
Review

A systematic review of the protective and risk factors influencing the mental health of forced migrants: Implications for sustainable intercultural mental health practice

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Abstract: This systematic review followed the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement to synthesize the existing literature with a goal to review current conceptual frameworks of mental health of forced migrants for further practice research priorities in social work. The search was done between January 2015 to January 2021. As a result, 29 studies met inclusion criteria. Medicalizing mental health issues by relying solely on the effectiveness of medicine was a controversial risk factor that negatively affected daily life activities of refugees and reduced their willingness for seeking professional mental health services. Empowering vulnerable minorities by giving them back their power and agency to be able to speak for themselves and raise voices of trauma and recovery was the missing protective factor for a sustainable mental health practice. The benefits of group-based interventions are highlighted in which communities and individuals address mental health issues as well as isolation through building collective identities and support networks. Information and communication technologies (ICTs) can add more strength to any kind of mental health interventions. Finally, benefits of applying ecological perspective for the mental health of refugees, and its implications for a sustainable intercultural practice are discussed. Social workers in this model are the representatives of at-risk groups, thus need more agency and creativity in reflecting client's concrete needs.

Keywords: mental health; risk factor; protective factor; refugee; asylum-seeker; sustainable intervention

1. Introduction

It is established that exposure to the traumatic experiences associated with forced migration endangers the overall mental health of refugees creating a worldwide mental health crisis [1,2]. The United Nations High Commissioner for Refugees estimates that global forced displacement has surpassed 80 million at mid-2020 including 26.3 million refugees, and 4.2 million asylum seekers [3]. UNHCR defines refugees as people who have been forced to flee their country because of persecution, war or violence, have a well-founded fear of persecution for reasons of race, religion, nationality, political opinions or membership in a particular social group in the country of their nationality [4]. Whereas asylum-seekers live in a more precarious situation as they must await formal recognition as 'refugee' to be eligible for the protections afforded to those with refugee status [5].

Across Europe and internationally there is a pressing need for the development of culturally appropriate mental health services for socially excluded and marginalized populations [6]. Approaches to mental healthcare are undergoing significant reforms around

mental health intervention and immigrants' health policies when social scientists realized that mental health and well-being are influenced by various social determinants [5,7]. Through efforts to acquire holistic approaches towards mental health, social scientists admitted that social, cultural, and historical diversity of refugees adds to the complexity of mental health service delivery but also presents opportunities for reform [8,9].

Considering all issues faced by forced migrants, especially in a time that services are stretched thin, social workers play important role in the mental health service delivery for refugee populations, and as a single medium between common top-down policies and forced migrants. Top-down policies place pressure on both social workers and forcibly displaced immigrants [10]. It is imperative that social workers are informed by research about what culturally appropriate interventions can be attempted and which would be most effective. This is not easy in a culturally diverse refugee population with social workers from the host country often very limited in knowledge of refugees mental and cultural landscape. However, the base-line is that it is critical for social workers to understand the mental health needs of this often highly traumatized population as well as having the cultural sensitivity necessary to be successful in helping refugees sustainably integrate into society and avoid mental health pitfalls.

At present, most of the research in the field of migration is reproduced through the same dominant top-down patterns, confined to pathology, and highlighting only prevalence rates of the mental health issues. Thus, voices, interests and expectations of the immigrant communities are ignored. However, with the continued migration of refugees, there is increased attention to how to address the ongoing needs of refugees and has resulted in greater demands for services appropriate to their needs.

Mental health services are one of the most important services that forced migrants urgently need upon arrival to the host countries. However, Watters criticizes the Western Mental Health Care approach in the refugee situation as often coming from a premise which because of trauma and cultural norms may be quite inappropriate [11]. The importance of post-migration stressors to refugee's mental health status suggests the need for sustainable therapeutic interventions with psychosocial elements that address the specific ecology of being a refugee as well as the conditions of refugees' lives. To do so, sustainable therapeutic interventions should fully cognizant of the wide range of cultural diversities in refugees' population, with a predictable dissonance between their concepts of mental health and those of the host country.

