GUIDE ON

# MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

FOR THE CARE OF THE MIGRANT AND REFUGEE POPULATION IN URUGUAY

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ONU MIGRACIÓN

CRISP
SUSTAINABLE RESETTLEMENT & COMPLEMENTARY PATHWAYS INITIATIVE

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# GLOSSARY

## STATELESS

It means a person who is not considered as a national by any State under the operation of its law (UNHCR, 1954).

## MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

It means any type of local or external support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders (IASC, 2007).

## EMIGRATION

It is a movement, considered from the perspective of the country of departure, made by a person from the country of nationality or usual residence to another country, so that the country of destination effectively becomes his or her new country of usual residence.

## MIGRANT FLOW (INTERNATIONAL)

It means a number of international migrants arriving in a country (immigrants) or the number of international migrants departing from a country (emigrants) over the course of a specific period.

## SOCIAL INCLUSION

It designates access to opportunities for the development of a better quality of life and the full exercise of individual and social rights. It includes aspects such as access to information and/or services, the achievement of an adequate bonding process with family members, emotional references, primary groups and/or link networking, housing, educational, labor inclusion, civic participation and/or acknowledgement and expression of values associated with cultural diversity.

## IMMIGRANT

It means, from the perspective of the country of arrival, a person who moves to a country other than that of his or her nationality or usual residence, so that the country of destination effectively becomes his or her new country of usual residence.

## UNACCOMPANIED MINORS

Minor persons, as defined in Article 1 of the Convention on the Rights of the Child, who are separated from both parents and other relatives and are not in the care of an adult who, by law or custom, has that responsibility.

## MIGRANT

A generic term that reflects the common understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students (IOM, 2019a, p. 30).

## INTERNAL MIGRATION

Movement of people within a State involving the establishment of a new temporary or permanent residence.

## INTERNATIONAL MIGRATION

Movement of persons away from their place of usual residence and across an international border to a country of which they are not nationals.

## INTEGRATION

The two-way process of mutual adaptation between migrants and the societies in which they live, whereby migrants are incorporated into the social, economic, cultural, and political life of the receiving community. This entails a set of joint responsibilities for migrants and communities and incorporates other related notions such as social inclusion and social cohesion.

## RECOVERY (APPROACH)

The recovery approach in the field of mental health represents a determined commitment to placing the person who has a mental health problem as the true protagonist "in first person" of his/her therapeutic process and personal growth.

## REFUGEE (1951 CONVENTION)

Person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his or her nationality and is unable or owing to such fear, is unwilling to avail himself or herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former usual residence, as a result of such events, is unable or due to such fear, is unwilling to return to it.

## RESILIENCE

Resilience reflects the dynamic confluence of factors that promote positive adaptation despite exposure to adverse experiences. Resilience is considered to be a component of adequate psychosocial adaptation and it is associated with mental health.

### FAMILY REUNIFICATION (RIGHT TO)

Right of foreigners to enter and reside in a country in which their family members legally reside or of which they have the nationality, in order to preserve family unity.

### INTERNALLY DISPLACED PEOPLE

Persons or groups of persons who have been forced or obliged to escape or flee from their home or place of usual residence, in particular as a result of the effects of an armed conflict, of situations of generalized violence, of violation of human rights or of natural or man-made disasters, or in order to avoid such effects, and who have not crossed an internationally recognized state border.

### ASYLUM SEEKER

A person seeking international protection. In countries with individualized procedures, an asylum seeker is a person whose application has not yet been the subject of a final decision by the country where it was submitted. Not all asylum seekers are recognized as refugees, but all refugees in these countries are initially asylum seekers.

# INTRODUCTION

One of the characteristics of contemporary societies throughout the world is that people, for various reasons, move both across international borders and within national limits, in search of better living conditions. As a consequence, cultural diversity, multiculturalism, multinationality, are considered as characteristics associated with this contemporaneity.

Human mobility is a universal process that challenges current societies and their strategies to guarantee rights, which is why the International Organization for Migration (hereinafter IOM), in its document IOM Health, Border and Mobility Management Framework (2021), establishes as objectives:

1) to help governments and communities to address public health threats related to mobility, and

2) to ensure that affected and at-risk populations receive adequate and timely support.

These efforts are essential to safeguard global health security and to strengthen health systems that take into account mobility and provide everyone, including migrants, with a universal, person-centred health coverage (IOM, 2021a, p.7).

Health is an aspect that can be compromised by migratory experiences, especially when people are exposed to violations of rights due to the dangers experienced on the routes, or due to issues associated with the intersectionality of the dimensions of gender, ethnicity, socioeconomic conditions, national origin, religion, among others. Not letting aside, that the neglect in terms of health and well-being, experienced in the countries of origin, are often influential factors on the processes of human mobility.

When we talk about the mental health and psychosocial welfare of people who are mobile, we must pay attention to the fact that migrating can be a demanding process in several ways, both because of having left behind the country of origin or usual residence, with the mobilization that involves leaving bonds, managing expectations, fears, feelings of uprooting; as well as arriving in a new environment that will demand processes of recognition and adaptation, where sometimes anxiety and stress are central. This reality of mobility processes becomes more complex when people do not share the same linguistic and cultural codes, when they experience situations of discrimination based on racism or xenophobia (or other types of discrimination), they are exposed to material deficiencies that limit their subsistence, they feel in danger or are under threat, or for example, they live with a mental illness that is affected by the circumstances of migration, or is triggered by them. Therefore, mental health cannot be thought of or limited exclusively to clinical approaches specific to health services, but rather implies a multisectoral and comprehensive approach.

This guide starts by presenting the psycho-emotional reality of migrants and refugees from a non-pathologizing point of view (avoiding focusing the experience solely on the description of the illness or disease), since this scaled down vision does not reflect the diversity of people's experiences and situations in a mobility situation. Psycho-emotional challenges may vary depending on the success or failure in the integration process, which is why it is important to highlight the dynamic aspect related to migration experiences. In this sense, the starting point is the conception that the mental health and psychosocial well-being of migrants and refugees can be associated, in particular, with access to rights and the possibilities of integration in the destination society, as well as the tools of emotional management and agency, which people have during their immigration processes.

Beyond making this consideration, it should be noted that, for those people who experience serious and moderate mental illnesses, whether from their country of origin or triggered in the new territory, being exposed to discontinuing treatments or lack of early diagnosis, the migration can mean an aggravation in his/her general state of health. In this sense, migrations can generate specific psychosocial vulnerabilities that, if combined with other determinants, can affect the mental health of migrants and refugees (IOM, 2020).

For all of the above, it is necessary to review the mental health care experiences that people have in the integration processes, to contribute to the population's care strategies, based on evidence, framed in current national immigration regulations in Uruguay, focusing on people's experiences from an intercultural approach. Health systems need to be prepared to address the pressing and long-term needs of diverse populations on the move and transnational communities and to cope with increasing global human mobility (IOM, 2016).

From the IOM Country Office for the Republic of Uruguay (hereinafter Uruguay), in its capacity as the leading United Nations agency in migration matters, this *Guide on mental health and psychosocial support for the care of the migrant and refugee population* was developed, to strengthen the capacity of the actors involved in the provision of services of this nature to these populations, promoting integration processes in the host society. This document takes the guidelines established by the IOM, in relation to the approach to Mental Health and Psychosocial

Support (SMAPS for its initials in Spanish) within the framework of comprehensive health and from a community perspective. This guide intends to be a tool that allows those who assist in mental health services and psychosocially accompany people in situations of human mobility, either in clinical or community environments, to more broadly understand mental illnesses (whose determinations are multiple) from a critical and non-pathologizing stance, using the bio-psycho-social model as a comprehensive approach, contributing to its perspective, the particularities of the context associated with human mobility. In turn, the material is proposed as a fundamental input for the delivery of workshops and training to workers, managers and authorities, to promote and improve access to mental health services and psychosocial support for migrants and refugees who reside in Uruguay and participation in community environments that, with actions focused on the socio-relational, cultural, artistic, and sports fields, can influence in a social cohesion that builds environments conducive to integration and leads to good mental health.

This material has been produced within the framework of the Initiative for Resettlement and Complementary Sustainable Pathways (CRISP), jointly led by the International Organization for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR).

# CHAPTER 1) CONSIDERATIONS ON MIGRATION AND REFUGEES

## 1.1 REGULATORY FRAMEWORK IN URUGUAY

In Uruguay there is a regulatory framework (The National Migration Law No. 18,250 of 2008 and Law No. 18,076 of Refugees, of 2006) that sets forth in article 7 of the Migration Law, that "foreigners who enter and remain in the national territory in the forms and conditions established in this law are guaranteed by the Uruguayan State the right to equal treatment with nationals as subjects of rights and obligations", as well as it is established (in article 8 of the aforementioned law) that "migrants and their family members will enjoy the rights to health, work, social security, housing and education on an equal bases with nationals. These rights will have the same coverage and protection in both cases." Likewise, the law determines that the regulations regarding admission, entry and permanence of foreigners in the national territory must be interpreted and applied in a manner compatible with International Human Rights Law, International Humanitarian Law and International Refugee Law.

Article 2 of the Refugee Law sets forth that it will be recognized as a refugee any person who owing to a well-founded fear of being persecuted for reasons of membership of a particular ethnic or social group, gender, race, religion, nationality, or political opinion, is outside the country of his/her nationality, and is unable to, or owing to such fear, is unwilling to avail himself/herself of the protection of that country. Or who, lacking nationality and being, as a result of such events, outside the country where he/she previously had his/her usual residence, cannot or - because of said fears - do not want to return to it. Or he/she has fled the country of his/her nationality or, lacking nationality, he/she has fled the country of residence because his/her life, security or freedom are threatened by generalized violence, foreign aggression or

occupation, terrorism, internal conflicts, massive violation of Human Rights or due to any other circumstance that has seriously disturbed public order (Law No. 18,076, 2006).

**Right to Migrate** States have the competence to govern migration within their jurisdiction, in accordance with their obligations established in agreements on Human Rights, so all people who are in a situation of human mobility, regardless of their nationality, their migration status, their way of getting to the border, their origin or their appearance, have the right to enjoy their human rights[1].

It should be noted that in Uruguay, immigration implies an administrative process of regularization of documentation, which can be: regular or irregular migration; in no case the immigrant, only for the fact of entering the territory, beyond their documentary situation, is committing an ILLEGAL act.

**Right to Reside** Residency is the procedure that a foreigner intending to reside in the country must complete to regularize his/her documentary situation; it is the government authorization that enables a foreigner to reside, study and work in a country.

Migration regularization refers to the process through which foreigners express their desire to reside in the territory, acquiring national personal identification documents, through processes established by Uruguayan legislation.

