, Evidence & Narrative Practice <http://www.dulwichcentre.com.au/narrative-therapy-research.html>)

Narrative Exposure Therapy

WHY THIS THERAPY IS USED

Mental health problems that it is useful for – as shown by research evidence, grey literature and expert opinion (best practice/promising practice)

Community base treatment approach – a standardised short-term strictly manualised approach based on principles of cognitive behavioural exposure therapy, adapted to meet the needs of traumatized survivors of war and torture. The client constructs a narration of his/her life from birth to present day, focusing on detailed exploration of traumatic events and experiences. Similar to **Testimonial Psychotherapy and Cognitive Processing Therapy**, see above.

POTENTIAL ISSUES

Issues particularly important when working with older people that are specific to that therapy

Any particular cultural issues for Maori, Pacific, Asian and refugee/new migrant communities that are specific to that therapy

REFERENCE MATERIAL

Lustig, S.L., Weine S, M., Saxe, G.L., Beardslee, W.R. (2004) Testimonial psychotherapy for Adolescent Refugees: A Case Series. *Transcultural Psychiatry*, 41, 31-45

Schauer, M., Neuner, F., & Elbert, T (2005). *Narrative Exposure therapy: A short term intervention for traumatic stress disorders after war, terror or torture*. Gottingen, Germany: Hogrefe & Huber

Schulz, P.M., Resick, P.A., Huber, L.C., Griffin, M.G., (2006) The effectiveness of Cognitive Processing Therapy for PTSD With Refugees in a Community Setting (2006)

TRAINING

No specific training in New Zealand but experienced therapists could work from manuals or by reading the literature.

LIMITATIONS

Limitations of the therapy

A Community Psychology Approach

WHY COMMUNITY PSYCHOLOGY IS USED

A Community Psychology approach is not considered to be a 'talking therapy,' however Community Psychology has a great deal to offer service planners and funders responsible for mental health service delivery for migrant and refugee Communities. Community Psychology is fundamentally concerned with the relationship between social systems and individual well-being in the community context. This is important for Refugee Communities for whom settlement stressors including language difficulties, lack of employment, poor housing, access to education and racism are reported as major contributors to mental health problems. Community Psychologists are therefore interested in helping Refugee Communities take control over their environment and their lives in ways that will also contribute to a greater 'psychological sense of community' characterised by people from Refugee backgrounds: living dignified and self determining lives; being able to develop personally and socially; being able prevent mental health problems before they start; and being able to access appropriate help when needed (Webster & Robertson, 2007).

Community Psychology is an approach which attempts to recognise the social and political realities of refugee and new migrant communities. Macro analysis of problems is preferred to identify social and interactional causes. Service delivery is proactive, community based and prevention focused. Community Psychologists prefer to share, develop and utilise psychological knowledge and skills with communities to help address social and political injustice that impacts on community well-being. Community Psychologists develop services for Refugee Communities that are more fitting with their own cultural constructions of well-being. They draw on existing social and cultural processes within Refugee Communities to identify problems and develop solutions that are culturally acceptable and understood. This might include helping mitigate stigma associated with mental health by acknowledging the social and political causes of psychological distress experienced by Refugees.

POTENTIAL ISSUES

A Community Psychology approach will begin by seeking to understand Refugee Communities experiences of mental health problems. These understandings can then be form the basis of planning culturally useful service delivery. A direct outcome of this consultation approach is the development of working relationships between service providers and Refugee Communities. However this assumes a shared notion of 'community' and many Refugees find themselves isolated from their cultural communities due to mistrust, political divisions and stigma around mental health. In consultation with Refugee Communities there can also be difficulties ensuring equitable participation. Due

to social position in some cultures it might be difficult for everyone to participate in defining their own problems and accessing resources to develop satisfactory solutions to them. For example women, children and the elderly may be excluded from participation. Often Refugee Communities are also either reluctant to engage with traditional clinical services or rely heavily on them to provide quick 'cures' for problems based on previous experience of traditional medical services for treating illness and a lack of experience with alternative therapeutic interventions. Community psychologists might address these difficulties by working with Refugee Community Leaders and volunteers to provide training, support and supervision with the aim of strengthening culturally appropriate and inclusive service provision.

