Rights-based approaches to mental health services with refugees:

An annotated bibliography

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for

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Contents

1. Introduction

The Wellington Refugees as Survivors Trust (WNRAS) commissioned this annotated bibliography to provide an overview of Aotearoa New Zealand and international literature relating to rights-based approaches to mental health services with former refugees.

The stresses experienced by refugee-background communities in Aotearoa New Zealand are multiple and cross-cutting. Inequitable access to mental health services – including the provision of health services that are not rights-based or culturally appropriate – is only one of the many challenges faced by refugees upon their arrival to Aotearoa New Zealand.

While refugee-background communities share a common burden in terms of accessing essential services (including health), 'each intake has a unique range of pre-migration, migration and post-migration experiences, as well as different... cultural values and cultural patterns of responding to stress'.[1]

A report by the New Zealand Ministry of Health acknowledges Aotearoa New Zealand's growing ethnic diversity.[2] It stipulates that mental health services must be able to respond to the unique needs of Aotearoa New Zealand's specific population groups, which implicitly includes refugee-background communities.

Acknowledging some of the specific barriers to mental health that are relevant to former refugees (e.g., language, social isolation, and disrupted families), the Ministry's report emphasises the need for responsive services that 'focus on recovery...and consider people's cultural needs as well as their clinical needs. Issues to be taken into

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[1] Te Pou. (2008). *Refugee and Migrant Mental Health and Addiction Research Agenda for New Zealand 2008-2012.* Auckland: Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.
[2] Minister of Health. (2005). *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health.

account include spirituality, family and different understandings of mental health and well-being and recovery'.[3]

There is more than just a 'need' for these services; former refugees – like everybody else in Aotearoa New Zealand – have *rights* to access mental health services that are appropriate to each person's specific culture, ethnicity, and spirituality.

In order to achieve the goals of an inclusive, culturally responsive model of mental health care, former refugees must be fully involved in developing strategies and delivering services; concurrently, those in policy and service delivery need to work to international human rights standards, and provide opportunities for refugee-background communities to present their interests and priorities.

This resource will support WNRAS in their therapy services and advocacy work, by providing summaries of relevant documents that inform and/or explain the increasing shift from welfare-based models of mental health care towards rights-based models.

2. What is a rights-based approach?

Simply put, a human rights-based approach incorporates concepts that support the realisation of human rights, such as non-discrimination, social justice, participation, and accountability.

In practice, a rights-based approach generally refers to working to a set of principles that (implicitly or explicitly) include a blend of adherence to international treaties and conventions and participatory development models.[4]

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[3] Minister of Health. (2005). Watters, C. (2001). 'Emerging paradigms in the mental health care of refugees.' *Social Science & Medicine* Vol. 52, No. 11. Mortensen, A. (2008). *Refugees as 'others': social and cultural citizenship rights for refugees in New Zealand health services.* Retrieved 15 May, 2010, from http://muir.massey.ac.nz/bitstream/10179/631/1/02whole.pdf.

[4] For a comprehensive range of definitions of rights-based approaches from UN agencies, and international development and community organisations, go to *Definitions of Rights Based Approach to*

The International Human Rights Network defines a rights-based approach as one that: (1) uses international human rights standards; (2) empowers target groups; (3) encourages participation; (4) ensures non-discrimination; and (5) holds stakeholders accountable to fundamental rights.[5]

While there is no single 'rights-based approach', it is commonly recognised in literature and practice by its pronounced and conscious shift from a welfare-based system subject to the 'vagaries of charity',[6] towards a system where people are empowered to make their own choices and claims, and where policy-makers and service providers are obligated to address those claims.

References to rights-based approaches most commonly occur in literature relating to development or aid projects in poor or conflict-affected countries. However, as some of the resources listed in this bibliography show, a rights-based approach can be – and increasingly is – applied to other initiatives that involve striving for the well-being of a population.

2.1 Human rights conventions and mental health

International human rights conventions and treaties play a key role concerning the quality of – and access to – mental health services. These instruments demand that individuals requiring mental health care are entitled to the same human rights as everybody else.

International instruments that are particularly relevant to a human rights approach to mental health care include:

Development. Retrieved 8 August, 2010, from
http://www.crin.org/docs/resources/publications/hrbap/Interaction_analysis_RBA_definitions.pdf.
[5] *Overview of a human rights-based approach to development*. Retrieved 15 May, 2010, from
http://www.ihrnetwork.org.
[6] Posner, M, & Clancy, D. (2005). *A human rights-based approach to refugee assistance.* Human Rights First. Retrieved 15 May, 2010, from
http://www.humanrightsfirst.org/intl_refugees/regions/approach_refugess.pdf.

The International Covenant on Economic, Social and Cultural Rights, which states that all individuals have the right to 'the highest attainable standard of physical and mental health'.

The International Covenant on Civil and Political Rights, which deals with a range of human rights, e.g. the right to equal protection of the law.

The Universal Declaration of Human Rights, which states that everyone has the right to a standard of living adequate for health and well-being, including medical care and necessary social services.

The International Labour Organisation ILO Convention, which notes that all people have the right to equal treatment in employment regardless of physical, intellectual, psychiatric or mental disability.

The Convention on the Rights of Persons with Disabilities, which emphasises the importance of accessibility to health services.

The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which is a useful tool with which to apply international human rights standards to those people needing mental health care. The principles have important linkages to the rights addressed in the International Covenant on Civil and Political Rights and the Declaration on the Rights of Disabled Persons.

