Exploring Higher Education as a space for promoting the psychosocial wellbeing of refugee students

Abstract

Objective: This study aimed to investigate how well a single higher education institution (HEI) was perceived to be meeting the psychosocial support needs of refugee students, and to identify possible ways in which the HEI might better promote refugee students' psychosocial wellbeing.

Design: Adopting an exploratory, focused case study design, the research employed a qualitative interpretive approach utilising three data collection methods: narrative inquiry, Photovoice and key informant interviews. The social ecological model and the health promoting university approach guided the enquiry and analysis.

Setting: A single higher education institution (HEI), Albarn University (AU), in London, UK[1]

Results: Refugee student participants reported stressful and traumatic experiences at different points in their migratory experience. Participants were motivated by being involved in education but identified barriers to seeking institutional support to improve their health and wellbeing. Student participants and staff identified ways in which support for refugee student wellbeing at AU could be improved.

Conclusion: Refugee students at AU were found to have specific health and wellbeing support needs which were not met due to a range of organisational constraints. The social ecological model and the health promoting university offer frameworks for HEIs which may respond better to the diverse health and wellbeing needs of students.

Keywords: Refugee students, Health Promoting University, social-ecological model, psychosocial wellbeing.

[1] The name of the setting is fictional and the names of participants have been changed to protect anonymity

Introduction

The United Nations High Commission for Refugees (UNHCR, 2016) estimates that globally 65.6 million people have been forcibly displaced as a result of persecution, violence, armed conflict or climate change. There is a growing literature on the impact of forced migration on people's psychosocial wellbeing as a result of factors leading to their flight (Masten and Osofsky, 2010; Boothyby et al., 2006); threats and risks associated with their journeys (Siriwardhana et al., 2014); and what are known as post-flight stressors within countries of refuge including the asylum seeking process, work prohibition and insecure visa status (Brabant and Raynault, 2012; Nickerson et al., 2011; Ryan et al., 2008). Consequently, mental health difficulties including post-traumatic stress disorder (PTSD), depression and anxiety are commonly associated with the refugee experience (Slobodin and De Jong, 2015; Bogic et al., 2015).

Aside from being an enabling and inalienable human right, education has been shown to protect psychosocial, physical and cognitive wellbeing of refugees (Smith, 2010), serve as a catalyst in refugee communities' understanding of and coping with their situation and affording meaning to life in protracted crises (Alzaroo and Hunt, 2003; Nicolai, 2003). Higher education in particular facilitates integration into host societies, helps promote economic self-reliance (Dodds and Inquai, 1983) and foster individual and collective heightened social consciousness geared towards giving back their own communities (Crea, 2016).

Nevertheless, refugees in higher education are likely to face different or additional mental and psychosocial health stressors (Lindert et al., 2009; Bogic et al., 2015) that may be alienating and overwhelming (Student, Kendall and Day, 2017). There are often issues concerning language, credential, system and service barriers (Streitwieser et al., 2017), insufficient access to consistent and accurate information on how to navigate the HE system (Bajwa et al., 2016) and often times, patterns of institutional detachment and abuse of power among university staff (Student, Kendall and Day, 2017) to name a few.

The literature also indicates that refugee students are unlikely to seek help in such settings, bearing in mind these barriers and as a result of lack of information on the topic of mental health, the associated stigma surrounding it, and cultural practices and norms (Saechao et al., 2012; Shannon et al., 2012). An emerging body of research from Australia has shown how higher education establishments have been slow to tailor support to the specific needs of

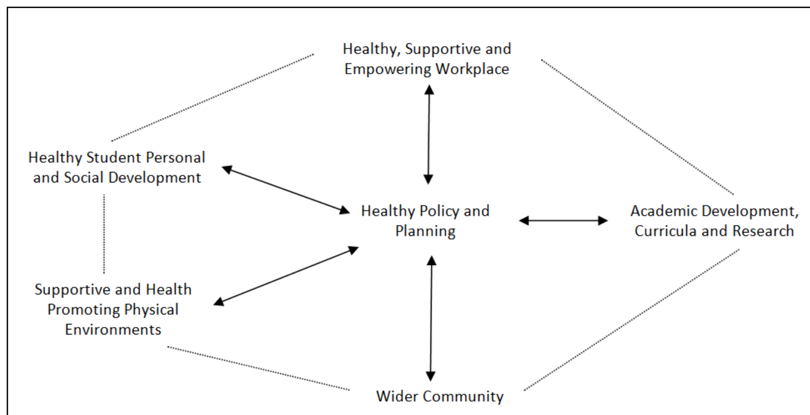
refugee students (Joyce et al, 2010, Lenette, 2016) or improve their retention and progression in higher education (Kong et al, 2016).
Practically nothing is known about the specific mental health needs of refugee students in higher education in the UK and what models of health and support services might be most conducive to their health and wellbeing. This paper draws on a small exploratory study of the mental and psychosocial impact of forced migration on refugee students and how well a single higher education institution (HEI) was perceived to be meeting their psychosocial support needs.

