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Contents

Textboxes, figures an tables

Abbreviations

MH Mental Health

MHPSS Mental Health and Psychosocial Support

PFA Psychological First Aid

PHC Primary Health Care

PTSD Post-Traumatic Stress Disorder

1 Introduction

Objective

European Refugees-Human Movement and Advisory Network (EUR-HUMAN) is an EU founded project aimed at supporting and assisting European member states in dealing with the current refugee and migrant crisis. Specifically, the main objective of the project is to help EU member states effectively address various health needs of refugees and migrants by defining, devising and evaluating comprehensive interventions for the provision of primary health care with a special focus on vulnerable groups. Such interventions are intended to be person centred, culturally sensitive and unbiased in the sense of respecting the wishes and expectations of refugees and migrants and ensuring equal access to the necessary health services. Considering that the project focuses on the period of early arrival as well as longer term settlement, its goal is not only to asses and address refugee's and migrant's initial mental, psychosocial and physical health needs but also to ensure continuous re-evaluation and care during the integration period.

As a part of overall aim of the project, Work Package 5 (WP5) focuses specifically on mental health (MH) and psychosocial needs of refugees and other migrants; a health issue that has often been overlooked.[1] Specifically, WP5 objective was to develop a protocol for early identification of highly traumatized refugees and other migrants, including tools, guidelines and procedures for rapid assessment of MH needs and psychosocial status that can be easily implemented in real settings, and to facilitate early and appropriate interventions and services based on psychological first aid leading to shorter period of recovery from adverse life experiences and exposure to trauma. This is expected to foster successful integration into hosting societies and decrease social isolation and risk for internalised oppression. Such procedures and services should be comprehensive and practically oriented within the framework of integrated and person-centred primary care.

Methodology

This report aimed to build on existing scientific knowledge and expert consensus, while adapting it to current situation. A hierarchical approach was utilised. First, several key guidelines were addressed, focusing on overall approach to mental health and psychological support (MHPSS). Second, over 20 handbooks, manuals and reports focusing on more specific MHPSS topics were collected and assessed. Finally, a comprehensive search of peer-reviewed studies was conducted in order to focus specifically on tools for rapid assessment of MH needs. In the text below, we summarise these steps.

Overall approach to MHPSS in this report is guided by several expert guidelines:

- National Institute for Clinical Excellence (NICE) Guideliness;[2]
- Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings;[3]

- NATO-TENTS Guidance for responding to the psychosocial and mental health needs of people who are affected by disasters or major incidents;[4]
- Canadian Collaboration for Immigrant and Refugee Health (CCIRH) Evidence Based Migrant Health Guideline;[5]
- Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention.[6]

These guidelines influence development of all procedures in this report, ensuring overall approach based on best practices and expert knowledge. We stress core principles of MHPSS approach[3] in Box 1, and discuss how we implemented them to achieve our goals.

Box 1 Mental health and psychosocial support (MHPSS) Core Principles

Ensure human rights and equity

Special concern will be given to individuals under heightened risk of human rights violations, such as children and adolescents. Developed procedures aim to maximise fairness in the availability and accessibility of MHPSS across gender, age and culture.

Participation

Refugees and migrants should be active participants in MHPSS. By having comprehensive information on MHPSS, they should be able to make informed decisions on accessing appropriate health care.

Do no harm

Procedures and tools are carefully developed and selected based on the key principle of doing no harm. Cultural sensitivity and the value of participatory approaches are stressed.

Build on available resources and capacities

Proposed interventions aim to identify and build on available resources and strengths, support coping capacity and strengthen the skills of individuals and families.

Use integrated support systems

Rapid assessment of MH needs and MHPSS are integrated in overall health care. Apart from being more sustainable, integrated services tend to carry fewer stigmas.

Provide a multi-layered support

Support should be organised in several layers. Above and beyond basic services and security, as well as fostering family support (e.g. family tracing and reunification), some number of people will need additional help. Focused, non-specialised support based on PFA should be first offered, followed by with specialised services only for those who need additional support.

Furthermore, handbooks, manuals and reports at the websites of agencies and previous EU projects focusing on MH and/or refugee and other migrant health were assessed. Special topics of interest were procedures and tools for triage and screening, MHPSS and psychological first aid (PFA) and cultural aspects of providing help to refugees and migrants. Although not systematic, this search was comprehensive and resulted in identifying a large number of practically oriented guidance documents (over 20). A short list of most relevant sources for this report can be found in Table 1.

Table 1 List of most relevant handbooks, manuals, reports and projects for current report

Handbooks, manuals and reports	Author(s) (year)	Link
Psychological first aid: Guide for field workers	WHO, War Trauma Foundation and World Vision International (2011)	http://www.who.int/mental_health/publications/guide_field_workers/en/
Psychological first aid Field Operations Guide	Brymer, Jacobs, Layne, Pynoos, Ruzek, Steinberg, Vernberg, Watson; National Child Traumatic Stress Network and National Center for PTSD (2006)	http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf
Walking together: A mental health therapist's guide to working with refugees	Farmer (Ed.); Lutheran Community Services Northwest (2015)	http://www.academia.edu/14444974/Walking_Together_A_Mental_Health_Therapists_Guide_to_Working_with_Refugees
Assessing mental health and psychosocial needs and resources	WHO and UNHCR (2012)	http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/
Culture, context and the Mental Health and Psychosocial Wellbeing of Syrians	Hassan, Kirmayer, Mekki Berrada, Quosh, el Chammay, Deville-Stoetzel, Youssef, Jefee-Bahloul, Barkeel-Oteo, Coutts, Song S, Ventevogel; UNHCR (2015)	http://www.unhcr.org/55f6b90f9.pdf
mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies	WHO and UNHCR (2015)	http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf
Health assessment of refugees and migrants in the EU/EEA: Handbook for Health professionals	European Commission, Directorate-General for Health and Food Safety (2015)	http://ec.europa.eu/dgs/health_food-safety/docs/personal_health_handbook_english.pdf
Psychosocial interventions: A handbook	International Federation Reference Centre for Psychosocial Support (2009)	http://www.ifrc.org/en/what-we-do/health/psychosocial-support/

