Understanding the Environmental Risk Factors of Psychosis for Refugees in Canada

By

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Abstract

Every year Canada becomes home to thousands of refugees and asylum seekers from all over the world who are fleeing persecution from their country of origin. Extensive research in several European countries has shown that all categories of psychosis are higher in migrants, refugees, asylum seekers and minority ethnic populations than in the host population, with psychosocial factors identified as a key contributing factor to the higher incidence in this population group. There is limited research in Canada on the incidence of psychotic disorders among all categories of migrants. This literature review aimed to analyse studies on the incidence of psychotic disorders in refugees and asylum seekers in Canada, primarily focusing on post-migratory factors relating to the social determinants of health. Findings from the selected study showed higher rates of psychotic disorders in refugees from East Africa and South Asia (95% and 51% increased risk, respectively) than in the general population (Anderson et al., 2015). The disparity of risk across ethnic subgroups suggests that environmental factors associated with migration may contribute to the risk of psychotic disorders (Anderson et al., 2015). Social Workers function in a vast array of roles in resettling migrants, refugees, and asylum seekers. Social Workers need to understand the psychosocial challenges faced by refugees in Canada to enable them to use appropriate practices and advocate for necessary policies, to inform Social Work interventions that are responsive to the complex needs of refugees. This paper has highlighted approaches of anti-oppressive and strength-based practices, cultural humility, peer support, group models and community empowerment to promote positive social identity and increase social connectedness to improve the mental well-being of refugees, asylum seekers and ethnic minority groups in Canada

Definitions

Migrant is a person who moves away temporarily or permanently from their country of residence to another country (Canadian Council for Refugees, 2010).

A *refugee* is a person who has involuntarily fled or displaced from their own country for several reasons such as war, persecution or natural disaster and is resettled in a new country, usually under agreements between international aid agencies and the governments of the host country (Canadian Council for Refugees, 2010).

Asylum Seeker or *Refugee Claimant* is a person who has left their country by their own choice in search of international protection because of fear of persecution or violence but is yet to be recognized as a refugee (Canadian Council for Refugees, 2010).

Host Country of migration: Host country and resettlement country are used interchangeably, a country where migrants, refugees or asylum seekers resettle.

Psychosis is defined as a condition that affects the mind, associated with symptoms of delusion and hallucination, consequently impairing the way a person thinks, acts, feels, or senses things (CAMH, 2021).

First Generation Migrants: born outside Canada, parents both born outside Canada (O'Donoghue et al., 2021)

Second Generation Migrants: born in Canada, parents both born outside Canada (O'Donoghue et al., 2021)

Host Population: born in Canada, parents both born in Canada (O'Donoghue et al., 2021)

Pre-migration: stage in the relocation process where refugees are still in their home countries. Trauma experienced in the pre-migration stage is a significant determinant of refugee and asylum seekers' mental health (Anderson et al., 2015).

In Transit: this is the temporary stay of migrants in one or more countries to migrate to a destination country (Anderson et al., 2015)

Post Migration: resettlement stage in a host country. At this stage, key determinants of mental health include resettlement stressors such as poverty, unemployment, separation from culture and family members, social isolation, loss of valued societal roles, and identity confusion (Leaune et al., 2018).

Environment is everything that is external and non-genetic to the human host (Hynie, 2018).

Environmental Factors are external influences that can impact an individual's health (Kirkmayer et al., 2011).

Understanding the Environmental Risk Factors of Psychosis for Refugees in Canada

Refugees and asylum seekers are a sub-group of migrants who have been displaced or fled from their home country because of armed conflicts, natural disasters, climate changes or persecution (Citizenship & Immigration, 2021). According to the United Nations Refugee Agency (UNHCR), there are over 70 million forcibly displaced persons (FDP) around the world (UNHCR, 2020). There were about 11.0 million FDP in 2019 and 11.2 million in 2020 (UNHCR, 2020). Canada is a nation with a policy of multiculturalism and a history of welcoming refugees worldwide. Every year Canada becomes home to thousands of refugees and asylum seekers from all over the world who are fleeing persecution from their country of origin. Since 1989, Canada has resettled 1,088,015 refugees. In 2019, Canada resettled 30,082 refugees, ranking at the top of the list among 26 developed host countries (UNHCR, 2019). Extensive studies in several European countries have shown a strong association between migration and psychosis, with forced migration experienced by refugees and asylum seekers being identified as an ethnic minority showing an increased vulnerability for psychotic symptoms compared to host population and non-refugee migrants.

Psychosis

Psychosis is described as a condition of the mind that affects an individual's ability to distinguish what is real or not (CAMH, 2022). Symptoms may include delusions, hallucinations and disturbing thought patterns/behaviours, which are termed positive symptoms (Trotman et al., 2013).

Additional symptoms, termed negative symptoms, include disturbed sleep patterns, social withdrawal, lack of motivation, and difficulties completing daily activities (Trotman et al., 2013). The incidence of other psychiatric illnesses (Post Traumatic Stress Disorder and Depression) has also been higher in migrants in extensive studies. However, this paper focuses on psychosis because psychotic disorders continue to rank high as one of the most serious and debilitating mental illnesses. Psychotic disorders are lifetime disorders characterized by periodic self-sufficiency and relapses (Trotman et al., 2103). On a personal level, the burdens on the individual and their families are immense as the disorder impairs functioning in all areas of the person's life. On a societal level, the socioeconomic and medical costs of psychotic disorders can be immensely high (Trotman et al., 2013). Historically the etiology of psychosis has mostly been studied as a biological condition; however, recent research is showing convincing evidence that environmental factors are linked to the development of psychotic symptoms.

There is a lack of Canadian evidence on the incidence of psychotic disorders among refugees and asylum seekers. With 250,000 people arriving to settle in Canada each year on both economic and humanitarian grounds, reliable findings from a Canadian context on migrant and refugee risk of psychosis will be of value to Canada's immigration policy and resettlement services.

Canada's Migrant Population

There has been a marked shift in the ethnicity of Canada's migrant population. Before the 1960s, most migrants to Canada originated from Europe. Post-1960s, Canada and other western countries have resettled more ethnically diverse migrants originating from Asia, Middle East, the Caribbean, Latin America and Africa (Schwartz et al., 2010). These regions mostly have a collectivist culture where the focus is on family, clan, nation or religion compared to Canadian and other western countries that emphasize individualism resulting in

acculturation stressors from many gaps in cultural values between many migrants (Schwartz et al., 2010). Acculturation is the process in which an individual integrates into a new culture, typically a dominant culture and acculturative stress refers to the stressors associated with being an immigrant or ethnic minority and going through process of adjusting to a new culture. Acculturative stressors can stem from learning a new language and culture, navigating through new institutions, social isolation, and the experience of taking on a minority status that may be perceived as lesser (Grayman-Simpson, 2017).

Problem Statement and Significance of Study

This paper aims to investigate if refugees and asylum seekers in Canada experience similar susceptibility to psychotic disorders, as evidenced in multiple studies in several European countries and understand the psychosocial/environmental factors that contribute to this susceptibility. As highlighted in Kirkmayer et al. (2011), policies and practices in addressing general mental health problems are complicated for immigrants and refugees because of differences in culture, values, language, coping methods and help seeking behaviours. Therefore, recognizing the association between migration, ethnicity, and environmental factors on mental health is vital for creating policies on preventative health strategies relevant to this population's needs. The mental health challenges faced by immigrants and refugees must be understood and addressed as it impairs economic and social functioning, which in turn disrupts their resettlement.

Research Questions

The research questions guiding this study are:

1. What is the prevalence of the psychotic disorder in refugees and asylum seekers in Canada?
2. What are the environmental factors that contribute to the risk of psychotic disorder?

The sub-questions are as follows:

1. What are the social determinants of mental health for refugees and asylum seekers?
2. What are the effects of post-migration stressors on refugees' and asylum seekers' mental health?
3. Is there an overemphasis on pre-migratory factors in understanding refugee and asylum seekers' mental health challenges?

Literature Review

There is extensive evidence in the literature, predominantly from European countries, to suggest that forced migration is a predisposing risk factor for developing psychosis. Brandt et al. (2019) showed that refugee experience is an independent risk factor in developing nonfictive psychosis among refugees in Denmark, Sweden, Norway, and Canada. Hollander et al. (2016) showed similar findings that refugees face an increased risk of schizophrenia and other non-affective psychotic disorders compared with native born Swedish population and non-refugee migrants from similar regions of origin.

