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EPA Guidance mental health care of migrants

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ABSTRACT

Migration is an increasingly commonplace phenomenon for a number of reasons. People migrate from rural to urban areas or across borders for reasons including economic, educational or political. There is increasing recent research evidence from many countries in Europe that indicates that migrants are more prone to certain psychiatric disorders. Because of their experiences of migration and settling down in the new countries, they may also have special needs such as lack of linguistic abilities which must be taken into account using a number of strategies at individual, local and national policy levels. In this guidance document, we briefly present the evidence and propose that specific measures must be taken to improve and manage psychiatric disorders experienced by migrants and their descendants. This improvement requires involvement at the highest level in governments. This is a guidance document and not a systematic review.

1. Introduction

Migration has been going on for millennia. It is well evidenced that, from the origin of humankind in Southern parts of African continent, individuals spread around the globe. Part of the reasons for this original migration were obviously about survival but it is also likely that adventure or political reasons may well have contributed to this migration. These reasons remain important and pertinent even now. It is only since the 18th century onwards – with the expansion of the British, Spanish, French, Dutch and other empires – that a closer study of race and migration began. The present document provides guidance towards managing psychiatric and mental health needs of the migrant groups. This is not and does not purport to be a systematic review of the literature.

2. Types of migration

The act of migration itself is not a homogenous process and different individuals migrate for different reasons and also respond in very different ways. In this document we propose some general guidance for clinicians, policy makers and service providers on how to manage patients who may be migrants and their descendants, as the influence of migration may continue to be felt across several generations. We are using the term migrant here as it is a legally accepted term and also reflects some commonality in the process and in belonging to groups in spite of the heterogeneity. The impact of migration following wars and political turmoil and resulting displacement brings with it additional factors at play especially for refugees and asylum

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seekers [19]. Migration can be to another country or can be within the same country, moving from a rural to an urban area or vice versa. Migrants may get pulled towards the new setting through various pull factors, such as educational or economic growth or personal factors, or they may be pushed out of a country due to push factors, such as political, poverty, terrorism, displacement, war or religious factors [83]. Individuals can be primary migrants, i.e. they are the first ones to migrate, and then they may get others to follow over in subsequent waves, who will be then seen as secondary migrants. Similarly, stresses experienced by primary migrants will be very different from those experienced by secondary or even tertiary migrants. Primary migrant may have more stresses in settling down whereas secondary migrants may well have additional support available through the primary migrant. In Western Europe, often there is seasonal migration of labour for farming purposes. This may occur annually or several times a year depending upon the seasonal requirements. This seasonal migration will raise issues of adjustment not only for migrants but also for those left behind. Group migration may carry with it an element of social support and social capital but it may also be more stressful if they have to look after the family's needs as well. Voluntary or forced nature of migration will also affect subsequent settling down and acculturation.

3. Impact of migration

The impact of migration should be seen on various levels – on the individuals who migrate, on the families and individuals they leave behind or bring with them, on the culture and community they move to and the cultures and communities they leave behind. The process of migration can be roughly divided into three arbitrary stages: pre-migration, migration and post-migration [6,12] which may have a degree of overlap. Pre-migration is the period when the individual, singly or as a group, decides to migrate and then prepares themselves to do so, using financial, legal and political resources. Migration itself is the actual stage of moving across boundaries. The post-migration period can last for the lifetime of the individual and may well affect the next generations of descendants. At an individual or community level, the post-migration period will be important for the individual to adjust and settle down. At this stage there may be processes of acculturation which may lead to assimilation or deculturation (which means losing their own cultural values) [2]. These processes of acculturation as described by Berry [2,4] are incredibly helpful in trying to understand individual migratory experiences. Some authors [71] have given the analogy of the striped zebra, where individuals keep both the old and new cultures in parallel. In different cultures different terms will be used to describe these experiences. For example, in Canada and South Africa the concept of rainbow nation, in the USA melting pot and in the UK the ideas of multi-culturalism are used. It is important to be aware of these processes of adjustment and acculturation which will affect settling down and contributing to the new society and these will also influence new society's attitudes towards migration.

