How do pluralist economics approaches address refugees' mental health issues in the U.S.?

Refugees and mental health

As people around the world become refugees, their mental health undoubtedly becomes at risk as they flee unsafe living conditions and navigate the uncertainty of seeking asylum in other countries. There has been a significant increase in the number of people seeking asylum in recent years. Specifically, within the European Union (EU) between 2015 and 2019 approximately 4.46 million people have sought asylum.[1] In 2022, according to the United Nations, 5 million Ukrainians have fled their home since Russia's invasion. Hence, because of the expected growth of people on the move due to poverty, lack of security, lack of access to basic services, conflict, environmental degradation and disasters, addressing this issue seems crucial. (WHO, 2 May 2022, refugee and migrant health)

Introduction

While each individual experiences becoming a refugee differently, here we identify the most common mental health illnesses that they experience and their sources. Post-traumatic stress disorder (PTSD), depression, distress and low level of life satisfaction are considered to be the main mental issues among refugees.

PTSD

The risk of developing PTSD in refugees and asylum seekers is significantly higher compared to the general population. [2] Many studies confirm the traumatic experiences of refugees. One such study found that among Iraqi refugees residing in Sydney, almost half of participants in the survey reported unnatural death (47%) or murder (46.7%) of a member of their family or a friend, 41% had experienced being close to death, and almost 40% had suffered a lack of food or water. [3] Moreover, pre-migration experiences such as being close to death and being forcibly separated from family members were also important causes of PTSD. [4]

Depression

Depression is a widespread mental problem estimated to affect about 9.8%-67.4% of refugees globally. [5] The most important factors that lead to depression in refugees are younger age, experiences of premigration trauma, refugee camp internment, and postmigration stressful events. [6]

distress and low level of life satisfaction

Negative and pending outcomes of the asylum process and separation from family are related to higher levels of distress and lower levels of life satisfaction. [7]

How do economists see mental health?

The subject of mental health today is more widely used in politics and economics than before. While neoclassical economics would focus on the cost of mental illnesses for a country, marxian economics focuses on the nature of contemporary institutions and fundamental systems for addressing mental health problems. [8] The main purpose of this policy brief is to propose avenues of analysis and the problem with a pluralist economics approach; therefore, we will try to explain how mental health relates to the economy with a non-neoclassical point of view. Political economics views income inequality and poverty as main drivers of mental ill-health. [9] According to Acemoglu, Johnson & Robinson, good institutions are crucial for economic performance; hence, looking at the problem of mental health with a non-neoclassical view seems essential if we strive to structuraly address this issue.

Mental health of the refugees in the U.S.

A: Female Refugees mental health issues

Fewer than 12,000 refugees were resettled in the US in 2020 in the last year of Trump administration, marked by reduced caps on refugee admissions. Current administration pledged 62,500 and 125,000 resettlement places for refugees in 2021 and 2022, respectively. In 2020, most refugees came from the Democratic Republic of the Congo, Myanmar (aka Burma) and Ukraine.[10] Russian invasion of Ukraine in 2022 and escalation of conflicts around the globe have led to a record of 26.6 million people fleeing their homeland which is expected to increase the number of refugees in European countries and the US.[11] 64% of all refugees arriving in the US between 2010 and 2020 were children under age of 14 and women, with female refugees constituting around 50% of the displaced.[12] Refugee women suffer from a higher incidence of mental health disorders than refugee men and non-refugee immigrants, with a higher prevalence of depression and post-traumatic stress disorder (PTSD) caused by pre-migration stress and asylum seeking process.[13] Unlike men, female refugees are often victims of sexual and gender-based violence, including rape, as well as exploitation and discrimination both in the countries they have left and arrived to. [14] Refugee women are entitled to the same level and quality of support and healthcare as refugee men, but also face specific barriers to care and structural issues in addressing their mental health problems. A case is made to introduce gender-affirmative policies that would target female refugees and improve their access to quality mental health and psychosocial services (MHPSS).

Refugees often experience difficulties accessing MHPSS in high-income countries. In 2015, only 5% of refugees in need of mental health services received them in Germany. [15] Meanwhile, only 3% of refugees are referred to mental health services following screening in the US. [16] Lack of understanding of a new health system, structural barriers such as scheduling or restrictive timing, linguistic barriers, attitudes, and perceived discrimination were identified as obstacles to women receiving MHPSS in high-income countries.[17] These obstacles also vary across countries and depend upon peculiarities of the country's healthcare system. US healthcare is notoriously complex and expensive and relies on the combination of employer-based and public health insurance programs. Upon arrival to the US, refugees receive Refugee Medical Assistance (RMA) - a short-term health insurance available up to eight months. Medicaid or the Children's Health Insurance Program (CHIP) which provides insurance for several years is also availble to some refugees [18]. Fitzgerald (2017) identified stigma, fear, cultural differences, language barriers, practical barriers, lack of education, and spiritual/religious barriers as the barriers to mental health treatment in the state of Maine. [19] Wong et al (2006) found that cost of healthcare and language were the most prevalent obstacles to care among US Cambodian refugees, hinting that structural and not culturally based, barriers are the most critical obstacles to care in this community [20]. Morris et al (2009) points out lack of education about the mental health system and resources, health insurance issues, transportation, language proficiency, or provider refusal to see refugees as key structural issues. [21]

