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Expatriate mental health: Breaking the silence and ending the stigma

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“Mental health issues are ubiquitous, affecting prince and pauper, world traveller and homebody alike.”

An unnamed American working in the Persian Gulf region took her own life on 24 February 2017, the apparent victim of clinical depression. Her fellow expats were shocked – in part because the woman had been “vivacious and full of life,” in part because her death brought to mind their own struggles. A friend of the woman and former expat from Great Britain wrote on the Poleax blog, that her death made him realise that “it could have been me, just as it could have been one of many others I knew in the Gulf with untreated or improperly treated mental health issues. I know I’m not unique in this regard. Any of us could have been an internet montage, a Facebook group, an I-knew-that-guy.”¹

Mental health issues are not, of course, unique to the expat community. Not long after that private tragedy in the Gulf, Britain’s Prince Harry very publicly revealed his 20-year struggle with depression, which was brought on by the 1997 death of his mother, Princess Diana. In an interview for journalist Bryony Gordon’s Mad World podcast, the 32-year-old royal described how he endured two years of “total chaos” and several near-breakdowns before friends and family convinced him to seek counselling at age 28.”²

Mental health issues are ubiquitous, affecting prince and pauper, world traveller and homebody alike. But being a stranger in a strange land can exacerbate – or even bring on – depression and other problems. At Aetna International, we have found that for many expats, working in an unfamiliar context far removed from friends and family is a recipe for disaster. We at Aetna International believe that it’s time to focus serious attention on the problem of expat mental health and to explore potential solutions.

Gauging the problem

Experts often describe mental health problems as a silent crisis and a silent epidemic. As the world focuses on cancer, heart disease, and emergent threats like Ebola and Zika, the two main types of mental health disorders – depression and anxiety – quietly continue to affect families across the globe. According to the World Health Organization (WHO), more than 300 million people faced depression in 2015, and nearly as many suffered from anxiety disorders. (Some faced both conditions, so it’s inappropriate to simply add these numbers together to reach a grand total.) In fact, depression is the single largest contributor to global disability (7.5 percent of all years lived in 2015), while anxiety disorders rank 6th (3.4 percent of all years

1. <https://medium.com/dohanews/expats-suicide-spurs-questions-about-mental-healthcare-in-qatar-a0de9e8d86a5>, <https://thepoleax.com/a-danger-in-a-strange-land-e8f241484118>
2. <http://www.telegraph.co.uk/news/2017/04/16/prince-harry-sought-counselling-death-mother-led-two-years-total/>

lived). Beyond being disabling, depression is the major contributor to suicide deaths, which number close to 800,000 per year.³ Depression ranks third on the list of the world's top chronic diseases, according to the World Health Organization, and rates continue to rise. Depression will likely overtake heart disease and cancer to become the single most common chronic disease by 2030.⁴

So how big a problem is expat mental health? While there have been plenty of alarming reports over the past three decades, most have been based on anecdotal evidence and uncontrolled studies.

One exception was described in the *International Journal of Mental Health* in 2011. The study compared two cohorts of American workers: a group of 950 expatriates who were working overseas for a minimum of six months and a group of 1,460 domestic employees primarily located in the Midwest and Southern regions of the U.S. Researchers asked both groups to complete an online survey about common psychological, behavioural, and personal problems (called the Global Appraisal of Individual Needs–Short Screener). Fifty-six percent of expats who completed the survey reported signs of anxiety or depression, compared with 21 percent of domestic workers. In other words, the expats were 2.5 times more likely to face these problems than their countrymen back home.⁵

In a 2017 study of 500 American expats commissioned by Aetna International to gauge what American expats miss about being back home, respondents all indicated that they missed their friends and family – in other words, their support networks – to some degree during their assignments. Forty-three percent of respondents claimed to miss their friends and family ‘a lot’.⁶ As our clinical experts have provided support to

our members, they have found that the absence of the friend and family network compounds stress and anxiety suffered by expatriates on foreign soil. We have found this is can often be the case for the dependant spouses of members who are employees on assignment. The dependant often struggles to adapt to their new circumstances and lifestyle, and does not receive the support they need from their partner, who is all-consumed by their new assignment.

