References (in alphabetical order)

1. Bhugra D. Migration and mental health. Acta Psych Scand, 2004;109:243–258.
2. Bhugra D, Becker M. Migration, cultural bereavement and cultural identity. World Psychiatry, 2005;4:18–24.
3. Bhui K. Apples, refugees and emotions. Br J Pychiatry, 2015; 207:369-70.
4. Bogic M, Ajdukovic D, Bremner S, Franciskovic T, Galeazzi GM, Kucukalic A, Lecic-Tosevski D, Morina N, Popovski M, Schützwohl M, Wang D, Priebe S. Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK. Br J Psychiatry. 2012;200:216-23.
5. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. BMC International Health and Human Rights, accepted in 2015, in press.
6. Carballo M, Divino JJ, Zeric, D. Migration and health in the European Union. Tropical Medicine & International Health, 1998;3:936–944.
7. Carta MG, Oumar FW, Moro MF, Moro D, Preti A, Mereu A, Bhugra D. Trauma- and stressor related disorders in the Tuareg refugees of a Camp in Burkina Faso. Clinical Practice and Epidemiologic in Mental Health 2013;9:189–195.
8. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. Lancet. 2005;365:1309-14.
9. Fazel M, Karunakara U, Newnham EA. Detention, denial, and death: migration hazards for refugee children. Lancet Glob Health. 2014;2:e313-4.
10. Gerritsen AA, Bramsen I, Devillé W, van Willigen LH, Hovens JE, van der Ploeg HM. Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. Social Psychiatry and Psychiatric Epidemiology, 2006;41:18–26.
11. Giacco D, Matanov A, Priebe S. Providing mental healthcare to immigrants: current challenges and new strategies. Curr Opin Psychiatry. 2014;27:282-8.
12. Laban CJ, Gernaat HB, Komproe IH, Schreuders BA, De Jong JT. Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. The Journal of Nervous and Mental Disease, 2004; 192:843–851.
13. Lindert J, Ehrenstein OS, Priebe S, Mielck A, Brähler E. Depression and anxiety in labor migrants and refugees--a systematic review and meta-analysis. Soc Sci Med. 2009;69:246-57.
14. Llosa AE, Ghantous Z, Souza R, Forgione F, Bastin P, Jones A, Antierens A, Slavuckij A, Grais RF. Mental disorders, disability and treatment gap in a protracted refugee setting. Br J Psychiatry. 2014;204:208-13.
15. Priebe S, Matanov A, Schor R, Straßmayr C, Barros H, Barry MM, Díaz-Olalla JM, Gabor E, Greacen T, Holcnerová P, Kluge U, Lorant V, Moskalewicz J, Schene AH, Macassa G, Gaddini A. Good practice in mental health care for socially marginalised groups in Europe: a qualitative study of expert views in 14 countries. BMC Public Health. 2012;12:248.
16. Sandhu S, Bjerre NV, Dauvrin M, Dias S, Gaddini A, Greacen T, Ioannidis E, Kluge U, Jensen NK, Lamkaddem M, Puigpinós i Riera R, Kósa Z, Wihlman U, Stankunas M, Straßmayr C, Wahlbeck K, Welbel M, Priebe S. Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries. Soc Psychiatry Psychiatr Epidemiol. 2013;48:105-16.
17. Slobodin O, de Jong JT. Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? Int J Soc Psychiatry. 2015;61:17-26.
18. Steel Z, Momartin S, Bateman C, Hafshejani A, Silove DM, Everson N, Mares, S. Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. Australian and New Zealand Journal of Public Health, 2004;28:527–553.
19. Walsh F. Traumatic loss and major disasters: strengthening family and community resilience. Family Processes, 2007;46:207–227.

Authors:
Domenico Giacco and Stefan Priebe

World Health Organization
REGIONAL OFFICE FOR Europe

WHO EUROPE POLICY BRIEF ON MIGRATION AND HEALTH:

MENTAL HEALTH CARE FOR REFUGEES

Mental disorders in refugees

Extensive research has shown that, overall, the rates of mental disorders identified in refugees vary substantially across studies.

This heterogeneity is due to at least the following three factors.

a. The characteristics of the groups studied: their background, qualifications and motivations vary widely.
b. The context and situation in the host country: generally speaking, the poorer the host country the higher the prevalence of mental disorders (Carballo et al., 1998; Lindert et al., 2009).
c. The quality of the studies and in particular the sampling method: studies of higher methodological quality with random sampling generally report much lower prevalence rates than poorer studies with convenience samples (Bhugra, 2004; Fazel et al., 2005).

Considering these problems, the most comprehensive systematic reviews and meta-analyses of the mental health of refugees (Fazel et al., 2005; Bogic et al., 2015) showed that:

- major depression rates in refugees are similar to those in the general population in Western countries;
- refugees are about ten times more likely than the age-matched general population to have post-traumatic stress disorder (PTSD) – 9% of refugees in general and 11% of children and adolescents have PTSD;
- the prevalence rate of psychosis in refugees is around 2%, which is similar to psychosis rates among the general population in western countries (Llosa et al., 2014); and
- The prevalence of mental disorders may be higher in refugees who stay in the host country for more than five years, which could be due either to the selection of those who remain in the host country or to long-term stress factors, or both.

