Factors that protect and promote refugee mental health

A systematic review

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March 2023

Note. Photograph by Khosravi, 2020.

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Executive Summary

Traditionally, research investigating refugee mental health has followed a deficit framework, emphasising the identification of factors which place refugees at risk for poor mental health outcomes. Studies have found, however, that the depth, pervasiveness, and persistence of psychological symptoms amongst refugees varies greatly between individuals, with many refugees not reporting clinically-significant symptoms despite exposure to trauma and other forms of adversity [2-5].

Recently, there has been increasing interest in the demographic, psychosocial, and situational factors which can predict resilient outcomes in refugees and adversity-exposed populations more broadly. Despite this recent surge of interest, more is known about factors that can predict mental ill health than factors which may protect refugees from poor mental health outcomes or promote resilience amongst refugees [9].

Thus, this report has been commissioned by the Social Policy Group and led by the Refugee Trauma and Recovery Program at the School of Psychology, UNSW Sydney, to identify the factors which protect refugees from poor mental health outcomes as well as promote greater positive mental health outcomes.

Four electronic research databases (PubMed, EMBASE, ProQuest, and PsycInfo) were systematically searched up to December 2022 to identify relevant, peer-reviewed studies pertaining to protective and promotive factors of refugee mental health. After screening 3466 studies, the data from 174 studies were extracted, evaluated, and synthesised.

This process led to the identification of factors that were associated with better mental health outcomes across four key domains: sociodemographic, external, socio-cultural, and internal. These factors included younger age, male gender/sex, better housing conditions, financial security, having a protected or permanent visa, social support, religiosity, greater use of cognitive strategies, and higher self-efficacy.

These findings inform settlement policy by highlighting tangible targets for supporting positive mental health in refugees. Specifically, these findings suggest that 1) providing refugees with a secure environment and adequate resources for daily living, 2) facilitating strong social connections, and 3) drawing on and building psychological skills, may be important pathways to positive mental health in refugees. Additionally, findings suggest that tailoring support to specific groups of refugees (e.g., according to gender/sex and age) is required to ensure their unique needs are addressed.

Overall, these results highlight a growing evidence base that speaks to the importance of a strengths-based approach to resettlement that is informed by the insights and voices of refugee communities.

02
Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), the number of forcibly displaced persons worldwide exceeded 100 million in 2022, meaning that one in every 78 people in the world had been forced to flee their homes (4). Of these, over 27.1 million are considered refugees, and this number is set to increase in 2023 (5).

Spanning the past two decades, Australia has been the third largest resettlement destination worldwide, accepting 8.6% of the total refugees referred by UNHCR (94 099) (6). Migration is central to Australia's identity and its societal and economic success (8, 9). This success, however, hinges on effective and targeted settlement and support services.

> **Migration is central to Australia's identity and its societal and economic success**

Refugees generally have greater settlement needs than other migrant communities (10). This is because refugees are subject to a number of negative experiences in their home country, during displacement, and after resettlement including, but not limited to, human rights violations and abuses, exposure to traumatic events, loss of loved ones, marginalisation and discrimination, limited access to basic services and commodities, uncertain legal status, and loss of culture (11, 12). These adverse experiences pose risks for mental disorders and other poor psychological outcomes (13) which can persist for years, even after resettlement (14, 15). For example, the prevalence rate for posttraumatic stress disorder (PTSD) in refugees in Australia is 31% (16), around five times higher than that seen in the broader Australian population (17).

Who are refugees?

According to the UNHCR (1951, 1967), refugees are people who are displaced across international boundaries and unable to return to their country of origin due to a well-founded fear of being persecuted on the grounds of race, religion, nationality, membership of a social group, or political opinion.

Nonetheless, studies find that many refugees do not report clinically-significant psychological symptoms following resettlement (18-21). In the last few decades there has been increasing interest in the demographic, psychosocial, and situational factors which can predict resilient outcomes in refugees and adversity-exposed populations more broadly (22-25).

Despite this recent surge of research, more is known about factors that can predict mental ill health than factors which may protect individuals from poor outcomes or promote positive development following adverse events (26). While this deficit approach reflects the breadth of contextual and internal factors that place refugees at greater risk of mental health difficulties, such an approach also comes at the expense of understanding the resilience and strengths of refugee communities.

This gap in research means that, to date, there is not a strong evidence base to inform settlement policy on strengths-based approaches to supporting refugee mental health, nor to identify strategies that settlement and other community workers can utilise to strengthen refugee wellbeing during resettlement.

The current report aimed to systematically investigate protective and promotive factors for refugee mental health to inform policies

and interventions that support refugees. While there have been previous systematic reviews examining factors that predict the mental health of forcibly displaced populations, these reviews have focused on specific subpopulations such as children (18, 27-34) or voluntary migrants (35, 36). Further, to our knowledge, there has been no review undertaken to date focused specifically on factors contributing to better mental health in refugees.

In this review we followed the conceptualisation of Tol and colleagues (32) to define **protective factors** as those associated with lower negative mental health outcomes and **promotive factors** as those associated with greater positive mental health outcomes.