A **refugee** is defined as someone who has been forced to flee from their home country and is either unwilling or unable to return because of fear of persecution (UNHCR, 2010). While a 'refugee' has been given refugee status by a host government in accordance with the refugee convention (UNHCR 1951), an 'asylum seeker' is someone who is currently in the process of applying for refugee status within the country they have travelled to for safety. For the purpose of this research, refugees and asylum seekers were referred to as 'refugees'.

Conceptual frameworks for promoting health and wellbeing in Higher Education

Two interlinking conceptual frameworks informed this exploratory study into how universities might promote the health and wellbeing of students and staff in general and refugee communities of students in particular: *The Health promoting University (HPU) and the Social Ecological Model (SEM).* Universities UK (2013) claims that there are some 162 HEIs accommodating approximately 2.5 million students and over 378,000 members of staff. Launched in 1995, the HPU initiative was developed as a settings-based agenda for action (outlined in Figure 1 below) with two overarching aims: (i) To embed a commitment to health promotion within HEIs' processes, structures and culture; and (ii) to effectively promote the health and wellbeing of students, staff and the wider community (Tsouros et al., 1998; Dooris, 2001).

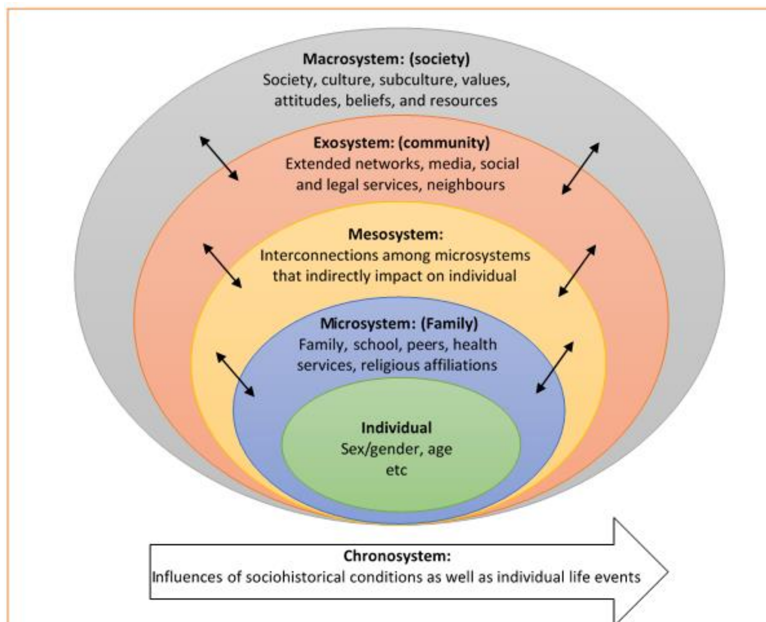
Figure 1: HPU agenda for action



Source: Dooris (1998)

The HPU works from an understanding of health as a state of physical, psychological and social wellbeing which becomes a resource for everyday life (Kickbusch, 2003). It adopts a holistic, socio-ecological approach to health promotion, taking into consideration how wider environmental and personal factors as well as the settings in which people live and work fundamentally influence their health (Dooris, 1998). The model draws from the Ottawa Charter for Health Promotion (OCHP) (WHO, 1986), recognising that it is the interactions between individuals and their social, physical and institutional environments which influence their health and wellbeing (Stokols et al, 1996; Sallis and Owen, 2002). Bronfenbrenner's (1970) social ecological system's framework (Figure 2) emphasises the relationship between the individual and the environment at five different system levels which interact to influence human development. Applying the SEM within the HPU framework arguably widens the scope of HEIs to better understand the complex dynamics of how the different layers of the model shape the psychosocial wellbeing of refugee students (Grant and Guerin, 2014).