EU projects	Link
Operationalising Psychosocial Support in Crisis (OPSIC)	http://opsic.eu/
The European Network for Traumatic Stress (TENTS project)	http://tentsproject.eu/
Best Practice in Health Services for Immigrants in Europe (EUGATE)	http://www.eugate.org.uk/

Finally, a systematic search was conducted in order to recommend specific tools for rapid assessment of MH needs. The goal of systematic search was to identify tool(s) that are simple, short and culturally appropriate; hence we focused on tools that were constructed and (or) validated specifically on refugee populations. We conducted the search in one electronic article database (PsycINFO), Google and Google Scholar engines and assessed two previous systematic reviews. For all 21 tools identified, the search was further expanded in order to find additional validation studies. Tools were evaluated based on predefined criteria, and one tool was deemed to suit the current purpose the most. The details of this search can be found in Appendix I.

The structure of the report

The report is structured to reflect WP5 objectives. In the *Background* section, previous studies on MH needs of migrants and refugees are discussed, as well as societal benefits from implementing integrated MH care. In the *Mental health care procedures* section we discuss current context in which MHPSS will be provided and describe stepped model of MH care integrated in overall primary health care. The next two sections, *Triage* and *Screening* describe procedures of rapid assessment of MH needs within the proposed model of stepped care. In *Psychological first aid* section, we describe overall supportive response to refugees and migrants in need of psychological support and give examples of specific and focused steps that can be taken to support them. In *Referral* section we briefly discuss the need for more specialised MH care and propose procedure for successful referral. The next section, *Children and adolescents*, focuses on implementing previously described procedures for these especially vulnerable groups. In section on *Additional topics*, some special issues are discussed, such and training and expertise needed for proposed procedures, working with interpreters, as including refugees and migrants in MHPSS. Finally, in the last section (*Final conclusions and implications for the EUR-HUMAN project*) we discuss this report with respect to other work packages in the project and summarise next steps.

2 Background

By the end of 2014, 59.5 million people were forcibly displaced around the world due to violent conflicts or human rights abuse. Among these, 19.5 million people were refugees, persons who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, are outside the country of their nationality, and are unable to, or owing to such fear, are unwilling to avail themselves of the protection of that country."[7] Although an updated estimation of the number of individuals forcibly displaced or with refugee status was not available at the time of writing this report, the number has likely increased due to of conflicts and instabilities in Syria, Afghanistan, Eritrea, Somalia, and elsewhere. Europe in particular has evidenced a significant increase in the number of refugees and migrants in 2015; more than one million people were registered entering the EU. According to the UNHCR, out of the total number of refugees in the world, around 3.5 million are located in Europe.[8] In addition to traumatic experiences in their country of origin, many refugees face various difficulties during and after resettlement such as health problems, poor accommodation and nutrition, financial problems, separation from family members, language and cultural barriers and discrimination.[9] All this can lead to severe psychological distress and development of mental disorders.

Estimates of MH problems in refugee populations are not always consistent. Tere is evidence that during migration refugees and migrants often experience the "healthy immigrant effect" evident in terms of low levels of depression and anxiety on the way to their destination.[10] However, prevalence of mental illness tends to grow as soon as they settle down in the host country. Studies show high prevalence of psychological disorders (especially PTSD, anxiety and depression) among refugees living in Western countries. For example, the prevalence rates of PTSD range from 4% to 70%, and similar percentages are reported for the prevalence of depression (3% to 88%) and anxiety (2% to 80%).[11–13] Prevalence rates of mental disorders can vary depending on a specific sample studied as well as the precise time and method of assessment. Some studies suggest that the wide range of MH problems in refugees and migrants may be the result of applying Western models of psychiatric illness in cultures with different MH concepts.[12] Despite the fact that most people show resilience in stressful situations, refugees and migrants are at higher risk and special attention should be paid to highly vulnerable groups including people who were exposed to traumatic experiences, women, older people and unaccompanied minors.[14,15] Although alleviating this burden itself is a valued goal for healthcare workers, Box 2 further discusses different societal costs of trauma.

Among the current refugees and migrants there is a number of highly vulnerable individuals and families. Above and beyond adverse experiences in their home countries, they have suffered losses and trauma while traveling towards European countries. Media images of such tragic family losses have shocked the audience across Europe.[16] Some families have lost to death several members but had to continue their transit. The care-providers on the ground, in

the hot-spots, detention and transit centres are struggling to identify such individuals and provide adequate help and support.

