Mental healthcare for refugees

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Summary

Introduction: The current refugee situation in Europa also leads to an increasing number of people with mental disorders. Which measures need to be taken to ascertain adequate mental healthcare for refugees during and after fleeing from their home countries? Methods: Review of the current tasks, areas of action and future challenges of refugee mental healthcare. Results: Refugee healthcare poses new challenges for the receiving and the transit countries. Besides dealing with the acute refugee situation, long term aspects of mental and general healthcare for refugees need to be considered. This will also include the reconstruction of the healthcare systems in the countries of origin of refugees.

Schlüsselwörter

Psychische Gesundheitsversorgung, Flüchtlinge, Traumatisierung, Migration, psychische Erkrankungen

Zusammenfassung


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Currently around the world, approximately at least 60 million people are refugees. The greatest mass migration due to war refugees is currently occurring due to the conflict in Syria (3). The United Nations High Commissioner for Refugees (UNHCR) had registered 4.8 million Syrian refugees, of whom approximately 900,000 had sought asylum in Europe (29), and 7.6 million internally displaced persons within Syria.

Refugee mental health is not yet taking centerstage for healthcare systems in many countries. Research into refugee mental health needs indicates a need of acute mental healthcare in about 10–30% of the refugees from Syria (17) and long-term needs in 20–80% (with high inter-study heterogeneity of results) (5). The World Health Organisation and UNHCR have responded to the increasing need for mental healthcare in migrant and refugee populations due to humanitarian emergencies by publishing a guide for mental healthcare systems (30). A recent review in Die Psychiatrie detailed the needs and demands for refugee mental healthcare in Europe (25). The European Psychiatric Association (EPA) issued a position statement to bring attention to policy and decision makers of the importance of mental health care in crisis situations and calls for immediate action to improve mental health care for
refugees (9). The United Nations have laid down culture-sensitive review information for mental health professionals about mental health issues in Syrians (12). All of these documents and a previous EPA guidance on mental healthcare for migrants have outlined principles, demands and service provision necessities for refugee and migrant mental healthcare (4). However, the current European refugee situation affects not only the receiving countries, it is also an issue for the transit countries and of course the countries of origin (14). Experiencing war-related trauma and the hardships of losing one’s home have profound, diverse and long-lasting effects on refugee mental health beyond the acute traumatizing phase. Three stages of refugee migration may be distinguished: premigration, migration and postmigration resettlement (16), and all may cause different mental healthcare needs.

Providing healthcare for a large number of refugees is a strenuous effort for any healthcare system, including those in rich countries like Germany (2). An important issue is the development of effective screening strategies for mental health needs in refugee populations. Such screening will most probably be performed in primary care and a recent pilot trial in the U.S.A. evaluated the usefulness of a 16-item questionnaire (21). It showed that approximately one third of a refugee population (n=141, mainly from Bhutan and Iraq) screened positive for emotional distress, two thirds of these were available for follow-up and half of those with follow-up indicated need for mental healthcare. Thus, at least 10% were in need of healthcare – with some uncertainty about those not available for follow-up. Importantly, the need and type of traumatization varied between the populations from Bhutan and Iraq, indicating the importance of the kind of refugee situation when preparing for refugee mental healthcare needs. The limited rate of follow-up in this study suggests that establishing contact and ensuring continuity of contact may be an issue for mental healthcare systems. Studies reviewed by Njeru and coworkers (19) showed that there were considerable healthcare use disparities in migrant populations and while interpreter services may mitigate the problem, they do not eliminate them and “culture brokers” and the implementation of mental healthcare interventions with proven efficacy for migrants and refugees may be necessary (16). Mental health professionals will need to develop an understanding of culture-bound illness models and idioms of distress (1). A recent review indicated that there was a shortage of studies addressing the efficacy of these methods for refugee populations making it difficult to tailor optimal evidence-based interventions to individual refugee needs (27). Of note, it is questionable whether dealing with post-traumatic stress disorders alone will suffice, considering that refugees are affected by numerous mental disorders and this may be of importance for planning personalized and comprehensive refugee mental healthcare services (7). Initial experiences from Germany seem to indicate that besides post-traumatic