The refugee request can be made in person at the borders before any official at an immigration control post; in the Department of Montevideo: before the Permanent Secretariat of the Refugee Commission at the Ministry of Foreign Affairs, the National Directorate of Migration and the Ecumenical Service for Human Dignity (SEDHU fot its initials in Spanish). It should be noted that the presentation of an identity document is not required to apply for refuge. The competent bodies for determining refugee status are the Refugee Commission (CORE) and the Permanent Secretariat of the Refugee Commission. The refugee status ceases when he/she voluntarily avails himself/herself of the protection of the country of his/her nationality; if he/she loses it and recovers it voluntarily; if he/she has acquired a new nationality and that country protects him/her; if he/she voluntarily returns to reside in the country from which he/she fled; if the circumstances that generated the fear have disappeared and the situation has become normal either in the country of his/her nationality or in the country of his/her permanent residence.

Every migrant in Uruguay has the right to an individual evaluation of his/her protection needs, and not to be subject to arbitrary detention or discriminatory decision-making. Specific attention must be paid to migrants in vulnerable situations.

[1] Information available on the United Nations High Commissioner for Human Rights (UNHCHR) web page https://www.ohchr.org/es/migration/about-migration-and-human-rights

## 1.2 MIGRATION REGULATION

There are different procedures to reside in Uruguay, depending on the situation and needs of each person.

Every person seeking refuge has the right to be provided with a provisional identification document issued by the National Bureau of Civil Identification of the Ministry of the Interior, with the sole presentation of the certificate that accredits his/her status as a refugee applicant, issued by the National Migration Agency. Said document will contain the affiliation data and the date and place of birth of the applicant. This document is valid until a final resolution is issued on the refugee application. Once the legal status of refugee is recognized, said document is replaced by the identification document issued to residents.

The resident category is subdivided into permanent and temporary residents (Article 31 No. 18,250). It depends on the time, reasons, nationality, and family relationships with Uruguayans what type of residence the interested person may request. The types of residence are, within the Temporary:

-Temporary residence and Mercosur temporary residence.

Within the permanent residences:

-Permanent residence, Mercosur permanent residence and Permanent residence with ties to Uruguayans[2].

✱**Where to start the residency proceedings?** For all residences, an appointment must be requested at https://www.gub.uy/tramites/residencia-legal

**Family Reunification Rights** It refers to the right to maintain family unity. The Uruguayan State guarantees the right of migrants permanently residing in the country, who prove that they have the necessary economic means to support the people who request reunification, to family reunification with parents, spouses, cohabitants, unmarried children, either minors or of age with disabilities (art. 10, Law No. 18,250). In the case of refugees (art. 12 of Law No. 18,076), also providing refugee status to the members of the reunified family (which could be the spouse, the cohabitant, as well as any other relative by blood up to the fourth degree or affinity up to the second degree, unless they are excluded by an exclusion or cessation clause). Accessible, dignified and timely family reunification benefits both migrants and their host societies, creating sociocultural stability, facilitating integration and thus promoting economic and social cohesion.

The family reunification process is currently being carried out at the Ministry of Foreign Affairs (Directorate of Consular Affairs) by request via email to reunificacion@mrree.gub.uy[3].

[2] For further information on requirements, see https://www.gub.uy/ministerio-interior/comunicacion/publicaciones/tipos-residencias-uruguay

[3] For further information on requirements, see https://www.gub.uy/tramites/solicitud-reunificacion-familiar

**Right Not To Migrate**[4] When we talk about forced displacement, where the person migrates because he/she feels threatened or there is a life risk in his/her country of origin, or when people in search of a "better life" leave behind realities where there are violations, economic scarcity, and violence. The right NOT TO MIGRATE is a concept initially brought by the anthropologist Armandro Bartra (2014) who suggests that it is necessary to reflect on the circumstances that cause the expulsions of people from their countries where their social and labor security is not guaranteed.

In terms of social security, the State has agreements with other countries on the portability of rights and benefits obtained, including old-age pensions. Uruguay, through the Social Security Bank (BPS), is part of the Ibero-American Multilateral Agreement on Social Security and it has agreements on social security with more than thirty countries. These agreements include Uruguay's participation in Mercosur and agreements with several European countries regarding the "accumulation of periods of service in both countries." Migrants enjoy, with respect to social security, the same treatment as nationals to the extent that they meet the requirements established in the legislation of the Uruguayan State on the matter and the bilateral and multilateral instruments ratified by the country (Article 18, Law No. 18,250).

**Right To Be Informed** In article 9 of the Migration Law, it is established that: "Irregular migration will in no case prevent foreigners from having free access to justice and health facilities. The authorities of these centers will implement the necessary services to provide migrants with the information that makes their regularization in the country possible."

[4] The right not to migrate is a concept brought to the immigration field by the anthropologist A. Bartra, but currently it is not described in the Declaration of Human Rights, as a essential human right.

## 1.3 REPOSITORY AND SITES OF INTEREST FOR MIGRANTS AND REFUGEES

With the aim of this Guide being a tool for people who work clinically or psychosocially with people in a situation of mobility, information is shown below to be shared with the target population:


* "INFORMATION FOR MIGRANTS, REFUGEE SEEKERS AND REFUGEES WHO ARE IN URUGUAY".

It is a guide with relevant information on access to rights and resources available for migrants and refugees, developed this year by the United Nations Network on Migration, UNHCR, IOM and UNICEF.

LINK to the document

* OIM SITE. Where the task carried out by the International Organization for Migration in Uruguay is described, highlighting assistance to situations of socio-housing vulnerability and programs for cases with specific protection needs.

LINK to site

* ACNUR SITE (United Nations High Commissioner for Refugees). Where information is detailed for those who require information on how to benefit from the international protection of Uruguay.

LINK to site

Another site that itemizes information for refugees and refugee seekers

LINK to the site

* CIVIL SOCIETY ORGANIZATIONS WORKING WITH MIGRANT POPULATION. As part of the strategies for building the social fabric of support for people in situation of mobility, the importance of contacting community and associative proposals is highlighted.

Civil Association "IDAS Y VUELTAS" With proven experience in the field of care for the migrant population, the Non-Governmental Organization (NGO) offers advisory services on issues of immigration regularization, work in Uruguay, and legal consultations, intercultural nursing service, in addition to having exchange spaces and intercultural coexistence.

MANOS VENEGUAYAS Organization devoted to social work with the migrant population, especially from the Bolivarian Republic of Venezuela. It has assistance programs for situations of vulnerability, and labor and immigration guidance.

SERVICIO JESUITA A MIGRANTES Service devoted to care for populations in situations of human mobility.

# CHAPTER 2) MENTAL HEALTH AND HUMAN MOBILITY: DIALECTIC RELATIONSHIP

From the position of not stigmatizing migration by relating it in a linear manner to mental illnesses, we propose to think about the mental and psychosocial health care of people who are in a situation of mobility.

In the clinical field, they usually generate learning and accumulation of experience that, sometimes, leads to an over-pathologization of certain conditions due to an immediate response strategy in the face of the emergency, where we associate the new case to those already known. The review of the bias that often operationally is the bases for the diagnosis definition, in the case of migration, it implies taking into account several scenarios, such as the cultural and idiosyncratic background, religion, conceptions of health-disease of each community, as well as well as the expectations of self improvement and well-being, added to the conditions of risk, adversity and adverse protection to which the person may be exposed or the dissatisfaction of basic needs.Although it is important to consider that migrating does not necessarily mean an increase in mental health risk, it sometimes implies the redefinition of identities, roles and individual, family, group and collective value systems, which can stress individuals. When the migration process occurs under adverse conditions, people's physical and mental well-being can be compromised. Despite this, symptomatological presentations can be associated with a particular stage of the migratory process (depending on each experience), and the achievement of the expectations and objectives set in each case, so advancing in the realization of these can mean good prognosis.

In this section, we are interested in highlighting that those who make the decision to leave their country in search of new living conditions to promote personal, family, and community development are individuals with great power of agency, understood as the ability to generate movements and actions in favor of personal development that, in situations of emotional vulnerability, can be protective in terms of mental health.

## 2.1 MOBILITY AS AN STRATEGY OF SELF IMPROVEMENT AND AGENCY

The imaginary that places migrants associated with vulnerability generates stigmatization that can lead to stereotypical expressions or discrimination based on aporophobia - or other forms

of discrimination -, where the predominant vision exerts symbolic violence on those who circumstantially experience exposure to violation of basic rights due to migration.

In this sense, the need to approach work with people in situation of mobility is highlighted, from their historicity, as the protagonist of his/her survival and development strategies, with his/her own self-improvement tools aligned with the desire to access better living conditions, bearers of experiences and knowledge that indirectly favor the resilience processes of host societies.

As stated by Contreras and Alcaide (2021):

"theoretical contributions around agency highlight the role of the active subject aware of his/her place of enunciation, who, immersed in a ever lasting process of construction-deconstruction of meanings (...) has a subjective disposition to transform the social space. In this sense, agency "includes effective power to achieve established goals; it is related to the capacity and willingness to act based on individual and collective purposes (…), it implies responsibility in the making and execution of decisions" (…). In accordance with this, the capacity for agency generates new meanings, possibilities and subjectivities that favor opening spaces for political and individual action of the subjects (...). Ultimately, it points to well-being and decision-making power (Contreras and Alcaide, 2021, p. 501)."

In addition to the above, it should be noted that migration can mean for individuals the possibility of engaging in new social interactions, the acquisition of new cultural meanings or a renewed and multiple sense of belonging. Any psychological experience of migration must be read holistically, considering the combination of positive and negative effects (IOM, 2021b)."

## 2.2 SOME CONSIDERATIONS ABOUT MENTAL HEALTH OF INDIVIDUALS IN SITUATION OF MOBILITY

If we start from the definition of mental health as it is conceived, not only as the mere absence of mental disorders, but as "a state of well-being in which the individual is aware of his/her own abilities, can cope with the normal stresses of life, can work in a productive and fruitful way and is capable of making a contribution to his/her community" (WHO, 2001), we must reflect on the implications of the dynamism inherent to the contexts of human mobility, but in a concrete and particularized manner, in order to not stigmatize the migration-mental health relationship as a linear relationship to the detriment of the person's well-being.

Currently, in IOM's SMAPS (Mental Health and Psychosocial Support) programs, the focus is placed on the contextual and collective elements of human mobility processes and their individual and community impacts. This includes understanding the importance of collective reactions to adversity and social cohesion, as well as the social fabric as a determinant of social and individual well-being in contexts of human mobility. This perspective involves the activation of multidisciplinary support systems, the identification and support of the existing strengths of the affected communities, as an approach strategy that exceeds the clinical perspective where only emerging symptomatology is addressed.