The Principles state that all people 'have the right to the best available mental health care, which shall be part of the health and social care system', and that 'people with a

mental illness shall be treated with humanity and respect for the inherent dignity of the human person'.[7]

In Aotearoa New Zealand, the right to health is protected in the **New Zealand Public Health and Disability Act 2000.** Objectives that are relevant within a mental health context include: improving, promoting and protecting health; ensuring the best care and support of those in need of services; and reducing health disparities.

The right to health is also protected by the **New Zealand Bill of Rights Act 1990 (BoRA)**, the **Human Rights Act 1993 (HRA)**, and the **Health and Disability Commissioner Act 1994**. The HRA prohibits discrimination on the grounds of disability, race or ethnicity, sex and age, and along with the BoRA, focuses on ensuring equality.

Other conventions relevant to mental health providers working with refugees include:

- The Convention Relating to the Status of Refugees (1951)
- The Convention for the Elimination of all Forms of Racial Discrimination (1965)
- The Convention on the Elimination of all Forms of Discrimination against Women (1979) and the Optional Protocol to the Convention (1999)

3. Parameters of the literature

There is a limited amount of literature that focuses solely on rights-based approaches to mental health care with former refugees.

This bibliography reframes some of the broader issues surrounding rights-based approaches to make them more relevant to a rights-based model of mental health care with refugee-background consumers. It also places participatory and/or culturally responsive approaches in a rights-based context.

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[7] Office of the United Nations High Commissioner for Human Rights. (1991). *Principles for the protection of persons with mental illness and the improvement of mental health care.* Retrieved 13 July 2010, from http://www2.ohchr.org/english/law/principles.htm.

Research for this bibliography focused on material written in the last fifteen years. Material has been drawn from internet search engines and online journal databases. Much of the material found has been produced by advocacy, mental health, or refugee-focused organisations that share similar goals with WNRAS.

Material has also been sourced from academic publications, and from the New Zealand Government. It is interesting to note that although the Ministry of Health's 2001 resource, 'Refugee Health Care: A Handbook for Health Professionals' provides useful – although now outdated – insights into the cultural and ethnic backgrounds of the main refugee groups in Aotearoa New Zealand and guidance on conducting culturally sensitive consultations, an awareness of rights-based discourse is not apparent. In contrast, the 2007 resource from the Victorian Foundation for Survivors of Torture in Australia, 'Promoting refugee health: A guide for doctors and other health care providers caring for people from refugee backgrounds', includes a section on promoting healthcare rights and responsibilities.

4. Themes arising from the research

Literature chosen for this bibliography broadly fit the criteria of the following four areas:

1. Rights-based approaches to working with refugees
2. Rights-based approaches to health
3. Rights-based approaches to mental health
4. Rights-based approaches to mental health work with refugees

The first thematic area focuses on rights-based approaches to working with refugees. It looks at the (ongoing) paradigm shift within NGO communities from a welfare-based approach towards working within a rights-based framework.

The second thematic area focuses on similar shifts within health from traditional health projects, towards programmes that promote social change. Much of this

literature includes advocacy towards a rights-based health care approach in both policy and practice. Some researchers and/or organisations make specific recommendations, and others highlight the benefits of re-framing health within a rights-based context.

The third thematic area looks at mental health as a subset of the above, and the final thematic area, 'Rights-based approach to mental health with former refugees', captures some of the literature that focuses specifically on refugee-background communities, although it also includes other culturally and linguistically diverse (CALD) communities.

5. Overview of findings

The findings of this bibliography predominantly point to an increasing awareness of the need to move towards mainstreaming human rights-based approaches across community development and health sectors, including refugee mental health.

The literature reviewed for this bibliography revealed a mostly-shared understanding that core priorities of rights-based approaches include:

- Upholding obligations to international human rights conventions
- Providing culturally-sensitive care, including an awareness of the differences between western and other cultural models of mental health
- Involving consumers in their care
- Understanding the impact of the refugee experience (prior to resettlement and the myriad post-arrival stresses).

There is broad acknowledgement across the literature that both internationally and in Aotearoa New Zealand, former refugees experience problems in accessing appropriate mental health services because of language difficulties, inadequate information about

how to access services and lack of understanding and appreciation of cultural difference on the part of health professionals.[8] A report from the New Zealand Human Rights Commission bluntly notes that refugees settling in Aotearoa New Zealand 'could expect to experience difficulties with the health system'.[9]

For those advocating for an increase in rights-based mental health services, research that links good mental health with social and economic rights is very relevant. The New Zealand National Health Committee states that in order to improve health, the determinants of health must be understood. The Committee defined these determinants as including social and economic factors such as income, employment, education, housing, and culture and ethnicity, and concluded that 'there is now good evidence that social, cultural and economic factors are the most important determinants of good health'.[10]

Findings from the Human Rights Commission also reflect these views, commenting that some refugees claimed that 'they were denied access to the underlying determinants of health by being placed in the worst housing and were discriminated against in employment'.[11] One report in this bibliography concluded that current mental health approaches with refugee populations in Aotearoa New Zealand are unlikely to succeed unless long-term structural inequalities (housing, employment, language acquisition) are addressed.[12]

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[8] Mortensen, A. & Young, N. (2003).'Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand'. *Journal of Emergency Nursing*. Vol. 29, No. 4, pp 337-341. The New Zealand Human Rights Commission. (2005). *The New Zealand Action Plan for Human Rights — Mana ki te Tangata. Chapter 14:The Right to Health*. Retrieved 4 August, 2010, from http://www.hrc.co.nz/report/chapters/chapter14/health01.html
[9] The New Zealand Human Rights Commission. (2005).
[10] National Health Committee. (1998). *Social, cultural and economic determinants of health in New Zealand: Action to improve health.* Wellington: Ministry of Health. Retrieved 14 July, 2010, from http://www.nhc.health.govt.nz/moh.nsf/pagescm/720/$File/det-health.pdf
[11] The New Zealand Human Rights Commission. (2005).
[12] Mortensen, A. (2008).