Parret and Mason (2010) presented evidence that refugees had higher prevalence of psychosis, with increased risk in the early post-migratory years for the first generation. The role of psychological trauma in the pre-migratory and the post-migratory stage is identified as an etiological factor for psychosis in refugees (Anderson et al., 2015; Brandt et al., 2019; Parret & Mason, 2010).

Henssler et al. (2019) suggest that social stress emanating from feelings of social isolation and being socially disrespected over time may alter cognitive processes to harbour more rigid beliefs about general environmental hostility, consequently creating a sense of hypervigilance that could lead to psychotic experiences.

This study also suggests that the increased rates of schizophrenia and related psychoses extend to second-generation migrants and refugees.

There is also evidence to suggest that the increased risk of psychosis amongst refugees varies by ethnicity, where individuals from Black/Afro Caribbean countries are at a higher risk than individuals from other ethnicities. Hutchinson and Haasan (2003) summarized findings that in Britain, the Caribbean, and African migrants were especially vulnerable to experiencing psychosis. In the Netherlands, Caribbean migrants were found to be at increased risk and in other European countries, increased risk in East and West Africans was evident.

Leaune et al. (2018) investigated if ethnic minority position is independently associated with an increased report of psychotic experiences and symptoms. This study also accessed the influence of ethnicity, host country and age as risk factors in developing psychosis. Their findings suggest that ethnic minority position is independently associated with the increased report of psychotic experiences and symptoms. It further suggests that the risk was elevated in ethnic groups experiencing discrimination and deprivation.

Dapunt & Heinz's (2017) review of selected studies showed an increased risk of psychotic disorders in refugees in Germany compared with both the native population and non-refugee migrants with increased risk elevated in refugee men.

A summary of the literature associates a higher risk of psychosis with refugees from developing countries and migrants from countries with a predominantly black population. The studies reviewed suggests that marginalization and discrimination associated with migration is a key contributing factor to the risk of psychosis. Further research on the incidence of psychosis in second-generation migrants is needed, as little preliminary evidence has shown increased incidence in second-generation migrants.

Post Migratory Stressors

Refugee and asylum seekers' experiences have been differentiated into "pre- migratory," "in transit," and "post-migratory" factors (Leaune et al., 2018). Initial literature on refugee and asylum seekers' mental health was focused on the impact of pre-migration factors such as psychological trauma as predominantly the sole determinant of mental health. Findings in this area showed that individuals with elevated rates of trauma have corresponding increases in the severity of mental health disorders such as psychosis, PTSD, and depression, (Leaune et al., 2018). Hence, most research initially focused on the impact of pre-migration factors, mainly trauma, as the most important environmental predisposing factor in the development of psychosis amongst refugees and asylum seekers. However, meta-analytic reviews on this topic across several countries and populations have continued to show an increased risk of psychosis, and other mental health disorders are not only first but in second-generation voluntary migrants, refugees and asylum seekers compared with the host population, thus invalidating prior "sole" focus on pre migratory factors such as trauma for increased risk of psychosis and other mental health disorders (Blackmore et al., 2020). This review will add to the growing literature that shows environmental factors in the post-migration stage is a significant determinant of mental health that can exacerbate the development of psychosis in refugees and asylum seekers.

There are several important factors when resettling in a new country, and these factors are key to positive health outcomes. They include finding employment, stable housing, access to education, building social connections and the ability to access relevant services (Ziersch et al., 2017). For refugees and asylum seekers, leaving behind everything they have known and starting afresh in a different country with a different language, culture, laws, health system, and education can be a difficult process giving rise to a highly stressful

socioeconomic, social, and interpersonal environment in the host country (Ziersch et al., 2017). Several studies, including Blackmore et al. (2020), have suggested that the long-term mental health of refugees and asylum seekers is at risk deterioration because of acculturation stressors in the host country (Blackmore et al., 2020). This reaffirms studies suggesting that long-term exposure to ongoing stressors contributes to developing psychosis (Leaune et al., 2019). According to Sareen et al. (2011), individuals from marginalized groups with less access to power and material resources are at a higher risk of developing psychosis and have poorer mental health. Hynie (2018) came to a similar conclusion that "post-migration factors may moderate the ability of refugees to recover from pre-migration trauma." This calls for a need to target post-migration factors and the social determinants of refugee mental health. Social determinants of health are some of the most important factors that impact an individual's mental and physical health (CAMH, 2021).

These determinants include material variables such as employment, safe and adequate housing, adequate food, health care, and personal factors such as discrimination, acculturation stress, low social status, and experiences of social isolation. As highlighted in Hynie (2018), "material and interpersonal social determinants influence health and mental health through psychological states such as stress, perceptions of control, and social networks, which have effects through biological pathways including neuroendocrine, neuroimmune and epigenetic responses."

Social Determinants of Refugees Mental Health

Refugees and asylum seekers encounter multifarious risk factors for poor health and well-being (Ziersch et al., 2017). Data has consistently shown that many refugees and asylum seekers experience financial difficulties and even experience poverty in the settlement environment. Refugees and asylum seekers may a myriad of barriers to

employment, including language barriers and lack of recognition of qualifications from their home countries, leading to increased unemployment and underemployment rates. According to Hynie (2018), refugees and asylum seekers with limited opportunities to improve their economic status due to limited employment opportunities and workers' rights have the lowest mental health outcomes.

Poverty and limited access to resources in host countries mean that many refugees face challenges securing stable housing in the settlement environment. As highlighted by CAMH (2021), "secure housing is a human right and an important social determinant of health" A qualitative study by Ziersch et al. (2017) in South Australia examined the impact of housing experiences on the health and well-being of people from refugee and asylum-seeking backgrounds. The results indicated that housing was of central importance to health and well-being.

The social determinants of health are not only material variables; it also includes interpersonal variables, like experiences of discrimination, language difficulty, social isolation, cultural identity discontinuity and low social status. Language is a barrier to employment, education, housing, social assimilation, accessing healthcare, and accessing several social and legal policies that enable refugees and asylum seekers to integrate, understand and advocate for their rights (Hynie, 2018). Social isolation is a particularly important determinant of mental health for the general population and even more salient for refugees and asylum seekers. Family separation, the language barrier, cultural/identity discontinuity, loss of valued social roles and discrimination contribute to social isolation for refugees and asylum seekers.

Racial stratification in institutions such as education, health, and employment leads to stressors that perpetuate oppression, victimization and microaggressions, and this can consequently lead to adverse mental health outcomes. Thus, discrimination is a key structural determinant of health. Beisier & Hou (2016) Canadian study

examined the role of pre and post-migration trauma in explaining differences in refugee and immigrant mental health in youths; findings suggest post-migration perception of discrimination by refugee youths' participants explained higher levels of internalized disorders in refugee youths compared to immigrant youths in the study.

Social Location

My social location is significantly shaped by growing up in a collectivist culture. This culture is deep-rooted in the sense of collective responsibility to care for others as one also feels the psychological safety of knowing people care about you even when in an unfamiliar environment. This sense of responsibility has helped shape some of my values that align with my career decision to become a Social Worker. Some of these values include empathy, service, social justice, and the importance of human relationships. Growing up in Nigeria, this collective identity impacted how social constructs like success, health, right, and wrong were all constructed; for example, people are referred to by their family names, and one's good or bad behaviour could either uphold or tarnish one's family image. There was a sense of kinship as everyone within one's age group was considered brother or sister, and those much older were considered father or mother. The idea of cousins or aunts and uncles was inapplicable in the Nigerian family dynamics. It was a key culture shock when I moved to England to further my education. It was a shock to know that I am seen differently and could be treated differently because of my skin colour, my accent, and other features and characteristics native to me. I wasn't naive to hearing about racism before my migration from watching movies and reading literature but reading and experiencing it are completely different.