In the US, states ensure a public health screening for all newly admitted refugees, providing a physycial and mental assessment. In their description of the screening process in Denver, Colorado, Savin et al (2005) writes that 9.2% of 1,580 screened individuals were referred to on-site mental health professionals, while only 37% of those positive turned up. [22] On top of the US public health screenings, multiple efforts are coordinated by international organizations such as the UN Refugee Agency, International Rescue Committee, World Relief etc. [23] Even though materials detailing care for female victims of sexual and gender-based violence as well as domestic violence, can be found among public health providers' resources (Wisconsin Department of Health Services) [24], no specific policies targeting refugee women and girls on federal or state level have been found in the course of this project. Intervention studies featuring group-based workshops and individual counseling among refugees are ongoing, but do not seem to focus on women. [25]

The amount of respective research shows that the US refugee policy focuses on admitting, screening and resettling refugees without particular attention to the healthcare needs of refugee women and girls and mental health needs in particular. This speaks to a larger problem voiced by Women's Commision of Refugee Women and Children (2003): "The internationally accepted definition of a refugee, which has been adopted by the United States, does not explicitly recognize gender and age as grounds for refugee protection, making the presentation of claims based on such issues particularly complex and challenging." [26] Women's Refugee Commission (2022) has defined the following challenges of the current humanitarian system: neglect of structural causes of conflict, over-reliance on one-size-fits-all approaches that do not account for differential impacts of crises, marginalization of the agency, competencies, and capacities of place-based actors, lack of accountability to affected populations. [27] Guided by the principles of the Feminist Humanitarian Network, it stresses the role of feminist place-based approaches and actors in addressing the needs of refugee women and girls by legitimizing feminist place-based experiences and knowledge, reclaiming narratives, building on the collective agencies and communities and refocusing the funding mechanisms. A separate focus is made on the impact of cash and voucher assistance (CVA) on the prevention of and response to gender-based violence (GBV) in humanitarian settings. Refugee women and girls have an unmet need in addressing their mental health problems due to cultural and structural obstacles faced by all forcibly displaced. However, as the most vulnerable and marginalized group of refugees, they also suffer from structural gender-based inequalities and barriers to care in the host countries. Feminist approaches have a capability of resolving some of these issues.

B: Child Refugees mental health issues

Refugee children are often affected by adverse and traumatic experiences. [28, 29]Continued distress can influence child's development and affect mental health, causing post-traumatic stress disorder, depression, and anxiety [30, 31]. Moreover, mental health conditions in childhood are associated with the significantly increased risk of persistence of mental health conditions in adulthood. [32] However many refugee children resettle with the family, about 200 children arrive to the US as unaccompined minor (Bridging Refuge Youth & Children's Services. 2018).

Existing evidence demonstrates that refugee children separated from parents have an increased risk for development of mental health conditions. At the same time, refugee children are less likely to access mental health services [33, 34, 29]. The Unaccompanied Refugee Minors (URM) Program was originally developed in 1980 and helps refugee children and youth in the US to receive a full range assistance and care services available. The URM programs also provide mental health services, including screenings, individual therapy/counseling, group counseling, psychotropic medication management, substance abuse treatment, and services for victims of torture.

The URM program reports the following barriers to provision of mental health services: stigma, lack of culturally and linguistically appropriate services. One of the suggested approaches to address the barriers is developing trust and support to overcome stigma associated with mental health diagnoses and treatment. Participation in mental health services was associated with positive changes as reported by foster parents. [35]

C: How does the U.S. address PTSD in refugees?

Posttraumatic stress disorder (PTSD) - is a mental disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war, combat, or rape or who have been threatened with death, sexual violence or serious injury. People with PTSD could feel intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may remember the event through flashbacks or nightmares, they may feel sadness, fear or anger. Also, they may feel detached or estranged from other people. People with the diagnosis of PTSD may avoid situations or people that remind them of the traumatic event and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch. That is why this mental disorder strongly relates with the refugee problem because those people have mostly experienced traumatic events. [36]

Studies have shown that upward of 40% of refugees, and as many as 90% of refugee children, suffer from post-traumatic stress disorder.

The leading countries by the number of refugees are from those countries: Democratic Republic of Congo (16%), Syria and Burma (15%), Iraq (12%), Somalia (11%). [37] The problem is that there are no clear and valid statistics about the number of refugees with diagnosed PTSD by country, but there are several papers which could help us to understand the perspective.

