

RAS Clinical Activities at Mangere Refugee Resettlement Centre (MRRC)

1. Rationale and Objectives for RAS Clinical Programmes

1. Rationale

Newly arrived Quota Refugees and Asylum Seekers who are in the early stages of resettlement in New Zealand have typically experienced long periods of uncertainty during which they have had little control over events. These experiences have been disempowering for them. Many have been traumatised by experience of physical or psychological harm or threat of harm to themselves or their loved ones. Some have been tortured.

A large body of international research shows that some refugees develop clinical levels of psychological distress as a result of these experiences. Such poor mental health may be of long duration unless culturally sensitive mental health services are provided by practitioners that have specialist knowledge of refugee mental health issues. Research also shows that, for some, the additional stresses of resettlement contribute to poor mental health in the resettlement country. The limited number of studies of refugees who resettle in New Zealand show that they resemble refugees elsewhere and that a significant minority are deeply distressed long after the period of initial resettlement.

Most refugees come from countries where there is little provision for those with poor mental health and where traditional beliefs about its nature and causes still prevail. In these communities poor mental health is highly stigmatised. The great majority of refugees do not discuss issues relating to poor mental health outside their immediate family. Given the stigmatization and the unfamiliarity with mental health services, it is considered that refugees and asylum seekers are best served by a specialist agency, with staff that become well-known and trusted by the client group. RAS (Auckland Refugees as Survivors) is funded by the Ministry of Health to make an initial assessment of the mental health status of newly arrived Quota Refugees during the 6 week period they spend at the Mangere Refugee Resettlement Centre, for Asylum Seekers, and to provide treatment for children, adolescents and adults who present with mental health problems.

2. Supporting Research

Traumatic experiences that rupture people's sense of predictability and invulnerability can profoundly alter the ways that they subsequently deal with their emotions and with their environment. Post Traumatic Stress Disorder (PTSD) can follow different stressors as war, imprisonment and torture, persecution, physical and sexual assaults, accidents, and other natural and man-made disasters.

Several studies in recent years have shown that PTSD is among the most common of psychiatric disorders. The National Vietnam Veterans Readjustment Study (Kulka et al, 1990) found that approximately twenty years after the end of the Vietnam war 15.2% of Vietnam theatre veterans continued to suffer from PTSD. However, PTSD is not confined to combat soldiers, but is quite common in the general population, particularly among psychiatric patients. Various studies have demonstrated a life time prevalence of between 1.3% (Helzer et al, 1987) and 9% (Breslau & Davis, 1991) in the general population and at least 15% in psychiatric inpatients (Saxe et al., 1993). PTSD is associated with high levels of chronicity, co-morbidity and functional impairment.

Among the refugee field, international research shows that people with refugee like backgrounds have greatly elevated rates of poor mental health in comparison with local populations. They are often co-morbid for two and sometimes three major psychiatric disorders, the commonest combinations of these being anxiety, depression and (PTSD). (Summarised in Appendix 1).

Overseas studies show that these disorders do not spontaneously resolve for all sufferers in the medium term (up to about 10 years) although some do recover slowly over that period. Further, chronic PTSD is associated with changes in brain structure, biochemistry and functioning. The disorder appears to have a kindling effect for depression and anxiety, but these two disorders become increasingly independent of the PTSD over time, increasing the likelihood that patients will develop these disorders in response to non-trauma related problems of daily living (Van der Kolk, 1996).

In New Zealand, studies of resettled refugees in the community have yielded similar data to that obtained overseas. Pernice and Book (1994) and Liew (1995) both reported that 29% of their samples were suffering from clinical levels of depression, Reeve found that 7% of a sample at Mangere Refugee Resettlement Centre had PTSD and Cheung reported 12% PTSD in a community sample. Clinical levels of anxiety were reported for 15% and 39% of the samples in the Pernice and Brook and Liew studies respectively. Asylum seekers are also identified as having high levels of mental health problems in New Zealand. Auckland Public Health Protection referred 18% of asylum seekers they assessed to RAS for assistance with mental health problems during the period 1999-2000 (Hobbs, Moor, Wansbrough & Calder, 2002).

3. Clinical data obtained at RAS

Data gathered during the period 2001-2002 revealed that 38% of clients met criteria for clinical levels of depression, 22% had PTSD and 50% had anxiety disorders. Many were co-morbid for two of these disorders and some had all three. These results were obtained during a period when clients at RAS included newly arrived quota refugees, resettled refugees from the community and asylum seekers waiting the outcome of their application for permanent residence. Jackson K. (2004), unpublished.

4. Objectives

- Assessment of mental health status of refugees and asylum seekers
- Treatment of newly arrived refugees and asylum seekers who are experiencing significant psychological distress, above and beyond that typically experienced by the group during a period of change
- Education about stress and how it affects body, mind and behaviour
- Introduction to some skills and knowledge that empower newly resettled refugees once they leave MRRC
- Appropriate and early social service referrals to RMS (Refugee Resettlement Service), Clinical referrals to GPs and Community Mental Health Services (CMHC).