3.1. Impact on individuals

Berry and colleagues [2–4] suggest a framework which suggests that individuals may choose to keep their own cultural values or norms or acquire the new culture's identities and characteristics. However, families may acculturate at different rates. Not surprisingly, the process of acculturation is affected by economic, educational, social, psychological, physical and cultural factors. Individual factors such as gender, gender role expectations, generation they belong to, culture of origin, language proficiency in the new society, social and economic factors, religion, educational status, etc. will contribute in different ways to the processes of acculturation and adaptation as well as post-migration adjustment.

Hofstede [51] describes various dimensions of culture's characteristics. These dimensions are: collectivism/individualism; feminine/masculine; long-term orientation of the members of the culture's distance from the power and avoidance of uncertainty. Bearing in mind that not all members of a culture will have all these dimensions or characteristics, it is useful for the clinician to remember that these dimensions may well interact with similar or different dimensions in the new culture. Thus acculturation becomes a more complex phenomenon than previously thought.

It is well established that migrants make huge contributions to the local culture and economy as well as to the economies of the countries or regions they originate from. Migrants worldwide remit back billions of dollars to families (300 billion US dollars worldwide and 7 billion US dollars to Morocco alone), thus contributing heavily to these regions and to the local GDP in a positive manner.

3.2. Migration and stress

The process of migration can lead to a whole spectrum of mental health disorders, e.g. psychoses, PTSD, common mental disorder (CMDs), eating disorders, suicidal acts, etc. The research evidence for prevalence of psychosis is the strongest (see [54] and also below). Multiple factors and complex interactions will determine the post-migration adjustment and the outcome of migration. Stress can result from the actual process of migration as well as post-migration adjustment.

4. Development of the guidance document

European Psychiatric Association decided to produce Guidance documents on a number of topics and this topic was selected following discussions within the Guidance Committee. This guidance document was developed with reference to the current knowledge based on existing policy documents issued by relevant bodies. Various international and European experts in the field were consulted. Following a two-day meeting in London, contributions were sought from a number of researchers and clinicians. There are very few systematic reviews and it was decided to gather evidence from experts who also contributed to the writing of the paper. We deliberately chose not to follow systematic reviews but the views of researchers and clinicians. Studies such as EUGATE have chosen very narrow focus by concentrating on legal migrants who are limited to working age and have regular income which are specifically narrow criteria as majority of migrants will move from poor to rich countries and may not find jobs easily. Furthermore, migrants moving across countries carry with them specific challenges. Italian migrants to Switzerland although moving from one developed country to another will also carry with them certain stresses. A literature search was conducted using the electronic databases; all EBM reviews, EMBASE, Medline and PsychInfo. The search was conducted using terms: migration, migrant, refugee, asylum seeker, race, ethnic, mental illness, mental health, psychiatric illness, psychiatric disorders, psychiatric interventions, psychotherapy, intervention or therapy. These terms were used under keywords in OVID. The inclusion criteria were: published in English, and specific for migrants, refugees, asylum seekers, and migration. This combination produced 538 papers which were subsequently reduced to 10 when further limits on the date of publication were introduced. Of the 10 publications, two turned

out to be chapters in the same book, so these were dropped. The papers were screened and due to constraints of space and also as we were not carrying out a structured systematic review, we selected papers which had something significant to say. It was decided not to use other languages for a number of reasons – firstly as the main language of the EPA activities is English. Secondly, it was not possible to gather accurate translations which could be compared across countries at such short notice. Additionally, we looked at secondary references from key papers and grey literature was searched by hand using existing publications. We also checked web sites of some psychiatric organisations especially focusing on English speaking countries to collect relevant information. The document was then circulated to the members of the EPA Guidance for their comments and was amended accordingly. Then the document was submitted to the EPA Board who approved it and their suggestions were taken into account.

5. Background–Migration and mental disorders

We shall very briefly summarise some of the research findings on certain psychiatric illnesses. Several factors, such as attachment patterns, development, infections and cannabis, etc., are also factors in the countries of origin.

5.1. Migration and psychosis

In a classic study, Odegaard [74] observed that rates of schizophrenia among Norwegian migrants to the USA were higher than those who lived in Norway. He attributed this increase to emigration but he also noted that this increase occurred 10–12 years after migration, suggesting that there may be other reasons for this increase. In the UK, rates are particularly high among young Caribbean men, especially British-born young men – 18 times higher in one study (see [54] for a review, see also Liu and Cheng [64]). In the Netherlands, Moroccan migrants are up to 7 times more likely to have developed schizophrenia. However, they hail from the Rif region in the north of Morocco, which is a very poor and deprived region with a rigid and patriarchal culture.

