Socioeconomic and Political Determinants of Mental Health of Middle Eastern Refugees

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Abstract

The refugee crisis in the Middle East is the largest and most pressing displacement crisis of our time. As the crisis unfolds, it is clear that a majority of asylum seekers and refugees are encumbered by mental health stress due to the traumas suffered throughout the conflicts they fled. It is crucial to understand the socioeconomic and political determinants of mental health that refugees are subjected to through displacement in order to elevate the quality of healthcare and to pursue better mental health outcomes. Refugees contribute to host nations' workforces, whilst endeavoring to integrate into their societies. Yet mental health stress and its stigma hinder the rehabilitation of those who fled persecution. Establishing a better understanding of refugee mental health allows healthcare professionals and policy makers to provide better care for these populations by developing effective measures that support rehabilitation. The aim of this study is to analyze the socioeconomic and political determinants of mental health of refugees in the Middle East through a review of the existing literature, in conjunction with my observations and experiences serving as a medical assistant in U.N. High Commission for Refugees (UNHCR) clinics in the Hashemite Kingdom of Jordan. Results indicate that mental stress affects refugees not only during the course of displacement, but also during the asylum seeking process, further demonstrating a need for revised measures. Therefore, I suggest future directions in healthcare protocols and policy making that would improve the quality of life and the mental health of refugees and asylum seekers.

Keywords: *determinants of health, refugee mental health, UNHCR, rehabilitation*

Introduction

In the study of health and society, few demographics elucidate the importance of social factors in garnering good health more than refugee populations. It is abundantly clear that the social determinants of health that affect all individuals around the world are further pronounced within refugee populations, who are overwhelmingly underserved in various facets of their lives. In my experiences with refugees and their access to healthcare, I found that some of the most pressing questions arise with respect to refugee mental health, which is complicated by poverty, minimal advocacy, and other social factors. Therefore, I study the effects of a number of social factors on the mental health of refugees displaced from the Middle East and residing both inside and outside of the Middle East, and I hope to present a compelling case for the plight of refugees as well as policy suggestions that would benefit their mental health outcomes and quality of life.

The United Nations High Commission for Refugees (UNHCR) has made a pronounced effort to quell the misery experienced by refugees displaced from their countries of origin due to war and poverty within the Middle East. However, the immense volume of refugees, coupled with the limited nature of international aid, leaves most efforts focused on maintaining the simplest of living conditions for these populations. Therefore, we find the studies conducted on the health of refugees to be predominantly quantitative, due to a shortage of personnel able to dedicate the countless hours needed to spend time with these refugees to gain a better understanding of topics like refugee mental health. Through my personal experiences in the refugee clinics of the Hashemite Kingdom of Jordan, wherein I spent seven months familiarizing myself with some of the mental health issues of these populations, and having spent the majority of my life in the Middle East, I bring a new perspective to the studies conducted by the UNHCR

and other humanitarian organizations through my ability to transcend cultural and linguistic barriers, given my Middle Eastern background and fluency in the Arabic language. In addition to the myriad of quantitative data available regarding the health outcomes of refugees, my experiences provide me with an ability to view the available data from the eyes of refugees, and allow me to ask and answer specific questions that further elucidate the plight of refugees and their mental health.

Understanding the mental health of refugees, and the determinants that alleviate or further harm these populations in their pursuit of quality healthcare and better mental health outcomes is greatly significant, as its implications are humanitarian, socioeconomic, and political. The reality of the existence of refugees externally displaced from their countries of origin is that they often contribute to the host nation's workforce and integrate into its society. Establishing a better understanding of the mental health of refugees will allow physicians and social workers to provide better care for these populations, allowing them to be more productive members of society and increasing their likelihood of full rehabilitation. I hope to bring together the various facets of this issue in a synthesis of information that provides scholars with a framework through which to understand the issue, and groundwork on which to continue building our efforts to support refugees and bolster their mental health outcomes.

Throughout this thesis, I explore quantitative and qualitative data presented within existing literature, and analyze this data through the lens of my clinical experience in the refugee clinics of the UNHCR in the Hashemite Kingdom of Jordan. I documented common themes of the healthcare encounter over the course of my service, and reference these lessons learned where relevant.

Background

History of Refugees and Asylum Seekers

Oral histories, artistic expressions, and written documents tell the stories of groups of people who relocated from lands they would describe as their home for a multitude of reasons, ranging from a lack of resources and opportunity to violence that made life so unbearable that these groups found no recourse but to upend their lives, often leaving behind loved ones whom they would never see again. Yet until modern history, these were realities of life that were often necessary and therefore accepted.

Leading into the 20th century, concepts of self-determination were propagated by the intellectual and the layman, and were opposed by imperialists and others with vested interests in maintaining the status quo. As self-determination and similarly liberating manifestos were beginning to be preached and practiced in some parts of the world, other parts were torn by a war we would come to call the First World War, or WWI.

After the end of WWI, a pressing issue began to come to the forefront of the international stage. Individuals fleeing the Russian revolution posed a unique dilemma to the international community, seeing as the world had recently undergone a conflict that revolved around the concept of sovereignty, which caused an upsurge in nationalism and isolationism (Department of International Protection, 2005). These groups desperately needed asylum from persecution and poverty, but the tide of nationalism gave way to isolationist attitudes, and the question quite simply was, “Where do they go, since nobody wants them?” In 1920, an international, global body was commissioned to prevent global fallout of the scale of WWI from happening ever again; this body was called the League of Nations.

Although short lived, the League of Nations benefited the world by establishing the Office of the High Commissioner for Russian Refugees, the first initiative of its kind and scale that operated on an international level (DIP, 2005). From 1921 to 1930, the High Commissioner, Dr. Fridtjof Nansen, and his office worked diligently to provide refugees not only with the resources to legally immigrate into host countries, but also the tools to establish roots through employment so that they could lead productive, healthy lives (DIP, 2005). After the asylum seekers from Russia were cared for, Nansen continued his service through relocating individuals who were displaced by the fall of the Ottoman Empire, and further established the concept of assisting refugees by working to bring countries that were previously opposed to hosting refugees into the fold (DIP, 2005). His influence lived on past his death in 1930, and by 1938, the office of the High Commissioner for Refugees was established. Although limited by the Second World War and the subsequent disbandment of the League of Nations for its failure to prevent WWII, this office was in operation until 1947 when it was replaced by the International Refugee Organization, or the IRO (DIP, 2005).

The IRO aspired to tackle all aspects of refugee lives, from registration and determination of status to repatriation and resettlement. However, due to a dwindling budget, lack of international support, and growing tensions surrounding the perceived inconvenience of accepting refugees, the IRO was doomed for failure and disbanded in 1951 (DIP, 2005). After numerous debates and compromise from the member states of the United Nations, the United Nations High Commission for Refugees (UNHCR) was launched at the beginning of 1951 as a subsidiary organ of the General Assembly on a three-year trial basis. The core mandate of the UNHCR was simply to provide refugees with non-political, humanitarian aid and resources to find permanent solutions by way of resettlement into host nations (DIP, 2005). Over the course

of the coming decades, the mandate of the UNHCR was renewed by each session of the General Assembly, until 2003 when it was authorized with a broad mandate to serve until all refugee crises around the world are deemed settled (DIP, 2005).

A key concept in refugee aid, firstly established by the UNHCR, is the international protection of refugees. The international protection of refugees is a process that begins with the resettlement of a refugee into a host country, includes the achievement of equal rights under the law for the individual, and ends only when a permanent, humane solution is found for the individual that allows them to live in peace and dignity (DIP, 2005). Over time the UNHCR's scope has been expanded to include assistance programs and humanitarian aid delivery not only to refugees, but also to stateless and internally displaced people. These individuals fall into the category of persons of concern, which will be elaborated on below. As of June 2018, the UNHCR reports that 68.5 million people around the world are forcibly displaced and reside outside of their native homes. Although a number of different bodies exist within the United Nations to serve specific groups of refugees and asylum seekers, the UNHCR continues to be the United Nations' leading body intended to serve refugees (UNHCR, 2018).

