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Mental health services for Syrian refugees in Europe. Critical review

KEYWORDS

mental health, Syrian refugees, refugee in EU

ABSTRACT

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The purpose of this paper is to present background information about Syrian refugee mental health who arrived at Europe Union countries between 2015-2018 and provide statistics about prevalence to some mental health related issues. As well as illustrating the challenges and barrier to provide effective Syrian refugee mental health services. In addition, this paper presents some European countries experience in intervention program to improve mental health among Syrian refugee with providing examples about German and Jordan. This paper provided examples about some wide used programs in EU and middle East Countries that used to deal with refugee mental health issues such as STRENGTH program, PM+ and MHGAP. Many recommendations were suggested with focus on providing culture and language sensitive psychotherapy for refugee in EU countries.

Introduction

The Syrian crisis forced million to displace their homes to the surrounded countries the numbers indicates that around 12.5 million of Syrian citizens are displaced. This number shows that a significant number of the Syrian population in

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2011 influenced by the armed conflict that made them sought safety and protected life circumstances (Connor, Krogstad, 2016).

In June 2018, the published information shows that about (5,637,671) registered Syrian refugees, the majority of them have fled to Syria's neighboring countries and living in Turkey, Lebanon, Jordan, Iraq, Egypt, and North Africa (UNHCR, 2018). Also, there is about one million refugees moved to different part of European union countries since 2011. The data shows that around half a million of the refugees who arrived between 2011–2017 to Europe resettled in Germany to make it the fifth place of Syrian displaced population. In addition, Syrian refugees or asylum seekers arrived in many other parts in Europe such Sweden and Australia where received about (110,000 and 50,000) refugees respectively (UNHCR, 2018).

The refugee status impacts the high-income western hosting country in the same way that country hosting refugees beside Syria impacted. After-migration; there are several challenges that might face the refugees, including social engagement, dealing with prejudices and discrimination against them, changes and fluctuated in political attitude toward them, suffering from social isolation and loneliness, lack or limited working opportunities, children education disruption due to family instability factors and economic pressure due to low income (Kirmayer et al., 2011).

There is some evidence regarding the relationship between the mental health presenting issues and social integration. For instance, the limited social integration among refugees who are living in Switzerland shows a high negative correlation with the quality of health, impairment for daily function, as well as, manifestation for sever depression, anxiety and PTSD (Schick et al., 2016).

Furthermore, refugees unsure about the length to complete the procedure to gain permanent residential status in the hosting country. Besides; the refugees may go to multiple locations inside the same country to find a place that feel more comfortable and fit with his culture and religious background. Additionally, highly qualified Syrian professionals stressed by lack of recognition to their academic degrees and professional experience, when they relocated to European country (Robila, 2018).

Pre-immigration factors and mental health

Instable social and economical conditions that refugees and new arrival facing in new hosting countries, as well as, their previous trauma and life hardship they lived through and before arriving will be forming emotional factors that put them

at risk to develop some mental health conditions including posttraumatic stress disorder (PTSD), anxiety, depression, physical compliance and symptoms (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, Kirmayer, 2016). The research shows that the prevalence of mental health conditions in war and conflict regions is estimated for each depression, and anxiety are 12.9%, and 7.6% respectively (Charlson et al., 2016). While the WHO (2017) reported that the depression among general is estimated 4.4%, and PTSD estimation is 3.3% (Stein et al., 2014) which means the war and conflicts regions have significant higher percentages of different kind of mental health conditions.

Post-immigration mental health

Importantly, the PTSD in refugee's population in Europe around (9%), while the estimation in the hosting countries (1–3%), this means the percentage is three times higher in the hosting countries. This result shows also evidence that the prevalence of PTSD is even higher in refugees who have been exposed to potentially traumatic experiences, child and adolescent refugees (Atwoli, Stein, Koenen, McLaughlin, 2015).

Furthermore, there are few researches focused on substance abuse among refugees in Europe and limited to four hosting countries (Germany, Italy, the Netherlands and the United Kingdom). The prevalence of substance use rate for alcohol-related disorders among refugees are similar to rate of host country populations at the time (World Health Organization, 2017).

