World Health Organization

REGIONAL OFFICE FOR Europe

Mental health promotion and mental health care in refugees and migrants

Technical guidance

This project is funded by the European Commission.

Knowledge Hub on Health and Migration

The Migration and Health programme

The Migration and Health programme, the first fully fledged programme on migration and health at the WHO Regional Office for Europe, was established to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020, providing support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect public health in the host community.

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Abstract
The experience of migration can be complex and stressful, related to events before departure, during travel and transit, and after arrival. Consequently, refugees and migrants can suffer from mental disorders, although prevalence is highly variable across studies and population groups. This technical guidance reviews the prevalence of some disorders such as post-traumatic stress disorder and depressive and anxiety disorders. Based on best-available evidence regarding risk factors and areas for intervention, eight key priority action areas are identified for consideration by policy-makers regarding the mental health of refugees and migrants. While different countries may be more or less able to adapt depending on their baseline capacity, areas and models for intervention to promote mental health and provide good mental health care to refugee and migrant groups include social integration, facilitating access to care, fostering engagement with care and treating patients with manifest disorders.

Keywords
MENTAL HEALTH; MENTAL DISORDERS; ANXIETY DISORDERS; STRESS DISORDERS, POST-TRAUMATIC, STRESS, PSYCHOLOGICAL; REFUGEES; TRANSIENTS AND MIGRANTS; HEALTH PROMOTION

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Abbreviations

IOM	International Organization for Migration
NGO	nongovernmental organization
PTSD	post-traumatic stress disorder

Summary

The process of leaving one's home country and adapting to a different environment, culture and life situation is often stressful. Many refugees and migrants can suffer from mental disorders, although prevalence is variable across studies and population groups. Higher prevalence of mental disorders in long-term refugees is associated with lack of social integration and specifically with unemployment.

While prevalence of mental disorders is an important factor for consideration, the total number of refugees and migrants in a country is also critical. If the total number is very high, there are likely to be many with manifest mental disorders, regardless of whether or not the prevalence for all or some disorders differs from the host population. It is also this absolute number that poses challenges to health care systems, as different countries may be more or less able to adapt depending on their baseline capacity. Areas and models for intervention to promote mental health and provide good mental health care to these groups include through social integration, facilitating access to care, fostering engagement with care and treating patients with manifest disorders.

This technical guidance has been produced to summarize the research evidence and previous recommendations, and to assist policy-makers in the WHO European Region with considerations for promoting mental health and providing good mental health care for refugees and migrants. The advice focuses on how policies can help refugees and migrants to maintain good mental health; how health care systems can improve access to and engagement with mental health care if and when required, and how services can ensure that effective interventions are provided.

At present, the existing evidence for interventions for the prevention and treatment of mental disorders in refugees and migrants is scarce; however, principles of good practice can drive further research. This technical guidance includes case studies as illustrations of promising practice principles as they reflect positive initiatives that might stimulate further research and practice development.

As with many of the issues related to the health of refugees and migrants, efforts to improve the well-being of these groups involves commitment and cooperation across multiple levels – including mental health care, physical health care and social services.

Eight key priority action areas are identified for consideration by policy-makers regarding the mental health of refugees and migrants:

- promoting mental health through social integration;
- clarifying and sharing information on entitlements to care;
- mapping outreach services (or setting up new services if required);
- making interpreting services and/or cultural mediation services available;
- working towards integration of mental, physical and social care;
- ensuring that the mental health workforce is trained to work with migrants;
- investing in long-term follow-up research and service evaluations for service planning and provision; and
- sharing principles of good practices across countries.

Introduction

Mental health in the context of migration

Since the late 2000s, increasing numbers of refugees and migrants have been arriving in the WHO European Region. Migration commonly reflects different population movements and includes different categories of migrant, such as economic migrants, refugees, asylum seekers and migrants in an irregular situation *(1–5)*. The same individual migrant can belong to different categories at different points in time: people who travel irregularly can ask and obtain asylum; rejected asylum seekers become migrants in an irregular situation (which are referred to here, for brevity, as irregular migrants); and economic migrants who become unemployed or whose documents expire may become irregular migrants. Against this, some irregular migrants may succeed in finding a job and in achieving recognized migrant status in a country *(1,2)*.

For all migrants, the process of migration can be complicated and stressful. It involves leaving the home country and adapting to a different environment, culture and life situation *(6,7)*. Moreover, refugees and migrants can be exposed to stressful events before departure, during their travel and after arrival, and they may struggle to fully integrate in the social context of the host countries *(6–10)*.

The exposure to stressful situations can vary substantially among different migrant groups (economic migrants, refugees, asylum seekers and irregular migrants) but also within each of the groups, depending on the given context of the migration and settlement in the host country *(10,11)*.

Independently of their legal status, some refugees or migrants have encountered a particularly long, unpredictable and cumbersome journey before arrival in the host country and have faced extreme adversities or poor economic conditions. In addition, refugees have often been exposed to stressful events such as wars and other forms of armed conflict, persecution, discrimination or natural disasters before departure from their countries.

Following arrival in the host country, migrants have to cope with the need to adapt to a new environment, often with a new language and a different majority culture. This can be linked with concerns about the fate of their families, no matter whether the families migrated with them or stayed in the country of origin. Other challenges may involve addressing the bureaucratic requirements for obtaining permission to stay in a country. Particularly for asylum seekers and irregular migrants, there is the additional stressful uncertainty about how long they can stay in the new country. They face the potential threat of being deported and/or detained and long waiting times until their status is determined.

To complicate this further, migration is often not a simple and direct move from one country to another: country of origin to a country of destination or host country. They frequently access and reside in a number of countries (so-called countries of transit)

before arriving in the country of their final destination *(12,13)*. Whether they reside in a country of transit in the longer term may depend on several factors such as their economic resources, the success of temporary settlement in the country of transit and their entitlements to move on to other countries *(12,14)*.

Whether influenced by stressful events during migration or independent of these stressful events, refugees and migrants can suffer from mental disorders and might benefit from treatment in professional health services. Yet accessing care is often difficult for them, and some problems in access are shared by all refugees and migrants *(15,16)*. These can include language barriers, lack of information about the health care system in the host country, limited entitlements to receipt of free care, different explanatory models of mental distress, and different attitudes to medical and psychological treatments compared with those of the majority population in the host country.

