‘Give us some time...’

Supporting resettled refugees with psychosocial impairments

SHARE

EUROPEAN RESETTLEMENT NETWORK

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CENTRE OF EXPERTISE ON HEALTH DISPARITIES

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Evert Bloemen, Erick Vloeberghs

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INTRODUCTION

The aim of resettlement is to help refugees whose lives and safety are at risk or whose human rights are at risk in the countries they fled to. Resettlement is also a long-term solution, because it entails countries assisting each other in spreading the load of resettling refugees, because the majority of those who flee their own countries are initially hosted by neighbouring countries. Refugee resettlement helps to reduce the load on such neighbouring countries (e.g. Kenya, Thailand, Nepal and India).
This manual aims to assist those who work with resettled refugees and who are faced with psychosocial issues while working with refugees. These problems include both mental health issues and the resulting social issues.
The manual was written in consultation with refugee support workers working for the Dutch Council for Refugees (DCR) and their supervisors. Interviews with these support workers revealed the types of issues or problem behaviour involved and the specific obstacles. In addition, the authors looked at experiences with resettled refugees in countries outside of the Netherlands, as well as methods and resources with proven effectiveness in addressing the psychosocial problems encountered by these refugees.
This guide will first cover general information, followed by examples of real life situations, and will finish by providing some concrete, practical steps which might help readers to establish a good working relationship with both refugees and local caregivers and service providers.
Chapter 1 will provide a brief overview of the model used to support resettled refugees and the handover of medical details, while Chapter 2 will elucidate the concept of vulnerability and any 'aggravating' and 'protective' circumstances that may impact on refugee resettlement.
Chapter 3 will describe what practical actions can be undertaken, and how to address refugee issues and symptoms in a structured manner. It is best to take the first steps towards addressing these issues prior to the refugee's arrival in the host country. Chapter 4 will present four case studies (exemplars), each following a fixed format, with topics including physical and mental health issues, disabilities, unrealistic expectations, parenting problems, issues with refugees refusing to be seen by healthcare practitioners, and how to organise a collaborative approach to care. Each case study will finish with a short list of take-home messages.
The manual has a number of appendices. Some of these list the resources support workers may use to assist them in their interaction with both resettled refugees and care providers. Having good rapport with resettled refugees will make the initial period of their stay in their new 'home country' more bearable. Starting afresh in a new country is not an easy task for anyone. Good support, supervision and a bit of luck will help resettled refugees and their children regain their equilibrium. After a period of time even resettled refugees with psychosocial problems may start to feel at home.

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CASES

A woman from an Asian country, moves together with her two children, to a European country as a resettled refugee. After a while she seems to find life in Europe more difficult than she had expected. When she hears that some of her disappeared relatives have surfaced again, she has a sharp psychosocial relapse.

The refugee support worker of this family (buddy), assigned to them by the local refugee council, plays an important role. She recognizes the sudden increase in psychological stress and ensures that the woman and her family receive the needed support.

A couple from an African country, move together with their two children, to Europe as resettled refugees. Both the man and the woman have medical problems: one has a congenital bad heart condition, the other physical disabilities. Their expectations regarding medical care in Europe are high. As such the woman is convinced that her disability will heal completely. If this expectation cannot be met, the disappointment will be huge. This will have consequences for her behaviour and health.

The refugee support worker of this family is struggling hard on how to deal with these high expectations. As well as with the reactions of the couple when their expectations cannot be met with.

A man has been resettled from a Middle East country to Europe. Immediately after his arrival it appears he has serious psychological problems as a result of what he has experienced. Later on it turns out that he has physical symptoms too, which seriously hinder him to follow the civic integration course.

The refugee support worker has her hands full at the start with arranging proper care. As well as later on when it appears that the man has physical symptoms that are difficult to fathom. The additional problem is that the man refuses (psychological) treatment. What can be done to get out of this situation?

A man from an Asian country together with his 12 year old son and a 62-year-old aunt arrive in Europe as resettled refugees. All three live together in one house. Soon after arriving in the town of residence it becomes clear that the aunt is clinging on to the other two. She is illiterate and understands little to nothing of the state of affairs in the new home country.

For the refugee support worker of this family, it is clear that the aunt is hindering the development and integration of the two other refugees. But what exactly is going on with the aunt and how can this deadlock be broken?

If you as refugee support worker or (voluntary) buddy encounter such a situation, what are the options and what can be done? What could you do yourself and when should you involve others? And how do you handle that exactly?
Read this manual and you may find answers to many questions that you previously had or will ever get. The four situations above are described in detail in Chapter 4.

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CHAPTER 1
Resettled refugees

A brief overview

In fleeing violence, a large number of refugees end up in refugee camps, usually in neighbouring countries. The United Nations High Commission for Refugees (UNHCR), runs a programme to select a number of people from refugee camps for resettlement in a third, safe country. Most eligible refugees will end up in large immigrant nations such as the USA, Canada and Australia, while a small number is places in Western European countries. The refugees will, upon arrival, officially be recognized as refugees and will receive a residence permit.

The International Organisation for Migration (IOM), is responsible for arranging the transfer of refugees to other countries and in 2011 supported the transfer of a total of 62,000 refugees to 22 different countries. The Netherlands receives 500 resettled refugees annually.

Medical information

Refugees undergo a standard medical assessment prior to being nominated for resettlement. To this end, the UNHCR makes use of the Medical Assessment Form (MAF). If the individual is in reasonably good health and if any health issues can be treated locally, they will be assessed as 'not an emergency case' and the standard procedure will then be followed. In such cases the resettlement process may take up to six months. If treatment is not possible locally, or in those instances where the health risk is unclear, a second assessment tool may be used, the so-called: Heightened Risk Identification Tool (HRIT). This tool is also used if a refugee is identified as 'at risk', something which applies to unaccompanied women, girls, older people, victims of torture or people with a disability. The latter include individuals who are blind or deaf or who have some other type of disability. The HRIT is used to assess whether individuals require resettlement for a serious medical condition, which will depend on how well they cope with this condition. Refugees who have been able to adapt to their impairments or disabilities, and are able to live with these, will not be eligible for resettlement under the Health and Disability (medical) category – the normal (longer) procedure will apply to them.
Transfer to one of the European countries will be arranged and supervised by the International Organization for Migration (IOM). IOM supervisors ensure that refugees arrive in reasonably good health. They issue a fit-to-fly authorisation. To this end, a general medical assessment will focus on any medical reasons which might be an impediment to air travel, such as serious heart disease, a recent stroke or acute psychiatric issues. The medical record will include the above details, collected by the UNHCR and the IOM, and may also contain information about any current medical treatment received by the refugee. This additional information is included in order to safeguard appropriate continuity of medical care after arrival in the host country. This is why both UNHCR and IOM urge staff to ensure that the medical record is complete.

The medical handover is important because information from both UNHCR and IOM suggests that the health status of refugees may be worse than one might think based on the medical file. Refugees may pretend to be in better health than what they really are – for fear that otherwise they may have to stay longer in the camp. They are keen to get out of their temporary shelter as soon as possible, to be able to start a new life in a European host country. They would rather not dwell on or talk about illness or painful memories.
It is therefore very important that the family doctor and others in the host country can have access to both the current medical file and information about previous healthcare problems. In practice this goal is not always fully achieved.

At arrival

Resettled refugees are supported when arriving in a European country. Obtaining the necessary documents is often arranged immediately after arrival with the help of interpreters. After which the refugees arrive in their new hometown. In those cases important issues such as the health insurance and opening a bank account are also taken care of. When dealing with emergency cases however – whose names are known only shortly before coming to Europe – the administrative process is not always dealt with in the first days. In that case, it will take place after the refugee has moved to the new residence.

As will become clear, resettled refugees need support and assistance in finding a balance in this new stage of their lives, especially at the start. The following chapters will show that this is best achieved through encouraging refugees to be active and to participate.

CHAPTER 2

Vulnerability, protective and aggravating factors

Providing support to resettled refugees who have only recently arrived on European soil requires having a good insight into this target group. An awareness of personal and other factors impacting on refugees' feelings and behaviour is essential to a good assessment of the support they may need. This chapter provides further insights into such factors, enabling support that is closely aligned to the refugee's needs.

Vulnerability

We need to accept that every human being is vulnerable to a certain extent. The more vulnerable an individual is, the larger the chance of that person developing (serious) psychosocial problems. In principle every refugee will have some degree of vulnerability to some extent as (forced) migration involves the loss of (part of) one's family, friends, home and property.
Certain groups of refugees are more vulnerable than others. Examples are older people, minors, pregnant women, unaccompanied women (with or without children) and victims of torture, sexual abuse and other types of violence. Therefore, a first look at a refugee's basic details can give some indication of their [potential] vulnerability. That said, not all individual resettled refugees are vulnerable to the same extent. There are also factors at the level of the individual which either increase or reduce that person's vulnerability. This may include traumatic experiences in the country of origin or during the flight, or homesickness and problems adapting to the new home country. Hence it is important to identify factors which determine an individual's level of vulnerability. This can be done really well by trying to gain an impression of the balance between coping ability and challenges at the individual level.

It is the balance between coping ability and life's challenges which determines the extent to which the individual is able to cope with problems in life. Ideally, every individual experiences an adequate balance between the issues they face (i.e. life's challenges) and their capacity to cope with the same (i.e. coping ability). If the individual has adequate coping ability, minor issues do not get to develop into major problems. An imbalance may arise when the individual experiences too many (external) stressors and/or (internal) mental health problems. Such imbalances may often lead to problem behaviour, such as aggression which is difficult to manage [on the one extreme] or apathy [on the other extreme].

We refer to factors which add to life's challenges as aggravating factors, while we will refer to factors which strengthen a person's coping ability as protective factors. By mapping out such aggravating and protective factors, we can arrive at an impression of an individual's capacities and potential, and thus provide appropriate support.

A. Aggravating factors

Many different circumstances/conditions may add to the challenges of resettled refugees. This may include both events prior to the individual's arrival in Europe and conditions in the host country.

Prior to arrival in the host country

Most resettled refugees initially fled their home countries because they were not safe there or because they had distressing experiences. Both the flight itself and life in refugee camps may be stressful and involve additional hardship. For this reason physical and mental health problems tend to be relatively prevalent among refugees. Common physical complaints may include infectious diseases (such as tuberculosis and hepatitis), vitamin deficiencies, and general symptoms whose root causes may be difficult to identify, such as abdominal pain, headaches

and back pain. In addition to poor nutrition and hygiene, some of the physical complaints reported by refugees may result from (sexual) violence and stressful living conditions.
It is commonly accepted that tension and worries may result in joint pain, headaches and abdominal pain, while fear and hyper-alertness may lead to feeling exhausted; however we cannot always find medical evidence to prove this. Many of the physiological complaints experienced by refugees may originate from feelings of fear and depression. Such complaints may lead to conditions such as post-traumatic stress disorder (PTSD) or depressive disorders.

After arrival in the host country

Life in a European country is completely different to life in a refugee camp. Aid organisations provide the basic necessities of life to those living in refugee camps, resulting in many refugees developing dependency. Only a handful of refugees (often strong personalities) get into informal jobs while still in the camp and are able to lead reasonably independent lives. In Europe people are expected to show initiative and make their own choices. Understandably many refugees find this difficult.
In Europe, we not only emphasise the importance of 'standing on one's own two feet' but we also value personal freedoms and the individual's rights and possibilities. There is often a huge contrast between this approach and the cultural background of many refugees, where the group (family, clan) and group norms are considered more important than the individual. In addition, there may be differences in views around women's roles, sexuality or the role of religion, and these may be difficult to overcome. Such differences in opinion may cause refugees to feel uncomfortable when such topics are broached. This may also result in refugees avoiding certain interactions or situations. Feelings of exclusion or of being misunderstood may be reinforced by a lack of language skills, having different customs and dietary habits and not being familiar with host society (cultural) traditions.

Grieving and feeling uprooted

The many ways in which refugees and their families have to adapt can result in mental health and social problems. Central to this is the concept of feeling 'culturally uprooted' – the sense of being alone in the world from that point on, of feeling disconnected from one's past, culture and traditions. Feeling uprooted may be seen as a form of grief and refugees often have to go through a grieving process. It may be some time before refugees are ready to face a new society.
Socially speaking, the sense of no longer being embedded (not having a job, no goal in life, loss of social role and identity, missing family members) is experienced as a serious loss, and may often result in the individual feeling socially isolated. The fact that refugees are not used to the way help is provided in Europe also plays a role. If refugees have negative experiences in their interactions with service providers and support workers in the host society, this may reinforce feelings of loneliness and hopelessness.

The table below lists aggravating factors which may be present among resettled refugees:

Aggravating factors		
Physical	***Psychological***	***Social***
Infectious illnesses (tuberculosis, hepatitis)	Fear and/or anxiety and/or feelings of hopelessness	Avoidance behaviour and communication problems
Vitamin deficiency	Apathy and/or lack of initiative (depression)	Homesickness and/or going through a grieving process
Tropical diseases	Nightmares, concentration and memory problems (PTSD)	Loneliness and/or social isolation (no social embeddedness)
Unexplained physical complaints	Irritability (short fuse) and distrust	Low health literacy and no knowledge of the country's healthcare system and social services
Sexually transmitted diseases	Feelings of shame and/or embarrassment	Being unemployed and/or having no goal in life
Growth disorders (in children)	Bed wetting and/or other symptoms of psychological regression	Relational, family and parenting problems

B. Protective factors

Some of the factors listed above apply to all resettled refugees, however a majority of refugees are able to cope with these challenges. If an individual has an adequate ability to cope, problems do not tend to develop into psychosocial problems. We develop the ability to cope if there are enough protective factors – factors which help make problems tolerable, or which can either prevent or help people overcome problems. Much of this ability to cope is inherent to the person. Possessing an optimistic mind-set, intelligence, and a sense of humour can help people deal with difficult circumstances.

The following three protective factors play a part in the life of resettled refugees: safety, security and time. The newly found sense of safety in the new home country can help restore refugees' basic sense of trust, which had been lost. Together with the new-found sense of safety, refugees may recover their basic sense of security – trusting that everything is going to be alright, that they will be able to look after themselves and their children once again.

People certainly do not develop a basic sense of trust in safety and security from one day to the next, time being the most important factor. The phrase about time being a powerful healer applies to resettled refugees. Research conducted in Australia and Canada has shown that it takes time for resettled refugees to start to feel better. In Canada, Professor Morton Beiser found an increase in mental health problems during the first 10 to 24 months, followed by a decrease.[1] Overcoming negative experiences and getting used to new living conditions and a new way of life all take time. How much time will depend on any aggravating factors present and the individual's personality.

THE DISILLUSIONMENT MODEL

The disillusionment model, which was first introduced by León and Rebeca Grinberg (1984), is based on stages in the psychological process of adapting to one's new country.[2] A Canadian study has since shown that these stages only apply to the first ten to twelve months post-arrival in the host society. The model distinguishes three different stages:

- **Stage 1.** *Euphoria upon arrival:* The 'new arrival' feels relieved and filled with hope.
- **Stage 2.** *Disillusionment:* The new arrival feels disillusioned and expresses feelings of home-sickness. They wonder why they moved to the host society. Professor Beiser says that new arrivals are 'at high risk for developing psychiatric disorders' in this stage.
- **Stage 3.** *Adaptation:* The migrant feels more at home, adapts and starts to behave in conformity with local norms. Mental health problems diminish.

In addition to the aforementioned factors which are specifically related to the flight experience of the resettled refugee, there are protective factors which apply to all those who need to adapt to and learn to participate in a new society, namely physical and social activation. This means taking an active role and participating.

Resettled refugees benefit significantly from social support and contacts, as these enable them to regain a feeling of connectedness. They help them rebuilding faith and hope and regaining trust in themselves and others. Social contacts can help refugees to become familiar with the complex system of different services. They also provide refugees with a network of support and with this the opportunity to try out new types of behaviour and new social skills.

By taking an active role (undertaking something) and participating (undertaking something together) refugees make a positive contribution to their environment. This helps them feel useful and appreciated and reduces their feelings of dependence. It is also important for refugees to become physically active. Physical activity demands endurance and the ability to meet new challenges, but it also gives new hope. It may stimulate self-confidence, a reduction in physical complaints and is mood enhancing.

Playing sports, being creative or undertaking other types of activities will enhance adaptation to the direct surroundings (e.g. going for a cycle trip or learning to ice-skate in winter). Such activities will also assist refugees in learning a new language which will also enhance the process of integration. This will be most successful if the refugee is left in control of such activities and thereby in control over their own life. This is not to say that they may not be in need of encouragement and support.

See the table below for a summary of protective factors:

Protective factors		
General	***Individual***	***Social***
Safety and security	Personality (sense of humour, energy, a positive mind-set)	Social support by compatriots or family members
Outlook, sense of having a future	Intelligence	Being physically active together with other people (sports, other types of activity)
Adequate support and care	Good health	Being socially active

People who are ill, or people who experience many of life's challenges, often find it difficult to maintain a positive self-image. They realize that they have a social and/or mental health problem. Doubt, feelings of embarrassment and shame may cause refugees to be hesitant to undertake activities when there are other people around. This barrier may be removed a bit by talking to refugees about things they find difficult to do, about the importance of proper self-care or about social customs in the host society. This is based on the principle that clear explanations and reliable information may provide a sense of certainty. A sympathetic ear creates trust and improved mutual understanding. Psycho-education or providing information about issues the refugee is concerned about may help them to feel relieved and encouraged. This may also make them feel more motivated to adhere to things that were previously agreed upon.