Classifications of Refugees and Asylum Seekers

It is important to note the difference between asylum seekers and refugees. Asylum seekers are individuals who seek international protection from conditions within their home country, but whose legal status has yet to be determined, while refugees are individuals who have been forced to flee their home due to violence or persecution, most often without warning or recourse (DIP, 2005). By 1951, the number of refugees reached record highs, which led to the establishment of the principal definition of a refugee in the 1951 Convention. The 1951 Convention set out to establish the definition of a refugee in the form of clauses that serve as

parameters to be used in evaluating asylum seekers for refugee status and determining their need of international protection (DIP, 2005). These clauses consist of inclusion, exclusion, and cessation clauses, and outline the basis of eligibility for refugee status, the grounds on which refugee status can be denied, and the conditions under which refugee status comes to an end (DIP, 2005). Article 1A(2) of the 1951 Convention states that a refugee is any person who:

> Owing to 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; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (DIP, 2005)

According to this inclusionary provision, the following five criteria must all be met for the UNHCR to consider an asylum seeker qualified for refugee status: "… well-founded fear; persecution; belonging to a minority race, religion, nationality, or social or political group; outside nationality or former residence; or inability or unwillingness to seek protection from the country of residence for fear of persecution" (DIP, 2005). UN officials evaluate these conditions both subjectively and objectively to best determine whether an individual needs international protection and the aid of the UNHCR.

In evaluating well-founded fear, both subjective and objective elements are taken into account. Subjectively, asylum seekers are scrutinized based on the statements they make to evaluators as well as their behavior and demeanor to judge whether or not they are truly fearful of returning home. Objectively, the social, economic, and political conditions in the asylum seeker's home country or region are judged, and these conditions alone may qualify an

individual for refugee status. However, some countries will refuse refugee status to an individual who has found some temporary refuge in a different part of the home country, citing a provision on “internal flight or relocation alternative” that contends that if the well-founded fear stemmed from non-state actors in the part of the country that the individual is now free from, then they no longer have a reasonable claim of fear and do not qualify for international protection (DIP, 2005). This can often perpetuate the refugee crisis in the area, as these individuals find themselves in a state of limbo, internally displaced within their country and unable to return home or to reestablish roots elsewhere due to a lack of socioeconomic or political resources.

The definition of persecution is purposely left out of the 1951 Convention to allow for flexible interpretation; however, persecution is understood to be the use of violence or the threat of violence against an individual or group of people, often in a systematic, institutionalized manner by either governments or non-state actors (DIP, 2005). In some instances, such as civil war crises, the government may condemn one group for persecuting another, but will have no power to assist the persecuted if they reside in rebel territory, which allows them to qualify for international protection. Discrimination is not to be confused with persecution, which has the added element of violence, but particularly severe cases of systematic discrimination can be considered forms of persecution (DIP, 2005). Moreover, the threat of persecution due to an individual’s alignment with a minority race, religion, nationality, or social or political group qualifies an individual for refugee status.

The fear of persecution can also arise while the individual is outside of their home country, due to changes within their home country that subsequently present a well-founded fear of returning home. In these cases, these asylum seekers are considered stateless individuals, or “sur place refugees,” and do not refer to their country of origin as their home country but as their

"country of past habitual residence" (DIP, 2005). This further highlights the roots of persecution within countries with civil conflict, where the individual is unable to seek the protection of their government because the government itself is persecuting its citizens, is turning a blind eye on non-state actors' persecution of groups, or is incapable of providing necessary protection.

The five aforementioned provisions must all be met for an individual to qualify for refugee status, which often leaves out asylum seekers in unique situations, a commonplace phenomenon for people in regions of conflict. Moreover, there exist exclusion clauses that could result in a refusal of refugee status, even if the individual meets all inclusion clause provisions.

Within the exclusion clauses of the 1951 Convention lie provisions that disqualify an individual from being given refugee status under the UNHCR, pursuant to a lack of foundation for their need of international protection (DIP, 2005). One of these provisions is having access to protection under a different United Nations body than the UNHCR, such as the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), which is the only body of its kind presently (DIP, 2005). Another one of these exclusionary provisions is being deemed an equal resident of another country in which an individual takes residence by the government of that country. In this case, refugee status is deemed unnecessary and is therefore denied. The last exclusionary provision is for people undeserving of international protection, and applies to individuals who are determined to have committed any of the following acts: "… a crime against peace, a war crime, or a crime against humanity; a serious non-political crime outside of the country in which they are seeking refugee status; or any acts deemed contrary to the principles and objectives of the United Nations" (DIP, 2005). These provisions may be clearly articulated and understood, but very careful consideration is given in cases invoking the use of Article 1F, the exclusion clauses, as denying refugee status to an individual oftentimes

leads to grave consequences for the refused asylum seeker. Moreover, every individual in a group is entitled to individual consideration, and nobody is punished for the misdeeds of others within their group if they were not complicit in the acts. Article 1F is used sparingly due to the possibility of resulting in grave consequences, such as in situations of genocide, wherein aggressors may claim to be victims of persecution to qualify for refugee status. For example, in genocide, aggressors could join groups of victims in an attempt to blend in and be resettled in a Western country. Yet these aggressors are not denied refugee status because of a lack of information on the rapidly developing conflict, and due to the risk of denying asylum to an innocent individual and leaving them to become a victim of genocide.

The 1951 Convention also establishes the process by which an individual, who has been previously granted refugee status, is deemed to no longer require international protection, and is therefore no longer eligible for refugee status. Under the cessation clauses, detailed in Article 1C, refugee status ends when an individual meets any of the following conditions: "… voluntarily accepts the protection of their country of nationality; voluntarily reacquires nationality after losing it; acquires a new nationality and gains equal protection under the country's laws; voluntarily re-establishes themselves in the country from which they fled because of the fear of persecution; change in the political conflict from which they fled, allowing for a return to the home country and gaining the protection of the government; or change in the political conflict from which they fled, which forces a stateless individual to accept the protection of the government and to subsequently return to their country of habitual residence" (DIP, 2005). The provisions of the cessation clauses allow for individuals to petition a specific review of their case in situations where entire groups of people are deemed to qualify for "ceased circumstances" and are determined to no longer require international protection (DIP, 2005).

Situations that may warrant an individual to keep their refugee status after changes allow for their safe return to their home country include instances of severe torture, whereby a great psychological trauma remains despite the end of the crisis, and the refugee's return to their home country could be troublesome for their mental health (DIP, 2005).

Although the definition of a refugee has been established by the UNHCR, and is often directly translated into law within the national governments of member states of the United Nations, nations are able to expand on the definition of refugees under their laws in order to widen the scope of protection to others who do not fit the definition of refugee as per the 1951 Convention (DIP, 2005). Sovereign states may choose to expand their definition to include returnees, stateless individuals, and internally displaced people. Although these individuals do not fit the established definition of refugees, they too may receive assistance from the UNHCR. Returnees, or individuals who were formerly refugees but voluntarily return to their home country, are assisted and monitored by the UNHCR in order to ensure that the standards of treatment upon their return are dignifying and their human rights are upheld (DIP, 2005). Stateless individuals are also assisted by the UNHCR, which is the only international body with a mandate to serve and protect the stateless, given that they are not entitled to any rights afforded to citizens of nations (DIP, 2005). In concordance with resolutions passed by the General Assembly of the United Nations, the UNHCR endeavors to protect the rights of the stateless and works to urge nations with whom a stateless individual may have any ties to grant them citizenship and equal protection under their laws.

Internally displaced people are similar to refugees, but differ in that they fled from one part of their country to another part of the same country, as opposed to refugees who fled the country entirely. This makes for a tricky situation, as they often continue to be citizens of a

sovereign state, yet require assistance from the United Nations. The UNHCR achieves this through assistance initiatives in conjunction with other agencies of the United Nations, under the direction of the UN Emergency Relief Coordinator (DIP, 2005).

Clinical Service and Lessons Learned

My clinical service as a medical assistant in UNHCR refugee clinics began in February 2017 and ended in August 2017. Over the course of this period of time, I served as a medical assistant to three physicians permanently employed in the clinics, which operate under the direction of the UNHCR, and more specifically a subdivision in charge of refugee health services in the Kingdom of Jordan called the Jordan Health Aid Society International (JHAS-I). The clinics I served in serviced both asylum seekers and refugees, so long as they are registered with the UNHCR. Moreover, due to the high demand for medical attention and scarce human resources, I evaluated upwards of a hundred patients a day myself, and was supervised by an attending physician who also serviced patients. My tasks ranged from taking histories and sorting out the documentation of patients, to phlebotomy (blood-draws) and laboratorial work, to primary assessments and patient follow-ups. In all instances of my service, I worked within my scope of practice as an EMT-Basic, and deferred to my supervising physician any patients for whom I was ill suited to provide care. A year prior to my service, I prepared for this position by undertaking the Emergency Medical Technician – Basic (EMT-Basic) training in Austin, Texas, and registering as an EMT-Basic in the State of Texas. Over the course of my clinical training as an EMT, I focused my efforts on learning the nuances of patient interaction and advocacy, in order to prepare for my responsibilities as a medical assistant to asylum seeking and refugee patients.

