CHAPTER 11

Depression and anxiety in migrant, refugee and war-zone populations

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11.2 MENTAL HEALTH SCREENING OF SYRIAN, IRAQI, AFGHAN AND OTHER REFUGEES AWAITING MIGRATION FROM TÜRKIYE TO THE UNITED STATES

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INTRODUCTION

Drawing on data from the Internal Displacement Monitoring Centre, the United Nations High Commissioner for Refugees (UNHCR) estimates that global forced displacement reached 103 million in mid-2022, of whom 53.2 million were internally displaced people, 4.9 million were asylum-seekers and 5.3 million were other people in need of international protection. The UNHCR estimates that refugee numbers reached 32.5 million in mid-2022.[1,2]

Millions of Syrians (50% of refugees are Syrian), and now Ukrainians, have been displaced, with further displacement elsewhere in 2022. This means that 1 in every 78 people on earth has been forced to flee – a dramatic milestone that few would have expected a decade ago.

Refugees are defined narrowly by the Refugee Convention as individuals who have been forcibly displaced outside their native countries. Hundreds of millions of forced displaced people could be at excess risk of psychiatric morbidity. The relevant epidemiological evidence is, however, generally sparse, scattered and apparently conflicting. Türkiye hosts the largest number of refugees, with 3.7 million people officially registered. No one really knows the real numbers, as many are not registered or now have Turkish citizenship. The population of Türkiye is 85 million, roughly 10% of whom are migrants. Some of them are aiming to migrate to the United States of America. Immigrant medicals are performed in Ankara, and refugee medicals are performed in Istanbul.

MENTAL HEALTH ISSUES IN REFUGEES AND MIGRANTS

A screening programme for migrants to the United States is run through the Centers for Disease Control and Prevention's (CDC's) Division of Global Migration and Quarantine, Quality Assessment Program (QAP) of the United States. Panel physicians (PPs) are medically trained on technical instructions (TIs), are licensed and experienced general practitioners/family doctors (GPs/FDs) practising overseas and are authorised by the local US embassy or consulate under approval of the CDC. More than 760 GPs/FDs worldwide are PPs, performing overseas pre-departure medical examinations in accordance with requirements of the TIs. Two main groups are screened in primary care panel practices: Immigrants and refugees. Screening consists of physical and mental examination and laboratory tests including urinary drug screening when necessary. Mental evaluation is routine during the consultation, and short mental screening tests in applicants' languages are also used, such

as the PHQ-9 depression scale, Generalized Anxiety Disorder (GAD) and State/Trait Anxiety Inventory anxiety tests and PTSD-4 for post-traumatic stress disorder. Any suspected harmful behaviour or substance use is referred to panel psychiatrists who have specific CDC TI training. A diagnosis of harmful behaviour or substance use is an inadmissible condition named as Class A. Other mental conditions usually require a follow-up before and/or after arrival to the United States, which is noted in the final report.

Refugees may present differently in primary care, because they have been forcibly displaced, not moving from choice. Unlike refugees, immigrants are motivated to leave their native countries for a variety of reasons, including a desire like marriage, a fiancée, economic prosperity, family reunification, escaping conflict or natural disaster or simply the wish to change one's surroundings. Migrants seen in PP practices usually tend to hide their mental conditions, do not seek help and generally are more mentally healthy, as they have chosen to live in another country. Diagnostic tools or *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) guidelines are rarely applied to immigrants, as they do not seek any help, and the guidelines usually used are those that are developed for routine clinical practice. It is for the primary care provider who cares for immigrants to identify those who need help but are not asking for it.

Whatever the reason, GPs/FDs should pay special attention to the mental condition of migrants, but especially of refugees, as they usually need help from outside their home countries and suffer (or fear) persecution on account of race, religion, nationality or political opinion; because they are a member of a persecuted social category of persons; or because they are fleeing a war.