Cantor-Graee and Pedersen [30] noted that the risk for mental illness was as high for second-generation immigrants as it was for non-immigrants and observed that this increased risk could not be explained by urbanisation of birthplace or parental characteristics. Higher risk for psychosis was reported among immigrants from Caribbean (Caribbean black) to the Great Britain [15,42,46,93], among immigrants from Surinam, the Dutch Antilles and Morocco in the Netherlands [103] and among immigrants from Australia, Africa and Greenland in Denmark [32]. In a meta-analysis by Cantor-Graae and Selten [31], relative risk of 2.7 for schizophrenia (95% CI = 2.3–3.2) was found in the first generation which increased to 4.5 (95% CI = 1.5–13.1) in the second generation. Their analysis showed that the relative risk for schizophrenia among immigrants from developing countries was 3.3 (95% CI = 2.8–3.9). They showed that based on skin colour, black migrants had a risk nearly five times: 4.8 (95% CI = 3.7–6.2). Thus, they note that different migrant groups from different economic backgrounds show significant heterogeneity.

Ethnic density has been shown to be an important factor in understanding the elevated rates of schizophrenia in some immigrant groups [8,27]. Bhugra [8] postulated that cultural congruity, when people with similar cultural values live close to one another, may be more important in this respect. Further work is urgently needed to map cultural congruity and ethnic density with epidemiological data [20]. To summarize, immigrants have a strongly increased risk for schizophrenia, which is associated with psychosocial stress factors such as social isolation and exclusion [31,105]. Perceived discrimination and self-discrimination [104,106], exposure to individual social adversity such as markers of disadvantage as well as area-level factors such as ethnical density [91], and neighbourhood deprivation and social strain [96] need serious consideration.

5.2. The role of social and economic inequalities

It is often difficult to untangle the impact and the role which social factors and inequalities play in the genesis or perpetuation of mental illness.

According to the Fourth National Survey in the UK [69], one in eight ethnic minority people experiences some form of racial harassment in a year. Repeated racial harassment is a common experience, including physical attacks on self or property. One-fifth of the sample report being refused a job for racial reasons and only a few believed that there was no racial prejudice among employers. One in four whites reported prejudice against Asian people and one-fifth against Caribbean people.

In the UK, African-Caribbeans are three to five times more likely than white people to be admitted to a psychiatric hospital with a first diagnosis of psychosis [54]. They also have more complex and possibly coercive pathways into professional care in that they are admitted and treated compulsorily, they also report greater levels of dissatisfaction with services but it is not a clear cause and effect [see [54] for detailed discussion].

Studies from the countries of origin do not support increased rates there and so bring the migratory and post-migratory factors under greater scrutiny [14,48,67]. There is some indication that rates of schizophrenia are not similar worldwide and there can be some regional variations in local populations [89]. Historically, higher rates of mental illness have also been reported among the UK Irish population [35,37] who experience little language difficulties.

Ethnic density may be a protective factor and has been inversely linked to the prevalence of schizophrenia in migrant communities according to some studies [27,55,92,103], but not in all [36]. The increased rate of schizophrenia in second/third generations of descendants of migrants is difficult to explain. It is unlikely that the causation is biological as the evidence is not very strong. It is possible that social and demographic factors or acculturative processes may be contributing to vulnerability. A discrepancy between achievement and expectation may be a contributory factor [86]. This gap between achievement and expectation was highest for black African-Caribbean cases than all other groups (i.e. black African-Caribbean controls, white cases and controls) [86]. Although various biological factors have been hypothesised in aetiology, such as intra-uterine infection in a population susceptible to local infections, relative poor nutrition, use of cannabis and psychoactive substances, obstetric complications and flu epidemics, the findings are not conclusive except for the use of cannabis in vulnerable individuals. Thus, socio-cultural problems around identity, intergenerational differences, ambivalence towards both host and originating cultures, and dysfunctional acculturation, complicated by cumulative discrimination and racism (both overt and covert), may well prove to be significant factors in contributing to the stresses experienced by these groups and deserve further detailed exploration.