Through focused application of my skillset to my clinical service as a medical assistant, I was able to confidentially note the themes of my patient interactions, and I use these lessons learned to complement my exploration of existing literature. As a native speaker of English and Arabic, as well as being an ethnic Palestinian (culturally nearly identical to both the Jordanian

hosts and the Middle Eastern refugees), I was able to engage with my patients and my supervisors without a language or culture barrier. My ability to directly communicate with my patients in their native tongue allowed me to establish trust and rapport in their healthcare encounter and in our dialogue of their experiences as refugees. This ultimately allows me to most aptly translate the essences of their struggles within the asylum seeking and refugee system, and to elucidate how these struggles affect their mental health outcomes.

Although a myriad of insights were made through the course of my service, all of which inform my analysis of the existing literature investigated in this thesis, my five most notable themes are synthesized into Table 1. I will reference this table over the course of this thesis, as these lessons provide real-life themes of the experiences of refugees that were most evident.

Table 1. Clinical Service - Lessons Learned
Lesson 1: Conditions most frequently observed in healthcare encounter: **a)** acute illness, **b)** non-communicable diseases, and **c)** anomalous cases.
Lesson 2: Many ailments encountered are rooted in a lack of health literacy, which **a)** facilitates or **b)** exacerbates disease.
Lesson 3: Deep-rooted distrust of the healthcare system is ubiquitous, and subsequently the healthcare encounter is characterized with **a)** low patient expectations and **b)** lack of patient participation, both of which lead to worsening health outcomes.
Lesson 4: A common theme expressed amongst patients is **a)** a lack of concern about the politics of the crises that led to their displacement; instead, **b)** patients commonly expressed a yearning for basic dignity and opportunity for their families and children.
Lesson 5: Due to the cultural stigma against expressions of psychological distress, male patients specifically were **a)** most often negligent or in denial of their deteriorating mental health outcomes, and were **b)** often referred for a psychological evaluation by a concerned female relative (wife or daughter, who were more open about mental illness).

The lessons detailed in Table 1 are integral to an effective understanding of the determinants of mental health of Middle Eastern refugees. Every ethnic and cultural group is multifaceted in its own ways, and the same applies to Middle Eastern refugees and

asylum seekers. Therefore, understanding literature detailing the conditions of Middle Eastern refugees can be a powerful tool if the literature is contextualized in the real life experiences of these populations specifically. My observations largely reinforce existing conclusions presented in literature, and further provide nuanced insights into the experiences of refugees and asylum seekers. Through the lessons articulated in Table 1, I will complement the existing literature pertinent to refugee and asylum seeker mental health, and will propose policy interventions that are specifically reflective of the needs of Middle Eastern refugees and asylum seekers.

Methodology

A plethora of informative sources exist on the vastness of the Internet, yet steps were taken in the writing of this thesis to obtain reputable, relevant information and data. To begin consolidating sources, PubMed and Google Scholar were used to search for articles in peer-reviewed journals with keywords that are relevant to this field of study. Some of the keywords used were: determinants of health, refugee health, refugee mental health, UNHCR, refugee rehabilitation. PubMed and Google Scholar were used to search for scientific and non-scientific sources of similar importance, such as peer-reviewed scientific studies, and policy briefs and studies from organizations such as the United Nations, World Health Organization, and other key players in this field of study. The sources used in the writing of this thesis can broadly be classified into three categories: case studies, policy studies, and multivariate data analysis studies.

Although no one source must encapsulate every element of the following criteria, these criteria were helpful in establishing the integrity and relevance of sources:

1. The source elucidated relevant information about a subtopic of the field of study.
2. The source provided a previously unexplored perspective on an established policy or intervention.
3. The source focused on elements within the study of refugee health that directly or indirectly affects the mental health of Middle Eastern refugees and asylum seekers.
4. The source is published in a peer-reviewed journal, by a governmental agency, or by a well-reputed non-governmental organization.

In addition to the aforementioned sources, my personal field notes, chronicled over the course of my service in UNHCR refugee clinics in the Hashemite Kingdom of Jordan from February 2017 to August 2017, are used to provide a more humanistic, personal, and holistic understanding of the somatic and mental health conditions of Middle Eastern refugees. The thematic lessons learned are consolidated in Table 1 and will be referenced throughout the thesis.

Literature Synthesis and Findings

According to a policy brief published by the European University Institute (EUI), public attitudes towards refugees are epitomized by the Syrian refugee crisis and the subsequent mass migration into the neighboring Kingdom of Jordan (Achilli, 2015). In fact, Secretary-General of the United Nations António Guterres has declared:

> Syria has become the great tragedy of this century, a disgraceful humanitarian calamity with suffering and displacement unparalleled in recent history. (Achilli, 2015)

The Syrian Civil War has set itself apart from other crises around the world in the refugee crisis it has developed (HRW, 2017). I still remember visiting Syria as a child, before the Syrian Civil War. The history and beauty of Damascus and Homs were apparent to anyone who entered the ancient cities. Since 2011, however, Syria has been overwhelmed by a civil war between the Sunni majority population and the Alawite minority government led by Bashar Assad, the dictator of Syria (HRW, 2017). Assad has refused to loosen his grip on his power for the past eight years, and instead has inflicted upon his citizens a litany of cruel conditions, ranging from persecution to full-blown attacks with chemical weapons, indiscriminately eliminating anyone in his path (HRW, 2017). Moreover, these conditions have led to a political vacuum that allowed the development of ISIS, a multinational terrorist organization that joined the conflict and led to a number of destabilizing forces meddling in the region, such as the United States and Russia (HRW, 2017). The Human Rights Watch reports, “The race to secure territory and consolidate gains [by opposing forces] was accompanied by grave violations of human rights and humanitarian law that have come to characterize the Syria conflict” (HRW,

2017). Ultimately, the Syrian refugee crisis is the largest of the refugee crises that have characterized the Middle East, and Syrian refugee populations can serve as effective models of Middle Eastern refugees.

Attitudes Towards Asylum Seekers and Refugees

Although general attitudes towards refugees and asylum seekers differ around the world, it is clear that some of the same concerns regarding the resettlement of these populations into a host country are conserved from one nation to the next (Norredam, Mygind, & Krasnik, 2006). These concerns can be broken down into concerns by host countries' governments and host countries' private citizens. Understanding the attitudes of host countries' governments and private citizens towards refugees is integral to understanding the socioeconomic and political determinants of refugee mental health, as these attitudes translate into ineffective policies and interventions that contribute to mental stress, and subsequently exacerbate mental health concerns for refugees.

The UNHCR estimates that 5.6 million refugees have been displaced from Syria since 2011, most of whom have fled to neighboring countries such as Jordan, Lebanon, Turkey, and Iraq (UNHCR, 2018). This number only partly touches on the calamity of the conflict: 13.1 million Syrians are considered "in need," 6.6 million are internally displaced, and 2.98 million are in "hard-to-reach and besieged areas" (UNHCR, 2018).

Although Syrian refugees often live in dire circumstances irrespective of the host countries they find themselves in, the refugees in the Kingdom of Jordan characterize the displacement epidemic, with 93 percent of the population living under the poverty line (UNHCR, 2018). As of April 2018, over 655,000 Syrians are registered with the UNHCR in Jordan (UNHCR, 2018). This large influx of refugees has been significantly impactful to Jordan, which

already suffered from limited national resources. Just in 2015, the Syrian crisis cost the Kingdom $1.2 billion, with estimates of $4.2 billion by 2016 (Sharp, 2016). Although more recent expenses have not been published, the costs have been incredibly detrimental to the Jordanian economy and are expected to continue rising as the crisis remains unmitigated.