Depending on the educational level and background of an individual refugee or migrant, language barriers, the ability to interact with health care professionals and skills to express mental health problems can vary greatly *(17)*.

Access to professional care is particularly difficult for irregular migrants. Their entitlements to receiving free care can be very limited, and they typically do not have the means to pay for mental health treatment themselves. Additionally, they can be reluctant to access a health care service out of fear they might be reported to the authorities and face adverse consequences, including deportation *(10)*.

A number of different professional associations and international policy-making bodies have published reports acknowledging the physical and mental health needs of refugees and migrants *(8,9,18–24)*.

Objectives

This technical guidance has been produced to summarize previous recommendations and the research evidence on mental health promotion and mental health care, and to provide considerations, not fixed recommendations, to policy-makers in the WHO European Region for the promotion of mental health and the provision of good mental health care for refugees and migrants.

The guidance focuses on how policies can help refugees and migrants to maintain good mental health, how health care systems can improve their access to and engagement with mental health care if and when required, and how services can ensure that effective interventions are provided for this diverse grouping.

Methodology

This technical guidance is based on an evidence synthesis produced in collaboration with a group of experts from different countries and organizations in Europe (Humanity

Crew, International Organization for Migration (IOM), Queen Mary University of London, University of Verona, WHO Regional Office for Europe and WHO Country Office for Serbia). The group of experts had a face-to-face meeting in London and then corresponded.

The relevant evidence for policy-making on mental health care for refugees and migrants was synthesized focusing on:

- prevalence and risk factors for mental disorders in these populations
- areas and models for interventions
- case studies of good practice of interventions and services in European countries.

Evidence was collected on prevalence of mental disorders and on interventions, prioritizing high-quality and most recently updated systematic reviews on these topics *(10,25–29)*. This was complemented by literature searches of a range of databases on health and social care (Applied Social Sciences Index and Abstracts, CABI Global Health Database, Cochrane, Embase, Google Scholar, OpenGrey, PubMed and Social Sciences Citation Index) using descriptors of population (refugees, migrants, asylum seekers, irregular migrants), mental disorders and areas and models of relevant mental health care interventions. A narrative synthesis approach was used to identify and describe the identified studies.

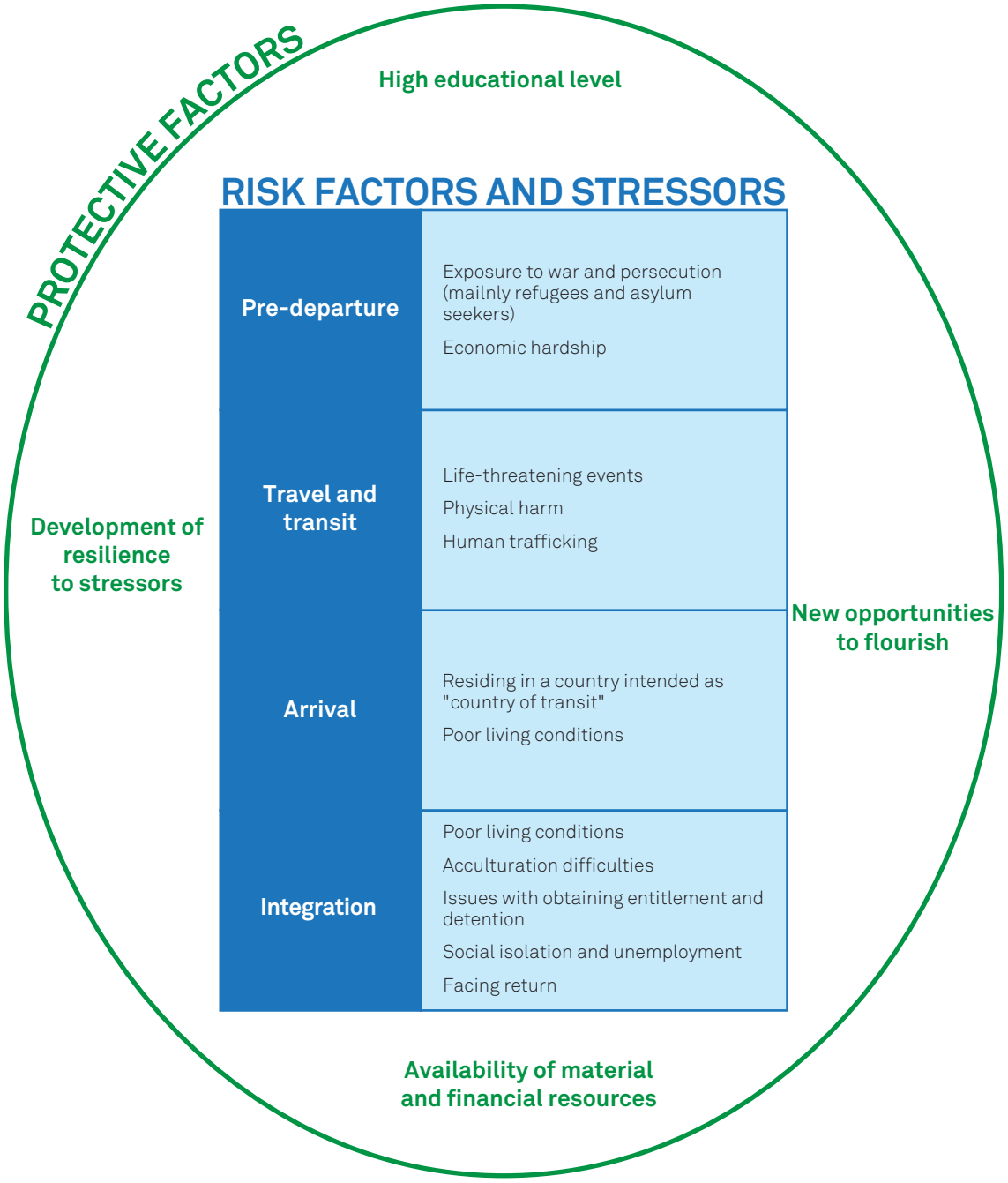
Case studies were added to describe good practice, including practice that may not have been published in scientific journals. Case studies were identified through a search of both published literature and the websites of government organizations and nongovernmental organizations (NGOs) involved in supporting refugees and migrants. Given the broad search and the lack of high-quality research evaluation of the identified case studies, they are intended only to illustrate good practice principles. No definite conclusions can be drawn on the effectiveness of the specific interventions that they describe.