We were guided by existing theoretical frameworks that highlighted the impact of environmental factors, psychological or internal factors, and sociocultural frameworks on refugee mental health (37-39). Therefore, we predicted that protective and promotive factors would be identified across the following domains: sociodemographic characteristics, external factors, socio-cultural factors, and internal factors. Synthesising research evidence on such factors is a critical step to informing approaches that support refugees to adapt well following exposure to trauma and displacement.

There is not a strong evidence base to inform settlement policy on strengths-based approaches to supporting refugee mental health, nor to identify strategies that settlement and other community workers can utilise to strengthen refugee wellbeing during resettlement

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Methodology

Study selection

Four electronic databases (PubMed, EMBASE, ProQuest, and PsycInfo) were systematically searched in July 2022 to identify relevant, peer-reviewed studies relating to three core concepts: refugees; mental health; and protective and promotive factors.

The initial search yielded 4714 studies. Searches were conducted again in December 2022, resulting in an additional 336 studies. After de-duplication, 3466 articles remained. 26 additional articles were identified via hand-searching of other relevant systematic reviews and in consultation with authors.

Studies were selected through two rounds of screening: a title and abstract screen where Criteria A to G were applied, and a full-text screen where the full criteria were applied. This approach was taken to enhance the sensitivity of the screening process.

After screening, 174 studies were included, amounting to 716 unique findings.

Selection Criteria

A. Population investigated: refugees, asylum seekers, and/or forcibly displaced people who have crossed an international border.
B. Written in English.
C. Peer reviewed.
D. Minimum of 50 participants.
E. Average age of participants was 18 years or older.
F. Study outcomes were psychological variables indexing health and mental wellbeing.
G. Cross-sectional, experimental, or longitudinal design with quantitative data.
H. Applied a statistical analysis that could theoretically control confounding factors.
I. Assessed factors that protect or promote refugee mental health and wellbeing.

Data extraction

Data extracted from included studies comprised:

- **Key characteristics**: design, setting, population characteristics, inclusion/ exclusion criteria, and recruitment method
- **Outcomes**: instruments and measurements used
- **Findings**: instruments and measurements used, analysis approach, and results

After extraction, studies were coded as having been conducted in low-and-middle-income countries (LMICs) or high-income countries (HICs) using the World Bank classification of gross national income per capita (40) to investigate the differential factors influencing mental health for refugees in different contexts.

Quality Appraisal

A quality appraisal was conducted to evaluate the risk of bias and strength of evidence in included studies. The Systematic Assessment of Quality in Observational Research (SAQOR; (41)) was used to rate the quality of studies according to six domains: sample, control/comparison group, quality of exposure/outcome measures, follow-up, distorting influences, and reporting of data. Amendments were made to the SAQOR criteria, largely following the adaptations of Betancourt and colleagues (42) and Scharpf and colleagues (31) to enhance the flexibility and sensitivity of the tool for refugee research. All studies were given a grade of low, moderate, or high based on the quality assessment.

This review accords with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (1) and was pre-registered with PROSPERO (CRD42022367358).

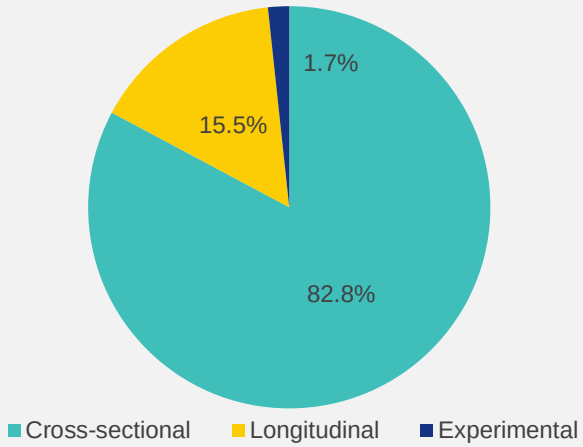
04
Key Findings

Snapshot of included studies

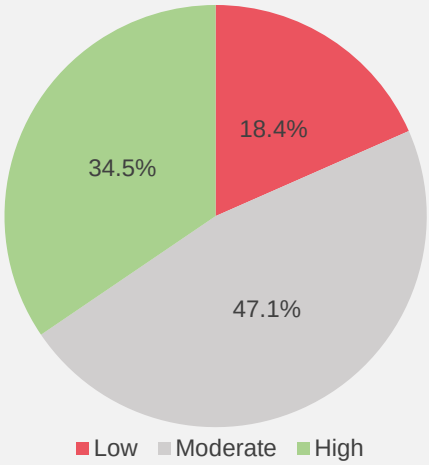
174

studies included

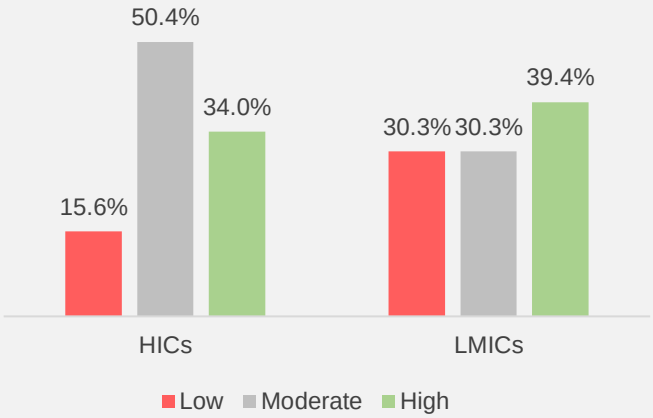
Study design



Study quality



Study quality by country income



Findings across domains

(n = 716)

- Socio-demographic (n = 264, 53%)
- External Factors (n = 145, 52%)
- Socio-cultural Factors (n = 202, 63%)
- Internal Factors (n = 105, 84%)

n is the number of unique findings identified across studies in the specified domain, % is the proportion of findings in the specified domain that showed a protective and promotive relationship

Summary of protective and promotive factors

How do I read this table?

