

## Editorial

Meeting the mental health needs  
of refugees and asylum seekers†

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**Summary**

Mental health provision for diverse refugee populations is faced with a number of challenges, and requires the development and evaluation of flexible service models that maximise capacity and utilise existing non-specialist resources. Emerging therapeutic approaches should be

applied in real settings, adapted to cultural needs and integrated with the other agencies involved.

**Declaration of interest**

None.

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**A global issue that affects all public sectors**

Worldwide, around 44 million people are forcibly displaced because of conflict and persecution, including 15.4 million refugees, 27.5 million internally displaced individuals and over 800 000 awaiting resolution of their asylum application. Between 31 and 55% of these groups are children under 18 years. Low-income countries host 80% of the world's refugees.<sup>1</sup> Concentrated efforts and some positive results, for example 3 million individuals returning home annually, are hampered by new humanitarian crises such as in Libya and Syria. Most refugees are accommodated in camps and settlements in rural areas, and individual accommodation in cities. Annually, 15 500 asylum applications are made by unaccompanied children in a total 70 countries. These figures indicate the heterogeneous nature of these vulnerable populations; there are also misconceptions regarding definitions. In order to seek asylum there must be well-founded grounds of persecution on account of race, religion, nationality, political belief or membership of a particular social group if the individual was to return to their country of origin. A successful application leads to refugee status. Although these two groups should be distinct, in reality there can be overlap, with economic migrants seeking employment in another country. Among refugees and asylum seekers there are also many differences in terms of culture, ethnicity, race, religion, trauma exposure, family composition, and resettlement experiences and status. Such diverse characteristics and needs, therefore, necessitate different solutions and models of healthcare, including mental health services and interventions.

**Mental health needs and underpinning mechanisms**

An expanding volume of research across different countries and situations has led to fairly consistent findings of an increased prevalence among refugee groups of all ages of, predominantly, post-traumatic stress disorder (PTSD), depression and anxiety, but also of other psychiatric disorders; comorbidity; physical ill health such as malnutrition; and continuation of symptoms and

impairment. Although research evidence indicates the complexity of the mechanisms involved, interpretations of causes of mental health problems can be oversimplified, ranging from being unaware of the impact of trauma to overattributing all mental health presentations to past experiences. Instead, a range of factors interplay such as war conflict, natural disasters, family loss, different types of violence, abuse and sexual exploitation, and brain changes. These have a cumulative effect, but are also mediated by post-immigration stressors of socioeconomic adversity, adjustment to a new society and isolation.<sup>2</sup> This combination of adverse events before, during and after the forced immigration should influence the thinking behind the development of interventions and services. Enhancing protective factors relating to safety, family and social supports, integration with a new society, maintaining cultural identity, faith and coping strategies that moderate vulnerabilities are all important.<sup>3</sup>

**Therapeutic interventions, mental health services and unmet needs**

The heterogeneity of refugee populations and their circumstances is a challenge for both services and research, particularly relating to the generalisation of findings on treatment effectiveness. Nevertheless, there is expanding evidence regarding some therapeutic modalities for the more common disorders, for example those specifically developed for refugees with PTSD, depression or anxiety. The methodological quality of evaluation varies, with some programmes being less structured or validated, but overall there are positive findings of symptom reduction through cognitive-behavioural, expressive, exposure, testimonial, creative, interpersonal, and eye-movement desensitisation and reprocessing therapies.<sup>4</sup> The majority of these interventions target re-experiencing and reconstructing trauma-related beliefs and emotions. However, what is lacking is their application in real settings and adaptation to focus on refugees' specific needs by complementing trauma- and symptom-focused modalities with psychosocial therapies that encompass an understanding of their experiences, enhance their resilience and assist with resettlement. Hence, interventions should be placed in the context of refugees' need for safety and other basic needs, their life circumstances, daily stressors and hardships, which all impact on their contact with services.<sup>5</sup> This does not imply that mental health professionals should address this gap, but rather that their input should be closely integrated with systems and agencies already involved.

