Barriers and solutions to sound mental health for refugees and migrants of Arabic backgrounds-

Preventative measures

- **Barriers:**

Prevention is better than a cure!

From my experience of my own community being a former Iraqi refugee about 20 years ago, I believe that collectively the Arabic speaking community along with the mental health practitioners needs to focus on the concept of mental health issues 'prevention in terms of *self-care* for the new and emerging Arabic refugee communities.

While for a great number of those families with mental health issues fleeing war zones, cure in terms of accessing traditional mental health service is definitely needed and urgently! However for many refugee individuals and communities who are either declining access to mental health care for cultural reasons OR are at-risk of developing mental health issues, I suggest a prevention model, which supports the existing mental health services in addition to the proposed mental health proposal by the Foundation House Advisory Group. The proposed prevention model wraps around the concept of *Self-Care*.

The Understanding of the Term "Self-Care"

The concept of *self-care* is undoubtedly one of the leading factors for sound mental health and wellbeing for any person to protect them from mental health issues down the track.

However the concept in many of the Syrian and Iraqi communities may look quite differently to the way self-care is practiced in Australian mainstream communities. While the term self-care may be translated in a broad range of activities in Australian communities ranging from a simple morning yoga sessions to calling the doctor when being sick mentally or physically, typically these former refugee and migrant communities may lack this kind of understanding of this type of self care and even sometimes discouraged from doing them so as to not to show signs of weakness, speaking of experience being a former refugee myself.

Individuals are strongly being told to soldier on in their different life stages and roles, as a child, mother, father, worker and elderly. The practice has its roots in the way traditional Arabic communities live in communal manners where individuals blend in a network of core and extended family, tribal members and even local area residents to rely on for general support which all of this support network fades in resettlement journey and the now-refugee becomes lost without any network of support while still unaware of self-care and self-prioritisation concepts as adopted by his/her new cultural surroundings.

This in itself creates lots of twists and turns for sound mental health for individuals of these communities but also for the mental health workers as the problem has root causes stemming from the way individuals view and prioritise their own health.

- **Solutions:**

Following on from the above, the solutions in my opinion to good mental health practice in these communities should include a great deal of education and awareness-raising on a broad range of self-care topics and practices starting from simple discussion about the importance of self care to real-life mentoring programs for these communities. The way I see real life mentoring would include some aspects of:

a) **1:1 coaching/mentoring** for those requesting deeper understanding and practice of own self-care

b) **Group coaching/mentoring:** this might include a combination of workshops and family outings with excursion/ incursions that focuses on various topics. Some suggestions include:

1- Sports and general personal wellbeing sessions of gym, yoga and physical activity. Please see [redacted] 2020 Active strategy which clearly illustrates the gap of physical centers' access by refugee communities although the existence of the sports infrastructure in their local area.

2- Personal boundaries workshops: I have been to a few of these workshops and for me being of my own background, some of the content was eye opening for me and have learnt a lot.

3- Good parenting tips and practices: many parents used to share the load with extended family members which they don't have anymore in settlement land hence parents tend to overload and burn out and never touch on the concept of self care to maintain the balance between parenting and mental health. Workshops are to be conducted in a culturally sensitive manner by professional parenting experts.

4- General excursions: Many of the refugee communities are fighting to establish themselves financially and hence self-prioritisation is down the bottom of their list, refugee families tend to feel isolated and burnt out but never think of establishing good practices of self care visiting local places and attractions. For example, I have worked in a youth organization called Beacon of Hope offering recreational events for young people of diverse backgrounds. The events that we used to run going on snow trips for example was very new to many individuals and very popular not to say life changing to some. Many start to form trust relationships with other young people and general populations helping them establish better connections with the people and the land while also easing some of the mental pressure they may have had from previous war torn areas.

5- Supporting their own cultural celebrations: In the process of acculturations where acculturative stress in migration has been identified as a mental health risk factor, and while this process is dependent on the attitudes of both the migrant and host groups[1], it is evident that supporting this process will alleviate some of the stress

[1] The Increased Vulnerability of Refugee Population to Mental Health Disorders https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5834240/ and Effects of acculturative stress on

due to the resettlement and assist in preventing mental health issues across vast majority of community sectors. Supporting community events like community festivals with grant money or mentoring programs would support the cultural recognition of these communities and individuals.

Two very important solutions to educating and increasing awareness within these communities are:

1- Empowering refugee communities:

Many, if not the vast majority, of the mental health initiatives are not led by or involve consultation with refugee communities and talents themselves but provided *for* them. The practice needs to shift the focus from using mainstream western model to working on models that works *with* these communities. There is no denying that there are service access issues by community members for cultural and pre-perceived beliefs and this possibly requires a model where refugee communities feel they are empowered to take control of their own mental health issues working alongside mental health professionals in a manner that is culturally suitable. This may look like mental health care worker accessing clients' homes or speaking the refugee's mother tongue or establishing advisory groups or even looking at re-shaping the entrance/ reception of mental health centres to cater for the taboo aspect of the mental health access in these communities.

Another point to mention that without the use of proper culturally-sensitive measures led by the refugee communities, health care professionals may miss the target. For example, the current method of working with families of Iraqi groups may involve the traditional western style of inviting the whole family to a workshop for example or working with both genders in one setting. While for effective results and for culturally-sensitive setting, workshops need to be culturally aware where the Iraqi communities are used to having separate workshops for the two genders instead of the mixed style. The mixed gender style causes women for example to shy away and men to dominate naturally in these settings hence it might not be effective for the females. Therefore empowering refugee communities to run different things according to their own knowledge of their own community might help hit the target with minimal cost and frustration for the health care workers and for the refugee communities.

2- Raising awareness of mental health services and systems in Australia:

This is definitely of paramount importance for all community members to be able to nurture community ambassadors to be advocates for mental health for their own peers of their own communities. Traditionally speaking these communities have little recognition of the type of this service being almost taboo and absent in home countries. Creating bi-cultural workers alongside culturally sensitive mental health centres is another great segue to source community trust and also to build effective mental health centres for Arabic communities of refugee backgrounds. Being aware of Foundation House's

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PTSD, depressive, and anxiety symptoms among refugees resettled in Australia and Austria https://www.ncbi.nlm.nih.gov/pubmed/26886488/).

Community Advisory group, I believe many of these resources have been built into their pilot projects and mental health library and can be accessed for such initiatives.

In conclusion:

I believe there are great current discussions on evaluating mental health access and providing alternatives for the ever-growing mental health issues in refugee communities settling in Australia especially from Arabic backgrounds. However I would like to bring to the attention the importance of the discussion of the preventative measures supplementing existing traditional mental health practices.

Above is a suggestive list, which is only bound by human imagination. I am also sure that the Arabic refugee community would be happy to engage in further conversation in terms of consultation, planning and delivery of any preventative measures and initiatives once have the opportunity.

Regards,
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