The theory describing social defeat is not dissimilar to the achievement-expectation hypothesis. Social isolation and cultural congruity are also likely candidates, as are abnormal attachment patterns and separation from fathers for longer than 4 years. This separation is more from fathers rather than mothers indicating that attachment patterns and role models may play some role which need further investigation.

5.3. Migration and affective disorders

The prevalence of depression varies between 4.2–29.5% in different countries [90,109,110] indicating that there may be different ways depression can appear across cultures. The world-wide lifelong prevalence of depression is estimated to be 5.8% for men and 9.5% for women [111]. In a meta-analysis by Swinnen and Selten [98] regarding migration as a risk factor for affective disorders (including bipolar disorders), a slight increase of risk for affective disorders was found, but no evidence for an increase in unipolar depressive disorders was found. In a cross-sectional study of a multi-ethnic working population, Sieberer et al. [94] found that first- and second-generation female migrants were more likely to suffer from depressive features compared with non-migrant females. Interestingly there are low rates of treatment for depression among Caribbean people. It can be argued that variations in language and the fact that several languages do not have words describing depression, the standard diagnostic tools may miss these. As a possible trigger for depressive disorders, conflicts concerning migration [5], acculturation in the families [80] which may occur at different rates and may contribute to cultural conflict and poor support in the new country [45] may act as precipitating factors. In some cultures depression may be seen as part of life's ups and downs not needing medical intervention but religious approaches [16].

5.4. Common mental disorders

The findings are mixed for differences in prevalence of common mental disorders and rates are elevated in every migrant group. Two major UK studies found differences in the prevalence of depression: the ONS National Study of Psychiatric Morbidity did not find any evidence of raised rates in black groups [53] while the Ethnic Minority Illness Rates in the Community [EMPIRIC] observed 60% higher prevalence in black compared with the white group [108]. This may reflect variations according to time. As in many languages there are no words to describe or define depression, it may not be easily diagnosable. Smaller studies have found raised rate in some groups with possibly higher somatisation disorders [87]. Most research on PTSD is in migrants or refugee and asylum groups, and a review found PTSD to be ten times more likely in these groups than the general population [10,41]. There may be some overlap with psychosis (15–40%) and of greater risk of common mental disorders (also see [33,47]).

5.5. Migration and addictive disorders

The increased use of alcohol and various illicit substances have been linked to specific migrant populations [38,39].

Cultural explanations on the one hand and cultural barriers on the other can contribute to tensions between the migrants and the new countries. An example of cultural influences is the use of Khat in the Somali and Ethiopian migrant communities in some European countries has raised serious issues about how to manage this kind of addictive behaviour [23]. These differences need to be tackled by providing the right information [77,78]. Different explanatory models used by different cultural communities need to be understood so that any interventions put in place are culturally appropriate. For example, studying the explanatory models of addictive behaviour among Turkish and German youths in Germany it was found that German but not Turkish youths clearly differentiated between illegal drug abuse and the abuse of alcohol and nicotine. Nearly half of all Turkish youths rejected central medical concepts such as "physical dependence" or "reduced control of substance intake" [77]. Preventive work is necessary but must take into account cultural variations and explanatory models. Even when people migrate within broadly similar cultures there are variations noted as in the case of Finnish migrants to Sweden who are twice as likely to be admitted in comparison with the local population [50].

5.6. Migration and suicidal behaviour

Suicidal and self-harm behaviour appears to vary with ethnicity and sex. Asian men have lower rates of suicide in UK than white men [7]; Asian women, particularly in the younger age group, have higher rates, but this might be changing [24]. These gender differences may reflect cultural conflict for women who may find it difficult to meet gender role expectations from their families. They may be expected to behave in traditional manner at home and elsewhere whereas new community may expect them to be behaving like majority female group. Asian men also tend to drink more heavily which may reflect another kind of self-harming behaviour. Many Asian immigrant communities have maintained their cultural identity and traditions even after generations of overseas residence. Pressures are intensified for young Indian women, given their rigidly defined roles in Indian society: submission and deference to males and elders, arranged marriages, the financial pressures imposed by dowries, and ensuing marital and family conflicts [7]. Rates of completed suicide vary across different migrant groups. Lower rates of suicide in the black Caribbean group have been reported, but higher for Surinamese immigrants to the Netherlands [29]. Studies have found higher rates of suicide in migrants to Sweden, particularly second-generation groups [49]. There is evidence of higher rates of suicide among young South Asian women in the UK and among young Turkish women in Germany, Netherlands and Switzerland [101].