†See pp. 208–213, this issue.

To that effect, there is limited but promising evidence on mental health service models that can maximise the impact of interventions. Williams & Thompson<sup>2</sup> have identified community-based service components that were shown to be particularly relevant to refugee groups, including outreach or school interventions for those living in Western countries, contrasted with active community involvement through education programmes or consultative activities in countries of origin.

There is also unsurprising evidence on extensive unmet service needs and gaps. This is highlighted by Llosa *et al's*<sup>6</sup> study in Lebanon. Despite the refugee sample in their study being unusually chronic and stable, they found its service use lagged considerably behind that of the general population. Several reasons have been put forward for this mismatch such as services not adjusting for refugees' specific needs, stigma, presenting psychopathology that might differ slightly from the usual referral problems, language and literacy barriers, engagement difficulties that might be related to legal status, non-integration with other agencies and transport. The lack of understanding of help-seeking by refugee groups is an overarching theme in these findings; so are difficulties with engagement and trust in services.<sup>7</sup> Although cultural adaptation of interventions has been reported by several studies, this is not often described in detail. Lack of clear theoretical frameworks in the approaches used, pragmatic constraints in their evaluation design and confounding factors are additional difficulties facing clinicians and researchers in this field.

### How mental health services can improve access and meet needs

The main challenges for mental health services are to adapt to constantly changing populations, and across countries with different health and social care systems. For this reason, it is important to consider emerging models that reflect refugees' pre-flight, flight and resettlement experiences, and which spread war torn, stable low income, and high income – predominantly western – countries. Some principles apply to all three types of countries, namely adaptation of interventions and services to local characteristics and strengths, cultural sensitivity, a multi-modal approach and integration with other agencies.

Services in low-income countries, whether in acute/transient or long-term settings, have limited specialist resources and should therefore aim for capacity building,<sup>8</sup> as well as training of existing primary care staff and consultation with non-governmental organisations. This requires clear operational definitions to ensure continuity of sectors that do not always work in collaboration, and may even be competing for external funds. Western constructs may not wholly apply to client groups; thus, awareness of local healing and grief concepts, of both an individual and a collective nature, is a prerequisite to innovation, if more systematic detection of problems and effective use of resources is to be achieved. High-income countries need to consider this as well. Both international and national policy should set standards and develop evidence-based training materials for organisational networks, rather than *ad hoc* application.

High-income countries have extensive access to specialist resources but these are not unlimited and they face problems of a different nature such as adapting their existing models or responding to an influx of high-needs groups in concentrated areas, for example in the proximity of new hostels and residential settings. Working closely with other organisations (notwithstanding

the controversies surrounding reception and detention centres) can help shape a welfare ethos among staff and establish close links with local services. Similar collaboration is important with refugee councils and non-governmental organisations nationally and locally, i.e. strategically and at a front-line level. As there are often tensions in the links between mental health services and non-statutory organisations, pre-set conditions by funding bodies would safeguard against agencies operating in isolation. There should be clear demarcation from the legal process, with minimal delays because of the interface with professional reporting. Care pathways in targeted areas, training of interpreters, evolution and evaluation of interventions are all important strands for the future.

As service experience and evidence grow, different predictors and profiles will emerge. For example, which refugees are more likely to utilise psychological interventions straightaway; which may require several attempts before they are able to access them emotionally (whether because of their adjustment to the new society or feeling sufficiently safe); and which may need other approaches to enhance their resilience.<sup>9</sup> Additional considerations should be given to the needs of children, whether unaccompanied or living with their parents, and the prominent role of schools.<sup>10</sup> Also, consideration needs to be given to women and elderly people, although all services should aspire to the same overarching principles and human rights frameworks. Service planners and commissioners should use available evidence by building on the existing strengths of mainstream services while tailoring provision to the specific needs of these vulnerable groups.

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