Also, the systematic metanalysis about refugees mental health conducted Bogic, Njoku, & Priebe, (2015) by listed the major conclusion about refugee mental in European countries which are:

- The rate of major depression among general population in Western countries and refugees are similar.
- The prevalence of PTSD among refugees is ten times higher comparing with same age a group in general populations. About (9%) of refugees suffering from PTSD, while the PTSD percentage increase to (11%) among children and adolescent.
- The prevalence of psychosis disorder among refugees estimated around (2%), this percentages are close to the rate of psychosis for general western population.
- Long stay (five years or more) in host country increase the rate of mental disorders among refugees.

Refugee mental health challenge in EU

Providing mental health services to refugees in Europe countries are challenged and limited to major factors which are according to Giacco, Matanov, Priebe, (2014).

- **Language barriers:** majority of refugees may have poor or limited command of the language of the hosted country. To receive many refugees, have a poor command of the language; in this case to receiving mental health services require assistance from interpreter during services. Also, the indirect communication between services provider and client may impact the consultation services negatively.
- **Client systems of belief:** the client comes from different system of beliefs and background about mental health services, which may create barriers to provide details and information for the mental health provider that influence the process of assessments and limit the chance to understand the client presenting issues accurately.
- **“Cultural expectations”** Culture plays a critical role in mental health expectation fields; thus, the client may build his own expectation based on his own culture reference point that might create discrepancy between the client expected and what mental health professional offer. That thing puts the diagnosis and treatment process into risk.
- **Building trust:** The trust related issue considers a heart of mental health services, in case of refugees; the lack of trust about services provider or the mental health system in country of origin will be one of limitation for the refugees to open and collaborate with mental health services provider. In addition, the refugees might be unfamiliar with the services that are provided by mental health care systems in hosted country. Moreover, the Syrian refugees created substantial challenges to European countries national health system, whereas, a little attention was given to the contribution of primary health systems in refugee’s transition and social integration, through providing enhanced care upon arrival.

Understanding refugees process systemically start from their own home countries would shed light on their pre-immigration mental health conditions as well as, learning about refugees transportation shows the degree of physical danger, emotional harm and life threaten conditions that the refugee have had gone through while crossing to hosting countries. Either by unsafe crowded boats through the sea, or traveling in the back of trucks and using unsafe routes through mountains (Bell, Zech, 2009). On the emotional side, they have left social and family ties

behind them in which limited the refugees supporting network. In addition, there is ascertain conditions children and youth were separated from their family due to war lost or death (Hebebrand et al., 2016). All the pervious loss and separation conditions have negative and painful impact on refugee mental health and integration in the new hosting countries.

In this paper there is some example for mental health services that offered to refuge in different European countries. Nicolai, Fuchs, von Mutius (2015) report about the challenge for health care system that accept Syrian refugees in Germany, through addressing issues related to cultural sensitivity to enable health care providers to understand their clients' needs through the recognition of cultural idioms of distress and coping strategies. As well as, the ways of expressing illness, and the norms organizing seeking help. In this case the health providers used the UN High Commissioner for Refugees to obtain understanding for Syrian refugees by developing a cross-culture relevant consultative education and services.

Mental health Intervention programs in EU

The experience of Charité University Hospital in Berlin could be a leading initiative about mental health for Syrian refugees in Jordan for three years. The same initiative now is replicated by Germany and led by the government efforts. The main initiative called CharitéHelp4Syria project (CH4S), served more than (1700) patients in three different locations in Jordan (Nicolai et al., 2015) The CH4S programme has four inter-related aims: the education of experts, psychological and psychiatric treatment, technology-based remote supervision and awareness campaigns. The main points learned from this experience are as following:

- 1) There are traumas beyond war experiences: about one-third outpatients in our Berlin clinic reported traumatic experiences that happen either in their home country or during migration and relocation.
- 2) There are disorders beyond PTSD: in all three treatment centres in Jordan, patients reported a broad range of psychiatric disorders resulting from traumatic experiences: one-fourth reported affective disorders and one-fourth had anxiety disorders, whereas PTSD accounted for only 15% of overall the cases.
- 3) Stigma prevents the use of mental health services. Patients often visited the outpatient clinics with somatic symptoms, which are more culturally accepted than mental health issues and preferred therapists of their peer group (e.g., Syrian psychologists). Thus, services in Germany and else-

where need to take these barriers into consideration by adopting a culturally sensitive approach and providing culturally accepted services and explanations of mental health disorders (Puchner et al., 2018).

