

## Careif Position Statement on Migration and Mental Health

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**Abstract:** *People have moved from one place to another within the same country or across national borders for millennia. The reasons for such movements have varied, as does the duration for which people migrate. With globalisation and global connections across countries, migration has increased. The process of migration and its impact on the mental health of individuals has been and will remain heterogeneous. The responses of migrants to the process vary, depending upon a number of factors. Individuals may migrate individually, with their families or in groups. They may move to avoid political or religious persecution and seek political asylum in another country (forced migration) or migrate for personal, employment, economic or educational reasons (voluntary migration). Although these two categorisations are often a little more complex than this. Not all migrants will feel negatively affected by migration. People may migrate on a seasonal, recurrent, permanent or temporary basis. It may be within or across generations. Many migrants will never access mental health services, whilst others may use these in varying ways and with diverse requirements or presentations. The experiences and requirements of voluntary and involuntary migrants may differ. Mental health Services may need to ensure that they are accessible and appropriate to all members of society including those who have migrated. This paper makes some suggestions in relation to this.*

**Keywords:** *migration, mental health, impact, culture*

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### INTRODUCTION

Geo-politics, national and international agendas provide a context and may affect the way the term migrant is used (Persaud, 2015). This has on occasions led to the term being given a negative connotation or association (Balibar, 1991; Du Bois, 1989; Tribe, 2018). If a long enough perspective is taken, most people are the descendants of people who migrated for one reason or another. Migrants refer to a wide range of diverse people and an enormous range of experiences and motivations. Definitions of migrancy are both multi-dimensional and contested, and therefore the term migrant may be best considered as one of self-definition (Tribe, 2011). The term migrant has been defined as "any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country" (UNESCO 2009). However, this appears to need challenging as according to some states' policies, a person may be considered as a migrant even when

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s/he is born in the country. Whilst the relationship between high, middle and low income countries is also ever present and may play a role in definitions and perceptions of migration, as may issues of colonialism and power (Fernando, 2014; Persaud, 2015).

As stated earlier, the most common differentiation used is between forced migrants (this would include people who are forced to migrate for reasons of persecution, natural or man-made disasters and includes refugees, people seeking asylum and internally displaced people). Whilst, the other group are termed voluntary migrants (people who choose to migrate due to a variety of reasons which will include family, employment, education). Voluntary migrants are usually equipped to make a choice about migrating over a period of time and may be able to make some of the necessary practical and psychological preparations for this move (Bhugra & Ghupta, 2011). Other categorisations are also used, and within each group there will be a range of individual experiences. Any kind of migration can bring a range of changes which may lead to challenges as well as opportunities. Some of these changes and the associated losses may be challenging to mental health and well-being (Blackwell, 2005). There are will also be temporary and permanent migrants. Some people will migrate as part of a contract with an international organisation or for season work, others will migrate permanently.

The relationship between high, middle and low income countries, issues of power and colonialism will often play a part in how the discourse around migration and perceptions of migration are controlled and defined (Fernando, 2014; Tribe, 2018). It is important to try and understand the meaning-making process of each migrant as well as understanding their explanatory framework relating to mental ill health or distress. Some migrants may come from places where requiring or using mental health services carry a stigma; this needs active consideration by service providers and clinicians.

## REFUGEES

The United Nations High Commissioner for Refugees (UNHCR) estimates the number of people forcibly displaced worldwide in 2016, to be, 65.6 million. These figures are made up of 22.5 million Refugees, 10 million Stateless People and 33.1 million displaced people. Internally displaced people are people who may be forced to move within their own country. The latter group are people who because of territorial disputes or collapsing states become stateless. War, conflict and political turbulence in many regions of the world have increased the number of displaced people fleeing complex emergencies and disasters. People seeking asylum, often end up in large camps with low and middle income countries hosting over 86% of the world's refugees, compared to 70% ten years ago (UNHCR, 2016). The countries currently producing the most refugees are Syria and South Sudan, but the national make up of refugee populations changes as world events and politics force people to flee. The countries currently hosting the vast majority of refugees from Syria are reaching breaking point. Turkey, Pakistan, and Lebanon were sheltering 5.3 million Syrian refugees in 2017, between them, are overwhelmed and international humanitarian funding are falling far short of the need. Many would rather attempt the dangerous journey to Europe than exist in impoverished, overcrowded refugee camps for many years, where they can experience even more violence, rape and death (Persaud, 2015).

## MIGRANT FIGURES

By the end of 2016, Syria had become the world's top source country of refugees, overtaking Afghanistan, which had held this position for more than three decades. Today, on average, almost one out of every four refugees is Syrian, with 95 per cent located in surrounding countries. In 2017, approximately 50% of refugees were children (UNHCR, 2018) the highest figure for child refugees in more than 10 years.

About 38.2 million people were forcibly uprooted and displaced within their own country and are known as Internally Displaced People (IDP). Iraq witnessed massive new internal displacement as a result of the Islamic State (or 'ISIS') offensive across multiple parts of the country. Renewed fighting in the Democratic Republic of Congo displaced 1 million people, bringing the total number of IDP in that country to 2.8 million. The conflict in South Sudan, which erupted in December 2013, displaced more than 1.5 million individuals within the country. In addition conflict in The Central African Republic (611,000), South Sudan (200,000), and Yemen (85,000) has added to crisis.