Overview

Risk factors and protective factors for mental health in refugees and migrants

Fig. 1 is an infographic outlining the risk factors and protective factors for mental health in refugees and migrants.

Fig. 1. Risk factors and protective factors for mental health in refugees and migrants



Source: data from several publications *(11,30–32)*.

Evidence

What is known about prevalence of mental disorders in refugees and migrants

The prevalence of mental disorders in refugees and migrants has been assessed in numerous studies and collated in reviews *(25,26,29)*. The findings of these studies can be summarized as follows.

- Prevalence of mental disorders in refugees and migrants shows a very high variation across different studies *(15,25,26,33)*. A comprehensive review identified a prevalence of depression ranging from 5% to 44% in refugee and migrant groups in different studies, compared with a prevalence of 8–12% in the general population *(26)*. For anxiety disorders, prevalence ranged from 4% to 40% compared with reported prevalence of 5% in the general population. Fewer studies assessed prevalence of psychotic disorders *(26)*, but where these values were available they were two to three times higher in refugees and migrants than in host populations *(25,26)*.
- At present, there is no clear and consistent evidence of higher prevalence of psychotic, mood or anxiety disorders in refugees and migrants at arrival compared with the host populations. The only disorder for which substantial and consistent differences in comparative prevalence have been reported is post-traumatic stress disorder (PTSD); this is specific for refugee groups (9–36% in refugees compared with 1–2% in host populations) *(10,25,26)*. However, PTSD is not the most prevalent disorder in refugees. Mood disorders, such as depression, are more frequent than PTSD in refugees and migrants (prevalence can vary between 5% and 44%), although prevalence does not consistently differ from host populations.
- Refugees who have lived in a host country for more than five years tend to show higher rates of depressive and anxiety disorders than the host population. Estimates for prevalence for depressive disorders and anxiety disorders are typically 20% or more in long-term refugees. However, variability is very high (depressive disorders: 2.3–80%; anxiety disorders: 20.3–88%; PTSD: 4.4–86%) *(29)*. There is no conclusive evidence that the prevalence of psychotic disorders changes over time in refugees and migrants, but a recent large study in Sweden showed higher incidence for psychotic disorders (i.e. more newly diagnosed psychotic disorders) in refugees compared with the host population *(34)*.
- Higher prevalence of mental disorders in long-term refugees has been associated with a lack of social integration and specifically with unemployment *(29)*.

It is important to note, however, that prevalence is the proportion of people in a population who have a particular disease or attribute at a specified point in time or over a specified period of time. Consequently, the prevalence of mental disorders is only one of two factors that determine the absolute number of refugees and migrants with mental disorders in a country. The other factor is the total number of refugees and

migrants in the country at that time. If that total number is very high, there are likely to be many refugees and migrants with mental disorders that have been identified (referred to here as manifest mental disorders), no matter whether or not the prevalence of all or some disorders differs from the host population. The challenge to health care systems depends on the absolute number of refugees and migrants with mental disorders. Health care systems in different countries may also be more or less able to adapt to this need, based on their baseline capacity.

What is not known about prevalence of mental disorders in refugees and migrants

A number of important questions remain unanswered by research, including

- whether true differences in prevalence among different migrant groups exist
- whether risk factors can predict prevalence of mental disorders in migrant groups
- how and why prevalence increases after migrants have settled for a long period of time.

Are there true differences in prevalence among different migrant groups?

As outlined above, prevalence of mental disorders varies greatly among studies. At least to some extent, this variation might reflect true differences, although some of the differences across studies may reflect methodological diversity.

- Refugees and migrants vary in their social characteristics, background, education, professional qualifications and skills, motivation to leave their country of origin and willingness to settle in the host country in the short or longer term. Also, the context of adaptation in the host country and the possibilities for integration in the new society vary. All of these factors might influence mental disorders and, therefore, explain the differences seen in prevalence *(26,29,35)*, but there is no clear evidence in this area. There are a number of reasons for the lack of evidence, one of which is that these factors often have not been well assessed in studies.
- A further issue is that studies have used different methodologies for selecting those interviewed in migrant groups, the type of interviewers and the methods for assessing mental disorders *(10,28)*. These differences in methodology can lead to very different findings. Meta-analyses have shown that studies of higher quality tend to show lower prevalence for mental disorders *(25,26)*. Higher-quality studies are those which use (i) random sampling approaches with a more representative sample of interviewees, (ii) interviewers who are native speakers of the language of the refugees and migrants interviewed, and (iii) validated standardized instruments for diagnosing mental disorders.
- An additional difficulty in epidemiological studies is that expressions of mental distress can be variable. Expressions are influenced by cultural background and

could be over- or underestimated by the standard diagnostic tools available in Europe *(9)*.

In summary, it is not known to what extent the substantial differences in prevalence among different migrant groups that are reported in research studies reflect true differences between groups or are just a result of inconsistent methodologies.

Can risk factors predict prevalence of mental disorders in migrant groups?

- Some factors are known to increase the risk of mental disorders in refugees and migrants. Exposure to stressful events before departure or during travel and difficulties with settlement and integration in the host countries are associated with higher rates of mental disorders *(32,36,37)*, as shown in Fig. 1. A study of long-term refugees from the former Yugoslavia in three different countries (Germany, Italy and the United Kingdom) found that these factors did increase the risk of a mental disorder in refugees in all three countries *(35)*. However, even if all these factors were taken into account and adjusted for statistically, there were still large differences in prevalence between the three countries. These findings show that, even when the main known risk factors in a new group of refugees or migrants can be assessed, it is still not possible to predict the prevalence of mental disorders very well. Consequently, it is very difficult to make any prediction of prevalence on a group level.
- Although some risk factors are linked to a specific stress that a migrant might face, predicting on an individual level which arriving migrants facing that stress will develop a mental disorder in the host country and who will not is an even more difficult task.
- Current knowledge about risk factors does not allow sufficiently accurate a prediction for groups and even less so for individuals *(35,38)*. Further studies and the use of large routine datasets in various countries and migrant groups might help to identify generic and specific factors that might be used for the prediction of mental disorders *(38)*.