Box 2 Societal costs of trauma

Family level

Experiencing traumatic events in war or disasters can lead to intergenerational transmission of dysfunction and violence. In families where parents suffer from MH problems, children have heightened risk of psychopathology and social dysfunction.[17] Some authors propose that this is due to changes in parent-child interactions.[18,19] Furthermore, several studies have shown links between exposure to war and heightened risk for domestic violence.[20] This, in turn, is related to heightened risk of MH problems[21] as well as aggression and violent behavior[22] in children.

Community level

Numerous studies suggest that MH problems, including PTSD, can persist throughout life. This chronic condition of suffering and helplessness can lead to passivation, work impairment, inability to take care of family members and hinder participation in socially productive activities;[20] conditions which make it difficult for migrants and refugees to integrate in community and society as a whole.

Health system

A growing body of research shows relationship between trauma related disorders, especially PTSD, and various health problems, such as decreased immunity, cardiovascular, pulmonary, neurological and gastrointestinal complaints, somatic pain, susceptibility to infectious diseases and even increased risk for cancer.[20] It comes as no surprise that trauma survivors with PTSD are more often on sick leave and are more frequently hospitalised,[20,23] which may lead to greater strain of health system.

3 Mental health care procedures

Rationale

The current status of refugee and migrant crisis in the Western Balkans corridor has introduced a high level of uncertainty in the resettlement and support system. Before mid-February the Western Balkans corridor had two major migrant routes to Europe: the land route from Turkey to Bulgaria and the sea route from Aegean Sea to Greece. However, the corridor has been officially closed for all migrants on 8 March. Furthermore, on 18 March EU and Turkey signed an agreement in order to end the irregular migration from Turkey to the EU and replace it with legal channels for resettlement of persons entitled to international protection.[24] According to this agreement, all new irregular migrants after 20 March, regardless of their nationality or need for international protection, will be returned from Greek islands to Turkey. In addition, for every Syrian being returned to Turkey, another Syrian from Turkey will be resettled to the EU directly. These events have resulted in a number of procedural and humanitarian problems. Greece has moved all previously arrived refugees and migrants from the islands to the mainland and now approximately 48 000 of refugees and migrants, who arrived before 20 March, have limited options for onward travel. Significant numbers of refugees and migrants continue to enter Greece from Turkey and new arrivals (after March 20) are held in detention facilities. A majority of them will probably be returned to Turkey. Although the system for assessing asylum claims in Greece is already understaffed, there has been a large increase in the number of asylum claims and EU relocation programme applications among the stranded refugees and migrants in Greece.[25]

Considering the current situation, it is difficult to predict how the system for relocation will be organised from now on. One possibility is that the majority of refugees and migrants currently stranded in Greece and Turkey will be directly transferred to host countries within the EU through the EU relocation programme. Another possibility is that the number of arrivals in Greece will increase dramatically leading to sporadic, facilitated movement of large number of people through Balkan countries as the border officers in the Former Yugoslav Republic of Macedonia will be unable to prevent the further entry of such large number people. Accordingly, we cannot be sure where and how the procedures for MH screening and PFA will be organised. Therefore, we aimed to develop a comprehensive procedure for rapid assessment of MH conditions and interventions that can be implemented in various settings and scaled up or down based on the needs and available resources. However, we also recommend the context in which certain parts of the process will be most feasible to conduct.

Procedures

Like all other types of health care, MH care starts with identification of people in need. However, MH conditions are typically more difficult to identify. From health care provider perspective, it is difficult to assess such problems since they are usually internally experienced; from patient perspective it is oftentimes difficult to request help for various

reasons, most often fear of stigmatisation.[26] Therefore, identification of MH care needs should be systematic and comprehensive, while in the same time it should also be patient-centred, culture-informed and non-stigmatising.

Following well established principles in provision of MHPSS[3], we propose a stepped model of rapid assessment and care. The purpose of the stepped model of care is to provide MHPSS services based on different levels of individual needs. In the proposed model, assessment of MH needs and provision MHPSS are integrated in overall health care. There are several arguments for this. First, integrating MH care in overall health care reduces the stigma usually attached to MH issues.[3] Second, people are often not aware of strong connection between body and mind symptoms. Refugees and migrants can complain about what seem to be purely physical health conditions which are in fact caused by distress (e.g. chest pain, fatigue, dizziness, headache, edema, back pain, shortness of breath, insomnia, abdominal pain, and numbness as most common).[27] Finally, although there is a substantial rate of psychiatric disorders present in primary care, individuals may not accept a referral to a MH provider at another location, making primary health care appropriate setting for addressing MH problems.[28] The integrated and holistic model of primary health care is shown in Figure 1, while in the text below we briefly describe steps in rapid assessment and delivery of MHPSS care.

Step 1: Triage

MH care for refugees and migrants starts with triage. The purpose of triage is twofold: to recognise urgent, life-threatening conditions and to identify people with immediate health needs. Therefore, the focus in MH triage should be on recognising refugees and migrants whose functioning is so severely impaired that their safety or safety of people around them is endangered. For those migrants and refugees, immediate escort to a specialist should be ensured. If there are no indications of immediate risk to safety during the triage, but the person is highly distressed (e.g. severe anxiety), immediate help should be provided, based on PFA principles of stabilization, establishing safety, calming, connectedness, self-efficacy and hope. For those refugees and migrants, further referral can be made to MH care specialist, if needed.

