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Invited Submission

Biomedical Approaches to Refugee Mental Health in Areas of Limited Capacity: Current Trends and Implications on Refugee Mental Health and Mental Health Practice in Europe's Refugee Centres

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Abstract

The use of biomedical approaches in evaluating and treating mental health challenges among refugee populations has been shown to have detrimental effects on individual mental health, as it negates individual resilience, agency, and sociocultural context, and contributes to stigma. In Europe's migrant resettlement and reception centres, the overwhelming demand for mental health services brought on by the current refugee influx and the inability of national health systems to respond to this demand have contributed to prolonged detention, dangerous living conditions, uncertainty, limited access to information, and a severely limited capacity to evaluate the long-term effectiveness of treatment methods. These conditions have exacerbated the medicalization of trauma and the use of "quick fix" approaches to mental health treatment that have contributed to re-traumatization and trauma prolongation. In light of these capacity deficiencies, mental health practitioners working in migrant reception centres must utilize locally available resources and knowledge, and not remain dependent on overburdened national health systems. Utilizing community-based and informal mental health frameworks will allow practitioners to circumvent capacity shortcomings, build community mental health response capacity, and address the overuse of medical labels.

Key words: refugee mental health; trauma medicalization; European refugees; capacity development; community knowledge

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Introduction

It is widely acknowledged that refugees arriving from conflict-affected regions have often witnessed or experienced violence and displacement (Nicholson, 1997). From a mental health perspective, these potentially traumatic events can exhibit themselves in behaviours and emotions that can vary substantially across populations and individuals, and the context in which they occurred. Numerous scholars have demonstrated that individual refugees evaluate and perceive their trauma differently in accordance to cultural nuances, and that these perceptions can substantially influence these individuals' needs and the effectiveness of treatment (Savic et al., 2015; Summerfield, 2003; Sousa & Marshall, 2017; Papadopoulos, 2001). For refugees arriving in Western countries, their perceptions of their own experiences and traumas often put them at odds with established biomedical mental health treatment frameworks, which tend to view them neutrally as vulnerable victims of violence who are in urgent need of psychiatric treatment (Summerfield, 2000; Karageorge et al., 2017).

In examining the current refugee movement affecting Europe, the paper seeks to bring attention to the growing tendency to medicalize individual refugees, its relationship to capacity shortcomings, and its implications on the mental health of migrants and the effectiveness of treatment approaches. The paper first provides an overview of literature on what trauma medicalization is, and its implications on the mental health of individual refugees. Following this, the substantial refugee movement currently affecting south and southeast Europe will be examined in order to highlight the implications that these factors have on refugee mental health and treatment. Subsequent to this, recommendations and potential alternative treatment approaches will be briefly highlighted, followed by conclusions on how mental health workers can adapt their methods in areas of limited mental health response capacity.

Methodology

The paper utilized predominantly peer-reviewed journal articles and reports published by international non-governmental organizations (NGOs). Articles were collected via EBSCOhost and JSTOR using keyword and author searches, as well as through examination of individual article

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reference lists. NGO reports were gathered via document and publication searches on NGO websites and through article reference lists. Only English-language publications were referenced.

Background

Trauma medicalization is defined by Clark (2014, pg. 2) as “a process by which human problems come to be defined and treated as medical problems.” The use of biomedical models in viewing individual mental health often results in everyday feelings and emotions becoming categorized as medical diagnoses that require treatment by mental health professionals. Clark argues that the tendency of using such approaches is growing, partly due to the growth of diagnostic categories in both mental and physical health. For instance, Clark (2014, pg. 2) notes that the World Health Organization categorizes “depression, anxiety disorders, schizophrenia, bipolar disorders, alcohol and drug use disorders, mental disorders of childhood, migraines, dementias, and epilepsy” all under the collective banner of MNS (mental, neurological, and substance-use disorders). Such broad and all-encompassing labels pathologize a wide range of emotions and symptoms, often to the detriment of individual mental health (Clark, 2014). Summerfield (1999) supports these views, arguing that “everyday encounters” and feelings such as motor-vehicle accidents, anger, loneliness, and fear have increasingly been drawn into mental health symptomatology and illness, contributing to medicalization of human emotion (pg. 1451). For refugees who have escaped active war zones, these preconceived notions lead to a tendency to view these individuals as brutalized, sick, and in need of intervention to stop the entrenchment of self-destructive symptoms (Summerfield, 2002).