How and why does prevalence increase after migrants have settled for a long period of time

- While much research has focused on prevalence at one point in time, much less evidence exists for how prevalence and disorders may change over time and which factors influence the changes. The few available studies of mental disorders in refugees and migrants after more than five years in the host country suggest that prevalence may be higher than in the host population. However, it is not know which changes over time can explain this *(29)*.
- One possible reason for the increased rates observed over time for mental disorders may be a selection process, with those migrants without mental disorders being more likely to leave the host country after a period, while those with mental disorders stay for a longer time *(29,39)*. Alternatively, there could be a tendency

for refugees and migrants who arrived without mental disorders to develop them in the host country over time.

- The available evidence suggests an association between poor social integration and a higher likelihood of having a mental disorder, but cause and effect remain unclear *(10,29)*. Poor social integration could be the cause or the consequence of mental distress, or both. If it is the cause, how might specific interventions help to improve social integration or to ameliorate the negative consequences of poor integration? Good longitudinal studies would be required to answer these questions.

What is known about areas and models for interventions

Observational studies have identified both risk factors and protective factors for mental disorders (Fig. 1) *(32,40,41)*. Other studies have also found that refugees and migrants may encounter problems in accessing and engaging with care when it is needed *(41)*. Based on this evidence, interventions to promote mental health and to provide good mental health care to these groups have focused on the following four areas *(10,16)*:

- area 1: promoting social integration
- area 2: overcoming barriers to access for mental health care
- area 3: facilitating engagement with care
- area 4: treating refugees and migrants with manifest mental disorders.

Rationale for different interventions

- General policies and interventions to promote mental health through social integration can be beneficial for migrants on a large scale and help them to become more included in the new country. This is likely to have a preventive effect and will probably reduce the development or deterioration not only of mental disorders but also of those physical health problems that can lead to marginalization with its range of negative consequences, such as higher crime rates and lack of productivity.
- Strategies to facilitate access and engagement with care can enable successful treatments or, at least, prevent the deterioration of existing mental disorders in those refugees and migrants who experience mental disorders.
- Evidence-informed treatments for manifest disorders (i.e. pharmacological and psychological treatments) are commonly available in European host countries. For almost all mental disorders, treatments have not been separately tested in refugees and/or migrants. There is good reason to assume that the evidence-informed treatment guidelines that have been developed for the population of the host country would also apply to refugees and migrants. Most migrants with substantial mental distress suffer from depression and/or anxiety disorders. For those who suffer from ongoing symptoms of PTSD, specific psychological

treatments have been developed, offered and tested in studies. However, it must be noted with regard to refugees that, overall, less than 10% have PTSD (as found in the highest quality prevalence studies) and there was substantial variability in prevalence in different studies *(28)*. Prevalence of PTSD is generally lower in other migrant groups *(28)*.

Settings in which interventions can be implemented

Interventions to address these identified areas are implemented in different settings.

- Interventions to promote mental health through social integration can involve a broad range of agencies and actors such as social care services, employment support agencies and communities at large *(42,43)*.
- Interventions to facilitate access and engagement are more frequently offered as part of health care services.
- Psychological interventions for PTSD are more likely to be provided as part of specialized mental health services.

Evaluation of interventions

- Interventions to promote mental health through social integration are likely to reduce the prevalence and burden of mental disorders in refugees and migrants, considering the link between lack of social integration and development of mental disorders *(29)*. However, there is no evidence for the effectiveness of specific models to achieve better integration and, through that, lower prevalence of mental disorders *(42,44)*.
- Interventions to facilitate access and engagement with care (e.g. high-quality interpretation services, cultural mediation and cultural competency training courses for clinicians) have been evaluated only in low-quality studies *(41,45)*. These studies have shown that interventions of this type do have the potential to widen the reach of mental health interventions and to improve the experience and outcomes of treatments. Larger and better-quality studies are required to provide more reliable and more specific evidence for such interventions.
- In terms of provision of treatment for manifest mental disorders in refugees and migrants, randomized controlled trials have mainly examined psychological interventions for PTSD. Although some of these trials have shown promising results, they do not provide conclusive evidence that these psychological treatments are effective *(27,28)*.

What is not known about areas and models for interventions

At present the existing evidence regarding interventions for the prevention and treatment of mental disorders in refugees and migrants is scarce; however, principles of good practice should drive further research. The objectives of such research should include:

- specifying how the general principles of good practice can be translated into well-defined interventions and obtaining systematic research evidence on how these defined interventions are implemented and what their outcomes are;
- identifying factors in specific situations and contexts that would support decision-making on which of a range of possible interventions should be used;
- establishing the right time after the arrival of refugees and migrants for applying the different interventions as intervening too early might undermine self-help processes and interfere with a spontaneous recovery while intervening too late may not be effective and fail to avoid a negative cycle of social exclusion and mental morbidity;
- developing interventions for the specifically challenging context of transit countries, when people with mental disorders, in particular those with severe disorders, who require professional help may struggle to engage in care as they intend to leave the country soon; and
- exploiting the potential of new communication technologies for dealing with language barriers, facilitating diagnostic assessments and promoting an innovative provision of psychological interventions or other mental health or social interventions (i.e. utilizing the already wide and probably further increasing use of smartphones and the Internet by refugees and migrants).

Areas for interventions

This section describes the four areas for interventions in refugees and migrants outlined above and based on current evidence. Interventions in these areas need to be carried out in different settings and involve different actors (mental health professionals and services only, or a collaboration of mental health care with physical health care and social services or community initiatives).

The case studies describe promising interventions that have not been systematically evaluated but reflect positive initiatives that might stimulate further research and practice development. The implementation and benefits of these case studies may be context depending or specific.

For the fourth area (treating refugees and migrants with manifest mental disorders), no case studies are provided but findings of systematic reviews and studies on interventions within this area are summarized.

