Approved at the General Assembly in Vienna on 30 September 2023

Working Group on Providing Mental Health Care for Migrants and Refugees Item GA23.10.1

Marianne Kastrup; MD, PhD; Denmark

Levent Küey; A/Prof, MD, PhD; Turkey

Roberto Lewis-Fernández; Prof, MD, MTS; USA

Harry Minas; A/Prof, MBBS, FRANZCP; Australia

Solomon Rataemane; Prof, MD, PhD; South Africa

Hans Rohlof; MD, PhD; Netherlands

Meryam Schouler-Ocak; Prof, Dr med; Germany (Chair)

Position Statement:

The COVID-19 Pandemic and Mental Health of Migrants and Refugees

Introduction:

As COVID-19 (caused by the SARS-CoV-2 virus) sweeps the globe, resulting in high morbidity and mortality, health care workers, their patients, families, and caregivers face unprecedented, rapidly evolving significant social, economic, and medical challenges. It is evident that the COVID-19 pandemic is affecting not only physical health but also mental health and well-being (Brooks et al., 2020; Shigemura et al., 2020; Gruber et al., 2021). Moreover, it is clear that the number of people who are not mentally ill and who suffer from the psychosocial consequences of the pandemic as well as the number of those who need psychiatric help have increased. In addition to infection by the SARS-CoV-2 virus itself, the fear of infection and especially the containment measures associated with the pandemic, including quarantine, social distancing (meaning physical distancing, Wasserman et al, 2020) and self-isolation, have a substantial impact on mental health (Kluge et al, 2020; Moreno et al., 2020; Kumar & Nayar, 2021; Gruber et al., 2021). In particular, reduced social interactions and increased loneliness are risk factors for onset of various mental disorders, particularly anxiety disorders and major depression, and exacerbation of existing mental disorders, including schizophrenia and substance use disorders. A positive correlation has been found between increased length of quarantine or isolation and higher levels of anger, anxiety, avoidance behavior, and stress-related disorders, including PTSD (Henssler et al., 2021). Social isolation is associated with neurophysiological changes (Shams et al., 2016) and can lead to an increase in depressive, anxiety,

and stress symptoms as well as stigmatization (Röhr et al., 2020). Other direct consequences of general lockdown measures range from stressful family conflicts to traumatizing domestic violence (Ghoshal, 2020; Mazza et al., 2020; WHO, 2020).

Migrants and forcibly displaced persons (Internally Displaced Persons, Refugees, Asylum Seekers

The estimated number of international migrants has increased over the past five decades and in 2020 was estimated to be 281 million – 3.6% of the world population (World Migration Report, 2020). The estimated number of internal migrants is 763 million. In 2021, UNHCR (2021) estimated that, of the total number of global migrants, 84 million are "persons of concern" (experiencing forced displacement): 48.0 million were internally displaced persons, 26.6 million refugees, and 4.4 million asylum seekers. Migrants are a heterogenous population, including regular and irregular migrants, labour migrants (both internal and international), temporary migrants (e.g., international students and tourists), and persons who have experienced forced displacement. The various types of migrants have had very different experiences prior to and during migration and confront distinct circumstances in the countries to which have migrated. They therefore have diverse health needs and face varying, and often substantial, barriers to care (Greenaway et al., 2019). Eighty percent of refugees live in low-income and middle-income countries, many of which have weak health care systems, scarce protective equipment, poor testing and treatment capacity, and very low vaccination rates. While nearly 60% of the world population has received at least one dose of a COVID-19 vaccine, this rate is only about 9.5 % in low-income countries (Our World in Data, 2022). It is clear that low- and middle-income countries need enormous global support to deal with the COVID-19 crisis (The Lancet, 2020).

Direct and indirect consequences of the COVID-19 pandemic

Although individual psychological and financial resources, social support, successful acculturation, and time since resettlement are significant protective factors that can reduce the risk of mental disorders among international migrants, multiple factors increase the risk of poor mental health as a result of COVID-19. Among these are lack of social support, social exclusion, limited familiarity with rights and entitlements, gaps in health literacy, and limited access to authoritative pandemic-relevant information (Guruge et al., 2015; Moreno et al., 2020). The prolonged periods of worry associated with the global reach of COVID-19 can increase the risk of serious mental disorder, including anxiety disorders (e.g., panic disorder), obsessive-compulsive disorder, and stress and trauma-induced disorders (Brooks et al. 2020; Gruber et al., 2021). In addition, the negative economic impact of the pandemic is expected to be greater among migrants and refugees along with other underprivileged groups than in the general population (Abedi et al., 2020). Loss of savings and

economic security pose a greater and more lasting risk to mental health among these groups in particular, associated with a significant rise in suicides (Economou et al., 2016; Sher, 2020).

Stay-at-home policies have been implemented worldwide to reduce the spread of the SARS-CoV-2 virus. Evidence of elevated levels of anger has been reported in populations under quarantine or isolation, increasing with greater duration of containment (Henssler et al., 2021). However, there is a growing concern that these policies may increase domestic violence, a concern borne out by recent evidence (Agüero, 2021). The COVID-19 outbreak has confronted people with an invisible enemy that can cause severe illness or sudden, depersonalized death, leaving them feeling disarmed and facing the loss of individuality and the fear of becoming just a number in the flood of mass casualties (Mazza et al., 2020).

People with a refugee background are disproportionately affected by exposure to extreme stressors such as torture and war before and during migration (Bogic et al., 2012; Priebe et al., 2016). In times of containment measures, it can be assumed that very distressed refugees make even less use of potential supports. Although voluntary support systems can be very helpful as social contacts, during lockdowns these supports are reduced or discontinued, with a disproportionately large impact on vulnerable populations, including refugees.