Pilgrim and Bentall (1999) elaborate that distinguishing between “depression” and emotion is made similarly difficult by “the ambiguity about what constitutes depression,” due to the widening of relevant symptomatology (pg. 263). Howell (2012) further argues that symptoms warranting a Post-Traumatic Stress Disorder (PTSD) diagnosis can be “experienced, witnessed, or even learned about,” which has correspondingly led to increased diagnosis rates and diagnoses “en masse” (pg. 216). The author also states that this overuse of the PTSD diagnosis is prominent towards migrant populations who may question the term’s applicability, and that PTSD has become increasingly neutral to sociopolitical context.

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Implications of Biomedical Models on Refugee Health

The use of biomedical labels in categorizing individual behaviour and emotion is intricately tied to an inadequacy by practitioners to recognize variations in belief systems across cultural groups (Pilgrim & Bentall, 1999; Savic et al., 2015; Summerfield, 1999; Summerfield, 2000; Clark, 2014). Summerfield (2000) argues that mental health practitioners often assume incorrectly that frameworks designed for Western populations are applicable to all individuals, and can transcend cultural boundaries. Pilgrim and Bentall (1999) state that the assumed universality of these frameworks, and of terms such as depression and PTSD, leads to a clash of cultures where refugees who may not see themselves as ill are assigned a medical diagnosis in spite of their perspectives. Savic et al. (2015) present an Australia-based study of 20 Sudanese refugees and community workers that exemplifies this clash. Several of the study's participants did not recognize depression as a diagnosis applicable to them, and were often not limited by their past experiences living in a conflict zone. Despite this, many were viewed by community health workers as requiring treatment in order to guarantee long-term mental health, despite the lack of relevant symptomatology.

Abraham, Lien, and Hanssen's (2018) study of 18 female Eritrean refugees living in a Norwegian asylum reception centre yielded similar results. The authors report that participants viewed their mental health challenges as normal consequences of their experiences during conflict that did not warrant mental health intervention. The authors of this study, as well as Savic et al. (2015), conclude that the perspectives and interpretations that individual refugees have of their own experiences must be given more attention in evaluating and treating mental health challenges.

The two cases highlighted above indicate that pathologized approaches to traumatic experiences and memories cannot be applied to all populations; refugees arriving in Western countries often have their own perceptions of their experiences that go against these frameworks. The use of these frameworks on refugees, and limited acknowledgment of individual healing and coping mechanisms, can be detrimental to their mental health in various ways, to be examined next.

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Resilience and Agency

Medicalized approaches to refugee mental health often fail to acknowledge individual *resilience*, defined as "an ordinary process and basic human adaptation to circumstances that occur in one's life," that is "dynamic in nature, is not an either-or status, and is influenced by one's culture and context" (Goodman et al., 2017, pg. 310). Pupavac (2006, pg. 14) states that perceiving refugees as suffering from illness has created an atmosphere where they are viewed as helpless, "feminized" victims, which undermines their ability to confront challenges they may be struggling with. Summerfield (1999) also supports this notion, stating that refugees who do not seem negatively affected by past violent experiences are often assumed to have traumatic scars 'under the surface' that can only be addressed by medical professionals. Papadopoulos (2007) similarly contends that "the mere existence of certain devastating events should not lead to a conclusion that every person exposed to them is likely to be psychologically traumatized" (pg. 304). Individuals who have survived the journey from conflict-affected regions often have their own methods of healing and coping that have helped them overcome adverse challenges, and adjust to a new environment (Savic et al., 2015). Abraham, Lien, and Hanssen's (2018) study participants, as mentioned above, did not view themselves as traumatized victims and expressed hope for their future prospects, an indication of their resilience and ability to cope with challenges.