Area 1: promoting social integration

Rationale

A lack of social integration, particularly social isolation and unemployment, is linked with higher prevalence of mental disorders in refugees and migrants *(10,29)*. While social exclusion is also a predictor of mental health difficulties in the general population of host countries, refugees and migrants have a particularly difficult task in integrating in a new country and culture. Moreover, they may face negative attitudes, prejudices or even discrimination, which could undermine and hinder their efforts for integration. Social exclusion is a modifiable risk factor for mental disorders that can be addressed through appropriate preventive interventions.

Interventions

The first level of intervention is to guarantee basic needs. Interventions and experiences in difficult settings are described in the Inter-Agency Standing Committee's guidelines on mental health and psychosocial support in emergency settings *(22)*. The same or higher standards in terms of these needs (e.g. food security and nutrition, accommodation and general subsistence) should be provided as a minimum to refugees and migrants upon arrival in high-income countries *(46)*.

Higher-level interventions can focus on education. The school environment and education (particularly for children and adolescents) can be an effective area for reducing social isolation and for providing support for finding and maintaining employment *(42,43,47,48)*. Educational programmes may include classes to learn the language of the host country, help with converting the professional qualifications

of refugees and migrants to what is needed for acceptance in the host country, and vocational training for acquiring skills and new professional qualifications.

Interventions can target general social isolation. Interventions to reduce social isolation can involve events targeted at refugees and migrants, such as community forums or peer-mentorship programmes from already integrated members of the same refugee or migrant group. Social activity programmes with volunteers of the host population may also facilitate social integration. These programmes can also take the form of organized sport activities, cultural exchanges and recreational activities. Social integration programmes should be based on a person-centred assessment of skills and needs. Examples of these approaches are presented in Case studies 1 and 2.

Case study 1. A person-centred need assessment for social integration of refugees

Provider: The Holistic Integration Service, Scottish Refugee Council (United Kingdom).

At the heart of the Holistic Integration Service, there is a person-centred assessment framework that identifies four broad categories of service user:

- resilience: refugees who have good English language skills and require little input to rebuild their lives in Scotland;
- guidance: refugees who require language qualifications and assistance in understanding new systems and processes;
- complex: refugees who require guidance but also support and advocacy (e.g. with physical or mental health problems and requiring assistance to go to appointments for benefits applications); and
- critical: refugees who may have additional support needs but whose circumstances are further compounded by other issues (e.g. evictions).

An action plan is used to ensure realistic goal setting. This is done through a comprehensive assessment tool covering housing, financial stability (including benefits), health, education, employment and social connections.

Source: Refugee Council United Kingdom, 2018 *(49)*.

Case study 2. Volunteering programmes to help social integration (Belgium, Denmark, Finland, the Netherlands and the United Kingdom)

Providers: Campaign "Wanted – Part Time Hero", Dutch Refugee Council; Resettlement Volunteering Programme, British Refugee Council and Refugee Action United Kingdom; "Samen Inburgeren – Integrate Together", City of Antwerp, Belgium; VAPAA "Volunteering in Refugee Work" Project, the Finnish Red Cross; Volunteer Network in Denmark, Danish Refugee Council.

All of these provided programmes involve recruitment of volunteers who support refugees in obtaining knowledge of the area in which they live. The programmes can be based on different options:

- one-to-one volunteer–refugee matching (Belgium and the Netherlands);
- putting in contact families of refugees with a local "network family" (Denmark); and
- having volunteers to provide practical support or organize activities to help refugees' social integration (Finland and the United Kingdom).

Examples of social integration activities are language learning and cooking clubs; first-aid activities; handicrafts and small-scale agriculture in groups; visits to local firms in order to create employment opportunities; and homework help for children. Practical support for immigration documents and procedures is also provided as part of all the programmes.

In some programmes (United Kingdom), refugees can participate as volunteers once they have gained enough knowledge about the area in which they live.

Source: European Resettlement Network, 2018 *(50)*.

Interventions can target mental health. Social interventions for refugees and migrants may be part of a multimodal approach aiming to promote the mental health of a whole population and identifying those who might require more specialized mental health treatments *(51,52)*.

Irregular migrants may need specific interventions. Migrants are in an irregular situation because they lack the appropriate documentation, have failed to seek asylum using the required procedures or have had an asylum request rejected. They may face detention and potentially deportation to their countries of origin *(10,53)*. Guidelines on how to consider and assess physical and mental health problems in such situations and how to provide psychosocial support to people threatened with deportation have been developed in the Netherlands *(54)*. These may be a helpful tool for consideration in and adaptation to other countries and contexts.

Actors involved

The initiatives described here should involve a broad network of services and agencies. Mental health professionals should seek and receive information about the work and

processes of other relevant agencies that may impact on the mental health of the migrant. Health care services should closely collaborate with social services, voluntary organizations, community groups and school and work institutions. Organizing regular meetings between different services or intersectoral working groups can help to develop joint interventions and health and social care pathways.

Area 2: overcoming barriers to access for mental health care

Rationale

Various studies have demonstrated that refugees and other migrants can encounter barriers to accessing mental health care *(40,41)*. This can delay treatment, potentially leading to further complications of the mental disorders and making them less amenable to existing treatments. Some of these barriers are common to other health care services (e.g. lack of knowledge about entitlements to care). Others are more specific to mental health care and are related to different ways of expressing mental health difficulties, sometimes through physical complaints or supernatural explanations, and to fear of discrimination experienced by some migrants who have mental health problems. This makes it less likely that some of them access mental health services and receive appropriate treatments in a timely fashion.

Moreover, irregular migrants may not be entitled to access specialist care. Since in some countries many mental health care interventions are provided only within specialist services, irregular migrants may not be able to access and benefit from the full range of mental health interventions that is available.

Interventions

The literature describes a number of interventions that aim to overcome barriers to mental health care. They include the provision of information on mental health care entitlements to migrants and clinicians; the establishment of outreach services; and the integration of mental, physical and social care.

Information on entitlements should be provided to both users and providers of health care. Often neither the refugees and migrants themselves nor their clinicians are fully aware of the entitlements to access different types of health care. This is particularly relevant for asylum seekers and irregular migrants. Provision of such information can help these patients to seek treatment, as and when available, and help clinicians to make appropriate referrals *(42,55)*. However, it appears important to tailor the provided information to the characteristics of the groups and individuals that have to be reached. Websites or written information can be sufficient for many refugees, while for others, who are not fully literate or are more used to communicating orally, information through videos or verbal messages and direct oral communication is likely to be more effective *(56,57)*. Classroom-based approaches can be rather expensive and logistically difficult to organize but also address the target of reducing social isolation *(58)*.