As primary care providers, we experience that refugees seek help and try to shorten the waiting period here in Türkiye where they are temporary visitors, or tend to hide culturally unacceptable things that happened in their history. A GP/FD must be careful about the reliability of history. A large percentage of refugees may develop symptoms of PTSD or depression. These long-term mental problems can severely impede the functionality of the person in everyday situations; it makes matters even worse for displaced persons who are confronted with a new environment and challenging situations. Among other symptoms, PTSD involves anxiety, over-alertness, sleeplessness, chronic fatigue syndrome, motor difficulties, failing short-term memory, amnesia, nightmares and sleep paralysis. Depression is also characteristic for PTSD patients and may occur without accompanying PTSD.

CLASS A AND CLASS B MENTAL CONDITIONS

Final diagnosis of the mental condition in detail is not our aim in primary care, but rather identifying the presence of any harmful behaviour or potentially harmful conditions and preventing harm. A patient with a

disease associated with any harmful behaviour (Class A) cannot migrate. Those requiring only follow-up and treatment but who can travel are instructed to have a follow-up – these are Class B mental conditions. We have checked our data in hand from May 2014 to March 2022 and tried to share any differences between the mental disorder prevalence of refugees and immigrants of the same nationality (i.e., Iran) living in Türkiye in the same time period.

We have extracted the Class B and Class A mental classifications from our software both for refugees and also for the immigrants. The data were searched for both refugees and immigrants between May 2014 and November 2022 (past eight years), and 24,224 immigrants and 25,582 refugees (total of 49806) were included.

As shown in Table 11.4, Iranian, Iraqi, Afghan and Syrian are the major nationalities screened as immigrants and refugees. The Iranian population is high in immigrants, whereas the Iraqi population was highest among refugees.

As others are not well comparable due to small sample sizes, we have checked the prevalence of mental condition only between the refugees and immigrants, and there was a statistically significant difference between the prevalence of mental condition of the two migrant groups of the Iranian and Afghan nationalities ($p < 0.05$). Afghan refugees have a significantly higher mental condition prevalence (19.1%) compared with the other nationalities ($p > 0.05$). The prevalence in Afghan refugees (22.1%) is considerably higher than in Afghan immigrants (4.1%). One in five of the Afghans in the sample had at least one mental condition.

When we look at the diagnostic distribution according to DSM-V, the immigrants are more likely to have mental conditions such as anxiety or minor depressive disorders, whereas the refugees may have PTSD or major depression, congenital or acquired neurological defects and other serious conditions.

A review by the World Health Organization (WHO) estimates the point prevalence of mental disorders as around 8–28% (22%).[3] However, there is considerable heterogeneity among studies in the literature, with variability in results due potentially to methodological factors such as differences in assessment tools and sampling, studies using clinical interviews (instead of self-report instruments), random sampling and larger sample sizes reporting lower rates of mental disorders. Other differences in refugee populations in terms of trauma exposure, migration difficulties and living conditions in host countries may explain heterogeneity in prevalence rates across studies. Studies have identified high rates of mental disorders in refugees, but most used self-report measures of psychiatric symptoms, unlike the screening program for the migration to the United States.

TABLE 11.4 Mental class status for refugees and immigrants from Iran, Iraq, Afghanistan and Syria

Country	Refugees			Immigrants			Total migrants		
	Mental class A&B (n)	Total (n)	Mental class A&B (%)	Mental class A&B (n)	Total (n)	Mental class A&B (%)	Mental class A&B (n)	Total (n)	Mental class A&B (%)
Iraq	645	10,037	5.1	110	2,811	2.1	755	12,848	4.1
Iran	392	3,790	9.1	1,617	21,161	6.1	2,009	24,951	7.1
Syria	544	6,241	7.1	21	752	1.1	561	6,993	7.1
Afghanistan	961	4,156	22.1	50	858	4.1	1,011	5,014	19.1
Overall	**2,542**	**24,224**	**9.1**	**1,798**	**25,582**	**6.1**	**4,336**	**49,806**	**7.1**