Papadopoulos (2001) brings attention to the effect that the portrayal of refugees as helpless beneficiaries of treatment can have on individual agency. Individual agency is defined as "the capacity possessed by people to act of their own volition" (Castree, Kitchin, & Rogers, 2013, pg. 8). The assumption that refugees do not have the capacity to alone deal with any challenges they are confronted with leads to their dependence on mental health professionals, which Papadopoulos (2001) argues leads to "cycles of dependence" that negate agency (pg. 417). Other authors have also made this claim. Howell (2012) states that presenting refugee mental health challenges as "something to be cured" implies that these individuals have no choice but to entrust its treatment to medical professionals (pg. 216). This ignores their own unique methods of healing, and their ability to confront traumatic events.

Pupavac (2006) echoes this perspective, asserting that undermining refugee resilience and medicalized labels cause individuals to "[become] an object of professional management" and "legitimizes their rights being inverted into the rights of the external advocate," that external advocate

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being a medical professional acting on their behalf (pg. 20-21). Pupavac further states that placing refugee individuals under the 'management' of a health professional also leads to the assumption that individuals with mental health challenges cannot be held accountable for their own actions, contributing to further loss of agency and self-ownership.

Community and Context

A common critique of the medicalized approach to refugee mental health is that it tends to focus overly on the individual unit, disregarding the wider community and sociopolitical context that accompanies the refugee experience (Sousa & Marshall, 2017).

Sousa and Marshall (2017) present a study of several youths in Palestinian refugee camps in the West Bank, where the authors demonstrate that the historical and sociopolitical context from which individual perspectives are formed are critical in understanding individual mental health. Many of the study participants viewed their experiences as a "collective struggle of the family, the camp, and the nation" (pg. 792), and gained purpose and drive from their familial obligations, religion, and community's support. The authors, however, state that "collective responses" clash with the medicalized notion that the individual is ultimately responsible for confronting mental health challenges, and that the political context that the participants were embedded in was mostly ignored by community organizations (pg. 790). The authors also state that past project proposals did not mention the context of the Palestinian conflict, the Israeli occupation, and the conflict's deeply embedded and long-running sociocultural influence. Instead, Palestinian youth were identified as targets for intervention due to behavioural issues, social issues, and a propensity for violence. Sousa and Marshall argue "this medicalization of political violence de-contextualizes and dehistoricizes trauma, effectively ignoring how larger structures, such as families, communities, and entire societies are both affected by and actively respond to political violence" (pg. 789).

Zarowsky (2004) reinforces this view, claiming that treating sociopolitical context as secondary to the individual refugee, and a failure to "situate the individual suffering and emotional experience and expression of refugees in relation to the broader political and economic forces" will result in an inability to comprehend individual collective memory (pg. 202).

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Papadopoulos (2001) similarly states that the sociopolitical context that underpins the refugee experience is often difficult for clinicians to discern from "background noise" and irrelevant data (pg. 407). Critically, Papadopoulos states that such a perspective leads clinicians to pursue only the information deemed relevant by themselves, with limited insight into alternative treatment approaches and refugees' own perceptions. He also states that there is often a tendency for practitioners to relate any mental health challenges a refugee may face to the fact that they are refugees, viewing all these individuals as equal and part of a homogenous diagnostic category (Papadopoulos, 2001; Papadopoulos, 2007). As Sousa and Marshall's (2017) study indicates, sociopolitical and historical context underpins individual beliefs and perspectives, and is therefore crucial for understanding individual mental health challenges. The studies conducted by Abraham, Lien, and Hanssen (2018) and Savic et al. (2015) support the notion that culturally-specific healing and coping methods, such as religion and community, substantially influence perceptions on mental health and treatment, both at individual and community levels. Sousa and Marshall (2017) conclude that "acting on the political context of suffering" builds resilience, purpose, and agency among individual refugees, contributing to improved treatment effectiveness (pg. 794).

Stigma

Stigma with regard to mental health is not exclusive to refugee populations; however, for refugees, the stigma already prevalent with refugee status alone can be made worse by medicalized labels that further isolate individual refugees as dangerous and burdensome (Savic et al., 2015). Kvaale, Gottdiener, and Haslam (2013) state that it is often incorrectly assumed that biomedical explanations for mental health can help to reduce stigma, since individuals struggling with mental disorders are seen as being at the mercy of an illness they have no control over. The authors' findings indicate that medicalized labels instead contributed to a perception of individuals as dangerous and a desire to keep distance from them due to their supposed unpredictability.