Only limited data are available on the impact of COVID-19 on morbidity and mortality indicators specifically among migrants. Migrants living in refugee camps, detention centers, and reception centers are at particularly high risk for COVID-19 exposure (ECDC, 2020), as are international labour migrants living in labour hostels and other such crowded and poor-quality accommodations.

Migrants in general, and refugees and labour migrants in particular, are more likely to live in areas of cities where medical care is limited or of poor quality. The disproportionate burden of chronic medical conditions is compounded by lower access to healthcare among some racial and ethnic minority groups. The higher observed incidence and severity of COVID-19 in ethnic minority groups and some migrants are likely due to the complex interaction of socioeconomic health determinants, barriers to accessing care, and higher prevalence of underlying medical co-morbidities that lead to more severe disease (Tai et al., 2021). These populations often live in crowded multi-generational dwellings, increasing the risk of transmission within households and making it impossible to physically distance or isolate from family members who are elderly or have underlying co-morbidities (Platt et al., 2020).

Ethnic minority, migrant, refugee, and asylum seeker groups generally have poor access to health care due to poverty, cultural and linguistic barriers, racial discrimination, difficulties navigating the health care system, and/or lack of entitlement to health care (Platt et al., 2020). The ability to access health care services in humanitarian settings is usually compromised and exacerbated by shortages of medicines and lack of health care facilities (WHO, 2018). Migrants and refugees are often

stigmatized and unjustly discriminated against, accused of spreading disease, especially Asian-background migrants. Such unacceptable attitudes further increase the risk of negative public health outcomes, including for the host populations, since refugees and migrants may become afraid of seeking treatment or disclosing symptoms, thus potentially contributing to the unchecked spread of the virus (Norwegian Refugee Council, 2020).

Refugees and migrants are the world's collective responsibility as unanimously agreed at the United Nations General Assembly's New York Declaration, which recognized that "No one state can manage such movements [of refugees and migrants] on its own" and that "greater international cooperation is needed to assist host countries and communities" (UN General Assembly, 2016). It is essential that high-income countries discharge their obligations in this time of need, by supporting low- and middle-income countries with large numbers of refugees and migrants and by increasing their own intake of migrants and refugees rather than continuing to leave the great majority to be cared for in resource-constrained low- and middle-income nations.

The COVID-19 pandemic has exposed health disparities among ethnic minorities and migrant groups that have resulted from long-standing structural inequities and individual socioeconomic health determinants (Greenaway et al., 2020). It has also created an opportunity to address the causes underlying these inequities. Global mental health efforts focused on enhancing public health messaging and interventions that are adapted to the linguistic, cultural, and social circumstances of marginalized groups are crucial to effectively prevent transmission within and beyond these communities (Tai et al., 2021). The spotlight that the pandemic has shone on structural inequities experienced by migrants and refugees also highlights the need, and presents an opportunity, to strengthen and reform general health and mental health systems so that they are able to meet the needs of all members of the population, especially those who are most vulnerable.

WPA established an Emergency Response Executive Group, which initiated emergency responses in 2020. An Advisory Committee for Responses to Emergencies (ACRE) brought together the leaders of several interested Member Societies to facilitate practical and concrete aid to Member Societies in need. The group is fostering education, information collection and the development of local, national and international strategies to cope with the mental health consequences of emergency conditions. Our working group supports ACRE and has prepared the supplementary followings regarding The COVID-19 pandemic and mental health of migrants and refugees:

Recommendations:

1. Understanding the physical and mental health of migrants requires substantially improved health and mental health information systems and disaggregated analysis and reporting of data. Governments must include collection of migration-relevant data in their health information systems and in their pandemic-related data collection.

2. Barriers that impede access by migrants and refugees to authoritative pandemic-related health and mental health information must be identified and eliminated. Governments and health agencies must provide culturally and linguistically accessible information about COVID-19 and its impact on oneself and others. In addition to general information strategies, it is of utmost importance to establish excellent communication with those migrant groups that show distrust in governments, including because of their background experiences, and refuse methods to avoid virus contamination and vaccination against COVID-19. Appropriate outreach methods will vary according to the particular needs and preferences of different migrant and refugee groups.
3. Where migrants, asylum seekers and refugees live in circumstances that increase the risk of SARS-CoV-2 infection - such as labour hostels, refugee camps, and administrative detention centers – it is the responsibility of governments and employers to ensure that these accommodations are COVID-safe or to provide alternative accommodations that are.
4. Migrants and refugees must have equitable and affordable access to appropriate personal protective equipment, especially if they continue to live in relatively unsafe environments, such as labour hostels, refugee camps, and detention centers.
5. During the pandemic, migrants and refugees must receive equitable and free access to testing as required, measures that protect against infection and serious illness including vaccines, and equitable and free access to high-quality health and mental health care.
6. Mental health workers need training in cultural and structural competence to understand these vulnerable groups. Mental health care services need to reduce barriers to access for these vulnerable groups, such as providing adequate resources like interpreter coverage and mandatory skills training for staff. An inclusive approach to refugee and migrant health that leaves no one behind during the COVID-19 pandemic should guide global mental health efforts.
7. As governments tighten border controls and implement other measures in response to COVID-19, they need to consider the impact on refugees and migrants and ensure that such actions do not prevent people from accessing information, safety, and health care services. Not only would such a decision result in a humanitarian crisis but it would contribute to further sociopolitical unrest with far-reaching global implications (Brito, 2020). A transnational humanitarian action agenda is needed.
8. To maintain the best-possible balance of measures, decision makers must constantly monitor the outbreak and the impact on specific population groups of the measures implemented (Nussbaumer-Streit et al., 2020), including refugees and migrants. There can be no public mental health without refugee and migrant mental health (Tai et al., 2021; Kluge et al., 2020).

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