Summary

The protective factors listed below impact on refugees' psychosocial well-being. Support workers can help strengthen such factors.

1. ***Information:*** Knowing where you are at; being able to anticipate a different social and cultural context; learning to cope with issues; increased willingness to work with others.
2. ***Certainty and security, time as a healer:*** Significant problems are now in the past; having a home, children are now safe; time heals many wounds, having a future again.
3. ***Social contacts:*** Preventing social isolation; maintaining the person's individual identity; a sense of interconnectedness; the opportunity to try out new behaviours.
4. ***Being active, participating and having an outlook result in:*** Giving a sense of purpose to life; preventing boredom; developing the ability to use one's own capabilities, empowerment and resilience.
5. ***The possibility of access to a good system of care and adequate care:*** Support workers can help the refugee to get adequate treatment in the first stage after arrival..

Background information on refugee children may be found in Appendix 2.

References

1 Beiser, M. (2009). Resettling Refugees and Safeguarding their Mental Health: Lessons learned from the Canadian Refugee Resettlement Project. *Transcultural Psychiatry* 46 (4), 539-583.

2 Grinberg, L. & Grinberg, R. (1984). A psychoanalytic study of migration: Its normal and pathological aspects. *Journal of the American Psychoanalytic Association* (32), 13-38.

CHAPTER 3

Practical steps in the support of resettled refugees

Activation and encouraging participation in the host society are the basic principles underpinning the provision of psychosocial support to resettled refugees. For refugees this involves building on the skills needed to find their place in the host society step by step. Activation and participation will contribute to refugees being accepted into the host society, and will contribute to refugees establishing their own networks, which will make them feel better. At the very least it will result in improved subjective health and get people moving (both physically and psychologically).

Building on information presented in previous chapter, we will outline a number of possible steps in the psychosocial support provided to this group. These steps can be taken at different points in time, starting immediately prior to and following resettled refugees arriving in their new place of domicile, and eventually in situations where it is clear that there are (complex) problems.

The following steps will be discussed within the context of support work:

1. The social map
2. Identifying vulnerability and protective/aggravating factors
3. First points of contact
4. Picking up signals
5. Contacting professional service providers
6. Consultation and referral
7. Collaboration
8. Prevention of burnout among (voluntary) support workers

A. Prior to arrival in their new place of domicile

1. The social map

Creating a social map of local and regional bodies is an important step which can be taken prior to a refugee arriving in his new place of domicile. This social map refers to a mapping of all support services within a particular area. These may often be listed in guides or lists of addresses maintained by local authorities. Such social maps may provide an overview of service providers and agencies in the area of welfare and healthcare. Social maps also indicate the target groups of the various services and describe how they operate (approaches, aims).

As soon as a number of refugees are resettled within a particular municipality, it will be useful to have a good overview of agencies and care providers which may be involved if healthcare problems arise. In many cases, support workers have become familiar with such agencies and have a reasonable idea of what professional care may be available for refugees locally. This may include knowledge as to past experiences, be they favourable or less favourable, with particular agencies or individuals.

The preparatory work prior to the arrival of refugees will usually involve the local refugee support organisation trying to find the refugees a family doctor. If the family doctors is known he will benefit from general information about the reception of a particular group of refugees or individual refugees. Family doctors frequently need this type of background information. It is also good for the family doctor to know which support worker to contact when recently arrived refugees are identified as having medical issues.

In some municipalities or areas, there is consultation between the various care providers around individuals who find themselves in difficult situations. It is a good idea to inform and/or advise such people prior to the arrival of resettled refugees – it may be necessary to arrange structured professional care and support for some of these.

Appendix 3 contains an example of a social map which may be used. This contains some of the most relevant support bodies and may be supplemented with information on the national/local situation.

2. Identifying degree of vulnerability, protective and aggravating factors

A second step consists of trying to determine the refugee's level of vulnerability beforehand. In many cases it will be possible to analyse any protective or aggravating factors which may apply to the person. This will assist in focussing on a refugee in detail. Such an analysis may provide a good platform for the support worker and the refugees to work from after the latter's arrival.
Basic information on a refugee's personal details and matters such as the person's background and education will be available prior to a resettled refugee arriving in his new place of residence. Such details will have been provided by the UNHCR, which has put the refugee forward for resettlement, and by the organisation which is involved in selecting refugees and looking after the cultural orientation programmes. Individual reports are written up following these training programmes, and these are usually made available to the local body in the refugee's new place of residence There may not be that much information available on resettled refugees who come to Europe without any family members (usually as 'emergency cases'). These refugees will be supported in their passage to a European country very quickly (within six weeks), either without first receiving any cultural orientation training, or only very superficial training. Medical records are often only sent on afterwards. This leaves a greater likelihood of unexpected revelations, either favourable or unfavourable, than in the case of group arrivals where refugees have been in touch with the selection mission.

Appendix 4 contains a survey in relation to protective and aggravating factors and information on how to use this survey.

B. After arrival in the new place of domicile

3. First points of contact

Support for resettled refugees is provided within established national frameworks. Support workers are usually trained in established approaches, also receiving supervision and coaching. The Netherlands make use of the so-called CODA Model, which consists of support in four phases: (1) making contact, (2) exploring the new situation, (3) establishing objectives and (4) getting active. The CODA Model is addressed in basic training programmes offered to support workers with the Dutch Council for Refugees (DCR). This model emphasises the importance of the first contact, leaving room for both refugee and support worker to ask questions and provide information.
Refugees travelling from abroad to their new place of residence may find this transition fast and overwhelming. In practice, the period of getting to know people may take a couple of weeks. It is a good idea to introduce the refugee to a wide range of people soon, although step by step. This involves the support worker and the refugee visiting neighbours, other refugees, agencies such as local authorities and banks, teachers, family doctors, and so on. The support worker may provide care providers and neighbours with written material about resettled refugees (in general). During this time the support worker gains an impression of the refugee while the refugee gets to know important people on the social map. These interactions will help the support worker gain an impression of any possible psychosocial issues.

It is important that refugees receive information about the healthcare system in their new country of residence. This information is often given at the individual level; however information can also be provided to groups in instances where a group of refugees has settled in a new town or area. Good information sessions should be aligned with the refugees' way of thinking as much as possible. However, one should also take into account that many refugees have low health literacy skills. Refugees may have considerable gaps to bridge in the following three areas:

- Reading and understanding written materials. Written information is not much use to refugees because they are hardly able to read or speak the host country language. However it turns out that they often also have real trouble understanding oral (interpreted) information, such as instructions relating to medication.
- People in Europe are often familiar with their own contribution to poor health (unhealthy diet, stress, lack of exercise, etc.). Refugees are not as focused on a healthy lifestyle and used to stand up for oneself in case of illness. Also, many refugees are not used to or not familiar with the concept of disease prevention.
- Mental health problems in particular are often labelled as something else – people are crazy, or bewitched or there are evil spirits at work. The causes of such disease are extraneous to the person – as are the cures (rituals, sacrifices, etc.).

4. Picking up signals

Support workers often play an important role in identifying signals of psychosocial issues in resettled refugees. Picking up signals here refers to observing certain expressions and events which may have a negative impact on someone's situation and interpreting these in a certain

way. Given the risk that resettled refugees can either suffer or develop psychosocial problems, as outlined in the previous chapter, it will be beneficial to the support provided to these refugees that such problems are identified in an early stage.
Identifying signals is aimed at improving a particular situation – either directly or indirectly. Identifying signals is usually aimed at identifying warning signs for danger, threats or unusual circumstances or events. A feeling of unease is one such sign – referring to a sense that 'things are not quite right' with the refugee, even in the absence of any obvious indications. This 'pre-stage' may be a cue for more focused observations.
Focused observations involves picking up signals in a step-by-step fashion. This will involve the following steps: Observation, mapping, analysing, deciding on what action to take, taking action and evaluating. By moving through these stages of identifying signals in a purposeful manner, the refugee support worker will arrive at a better understanding of the level of vulnerability of individual refugees and any protective or aggravating factors which may be at play.
An individual's level of vulnerability can only be gauged by means of an individual assessment. It is essential that the support worker contacts the individual, talks to them and asks questions. Professional care providers have been trained to do this and may make use of questionnaires. It is more difficult for support workers without a background in medicine or psychology to carry out such an assessment. The PROTECT Questionnaire may help the support worker to identify possible refugee mental health problems early on.

USING THE PROTECT QUESTIONNAIRE AS A TOOL

The PROTECT Questionnaire was developed to identify possible mental health problems in asylum seekers early on. The questionnaire was developed to gain an impression of the likelihood that an individual may have or may develop mental health problems. The questionnaire is aimed to be used by non-medical professionals and can also be used to support resettled refugees. The questionnaire enables the support worker to quickly identify any possible mental health problems which may need further investigation or treatment.
The PROTECT Questionnaire is succinct yet complete and at the same time easy to use. The list contains ten questions about mental health problems which can have a Yes or No response. These questions cover those problems most commonly encountered in refugees, such as symptoms often seen in anxiety and depression, in combination with physical symptoms often associated with the former. Questions have been formulated in a clear, simple and unambiguous manner.
There is space for observations at the end of the questionnaires (e.g. body language is tense, quick to anger, signs of agitation, cries a lot, suddenly lost in their own world, does not show any emotion whatsoever). Such comments provide information on the refugee's non-verbal behaviour and serves to provide additional information.
Results are easy to interpret – the questionnaire does not contain any items which are in contradiction to other items, every positive answer receives a score of one point and scores are then simply added up. The higher the score, the higher the risk for vulnerability from a mental health perspective (0-3: low risk; 4-7: medium risk; 8-10: high risk).
The questionnaire may be found in Appendix 5 together with instructions for use, answers to frequently asked questions and practical tips.

When to assess for potential signals?

Assessing for potential signals may be done at various points of time when supporting refugees.

In the first few weeks

- One may choose to assess every resettled refugee for potential signs of vulnerability for mental health problems within the first weeks post arrival. This means that this interaction takes in the nature of a short intake (with questions about personal details and personal matters). Specifically in those instances where not much is known about individual refugees or where it is obvious that an entire group of refugees may be vulnerable to mental health issues, it is a good idea to collect information from them in a structured manner, including information about their mental health status.

Soon after arrival in instances where there is an obvious vulnerability

- In those cases where it is immediately obvious that a family is vulnerable, an early assessment may be useful in order to provide highly focused support and care as early as possible, or other assistance, e.g. help with parenting. The PROTECT Questionnaire may be a useful tool. The family doctor, who will hopefully also have access to relevant medical background information on the family, may also play a role. It is a good idea to advise the family doctor beforehand about the use of the PROTECT Questionnaire, as this will ensure that they are familiar with questions asked and that they will be aware that refugees may end up needing their care should the questionnaire identify any concerns.

Focused assessment when there is reason for concern

- If there is no direct indication that there are any psychosocial issues, support workers may choose to do nothing until there is reason to do so. Signals of possible psychosocial problems may be identified in the period immediately following arrival, but also after some time. We cannot provide an exhaustive list as there are a number of events, incidents and behaviours which may be due to unobserved mental health problems. This may include: Seeking to isolate oneself, being awake all night (either because of bad dreams or because circadian rhythms are upset), lots of complaints relating to pain or other physical symptoms, fatigues, apathy, problems within the family or relating to the children, truancy, and so on.

When to carry out assessments (with all newly arrived refugees, with vulnerable refugees, or only if concerns have arisen around individual refugees or families) will vary per situation and will depend on practical matters and the chosen approach. Matters such as the number of available support workers, their experience, the size of the group of resettled refugees and whether there is information available about their health, will all play a role in influencing this decision. Clearly, there will need to be immediate action in those instances where refugees suffer obvious acute and serious medical problems.
The third option – assessing for potential mental health problems only when there is reason for concern – involves more of a wait-and-see approach. A diverse range of concerns (physical, mental health, social) may lead support workers to use the PROTECT Questionnaire to identify potential issues. In case of the second option, where indications already exist that the refugee is vulnerable, (e.g. based on the report of the cultural orientation training) a focused assessment may take place in an earlier stage. In this case too, it will be a good idea to use the PROTECT Questionnaire. Mapping possible mental health problems will assist with focused referrals to the available healthcare professionals.

How to use the findings?
The results of the PROTECT Questionnaire will give an indication of the level of vulnerability to possible mental health issues. Where refugees are identified as being at either 'high' or 'medium' risk, it is important to discuss this with them – not with the intention of providing care, but more in particular to prepare them for referrals to healthcare professionals. It is also important to listen to refugees in order to find out how they view their own situation and problems. Questions to ask refugees may include:

- What do you think caused these problems?
- If you were still in your country of origin, what kind of help would you seek?
- Whom would you ask for help?
- What do you think would really help you overcome these problems?

It is very helpful for support workers to explain that other refugees in difficult situations experience the same problems, and that lots of people experience memories of bad things that happened in the past and that these do not just disappear by themselves. It is important to discuss what the refugee can do to address these problems. Useful and practical tips may often be effective. In many cases getting active is the key: Getting busy with DIY (Do It Yourself) or helping others may act as diversions. Exercise is known to be very effective as an antidote to depression – activities such as going for a bike ride, walking or fitness routines often help people gain more energy. Others benefit from playing music, sewing or cooking together. It is also a good idea to talk to refugees about the importance of any options for professional help while explaining how this is organised in the host country.
Professional help usually starts with the family doctor, who plays a central role in the assessment of the seriousness of signs and symptoms in most EU countries. Moreover, family doctors have an overview of options in the healthcare system, either within their own practice or through referral to specialist care providers (mental health care).
In quite a number of cases refugees are unwilling to discuss such matters and unwilling to be referred on. In such instances, it is important to express understanding and to provide further explanation. This may involve explaining how the care system works, the importance of talking

about difficult topics and the relief this may provide. Revisiting the same at a later point in time may help persuade someone to move towards accepting care. Sometimes the PROTECT Questionnaire may be completed again to see if there have been any changes, whether things have improved as time went on or whether the opposite is true.

A low score may provide some reassurance, however it does not offer any guarantee that there are no mental health problems. Mental health problems may not always be immediately apparent in the period following arrival in the host country. The literature has shown that resettled refugees do not have much time to think about mental health issues in the period immediately post arrival. Refugees may also feel embarrassed and fear creating a negative impression, which may lead them to remain silent about any mental health problems. Individuals may only bring up such matters once they have sufficient trust in their support person, and that takes time.

How do refugees feel about this?
Resettled refugees tend to be oriented towards a new beginning and may not (dare to) recognise mental health issues, and therefore a focused assessment based on an actual concern may be the preferred option. If this is done too early, there will not have been time to establish sufficient rapport and chances are that the support worker will not receive any reliable responses to their questions. We are talking about sensitive information here! Refugees may also feel that we are putting them into the role of victim or patient. This needs to be avoided as most refugees most definitely do not want to be seen as either victims or invalids.
It is good to emphasise that there is no shame in asking for help when problems arise. We need to point out that well-qualified people are available who can help the refugee either by talking, by giving practical advice or by prescribing medication. We also need to add that it is the family doctor's role to see what healthcare provider would be the best person to help people with these sorts of problems.

5. Contacts with professional healthcare providers

In many European countries, family doctors play a crucial role and act as the gatekeepers to the healthcare system. As many refugees do suffer health problems it is important for them to be seen by their new family doctor soon after arrival. This is also useful because many refugees will be unfamiliar with the role of the family doctor. It is therefore very important to explain the healthcare system in the host society, including how to make an appointment. The same applies to the healthcare insurance system, as this too will be unfamiliar territory. An introductory visit to the family doctor may enable the latter to ask refugees about their background and health, while also providing information on how things are done in his practice. If the family doctor practice includes the doctor's receptionist and nurses who carry out specific tasks, patients may also been seen by these. It is also useful for the support worker to establish a good rapport with allied staff working within the family doctor practice.

Aside from family doctors, there are a few other healthcare professionals who may be involved without a referral.

- Dentists are of importance because resettled refugees often have very poor dental health. Dental care can be expensive and as not everything may be covered by health insurance, it will often be a good idea to ask for quotes first and submit these to local authorities for possible reimbursement.
- Social services may be approached for assistance with a wide range of psychosocial issues, including financial problems, relationship issues and parenting problems.
- In cases where refugees need home support and home-based care, community health services may be called upon. In some cases specialised community services or district nursing care may be available for those with mental health issues or complex parenting issues, however this may often be available only after referral.
- In cases of psychosocial issues affecting children or parenting problems, specialised youth and family service providers may be drawn in.

Of particular importance to refugees are hospitals and mental health services when it comes to either mental health or psychiatric care. Resettled refugees who came to Europe because of medical emergency in particular will often be reliant on specialist medical care. In cases where this has to commence immediately after arrival, this will usually place a heavy burden upon the support worker. Refugees do not know their way around the system, which is why specialist appointments are only possible through special effort on the part of the support worker (making the appointment, arranging transport, coming along to the appointment).
As resettled refugees are more likely to have mental health problems, they may on occasion need to have specialist care provided by mental health services. Due to refugees not being familiar with this type of care, and mental health services not being familiar with the needs of this special group, care may not always be well aligned with the needs and expectations of this group. This means the support worker will have to

explain what mental health services entail. In addition, care providers working for mental health services may ask support workers to clarify issues and to liaise.