1.1. Literature Review

Literature shows that mental health of forced migrants has been extensively studied, however studies produced additional puzzles and noncomprehensive frameworks for analysis, and intervention. Research clearly indicates that refugees' mental health is highly influenced by the conditions that they find themselves in post migration [12], often abject squalor such as the camps on the Turco-Syrian border. The clash of cultures, the fear of deportation and the almost ubiquitous instability are only some issues. It is of great concern that refugees who have lived in a host country for more than five years continue, despite this time in a relatively safer environment, show higher rates of depressive and anxiety disorders than the host population [13-17]. It is therefore clear that the stimuli for mental instability continue to have repercussions, whether in post-traumatic stress with nightmare or simply replay of traumas past. Of great concern is a Swedish study which showed higher incidence for psychotic disorders (i.e., more newly diagnosed psychotic disorders) in refugee compared with the host population [18]. This raises the question of epigenetics as an underlying element in people who have been exposed to high levels of trauma over long periods [19]. Recently this recognition has embraced new directions of study for this condition, in particular defining populations with resilience and populations who are prone to PTSD, opening the possibilities of targeted novel PTSD therapies [19].

Other studies on utilizing mental health services by refugees show that despite higher prevalence rates of mental health issues being documented, there still exists an

underutilization of Western mental health treatment by refugee populations, the reasons given including both structural and cultural barriers [20-22]. Thus existing research on mental health service barriers has identified issues of stigma, distrust of services and social and cultural problems that impact on “how problems are understood” and the question about whether help should be sought and if so, how” [23-25]. It is therefore important for social workers to understand the barriers and reasons why underutilization exists and how to better support this vulnerable population [21,26].

1.2. Applying an ecological perspective

When working with refugees, Kira and Tummala state the importance for social workers to adopt an ecological model of recovery [27]. This provides a holistic approach in addressing the differing needs refugees face after resettlement. Informed by Urie Bronfenbrenner’s ecological perspective (Bronfenbrenner 1979) it suggests that human development is shaped by several systems or contexts, and social workers can then understand how an individual is impacted by their family, community, and environment [28]. This will better support refugees themselves when identifying the quality of interactions, they have with their micro, meso and macro systems.

In a German study with Syrian refugee women in identifying and understanding the barriers in accessing mental health care, McLeroy’s adaptation of the socio-ecological model (SEM) was used as a framework to situate the barriers on the various SEM layers spanning from individual to policy level, explaining specifically how different individual and environmental factors determine health behavior in individuals [29]. The SEM is a useful framework because it conceptualizes human development by placing the individual into the centers of circles surrounding it, highlighting the interrelationship of multiple determinants of development and interactions at the personal, relational and collective levels within this dynamic socio-ecological environment [30,31]. With this framework, there is an assumption that individual decisions and behaviors are determined by reciprocal interactions within and between the social and physical environment of individuals. Simultaneously, individuals contribute to their social ecology in terms of constructing norms, beliefs, and culture across multiple macro-systems [30]. Intrinsically, the SEM states that individual level behavior is shaped by multiple environmental factors and vice-versa, recognizing the important social environmental and biological factors that either cultivate or inhibit individual attitudes and behaviors [32].

Addressing the ecological perspective for mental health intervention is a critical component for cultural appropriate and sustainable practice, where the micro-system considers the individual and family relationship and interactions. The meso-system acknowledges the individual and what supports they have or lack within the community. The macro-system focuses on the programs, assessments and policies that affect the lives of refugees and their families.

2. Materials and Methods

2.1. Design

The systematic review followed the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement [33]. The PRISMA statement includes 27-item checklist which assures the transparency, iteration, and complete reporting for systematic reviews.

2.2. Search Strategy

The search was conducted in ScienceDirect, Scopus, PubMed, Medline, Web of Science, ProQuest, Wiley, and Elsevier in December 2020 to January 2021. The electronic databases were searched using the below terms identified from the title, abstract, keywords, or headings: (‘mental health’ OR ‘refugee’ OR ‘asylum seeker’ OR ‘risk factors’ OR ‘protective factors’ AND ‘predictors’ OR ‘measurements’ OR ‘determinants’. The search terms

were adapted from the previous review studies with a similar purpose. We also manually searched reference lists of relevant articles to identify additional publications. Finally, references of all included studies were listed to eliminate the duplications and resolve proper reporting guidelines for the selected articles. different synonyms were used for the search.