The UK Department of Health has similarly found that human rights must be presented as an inherent part of care, not an 'add-on',[13] yet the New Zealand Human Rights Commission has found that it is increasingly common practice to contract external organisations to provide culturally appropriate services, rather than addressing necessary structural changes.[14]

To summarise, key findings emerging from this review of literature include the following recommendations:

- Advocacy is a tool with which to achieve health and well-being.
- Both refugee-background communities and service providers need better education about the effects of mental illnesses and trauma.
- Former refugees should be able to 'own' their mental health.
- Services should be aware of international instruments that clearly define service providers' obligations and responsibilities.
- Services should be aware of cultural specifics (current context, pre-migration, post-arrival, and traditional ways of thinking about things). Treatment/service should be culturally relevant.
- The focus should be on resilience rather than victimhood/suffering.
- There is a need for more stakeholder engagement, i.e. training and employing former refugees to work in mental health services.
- There is a need for relevant, specialised services.
- There needs to be systemic change within mental health service organisations, not just 'add-ons'.

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[13] Equality and Human Rights Group, Department of Health, UK. (2008). *Human rights in healthcare: A short introduction*. Retrieved 2 August, 2010, from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088971.pdf
[14] The New Zealand Human Rights Commission. (2005)

5.1 Gaps in literature and services

While some articles in this bibliography highlight case studies of research or projects with specific groups, most of the rights-based literature focuses on general discussion about the ways that human rights can be used to achieve mental health.

Although the universal application of human rights is an essential part of providing mental health services, one of the things so important about a rights-based approach is the participation of mental health consumers and their specific needs, and their understanding of the issues around their achievement of good mental health (e.g. their rights).

As this bibliography shows – and concurrent with the findings of Te Pou's report on Refugee and Migrant Mental Health[15] – there is scarce research about models of mental health care that are specific to – and appropriate for – working with individuals from refugee backgrounds, although there is significant research on post traumatic stress disorder (PTSD) and the effects of trauma on refugee health and well-being.

While general research on rights-based approaches to mental health is scarce, there is even less material that focuses on specific issues or strategies associated with different groups (i.e. ethnicity, gender, age). Aside from a few exceptions that outline rights-based approaches to women or young people, and occasionally by ethnic group, e.g. Somali refugee-background communities in Aotearoa New Zealand, there is very little research that goes beyond the monolithic 'refugee' label to address gender/ethnicity/age -specific issues.

One explanation for this gap in literature could be that an emphasis on international human rights comes at the expense of less attention to specific groups (e.g. women, older people, etc). Human rights are intended to be applicable to all people (e.g. full

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[15] Te Pou. (2008).

and equal access to mainstream services), regardless of ethnicity, age, community, gender, etc.

However, human rights benchmarks alone are not enough; specialised attention is also needed. For example, a report from the Women's Commission for Refugee Women and Children noted that 'nearly all the field studies cited a lack of sufficient mental health services and specialist medical services'.[16] Organisations have responded in different ways to these gaps, e.g. in direct response to gaps in services addressing the specific needs of Palestinian refugees, the Gaza Community Mental Health programme has established its own human rights-focused mental health training project.

6. Annotated bibliography: summaries of texts

6.1 Rights-based approaches to working with refugees

6.1.1 Couch, J. (2005). 'An agenda for change: Developing good practice principles in working with young refugees'. *Youth Studies Australia*: Vol.24, No.3, pp47-50.

In this advocacy paper, the author (from the Centre for Multicultural Youth Issues) argues that principles based on values of trust and social justice need to be incorporated to develop a 'rights-based model of social policy and service delivery, rather than a service model based on needs'. The author states that refugees have the right to access services that are 'flexible and responsive'; arguing that Australia has an obligation to meet these rights through their commitment to numerous international human rights instruments.

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[16] Women's Commission for Refugee Women and Children. (2008). *Disabilities among refugees and conflict-affected populations: Resource kit for fieldworkers.* Retrieved 15 May 2010, from http://womensrefugeecommission.org/programs/disabilities

6.1.2 Posner, M, & Clancy, D. (2005). 'A human rights-based approach to refugee assistance'. *Human Rights First.* **Retrieved 15 May 2010, from**
http://www.humanrightsfirst.org/intl_refugees/regions/approach_refugess.pdf**.**

This paper emphasises the critical need to acknowledge the human rights implications of providing support to refugees. It describes a human rights approach as one that acknowledges that refugees are entitled to a certain standard of treatment. The authors hold that when countries ratify human rights conventions, they are obliged to uphold these rights in their assistance to refugees. The report provides practical examples of rights-based approaches, and shows how assistance that doesn't have rights-based thinking at its core can actually leave people more vulnerable. The approach also prioritises involving refugees in decisions/services that concern them.

6.1.3 Women's Commission for Refugee Women and Children. (2008). 'Disabilities among refugees and conflict-affected populations: Resource kit for fieldworkers'. *Women's Commission for Refugee Women and Children.* **Retrieved 15 May 2010, from** http://womensrefugeecommission.org/programs/disabilities**.**

This resource kit places a rights-based approach at the centre of working with refugees. It states that all humanitarian action should be informed by human rights principles and standards, e.g. principles of non-discrimination, respect for the inherent dignity, autonomy and independence of the individual, and respect for difference and diversity.