It is not always easy for support workers to perform the aforesaid roles as they concern matters over which they usually only have limited control. It is not always possible to change the ways refugees view their mental health issues. It requires communicative skills, to try and align any explanations given to the refugee's use of language, expectations and perceptions. Some forms of care are difficult to access for this target group. Moreover, there will often be a gap between the care that is offered and the refugee's own ideas and views as to that care. This applies to mental health services in particular.

C. What to do in cases of (complex) problems

6. Consultation and referral

It is sometimes difficult to assess when a problem or situation has become so serious that it warrants professional assistance. A situation may deteriorate or problems may worsen if resettled refugees find themselves unable to comprehend changes in their lives or are unable to adapt to their new circumstances. In some instances people may develop psychosocial problems following an initial period in which everything appeared to go well (see Chapter 2).
Any such assessment is largely a matter of 'weighing up' the situation. Any responses on the part of refugees – behavioural changes – may be said to be of concern if they are intense, recur frequently and are of longer than one month's duration. At that stage people in the immediate environment will also respond differently to any unusual behaviours. If mental health problems are suspected, it is time to call in professional help, starting with the family doctor. Of course this can only be done with the refugee's agreement.
Appropriate consultation with the family doctors and other healthcare providers requires a good understanding of the refugee's problems. To this end, the PROTECT Questionnaire mentioned earlier is a very useful tool, as it contains focused questions relating to issues which may point in the direction of mental health problems. Such insights will assist in the consultation with or referral to professional healthcare providers. Combining such findings with one's own observations, as well as indications received from third parties, will aid a better assessment of the situation, by healthcare providers as well.

Having an overview of what agencies and healthcare providers are available thanks to the social map mentioned earlier (see Appendix 3) is very useful to see who can be approached.
Primary care providers will be represented by the family doctor in combination with a number of other professionals (including social workers, youth workers, physiotherapists, district nurses, psychologists and dentists). The family doctor is usually in a good position to assess what care is needed in a particular situation; they know whether the problem can be addressed by primary care providers, or whether more specialist care may be needed, either in a hospital, or as provided by mental health services.
The fact that, in some countries, the government no longer pays for interpreters in healthcare poses a growing problem in the professional care setting. Where interpreters are available within the framework of receiving resettled refugees, it may be useful to involve that same interpreter for healthcare consultations. 'Borrowing' such interpreters for visits to the family doctor or specialist may be more beneficial than not using any interpreter.

It may be useful for support workers to have some prior consultation with the healthcare provider refugees are being referred to, not just to inform and discuss the referral but also to provide some background information about the person. Moreover, such interactions provide the opportunity to ask for advice as to how support workers who are not medical professionals can deal with certain situations. Consultation helps create a form of togetherness with regard to a problematic situation, something which will benefit all concerned.

7. Collaboration

Referrals do not entail a complete handover of a refugee's problems by the support worker. The support will continue, and the worker will remain in touch with the refugee, even though the care is taken over by professionals. Continued regular consultation will be needed. The support worker can continue to play an important role within the network of service providers, but always in consultation with the professional healthcare providers. This will enable the support worker to see how the process of care is progressing or stagnating. Their role will be to provide (practical) support, answer questions, to see how things progress and to advocate for the refugee where necessary.

When collaborating with professional service providers it is essential that there is adequate consultation and that the service providers involved align their roles. Regular meetings are useful. Interdisciplinary case discussions enable a discussion of what care is needed in complex situations, which care provider will do what, what initiatives will be left to the refugee, how all those involved will keep each other informed and what to do and whom to call in crisis situations.
In some situations, support workers may deem such meetings with care providers necessary and may take the initiative in arranging the same. This usually occurs in situations where it is unclear what care providers are involved, or where they have withdrawn, leaving the support worker isolated, as the refugee's last resort. This type of situation is undesirable as it can quickly lead to burnout, making it important to (re) involve others in the care for the refugee. Some situations in which this type of isolation may occur may involve: Serious issues or problems without a clear-cut solution; when all sorts of care has been offered, but all to no avail; when refugees are irritable and quick to anger, leaving care providers in fear and quick to distance themselves; or where refugees engage in chronic drug and alcohol abuse. It may also happen that refugees refuse care. In the Netherlands such people are referred to as 'care avoiders'. Support workers end up being the only ones in touch with such care avoiders, in the absence of the involvement of any other care providers. This will end up placing significant burden on the support worker, especially if the situation is serious and problematic. In such instances it may be a good idea to talk to the family doctor, as they will often know what avenues and options may be open in such difficult situations.
Collaboration is especially crucial in complex or difficult situations. Bringing professional care providers together can contribute to 'everyone singing from the same hymn sheet', and agreeing on an approach in which each individual contribution is clear. Interdisciplinary case discussions may also boost the care provided by each of those concerned. To this end it is important for the support worker to be very clear about the boundaries of their involvement as a non-medically trained volunteer.

8. Preventing burnout of the (voluntary) support worker

Supporting resettled refugees automatically implies being confronted with the reasons for their flight. Accounts of suppression, war and violence may crop up at any time during the course of providing support. Sometimes this may happen in a very explicit manner, when a refugee recounts their flight story once a relationship of trust has been established with the support worker. Sometimes this happens in a more explicit manner, when it gradually becomes clear what someone has been through and what may be at the root of a person's psychosocial problems. Such personal histories and associated emotions can be very powerful and involve strong emotions, and will usually have an impact on the support worker. This is especially likely when providing support is very complex and there are feelings of powerlessness. The impact of such narratives and emotions can have an excessive impact on the support worker and contribute to feeling emotionally overloaded. This may lead to things getting on top of support workers when things go badly (again) for the resettled refugee, and to them developing burnout.

Working with survivors of war and political violence can put support workers at risk for developing strong adverse emotional responses (such as irritability) and overload. Other factors which may turn support work into a burden may be the refugee's different socio-cultural background, which may surface in the form of communication problems, other ideas on health, (mental) illness and assistance. The support worker's personal traits play an important role. We know that intensive and empathetic interactions, an involved response style, youth and a lack of knowledge and skills are all factors which may put workers at risk for strong adverse responses and overload. Studies have shown that women are more likely to become emotionally overinvolved and overloaded.
It is good to recognise that there are a number of different ways in which support workers may carry out their roles. Support workers may see their own roles in different ways. Below we will outline a number of roles which support workers may choose to play, be it consciously or unconsciously:

- *The rescuer*
  The 'rescuer' is sensitive to what the refugee has suffered and keen to help them, for example, by talking about what the refugee has been through and by looking for solutions. Such support workers are guided by compassion, strong engagement and want to offer protection. 'Paternal' or 'maternal' feelings may arise. The rescuer tends to demand less of the refugee, due to feelings of compassion. In extreme cases support results in a form of 'adoption'.
- *T*The treatment provider
  The 'treatment provider' finds it hard to deal with the refugee's suffering and considers themselves to be the person who can treat the refugee. This may end up in the support worker going too far and doing things that have not been discussed with professional healthcare providers and which do not fit with their role of (voluntary) support worker.
- *T*The referrer
  The 'referrer' finds themselves unable to cope with the refugee's situation or behaviour and insists that they are referred to the care of others. They are keen to distance themselves from a difficult situation and wish to hand it over to others.

All roles outlined above are in fact expressions of different response styles. Individual response styles help neutralise the person's emotions, discomfort and stress and help the person feel better temporarily. However, it is known that when support workers exhibit extreme response styles, this will hinder support options. In the end this helps neither the support worker nor the refugee.

Response styles may be classed into two different categories, roughly speaking:

1. *Remaining distant and aloof (Type I)*
   This type entails denial, minimisation and playing down problems, avoiding any real rapport, resulting in the impression of being indifferent and remote. Support workers often withdraw. This attitude may end up in blaming the victim: It is all the fault of the refugee.
2. *(Over)involvement and closeness (type II)*
   This type involves a heightened sense of responsibility, taking over from the refugee, getting caught up in the complexity, feeling responsible for the refugee's well-being, rescue tendencies, a strong inclination to take actions, feelings of guilt and shame, personally suffering from moral dilemmas. There is an overemphasis of the impact of traumatic experiences on a person's behaviour. Eventually the support worker ends up feeling they are the victim, starts to feel ill and discontinues.

Recognising both extremes in response styles may assist support workers in taking up a middle of the road position. This will involve a certain extent of distance in some situations, while showing involvement in others. Support workers are most impactful if they take up a position in between distancing themselves and being over-engaged.
Insight into both extremes is also important in order to be able to recognise extreme response styles in oneself or in other people. Elements of either of the response styles outlined above may also signal a support worker leaning too much into either direction. This may involve mounting irritability, avoiding difficult tasks, being more absent, consulting less, on the one side, or showing more compassion, having strong emotions, feeling misunderstood and being demanding, on the other side. It is good for such signals to be discussed between refugees and support workers. This will result in insights into how one functions and in the support provided. Alerting support workers to showing an extreme response style can help them modify their responses, and interactions with the refugee will benefit from the same.
Generally speaking there are a number of ways to help prevent strong emotions and extreme response styles among support workers. It is of the utmost importance that there are efforts around:

- Finding an adequate balance between private life and support work;
- Discussion, mutual exchange and support in difficult situations;
- Supervision and team intervision focusing on the personal aspects of this type of work;
- Training aimed at providing support workers with skills, resulting in support workers being less likely to develop extreme response styles.

Summary

1. ***A social map*** is very useful to provide an overview of available services and agencies.
2. Prior identification of any ***protective factors and aggravating factors*** will help assess to what extent refugees are potentially vulnerable.
3. ***Proper introductions*** will provide the basis for adequate support for resettled refugees in the first interactions.
4. ***Identifying signals*** using the PROTECT Questionnaire will help identify mental health problems in an early stage.
5. ***Contacts with professional healthcare providers*** are essential for the support of refugees.
6. If there are indications that there may be (complex) problems, it is a good idea to ***consult and refer if need be***.
7. In some situations ***collaboration*** with (several) professionals is a necessity.
8. It is important for support workers to ***avoid burnout***. That is why it is important to understand how this comes about.

CHAPTER 4

Case studies involving a number of recurrent themes

This chapter will provide a detailed description of four case studies which are all based on practical experiences with the provision of support to resettled refugees in the Netherlands. These case studies will build on the theory, experiences and background information outlined in previous chapters.

The case studies (exemplars based on practical experience) will follow a fixed format. All will be described from the perspective of the support worker, while also trying to reflect resettled refugees' perceptions. Each case study will list a number of relevant key words.

CASE STUDY 1: 'I AM ALL ALONE WITH MY TWO CHILDREN...'

KEY WORDS:
Young single mother; parenting issues; mental health issues; longing for family; collaborating towards the provision of services

A. Personal details

Thana, a 22-year old woman, arrives in your country as a resettled refugee from a country in Asia, together with her 5-year old daughter, and her little boy, who has not yet turned 1.

B. Information prior to arrival

In your role as the support worker you have been told that Thana and her two children will be resettled by UNHCR as an emergency case. She initially fled her country, only to end up in the capital city of a neighbouring country, rather than in a refugee camp. There she wandered the streets as a single mother and was constantly being harassed. Because this situation was too unsafe she was placed in a women's shelter through UNHCR intervention and this is where her son was born. UNHCR put her name forward for resettlement because, being a single mother, she was at risk. Because she was identified as an emergency case and being at risk, she left very quickly without attending a cultural orientation programme.
We know that she attended school in her country for only a few years, unable to attend after that, due to fighting and other problems. She has some English, which she picked up while wandering the streets and during her stay at the shelter later on.
This is all the prior information available to you, something that is not at all unusual when refugees are being resettled after a selection mission. This makes gaining a first impression of the person you are about to support more difficult.

C. Protective factors and aggravating factors

Prior to Thana's arrival, you, as the support worker, reflect on some of the factors which may constitute protective and/or aggravating factors for Thana and her children. This includes the following.

- As a single woman, she may have been subjected to experiences which have had a major negative impact, but it is not known whether this was indeed the case, as there is only limited information available.
- Nothing is known about her family. Does she know whether her relatives fled and if so, where they are now? Uncertainty about family members may have a major negative impact.
- The fact that she has two children may act as a protective factor, as this will give her life structure and meaning. However, it may also be an aggravating factor, as it is hard to bring up children as a young solo mum, especially in an unfamiliar environment. You do realise that Asian women generally have children at a younger age than women in Western countries.
- You wonder as to how the children were conceived, because sexual violence might enter into the picture, in view of the life she was forced to lead at the time.
- Moreover, she does not have any family, who might otherwise be able to assist her in bringing up the children. In her country, children are often brought up within an extended family.
- The fact that she has some English, may help you in your interactions during the period immediately following her arrival.
- You cannot think of any other protective or aggravating factors because of the limited information available to you. This situation is not new to you as a support worker.

Looking at the documentation around a certain case helps you form a first impression of the refugee before he or she arrives. Having such an overview can help you remain alert to various factors once Thana has arrived. In other words, this helps prepare you for your role as a support

worker. This is not about labelling people, but about making a brief analysis of the challenges somebody faces and their ability to cope. And of course, some factors may only become apparent once Thana has arrived in the country .

D. Period immediately post-arrival

You notice Thana's initial happiness with her new home and her new country. Her spoken English is better than expected, and this makes it relatively easy to interact with her. It does turn out to be difficult to arrange childcare for her little boy, as there are no places available. As a result, Thana's ability to attend language classes is limited initially, as she spends the entire day at home with her son, while her daughter attends primary school. You arrange for a woman friend to visit Thana at home twice a day, to help her make a start with learning the new language. Thana appears to look after her children well and seems to be a caring mother. The neighbours say that her little boy often cries at night.
In the course of your frequent interactions with her, you learn that Thana became pregnant due to unwanted sexual contact in the chaotic period surrounding her flight and the time she spent wandering around. It is not clear whether the pregnancies resulted from sexual violence, as Thana remains vague on this point. You also learn that she has no idea what fate befell her family (mother, two sisters and a brother), as Thana lost sight of them in the chaotic period during her flight. She says she often worries about her family and that she dreams about them a lot. You can see that this is causing her sadness.

E. Assessment

You wonder whether it might be useful of try and do a more focused assessment based on what you now know about Thana, and whether it might be good to use the PROTECT Questionnaire. You discuss this with your supervisor or a colleague. You both feel it might be a good idea to go through the questionnaire with Thana, due to the existing aggravating factors and because she appears to be experiencing stress. However you are worried whether this will be okay with Thana. You explain to her that you would like to go through some questions to do with her mental health. Thana does not understand the concept of 'mental'. You explain that this is to do with the health of what is in her head, because she has been through a lot and worries about this a lot, and also worries about her family, and really misses them. Thana understands and agrees to go through the questions. You feel relieved that you have managed to get to this point.

You are not looking forward to going through the questionnaire, as all questions are very personal, relating to things which are highly emotionally charged. Still, things go better than expected and it only takes fifteen minutes to get through all the questions. Bit by bit, Thana tells you more and more, even though her lack of English makes it difficult. It is almost as if she feels relieved to be able to get things off her chest, and talk about her feelings. Afterwards she thanks you, saying that she is happy you asked those questions, because she often feels out of sorts.

You are quite taken aback with her replies to the ten questions, because she says 'Yes' to a lot of them. Thana has problems sleeping and has bad dreams about painful past events. She often worries about those and also worries about what fate may have befallen her family. Because of this, she often suffers from headaches. She realizes that she is irritable and gets upset with her children quite easily. She tells you that she has no interest in a lot of things and would rather stay home all day. The language classes are not going very well either, she finds it difficult to concentrate and forgets a lot of things she is supposed to try and remember. In the course of the conversation her eyes fill with tears a few times. Looking at her replies to the questions in the PROTECT Questionnaire, they add up to a score of between 8 and 10. This means she is at high risk. You realise that Thana is showing a lot of symptoms which may signal mental health issues and that additional medical and psychological screening will be needed.

You tell her that it will be a good idea to see who may be able to help her feel better and stronger and quieter in her head, so that she may be able to sleep a bit better. Thana says that she does not want to talk about these things with other people yet again, because she finds it too hard and too hurtful. You do not want to pressure her, but would like to give her some time. So you ask her what she thinks she will need to feel better.
It has become very clear to you that Thana has mental health problems because of everything she has been through and all her losses. You worry that this may only cause more problems in the not-too-distant future.

F. What happens next

A few weeks later Thana tells you that she has learned from people who are also from her home country that her mother, and a brother and sister are still in life. They have surfaced in a refugee camp in the same country as that which Thana left to come over to your country. This

news has an impact on her behaviour. She finds it impossible to do anything except worry about the situation her family are in. Every time you meet her the conversation turns to them. She demands that they are brought over as well. You know from experience that this will be difficult and involve complex bureaucratic processes. You are unable to get this across to Thana. Whenever you try, she gets sad, rebellious and angry. She says that without her family here with her, her life has no meaning.

There are more and more signs that things are not going well with Thana after this point. Her attendance at language classes is dropping off. You seem to find her lying on her bed more and more often whenever you visit. She also appears to show less interest in her children. She tells you crossly that she keeps worrying about her family and that she is unable to sleep. She says that she wants to be with them, and if they cannot come here, she wants to go back to Asia. The neighbours are complaining that they can hear things going on at night, as well as the sound of crying children. When things get out of hand one night, the woman next door rings the police. When the police go and have a look, they find Thana at her wits end, her two children by her side. Her little boy has a big bump on his head. Thana says he has fallen out of bed. The sight of the police officers on her doorstep at night seems to give her a huge fright. The police are able to settle things down a bit.
The next day, the police advise the local authorities as to what has happened. They in turn advise the support worker and Child Protection Services. You know that it is time to provide additional support to Thana and her children but you are unsure how to go about this.