2.3. Eligibility Criteria

All quantitative and qualitative studies were considered for the systematic review. Studies were included if they (1) Evaluated overall mental health issues of the forced migrants; (2) assessed any association between depression, post-traumatic stress disorder, mental disorder determinants and migratory backgrounds; (3) tested any theoretical framework related to mental health (4) compared mental health issues or its determinants between particular migrant populations or with general populations in the host societies; (5) conducted a literature review, systematic review or meta-analysis/ synthesis on mental health determinants of forced migrants e.g. refugees, and asylum seekers. Studies published in full in peer-reviewed journals between January 2015 and January 2021 and in English language were included. Studies with less than 50 participants in quantitative articles were excluded. We eliminated dissertations, conference abstracts and organizational reports from the review. Different stages of sampling are provided (Figure 1). We reviewed prevalence rates, risk, and protective factors for the 3 common mental health issues among refugees and asylum-seekers including post-traumatic stress disorder, depression, and mental disorder. These three negative mental health outcomes are reportedly frequent among refugees and asylum seekers from the initial pre-migration stages to host country resettlement and post-resettlement [34].

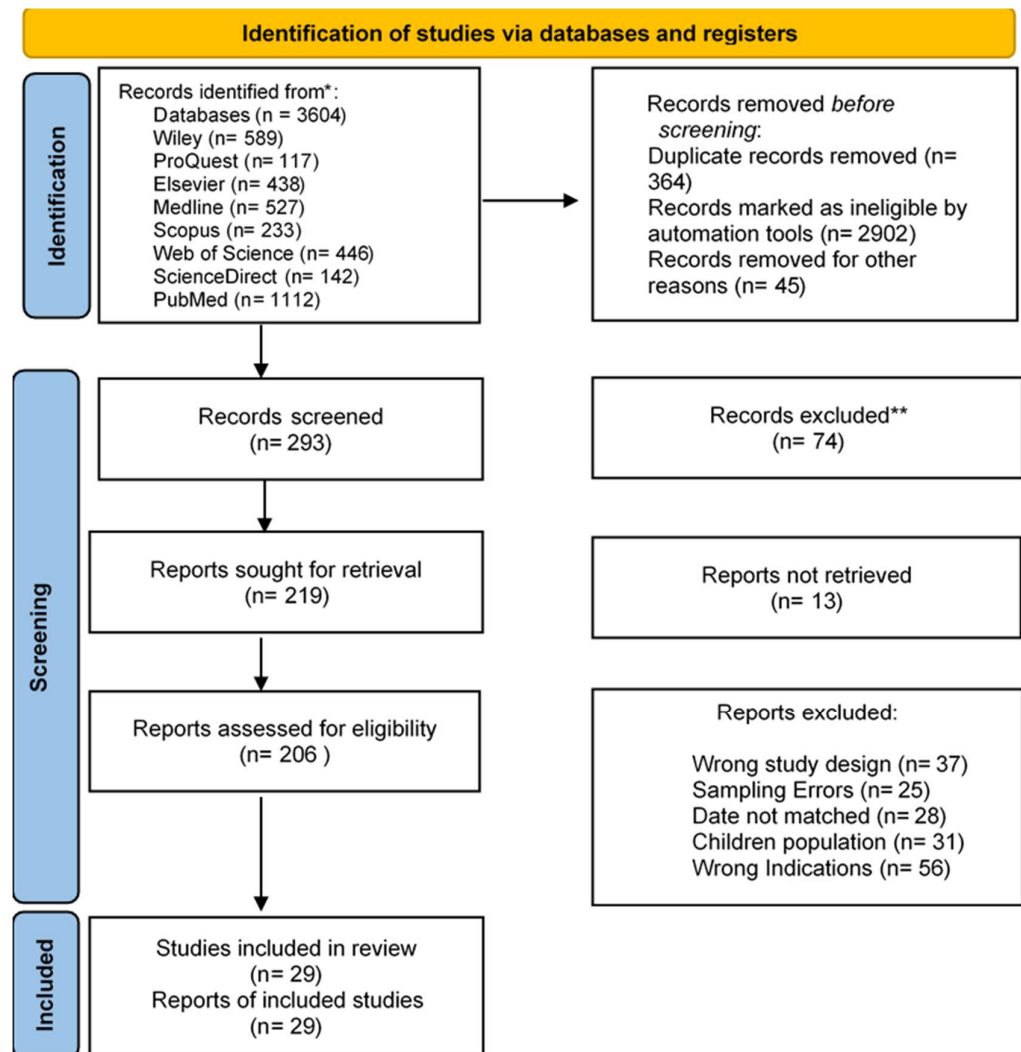


Figure 1Flow diagram depicting different stages of sampling [35]

2.4. Selection of the Studies

Titles and abstracts of the studies derived from the databases were reviewed twice by two independent authors before proceeding to the next stage of the review. To solve the disagreements between authors in eliminating or including papers in the review process, third author was consulted. Full texts of all included studies were checked twice according to the eligibility criteria by the authors and disagreements were resolved.