Triage and elementary PFA should be conducted primarily at hot spots (detention centres) and during transit route. However, these procedures should be available at each contact points with refugees and migrants, since serious MH issues can manifest at different times during resettlement period. In the *Triage* section of this report these procedures are further described. Triage can be conducted by health care personnel, MH professionals, as well as by trained lay persons and volunteers.

Step 2: Screening

The purpose of MH screening is to identify individuals who are experiencing high level of distress and are more likely to develop serious MH problems and MH disorders. The focus of screening is on identifying high risk for MH disorders that are common in the refugee population, such as PTSD, anxiety and depression.[29] For refugees and migrants who

experience high level of symptoms, immediate help based on PFA principles should be provided together with referral to specialised care provider for full assessment and further care. For others, psychoeducation on MH problems and information about accessing services should be provided should their condition deteriorate.

Screening for MH problems should be conducted as a part of any comprehensive health screen. Although the benefits of routine screening are yet to be seen, experts recommend the use of a brief screening instrument due to high levels of distress in refugees and asylum seekers.[2] Because of time constraints, MH screening (as well as comprehensive health screen) will most likely be conducted at temporary or first hosting locations and at permanent locations in the EU. In the *Mental health screening* section we describe the procedures and propose tools that can be used for screening. Care providers conducting screening can have different professional backgrounds (e.g. medical doctors, nurses, psychologists, social workers), however, specific training should be organised.

Step 3: Referral

Based on the model of stepped care, referral to specialised MH services is recommended only in cases where other types of basic interventions and support are not sufficient. In the *Referral* section we describe the procedures that should be used as well as some good practices. Referral should be available at all points of contact with refugees and migrants, during transit, but especially at more permanent locations where the refugees and migrants are resettled.

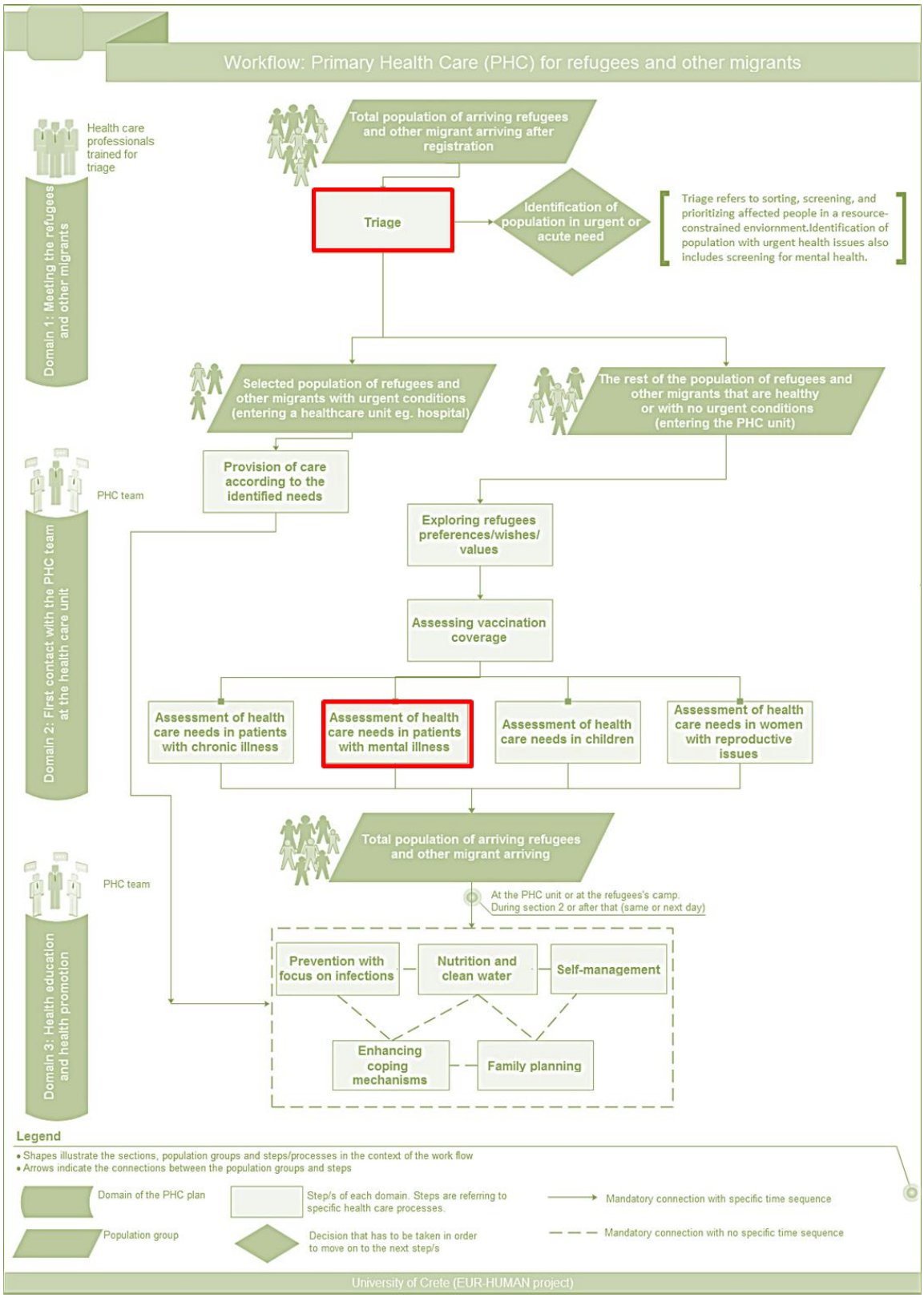


Figure 1 Integrated model of primary health care for refugees and other migrants (red frames indicate points where MH assessment and interventions are integrated in the overall health care)