Figure 2: Depicting Bronfenbrenner's social ecological model



Source: Bronfenbrenner (1970)

Refugees are first embedded within the *micro-system* which consists of their individual selves, home, and relationships with others. This is where significant stress may arise due to a combination of factors such as multiple forms of loss or bereavement, an inability to meet basic needs or incapacity to care for selves and other family members (Catani et al., 2009). However, it is in this micro system that refugees can potentially develop their social capital, which is fundamental to them engaging successfully with their host society.

The **exo-system** consists of the educational systems, governmental agencies, and transport networks, all instrumental in shaping the lives of refugees. The exo-system is also where refugees may experience issues such as stigmatisation, societal isolation and discrimination. Access to education is widely valued by refugees and lack of access has consistently been highlighted as a source of distress (Miller et al., 2009; Wessells and Strang, 2006). In essence, refugees often view education as vital in developing their capital (social, human, financial), and as a pathway to a better future. In the far-reaching *macro-system,* the economic and political systems of society are combined with the dominant ideologies and beliefs of the living environment (Grant et al., 2014). This system encapsulates those social, political and economic problems that serve as risk factors of mental and psychosocial health issues within the refugee community. Further, policy initiatives within the political systems of the host country can have adverse effects on refugees building agency and developing their capital and consequently their mental and psychosocial wellbeing.

The *chrono-system* is the dimension that depicts change over the life-course of the refugee (Grant et al., 2014) and includes pre-flight experiences, forced displacement, the journey and arrival and settlement within the host country. It is fair to extrapolate that the chrono-system is instrumental in the mental and psychosocial wellbeing of refugee students and their capacity to integrate into their new society as well as their ability to engage effectively with higher education.

Study design

This research employed a qualitative interpretive research methodology with the aim of providing an insight into the perceptions of research participants and professionals working with them. Three data collection strategies were employed: Photovoice, narrative inquiry and key informant interviews.

Sampling and recruitment

Purposive sampling was used to identify student-participants for the study who identified as 'refugees', having been forcibly displaced from their home country and who were seeking or had been granted refugee status in the UK. Student-participants were recruited through flyers placed on all campuses of the HEI and the flyer was also distributed via the HEI's electronic academic platform. A total of 10 student-participants took part in the study from different levels of study at the HEI and varying countries of origin including Burundi, Nigeria, Sierra Leone, Uganda, Congo and Somalia.

Key-Informants were recruited through the form of a letter emailed to several academics, the head of the health and wellbeing team and head of teaching and learning, inviting them to take part in the research. The three key informants participating in the research included two academic staff with a role in supporting student health and wellbeing and one manager of the health and wellbeing team.

Table 1 – Participant demographic

Participant (Pseudonym)	Participant Type	Male/ Female	Age	Level of study
Janet	Student-Participant	Female	38	BSc-Undergraduate
Julia	Student-Participant	Female	41	BSc-Undergraduate
Agnes	Student-Participant	Female	44	BSc-Undergraduate
Hassan	Student-Participant	Male	62	BSc-Undergraduate
Karen	Student-Participant	Female	39	BSc-Undergraduate
Roxanne	Student-Participant	Female	46	BSc-Undergraduate
Michael	Student-Participant	Male	40	BSc-Undergraduate
Wayne	Student-Participant	Male	42	BSc-Undergraduate
Samantha	Student-Participant	Female	34	BSc-Undergraduate
Monica	Student-Participant	Female	30	MSc-Post-Graduate
KI1	Key Informant (Academic)	Female		
KI2	Key Informant (Academic)	Female		
KI3	Key Informant (Manager)	Male		

Methods

Students participated in the research through a combination of Photovoice and narrative enquiry. Photovoice has been used for some time now as a means of cutting across some of the power dynamics in the research process and enabling participants to focus on aspects of their lived experiences which are of greatest importance to them (Darbyshire et al 2005; Novak 2010). In this project, Photovoice enabled refugee students to visually represent and reflect on the factors influencing their psychosocial wellbeing, including the role of higher education. They were asked to take photos of the things that impacted either positively or negatively on their sense of wellbeing. These photos were then used to generate a narrative of their experiences, their concerns and their hopes for the future.