2.5. Data Extraction

To ease the review process, data were entered into a previously prepared data extraction sheet. In the data extraction sheet we itemized (1) study characteristics including author names, publish year, and country; (2) sampling method and target population; (3) methods of assessment and analysis, and (4) key findings including risk and protective factors for mental health. Characteristics of the included qualitative and quantitative studies are consecutively shown in Table 1 and Table 2.

Table 1. Characteristics of the included qualitative studies

Study ID	Author (s) Country	Time period	Sampling method	Interview method	Study population	Sample size	Age range	Protective factors	Risk factors
1	Affleck et al, 2018 [36] Canada	2012-2016	Convenience Snowball	Semi-structured	Sri Lankan Tamil refugee men	33	20-60	Participating in religious rituals, meditation, adherence to familial and community duties	Inability to protect family members, inability to fulfill cultural duties, inability to perform social roles, Un/Under-employment, inner-family conflicts
2	Alemi et al, 2016 [37] USA	July-October 2012	Snowball	Semi-structure	Afghan refugees & asylum-seekers	18= (11) males, (7) females	36-71	Family reunification, community support, prayers, successfulness of the children	Imprisonment of family members, arbitrary home invasions, constant fears of being killed or maltreated, harsh fleeing path, abrupt separation from family-cultural adjustment issues, fear of deportation, language learning barriers, intergenerational challenges with children, unemployment, cultural insensitiveness of social services, losing culture and identity
3	Im, Ferguson, and Hunter 2017 [38] Kenya	Unknown	Purposive	Semi-structure and focus groups	Somali refugees	15 key informants, 31 focus group participants	18 -56	Counseling, job opportunities, mindfulness exercises, socializing, prayers, personal reflections,	lack of educational opportunities, work and decent life, isolation, daily physical health issues, distressing events, unfulfilled desires. insufficient means of support, losing loved ones, community violence
4	Omar, Kuay, and Tuncer 2017 [39] Astralia	2013-2014	Purposive	Semi-structure and focus groups	Muslim refugees from Somalia, Eritrea, Ethiopia, and Djibouti	36	18-60	Prayer, confidence in Allah, family and community support, cultural rehabilitation methods (visiting African environment)	Unemployment, underemployment, intercultural conflicts in the host country, religious boundaries, inability to support families overseas, lack of mental health literacy, doubt in identifies treatment strategies (faith-based) treatments,
5	Savic et al. 2016 [40] Australia		Unknown	Semi-structure	Refugees, health service providers	45	+18	Community counselling, community supports	Pre-migration experiences e.g., exposure to violence, rape, loss of loved ones, distrust of western mental health services, medicalized nature of western mental health services, stigmatization of mental health issues, incompatibility of needs and offered mental health services
6	Poudel-Tandukar et al., 2019 [41] USA		Convenience Snowball	Focus groups	Bhutanese refugees	67	+18	Community supports, sharing problems with peers, cultural empowerments and raising awareness	language learning issues, decreased support systems, increased responsibilities in the host countries, socio-economic disadvantages, lack of access to services, change in family

								dynamics, discrimination, stigmatization,
7	Yaser et al., 2016 [42] Australia	2015-2016	Convenience Snowball	Semi-structure	Afghan Refugees	150 = (74) males, (76) females	20-45	Improving diet or exercise, raising self-awareness, psychotherapy focusing on the past events, finding new hobbies, physical activity, socializing, meditation, herbal medication,
8	Yassin et al., 2017 [43] Lebanon	August-November 2015	Convenience	Semi-structure	Palestinian refugees	49 = (28) refugee s, (11) service provide rs, (10) local commu nity represe ntatives	24-58	Easy access to services, home visits of social workers, individual based treatments, raising awareness of refugees about mental health, access to the history of mental health issues of refugees, sustainability of the mental health services, prompt access to mental health services upon entry to the country
9	Yu et al., 2018 [44] South Korea	July-August 2013	Purposive	Semi-structure	North Korean refugees	10 = (8) females (2) males	20-69	Prompt treatment upon arrival, raised self-awareness, counselling
10	Vitale, and Ryde, 2016 [45] U.K.	2015	Purposive	Semi-structure	Refugees (Iraq-Sudan-Iran-Eritrea-Morocco-Somalia)	9	29-62	Absence of mental health awareness, issues of survival, stigmatization, lack of access to mental health services, trauma experienced during the escape, cultural encounter shocks, isolation and lose identity Stress of deportation, asylum seeking process, sense of powerlessness, confinement in the detention centers, inadequate supports, feelings of re-traumatization, un/underemployment, high expectations upon arrival, inadequate means of living, lack of practical information, lack of integration in the host community, inability to establish new networks, cultural barriers, inadequate mental health services, no opportunities to be an active citizen