REFERENCE MATERIAL

Goodkind, J. *American Journal of Community Psychology*. Volume 36, Numbers 3-4 / December, 2005.
Effectiveness of a Community-Based Advocacy and Learning Program for Hmong Refugees

Goodkind, J & Foster-Fishman, P. (2002) *Journal of Community Psychology*. Vol 30: 4, Pg 389 – 409. Integrating diversity and fostering interdependence: ecological lessons learned about refugee participation multiethnic communities

Miller, K & Rasco, L (eds). (2004) *The Mental Health of Refugees: Ecological Approaches To Healing and Adaptation*. NY: Routledge

Moritsugu, J; Wong, F; Grover Duffy, K. (2009). *Community Psychology*. London: Allyn & Bacon

Reich, S; Riemer, M; Prilleltensky, I; Montero, M (2007) *International community psychology: history and theories*. New York: Springer

Webster, A & Robertson, M. *The Psychologist Volume 20 - Part 3 - (March 2007)*. Can community psychology meet the needs of refugees?

TRAINING

Post graduate diploma community psychology – Waikato University.

<http://www.waikato.ac.nz/wfass/subjects/psychology/commpsych/handbook/intro.shtml>

Masters in Psychology (Community Psychology) – Edith Cowan University, Perth, Australia

<http://www.psychology.ecu.edu.au/courses/psychology/postgraduate.php>

Master of Applied Psychology (Community Psychology) - Victoria University

<http://www.vu.edu.au>

LIMITATIONS

Resettlement stress is well understood to contribute to poor mental health for refugee communities. Community psychology is interested supporting refugee's regain a sense of control and influence over their environment during stressful cultural transition experiences. Social and political advocacy plays an important role in community psychology practice. Addressing social inequalities and facilitating social action are considered to be as important as supporting individual empowerment and healing. Within traditional clinical funding models it is difficult to develop collective responses to mental health in which refugee communities define their own mental health needs and ways of addressing them. Qualitative and action-based research preferred by a Community Psychology approach may also not fit with expected evidence-based research practices valued by most service planners and funders also limiting access to resources.

Body Therapies

WHY THIS THERAPY IS USED

Body therapies (BTs) cover a wide range of practices, including “traditional massage” (which in itself varies from culture to culture), Bowen Technique, Feldenkrais Method, Neuromuscular Therapy (NMT), and body-mind practices such as Emotional Freedom Therapy (EFT), yoga, Qigong and T'ai Chi.

Due to this diversity of techniques within BTs, it is inappropriate to make generalised statements regarding their efficacy. Owing therefore, to limitations of space, massage has been selected for primary focus, because of its near-universality across cultures and due to the predominance of research studies in this therapeutic modality.

A further limitation to being unequivocal regarding efficacy of BTs is that there has been little quality research undertaken to assess their benefits when working with traumatised refugee or migrant populations. On the other hand, there has been a substantial amount of research undertaken with non-refugee population samples, which fortunately present with clinical symptoms very similar to traumatised refugee and migrant populations. Clearly, though, caution must be exercised in extrapolating from this research, owing to cultural and contextual dissimilarities between populations.

It is well-known and documented, that due to the body-mind connection, emotional distress and anxiety can greatly heighten the client's subjective perception of pain, and vice versa (Grodin et al, 2008). Therefore, any decrease in anxiety and hyperarousal that BTs can induce in the client, will often lead to amelioration in perceived pain level. Conversely, a decrease in perceived level of bodily pain and discomfort, will often lead to a decrease in negative emotions such as anxiety, sadness and anger. (See, for example, Field et al, 1997)

Neuro-physiological mechanisms whereby BTs lead to reduction in anxiety and arousal and improve health have been well-established. Specific examples include: decreases in cortisol, catecholamines, norepinephrine, heart rate, blood pressure, and general sympathetic nervous system activity; and increases in serotonin, dopamine, parasympathetic activity, alpha and theta brain waves, and in Natural Killer Cell numbers. (See Delaney et al, 2002; Grodin et al, 2008; Hart et al, 2001; Hernandez-Reif et al, 1998; and Ironson et al, 1996.)

Research and clinical practice have amply demonstrated that various forms of body therapy can prove very helpful with clients who present with the following (relevant) issues: acute and chronic body pain (Foster et al, 2004; and Hasson et al, 2004); poor body awareness, body satisfaction and interoception (Hart et al, 2001); sleep difficulties (Field et al, 1997b); anxiety (Field et al, 1992; and Sherman et al, 2010); depression and low mood (Field et al, 1996a); a range of symptoms inherent in PTSD (Field et al, 1996a); gender-based violence (Field et al, 1997a); attention difficulties (Field et al, 1996b); and anger and hostility (Field et al, 1998).