I recall becoming very conscious of people's motives and behaviours towards me, consequently feeling hyper-vigilant about ways I could protect myself from these subtle but harmful comments and behaviours that subordinated my existence to simply "an immigrant from Africa." This social label followed me everywhere and made me feel isolated despite my effort to embrace the culture in this new country,

This exhaustive journey of being a minority made me seek out my community to gain a sense of belonging. I was lucky to live in a diverse part of England where I did not have a hard time finding people who shared my experiences and offered me an opportunity to hear from the perspectives of immigrant students, refugees, citizens, and undocumented migrants. Living within my enclave and hearing people with similar experiences was my healing through this angst. My experience shaped my awareness of the struggles of immigrants and the impact of social isolation on mental health. I believe these experiences would have been a lot more challenging if England was not culturally diverse and I did not find a community.

Theoretical Framework

This paper will be using the theoretical framework of Social Identity Theory, Acculturation Theory and Anti Oppressive to provide a critical lens in understanding how marginalization contributes to psychosocial and acculturation stressors.

Migration results in social change, and a common denominating factor faced by all migrants is the probable loss of a migrant's cultural identity attached to their home country. Cultural identity is a social and psychological construct; according to Grayman-Simpson (2017), it is a person's social perception of self linked to a certain

culture. Refugees who have experienced forced migration experience a far greater loss in their social and cultural identities that were attached to their home countries. The loss of identity is most severe for asylum seekers who often arrive in host countries without any proof of identity. They are given "the bureaucratic identity" of "refugees" and "asylum seekers," an identity which is almost seen as "undesirable," "less," and "burden." At the same time, they face the struggle of acculturation and re-building new identities. There are sentiments of some citizens and political parties in host countries that perceive refugees and asylum seekers as a burden on the host country's resources, resulting in discrimination against refugees and asylum seekers. As highlighted in Schartz et al. (2010), when refugees and asylum seekers experience discrimination in the host country, they do not only face transcultural challenges, but they may also resist adopting identities, values and practices of the host culture.

Social Identity Theory

Social identity theory was developed by social psychologists Henri Tajfel and John Turner in the 1970s (Vinney, 2019). The theory emphasizes how people identify themselves as part of a group and presents the process through which a person's identification with a social group becomes more central than their personal identity and how social/group identity can influence self-esteem and intergroup behaviour (Vinney, 2019). The theory is based on three key "cognitive components: social categorization, social identification, and social comparison" (Islam, 2014).

The first process, social categorization, is how individuals are categorized into social groups. It enables a person to define themselves and others based on the groups that they belong to as a way of understanding and navigating the social world. This process of categorization results in focus on the similarities of people in the "in groups" and the differences between people in the "out-groups" (Vinney, 2019). The second process, social

identification, describes how a person identifies as a group member. Group identification influences how a person believes they should behave. The person's self-esteem and perceived status are therefore influenced by the status of their groups. The third process, social comparison, is how a person compares their group with the "out-groups" in terms of the group's social status. To have positive self-esteem and value, one must perceive their in-group as having a higher social standing than an out-group (Islam, 2014).

Another notion of self-identity theory is self-continuity. As highlighted in Smeekes et al. (2017), "self-continuity refers to having a sense of connection between one's past and present self." A perception of self-continuity is correlated with positive self-identity and improved mental health and well-being, while a sense of self-discontinuity is correlated with adverse mental well-being, such as feelings of "dissociation, distress, and even suicide" as highlighted in Smeeke et al. (2017).

Acculturation Theory

Migration can afford refugees and asylum seekers opportunities to thrive in host countries; on the other hand, it also carries risks of marginalization, exclusion, and the challenges of cross-cultural transition. Juang & Syed (2019) describe cross-cultural transition as "a series of stress-provoking events that can in extreme cases go beyond a person's coping resources and cause complete withdrawal from social life and even mental illness."

Acculturation theory offers a comprehensive critical lens through which refugees and asylum seekers adapt through this cross-cultural transition. According to Ward & Geeraert (2016), acculturation is how an individual responds to and adapts to prolonged contact with a new culture. One of the most prominent acculturation frameworks has been Berry's two-dimensional model, which describes the extent to which individuals adapt toward the majority culture and from the individual's native culture. (Juang & Syed, 2019).

The first dimension of adaptation strategy pertains to if the individual retains or rejects their native culture. The second dimension pertains to if the individual adopts or rejects the host culture. From these two dimensions, four acculturation strategies that the individual may adopt emerge: assimilation, separation, integration, or marginalization (Juang & Syed, 2019)

• Assimilation is when a person embraces the cultural values of the host culture over their native culture.

• Separation occurs when a person preserves their native culture and rejects the host culture. The availability of ethnic enclaves creates an opportunity for separation.

• Integration occurs when a person harmonizes host and native culture. Integration creates room for biculturalism/multiculturalism.

• Marginalization results when a person rejects native and host cultures (Juang & Syed, 2019).

Social Identity, Discrimination and Acculturation Challenges

Refugees and asylum seekers are faced with the risk of identity discontinuity, identity denial, discrimination, and marginalization in the resettlement society. Experiences of discrimination and feelings of marginalization introduce refugees and asylum seekers to a group identity that is perceived and regarded as "inferior," "a burden, or "unwanted."

The process of social comparison in social identity theory proposes that an individual's perception that one's group is devalued or seen as lesser tends to lower self-esteem as well as diminish self-identification with the group. Such distancing from and devaluing one's social/cultural identity increases social isolation (McIntyre et al., 2016). Social connection, which is one of the key social determinants of health, has been defined as a key protective factor in vulnerable people with a range of physical and mental health problems. McIntyre et al.'s (2016) article examined

elevated rates of psychosis in migrants through a social identity and acculturation lens. Key speculation in the article proposes that people with psychotic symptoms of paranoia/ paranoid delusions tend to have "low self-esteem, loss of/lack of identity, perception of negative attitudes of others towards them combined with an external locus of control (believe that environmental factors, actions of others, powerful forces determine the course of their lives/events). In sum, the article proposes that "paranoia is a disorder of social relationships," emphasizing that a loss of sense of cultural identity, valued social roles, self-esteem combined with the inability to foster positive and meaningful identities following migration are susceptible to developing paranoid delusions.

According to McIntyre et al. (2016), refugees and asylum seekers are at a higher risk of feeling marginalized, and this contributes, in combination with other environmental risk factors, to the elevated rates of psychosis seen in the literature.

Refugees and asylum seekers, as well as ethnic minorities, are viewed by some populations of receiving country as a burden on the host country's resources or may be discriminated against because of their race, religion, or culture. Migrants who experienced rejection or discrimination in the host society have more challenges with integration and may oppose embracing the cultural values of the host culture; this adds to their integration challenges and increases social isolation (Juang & Syed, 2019).

Anti Oppressive Practice

Although there is little literature about the intersecting effects of discrimination on the development of psychosis amongst refugees and refugee claimants, the small body of literature has identified experiences of discrimination in various aspects of resettlement, including housing access to mental health care and other key

aspects of living (Kirbride & Hollander, 2015). Experiences of discrimination are shaped by multiple intersecting structures of power and privileges; thus, this paper will analyze these effects from an anti-oppressive framework.

To better understand the reason and purpose for anti-oppressive practices, it may be helpful to understand oppression. Baines (2011) described oppression as an act or policy enacted unjustly on an individual or group because of one's connection to the group. These policies or acts may deprive the group of opportunities for self-development, access to resources or certain rights that the dominant groups have, assigning them second-class citizenship, not because of individual merits or failures but by their affiliation to a particular group.

An anti-oppressive framework is a framework that recognizes the structural origins of oppression and power dynamics at a structural level and promotes social transformation by drawing on critical theories like anti-racism, feminism, Marxist, postmodernism, indigenous, post-structuralist, critical constructionist and many more (Baines, 2011). There are several different concepts in the anti-oppressive framework. Three of these concepts will be used to demonstrate how oppression adversely affects refugees' mental health. The first concept; social categorization/divisions explain how groups are categorized based on inequalities in access to resources, the second concept of social inequalities shows the consequence of inequalities of power and access to resources on the oppressed, and the third concept is social exclusion (key social determinant of health) demonstrates the marginalization of oppressed groups. Refugees and asylum seekers are categorized into lower-status groups with unequal access to resources. Their experiences and perceived experiences of discrimination and marginalization are key contributors to psychological distress that is evidenced in their health inequities.

