

Refugee Mental Health: A Primary Care Approach

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► See related article on page 112.

The term refugee is an internationally recognized legal classification for persons fleeing their home country based on a well-founded fear of persecution for reasons of race, religion, nationality, or membership of a particular social group or political opinion.¹ These persons have been forced to flee their homes and sometimes their families, often because of violence. The number of displaced persons reached an all-time high in 2015: more than 65 million worldwide.² Although the ultimate goal is repatriation to their country of origin, ongoing conflicts often prevent this. Thus, the work of resettlement begins.

With our focused training on care for the whole patient, and on our patients' relationships with their families, social environment, and mental health, family physicians are well equipped to serve refugees. In this issue of *American Family Physician*, Mishori and colleagues review the refugee

resettlement process and the clinical aspects of caring for patients who have experienced war, conflict, violence, and threats.³ Because of their history, refugees are at higher risk of mental health disorders than other immigrant groups.⁴ Attempting to address such needs can be daunting for primary care physicians, especially if their clinics lack integration with behavioral health consultants.

The Centers for Disease Control and Prevention addresses these concerns with three recommended action plans based on refugees' mental health needs (*Table 1*).⁵ First—as with all patients—refugees with acute or life-threatening mental health disorders should be referred for immediate psychiatric evaluation and treatment. The second group of patients, those with less serious mental health conditions, can be followed by family physicians and referred for subspecialty evaluation as needed. Finally, most refugees require no clinical mental health services; despite suffering varying degrees of loss, refugees and other immigrant groups can exhibit considerable emotional resilience.^{6,7}

The stigma surrounding mental health in refugees' countries of origin may dissuade them from discussing certain mental health concerns during their initial visits. ►

Table 1. Mental Health Evaluation of Refugees

<i>Symptom severity</i>	<i>Characteristics</i>	<i>Recommendations for physicians</i>
Chronic/serious or acute mental illness	Psychotic break, severe functional limitations, suicidal or homicidal ideation	Identify potentially unstable patients; refer immediately for psychiatric evaluation; consider inpatient behavioral health services
Less acute mental illness or symptoms	Decreased interest in usual activities, difficulties with sleeping and concentration, irritability	Screen to identify those not previously diagnosed with mental illness; establish ongoing care with primary care physician; ensure that mental health resources are available if necessary
No identified mental illness	Demonstrate resilience when discussing past trauma; may have some transient symptoms	Coordinate care with local resettlement agencies; if treatment is available, screen for depression and posttraumatic stress disorder

Information from reference 5.

By remaining open and allowing a patient's story to unfold over the course of several encounters, physicians and patients can establish a therapeutic alliance that leads to more successful interventions.⁶ An understanding of the patient's cultural background and potential for having experienced violence can also guide physicians in the types of questions they should ask. The Centers for Disease Control and Prevention offers a series of health profiles for certain refugee populations to help educate physicians about their backgrounds, the resettlement process, and health conditions for which they may be at risk.⁸

Post-resettlement experiences can unmask prior underlying mental health conditions.⁹ Resettled refugees undergo social stressors related to language barriers, acculturation, housing, employment, and poverty. Although refugees often have broader eligibility for public health services than other immigrant groups, they may have difficulty accessing these services because of language, literacy, and cultural issues.¹⁰ Moreover, refugees have already experienced trauma at the hands of government officials and organizations, and they may be too wary of government entities and those in perceived positions of power to pursue available help.¹⁰

These barriers to access raise important questions and can potentially complicate public policy on the often misunderstood process of refugee resettlement. Unfortunately, public misconceptions about refugees abound, including a perception that refugees are simply economic migrants rather than persons fleeing conflict and war. Such notions can further negatively impact the mental health of those who have already experienced violence and persecution. By educating ourselves about refugees, we can work to care for our patients and increase knowledge of their needs among the public and policy makers.

Family physicians, having been trained in open engagement and facilitated listening, can address many of the psychosocial needs

of refugees. The converse also holds true: through their example, refugee patients can strengthen physicians' own resilience, another timely topic in this era of burnout. Working with refugees can reinvestigate a sense of purpose among clinicians. As conflict escalates around the world, family physicians will continue to need to provide care for those resettled within our borders.

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