The level of PTSD diagnosis and symptoms in Bosnian refugees remained substantial 1 year after their resettlement in the United States, although there were notable overall decreases. Older refugees appeared to be at greater risk. [38]

Since 1999, almost 16,000 Kosovar refugees have entered the United States. Few studies have investigated trauma and symptoms of posttraumatic stress disorder (PTSD) in this population. In one such study, they conducted a caseworker-assisted survey of 129 Kosovar refugees (aged 18 to 79 years, 55% male). Of these individuals, 78 (60.5%) showed the likely presence of PTSD. The mean number of war-related traumatic events reported was 15 (*SD* = 4.5). Higher PTSD scores were associated with more traumatic events and female gender. [39]

Refugees are extremely vulnerable of developing the PTSD due to number or reasons, the most common of which are experience of torture, misiles explosions, war fights experience, language and cultural difficulties of the host country, financial issues and poverty, homelessness or poor accommodation and lack of employment opportunities. So as we understand now - PTSD could develop in any stages of the settlement process for the refugee. [40]

The two main interventions organized by the government on the regular basis are the most effective physiological approaches - APA and counseling psychology.
APA and the field of counseling psychology, as global leaders in mental health, have been relatively quiet on how best to serve refugees and on the impact of the current administration's ever decreasing support for refugees, both nationally and internationally. In the fall of 2019, APA first issued a policy statement in support of refugees. The Immigrant and Refugee Policy Statement documents APA's acknowledgement of the risks immigrants and refugees can endure in their journey towards safety, including violence, trauma, human trafficking, and stress, as well as the potentially damaging impact of these stressors on both mental and physical health. It also acknowledges the cruelty of separating children from their parents and threating deportation and the effects this has on mental health. The statement also calls for federal and state governments to provide funding for needed mental health and social services. [41]

Policy implications

From the previous overview, we propose policy interventions for some of the salient sources of mental health stress for each relevant demographic. That is, we focus on some of the sources of mental health stress to illustrate the application of a mix of pluralist economics.

A. Women

One of the main sources of mental health stress for women refugees in the US is the stress associated with the asylum seeking process. Therefore, we propose a policy to reduce this stress, which challenges the neoclassical assumption that these women should and will act hyper-rationally during this process.

The policy is to **reduce asymmetric information between women asylum seekers and border control**, which might increase the burden of proof on the former, undermining their emotions and experiences. For this, women refugees could be automatically registered to participate in a group interview with other women refugees, preferably from their same country. They can opt out rather than opt in, since the cost of opting in is higher than that of opting out due to perceived and real surveillance.

This policy is informed by feminist economics, which recognizes that the institutions which women navigate are not neutral, but can even be violent towards them, undermining their integrity and agency. Moreover, this policy recognizes that solidarity between women could allow them to re-establish a sense of confidence in their own experiences that would otherwise be threatened. Additionally, this policy incorporates learnings from behavioral economics by differentiating the opportunity cost of opting in and opting out.

B. Children and refugees with PTSD

Refugees could develop PTSD during any or all stages of the forced migration and settlement process. Even though the recipient country cannot undo the traumatic experiences refugees experienced before arriving, it should ensure that it reduces the burdens they face. One of the main sources of mental health stress for refugees with PTSD are the language and cultural barriers of the host country, which curtail access to basic services and to longer-term prospects in the receiving country.

Similarly, one of the main sources of mental health stress for children refugees in the US is the lack of culturally and linguistically appropriate mental health care services. Therefore, we propose a policy to reduce these linguistic and cultural barriers.

The policy is to **encourage locals to learn refugees' languages and vice versa.** To avoid placing all the burden of intercultural engagement on refugees, both refugees and locals should participate.

(1)Refugees' languages:

a- Supply-side: Hire refugees to teach locals their language. Prioritize language teachers, then teachers, and then anyone who is willing to teach. This provides jobs and empowerment.

b- Demand-side: Provide conditional cash transfers to locals (e.g. those working in businesses nearby the refugee entry zones, healthcare workers, etc) who attend these language classes. Provide larger cash transfers to those that learn the most, based on the refugee teacher's judgment.

(2)Receiving country's main language:

a- Supply-side: Hire teachers of the local language. Prioritize refugees who know this language, then locals. If hiring refugees, this provides jobs and empowerment. If hiring locals, this hinders the view that refugees are detrimental to the local economy.

b- Demand-side: Provide conditional cash transfers to refugees who attend these language classes. Provide larger cash transfers as they continue attending, and larger cash transfers as they advance language levels.

(3) Intercultural exchange: Hire refugees from different countries to cook for the refugee community. Prioritize cooks. Provide infrastructure for it. Pay them by time rate, but provide bonuses if they refer someone to attend a healthcare center (and they do).

Children would benefit from more exposure to bilingual interactions, but they should not be expected to follow up with learning a new language as adults. Moreover, the economic incentive would not, and should not, work for them. That is why there must be other ways of incentivizing them to express their feelings and experiences with trained therapists. For this, instead of one-on-one counseling sessions, children would benefit from a group play-oriented setting, accompanied by their parent(s) or guardian, if any.

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