In the same way that people who have not gone through (medium and long term) mobility processes experience effects at an organic level, due to the environmental, social, family dynamics of which they are part during the mobility processes, and depending on the circumstances of each migration, various states are experienced associated with processes of instability and uncertainty. This instability sustained over long periods can lead to emotional suffering that requires clinical approaches and referrals to specialized mental health services.

Being able to study the relationship between migration and people's mental health, taking into account the considerations made above, allows us to build evidence that contributes to the design of both health and mental health policies that contemplate the reality of the migration phenomenon in all its complexity:

> "The IOM strongly opposes any default and non-evidence-based association of all forms of migration with trauma, Post Traumatic Stress Disorder (PTSD), depression and other clinical problems with grief processes, as well as against the pathologization of the normal psychological consequences of migratory experiences, representing these as migratory syndromes" -as is the case of the so-called Ulysses Syndrome[5] - (IOM, 2021b).

According to the report of people specialized in mental health issues consulted within the framework of this document[6], when explaining the most recurrent reasons for consultation by migrants and refugees, they include: stress as a generator of discomfort; anxiety about separation and the demands of integration, the fear of experiencing situations of lack of protection and lack; the hopelessness of not achieving the objectives set at the time of leaving; stress due to work and study issues; decompensations due to emotional issues; the lack of confidence in the decision made, leaving the person at the mercy of the feeling of uncertainty, defeat, damaged self-esteem; the lack of energy resulting from the expressions mentioned above (among others). They also mention that sometimes people who have gone through very long and complex routes, in unfavorable conditions, experience states of confusion and altered consciousness, as well as situations of wit (presenting, for example, possible alterations at the level of mood and/or thinking).

In relation to the processes of integration into the country, when expectations have not been exceeded, feelings of inferiority with respect to the host population may appear, a situation often marked by previous - and local - experiences of racism and xenophobia, leading to expressions of overflowing anger or sadness and melancholy. These situations can lead to isolation, disconnection from the present or permanent longing for the past. These emotions can also have a somatic correlation, being accompanied by ailments, discomfort or physical difficulties such as lack of appetite, headache, digestive discomfort, lack of concentration or difficulty sleeping and making decisions. It should be noted that beyond the perspective of thoughts about mental health and migration proposed in this Guide, the fact that there are singular and specific personality factors that can make a person more vulnerable to

[5] The so-called "Ulysses syndrome" described by Achoteguy in 2009, groups together symptomatic presentations directly associating them with migratory processes, thus considering them a risk factor for mental health.

[6] Interviews were conducted with mental health professionals with experience in clinical work with migrants (health providers, public and community services provided by civil society, members of international organizations and the Uruguayan Psychiatric Society) and psychosocial teams.

psychological suffering is not ignored and not finding tools or resources to be able to cope with the new daily life scenario. These factors are those that, in an overlooked way, operate by triggering somatic manifestations that usually cause migrants to reach health clinics or emergency doors.

In a similar way, it is worth mentioning that mental illnesses can also have biological causes that may depend, in part, on genetic factors, brain biochemical imbalances or organic imbalances (metabolic, hormonal, among others) that always have to be attended and managed.

It would be a mistake to address the problems by focusing exclusively on only one of these determinations, since the human being as an integral subject, and his/her way of living and suffering, is the effect of the interactions among all of them. Hence, any counselling that resolves, for example, depression only through medication is inappropriate and incomplete (IOM, 2021b).

## 2.3 RISK AND STRESS FACTORS, AND PROTECTIVE FACTORS OF MENTAL HEALTH IN MIGRANTS AND REFUGEES

There are factors that, directly or indirectly, and to various extents, can affect the mental health of the migrant and refugee population. Some notable factors are mentioned below (IOM, 2016):

a) In the country of origin. Occurrences prior to departure, in particular traumatic events (war, human rights violations or torture) especially in relation to forced migration flows. Living and health condition, in the country of origin as well as in the countries of transit and destination.

b) The causes of migration, if it is forced, crossed by experiences of smuggling and trafficking, or if personal or family security is compromised if the person does not migrate.

c) On the way. Experiences of exposure to violence and abuse, as well as material and nutritional deficiencies.

d) The processes of adaptation - and maladaptation - in the destination country. Linguistic, cultural and geographical proximity to the destination.

e) Experiences of discrimination based on xenophobia, racism, gender identity, religion, among other forms of discrimination.

f) Poor working conditions or restrictions for professional development in accordance with expectations.

g) Lack at an economic and material level, which determines access to sufficient and adequate food.

h) Overflowing psycho-emotional experiences without proper care. Ideas of self-elimination, hopelessness.

i) Medium or long-term mental illnesses with discontinuation of treatments, and exposure to stressful situations.

j) Lack of access to utilities.

Exposure to stressors, of course, varies between different groups of migrants (economic migrants, refugees, asylum seekers, migrants in an irregular situation) but, in addition, within each of these groups there are also variations associated with the context in which migration and settlement in the destination country occur (WHO, 2018).

As mentioned above, being a migrant or refugee is not always a cause of vulnerability, although migration can become a condition that favors and even leads to experiencing situations of vulnerability (Lussi, 2015). Likewise, it is important to distinguish whether there is a violation of rights prior to migration or in the migration process. All of these are situations that must be identified as susceptible to vulnerability (Cuestas, 2011; Pussetti, 2010), to which we can add irregularity, the lack of adequate social, educational and health support, among other social determinants of health, including exclusion and discrimination.

Among the protective factors of mental health, there are:

1. 1 the regulatory context that guarantees accessibility to early diagnosis and an assertive mental health treatment, which promotes adherence and continuity,
2. 2 the educational and sociocultural level,
3. 3 the development of the capacity for resilience,
4. 4the availability of personal, material and economic resources,
5. 5 the opportunities to project progress in one's own personal life project
6. 6 the possibility of establishing social and emotional support networks (among others).

In this sense, strengthening protective factors can help achieve favorable integration and reduce psychological suffering.

## 2.4 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT AS COMPLEMENTARY CONCEPTS

Taking into account what was proposed by the Inter-Agency Standing Committee (IASC), mental health and psychosocial support are defined as “all types of local or external support whose purpose is to protect or promote psychosocial well-being and/or prevent or offer treatment for mental disorders” (IASC, 2007). Mental health cannot be conceive of or limited exclusively to clinical interventions, nor can it be thought of as a field whose sole responsibility is the health sector, but rather requires multiple sectors for a comprehensive approach (IOM, 2021b). Hence and taking into account the Mental Health Law of Uruguay, which establishes that any health

impairment in human beings involves mental and somatic components, which occur in a specific social context (Law No. 19,529, 2017).

When arriving in a new country in the context of a migration process, the migrant's attention is placed on acquiring relevant information for survival during the first days (in the case of people who migrate in search of better living conditions, minimizing this statement in the case of people who migrate for reasons of study, tourism, or work), as well as to obtain basic accommodation, food, security, leaving mental health often in a second place.

In this sense, it is essential to incorporate the social dimension in the strategy of therapeutic approaches, involving interdisciplinary teams that promote contact with public policies and community services, both to achieve priority objectives (such as obtaining an identity card, obtaining affiliation to a health provider, joining educational communities, etc.) as well as to contribute to recreation and community life, empowerment and emancipation. In this sense, work with communities is essential to the IOM SMAPS proposal.

Working with psychosocial strategies as complementary to mental health treatments, favors personal and community psychoeducation (within migrant communities, for example), the prevention of psychoemotional conditions and promotes a better quality of life, understanding that well-being is restored, addressing all dimensions of being. “It is essential for the dignity of migrants to be treated as subjects and citizens. To accompany them in this task, the role of psychosocial workers is vital” (IOM, 2021, citing Schininá, 2017)

# CHAPTER 3) MENTAL HEALTH IN URUGUAY

## 3.1 ARRIVAL TO URUGUAY CONDITIONS AND ACCESS TO HEALTH CARE

In relation to the health requirements for entering the national territory, in accordance with the provisions of Decree No. 55/023 (February 2023), all health provisions that establish entry requirements for the national territory for those foreigners who intend to enter the country by any air, sea or land transportation are repealed. They will not need to have health coverage or medical insurance, which means that neither vaccination certificates nor the presentation of Covid-19 test results will be requested from travelers, regardless of their age or nationality[7].

Likewise, the law provides that migration irregularity does not prevent foreigners from having free access to health facilities. The authorities of these centers must implement the necessary services to provide migrants with the information that makes their regularization in the country possible (Article 9, Law No. 18,250, 2008). Considering that health is expressed in all spheres of being, and that it feeds back on the well-being associated with educational and labor integration, we highlight that non-national people also have access to education on equal terms

[7] Information as of November 2023 in the “Ministry of Public Health web”

to national people, beyond their documentary situation, according to the Migration Law. It is also worth pointing out that, according to Articles 16 and 17 of the National Migration Law, “migrants will have equal treatment with nationals with respect to the exercise of a work activity” and “the State will adopt the necessary measures to ensure that “migrants are not deprived of any of the rights protected by labor legislation due to irregularities in their permanence or employment.”

The Uruguayan regulations aim to guarantee the right to protection of the mental health of the inhabitants residing in the country, with a perspective of respect for the human rights of all individuals and particularly of those users of mental health services within the framework of the National Integrated Health System (Law No. 18,076, Art 2, 2006).

The Republic of Uruguay stands out for having an inclusive health system, with access to all inhabitants and including all migrants (beyond their administrative situation), asylum seekers and refugees.

### 3.1.1 CHALLENGES WHILE ACCESSING THE RIGHT TO HEALTH CARE PROVIDERS FOR MIGRANTS AND REFUGEES IN URUGUAY

The IOM uses six parameters to analyze the full accessibility of migrants and refugees to health services: legal accessibility; geographical accessibility; economic accessibility; information accessibility; provision of translation services; and cultural adaptation and awareness among service provider personnel.

The difficulties in achieving full accessibility in health are understood as barriers, and are classified according to various dimensions involved. Some authors propose a distinction between economic, social, cultural and administrative barriers. Different overlapping dimensions are also referred to in the accessibility criterion: non-discrimination, physical accessibility, economic accessibility and access to information (Ase and Burijovich, in Finkelstein, 2017). There are also those who consider that the geographical, economic-financial and organizational dimensions emphasize the cultural or symbolic dimension and define accessibility as the bond that is built between subjects and health services.

Regarding the care of migrants and refugees, linguistic, communication and/or cultural access barriers have been highlighted. Language barriers are not the only factor to consider regarding the possibility of establishing contact and communication, but they both constitute an aspect of singular importance, as will be seen later. According to the general recommendations on access to health in the IOM member countries, it is desirable that in different public offices in the health, education and justice sectors, among others, be the inclusion of translators or interpreters of these languages taken into account as well as, applications or, at least, establishing contact with community leaders and/or organizations to facilitate communication and improve access to services.