Methods

A systematic review was conducted to identify possibly relevant studies that highlight vulnerability for developing psychosis amongst refugees and asylum seekers in Canada. Articles in this study were extrapolated from Google scholar and the University of the Fraser Valley database – Academic Search Complete. Key search terms were employed, and search results listed below were derived from EBSCO- refugees, causes or reasons or factors, psychosis – 174, Relationship between refugee and psychosis – 56, Causes of psychosis in refugees – 10, non-genetic factors of psychosis in refugees, refugees, AND psychosis, AND Canada – 23 results, Environmental factors AND psychosis AND Canada - 111, Etiology of psychosis AND refugees AND Canada, factors prompting psychosis in refugees -11,688, factors provoking psychosis in refugees – 8438. A multistage screening was used to eradicate studies that were irrelevant to the study or did not meet the selection criteria.

The initial search involved identifying article titles that are relevant to the research question (understanding the environmental factors that increase the prevalence of psychosis amongst refugees and refugee claimants in Canada). Their links were then opened, and the abstracts read. If the content on the abstract was relevant, the full study was searched for, and the study was scanned through to determine its relevance to the research question. Relevant studies were analyzed more thoroughly to identify themes and other important information relevant to the study. To uphold the relevance of this literature review, only publications from 2010 to 2022 were included. Consideration was given to studies published in 2010 because of the limited research on the area of study. The citation list of the studies was reviewed to identify prominent literature in the field to get a sense of the guiding discussions. Only peer-reviewed qualitative and quantitative studies in the English language were selected for this literature review.

Discussion of Findings

After a thorough search, one study, Anderson et al. (2015), met the criteria for this review. The study linked data from Institute for Clinical Evaluative Sciences (ICES) and Citizenship and Immigration Canada and used a retrospective cohort design to estimate the incidence of schizophrenia and schizoaffective disorders among immigrants and refugees in Ontario (the province which has the largest proportion of first-generation migrants in Canada), relative to the general population. Incidence rates were compared between first-generation migrants, refugees, and the general population. The finding of this review is strengthened by the use of a large database, and adjustments were made for age and gender as well as income and population density. The cohort included 4 284 694 people, of which 9.8% (n = 418 433) were first-generation migrants. Of the migrant group, 22.7% (n = 95 148) had refugee status. The incidence rate of psychotic disorders among the general population in the cohort was 55.6 (95% CI 54.9–56.4) per 100 000 person-years. The rate was similar among immigrants at 51.7 (95% CI 49.2–54.4) per 100 000 person-years and higher among refugees at 72.8 (95% CI 67.1–78.9) per 100 000 person-years.

Refugees

Refugees were found to have a 25 percent greater risk of psychotic disorders compared to immigrants in the non-refugee group. Refugees originating from both East Africa and South Asia had a significantly higher risk of having a psychotic disorder than the general population (95% and 51% increased risk, respectively).

Immigrants

Immigrants from the Caribbean and Bermuda showed elevated rates of psychotic disorder compared with the general population compared to immigrants from Northern Europe, Southern Europe, and East Asia. A protective factor identified was neighbourhood-level income, as migrants who resided in the wealthiest

neighbourhoods in the province showed half the risk of psychotic disorders compared to migrants residing in the poorer neighbourhoods.

A striking deviation in the finding from similar studies in European countries is the disparity in the elevated rates of psychosis among non-refugee first-generation migrants relative to the general population. Migrants from East Asia and most parts of Europe had lower incidence rates compared to Ontario's general population. Only first-generation migrants from the Caribbean and Bermuda had an elevated risk (60% higher incidence). According to Kirkbride & Hollander (2015), in their review of Anderson et al. (2015) findings, the Canadian immigration policy of requiring migrants to pass a medical examination as part of their qualification criteria for immigration may contribute to the "healthy immigrant effect" (a phenomenon where first-generation migrants on average, are healthier than the host population). Kirbride & Hollander (2015) further proposed that Canada's immigration point system selects highly skilled, young, and English/French-speaking applicants who are able to integrate more quickly into Canadian society.

Another protective factor that may explain the lower incidence rates among migrants from East Asia and Europe relative to the host population is Canada's multiculturalism. Canada's multicultural policy encourages new Canadians to harmonize both their native and Canadian culture allowing immigrants to establish social and economic support and networks and establish new social identities more quickly and easily. These speculations by Kirkbride & Hollander (2015) on the protective effect of multiculturalism align with the theories of social identity and acculturation theories; that immigrants' ability to integrate their heritage cultural identity and the cultural identity of the host country to form a positive self-concept is positively associated with long-term psychological well-being (Carpentier & de la Sablonnière, 2013). According to Carpentier & de la Sablonnière (2013), a positive

self-identity provides a protective effect from social, socioeconomic, and acculturation stressors often experienced post-migration.

A contrary plausible explanation to the "healthy immigrant effect" for why rates of psychosis were not elevated among some groups of non-refugee immigrants is the possibility that recent immigrants delay seeking help for mental health problems due to several factors such as cultural beliefs, language barriers and unequal access to health. As highlighted in Maraj et al. (2018), the Canadian mental health care system and service providers have faced challenges in fully accessing and engaging immigrant and ethnic minority groups, who are likelier to delay seeking and fully engaging in mental health services. Strategies to improve engagement are discussed in the next sections of this paper.

This protective effect of some groups of non-refugee migrants is not, however, extended to Black migrants in both refugee and immigrant categories. Extensive research has shown that anti-Black racism is a key determinant of health inequalities faced by Black Canadian communities. Anti-black racism is a term used to highlight how black people, in particular, experience racism. While other ethnic minorities and racial groups experience racism, anti-Black racism underscores the unique experiences of racism for Black people (Government of Canada, 2022). Black Canadians experience health and social inequities at multiple levels as a result of institutional and societal discrimination (Government of Canada, 2022). Racism and discrimination have relegated Black Canadians to a lower-status social group. There are unanimity societal perceptions of status across racial groups, with Black, Aboriginal, Hispanic, and Asian groups being perceived as lower status groups than White (Stern & Axt, 2018). Social Identity theory links perceived/categorized lower social group status with low self-esteem and disassociation from group identity, which is a risk factor for mental health disorders. Members of

groups categorized and stigmatized as lower status develop shared understandings of this status, that their group identity is devalued, and irrespective of personal identity and experiences, this negative identity is associated with negative well-being (Quinn & Earnshaw, 2013). Black immigrants and refugee do not only lose their social identities from native countries and face post-migration struggles during their resettlement in Canada but they are also integrated into a lower status group. Black refugees and asylum seekers face the intersection of being categorized into lower status by their race and status of refugees and asylum seekers.

A key limitation of this study is that participants included only first-generation migrants. Several meta-analytic reviews, including Dorsettt, Rinzio & Weale (2018) and Hollander et al. (2016), on this research area across several countries and populations, have continued to show an increased risk of psychosis and other mental health disorders is not only first but in second-generation voluntary migrants, refugees and asylum seekers compared with the host population. Longitudinal studies and surveys on the mental health of Canadian immigrants confirm that the healthy immigrant effect is stronger for recent immigrants and deteriorates among more established immigrants (Zoua et al., 2015). A Canadian Community Health Survey showed that the lower rates of depression in recent first-generation immigrants to Canada compared to Canadian-born residents declined over time with increased length of stay in Canada, and higher incidence rates of depression were evidenced in the second generation (Pahwa et al., 2012). Studies on the prevalence of psychosis in second-generation migrants and refugees are an important area for future studies.

Implications for Social Work Practice

Social Workers function in a vast array of roles in the resettlement of migrants, refugees, and asylum seekers. Social Workers need to understand the health and psychosocial status faced by refugees in Canada to inform clinical Social Work practice that will be sensitive and responsive to the needs of refugees and asylum seekers.

Social Work practice recognizes the effect of environmental factors on the health of individuals and communities. Social Workers have an ethical responsibility in helping to improve health outcomes by recognizing and targeting environmental factors that may negatively affect health, such as discrimination, social injustice and inequality (Canadian Association of Social Work, 2020). The core values that guide Social Work practice are invaluable to the well-being of this population.