Semi-structured, face- to-face interviews were used to collect data from professionals and academics at the university specialising in or influencing aspects of students health and wellbeing. Interviews were organised around a set of pre-determined themes relating to the nature of support services available to students and how well these were perceived to meet the needs of students in general and refugee students in particular.

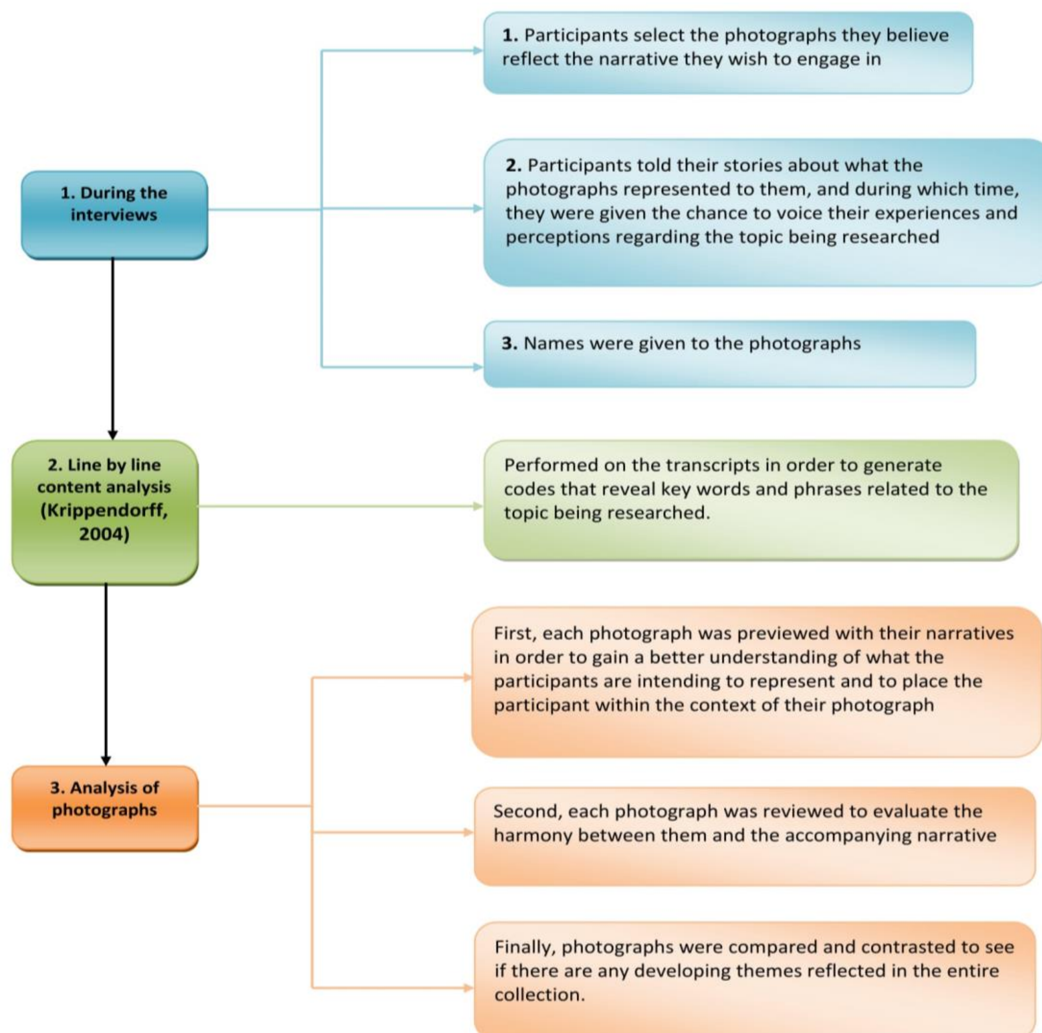
Ethical considerations

Ethical approval for the research was given by University College London Institution of Education and the work adhered to the British Educational Research Association's (BERA) Ethical Guidelines for Educational Research. In addition, ethical approval was also given by AU where the research was conducted. All interviews were recorded with prior written consent of and all audio recordings were then transcribed verbatim in order to be analysed.