G. Further investigations

You go and talk to Thana. The fact that police officers turned up at her door at night, asking questions about her children and the bump on her little boy's head has given her a big fright. She anxiously wants to know whether the police will take her child away. People from her country have told her that this can happen in your country. You tell her that this would only happen if somebody is not looking after a child very well, and that you don't think this is the case in Thana's situation. You try to find out what happened that night. She tells you openly and without any qualms that she felt sad that night and unable to sleep. Her little boy had been whining all day. That night she had had enough. She gave him a push in his cot, which caused him to knock his head hard against the side of the cot. He cried at the top of his lungs and a bump appeared on his head.

After hearing from the Police, Child Protection Services want to investigate and visit Thana at home. The lady from Child Protection Services asks you, as her support worker, for more information. You provide her some general information about resettled refugees, adding that you cannot provide more details about Thana because that is confidential information. In the end the child protection lady asks whether you would like to be present when she visits. You both agree that you will talk to Thana about this first.

When talking to Thana a few days later on, you need to do a lot of explaining and take a lot of time to take away her fears and suspicions. She gets angry too, saying: 'They won't let my family come here and now they want to take my kids away from me as well.' You manage to reassure her by saying that you can see that she looks after her children well. You add that you want to help her explain this to the lady from Child Protection Services. She is happy for you to do that.
The home visit takes place one week later, with an interpreter present. The interview goes well and Thana is able to tell her story. She talks about her difficult life and how much she misses her family. She again openly talks about the incident that resulted in her little boy having a bump on his head. The lady from Child Protection Services is empathetic. She tells Thana that she can see that things are not easy for her. She asks Thana how she would feel if another lady came to help her take care of her child at home, to provide parenting support in the home. Thana assents. The child protection lady also says that she thinks Thana should tell her family doctor that she has problems sleeping. You say that you have already discussed this with Thana, but that she is a bit hesitant. The child protection lady says that she will come around again in a little while to see how Thana and her children are getting on.
Thana looks relieved once the child protection officer and the interpreter have left. She is not quite sure what sort of help she will get, but she is okay with it. You are happy with this first step towards professional involvement. You do urge Thana to go and see the family doctor in a few days' time. Thana wants you to come along too. You are quite happy about this, because you are not sure if Thana will be able to convey to the doctor what it is she needs. Besides, she does not really understand what a family doctor can do for her. It also means you and Thana will be able to let the family doctor know about the outcome of the PROTECT Questionnaire.

H. Consultation and referral

A few days later the family doctor makes time to see Thana. He is taken aback by the results of the PROTECT Questionnaire assessment, but he is happy to have them. When he asks Thana how many hours of sleep she might get at night, it turns out she only sleeps 4 to 5 hours on average. The

doctor says this is insufficient and proposes to prescribe some sleep medication which she can use three times per week in order to sleep a little better. He asks Thana to come and see him in a few weeks' time to let him know whether the pills are helping her.
A week later Thana tells you that the pills are not helping her, that they are giving her more bad dreams, with images of her family and bad, aggressive men. She sounds angry and frantic when she says that without her family her life is not worth living. She tells you in an ominous tone that she cannot go on living like this. You are taken aback and not sure what to do. Is Thana manipulating you, should you take this seriously? You tell her that if things are that bad, you would like to take her to the family doctor again. Fortunately you manage to get an appointment quickly. Initially, the family doctor does not really know what to do with the situation either. He asks Thana whether she has suicidal intentions. She replies that she does not want to go on living without her family at her side. The family doctor asks you what options there might be for arranging for her family to come over as well. You explain that this will be difficult to organise. The family doctor is clearly of the view that it should be possible to arrange this. Thana is visibly pleased to see the family doctor a bit upset as well. After some further discussion you promise to bring up Thana's difficult circumstances with the authorities in charge of asylum seekers. You try not to give her too much hope. The family doctor also says that he wants Thana to talk to a psychologist. He explains to her that a psychologist is someone who specialises in the sorts of problems which make people worry too much and unable to sleep very well. He will try his best to arrange this urgently.

Ten days later Thana has a meeting with the psychologist / psychiatrist. Thana finds it tough having to go through her story yet again. Following this, another appointment is made for another meeting so Thana can be told how the professionals may be able to help her. In the meantime, the homecare services lady providing parenting support has started to visit Thana at home.
A few days later, the woman living next door to Thana rings you up and tells you she is really worried about Thana's home situation. She tells you that Thana has been up half the night, pacing up and down the street. You see this as a sign that things are going downhill for Thana. In consultation with your supervisor, you try and organize an urgent meeting of all those involved in providing assistance to Thana, to discuss her problems and to ensure the care is properly aligned. After advising the family doctor, you ring and email the other professionals on his behalf as well. You manage to arrange a meeting for a date a few weeks' from now. In the meantime, the family doctor has contacted mental health services for advice on some more suitable medication. He is told to give Thana a strong sedative at night, albeit only on a temporary basis. This medication works for her and she has more restful nights.
The meeting to discuss her case is held three weeks later and involves a number of other service providers, including the family doctor and representatives from mental health services, home care and Child Protection Services. It is decided that a more intensive approach is needed, which will involve not only medication and talks, but also support with practical activities (such as grocery shopping, taking her little boy for walks outside, and attending a church service). This approach appears to have the desired effect. Thana is sleeping better and is getting used to the various individuals who are trying to assist her. After a while she starts to attend classes again as well.

During a follow-up meeting, two months later, you ask those present to provide a written report on their medical information and findings with regard to Thana. You aim to send this information to the authorities in charge of asylum seekers, together with a request for Thana's family to be allowed to come to this country as well. You are now a bit more hopeful that this may work out after all.

I. Take-home messages regarding support

1. It is possible to map a refugee's level of vulnerability at an early stage.
2. A focused assessment of mental health issues may be necessary as resettled refugees are unlikely to report these themselves. The PROTECT Questionnaire can be used to enter into a dialogue about this and can be useful when referring to other care providers.
3. Explaining how things work in the new home country and talking about psychosocial matters are important tasks for the support worker. It is essential that this is done in a way that is aligned to the refugee's level of language and understanding. Repetitions may be very necessary when the person has been traumatised.
4. Providing support to resettled refugees involves the support worker acting as a liaison and negotiator in relation to various agencies and service providers, especially initially.
5. There will be tensions between the trust that is needed to be able to talk together in an open and honest manner, and the feelings of insecurity which are associated with starting to live in a new country, and not being used to talking about what one has been through, or not wishing to talk about such experiences. Establishing a relationship of trust will help reduce such tensions.
6. When providing support to refugees it is important to have a good relationship with the family doctor involved.
7. It may be necessary to call a meeting of service providers (who are already involved) once a situation gets more complex. The support worker may take the initiative towards arranging such a meeting, however it is best to always do so in consultation with the family doctor.

CASE 2: 'WHY CAN'T I HAVE A NEW FOOT?'

KEY WORDS:
Disability; serious illness; high expectations from the medical professionals; absence of family; collaboration in the provision of care

A. Personal details

Lula, a 29-year old woman, her husband, 31-year old Oualo, their 6-year old daughter, 4-year old son and 1-year old daughter arrive in your country from Africa as resettled refugees.

B. Information prior to arrival

As the support worker, you have been given information by both the UNHCR and the national selection mission. Lula will be resettled as an emergency case: She cannot walk well because she has a congenital defect affecting one of her feet. Her foot is misshapen, and the only thing she can put on it, with some difficulty, is a slipper she has made herself. She waddles. Lula was given a simple orthotic shoe while she was at the refugee camp, but she hardly wore it, because it was so heavy. She hopes that she can have treatment in your country, and that she will be able to walk normally.
Oualo, her husband, has a heart defect, which was picked up in the refugee camp. He has been tired all of his life and is not able to exert himself. He has also remained smaller than other people in the family. It is said that he has a hole in the heart and this could in principle be treated by means of surgery. According to the information available, the aim is for him to undergo an operation soon after arrival in his new hometown. He will also be resettled as an 'emergency case'.
Lula and Oualo have been living in the refugee camp for eight years. They met each other there and had their children there. Lula's mother and sister stayed behind in the camp; they were not allowed to come along. It is not known what happened to Oualo's parents.
Lula and Oualo speak a language for which there are not many interpreters in the country. Oualo also speaks a bit of English, which he was taught privately in the camp. Finally, they are of the Catholic faith.

C. Protective and aggravating factors

Prior to the family's arrival, you reflect on some of the factors which may be either protective and/or aggravating factors for Lula, Oualo and their children. This includes the following.

- Lula's disability would appear to be an aggravating factor, not only because of the resulting limitations, but possibly also because of the stigma it might cause her to experience.
- The same applies to Oualo's heart defect and the resulting impairments. He may not experience any stigma, as his medical problem is not visible from the outside.
- The fact that they have three children together may act as a protective factor, as this will give their life structure and meaning. However, it may also be an aggravating factor, as it is hard to bring up children in an as-yet unfamiliar country.
- As far as their medical problems are concerned, healthcare in this country is better than where they came from. This is a protective factor, as they may expect to do better here. However, there is always the risk of unrealistic expectations. This applies to Lula and her congenital defect in particular. If unrealistic expectations are not met, this may turn into an aggravating factor.
- The uncertainty as to what has happened to Oualo's family and the fact that they have had to leave Lula's mother and sister behind will be a cause for concern for both of them.
- Both parents are relatively young, still able to learn a language and become part of society. It is to be hoped that they both have the resilience required.
- As they are both Christians, they may be able to become involved in a church. Involvement in church communities often has a protective effect. Church members often provide support and practical help.
- Communication problems can be aggravating factors, the more because there are so few interpreters available working in their language.

Looking at the case helps you to be better prepared for the 'real' work, once the family has arrived. This is not about labelling people, but about a methodical approach to a family you will be caring for. This includes a brief prior analysis as to level of vulnerability of this family. Some factors may only become apparent once the family has arrived in the host country.

D. Period immediately post-arrival

Initially there is a sense of euphoria about all sorts of things. The family are happy with their new home, admire all their new possessions and are very excited about it all.

You notice immediately that Lula is not able to walk very well, moving around on a sort of thick flip-flop. She can only walk short distances and only moves slowly. Soon after the family's arrival, you organize for them to be seen by the family doctor. Fortunately, he has received medical information about the family and is prepared. The family doctor refers both parents to medical specialists. Lula is referred to the orthopaedic surgeon at the regional hospital, while Oualo is referred to the cardiologist at the university hospital clinic. You get busy organising transport. Lula and Oualo have only just arrived in the country, and are not familiar with either public transport or with how things are done at the hospital. An added complication is that you are often unable to have an interpreter present, because the few interpreters working in their language are otherwise engaged. A lot of sign language is used during the interactions. You feel that this may lead to misunderstandings.

It turns out that Oualo not only has a heart defect, but also chronic inflammation of the liver. This needs further investigation before he can have an operation.

For Lula the road to medical treatment is not easy. The orthopaedic surgeon realises that she has an untreated club foot. This is a congenital defect that can be successfully treated surgically soon after birth. However, things are very different in Lula's case, because she is an adult now, and has never had surgery. She is referred to a local rehabilitation centre, which specialises in the treatment of new-borns with club feet. Through an interpreter, the specialist at the centre explains to Lula that full recovery will not be possible. The doctor wants to see if Lula can learn to walk better with the aid of physiotherapy and special [orthotic] footwear. Lula does not seem to understand. She keeps insisting that she wants an operation and a 'new foot' in order to be able to walk normally. The specialist asks you to take the time to explain everything once more when Lula gets home. But even there you do not manage to make it clear to her that even in Western countries it is not possible to instantly 'fix' something that has been there for such a long time. She does not want any special shoe, but instead keeps asking for a 'new foot'.

After a couple of appointments to see the physiotherapist and the orthotic shoemaker, Lula refuses further treatment. She is irritable and seems to be behaving in an increasingly inactive manner, spending more and more time lying on her bed.

Because of Lula's limitations, Oualo has to do a lot for the children (taking them to school, picking them up, doing the shopping). He often complains about feeling tired. He too insists that his wife needs some proper treatment. He turns out to have chronic inflammation of the liver (hepatitis), and is put on a course of medication.

Due to all these medical problems and hospital visits, Lula and Oualo miss out on a lot of their language classes. You worry that in this family the parents are at a standstill, and that Lula's behaviour in particular is difficult to understand.

E. Assessment

You are at your wits' end, because Lula stays in bed more and more often and appears to show less and less interest in her family. You think that Lula may be getting depressed. You talk to your supervisor, because you feel unable to get a grip on her situation and do not know what to do next. You like his suggestion that you go and talk to Lula about her mental health issues, with the aid of the PROTECT Questionnaire and the help of an interpreter. You hope that this will enable you to find a way through to her.

When you bring this up, Lula seems to be evasive at first, because she does not appear to understand what you are talking about. It is only when you tell her that you want to talk about her feelings, whether she has trouble sleeping, whether she cries a lot or not, that she finally seems to understand. She says she wants to talk about these things.

Going through the questions with the aid of an interpreter has a remarkable impact. For the first time ever Lula talks about her life, how difficult things have been with her disability, how she has been bullied, how she has always felt worthless and useless because of her disability. Her replies to questions indicate that she sleeps poorly, often has headaches, often gets angry with her husband and children, has lost interest in a lot of things, is forgetful and finds it difficult to concentrate. Sometimes she dreams of having to run away from fighting, and not being able to, and then waking up in a sweat. While talking about this she keeps getting sad and crying. However you also get the impression that Lula is relieved that she is finally able to talk about this.

You realize for the first time just what impact Lula's disability has had on her life, and that this has shaped her personality. This also explains

why she is so stubbornly clinging on to her hopes for a complete cure. This is an unrealistic expectation, she seems unwilling to let go of.
At the end of the interview she asks whether you are prepared to help her with her foot. You tell her that you are not a doctor, but that you will find out what may be possible. You in turn ask Lula whether she might be willing to try not to stay in bed as much, and help her husband care for the children a bit more. She promises to try to do that.

F. What happens next

Following on from this conversation you notice Lula trying to do more around the house. She tries to help her husband with the cooking, but she does not want to help him take the kids to school. She says it is too far, even though the school is only a few streets away from where they live. When you ask whether she would prefer not to be seen outside because of her disability, Lula agrees. In the meantime you find out that Lula is still sleeping poorly and occasionally keeping Oualo awake at night also.
Your attempts to get her to return to the rehabilitation centre prove unsuccessful. She perseveres in her opinion that the people there cannot help her, and that there must be others who can. She even asserts that other people do get new feet, but not her because she is a refugee and does not speak the language well enough. You can sense yourself getting annoyed with such statements, but you bite your tongue and don't say anything.
In the meantime Oualo is receiving treatment for his hepatitis and this is going well. He goes to the hospital all by himself to have his weekly injections. He is experiencing some side effects, and these mean he is even more tired than previously. He also seems to have lost a bit of his love of life and you have the impression that he is withdrawing from his wife more and more.

G. Further investigations

You realize that Oualo plays a vital part in keeping this family going, also in terms of caring for the children. You think it may be a good idea to openly focus your support more on him instead of mainly on Lula. In a way this means rewarding Oualo for all his efforts, and paying a little less attention to Lula's behaviour. You see it as a type of trial, to see whether this will elicit a response. If your change in focus has an impact, then perhaps the equilibrium between Lula and Oualo can still be altered.
You are surprised to see that giving Oualo more attention has an immediate effect. He happily responds to questions and starts to talk more without being prompted. He appears to enjoy the extra attention. Lula, however, seems to be getting a bit upset, as if she is envious that her husband is getting more attention than her. You explain to Lula that you want to talk to Oualo as well. He is important, because without him, things would not go well for the children. Lula has to agree, but only grudgingly.

H. Consultation and referral

You consult your supervisor and together you decide on the next few steps. One of the goals is to take the load off yourself, because supporting this family has been taking up a lot of your time. The main aim is to involve other people as well, including professional care providers. Since Lula is not taking the initiative to ask for help, you want to manage this process more actively.
The first thing you want to do is to get Lula to see the family doctor for her mental health issues. You are particularly worried about the fact that she is sleeping poorly and is quite apathetic. You are well aware that Lula will not be familiar with the Western way of providing help to people with mental health issues. Fortunately, you manage to encourage Lula to go and see the family doctor. She asks you to come along too. This is what you wanted to do in the first place, because this means you can manage their interaction a little better. The family doctor is happy to have the findings of the PROTECT Questionnaire. She briefly talks to Lula about her issues, with the aid of a telephone interpreter. She tries to explain to her that she is suffering from depression. Lula does not appear to understand what she is trying to say. She does respond positively when the doctor proposes to give her some medication to help her sleep, to give her more energy. The doctor also says that she wants to talk to the doctor at the rehabilitation centre to see how she can get her to continue her treatment.
A week later you receive a phone call from the social worker at the rehabilitation centre. Following consultation between the family doctor and the doctor at the rehabilitation centre, it has been decided that the social worker will try and contact Lula, to see if she can persuade her to continue her treatment again. The social worker wants to visit Lula at home. She will also try and contact the association for people with club feet, because there are likely to be other 'newcomers' who have problems accepting this particular disability. Some form of peer support might also be beneficial.