Whilst, statelessness refers to the condition of an individual who is not considered a national by any state. This may be due to collapsing states, places which are not viewed as states or in some countries on the basis of gender or ethnicity. Although stateless people may sometimes also be refugees. For example, there are more than 300,000 denationalized Kurds, Kuwait has 93,000 Bidoon (*Bidoon Jinsiya*), the Dominican Republic has an estimated 900,000 to 1.2 million undocumented individuals of Haitian origin, many of who are stateless or at risk of statelessness.

### Europe's Migrant Crisis:

Europe is struggling to cope with the large-scale influx of migrants making their way across the Mediterranean to Europe in 2015, the biggest since the aftermath of World War II,<sup>3</sup> - sparking a crisis, as countries struggle to cope with the influx, and creating division in the European Union (EU) over how best to deal with resettling people. Squalid conditions in makeshift refugee camps and a heartbreaking photograph of a drowned Syrian toddler have all helped bring Europe's refugee crisis into the global spotlight. This has not stopped people making desperate bids to reach Europe. According to the UNHCR, more than 380,000 migrants and refugees have landed on Europe's southern shores so far this year, up from 216,000 arrivals in the whole of 2014. They are fleeing persecution, poverty and conflicts that rage beyond the continent's borders. The voyage from Libya to Italy is longer and more hazardous; but not all manage to reach safety -according to The International Organization for Migration (IOM)<sup>4</sup>, more than 2,700 migrants are reported to have died trying to make the crossing this year - altogether, 2,988 people have died in the Mediterranean in 2015. With tensions running high, Europe's leaders remain divided and challenged on how best to respond to the crisis; with a disproportionate burden continue to be faced by some countries, particularly in Greece and Italy.

## CULTURE, MENTAL HEALTH AND MIGRATION

During the past several decades, there has been a steadily increasing recognition of the importance of cultural influences on life and mental health (Fernando, 2014; Persaud, 2015). Culture may influence constructions of mental health so that culturally relevant care is needed for patients of diverse ethnic, racial and cultural backgrounds regardless of their country of residence (Persaud et al, 2015; Rathod et al, 2018; Bhugra & Bhui, 2018; Bhui and Bhugra, 2004; Dogra & Bhugra, 2013). Many societies are becoming increasingly multi-ethnic and polycultural in nature. From a clinical and societal perspective, there is a need to improve cultural competence to provide appropriate mental health care of each patient, (should they require it) considering their ethnic/racial/cultural background, regardless of minority or majority status. Issues of culture and racism require attention if services are to be appropriate and accessible to all (Fernando, 2017; Bhugra & Bhui, 2018). In addition all clinicians should be trained to work effectively in partnership with interpreters, (Tribe & Raval, 2003) as many newly arrived migrants may not be fluent in the language of the country to which they have migrated. The British Psychological Society (2017) recently issued guidelines on working with interpreters. In addition the British Department of Health (2011) produced a short training DVD for clinicians, available via Utube.

## RELEVANT TERMINOLOGY

### Refugee

The United Nations Convention on the Status of Refugees, (1951) defines a refugee as a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable to or, owing to such fear, is unwilling to return to it" (Article 1 (A)(2) (UNHCR, 2017) reports that there are 22.5 million refugees worldwide.

**Asylum seeker**

An asylum seeker is someone who has applied for asylum/protection/ to become a refugee and has moved across a national border/s to apply for asylum. Their rights to legal and health services may be much more restricted depending on the policy of the country they are seeking asylum from.

**Separated or unaccompanied children**

This refers to someone who is under 18 years of age or the national age of adulthood and who is not in their country of origin and has no parents or legal guardian or carer with them. The United Nations Children's Fund (2017) reported that there are 300,000 unaccompanied and separated children worldwide in 2015 and 2016.

**Internally Displaced Person (IDP)**

IDPs are also sometimes called 'internal refugees' although they do not have the same legal protection as refugees who cross country borders. There are reported to be 40.3 Million displaced people world-wide (Norwegian Refugee Council, 2017). An internally displaced person is usually someone who has been forced to flee from their home and community owing to civil war or persecution, often on political or religious grounds, but has been displaced within their country of origin, rather than to a different country.

**SERVICE PROVISION FOR MIGRANTS, REFUGEES AND ASYLUM SEEKERS**

This needs consideration in terms of adults, young people, children and unaccompanied minors. Many asylum seekers assume that arrival in a host country means that their difficulties are over and whilst they are now physically safe, the asylum process can take some time and settling in a new country can be a complicated and challenging process and will not be without its practical and psychological challenges (Patel et al, 2018). Many asylum seekers and refugees are very resilient having managed to organise flight from their countries of origin. Although many will face uncertainty about their asylum application and may be living with the fear of being deported and living with multiple losses.