Data analysis

For the Photovoice process, three methods of data analysis were employed – adopted from Oliffe et al., (2008) and illustrated in Figure 3.

Figure 3: Methods of PV data analysis



Key informant interviews were analysed using Braun and Clarke's (2006) six phases of thematic analysis: familiarising oneself with data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and writing the report.

Limitations

The main limitation to this study was that it involved a small sample of refugee students combined with key informant interviews at a single higher education institution. The findings include experiences of refugee students whose English language proficiency, length of time in the UK, reason for forced migration and the perceived effects of migration varied greatly.

FINDINGS

Traumatic experiences during the stages of flight

Nine of the ten student-participants cited war as the reason for their forced-migration, often recounting traumatic experiences prior to their flight in search of safety. Roxanne[2], for example, a female student from Burundi spoke about how the war in her country had affected her and her family.

> *My father was a politician (crying)…he had to flee because of his position…his government, they toppled the president…I am from the Tutsi tribe…he stayed with us for 4 nights, and they came at night, the army came, took him, 2 days later they brought his head to my mom's house).*

Presenting a picture of a park here in London, Janet, a student originally from Sierra Leone, explained how the park reminded her of her life back in her home country and how she suffered trauma because of the war.

> *This picture takes me back home where I used to live with my mom and dad. When I see this picture I think I wish we can all come together again, where we can all be in the same place live together again. But now that will never happen, because my dad was killed during the war.*

Other reasons for forced migration ranged from cultural beliefs and practices, extreme poverty, or a combination of factors. Agnes, for example, originally from Nigeria presented

[2] Participants' names are presented in the form of pseudonyms to protect confidentiality and anonymity

an old photograph of herself and her family and went on to describe how her mother 'sold her' to a man for marriage so that her brothers could benefit:

> *I was sexually assaulted at the age of 14, she (mother) will take me to places and she will say 'oh we are going to see a family friend'… and she will give me to these men, and they will do whatever they want with me…she took me to a place and said I was getting married…my mother just sold me to the man, just like that...so that he will help my brothers and my mother can get a car and all of that.*

For five of the seven female participants, the trauma did not end after escaping their home countries and some described being sexually exploited as they fled to other countries in search of refuge, before ending up in the UK. Roxanne recalled:

> *My father-in-law arranged for us (myself and the kids) from the Tanzania border cause my husband had to go to Rwanda...he made all the arrangements, and handed us over to men he called his friends…*crying*…I was raped repeatedly…I don't want to talk about it.*

Several of the male student participants were soldiers while others had parents or other family members who were conscripted or worked for the government. Both Michael and Wayne expressed great fear of being incarcerated or even killed and spoke of the measures they took in order to escape their home countries. Janet spoke of how she was imprisoned as she sought refuge in Guinea from Sierra Leone:

> *Neighbours in Guinea had it that he (her now husband) was keeping people from Sierra Leone. So anyone at the time from Sierra Leone who come to Guinea, they will capture you and say you are a rebel. So in that process, we ended up in jail…we only escaped because there was an explosion at the prison.*

Data collected from participants further illustrated adverse experiences even after they finally arrived in the UK, often as a result of the asylum and immigration process they encountered on arrival. Roxanne, for example, presented a photo of an immigration document she was required to sign every month and spoke of the effect of the immigration experience on her being able to control her body.

> *In 2002, I received a letter saying that they denied our status and we are under the group of those people who can be deported. And that's when they gave me this to be signing on every 1st of the month. I was so scared, I started weeing myself…2003 I had another court hearing, I went to court and they said they've denied it. I appealed and we went there in 2004…I think it was the trauma, cause I started shaking, and my left side has gone by then, cause I used to limp and I was so afraid that when we sat in court I think the urine went through my clothes.*

Having experienced these traumatic events at different stages of flight, participants gave accounts of the different support mechanisms within their social ecology once they were in a place of safety. For the participants who had a family, the support they received from spouse and/or children was paramount in their ability to cope with what they had been through. For Janet *'my husband was my greatest support…he drove me to succeed in whatever I do'*. Agnes presented a picture of her daughter as a baby, describing her children and her partner as her *'backbone, my life'*. And where people had no family, some found strength through other means. Karen, for example, spoke of how she received a lot of help in coping with her trauma through a women's group, 't*hey built up my confidence. And I got counselling support; they encouraged me to do further education.'*

These experiences are indicative of how the different layers of the social ecological model impacted on the lives of participants in the study prior to, during and after their migration. Macro level factors created the conditions under which they were forced to migrate, often combining with elements at the micro and meso level which exacerbated their circumstances. Yet these different systems equally provided spaces of safety and healing at different points in time. The chrono-system is evident in the narratives, particularly in the passing of time during the journey and the typical 'waiting' time during the process of seeking asylum in the UK, often for a number of years (see Allsopp and Chase, 2014).

