MENTAL HEALTHCARE FOR REFUGEES
ATENCIÓN EN SALUD MENTAL PARA REFUGIADOS

Julio TORALES1, Israel GONZÁLEZ2, Iván BARRIOS3, João CASTALDELLI-MAIA4, Margarita SAMUDIO5, Antonio VENTRIGLIO6.

1Researcher and Professor of Psychiatry and Medical Psychology, School of Medical Sciences, National University of Asunción, San Lorenzo – Paraguay. 2Resident physician of Psychiatry, School of Medical Sciences, National University of Asunción, San Lorenzo – Paraguay. 3Teaching assistant, Research Methodology Department, School of Medical Sciences, National University of Asunción, San Lorenzo – Paraguay. 4Researcher and Professor, Department of Psychiatry, School of Medicine, University of São Paulo, São Paulo – Brazil. 5Researcher, Institute of Research in Health Sciences, National University of Asunción, San Lorenzo – Paraguay. 6Researcher, Department of Clinical and Experimental Medicine, University of Foggia, Foggia – Italy.

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ABSTRACT

The aim of this paper is to highlight some of the difficulties that mental health providers face when trying to provide the best standard of mental healthcare to refugees, especially in countries where the political environment is skeptical of, or even hostile to, creating programs specifically designed to improve the standard of living of this population. We also focus briefly on the dichotomy between the need to do research in this population in order to obtain data that will help us offer the best care possible to them, and the peril of undermining their autonomy by subjecting them to studies they might have otherwise refused to be part of, if they were in a less precarious position. Throughout the article, we offer practical advice that mental healthcare providers can follow to ensure that they are offering the best possible care to their patients while remaining respectful of their rights.

Keywords: Mental health providers; Mental healthcare; Refugees.

RESUMEN

El objetivo de este artículo es destacar algunas de las dificultades que enfrentan los proveedores de servicios de salud mental para tratar de proporcionar el mejor nivel de atención en salud mental a los refugiados, especialmente en países donde el entorno político es escéptico o incluso hostil, a la creación de programas específicamente diseñados para mejorar el nivel de vida de esta población. También nos enfocamos brevemente en la dicotomía entre la necesidad de investigar en esta población para obtener datos que nos ayuden a ofrecerles la mejor atención posible y el peligro de socavar su autonomía al someterlos a estudios que de lo contrario podrían haber rechazado, si es que estaban en una posición menos precaria. A lo largo del artículo, ofrecemos consejos prácticos que los proveedores de servicios de salud mental pueden seguir para garantizar que brindan la mejor atención posible a sus pacientes sin dejar de respetar sus derechos.

Palabras clave: Prestadores de salud mental; Atención en salud mental; Refugiados.
INTRODUCTION

The United Nations Refugee Agency provides stunning statistics about the number of refugees around the world. The global refugee population is the highest on record. According to the data displayed in their website, there are 65.6 million forcibly displaced people worldwide, 22.5 million of these people are refugees (1). Refugees are defined by the United Nations High Commissioner for Refugees (UNHCR) as those “…who are outside their country of nationality or habitual residence and unable to return there owing to serious and indiscriminate threats to life, physical integrity or freedom resulting from generalized violence or events seriously disturbing public order” (2). 84% of the refugees, about 14.5 million people, are being hosted in developing regions. More than half of them come from Syrian Arab Republic, Afghanistan, and South Sudan. Turkey is the largest host of refugees worldwide, with 2.9 million people, followed by Pakistan, with 1.4 million, and Lebanon, with 1 million. Europe hosts 17% of this population, and the Americas 16% (1).

Refugees, as all people, are entitled to the health protections afforded in the article 25 of the Universal Declaration of Human Rights (3), and in the article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESR) (4).

Ensuring refugees attain the “highest attainable standard of physical and mental health” proposed by the ICESR constitutes an important strain on the healthcare infrastructure of the hosting countries. Some of them have poorly structured systems and not enough economic resources to withstand the influx of hundreds of thousands of migrants to their hospitals and clinics. On the other hand, some countries, such as Lebanon, have used this situation as an opportunity to learn and improve public healthcare services by using international donations to fund computerized health databases, purchase much needed equipment and hiring more doctors (5). Suggesting solutions for these systemic problems is outside of the scope of this paper. Nevertheless, nations, especially those in the vicinity of areas of conflict, should use all the information and resources available to make necessary changes to their healthcare infrastructure for the arrival of large groups of migrants, since providing a quick and effective response to these situations can be extremely complex, costly and socially disruptive if measures to prepare for the influx of these people are not taken in advance.