The policy brief published by the European University Institute (EUI) details some of the effects of the Syrian refugee influx on the structural vulnerabilities of Jordanian society; for example, "The influx of refugees has increased intolerably the demand on school, sanitation, housing, food, energy and water" (Achilli, 2015). Moreover, given that the majority of refugees are not housed in refugee camps, and instead rent in the private housing sector, there has been an incredible amount of strain placed on the national housing sector. In areas with a high density of refugees, such as the capital city of Amman, where 28 percent of refugees have settled, housing rent prices have tripled (Achilli, 2015). This has placed considerable strain on Jordanian families, who are generally working class and live in rented housing (Achilli, 2015). Refugees are often able to meet these inflated rent costs by living with multiple families, as they are forced to settle for a lesser quality of life. However, this phenomenon has created social tensions between Jordanians and refugees, as Jordanians attribute their financial burdens to the influx of refugees. Whereas Jordanians were by and large welcoming hosts at the outset of the Syrian crisis, the general populace is now increasingly resentful of refugees. Moreover, refugees desperate for work have been willing to undercut the Jordanian workforce on wages, and are perceived by Jordanians to be directly responsible for the rising unemployment rate (Achilli, 2015). According to a 2015 study published by the International Labour Organization (ILO), a number of key factors are in play with respect to the labor market in Jordan (Stave & Hillesund, 2015). While almost 100 percent of Jordanian children are enrolled in school, only 65 percent of Syrian

children are (Stave & Hillesund, 2015). This is likely attributed to Syrian refugees' need for wages, which forces families to discontinue primary education for their children in lieu of work, contributing to a growing child labor issue (Stave & Hillesund, 2015). In my experience, this necessity weighs heavy on the minds of refugee parents, most of who would far rather see their children educated and successful. The desire to establish a life of dignity and opportunity for one's family is something I heard reiterated by refugees on a daily basis. I detail this in Lesson 4 of Table 1, as it is the worldview of many refugee parents. This lesson informs our understanding of much of the mental stress that refugees face at the prospect of failing their families. To further illustrate the mental stress experienced by refugees, the ILO found that although the Jordanian labor force participation rate has remained unchanged since the Syrian refugee crisis, the Jordanian unemployment rate has increased from 14.5 percent to 22.1 percent (Stave & Hillesund, 2015). This phenomenon contributes to the hostilities between the Jordanian populace and refugees, and has sparked a number of national protests (Stave & Hillesund, 2015). These conditions and tensions elucidate the ongoing mental stress faced by refugees, most of whom find no security in housing, work, or their relationship with the host populace.

Host Nations' Asylum Seeking and Refugee Policies

As the refugee crisis in the Middle East continues to grow, host nations around the world have adopted policies that are at best ineffective and at worst explicitly harmful to refugees. These policies continue to exacerbate the mental stress experienced by refugees, and contribute to a cyclic deterioration of their mental health outcomes (Robjant, Hassan, & Katona, 2009). In Lebanon, for example, refugees represent upwards of 30 percent of the population of the country (Blanchet, Fouad, & Pherali, 2016). This enormous burden is borne in part by the civilian population, since the Lebanese government has banned the construction of refugee camps

(Blanchet, Fouad, & Pherali, 2016). Therefore, refugees live in the general population, and the aforementioned social and economic effects found in Jordan are similarly seen in Lebanon, and are especially negatively affecting the healthcare system in Lebanon, which is under strain due to the large influx of refugees (Blanchet, Fouad, & Pherali, 2016).

According to the aforementioned EUI study, national policies regarding asylum seekers and refugees in the Middle East have been subject to adverse changes as the Syrian crisis progressed (Stave & Hillesund, 2015). At the outset of the crisis, the Jordanian government adopted an open-border policy and took a strong stance in favor of humanitarian assistance towards their Syrian neighbors (Achilli, 2015). This is attributed to the strong cultural and ethnic ties between Jordanians and Syrians. In fact, the Kingdom of Jordan and the Jordanian people have earned international praise for their embrace of refugees from neighboring countries for decades. My family, for instance, immigrated to Jordan from Palestine as refugees many decades ago, and have found in the Kingdom a second home. However, the enormity of the Syrian crisis has recently caused a change in the Kingdom's open-border policy, as Jordanian citizens began to experience the strain of the massive influx on their economy (Achilli, 2015).

Although the Jordanian government has maintained that there have been no changes in the Kingdom's official policies, the UNHCR has asserted on a number of occasions that "local authorities have refused to let refugees cross the border" (Achilli, 2015). Moreover, humanitarian organizations such as Amnesty International and Human Rights Watch report instances of "refoulement," or forcing refugees to return back to Syria, an act that explicitly violates the UN mandate of International Protection (HRW, 2019). Instances such as this have led to a growing fear within refugees in Jordan and around the world of being unlawfully forced back to Syria or their respective country of origin, where persecution and even death may be imminent.

On the 14th of July 2014, the Jordanian government instructed the UNHCR to cease issuing Asylum Seeker Certificates (ASCs) to refugees who leave their designated camps or enter the country without the proper documentation, a move that many refugees find themselves making for lack of a better option (Achilli, 2015). This policy has been incredibly detrimental to refugees, as they are unable to access UNHCR services and resources such as cash stipends and food assistance without ASCs (Achilli, 2015). Devastatingly, this policy also applies retroactively to individuals who violated its conditions before it was passed or even proposed. Such changes in policy have resulted in an increase in the vulnerability of the refugee population, and a subsequent increase in negative practices in order to survive, such as dangerous work conditions and working without a permit (Achilli, 2015). An ILO study found that almost half of refugee families in Jordan have at least one child who works, oftentimes in deplorable conditions and for low wages (Stave & Hillesund, 2015). These families resort to such extremes out of a lack of options, and this contributes to the deterioration of mental health outcomes for both the children and their family members (Robjant, Hassan, & Katona, 2009).

Implications of Detention Policies: Deteriorating Mental Health Outcomes

While some policies practiced by host countries create conditions that have a downstream negative effect on the mental health of refugees, other universally practiced policies are directly responsible for significant mental distress of horrifying proportions. For example, the practice of detaining asylum seekers, most of who apply for refugee status through legal channels, has seen a sharp increase globally (HRW, 2019). Although governments that engage in this practice claim that this allows them to judiciously evaluate each asylum seeker's petition for refugee status, a number of studies that are explored in this section have found that the detention of asylum

seekers is a practice that places undue stress on these individuals, and is directly responsible for the deterioration of their mental health (Robjant, Hassan, & Katona, 2009).

A 2009 study published in *The British Journal of Psychiatry* evaluated both quantitative and qualitative sets of data describing the detention of children, adolescents, and adults, and came to the conclusion that this practice exacerbates mental stress and is associated with worsening Post-Traumatic Stress Disorder (PTSD), Depression Disorders, Anxiety Disorders, and other mental health disorders (Robjant, Hassan, & Katona, 2009). This is far from a novel revelation, given that studies conducted decades prior have warned of the negative consequences of detention on the mental health outcomes of detainees. In a 1991 study published in the *Psychiatric Bulletin* investigating Palestinian detainees, researchers found that the time spent in detention was shown to be positively correlated with worsening mental health outcomes and have led to self-harm and even suicidal ideation (Bracken & Gorst-Unsworth, 1991). Moreover, recent evidence points to an alleviation of mental health status upon release from the detention centers, confirming the negative environmental stressors existing within these centers (Steel et al., 2006). As if the strain placed on asylum seekers in detention centers is not enough, the Home Office of the United Kingdom has reported that in 2005 roughly 59 percent of asylum seekers that spent extended periods of time in United Kingdom detention centers were deported at the end of the process, having been deemed "failed asylum seekers" (Heath, Jeffries, & Pearce, 2006). Although the British government and other governments purport to oppose the detention of asylum seekers with mental health disorders as per the policies of the Home Office or the respective governmental department, studies conclusively show great evidence to the contrary.

Furthermore, in a 2001 observational study of 33 detainees in Australian detention centers, all of whom had spent at least nine months in detention as per the criteria for the study,

researchers found that detainees experienced “grave ongoing psychological injury” (Sultan & O’Sullivan, 2001). The sample used included 89 percent of the target population, and is therefore considered to be highly representative of the entire detainee population (Sultan & O’Sullivan, 2001). Among the detainees observed, 85 percent reported chronic depressive symptoms, 65 percent reported suicidal ideation, 39 percent were experiencing paranoid delusions and 21 percent showed signs of psychosis. In addition, 57 percent of participants required psychotropic medication (Sultan & O’Sullivan, 2001).

Accurately quantifying the mental stress effects of detention on asylum seekers is difficult due to the prevalence of pre-existing mental health problems as a result of the stresses experienced in the conflicts that lead to the displacement of these individuals. However, by way of comparing the rates of mental health problems between refugees who are by definition granted asylum in a host country and asylum seekers who are held in detention, it is clear that asylum seekers in detention exhibit greater rates and severity of mental health detriments. The differences in mental health status between refugees and asylum seekers held in detention, coupled with the aforementioned finding that duration of detention is positively correlated with worsening mental health outcomes, strongly points to the conclusion that detention is gravely affecting the mental health of those individuals the international community has a mandate to protect.

In a study conducted on the mental health outcomes of Persian-speaking asylum seekers who were held in Australian detention centers, it was shown that the mental health outcomes of asylum seekers continued to deteriorate even after release, specifically if this release was predicated on a temporary asylum status through temporary protection visas (TPVs) (Momartin et al., 2006). When comparing individuals with TPVs against individuals with permanent

protection visas (PPVs), those granted TPVs were held in detention for one year on average, while those with PPVs were not detained (Momartin et al., 2006). Using univariate analyses, which are statistical tests that were used to compare the two sets of data to find associated differences in mental health outcomes, researchers found that those who experienced detention presented with significantly worse anxiety, depression, PTSD, and general distress (Momartin et al., 2006). The study enforces selection criteria to ensure that the statistical analysis performed accounts for and neutralizes the factor of pre-migration trauma, and therefore supports the conclusion that detention is in fact responsible for the worsening mental health outcomes of asylum seekers (Momartin et al., 2006). Further univariate analyses demonstrate that while any extended detention of asylum seekers leads to worsening mental health outcomes, the negative effects are especially pronounced in those who are detained for more than six months as compared to those who are detained for less than six months (Momartin et al., 2006). This should inform policy makers on the time-dependent effects of detention in situations where asylum seeker detention is deemed necessary.