4 Triage

Rationale

In order to provide immediate MH care to survivors in any emergency setting, the intervention should start with triaging the most psychologically severely affected individuals ("the psychological casualties").[30] By definition, triage includes sorting, screening, and prioritizing affected people in a resource-constrained environment.[31] Triage of serious health issues, including MH, is essential, high-priority response that should be implemented as soon as possible in an emergency. In this early response, triage is not intended for diagnostic purposes but rather to identify those individuals who require immediate attention,[32] primarily for being at risk to themselves or other people.

In recent current refugee crisis thousands of people arrived to Greece on a daily basis. Although the exact "entry point to Europe" is likely to change since the 18 March 2016 agreement,[24] the need to develop procedures to identify individuals who are at immediate risk remains. In terms of MH issues, we define immediate risk as threat to personal safety of the affected people, or threat to safety of people around them. These severe MH problems need immediate specialist attention. However, identifying such individuals is challenging. How can care providers recognise people under such severe distress that their safety is endangered? And what procedures can be used within current situation where thousands of people potentially require help?

Procedures

To our knowledge, there are no prior developed procedures to tackle the issues of MH triage in the context of refugee crisis. Therefore, we aimed to propose procedures that can be easily implemented with limited resources, that rely on a stepped approach and that can reach out to large number of people. The proposed procedure consists of three main steps:

1. Recognition of behavioural signs that indicate severe distress;

2. Rapid assessment and immediate assistance;

3. Referral.

The process is shown schematically in Figure 2, and described in the text below.

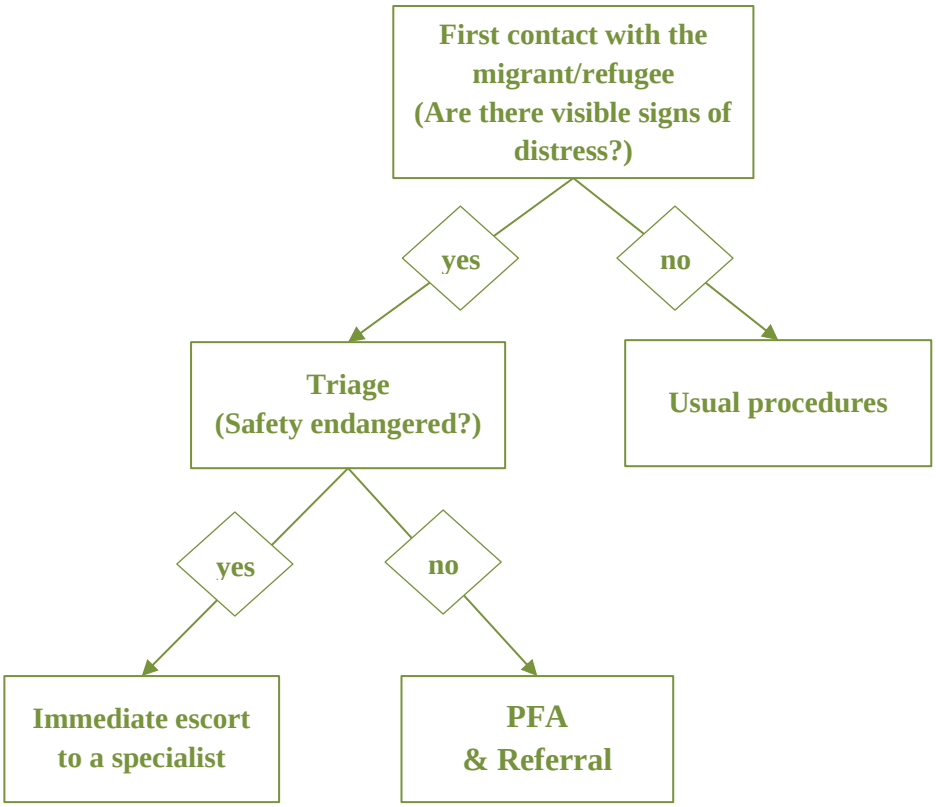


Figure 2 Triage procedures

Step 1: Behavioural signs

Although people react differently to stressful events, there are some physical signs that indicate severe distress in majority of people. In a group of refugees and migrants, care providers should look for signs of being disoriented or overwhelmed[33–37] (Table 2). Care providers should approach directly people showing any of these signs and engage in interaction.

Table 2 Physical/behavioural and emotional/cognitive signs of severe distress

Physical/behavioural	Emotional/cognitive
Looking glassy eyed and vacant, unable to find direction	Exhibiting strong emotional responses, uncontrollable crying
Unresponsive to verbal questions or commands	Feeling incapacitated by worry
Disorientation (engaging in aimless disorganized behaviour, not knowing their own name, where they are, or what is happening)	Unable to care for themselves or their children
Rocking or regressive behaviour	Unable to make simple decisions
Hyperventilation	Feeling anxious or fearful, overwhelmed by sadness, confused
Experiencing uncontrollable physical reactions (shaking, trembling)	Physically/verbally aggressive
Exhibiting frantic searching behaviour	Feeling shocked, numb
Self-destructive or violent behaviour	Guilt, shame (for having survived, for not helping or saving others)

Step 2: Rapid assessment and immediate assistance

Once the care provider identifies a person showing visible signs of distress, it is important to engage in conversation. During the conversation, the care provider has two main tasks: first, to conduct rapid assessment of immediate risk, and second to calm and reassure the person, while offering practical assistance. Guidance on immediate assistance will be presented in detail in *Psychological first aid* section, while rapid assessment will be presented in detail in this section.