The resource describes a rights-based approach to health as one that focuses on the 'physical, social, attitudinal and environmental barriers that prevent [people] from participating in their society fully and on an equal basis with others in their community'. It contains practical rights-based suggestions based on ideas gathered from the field studies.

6.2 Rights-based approaches to health

6.2.1 Australian Research Alliance for Children and Youth (ARACY). (2009). 'A rights-based approach to improving Aboriginal child health'. *Conference presentation*: *Transforming Australia for our children's future: making prevention work.* **Retrieved 10 June 2010 from**
http://www.aracyconference.org.au/Thu%20IA3%201545%20Brown.pdf.

This presentation looks at how rights-based approaches can link and drive health and social justice efforts, and hold agencies accountable to delivering against health targets. It defines a rights-based approach as one that seeks to integrate human rights mandates and conventions that focus on the broader determinants of well-being. The paper also explains how UN conventions may be used as tools to develop rights-based initiatives to support children, their families and communities.

6.2.2 Domoto, A. (1999). 'A rights based approach to women's health'. *Statement by Akiko Domoto (Asian Forum of Parliamentarians on Population and Development) on behalf of the Asia-Pacific NGO Caucus for ESCAP '99.* **Retrieved 12 July 2010, from** http://www.aworc.org/bpfa/gov/escap/health.html.

This statement asserts that the right to adequate health care is a basic human right. The author goes on to clarify what is meant by a rights-based approach in relation to health, which includes the availability, accessibility and affordability of services; access to information, and appropriate resources necessary for people to make their own decisions regarding their health. The author also demands that services and education be based on the right to dignity, respect and self-determination.

6.2.3 Equality and Human Rights Group, Department of Health, UK. (2008). *Human rights in healthcare: A short introduction*. **Retrieved 2 August 2010, from**

[http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/docu](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088971.pdf)
[ments/digitalasset/dh_088971.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088971.pdf).

This is a brief introduction to developing and applying human rights-based approaches to improve the design and delivery of healthcare. Human rights are presented as an inherent part of care, not an 'add-on'.

The resource includes a table of rights from the UK Human Rights Act (HRA) with corresponding notes of how each of these rights is relevant to healthcare, along with service delivery examples. This rights-based approach is based on the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy), which equate to various articles of the HRA (see FREDA listing later in this bibliography).

6.2.4 Igras, S., Muteshi, J., WoldeMariam, A., & Ali, S. (2004). 'Integrating rights-based approaches into community-based health projects: Experiences from the Prevention of Female Genital Cutting Project in East Africa'. *Health and Human Rights*. Vol. 7, No. 2, pp. 251-271.

This article outlines how an anti-female genital cutting (FGC) project shifted from a needs-based approach to a rights-based one. The shift included reframing the project from a purely health context to a health, social well-being and advocacy focus. A participatory, qualitative, community-driven methodology was used to inform the project.

6.2.5 Kols, A. (2003) 'A rights-based approach to reproductive health'. *Outlook*. Vol. 20, No. 4.

This article provides a comprehensive summary of a rights-based approach to health (in particular, reproductive health) and why it is valuable. It states that a rights-based approach can 'provide tools to analyse the root causes of health problems and

inequities in service delivery'. The article also advocates using international human rights conventions to pressure 'governments into working proactively'. It includes a table that outlines human rights and their corresponding reproductive health obligations, which could be modified to address rights-based mental health service provision.

6.2.7 Mortensen, A. & Young, N. (2003). 'Refugees and asylum seekers: Implications for ED care in Auckland, New Zealand'. *Journal of Emergency Nursing*. **Vol. 29, No. 4, pp 337-341.**

This article looks at the ways in which former refugees access health services in Aotearoa New Zealand. The authors outline key concerns in accessing health services for former refugees. They point out that although Aotearoa New Zealand ranks first in the world (per capita) in the number of refugees accepted, it rates the lowest in post arrival support and services, outlining the numerous resettlement stresses.

While this article does not specifically highlight a rights-based approach, it does highlight the importance of culturally-sensitive care, and the need to understand the impact of the refugee experience in order to understand refugee responses to illness. The article highlights the lack of equity in Aotearoa New Zealand's health services for refugee-background communities, and is a useful starting point for examining more appropriate approaches to care.

6.2.7 National Health Committee. (1998). *Social, cultural and economic determinants of health in New Zealand: Action to improve health.* **Wellington: Ministry of Health. Retrieved 14 July 2010, from**
http://www.nhc.health.govt.nz/moh.nsf/pagescm/720/$File/det-health.pdf.

The National Health Committee's report identifies economic, social and cultural determinants of health (including mental health). The Committee found that the social

and economic factors that have the greatest influence on health include 'income and poverty, employment and occupation, education, housing, and culture and ethnicity'.

6.2.8 The New Zealand Human Rights Commission. (2005). *The New Zealand action plan for human rights — Mana ki te Tangata. The right to health, Chapter 14.* **Retrieved 4 August 2010, from**
http://www.hrc.co.nz/report/chapters/chapter14/health01.html.

The Human Rights Commission (HRC) Action Plan[17] notes that currently in Aotearoa New Zealand, a needs-based approach is used to apportion health resources, which is broadly considered the most transparent way of 'prioritising the use of scarce resources'. It highlights the perception that a rights-based approach to health could 'lead to expectations of universal entitlement', which would put a strain on resources. The report notes a technicality in the area of international rights responsibilities, observing that 'states are given substantial discretion about how they go about realising [these rights]'.