Regarding continuity of care, both in general health treatments and in mental health approaches carried out by migrants and refugees, situations of low adherence, interruptions, desertions

and/or abandonment have been described. Therefore, currently, the greatest challenge for addressing illnesses in general is being able to guarantee continuity of care in the community, in territories and areas where individual's daily lives occur. For this, it is important to assign value to the therapeutic project and to the bond established between the professional or health care team and the individual, contemplating the ways in which the general condition of migrants and refugee seeking counsel is combined with the peculiarities evaluated in the singularity and particularity of each case.

A dimension that has not yet been studied in depth at the local level has to do with the challenges of not having an administrative variable that reports the origin and ethnic-cultural background in the records of mental health care services at the national public level. Having information regarding the origin and time of arrival in the country could make it possible to outline policies on health and on mental health, adjusted to the reality of migrants, as part of a comprehensive strategy that takes into account diversity.

## 3.2 MENTAL HEALTH LAW N° 19.529

At a global level, mental health problems and those linked to substance use constitute a public health problem with a significant incidence of morbidity, disability and premature death (PNSM, 2020). In Uruguay, disability due to non-communicable diseases accounts for almost 90% of the total years lost due to disability (YLD) and mental disorders account for 33%. Considering disability due to specific disorders, depression and anxiety are those that have the highest percentages, 7.6% and 5.2% respectively. This is followed by the incidence of suicide and self-harm at 2.6% of disability-adjusted life years (DALYs). Severe mental disorders such as schizophrenia and bipolar disorder have 1.9% and 1.4% of APD respectively (PAHO, 2018, cited in PNSM, 2020).

Mental Health Law No. 19,529 (2017), sets forth as an object to guarantee the right to protection of the mental health of the inhabitants residing in the country, with a perspective of respect for the human rights of all people and particularly of those users of mental health services within the framework of the National Integrated Health System (Law 19,529, 2017). In 2020, the National Mental Health Plan 2020-2027 (hereinafter PNSM for its initials in Spanish) was created, intended to comply with Mental Health Law No. 19,529 in Uruguay.

According to the National Mental Health Law which is based on the WHO definition: "Mental health is understood to be a state of well-being in which the individual is aware of his/her own abilities, he/she can cope with daily life stresses, work productively and fruitfully, and he/she is able to make a contribution to his/her community. This state is the result of a dynamic process, determined by historical, socioeconomic, cultural, biological and psychological components." Likewise, the law also defines mental disorder as the "existence of a set of clinically recognizable symptoms and behaviors, associated in most cases with discomfort and interference with personal functioning. Social deviation or conflict, taken in isolation and without being linked to personal dysfunctions, should not be included in the notion of disorder."

The PNSM states that: “the general framework of mental health is to promote favorable conditions and support individuals, groups, communities and societies with the maximum development of their capacities and in the enjoyment of well-being. Mental health is an essentially unstable subjective and objective experience, characterized by the ability to face crises, enrich subjectivity and deal with one's own mental experience (PNSM, 2020).”

Principles on which the Mental Health Plan is based (stated in Law 19,529):

a) Considering the person as a whole, considering his/her biological, psychological, social and cultural aspects which constitute and determine his/her uniqueness.

b) Human dignity and human rights. The person must always be recognized as a subject of law, with full respect for his/her private life and freedom of decision about it and his/her health.

c) Principle of non-discrimination.

d) Promotion, with emphasis on the determining factors of the environment and the lifestyles of the population.

e) Universal coverage, accessibility and sustainability of services.

f) The equity, continuity and timeliness of benefits.

g) Care must be health and social, of high quality and humanized with an interdisciplinary and intersectional approach, which, in accordance with technical standards and care protocols based on scientific bases, respects the principles of bioethics and the human rights of health care services users.

h) The achievement of the best possible conditions of family, work and community integration of the person.

i) The state of the person with a mental disorder is modifiable.

j) The possibility of people to self-determination.

k) The linking of mental health to the effective exercise of the rights to work, housing, education, culture and a healthy environment.

l) The other guiding principles and objectives of the National Integrated Health System, set forth in articles 3 and 4 of Law No. 18,211, of December 5, 2007, that are applicable.

## 3.3 COMMUNITY MENTAL HEALTH

The Uruguayan Mental Health Law guides the mental health care process preferably at the community level, in coordination from that level to the levels of greater complexity when necessary. The Community Model establishes that mental health care is immersed and participates in the community reality and its complexity, it focus on the socio-community inclusion of people and seeks to provide the conditions that contribute to the full exercise of

rights and socio-emotional well-being. It allows to understand the importance of the context in the health and recovery of the person, it favors his/her social inclusion by recognizing people as part of a peer group (family or other) and a community, under the principles of integrality, territorialization and continuity of care (Ministry of Health, 2017).

Although three models of mental health care currently coexist in Uruguay (asylum, hospital and community based), the community health model has little development, mainly in the private health subsector (PNSM, 2020).

The IOM highlights the importance of the active participation of migrants and refugees, both individually and collectively, in building responses to their different problems (IOM, 2020). While social exclusion is a predictor of mental health conditions in the general population of host countries, migrants and refugees have a particularly difficult task in integrating into a new country and culture, as they often face negative attitudes, prejudice and even discrimination, which can undermine and hinder their efforts to integrate (WHO, 2018).

Social exclusion is a risk factor that generates psychological suffering and that can be modified and addressed through different interventions that favor the promotion of mental health.

Assuming the paradigm of community mental health implies, among others, a change of focus that goes from the individual to the community as the main axis. This passage allows for the incorporation of new instruments, such as community diagnosis, and new notions, such as population at risk, vulnerable groups and crisis intervention, which will be taken up here based on migrants and refugees.

People are always thought of in relation to a larger, community system. Communities host and are crossed by the interrelation between various other systems (such as the family, the peer group, religion, ideology, membership in diverse institutions, workplaces, among many others) and, therefore, they are a key axis in the planning of community mental health programs, differentiating them from those programs that tend to focus on individual needs (IOM, 2019).

On the other hand, to promote integration processes in the destination community, mental health aid must, on the one hand, always consider the articulation of collaboration schemes, establish a coordinating group that can bring together the various aspects of care of general health intertwined with mental health and in turn in coordination with other sectors.

The articulation is carried out between (IOM, 2019; IASC, 2007):

› social or protection services

› hostels

› food aid and other basic needs

› community centers, self-help and support groups

› income-generating work activities

› other activities of interest

› formal / informal education

› spaces for boys, girls and adolescents.

This articulation is extremely important to guarantee basic services and people's safety.

As indicated above, the community is the territory where the subjectivity of people is interwoven with other meanings and with social institutions. It is there where identities can be built, consolidated, strengthened or broken and relational processes of transformation unfold. In this way, the community participates as a process and as a result. As a process, it reduces conflicts, it commits and involves other people at different levels, managing expectations and avoiding misunderstandings, and it facilitates accessibility to different services. The community as a result helps to repair the torn social fabric, strengthens social cohesion and facilitates recovery by connecting organizations that can support various social groups (IOM, 2019). A more specialized level of interventions could focus on education and the health field, since educational and health institutions are almost unavoidable places for migrants and refugees.

As part of the recommendations presented in this Guide, the importance of sharing with migrants who are consultting the information on community organizations detailed in the section ***Repository and Sites of Interest for Migrants and Refugees*** is highlighted.

## 3.4 CLINICAL HEALTH SERVICES FOR MIGRANT CHILDREN AND ADOLESCENTS (IOM AND UNICEF)

As part of the strategies to address the reality of the IOM migrant population, in 2023 it was implemented in District B of the Municipality of Montevideo of Uruguay, in the Reference and Orientation Center for the migrant population (CRO for its initials in Spanish) located in the headquarters of the Peñarol Palace, a project jointly with UNICEF, to address the psycho-emotional needs of this population. It has both a psychological care service (provided by professionals from the Psychoanalytic Association of Uruguay (APU for its initials in Spanish) and social care (provided by the IOM social team) for children and adolescents (hereinafter NNA for its initials in Spanish). Within the objectives proposed in the project, in addition to the clinical approach, work is carried out on the socio-community sphere of children and adolescents and their families, taking social support as part of the well-being strategy. Likewise, the project stated the objective of systematizing the data collected to shed light on the specific reality related to the psycho-emotional sufferings of migrant children and adolescents, contributing to the still discrete clinical evidence about this reality in Uruguay.

This information will be available on the IOM website, starting in 2024.

# CHAPTER 4) TOOLS FOR MENTAL HEALTH ASSISTANCE WITH MIGRANT POPULATION

## 4.1 BIO-PSYCHO-SOCIAL MODEL IN A HUMAN MOBILITY CONTEXT

In order to contribute to thoughts on mental health care processes, with a focus on the population in situation of human mobility, IOM Uruguay, taking into account the considerations established in the preceding sections, propose the use of the bio-psycho-social model of clinical approach for health care professionals developed by Engel (1977), from an integrated reading of the three dimensions defined by the author, in addition to including a new dimension that intends to address the circumstances of human mobility processes, to respond to the needs of migrants and refugees in a comprehensive manner.

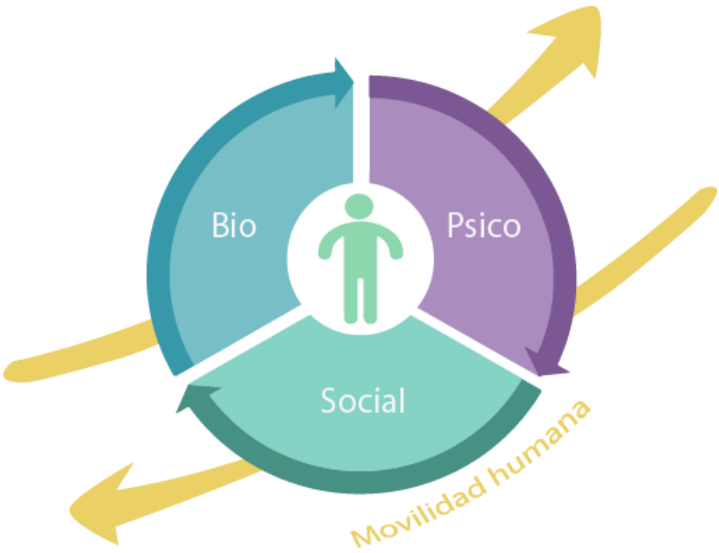



Fig. 1 Modelo Bio-psico-social en contexto de movilidad

The bio psychosocial model (Engel, 1977) was proposed with the objective of problematizing the biomedical model oriented solely to the disease as a discrete, isolated unit, but not to the person as a whole, exposed to several ongoing dynamic events. The conception focused solely on attention to the clinical presentations of the illnesses enables a distancing in the health care professional-patient relationship causing a dehumanization in the relationship between both.