The benefits of higher education for health and wellbeing

Participants spoke of the time it took from their arrival in the UK to a point when they could enter higher education. The barriers to access for people seeking asylum are now well documented (see Oliver and Hughes, forthcoming 2018). Despite these hurdles, participants spoke of the enormous potential value of education in their lives. Michael, for example, reflected:

> *…first of all, where we are from, you know they say – you may have come out of the bush, but that bush will never come out of you. Now I feel like I can solve every problem, though it's not actually possible that you can solve every problem…but I do believe in myself that much…education has done that for me.*

For Janet, gaining an education enabled her to engage in her child's education by being able to communicate with teachers:

> *…when my daughter used to bring letters at home I couldn't read them. So my main aim was that I need to go to college so that I will be able to read letters that my children brought home…I want to talk to teachers and see how my children are doing in school*

As well as gaining a sense of self development and purpose, participants were also highly pragmatic about the employment possibilities which they could ultimately expect from pursuing a university degree. Julia, for example, commented,

> *I think if I go to uni and have my degree, maybe I am going to find a good job. I am going to have more knowledge, and experience.*

And Hassan:

> *Now, I decided to start health and social career, I mean I was an assistant carer and I knew that will help push me towards a university course which will help me to get a better job.*

Alongside the potential for better employment, participants expressed their desires to eventually return to their home countries where they may be able to contribute in one way or another. Karen, a Public Health student originally from Sierra Leone, presented a picture of one of her lecture slides and explained:

> *I am doing Public health, to know what is going around, because I saw a lot of stuff in the camps that I was in, hygiene problem and other things. So people need to go out there and teach those who do not have opportunities…help them become somebody and climb career ladder.*

Similarly, Samantha believed that she would be able to utilise her education back in her home country:

> *Well because from what I have seen other people needs help, I want to be able to help people broaden their knowledge. That's what I plan to do…go back and help other refugees. (Samantha)*

Perceived barriers to AU supporting student health and wellbeing

When asked to reflect on how well AU as a higher education setting promoted the wider psychosocial health and wellbeing of students, both students and key informants described a number of limitations to this role. From the perspectives of student participants, a major

barrier to seeking support was that they were simply unaware of the health and wellbeing service at the university. Even those who knew about its existence had no real idea of what support was available and how they could access it. They also spoke of how they felt unable or unwilling to connect to a facility with which they were not familiar. Karen, for example, said, 'X *(name of personal tutor) has told me about this counselling, that somebody will contact me, but they never did.* And while Monica described how she found it easy to talk freely to her module leader, she declined the advice to go to the 'Hub' (student support service) because '*I don't know these people'.* Similarly, Julia felt that even if she had known about the service, she had no confidence that it would be beneficial to her:

> *I have never heard about the health and wellbeing service, but even if I've heard of it, I know it wouldn't help me.*

This lack of awareness of the service was confirmed by one of the academic key informants:

> *I think there is an argument to do more to promote them (the health and wellbeing service). I am concerned that a personal tutee will come to me with an issue and when I ask them if they have sought help from the wellbeing service, they ask me what that is.*(KI2)

Participants also placed significant emphasis on stigma related to their African cultural identity as a barrier to why they do not seek help. Almost all student-participants described the attitude within their community regarding talking about mental health and being expected to just 'get on with it':

> *I don't know I am not someone who like to talk about things like that or to look for, or especially like in the African community, it is not an issue…we are expected to just get on with it. (Janet)*

These sentiments were echoed by Wayne who stated that '*for African people that is normal, you don't need to go and talk to someone about that'.* Other stigma within the African community saw participants being reluctant to seek help and openly acknowledging that they have a mental health issue, thus restricting their willingness to seek help. One participant had not sought help because she had been told that even discussing her mental turmoil with a professional would result in the social services department removing her children away and herself being sectioned under the Mental Health Act.