- Respects for the inherent dignity, worth and autonomy of every person
- Respects the human rights of individuals and groups
- Importance of human relationships
- Duty of care and duty to avoid harming others
- Social justice
- Respect for group identity (CASW, 2020)

Post-1960s, the change and increase in the numbers of ethnic and racially diverse immigrants from non-European countries has influenced public policy and practices in Canada. This evolution has influenced the Social Work profession and education, indicative of changes in the Canadian Association of Social Work Education accreditation policies and ethical guidelines. The profession has made an extensive effort to promote and support

all social workers working with minority groups to gain training and competence in cultural sensitivity (CASW, 2020). Recently anti-racism and anti-oppressive practice has become more prominent in Social Work discourse in Canada. However, there are serious deficiencies in policies, practices and attitudes which create additional burdens and challenges in the profession's ability to effectively provide services to ethnic minorities, refugees, and asylum seekers.

Positionality

Positionality is described as the way one's position in the social hierarchy impacts their worldview (Reid, 2017). During my reflexive process, while embarking on this literature review, the need to thoughtfully consider my research question and its implication for practise was guided by my positionality as an immigrant who identifies as an African Canadian and a Social Worker in the field of mental health. As part of my role as a therapist providing counselling for kids and youths with mental health challenges through MCFD Child and Youth Mental Health (CYMH), I come across immigrant and refugee youths who are struggling with symptoms of psychosis. They are usually referred to CYMH by the Early Psychosis Team for ongoing community mental health support. These client populations mostly present with very complex psychosocial needs, and clinician colleagues of mine have expressed difficulties with effective ways of engaging these clients.

The difficulties expressed by my work colleagues were reaffirmed by Sakamoto et al. 2018, referencing a survey done by Yan & Chan, 2010 on registered Social Workers at the BC College of Social Work. Despite their training in cultural competency, social workers who participated in the study reported minimal knowledge about the complexities of newcomers and immigrants' issues like immigration laws, settlement processes, and cultural

and language barriers. Other social workers in the study reported that they do not think that immigrants and refugee issues were within their scope of practice (Sakamoto et al., 2018).

Through observations in my practice, Social Workers and other helping professionals adapt their western trained approach to caring for immigrants and refugees, and when this "one shoe fits all approach" fails to meet the client's need, they are sometimes referred to as challenging. An example of the gap in support I noticed while working with a 19-year-old refugee who shared his struggles with symptoms of psychosis was the insufficient information he was provided upon discharge from the hospital after his first psychotic episode. The youth reported he was informed at the hospital that he had symptoms of first-episode psychosis with the assumption that he must be familiar with this term. Youths in western countries are well exposed to mental health disorders and their symptoms; however, many from developing countries where mental health stigma is quite pervasive are not always familiar with the nuances of different mental health challenges. This youth lived with her aunt; hence when the positive symptoms were in remission, there was lots of conflict with his aunt because the aunt misinterpreted the negative symptoms as laziness. The need for family-based interventions in accessing and supporting refugees and immigrants is a key component of the treatment. Suppose the family needs were accessed, and the aunt was provided psychoeducation on the negative and positive symptoms of psychosis. In that case, this may have reduced the conflict at home, which consequently increased the young person's stressors. They reported feeling isolated after conflict with the aunt and would sometimes go through days and not having anyone to speak with about these changes he is noticing in his body. He added this created a deep fear of himself and an identity crisis. The youth shared experiences of depression which presented as increased irritability and externalizing behaviours. We discussed how his symptoms did not fit into the western understanding of depression; hence the depression was not

identified. Care providers focused on his behaviours and were considered a safety risk; hence support services became restricted. He reports being lucky to have gotten one of his depots from a nurse who understood his presenting needs and was able to advocate for more support for him.

Social Work Educational institutions have a key role to play in ensuring that the Social Work education curriculum includes a course on immigrants and refugee mental health. This would be a great starting point for Social Workers to learn about this population.

Social Work Approaches to Refugees and Asylum Seekers Resettlement

Social work practise offers valuable expertise in providing meaningful interventions and coordinating referral pathways to services for refugee and asylum seekers' resettlement and integration into Canadian communities. The following framework approaches are recommended to target and mitigate the barriers and struggles of refugees and asylum seekers identified in this review.

Cultural Competency

Social Work refugee resettlement intervention requires cultural competency. The Canadian Association of Social Work (CASW) emphasizes the need for practitioners to be culturally self-aware and have knowledge of the client's culture to be able to adapt interventions in meaningful and appropriate ways skillfully. This is referred to as cultural competence (CASW, 2020). Social Workers need to be responsive to the environmental stressors refugees experience to become competent in this area of practice (Lau & Rodgers, 2021). Cultural competence is important for the provision of effective and equitable services for refugees and asylum seekers. Cultural competence has also been defined in health care settings by Lau & Rodgers (2021) as "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs."

As discussed in earlier sections of this paper, refugees and asylum seekers experience a great loss in their social and cultural identities that were attached to their home countries and are imposed the identity" of "refugees" "asylum seekers," an identity that carries connotations such as "undesirable" "less" in need of help" At the same time they face the struggle of acculturation and re-building harmonious identities. It is imperative that in providing service, people from refugee backgrounds and asylum seekers are seen "in their totality," not just as "refugees" Cultural competence involves understanding the various cultures and home countries of refugees, including different ethnic groups, languages and dialects, religions, gender norms, cultural beliefs, and practices. It is important to understand the challenges at different stages in their migration and resettlement process, including possible stressors such as trauma loss/separation of family pre-migratory and transit stages as well, negative experiences with the refugee process and challenges in the post migratory stages such as environmental/psychological distress, discrimination/marginalization, social exclusion, and financial hardship.

It is understandable that cultural competency can be overwhelming and implies that competency is a one-time training, and an individual is expected to become well versed in various cultures. Cultural humility is a more realistic and effective goal for Social Workers. According to Yeager & Bauer-Wu (2013), "Cultural humility is a process of reflection to gain a deeper understanding of cultural differences to improve the way vulnerable groups are treated and researched" Cultural humility requires a modest attitude regarding one's cultural deficiencies and is open to learning and guidance. Cultural humility is when Social Workers are humble and respectful of the refugees and asylum seekers' cultures and work in collaboration with asylum seekers and refugees to determine what benefits or hinders their resettlement in their new context.

Social Workers should recognize that refugees have skills, strengths, and talents and be conscious of the importance of sharing power to ensure meaningful participation of refugee clients and communities in the planning, design, and evaluation of policies and programs.

It is important to cultivate partnerships with refugee communities and involve family and community members in service delivery, where appropriate.

The language barrier is one of the greatest challenges in Social Work with ethnic minority groups; along with the use of interpreting services to mitigate language barriers, more effort must be made to increase the diversity of social work to include more practitioners that identify as ethnic minorities or have bicultural identities (Bo, 2015).

As highlighted in Ornett (2020), there is growing evidence that cultural brokers improved service to target populations such as refugees and asylum seekers. A cultural broker is an individual who acts as a bridge to improve communication and understanding between groups or persons of different cultural backgrounds (Ornett, 2020). Cultural brokers from refugee communities who have firsthand experience of refugees' cultural, social, economic, and language challenges allow Social Work practice to bridge the gap in services for refugees and asylum seekers.

Anti- Oppressive and Anti – Racist approaches to practice

According to Ziersch & Walsh (2020), discrimination is "a socially structured phenomenon which maintains privileges for members of a dominant group at the cost of others" discrimination can occur at an interpersonal level between individuals and can occur at a systemic level in policies and practices that maintain inequalities across groups. Discrimination can be overt and covert, ranging from exclusion, microaggressions, insults, threats and physical violence to inequities in access to resources such as employment, education and housing (Ziersch & Walsh 2020).

Discrimination and stigma against asylum-seekers, refugee groups and minority ethnic groups are still widespread on an interpersonal and institutional level. In recent years, Social Work has promoted anti-oppressive and anti-racist approaches to practice. It is imperative that Social Workers recognize how racism and discrimination affect the everyday lives of many immigrants and ethnic minority groups and deploy anti-racist skills in their practice.