Factors that significantly predicted better mental health outcomes in at least two studies included in this review were summarised in this table, delineated by the income level of the country the research was conducted in (LMIC vs HIC). Superscript indexes the number of studies that found the respective relationship in the current review. Unless otherwise specified, higher levels of each factor were associated with better mental health outcomes. Where there was contradictory evidence regarding the protective or promotive effect of a factor (e.g., in the case of gender/sex), the weight of evidence in both directions was indicated in brackets.

	Socio-demographic	External	Socio-cultural	Internal
HICs	Gender/Sex (Male[38], Female[4)] Age (Younger[29], Older[9]) Ethnicity/Region of origin[15] Education (Higher[10], Lower[4])	Protected/ Permanent visa[14] Employment[13] Time in host country (Less[8], More[7]) Good housing conditions[7] Healthcare/Health cover[2] Income[2] Satisfied with employment[2]	Received/Perceived social support[27] Support network/Live with family[15] Host country language (Proficient[11], Not proficient[2]) Relationship status (Married[7], Not married[2]) Religiosity/Religious coping[7] Social coping/ Trust of group membership[6] No children[4] Ethnic identity/Support[4] Family cohesion or functioning[3] Perceived welcome in host country[3] Balanced acculturation to ethnic and host culture[3] Social support from own community[2] Acculturation/Adjustment to host culture[2]	Self-efficacy, self-esteem, control, hope, certainty, or optimism[15] Resilience[10] Sense of coherence[7] Emotion-focussed coping/Emotion regulation (More[5], Less[2]) Cognitive coping[5] Problem-focussed coping[3] Atomistic perspective of time (present and/or future focussed)[2]
LMICs	Male gender/Sex[8] Age (Younger[4], Older[2]) Education (Higher[4], Lower[3]) Ethnicity/Region of origin[3]	Income[4] Employment[3] Time in host country (More[2], Less[2])	Receiving or perceiving social support[7] Support network[3] Single[3] Willingness to share problems[2]	Self-efficacy, hope, or perceived control[5] Resilience[3] Problem-focussed coping[3] Less emotion-focussed coping[2] Lower symptom awareness/ Normalisation[2]

Socio-demographic characteristics

Age (investigated in 90 studies). There was strong evidence, particularly in HICs, that younger age (n=31) was associated with better mental health outcomes in refugees – including lower levels of PTSD, depression, anxiety, and better quality of life (19, 43-54). To a lesser extent, some evidence (n=10) also suggested that older age was linked with better mental health outcomes (55-62). In research conducted in LMICs, the evidence was more mixed: most studies found no link between age and mental health (n=8), while a handful of studies found a link between better mental health outcomes and younger age (63-65), older age (66), or mix a both (67).

Gender/sex (investigated in 90 studies). Across studies conducted in HICs and LMICs, male gender/sex was consistently linked to better mental health outcomes (n=46). For example, being male was associated with better scores on mental health indices relating to PTSD, depression, anxiety, and well-being (19, 23, 43, 48, 51, 52, 65, 68-94). Only a handful of studies (n=5), conducted in HICs, found that female gender/sex was associated with better mental health outcomes (77, 91, 92, 95, 96).

Education (investigated in 54 studies). The association between education level and mental health in refugees was mixed across studies conducted in HICs and LMICs. Both higher levels of education (n=15; (55, 91, 94, 97-102)) and lower levels of education (n=7; (43, 64, 84, 90, 93, 103, 104)) were associated with positive mental health outcomes, including lower levels of depression and higher levels of resilience and wellbeing. While the majority of research more broadly suggests that higher education was associated with good mental health (105), there are several explanations which may account for the discrepant findings in this review. First, individuals with higher education are disproportionately persecuted due to involvement in political activities in their home country, which may lead to a greater burden of psychological symptoms (106). Alternatively, individuals with higher education may be less likely to find employment opportunities in the resettlement environment that match their previous experience, potentially contributing to poorer mental health.

Understanding the findings.

'n' refers to the number of studies which found the specified relationship.

Comparing the number of studies which have investigated a factor with the number of studies that found a significant relationship can provide some information regarding the extent of available evidence.

This approach should be treated with caution, however, since it does not consider the quality of evidence in those studies.