According to Engel's model, health-illness is an integral process, where biological, psychological and social aspects are articulated, which interact generating harmonies and disharmonies that result in symptomatological presentations, but, above all, in experiences of suffering and well-being.

### 4.1.1 APPROACH FROM AN INTERGENERATIONAL POINT OF VIEW WITH AN ETHNIC-RACIAL AND GENRE PERSPECTIVE

As a starting point, before delving into the analysis of the model, we must point out that any approach that focuses on the person as a subject of rights, whether clinical or psychosocial,

aligned with professional codes focused on ethics, must necessarily be structured taking into account the intersections of the various dimensions that each person goes through.

When we carry out a situational analysis, when faced with a consultation on mental health issues, attention must be paid to the particularities presented by the different life stages, in addition to identifying whether we are dealing with a person with possible experiences of discrimination due to racism, xenophobia or unequal or discriminatory treatment because of his/her gender, or for being part of a minority of sex and gender diversity. It should be taken into account how migration impacts, and what elements the person (and his/her family unit, his/her community) has to manage expressions of mental illness.

For example, a behavior that appears deregulated in a certain scenario, for example in education, can be taken as an indicator of maladjustment due to poor emotional management, caused by: going through maturational processes, or experiencing discriminatory treatment, or for having experienced situations of abuse during the journey due to being in a more vulnerable condition (for example for being a young adolescent or a trans person), or it can be taken as a difficulty for integration to the new country. Or all those causes together. Thus, the challenge of analyzing and discriminating what is typical of migratory processes.

At the same time, it should be noted that, in the face of multiculturalism, it is necessary to think about the conceptualizations of topics, as for example, childhood, gender roles, treatments accepted or guided by religious or cultural codes, since these permeate not only the diagnostic context, but also the particularities of the therapeutic relationship.

It should be considered that the need for psychosocial support is intensified for those who have suffered some type of persecution or violation of rights in their country of origin, those who request asylum or have obtained refugee status. This group of people is a minority in quantitative terms, but qualitatively requires greater support both with respect to the satisfaction of basic needs for accommodation, income, support for language learning, among others, as well as in terms of the psychosocial sphere and support in mental health.

## 4.2 BIOLOGICAL DIMENSION

Considering that this Guide is conceived as a tool to strengthen the capacities associated with working with the migrant population in areas of mental health care and psychosocial support in Uruguay, in specialized as well as community services when referring to the biological dimension, we not only refer to the organic aspects, such as the biological or genetic causes of mental illnesses (brain biochemical imbalances or metabolic and hormonal imbalances, among others) that may present alterations or symptomatological expressions verifiable clinically or the medical history (if the person has documentation that confirms this fact), but also to the bodily experience that people go through during the migration processes.

The body as a machine which is at the service of subjective desire is activated (and often urged and pushed to its limits) subjected both to adaptation processes to new climatic, gastronomic, environmental scenarios, and to the effects of the circumstances experienced on the journeys or migratory routes.

The experiences of people who arrived from their country of origin by plane cannot be compared with those who did so after long periods of time walking, or using illegal and risky means of transportation, exposed to lack of water and food, to situations where housing conditions were unhygienic if they had to sleep outdoors, or were exposed to infectious diseases, or insufficient health care. Others have had to carry their sons and daughters in their arms, or to help older people during the journey, or who, as teenagers, had their physical and emotional security violated or were mistreated, or arrived in the country as victims of trafficking networks (among other possible situations). The energy and life force availability in each of these scenarios may be different.

Pre-existing mental disorders must also be taken into account to be addressed in a specific way, since they require special attention. This means paying special attention, acting quickly and operating where necessary so as not to exacerbate emotional issues that threaten the psychosocial well-being of migrants.

This perspective accounts for the multifactorial aspect of the “Bio” dimension of the model, in migrants and refugees.

## 4.3 PSYCHOLOGICAL DIMENSION

What is the place of migration in the life project of the person who experiences it? What are the psychological processes and mechanisms activated in the face of mobility and its circumstances? How is it expressed in a person to stop biographical projections, or to reconstruct them in another territorial scenario, another psychosocial scenario?

Identifying the causes of mental illness depends on several factors that may not be evident in a first anamnesis. In situations where illnesses associated with the effects of migrating are identified, it is suggested to be aware of the impact of asking questions about life circumstances during journeys, especially with those people who show deterioration in various aspects of life. Stories of pain are told, where from a local perspective, it can be challenging to understand the psycho-affective significance of migrating, for example, under non-regular circumstances, going through situations where other people guide the journey, in exchange for the promise of arrival.

Among the elements involved in mental illnesses in the migrant and refugee population, it is useful to think about the psychological context, conceiving not only the historical and idiosyncratic background, but also taking into account that the person scheduled for the appointment may be going through a migration process that has not yet reached its destination, since many of the people who currently arrive in Uruguay do so as part of a re-migration process.

A fundamental point in relation to mental health care for migrants and refugees is that, depending on the cultural codes, the therapeutic bond that is established can be experienced asymmetrically, with the person sensing a feeling of insecurity which can inhibit complete emotional expressiveness.

Active listening (of the manifest and latent reasons for consultation) and empathy are essential resources for establishing the therapeutic bond.

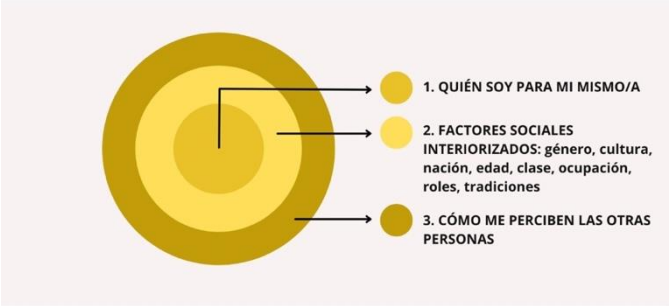
There are (as in native people), urgency indicators that must be considered with due responsibility by the medical and/or community reference personnel, such as the appearance of feelings of self-elimination or . Risk groups and care for severely ill patients and chronic patients, with and without a prior diagnosis, must also be prioritized.

## 4.3.1 IDENTIFYING PROCESSES AND MIGRATION

Identity is a central concept in the psychosocial well-being of individuals and groups, particularly in the face of adversity, crises and displacement. The definition of identity refers to the characteristics that determine what a person is like, and the same applies to collective identities, including communities and group identities.

For the purposes of this document, it is useful to generalize the most common underlying elements according to the different psychological and sociological theories in such a way that it could be summarized that identity is a system built by the interrelation of three components (see picture):

FIGURA 3. COMPONENTES DE IDENTIDAD




*FUENTE:* ADAPTADO DE SCHININÀ (2012) EN "MANUAL ON COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES AND DISPLACEMENT" (OIM, 2019D).

These three components continuously feed each other, since the construction of identity is always dynamic.

»The first component (in the center of the picture) is the concept of "self", which corresponds to who one is to oneself. This component is not neutral, since the "self" ascribes qualities, characteristics, cultural beliefs and roles based on internalized social factors, such as culture, beliefs, education, gender and other socially learned roles.

»The second component is provided by dynamic theories, which include here the influence of archetypes and unconsciously inherited elements, which are crossed by the hegemonic and secondary cultures to which one belongs, such as gender, culture, traditions, etc., either by assimilation or by contrast to them.

»The last component is relational and is determined by how one is perceived by other people: family, friends, colleagues, clients, neighbors and persons of authority. Identity is multifaceted. The "I" is made up of different aspects: the family aspect, the professional aspect, the romantic aspect, among others.

A topic that has appeared as central in the interviews carried out for this document is the fact of the stereotypical and discriminatory expressions that people on the move report having received, also in healthcare settings. For this reason, recognizing this fact as a barrier in the comprehensive assistance of the population is a duty of the professional technical teams involved.

The three components may have different impacts on the way an identity is shaped in a given community. And identity is the result of a permanent negotiation between a person's behavior with themselves, with their culture and with their community. Likewise, identity is in permanent development and changes according to one's own experiences, education and cultural transformations, within a system and with other similar ones. Identity is built and evolves, as it is affected and modified in people's daily lives (IOM, 2019).

### 4.3.2 PERSISTENCE IN CHANGES

The different changes in people's lives affect identity and these changes are part of the evolution natural process of a person in different stages of life when facing various situations and contexts.

We can mention the evolutionary changes (those related to the maturation development of the various stages of life): ways of getting sick of growing, of reaching old age. Situational changes (sudden, caused by external causes, often beyond the control of the person): separations, job losses, deaths of loved ones, constant changes of address.

But in human mobility processes, people can experience a persistence in changes that is experienced as instability, which, if sustained, can affect the person's adaptative mechanisms. Likewise, illnesses can be experienced at various times during the migratory process, showing symptomatological manifestations, for example, upon arrival, during the first months or years. In any case, the dimension of migration must be taken as an element to analyze.

Part of the resilient aspect of a migration history is that, for many people, if the life project does not materialize in the country of arrival, the possibility of continue migrating is an option; which can compromise adherence to treatments and the possibility of continuing them. For this reason, it is a recommendation that therapeutic indications be conceived taking this possibility into account.

### 4.3.3 MIGRATION AS AN EXPERIENCE OF BREAKAGE IN ROLES AND IN FAMILY STRUCTURES

Every time a person leaves his/her home, his/her individual and family life remains marked by the mobility process. There are many stories that tell of intra-family existence permeated by that migratory ubiquity where upbringings are shared through video calls, or more structural family ties are maintained through distant communication. Transnational families are a reality for many migrants and refugees in Uruguay. Migration may imply a modification or discontinuity of bonds. It is important to recognize how it impacts each life stage, for example, in the case of children, where uncertainty management depends on evolutionary development, distance can be experienced as a meaningful loss, resulting in a mourning.

Throughout society, there are affectionate, protective and other intra-familiar experiences that expose individuals to violence and abuse, which is why, in some scenarios, not having the

closeness of family and/or affectionate bonds can mean an element of deterioration of the close and psycho-affective community network; but in other scenarios, it can mean an element of improvement and survival as well as a reconstruction of family bonds. Despite this, in most cases, family networks are compromised.

### 4.3.4 SUBJECTION TO BREACHING OF BASIC RIGHTS

Although not all migratory stories are affected by poor travel conditions, in the current migratory flows above all in populations which migrate among the Americas, there are stories telling about very long journeys, with walking periods, subject to climate changes, with experiences of theft and loss of personal belongings, generating a deterioration in the general existence of those who arrive. These conditions generate a direct impact on people's well-being, with a priority objective being to address assistance strategies focused on restoring living conditions in a dignified manner enabling personal development.