Outreach services can provide a bridge into mainstream services. Some refugee and migrant groups may benefit from specialized outreach services because they have difficulties in accessing such services on their own *(40)*. These services go actively out to a migrant group and mediate between the group and the appropriate public service or NGO. They may also act as temporary services until trust and familiarity with the generic mental health services is achieved *(55,57)*. Outreach services can provide practical and organizational support (e.g. booking appointments or facilitating referrals to and between different services). European countries often have complex care system pathways that are difficult to navigate for newcomers, particularly those who have an imperfect knowledge of the language. The functions of outreach services need to be tailored to the needs of the migrant group *(55)*. For example, in groups in which there is a negative attitude to professional mental health services, outreach can focus on psychoeducational initiatives and the provision of appropriate information on mental health services. In elderly populations or unaccompanied minors, outreach services may concentrate on provision of practical support in navigating the system. An innovative model to facilitate access to care and provide low-intensity mental health support used trained peer refugee workers (Case study 3).

Case study 3. Training peer refugees to offer low-intensity mental health support (Germany)

Provider: Médecins Sans Frontières in collaboration with Schweinfurt Hospital.

This project helps refugees to receive information about how mental health care works in Germany and to access low-intensity psychological support from trained fellow refugees. Refugees working as psychosocial peer counsellors are employed as they are native speakers of patients' languages and are familiar with the culture and situations that the refugees have come from. They are trained to give people the skills to manage stress and anxiety themselves, before their symptoms get worse.

The refugee peer supporters receive training from trained psychiatrists and are employed by the Schweinfurt Hospital. New patients are assessed one to one by peer supporters and asked about themselves, their worries and their journeys. Group therapy sessions and mindfulness exercises are also a part of the programme.

The peer supporters are also instructed to identify those who may need a higher intensity of support (e.g. when there is risk to self or others) and to refer patients to psychiatrists, accompanying them and explaining and translating for them.

Source: The Guardian, 2017 *(59)*.

Coordinating mental and physical care with social services allows a holistic and nonsectoral perspective. This integrated approach can help refugees and migrants for two main reasons: some experience severe disorders with an interplay of mental, physical and social difficulties; and some express psychological difficulties

predominantly with physical complaints or when social crises arise, and so may not access mental health services in the first instance when needing help *(10)*. Regardless of the specific issues relating to refugees and migrants, improving coordination of different components of care is a commonly acknowledged challenge across the care systems of the WHO European Region, and ways to achieve better coordination are discussed in the general literature on health and social care *(60)*. Integrated and specialized services for particularly vulnerable subgroups (e.g. those exposed to torture *(61)*) or brokering services to signpost migrants to mainstream services *(62)* are potential options for achieving this coordination for refugees and migrants, although there is no clear evidence that would favour one approach over another. Preferences for different approaches may vary depending on national traditions, the available resources and infrastructure, the context of mental health care systems, or specific characteristics of the groups or subgroups of migrants that are to be supported. Specialized integrated services would normally be established if there is a critical mass of potential patients with complex needs who would benefit from and use such a service. Case studies 4 and 5 describe two instances of integration of physical and mental health care. In Case study 4, medical, psychological and social support is provided by the same service. In Case study 5, refugees are assessed by a group-specific service and then signposted to relevant services in the geographical area.

Case study 4. Integrated medical, psychological and social support for refugees exposed to torture (Greece)

Provider: Médecins Sans Frontières.

This project was developed to provide a service for integrated treatment of victims of torture and other forms of ill-treatment. The medical services are complementary to the mental health, social and legal support provided to victims of torture by BABEL Day Centre and the Greek Council for Refugees. This is in the framework of Prometheus, a European Union-funded rehabilitation project for victims of torture.

Medical support includes clinical examination and assessment of torture residuals; treatment plan focusing on the management and rehabilitation of torture-related disabilities; physiotherapy and chronic pain management; psychiatric treatment, including assessment, counselling, psychological interventions and support; referrals to specialists for further assessment and treatment in public services, private health facilities and other medical non-profit-making organizations; and management of other chronic morbidities.

Between October 2014 and December 2015, 154 beneficiaries from 33 countries received support. More than half of the beneficiaries sought mental health support to overcome different types of traumatic exposure (torture, detention, difficult journey to Europe, racist attacks) as well as current stressors such as uncertainty in relation to the outcome of the asylum process, practical difficulties and social marginalization.

Source: Kotsioni et al., 2017 *(61)*.

Case study 5. Assessing the needs of refugees and asylum seekers for support and signposting to relevant services (Italy)

Provider: Protection System for Asylum Seekers and Refugees (SPRAR)

The SPRAR project in Italy aims to facilitate the provision of integrated physical, mental and social care for refugees and asylum seekers. The refugees and asylum seekers receive an assessment of their strength and resources and of their vulnerability. They are helped with obtaining knowledge of the area, city and borough in which they live. If physical and mental health needs are identified, the patient is signposted to relevant services. Rehabilitation and integration programmes follow from collaborative arrangements with mental health services, taking into account difficulties and strengths of the patient. SPRAR also has active contacts with other volunteering organizations and local companies for job opportunities, as well as legal and social guidance and support, in order to help the development of individual programmes to promote socioeconomic inclusion and integration.

Source: SPRAR *(63)*.

Actors involved

In order to overcome barriers to access for mental health care, a broad perspective is again required, linking the work and agenda of the mental health services with those of other agencies such as physical health services, social care, NGOs and community or religious groups. For example, outreach services can be established within the health care sector, by NGOs or by religious organizations and can help with connecting people with physical, mental or social care services.

Area 3: facilitating engagement with services

Rationale

Once refugees and migrants have accessed mental health services, there are a number of potential barriers to establishing a positive therapeutic relationship with clinicians and engaging patients in treatment. This affects both the uptake and the effectiveness of the provided treatments. Among the barriers to engagement are language difficulties, cultural beliefs and cultural expectations *(10,41,57,64)*.