Numerous studies have reported highly elevated rates of suicide as well as of suicide attempts amongst young migrant women [18,25,28,43,62,63,76,85,100–102,112]. Like the South Asian populations in the UK, the attempted rate of suicide among men of Turkish origin was lower compared with Turkish women. In Switzerland, women of Turkish origin had the highest rate of attempted suicide [28]. Risk factors include familial problems and pressure from the community and culture conflict [9,21]. Young women may find themselves trapped, with male values dictating how they behave. Young males may similarly be attracted to alcohol, drugs and gangs in order to fortify their identities.

Eating disorders: acculturation can produce elevated rates of eating disorders among migrants. In various studies it has been reported that some migrant teenagers are more likely to develop eating disorders compared with native populations [10,17] which depends upon the cultural concepts of the self [70]. As noted above, the socio-centric self may encourage people to behave in different specific ways, thereby creating further conflict with others around oneself.

6. Migration and vulnerable groups

6.1. The elderly

Migration can affect the elderly in various ways. Apart from the usual reasons and motives, they may have to migrate due to their dependent status and may leave established networks of support behind and may find it difficult to develop new circles of friends. Another group is those who grow older in the new country. Boneham [26] highlights multiple jeopardy of aging migrants caused by ageism, racism, gender disparities, restricted access to health and welfare services and class struggle. This is primarily true for those from the black and minority ethnic groups [84]. In a Survey of Health, Ageing and Retirement in Europe (SHARE), a

cross-national, multidisciplinary, household-based panel survey using nationally representative probability samples (n = 28,517) of 11 European countries of the non-institutionalized population aged 50 years and older depression was measured [1]. The influence of migration status on the prevalence of depression was significantly greater in Northern and Western Europe, compared to Southern Europe. A higher prevalence of depression in first-generation immigrants aged 50 years or older, together with relevant geographical variation, was found. This difference was not due to other known predictors of depression at an older age [1].

6.2. Migration and dementia

The elderly population of immigrants is increasing in most European countries, but immigrant patients are under-represented in dementia assessment and care [56]. The reasons can be seen in different cultural perceptions of ageing and dementia and lack of knowledge among immigrants about the available support. The interpretation of cognitive test results may be a major challenge [73]. In London the prevalence of dementia among immigrants was estimated at 17.3% probably due to cardiovascular co-morbidity [79]. An increased frequency of diabetes type-2 was found as well as nearly twice the prevalence of dementia among Turkish migrants to Denmark [88] who also noted that Mini Mental State Examination could be used as a screening tool but with modifications for those who were illiterate and poorly integrated.

6.3. Common mental disorders in elderly migrants

Among older adults, depression is associated with being female, having poor physical health (especially chronic) and functional deficits, low income, poor housing, isolation and low family and social support [65,68,95]. Paradoxically a study looking at the elderly in Thailand showed that those elders whose children had out-migrated showed lower levels of depression which increased if one child stayed with them or moved back with them [107]. This observation needs further exploration. It may be that these elder individuals feel they need their space or that their children have not moved out of the country so nearness remains possible.

Social groups, day centres and residential placements for older adults from ethnic minorities are often lacking. Culture-specific services may have advantages in engaging people from specific cultures but may also create a sense of isolation. Perhaps the best models of service delivery are a mixture of the two – specific specialist and general specialist services. This means that services for the elderly may be required with separate training but equally that general adult psychiatrists need to be aware of the specific needs of older patients.

Finally, the plights of many elderly people left behind by migrating families and the ensuing stress on both parties need acknowledgement. The complexity of relationships and social capital must be taken into account. Rapid expansion and access to social media has made the contact regular and relatively easier. Even in low- and middle-income countries, penetration of access to mobile telephones is impressive making it easier for those migrating to keep in touch with the families and friends left behind.

6.4. Migration and its effect on child mental health

Various factors will impact on the outcome of migration in children. Their experiences will be moulded by factors such as whether migration occurs with parents and family, separation from one or both parents (due to either migration of the parents or of the child), who they are cared for and where they migrate to. Migration can range from seasonal migration of parents or youngsters for work away from home, serial migration of family members, parental migration without the children, family migration, etc. Children can be lone migrants seeking better education or occur because of factors related to safety. Trafficked children have special needs and these are discussed further below.