The HRC argues for a rights-based approach to health services, referencing the International Covenant on Economic, Social and Cultural Rights (ICESCR) as providing that, 'where resources are limited, the available resources should be targeted to the groups that are most vulnerable, [which] provides a mechanism for reconciling a needs-based approach with a human-rights approach'.

The Action Plan also acknowledges that refugees are particularly vulnerable to how their rights to health are realised. It criticises access to – and quality of – health services, and recommends developing 'special measures or targeted programmes to redress the inequalities currently experienced'.

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[17] The Human Rights Commission is currently conducting a review of human rights in New Zealand, and an updated draft of the Action Plan is in progress. For more information about the latest draft, go to: http://www.hrc.co.nz/home/hrc/humanrightsenvironment/reviewofhumanrightsinnewzealand2010/reviewofhumanrightsinnewzealand2010.php

6.2.9 Perkins, F. (2009). 'A rights-based approach to accessing health determinants'. *Global Health Promotion.* **Vol. 16, No. 1, pp. 61-4. Retrieved 2 August 2010 from** http://www.ncbi.nlm.nih.gov/pubmed/19276336.

This article summarises the experience of the El-Shehab Institution in Cairo, a street outreach programme for the prevention of Sexually Transmitted Infections (STI) among vulnerable women (including refugee women). El-Shehab's rights-based approach to their work provides an example of a successful way to achieve access to basic health determinants.

The Ottawa Charter (produced by the World Health Organisation in 1986) lays out the determinants of health, including social justice. El-Shebab has successfully used the Charter to fight for these determinants in the courts, and win the right to access clean water, to have sewage removal provided and access to electrical power in their communities – i.e. have the same rights as afforded Cairo residents living in more affluent neighbourhoods.

6.3 Rights-based approaches to mental health

6.3.1 Curtice, M., Symonds, R., & Exworthy, T. (2010). *FREDA – A human rights-based approach to clinical practice.* **The Royal College of Psychiatrists. Retrieved 14 July 2010, from** http://www.psychiatrycpd.co.uk/pdf/FREDA%20human%20rights-based%20approach%20to%20clinical%20practice_THN.pdf.

This paper is part of an online learning module by the Royal College of Psychiatrists to teach how a human rights-based approach can be used in clinical practice. The authors acknowledge that despite the introduction of the UK Human Rights Act in 1998, there has not been widespread understanding among healthcare professionals or within organisations.

The FREDA model is an attempt to render human rights principles accessible to apply into practice, without requiring a technical knowledge of UK human rights law. The focus of the learning module is explaining the applications of core human rights values (Fairness, Respect, Equality, Dignity, Autonomy i.e. FREDA) and applying the approach to clinical practice.

6.3.2 Fatimilehin, I., & Coleman, P. (1999). 'You've got to have a Chinese chef to cook Chinese food!! Issues of power and control in the provision of mental health services'. *Journal of Community and Applied Social Psychology*. **Vol. 9, pp 101-117.**
This paper examines issues of power and control in mental health service provision, as discussed by African-Caribbean parents within a series of focus groups. These issues incorporate aspects of confidentiality, stigmatisation, accessibility and ethnic matching. The paper also discusses the implications for the provision of mental health services.

6.3.3 Inter-Agency Standing Committee (IASC). (2007). IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: IASC. Retrieved 4 August 2010, from
http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf**.**

These guidelines, drafted by a broad range of international development, health and human rights organisations, universities, and UN agencies, provide suggestions on implementing mental health services that promote and protect human rights. Core principles of the guidelines include equity and participation.

Among other tools, the guidelines include a 'Do's and Don'ts' table that may be relevant to mental health work with former refugees, for example:

DO: Learn about and, where appropriate, use local cultural practices to
              support local people.

              Use methods from outside the culture where it is appropriate to do so.

DON'T: Assume that methods from abroad are necessarily better or impose
              them on local people in ways that marginalise local supportive practices
              and beliefs.

              Assume that all local cultural practices are helpful or that all local
              people are supportive of particular practices.

6.3.4 Lord, J., Ochocka, J, et al. (1998). 'Analysis of change within a mental health organization: A participatory process'. *Psychiatric Rehabilitation Journal*. Vol 21, pp 327-340.

This article provides a case study of a process of organisational change within a Canadian mental health organisation. It provides useful documentation of the methodology (including planning, implementation and outcomes) used to drive the organisation's shift towards a philosophy and practice 'based on the concepts of empowerment and community integration'. The community integration model includes a focus on 'ownership' and consumer participation. The article also notes dilemmas experienced during the process.

6.3.5 Human Rights Law Centre. (2009). 'Dignity, equality, freedom and respect: A human-rights based approach to mental health'. *Submission to the Review of the Mental Health Act 1986*. Retrieved 13 June 2010, from
http://www.hrlrc.org.au/files/I6KMFW1GC3/HRLRC_Submission_to_the_Review_of_t he_Mental_Health_Act_Feb_09_FINAL.pdf.

This submission provides an overview of the relevant international human rights instruments and their application to mental health law in Victoria, Australia. It highlights the Convention on the Rights of Persons with Disabilities (CRPD), stating

that the CRPD's international framework of rights should form the basis of mental health legislation. The paper also notes that culturally and linguistically diverse (CALD) groups may require different mental health care in order to realise their human rights.