Yet few expats worry about their mental health, or that of their trailing dependant family members, before heading overseas. When Aetna International surveyed a group of 5000 globally mobile individuals in 2016, just 6 percent expressed concern about mental health issues, about the same percentage as were worried about auto-immune conditions. By comparison, more than a quarter were concerned about heart disease, high blood pressure, diabetes, and cancer.⁷

In addition, we found among the people surveyed, that expats on assignment expressed a reduced need or desire to take action prior to arrival. Our data suggests that most expats have a mind-set that embraces risk and challenges, but we suggest an unhealthy by-product can be a reduced willingness to put health-related safeguards in place in advance.

When it comes to mental health claims, our global membership data between 2014 and 2016 revealed that more women than men seek treatment, and that the most significant proportion of claims are made by those between the ages of 30 and 49.

As a percentage of total population, member prevalence for mental health rose in each of our regions during this time period. The greatest increase in mental health prevalence was recorded among our

3. http://www.who.int/mental_health/management/depression/prevalence_global_health_estimates/en/

4. <http://www.apa.org/monitor/2012/05/global-health.aspx>

5. <http://chestnutglobalpartners.org/Portals/cgp/Publications/ExPat%20Mental%20Health%20Paper%20-%20May%202011.pdf>

6. What do American expats miss about home? A study of 500 U.S. expats. February 2017. Aetna International.

7. *Pioneering Change: Understanding Health & Healthcare for Globally Mobile & High Net Worth Local Populations*. Aetna International, October 2016.

Europe population (33 percent), followed by the Middle East and Africa (28 percent), Americas' population (26 percent), and Southeast Asia (19 percent).

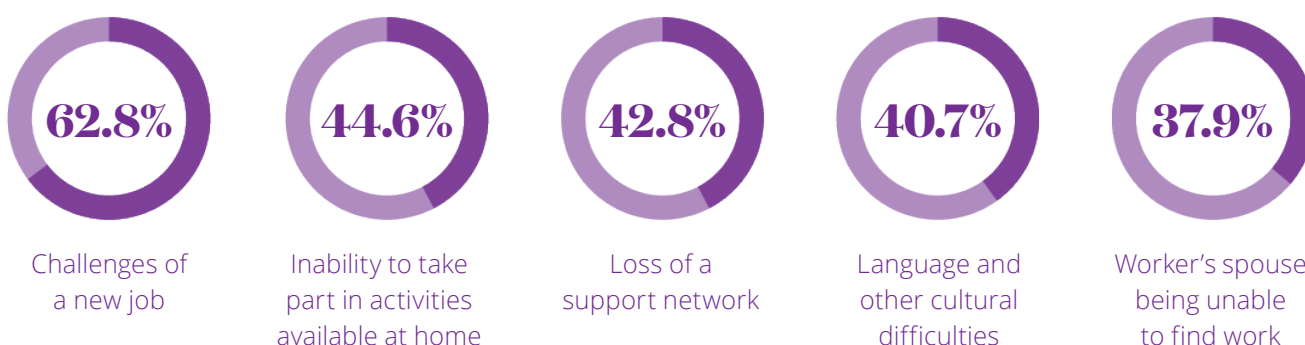
According to our data, the prevalence for depression and anxiety among our members ranked first and second, and were the highest in terms of all mental health claims prevalence (claims for bipolar, psychoses, dementia, post-partum and eating disorders accounted for comparatively low percentages although were also increasing). The Americas and Southeast Asia data were fairly evenly matched in their prevalence increases for both conditions (18 percent anxiety, versus 21 percent depression in the Americas, and 14 percent anxiety, versus 13 percent depression in Southeast Asia). However, in the Middle East and Africa, the increase in claims prevalence for depression far outweighed those for anxiety (3 percent anxiety, versus 37 percent depression). The opposite was true in Europe (25 percent anxiety, versus 7 percent depression).

The overall cost of mental health claims among our global membership increased between 2014 and 2016,

as would be expected as the prevalence of members diagnosed with mental health conditions was greater year on year during this period. However, among our Americas' members, the cost per member for mental health claims decreased.