In a meta-analysis of 33 studies, Angermeyer et al. (2011) conclude that "biogenetic causal attributions" for mental health did not lead to more tolerant attitudes towards individuals with mental health challenges, instead contributing to rejection and a "desire for social distance" (pg. 367, 369). The authors also conclude that as "a medical definition of the problem suggests a medical solution,"

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medicalized labels can lead to increasing reliance on mental health professionals to address the unique needs of individual migrants (pg. 370).

Jorm, Reavley, and Ross's (2012) meta-analysis of 125 mental health studies similarly concludes that public beliefs in the dangerousness of individuals labelled as having mental illnesses is common and made worse by the 'illness' label. This is especially prevalent in attitudes towards males. Read and Harré (2001) further support these findings in a study of 469 undergraduate students in New Zealand, concluding that the label of "mental patient" contributes to beliefs of dangerousness, unpredictability, and anti-sociality, which may lead to discrimination against these individuals with regard to employment and other opportunities (pg. 223).

For refugee individuals, the stigma attached to mental health 'illnesses' is often exacerbated by their refugee status. Refugees have long faced discrimination as "threats to national security and the global political-territorial order," especially in the aftermath of the 9/11 attacks (Loyd, Ehrkam, & Secor, 2018, pg. 3). Murašovs et al. (2016) indicate that refugees are mostly perceived negatively in Latvia by the general public, due largely to misconceptions about refugees taking economic opportunities and welfare away from the host population, and negative media portrayals of refugees. Plener et al. (2017) similarly found that public perceptions in Germany have favoured the immediate deportation of unaccompanied refugee minors from the country, particularly those from the Balkans and Africa. The refugee influx has also contributed to divisive political and societal debates throughout Europe regarding refugee resettlement and its supposed risks (Al-Jazeera, 2015). Considering the prevalence of such stigma, medicalized labels can contribute to further isolation and marginalization of individual refugees.

Current Trends in Europe's Refugee Centres – the Relationship Between Biomedical Approaches and Limited Capacity

Migrant access to psychiatric services has been strained in countries that have seen exceptionally large influxes of asylum seekers. Germany, Greece, Austria, Hungary, Denmark, and Italy have all implemented various forms of border control to deal with the influx (Blitz et al., 2017). Per capita, Greece saw the largest influx of migrants in Europe in 2015, which commonly serves as an entry point to the rest of Europe (Global Detention Project, 2018). In response to these numbers,

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migrants are increasingly housed in reception centres on Greek islands and barred from accessing the mainland or travelling on to other parts of Europe. The Global Detention Project reports that many of these camps are unsanitary and unsafe, and that many detainees do not have access to medical care. They further report that vulnerable migrants often face months of detention due to a lack of alternatives. Similar capacity deficits are reported with a lack of qualified mental health personnel, lack of interpreters, and lack of access to information and mental health knowledge in Greek and Italian reception centres (Blitz et al., 2017; International Medical Corps, 2016). Several organizations and observers have reported that these camp conditions have contributed to further mental health distress, deterioration, and re-traumatization among the migrant population, as they face the uncertainty of prolonged detention, have limited information or access to interpreters, and limited autonomy. High suicide and self-harm rates have been reported, as well as domestic violence, alcohol and drug abuse, miscommunication, exploitation, and discrimination, which have been caused or exacerbated by prolonged detention and isolation (Al-Jazeera, 2017a; Al-Jazeera, 2017b; The Guardian, 2016; Amnesty International, 2018). In some cases, refugees have arrived in reception centres hoping for safety, only to find that conditions are exacerbating their past experiences and mental health challenges (MSF, 2018b).

Blitz et al. (2017) report that Italian reception centres have encountered similar issues. Centres often do not have sufficient medical staff present, with only 35% of migrants in the country having access to psychiatric services at the time of study, compared to only 26% in Greece. Even when psychiatric services were available, many interviewees reported that they were never made aware of this availability. The availability of these services also depended substantially on the location of migrant camps, with large variability across locations.