During the integration processes into the new society, it is common for people during the first months in the country to solve their housing, in spaces of collective coexistence such as boarding houses. In these places, coexistence is not always presented in an emancipatory way, but it is experienced from the compression of individual and family spaces. Under these circumstances, states of great stress and problems in managing emotions can be experienced. Decompressing these spaces, for example, referring to recreational and leisure activities outside the coexistence centers, can collaborate in therapeutic or psychosocial integration processes.

## 4.4 SOCIAL AND COMMUNITY DIMENSION

Considering that this dimension refers to the social framework, where aspects such as the historical background of people, interpersonal, family, and community relationships can be identified; idiosyncrasy, cultural and religious backgrounds, as well as socio-economic and labor development aspects, when we talk about people who, having been born in a territory for various reasons, have experienced migration, this dimension takes on another meaning.

The first level of intervention in social integration is to guarantee the basic needs that make up people's subsistence conditions, in compliance with essential rights.

All those “basic” integration aspects that native people have, or have gradually incorporated, such as having an ID card, being affiliated with health services, knowing the educational and work dynamics - and being part of these -, having a social and community network of closeness, of emotional support, are elements that newcomers must resolve in the short and medium term.

In Uruguay there are several civil society organizations working with the migrant population (detailed in section 1.3) and generating initiatives that address various dimensions of integration. In this sense, the Intercultural Nursing service (EIC for its initials in Spanish) stands

out, for example, among the activities proposed by the NGO “Idas y Vueltas”, where assistance is provided in the affiliation processes to public and private health providers, as well as early detection of clinical diagnoses and referrals to specialized services is worked on. In relation to mental health services, several organizations provide assistance on psycho-emotional issues to the migrant and refugee population.

Within the mental health protection components, the community dimension is essential in the processes of agency and empowerment of those people who, as a result of the migration processes, have experienced emotional decompensation or acute states of chronic mental illnesses. In this sense, in the NGOs referred to above, recreational and meeting spaces are provided, so it is important to refer to these services as a strategy for community support of mental illness and strengthening social ties as a protective element.

In the context of mental health counseling or psychosocial support, in addition to taking into account the socio-temporal context where the counseling is carried out, to address care from an intercultural perspective, it is necessary:

-To take into account the closest social context. If the person traveled alone, if they have done so as a family. Whether the experience of integration with the immediate environment is being experienced in a pleasant way or the person is experiencing discomfort. The socio-relational aspect has to do with the quality of the relationships between each individual, his/her family and the broader social systems and communities to which he/she belongs to.

- Integration processes in the destination community. What role is played in the integration processes (for example, due to the difficulties of practicing the profession or trade in the destination country or the difficulty of finding work.)

-If respect and validation of the cultural and idiosyncratic background is experienced by the host society, or a sense of acculturation is experienced from a perspective of assimilationist (the person feels forced to a loss of cultural identity, due to discrimination or solitary confinement), or discrimination based on xenophobia, racism, aporaphobia.

-If he/she has been a victim of human trafficking, as well as if his/her autonomy has been compromised and violated.

-The possibility of establishing contact with organizations and associations of people from the same country of origin. There have been experiences where establishing ties with these community reference groups has collaborated with therapeutic progress.

Facing new roles, social structures, language and ways of understanding the world (among others) is a challenge that puts migrants in the dilemma between adapting (acculturating) or maintaining their own cultural identity, a reality that can be affected by the pace of the integration process (slower, faster) and the possible existence of discrimination associated with their status as migrants.

In crisis and emergency contexts, psychosocial support teams become key emotional references for affected people. In this sense, they are in the position of co-builders of the identity of the affected populations, which places them in a position of power. It then becomes essential that

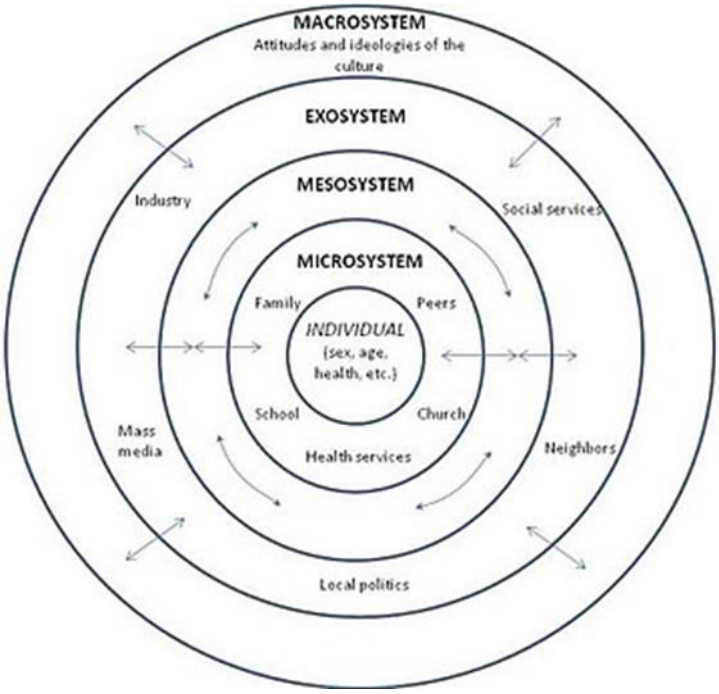
those people who work in crisis or emergency contexts do not contribute to creating a negative identity in the affected populations founding the relationship exclusively on the needs and vulnerabilities of the people, since there is a risk of creating a victimizing identity or one based on pre-established categories. A community approach advocates for the protection of the richness of the identities of affected populations and always thinking that those who intervene in crises (organizations, institutions, teams and workers) are part of the system that can determine to a certain extent the development of these identities.

### 4.4.1 THE COMMUNITY NETWORK AS A PROTECTIVE FACTOR FOR MENTAL HEALTH

The psychosocial well-being of people on the move is strongly linked to factors that are strictly interrelated with the concept of community. These factors include sense of belonging, social roles, culture and cultural adaptation, dynamics between tradition and change, differences in social support paradigms, sense of identity, relationships and endogenous and exogenous stigmas (IOM, 2021).

Communities can be drivers of their own care and change and must be meaningfully involved in all stages of SMAPS responses. People affected by the circumstances of migration should be seen as active participants in improving individual and collective well-being, rather than passive recipients of services designed for them by other people. This community-based psychosocial approach helps families, groups, and communities understand ways to encourage recovery and resilience, focusing on rebuilding and strengthening those structures and systems essential for daily life and well-being (IASC, 2019).

At IOM we start with the idea that individuals are part of a socio-ecological system that includes families, larger human systems and communities (see figure 1), and, consequently, communities are the cornerstone of SMAPS programs. which, instead, tend to focus on individual needs.




People are always conceived in relation to a larger community system. In the broadest sense, “community” refers to a group whose members share certain common traits – such as geographic location or perceived location of origin, language, interests, beliefs, values, tasks, political affiliation, ethnic or cultural identity, the sense of belonging and others and whose size varies from very small, like a nuclear family, to extremely large, like the inhabitants of an entire continent. More precisely, communities are human systems characterized by interrelations and interactions among their members in a given context, crossed by the interrelation with other systems (such as the family, the peer group, religion, ideology, membership in various institutions, workplaces, among many others) and, therefore, are a key axis in the planning of community mental health programs, differentiating them from those programs that tend to focus on individual needs (IOM, 2019).

Interactions among individuals, the human systems resulting from these interactions, and between these systems and more transcendental elements - such as culture, beliefs and epistemologies - create a sense of belonging and security and are central to the definition of identity. Identity is the cornerstone of a sense of community and psychosocial well-being, and is essential to understanding the psychosocial well-being of migrant populations affected by crisis.

# CHAPTER 5) INTERCULTURAL APPROACH TO FAVOR THE INTEGRATION OF MIGRANTS AND REFUGEES IN PSYCHOSOCIAL AND MENTAL HEALTH CARE PLACES

When we talk about an intercultural approach, it is one that accounts for the simultaneous presence of populations with different cultural belongings in the same territorial space, recognizing that it is not only important for cultures to coexist, but also the importance of generating strategies to strengthen this co-presence, based on the recognition of the existence and value of cultural diversity, promoting dialogue between them (IOM, 2017).

The concept of interculturalism attempts to reflect the relationship among the different cultural groups that coexist in the same social space, without ignoring the unequal power relations on which many of the alleged cultural differences are built. In this sense, interventions based on an intercultural approach involve not only recognizing differences and promoting the encounter and coexistence between cultures, but also questioning the conditions through which many of these differences are built and ordered hierarchically, through a monoculture paradigm that in Western society is strongly characterized by a white, masculine and heterosexual identity (IOM, 2014).

It is necessary for those devoted to psychosocial work with people in situation of mobility adopt an intercultural approach that allows them to communicate effectively, shorten the distance in the relationship with migrants and generate a relationship of trust in order to provide efficient and relevant care. It is about respecting the beliefs of those who consult, overcoming cultural and linguistic barriers, and proposing health care that does not conflict with their frame of reference.

Although definitions of culture vary significantly in literature, for the purposes of this document, culture is considered as a system of shared beliefs, symbols, myths, behaviors, canons, images, narratives, metaphors, artistic productions, rituals, values and customs that members of a society use to give meaning to their world and relate to others. Culture includes collective materials and immaterial elements that allow the specific community to represent itself as distinct and cohesive. In this perspective, culture and its elements could offer protective, restorative and transformative support after disruptions, promoting participation, a sense of continuity, acceptance, resilience and a place for positive social interactions in emergency settings (IOM, 2021). A fundamental issue when working with migrants and refugees is to respect the cults and religions that are part of their culture. The intercultural perspective supposes a communion of understanding and respect for the comprehensiveness of the cultural background of migrants and refugees assuming that dominant cultures may differ between migrants and their host communities, with the problems of sense of identity that this may create in the two communities. On the positive side, subcultures can cross the boundaries of the dominant culture with alliances, thus driving integration. Indeed, subcultures allow mutual recognition and convergence of interests among

individuals with the same subculture within different dominant cultures, such as migrants and members of the host culture who share a subcultural identity (e.g., the same religion, the same musical culture, LGBTQI individuals).

Therefore, it becomes relevant for health workers to consider practices linked to religion, since they greatly influence the points of view that each person has towards health, pathological processes and their healing (Jelin, 2006). In this sense, it is necessary to start from the basis that there are different conceptions linked to the processes of health – illness – attention – care (PSEAC for its initials in Spanish), depending on the different cultures. It is advisable to get acquainted with these concepts, to try to understand and respect them, seeking points of agreement between professional and patient for care and treatment.

According to Langdon and Wilk (2010: 184), "each and every culture has concepts about what it is to be sick or healthy. They also have classifications of diseases, and these are organized according to criteria of symptoms, severity and others. Their classifications and concepts of health and disease are not universal and rarely reflect biomedical definitions.