Table 2. Characteristics of the included quantitative studies

Study ID	Author (s) Country	Time period	Methodology	Study population	Sample size	Protective factors	Risk f factors
11	Poole et al, 2018 [46] Greece	January 2017	Survey	Syrian Refu-gees	135	Not mentioned	Gender (being women), having children, increased time in the asylum process
12	Chung et al, 2018 [47] Turkey, Sweden	2017	Survey	Syrian Refu-gees	1197 (482 females,	Age (younger refugees are more resilient), stable	Location of resettlement, came alone of with family,

					715 males)	relationship with community, employment, social networks	having less community networks
13	Hocking, & Sundram [48] Australia	Not mentioned	Survey	Refugees (n= 33) and asylum seekers (n= 98) from Zimbabwe, Afghanistan, Iran, Iraq, Lebanon, Pakistan, Sri Lanka	131	Social networks, employment	Gender, age, social isolation, low socio-economic status, family separation, unclear residence status, detention experience, mode of arrival
14	Campbel et al, 2018 [49] U.K.	2005-2007	Longitudinal survey	Refugees	5678	Involvement in community networks, easy access to healthcare services	unemployment, language barriers, unsatisfactory accommodation, being victims of discrimination, infrequent contact with relatives
15	Şimşek et al, 2018 [50] Turkey	2015	Cross-sectional, interview	Refugees	458= females, 15-49 years old	social support, community-based and culturally sensitive health education programs, inclusion of mental health care within basic primary care services	Household size, difficulty to get health services
16	Dietrich et al, 2019 [51] Germany		Interview, survey	Refugees from Syria and Iraq	2057	social support and networks, higher education	Experience of violence, poor housing and sense of insecurity
17	Georgiadou et al, 2018 [52] Germany	Not mentioned	Survey	Syrian refugees	518	Inclusive welfare system	Death of a loved one, age, shorter validity of residence permit, longer duration of asylum procedure, poor economic conditions
18	Schweitzer et al, 2018 [53] Australia	2013- 2015	Cross-sectional survey	Refugees	104	Access to health and welfare services, improved pre-arrival information about the host societies	Traumatic experiences, racial discrimination
19	Segal et al, 2018 [54] Lebanon	2012- 2013	Survey, interview	Palestinian refugees	254	Housing stability, economically gainful employment, social networks, immediate access to mental health clinics	Traumatic experiences, human right violations

20*	Grupp et al, 2018 [55] Germany	Not mentioned	Survey, focus groups	African refugees, German population	239	Praying, ability to fulfill religious rituals	Isolation, Intergenerational conflicts
21	Kandemir et al, 2018 [56] Turkey	Not mentioned	Survey	Syrian refugees	355	Social and welfare supports, education, Social networks	Traumatic experiences, gender, proper housing, enough food, experiences of discrimination and racism
22	Shawyer et al, 2017 [57] Australia	Not mentioned	Survey	Refugees, and asylum-seekers	135	Culturally responsive mental health services, early mental health assessments and treatments	Human right violations, stressful migration experiences, cultural and language barriers to get access to mental health services, country of origin
23	Slewa-Younan et al, 2017 [58] Australia	2013	Interview, survey	Afghan refugees	150	Early intervention programs	Past traumatic experiences
24	Tinghög et al, 2017 [59] Sweden	2011-2013	Cross-sectional survey	Syrian refugees	1215	Reunion with family members	Gender, traumatic experiences, lower education, Isolation in host society, ethnic discrimination
25	Lillee et al, 2015 [60] Australia	Not mentioned	Survey	Refugees	300	Routine use of mental health services, culturally sensitive mental health care	Marital status, having more children, past traumatic events, stigmatization,
26	Leiler et al, 2019 [61] Sweden	Not mentioned	Survey, interview	refugees and asylum seekers	510	Safety, access to health care upon arrival, shortening asylum process	unclear residence permit status, poor neighborhoods
27	Rizkalla and Segal, 2018 [62] Jordan	2014- 2016	Survey	Syrian refugees	250	Active NGOs, refugee-friendly mental health services	Traumatic events, un/ underemployment, poor neighborhood disadvantages
28	Acarturk et al, 2018 [63] Turkey	March-May 2013	Survey, interview	Syrian refugees	781	Inclusive public health policies	Traumatic events, losing sources of income, gender, living in camps
29	Pandya, 2018 [64] Europe	Not mentioned	Survey	Refugees	4504	Voluntary participation in mental health programs, self-practice willingness, spirituality, group-based interventions	Country of origin, refugee status duration, gender, past traumatic experiences