In examining the situation in Greece, the International Medical Corps (2016) reports that the country does have a national mental health plan, and has offered free mental health clinics to migrants; however, the large number of migrants, as well as language barriers, has meant that access is limited, and that NGOs provide the majority of mental health services in reception centres to fill the capacity gap. It is further reported that there exists only one centre in Athens offering psychiatric services tailored specifically for the unique needs of refugees and asylum seekers.

Médecins Sans Frontières (MSF) further states that the Greek detention centres on the islands of Lesvos and Samos do not have adequate mental health facilities, with individuals often waiting

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months for psychiatric care due to the large demand for services (MSF, 2017a). MSF (2016a) also reports that funding and staff shortages have led to insufficient psychiatric support for migrants in Italy, and that in many of Italy's Extraordinary Reception Centres (CAS), such services are similarly non-existent or improvised by staff.

The capacity deficits evident throughout the migrant reception systems of host nations have had numerous implications on the approach taken to address the mental health of migrants. For instance, Human Rights Watch (2017a; 2017b) reports that the European Union has increasingly pressured Greek officials to reduce the number of refugees categorized as 'vulnerable,' a designation that would have them fast-tracked to the European mainland. This move was largely enacted to stem the flow of asylum seekers to Europe, due to limited response capacity and to deter further migrant crossings.

In an analysis of Italy's CAS sites in Rome, Milan, and Trapani, MSF (2016a) reports that individuals who exhibit mental health symptoms are only reported once aggression or "disturbing attitudes" are shown, leading to hospitalization as a "quick but unstructured" solution to individual mental health challenges (pg. 14-15). MSF elaborates that hospitalization is often used as a way to get rid of problematic individuals, even those who do not have mental health impairments, a practice that is common within the reception system. The organization has also reported that in Greek reception centres, individuals who exhibit risky behaviour are often kept in jail as a way to keep other individuals safe, and that many are detained in spite of mental health diagnoses (MSF, 2017a). Migrants who display such risky behaviour or attitudes may also simply be transferred to other reception sites, where their access to services is equally minimal. MSF (2016a) states that this practice is directly related to the limited response capacity of local health systems, and that these practices will continue as long as this capacity gap exists. Local mental health systems are also not adapted to the unique cultural context of diverse refugee groups, meaning that the perceptions and belief systems of the refugees themselves are often ignored. Individuals who are hospitalized or transferred are not kept track of after release, making follow-up reporting impossible.

A separate MSF (2018a) study reveals that due to capacity deficits in Italy's reception centres, hospitalization is often the only way for migrants to access mental health care. Due to an overreliance on western notions of mental health and the strain placed on health systems, certain regions in Italy now require medical certificates as proof of a genuine asylum claim (MSF, 2018a).

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The prevalence of such practices is supported by Fassin and D'Halluin (2005), who state that medical certificates are increasingly used as evidence of refugee status by officials, forcing migrants to seek out medical diagnoses as proof of their plight, even if such a diagnosis may be unnecessary.

This trend has also been noted today in Turkey, where Loyd, Ehrkam, and Secor (2018) state that medical certificates showing a PTSD diagnosis can substantially influence an asylum claim's success. The authors state that the United Nations High Commissioner for Refugees (UNHCR) often uses medical certificates to verify asylum claims and decide which individuals are eligible for resettlement in Western countries. Furthermore, if an asylum seeker's story does not fall in line with the medical certificate, this may preclude them from consideration due to preconceived notions of how individuals with PTSD are supposed to react to trauma.

Discussion

The literature analyzed indicates several implications for mental health practitioners to consider with regard to examining the refugee experience through an overly medicalized lens.

Inadequate recognition of the resilience and agency of individual refugees removes their ability to maintain control over their futures and wellbeing, and puts them under the tutelage of medical professionals who may pursue unsuitable frameworks to address mental health challenges. Confronting this mismatch is crucial for mental health practitioners and for the health of individual refugees.

