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Review

Review

Mental health needs and services for migrants: an overview for primary care providers

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Abstract

Background: The objective of this article is to present an overview of the burden, spectrum of diseases and risk factors for mental illness among subgroups of migrants, namely, immigrants, refugees and individuals with precarious legal status. This expert review summarises some of the implications for primary care services in migrant receiving countries in the global North.

Methods: A broad literature review was conducted on the epidemiology of mental health disorders in migrants and the available evidence on mental health services for this population focusing on key issues for primary care practitioners in high-income countries.

Results: Although most migrants are resilient, migration is associated with an over-representation of mental disorder in specific subpopulations. There is a general consensus that stress-related disorders are more prevalent among refugee populations of all ages compared to the general population. Relative to refugees, migrants with precarious legal status may be at even higher risk of depression and anxiety disorders. Persistence and severity of psychiatric disorders among migrant populations can be attributed to a combination of factors including severity of trauma exposures during the migration process. Exposure to stressors after resettlement, such as poverty and limited social support, also impacts mental illness. Services for migrants are affected by restricted accessibility and should address cultural and linguistic barriers to and issues in the larger social environment that impact psychosocial functioning.

Conclusion: There is substantial burden of mental illness among some migrant populations. Primary care providers seeking to assist individuals need to be cognizant of language barriers to and challenges of working with interpreters as well as sensitive to cultural and social contexts within the diagnosis and service delivery process. In addition, best practices in screening migrants and providing intervention services for mental disorders need to be sensitive to where individuals and families are in the resettlement trajectory.

Key words: mental health, immigrants, refugees, asylum seekers, undocumented migrants

In an attempt to improve the health of migrants, increasingly travel medicine providers are involved in the care of migrants.[1,2] Risk and protection factors in travellers[3] will be different to those in migrants. Although general travellers may face psychological problems during travel,[4–7] or are travelling with mental health problems,[8] mental health issues in migrants are more complex and require a different approach because of the different timeline and expectations that migration entails. In an effort to increase awareness about marginalised persons crossing international borders such as vulnerable migrants, the Journal of Travel Medicine has recently published several review and original articles related to migration health.[1,2,9,10] However, none of these papers adequately addressed the mental health predicament of migrants. Hence, in this paper, we provide a comprehensive overview for practitioners and elaborate on potential strategies for service development in this domain.

Human beings have always been a migratory species organised in societies which either settled on a specific land when conditions were favourable or opted for mobility across different territories in order to maximise access to resources.[11] Historically, human migration has been associated with shifting patterns of risk depending on complex webs of relationships between push factors (like war or drought) and pull factors (like economic opportunities, perceived safety or a more favourable climate).[12–14] These push and pull factors can be sub-categorised into macro, meso and micro levels of influence, such as war and climate change (macro level), social networks or social ties (meso level) or individual-level characteristics, including gender, education and employment opportunities.[15,16] The number of migrants has increased dramatically in the past twenty years, making it a population that warrants more attention from medical professionals. The boundaries of travel medicine have expanded greatly, no longer confined to health care professionals working with temporary travellers but including general practitioners interacting with individuals engaging in both short- and long-term migration for both voluntary and involuntary reasons.[1] Within the realm of mental health, it is imperative that practitioners have a basic understanding of the psychiatric needs of diverse migrant populations and best practices in service delivery.

There are different pathways that explain the onset and persistence of mental disorders among migrant groups. Recent research has emphasised the need to develop models of mental health that incorporates both exposures to traumatic events prior to, during and after the migration experience as well as secondary stressors that are experienced in countries of resettlement.[17] The migration experience can lead to exposure to adverse events, such as witnessing or experiencing violence, that negatively impact mental health.[18,19] Persistence and severity of psychiatric disorders among migrant populations can be attributed to a combination of factors, including the degree of severity of initial trauma exposures and clustering of trauma exposures during the migration process. Exposure to secondary stressors after resettlement, such as poverty, unemployment and limited social support, also impact duration of mental illness and prevent recovery.[20–22]

In both sociology and health studies, the distinction between categories of migrants—namely, immigrants and refugees—arose in specific historical contexts and was promoted by European and North American researchers.[23] For the purposes of this review, 'immigrant' is a term used to encompass individuals who voluntarily migrate from one location to another, while 'refugee' refers to individuals and groups forced to migrate to a new country because of fear of persecution. Focus on these two categories has to a large extent minimised research on migrants with precarious legal status, a largely invisible population that includes undocumented immigrants and asylum seekers, despite their vulnerability to adverse mental health outcomes.[24] Although we will be referring to immigrants, refugees and migrants with precarious legal status throughout this review, it is important to acknowledge that these categories are somewhat artificial, as reasons for flight from country of origin, such as exposure to violence and economic stressors, influence the migration experiences of all three groups, thus calling into question the division between 'voluntary' and 'involuntary' migration.[23]