2.6. Quality Assessment

The quality of the eligible studies e.g. heterogeneity and variability in the design, was assessed by the GRADE approach for grading the quality of evidence and the strength of the recommendations in systematic reviews. GRADE approach was developed to improve the transparency of the process of systematic reviews and presenting a logical support or evidence and recommendations [65-67]. According to GRADE guidance, five main quality factors of evidence are as follows: (1) risk of biases, (2) inconsistency of results, (3) indirectness of evidence, (4) impression, and (5) publication bias. Most of the selected studies were non-experimental and their quality were ranked as low. Articles were excluded in this review if they were seriously lacking experimental feature. The main author doubly checked selected studies to assess the quality. A second author checked for the precision of the assessment. Disagreements were resolved through discussion.

2.7. Data Analysis

Due to the heterogeneity of the measurements, methods, and theoretical bases of the selected studies, utilizing statistical methods to combine data for further analysis were impossible. Moreover, study countries, population characteristics and data collection methods were different. As a result, data were narratively synthesized in the systematic review. Selected studies were categorized by the origin of the sample population, mental health risk factors and protective factors, and the prevalence rates of the identified mental health issues e.g. depression, post-traumatic stress disorder, and mental disorder. Within each category, consistency, or contradictions regarding the results of the selected studies were synthesized. Reasons for conflicting results in the prevalence rates, or risks and protective factors for mental health were interpreted according to the evidence and study characteristics e.g. methodological errors, sampling bias, or measure shortcomings.

3. Findings

3.1. Prevalence Rates

Prevalence rates of post-traumatic stress disorder among refugees and asylum seekers in the included quantitative studies were substantially heterogeneous with a range fluctuating between 5.1% [54] to 83.4% [63]. A critical factor in understanding conditions impacting post-traumatic stress disorder in refugee population is the country of origin and the migration pathway. As Pandya contended in a study of five refugee groups from Syria, Iraq, Afghanistan, Eritrea, and Somalia, the country of origin was a significant determinant in PTSD, depression, and mental disorder prevalence rates [53,64]. Refugees studied by Segal were Palestinians who had lived in Lebanese camps for 21 years [54]. They appeared to have less problems in terms of learning language, developing social networks, and integrating into the host society simply because of the very similar culture and the official Arabic language in the host country in Lebanon. They had fewer PTSD symptoms than participants in similar studies, but their general mental health was critical. However, Leiler et.al reported that levels of PTSD symptoms among refugees were about twice as high as in global general population studies [61]. Lillee et.al found significantly higher PTSD prevalence rates among refugees than among the general population [60].

Depression prevalence rates varied less than post-traumatic stress disorder, however, it was still impossible to attain an understanding of the situation. Major depressive disorder ranged from 14.5% [52] to 53.1% [48], which is substantially higher than the rates among the general population of the host society. Leiler et.al concluded that the prevalence of depressive symptoms was five times higher in the sample population than in the Swedish general population [61]. Georgiadou et al, investigated PTSD symptoms among settled refugees with residence permits in Germany [52], while the sample population in Hocking and Sundram's study investigated asylum-seekers in Melbourne, Australia, without residence permits [48]. This reason may justify the gap between the findings of the two studies and highlights the importance of having a residence permit [52].