We hope the trending increase in mental health claims shows that individuals are becoming more confident about seeking support for their mental health needs. However, it's just as likely that stress, anxiety, and depression are on the rise among expatriate populations. Meanwhile, we suggest that the decrease in cost per member in the Americas is the result of proactive care delivered to vulnerable members through our Americas-based In Touch Care program. For instance, where a member might have previously made multiple visits to a mental health practitioner, our on-going one-to-one support may have reduced the frequency of those visits. The overall success of the program in positively impacting our members' health in the region to date has prompted its roll out across the rest of the world.⁸

The top five pressure points for international assignees were:⁹



8. Aetna International membership data – 2014 to 2016.

9. <http://www.hrmguide.net/international/work-life-balance.htm>

Reasons for expat mental health issues

There are many definitions of well-being, but among the simplest is one proposed in the International Journal of Wellbeing in 2012. Well-being, the authors wrote, is “the balance point between an individual’s resource pool and the challenges faced.” Imagine a seesaw or fulcrum with psychological, social, and physical resources stacked on the left and psychological, social, and physical challenges stacked on the right, and it’s easy to understand how even a minor crisis can upset a person’s equilibrium.¹⁰

The seesaw model also hints at why expats face more mental health issues than colleagues back home. On the resource side, they may be disconnected from support networks six time zones away; on the challenges side, they may be struggling to adjust to a new language and a new culture.

The 2007 Expatriate Work-Life Balance Survey from ORC Worldwide (now part of Mercer) showed how international assignments can affect well-being. According to the survey, the top five pressure points for international assignees were: the challenges of a new job (62.8 percent), the inability to take part in activities available at home (44.6 percent), the loss of a support network (42.8 percent), language and other cultural difficulties (40.7 percent), and the worker’s spouse being unable to find work (37.9 percent). Moreover, just over half of respondents felt overworked – and were, in fact, working an average of 13.4 more hours than people doing similar jobs back home. This was due to a “24-7 business mentality” and presumably the need to be available during office hours both on site and in the headquarters country.⁹

Of course, why individuals are overseas can affect how the experiences change them. In our 2016 study of the globally mobile, we found that the expatriate population can be divided into two categories, each with distinct attitudes that shape how individuals respond to circumstances that can affect well-being. For example, expats on assignment – those who have moved for work or a specific assignment – view their challenges as difficulties, expect support to be forthcoming in their placement, and remain rooted to their home culture. The independently mobile – those whose decision to move was a lifestyle choice, even if driven by financial reasons – view their challenges as opportunities and tend to be more self-reliant, easily aligning themselves with their new culture. This data suggests that mobility status influences how prepared individuals are for challenges to their mental and emotional well-being. Not surprisingly, our study found that missing home and languages barriers were the biggest challenges to well-being the people we surveyed faced. Many expats on assignment (without trailing dependants) felt they had “trained themselves to be lonely,” a key attribute people needed in order to survive in their new surroundings. Few respondents to our survey regretted their decision to move, but some said they had underestimated just how eye opening it would be.¹¹

The experience of mental health care overseas

Beyond facing the challenges of moving far from home, expats discover that mental health services are disproportionately distributed across the globe, as is the case with other forms of health care. According to the WHO’s Mental Health Atlas 2014, the number of mental health workers per 100,000 persons ranges from less than 1 in low-income countries to more than

9. <http://www.hrmguide.net/international/work-life-balance.htm>

10. www.internationaljournalofwellbeing.org/index.php/ijow/article/download/89/238

11. Pioneering Change: Understanding Health & Healthcare for Globally Mobile & High Net Worth Local Populations. Aetna International, 2016.