A few months later things have clearly changed for the better for Lula and Oualo. The antidepressant medication is working well. Lula is sleeping better, is more upbeat, is more involved with her children, and even goes outside with them from time to time.
The social worker at the rehabilitation centre has managed to establish a good rapport with Lula. This is partly because the association of club foot patients has put her in contact with an African woman who has a similar disability to Lula's. This woman was happy to talk to Lula about the condition and treatment options. They particularly talked about Lula's feelings of embarrassment about her condition and how to overcome these. This African lady visits Lula once every two weeks in the afternoon and they have built up a good rapport. As a result of this interaction, Lula is seeing the physiotherapist again and trying to walk on her orthotic shoes. Oualo has almost completed the hepatitis treatment, and hopes to have his heart operation soon after.

I. Take-home messages regarding support

1. Considering protective and aggravating factors prior to the refugee's arrival is good preparation for the support worker.
2. If support work seems to hit a road bump and if there is a suspicion of mental health problems it may be beneficial to use the PROTECT Questionnaire for a focused assessment. It can also be used as a tool to talk about issues which people do not usually talk about unprompted. The questionnaire is also useful when involving other service providers.
3. Supporting resettled refugees can be quite time-consuming, especially in the early stages. It is a good idea to watch your own boundaries and to get other, professional service providers involved. Support workers can play an important directive role in this process.
4. Having a good rapport with the family doctor is important when providing support to resettled refugees.
5. Resettled refugees are often not familiar with certain forms of assistance, especially where mental health problems are concerned. This means having to identify a form of support that is acceptable to the refugee. Getting the refugee on specific medication through the intervention of the family doctor may be a good (first) step, especially in those instances where the refugee is not keen or finds it difficult to talk about things.
6. Sometimes a creative solution has to be found when it comes to identifying the right person or agency who might be able to get support around the refugee moving again. Involving other refugees or people from the same country of origin can be highly effective.

CASE 3 'LIFE'S NOT WORTH LIVING ANY MORE'

KEY WORDS:
Physical and psychological issues; imminent mental health crisis; collaboration in the provision of care

A. Personal details

Selam is a 35-year old man who has come to your country as a resettled refugee from a country in the Middle East.

B. Information prior to arrival

The UNHCR and the organisers of the Cultural Orientation Programme who were at the refugee camp have told you that Selam had been active as a human rights activist in his country of origin. This led to problems with the government there and he received threats. You also know that his wife and children were murdered in front of him. Selam went into hiding, managed to escape to a neighbouring country and reported to UNHCR. He has been urgently resettled in a European country because he received threats in the refugee camp as well. No further information is available.

C. Protective and aggravating factors

In your role as the support worker, you consider any factors which may have an aggravating or protective effect on Selam. You list the following:

- Firstly there is the fact that his wife and children have been killed and that they died in front of his eyes. This traumatic event makes you worried about his mental state. It is obvious that this puts him at great risk.
- This also means that he is a widower and all alone, which puts him at even more risk.
- What is not known at this stage is whether he was also the victim of physical violence, as that would be an additional aggravating factor.
- The fact that he was a human rights activist probably means that there will be opportunities for Selam based on his intelligence and educational background. This can be have a protective effect.
- You have no idea about other protective or aggravating factors as this is all the information you have available to you at this point.

You now know that you will face a complicated and difficult task in providing support to Selam. But the full extent of this will only become clear once he has arrived in the municipality.

D. Period immediately post-arrival

As soon as you meet Selam after his arrival you can see that he has been traumatised. Luckily he has quite good English, so you are able to communicate with him reasonably well. The first time you meet him, he mentions physical pains and problems sleeping. He speaks almost mechanically, in a monotonous tone, punctuated by deep sighs, while staring past you into the distance. He tells you that a local doctor had already started him on sedatives in the weeks before he left for your country.
You quickly arrange for him to see the family doctor, whom you have only approached the previous week. Luckily, this family doctor looks after other refugee patients as well, and they are happy with his care.
You go along to the family doctor with Selam within two days of his arrival. Selam really wants you to be present. The family doctor is a bit hesitant, because of patient privacy. You are not sure whether it is wise to come along. However you come along anyway because Selam really wants you to and that is why the family doctor agrees to it. Fortunately the family doctor takes the time to see Selam, but he is visibly upset because Selam is in obvious despair. You hear how Selam sleeps poorly in spite of taking sleeping tablets and is haunted by images of the death of his wife and children. They died three months previously. He has also lost 10kg in that time. He tells the doctor that to him life is not worth living any more. When the doctor asks whether he often thinks about killing himself, Selam admits that this is the case, in a hesitant and embarrassed manner. He says that just the previous month some friends had to stop him from jumping off a bridge.

The family doctor struggles with the situation and is not quite sure what to do. He is looking to you for advice. You feel uncomfortable about that. Because you say in your opinion this is a crisis of sorts, the family doctor decides to ring the Mental Health Crisis Team. He urges the Crisis Team to get in touch urgently. They propose to see Selam the following day, provided the family doctor can get him to promise not to take his own life in the meantime. Fortunately Selam promises that he will not. The (nurse / psychologist of the) mental health crisis team also advises the family doctor to prescribe some stronger medication for that night.
Together you and Selam go to the pharmacy to pick up the medication. You use the opportunity to explain about the family doctor and the pharmacy. But you realise he is not taking in any of this information.
You realise that this has immediately become a very tough assignment for you as the support worker. You are worried about Selam, and you are not at all sure that he will take his medication tonight. You consult your supervisor. You know you have to set boundaries to the support you offer, but you also know that there will not be any other care available for Selam tonight. Together you arrive at a plan that involves you taking Selam some soup tonight and making sure that he takes his medication and goes to bed. You will then pick him up the next morning for his appointment with the Crisis Team.

E. Assessment

There is no point in doing an assessment when the problems are so strikingly obvious. In Selam's case the reality has already made an assessment pointless.

F. What happens next

The next morning you are relieved to find that Selam has managed to get about five hours' sleep for the first time in weeks. He looks visibly better than the previous day. He does say that he is feeling quite weak and sleepy.
Selam spends over an hour talking to the nurse of the mental health crisis team. You are happy that you were not allowed to be present. The nurse was very clear on that point – he wanted to talk to Selam alone.
Selam looks exhausted after the interview, his eyes red and wet with tears. You are told that he will be put on the waiting list for PTSD Counselling. In the meantime, he will keep seeing the nurse, and they will also prescribe him medication.
On the way home Selam says he finds it difficult to keep talking about what happened in the past and that it makes him feel the pain in his heart again. You agree that this is very hard, but at the same time essential if he wants to regain his strength. You feel helpless and you wonder whether his suffering might be so overwhelming that nothing can alleviate it. Still you want to give Selam heart, so you tell him to persevere and that things will get better, albeit very gradually. You tell him about another refugee you have supported in the past who eventually managed to come out the other side.
In the weeks that follow, Selam initially sees the nurse twice a week, and then once a week, to talk and to get medication. This is helping him to sleep better and he appears noticeably less stressed, even a little drowsy. He now makes his own appointments with the crisis team (nurse/ psychologist). He says he is benefiting from the talks and especially from the pills, which are making him feel a bit sedated and less aware of the pain. He also says that his appetite has improved. He has clearly put on a bit of weight. After a few months he is handed over from the mental health crisis team to a another department where he starts a trauma treatment

G. Further investigations

As Mental Health Services are now involved, your involvement as a support worker now focuses on more practical matters. You try to keep up to date with how things are going with the support Selam is receiving now. You ask Selam whether he is happy with the care and if he feels it is having the desired effect. Selam is positive about it, but you find it difficult to get a good sense of what is going on. However, you leave it for the time being, because you don't think it is your job to get involved.
After a while your supervisor tells you that Selam's attendance at language classes is dropping off. Initially the school did not say anything because of his poor mental health state, but now that things seem to be going better they are not putting up with it any more. People at the school have already talked to Selam, but he told them it was because he was sick. You intend to bring this up when you talk to Selam next.
One week on you have the opportunity for a quiet talk to Selam. When you ask how things are going at school, he tells you that he is finding things very difficult. He is finding it hard to concentrate or remember what he is trying to learn. He also tells you that the medication he has been prescribed is making him feel very tired in the morning. He often fails to get up on time and once that has happened he just leaves it

and does not go to school. He also has appointments with his psychologist once a week and does not attend school then either. This explains his non-attendance. You explain once again just how important it is for him to go to school. He understands, but he assures you that he really cannot manage. He says that he explained this to his mentor at school, but says his mentor was very strict. He asks you to ring the mentor for him and you promise to do this.

H. Consultation and referral

When Selam's language teacher (mentor) rings, she tells you that he only told her that he was sick and that he often does not take the trouble to tell her when he does not attend. She is not aware of his counselling with Mental Health services nor of his medication. This might change things. You ask his mentor whether it might be possible to arrange for Selam to have different hours, with him starting later in the day or only attending class in the afternoon. The mentor objects and says that this will be very difficult in practice and that the educational institution will have to justify making a special case for him. She says that exceptions are only possible if his therapist writes a letter explaining why Selam cannot come to class in the morning. You are annoyed at how difficult it is to convince the school to take somebody's special circumstances into account. You can sense where this is heading: You will have to make sure this happens, because you don't think Selam will be able to convey this request to his psychologist.

Because you are unable to get hold of his counsellor over the phone, you go along to one of Selam's counselling appointments to discuss the school's request, after discussing the situation with Selam. The therapist turns out to be very understanding. He is happy to write a letter outlining the effect Selam's issues and treatment may have on his ability to attend school. Once Selam has handed the therapist's letter in at school they do appear to be able to make arrangements and Selam is able to start classes later than before. This appears to address his non-attendance issues. He attends school regularly and is making better progress.

While talking to the therapist, you ask whether he might be able to see if there are any opportunities for Selam to get involved with exercise, because that often proves beneficial for people with mental health issues. He has already discussed this with Selam, but Selam seems to be unable to organise anything himself. He asks you whether you might be able to help.

You talk to Selam about getting involved in some form of exercise. He is a bit dubious, not sure whether he can, as he has never done any exercise before. While talking you end up with two options – running or fitness. You know that there are several groups doing organised runs from the Community Centre close to where Selam lives. When making inquiries you are told that there are a few Turkish men involved in the group. When you tell Selam, he wants to try running with this group. He goes to have a look and a few weeks later starts running, gradually building up. You have already spoken to the man who runs the group and explained some of the background to Selam participating. This is met with a lot of understanding, as others in the group have their own specific issues and history. Selam seems to enjoy running and it seems to be doing him a lot of good. He even goes for an additional weekly run with one of the Turkish men.

A few months later Selam truly seems to be feeling better, both physically and mentally. He is sleeping better. His counsellor is considering reducing his medication a little bit. He is also doing well at school. He has moved to another group and he manages to attend morning classes at school a few times per week.

You realise that Selam seems to have found his way a little. It has taken some time, but he has achieved a new start in life, in spite of all the odds, thanks to the involvement of a number of different people.

I. Take-home messages re support

1. By mapping out protective and aggravating factors prior to the refugee's arrival, you can quickly anticipate any potential issues facing the refugee following their arrival.
2. It is good to realise beforehand that being faced with the refugee's problems may hit you hard.
3. Once the seriousness of mental health issues has been established, professional care should be called in very quickly. This is usually arranged with the help of the family doctor.
4. Initiating appropriate care may be an important part of support. This includes explaining things and motivating the individual, but in particular also practical matters such as making appointments with professionals and ensuring that the refugee shows up to such appointments.
5. Even when the refugee is receiving professional care, there will be plenty of things for (voluntary) support workers to do. Aside from the practical matters mentioned above, this will include acting as a liaison between the various parties involved in working with the resettled refugee.
6. Trying to get the refugee to join up with local initiatives, e.g. relating to sport and exercise, can supplement treatment already offered. This will also contribute to integration and social contacts.

CASE 4 'MY AUNTIE HAS TROUBLE UNDERSTANDING THINGS'

KEY WORDS:
Below average intelligence; activation; collaboration in the provision of care

A. Personal details

Thop, a 42-year old man, his son Ku (age 12) and 62-year old Phura (one of Thop's aunties) are Asian refugees who have been resettled in your country.

B. Information prior to arrival

According to information supplied by UNHCR, IOM and other agencies these three are the only surviving family members following an attack on their village by government troops six years previously. They belong to an ethnic minority which strives for more autonomy and which is involved in an armed conflict with the government. There is nothing else of particular interest in the report. Thop has worked as a handyman in the refugee camp. Additionally, Phura seemed unable to comprehend the cultural orientation training sessions and appears to be clinging to her nephew.

C. Protective and aggravating factors

Prior to the arrival of these three family members, you do a stocktake of any possible protective or aggravating factors. This includes the following.

- The loss of their family members is an aggravating factor. It is not clear which family members were killed. For the time being the impact of this loss does not seem to be the most significant factor. Perhaps time has helped alleviate some of the grief?
- They still have each other. This can have a protective effect, provided the three get on well.
- The fact that Phura is so dependent may pose a burden on the other two.
- The fact that Thop is an active and skillful man may help his future in the new country and may be considered a protective factor.
- The fact that Ku is still young means he may be able to integrate quickly. This will protect him from a psychosocial perspective. The presence of a child in this special family will provide meaning and structure for other members of the family. However, it may also be an aggravating factor, because Thop will have to parent his child as a single father and will most probably also have to take care of his auntie on top of that.

You are not quite sure what to expect as this family has a somewhat unusual family structure. All will be revealed once they have arrived in the municipality.

D. Period immediately post-arrival

Once they have arrived in the municipality, Thop, Ku and Phura are clearly happy to have their new dwelling all to themselves. It turns out that Thop has some English, and this is quite useful for basic matters. Thop, Ku and Phura are friendly and often smile in response to your questions, but you are not really able to find out what they are really thinking. You conclude that these people are difficult to fathom.

You have already been to introduce them to the family doctor. It turns out he has received medical information from the camp the family used to live in. The family doctor wants to share some of this medical information with you. Phura underwent treatment for tuberculosis at the camp. She needs to be seen for a check-up to see if this treatment has been successful. She also appears to suffer from cataracts and will need to see the eye specialist. The family doctor seems happy to leave it up to you to see that these matters are arranged. You know from experience that it is a good idea to accept, as there is bound to come a time when you will need the family doctor to do something for you in return.
After a few weeks it becomes obvious that Phura is too scared to be home alone and always wants to be with either one or the other of her family members. When attending school, Phura wants to be seated next to Thop even though she is unable to follow the class. Thop tells you that his auntie has been complaining that her head is 'sick', especially at night, when she is unable to sleep. She complains that she feels cold in her body, starts walking up and down, keeping the other two awake as she does so.
Together with Thop you discuss the idea of you talking to Phura on your own, with the aid of an interpreter, so you can find out more about her problems. He thinks that will be a good idea.

E. Assessment

Because you find it difficult to get a handle on what is going on with Phura and because her behaviour is cause for concern, you would like to use the interview to also do a focused assessment with the aid of the PROTECT Questionnaire. Your supervisor thinks this is a good idea.
Initially you find it difficult to talk to Phura. She seems unwilling to cooperate but it is not clear why. When you tell her that you want to understand her problem to see if a doctor might be able to help her, she appears to understand and becomes slightly more accommodating. She says that she often has the feeling that something is creeping around in her head, especially when she is lying down. That is why she wants to walk around at night, because the feeling returns as soon as she lies down. This frightens her and she says that is why she cannot be by herself. As you ask further, it becomes clear that this all started when she was living in the camp. She did not experience it before she fled her country. You take the opportunity to ask her about her previous life. It turns out she always lived with one of her brothers (Thop's father) until he was killed during an attack by government troops. She did have much to do, she just took care of the garden and the few livestock they kept.
You ask Phura if you may ask her some questions about her health. She consents. It turns out that she does not sleep well, often suffers from headaches and anxiety. She does not understand your questions about nightmares or painful memories. It seems as if she does not understand the concepts of 'dreams' and 'memories'. Next you ask whether she might still see her deceased brother from time to time. This question turns out to be a trigger for a strong reaction: She grabs her head, turns inwards, becomes inaccessible. She moans softly, starts pacing up and down. You realise that you have touched on something very painful. Gradually, Phura settles a bit, you give her a cup of tea. You try to carry on with the interview, but she does not want to. The only thing she says is that she can feel the creeping sensation in her head again.
It is clear that you now have more information, but trying to make sense of it is still problematic.