Adjustment to the new cultures may well vary. They may have difficulty forming attachments and coping with losses and reunion with families after a period of time. At times older children may end up looking after younger siblings. Parents themselves may also suffer the consequences of separation, e.g. guilt and loss. Children, especially girls who are separated from families, are particularly vulnerable to physical, emotional and sexual abuse as well as exploitation.

Vollebergh et al. [107] did not find higher rates of mental illness in migrant children in the Netherlands. However, immigrant parents reported more problems in their daughters than non-immigrant parents in the Dutch study. Isolation can lead to problems such as poor academic achievement and substance misuse. Kupersmidt and Martin [57] found elevated levels of pathology: 59% of the children revealed one or more psychiatric disorders, the commonest being anxiety related (50%) among Mexican-American children. Anxiety may reflect a normal response to psychosocial pressures such as constant mobility, poor social ties, living in poverty. Migration was found to be a risk factor for mental illness along with age, sex and socio-economic status in a German study [52]. Parenting styles are strongly influenced by culture and thus may vary and could be misinterpreted as maltreatment. In some cultures, parents feel that if they became too controlling local social services will step in and take the children away so they become too lax, leaving the children to manage on their own in gangs. Factors such as language barriers, attitudes faced in the community and school, integration attained by the family in general, residency status and intergenerational differences may all play a role.

Children of parents who develop mental illness are faced with other problems such as caring for them, interpreting their needs and negotiating with service providers, thereby affecting their own growth and development. These responsibilities may well affect their peer relationships and educational development.

6.5. Refugees and asylum seekers

Perhaps the most affected and vulnerable groups are refugees and asylum seekers. The 1951 Geneva Convention defines a refugee as someone who has '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 or owing to such fear, is unwilling to avail himself of the protection of that country…'. A further distinction of 'asylum seeker' is made for people who have left their country of origin, have applied to be recognized as a refugee and are awaiting a decision from the new society. Currently, there are over 20.8 million 'people of concern' to the United Nations, and about 40% of these are refugees. According to the United Nations High Commissioner for Refugees in 2005, there were some 668,000 applications for asylum or refugee status in the industrialized world, the majority to Europe (374,000). The USA is followed by the UK and France with the largest number of asylum applications overall but numbers are starting to fall (United Nations High Commissioner for Refugees. Basic facts, 2006. Available at: http://www.unhcr.org/cgibin/texis/vtx/basics).

Forced migration can contribute to a sense of depression by the attitudes of the host countries. After the initial relief of post-migration arrival in a safe haven, it is not uncommon for frustration and disillusionment to set in. Protracted asylum procedure can be a

risk factor for developing psychiatric problems [58,59]. Experiences of being a refugee or asylum seeker may be influenced by gender. Men may be primary asylum seekers and may have escaped from the army or may have been involved in political activism. For example, women may undergo repeated sexual assaults and men may feel unable to help themselves or others affecting their self-esteem.

The most common disorders are those characterized by anxiety and depression, such as post-traumatic stress disorder (PTSD) and major depression, reflecting the experience of trauma and loss that these populations experience. It is worth remembering that sometimes PTSD is over-diagnosed whereas the underlying problems may simply be due to anxieties around families left behind or guilt at having migrated. Post-traumatic disorders are often high (reported rates vary between 3–86%) in those fleeing troubled regions, physical and sexual violence, torture, loss of family members and persecution. Recent meta-analysis concluded rates of common mental disorders (CMD) are twice as high in refugee populations as in economic migrants (40% vs 21%) [61]. Refugees are 10 times more likely to have PTSD than age-matched native populations in the countries surveyed [41]. Substance abuse and self-harm are also commonly reported. The risk of PTSD and CMD in asylum groups increases with length of stay in detention [58,81] and with unemployment, absence of family support and complicated asylum processes [59]. Asylum seekers may be less likely to engage with health services [58] and access blocked by multiple barriers. The traumatic experiences of trafficked women have been compared with torture and other forms of ill-treatment [75]. Domestic legislation and international co-operation must be considered in order to meet the clinical and social needs of these individuals.

6.6. Refugee children

Children themselves may be refugees and seeking asylum or they may be accompanying adults who may be refugees or those who have been separated from their parents. They may appear mature beyond their age in some settings yet immature in others thus leading to problems in age-recognition and appropriate placement and may present with anxiety, depression, Attention Deficit Hyperactivity Disorder and conduct disorder. Appropriate placements are crucial.