Regarding highly-traumatised refugee clients, Van der Kolk (2006) has repeatedly established that intervention must initially focus on improving the client's bodily awareness and interoception, gradually assisting the client to perceive, tolerate and eventually befriend his/her own body. Key to this process is helping the client de-arouse and thereby to gradually bring back "on-line" higher-order brain centres in the pre-frontal cortex. Van der Kolk emphasises the centrality of various body therapies in achieving this. (Approaches particularly recommended as effective include massage, EFT, Qigong, T'ai Chi and yoga.)

For further research findings, particularly in terms of massage, see the "Touch Research Institute" (Miami University School of Medicine) at: <http://www6.miami.edu/touch-research/Research.html>

POTENTIAL ISSUES

Extensive clinical experience with a wide range of refugees - from all continents of the globe - has produced very little in the way of apparent limitations or contra-indications for body therapy. That is, clients most often report at least some improvements in body and/or mind symptoms. And differences such as age, culture and previous exposure to "massage" seem to have little or no impact on results. Further, it is rare for clients to miss appointments or to drop out of treatment.

At the same time, clinicians note that it is important to discuss client expectations of therapy before commencing treatment and to enquire as to previous exposure to any form of body therapy and outcomes achieved. (Prior poor or undesired outcomes may hamper the client's ability to trust the treatment and therapist.)

The key guiding principle is for therapist and client to share expectations and to negotiate a mutually-agreed course of treatment: A subjective attuning of the therapist with the client.

Due to experiences of trauma and torture, some individuals can be hyper-aroused and experience dissociation, constriction, and/or helplessness (Levin, 1997) and may only respond favourably to gentle, relaxing massage, or to Bowen Technique. Firm treatment in this case would only increase hyper-arousal, resulting in a very agitated nervous system. Therefore, it is imperative that the therapist is able to determine if a client is becoming hyper-aroused – and

to be monitoring this throughout the session. And, have the client identify areas of the body that are subjectively safe for therapy.

Prior to arrival in NZ, many refugees have been living for extended periods in sub-standard conditions with inadequate diet, hydration, or exercise. This can have a deleterious effect on their soft tissue and thereby impede their response to treatment.

When working with refugees it is generally helpful if the therapist is of the same sex as the client due to prevailing cultural norms. In some cultures it may not be appropriate for a younger therapist to touch an older client, or for the client to expose skin to a stranger. Having family members as interpreters is usually not advised.

SOME REFERENCE MATERIALS

Bowen Technique

Wilks, J. (2007). The Bowen Technique. CYMA Ltd, Dorset, UK, 2007.

www.bowtech.com (Bowen Website for Australia and the world)

Emotional Freedom Techniques www.emofree.com

General Trauma Text: Levine, P. A. (1997) *Waking the Tiger, Healing Trauma*. Berkley: North Atlantic Books, p144.

TRAINING AVAILABLE

New Zealand Bowen Therapy Incorporated Tel: 64 9 534-3476

New Zealand College of Massage (Bachelor of Health Studies in Massage and Neuromuscular Therapy).

Email: info@massagecollege.ac.nz Web: www.massagecollege.ac.nz

LIMITATIONS

Clients do vary quite a lot in terms of how responsive they are to treatment. Often the more chronic the physical or emotional pain, the longer the course of treatment and the slower the rate of improvement.

Ability to continue treatment in the community is sometimes compromised, owing to factors such as the lack of finances, transportation difficulties, or an ambivalent relationship with the interpreter or therapist.

Psychotherapy With Children

WHY THIS THERAPY IS USED

Children have often personally experienced or witnessed extreme violence and trauma (torture, murder, rape, imprisonment, privation). They may have had close family members die or be lost to them in a variety of ways; they may be alone (Unaccompanied Minors), separated from all family or with extended family members. They may have been coerced to perform acts of war, either as child soldiers or by their captors. In order to survive they may have, amongst other possibilities, engaged in theft, child labour or prostitution and may have had involvement with drugs and/or alcohol. They may also have observed their parents doing these things. Most arrive in the country without any possessions that are familiar to them, sometimes without any education. Language acquisition may be slow and school may become difficult for them.

Hence children will possibly be suffering, as do their parents, from Posttraumatic Stress Disorder (PTSD), depression, anxiety, grief and loss. Their behavioural manifestations may include some forms of “acting out” such as violent behaviour, somatisation, poor sleep, intense distress as a response to seemingly innocuous stimuli, amongst other behaviours. They may be disobedient or overly compliant, withdrawn, dissociative or appear to be hyperactive.