In the last decades, globalisation has transformed migration patterns and resettlement conditions in various ways. On the one hand, the increase in professional mobility and the expansion of transnational networks have buffered migrants from the traditional isolation and cultural shock previously experienced. On the other hand, the upsurge in social inequalities is presently fuelling xenophobia and anti-migrant rhetoric and associated with restrictive migratory policies that shatter the protective nature of societies traditionally considered as safe havens for migrants and refugees.[25–28] This very rapidly evolving social context has important mental health implications for immigrants and refugees.

This paper is aimed at practitioners working in primary care services with migrant individuals and families. We first present an overview of the state of knowledge about the burden, spectrum of disease and risk factors for mental illness among three groups of migrants. Subsequently we summarise some of the implications for primary care services in immigrant receiving countries in the global North. The migration between countries of the global South may entail very different dynamics that are not covered in this paper.

The mental health of immigrants, refugees and precarious status migrants

Overall, immigrants tend to be in better health compared to their host country counterparts, a phenomenon which has been called the 'healthy immigrant effect'.[29–34] Explanations for this include external screenings and medical examinations in receiving countries as well as the fact that organising a migration journey is very demanding and requires skills, agency and to a certain extent, good health. This relative protection, associated with better health habits (less tobacco, drug and alcohol consumption), tends to decline with generations,[35] reflecting both the adaptation of host country norms and the impact of medium- and long-term discrimination and marginalisation, which may erode the initial expectations associated with the migration.

In spite of this overall positive picture, migration has been associated with an over-representation of mental disorder in specific populations, suggesting that for some groups the risks associated with the migration process outweigh the opening of opportunities.[36–38] For instance, mental health difficulties may be more prevalent when immigration takes place during specific periods of the life cycle. Adolescence, because of the dual burden of having to face simultaneously internal transformations and external changes, may be a particularly sensitive period for immigration.[39–41] Similarly, in old age, the losses are most of the time clearly exceeding the opening of opportunities.[42–50]

Recent literature reviews (systematic literature reviews and scoping reviews) suggest that migrants are at increased risk of psychotic disorders compared to their host country majority counterparts.[37,51] This may partially be due to strategies of case identification that result in overestimating the incident rate of psychosis among some migrant groups.[52] The social defeat hypothesis proposes that experiences of marginalisation and discrimination may shatter the expectations associated with migration and lead to an increased prevalence of psychosis.[51] In terms of suicide, studies suggest that the stress associated with

migration may lead to increased suicide mortality under some conditions.[37]

With regard to migrant children and youth, the North American and European literature do not report overall higher prevalence of emotional and behavioural problems, although some studies indicate that immigrant children in Europe may present with more internalising symptoms compared to native children.[53] Unsurprisingly, social and familial risk factors are, however, consistently associated with increased problems. In terms of perinatal mental health, a systematic literature review found no association between migrant status and post-partum depression.[54] However, low social economic support and lack of language skills in the host country were associated with an increased risk of elevated depression symptoms.

Specific to refugees, there is a strong consensus about the over-representation of stress-related disorders in both adult and children compared to the general population.[55–58] Few studies examine the mental health risks of refugees relative to individuals who were exposed to war and political conflict but not displaced.[59] Overall, this research suggests that the experience of being a refugee is an adverse exposure that increases the risk of poor mental health among war-affected populations. Exposure to forced displacement is associated with increased risk of PTSD, major depression and overall psychological distress.[60–63]

Evidence on persistence of psychiatric disorders among refugees is mixed. Several studies report a reduction in psychiatric symptoms and mental health diagnoses over time.[21,64–68] Other studies found that mental health did not improve over time[69,70] or that trajectories may differ based on diagnosis, with symptoms and diagnoses of PTSD persisting, while depression declined.[71–74] A major limitation of this research is short-term follow-up. A recent systematic review reported a long-term increase not only in post-traumatic stress disorder (PTSD) but also in depression or anxiety disorders.[75] Although the literature had first focused on the impact of pre-migratory trauma,[18,76] the role of the resettlement stress in the post-migratory environment is increasingly recognised.[17,20–22,77–81] A recent study found that perceived discrimination in the host country (Canada) was a more important determinant of mental health than the exposure to pre-migratory trauma, suggesting that the upsurge in xenophobia and anti-refugee feelings may further undermine refugee mental health.[82]