When thinking about the diverse expressions of cultural background, it is interesting to pay attention to the existence of diverse parenting models, where without this intercultural analysis, there are risks of pathologizing attachment experiences, or over-adaptation behaviors of childhood, the product of taking a position closer to the "adult" one in following cultural patterns, or due to emergency issues in integration.

## 5.1 SUGGESTIONS TO ADOPT AN INTERCULTURAL APPROACH IN MIGRANT POPULATION CARE

- To take into account that people who search for counseling, health workers and administrative staff of health centers may have different conceptions about health and disease processes, depending on their beliefs, practices and values.
- It is important to develop and strengthen intercultural competencies in order to offer more appropriate, effective and relevant healthcare.
- To generate a relationship of trust with the person, showing empathy and tolerance in the face of cultural and linguistic barriers that may arise.
- To take care of expressions of contact and behaviors that may invade people's personal spaces.
- In addition to vocal communication, it is necessary to pay attention to the non-vocal register, such as gestures, expressions, postures, tone of voice, silences, etc. This type of communication can provide valuable information about who is consulting.
- Should it be necessary, incorporate the interpreter and/or cultural mediator role

- If possible, write the diagnosis and treatment so that, if the person is unable to understand or remember it, somebody can read the outcome of their counselling to them.
- Creativity to communicate with migrants is essential, given that understanding and accompaniment others require the use of original mechanisms. For example, having picture cards that point out different situations that people seeking attention may go through, whether common actions, objects, or other ways of reflecting feelings or emotions, can be useful to start an exchange. Colors can also be used to connect medication boxes to the schedule or order in which they should be taken, among other creative options.
- Ask or observe if the person really understands the language in which they are being spoken to, or if they have difficulties understanding it. If so, use an interpreter, consult the health center staff or, if such possibilities do not exist, use graphic means of communication: drawings, pointing out body parts, etc.
- If possible, avoid having the children of those who consult act as translators. Generally, and as children usually learn the language and adapt to the new context before their parents do, they are assigned this type of responsibilities, the consequences of which are the overload of children and adolescents, the demotivation of parents to learn the local language and the reversal of roles that ends up structurally affecting families.
- Many times, the difficulties do not lie in the language, but in the lexicon, which is why it is suggested to clearly explain the situation in which the person finds him/herself and ask them if they have understood correctly, since it is possible that some of the information may not have been grasped. It is a right to know about his/her health status and it is an obligation of his/her professionals to collaborate with this objective.
- What has been developed so far can be thought of as tools to facilitate the integration of migrants and refugees in destination communities from an intercultural perspective that favors the promotion of health and mental health.

# CHAPTER 6) OTHER RESOURCES FOR THE APPROACH TO HEALTH CARE

## 6.1 PSYCHOLOGICAL FIRST AID

The so-called “Psychological First Aid” (PAP for its initials in Spanish), is an intervention proposal that can be carried out by people in the community who do not have specific training in mental health with the aim of helping and supporting people who are dealing with crisis.

Although the PAP was originally intended as a resource to respond to the immediate needs of people who are dealing with crisis after going through humanitarian emergencies, catastrophes and/or forced massive displacements, this does not characterize the majority migration processes in Uruguay.

However, the PAP offers guidelines that can be considered by health personnel in general as well as by mental health professionals and various NGOs specialized or not in working with migrants.

Next, some of its fundamental principles will be developed, but not before recommending the complete reading of “Psychological First Aid: Guide for field workers” (WHO, 2012). The use of PAP techniques has been recommended by several consensus groups and international experts, including the United Nations Inter-Agency Standing Committee (IASC) and the Sphere Project.

Psychological First Aid consists of the implementation of a set of techniques that in the first place respect the rights of the person and as a final objective enable people to help themselves and recover their rights and psychosocial well-being. This is a non-specialized technique that can be implemented by anyone who has been trained for this. No particular certification, qualification or academic degree is required.

The essential rule of every PAP is to guarantee security, rights, privacy, confidentiality and respect for what the person decides and chooses to share. To achieve this, it is important to hierarchize empathy and to decenter one's own gaze, which implies to:

- review prejudices, stereotypes and personal preferences;
- adapt the action by not imposing one's own cultural guidelines on the people who are going to be accompanied;
- show availability to listen (to pay attention to vocal and body language), giving the space and courage necessary for the person to share his/her story if they wish to.

The three basic principles of PAP action in any context are to carefully observe, listen and connect the needs and concerns defined by people, establishing priorities between what urgently needs to be resolved and what can be postponed. The last point is crucial, since it implies facilitating access so that migrants can resolve their basic needs and resume those that may be impeded or restricted. Below are some very important recommendations when providing first psychological aid.

PICTURE 6 – RECOMMENDATIONS TO PROVIDE FIRST PSYCHOLOGICAL AID

| WHAT TO DO AND WHAT TO SAY | WHAT NOT TO DO AND WHAT NOT TO SAY |
|---|---|
| • Try to find a quiet place to talk, minimizing outside distractions.<br>• Respect privacy and keep the story confidential, except for reasons of force majeure.<br>• Stay close to the person while keeping an appropriate distance according to his/her age, gender and culture.<br>• Let him/her understand that you are listening, e.g. nodding your head or saying "hmmm...".<br>• Be patient and keep calm.<br>• Offer concrete information if you have it. Be honest about what you know and what you don't know. "I don't know, but I'll try to find out."<br>• Give the information in a way that the person can understand, that is, in a simple manner.<br>• Let him/her know that you understand how he/she feels and that you are sorry for his/her losses and what has happened to him/her, such as becoming homeless or losing a loved one. "I'm very sorry. I imagine this is very sad for you."<br>• Let him/her know that you recognize his/her strengths and how he/she is helping himself/herself.<br>• Leave spaces for silence. | • Don't pressure the person to tell his/her story to you.<br>• Don't interrupt or rush the person while telling his/her story (for example, don't look at the clock or speak too quickly).<br>• Do not touch the person if you are not sure it is appropriate.<br>• Don't judge what he/she did or didn't do nor his/her feelings. Don't say things like "You shouldn't feel like this," "You should feel lucky to having survived."<br>• Don't invent things you don't know.<br>• Do not use overly technical expressions.<br>• Don't tell someone else's story.<br>• Don't talk about your own problems.<br>• Don't make false promises or give false reassuring arguments.<br>• Don't think or act as if you have to solve all of the person's problems for him/her.<br>• Don't take away his/her strength, his/her feeling of being able to take care of himself/herself.<br>• Don't talk about other people in negative terms (for example, calling them "crazy" or "disorganized"). |

*Source: adapted from: "first psychological aid: guide for field workers" who, 2012b*

Given that PAP is a strategy that includes different levels of multisystemic intervention, it is essential that the person who is going to provide help is located as a link within a network of functions and responsibilities of different people and services that are collaborating. Support implies always working as a "liaison" that enhances the progressive acquisition of notions of self-care by the people who receive help and always taking into account the scope of the task itself.

In this sense, there may be situations in which the person needs much more advanced support than just PAP. It is important to know your own limits and seek help, for example from healthcare personnel (if available), colleagues or other people in the area, local authorities or community or religious leaders.

People in the following situations need immediate medical or other support as a priority to save their lives:

- people with serious, life-threatening injuries who need urgent medical attention;
- people who are so upset that they cannot take care of themselves or their children;
- people who can harm themselves
- people who can harm others.

## 6.2 MHGAP GUIDE: CARE IN FIRST LEVEL AND REFERRAL TO MENTAL HEALTH CARE

From the Mental Health Gap Action Programme (MhGAP), they developed the MhGAP Intervention Guide in its Spanish version 2.0, which was published by PAHO / WHO in 2017. It was prepared with the objective of training in mental health, health workers who provide non-specialized care in first and second level health care facilities. There is also another version of the MhGAP Intervention Guide, focused on the clinical management of mental, neurological and substance use disorders in humanitarian emergencies. It is known as the "mhGAP Humanitarian Intervention Guide" (GIH-mhGAP).

This guide urges to integrate the parameters mentioned above about particular attention to migrants and refugees into the MhGAP Intervention Guide. The most important action points are summarized below.
Its general principles are:

- Use of effective communication skills, for which it is proposed:
- To create an environment that facilitates open communication in a private place, if possible.
- To involve the person in all aspects of the evaluation, as much as possible.
- To start by listening, being understanding and sensitive.

- To be friendly and respectful at all times, without judging the person.
- To use good vocal communication skills, with simple and clear language.
- To respond sensitively when people disclose difficult experiences (such as sexual assault, violence, or self-inflicted harm).
- To promote respect and dignity,
- Without discriminating or overlooking the priorities or wishes of people with mental disorders and protecting the confidentiality of people.
- To promote autonomy and independent living in the community. Among the essential elements of mental health clinical practice, it is always suggested to first evaluate the person's physical health, taking note of his/her history and asking about risk factors. At the same time, to accompany it with a physical examination in which a differential diagnosis be considered and comorbidities be detected. Always keep in mind that this is an opportunity to promote a healthy lifestyle and to give advice on the importance of creating lifestyle habits that include physical activity and healthy nutrition.

## IASC GUIDE ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN HUMANITARIAN EMERGENCIES AND CATASTROPHES

While this chapter will focus on contexts where emergencies and disasters do not typically occur, the IASC (Inter-Agency Standing Committee) guide presents recommendations that can be used in all contexts and provides an appropriate theoretical framework for mental health and psychosocial support interventions for migrants and refugees. This guide was published in 2007 with the purpose of generating recommendations that enable "humanitarian actors and communities to establish, plan and coordinate a set of minimum multisectoral responses to protect and improve the mental health and psychosocial well-being of people in emergency situations" (IASC, 2007). This guide focuses, above all, on the implementation of minimum responses, i.e., the essential and high priority responses that should be implemented as soon as possible in an emergency. Minimal responses are the first thing that must be activated, they are the essential first stages that lay the foundation for later more comprehensive tasks (IASC, 2007). Below, its fundamental principles are detailed, which should guide all the actions of people involved in psychosocial support tasks, regardless of the situation in which they are carried out.

**» 1. Human rights and equity**: Those providing humanitarian assistance should promote the human rights of all affected people and protect individuals and groups most at risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination.

**» 2. Participation:** Humanitarian assistance should maximize the participation of affected populations in the humanitarian assistance response. In most emergency situations, there are

many people who are resistant enough to participate in relief and reconstruction efforts.

**» 3. Do no harm:** Work in mental health services in psychosocial support can cause harm as it deals with extremely sensitive issues. Humanitarian aid providers can reduce the risk of harm in a variety of ways, including:

> a) to participate in coordination groups to receive information from other actors and to minimize duplication and gaps in the response.

› b. to design interventions based on sufficient information.

› c. to commit to evaluating and accepting external audits and reviews.

› d. to develop cultural sensitivity and competence in the issues in which one intervenes or works.

› e. to stay up to date with the practices that are considered most effective.