Rapid assessment should focus on two most important aspects: overall level of distress and signs that the person functioning is so severely impaired that their safety or safety of people around them is endangered. These signs can be considered as “red flags”; signs that indicate that special attention is probably needed. In addition, it is important to identify available resources, so that immediate practical assistance can focus on strengthening them. These elements of assessment are shown in Table 3, while in the text below, we give practical guidance in conducting this conversation.

Table 3 Rapid assessment during triage (assessed by caregiver)

Distress level	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Personal safety or safety of other people endangered	No Yes
Resources (note up to 3 most important resources)	1. 2. 3.

Starting the conversation. Talking about their MH issues is still uncomfortable for most people. When talking about distress, care providers should first: (1) create a safe, comfortable and confidential setting, (2) establish a basic trustful relationship. Therefore, before asking any further questions, care provider should:

- Introduce himself/herself;
- Ask the person if he/she could be of any help;
- Provide adequate place to talk.

An example of the first contact is shown below:

> *"Hello. My name is XY, and I work for Z organization. Can I help you in any way? It seems to me that you are tired/worried. I can offer you to rest a bit in a more comfortable and quiet space nearby* (point where). *From that place you can still see everything that is going on here, but it might be more comfortable for you."* If the person is under such severe distress so that interaction is impossible, try calming them (Box 3).

It is very important that care providers ensure adequate physical space for conversation. The space should be comfortable and quiet, while also near the central spot of the camp/reception area. Refugees and other migrant should not be exposed to additional stress of worrying about their group leaving without them, e.g. because of train or bus departure, or feeling isolated from others. Families **must not** be separated. A waiting space/room and place for children to play should be established, so that families with children can stay together.

Once the person/family has rested for a few moments, talking about MH condition can start. In the beginning, the conversation should focus on the symptoms the care provider noticed, e.g.:

> *"Earlier it seemed to me you were a bit distant, like many thoughts were passing through your mind. Many people who have gone through difficult situations feel like this. How are you? Can I help you in any way?"*

Box 3 Orienting emotionally overwhelmed survivors[38]

If the person appears extremely agitated, shows a rush of speech, seems to be losing touch with the surroundings, or is experiencing ongoing intense crying, it may be helpful to:

- Ask the individual to listen to you and look at you.
- Find out if he/she knows where he/she is, and what is happening.
- Ask him/her to describe the surroundings, and say where both of you are.

If none of those seems to help to stabilise an agitated individual, a technique called "grounding" may be helpful. You can introduce grounding by saying:

"After a frightening experience, you can sometimes find yourself with emotions or unable to stop thinking about or imagining what happened. You can use a method called "grounding" to feel less overwhelmed. Grounding works by turning your attention from your thoughts back to the outside world. Here's what you do…"

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five non-distressing objects that you can see. For example you could say: "I see floor, I see a shoe, I see a table, I see a chair, I see a person."
- Breathe in and out deeply.
- Next, name five non-distressing sounds you can hear. For example: "I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing things you can feel. For example: "I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel blanket in my hands, I can feel my lips pressed together."
- Breathe in and out slowly and deeply.

You might have children name colours that they see around them. For example, say to the child: "Can you name five colours that you can see from where you are sitting. Can you see something blue? Something yellow? Something green?"

If none of these intervention aids in emotional stabilization, consult with medical or MH professionals, as medications might be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

(Quoted directly, page 51)

Assessing distress level. To estimate the level of distress, care provider should pay close attention to: tone of voice, body language and behaviour that may indicate higher levels of anxiety or depression than expected,[39] for example behavioural/physical and emotional/cognitive signs described in Table 2. Attention should also be given to the refugee's or migrant's ability to communicate thoughts in a coherent fashion (this may require input from an interpreter, if interpretation is needed).

Assessing danger to safety. To assess immediate danger to safety, either to self or others, several indicators need to be taken into account:[37]

- Presence of psychotic symptoms: hallucinations, delusions, paranoid ideas, thought disorder, bizarre/agitated behaviour;
- Presence of affective disturbance: severe symptoms of depression/anxiety, elevated or irritable mood;
- Confused, disorganised behaviour, can't take care of self or children (if applicable);
- Reporting threat of self-harm;
- Reporting threat of harm to others.