Focus on Post Migration Stressors/Social determinants of Health

To be effective, Social Workers need a thorough understanding of the relocation and resettlement process that contributes to the health iniquities seen in refugees and asylum seekers. Refugees are affected by the same social determinants of mental health as the host population, but it impacts their post-migration struggles to a far greater extent because of the adversities faced by refugees and asylum seekers in all stages of the migration experience. Social Work interventions should extend beyond trauma relation struggles from pre-migratory experiences to focus on refugee and asylum seekers' post-migration resettlement stressors. These challenges include helping with meeting human needs such as finding and building identities and connections, seeking housing, employment, education and gaining access to needed healthcare (Disney & McPherson, 2020).

Acculturation Approach

Acculturation stress results from adjusting to a new culture. The difference in cultures, values and identities creates difficulties in resettling into a new society, establishing new identities and coping with environmental stressors. Refugees are faced with a loss of identity, identity denial and marginalization. Earlier sections of this paper proposed a social identity critical lens theory on how identity discontinuity and social isolation can increase the risk of psychosis and especially paranoid symptoms isolation (McIntyre et al., 2016). The best social work

practice is one that promotes biculturalism/multiculturalism. This allows refugees to form a harmonious identity that integrates their own culture and beliefs with the host country's cultures. A biculturalism/multiculturalism framework promotes post migratory environment of inclusion and belonging. According to Schwartz et al. (2010), "bicultural individuals tend to be better adjusted, have higher self-esteem, report lower depression, and overall demonstrate prosocial behaviours."

Recommendations for Psychosocial Interventions

Policies and interventions to promote the mental well-being of refugees and asylum seekers should focus on the social determinant of refugees' and asylum seekers' mental health and the re-establishment of meaningful roles and identities in Canada.

Social determinants of refugee and asylum seekers' mental health were discussed in earlier sections. Interventions that support refugees and asylum seekers in obtaining secure immigration status, securing employment, education, adequate housing and food, services that provide language skills, improved access to healthcare and anti-oppressive policies and interventions that protect refugees from discrimination and systemic racism mitigate post migratory stressors and improves the mental well-being of refugees and asylum seekers.

Interventions that support refugees and asylum seekers to reconnect with the cultural and religious institutions that are familiar to them promote identity continuity and assist them in maintaining their cultural integrity while building new identities and connections in resettlement society (UNHCR, 2022). Supportive relationships with members of established refugees through mentorship and peer support interventions can help refugees to build their connections with the resettlement society.

Vision for Social Work Practice: Shifting the context for refugee settlement

Acknowledging the inherent strengths of refugees and asylum seekers is an important starting point for social workers and other health and resettlement professionals. A strength-based approach is a vital approach to structuring interventions, policies and practices.

A strengths-based approach focuses on people's resilience instead of their deficits and recognizes that all people have strengths, and utilizes these strengths to empower individuals and their communities. According to Pulla (2017), "the Strengths Perspective recognizes that for most of life, people face adversity, become resilient and resourceful and learn new strategies to overcome attending adversities."

Refugees and asylum seekers face multiple resettlement stressors in their new environment. The way these challenges are addressed will either result in a community being positioned as passive and in need of help or, on the other hand, a community that is positioned as resilient and able to harness its resources through meaningful support eventually. Changing the narrative of refugees and asylum seekers from being perceived as a drain to the Canadian economy to be seen as contributors to the vitality of Canadian society imperative to improve host population attitudes towards migration and reduce stigmatization and discrimination, which is still widespread in Canada and as evidenced in this paper has significant consequences for health and well-being of refuges. A strength-based approach has the potential to enhance refugees' overall resilience and well-being by celebrating their unique strengths and cultural assets.

Strengths-Based practices and support programs and interventions that promote refugees' health, psychosocial well-being, and integration in a real-world context are still emerging, and there are currently no best

practices or gold standards. This paper proposes three practices that have shown success with refugees resettled in high-income countries:

1. Peer Support Models
2. Group Models
3. Community centred approaches

Peer Support Models

Peer support groups are increasingly being used in health care and social work disciplines. Social support theory proposes that emotional and informational support from peers can help people overcome challenges and improve well-being (Orrnet, 2020). As highlighted in Shommu et al. (2016), Peer support models have shown success in improving refugees' health, well-being, and social integration. Peer supporters are ideal members of the refugee community who undergo specialized training. These models have been used for community development, to increase access to health and social services, and to address health disparities. This approach is strengths-based because it leverages the cultural expertise, ideas, and language skills of community members (Orrnet, 2020). Refugees and asylum seekers can learn from 'established refugees' with firsthand experience in gaining the norms and social skills needed to integrate into resettlement societies. Peer-based interventions can increase participant involvement, decrease feelings of isolation by building bonds and community networks and increase feelings of belonging and empowerment within the community (Orrnet, 2020).

Ospina (2013) investigated the role of the Multicultural Health Brokers Co-operative (MCHB Co-op) in targeting the health disparities of immigrant women and their families in Edmonton, Alberta. The multicultural health workers provided linguistic and cultural assistance to immigrant and refugee women and their families in

collaboration with health and social service providers. The study found that MCHBs were successful in increasing immigrant and refugee women and their family's access and engagement with healthcare and social services as well as their integration into Canadian society.

Group Models

Group Models are interventions that bring individuals together to address a shared challenge or problem (Kronick, 2020). Group models with target populations have focused on health promotion and psychoeducation. Group models in refugee and asylum seekers' services can promote psychosocial health by improving engagement in targeted services and enhancing social/environmental networks. This strategy is strengths-based because it fosters social connections, providing a space for individuals with refugee backgrounds to exchange ideas and problem-solve together.

Interventions that connect refugees and asylum seekers with their ethnocultural communities can help protect them from isolation and marginalization (Kronick, 2018). Sociotherapy is one of the few well-researched group psychosocial interventions. The primary focus of psychotherapy is fostering connections between people (Kronick, 2018). Biracyaza & Habimana (2020) found that psychotherapy promotes social cohesion among individuals who identify as being of the same group.

A prominent group model that is recently being used in refugee therapy is Community-Based Sociotherapy (CBS). It is a group therapy model developed in post-genocide Rwanda to aid community healing:

"The intervention is delivered to groups of 10-15 people who live close to each other. CBS is delivered in 15 weekly group sessions of 3 hours duration. Group members are facilitated to focus on phases of safety, trust, care, respect, new life orientations and memory. The social space of the group is governed by principles including democracy, equality, and confidentiality, aiming for participants to regain their capacity to relate and connect to others so that they can experience the vitality of humanity again and feel mentally healthy" (University of Liverpool, 2022)

Group therapies can be offered to refugees and asylum seekers to share and discuss their acculturation challenges ranging from interpersonal disputes, personal trauma, health stressors and marginalization/discrimination and the effects on their psychosocial wellbeing. As highlighted in Biracyaza & Habimana (2020), the aim of Sociotherapy is to restore the psychosocial health and identiyu of the participants and community as it creates opportunities to build social networks, which is crucial for successful refugee resettlement by providing a sense of belonging.

Community-Centred Approaches

A strength-based approach involves the empowerment of communities by consulting with and utilizing existing resources in the community. Empowering community-based approach must consult and collaborate with refugee communities in the development and facilitation of programs/interventions. Collaboration with community partners can bring about experiential knowledge to inform responsive service provision. Collaboration is especially important for refugees and asylum seekers, where fear of or lack of trust in public authorities due to possible

precarious legal standing in the country may be a barrier to engagement. As highlighted by World Health Organization (2018), "community-based organizations can play a key role as interagency intermediaries between government services and the specific needs of refugee and migrant communities, and provide an efficient link for the delivery of information, resources and services."

Community interventions and resources can also create an avenue for integration of services to improve access to essential services for integration, such as health care, employment, housing, and education services.

As highlighted by the Canadian Association of Mental Health (2021) best practice model of service delivery follows an integrated approach, where: a single point of access provides a variety of services. Community resource centers/hubs can provide a space to build a social network as well as integrate integral resettlement services that would traditionally be accessed independently.

British Columbia Settlement and Integration Services (BCSIS) provides wrap-around support services through integrated community resources centers and hubs throughout the lower mainland. These services include employment, community connections, language services, capacity building, and individual, family and group counselling.