Therapy would take the form of addressing these symptoms as well as dealing with the past traumas. It may take many forms. One of the aims of therapy is to include the fostering of resilience by building capability in the child. It is useful to work with the family as well as children individually in order to ascertain the coping strategies used to survive the traumatic experiences, also the school and social groups need to be considered and interlinked if at all

possible. Family therapy interventions are helpful to assist the child to feel contained within the family unit and to assist the child's caregivers to manage the child, also to ensure that the family survives as a unit within their culture. However it is important to see the child on their own in order to exclude any possible current violent situations. The use of Art Therapy methodologies (painting, sand tray work) has proven most useful in the MRRC as part of assessment and the promotion of mastery.

POTENTIAL ISSUES

Children may not have a previous point of reference in terms of "life before" refugee status, unlike their families. They are unable to express themselves as well as most adults. Restoration of safety is a prerequisite with all people but with children is the first priority.

REFERENCE MATERIAL

Barrett, P.M., Moore, A.F., Sonderegger, R. (2000). The FRIENDS program for young former-Yugoslavian refugees in Australia: A pilot study. *Behaviour Change*, 17(3), 124-133.

Ehnholt, K.A. & Yule, W., (2006) Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma *Journal of Child Psychology and Psychiatry* 47:12 1197-1210

Ehnholt et al (2005). School based CBT group intervention for refugee children who have experienced war-related trauma. *Clin Child Psychol and Psychiatry*, 10(2) ,235-250.

TRAINING

Training available for the therapy in New Zealand – as per the other Te Pou manuals

LIMITATIONS

Limitations of the therapy may be related to the availability of experienced art or child therapists, training or equipment.

Eye Movement Desensitization and Reprocessing

WHY THIS THERAPY IS USED

EMDR was developed by Francine Shapiro to reduce distress associated with traumatic memories and it has been established as an effective for treatment of PTSD. It has the capability to facilitate intense therapeutic change in less time and many controlled studies have shown 77- 90% of reduction in PTSD symptoms in civilian populations in a few sessions (as cited in Shapiro 2001).

In EMDR after a thorough client history and preparation for the therapy sessions, the client visualizes the targeted traumatic event in their mind. Alongside this the client selects the sensory image which best represents traumatic memory with a negative belief (e.g. "I am in danger") while simultaneously focussing on bilateral stimulation. The client is then asked to rate the disturbance level on a Subjective Units of Distress (SUDs) scale, which ranges from 0 to 10, with 0 being no disturbance and 10 being extreme disturbance. The client is then encouraged to visually follow the therapist's finger until the SUDS rating falls to 0, thus helping to process the traumatic memory and enable the client to reach an adaptive resolution. Aside from eye movements other forms of stimulation like tones or finger tapping have also been used. Wilson et al., 2000 successfully used "butterfly hug" a form of dual stimulation to treat traumatised children in refugee camps (as cited in Shapiro 2001).

Often clients experience extreme distress in discussing details about the trauma and/or are unable to recall the details of the traumatic incidences. In order to use EMDR it is not essential to know details of the trauma, as it helps in processing the distressing memories and allows a natural healing process of assimilation and adjustment to function.

According to Shapiro (2001), many studies have been published to accentuate the use of EMDR in the treatment of other disorders such as anxiety disorders, personality disorders, dissociative disorders and somatoform disorders. The author has successfully used EMDR with 3 refugee clients from different countries who presented with symptoms of PTSD and depression. All of them were sexually abused, had been exposed to multiple traumas, and experienced

profound grief as well as having encountered ongoing personal stressors during the treatment. Post treatment there was a 90 % reduction of PTSD symptoms such as nightmares, flashbacks, intrusive memories etc and a decrease in symptoms of depression with better coping abilities. EMDR was also found to be effective when used with a client who presented with symptoms of depression and hypochondria.

POTENTIAL ISSUES

Sometimes refugee clients migrate from countries where stigma about mental illness is present and awareness about mental health professionals and interventions is very limited. Also occasionally clients can misinterpret the therapist's action of conducting eye movements or finger tapping to be black magic. Thus it is very helpful to provide a simplified explanation about the background of EMDR. Furthermore it helps when clients are presented with case examples and read letters written by past clients who have experienced positive improvements in their life with EMDR treatment.

While using interpreters, it is very helpful to train them about the procedures of conducting EMDR before this information is shared with the clients. This helps the interpreters in explaining the procedures to the clients in a much better way.

REFERENCE MATERIAL

Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing: Basic principles, protocols and Procedures (2nd ed.). New York: Guilford Press

Tinker, R. H. & Wilson, S.A. (1999). Through the eyes of a child: EMDR with children. New York: W.W. Norton & Company

TRAINING

Training in EMDR is widely available in Australia and many of these trainers are willing to conduct training in New Zealand for a group of mental health professionals.