Migrants with precarious legal status live under high stress and permanent uncertainties in their resettlement environment,[83] which may have a negative impact on mental health. Research with this population is overall limited, given this group is often restricted from receiving health care and/or afraid to participate in studies because of legal status.[84,85] One study found a higher prevalence of depression, panic and general anxiety disorder among undocumented Mexicans living in the United States as compared to the general population.[86] Among asylum seekers, evidence suggests that the detention experience itself is a risk factor for adverse mental health, with studies documenting increases in prevalence of depression and PTSD over time among both adults and children after being detained.[87–89] One study found poorer mental health among detained asylum-seeking children compared to the resettled refugee youth.[90] Research also indicates that the outcome of the refugee determination process is associated with mental health, with mental health improving among successful applicants and declining among those who are rejected (Figure 1).[88]

Mental health services for migrants, refugees and precarious status migrants

Studies have repeatedly shown that migrants and refugees underutilize mental health services.[91] Explanations for this include stigma around mental illness, linguistic obstacles and lack of cultural sensitivity of service providers. Primary care services, also defined as proximity services, are well positioned to offer care to recently arrived immigrant and refugee families because migrants are often already familiar with these facilities, which are not considered as stigmatising.[92,93] When developing or providing mental health services for migrants and refugees, clinicians and administrators may consider the following broad issues: accessibility, cultural adaptation of services and an ecological systemic and public health approach to address social and structural determinants of mental health. In addition some specific considerations are needed when delivering services to vulnerable groups of migrants such as refugees, asylum seekers and undocumented migrants.

Accessibility

Accessibility of mental health services is a key issue for all categories of migrants. Most of them encounter difficulties stemming from the absence of knowledge about host country services and linguistic barriers.[94] The literature emphasises the use of interpreters and cultural brokers as an essential step to improve accessibility of mental health services. The use of interpreters is too often restricted to patients who have absolutely no proficiency in host country language(s). Limited language skills are, however, not sufficient to perform a comprehensive mental health assessment, and this sub-standard practice often leads to erroneous diagnosis, a lack of understanding of the patient predicament, and sometimes to the misuse of medication when psychotherapy is more appropriate.[95] In situations of linguistic barriers, family members and friends are often asked by the clinicians to help with interpretation. This is inappropriate both in terms of confidentiality and because it has been associated with

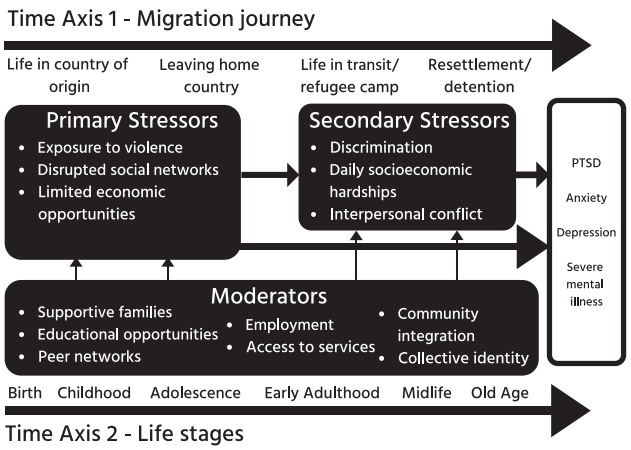

Figure 1. Risk and protective factors for migrant mental health.

shifts in intra-familial roles and relations, creating further relational imbalance for the patient and his or her family.

Using professional interpreters improves clinician–patient communication and support the access to a range of more appropriate services. However, this involves costs for the institution, which is unfortunately too often the limiting factor. In many countries, it is common to have access to interpreter services only over the phone (i.e. the interpreter is not physically in the same room as the patient and clinician). This presents additional barriers to effective communication and establishing trust between the three parties. If interpreters are available, clinicians need to learn how to work with them efficiently. This includes meeting with the interpreters before the interview to set the goals of the interview, exploring the process of an interpreted interview (triangular relation with clarification when needed) and taking into account the interpreter feedback to enrich the understanding of the content and process of the interview.[38] Unfortunately, interpreters are typically not trained in the nuances of psychiatric symptoms; as such, clinicians may want to take additional time to discuss some of the common mental health concerns and issues that patients may raise in an interview. Professional interpreters are often not specifically trained to work with children and youth. Development factors and family relations need to be taken into account to establish an alliance with all family members, make a differential diagnosis and propose a treatment plan that takes into account the different level of acculturation of the family members.[96]

Even if the use of interpreters is highly recommended, in some situations, the patient or family will refuse it, because of confidentiality concerns or because of feelings of shame and distrust (this is quite common among asylum seekers).[95] In those situations, the patient-expressed wish should be respected, keeping in mind that the presence of an interpreter may become possible at a later stage when the alliance is well established.