In an independently conducted longitudinal study published in *The British Journal of Psychiatry* that sought to evaluate the mental health outcomes of detainees over time, the findings were consistent with the aforementioned Australian studies (Keller et al., 2003). Researchers evaluated the baseline mental health statuses of a sample of 70 detainees who had on average spent five months in detention at the outset of the study (Keller et al., 2003). After 101 days, a follow-up evaluation of the detainees showed significant differences between those who were still in detention and those who were released (Keller et al., 2003). Seventy percent of those still in detention subjectively reported a deterioration in their mental health. Moreover, clinical results demonstrated worsening depression, anxiety, and PTSD in the sample, at rates of

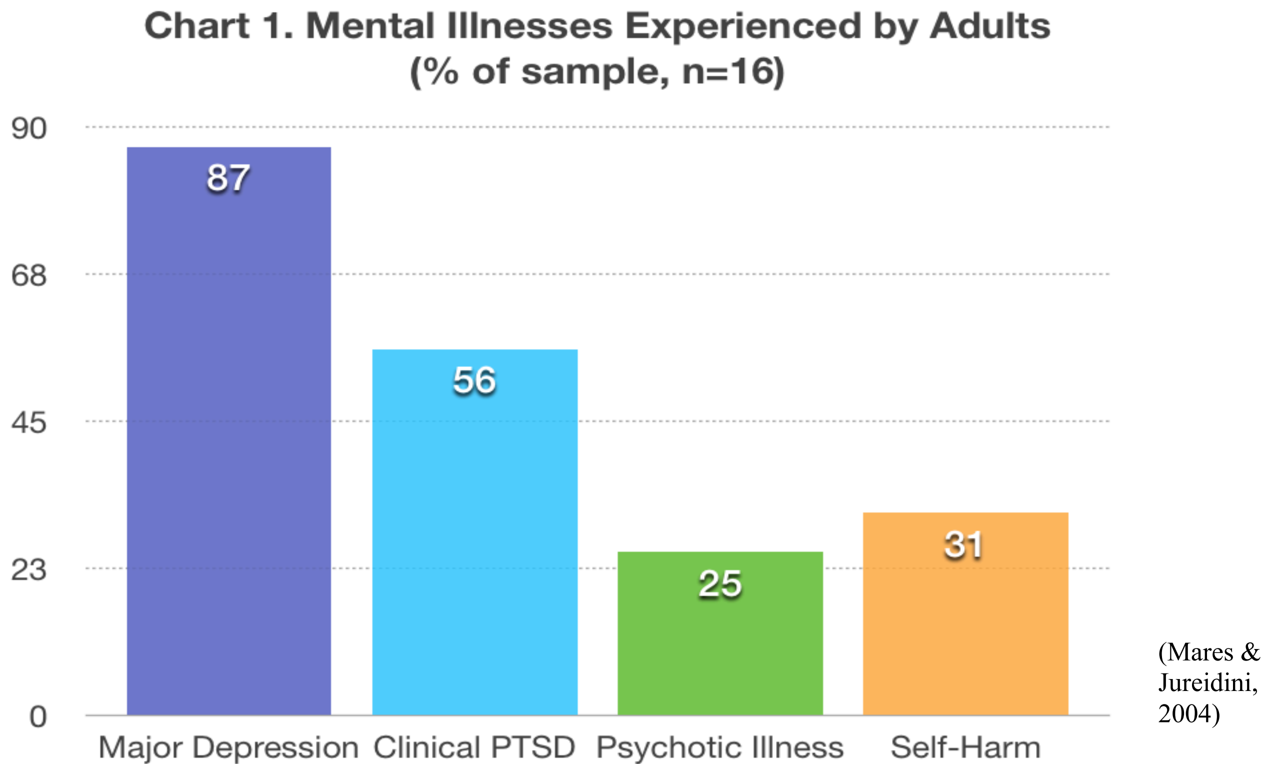
86 percent, 77 percent, and 50 percent, respectively (Keller et al., 2003). When comparing the two samples (those still in detention and those who had been released), independent sample t-tests were employed to test for objective, statistical differences. At baseline, there were no differences between the two samples; however, the difference at follow-up was significant, with reduced symptoms in those who had been released and worsened symptoms in those still in detention (Keller et al., 2003).

To better understand the psychological effects of detention that lead to worsening mental health outcomes, a unique study was undertaken by Pourgourides et al. in 1996, and reexamined by Robjant et al. in 2009. By conducting in-depth interviews with 15 detainees in both private and group settings, Pourgourides et al. were able to establish a grounded theory of how and why detention leads to such mental health detriments, as summarized by Robjant et al. in the following excerpt:

> The results of psychiatric diagnostic interviews with the detainees were reported: 27% were diagnosed with PTSD, 60% with depression, 7% with panic disorder and 7% with psychosis… The detention experience incapacitates detainees, in that it does not allow utilisation of usual coping skills, and constitutes a meaningless environment. Detainees are therefore preoccupied by time and experience extreme boredom and frustration as well as a sense of having no future. The potential for the detention environment to reactivate and exacerbate previous traumas was also raised as a theme. (Robjant, Hassan, & Katona, 2009)

Depicted below in Chart 1 is a visual representation of the proportion of men struggling with devastating but unfortunately prevalent mental illnesses as a result of

detention for at least one year, according to a 2004 study conducted by Mares & Jureidini:



(Mares & Jureidini, 2004)

As one would imagine, the mental trauma experienced by detainees at the hands of the bleak detention process is significant. However, the effects of detention on adolescents and children further highlight the gravity of permanent and severe mental anguish.

In the 2004 Mares & Jureidini study, ten referrals were made to an adolescent and child mental health service in Australia from detention centers (Mares & Jureidini, 2004). Five families who had been in detention for one to two years at the time of the initial interviews were evaluated a year later to observe the long-term effects of detention on the adolescents and children and their families (Mares & Jureidini, 2004). In addition to the litany of mental health detriments observed in adults, adolescents and children exhibited countless other psychological disorders:

Of the 10 children five years and under, seven had spent at least half their lives in immigration detention. Five (50%) presented with delays in language and social development and/or emotional and behavioural dysregulation. Their parents reported that the children had disturbed sleep and feeding routines and complained that they "didn't know how to play", and no longer obeyed them. Three of the infants (30%) showed marked disturbance in their behavior and interaction with their parent or carer, indicating disturbances or distortion of attachment relationships. All of these children had been exposed to violence and chronic parental mental illness. Over the 12-month follow-up, oppositional behavior and parent-child relationship difficulties were identified in a further three children, indicating that 8/10 preschool children had displayed some form of developmental or emotional disturbance. (Mares & Jureidini, 2004)

In summary, the preceding and many other studies depict the effects of detention on asylum seekers and thematically paint a picture of continued suffering for individuals who yearn for nothing more than security for themselves and their families. Despite this, host countries mandated with the principle of International Protection continue to subject asylum seekers to the inhumanity of prolonged detention, which to many serves as a continuation of the terror that they attempted to flee at the time of their displacement. To add insult to injury, many if not most of those who are subjected to prolonged detention will find themselves deemed unfit for refugee status, and are deported to a third country to relive their detention terror, or even back to their home countries where they face persecution, poverty, and often death (Heath, Jeffries, & Pearce, 2006).

Determinants of Refugee Health

From the civil war and violence that spawned the Syrian refugee crisis to the famine and disease that has driven Yemenis to leave their homes in search of asylum, it is clear that the

conditions that drive individuals into displacement are inextricably linked to poor health. In investigating determinants of health of Middle Eastern refugees, the Syrian refugee crisis is often cited, due to the long duration of the crisis, which has allowed for the crisis to be well documented. Unfortunately, the Yemeni crisis does not follow suit, seeing as the political nuances of the Yemini crisis have had the effect of hiding the health status of Yeminis, in an effort by warring opposition governments to contain the humanitarian implications of the conflict. It is therefore important to look at a number of different crises within the region, all of which produce refugees, albeit having different needs and health outcomes.