F. What happens next

A few weeks later Thop's language teacher contacts you. She indicates that there is no point in Phura being in the classroom. She is not learning anything, does not appear to be 'teachable' and is therefore unable to participate. This is starting to be an increasing problem both for her as the teacher and for the other learners. It also serves to isolate Thop from his classmates. You and the teacher try and explore options which might be better aligned to Phura. However, you realise that the problem goes deeper than the matter of her attendance at language classes. You ask her to please be patient a while longer while you consult the family doctor as to what to do about the situation Phura is in.
Later you ask Thop for his side of the story. It turns out that he too is increasingly troubled by his auntie's behaviour, and that he stays home more often than he would like, because he doesn't want to take her to class. This seems partly due to feelings of embarrassment.
In consultation with your supervisor, you approach the family doctor for advice of what to do about Phura. The time has come for you to ask the doctor for a favour in return. Luckily, he knows you and is prepared to ponder the situation as well. However he admits that he does not know all the factors at play here either. Various factors may play a role, including below average intelligence, traumatisation or dementia. However all of these would need specialist investigation. You feel that this might be a step too far. You expressly ask the family doctor to have a talk to Phura. He is a bit reluctant at first ('I don't know what I could do…'), but eventually gives in. You promise that you will arrange for an interpreter to be present during this appointment.
A week later the family doctor rings to tell you that he has had a talk to Phura. He did not get much further. She did tell him that she is not able to think very well and that she has trouble remembering things. The family doctor suggested to her that he would give her a pill to help her sleep better. He wants to see if this might have an effect in terms of the agitation and other symptoms she suffers at night. He also spoke to Phura about seeing a specialist. The family doctor is not sure whether to refer her to a neurologist or an old age psychiatrist.
Some ten days later you talk to both Phura and Thop, and you find out that the sleeping tablet did work the first few days. Phura had less trouble falling asleep and was less agitated. However, over the last few days, her previous behaviour has started up again in the course of the night, and there have been no changes at all during the day. Thop does not say much, but his body language suggests that he is struggling with the situation.

G. Further investigations

A few weeks later you accompany Phura and Thop to a follow-up appointment with the family doctor. It becomes clear that the initial success of the sleeping medication has gradually ebbed away, the only apparent benefit being that Phura seems a bit calmer. The family doctor has discussed Phura's case with a psychiatrist at the regional hospital. He suggests referring Phura there. She is fine with that, but you don't think she understands what this really means. However you are happy that she seems to trust the family doctor and you after all.
The situation continues. Six weeks later and it is time for Phura to see the psychiatrist. Unfortunately the interpreter is not available that day.

However, Thop now knows a few people from his country and one of them is happy to interpret. You decide to leave things over to Thop for now and decide not to come along with her. Later Thop tells you that Phura did not want to say much and left it to Thop to tell the story. You understand that she will have some blood tests and that they will do a scan of her head. Once all these investigations have been done, she will see the psychiatrist for a follow-up appointment. You do not ask if you may be allowed to be present and Thop does not ask. You realise you are getting tired of thinking about this situation, which is not showing any signs of improvement.
Thop tells you that the psychiatrist said that all findings were normal and that they did not find anything of note. No new appointment has been made. You feel disheartened that everything appears to have gone back to the start.

H. Consultation and referral

You discuss this impasse with your supervisor, feeling a bit defeated. He promises to temporarily release you of some of your responsibilities and says he will talk to the family doctor and to municipal services.
Later on your supervisor tells you that the family doctor was also very disappointed in what the psychiatrist did. The only thing he did was suggest some medication. He was told to try an antidepressant or another type of sedative. The family doctor is not keen on that. He is wondering whether it might be a case of lower than average intelligence. He suggests contacting an organisation which supports people with (physical or intellectual) disabilities. With a new possible approach in sight, your supervisor hands it back to you. The lady from the organisation which will become involved with Phura rings you a few times. You share general information about this group of resettled refugees and give her a brief overview of the problems faced by this family. You are very happy to hear that the organisation will take care of everything. The lady rings Thop for an appointment and arranges for an interpreter to be present. You are present at one of these meetings and you hear the lady discuss the option of Phura working in a garden. Phura is clearly very happy with this suggestion.
After a few more meetings the representative from the organisation shares her findings with you. What is remarkable is that she does not talk about the background or how the situation has come about, but focuses mainly on practical issues. The only problem is that someone will have to establish that Phura has a low IQ (Intelligence Quotient), because that is a requirement for being eligible for support by the organisation. Fortunately the representative manages to find a psychologist who determines this with the aid of a few non-verbal tests.

Talking to Thop you notice that all these appointments are keeping him very busy. You do feel a little bit guilty, because it has meant that you have not had to spend as much time providing support over the last few weeks. You decide to pop in a bit more often, to keep your finger on the pulse.
One month later you find out that Phura has been to the garden project to have a look. You are told that they have managed to get Phura to participate in the garden project. This soon proves to have a positive effect on Phura. She is gradually becoming less dependent on Thop, who is visibly relieved. Phura takes home all sorts of fruit and vegetables, and is also taking a more active role when it comes to housework. And she is picking up some words in your language while working with the other people in the project.
After a while it is obvious that this form of activation has had a positive effect on Phura's behaviours and anxieties. She is sleeping better and is even brave enough to walk to the project by herself, a distance of 3 km. During winter there is less work in the garden, and the project coordinators are organising odd jobs to do inside. Phura has met a few people through 'her' garden and they sometimes visit her at home.

I. Take-home message s regarding support

1. Support workers can prepare for the arrival of resettled refugees by doing a stocktake of protective factors and aggravating factors prior to the refugees' arrival.
2. Having a good rapport with the family doctor is really beneficial when providing support to resettled refugees, as consulting or involving the family doctor will be easier as a result.
3. Using the PROTECT Questionnaire for an assessment can help the support worker obtain a better overview of what mental health issues are at the root of complicated situations.
4. When providing support to refugees it is important to try and identify an approach or a referral that best fit their experiences and views. This can be more important than trying to find specialist assistance.
5. If the support worker has reached a dead end, it may be a good idea to ask someone else to take over for a while. This will allow the support worker a bit of a break, while at the same time providing new impetus.

APPENDIX 1

Background: Vulnerability, aggravating and protective factors

When supporting resettled refugees it is important to consider their background in terms of protective and aggravating factors. The balance between the two will determine the degree of vulnerability of the refugee. Appendix 1 will explore this theme in more detail, based on previous studies and publications.

Vulnerabilities

Every individual has inherent vulnerabilities. These are impacted by aggravating and protective factors. In principle, every refugee is vulnerable to some extent. Fleeing implies the loss of a lot of things (home, work, family, friends). This general level of vulnerability applies to every refugee.[1, 2] Within the larger group of resettled refugees there are groups which are more vulnerable than others, and this includes seniors, minors, pregnant women, single women (with or without children) and the victims of torture, sexual violence or other forms of violence. Such refugees may be seen to possess a more particular form of vulnerability.[3] In such cases the degree of vulnerability can be determined by simply looking at the basic details available about individual refugees.
A more focused assessment of vulnerabilities will help gauge vulnerability at the individual level. This often involves aggravating factors which may have weakened the person on a material, physiological or psychological level. A combination of traumatisation, migration and problems adapting may contribute to this type of vulnerability, which may include a number of medical and mental health risks, as well as functional impairment. It is therefore important to do a stocktake of different aspects of vulnerability by first identifying the same.

The concepts of protective and aggravating factors arise from the Competence Model.[4, 5] This model involves every individual trying to find a balance between their challenges and capacities. In other words, there needs to be a balance between what someone needs to do to further develop themselves and the capacities that person is developing or already possesses. This balance can be disturbed by (external) stressors or by (internal) mental health issues. Any disturbance of this balance will result in problem behaviour.
Doing a stocktake of protective and aggravating factors helps to map out someone's capacities and possibilities.

Aggravating factors

Various studies have shown that refugees are more likely to suffer poor health than other migrants.[6, 7] This is partly due to their experiences and partly due to living in a new country and in particular the adjustments this requires. This section will briefly discuss refugees' background and history, before moving on to factors which may play a role in European countries.

Factors prior to arrival in the new home country

Resettled refugees flee their country of origin because of (the threat of) violence, discrimination or starvation, before eventually ending up in a camp outside the city or outside the national borders. In fact the period prior to migration consists of two phases: The first one involving the flight from the country of origin and then living in a neighbouring country for a period of time. Refugees who find shelter in a city, usually live with family, friends or compatriots.
However, a majority of refugees spend years living in a camp under appalling circumstances. Aside from the lack of security, which is inherent to most refugee camps over-flowing with refugees, there are usually hardly any provisions in terms of accommodation, work, hygiene, nutrition or care. This results in a significant number of refugees developing a host of physiological problems and conditions. Examples would be infections, malaria and parasitic illnesses, poor dental care, anaemia and vitamin deficiencies. Tropical diseases, tuberculosis, hepatitis, HIV/AIDS and sexually transmitted diseases are also prevalent.[8] Once the refugees have arrived in Europe, they are often found to have been either undiagnosed or misdiagnosed. This can undermine individual refugees' chances of effective integration into the new country.

Mental health and behavioural issues are also prevalent. An overview of twenty studies involving a total of 6,743 resettled adult refugees in seven different host countries showed that nine percent had been diagnosed with Post Traumatic Stress Disorder (PTSD), and another five percent with depression. Moreover, a proportion of refugees are both traumatised and depressed.[3] The overview referred to above also includes five studies which involved children under the age of 15. These studies showed that eleven percent of these children had trauma-related symptoms.
These high percentages are mainly due to the fact that people flee their home country because of the unsafe situation there and because of traumatic experiences.
Aside from women, it is particularly older people and those with unresolved traumatic experiences who are more vulnerable.[9] Older refugees may feel that they are growing old 'in the wrong place'.[10] Uncertainty about family members who were left behind may also impact refugee mental health, especially when relatives are unable to be contacted. Refugees carry their feelings of doubt and guilt with them to the new country and these may be an ongoing source of concern.

Aside from previous traumatic experiences, life in the refugee camp will also have had a major impact. Vulnerable individuals such as seniors, single mothers, orphans and people with a disability are often treated in an appalling manner. Sexual violence is prevalent; single women may be forced to have sex, while in other cases women may need to 'buy' their safety by providing forced sexual services.

Resettled refugees may have specific physiological complaints as a consequence of all these instances of violence. They may have noticeable signs and symptoms including (old) fractures, (chronic) headaches and abdominal pains as a result of head injuries or sexual violence, scars or other injuries as a result of beatings or bullet wounds. They also may have symptoms for which no clear medical reason can be found. Tensions and worrying are known to be able to result in headaches and abdominal pains, while anxieties and hyper alertness can lead to exhaustion, but it is not always possible to find a medical reason for such complaints. The main poorly understood physiological consequences of stress are a feeling of tightness in the chest, nausea, backaches, headaches, perspiration, shaking, fatigue and abdominal cramps.[11]
Refugees may suffer these and other physiological complaints to a greater or lesser extent due to their experiences prior to arriving on European soil.

Factors prior to arrival in Europe

Life in Europe is completely different to life in a refugee camp. Many refugees have spent years, sometimes even decades in a refugee camp. All that time aid organisations have provided their basic needs, including shelter, food, water and medication. Strong individuals may find their way to informal employment or to working for the various organisations in the camps. They are able to support themselves reasonably well. However many others, and vulnerable individuals in particular, are in a position of dependency. They hold out their hand and wait for it to be filled. If this carries on for a long time, it often leads to people showing a lack of initiative. They have become so used to the fact that any solutions will always be found by someone other than themselves – as long as they wait long enough – that they develop a degree of apathy, unable or unwilling or too scared to give direction to their own lives.[12]
Being resettled in Europe requires an enormous mental shift from vulnerable refugees. They are expected to make their own choices and show some initiative. This is particularly true when refugees are resettled in the community almost immediately. Resettled refugees are offered support following their arrival in a European country, but even then the assumption is that people will quickly regain their independence, as this is the norm in European societies. Some refugees may not understand this at all, or may indicate that they are not able to do this, and this is understandable given that they have spent many years in a dependency-inducing environment.

In addition, refugees may originate from cultures which have different rules for social interactions than Western cultures. In Europe personal freedom is highly valued, but in many non-western cultures, individual views are overridden by those of the group the individual is part of (family, clan, community). Moreover, in Europe people are taught to be assertive, but many refugees have been taught from childhood that they have to adapt to what the group wants, i.e. what others want. These are contrasting messages and may occasionally result in doubt as to how to behave. Also, there may be some differences which are difficult to overcome, and these may involve women's roles, how to deal with sexuality, or the role of religion. Such changes in opinion can cause a refugee to feel uncomfortable when such topics are broached in conversation. It may also lead to them avoiding certain interactions or situations. Feelings of being excluded or misunderstood may be reinforced by language problems, different cultural and dietary habits and a lack of familiarity with host country traditions. Resettled refugees may feel alienated by the way things are organised in Europe, especially when they have only recently arrived.

The many adjustments refugees and their families are required to make in the host country can lead to psychosocial problems. Research has shown that in 20% of all PTSD cases, the disorder developed in the period prior to the refugee arriving in the host country, but that in 14% of cases the PTSD evolved after migration.[13] We also know that refugees from a rural background and refugees who have enjoyed better education are more likely to develop mental health problems following resettlement. This is attributed to loss of status and limited opportunities in the labour market.[9, 14]
Longing or grieving for family, friends and acquaintances (their support system) is a problem for many refugees. They have had to leave behind a number of things which were important to them (people, behaviours, structures, and so on). The concept of cultural uprootedness (cultural bereavement) applies. Being uprooted, as the word implies, means that someone has lost their roots. This loss will be reflected in feelings of grief, regret and guilt. The ties with their ancestors, culture and traditions have been cut, and this is felt to be an enormous loss. A certain amount of homesickness is normal, and may endure for quite a long time. When people have been uprooted from their culture, they may also feel that they are alone in the world, that their ties with the past (the umbilical cord) have been irretrievably cut and that the future is uncertain.[15, 16] This is why feeling uprooted involves a form of grieving. There are a number of distinct subsequent phases to working through grief: 1) denial; 2) anger; 3) bargaining; 4) facing reality; 5) acceptance and being open to new experiences; and 6) integration. Resettled refugees most likely go through a comparable grieving process following their arrival in a European country.

Socially speaking the loss of embeddedness (no employment or goals in life, loss of social role and identity, being separated from family members) is experienced as a serious loss. Not having any or very few social contacts may also be associated with the consequences of the (physical) violence experienced. It is well known that people with PTSD often withdraw from social contacts, out of fear that they will be faced with triggers (sounds, words, images) which may remind them of the trauma. Refugees' perspective on health may also put them at risk. In-depth interviews with 40 resettled refugees in San Diego (US) showed that they had a different perspective on prevention, expectations around care, their attitude towards the care provider and stigma surrounding mental health conditions.[19] Refugees are not used to the idea of preventive screening or dental exams, and have different ideas about care in case of chronic illness ('curing chronic diseases instead of managing them'). They may have unrealistic expectations of healthcare and a different perspective on mental health issues. One of the interviewees said: "They think 'mental problems' that… those words should be reserved for… somebody with severe Down's syndrome or something. They don't think mental health can be things like depression or posttraumatic stress disorder."
Sometimes the problems resettled refugees face after resettlement are to do with the support workers' approach to them. Australian authors distinguish between active and passive perspectives. An active perspective views refugees as consumers, as citizens who can achieve things ('achievers'). A passive perspective views refugees as victims, as people who endure ('endurers'). This approach includes refugees readily feeling that what they need is medication and not showing a positive response to migration.[20] Other factors at play are the fact that traditional Western mental health care is not aligned with the refugees' preconceptions and the fact that refugees tend to present their problems as physical complaints. Italian research among first generation migrants and refugees has shown that people who have been through traumatic experiences are more likely to present with physical symptoms.[21]

Protective factors

The balance between coping ability and challenges determines to what extent someone is able to deal with the problems they experience. Many of the aggravating factors mentioned above apply to all resettled refugees; however many refugees are able to deal with this challenge. When people have an adequate ability to cope, difficulties do not get the chance to develop into problems. People have the ability to cope if there are enough protective factors – factors which make problems bearable or which help prevent problems.
Aside from personality factors, there are another three protective factors which particularly apply to resettled refugees. These are safety, security and the importance of time. In fact, these are three basic conditions which are all interrelated and which mean refugees are in a completely different situation than asylum seekers still seeking refuge.
The section below will discuss the various protective factors. We will first look at personality, safety, security and the importance of time. Next we will look at social support, building a network of contacts, getting active, and participation.

Personality

Individual coping ability is of course largely inherent in the person. An upbeat mindset, intelligence, and a sense of humour can help refugees to keep going when they face difficulties.
Intelligence can work both ways. It can be a protective factor, in that it can help someone to adequately assess what is expected of them and

what the options are. Intelligence is also useful in learning a new language, which in turn can increase someone's employment opportunities. The flip side of the coin is that intelligent people may be worse affected when things do not go as expected, turning it into an aggravating factor.
Resilience is an even more important personal factor. Some people find it hard to get going again when they face setbacks, while others only need a tiny bit of support to get going again. Yet another personality trait is the way an individual copes, in other words, how they deals with any problems. Some people might constantly see roadblocks and decide it is better to do nothing, while others tend to quickly look for a solution. Turning to others for support or trying to find solutions by oneself are all forms of coping. Coping also includes the use of substances. Alcohol and drugs are often used to try and blot out certain memories or issues, and to feel better for a while.
It is not easy to change someone's character or personality, but we know that people can definitely learn new coping styles. Being able to let go, reflecting, being flexible, showing resilience, are all important personality traits which may protect people facing challenging situations.