The Immigrant Services Society of British Columbia (ISSofBC), with locations in the cities of Vancouver, Burnaby, Surrey and Langley, is a one-stop support centre that offers a wide variety of services to meet the immediate needs of newcomers. It provides an avenue for immigrants and refugees to access various services in local and broader communities. Some of these services include cross-cultural peer support group programs, health settlement counselling and volunteer programs for newcomers to Canada to learn, practice and utilize their skills and knowledge in a variety of areas, language training programs and employment services (Immigrant Service Society of BC, 2022). Similar community resettlement hubs include Archway Community Services in Abbotsford,

Several Neighbourhood Houses in Vancouver, DIVERSEcity Community Resources Society in Surrey and many more.

Conclusion

The needs of refugees worldwide have never been greater with an increasing number of refugees and asylum seekers worldwide. In 2020, approximately 1.4 million refugees needed resettlement, but due to the COVID-19 pandemic, only approximately 2 percent (34,400) were resettled in host countries (UNHCR, 2020). The COVID-19 travel restrictions have only worsened persistent problems and contributed to the much lower numbers of resettlement in 2020 and 2021 (UNHCR, 2020). Canada, which is the leading country in the resettlement of refugees worldwide, will continue to resettle an increasing number of this subgroup of migrants. Policies and interventions must adopt a truly biopsychosocial approach that contextualizes refugees' mental health in a broader social perspective to target resettlement interventions and address refugee and asylum seekers' mental health.

The challenges refugees and asylum seekers face are complex and multiple, ranging from war, torture, loss of family members, violence, and arbitrary imprisonment in pre-migratory and in-transit stages to socioeconomic and acculturation stressors in post-migratory stages. Findings and themes discussed in this review suggest that social identity discontinuity, social exclusion and discrimination coupled with post-migration adversities in terms of social and economic disadvantage play a critical role in the development of psychosis.

Extensive literature in Europe in the past 50 years has found rates of psychosis up to five times higher in migrants from the African Caribbean and Africa than the native-born white population and other ethnic groups. The study used in this review which is the only Canadian study on the prevalence of psychosis in the migrant population, revealed a higher incidence of psychosis in refugees and asylum seekers and an even more elevated risk among both immigrants and refugees from the Caribbean. Studies on the link between discrimination and mental health have shown that the African-Caribbean population ethnic minority group report the highest degree of

discrimination, and it is evident that racism and discrimination is an independent risk factor for developing and exacerbating psychotic symptoms (Pearce et al., 2019). A focus on anti-oppressive practices and policies and a conscious commitment to eliminating structural racism are integral for the mental health of ethnic minority groups, refugees and asylum seekers.

Existing literature in this area indicates that migrants are more protected from the risk of psychological disorders when they have a stronger sense of belonging in their communities and positive self-esteem. This paper has highlighted approaches of anti-oppressive and strength-based practices, cultural humility, peer support, group models and community empowerment to promote positive social identity and increase social connectedness to improve the mental well-being of refugees, asylum seekers and ethnic minority groups.

The current mental health care system and social work practice is created and continues to operate from a Eurocentric lens and has been found by studies to be inadequate to attend to the complex needs of refugees and asylum seekers who struggle with varied mental health challenges. Concerns around the lack of access, lack of culturally appropriate services, and a lack of organizational commitment to improving services are a few of the gaps in the access to services for immigrants and refugees (Ontario Human Rights Commission, 2020). Further research is needed on the incidence of psychosis in migrant and ethnic minority populations to mitigate this risk as well as inform environmental/psychosocial interventions that promote the mental well-being of refugees and asylum seekers.

Social Workers function in a multitude of roles in the resettlement of migrants, refugees, and asylum seekers. According to the World Health Organization (2018), "ensuring that refugees and migrants achieve social integration in host countries can be regarded as potentially the most influential prevention strategy for mental

disorders on a public health level" With the increasing number of Immigrants and refugees welcomed into Canada and governments' projection of welcoming more, the Social Work profession has an ethical responsibility to ensure Social Workers are adequately prepared to step into the role of supporting Immigrants and refugee's acculturation journey as this fall into Social Work scope of practice.

Social Work faculty in all universities in Canada should provide an opportunity for students at the undergraduate and postgraduate levels to learn about issues concerning immigrants and refugees by creating a curriculum on Migration, Refugee Resettlement and Mental Health. Such a curriculum will prepare students to understand policies and laws about immigration refugee resettlement, promote much-needed research on refugee challenges and contribution to society and demystify the myths learned from public discussions on this population. This will prepare students with the needed skills to become effective in their role when working with and advocating for this population.

Social Work regulatory bodies like the British Columbia College of Social Work (BCCSW) and the British Columbia Association of Social Work (BCASW) use their platform in advocating for improvement in public policies on immigration and refugee resettlement, such as the elimination of refugee detention centres.

Social Work students and practitioners should be encouraged to engage in more research about refugees' contribution to society and help shift the single story of refugees and immigrants as a burden to society. Research should also focus on the intersectionality of structural racism and other forms of "isms" on the mental health and well-being of this population. This can inform better public policies and effective interventions to meet the complex needs of this group.

It is imperative to note that all people have strengths. Refugees and their families have overcome immense challenges, including the perseverance and tenacity needed to start over in a new country.

Care providers need to acknowledge and honour these strengths rather than focus on the deficits. Interventions geared towards the strengths of refugees and their unique cultural assets are needed to improve care providers' trust and facilitate better integration outcomes for refugees and immigrants.

References

Anderson, K. K., Cheng, J., Susser, E., McKenzie, K. J., & Kurdyak, P. (2015). Incidence of psychotic disorders among first-generation immigrants and refugees in Ontario. CMAJ: *Canadian Medical Association Journal, 187*(9), E279–E286. https://www.cmaj.ca/content/187/9/E279

Baines, D. (2011). *Doing anti-oppressive practice: Social justice social work*. Black Point, N.S: Fernwood Publishing.

Beiser, M., Feng Hou, & Hou, F. (2016). Mental health effects of premigration trauma and postmigration discrimination on refugee youth in Canada. *Journal of Nervous & Mental Disease, 204*(6), 464–470. https://journals.lww.com/jonmd/Abstract/2016/06000/Mental_Health_Effects_of_Premigration_Trauma_and.8.aspx

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. PLoS Medicine, 17(9), 1–24. https://pubmed.ncbi.nlm.nih.gov/32956381/

Bø, B. P. (2015). Social work in a multicultural society: new challenges and needs for competence. International Social Work, 58(4), 562–574. https://doi.org/10.1177/0020872814550114

Bourque, F., van der Ven, E., Fusar-Poli, P., & Malla, A. (2012). Immigration, social environment, and onset of psychotic disorders. Current pharmaceutical design, 18(4), 518–526. https://doi.org/10.2174/138161212799316028

Brandt, L., Henssler, J., Müller, M., Wall, S., Gabel, D., & Heinz, A. (2019). Risk of psychosis among Refugees: A systematic review and meta-analysis. JAMA psychiatry, 76(11), 1133–1140. https://doi.org/10.1001/jamapsychiatry.2019.1937

Canada Immigration and Citizenship. (2021, November 21). *Coronavirus disease (COVID-19): Refugees, asylum claimants, sponsors and PRRA applicants.* https://columbiacollege-ca.libguides.com/apa/websites

Center for Addiction and Mental Health. (2021, December 14). *Psychosis.* https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/psychosis

Disney, L., & McPherson, J. (2020). *Understanding Refugee mental health and employment issues: Implications for social work Practice.* https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=1025&context=jswgc

Dorsett, R., Rienzo, C., & Weale, M. (2019). Intergenerational and interethnic mental health: An analysis for the United Kingdom. Population, space and place, 25(2), e2195. https://onlinelibrary.wiley.com/doi/full/10.1002/psp.2195

Flenon, A., Gagnon, A., Vang, Z.M., & Sigouin, J. (2015). The healthy immigrant effect in Canada: A systematic review. Population change and Life course strategic knowledge cluster discussion paper series: vol. 3: Iss. 1, Article 4. https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1012&context=pclc

Gleeson, C., Frost, R., Sherwood, L., Shevlin, M., Hyland, P., Halpin, R., Murphy, J., & Silove, D. (2020). Post-migration factors and mental health outcomes in asylum-seeking and refugee populations: a systematic review. European journal of psychotraumatology, 11(1), 1793567. https://doi.org/10.1080/20008198.2020.1793567