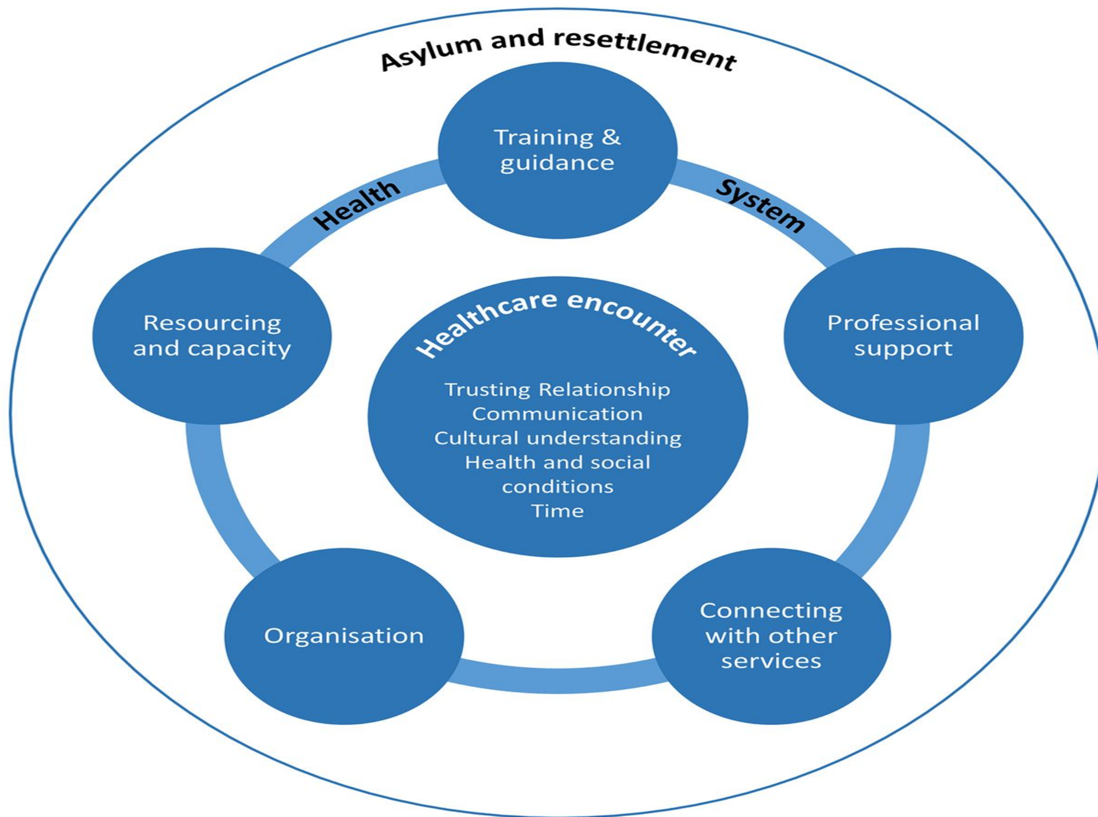
Although refugees continue to suffer from communicable diseases, which are contagious diseases that tend to be easier to treat due to the advances of modern medicine, refugee populations are demonstrating an epidemiological shift towards non-communicable diseases (NCDs), which are chronic diseases like hypertension or diabetes (Doocy et al., 2015). As indicated in Lesson 1 of Table 1, acute illness (communicable disease) continues to be seen in patients, but NCDs characterize the largest proportion of the three types of patients that typically seek healthcare in refugee clinics (Doocy et al., 2015). The high prevalence of NCDs in asylum seekers and refugees compared to private citizens of the host countries underscores the assertion that these populations often suffer from chronic disease and poor health due to the same conditions that led to their eventual displacement (Doocy et al., 2015). These conditions are often socioeconomic or political in nature, and characterize the determinants of health of Middle Eastern refugees. Understanding the determinants of health that drive the development of NCDs allows us to better understand the health outcomes of these populations (Doocy et al., 2015). This in turn highlights their struggles with health inequality and barriers to healthcare access, both of which factor into worsening mental health outcomes (Asgary & Segar, 2011).

If the question, “Why are refugees in poor health?” is posed, an intuitive and correct response would attribute poor health to poverty. Poverty limits an individual’s ability to provide themselves with the things in life that are conducive to good health, such as clean water, nutritious foods, hygienic living conditions, and other such necessities (Asgary & Segar, 2011). However, this answer fails to account for two factors upon which the issue of poverty is predicated. Firstly, providing the aforementioned resources to a group of individuals requires social, economic, and political considerations (Asgary & Segar, 2011). Take for example the crisis in Yemen, where an entire country’s population is currently experiencing what the United Nations has deemed one of the worst famines in living memory. Even if enough aid were provided to feed every Yemeni, the aid would never reach every Yemeni due to socioeconomic and political determinants that are often out of aid organizations’ hands. In any part of the world, the distribution of humanitarian aid is socially influenced, wherein the recipients of the aid determine who gets what. Saudi Arabian aid sent to the government-supporting populace and military in Yemen does nothing for political dissidents such as the Houthi rebels, who are in a bitter civil war with the Saudi-backed Yemeni government. Meanwhile, embargoes and economic sanctions placed on the Houthi rebels and the civilians of the areas they control plunges them deeper into famine and disease. And because of political factors, such as Saudi Arabia’s vested interest in defeating the Houthi rebels, there does not seem to be an end to the conflict in sight. These socioeconomic and political factors continue to prevent the general Yemeni population from living a life free of famine and disease, and therein lie a few of the many determinants of health for the Yemeni people. It is important to understand that socioeconomic and political determinants of health are heavily responsible for health outcome

inequalities, because then we can begin to address the true roots of the factors that superficially seem to be responsible for refugees' poor health (Asgary & Segar, 2011).

Determinants of health will differ for refugees depending on their country of origin, the nature of the conflicts that led to their displacement, their status within society before, during, and after the conflict, and any number of other factors (Asgary & Segar, 2011). However, an excellent synthesis of the major determinants of health that affect refugees and asylum seekers was published in a 2017 *British Medical Journal (BMJ)* study by Robertshaw et al. that helps contextualize the challenges that both displaced people and their healthcare providers face in the quest to improve the health outcomes of refugees and asylum seekers. Figure 1 aptly depicts the nuances of the determinants of health of all refugees, and especially Middle Eastern refugees and asylum seekers in higher-income countries (Robertshaw, Dhesi, & Jones, 2017):

Figure 1. Determinants of Health of Asylum Seekers and Refugees



(Robertshaw, Dhesi, & Jones, 2017)

The delivery of refugee healthcare occurs through healthcare encounters, which happen in health systems during the course of their asylum and resettlement process (Robertshaw, Dhesi, & Jones, 2017). Each of these three elements constitute a "thematic construct" that healthcare providers ought to be conscious of in their delivery of healthcare (Robertshaw, Dhesi, & Jones, 2017). In practice, these concepts should be taught to physicians, and physicians should apply them in their healthcare delivery. For example, when we consider the healthcare encounter, we find that the "descriptive themes" listed as components of the healthcare encounter are important for any doctor-patient interaction (Robertshaw, Dhesi, & Jones, 2017). However, upon deeper pondering and by referencing Lesson 3 of Table 1, which indicates that there is a low level of trust in the healthcare encounter in the minds of these patients, and subsequently low patient

participation, we begin to understand that addressing the determinants of health proposed here is indeed integral to improving refugee health services.

Understanding the three "thematic constructs," and the eleven "descriptive themes" that make them up will allow healthcare providers to provide better care, and can be used as a mechanism for understanding the true needs of refugees and asylum seekers, such as greater community involvement and less barriers to healthcare access (Robertshaw, Dhesi, & Jones, 2017). Moreover, the focus of refugee aid agencies on addressing not only the emergent medical issues, but also the health determinants that hinder the thriving of these populations will provide them with the help they really need, and will have long-term benefits to mental health outcomes, such as the alleviation of depression and anxiety symptoms (Robertshaw, Dhesi, & Jones, 2017).

Access and Quality of Healthcare

At this time, the notion of providing quality care predicated on addressing the determinants of health of refugees and asylum seekers is virtually non-existent. In the context of healthcare delivery to refugees and asylum seekers, most host countries feel obligated to provide the minimal level of care. An EU directive regarding the reception of refugees and asylum seekers includes the following line: "... member states may require medical screening for applicants on public health grounds" (Norredam, Mygind, & Krasnik, 2005). Although the EU directive was in an effort to provide refugees and asylum seekers resettling in Europe with a standard quality of care, governments had different reactions to the directive. For example, medical screening upon arrival was instituted in every country except for Greece, which opted to forgo screening the individuals it received (Norredam, Mygind, & Krasnik, 2005). In some countries, medical screening was mandatory of every new arrival, while other countries chose to

leave it to the initiative of the individuals who knew to ask for it (Norredam, Mygind, & Krasnik, 2005).

