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COMMENTARY

The Mental Health Crisis in Refugee Populations

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Massive migration waves have impacted the world in the last two decades. By the end of 2021, 89.3 million individuals worldwide were forcibly displaced as a result of violence and human rights violations.[1] Turkey has been hosting the largest population, and the United States has been the world's largest recipient of new individual applications for asylum.[1,2] The ultimate Russian-Ukrainian conflict shed further light on the growing refugee crisis.[3] The crisis is humanitarian, and primary care providers have a significant role in depicting and treating conditions throughout the phases of the refugee journey.[4] However, the mental health needs of this population are unique, and the host health care systems have been struggling to address them sufficiently and early enough.

Depression, anxiety, and posttraumatic stress disorder are reported to be endured by at least one out of three asylum seekers in high-income countries.[5] These diagnoses are interrelated to unfavorable conditions that can go undetected and untreated if not appropriately screened. Some refugees witnessed violent loss of dear ones or lived in areas of armed conflicts.[2] Others were tortured or victims of sexual and gender-based violence.[6] Some kids endured child marriage,[7] and other children or adults were subjected to labor, organ, or sex trafficking.[8,9] Not long ago, immigration detention was one of the border control practices that profoundly affected the mental health of the children and their families and has raised concerns for lasting psychological problems.[10]

As the focus during the first health care and social visits are considered priority problems, like settlement, schooling, vaccinations, infections, and chronic diseases treatment disruptions, it might take several visits before a primary care physician and their team can address mental health problems and ongoing stressors. Primary care providers in most host countries have limited knowledge and capacity to address refugee health concerns unless training programs were implemented to serve this end.[11,12] A referral to a mental health provider would be needed in most cases; however, months could pass before getting this professional help due to resistance to the refugees to seeking mental health care or due to the paucity of mental health workers. The American Psychiatric Association stated in a recent resource prepared by the division of health equity and diversity that most refugees will not receive needed mental health care due to a shortage of services and stigma against mental health and that only 3% of refugees are referred to mental health services following screening.[5]

Meeting the mental health needs of the refugees and anticipating complications are necessary to outpace the displacement. Nondiagnosed or nontreated mental health disorders in a considerable number of refugees is likely to increase the pressure on mental health services, have significant implications on the mental health of the refugees' children, and might have negative consequences on the well-being of the host country. To our knowledge, there are no studies examining the trajectory of refugee youth mental health over time and its implication on host societies.[13,14] Some are resilient and integrate well.[5] What has been reported so far is an increase in the incidence of violence in some countries[15] and that the host population might be violently racist against refugees, especially if they have already been enduring poverty and health disparities.[15] The absence of a nationwide mental health strategy that responds to the emerging refugee crisis complicates the management of the future spillover of mental health issues. It might impose a higher burden on the health system in terms of cost and exhaustion of resources and on the economy in terms of nonproductivity.

While governments should work on the early integration of the population into its system and legalizing their status to facilitate their employment and health coverage, primary health care professionals should be notified and trained as soon as the need emerges in their area of practice on migration health and be aware of the social determinants to reduce disparities among them. The host population should be prepared for the influx of refugees and educated about their culture to decrease violence incidents and xenophobia. Moreover, with a global health system already suffering from a shortage of mental health providers,[16] primary care providers find themselves obliged to enhance their capacities in mental health, including trauma therapy, to address the gaps within the system.[17] Primary care offices need to self-equip with cultural competence, access language translators and be aware of the common mental health issues in these populations.[18] A social worker who connects patients to community resources can be helpful.[19] Collaborating with the nursing and medical assistants' teams to conduct adequate mental health screenings among refugees can save time and prepare the primary care providers to address problems sooner. Hiring a mental health provider on the primary care site, in the areas where the refugees are located, is likely to make access to care in complex cases straightforward and more efficient. As for care interruption due to resettlement, the unified electronic medical file is one way to ensure continuity of care throughout the refugee displacement journey and to keep the efforts between host countries joined and not dissipated. Finally, universal guidelines and policies for refugee health should be followed to standardize care delivery to this vulnerable population.[19] Continuous research is necessary to provide a long-term vision of the crisis.

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