6.3.6 The Institute of Human Rights at Emory University, CARE USA, the human rights offices of the Carter Center, The U.S. Centers for Disease Control and Prevention, Doctors for Global Health & The World Health Organization. (2006). *Conference proceedings: Lessons learned from rights based approaches to health* **Retrieved 5 August 2010, from**

http://humanrights.emory.edu/download/ConferenceProceedings.pdf.

'Mental health and human rights' was one of the sessions at the aforementioned conference. This brief paper argues that, with the support of international agencies and mental health organisations, all states, regardless of resources, can develop national rights-based, mental health policies and plans of action with measurable targets.

6.3.7 International Federation of Social Workers and the International Association of Schools of Social Work (2004). *Ethics in social work: Statement of principles.* **Retrieved 13 July 2010, from http://www.ifsw.org/f38000032.html.**

The IFSW Statement of Principles lists specific UN declarations and conventions that are relevant to social work, and explains how these conventions are applied within a social work context.

Human rights and social justice form the basis of the International Federation of Social Workers (IFSW) ethos, and the IFSW's definition of social work explicitly contains human rights principles that inform social work practice.

6.3.8 McGuire, M. (2009). 'Dignity, equality, freedom and respect: A human rights-based approach to mental health'. *Health Issues*. Issue 101.

This article claims that human rights offer the best framework for promoting the effective, holistic treatment and care of people with mental illness. The author considers how the Victorian Charter of Human Rights and Responsibilities and international human rights principles relate to the treatment and care of people under the Victoria Mental Health Act. The article demonstrates how human rights can be utilised to promote the dignity and equality of people with mental illness in Victoria.

6.3.9 Yamin, A., & Rosenthal, E. (2005). 'Out of the shadows: Using human rights approaches to secure dignity and well-being for people with mental disabilities'. *PLoS Medicine Journal.* Vol. 2, No. 4. Retrieved 10 May 2010, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1087199/.

This article calls for changes that 'go beyond quality of care to include both legal and services reforms'. The authors claim that mental health is the most neglected area of health policy and programming. Citing the research of Mental Health Disability Rights International, the article provides a definition of a human rights approach to mental health policy and practice.

The authors demand that the location of care needs to be community based, that consumers and family members must be integrally involved in policy-making and programming decisions, and that mental health services must be linked with social justice and the full spectrum of rights (as set out by international conventions).

6.4 Rights-based approach to mental health with former refugees

**6.4.1 Afana, A. (2003). 'A model for community care in Gaza: Conclusions drawn from a community-based approach to mental health care in Gaza'. *Palestine-Israel*

Journal of Politics, Economics, and Culture. **Vol. 10, No. 4. Retrieved 1 September 2010, from http://www.pij.org/details.php?id=61.**

This profile of a refugee mental health service in the Gaza Strip describes a multi-level human rights approach to mental health service delivery. The article explains how the Gaza Community Mental Health Program (GCMHP) has worked to emphasise the relationship between mental health and human rights, by placing mental health care within the philosophy of community-based approaches.

GCMHP's interpretation of mental health includes 'environmental, family, and community' factors, not just an 'inflexible medical perspective'. Goals include more people 'embracing their own mental health related issues', and ensuring services are based on principles of 'justice... and respect for human rights'.

The GCMHP team includes nurses, psychiatrists, psychologists, and social workers. Staff (like those who access GCMHP services) are Palestinian refugees and thus their movement is restricted; this article explains how international specialists visit the centres to provide in-house training. GCMHP now run their own culturally appropriate training to other health professionals, and offer a post-graduate diploma in community mental health and human rights.

6.4.2 Atkinson, M., Clark, M., Clay, D., Johnson, M.R.D., Owen, D. & Szczepura, A. (2001). *A systematic review of ethnicity and health service access for London*. Coventry: Centre for Health Services Studies, with MSRC and CRER, for London Regional Office, NHS Executive.

This broad-based review notes high levels of severe stress and depression among Sudanese refugee mental health consumers. Review recommendations include:
- Having greater liaison between health providers and refugee communities and organisations

- Providing transcultural psychotherapy through the identification of culturally valid labels for distress states and valid methods of management
- Creating and financing support of refugees for mental health support and settlement projects
- Creating refugee stress clinics and employing refugee doctors in these clinics.

6.4.3 Auckland Somali and Afghani Communities, and Umma Trust. (2004). 'Working with Muslim communities in New Zealand'. *Conference presentation*: *Working with Muslim Communities in New Zealand*. **Retrieved 1 September 2010, from http://www.refugeeservices.org.nz/resources_and_links/?a=209.**

The authors, from a range of Muslim communities in Auckland, make a series of recommendations to improve mental health services for refugees, including developing a website to improve inter-agency knowledge of resources about mental health services for refugee and migrant families, and improving understanding of the barriers to well-being (e.g. trauma, isolation and unemployment).

6.4.4 Chun, R., Bemak, F., Ortiz, D. & Sandoval-Perez, P. (2008). 'Promoting the mental health of immigrants: A multicultural/social justice perspective'. *Journal of Counselling & Development*. **Vol. 86, pp 310-317.**

Although written from a United States, post-9/11 standpoint (i.e. highlighting US anti-Arab sentiment), the article is useful in that it points out some of the challenges that refugees and migrants may experience in coping with mental health approaches that 'sharply contrast with their own cultural beliefs and behaviours'.

The authors also provide specific recommendations for counsellors working with immigrant and refugee populations. These recommendations come from a social justice standpoint – which is a factor of rights-based approaches – that emphasise the need for counsellors to be aware of the multiple impacts of the socio-political

environment, immigration policies, pre-migration experiences and post-arrival challenges, and the many effects of racism and discrimination on the mental health of each client.