Ethnicity/region of origin (investigated in 18 studies). Due to the heterogeneity of factors investigated across studies, a consistent picture did not emerge when examining the association between ethnicity or region of origin and mental health. Some studies (n=6) found that refugees from Somalia had more positive mental health outcomes, such as lower levels of PTSD, depression, and anxiety, compared to individuals originating from other regions including, but not exhaustively, Afghanistan, Kenya, and Burundi (72, 77, 88, 101). There was also evidence to suggest that refugees originating from Africa (vs a range of other regions, (58, 107)), Afghanistan (vs Africa, (43)), Eastern Europe (vs Africa, (73),

Middle East/North Africa) and Asia (vs Oceania, (100)), Eritrea (vs Syria and other regions, (108)), and Syria (vs Afghanistan, (109)) had better mental health outcomes. Being Tamil- (vs Farsi, (110)), English- or Arabic-speaking (vs Farsi, Somali, and Dari speakers, (75)) was also associated with better mental health outcomes.

External Factors

Physical resources (investigated in 18 studies). In studies conducted in HICs, there was some evidence to suggest (n=7) that better housing conditions were associated with better mental health outcomes. For example, living in community settings (rather than refugee camps or housing; (53, 100, 109, 111)), being satisfied with housing (93), living in stable uncrowded housing (112), and owning a house (113) were associated with better mental health outcomes, including lower levels of psychological distress and better quality of life. In contrast, one study conducted in a LMIC found that individuals living in refugee camps had higher levels of resilience than those living in community settings (98).

The association between healthcare and mental health outcomes was only investigated in HICs (n=6). The majority of studies (n=4) found no association between healthcare related factors (e.g., having healthcare access or insurance, participating in health examination) and mental health outcomes (107, 111, 114, 115).

Immigration and visa status (investigated in 21 studies). While this factor was only investigated in HICs with permanent refugee resettlement programs, permanent and protected (secure) visa statuses emerged as one of the strongest and most consistent predictors of good mental health (n=14). Across cross-sectional (n=9) and longitudinal studies (n=5; four of which were conducted in Australia), having a secure visa status (vs insecure visa status) was associated with better and improving mental health including lower levels of PTSD, depression, and anxiety symptoms (45, 51, 72, 79-81, 86, 116). In contrast, one study found that insecure visas were associated with higher levels of resilience (i.e., adaptability, acculturation, and social support) (117). In a handful of studies, no association was found between mental health and visa status (cross-sectional, n=3; longitudinal, n=1) nor length of time with a residence permit (80).

Income (investigated in 10 studies). Few studies examined the association between income and mental health in refugees. Some evidence in LMICs suggested higher levels of current (n=5; (98, 118-121)) and premigration (122) income were associated with lower levels of depression and PTSD and greater resilience and posttraumatic growth (PTG). In HICs, the evidence was more mixed. Three studies found no association between income and socioeconomic status with mental health, whereas in another study, income was differentially associated with mental health

Longitudinal studies provide rich insights into the temporal ordering of factors influencing mental health. Take the example of visa status; longitudinal studies found that changes in visa status *preceded* improvements in mental health outcomes, whereas cross-sectional studies only highlight an *association* between visa status and better mental health.

Experimental studies allow for inferences to be made about causality and are useful to examine how factors can be enhanced or reduced. For example, in an experimental study investigating self-efficacy, participants in Group 1 completed a task that targeted and enhanced self-efficacy, while participants in Group 2 completed a task that did not target self-efficacy (3). The findings that Group 1 showed *reduced* psychological distress compared to Group 2 suggest that self-efficacy plays a causal role in promoting good mental health.

outcomes depending on the ethnic group (48).

Employment (investigated in 38 studies). Across some studies conducted in HICs (n=13) and LMICs (n=3), being employed was associated with better mental health outcomes including greater happiness, wellbeing, and lower psychological symptoms (45, 46, 48, 55, 61, 78, 79, 91-93, 123-125). Other employment factors, including occupational adjustment (126) and job satisfaction (127), were associated with better mental health outcomes, although there was no evidence to suggest that occupation type (66) or provision of host language training (43) was associated with mental health. Regarding pre-migration employment, one study found that being employed in a low-prestige job in the country of origin was associated with lower depression and PTSD following resettlement (103), but another study did not find any association between pre-migration employment status and mental health (128).

Socio-Cultural Factors

Institutional support (investigated in 7 studies). There was little evidence to suggest that institutional support was associated with mental health outcomes. Two studies found that receiving support from a range of institutions like government, family, or non-governmental organisations (NGOs) was not associated with mental health (121, 129). In contrast, one study found that receiving public financial assistance was associated with *higher* depression and anxiety for newly settled refugees and Lao refugees specifically (48). In four other studies, however, there was no association between social security payments and mental health outcomes (43, 67, 95, 119).

Time in host or resettlement country (investigated in 46 studies)**.** The association between how long an individual had lived in their host/resettlement country and mental health was inconsistent across studies conducted in HICs and LMICs. Of the studies conducted in HICs (n=39), five studies found that shorter time lived in the host/resettlement country was associated with better mental health outcomes, including lower psychological distress, depression, and anxiety (48, 75, 91, 92, 126), while in seven studies, longer time was associated with better mental health outcomes (76, 79, 87, 88, 123, 128, 130). In studies conducted in LMICs (n=7), two studies found that living for a shorter time in the host/resettlement country was associated with less negative affect and greater quality of life (66, 131), whereas one study found that living longer in host/resettlement country was associated with lower levels of neuroticism (64).

Family resilience (investigated in 3 studies). Across three studies, all conducted in South Korea, family cohesion and resilience, but not adaptability (the degree to which families can cope with change), were associated with better mental health outcomes such as lower levels of suicidal ideation, depression, and greater resilience (118, 132, 133).