According to the International Rescue Committee (IRC), Iraqi refugees arrive in the United States with more emotional and mental health issues than many other refugee groups, and the IRC has documented a high prevalence of depression, anxiety and PTSD among recently arrived Iraqis. A 2009 study estimated the lifetime prevalence of any mental disorder at 18.8% for Iraqi adults. Anxiety disorders were the most common (13.8%) class of disorders in the cohort studied, and major depressive disorder was the most common (7.2%) single disorder. The numbers are considerable when considering that many migrants get health services from the GPs/FDs. The difference in screening periods may be an influencing factor. There are known factors such as an acculturation difficulty after arrival to the destination, which may trigger any underlying PTSD and depressive disorder. We screen prior to US migration, and the IRC numbers show those after migration has been completed, settling in the United States.

Although comparisons cannot be accurately made, one may see that the numbers are high in both the United States and Türkiye. Those living in the United States might be affected by many other factors, such as wrong expectations and reality, coping with status change, adjustment problems and acculturation difficulty.

SCREENING MIGRANTS AND REFUGEES IN TÜRKIYE

Our screening population is around 50,000, larger than many other studies on migrant mental health. We do not have the qualitative data here, nor can we include the distribution of diagnoses, but as violence has declined between 2005 and 2011, those Iraqi refugees living in Türkiye for a while probably have mental conditions other than PTSD. As that was a relatively quiet period, mental conditions may be similar to those immigrants. When the country was stable, the prevalence among immigrants was lower than that found in refugees.

Immigrant and refugee groups of the same nationality differ in prevalence for all nationalities. Syrian refugees who are escaping from a still partially active war may have more PTSD. We expect to see more numbers from Syria and other neighbours in coming years. Among 7,000 Syrians, 7.1% of mental cases are lower than expected, although considerably high. Also the number of Syrians who immigrate to the United States may increase as time passes. More than 200,000 Syrian migrants are Turkish citizens now. Some were born here, and some applied for passports and settled here, making a gross change in the demography of certain cities and regions. They brought their own culture; hence, the migrants expect the GPs/FDs to understand their culture and social structure while providing medical care.

The information provided here is intended to help resettlement agencies, GPs/FDs, other clinicians and health care providers understand the mental

health issue of greatest concern pertaining to resettling refugee populations. This is based on our daily clinical experience and our expertise, and might be helpful to other colleagues with refugees in their daily practice.

MANIFESTATION OF MENTAL HEALTH ISSUES

We often see depression and anxiety together when screening refugees. Basically, refugees are already under intense stress; they are usually worried about many aspects of their lives, and usually they have marked anxiety, which a GP/FD may easily notice. What is interesting here is the refugees are all aware of this, and they relate/link and normalise this condition within their current status. However, they may not be aware that they are depressed. This is something really important for a GP/FD to know.

Refugees usually do not come with a current/acute psychiatric complaint. They often do not express their psychiatric complaints themselves, but these emerge when specific questions are asked. Routine psychiatric examination and initial questions used for depression, such as symptoms of sleep disorder and decreased interest may be asked, but a GP/FD shall keep in mind that these 'diagnostic questions lose their meaning' for this group, unlike other patients who seek help from a GP/FD. Kidnapping, abuse, violence and rape may have been normalised to the extent that they can be asked about in a routine question list, and especially domestic violence.

Every refugee entering the medical examination room is evaluated not only in terms of physical findings but also in terms of perception, orientation and mood. In addition, related core questions are asked regarding depression, anxiety and PTSD, according to the DSM-V. We ask these as family physicians/general practitioners in the migrant health screening practice. Validated tools and scales for primary care screening are applied with the help of an interpreter to communicate in the person's native language and not miss anything, especially the presence of impaired functionality, harmful behaviour history or harmful behaviour risk or the presence of any suicidal thoughts at any time. All are asked with clear sentences. Depending on our personal experience as experts in refugee screening, events such as rape, torture and suicide that are asked about in a clear and ordinary way makes the person being examined more comfortable and facilitates giving clear and real answers to the questions.