For vulnerable migrants who have a precarious migratory status, mostly asylum seekers and undocumented migrant, access to mental health services is also limited by the actual or perceived lack of entitlement to services.[97] Many countries have recently actively restricted the access to health care for asylum seekers, sometimes as a deterrence strategy.[94] Beyond legal and procedural entitlement to health care, the attitude of host country professionals toward asylum seekers and undocumented migrants' access to health care is very ambivalent, reflecting the increasingly negative perceptions about these groups of vulnerable migrants who are seen as abusing host country services.[98,99] These barriers in accessing services contribute to migrant stress and may in some cases lead to persistence or deterioration of untreated mental health problems.

Cultural adaptation of services

Overcoming linguistic barriers and accessing the appropriate services does not mean there is a good understanding of important cultural and social contexts within the service delivery process.[100] In order to help the clinicians address the cultural dimensions of mental health problems, different approaches provide theoretical and practical tools for the clinicians. The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM5) now includes a tool called the Cultural Formulation Interview (CFI), composed of a core module and of 12 supplementary modules.[101] The CFI can be used to guide the clinician in her or his exploration of the idiom of distress (the way in which the problem is presented), the meanings associated with the presenting problems (explanatory models) and the culturally acceptable strategies to resolve the problems, which may be integrated in the treatment plan. European ethno psychiatry[102,103] proposes a clinical approach structured around complementary psychoanalytical and anthropological theories. Clinicians are invited to decentre themselves and consider how the cultural traditions and resources of the family may contribute to the healing processes.

All of these approaches emphasize that the treatment plan should consider cultural and social issues in the presentation of clinical problems (idioms of distress), the meaning of the symptoms (explanatory models) and the path of action chosen to remediate the difficulties.

In primary care setting, mental health problems may, for example, present through unexplained medical symptoms, particularly pain and fatigue.[38] Traditional and spiritual explanations are commonly associated with mental health symptoms and may coexist with medical and psychological aetiologies.[104] Finally, patients may seek help through numerous concomitant avenues: from traditional healers, churches and temples and biomedical practitioners.[104] These alternative strategies may not be disclosed to the physician or clinician until a strong therapeutic alliance is established.

Addressing the familial and social environment

Because social adversity is often of paramount importance for immigrant and refugee mental health, addressing the presenting disorders through a symptomatic approach without reducing the associated sources of stress is likely to have limited efficacy.[81] Poverty and unemployment are often compounded by discrimination and may contribute to having difficulties and limited access to food. This adverse context may affect family relationship, increasing the risk of interpersonal violence and child maltreatment.[76] An ecosystemic intervention that supports and empowers the family and involves advocates to decrease adversity may be appropriate. Migratory status is a major source of stress. For example, the PTSD symptoms of asylum seekers are fuelled by uncertainty about their status. When they are detained for administrative reasons, they experienced re-traumatisation and present with more depression symptoms.[105] Again, in such situations, advocacy promoting a human rights approach and taking into consideration the best interest of the child is warranted.[106]

Specialised mental health services for groups of vulnerable migrants

When addressing mental health problems, it is useful for clinicians to consider important groups of vulnerable migrants, while keeping in mind that those groups may overlap (e.g. migrants may have endured organised violence). A number of authors and guidelines, such as those established by the National Institute for Health and Care Excellence,[107] recommend screening refugees and asylum seekers for PTSD. There is however no evidence of benefits of screening, in particular because mental health resources are scarce and insufficient to meet the needs of refugee. In addition, clinicians have expressed concerns about the potential harmful effects of screening in

asymptomatic patients, with the possibility of reactivating symptoms by evoking traumatic experiences.[96] Although screening may not be indicated, when assessing a refugee client clinicians should, however, maintain a high index of suspicions and evaluate the possibility of trauma whenever psychological distress or medically unexplained symptoms are present, with or without impairment.