This brings us back to the concepts of social determinants of health, which directly influence mental health outcomes. Although medical screening was available for new arrivals, many did not receive it, due to language barriers, personal perceptions of shame, a lack of health literacy, a lack of trust, or any number of other reasons (Norredam, Mygind, & Krasnik, 2005). This is consistent with my own observations in Jordan regarding the negative effects of poor health literacy on patients, detailed in Lesson 2 of Table 1. When it came to primary medical care, the aforementioned study, published in the *European Journal of Public Health,* reported that host countries either provided only emergency medical care, which would lead to worsening physical and mental health status until the individual was deemed sick enough to treat, or the primary care provided required extensive paperwork on months-long waitlists, which strongly discouraged refugees and asylum seekers from seeking treatment (Norredam, Mygind, & Krasnik, 2005). This translated to worse health outcomes in everything from non-communicable diseases, like hypertension and diabetes, which are manageable if treated but detrimental if they are not, to mental health conditions, which if attended to would dramatically improve productivity and quality of life (Norredam, Mygind, & Krasnik, 2005). Moreover, this study established certain barriers in the delivery of healthcare to displaced populations residing in the EU:

> The absence of legal restrictions to access does not necessarily imply equity in access as practical barriers may hinder this. We identified a number of practical restrictions in access to care. According to our responses, practical restrictions could overall be divided into (i) lack of awareness of available health care

> services, (ii) language barriers, (iii) cultural barriers, and (iv) structural barriers. Lack of awareness of availability of services was due to insufficient or no information to asylum seekers about the healthcare system in the host country. Language barriers were especially related to inadequate provision and education of interpreters. Cultural barriers were related to different ways of viewing illness and the role of health care providers versus patients. Two structural barriers were mentioned more than once. Firstly, services dealing with the specific needs of asylum seekers were considered inadequate. This especially was concerned with the access to treatment for traumatised asylum seekers. Secondly, in Austria and Greece, asylum seekers needed respectively a medical card and an identity card before they had access to health care services. In both countries, however, it could take several months before they received the card, due to bureaucratic delays. (Norredam, Mygind, & Krasnik, 2005)

Similar themes of refugees and asylum seekers feeling alienated from their host country's healthcare system are reported in studies conducted all over the world.

In a Johns Hopkins study that endeavored to better understand why these populations had poor access to healthcare, Asgary & Segar conducted comprehensive interviews with 35 asylum seekers and 15 providers/advocacy organizations (Asgary & Segar, 2011). They found that many of these patients exhibited signs of psychosomatic illnesses, which is a condition in which severe mental and emotional trauma manifests in unexplained physical pain. The authors contend, "The debilitating nature of mental illness acts as a significant barrier to care, exacerbating isolation and keeping individuals from seeking support" (Asgary & Segar, 2011). This clinical diagnosis was in line with the patients' expressed feelings throughout the course of the interviews and the

focus groups, through which they concluded that three major types of interrelated barriers kept the patients from seeking medical care (Asgary & Segar, 2011). Firstly, they reported “internal barriers” (Asgary & Segar, 2011), likely due to mental trauma suffered from their displacement and/or detention at asylum centers, which discouraged them from seeking out care. Secondly, they noted “structural barriers” (Asgary & Segar, 2011), such as a lack of financial resources to navigate a complex new system in which they have no employment or shelter security, and unfamiliarity with language and culture without an interpreter. Lastly, they found that “cultural assimilation barriers” (Asgary & Segar, 2011), such as a lack of community support, which was often a foundation of their lives in their home countries, left them feeling hopeless and dejected. All of these barriers, perceived or otherwise, fed into a cycle wherein refugees and asylum seekers experienced a diminished sense of purpose and health, which ultimately perpetuated their deteriorating mental health outcomes (Asgary & Segar, 2011).

It is especially important to note the Middle Eastern cultural element of shame with respect to mental illness, as characterized in Lesson 5 of Table 1. In many households, any mention of mental illness or mental distress is unthinkable, especially for men. Under any normal circumstances, it is unlikely for men to speak openly about any mental distress they may be experiencing, and in the context of refugees, this effect is compounded. As the traditional head of the household, a man may feel that he should be the rock that the family can lean on, and in a crisis that drives the family from not only its home, but its country, the notion of entertaining self-pitying thought – which is the perception of mental distress – is unthinkable. In my experience growing up in the Middle East, and then again serving countless refugees in my capacity as a healthcare provider, mental health care is the last thing most men would ask for. Interestingly, on multiple occasions the wives or daughters of my patients would approach me

and ask me to put in a request for a mental health check, oftentimes citing symptoms that are likely to be diagnosed as depression, anxiety, or PTSD. Herein lies the importance of a shift in our medical and social care of refugees and asylum seekers, whereby we deliver care whilst consciously factoring for interventions that take into account their individual socioeconomic and political determinants of mental and somatic health, and the barriers to accessing healthcare that they may be experiencing.

Recommended Interventions and Future Directions

In identifying some of the many aspects through which we can help asylum seekers and refugees not only survive in their host countries, but also prosper, I suggest an approach that is informed by the five lessons of Table 1, and built on the thematic synthesis model of Figure 1, as published in the *British Medical Journal* (Robertshaw, Dhesi, & Jones, 2017). As previously stated, this model emphasizes the healthcare encounter, the healthcare system, and asylum and resettlement. Indeed, this model is incredibly relevant, due to the fact that factors contributing to poor mental health outcomes are multifactorial and nuanced, affecting multiple facets of the refugee experience. If our interventions target the socioeconomic and political determinants of health described in this model, whilst bearing in mind and addressing the five lessons I propose through my experiences serving refugees, then we can begin to elevate the mental health outcomes of asylum seekers and refugees.

The model breaks down the healthcare encounter into the following facets: trusting relationship, communication, cultural understanding, health and social conditions and time (Robertshaw, Dhesi, & Jones, 2017). Establishing a trusting relationship is important with any doctor-patient relationship, and is significantly more important in the context of refugee mental health. From the outset of the conflicts that led to the destabilization of these individuals' lives, authority figures within their governments or societies may have abused their power, or acted in negligence, to allow their lives to be uprooted. Therefore, trust is even more difficult to earn from a refugee or asylum seeker, and healthcare professionals should be trained on how to build such relationships with their patients through re-education with elements of social work incorporated into their specialized training. Next up, communication and cultural understanding

work hand in hand to enhance the doctor-patient relationship, and moreover to strengthen the trust that healthcare professionals yearn to establish with their patients. Lastly, a great deal of time must be spent to achieve these outcomes, due to the severity of the traumas suffered by refugees and asylum seekers, and specific efforts need to be placed in taking the time to understand these individuals' living conditions. Understanding their current lives will help to address health and social conditions, which I refer to in this thesis as the socioeconomic and political determinants of health.

To this end, I propose that health providers serving under international refugee organizations such as the UNHCR ought to implement a system through which refugees and asylum seekers can provide feedback to their care providers. This would address much of the distrust of the medical encounter that we observe in Lesson 3, and would serve to also encourage patients to take an active role in their medical experience, by encouraging them to augment their health literacy, a shortcoming of the refugee conditions described in Lesson 2. Through a panel consisting of local humanitarian and religious leaders and refugees/asylum seekers, individuals can regularly meet to discuss the healthcare needs of refugee population patients, as well as needs external to the healthcare encounter. These could include resettlement concerns and socioeconomic and political determinants that pose mental stress concerns to refugees and asylum seekers. Such a panel, created for each specific refugee population, will allow for better representation of the needs of refugees, and will allow for more efficient and effective interventions that address specific populations of refugees and asylum seekers.

In examining the healthcare system, we find that a myriad of difficulties present in the following areas: training and guidance, professional support, connecting with other services, organization and resourcing and capacity (Robertshaw, Dhesi, & Jones, 2017). Quite intuitively,

these are elements of healthcare systems that need to be enhanced in order to allow physicians, nurses, social workers, and other individuals within a healthcare system to apply the aforementioned elements of the healthcare encounter to the refugees and asylum seekers whom they serve. No longer is it acceptable to present a refugee or asylum seeker as a quintessential medical patient. Their histories are far more complex, their traumas run deep, and their signs and symptoms are more often than not atypical. Using revisited and well thought out medical education seminars, physicians who interact with these patients should be able to understand the importance of their re-education, their cooperation with other services, and their need to spend time and resources on their patients. As seen in Lesson 1, there are three most commonly seen types of patients, and understanding how to best approach intervention whilst bearing in mind the needs of refugee patients specifically, as opposed to a typical patient presenting with the symptoms that refugees present without considering the multitude of traumatic factors that also plight these populations is not only ineffective, but also irresponsible. A child who has been burned from head to toe does not simply need to be disinfected, bandaged, and sent on her way. Such a child needs mental health intervention, lest she fall into mental health distress that she may never overcome. An old man who suffers of diabetes does not simply need an immediate intervention, but a sustainable treatment plan that will increase his longevity, quality of life, and dignity, a commonly reiterated theme witnessed amongst refugees and reiterated in Lesson 4. Yet the reality of my experience is that I myself treated patients such as this young girl, and medical, somatic treatment is all that they receive. This is because such refugee care facilities are understaffed and have very limited resources. It is not until policy makers understand and internalize the belief that these individuals deserve to have their human rights upheld, and that we cannot and will not stand for anything but the upholding of this mandate.