Figure 1  Stages of refugee mental healthcare. While a lack of mental healthcare in conflict areas and in the transit countries is the central mental healthcare issue during the stages of pre-displacement and migration, restriction of access to the local existing mental healthcare systems becomes the central issue in the initial post-displacement phase. New issues arise following this phase in the long-term: for refugees returning to their countries of origin, the question of reconstructing local mental healthcare systems arises. For those remaining in the new home countries, the question of long-term sustainability and accessibility of culturally sensitive, person-oriented mental healthcare for people with migration backgrounds in the receiving societies arises.
stress disorders, other mental disorders like depression and anxiety disorders are of paramount importance, and that stigmatization of mental disorders is a major factor in preventing refugees from contacting mental healthcare professionals (15). Another factor to be addressed is the accessibility of mental healthcare services for refugees – restrictive formal regulations may be detrimental and may not only cause individual lack of service utilization but also increased long term costs compared to low-barrier access systems (6). Initial exploratory studies in Germany performed in late 2014/early 2015, i.e., before the current rise of refugee numbers, indicate that there were health and healthcare utilization disparities between asylum seekers and the resident population, with asylum seekers having more unmet medical needs, less visits to physicians, increased rates of hospital admission and increased use rates of psychotherapists (23).

An issue of increasing importance will be the long-term psychosocial consequences of migration and experiencing war-related traumas. A recent field and literature study in New Guinea showed that after the Bougainville crisis of 1988–1997, an armed conflict leading to violence-related deaths and the displacement of more than half of the population, long term mental health problems in the affected population were not limited to post-traumatic stress disorder, but also included prolonged grief, depression, substance-related disorders, explosive anger and psychotic disorders (reviewed by Tierney and coworkers) (26). A cross-sectional study in Switzerland studied the complex interrelationship between psychological impairments, post-migration living difficulties (PMLD), and social integration level in refugees seeking treatment for severe post-traumatic stress disorder. Although participants had lived in Switzerland on an average for more than ten years, many showed poor social integration and frequent living difficulties (22). A register-based study from Sweden showed that the risk for psychotic disorders was increased by a factor of 1.7 in refugees compared to non-refugee migrants and 2.9 compared to the resident Swedish population indicating that etiopathogenetic mechanisms specific for the refugee situation may need to be considered in mental healthcare planning (13). A final aspect is the mental health situation in the original home countries after “return migration”. Research on this aspect is scarce (11).

An important long term issue will therefore be whether trust can be built in expatriate mental health experts to return to their original home countries and rebuild the local mental healthcare systems (3). Trust in mental healthcare is a prerequisite for its use (10). Experiences from Iraq show that even years after the original conflict, mental health problems of the affected population continue to challenge the healthcare system, and that low human and financial resources, a lack of trained mental health workforce and stigmatization are major issues (18).

Obviously, refugee mental health is a complex issue posing challenges to mental healthcare systems regarding service access, service utilization, optimal quality of service provision, and planning and implementing sustainable, comprehensive mental healthcare. What needs to be done now? Acute measures need to be taken to deal with the acute situation of migration (24). The German Society of Psychiatry, Psychotherapy and Psychosomatic Medicine (DGPPN) has recently issued a position statement on refugee mental health and is providing an information platform, which may serve as an example (8). Furthermore, long-term aspects need to be taken into account. Given the heterogeneity of refugee mental healthcare needs, large national programs may need to be supplemented by local assessments of needs, which may largely depend on the origin of the locoregional refugees and their specific mental healthcare traditions, experiences and needs (26). These needs will be time-variable (20, 31) so that mental healthcare systems will need to respond dynamically and reassess the situation repeatedly. Psychiatrists will not only be needed as local providers of expert mental healthcare, but also as advisors for policy makers and healthcare system developers, and as advocates for marginalized population groups. Beyond this, activities to train foreign medical students and psychologists, and to support the reconstruction of the home mental healthcare system in the future, will be needed to address the longterm challenges of refugee mental healthcare.

Refugee mental healthcare is a new issue for many countries. Allocating financial and human resources to general and mental healthcare for refugees now is not only a humanitarian necessity, it will also pay off.

Conflict of interest

The authors declare no conflict of interest.

Compliance with ethical guidelines

This article contains no studies on humans or animals.

References