6.4.5 DeSouza, R. (2007). 'Sailing in a new direction: Multicultural mental health in New Zealand'. *MindNet, Issue 10 – Winter 2007*. Retrieved 30 July 2010 from http://www.mentalhealth.org.nz/newsletters/view/article/10/112/foreword/

This paper describes some of the efforts being made to ensure that Aotearoa New Zealand mental health service delivery addresses the needs of refugees and migrants. It outlines NZ legislative and policy frameworks that support rights-based, culturally sensitive, mental health service provision, including *The Health and Disability Commissioner Act 1995*, *The Health and Disability Code of Rights 1996, The Mental Health (Compulsory Assessment and Treatment) Act 1992* (and the 1999 amendments), *The New Zealand Public Health and Disability Act 2000*, *The Human Rights Act 1993*, and *The Health Professional Competency Assurance Act 2003* (which requires practitioners to demonstrate cultural competence).

6.4.6 Guerin, B., Guerin, P. B., Diiriye, R. O., & Yates, S. (2004). 'Somali conceptions and expectations of mental health: Some guidelines for mental health professionals'. *New Zealand Journal of Psychology,* Vol. *33*. No. 2.

This paper focuses on the Somali population in Aotearoa New Zealand. It presents some of the cultural and religious issues influencing Somali conceptions and expectations about mental health services in an attempt to reduce barriers and difficulties.

The paper outlines some traditional treatments, and points out problems of specialist referrals and inadequate cultural knowledge. The authors recommend that health professionals spend more time finding out about clients' family and community

relationships, and incorporating Somali views on mental health issues and traditional treatments.

6.4.7 Guerin, P., Diiriye, R. & Guerin, B. (2004). 'Why 'Mental Health' is not working: A case study of Somali refugees in New Zealand'. *Paper given at the 18th World Conference on Health Promotion and Health Education: Valuing diversity, Reshaping Power: Exploring pathways for health.*

This paper critiques gaps in services and miscommunication between health professionals' understanding of the causes of ill mental health (i.e. PTSD) and clients' understanding (e.g. family separation, poor living situations). Researchers found that medication such as anti-depressants are over-prescribed at the expense of consideration by health professionals of traditional views and treatment.

The paper advocates for more Somali participation to develop relevant services, and for health professionals to take on more advocacy roles, and spend more time in communities (not just their offices). The paper provides quotes from Somali mental health consumers to illustrate gaps in services.

6.4.8 Mortensen, A. (2008). *Refugees as 'others': Social and cultural citizenship rights for refugees in New Zealand health services.* **Retrieved 15 May 2010, from http://muir.massey.ac.nz/bitstream/10179/631/1/02whole.pdf**.

Mortensen's thesis examines Aotearoa New Zealand health policies in relation to service provision for refugee-background communities. It claims that although the New Zealand Government deliberately selects refugees with high health needs, there is no structural framework to guide their integration in Aotearoa New Zealand. Mortensen provides an overview of 'universalist' health rights in Aotearoa New Zealand, and argues that these rights 'overlook' the health issues of refugee groups.

In Chapter 8 (Culturally diverse needs of populations and the health needs of refugees), Mortensen reviews international literature around the debate between 'psychiatric universalists' and those that view western psychiatric models as 'not attuned to the cultural nuances in non-western populations'. She notes that the western mental health models generally concentrate on notions of victimhood rather than resilience, which lead to a disproportionate focus on psychological well-being and not the social determinants of health, such as good housing, language acquisition, and employment.

The chapter also reviews international and Aotearoa New Zealand literature around theories of transcultural care and cultural safety, and stresses the need for knowledge and direct experience with ethnic minority groups, to achieve culturally competent health services.

Incorporating a social justice perspective, Mortensen expresses her doubts that approaches that are based primarily on counselling and psychotherapy are unlikely to succeed unless long-term structural inequalities (housing, employment, language acquisition) are addressed.

6.4.9 Mortensen, A. (2009) *ON TRACC: An intersectoral approach to health care for children and young people from refugee backgrounds.*

This powerpoint presentation is one of a number of online descriptions of On TRACC, an Auckland-based, integrated transcultural service to improve outcomes for children and young people with high and complex needs. Establishing the service involved refugee-background community consultation; key priorities of the service include involvement and participation (at the staffing level) of former refugees, culturally appropriate engagement, and an integrated approach.

***Unable to source original version of this presentation. For a similar source, see *ON TRACC: An intersectoral approach to health care for children and young people from refugee backgrounds. Retrieved 27 September 2010, from* http://www.nzfvc.org.nz/accan/papers-presentations/PDFs/Thursday-16-2-06-11am/Blossoming/Shaw-Peter.pdf*.*

6.4.10 Ministry of Health. (2001). *Refugee Health Care: A handbook for health professionals*. **'Mental health issues'. Wellington: Ministry of Health. Retrieved 12 July 2010, from**
http://www.moh.govt.nz/moh.nsf/0/d85ce7cd090faaa4cc256b050007d7cb/$FILE/Section5.pdf.

Although produced in 2001, the issues outlined in the Refugee Health Care Handbook are still relevant for health workers caring for former refugees in Aotearoa New Zealand. Chapter 5, which focuses on mental health, includes a section around conducting culturally sensitive consultations and acknowledging the Western context of therapy. However, the document omits discussions of care in the context of human rights, participation or empowerment models.