The timing of intervention is also of key importance. At the time of arrival, many refugees and asylum seekers may display acute stress symptoms that will disappear without treatment over time once a feeling of safety is established.[108,109] A few guidelines propose a phased approach of refugee care: during the first phase, the emphasis is put on non-specific interventions to respond to the immediate needs of resettlement (housing, financial, schooling) and provide emotional support. Supporting asylum seekers in their claims and undocumented in their regularisation process may be very important psychosocial interventions, though these forms of advocacy may be perceived as too political by some professionals. During a second phase, if survival is no more at stake and symptoms persist, specialised interventions may be warranted. Evidence supports the efficacy of different types of psychotherapy for PTSD in refugees.[110] Some have been adapted successfully to different settings and cultures.[111] Promising CBT interventions may help to decrease the distress associated with nightmares. For children and youth, school-based intervention can maximise the reaching out and provide means to work through the traumas and losses associated with the refugee trajectory (Figures 2).

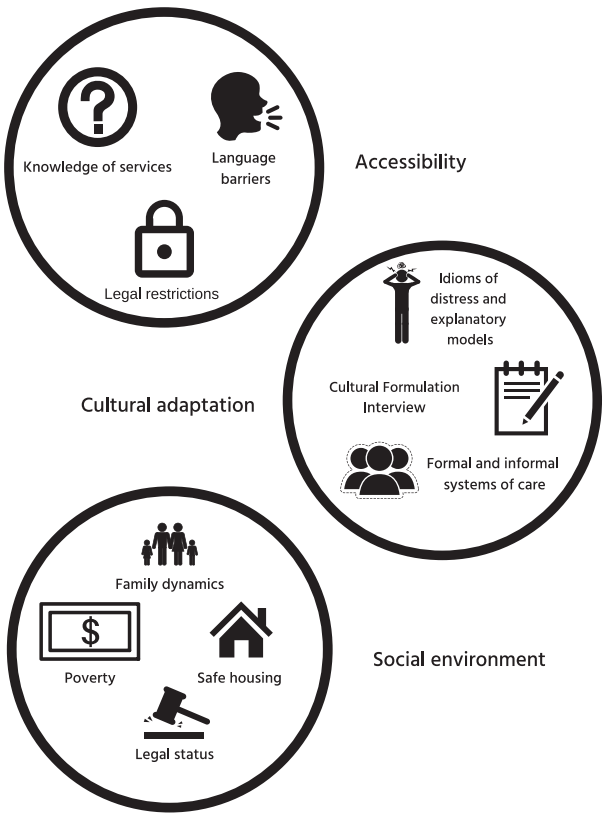

Figure 2. Considerations in mental health services for migrants.

Conclusion

The increase in number of migrants worldwide means that general practitioners are more likely than ever to have clinical encounters with immigrants, refugees and migrants with precarious legal status. Different subgroups of migrants have elevated the risk of onset and persistence of a variety of mental illnesses, including psychotic disorders, depression and PTSD. Risk factors include exposure to adversities and traumatic events throughout the migration process. Special consideration is needed for challenges experienced in resettlement or, as may be the case with asylum seekers and undocumented migrants, detention centres. Practitioners should consider parameters including access, cultural acceptability and appropriateness of mental health services when working with migrant populations. Particular attention should be paid to language barriers, exploring culturally informed expression and understanding of mental health problems, and making sure services align with and take into consideration the short- and long-term needs of individuals depending upon where they are at in the migration trajectory. Graded evidence for best practices is increasingly being developed for general travellers,[112] which may be useful for migrants.

In addition to providing sensitive and ethical care, clinicians and medical associations can become more involved by advocating for the right to quality health care for this vulnerable population. We encourage practitioners to educate themselves about the broader range of services available to migrants in order to collaborate with both formal and informal systems of care and support. It is imperative for clinicians to think broadly about the bio-psycho-social determinants of adverse mental health outcomes among migrants, and link patients to services and resources that target risk factors at all levels.

Key Points

Epidemiology of mental illness among migrant groups

- Subgroups of migrants have heightened the risk of onset and persistence of psychotic disorders, depression and anxiety spectrum disorders, notably PTSD.
- Risk factors include exposure to primary traumatic stressors in the country of origin and during the migration trajectory, and secondary stressors related to hardships experienced in resettlement.
- Protective factors include strong family, peer and community support, access to educational and employment opportunities and community integration.

Mental health services for migrants

- Migrants often undertilise formal mental health services; primary care providers may be the first point of contact for individuals with mental health problems.
- Clinicians need to consider three broad issues when providing care: accessibility, cultural adaptation of services and broader social determinants of health.
- Best practices indicate a phased approach to mental health care: first, address immediate resettlement needs and provide broad emotional support; second, provide referral for more focused interventions.

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