Placement and prevention

We believe that to the seven categories of programs suggested by the Alliance for Work-Life Progress, companies that make international placements should add an eighth: effective recruiting, onboarding, support, and repatriation.¹⁵

Some workers, no matter how effective they are back home, would not be suited for an overseas assignment. Yet 81 percent of companies don't assess candidates or their accompanying family members before sending them overseas, according to Worldwide ERC's 2012 Support and Retention Strategies for Cross-border Assignments.¹⁶

Many also skimp on language and cultural training that could help workers be successful, even while spending three to five times salary on long overseas assignments. In their white paper "The Anatomy of Failed Assignments," Lexicon Relocation shared the cautionary tale of a German employee who spoke only German and English, yet was put in charge of a Chinese-speaking sales team. "The assignment was the most costly the company had ever seen, but the company provided just four hours of cultural training at the beginning of the assignment," the report said. "Costs for Chinese lessons were only approved after being in the role for six months."¹⁷

Compare that executive's situation with the experience of Tessi Romell, an AstraZeneca employee posted to China several years ago. Romell and her husband participated in a two-day expat workshop and 25 hours of language training before the assignment began. She was also paired with an international assignment manager who provided support during her posting.¹⁸

Clearly, AstraZeneca was preparing its employee for success, while the German company was potentially setting up its employee for failure.

50 in high-income countries. (The median is 9.) Low- and middle-income countries spend less than U.S. \$2 per capita on mental health services, and much of that spending focuses on inpatient care, especially psychiatric hospitals, which are rarely the most appropriate or cost-effective care setting. "Fifty-one percent of WHO Member States have a stand-alone mental health law", yet many of those, the organisation says, "are not fully in line with human rights instruments, implementation is weak, and persons with mental disorders and family members are only partially involved."¹²

Of the countries in the Persian Gulf, where the unnamed American expat died in early 2017, Qatar offers an instructive, optimistic case study. Although the woman's death focused attention on the region's health care system, Qatari officials were already working to improve the situation. In a national mental health strategy unveiled four years earlier, officials outlined a comprehensive vision that includes raising public awareness, enacting mental health legislation, developing a high-quality mental health workforce, and ensuring that most people can access treatment in primary care and community settings. Their vision is to give people – both nationals and expats – access to the right care at the right time in the right place.¹³ Implementation of the Strategy has been phased over 5 years (2013–18) in the first instance. In 2014, the first community hub for mental health services opened in Doha, and all front-line family doctors have received relevant mental health training. A draft law to safe-guard the human rights of people with mental health illness is awaiting final approval. Much progress has been achieved since the launch of the Strategy and there is much that they yet want to accomplish.¹⁴

The economic cost of mental health conditions

Given the disproportionate allocation of mental health resources around the world and the fact that overseas deployments can contribute to mental health issues, it's entirely appropriate for multinational firms to take extra responsibility for their workers.

12. http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/

13. <https://dohanews.co/qatar-launches-strategy-to-combat-rising-mental-health-woes/>

14. https://www.rcpsych.ac.uk/pdf/PUBNS_IPv14n1_18.pdf

15. <https://www.worldatwork.org/aboutus/employee-engagement/pub/Seven%20Categories%20of%20Work-Life%20Effectiveness.pdf>

16. <http://www.worldwideerc.org/Resources/Research/Documents/Support%20and%20Retention%20Strategies%20Exec%20Digest.pdf>

17. <http://www.lexiconrelocation.com/failed-assignments>

18. <http://www.hreonline.com/HRE/view/story.jhtml?id=237918481>

“Among employees who were experiencing high levels of stress, **57 percent reported feeling disengaged at work.**”

Doing so is good for the workers, but it's also good for the businesses themselves.

Towers Watson's Global Benefits Attitudes survey in 2014 drew a direct connection between stress and workplace disengagement. Among employees who were experiencing high levels of stress, 57 percent reported feeling disengaged at work. And that wasn't the only impact. Disengagement led to absenteeism, with highly stressed employees taking 77 percent more sick days than their low-stress colleagues. And presenteeism – attending work when unwell and unproductive – was 50 percent higher for highly stressed employees.¹⁹

A common, longstanding offering that can support good mental health is an employee assistance program (EAP). Such programs offer telephonic support to workers facing all manner of concerns, from work-related stress to substance abuse to major life events like births and deaths. Employees typically have 24-hour access to counsellors who can, if needed, make referrals to local professionals. Moreover, full confidentiality is maintained; employers never learn which workers have used the service – much less what concerns those workers shared.