Poor command of the language of the host country can prevent effective communication. In mental health care, the diagnostic process is almost entirely based on oral communication, as are many interventions (e.g. psychological interventions). Misunderstandings between patients, interpreters and clinicians can make the diagnostic process more difficult and less accurate, causing under- or overestimation of the mental difficulties of the assessed patient, as well as negatively influencing the effectiveness of psychological treatments.

Cultural beliefs about mental health may hinder diagnosis and treatment provision. Specific beliefs about mental phenomena and psychological distress (e.g. supernatural explanations or physical presentations of psychological distress) can make the diagnostic process more complicated and lengthy and the engagement of patients with care more problematic.

Cultural expectations can also impact care provision. Cultural expectations influence how mental health care professionals are regarded, for example in relation to their status and ability to provide help. Some asylum seekers may be hopeful that clinicians can improve their difficult living conditions by moving them from their current unfavourable ones. Other migrants may have concerns that mental health professionals will report them to the authorities or will not keep the conversations confidential. Confidentiality concerns can arise in small migrant groups when the interpreter is part of the patient's social group. Discrepancies can also come up when discussing treatment choices. For example, tensions may occur if patients believe they are seriously mentally or physically ill and expect a more or less specific pharmacological or psychological treatment, which the clinician does not suggest or provide.

Interventions

High-quality interpretation services support effective patient–clinician interactions. Interpreters who are trained and qualified tend to provide a better patient experience *(41)* and can also improve the outcome of psychological treatments *(45)*. Service-level arrangements between mental health services and interpretation services, and agreement and formalization of expected standards, can improve diagnostic processes and the effectiveness of care *(10)*. Clinicians should also receive orientation and training in how to work with interpreters *(41,45)*.

Cultural mediators can help migrants to use and engage with health care services. This becomes a particularly important role when conflicts arise between health service providers and patients *(65)*.

Information technology has the potential for improving engagement with health care services. Face-to-face interpretation for all the possible languages can be expensive and difficult to organize. Telephone or online interpretation services are increasingly available and can reduce costs. A wide range of software can be used to carry out or translate assessments so that a culturally appropriate terminology is used and patients are able to understand fully the purpose and components of the assessments *(41)*. In some cases, consultations with clinicians who speak the same language as the migrants but are based elsewhere can be arranged through technology-based tools, such as video-conferencing (Case study 6) *(66)*.

Case study 6. Transcultural tele-psychiatry (Denmark)

Provider: Little Prince Psychiatric Centre, Copenhagen, Denmark.

A transcultural tele-psychiatry service was used to enhance the access of refugees to mental health care professionals who had appropriate bilingual proficiency and cultural competence. Consultations took place through video-conferencing. The clinicians involved also had a comprehensive knowledge of the health care system in both the host country and the patient's original country. The advantage perceived by participants compared with usual interpreter-assisted consultations was that a direct consultation with a clinician speaking their language would diminish their concerns regarding information confidentiality.

Source: Mucic, 2010 *(66)*.

Cultural competence training can be provided for clinicians and other professionals. Training programmes can help clinicians to understand and assess mental health difficulties according to different cultural explanatory models of psychological symptoms. Such training can be provided within the basic training curricula of mental health professionals or through further professional development courses *(67)*. Ensuring that mental health services have a multicultural staff may also be a way to foster cultural awareness and help to communicate understanding of cultural differences within professional teams in reflective practice meetings *(68)*. Cultural mediators and other professionals who are likely to be in contact with migrants might also benefit from training on how to communicate and mediate relationships between migrants and mental health services. Case study 7 describes a capacity-building exercise aimed at health professionals and other professionals who were likely to be in contact with refugees and migrants.

Actors involved

Facilitating engagement of refugees and migrants with services involves mental health professionals and the services in which they work. However, it also requires collaboration with external organizations such as interpretation services; information technology companies that provide the infrastructure for overcoming the language barriers; and with cultural mediators and specialized outreach teams, who can provide cultural competence and knowledge of specific migrant and refugee groups.

Case study 7. Building capacity among professionals involved in the mental and physical health care pathways of migrants (Croatia, Germany, Greece, Italy, Malta, Portugal and Slovenia)

Provider: IOM.

The Equi-Health project (Fostering health provision for migrants, the Roma and other vulnerable groups) aimed to build a comprehensive multisectoral approach and enhance the capacity of public health authorities, law enforcement services and health care providers in the southern countries of the European Union. A set of training materials on migration health for law enforcement officers and health care providers was developed and training took place in Croatia, Germany, Greece, Italy, Malta and Portugal. Following capacity-building activities (Re-health project) targeting cultural mediators, a training curriculum was developed and training took place in Croatia, Greece, Italy and Slovenia. The curriculum included units on migrants' mental health and on occupational health/self-care for staff. To date, almost 2500 health professionals, law enforcement officers, health mediators and social workers have been trained using IOM materials, with positive feedbacks from participants.

Sources: IOM, 2018 *(69,70)* and personal communication from IOM.

Area 4: treating refugees and migrants with manifest mental disorders

Rationale

Most refugees and migrants with mental disorders do not require different interventions from those that are commonly provided for people with mental disorders in the general host population. Evidence-informed guidelines apply to refugees and migrants as to any other group *(17,28)*. In public and professional debates, there is often a dominant narrative that associates the mental health of refugees with PTSD *(71)*. Yet, while refugees and asylum seekers have a higher prevalence rate of PTSD than the host populations, PTSD is not the most frequent mental disorder in absolute terms in these groups *(28)*. In refugees and other migrants, as in general populations in Europe, common mental disorders such as mild to moderate depression and anxiety are the most frequent mental disorders. Moreover, while some migrants, and most refugees, asylum seekers and irregular migrants, have been exposed to stressful and potentially traumatic events, only a minority of them develop PTSD. Those who do develop PTSD have a rather favourable prognosis even without treatment. Most migrants exposed to stressful events are likely to have developed resilience. Many have existing strengths and skills or develop new abilities in the host country that can help them to achieve full social integration and be a resource for the country that they live in *(17)*.

However, probably because of the increased relative prevalence of PTSD in migrant and particularly refugee groups compared with host country populations, there are

psychological treatments for PTSD that have been tested almost exclusively in these groups *(17,51)*.