The cultural and sociopolitical context from which individual perceptions and belief systems are formed are equally important to acknowledge. These experiences are often a source of resilience and strength for refugees, and are avenues through which they can confront and cope with challenges. They also influence perceptions of mental health and guide individual attitudes and receptiveness towards mental health treatment. Consequently, ignoring such context in favour of individualized biomedical frameworks risks negating the refugee experience.

Stigma against refugees is prevalent in many host nations. In the wake of the societal divisions created by the scale of the current refugee movement, such stigma has gained increased traction. The compounding of both mental health-related and status-related stigma can have a detrimental

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impact on individual refugees. This fact reinforces that arbitrary medicalized labels do a disservice to refugees attempting to resettle in Europe, in the wake of stigma they already may face due to their refugee status.

The lack of mental health response capacity in nations most affected by the refugee influx has resulted in many of these issues coming to the surface. Observations in reception centres of reliance on untrained personnel, improvised or insufficient services, and language barriers can limit recognition of individual needs and experiences. The failure to acknowledge the cultural context inherent in the refugee experience can lead to a poor understanding of individual emotions and behaviours, and overreliance on medical labels. Such practices can negatively impact individual resilience and agency, as the opinions of medical experts are given priority over the asylum seeker's narrative, and only information deemed relevant by the practitioner is considered.

Equally critical, however, is the fact that medicalized approaches, and the inadequacy of existing health systems to respond to migrant mental health, only contribute to the further overburdening of these systems, and further reliance on biomedical approaches. As migrants are left with limited or insufficient mental healthcare options and worsening mental health, demand for service provision will only go up, creating a deteriorating cycle that can cripple mental health systems further and increase the prevalence of improvised, insufficient treatment methods. The unnecessary hospitalization and jailing of troubled or challenging individuals can also contribute to this cycle; as examined above, discrimination and perceptions of migrants as dangerous and unstable increases stigma, and harms their ability to integrate and settle in host countries. As these individuals are released, the barriers created by incarceration and stigma can lead to continued dependence on mental health services, which will catalyze the strain on these systems and contribute to migrants' loss of agency, as they become "object[s] of professional management" (Pupavac, 2006, pg. 21). Unfortunately, as medical labels are often the only way for asylum seekers to access care, individuals will continue to seek out a medical diagnosis, contributing further to this cycle. The inability of many reception centres to keep track of asylum seekers after they are hospitalized or removed can also perpetuate discrimination and mental health challenges.

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Examples of Non-Biomedical Approaches to Mental Health Support

Given the severity of capacity deficits within refugee reception centres and camps in those nations hit worst by the refugee influx, mental health practitioners must alter their approaches to identifying and treating the mental health needs of migrants. As migrants are increasingly confined to isolated camps with limited access to comprehensive services, migrants risk haphazard diagnosis, hospitalization, and stigmatization, and also face having their experiences downplayed or generalized. In order to address these challenges, practitioners must focus their efforts on utilizing the knowledge and resources that are available within the camps and community, which are the migrants themselves. Community-based mental health interventions are one way to mobilize the resources available within the migrant camps, work around chronic funding and capacity shortages, and allow individual refugees to tell their stories and experiences without being arbitrarily labelled through biomedical frameworks. The cases examined below were selected to demonstrate community-based mental health interventions in a variety of settings, and to indicate the different ways in which such interventions can be utilized, their wide applicability, and the variety of ways traumatic events and experiences can be framed.

In the city of Schweinfurt, Germany in 2017, MSF launched a 12-month pilot program that addressed mental health service deficits by training recently settled former asylum seekers as “psychosocial peer counsellors” for refugees currently arriving (MSF, 2017b, pg. 8). The project sought to circumvent language barriers, epistemological differences, stigma, and lack of specialized care by mobilizing members of the migrant community to offer mental health support to their peers at a “low-threshold” level (pg. 6). Group and individual interviews were conducted in the participant’s “living environment” and in their native language, in order to allow migrants to connect with individuals of shared experiences, and build the capacity of the migrant community to respond to the needs of community members (pg. 12). While the program did encounter challenges due to the heterogeneity of participants and the difficulty some peer counsellors had in maintaining a “professional distance” from participants, MSF reports that the low-threshold pilot program was effective in confronting refugee mental health in an environment of limited resources (pg. 20).