LIMITATIONS

Further research needs to be done on effectiveness of EMDR on clients suffering from PTSD and other mental disorders using larger population, carefully designed, and randomized controlled studies. More research also needs to be conducted in order to understand the mechanism underlying its information processing. Also there is extremely limited research available on refugee populations.

Promising New Approaches:

Neurofeedback

Neurofeedback with EEG (electroencephalograph) and HRV (Heart Rate Variability) applications is a new emerging therapy that is showing promise for treatment of a range of conditions including tinnitus, anxiety disorders, pain management, brain injury and ADHD. Neurofeedback is being trialled in Sydney through Dr Moshe Perls and Mirjana Askovic at the STARRTS Centre. A recent publication (Martijn Arns, et al 2009) examines its efficacy in treatment of ADHD, which, although not directly related to trauma, indicates the success of the methodology with a disorder that is not very amenable to psychotherapy, talking or behavioural interventions. Additional research articles, some specific to trauma, can be found at www.isnr.org (bibliography) and at www.eegspectrum.com

LIMITATIONS AND ISSUES

Further research needs to be done on effectiveness of Neurofeedback on clients suffering from PTSD and other mental disorders using larger population, carefully designed, and randomized

controlled studies. More research also needs to be conducted in order to understand the mechanism underlying its effects. Also there is presently no published research available on refugee populations. Potential issues could include culture, paranoia or panic about electrodes and wires, success rates, and it is unknown which clients are likely to benefit most from neurofeedback.

SUMMARY

In brief summary, working in the area of cross-cultural international mental health can be highly rewarding and challenging. The aim is to assist migrants and refugees to overcome obstacles and enhance resettlement success. There are constant opportunities to learn about new cultures and concepts of mental health and different customs and ways of life. With an attitude of sincerity, openness, flexibility and a willingness to learn, a practitioner may acquire the skills and experience to be effective and helping people from a wide variety of countries, cultures, backgrounds and needs. In working with CALD clients, it is important to continue training and supervision, but particularly to seek specialist cultural advice in the process of assessment and case management. Working with people who have come from backgrounds of severe trauma can be challenging and the practitioner must particularly pay close attention to potential issues of vicarious traumatisation, transference, and role clarity. Attention to self-care practices, peer support, supervision and debriefing are particularly important for working in this area of specialised practice. There is a range of resources available for reference and there is continuing professional development training available in Aotearoa New Zealand and from overseas. Some of these resources are detailed below.

SECTION 4 -

RESOURCES AND LINKS

- [Asylum seekers, social policy, and psychologists](#)  (140kb)
Paper presented at symposium sponsored by Psychology in the Public Interest
43rd APS Annual Conference, Hobart, September 2008
- CALD Resource and CALD Training Manuals: Cultural Competencies for Health Practitioners in Working With Migrants and Refugees (2008). RASNZ and Waitemata District Health Board. order from admin@rasnz.co.nz or www.cald.org.nz
- Immigration Act 2009: <http://www.dol.govt.nz/actreview/>
- NZ Refugee Law website: <http://www.refugee.org.nz>
- RASNZ Refugees As Survivors New Zealand website: www.rasnz.co.nz
- Psychologists for Peace Interest Group: [Refugee Issues News](#)
- Researchers for Asylum Seekers: www.ras.unimelb.edu.au
- International Rehabilitation Council for Torture Victims: <http://www.irct.org/home>
- Interpreters and NAATI: <http://www.naati.com.au/>
- Australian Asylum Seekers Resource Centre: www.asrc.org.au
- STARRTS Centre, Sydney: <http://www.startts.org.au>
- Victorian Foundation: <http://www.foundationhouse.org.au/home/index.htm>
- Victorian Transcultural Psychiatry Unit: translated psychometric instruments:
<http://www.vtpu.org.au/resources/translatedinstruments>
- Cultural Detectives: <http://www.culturaldetective.com/>
- NZ Human Rights Commission: Te Punanga Refugee Focus
<http://www.hrc.co.nz/home/hrc/racerelations/tengirathenzdiversityactionprogramme/tepunan-garefugeeissues.php#letter>:

- Changemakers Refugee Forum: <http://www.crf.org.nz/>
- Refugee Council of New Zealand: <http://www.rc.org.nz/>
- Wellington RAS Trust: www.wnras.org.nz
- Centre for Refugee Studies, University of New South Wales; <http://www.crr.unsw.edu.au/>
- Migrant Resource Centre: <http://www.arms-mrc.org.nz/>

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