The aim of this paper is to highlight some of the difficulties that mental health providers face when trying to provide the best standard of mental healthcare to refugees, especially in countries where the political environment is skeptical of, or even hostile to, creating programs specifically designed to improve the standard of living of this population. We also focus briefly on the dichotomy between the need to do research in this population in order to obtain data that will help us offer the best care possible to them, and the peril of undermining their autonomy by subjecting them to studies they might have otherwise refused to be part of, if they were in a less precarious position. Throughout the article, we offer practical advice that mental healthcare providers can follow to ensure that they are offering the best possible care to their patients while remaining respectful of their rights.
PROVIDING THE HIGHEST ATTAINABLE STANDARD OF MENTAL HEALTHCARE TO REFUGEES

The refugee population is at risk for many health-related issues. A meta-analysis examined the association between predisplacement and postdisplacement conditions, and the consequent mental health status of the refugees. The associations with postdisplacement conditions were predictable: materially secure conditions, measured by economic opportunities and permanent accommodation were associated with better mental health, these results indicated that psychiatric disorders such as PTSD and depression are not inexorable results of the trauma of their situation, but that other factors may influence the development of these disorders. On the other hand, the association between predisplacement conditions and mental health run somewhat against the predicted outcomes: higher level of education and socioeconomic status were thought to be protective factors against mental disorders, instead, refugees with these characteristics had worse outcomes in the meta-analysis, one possible interpretation is that refugees with these predisplacement conditions suffer a larger loss, hence becoming more predisposed to mental health issues (6).

Studies show that discriminatory practices in many regions discourage ethnic minorities from using healthcare services. They are also less likely to receive the best standard of care once they obtain access to the healthcare system (7). Immigrants in general show lower rates of utilization of mental healthcare services, likely due to cultural and linguistic barriers to care (8). When immigrants face mental health issues, they usually turn first to family, friends, or religious groups (9).

A qualitative study in Montreal tried to explain why migrants are unwilling to use mental health services, they found that perceived excessive proneness of doctors to install pharmacotherapies, a dismissive attitude from physicians, and a strong belief in nonmedical interventions were the main factors leading migrants away from mental health services (10).

Establishing a meaningful relationship with refugee patients require making an effort to understand the history of the trauma that they have suffered and its symptoms (11). Despite recommendations that physicians take a complete history of the trauma paying special attention to the psychosocial aspect, loss of friends and family members, and traumatic disability (12), physicians often remain unaware of the refugee’s trauma histories (13), and are therefore unable to detect the mental health issues that may be associated to them. Some of them may be reluctant to start conversations with their healthcare providers due to a perception that cultural norms expect them to be submissive to their physicians or due to a lack of knowledge about the possible repercussions of the trauma in their mental health (14).

Posttraumatic stress disorder (PTSD) is usually considered to be the main mental health outcome of the trauma associated with being forcibly displace from one’s country, but an umbrella review of thirteen meta-analyses found that major depression and anxiety could be just as prevalent in this population, affecting up to one third of the refugees and asylum seekers in certain regions (15). Total number of trauma and exposure to torture are good predictors of both PTSD and major depression (16). An often overlooked fact is that psychotic disorders, including schizophrenia, may be more frequent in refugees compared to other immigrants and the general population (17, 18).
The Center for Disease Control in the United States (CDC), the World Health Organization (WHO), and many other national institutions encourage routine mental health screening during the domestic medical examination for newly arrived refugees, since this is their first interaction with the host’s healthcare system (16, 19, 20).

The following components of the mental health screening for refugees are suggested by the CDC (Table 1) (21).