For other student-participants, a similar lack of trust in the service stemmed from concern about what Agnes described as talking to '…a *stranger about my story'.* Roxanne explained:

> *I think it will be helpful to have that one person you can open up to and don't have to be talking to many different people. Like I've spoken to you about my story, I trust you to tell my story to, I don't know if I can trust someone in the health and wellbeing team because I don't know them*

Samantha expressed her disbelief that the service is culturally equipped or refugee –sensitive enough to help her:

> *I am in a class with many black people and other minorities, but most of my lecturers are white. I am going to assume the counsellors are white. Or even if they are not, how can they relate to me being a refugee? And that I never seen them anywhere or even heard about the service, who are they*

More broadly, Wayne made the point that before participating in the current study, he had not heard anyone on campus talk about refugees. In his view this was indicative of how services were not equipped to help them or other students who may have come from a traumatic background.

Resource constraint within the health and wellbeing service

Many of the current limitations identified to the health and wellbeing services at AU were attributed to structural and resource constraints, as expressed in detail by key informants. They felt that these were manifested at the macro and micro levels of the institution – from the management of the system to the service as a whole. KI1 stated:

> *There are a number of issues around the lack of real structure to the health and wellbeing support – and this is no offence to (name of health and wellbeing service manager)…I mean he told me he has 2.4 equivalent counselling staff and it is absolutely insufficient for supporting the students that we have…(AU) has a responsibility to the mental and psychological wellbeing of its students.*

This finding was confirmed by KI3 - the Health and Wellbeing Service Manager:

> *We only have 2.4 full time equivalent counsellors for the size of our university in comparison to a lot of other universities that will have more counsellors and psychological therapists.*

Talking about the implications of these constraints, KI1, a lecturer, who is not specialised in counselling spoke of how she was expected to provide students with counselling:

> *I've dealt with suicide, sexual assault on campus, female genital cutting, refugees' financial problems, pregnancy and abusive relationships…it is hard for ANY student who has experienced or continues to experience trauma to strive in a structure like this…and you know, to do counselling or therapy when you are not a counsellor or a*

> *therapist is like psychological violence…and that destroys the whole structure for the students and for the staff.*

Suggested improvements to services

Discussing the ways in which the service migth be promoted more effectively, both sets of participants agreed that embedding promotion of the service in specific learning modules would help to widen knowledge about support services available and encourage student engagement. As KI1 noted:

> *You need therapists and counsellors, who would know and work alongside lecturers, who come into the classes, who say hello. Yea, this is about relationships and connections…students do not actively go out looking for support…in my school, they have other support services embedded which has helped students to become more comfortable to seek help from people they know…*

The health and wellbeing services manager went on to say that he believed that embedding the service into the curriculum would reduce the stress of the stigma attached to mental and psychological and help '*normalise things'. H*assan reflected these sentiments as he believes that by embedding information and promotion of support services into core modules, everyone would have better knowledge of the service and what they can provide for students like him.

One of the academic key informants stressed the need to develop cultural competence within AU, by providing therapists who are versed in the complex issues likely to be faced by refugee students, given the university's stated commitment to widening participation in higher education.

> *When we have like 90% BME students I would hope there are some BME counsellors… this place needs specific trauma support for all those students who have been through trauma, like our refugee students or students who have experienced FGM and so on. It (the health and wellbeing support) is absolutely not fit for purpose.*

Discussion

Higher education can play a vital role in the lives of refugee students and is uniquely placed for providing them with transformative education opportunities while simultaneously promoting and sustaining their wellbeing and enabling them to move forward with their lives. For this to happen, AU needs to adopt a whole-system approach to health promotion which draws on the social ecological model embedded within the Ottawa Charter and premises the

idea that *'…health is created and lived by people within the settings of their everyday life; where they learn, work, play and love' (WHO, 1986, pp:3).* The findings from the current study suggest a number of systemic changes that need to take place for AU to be more effective in its role in supporting student wellbeing in general and responding to the specific needs presented by refugee students. Considering Bronfrenbrenner's (1970) assertion that interactions at different system levels influence the health and wellbeing needs of students, this same analysis could inform the institutional response in terms of how best to respond to these need, particularly where they may be complex and multi-layered as in the examples of refugee students in the current study.