Grayman-Simpson, N. (2017). Cultural identity. In A. Wenzel (Ed.), The sage encyclopedia of abnormal and clinical psychology (Vol. 1, pp. 934-935). SAGE Publications, Inc., https://dx.doi.org/10.4135/9781483365817.n360

Henssler, J., Brandt, L., Müller, M., Liu, S., Montag, C., Sterzer, P., & Heinz, A. (2020). Migration and schizophrenia: a meta-analysis and explanatory framework. European archives of psychiatry and clinical neuroscience, 270(3), 325–335. https://doi.org/10.1007/s00406-019-01028-7

Hollander, A. C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: a cohort study of 1.3 million people in Sweden. BMJ (Clinical Research Ed.), 352, i1030. https://doi.org/10.1136/bmj.i1030

Hutchinson, G., & Haasen, C. (2004). Migration and schizophrenia: The challenges for European psychiatry and implications for the future. Social psychiatry & psychiatric epidemiology, 39(5), 350–357. https://pubmed.ncbi.nlm.nih.gov/15133590/

Hynie M. (2018). The social determinants of Refugee mental health in the post-migration context: A critical review. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 63(5), 297–303. https://doi.org/10.1177/0706743717746666

Islam, G. (2014). Social identity theory. Journal of personality and social psychology, 67, 741-763. https://www.researchgate.net/profile/Gazi-Islam-2/publication/281208338_Social_Identity_Theory/links/55db57ec08ae9d6594935f59/Social-Identity-Theory.pdf

Juang, L. P., & Syed, M. (2019). The evolution of acculturation and development models for understanding immigrant children and youth adjustment. Child development perspectives, 13(4), 241–246. https://srcd.onlinelibrary.wiley.com/doi/pdf/10.1111/cdep.12346

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & Canadian collaboration for immigrant and Refugee health (CCIRH) (2011). Common mental health problems in immigrants and refugees: general approach in primary care. CMAJ : Canadian medical association journal - journal de l'Association medicale canadienne, 183(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Lau, L. S., & Rodgers, G. (2021). Cultural competence in Refugee service settings: A scoping review. Health equity, 5(1), 124–134. https://doi.org/10.1089/heq.2020.0094

Leaune, E., Dealberto, M.-J., Luck, D., Grot, S., Zeroug-Vial, H., Poulet, E., & Brunelin, J. (2019). Ethnic minority position and migrant status as risk factors for psychotic symptoms in the general population: a meta-

analysis. Psychological medicine, 49(4), 545–558. https://www.cambridge.org/core/journals/psychological-medicine/article/abs/ethnic-minority-position-and-migrant-status-as-risk-factors-for-psychotic-symptoms-in-the-general-population-a-metaanalysis/B1AF30675C6B064DAA05C5801577436E

Maraj, A., Iyer, S. N., & Shah, J. L. (2018). Enhancing the engagement of immigrant and ethnocultural minority clients in Canadian early intervention services for psychosis. The Canadian journal of psychiatry, 63(11), 740–747. https://doi.org/10.1177/0706743718773752

Migration policy institute. (2011). *Canada's immigration policy: a focus on human capital*. https://www.migrationpolicy.org/article/canadas-immigration-policy-focus-human-capital#:~:text=Today%2C%20the%20goal%20of%20the,within%20Canada's%20aging%20labor%20force.https://www.migrationpolicy.org/article/canadas-immigration-policy-focus-human-capital#:~:text=Today%2C%20the%20goal%20of%20the,within%20Canada's%20aging%20labor%20force

Ng, E., Zhang, H. (2021). *Access to mental health consultations by immigrants and refugees in Canada. Statistics Canada health report*. https://www150.statcan.gc.ca/n1/pub/82-003-x/2021006/article/00001-eng.htm

O'Donoghue, B., Geros, H., Sizer, H., Addington, J., Amminger, G. P., Beaden, C. E., Cadenhead, K. S., Cannon, T. D., Cornblatt, B. A., Berger, G. E., Chen, E. Y. H., de Haan, L., Hartmann, J. A., Hickie, I. B., Ising, H. K., Lavoie, S., Lin, A., Markulev, C., Mathalon, D. H., & McGlashan, T. H. (2021). The association between migrant status and transition in ultra-high risk for psychosis population. Social psychiatry & psychiatric epidemiology, 56(6), 943–952. https://pubmed.ncbi.nlm.nih.gov/33399885/

Pulla, V. (2017). *Strengths-based approach in social work: A distinct ethical advantage*. https://www.researchgate.net/publication/320411435_Strengths-Based_Approach_in_Social_Work_A_distinct_ethical_a

Pahwa, P., Karunanayake, C. P., McCrosky, J., & Thorpe, L. (2012). Longitudinal trends in mental health among ethnic groups in Canada. Chronic diseases & injuries in Canada, 32(3). https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/publicat/hpcdp-pspmc/32-3/assets/pdf/cdic-32-3-07-eng.pdf

Parrett, N., & Mason, O. (2010). Refugees and psychosis: A review of the literature. Psychosis, 2(2), 111–121. https://www.tandfonline.com/doi/abs/10.1080/17522430903219196

Rhodes, J.E., Parrett, N., & Mason, O.J. (2016). A qualitative study of refugees with psychotic symptoms. Psychosis, 8, 1 - 11. https://www.tandfonline.com/doi/abs/10.1080/17522439.2015.1045547

Rotenberg, M., Tuck, A., Anderson, K. K., & McKenzie, K. (2021). The incidence of psychotic disorders and area-level marginalization in Ontario, Canada: A population-based retrospective cohort study. The Canadian journal of psychiatry. https://doi.org/10.1177/07067437211011852

Sareen, J., Afifi, T. O., McMillan, K. A., & Asmundson, G. J. (2011). Relationship between household income and mental disorders: findings from a population-based longitudinal study. Archives of general psychiatry, 68(4), 419–427. https://pubmed.ncbi.nlm.nih.gov/21464366/

Sherrell, K., D'addario, S., & Hiebert, D. (2007). On the outside looking in: The precarious housing situations of successful Refugee claimants in the GVRD. Refuge: Canada's journal on Refugees, 24, 64-75. https://www.semanticscholar.org/paper/On-the-outside-Looking-In%3A-The-Precarious-Housing-Sherrell-D%27addario/7a5e39140ed4cafc6944295d291e48d0fa24e822

Shommu, N. S., Ahmed, S., Rumana, N., Barron, G. R., McBrien, K. A., & Turin, T. C. (2016). What is the scope of improving immigrant and ethnic minority healthcare using community navigators: A systematic scoping review. International journal for equity in health, 15 (1), 6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714538/

Trotman, H. D., Holtzman, C. W., Ryan, A. T., Shapiro, D. I., MacDonald, A. N., Goulding, S. M., Brasfield, J. L., & Walker, E. F. (2013). The development of psychotic disorders in adolescence: a potential role for hormones. *Hormones and behaviour*, *64*(2), 411–419. https://doi.org/10.1016/j.yhbeh.2013.02.018

Vinney, C. (2019, July 21). Understanding social identity theory and its impact on behaviours. ThoughtCo. https://www.thoughtco.com/social-identity-theory-4174315

Ward, C., & Geeraert, N. (2016). Advancing acculturation theory and research: The acculturation process in its ecological context. Current opinion in psychology, 8, 98-104. https://www.sciencedirect.com/science/article/pii/S2352250X1500247X

Werbeloff, N., Levine, S., & Rabinowitz, J. (2012). Elaboration on the association between immigration and schizophrenia: a population-based national study disaggregating annual trends, country of origin and sex over 15 years. Social psychiatry & psychiatric epidemiology, 47(2), 303–311. https://pubmed.ncbi.nlm.nih.gov/21286683/

World Health Organization. (2018). *Health promotion for improved Refugees and migrant health.* https://www.euro.who.int/__data/assets/pdf_file/0004/388363/tc-health-promotion-eng.pdf

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: an essential foundation for clinical researchers. *Applied nursing research: ANR*, *26*(4), 251–256. https://doi.org/10.1016/j.apnr.2013.06.008

Ziersch, A., Due, C., & Walsh, M. (2020). Discrimination: a health hazard for people from refugee and asylum-seeking backgrounds resettled in Australia. BMC public health, 20(1), 1–14. https://doi-org.proxy.ufv.ca:2443/10.1186/s12889-019-8068-3