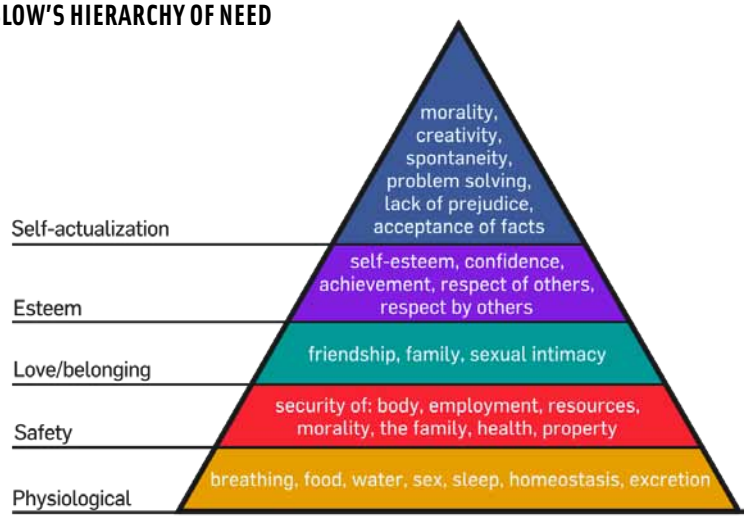
Safety

Safety is a basic condition for recovery from traumatic experiences. That basic sense of trust, of being safe in this world, is something that develops in early childhood. It supports people as they go through life and gives meaning to their experiences. A significant number of refugees have been through experiences which have damaged their basic sense of trust. Negative experiences may damage someone's trust in the natural or divine order of things and may result in an existential crisis: traumatic experiences may destroy our fundamental assumptions about how safe we are in this world, a positive sense of self and the meaning of life'.[22] Moving to and living on European soil means safety is assured for resettled refugees; they have literally been removed from the danger zone – a situation diametrically opposed to what their life in the refugee camps used to be like. Being granted immediate residency status means they can start processing all the terrible things they have been through. However, it often takes a while before they realise that they are safe. They usually remain hyper-alert after everything they have been through, feel exhausted and want to unwind a bit first.

Security

After a while resettled refugees may start to gradually feel more secure as well as safer. While staying in the camps, some have wondered for a long time about the situation they are in, whether things will ever improve, at what point they will finally be able to provide for their family, send their children to school, etcetera. In brief, they have faced significant uncertainty for a long time. Now that all that is behind them and they are living in a European country, be it together with family members or not, they can start thinking about the future. Resettled refugees are allocated their own home, have access to (better) care for themselves or their family, their children have access to education and development, and the parents are assisted in finding work or accessing study themselves. The fact that these and other provisions are available to them offers them structural security. Offering safety and security (both in a physical, material and immaterial sense) means that the basic needs (see Maslow's Hierarchy of Needs below) are met.

MASLOW'S HIERARCHY OF NEED



Maslow was a clinical psychologist who created a hierarchy of what he considered to be man's universal needs - in the shape of a pyramid. According to Maslow, people will only strive to satisfy needs which are higher up on the pyramid once the needs lower down on the pyramid have been met. The main criticism of Maslow's Hierarchy of Needs is that needs may be present on several levels concurrently.

Maslow's Hierarchy of Needs is outlined below:

1. ***Organic or physiological needs.*** These needs are associated with our organism and homoeostasis and include our need for sleep, food, water, and – somewhat surprisingly? – also sex.
2. The need for ***physiological safety and security.*** People try and find safety in organised groups, such as the neighbourhood they live in, their family and their own community. Having an extensive social security network will be beneficial.
3. The need for ***belonging***, friendship, love and positive-social relationships.
4. The need for ***appreciation, recognition and self-esteem***, which may increase competency and status within the group. The importance someone attaches to social status.
5. The need for ***self-actualisation***, in other words the need someone feels to develop his personality and ability to grow psychologically. Being in the right environment is very important in this respect.

From Maslow, A. (1954). Motivation and personality. New York: Harper and Row.

Time is a powerful healer

As explained above, feelings of safety and security may be fragile immediately after arrival in Europe. Time plays a major role here. A number of studies have shown that refugees only start to feel better over time. A study by Beiser (2009) found an increase in mental health issues during the first 10 to 24 months of refugees arriving in Canada, followed by a decline in those symptoms after that period.[23] The overview of studies among resettled refugees in seven different host countries referred to earlier showed that refugees who have not been through severely traumatic experiences experience better mental health after a five-year period. The researchers concluded that 'in general, it seems that time is a powerful healer'.[9] One of the studies they based this on was carried out among Vietnamese boat refugees in Australia. That study also showed an association between mental health problems and the number of upsetting experiences. After a five-year period, refugees who had experienced less than three traumatic experiences were just as likely to have mental health symptoms as people who had not experienced any trauma. This in contrast to those who had experienced three or more traumatic experiences, and who were still very likely to have mental health symptoms, although this 'progressively decreased over time'.[24] Yet another study which looked at the extent to which refugees in Canada were seeking care, found that 80% of these people were seeking care in the initial period. Four years later this percentage had gone down to 66%, lower than that of the Canadian population overall.[25] In other words, a large proportion of the mental health issues faced by

resettled refugees will either have resolved or have become more manageable over time.
Time is a significant protective factor for families with children in particular. These children will grow up in Europe and will have opportunities they would never have had in a refugee camp. They may have a bright future, and this can be a huge relief for their parents, as their initial worry about their children's future following resettlement in Europe will have lessened.

Social support and social contacts

There are other protective factors aside from safety, security, the healing powers of time, and the prospect of a new and better future, and social contacts would have to be the most important factor by far.
Resettled refugees benefit significantly from social support and social contacts. These give them the opportunity to experience a sense of belonging and help them to re-establish the belief, hope and trust in others.[22] Studies have shown that 'individuals with supportive relationships in their family and community have better physical and mental health than those with limited or poor quality support'.[26] In Canada, refugees lacking personal or social support were more likely to suffer from depression ten to twelve months after arrival.[23, 27] Having a social network is therefore crucial for starting a new life and processing or forgetting previous experiences.[20, 28, 29]

In other words, having a social network is of the utmost importance for people's development and also to meet their material, social and emotional needs. It enhances mental wellbeing in people who have experienced violence.[20, 22, 30] Additionally, it helps when people need help or are worried about something and are unable to find a solution by themselves.

PREPARING THE LOCAL COMMUNITY FOR THE REFUGEES' ARRIVAL

In British Columbia (Canada) *Operation Swaagatem* has been running since 2009. Over a four-year period, 5,000 Bhutanese refugees from Nepal were resettled in this Canadian province. Local authorities, NGOs, health services, schools, religious and refugee organisations got together and informed local residents prior to the arrival of any new group. This 'total approach' was decided upon following previous adverse experiences with negative stories in the media about Burmese refugees.

In Finland, in 2010, the Finnish Red Cross started the *Spirit project*. This project also focuses on openness towards and providing information to local residents, as well as trying to prevent any negative stereotyping of refugees. In this instance, volunteers have been trained to support the refugees during the initial period post-arrival and to organise activities which will help the refugees to establish a social network.

Adapted from: Paving the Way. A Handbook on the Reception and Integration of Resettled Refugees. ICMC, 2011.

Social contacts can help resettled refugees find their way around the myriad of provisions available; refugees acquire a network to fall back on, and with it the opportunity to try out new behaviours and social skills.
Most refugees only have a very small social network on arrival in their new home country and can certainly do with a bit of help when it comes to acquiring more social contacts. It is a good idea to create contact opportunities as soon as possible post-arrival – the sooner the better, in fact. In the initial period, contact with and support by people from within their own community are of the utmost importance.[28, 31] The latter know from experience what problems refugees may face and how to deal with them and/or what avenues to take. People from their own community may act as a bridge and may help reduce the dividing line between the past and the present, between how things used to be and what things could be like in their new home country.
At a later stage, refugees also feel the need for interactions with the local residents. A 3-year Norwegian follow-up study among 240 resettled refugees found that having Norwegian friends in combination with having a job, were indicative of refugees being in good health, regardless of whether refugees had experienced traumatic experiences.[29] The researchers concluded that if mental health support is offered, it should be accompanied by a broader approach, offering the opportunity for training, employment and meaningful relationships with others.

Getting active, participating and exercise

Getting active means 'doing things', while 'participation' refers to 'doing things together'. In both cases what is at stake is involvement with and participating in activities and processes which will impact on one's own future. The important thing will be for refugees to end up taking action themselves.[32] It is important for people to make a positive contribution to their environment through being active and participating, and that they feel useful, appreciated and less dependent on others. The most beneficial scenario will be for refugees to take control of their own activities, and thereby control of their own lives. But we also need to see to what extent we can assist individual refugees to achieve this. We know that refugees with PTSD problems have problems acquiring a new language – the higher the number of trauma related symptoms, the more stress that person will experience when learning a new language.[33] So it is a good idea to keep discussing what expectations exist on both sides. It is often better to offer clear frameworks and a fair degree of structure, than to simply leave it up to the resettled refugee to decide what activities he will undertake in the course of the day.

When talking to the refugee, we can point out that activities, participation and exercise in particular are important for someone's psychosocial wellbeing; the person will feel physically stronger, be able to take the initiative more and will be less vulnerable from a mental health perspective.[34] Physical exertion demands endurance and resilience, but also offers hope – it promotes self-esteem and is mood-enhancing.[35, 36] Moreover, exercising together or being creative or active in other ways promotes better alignment with people in the direct environment, (examples would be going on bike trips, or learning to skate in winter). Undertaking activities together with other people will not only assist refugees in terms of their mental health, but will also help them to learn the language, which in turn assists the process of integration.

ACTIVATION AND PARTICIPATION IN SHEFFIELD (GREAT BRITAIN)

The United Kingdom receives up to 750 resettled refugees per year. They are received into one of three programmes especially developed for this group (the UK Gateway programmes). The Sheffield programme is one of these three. During the first year post arrival, resettled refugees are gradually supported towards greater independence. Together support workers and refugees establish a Personal Integration Plan (PIP). This includes expectations and wishes, including directions the person wishes to develop in, and types of support the person thinks they may need during the first year. Buddies are sourced from Sheffield University and Sheffield College and undertake creative activities together with the refugee – speaking English all the while. Newcomers and their buddies also visit refugees from within the refugees' own community and meetings are organised within that community, to make it easier for refugees to get in touch with one another.

The Sheffield Refugee Council also supports resettled refugees in organising sporting activities, a support group for women, and other activities which may contribute to integration while also strengthening mutual support within a community. There is special focus on children and traumatised refugees. The latter are offered the opportunity to participate in the Greenfingers project. Greenfingers is a gardening project which teaches refugees, in particular those vulnerable to mental health problems, to work the land, together with others, including local residents, thus providing a form of distraction.

Adapted from: *Welcome to Sheffield. Reflexions on 8 years experience of receiving resettled refugees at local level* (2011), Sheffield City Council & ICMC.

Finally, people who are unwell often find it difficult to maintain a positive sense of self-esteem. They realise that they have a social and/or mental health issue. Feelings of doubt, guilt or embarrassment may cause resettled refugees to be reluctant to undertake activities with other people. Such barriers may be somewhat reduced by talking to them about what it is that they fear, by discussing the importance of good self-care or socio-behavioural norms in the new country. The principle being that clear explanations and reliable information may provide some scaffolding. Thus, the willingness to offer a listening ear will establish a foundation for trust and better mutual understanding. Providing information and explanations about things someone is worried about may be a cause for relief or encouragement, and will also motivate that person to abide by what was agreed.

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APPENDIX 2

Refugee children

Approximately half of all refugees are children and young minors from refugee families. Young refugees are a vulnerable group. They have often faced very hazardous conditions either in the country of origin or while fleeing. Some have spent years living in refugee camps. Their living conditions are often worse than those of many other children. However, these children are often highly motivated to achieve success in life.
Studies have shown that refugee children are more likely to have psychosocial issues than other children. The most important predictors are having a mother with mental health issues, and the absence of one or both parents. Children from small families tend to have more problems than children from larger families.
This appendix will discuss some [recurrent] themes which are relevant when it comes to supporting refugees with children.

Parenting in different cultures

Refugee parents are faced with a double challenge. Firstly, they have to get used to a completely different environment with different social norms and values, and secondly, they have to try and help their children find their way around in the new environment, and support them so they can get to feel at home. Therefore it is very important, when supporting refugee parents, to recognise their attempts to not only get used to their new environment, but also their attempts to parent their children in a manner that may be somewhat alien to them.[1]
In (many) refugee families, it is not customary for parents and children to negotiate, in the way of most European families. There may be quite a distance between parents and children in refugee families. This is not to say that these are not close and loving families. An authoritative parenting style can be very successful as long as children feel well-supported.
Refugee parents often indicate that they feel the need for parenting support. This may be in the form of information, parenting advice, a supportive network, encouragement of growth and development, and parenting courses. When providing parenting support it may be very useful to work with refugee organisations and some key individuals.

Parenting support

Good parenting support can reduce the risk of psychosocial problems, and this can include advising parents about their rights and responsibilities, encouraging children to stand up for themselves, as well as identifying any problems and discussing these with both parents and children in a timely manner. This demands a pro-active and dynamic approach. Swedish researchers emphasise that it is not a good idea to focus on symptoms of trauma in refugee children, as these tend to decline over time.[2] They argue that it is much more important to provide a supportive environment and information to parents around education and parenting. The main thing is to provide parents with scaffolding which will support them in their parenting role in the new country.

Domestic violence and child abuse

Child abuse is relatively common in families where parents feel under pressure. Unemployment, poverty, traumatic memories and the lack of familiarity with a new society can put parenting and relationships within refugee families under pressure. (The threat of) violence against children can have a great many direct and indirect consequences. Depression and anxiety are common among refugee children. When parents are unable to offer their children adequate protection, this can seriously damage their children's self-esteem and development. In addition, when parents have been through traumatic experiences, this may result in their children suffering psychological damage, neglect, and even abuse. Children from among the 'new ethnic and cultural minorities' are three times more likely to be abused than the average child in the Netherlands. However, it is important to take the family's socio-economic situation (SES) into account, because the authors also found that abuse statistics were not higher for migrant families with an SES comparable to that of the indigenous population.[3]

Sexuality and health

Young (single) women and girls from war torn areas are particularly likely to have been the victims of sexual violence prior to or during their flight. This may have a major impact within the family as well. However young refugees also run the risk of falling victim to sexual violence in Europe. This is because they are vulnerable in social terms, as they are not at home in their new country as yet.
As an example, numbers for teenage pregnancies and abortion rates are very low among young people in the Netherlands and Sweden because they are independent and able to stand up for themselves in this respect. Sex education is provided by schools and within families also. Refugee parents are not used to playing an active role in this respect. Parents are often not sufficiently conversant with the topic themselves. Refugee children arriving in a European countries as teenagers may receive insufficient sexual education at school. This puts them at risk for unwanted pregnancies and Sexually Transmitted Diseases (STDs). This means that both parents and children, boys and girls, need to be educated about sexuality and health, as soon as a relationship of trust has been established between the support worker and them.

Female Genital Mutilation (FGM)

Some refugees originate from countries where girls and women undergo female genital mutilation (FGM). This may be the most normal thing in the world for such families, but in actual fact FGM is illegal in any way, shape of form, and considered a form of child abuse. Having a girl undergo FGM, for example while on holiday in the country of origin, is illegal also. The support worker needs to discuss this with the parents. Those who support resettled refugees have to understand that parents may be under a lot of pressure, both socially and traditionally, to have their daughters undergo FGM, however at the same time they need to make it clear that this custom is not only illegal, but that it also causes a great many chronic physiological and mental health issues.[4]

Education

Parents often encourage their children to work hard at school, but are not always able to truly support their children. Nevertheless many refugee children do well at school. Schools often need to be extra vigilant when it comes to the health of resettled refugee children just as they should be in the case of other new arrivals. Teachers, youth health care professionals, and especially support workers can all play their part.

All in all, providing support to children of resettled refugees demands a more comprehensive approach. Not only do the children need support, but their parents also need positive guidance. This will enable them to meet the (sometimes unspoken) expectations which exist in European countries when it comes to parenting and providing support to one's children.

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APPENDIX 3

Social Mapping

The following list can be printed, and the locations and names of relevant support organizations and individuals should be added.

	What for	**Where**	**Who**
Family doctor	All medical and mental problems Referrals to specialists		
Dentist	Dental care/cure		
Social worker	Loneliness, psychosocial problems.		
Home care	Guidance and care Preventive care to children		
Community healthcare	Preventive care (e.g. vaccines), Public health in schools		
Hospital	Specialist medical care		
Mental healthcare	Psychological and psychiatric care		
Harm reduction (drug use)	Care with all kinds of addictions (tobacco, alcohol, sweet, gaming..)		
Pre- and postnatal nursing	Mother & Child Healthcare (0-5 y)		
Community nurse	Care at home (referral by doctor?)		
Care provision for disabled	Supporting chronic conditions and (physical and/or mental) limitations		
Pharmacy	Drugs and information about medicines		
Parenting support	Information on parenting (direct of after referral)		
Pre-school education	Educational support to small children (2-4 years)		
Physiotherapist	In case of muscles, bone or joint problems and when with pains		
Sport (fitness, jogging, swimming)	Is activating and preventive. Has positive impact on mood or in case of lack of energy and / or poor condition		
Municipality / town	Social affairs, housing and financial aid		

APPENDIX 4

Framework of protective and aggravating factors

The aim of this framework is to have an overview of any potentially protective or aggravating factors in relation to an individual or a family before they arrive. This enables support workers to better prepare for any difficult situations which might arise. The higher the number of protective factors, the greater the likelihood that the person will be able to cope in their new home country.

How to proceed: Ask yourself what the important factors are. This may include either negative (i.e. aggravating) or positive (i.e. protective) scores. Represent scores by using pluses and minuses, with +++ and - - - representing highest and lowest scores.