Within the framework of the social ecological model, the findings highlighted instances of distress among student participants at different points of migration (pre-flight exposure to violence and war, traumatic experiences of flight and adverse post-flight stressors) and at different levels of the social ecology (personal and societal). At the pre-migration phase and within the macro/societal-system, civil war and violence were reported as the most common reasons for forced migration. Several of the participants gave detailed accounts of their traumatic experiences and how these experiences had affected their mental wellbeing. Student participants also spoke about very distressing experiences in flight with some female participants recounting instances of fear of and actual experiences of sexual assault and rape (cf. Obradovich, 2009). Within the post-migration phase, immigration status directly or indirectly affected students' mental health and wellbeing and those who continued to experience uncertainty about their legal status in the UK described feelings of demoralisation, anxiety and distress.

Education was identified as a valuable opportunity within the social ecology of participants' lives, both in its role in securing better futures in the long-term and more immediately through building confidence and skills. As an HEI, AU was seen as a core component of the exo-system of the lives of refugee students and, in theory, has an established service structure to support the health and wellbeing of all students. However, participants in the current study identified several barriers to them seeking support from the services available. Several had no idea the service existed or how to access it. Furthermore, they were reticent to talk to professionals they did not know and sceptical of how such a service could begin to understand and respond appropriately to their specific backgrounds and circumstances.

Student participants highlighted the significant stigma attached to mental health within their culture and communities which hinders their willingness to discuss mental health. As indicated in the findings, cultural attitudes and norms deem it difficult for participants to admit mental health issues and seek treatment. Linked to this point was a perceived lack of cultural and refugee competence within services, leading students to believe that the service was not relatable and practitioners may not understand what they had gone through and the cultural norms and attitudes that shaped their help-seeking behaviours (Pastoor, 2015). By inquiring about and acknowledging cultural attitudes and norms as well as the individual experiences of a refugee, the wellbeing service may be more successful in getting participants to access the service (Shannon et al, 2015).

When discussing how the health and wellbeing service can be improved to accommodate refugee students, there was a general consensus about the need to raise the profile of the service within the modules throughout the university , thus helping to break down those barriers that students perceive (trust, stigma, and so on). According to Murray et el (2010), to be successful, mental health services for refugee survivors require adequate information about available services and fostering collaborative relationships to maximise autonomy and choice of treatment for those accessing the services.

As a higher education institution, AU could start by adopting a system-level analysis of the needs of its students and thinking about a whole system approach to its response to such needs (informed by the HPU and the Ottawa Charter for Health Promotion). By doing so, AU could aspire to think about how promoting health and wellbeing is implemented in such a way that relationships between academic staff, students, professional services, other agencies and the wider community, as well as behaviours and environments are all taken into account. In light of the findings presented here and based on the experiences of student participants, such an analysis would encourage strategies and investment which transform support services to be outward facing, cognizant of the diversity of student experience over the life-course, embed enhanced cultural competencies and which help facilitate student access through, for example outreach work, tailored mentoring and guidance over time and promotion of what is available in ways which are meaningful to students .

Conclusion

Despite previous traumatic experiences, refugee students often aspire to become valued members of their adopted societies through, at least in part, engaging in higher education. Nevertheless, refugee students may face significant barriers to learning due to a range of psychosocial and organisational constraints. This study highlighted an inadequacy in the promotion and practice of positive mental health and wellbeing for this student population. The study concluded that AU can build upon the interdependencies and inter-relationships of its members and the contextual systems on which health is influenced.
Adopting a social ecological model (Bronfenbrenner, 1970) to understanding the needs of refugee students in higher education allows a deeper understanding of how the multiple layers of the ecological system impact on their health and wellbeing over time. The study advocates the use of the social ecological model to analyse opportunities and constraints for promoting health and wellbeing combined with the HPU as a settings-based approach to promoting wellbeing. This approach can identify and respond to the specific mental health concerns for refugee students at multiple levels (intrapersonal, interpersonal, institutional, community and public policy) (McLeroy et al., 1988) while, at the same time, enhancing individual, group and institution-wide health and wellbeing. Collectively, by making mental health and wellbeing pivotal to their policy-making, universities, as centres for influence and

expertise, can potentially develop as advocates for health by demanding healthy public policy at local, national and international levels (Dooris, 2001).

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