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<thead>
<tr>
<th>TABLE 1. MENTAL HEALTH SCREENING FOR REFUGEES</th>
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<tr>
<td><strong>Review of records from oversea</strong></td>
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<td><strong>History and physical examination related to mental health</strong></td>
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<td><strong>Mental status examination</strong></td>
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<td><strong>Screening for depression and PTSD</strong></td>
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<td><strong>Referral for refugees considered at significant risk</strong></td>
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In following the aforementioned recommendations, mental healthcare providers must not overlook the importance of discussing the issues that motivated the migration, since they can help the physician understand the stresses that the refugee faced in the country of origin and in the route to the host country. Many refugees suffered the loss of family members, personal health and financial security. A great number of them have experienced famine, torture, and rape. The *UpToDate* database recommends limiting the initial screening to questions to identify suicidality and severe psychiatric disorders, leaving a more thorough mental health examination for a next interview when the physician has already established a good rapport (22). Physicians must evaluate these situations and tailor the treatment options offered to the patient to their suffering.

When a psychiatric disorder is diagnosed in these patients, the standard of care should be provided. While some clinical studies show differences in the doses needed or the adverse effect profiles in individuals from different ethnicities (23-25), in clinical practice, the pharmacologic approach does not differ greatly from what is used in the general population (26).

In order to achieve adherence to treatment in this population, physicians must assess the expectations of the patients about the drugs and their attitude towards them, ask about use of alternative or herbal medicines in a non-judgmental way, evaluate use of substances such as tobacco and alcohol with consideration of their cultural norms, and explain the side effects of
the medications in advance while monitoring them throughout the duration of the treatment (27).

Psychotherapies are the mainstay of treatment in PTSD and a first-line alternative in major depression and anxiety disorders (28). Standard cognitive behavioral therapy or psychodynamic approaches are usually the standard of care, but it can be hard to find enough trained providers to support an important influx of people to a host country.

Some therapies are being devised to directly address the needs of refugees (29). Brief, structured, and standardized psychotherapy packages that draw on trauma focused CBT have been developed and applied successfully to refugees over the last decades, these programs can be easily adapted to new cultures, and are designed so that workers can be rapidly trained to use them, instead of requiring years of training (30). Psychosocial interventions focus on the well-being of the population as a whole, studies have found that these interventions effectively increase self-confidence, decrease isolation, and increase access to mental healthcare services (31, 32).

ETHICS AND THE NEED FOR RESEARCH IN THE REFUGEE POPULATION

As physicians, we are constantly looking for evidence-based solutions to the problems we face. Refugees can certainly benefit from evidence resulting in better pharmacologic treatments, more directed and available psychotherapies, better targeted social approaches, and policies supported by strong evidence and not based merely on political arguments.

In order to find these solutions, researchers face a “dual imperative” to balance their concerns about reducing suffering and their professional duty to produce research with the highest scientific standards (33). Ethical considerations should guide the research process without compromising on research design, in order to produce studies that will be actually useful for the affected groups (34).

The European Commission provides a guidance note listing the general principles to follow when research involves refugees, including treating them with care and sensitivity, being objective and transparent, avoiding ethnocentricity, safeguarding their autonomy, dignity, well-being, and security, respecting their values and their right to consent, and giving special protections to participants with diminished autonomy, such as unaccompanied minors. They raise the issue that traditional informed consent forms can be harmful to the refugees because they can discourage participants, jeopardize their anonymity and be difficult to translate to their language in a comprehensible style. They suggest using less formalized procedures for providing information and obtaining consent. This can be achieved by including cultural insiders in the process, working with reputable NGOs, and using oral consent with the knowledge and approval of a competent Research Ethics Committee (35).

CONCLUSION

Access to the best standard of mental healthcare, and healthcare in general, is one of the most important human right to secure for refugees, since it is essential to allow them to enjoy other human rights (36). Refugees should be screened for mental health disorders as soon as they reach the host countries, and physicians must make adjustments in their style of questioning and their treatment approaches to accommodate to this special population.
Researchers should be encouraged to study this population in order to find the best strategies to provide care for refugees. At the same time, they should be held to a high standard not only in their research design, but in their respect for the autonomy and the dignity of this vulnerable group.

CONFLICTS OF INTEREST AND FUNDING

Conflicts of interest: none. Funding source: none.

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