We screen, detect and manage each case after diagnosis, until the departure with a pre-flight evaluation, and also help with arrangements after arriving with filling in and submitting special medical condition forms to let the resettlement agencies in the United States know about the condition, how to follow up and what is needed after arrival. In cases where a harmful behaviour risk is high or cannot be classified according to the DSM-V and CDC TIs, refugees are re-evaluated by a psychiatrist in our clinic face-to-face (or rarely

online in conditions like the recent pandemic). In addition, as they are usually living in satellite cities where they are settled by the Turkish government, as they are not officially living in Istanbul or in Ankara where we screen, we prepare and provide them with a detailed referral letter.

Türkiye's universal health system provides coverage of all health expenses for refugees – they can be treated in their cities the same as Turkish citizens. That is why they are referred to a psychiatric specialist in their own settlement city for treatment/follow-up if needed, in addition to regular follow-ups in our clinic by our own panel psychiatrist. We can call them back for a follow-up appointment the following month if necessary. They are paid by a resettlement agency for their travels, accommodation and daily expenses for this medical follow-up trip. Not only while they are living here in Türkiye as guests, we also indicate the necessity of follow-up for the resettlement process in the United States after arrival.

There are also cases where we refer patients with substance use for treatment to the Alcohol and Substance Treatment Center, an authorised governmental institution specialising in substance use disorders and management of diagnosed patients. This service is also free of charge for refugees.

HEALTH LITERACY

Although they have a similar rate of psychiatric disease burden to the society they live in, refugees do not have the same chance to access health services if no one guides them in the city/country where they are settled temporarily. They mostly do not have knowledge about where and how to access health services or how to reach psychiatry clinical services. On the other hand, especially in terms of psychiatric needs, they do not even think about seeking help regarding their housing, heating, food and work needs. They have accepted their current status of mind as a natural consequence of being a refugee. They show no effort or any search to get out of that situation. That is why screening, detecting and managing cases is of utmost importance to help such vulnerable people and also considering its importance for public health.

IMPROVEMENTS ARE NEEDED

Work is needed on specific tools for screening. Scales should be revised and validated for the refugee group. For example, asking questions such as 'Do you have sleep problems lately?' or 'Do you ever not enjoy things that used to make you happy?' to a woman who lost her husband in war, has one missing child, is unemployed, is homeless and has been living in a foreign country for five or six years where she does not speak the language is meaningless! Please feel empathy and then re-think the guidelines.

Suspicion/diagnosis of any psychiatric disease, aiming for a correct referral and finally classification of the applicant for migration are said to be the main

role of a PP. But this is no different from primary health care (PHC) in terms of holistic health approach and community mental health. All PHC physicians, not just PPs, should apply these same principles. FDs/GPs should consider every patient who enters the examination room from a biopsychosocial well-being perspective, and especially migrant/refugee groups who have language barriers, cultural barriers, suppressed sexual identities in some cases and live far from their family/country and social support.

Every headache, angina and tachycardia should be questioned in terms of 'depression/anxiety/somatic' problems. Undiagnosed or untreated depression/anxiety can become treatment-resistant, leading to functional impairment, and may even result in suicide. These issues can become part of collective memory and be passed onto future generations. Suicidal thoughts, which are often suppressed for 'religious' reasons in the current generation, may emerge in the next generation.

Overall, migrant mental disorder prevalence for the eight-year period from 2014 to 2022 is 7.1%. There is a significant difference between the refugee and immigrant 'mental health disorders' overall prevalence (9.1% vs 6.1%). What does that mean? As primary care physicians, GPs/FDs, you need to be careful with these vulnerable people in primary care, as they will be searching for help.

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