The list below is not exhaustive. The list may be customised by adding in other factors.

Protective	**Factors (see notes below)**	**Aggravating**
	1. Age	
	2. Gender	
	3. Education	
	4. Developmental history	
	5. Health	
	6. Religion	
	7. Living situation (single/family)	
	8. Expectations	
	9. Any family members in the new home country (host country)	
	10. Experiences of violence	
	11. Experiences of loss	
	12. Stay in the 'in-between' country (camp)	
	13. Cultural differences between the country of origin and the host country	
	14. Personality traits	
	15. Allocation of residential accommodation (as an individual/as part of a group	

Brief notes on the various factors

For each factor, an explanation is provided as to the way in which and the extent to which it can be considered to be either a protective or an aggravating factor in terms of the individual's health and well-being. Many factors can have both a protective and an aggravating effect, depending on how they play out in individual cases.

1. Age

Age is a challenging factor. On the one hand, children and young people may find it easier to integrate and may have better health. However, this may also very much depend on the tasks they face and to what extent they are safe in their families. As an example, children from families where the parents have mental health issues, may be more at risk of problems themselves. Similarly, young solo mothers often find parenting a challenge. Older refugees may find it difficult to fully integrate into a totally different society. From a psychological perspective, having children who manage to integrate may help to compensate for this.

2. Gender

Women are more at risk in a flight situation. They are more likely to be the victims of (sexual) violence. Men are more likely to be involved in violence related to war or political conflict.

3. Education

The better educated the individual is, the more likely it is that they will be able to quickly acquire a new language and to quickly integrate. The other side of the coin is that being well-educated may also lead to frustration around the barriers to achieve training or a career at a similar level as previously. A low level of education often means a lower level of health literacy. This includes not being able to understand written texts (health information flyers, instruction leaflets) and medical terminology. This means it is difficult to pass on knowledge about illness and healthy behaviours.

4. Developmental history

Having a carefree childhood in a safe family setting, will result in a healthy development. Having a difficult childhood involving abuse and loss will contribute to someone being more vulnerable. Generally speaking, refugees who were born in camps will have had a difficult childhood.

5. Health

Having a chronic illness or a disability constitutes an aggravating factor. This may lead to a further deterioration in health. Being in good health protects and offers options for further development. Longstanding physical health issues will erode mental resilience.

6. Religion

Religion can be protective in terms of giving life meaning, providing answers to life's questions and feeling safe as part of a community. However, it can be an aggravating factor when behaviour that deviates from the norm leads to someone being shunned and expelled.

7. Living situation

Living with one's family usually has a protective impact on individuals, provided that relationships within the family are positive. Dysfunctional families constitute an aggravating factor. Living by oneself means one is more at risk of feeling lonely. Living with a group of other people as a single person, may have either a protective or an aggravating impact. This will depend on the quality of relationships within the group.

8. Expectations

Having unrealistic and high expectations may result in frustration and disappointment. Achievable expectations will result in individuals experiencing success and therefore have a protective impact. Realistic expectations, once achieved, will encourage individuals to explore fresh options and expectations.

9. Family members in the host country

Having family members in the new home country is protective because (extended) families are very important. Again, this is only the case when relationships within the family are positive and meaningful. Families can be an aggravating factor when they involve strict norms which

hamper personal undertakings and options. People are ready to face a new future when their nuclear family is complete. If it is not complete as yet, this may mean that too much energy goes into family reunification (focusing on those who were left behind) with the attendant risk of the family not focusing on the here and now and their own development.

10. Experiences of violence

Having experienced violence is often an aggravating factor in terms of health and wellbeing. The impact depends on the severity of the violence experienced, the presence of any protective factors, and the individual's coping style. Generally speaking, activities which are creative or which involve moderate physical activities are protective, while apathy, social isolation and irresponsible use of drugs are aggravating factors.

11. Experiences of loss

The loss of loved ones, social status and possessions is aggravating. Not having experienced such loss is relatively protective.

12. Stay in the initial recipient country

A long stay in the initial recipient country, often in camps or under primitive circumstances, often means the life of a resettled refugee has come to a standstill and is therefore an aggravating factor. Having lived under such circumstances for a relatively short time is protective.

13. Cultural differences between the country of origin and the host country

Where there are significant cultural differences between the refugee's country of origin and the host society, it will be more difficult for refugees to integrate. This can be an aggravating factor. A greater similarity between cultures can make this process easier and is therefore protective. Obviously, personality traits also play a role in all this.

14. Personality traits

Migration places great demands on people's resilience and coping ability, especially in the case of forced migration. Such traits are partly to do with the individual person, making this a factor that is difficult to assess in this context. Even so, support workers may often have a gut feeling as to whether resettled refugees will find it easy to integrate or not. This may be to do with traits such as being flexible, having good social skills, showing interest and being emotionally stable.

15. Allocation of residential accommodation (as an individual/as part of a group)

Where resettled refugees are relocated as groups, this usually has a protective effect on individual refugees, because of the availability of social support and social contact. Being relocated as an individual may be more stressful.

APPENDIX 5

PROTECT Questionnaire for the identification of asylum seekers and refugees suffering post-traumatic symptoms

The PROTECT assessment tool was developed by a number of organisations in Bulgaria, Germany, France, Hungary and the Netherlands, and was financed by the European Refugee Fund (ERF)[1]. The questionnaire was originally intended to help identify at an early stage asylum seekers who are showing signs of being at risk for the psychological effects of severely traumatic experiences.
The PROTECT Questionnaire is also very useful for the support of resettled refugees, as they have usually been through experiences very similar to those of asylum seekers The questionnaire can be used by support workers without any health professional experience.

When to use the questionnaire?
If there are indications that the person may be suffering mental health problems.

How to use the questionnaire?
Tell the refugee about the questionnaire using the sample introductory text below. This will inform the refugee as to how the questionnaire will be used, and will encourage their cooperation.

Read the text below before asking the questions:

> *Dear Madam, Dear Sir*
> *This questionnaire has been created jointly by specialized health and legal professionals. The aim of this questionnaire is to support you through raising awareness about your special needs. Consequently, there are no good or bad answers to the questions and it is important that you answer as freely and naturally as possible.*
> *When answering, keep in mind your experiences of the last weeks.*

1 More information about the European PROTECT project, including the questionnaire in different languages, may be found on www.protect-able.net.

PROTECT Questionnaire for the identification of asylum seekers and refugees showing symptoms of post-traumatic stress

	QUESTIONS 'Often' means more than usual and causing distress	YES	NO
1	Do you often have trouble falling asleep?		
2	Do you often have nightmares?		
3	Do you often suffer from headaches?		
4	Do you often suffer from other physical pains?		
5	Do you easily get angry?		
6	Do you often think about painful past events?		
7	Do you often feel scared or frightened?		
8	Do you often forget things in your daily life?		
9	Do you find yourself losing interest in things?		
10	Do you often have trouble concentrating?		
	Number of questions answered by 'YES' →		

Assessment

Please put an X in the relevant box to indicatethe risk for post-traumatic problems

0 - 3	**4 - 7**	**8 - 10**
Low Risk	Medium Risk	High Risk

If the refugee is assessed as being either 'medium' or 'high' risk he or she will need to be referred for further investigations, usually to the family doctor (in the first instance)!

A 'low risk' does not imply that the refugee has not been through any traumatic experiences. Symptoms may surface at a later stage, at which time it may be necessary to undertake a repeat assessment.

Further observations:
(for example, the person cries a lot, does not properly respond to questions, appears to be in a world of their own.)

Name of refugee:
Date of birth:
Country of origin:
Date:
Name of support worker:

The findings of the PROTECT Questionnaire should be discussed with the refugee. The refugee should be given a copy of the completed questionnaire so that they can use this when seeking professional care.

I agree to a copy of this document being kept by the support organisation for the purpose of providing support and assistance.

(Refugee signature)

Frequently Asked Questions (FAQ) about the PROTECT Questionnaire

What follows below is a list of questions and answers about the use of the PROTECT Questionnaire.

1. What does the PROTECT Questionnaire aim to achieve?

- The questionnaire is a tool for identifying those refugees who are psychologically at risk because of traumatic experiences (including the loss of loved ones, or psychological, physical or sexual abuse, including torture and rape).
- Identifying who is psychologically at risk can help prevent the development of serious mental health issues and associated problems.
- Questionnaire findings can help support the argument that further assistance and referral are needed.

2. With whom can the PROTECT Questionnaire be used?

- It can be used with refugees showing signs of (mental health) issues. It can also be used in situations where it is unclear what is behind a refugee's problems or behavioural issues.

3. Can the PROTECT Questionnaire be used to assess children?

- No, the PROTECT Questionnaire was developed for use with adults. In some cases, it can be used with adolescents aged between 17 and 19.

4. How can we prepare a refugee for answering questions on the PROTECT Questionnaire?

- The objectives of the questionnaire need to be adequately explained to the refugee prior to starting. It is important that the refugee is told that completion of the questionnaire may help us better understand their health. The findings may make it easier to receive appropriate care.
- It is a good idea to explicitly state that some questions may be difficult to answer because they relate to memories of the past.
- In all this, it is important to show a supporting and empathetic attitude and acknowledgment of the refugee's experiences.
- You will need to accept a refugee's decision not to cooperate after you have explained all the above.

5. Is it okay to use the PROTECT Questionnaire with refugees?

- Yes. In principle talking about someone's issues and feelings is part of providing support. By using the questionnaire you can do this in a structured manner.
- The questionnaire has been developed in such a way that it can also be used by those who have not had any medical or mental health training.
- Some of the questions are of quite an intimate nature, which means they touch on a topic that is difficult and sensitive by definition. It is therefore important that the person asking the questions sticks to the way the questionnaire has been structured and does not discuss traumatic experiences in detail. This helps respect the person's privacy and helps avoid needlessly provoking emotion. This will enable the refugee to maintain control.

6. How do refugees feel about the PROTECT Questionnaire?

- Refugees may find it difficult to answer some of the questions – this will depend on the refugee's personal experiences, country of origin, and current psychological status. Refugees will often find it difficult to talk about traumatic experiences, and this will also include any related symptoms (such as nightmares or reliving the trauma). Questions about mental health symptoms may also elicit embarrassment, sadness or distrust.
- If this occurs too often, it will be better not ask further questions in order to acquire more in-depth information. It may be appropriate to refer to a health professional in such cases, but only if the refugee agrees.
- The questionnaire may also help the refugee gain more insight into their own situation. It may help them to recognise that there is a relationship between various symptoms, their origin and consequences. This may also lead to a different perspective on symptoms which may result in confusion or misunderstanding.

7. Can completing the PROTECT Questionnaire be harmful for refugees?

- In principle talking about health is not harmful, but talking about the relationship between health complaints and past experiences may have a negative impact.

- It is important not to discuss painful past experiences in detail.
- It is helpful if we maintain a neutral attitude and use the questionnaire as a guideline. This assists refugees in maintaining control of the situation.
- It is important not to enter into the role of therapist.

8. Who can use the PROTECT Questionnaire?

- Anybody involved in providing support to refugees can use the questionnaire. This applies to both volunteer and professional support workers and care providers such as social workers, registered nurses and physicians.

9. Can refugees complete the PROTECT Questionnaires independently?

- No, the support worker needs to guide the refugee through the questionnaire, with the help of an interpreter if required. The questionnaire is not intended to be completed by refugees unaided. Moreover, it is important to record further observations while refugees are completing the questionnaire.

10. What is the precise meaning of the word 'often' which is used in most questions?

- It is used to refer to the fact that something may occur more often than what the person concerned may consider to be usual and may therefore contribute to their situation.

11. What is the meaning of the 'Further observations' box?

- The support worker may use this box to record observations or comments which are worth noting. It is important to record such observations as factually as possible. Such comments may be useful to health professionals who may consider the case at a later point in time. Some examples would be:
  - The refugee's behaviour: Cries a lot, does not show any emotion, is fidgeting, is responding in an agitated manner, does not respond, appears preoccupied and so on.
  - Problems with the questions, or the way they are formulated – vague, difficult to understand, difficult to translate, and so on.
  - Special circumstances affecting the completion of the questionnaire – delay after arrival, completing the questionnaire for a second time, and so on.

12. What should we do if going through the PROTECT Questionnaire results in a very distressed response?

- The main rule is to stay cool, calm and collected. That in itself can have a calming effect.
- Secondly, it is important to show a respectful and considerate attitude, asking what you can do to help the refugee (e.g. by fetching a glass of water, by telling the person to feel free to stay in the room a little longer, so that they can recover, by inviting a family member into the room, by taking a little break, and so on).

13. Will completing the PROTECT Questionnaire result in a diagnosis?

- No, the questionnaire can only lead to conjecture as to the degree of psychological vulnerability (low, medium or high). In case of high risk, further investigations will need to be undertaken by a qualified professional, such as a family doctor. These investigations will focus on the severity of the symptoms and any treatment options. This should be based on what the refugee wants.

14. What should we do if someone scores medium to high on the PROTECT Questionnaire?

- In that case refugees will need to be referred for further investigations into their health status, the extent to which he has been traumatised and any treatment options. Therefore, refugees should be referred to their family doctor in the first instance.
- In case of a medium score, where there is the impression that someone has the ability to cope with any symptoms himself, it may be possible to wait and see. In such cases the questionnaire can be administered again to see if the situation has changed.
- We cannot force someone to undergo medical examinations or treatment. All we can do is offer refugees these options. They have the right to decide whether they want to be referred or not. Some refugees are resilient enough or make use of other resources (family members, religion, their community, neighbours, and so on) to overcome their problems. It is important to understand the individual's specific needs and to advice or propose an appropriate referral aligned to these needs. There is no such thing as a one-size-fits-all solution.

15. What should we do if someone scores low on the PROTECT Questionnaire?

- A low score means that there are not many signs of risk for mental health issues at this point in time. However, you would do well to remember that the psychological impacts of distressing experiences may only surface over time. Embarrassment on the part of the refugee may also play a part, and this may relate both to the experience itself and to any symptoms they have.

16. How can we encourage refugees to accept 'support' or 'therapy'

- Refugees are often not familiar with mental health support. This lack of familiarity, plus the negative association they may have (afraid people will call them 'crazy'), may contribute to refugees refusing this type of support.
- It is important to choose your words very carefully. Talking about illnesses of the mind or psychiatric illnesses can result in refugees being very averse to support.
- The support worker may want to emphasise that seeking support may help alleviate symptoms, even if the refugee finds it difficult to talk about what happened.
- It may be useful to explain that there is a connection between traumatic experiences and any resulting symptoms. This may help refugees to better understand their symptoms and may help them see their way towards recovery.
- Refugees with mental health issues need to know that they always have the option of treatment at a later time and that it is up to them to decide when they are ready for treatment.
- It may be good to explain that talking about painful events can be very hard, especially at first, because it involves digging up things. With treatment talking gets better over time.
- It is important to respect the refugee's privacy, and their right to refuse to say anything. Try not to focus too much on what you think they should do. Respect the recovery process chosen by the refugee themselves.

17. Is the PROTECT Questionnaire available in other languages as well?

Yes, the questionnaire is available in several languages and all versions were made available on the PROTECT website towards the end of 2012. The questionnaire exists in the following languages:

Albanian, Arabic, Bulgarian, German, English, Ethiopian (Oromo), Farsi, French,
Hungarian, Dutch, Spanish, Polish, Russian, Serbo-Croatian.

It is expected that the questionnaire will be translated into an ever-larger number of languages over time. It is important for support worker and refugee to both understand the language chosen, (with or without the help of an interpreter).

APPENDIX 6

Information, and experiences in relation to resettled refugees

- The UNHCR publication *Refugee Resettlement: An International Handbook to Guide Reception and Integration* (2011) contains information about various aspects relating to resettlement. Chapters 2 and 3 (Parts 2 & 3) discuss initial reception, orientation, support, integration and care.
  To download, visit: www.unhcr.org/4a2cfe336.html

- The ICMC (International Catholic Migration Commission) has been working with resettled refugees for a significant period of time. Useful documents may be downloaded from the IOM website. Relevant publications include Paving the Way. A Handbook on the reception of resettled refugees (2011), Welcome to Sheffield, which reports on eight years of experience with the reception of resettled refugees in the Sheffield region - UK (2011) and Welcome to Europe! A comprehensive guide to resettlement (2013).
  To download, visit: http://www.icmc.net/publications-and-research

- The digital SHARE Network provides opportunities for online dialogues and an exchange of practical experiences. SHARE is a European network for those who provide support to resettled refugees, both in urban and rural areas. The website has information on special programmes for resettled refugees (being) developed in Europe.
  Website: www.resettlement.eu/resources

- The LinkedIn social network allows people to contact colleagues, community coaches, professionals and authorities. LinkedIn groups allow members to share and comment on practical tips and new initiatives, as well as findings in relation to accommodation, employment, social contacts, integration and care. Once you have joined LinkedIn (via www.linkedin.com or the LinkedIn App) you will be able to join other groups, including:
  - The EU Resettlement Practitioners Network
  - Immigrant and Refugee Community Organisation (IRCO)
  - Refugees United

VluchtelingenWerk Nederland

Postbus 2894
1000 CW Amsterdam
T (020) 346 72 00
info@vluchtelingenwerk.nl
www.vluchtelingenwerk.nl

Algemeen Nut Beogende Instelling ANBI

NATIONALE POSTCODE LOTERIJ

CBF KEUR VOOR GOEDE DOELEN