Special attention should be given to thoughts and feelings of self-harm, since they are less likely to be observed from behaviour. When talking about suicide, it is recommended to approach the topic gradually, by first asking about other aspects of distress and posing questions that may make it easier for a person to answer honestly, for example:

> *Some people with similar problems have told me that they felt life was not worth living* [40(p 50)].
>
> *Do you sometimes go to sleep wishing that you might not wake up in the morning?*[40(p 50)] *OR Have things ever been so hard or so bad that you felt you wanted to die or did not want to live anymore?*[41(p 73)]

Refugee and migrants may express being "tired of life", "done with life", or wishing that "God would take their life".[26,41] Sometimes these expressions are a way to convey distress, with no real intention of ending their own lives,[26] but if a refugee or migrant says "yes" , more specific questions should follow, for example:

> *Have you ever wanted to end your life or kill yourself?*[41(p 73)]
>
> *Do you think about hurting yourself?*[40(p 50)]
>
> *Have you made any plans to end your life? If so, how are you planning to do it?*[40(p 50)]

It is important to stress that directly asking questions on suicide is extremely important. Oftentimes people can seem stable and future oriented with a pleasant and positive appearance while still endorsing active suicidal ideation. Alternately, people who appear significantly distressed and decompensated can have no suicidal ideation at all.[41] Therefore, care providers should not make their own conclusions regarding a suicide threat without directly asking the refugee or migrant.

Finally, care providers who conduct triage should be culturally sensitive, since expression of distress varies between cultures. Description of some cultural diversities in MH concepts is shown in Box 4.

Resources. Apart from assessing immediate risk, the triage process should include identifying individual's available resources. One of the key principles of early interventions is to increase social support among individuals in distress, as this has been found to reduce the likelihood of chronic posttraumatic psychopathology.[32] It is important to get an insight how the individual perceives his/her own resilience. A simple question as *"What has helped you to survive so far?"* can be helpful. Whatever the answer, it is good to incorporate their response into the intervention. For example, if a person believes that their survival was due to God, then strengthening their connection to prayer or a faith community would be wise. If they believe that they survived for their children, then understanding the current relationship with their children is important.[41]

Step 3: Referral

If immediate threat to personal safety or safety of others is probable, the refugee or migrant should immediately be escorted to a specialist. However, if no such threat is probable, but distress level is high, it is important that the care provider offers PFA, and links the refugee or migrant to additional services. Steps to successful referral will be discussed in the *Referral* section.

Box 4 Cultural appropriate assessment - Syrian MH concepts[26]

Providing acceptable help requires understanding illness models and idioms of distress that are used in a given culture. A good insight in specific MH concepts allows appropriate intervention design to mobilise individual and collective strength and resilience.

Concepts such as "psychological state", "psychological wellbeing" or "mental health" are not commonly understood and often carry negative connotations in the Syrian or Arabic context in general, while suffering is commonly understood as a normal part of life, and therefore, not requiring medical or psychiatric intervention, except in severe cases.

Refugees and migrants with psychological or mental problems often first seek medical services and have physical complaints before addressing psychological, relational or spiritual dimensions of their condition. Most Arabic and Syrian idioms of distress do not separate somatic experience and psychological symptoms, because body and soul are interlinked in explanatory models of illness. People may resort to images, metaphors and proverbs that assume the connection of the psychological and the physical.

Attention should be given to use of everyday expressions and proverbs or metaphors of expressing distress. Some may be misunderstood as "resistance" to direct communication, or even misinterpreted as psychotic symptoms when observed through the prism of Western culture. For instance, some Syrians attribute obsessive rumination to satanic temptations, using the Arabic word "wisswas" (وسْواسْ), meaning both the devil and unpleasant recurrent thoughts. Other examples of such culturally specific expressions of MH issues in Syrian context are shown below:

General distress	Often expressed through physical symptoms, like cramps in the guts, pain in the stomach, head or heart, tightness in chest, numbness of body parts or having the feeling of ants crawling over the skin.
Fear and anxiety	"Falling or crumbling of the heart", "My heart is squeezing".
Helplessness	"The eye sees but the hand is so short or cannot reach", "I feel like I'm paralysed", "Nothing is coming out of my hands".
Sadness	"A black life", "Life has blackened in my eyes", "Blindness got to my heart".
Suicide	Wish they could sleep and not wake up.

5 Mental health screening

Rationale

Given that the focus in refugee and other migrant resettlement is on physical health problems such as injuries and infectious diseases, the detection and the treatment of MH problems is often overlooked. Among the EU countries, medical screening of newly arrived asylum seekers is common, however, MH screening is the least frequent component.[1] The purpose of MH screening is to identify the individuals who are experiencing heightened distress and who are more likely to develop more serious MH issues. Although there are no clinical trials demonstrating the benefits of routine MH screening yet,[5] there are several reasons why such procedures might benefit the refugees and migrants arriving to Europe.

First, majority of refugees and migrants arriving to Europe have suffered directly or indirectly from violence, trauma or loss, not only in their country of origin, but also on the way to their final destinations in the EU. Prevalence studies of mental disorders in refugees after resettlement show that the earlier the acute posttraumatic stress reactions are identified, the better the opportunities for successful intervention and treatment.[42] Furthermore, refugees are often less likely to seek out or be referred to MH services then their counterparts in the general population. For example, in Switzerland the average time between entering the country and admittance to therapy was 7.7 years for refugees who were victims of torture and war.[43] A longitudinal study on refugees resettled in the Netherlands suggests that only 21% of respondents with PTSD contact a MH professional in the first year and only slightly more than half in the first 7 years.[44] The reluctance to seek help for psychological disorders can be a result of language barriers, distrust, fear of stigmatisation, lack of knowledge, time or money, as well as lack of information on available services. In addition, because of the high prevalence of PTSD in refugee population, the National Institute for Clinical Excellence (NICE) recommends the routine use of brief screening to detect PTSD as a part of the initial refugee health assessment.[2] All of the above supports the importance of a systematic procedure for brief assessment of MH needs.