Lastly, we must strive to better our resettlement and asylum process. The extended detention of asylum seekers must end. This statement ought to come with a full stop, but I will elaborate anyways. I have presented the data, and the conclusion is clear. The detention of asylum seekers, and the practices that are undertaken against the asylum seekers during the course of their detention, cannot continue. The separation of children from their parents is abhorrent, leads to long-term psychological trauma, and violates every iota of our collective human rights. The detention of asylum seekers, who flee terror only to meet more of it at our shores, must end. To achieve this, national governments must internalize the cry we yell time and again; refugees are a priority, so treat them as such. Policy makers must make refugees and asylum seekers the top priorities of their foreign policy agendas, and must allocate more resources, more manpower, and more professional re-education of their staff in the determinants of mental health to allow this to occur.

It has been made abundantly clear over the course of this thesis that refugees and asylum seekers are facing severely negative mental health outcomes due to ineffective policy. Moving forward, however, what we need to see is more action geared towards eliminating the outcomes presented in the numerous studies investigated. To this end, I propose that one of the most important forward-thinking interventions we need to implement is the education of the general public on the issue of refugee mental health, through grass-roots efforts. While it is clear that medicine and social work targeting the socioeconomic and political determinants of mental health will be the tools that allow refugees and asylum seekers to attain better mental health outcomes, the mechanism through which the appropriate policies are legislated and implemented is grass-roots advocacy for refugees and asylum seekers, which places pressure on legislators to prioritize this issue. Moreover, this grass-roots effort will eliminate the cultural stigmas

surrounding the notion of mental illness in Middle Eastern refugees, and will provide for a better quality of life, as observed in Lesson 5.

Conclusion

As a global society, our policies determining the treatment of refugees and asylum seekers have deviated from their intended purpose of 'International Protection' (DIP, 2005), oftentimes in lieu of policy practices that reflect the bystander effect, wherein host nations neglect their responsibilities to actively assisting refugees and asylum seekers, and expect other countries to step up to the plate. Although it has been established through the studies presented in this thesis, as well as my clinical and social interactions as a medical assistant in UNHCR clinics, that the health determinants of Middle Eastern refugees and asylum seekers perpetuate negative mental health outcomes, there surely are limitations to these conclusions. The limitations witnessed herein are marked by a relative lack of data, given the number of conflicts that create asylum seekers and refugees. The numbers we have witnessed and explored are likely to be a minute fraction of the cases of psychological trauma and mental illness existing in the Middle East and worldwide as a result of refugee crises. Therefore, we must implement the interventions presented herein, and we must do so with conviction and an understanding that this issue is global, escalating, and in need of immediate action. The solution to ending the refugee mental health crisis is simple in its element… we just have to want to undertake it.

References

Achilli, L. (2015, February). *Syrian Refugees in Jordan: A Reality Check* (Issue brief). doi:10.2870/821248

Asgary, R., & Segar, N. (2011). Barriers to Health Care Access among Refugee Asylum Seekers. *Journal of Health Care for the Poor and Underserved,22*(2), 506-522. doi:10.1353/hpu.2011.0047

Blanchet, K., Fouad, F. M., & Pherali, T. (2016). Syrian refugees in Lebanon: The search for universal health coverage. *Conflict and Health,10*(1). doi:10.1186/s13031-016-0079-4

Bracken, P., & Gorst-Unsworth, C. (1991). The mental state of detained asylum seekers. Psychiatric Bulletin, 15(11), 657-659. doi:10.1192/pb.15.11.657

Burnett, A. (2001). Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. *Bmj, 322*(7285), 544-547. doi:10.1136/bmj.322.7285.544

Department of International Protection (DIP). (2005, August 1). *An Introduction to International Protection. Protecting Persons of Concern to UNHCR*(Rep.). Retrieved https://www.refworld.org/docid/4214cb4f2.html

Doocy, S., Lyles, E., Roberton, T., Akhu-Zaheya, L., Oweis, A., & Burnham, G. (2015). Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan. *BMC Public Health, 15*(1). doi:10.1186/s12889-015-2429-3

Heath, T, Jeffries, R, Pearce, S. (2006). Asylum statistics United Kingdom 2005. *Home Office Statistical Bulletin* 2006; 22 August: 1–90 (http://www.homeoffice.gov.uk/rds/pdfs06/hosb1406.pdf).

HRW. (2017). Syria Events of 2017. Retrieved from https://www.hrw.org/world-report/2018/country-chapters/syria

HRW Libya: Nightmarish Detention for Migrants, Asylum Seekers. (2019, March 11). Retrieved from https://www.hrw.org/news/2019/01/21/libya-nightmarish-detention-migrants-asylum-seekers

Keller, AS, Rosenfeld, B, Trinh-Shvrin, C, Meserve, C, Sachs, E, Leviss, J, et al. (2003). Mental health of detained asylum seekers. *Lancet* 2003; 362: 1721–3.

Mares, S, Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention clinical, administrative and ethical issues. *Aust N Z J Public Health* 2004; 28: 520–6.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet,365*(9464), 1099-1104. doi:10.1016/s0140-6736(05)71146-6

Momartin, S, Steel, Z, Coello, M, Aroche, J, Silove, D, Brooks, R. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *Med J Austr* 2006; 185: 357–61.

Norredam, M., Mygind, A., & Krasnik, A. (2005). Access to health care for asylum seekers in the European Union—a comparative study of country policies. *European Journal of Public Health, 16*(3), 285-289. doi:10.1093/eurpub/cki191

Pfortmueller, C. A., Schwetlick, M., Mueller, T., Lehmann, B., & Exadaktylos, A. K. (2016). Adult Asylum Seekers from the Middle East Including Syria in Central Europe: What Are Their Health Care Problems? *Plos One,11*(2). doi:10.1371/journal.pone.0148196

Pourgourides, CK, Sashidharan, SP, Bracken, PJ. (1996). *A Second Exile: The Mental Health Implications of Detention of Asylum Seekers in the United Kingdom*. North Birmingham NHS Trust, 1996.

Robertshaw, L., Dhesi, S., & Jones, L. L. (2017). Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: A systematic review and thematic synthesis of qualitative research. *BMJ Open,7*(8). doi:10.1136/bmjopen-2017-015981

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *British Journal of Psychiatry, 194*(04), 306-312. doi:10.1192/bjp.bp.108.053223

Sharp, J. (2016, January 27). *Jordan: Background and U.S. relations.* Washington, DC: Congressional Research Service.

Stave, S. E., & Hillesund, S. (2015). *Impact of Syrian refugees on the Jordanian labour market*(Issue brief). Retrieved from https://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_364162.pdf

Steel, Z, Silove, D, Brooks, R, Momartin, S, Alzuhairi, B, Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *Br J Psychiatry* 2006; 188: 58–64.

Sultan, A, O'Sullivan, K. (2001). Psychological disturbances in asylum seekers held in long term detention: a participant-observer account. *Med J Austr* 2001; 175: 593–6.

UNHCR. (2018). Jordan: Fact Sheet. Retrieved from http://reporting.unhcr.org/sites/default/files/UNHCR%20Jordan%20Fact%20Sheet%20-%20June%202018.pdf

WHO. (2017, September 25). About social determinants of health. Retrieved from https://www.who.int/social_determinants/sdh_definition/en/

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Abdurrahman 'A.K.' Kharbat was born in Tulsa, Oklahoma and raised in Dhahran, Kingdom of Saudi Arabia. Through his experiences living abroad, he has developed a passion for global health policy that he endeavors to apply to his study of medicine. Having spent an extended period of seven months serving as a medical assistant in United Nations High Commission for Refugees (UNHCR) clinics, he is passionate about his study of refugee health. Specifically, he has developed an interest in refugee mental health, as he has seen first hand the effects a life of displacement has on men, women, and children alike. He hopes to continue engaging with his research area into medical school, and to continue propagating effective refugee health policy in the Middle East.