We can therefore conclude that the very fact of being a refugee is not the most significant criterion for the potential risk of mental disorders.

However, refugees can be exposed to various stress factors that could influence their mental health. These are commonly categorized as pre-migration factors (such as persecution, economic hardship), migration factors (physical danger, separation), and post-migration factors (detention, hostility, uncertainty) (Laban et al., 2004; Steel et al., 2004; Bhugra & Becker, 2005; Gerritsen et al., 2006; Walsh, 2007; Bogic et al., 2012; Carta et al., 2013; Slobodin and De Jong, 2015; Bogic et al., 2015).

Once a mental disorder has become manifest in a refugee, post-migration factors are critical to whether the disorder (in particular depressive disorders) will become chronic (Lindert et al., 2009; Bogic et al., 2012; Bogic et al., 2015).

A study of refugees from the former Yugoslavia, conducted nine years after the end of the Balkan war, showed the importance of the support provided in the host country (Bogic et al., 2012). The study compared refugees hosted in Germany, Italy and the United Kingdom. Those in Italy showed the lowest rates of mental disorders, even after the findings had been adjusted according to the refugees' different characteristics, such as their levels of exposure to traumatic experiences during the war. Lower mental disorder rates were linked to being in employment, having appropriate living arrangements, and feeling accepted in the host country (Bogic et al., 2012).

Challenges in providing mental health care to refugees

There are several specific challenges to providing mental health care to refugees, the extent of which varies depending on a range of factors, including where the refugees have come from and the amount of time they have spent in the host country (Sandhu et al., 2013; Giacco et al., 2014).

a. Language barriers: many refugees have a poor command of the language of the host country, requiring an interpreter during consultations. Even if interpretation is available, the lack of direct communication may complicate proper assessments.
b. Belief systems: different belief systems may hinder mental health assessments and conflict with the practitioners' understanding, such as the possible tendency to seek physical explanations for psychological problems.
c. Cultural expectations: refugees may have different views on what to expect from mental health care and on what kind of information they want to disclose. This may impact on whether they accept a mental health diagnosis and the consequent treatment.
d. Establishing trust: Refugees may be particularly distrustful of services and authorities because of previous experiences in their country of origin. Moreover, they may be unfamiliar with the health care system in the host country, in particular with the way mental health care works.

Good practice in providing mental health care to refugees

The most important strategy for reducing the risk of mental disorders in refugees once they have arrived in the host country, is general support: meeting their basic needs and ensuring their safety, and that they are accepted and integrated into mainstream society. Integration, including support in the national education system, is especially important for children and adolescents among refugee groups (Fazel et al., 2014).

Irrespective of whether mental disorders do or do not occur more frequently in refugees than in the general population, there will always be refugees with mental disorders who need mental health care.

Several recommendations for good practice are identified in available literature. They address access to and organization of services, and the delivery of care (Priebe et al., 2012; Sandhu et al., 2013; Giacco et al., 2014). The implementation of these recommendations depends to a large extent on national legislation and on refugees' entitlement to receive health care. Yet research (Priebe et al., 2012) has also suggested that a significant number of health care professionals in European countries are willing and find ways to provide care for refugees, even if this is not in line with the national legislative and funding context.

Recommendations for good practice are outlined below.

- Establish outreach programmes for larger and difficult to reach groups of refugees. These programmes might be provided by specialized and potentially voluntary organizations. Outreach should aim to establish a trusting relationship, facilitate first contacts with professionals in the host country, and help refugees to overcome barriers in accessing mainstream services for physical and mental health care.
- Establish a generalized and multidisciplinary approach, in which physical health care and mental health care are provided with as little fragmentation as possible and facilitated by flexible administrative procedures. This is particularly relevant for refugees presenting with multiple health needs (Bhui, 2105).
- Optimize the coordination of services. Research has shown that in almost all western countries, experts identify the fragmentation of care systems as a major problem for marginalized groups, such as refugees. Coordination should include specialized, as well as generic, services.
- Provide sufficient information about entitlements and available services both to refugee groups and to the professionals dealing with them. Even in well-resourced areas, this information is often missing or presented in ways that are not fit for purpose. New technologies may support this and also help the provision of interpreting services (Ahmad et al., 2012; Moreno et al., 2012; Unlu et al., 2013).

How can good practice for mental health care of refugees be implemented?

Implementing the good practice recommendations requires funding, appropriate service organization, and staff training (Priebe et al., 2012).

a. Sufficient funding is required to ensure that enough care services are in place to deal with potentially large numbers of refugees, to make sufficient interpreting services available if and when needed, and to provide and disseminate information to refugee groups and professionals.
b. Appropriate service organization can help reduce administrative barriers and complex referral procedures, optimize the allocation of resources, and ensure good coordination. New technologies may help with this.
c. Training and supervision programmes for mental health professionals may enable staff to develop a better understanding of the background and experiences of refugee groups, and equip them to provide the best possible advice and treatment in a culturally appropriate manner (Mosko et al., 2013; Gallardo, 2013).