Mental Health Facts on Refugees, Asylum-seekers, & Survivors of Forced Displacement

AMERICAN PSYCHIATRIC ASSOCIATION

Scope of the problem

The number of people displaced from their home countries due to war, armed conflict, political violence, and related threats are growing. If current trends continue, one in 100 persons will be a refugee in the near future.[1]

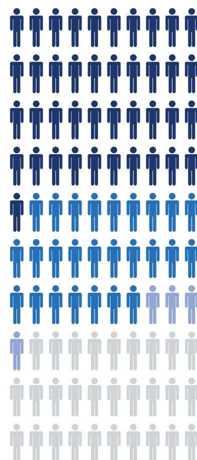
Unfortunately, most refugees, asylum seekers, unaccompanied minors, and other survivors of forced displacement will not receive needed mental health care due to scarcity of services and stigma against mental health care. Worldwide, over 65 million persons are currently displaced by war, armed conflict, or persecution, the majority of whom are located in low- and lower-middle income countries. Globally, half of the refugees live in unstable and insecure situations. There are 3.1 million asylum seekers and more than 25 million refugees, half of whom are under 18 years old. As of early 2018, almost 31 million children worldwide have been displaced by violence and conflict.[2]

Refugees are defined as someone 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 to or, owing to such fear, is unwilling to avail himself of the protection of that country[3]." An **asylum seeker** has also experienced persecution but has crossed borders to seek sanctuary. Refugees and asylum seekers differ only in where they are located when they make a request for protection[4].

The experience of **forcibly displaced youth** is varied – some have endured chronic pervasive exposure to interpersonal and community violence, the uncertainty of the future, personal

REFUGEES, ASYLUM-SEEKERS, & SURVIVORS OF FORCED DISPLACEMENT WORLDWIDE

70.8 MILLION
forcibly displaced



41.3 million internally displaced

3.5 million Asylum-seekers

25.9 million Refugees

57% of UNHCR refugees came from 3 countries

6.7 million Syria

2.7 million Afghanistan

2.3 million South Sudan

or family persecution, violent loss of loved ones, and an insecure environment[5]. Others have experienced a shorter exposure to high violence such as active war. Some youth come from areas of armed conflict and war with their conscription into the armed forces as "child soldiers", some arrive without parents or caretakers as **unaccompanied and separated minors**, and other youths flee with intact families.

The migration experience for youth forcibly displaced from their homes to the U.S. is also varied. Refugee and asylum-seeking youth may travel by plane or train without exposure to violence or danger if they have resources. Others have long migration journeys across multiple countries, exposure to physical and sexual assault, hiding, and lack of basic needs such as food, clean water, and the ability to maintain personal hygiene[6].

Oftentimes, forcibly displaced youth must abruptly leave all belongings except only the most necessary and quickly say goodbye to loved ones who may be unable to join. They do not necessarily want to leave the home environment and culture that raised them. Therefore, these youth lose not only material resources like housing, education, access to food and water, and security, but also social relationships and cultural supports.

Refugees do not choose which country they would like to live in. The United Nations High Commissioner for Refugees makes recommendations to select countries. There are eight U.S. federal agencies, six security database biometric security checks, three in-person interviews with the Department of Homeland Security, and medical checks that are involved in the thorough screening of refugees which can take between 1-2 years[7].

Historically, the U.S. resettlement program was one of the largest in the world since the 1970s, offering resettlement to the most vulnerable: at-risk women and children, female-headed households, elderly, and survivors of violence and torture, and those with acute medical needs. In the past decade, there were an average 75,000 refugees admitted into the U.S., but that number has gone down significantly recently. Only 22,491 refugees were admitted in the fiscal year 2018- the lowest in more than 40 years[8].

Due to a family separation policy, formally enacted in April 2018 that called for every illegal entry case across the border to be prosecuted, children (who could not be prosecuted) were separated from their parents. Between October 2017 and April 2018, an estimated 700 families were separated. In June 2018, an executive order was signed to end family separations at the border.

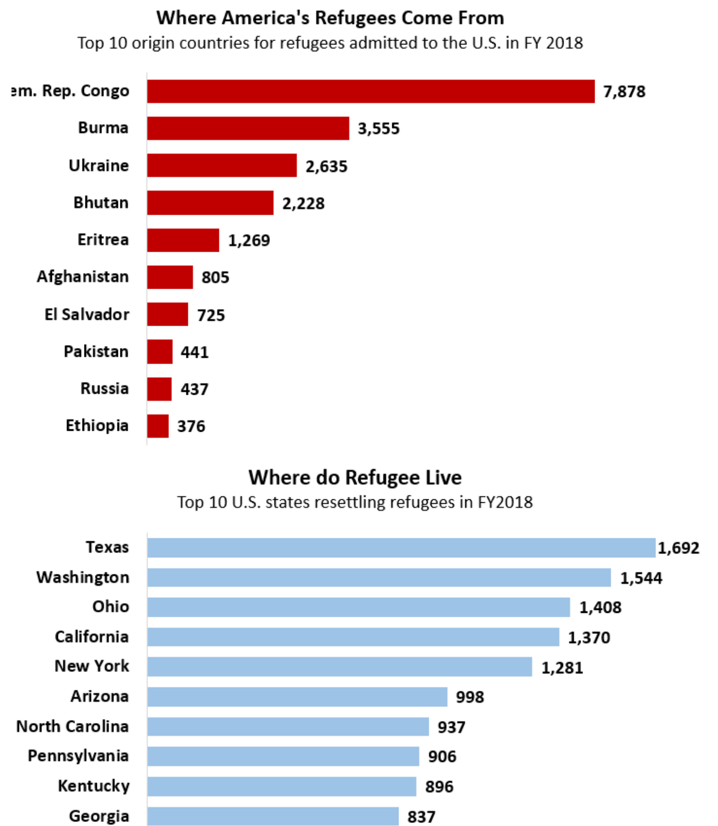


Figure 1: Data from the Refugee Processing Center wrapsnet.org

Mental health of survivors of forced displacement resettled in high-income countries

About one out of three asylum seekers and refugees experience high rates of depression, anxiety, and post-traumatic stress disorders (PTSD)[9].