Mental health prevalence rates varied from 35.7% [60] to 55% [59] in the selected refugee population. The country of origin was again found to be a significant mental

health determinant and could be a reason for the differences in the reports of prevalence rates of general mental health [64].

3.2. Comparing Risk and Protective Factors across Mental Health Diagnosis

The evidence presented in this systematic review supports the findings of previous studies that mental health issues of vulnerable populations are multidimensional, and widely measured outcome of health issues, yet of great concerns. However, the measures and perspectives that attempted to explain mental health issues are top-down and academic-marketing oriented, and less of them were supported to really explain refugee's points of views.

Socio-demographic factors in this literature review appeared to reflect the findings of previous research. Women were at greater risks of developing poorer mental health than men, and poor mental health was associated with having more children [46,54]. Due to the possibility of adapting to a new environment and behavioral resilience, young refugees could find adjustment to a new culture easier compared to the older age refugees [52]. The country of origin and the reasons for migration appeared to be positively associated with mental health, post-traumatic stress disorder, and depression symptoms [64]. Low socioeconomic and educational levels were strongly associated with mental health outcomes, as poorly educated refugees with lower incomes were at greater risks of adverse mental health outcomes [38,50,51]. However, it is proven that recently resettled refugees with higher education and socioeconomic backgrounds in their home countries were at greater risks of developing mental health issues during the period leading up to the outcome of their asylum application [68].

Unemployment was another important risk factor that was referred to across the selected studies [48,49,51,54]. However, the causation of the link between unemployment (or under-employment) and mental health remains contentious [51,69]. Campbell et al. referred to the direct effect of unemployment on mental health issues in which unemployed people suffer negative side effects in daily life [49]. Unemployment may result in financial problems and loss of self-esteem, loss of social networks and social participation, and may increase the risk of dangerous behaviors, such as smoking, drinking, and drug abuse [39].

Another common risk factor was the effect of housing quality. Some refugees were accommodated outside of urban areas in poor quality collective shelters. Dissatisfaction with accommodation resulted in isolation and low self-esteem and both factors endanger the mental health of refugees and asylum seekers [49,70]. Accommodation policies of the host countries have been a growing area of controversy. Phillimore and Goodson long before the 2015 refugee crisis contended that policies for accommodating refugees in dispersal areas may result in higher levels of unemployment. They concluded that these processes together exacerbate the general levels of social exclusion in the host societies [70].

Infrequent contact and interaction with relatives and friends found to be associated with poorer mental health outcomes [47]. Development of new social networks in host countries found to be an offsetting element [50]. The importance of language acquisition for social interaction was highlighted. Involvement in social activities and community networks requires acceptable knowledge of language skills [49]. Without linguistic skills, no connection, and consequently, no integration is possible. This problem was mostly common among older refugees. The potential for learning a new language decreases as age raises [69]. Thus, social isolation, because of not having enough language skills, was strongly associated with negative mental health issues.

Perceived discrimination and prejudice appeared to be associated with poorer mental health. Victims of discrimination and physical violence report that they suffer from adverse well-being feelings [71]. They constantly worry about the recurrence of such incidents and feel angry. This makes these victims isolated as time passes on, and in extreme cases, an individual may respond with violent behaviors [72].

Selected qualitative studies in the current review provided more in-depth view of the risks and protective factors for the mental health issues. In terms of protective factors,

community supports, and social networks of refugees seemed to play a crucial role in dealing with mental health issues [37-39,41,72]. According to the findings of Affleck et al., community representatives of Sri Lankan Tamil refugees, were actively screening mental health of each members of the community and in doing so, those who were recognized suffering from various mental health issues, were closely taken care and treated according to the traditional practices [36]. This can be a good example for a sustainable mental health program that shows how to use community potentials to manage its member's well-being, and health.

Cultural empowerments of service providers and raising awareness of the people in the host countries through sustainable intervention plans were another effective protective factor for the mental health of refugees [41]. Cultural awareness specially in the side of social workers and service providers creates mutual understanding of refugee's various needs. The compatibility of the services with the cultural beliefs and expectations of the stakeholders, as Pandya mentions, raises voluntary participation and self-practice willingness towards mental health services among refugees and asylum seekers [64].

Considering all risks and protective factors for the mental health of forced migrants, qualitative studies proved to be more detailed and reliable. Especially when it comes to the practice research and seeking sustainable solutions for the issues of forced migrants. Selected qualitative studies in this review also merited acquiring bottom-up approaches in which, refugees and asylum seekers are actively participated in the research process. This is in line with our contends on the benefits of the ecological perspective when dealing with vulnerable populations.