Host language proficiency (investigated in 27 studies). All studies examining the association between host language proficiency and mental health in refugees were conducted in HICs. Across 11 studies, greater proficiency or confidence in the dominant language in the host country was associated with better mental health outcomes such as lower anxiety, depression, PTSD, and psychological distress (34, 45, 48, 58, 61, 73, 134, 135). In one study, however, the protective effect of host language proficiency was only present immediately after resettlement and did not translate to improvements in wellbeing over time (93). In some studies (n=3), the protective effect of host language proficiency was only found in specific ethnic and cultural groups but not others (48, 91, 92), while others found no association between language proficiency and mental health (n=14).

Presence of support network (investigated in 58 studies). Across 13 studies, nearly all conducted in HICs, having a strong support network (e.g., having a large friendship network, living with a partner or family member, having family in the host country) was associated with positive mental health outcomes including lower psychological distress, depression, PTSD symptoms, and better psychological functioning and life satisfaction (48, 54, 62, 66, 74, 95, 101, 113, 114, 134, 136-138).

Most studies found no association between marital status and mental health outcomes (n=23). However, some studies (n=5) found

that being married was associated with better mental health outcomes in some domains, including lower psychological symptoms and suicidal ideation (47, 117, 119, 128, 139). Another two studies presented mixed results, with married participants demonstrating greater resilience and lower depression, but also greater financial anxiety and nightmares (59, 140). Regarding having children, results were also mixed. One study found no association between mental health and having children, three studies found that having no children was associated with better mental health (58, 101, 141) , and one study found that greater number of children was associated with lower psychological burden (but not wellbeing nor specific psychological symptoms) (73). Together, these mixed findings suggest that having fewer social responsibilities (i.e., being single, having no children) can be protective against poor mental health (n=6) (58, 64, 89, 101, 103, 141). This finding highlights the complexity of the association between social factors and mental health; while greater social connectedness can promote wellbeing, the increase in social responsibility or burden associated with supporting family members may have negative mental health effects.

Received/perceived social support (investigated in 43 studies). The majority of studies (n=27) found that greater social support (including perceived social support, satisfaction with social support, and strength of social relationships) was associated with better mental health outcomes such as lower psychological distress, risk of psychiatric disorders, and greater emotional health and quality of life (34, 54, 93-95, 123, 142-145). Some studies, however, found no association (n=9) or demonstrated mixed findings depending on the type of support received/perceived (n=6; (82, 102, 135, 146, 147)). One study found that less social support was associated with lower levels of depression (103). In LMICs, some studies (n=4) found that practical (e.g., instrumental or informational) support was more strongly associated with positive mental health outcomes than other forms of support (e.g., emotional support) (64, 148-150).

Religion (investigated in 15 studies). Nine studies, primarily conducted in HICs, found that identifying with a particular religion (73) or greater religiosity/use of religious coping (n=8; (83, 122, 130, 151-155)) was associated with better mental health outcomes – including lower PTSD, depression and anxiety symptoms and greater posttraumatic and spiritual growth. Five studies, all conducted in HICs, found no association between religiosity or identifying with a particular religion and mental health outcomes.

Social engagement (investigated in 56 studies). Different domains of social engagement were investigated across studies. Eight studies found associations between general indicators of social engagement (e.g., social coping, interpersonal trust, social capital) and positive mental health outcomes such as better quality of life and decreased PTSD and stress symptoms (51, 52, 84, 90, 94, 155-158). Five studies, all in HICs, did not find an association between social engagement and mental health.

In regards to social engagement specific to an individual's own community, greater engagement was found to be associated with lower PTSD symptoms and greater PTG, life satisfaction, and psychological adjustment (57, 78, 159, 160). In contrast, 12 studies found no or weak associations between engagement with own community and mental health. Relatedly, other studies (n=8) found that stronger ethnic identity or support from one's ethnic community was associated with better mental health outcomes including lower PTSD and depression symptoms and greater life satisfaction (57, 78, 87, 88, 97, 159-161). Two studies found that *lower* intra-ethnic identification (i.e., identification with any

ethnic group from the country of origin) was associated with lower psychological distress (134, 135).

Some studies also examined the association between social engagement with host community and mental health. Five studies, all in HICs, found that greater acculturation or cultural competence in the host country was associated with positive outcomes including greater life satisfaction, psychological adjustment, and lower depression symptoms (57, 87, 125, 133, 159). Three studies found, however, acculturation that was balanced between ethnic and host cultures was associated with positive mental health outcomes (134, 135, 138). Feeling more welcome in the host country (83, 159, 161) or having one's expectations of the host country met (162) were similarly associated with positive mental health. Nine studies, however, found no or weak associations between mental health and social engagement with host country (e.g., acculturation, strength of support network in host country, host country identity).

Internal Factors

Glossary of Terms

Definitions are adapted from the APA Dictionary of Psychology (2), unless otherwise indicated.

Emotion regulation. An individual's ability to modify or control an emotion or set of emotions.

Emotion-focused coping. A stress-management strategy in which an individual focuses on regulating their negative emotional reactions to a stressor. Rather than taking actions to change the stressor itself, the individual tries to control their feelings using a variety of cognitive and behavioural tools, including meditation and other relaxation techniques.