The period of time asylum seekers may wait will vary depending on the country of application and they may face a range of challenges and uncertainty relating to their asylum application. Whilst early intervention, appropriate assessments and interventions are important, psychiatrists should be mindful of not pathologising the reactions (to what are frequently abnormal and challenging circumstances) of any individual migrant or refugee (Blackwell, 2005). The importance of providing cultural appropriate care in an accessible manner is of course key.

There may be other ways of the psychiatrist assisting refugees and asylum seekers perhaps through working with refugee community groups (BPS, 2018; Tribe & Tunariu, 2018) or through schools (Halusi, 2018). The Royal College of Psychiatrists in Britain has set up an Asylum Seekers and Refugees Mental Health Network for psychiatrists and a group working with Syrian refugees. Guidance on working with refugees and asylum-seekers was launched by the British Psychological Society in 2018 and by the World Psychiatric Association (WPA) in January, 2016. At the national level we would suggest the six organising principles detailed below as helpful organising principles for psychiatrists and clinicians. To ensure that clinical assessments and interventions are culturally sensitive and appropriate and are regularly reviewed to this end.

1. The need to consider the context of migrants and refugees lives both pre, during and after flight.
2. The need to take a global perspective, which recognises the heterogeneity of migrants and refugees and of their experiences.
3. To take account of the resilience and coping strategies of many migrants and refugees and the range of survival and coping strategies many refugees and asylum seekers possess.
4. To consider working with Refugee Community Organisations if this is requested.

5. The need for professional interpreters to be employed as required to ensure access to services is not limited to those fluent in the language of the host country but is accessible by everyone who needs psychiatric assistance.
6. Psychiatrists to develop appropriate knowledge and skills in working effectively in partnership with interpreters.

## **WACP CALL FOR ACTION:**

WACP call on all Governments to respect, uphold and administer 'The UNITED NATIONS REFUGEE CONVENTION (1951)' with fairness and promptness. To act with humanity and compassion and to not let the evil of Europe previous history taint or threatened to repeat itself; European Governments with influence in the regions of conflict and war also with permanent positions at the UN Security Council must begin to draft solutions to resolve these conflicts and bring about an end to the crisis.

WACP call on all Governments to act with promptness and fairness in assessing, screening and deciding on the legal status of migrants; Prompt decisions on refugee and asylum status must be done with humanity and dignity. The host population must be reassured, their fears and concerns addressed, be involved with re-settlement programmes and importantly feel secure.

WACP call for all basic health care to be provided to migrants, with a clear emphasis on the immediacy of physical care, (injuries from violence, war, fractures, rapes, diabetes, child birth, etc) emotional and psychological care (effects of torture, violence, rapes, deaths, trauma, the journey, etc) and additional to children health, to include basic immunisations. WACP can act as a reservoir for cultural understanding and application to increase recognition of the importance of cultural influences on life and mental health.

WACP call for respect and protection for individual cultural, religious and spiritual dignity; Sometimes after the long haul of the trauma and the journey- these are the most revered of what people are left with as their survival and resilience; Safeguards and protection are needed so as to avoid any coercion and fear.

WACP to consider organising a special congress on this subject of the Europe's Migrant Crisis; The purpose is to bring together European politicians, advocates, media, communities, professionals, clinicians, organisations, professional bodies (public health, doctors, nurses, etc) and others with an interest, to formulate some health actions, offer intelligence on culture and its impact on mental illness, trauma and recovery.( Should be an EU funded event and WACP may want to seriously consider partners with very strong political, academic, clinical and international influences)

## **WPA POSITION STATEMENT MIGRANT CRISIS**

**Position Statement:** Europe Migrant & Refugee Crisis. A partnership with the Centre for Applied Research and Evaluation- International Foundation

### **WPA Call for Action:**

WPA and Careif call for all basic health care to be provided to migrants following urgent assessments. The interventions must have a clear emphasis on the immediacy of physical care (injuries from violence, war, rapes, child birth, physical illnesses etc.)as well as on emotional and psychological care (effects of torture, violence, rapes, deaths, trauma, the journey, cultural bereavement and culture shock etc.), with particular focus on children's physical and mental health. WPA through its member societies can offer to facilitate cultural understanding and application to increase recognition of the physical and mental health needs.

WPA in partnership with Careif, calls upon all Governments across the world to respect, uphold and administer The United Nations Refugee Convention (1951) with fairness and promptness and to act with humanity and compassion. At the present time governments with influence in the regions of conflict and war also with permanent positions at the UN Security Council must begin to draft solutions to resolve these conflicts and bring about an end to the crisis.

WPA in partnership with Careif also calls on all Governments to act with promptness and fairness in assessing, screening and deciding on the legal status of migrants in order to reduce uncertainty and provide physical and emotional support as needed. The potential new host countries must be reassured and supported, their fears and concerns addressed and they be involved with re-settlement programmes.

WPA and Careif call for respect and protection for individual cultural, religious and spiritual dignity. Sometimes after the long haul of the trauma and the journey- these are the most revered and stable of what people are left with and these may help their survival and resilience. Safeguards and protection are needed so as to avoid any coercion and fear.

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