ORIGINAL RESEARCH

11. The Effects of Community-Based Mental Health Interventions on Resettled Adult Refugees from Muslim-Majority Countries

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▶ https://www.youtube.com/watch?v=4rJ3DHWeKRs&list=PLhqNq3xJClbafO0Y5bvBcgMmXpgzJxd44&index=6&t=4169s

Background: Although refugees from Muslim-majority countries represent a vast percentage of displaced populations globally, limited data exists on their resettlement into high-income nations. This gap has resulted in an inadequate and inequitable method of care when addressing their mental health needs, often overlooking relevant cultural and religious frameworks. The religious beliefs of these individuals, paired with the sociocultural assumptions placed upon them both internally and externally, affect help-seeking behavior and psychosocial resilience which ultimately manifests in poorer health outcomes. These issues are compounded because refugees often face significant stressors through discrimination, societal stigma, and trauma from forced migration which exacerbate disparities. Furthermore, the COVID-19 pandemic disproportionately affected refugee populations that struggled with limited access to treatment and healthcare information. The pandemic amplified epidemic hysteria fueled stigmatization of refugee populations which further increased their distrust in Western medicine and decreased compliance with healthcare systems.

Aim: To identify the effects of community-based mental health interventions in resolving this population's unmet mental health disparities.
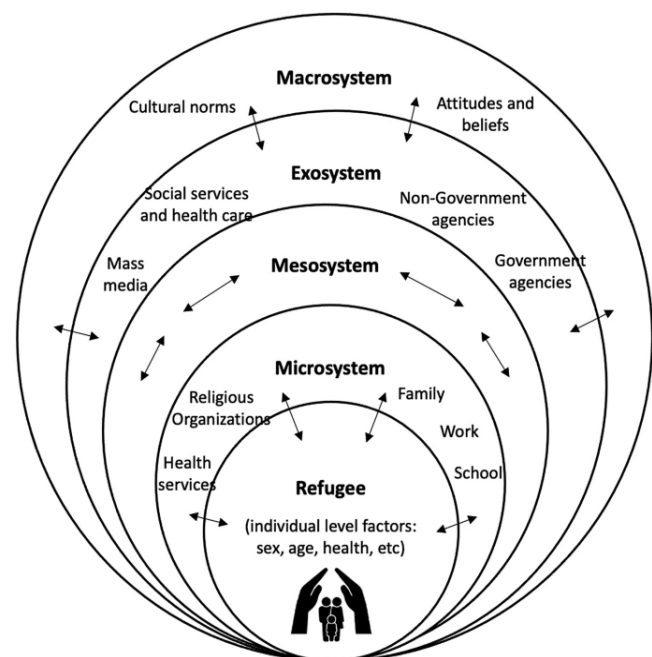
Methods: We conducted an integrative review of the literature on this topic to illuminate the effectiveness of this healthcare model for resettled adult refugees from Muslim-majority countries. Data extracted from the literature included information on interrelated environmental systems that affect mental health, descriptions of the measures taken at each of the four ecological levels of influence, and reported outcomes in regards to effectiveness and challenges.

Results: Interventions for depression, anxiety, and psychological distress were most prevalent, addressed most commonly through strengthened social-bondedness and interpersonal relationships among refugees and their communities. Programs which address cultural stigma through psychosocial support were suggested as developments which can reinforce Muslim refugee identity and thereby enhance healthcare delivery. Eligible publications suggest that mental health programs addressing social connectedness, early on-set community health intervention, and direct refugee engagement within program development improves overall psychosocial wellbeing. Common results included an increase in social encouragement among refugees, the implementation of communal healing practices, and a strengthened connection between refugees and their families overseas. Such family centered interventions have been shown to be feasible, accepted, and effective in reducing traumatic stress and depression in certain populations. Faith-informed interventions led by community members have likewise shown significant benefits for resettled Muslim refugees in terms of reducing PTSD and depression. The COVID-19 pandemic underscored virtual care as a promising potential tool for psychotherapy of refugee populations. However, telehealth must be properly integrated into telehealth systems to overcome technological and cultural barriers to provide meaningful care to refugee populations.

Conclusion: The persisting mental health and intervention needs among these resettled refugees warrant high-quality, advanced studies to facilitate the equitable mobilization of resources and attention. Collaborative partnerships with the stakeholders, local communities, and refugees play a vital role in the successful implementation of equitable health care.

Figure 1. Bronfenbrenner's Ecological Model Diagram Applied to Refugees.