Expressive suppression. A form of emotion control in which, following an event that has triggered an emotional response, an individual suppresses the urge to react emotionally to the event.

Flourishing. A condition characterised by good mental and physical health - the state of being free from illness and distress but, more importantly, of being filled with vitality and functioning well in one's personal and social life.

Hardiness. An ability to adapt easily to unexpected changes, combined with a sense of purpose in daily life and personal control over what occurs in one's life.

Posttraumatic growth (PTG). A positive psychological change experienced as a result of the struggle with highly challenging life circumstances (12).

Problem-focused coping. A stress-management strategy in which an individual directly confronts a stressor in an attempt to decrease or eliminate it.

Psychological flexibility. A dynamic process characterised by the ability to: (1) adapt to fluctuating situational demands, (2) reconfigure mental resources, (3) shift perspective, and (4) balance competing desires, needs, and life domains (15).

Re-appraisal / reframing. A process of reconceptualising a problem or event by seeing it from a different perspective.

Resilience. The process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands.

Self-efficacy. An individual's subjective perception of their capability to perform in a given setting or to attain desired results.

Self-esteem. The degree to which the qualities and characteristics contained in one's perception of themselves is perceived to be positive.

Sense of coherence. A dispositional orientation that reflects an individual's capacity to respond to stressors in daily life. It includes three components: comprehensibility, manageability, and meaningfulness (7).

Somatisation. The expression of psychological disturbance in physical (bodily) symptoms.

Symptom normalisation. The extent to which an individual believes their symptoms are a natural response to their situation (17).

Cognitive strategies (investigated in 8 studies). While few studies examined the association between cognitive strategies and mental health, the findings were relatively consistent. Six studies found that engaging in cognitive coping strategies (including cognitive reappraisal, positive appraisal, and positive reframing) was associated with better mental health outcomes, including lower perceived stress, lower PTSD symptoms, and greater wellbeing (99, 157, 160, 163-165). In contrast, one study found that engaging in cognitive reappraisal was not associated with depression, psychological burden, PTSD, panic, anxiety, or wellbeing. Another study found that less downward social comparison (i.e., seeing another individual as worse off than oneself) was associated with lower PTSD symptoms (166), but upward social comparison was not associated with PTSD symptoms.

Emotion-focused coping and emotion regulation (investigated in 13 studies). The association between emotion-focussed coping and mental health was mixed across studies (which were primarily conducted in HICs). In four studies, engaging in more emotion-focused coping was associated with at least one positive mental health outcome including better quality of life, PTG, and lower depression (156, 157, 167, 168). In contrast, two studies found no association between emotion-focused coping and PTG (70, 169) while, in another study, emotion-focused coping was associated with *greater* psychological distress and neuroticism (64).

In regard to emotional regulation strategies, two studies drawing from the same sample found that greater emotion regulation variability (i.e., more flexibility in the use of emotion regulation strategies) and emotion regulation capacity (indexed by heart rate variability) was associated with better mental health outcomes including lower PTSD avoidance symptoms and negative affect (170, 171). Another emotion regulation strategy - expressive suppression - was associated with mixed findings. In one experimental study and two other cross-sectional studies, less expressive suppression was associated with better mental health (132, 160, 172). In one study, however, expressive suppression was associated with lower depression symptoms (but not any other specific psychological symptoms) (73).

Problem-focused coping (investigated in 13 studies). Five studies found that engaging in more problem-focused coping was associated with at least one positive mental health outcome including lower PTSD symptoms, lower perceived stress, and greater PTG (122, 156, 157, 168, 173). Seven studies found no association between problem-focused coping and mental health outcomes while one study found that engaging in *less* problem-focused coping was associated with lower PTSD symptoms (70).

Self-efficacy and other related concepts (investigated in 30 studies). Research has consistently indicated that self-efficacy is associated with positive mental health outcomes in refugees. Ten studies found that a greater sense of efficacy (self or collective) was associated with better mental health outcomes including lower PTSD, anxiety, and depression symptoms as well as greater resilience (59, 63, 131, 174-179). Three studies found that greater perceived control was associated with better mental health outcomes including general mental health and life satisfaction (66, 96, 180). Other studies found that greater hope (94, 164), sense of certainty (166), optimism (83), hardiness (181), and psychological flexibility (45) were associated with at least one positive mental health outcome. Greater self-esteem was found to be associated to lower risk of suicidal ideation in one study

(60), but not another (132), and greater life satisfaction (182).

Seven studies (all in HICs) found that a greater sense of coherence was associated with better mental health outcomes, including better general mental health, such as lower PTSD, anxiety and depression and somatisation symptoms and higher quality of life (49, 91, 92, 96, 129, 143, 158). One study found no association between sense of coherence and mental health and, to the contrary, another study found that *lower* sense of coherence was associated with lower risk of PTSD (183).