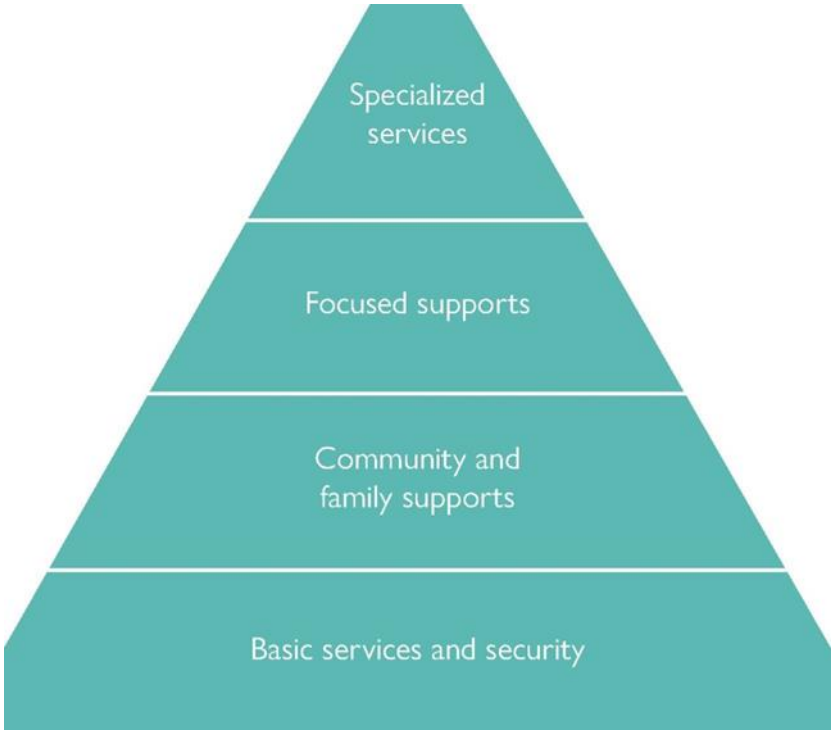
› f. to understand universal human rights principles, power relationships between foreigners and those affected by an emergency, and the value of participatory approaches, and constantly keep them in mind.

**» 4. To take advantage of available resources and capacities**: All affected groups have their own positive and adequate resources to mental health and psychosocial well-being. An essential principle - even in the early stages of an emergency - is the promotion of local capacities, supporting self-organization, self-aid and strengthening already existing resources. Driven and implemented programs from abroad often lead to inappropriate mental health and psychosocial support solutions with little sustainability. Where possible, it is important to build the capacity of both local government and civil society.

**» 5. Integrated support systems:** To the extent possible, activities and programming need to be integrated. The proliferation of services and stand-alone services, such as those that only care for people who have experienced sexual violence or people with certain diagnoses, such as post-traumatic stress disorder, can create a highly fragmented system of care.

**» 6. Multi-level supports:** In emergencies, people are affected in different ways and require different types of support. A key to organizing mental health and psychosocial support services is establishing a multi-tiered system of complementary supports that meet the needs of different groups. This can be illustrated using a pyramid, as will be seen below. All the levels of the pyramid are important and, ideally, should be implemented concurrently.

Once the fundamental principles have been stated, the pyramid of interventions for mental health and psychosocial support services in emergencies will be taken and broken down. Although the proposed model is designed for emergency and disaster contexts, it can also be applied to other types of scenarios.




Source: Manual on Community based mental health and psychological support in emergencies and displacement, IOM (2019D)

## I. BASIC SERVICES AND SECURITY

It is necessary to protect the well-being of all individuals (both migrants and non-migrants) through the establishment or re-establishment of security measures, adequate governance and services that respond to basic physical needs. For example, it is considered at this level the access to information regarding the rights and obligations that the Migration Law grants to migrants in the Republic of Uruguay as well as obtaining the Identity Card, access to health and education in decent conditions, access to housing, among others. "First Psychological AID" (PAP) is also included, since it is an intervention that can be carried out by people in the community who do not have specific training in mental health with the aim of helping and supporting people who are in serious crisis situations. A response to the need for basic services and safety consistent with the principles of mental health and psychosocial support may include the following: advocating to responsible actors for the establishment of such services,

documenting their effects on mental health and psychosocial well-being, and influencing on those providing assistance to provide services in ways that promote mental health and psychosocial well-being.

## II. COMMUNITY AND FAMILY SUPPORTS

The second level corresponds to facilitating processes to reestablish, in the host community, healthy family and community roles, according to the context in which migrants find themselves. At this level, useful responses include: family tracing and reunification, mass media dissemination of possible methods for host communities to actively participate in the integration of migrants, support programs for parents to solve problems with their sons and daughters, school and out-of-school education activities, activities to provide new livelihoods and activation of social networks, for example through women's groups and youth groups. It is essential that, upon arrival at the host location, migrants obtain containment, information and support to generate links and networks (Carpio, 2019). To achieve this, it is essential that the different actors involved in the integration processes of migrants can work together. In this sense, civil society organizations, migrant associations, international organizations and the State can propose effective devices for the elaboration of the migratory experience, to access relevant information in terms of access to rights, to weave a solid support network and to begin building an integration process in the country that is satisfactory for those who have migrated.

## III. FOCUSED SUPPORT

The third level corresponds to the support necessary for an even smaller number of people, who also need more focused interventions at the individual level, of family or group, by trained and supervised health workers (but who may not have years of training in specialized mental health care and psychosocial support). Targeting refers to the particular needs of the population group that requires a type of intervention specifically designed for their psychosocial needs. This intervention is not offered universally because it is only useful for a specific population group. Furthermore, it is possible that the psychological consequences that this population group presents require interventions on a therapeutic level, something that is not necessary for those who benefit from the interventions carried out at levels one and two. To give some examples,

survivors of violence benefit from this level of care and may need community health workers to provide a combination of emotional support and to help them achieve means of earning income that allows them to be financially independent. This level also includes the elements of psychological first aid (which will be developed later) and basic mental health care provided by primary health care agents.

## IV. SPECIALIZED SERVICES

The apex of the pyramid finally corresponds to the additional support needed by a smaller percentage of the population whose disorders, despite the supports already mentioned, are intolerable and who would encounter great difficulties in basic daily functioning. This assistance should include support from a variety of mental health specialists, including, but not limited to, specialized psychological (provided by clinical psychologists) or psychiatric support for people suffering from symptoms that could indicate serious mental disorders, such as depression, anxiety, post-traumatic stress, among others. These types of specialized services are pertinent when the pre-existing or emerging needs of the migrant or refugee are greater than the existing capacities of primary health care and health services in general. Of course, the response for each level must be designed according to the contextual needs and available resources  The proposal submitted here is a community-based multilevel approach, in which the community participates in the design and implementation of the processes (IOM, 2019). As seen in the pyramid, it is a system that organizes mental health and psychosocial support services into multiple levels of complementary supports to meet the needs of different groups. All levels of the pyramid are important and should ideally be implemented concurrently (IASC, 2007).

# CHAPTER 7) FINAL THOUGHTS

The objective of this guide has been to provide updated information and first aid tools in order to improve mental health care and psychosocial support for migrants and refugees residing in Uruguay.

Approaches and tools have been presented, from an intersectional perspective and with an intercultural approach, especially for people who work in psychosocial care with migrants. There, they warned about the risk of pathologizing migration processes and emphasized the importance of thinking about the feedback that occurs between the psychosocial well-being of migrants and refugees and the integration processes in the destination community.

It has been pointed out how the use of diagnostic categories without a broad understanding of the culture to which the person being treated belongs, can cause diagnostic errors and lead to inappropriate medicalization. Also to classify a cultural particularity as a pathological sign or to confuse a psychic or somatic manifestation expected within a migratory or refuge context with a clinical manifestation that could require urgent intervention.

Understanding these issues can help not to judge the beliefs and conceptions that people bring and to understand that these conceptions are part of their cultural configurations. These configurations, although they may be different from those the health professional possesses, cannot be considered inferior or superior. On the contrary, it is desirable that they be listened to and respected.

Not including the context of the production of suffering, leads to producing erroneous, decontextualized diagnoses and can lead to medicalizing situations that must be understood collectively, socially, politically and culturally.

The lack of knowledge about migrants and refugees residing in a country often hinders the possibility of establishing opportunities for encounter and fruitful exchanges and, rather, enhances the surge of stereotyped views.

As we have seen, these views cross society and its institutions, from which the institutions of the health system, educational institutions and state agencies in general may not be exempted.

Achieving awareness about the particularities of migrants and refugees seeks, on the one hand, to move the collective imagination of societies, and on the other hand to contribute to promoting universal access to mental health and psychosocial support systems without leaving anyone behind.

Ignorance of the cultural and linguistic frames of reference of the people searching counselling, on the part of the health center staff, can generate conflicts and misunderstandings. If, in addition to the linguistic difficulties that may be present at the time of the appointment, the person expresses insecurity, uncertainty and distrust towards the health worker, it is likely that the health care will be insufficient or not entirely effective.

Below are some thoughts for mental health intervention with migrants and refugees that can be of great help in building a trustworthy bond:

» To investigate whether the vital stages of childhood, adolescence, youth, adulthood and old age exist as such in communities of origin and are conceived in ways similar to those of the host society.

» To review and question the readings that assume migration is synonymous with breaking ties and investigate socio-familiar support networks, including those of people with close ties in the society of origin, with whom regular, supportive talks are held.

» When approaching the psychosocial care of migrants, it is essential to pay attention to the diversity of family configurations: nuclear family, extended family, single parenthood, single-parent family with a female head of household, blended family, homo-parenting, families and new reproductive technologies, and especially to consider remote motherhood and transnational chains of care.

» To do a more efficient job, it is advisable to take precautions regarding exercising value judgments on diverse family models, for example, with children or adolescents in the care of relatives in the society of origin: grandmothers, aunts/uncles, neighbors, on the exercise of the support and cutting function, conceived as maternal-paternal. This will result in a better psychosocial support, because the more you know the other person, the better the result will be.

» To inquire about the existence of ties and exchanges with native people. Furthermore, if this is investigated and an attempt is made to link migrants and native people, the impact and pain that the person may be going through in relation to the migration process will be less. Being isolated for a long time threatens people's mental health.

» To consider the complexity of situations of people who migrate with children, and those with children in societies of origin.

» To avoid moral judgment that blames, such as “she abandoned her children”, for example in migrant women and mothers. Migrants make and maintain decisions regarding parenting in frequent dialogues with the people who were left in charge of the children.

For all the reasons stated above, it is necessary that the mental health care and psychosocial support provided to the migrant population in destination societies adopt a rights-based, intersectional, intercultural, community perspective and be sensitive to all these issues, considering the dimensions presented above.

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