4. Discussion

4.1. Promoting mental health care – implications for sustainable social work practice

The bold fact of leaving one's home forever and adapting to a new environment and culture is highly stressful and when associated with lack of social integration and unemployment, the lived experience of stress increases in a stepwise manner [73]. The high prevalence of mental disorders associated with refugees can pose significant challenges such as the impact of pre-migration traumas on mental health in the settlement context. Very few studies have found that mental health interventions such as narrative exposure therapy have been successful. Sometimes therapies can focus on diagnostic features of PTSD whilst overlooking aspects such as relationships and a sense of meaning [74-76]. Interventions should include social integration, facilitate access to care as well as fostering engagement to promote and provide good mental healthcare to these groups in a culturally appropriate, holistic, and sensitive manner.

There are certain gaps in the research identifying what factors in specific contexts would help. Nevertheless, the literature has reported that certain interventions are more ecologically valid. Naturalistic mental health interventions could be seen as alternatives for refugees where treatment is provided in the context of an existing service including social and medical services [75]. Interventions that utilize available information and communication technologies (ICTs) would be seen to be advantageous. One of the most salient mental health issues results from refugees missing their loved ones and being concerned about their well-being and ICTs has not only facilitated refugees' well-being by facilitating their journey to their destination but also it helps them find out critical information post-arrival of their host country. Most importantly it bridges the gap between separated families. Therefore, it would be practical and innovative to use communication technologies that refugees already widely use that would even further facilitate diagnostic testing and address language barriers.

The issue of mental health in the Refugee context is therefore a complex one and because of the synergistic relationship between refugee mental health and the broader social context, it is important that more research is conducted identifying who benefits from certain interventions and at what point in their integration trajectory would be most effective. This knowledge is relevant for social work and policymakers to design and

deliver sustainable mental health care services with an ecological perspective harnessing the practical tools that refugees already possess. This can ultimately enhance the social wellbeing of this frequently marginalized population and it is also relevant to the whole process of successful integration which ultimately benefits economies of the receiving countries.

4.2. Limitations

Systematic reviews are useful methods for informing policy and practice and was chosen in this study because it allows us to combine various conceptualized topics from quantitative and qualitative research, by comparing current research traditions with comprehensive and rigorous judgements. Although “systematic reviews” are generally considered as rigorous, transparent, replicable, and unbiased ways to assess the quality of the evidence following a fixed process [77], they have considerable shortcomings as every other scientific method intrinsically acquire.

In summary, systematic reviews provide a more rigorous method of reviewing the literature to inform decision making, although the quality can be unreliable, and results are decontextualized. However, the purposes of this study were to focus on the risk and protective factors for the mental disorder, PTSD, and depression disorders, and secondly on the prevalence rates of the mentioned disorders, rather than the quality of the measures. A limitation of the present study is the fact that different sample populations in the selected studies made it difficult to conclude the exact prevalence rates. Refugees and asylum seekers that were studied in the current review had mostly Middle Eastern, African, or South Asian backgrounds. Although all the participating persons in selected studies were categorized as refugees or asylum seekers, they had different experiences of internal war in terms of the time, cultural, and religious backgrounds. One cannot sort all of them in a single category and generalize the findings to the whole refugee and asylum-seeker population. We think that the latter limitation is very important as systematic reviews decontextualize the studies from their specific context.

5. Conclusions

The findings of the current study indicate that risks and protective factors for the mental health of forced migrants are multi-dimensional and closely knitted with the everyday lives of refugees and asylum seekers. To address the mental health risks and protective factors amongst vulnerable refugee populations, the application of the bottom-up approaches would be more feasible. There are clear potentials within refugee communities that if recognized by practice research and empowered by policy, sustainability of interventions and therapies would increase.

We highlighted the need for acquiring a holistic approach in the field of mental health of forced migrants and insisted that socio-ecological framework is a critical component for a sustainable and culturally relevant practice. When socio-ecological perspective is in the forefront of a social worker’s approach to refugees, this vulnerable population’s needs will be more sustainably served --in a more culturally responsive manner. In the context of the barriers refugees face in accessing mental health care, it serves at least in a rudimentary way as a useful framework in identifying, systematically organizing, and analyzing the determinants.

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