Confidentiality is understandably important to employees and can be a major factor in utilisation. When the University of Calgary shifted from an on-site to a telephonic model, utilisation nearly doubled. (The

top reasons employees use the service? Stress, anxiety, and depression.)²⁰

Unfortunately, EAP benefits are not universal. According to Mercer Marsh Benefits' Medical Trends Around the World 2016, 34 percent of employers surveyed offer no access to personal counselling in their standard medical plans for employees. There does seem to be employer interest in expanding mental health coverage, but that interest varies greatly among regions. Nearly 90 percent of international employers based in Asia and Latin America were interested in at least a modest expansion of mental health coverage, while 73 percent of international employers based in the Middle East, Africa, and Europe were interested in the same.²¹ That's in part because employers and iPMI brokers are anticipating increased costs as a result of employees experiencing workplace or personal stress. Ninety-one percent of employers in the Middle East and Africa expect stress to increase employer-sponsored health care costs in the next three years by at least some extent. In Asia, 86 percent expect the same. While in Europe and Latin America, 80 percent and 77 percent respectively also expect stress to impact health care costs to some extent in the next three years.²²

Given that our data alone shows that the number of mental health claims are increasing faster in Europe than other regions, the expectation would be that more employers in the Europe would be keen to invest

19. <https://www.towerswatson.com/en/Press/2014/09/Workplace-stress-leads-to-less-productive-employees>

20. <http://www.benefitscanada.com/benefits/health-wellness/take-aways-66428>

21. <https://www.mercer.com/our-thinking/merc-marsh-benefits-medical-trend-survey-2016.html>

22. <https://www.mercer.com/our-thinking/merc-marsh-benefits-medical-trend-survey-2016.html>

Genetics and mental health

The causes of and triggers for mental health issues remain cloudy, but recent research has begun to quantify the role of genetics. In 2013, scientists reported that five mental disorders – depression,

bipolar disorder, ADHD, schizophrenia, and autism – can be traced to the same inherited genetic variations. In the genome-wide study, the genetic variations accounted for 17 to 28 percent of mental illness risk.²³

The researchers were quick to point out that much research still needs to be done. Nonetheless, they see the potential for “moving beyond descriptive syndromes in psychiatry and towards a nosology [disease classification] informed by disease cause.”

in an expansion of mental health coverage to protect their investment, both in their overall workforce and their overseas assignments.²⁴

Offering EAPs more universally would be a positive, but there is more employers can do. Perhaps the most important thing is to promote EAPs as wellness and prevention services, not just as problem-solving services. Of course, there will always be workers who need help solving problems, but we have found that effective behavioural therapy programs that provide people with coping techniques can often forestall problems, much as regular medical exams can often forestall the need for surgery. Removing the stigma from seeking help could convince more workers to utilise this important benefit. Given the value of preventive measures, it is heartening to know that more than 80 percent of respondents to our 2016 survey agreed that people should take more responsibility for their own health and well-being.²⁵

Employers should also deploy programs and policies that support work-life balance, which can reduce stress for all workers. Examples include family leave policies, onsite fitness and childcare facilities, flexible work scheduling, and programs on everything from nutrition to smoking cessation.²⁶

The Alliance for Work-Life Progress has identified seven categories of programs employers should consider offering: caring for dependants, proactive approaches to health and wellness, creating a more flexible workplace, financial support for economic security, creative use of paid and unpaid time off, community involvement, and culture change. Each has the potential to reduce stress and improve well-being. According to one survey, for example, “Nearly a third (31 percent) of those with dependent care were less likely to report lost productivity due to stress, and 25 percent had fewer personal health problems.”²⁷

Virtual health, or vHealth, services that connect workers with specialists – either international or back home – offer another promising avenue for expats. In a 2014 essay in *The Atlantic*, American psychoanalyst Joseph Burgo described the “life coaching” he offers – he can’t call it counselling due to licensure laws – to expats and others in countries from England to Australia and Israel to Japan. “Consider the situation of the American expat in Japan,” he wrote. “Given where he lived, he wasn’t able to find a therapist able to understand not only his language, but his cultural values and attitudes as well.” And that relationship only involved two countries. “If you’re a Russian married to a Spaniard living in Dubai, what are your

23. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3714010/>

24. Aetna International membership data – 2014 to 2016.

25. *Pioneering Change: Understanding Health & Healthcare for Globally Mobile & High Net Worth Local Populations*. Aetna International, 2016.