Resilience (investigated in 22 studies). Overall, research has documented a positive association between resilience and mental health outcomes. Across HICs and LMICs (n=14), greater resilience was associated with better mental health outcomes, including lower psychological distress, depression symptoms, anxiety symptoms, and PTSD symptoms, as well as higher wellbeing, PTG, life satisfaction, and flourishing (23, 50, 56, 94, 104, 120, 123, 173, 177, 184-188). A handful of studies (n=4) found no association between resilience and mental health, while one study found that resilience was *positively* associated with perceived stress (140). This finding is likely reflective of resilience being defined as the capacity to withstand adversity, and perceived stress representing a central component of that adversity.

Health beliefs (investigated in 4 studies). The association between health beliefs and mental health was only investigated in LMICs, and findings were mixed. Greater symptom normalisation - the extent to which someone believes their psychological symptoms are a natural response to their experiences - was associated both with poorer mental health outcomes (i.e., greater somatic, PTSD, anxiety, and depression symptoms; (65)) and better mental health outcomes (i.e., lower PTSD and depression symptoms; (84)). In one study, health literacy was associated with reduced likelihood of impaired psychological wellbeing (115), while in another, health literacy was not related to mental health (107).

Other factors. Two studies, conducted by the same research group, found that avoidance of the past (i.e., non-nostalgia) was associated with lower depression at baseline (46, 47). A second study with Southeast Asian refugees in Canada found that an atomised perspective of time (i.e., seeing no relationship between past, present and future) and future orientation was associated with lower risk of depression.

Limitations

There were several limitations associated with the studies in the current review that provide important potential avenues for future research.

Firstly, the vast majority (82.8%) of included studies were cross-sectional in nature, as opposed to longitudinal (15.5%), or experimental (1.7%). While these studies provide important information regarding the association between protective and promotive factors and refugee mental health, cross-sectional designs preclude inferences regarding causality. Therefore, there is still limited evidence for the specific protective and promotive factors that are responsible for positive mental health and resilient outcomes.

A second limitation of studies in this review relate to methodological concerns around 1) lack of standardisation in operationalising and measuring constructs and 2) significant degree of construct overlap in examined factors like posttraumatic growth, self-efficacy, and sense of coherence. Moreover, while our quality assessment process evaluated studies in terms of whether their instruments were validated in war, conflict and/or flight affected populations, it did not specifically consider the cross-cultural validity of the instruments. Together, these methodological concerns pose some challenges to the synthesis of information and thus their interpretation.

A final limitation of the studies in the current review relates to the siloed nature of research across multiple domains. Traditionally, research on external and internal factors influencing mental health has been underpinned by different theoretical perspectives and methodological approaches. Accordingly, factors from different domains have been examined individually. While this allows for a fine-grained consideration of how specific factors relate to mental health, in reality it is likely that factors across domains affect one another or even interact to influence mental health outcomes (19, 37, 39). For example, an individual with insecure visa status may experience decreases in their sense of self-efficacy, which may lead to increased psychological symptoms over time. Alternatively, for an individual separated from their family, strong emotion regulation skills may be protective against poor mental health. Further, important aspects of identity (e.g., ethnicity, religion, gender/sex, age) may intersect to influence mental health. To gain a comprehensive picture of factors influencing refugee mental health, studies should investigate factors across and within domains. Understanding how internal and external factors intersect to protect or promote refugee mental health will inform multi-faceted policies and programs that support wellbeing for individuals and communities.

05
Recommendations

The current report presented a synthesis of 174 studies investigating protective and promotive factors for refugee mental health. Findings highlighted the key factors associated with positive mental health outcomes across sociodemographic, external, socio-cultural, and internal domains. This information is important to inform policy and programming of government and NGOs in Australia who are tasked with supporting refugees and asylum-seekers to adapt to resettlement environments.

A critical summary of the review, with emphasis placed on findings relating to HICs to more closely reflect the Australian context, is provided below, along with related recommendations.

Tailoring support to the needs of specific refugee groups

Key sociodemographic characteristics that were associated with mental health outcomes included age, gender/sex, education level, and ethnicity/region of origin.

Specifically, there was strong evidence in HICs that younger age and male gender/sex was associated with better mental health outcomes. These findings suggest that female refugees and older refugees may be particularly vulnerable to mental health problems and benefit from specific and tailored support. These findings are consistent with the identification of older and female refugees as priority groups in humanitarian settings (189-191).

It should be noted, however, that internalising mental health disorders, such as depression and anxiety, often manifest in men as externalising symptoms, such as drug and alcohol use, violence, and risk taking (192) – outcomes which were, to some extent, outside the scope of this review. This is a key avenue for future research. Nonetheless, together the findings from the current review suggest that specific sub-groups of refugees have unique circumstances and challenges that may be best addressed through a tailored approach to programming.

The evidence around education level and ethnicity/country of origin was relatively less interpretable. The mixed findings relating to education level, however, should be situated in the context of the broader literature where higher education is robustly associated with positive mental health outcomes (105). This is consistent with the national settlement framework which identifies ‘education and training’ as one of nine priority areas (193).

Moreover, while the mixed findings relating to ethnicity/country of origin are primarily a reflection of the heterogeneity of research methods, it also speaks to the considerable diversity across refugee populations, pointing to the need for culturally appropriate and targeted services (194).