There effort that guided by The European mental health systems recommend stepped-care and collaborative care models for common mental health symptoms in adults (Clark, 2011). The stepped-up model may consider a promising for scaling-up interventions for Syrian refugees by adapting a shorter form of CBT and/or problem-solving treatment (PST) as the first attempt to treat the client to go for more specialized intervention, which could be delivered by a trained lay-counsellors. In Netherlands, as an example, the preventive psychosocial intervention has been delivered by peer-refugees in Dutch asylum centers (Kieft, Jordans, de Jong, Kamperman, 2008). Using stepped-care has a number of challenges such as the need for intense training and supervision, reduced the rate when it was applied with by volunteer and lay helpers (Murray et al., 2014). Additionally, the lay-counselor familiarity intervention materials with a little practical experience to integrate it with new techniques (Ventevogel, Spiegel, 2015).

Common intervention program in EU and middle

Another example about intervention programs that were offered for Syrian refugees in Europe are called EU STRENGTHS programme with aim to improve system responsiveness to mental health in Europe and Middle Eastern countries, through putting the adolescent and adult mental health services into community and primary care systems. Amsterdam University coordinated the STRENGTHS in the Netherland. There are many research and academic institutions involved in this program in addition to united nation agencies (UNHCR) and international agencies (International Medical Corps, the International Federation of Red Cross and Red Crescent Societies through its Reference Centre for Psychosocial Support). Furthermore, mental health not-profit-organizations like War Child Holland and War Trauma Foundation. The programme advisory board comprise from international experts, and mental health care experts in Refugees.

The effort also includes the WHO strategy that aims to reduce continuous stress among Syrians refugees. The WHO vision requires scalable evidence-based interventions that integrated within the communality and primary care system to help Syrian refugees reduce common mental disorders across Middle Eastern and European countries.

These programmes include Problem management Plus PM+ which was developed originally as face-to-face program for adult individuals, groups and smartphone users among young children adolescents. The refugees version of the programme is designed to deliver through a trained lay-counsellors including peer-refugees.

Both STENGTHS and PM+ programmes are implemented using psychosocial approaches and refugees peer to support reducing mental health disorder. While a clear and a consistence evidence about its effectiveness still under development; the need is still bigger than the international effort that has been invested until this day.

Conclusion and recommendation

In conclusion, the mental health indicators of the refugees show that some disorder such as depression and anxiety with national population rate, while the trauma is higher from three to four times than national population rate in Europe which means that the Syrian refugee is significantly traumatized. Moreover, despite the fact that mental health among Syrian Refugees is underserved in Europe there also, challenges and barriers that may limited the impact which means the significant proportion of the vulnerable refugees not served or they are not able to access continues mental health services in Europe.

Furthermore, the nature of the main WHO and Europe mental health programmes such as PM+, MHGab, STRENGTH were designed for general mental health purposes where the trauma is not the main component, thus there is concern about the emotional aspect of the trauma not to be addressed and acknowledged appropriately, especially the programs that are delivered in primary healthcare facilities or community center where there are limited number trained psychotherapist or clinical psychologist.

The following list of recommendations can be offer:

- Provide psychotherapy services by native Arabic speakers who understand the culture and emotional element of the trauma.
- Consider the emotional components of the trauma that is related to the lost and displacement experiences.
- It's critical to respond to the refugees need in timely manner before their mental health get complicated due to past traumas and current living conditions where there is possible marginalization and a little of integration.

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