6.4.11 O'Callaghan, C. (2010). 'Health and cultural rights in children's health care'. *Conference presentation: Diversity in Health Conference Melbourne, 2010*. **Retrieved 12 July 2010, from**
http://www.ceh.org.au/downloads/Diversity_in_Health/Presentations/Day2_A230_OCallaghan.pdf.

O'Callaghan's presentation highlights perceived tensions between the right to health and the right to cultural difference (in the context of children's health). The presentation argues that the best way of protecting human rights within a context of cultural difference is through dialogue and communication, and calls for guidelines for 'stalemates between families and health staff'.

6.4.12 Silove, D., Ekblad S., & Mollica, R. (2000). 'The rights of the severely mentally ill in post-conflict societies'. *The Lancet*, Vol. 355, No. 9214, pp 1548 - 1549.

The authors highlight controversies around applying western concepts of trauma among culturally diverse communities. They question the effectiveness of western diagnoses and treatments, noting in particular the argument that the label 'post-traumatic stress disorder' (PTSD) pathologises normal social responses to human rights abuses.

The article emphasises the need for culturally-appropriate community development responses to mass violence and displacement – community development approaches can reflect a similar set of values to rights-based approaches, such as the support of traditional family structures. The authors also, however, caution that too much 'ideological rigidity' can have negative impact on those communities that most need mental health services.

6.4.13 Szoke, H. (2010). *Invisible injuries, invisible people: Human rights, mental health and CALD communities*. Retrieved 16 July 2010, from http://www.humanrightscommission.vic.gov.au/news%20and%20events/speeches/20100608.asp

This speech by Dr Helen Szoke, Victoria's Human Rights and Equal Opportunity Commissioner, was made at the 2010 'Diversity in Health' conference in Melbourne, Australia.[18] Dr Szoke emphasised the importance of a rights-based approach to CALD (culturally and linguistically diverse) mental health service delivery, and called for 'a critical review of existing mental health service delivery... that goes beyond simply "adding on" a culturally sensitive approach'.

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[18] The 'Diversity in Health' conference in Melbourne, Australia was put on by the Centre for Culture, Ethnicity & Health: www.ceh.org.au.

Dr Szoke's speech identifies barriers experienced by both CALD consumers and mental health workers, and criticises the clinical focus on treating acute cases rather than valuing community-based care and support. It also stresses the need to move from a welfare model of social protection towards a rights-based model that specifically draws on human rights conventions.

As a practical tool to implement rights-based mental health service delivery, Dr Szoke highlighted the PANEL approach (Participation, Accountability, Non discrimination, Empowerment, Linkages to human rights standards).[19] Dr Szoke explained how PANEL can inform the 'development of mental health policy and health service delivery to better meet the needs of CALD consumers'. This is summarised as follows:

- **Participation** - genuine participation goes beyond consultation with CALD consumers of mental health services… the CALD community must be involved alongside government in identifying mental health strategies, setting mental health agendas, decision making, the implementation of strategies and accountability.
- **Accountability** - in the context of human rights, the notion of accountability extends beyond answerability: it actively involves CALD individuals and CALD groups in processes designed to monitor and evaluate performance.
- **Non discrimination** - equality and attention to CALD community and consumers of mental health services as a vulnerable group is required, to ensure that CALD people can enjoy the highest attainable standard of health and can participate equally.
- **Empowerment** – this increases the capacity of CALD consumers to claim and exercise their rights and to make rights-based complaints. Empowerment is about doing things with CALD mental health consumers, rather than to them.
- **Linkages to human rights standards** - this ensures that mental health planning and mental health service delivery identify the challenges in mental health in

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[19] See the www.humanrightscommission.vic.gov.au for more information about PANEL.

relation to CALD consumers and the relevant human rights that are needed to resolve them.

6.4.14 Te Pou. (2008). *Refugee and migrant mental health and addiction research agenda for New Zealand 2008-2012.* **Auckland: Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.**

Te Pou was commissioned by the Ministry of Health to develop a research agenda that would identify mental health and addiction research priorities for Aotearoa New Zealand's refugee and migrant population.

The report found that internationally and in Aotearoa New Zealand, there is very little research about which mental health services are most effective and appropriate for refugee or migrant clients. Among its recommendations, the report calls for increased knowledge about effective responses to the health needs of refugee and migrants, in order to influence promotion, policy and service delivery in Aotearoa New Zealand.

6.4.15 VSO United Kingdom. (2010). *Sri Lanka mental health summary.* **Retrieved 16 June 2010, from http://www.vso.org.uk/Images/sri-lanka-mental-health-summary-mar07_tcm79-20599.pdf.**

This summary briefly describes a Sri Lankan mental health programme that takes a rights-based approach to mental health services across policy and services. The programme applies a multi-sectoral approach, working with local communities, and NGO and government mental health providers.

6.4.16 Watters, C. (2001). 'Emerging paradigms in the mental health care of refugees.' *Social Science & Medicine. Vol. 52*, **pp 1709-1718.**

This paper looks at a range of issues concerning the mental health care of refugees, including 'the role of psychiatric diagnosis in relation to refugees' own perceptions of their need'. Paradigms discussed also include 'approaches that address the broader social policy contexts in which refugees are placed'.

This article highlights critiques of mental health that portray refugees as 'passive victims' suffering mental health problems, rather than focusing on refugee resilience and 'the ways in which they interpret and respond to experiences, challenging the external forces bearing upon them'. The paper includes a model to examine the relationship between institutional factors and individual treatment of refugees within mental health services.