Going beyond basic needs: fostering an environment of security and controllability

Consistent with theoretical models and empirical evidence, environmental factors demonstrated a powerful effect on the mental health of displaced persons. Unsurprisingly, good housing conditions, employment, and financial security demonstrated strong associations with positive mental health outcomes in refugees. These findings are also consistent with the inclusion of ‘employment’ and ‘housing’ as priority areas in the national settlement framework and highlights the

critical importance of these targets to successful settlement (193).

Across studies in HICs, however, holding a protected or permanent visa status was one of the strongest and most consistent predictors of good mental health in refugees. This finding was supported by four longitudinal studies conducted in Australia (195-198) which demonstrated that having a permanent visa status was associated with significant improvements in mental health. These findings highlight that, in an external environment where basic needs are met, fostering a sense of predictability, safety, control, and certainty is critical in the resettlement process.

Accordingly, governments and NGOs should work to facilitate positive mental health outcomes by providing permanent resettlement options where possible and providing clear communication regarding immigration policies and timelines.

Empowering communities to support each other

There was also considerable evidence to suggest that socio-cultural factors were associated with better mental health outcomes in refugees. Findings in this review suggest that social support across a wide range of domains including at the individual level (feeling supported by friends or family), family level (having family in the host country), and community level (engaging with the one's own cultural community and the host community, engaging in religious practice) played an important role in refugee mental health.

Indeed, refugees are typically from collectivistic cultures that place high value on interdependent relationships with others as being integral to self-identity (74, 199).

Thus, this body of evidence highlights the need to move beyond the individual level when developing policies and programs to support refugee mental health. Supporting refugee communities to retain their cultural and religious ties, providing resources that allow for the sharing of emotional and practical support, and facilitating the development of language skills should be prioritised.

Moreover, some evidence suggests fewer social responsibilities (e.g., having no children, being single) is protective against poor mental health, potentially due to the increase in practical responsibilities that following having dependent family members (74). Thus, providing support for childcare or caring for dependent family members could be another potential target. There is also some limited evidence to suggest that family- (e.g., Bunn and colleagues (200)) and community-based (e.g., Goodkind and colleagues (201)) programs have a positive impact on the mental health of refugees and families, and this may be an important avenue for future investigation.

Together, these findings speak to the complexities of socio-cultural factors. Thus, there is a need to consider heterogeneity in preferences for, and the impact of, social support across cultural groups when developing programs.

Centering considerations of internal factors into settlement

Despite attracting relatively less research attention than other domains, internal factors demonstrated the most consistent protective/promotive effect with mental health outcomes. Some key factors associated with better mental health

included engaging in cognitive strategies, emotion-focused coping, problem-focused coping, and specific emotion regulation strategies. These findings highlight that psychological and cognitive factors are important pathways to supporting refugee mental services, particularly since they are malleable in nature. Prioritising access to mental health services that assist clients in developing these psychological skills is a key pathway to support the wellbeing of refugees. Further, integrating programs that develop skills relating to emotion regulation and specific coping strategies into refugee services represents an important potential avenue for enhancing wellbeing amongst refugees, potentially even in settings with significant uncontrollable stressors. This can also be done by training settlement and community workers to support the development of these skills in their clients.

Furthermore, the robust findings demonstrating the association between feelings of self-efficacy, control, and sense of coherence, and better mental health outcomes suggests that the extent to which an individual feels capable or in control when faced with adversity may be protective against poor mental health outcomes. Thus, it is important to center feelings of self-efficacy, control, and certainty into the resettlement process and, potentially, community programs. In addition to increasing transparency around immigration policy, other practical applications may focus on ensuring easy access to information and resources that refugees can retain beyond their engagement with settlement services.

Summary of recommendations

Targeting vulnerable groups	Meeting basic needs	Empowering communities	Centering the internal
• Female refugees • Older refugees • Refugees with lower levels of education	• Providing access to good housing • Enhancing access to employment services • Providing permanency and security (e.g., through permanent visas)	• Facilitating social connectedness at the individual, family, and community level • Promoting refugees' ties to own cultural and religious community, as well as host community • Enhancing acculturation to host country (e.g., providing language training, conveying sense of welcome)	• Embedding self-efficacy, sense of coherence, control, and resilience into settlement process • Prioritising access to mental health services • Upskilling settlements workers to support development of cognitive and coping strategies in refugees

Conclusion

Refugee research has often been criticised for its deficit-model approach, emphasising psychopathology at the expense of understanding the resilience and unique strengths of refugees (2-5). A similar commentary has been raised in the Australian context, with some researchers calling for a practical, strengths-based approach to support a sense of agency within refugee communities and ultimately facilitate social inclusion (2, 5).

A systematic synthesis of results from 174 research papers in this report suggest that there is a robust, and growing, evidence base to inform a strengths-based approach to resettlement. Key findings which have emerged from the literature show that providing refugees with adequate resources, facilitating strong social connections, and drawing on and building psychological skills represent important pathways in settlement services to foster good mental health outcomes amongst displaced individuals and communities.

These findings also highlight two broad implications for future directions: 1) researchers should actively seek to adopt a strengths-based lens in their research methodology and 2) there is growing evidence in support of structural reform that embeds strengths-based approaches to programming and resettlement policy. This reform can be facilitated by listening and responding to insights from communities. This will require actions, strategies and resourcing from governments, NGOs, and service providers that are underpinned by scientific evidence to support good mental health outcomes amongst refugee communities.

06
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