6.7. Lesbian, gay, bisexual and transgender migrants

In many countries around the world, these sexual variations are illegal and often punishable by law. These individuals may choose to leave the country of origin for safe havens and the attitudes of the new country will influence their subsequent adaptation and acculturation. Prevalent social and legal norms in the new society will influence acceptance by the new society. These groups are also vulnerable to high levels of psychiatric morbidity and therefore the needs for early and appropriate recognition and intervention must take that into account. Clinicians need to be aware of their own personal attitudes and prejudices towards sexual variations.

6.8. Undocumented/illegal migrants

Global migration has produced some 17 million "people of concern" (i.e. immigrants and refugees) worldwide and around 20–30 million irregular migrants (undocumented/illegal migrants) [34,114]. Their health problems are further compounded by not getting public health insurance in the countries that receive them and they cannot afford to pay for health care expenses [34,44,114].

According to "Healthcare in NowHereLand", it is estimated that 1–4% of the overall population in Europe are undocumented migrants (UDM), living in a NowHereland, where they face extremely precarious and health threatening living conditions. "NowHereland" is called a paradox country, in which migrant inhabitants are officially not visible, but they are part of social reality and health care providers have to deal with them (http://www.nowhereland.info/). The receiving countries could be divided into "no access" countries (e.g. Germany), "partial access" countries (e.g. UK) and "full-access" countries (e.g. Spain) according to offered health care to the undocumented migrants. They may face other barriers common to all migrants [97].

7. Issues in mental health service delivery

Access to appropriate and accurate information for migrants can be critical. Simple effective solutions would include providing a map of services akin to that of railways so that they know where to seek the required help from. It should be possible for the health providers to provide the migrants with their health history and results of investigations on a USB so that they can carry the information with them rather than having to repeat their history endlessly. Collaborative partnerships with communities with a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing confidential listening and assistance service (CLAS)-related activities will help.

There is a risk of pathologizing and medicalizing an otherwise normal human response to extreme adversity and losses. On the other hand, there is serious danger in dismissing too easily clinically significant disorders caused by trauma. Services have to be sensitive to the needs and required specialised skills including training of interpreters. Cultural competency training is helpful in many settings [25,40,82].

7.1. Response to psychotherapy

There is substantial evidence for the efficacy of psychological, psychosocial or 'talking therapies', which are primarily western in origin (please refer to EPA Guidance on Cultural competence Training). Their appropriateness among non-western cultures may be questionable at times as migrants from certain cultures may not be accepting of talking therapies. A more acceptable model for counselling might start with a background knowledge of the circumstances from which the patient has fled and provision of relevant practical advice and a more problem-focused (rather than emotion-focused) approach. As most psychotherapies are ego-based and developed in the West, these may not be acceptable across cultures. It is critical that therapists do not force ego-based therapies on socio-centric individuals. It is crucial that cognitive schema studies are carried out across cultures and cognitive behaviour therapy adjusted and offered accordingly. In addition, appropriate information on family education and illnesses is made available in appropriate languages and suitable levels so that patients and their carers are able to understand what is going on.

Behaviour therapies may be more acceptable in certain situations provided they are not upsetting and are understood in the context of the cultures. Basic principles are discussed elsewhere [11,13,66]. Co-morbid medical conditions may mask psychological problems and will require treatment. Trust is often the first casualty of these traumatic experiences and thus is extremely important. Time is required to build up trust, allowing the trauma story to emerge gradually and gently so that it becomes a familiar and comfortable theme rather than something shamefully hidden away. Disclosure is best managed when the social situation is stable and when both patient and health worker are confident about managing the disclosures and the distress that

may emerge as a result. Incarceration in hospital and enforced treatment may be reminiscent of earlier traumatic experiences, precipitating a resurgence of PTSD symptoms on top of those of the psychosis itself. Risk assessments may be particularly difficult where there are strong cultural and religious taboos regarding discussion of suicide and self-harm. The main aim of mental health and social care should be to provide psychological support, treatment and support to the refugee patient to achieve basic goals and some normalcy in the host society such as attaining stability, education and work opportunities, housing, etc. This requires multi-sector collaboration with social workers, refugee organizations, housing and employment agencies and needs appropriate government and international funding.