26. http://www.ccohs.ca/oshanswers/psychosocial/worklife_balance.html

27. <https://www.worldatwork.org/aboutus/employee-engagement/pub/Seven%20Categories%20of%20Work-Life%20Effectiveness.pdf>

chances of finding a compatible in-person therapist?" Burgo asked.²⁸

In some ways virtual counselling could be more effective than in-person consultation. Besides being able to connect with specialists back home, clients may be more open when they're not in the same location as the counsellor. And the ability to connect virtually removes the need of travelling to the counsellor's office, something that's often difficult for on-the-go executives.

While more research should be done on the efficacy of virtual counselling, we envision a day when employers regularly offer, and insurers pay for, such services for their overseas workers.

Offering mental health first aid

Basic and advanced first aid training is common in today's offices and has been proven to save lives. According to the U.S. Occupational Safety and Health Administration, up to 60 percent of heart-attack victims resuscitated with automated external defibrillators survive at least one year post-incident, compared with just 5 to 7 percent of those who must wait for emergency medical personnel to arrive.²⁹

Supervisors and others trained in mental health first aid (MHFA) can play a similar role. As with traditional first aid, MHFA uses trained volunteers to offer initial support until professional care becomes available. Begun in Australia in 2000, the movement has spread to more than 20 countries and has trained at least 1.7 million people.³⁰

A meta-analysis of 15 studies published in the *International Review of Psychiatry* in 2014 found that

MHFA programs increase mental health literacy. But they do more than that. As the researchers concluded, "results indicate not only changes in knowledge and attitudes, but also changes in the behaviour of those who attend the training. This is of major importance because it shows a pragmatic change in trainees who become more active in supporting those with mental health problems and suicidality."³¹

Who should be trained in MHFA in the workplace? E. Kevin Kelloway, Ph.D., the Canada research chair in occupational health psychology at Saint Mary's University in Halifax, Nova Scotia, argues that supervisors are uniquely positioned for the task, both because they are in frequent contact with employees (and are thus most likely to notice changes in behaviour) and because they are motivated to help employees who are struggling.³²

Kelloway and his colleagues implemented a Mental Health Awareness Training (MHAT) program in two organisations and found that managers who received the training demonstrated "increased knowledge about mental health issues, improved attitudes toward individuals with mental health problems, increased self-efficacy around dealing with mental health issues, and increased intent to promote mental health." What's more, in one of the organisations, researchers found that disability claims related to psychological problems were, on average, 18 days shorter after the training was implemented.³³

Some might argue that supervisors have no business intruding in employees' personal lives. Kelloway counters that all sorts of relevant behavioural clues are both observable by managers and well within their scope of authority; examples include workers missing deadlines, leaving work early, and wanting to quit their

28. <https://www.theatlantic.com/health/archive/2014/12/the-skype-psychologist/382910/>

29. <https://www.osha.gov/Publications/3185.html>

30. https://en.wikipedia.org/wiki/Mental_health_first_aid

31. <http://www.tandfonline.com/doi/full/10.3109/09540261.2014.924910>

32. <http://www.tandfonline.com/doi/full/10.3109/09540261.2014.924910>

33. <http://www.apa.org/pubs/journals/features/cap-cap0000084.pdf>

jobs. For example, we suggest that supervisors don't need to (and never should) say, "I think you're crazy." They could, instead, say, "I notice you've stopped going to coffee with the team. Is something wrong?"

Improving the world's mental health care

But the burden can't lie with employers alone. EAPs and Skype counselling sessions will never fully replace outpatient options such as in-person talk therapy, or inpatient treatment. We thus return to the issue of the provision of mental health services around the world.