However, systematic reviews show that prevalence estimates of mental health disorders

for this population vary widely from 20% to 80%[10,11] specifically.

- 4 to 40% for anxiety,
- 5 to 44% for depression
- 9 to 36%[12,13,14,15] in PTSD

While most refugees and asylum seekers with PTSD and depression show a reduction over time, particularly if there are low resettlement stressors[16,17] others may experience years of PTSD[18,19].

Early mental health care should, therefore be a priority for resettled youth[20], as post-migration stressors such as prolonged detention, insecure immigration status, and limitations on work and education, can worsen mental health[21]. When individuals and families seek safety by leaving their homes, cultures, and communities due to the threats of violence and persecution, emotional distress can be heightened[22].

Once forcibly displaced persons reach the U.S., they often face multiple postmigration stressors of poverty, insecure housing, unemployment, multiple moves with changes in neighborhoods, isolation, stressful legal issues, poor access to services, and general disadvantage in the host country, which can all adversely impact mental health[23],[24],[25];

Systems of care for the mental health of refugees and asylum seekers

Providing mental health care for refugees and asylum seekers should be done in partnership with the other social, cultural, and family supports around the individual. Such an approach highlights the influence of environment on mental well-being. Clinicians can serve as advocates by linking refugees with psychosocial support to assist with housing, legal aid, access to health care, education, and employment.

Refugees and asylum seekers may be resistant to seeking mental health care due to beliefs that diagnosis will interfere with jobs and housing, that there is no treatment[26], cultural values surrounding silence/disclosure[27], differing beliefs surrounding etiology/manifestation of emotional health, and lack of incorporation of these beliefs into care[9].

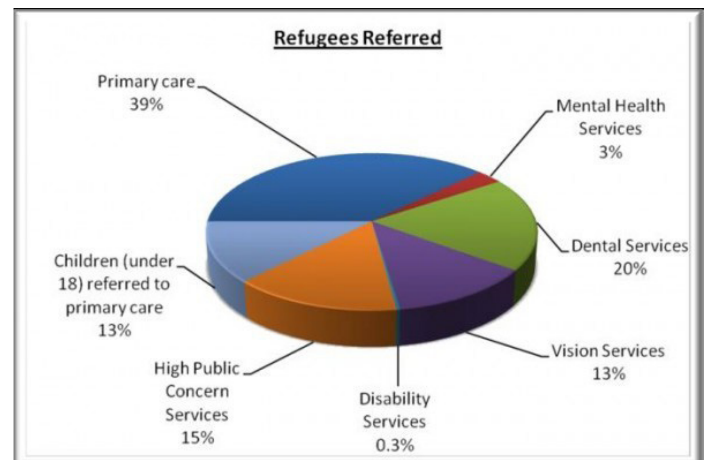


Figure 2: ORR Refugee Health Newsletter, 2013

Common structural barriers to care are lack of education about the mental health system and resources, health insurance issues, transportation, language proficiency, or provider refusal to see refugees[28].

Refugees may have barriers to seeking care, but health systems may also have barriers to referring people for services, as only about 3% of refugees are referred to mental health services following screening[29].

Strengths and protective factors common to refugees and asylum-seekers

Despite the high rate of exposure to traumatic events among the refugee population, many do not have chronic psychiatric impairment[30],[31]. Clinicians should, therefore, make the distinction between normal responses to the abnormal situations of war, protracted violence, and other traumatic experiences that many conflict-affected persons face, and the more severe and less common psychiatric response.

Mental health providers can highlight the resilient processes that conflict-affected people can draw upon. Commonly thought of as the ability to adapt in the face of adversity, resilience is time- and context-dependent, and a process that can be developed across individual, family, and community levels[32].

Clinicians should be mindful of the on-going stressors that one may face, of ambiguous or traumatic loss of loved ones and separation from culture and supports, on-top of the host environment that may foster discrimination and marginalization. It is important to highlight the socio-ecological supportive factors that assist in re-building a new normal.

Helping patients engage with family strengthening and building social networks can develop a sense of connectedness to minimize isolation and foster increased resilience and improved mental health. Providers can assist in making the environment less difficult by conceptualizing mental health, social environment, and individuals and families as interconnected, to decrease risk factors for adverse mental health and promote well-being.

This resource was prepared by the APA Division of Diversity and Health Equity. It was authored by Suzan Song, MD, MPH, Ph.D. and Sara Teichholtz, M.D., and reviewed and edited by Steven M. Weine, M.D. and Sejal Patel, M.P.H.

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3. United Nations High Commissioner for Refugees. Convention/ Protocol: https://www.unhcr.org/3b66c2aa10.html)
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