7.2. Response to pharmacotherapy

There is considerable evidence to suggest that cultures influence biological factors which affect pharmacokinetics and pharmacodynamics of drugs [11,60,72,113]. Social and environmental factors which affect metabolism and efficacy of psychiatric medication include gender, ethnicity, enzyme differences, diet and dietary taboos, among others. Ng et al. [72] demonstrated that different ethnic groups need different doses of medication as they are likely to develop side effects on small doses due to differences in prevalence of certain enzymes which affect metabolism of drugs. We do not intend to go into details here but would like to caution that cultural and ethnic differences are critical in response to certain psychiatric medications and these must be remembered. Dietary and religious taboos, smoking and alcohol dependence must be explored prior to starting treatment. It is important to start with a small dose and to have a low threshold for identifying and dealing with side effects and provide the patient and their carers as much information on the drugs as possible and to ensure that they have understood it. Attitudes towards medication and also parallel use of complementary medication must be explored and remembered.

8. Policy recommendations

Policy recommendations are complicated by the lack of established aetiological explanations for elevated rates and considerable heterogeneity between cultural groups, by age and sex, and between generations as well as by health care systems and resources.

8.1. Need for training and provisions for culturally sensitive services

These are covered in the EPA Guidance on cultural competency training and development of psychotherapeutic skills. It is essential that psychiatric services are culturally and geographically appropriate and accessible. This means that patients are made to feel welcome by the use of appropriate interpreters, food, religious opportunities, availability of culturally appropriate make-up, etc. Bhugra et al. [22] in a randomised controlled trial comparing standardised treatment with treatment by a culturally sensitive non-governmental voluntary agency found that the latter offered more culturally appropriate services which were appreciated more by the patients and their families.

8.2. Good practice in using interpreters

Communicating distress, especially with language barriers, and with varying idioms of distress can be a significant reason for non-engagement and increased levels of dissatisfaction. The need for good use of interpreter services and their availability is critical in providing services which will be used by individuals. There is no doubt that there is a profound danger in using diagnostic tools developed in different countries blindly without taking conceptual equivalence into account. Health services need to be geographically and emotionally accessible.

Failure to provide appropriate interpretation when there is a known language need is indirect discrimination. Translation is an interactive dynamic medium and not mere literal translation. According to Tribe [99] the four modes of interpreting are: (1) psychotherapeutic or constructionist, (2) linguistic, (3) the advocate or adversarial/community and (4) cultural broker/bicultural so that interpreters are aware to prevent withholding information if they feel that sharing something may bring disrepute to the culture. Cultural mediators and culture brokers may be required.

8.3. Recommendations

These recommendations were developed using existing policy guidelines and sifting themes from research evidence.

For policy makers:

1. there should be clear policies taking into account housing, employment and physical and mental health needs of migrants;
2. appropriate resources must be made available to meet their needs;
3. appropriate resources for training of professionals across the spectrum should be available;
4. public mental health and public education about migration, migrants, their needs and obligations must be part of the communication strategies;
5. collection of accurate data and information.

For service providers:

1. services should be culturally, geographically and emotionally accessible;
2. separate or mainstream services should be decided according to local need;
3. cultural competence and diversity training should be part of induction processes;
4. local needs to be determined regularly;
5. regular audit of services;
6. may need to consider cultural mediation, culture broker or other models.

For clinicians:

1. clear information and resources should be available;
2. cultural awareness and cultural competency training should be a mandatory part of training and be embedded in the curriculum;
3. specialist or generalist services need to be discussed according to need and resources;
4. cultural training for ALL health professionals is a must.

9. Conclusions

There is no doubt that migration itself is a heterogeneous process and carries with it considerable internal and external risks. Some types of migration are more stressful and threatening. Individual responses to the stressors will be determined by a number of factors. Some groups are more vulnerable to developing psychiatric disorders than others and clinicians must be aware of

their own personal prejudices and the impact discrimination has on migrants. Migrants will respond differently to pharmacotherapy and to different schools of psychotherapy. Policy makers need to take these variations into account and those who provide health services must respond to local needs which may be very specific to specific groups. Migrants may be running from or running towards specific structures and it is imperative that their experiences are acknowledged and appreciated and responded to accordingly.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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