In its Mental Health Atlas 2014, the WHO set out four broad objectives: 1) to strengthen effective leadership and governance for mental health; 2) to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings; 3) to implement strategies for promotion and prevention in mental health; and 4) to strengthen information systems, evidence, and research for mental health. Data supporting the report demonstrates how far the world has to go. For example, the WHO wants 80 percent of countries to have at least two national mental health promotion and prevention programmes in place by 2020; as of 2013, just 41 percent of member states met this standard. There is similar room for improvement on each of the other objectives.³⁴

The role of insurers and providers

Like physical disorders, mental disorders rarely appear out of nowhere. After a suicide, friends and family often remember warning signs they missed that are blindingly obvious in hindsight. Similarly, physicians routinely screen for mental health issues at annual check-ups, asking questions like "During the past

month, have you often been bothered by feeling down, depressed, or hopeless?" and "During the past month, have you often been bothered by little interest or pleasure in doing things?"³⁵

While such questions can identify patients who are experiencing depression and other mental disorders, they are far from perfect predictors. According to some research, just 30 percent of those who attempt suicide disclose their plans, while the vast majority of people who do acknowledge suicidality never follow through on their intentions.³⁶

Data mining offers the promise to do a better job at identifying those who are at risk of experiencing mental health issues. Recently, researchers in the United States studied the medical records of 100 patients of the U.S. Veterans Health Administration, some of whom had committed suicide, some of whom had been admitted to inpatient psychiatric units but had not committed suicide, and some of whom had not used mental health services. Computers analysed raw clinical notes – everything from physician observations to medication names – and were able to correctly guess 65 percent of the time which patients had committed suicide. We believe the use of data-mining techniques like this could help insurers and physicians better serve at-risk individuals.³⁷

For example, Aetna International's In Touch Care Program incorporates support for members with acute and chronic mental health concerns, such as depression and anxiety (as well as for other diseases and conditions including diabetes and chronic kidney disease). Our clinicians use predictive analytics to find, engage, and help members with these conditions and then provide ongoing support so that each member can achieve the best health possible. We do this

34. http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/

35. <http://www.medscape.com/viewarticle/511167>

36. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0085733>

37. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0085733>

through dedicated one-to-one nurse support where our clinicians look at the whole person and their support network, as well as providing online self-guided coaching modules and access to external resource libraries. The intention is to support and upskill our members, and their support network, which often includes employers. We do this by providing preventative and coping behavioural health techniques, and we believe that it improves knowledge and attitudes towards mental health conditions. Similarly, we provide members with pre-trip planning assistance, supporting employees on assignment and their dependants, as well as the independently mobile before, during and after their move. The needs of our members have shaped the nature of this support, which ranges from cultural awareness to medication planning and continuity of treatment.

Conclusion

There's no single solution to the pervasive mental health issues that affect expatriates. Data mining, EAPs, pre-assignment screening, and programs that promote better work-life balance can all help, but ultimately we all must work together to break the silence and beat the stigma; a stigma that may be worse among expats who pride themselves on self-sufficiency.

We at Aetna International look forward to the day when those walls come down, when people seek help, and when help is available regardless of where they are in the world.

Building a Healthier World®

Aetna International is part of Aetna, one of the leading diversified health care benefits companies in the U.S., serving an estimated 46.5 million customers with health benefits and resources to support them in making better informed decisions about their health care.

Aetna International is committed to helping create a stronger, healthier global community by delivering comprehensive health care benefits and population health solutions worldwide.

One of the largest providers of international private medical insurance services, Aetna International serves more than 700,000 members worldwide, including expatriates, local nationals and business travellers. Its global benefits include medical, dental, vision and emergency assistance and, in some regions, life and disability.

Aetna International also offers customised programs, technology and health management solutions to support health care systems, government entities and large employers in improving access to quality care and health care outcomes in tandem with controlling associated costs.





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As Medical Director for Aetna International, Dr. Patel provides guidance, support, and medical leadership for care management activities in Europe. Dr. Patel also manages Aetna International's emergency evacuation program, helping to ensure appropriate health care delivery for our members around the globe. Dr. Patel graduated from King's College University, London and also has a Healthcare Management degree from Imperial College, London. He is also a practicing physician in Emergency Medicine.

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