A second example of a community-driven mental health approach is reported by National Geographic (2018). The aid organization Humanity Crew launched a project called the Heroes Project in 2018 to address the limited availability of mental healthcare in Greece’s migrant reception

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centres. The project sought to "reshape the narrative of traumatic events as they happened" by treating the experiences, journeys, and narratives of individual refugees as accomplishments, and indicators of their resilience in the face of challenging odds (National Geographic, 2018). These stories would then be communicated between residents in the camp. Humanity Crew states that this approach was effective in confronting traumatic memories at the source. The project also helped acknowledge the refugee experience and avoided treating refugees as helpless victims, transforming "a traumatic experience into an empowering one" and recognizing individual agency (National Geographic, 2018).

Denborough et al. (2006) present a different community-based narrative model to confronting mental health challenges in Australia, between the Northern Territory communities of Gunyangara and Yirrkala, and the South Australia city of Port Augusta. The project was designed to confront the high prevalence of suicide in these Aboriginal communities, by having individuals share narratives of their experiences, coping mechanisms, and healing methods. Letters and recordings of individual narratives were sent between the communities, while community health workers were trained in "witnessing and responding" to these stories (pg. 47). The authors state that members of the very distant northern and southern communities were very enthusiastic in sharing their experiences, due to a shared identity, similar cultures, and very similar experiences of mental health challenges, substance abuse, and suicide. The narrative approach was an effective framework for giving community members a sense of purpose and resilience, as they were "making a contribution to the lives of others" who shared their identities and experiences (pg. 47). This study is an example of how a community's own knowledge can be mobilized to tackle mental health challenges and build capacity within and between communities.

In order to understand the various ways in which traumatic experiences and events can manifest in individual refugees, Papadopoulos (2007) presents what he calls the Trauma Grid. The trauma grid frames trauma as potentially having positive, negative, and neutral effects that can affect not only the individual, but also their familial, communal, and wider societal spheres. Papadopoulos states that this framework can help practitioners recognize the variety of responses that individual refugees can exhibit to trauma, and that these responses are not restricted to the negative. He also states that the framework can remind practitioners "to see each individual in terms of their differentiated functions and responses" rather than as homogeneous entities (pg. 309); that positive,

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negative, and neutral effects of trauma can have implications for families, communities, and cultures, as well as at the individual level; and that the community and cultural context plays an active role in defining individual perspectives.

Conclusion

Biomedical approaches to migrant mental health are more often than not incompatible with the epistemological differences inherent across diverse populations. In the context of the current refugee influxes affecting European host nations, this approach is tied to the limited capacity of individual countries' healthcare systems to respond to migrant mental health needs. This is particularly evident in Germany, Greece, and Italy. As healthcare systems are increasingly overstretched, the ability of these systems to respond to the unique needs of individual migrants is limited, resulting in haphazard, improvised, short-term approaches that can exacerbate existing mental health challenges and medicalize individuals. The hospitalization, jailing, and extended detention of vulnerable migrants is indicative of this capacity shortcoming, which can lead to further stigma, loss of resilience and agency, and overlooking of migrants' experiences. These observations also indicate that practitioners working with migrant communities in areas most affected cannot depend on national healthcare systems alone to adequately meet the mental health needs of those residing in camps and reception centres.

Given this issue, mental healthcare practitioners who work in Europe's refugee camps must focus their efforts on utilizing the experiences, knowledge, and skills of refugees residing in communities as a primary avenue for addressing mental health challenges, and be cognizant of the inapplicability of a one-size-fits-all framework. As migrants spend increasingly longer periods of time in centres, individuals living in these communities are well-positioned to address their mental health needs. The three cases briefly examined above highlight the various ways in which migrants can be mobilized by health practitioners to address mental health challenges within their own communities, share experiences, and build local mental health response capacity. Papadopoulos' (2007) trauma grid provides a framework that practitioners can utilize to remind themselves of the uniqueness of individual experiences, events, and perspectives on trauma, and the context inherent to any individual belief system. In light of low national mental health response capacities and limited

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resources in many of Europe's refugee centres, such approaches present a more appropriate and realistic framework for addressing migrant mental health needs.

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