Interventions

The interventions with the most promising evidence base are:

- narrative exposure therapy, which aims to help patients to develop a chronological narrative of their life story with a focus on the traumatic experiences in order to transform fragmented reports of the traumatic experiences into a coherent narrative; and
- trauma-focused cognitive behavioural therapy, which aims to reduce distress related to traumatic memories and their impact on the current life of the patient, using behavioural and cognitive techniques (e.g. exercises to reduce avoidance and hyperarousal).

The effectiveness of these psychological treatments, however, has only been evaluated in studies of low methodological quality and only small-to-medium effect sizes were found. These effects are not consistently found in all studies and appear limited to PTSD symptoms and less frequently to depressive symptoms *(27,28)*. Most studies were carried out in high-income countries *(27,28)*. The general guidelines for PTSD treatment also recommend other interventions such as stress management and eye movement desensitization and reprocessing, the effects of which, however, have not been systematically studied in refugees and other migrant groups.

Actors involved

Mental health services and professional associations and groups need to work together to ensure that there is an appropriate number of professionals competent and confident in delivering evidence-informed interventions. In most cases, these interventions are similar to those provided to people with mental disorders in the host population, although a minority of refugees and migrants may benefit from trauma-focused specialized treatments.

The extent of the required provision may vary rapidly when large numbers of refugees and migrants access a specific country. In such a case, specific initiatives may be needed to prepare professionals and disseminate training in a short time frame.

Policy considerations

This section summarizes eight policy considerations for policy-makers. These considerations are based on the evidence in this guidance including risk factors and areas for interventions identified in the available research evidence.

Health care services

Promoting mental health through social integration

Making sure that refugees and migrants achieve social integration in host countries can be regarded as potentially the most influential prevention strategy for mental disorders on a public health level. This goal can be achieved in various ways depending on the societal context and on the landscape of agencies and providers available in each country. However, the general principles that should be followed are access to work, a person-centred assessment of need and close collaboration across health and social care services as well as with providers of legal support and employment opportunities. For child refugees and migrants (particularly if they are unaccompanied or separated from parents), school-based programmes should also be considered. Encouraging volunteering or training refugees and migrants as peer supporters can lead to particularly powerful initiatives for social integration of refugees and other migrants.

Clarifying and sharing information on entitlements to care

Entitlements to care for refugees and migrants can be complicated and highly variable from country to country and with the characteristics of the migrants. Devising and publishing clear online or print information on what care each category of migrant is entitled to will facilitate appropriate access to care for many migrants. Tailored strategies will need to be adopted for other groups who are less used to written communication. In general, all communications should be designed in a culturally sensitive fashion. Information resources should also be made available to health professionals, particularly in primary care and accident and emergency services, in order to help them to signpost and refer refugees and migrants as appropriate.

Mapping outreach services (or setting up new services if required)

For some migrant groups, specific outreach services may help to establish trust and familiarity with health services in the new country, clarify health care entitlements and facilitate access to mainstream services. These may already be available in a country or may need to be established. These outreach services may be considered in particular for very vulnerable populations such as unaccompanied minors and elderly migrants. Outreach services should act as mediators with mainstream services rather than as autonomous providers of care.

Making interpreting services and/or cultural mediation services available, including through information technology

High-quality interpreting services should be provided to overcome language barriers. This is of particular relevance in mental health care because of the confidentiality of the content discussed during mental health consultations and the need to translate language expressions with subtle nuances. High-quality interpretation services can help in making appropriate diagnosis and in promoting mutual understanding and establishment of a therapeutic relationship between patients and clinicians. In some cases, and for some patients, collaboration with cultural mediators may also be beneficial. Training of professionals on how to communicate with refugees and migrants who have mental health problems and to interact with interpreters and cultural mediators can maximize the benefits of their involvement.

Phone services, computer technologies and tele-psychiatry are tools that can be explored as an alternative to face-to-face interpretation and may become more important over time, given their potential for cost reduction and easy access. However, it should be ensured that the technical quality and the training and qualifications of interpreters, cultural mediators or clinicians (in case of tele-psychiatry) working in these services meet appropriate standards and that systems exist to monitored the process.

Working towards integration of mental, physical and social care

For some migrant groups with very complex needs and high vulnerability (e.g. unaccompanied minors, pregnant women or those who have experienced torture), the provision of mental, physical and social care in the same service may be appropriate. In most cases, however, the integration of mental, physical and social care will need to be built up through close collaboration among services and agencies, facilitating uncomplicated referrals and person-centred evaluation of needs and care plans. Ensuring that professionals working in different sectors such as law enforcement, education and work companies receive awareness training on mental health conditions can help to increase access of refugees and migrants to mental health care interventions when required.

Ensuring that the mental health workforce is trained to work with migrants

Clinicians should be aware of the health care entitlements of refugees and migrants. They should also be competent and confident in diagnosing and managing unusual presentations of mental disorders and understand the dynamics related to different family and social structures. These skills and competences can be partially obtained through training courses. Sharing experiences within the team in reflective practice meetings and communication about competences across different services can foster these competencies. On a wider geographical level, model services could be identified and visits of professionals from other services could disseminate good practices.

Service planning and evaluation

Investing in long-term follow-up research studies and service evaluations in order to better inform service planning and provision

Improving mental health care provided to refugees and migrants may require investment in research studies. Good longitudinal studies following up representative cohorts of refugees and migrants will need substantial funding. These studies should be complemented by local service evaluation of protocols to inform care in specific contexts and services.

The increasing availability of electronic medical records offers an opportunity for long-term evaluation of interventions in the routine provision of health services. Exploring long-term pathways into care for refugees and migrants with mental disorders can help to identify barriers to engagement with interventions and specify adaptations required for the needs of these groups.

Sharing principles of good practices across countries

Refugees and migrants are a very heterogeneous group. It is difficult to predict which new groups will arrive in a country, what the societal context will be that influences their social integration, what the nature and extent of their mental health problems will be, and how they will access and engage with health care services and treatments.

However, widely available information about examples of good practice and local or national experiences could help future efforts in the same or in different countries. A shared international repository of case studies and services may guide how good practice can be adapted to the local contexts and the characteristics and situation of a new migrant group. This, in turn, may support the design and delivery of timely and effective interventions to reduce mental distress in refugees and migrants, for the benefit of both the arriving individuals and the host society.

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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