Procedures

Experts in the area agree that MH screening should be conducted as a part of comprehensive health screening.[2,45] Since comprehensive health screening will most likely be conducted in the host country, it is probable that specific context will vary from country to country depending on administrative regulation and laws. Therefore, we aimed to propose procedures that can be implemented within the EU primary health care system. The proposed procedure consists of three main steps:

1. Recognition of behavioural signs that indicate severe distress,
2. Applying the MH screening tool,
3. Referral to a specialist, if needed.

The process is shown schematically in Figure 3, and described in the text below.

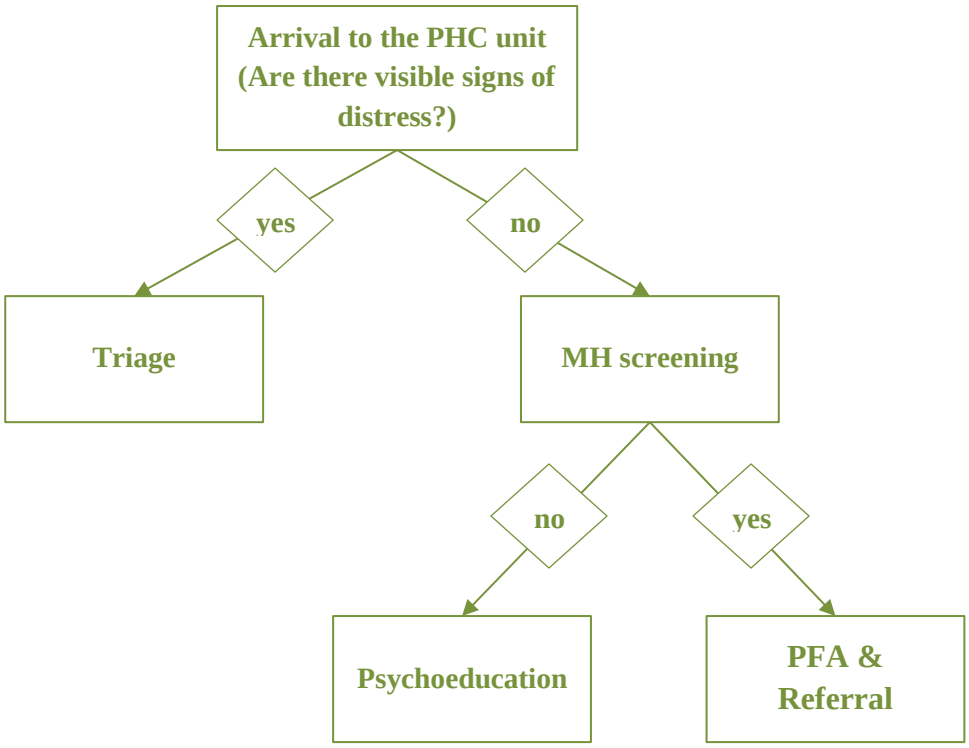


Figure 3 Screening procedures

Step 1: Behavioural signs

Upon the refugee or migrant arrival to the primary health care (PHC) unit, care provider should observe if there are visible signs of severe distress (according to the symptoms described in Table 2. in *Triage* section). If a refugee or migrant shows signs of severe distress, triage and immediate assistance should follow, before starting comprehensive health screening. Otherwise, health care providers can start with overall health screening, including MH.

Step 2: MH screening

When MH screening is conducted as a part of comprehensive health screening, general practice is to conduct the screening at the end of the procedure.[39] Since talking about MH is often uncomfortable, this allows establishing a trustful relationship prior to the MH screening procedure. However, it is important to emphasize that if physical health screening shows that immediate assistance is needed, solving this issues has priority over MH screening.

MH screening is usually conducted by self-administered instruments, where an individual assesses the intensity of certain symptoms. Based on the extensive review of available instruments (Appendix I), we recommend using The Refugee Health Screener 13 (RHS-13) as a screening instrument in primary health care settings for migrants and refugees from age of 14. Additional information on the characteristic of MH screening instruments and RHS-13 can be found in Box 5, while the whole instrument is presented in Figure 4. In the text below we focus on the practical aspects of administering screening instruments in general.

Establishing trust. The issue of trust is extremely important in the context of MH screening, even in if the same primary care provider who conducted physical health screening is conducting the MH screening. Refugees and migrants may be particularly distrustful of services and authorities because of previous experiences in their country of origin. Moreover, they may be unfamiliar with the health care system in the host country, in particular with the way MH care works.[46]

Before administering the screening instrument, the care provider should introduce him/herself and explain what is going to be asked and what the individual can expect in this part of health screening procedure. Making the individual familiar with screening procedure and informing that this part of health screening involves questions about how they are doing both in their body and in their mind is essential. It should be explained that the questions will be about sadness, worries, body aches and pain, and other symptoms that some people get when they have bad experiences, stress at home, or when they travel to a new country. Also, confidentiality of screening should be emphasized. It is important that this is seen as another part of the overall medical check-up. The screening could begin as follows:[41(p 58)]

> *"Hi. My name is XY. Can I get you some tea or water? Again, my name is XY and I work here as a Z. This part of medical check-up will be about things that may be bothering you at the moment. In the EU health care also includes taking care of a wide range of feelings and emotions – from being sad all the time, to not being able to sleep at night, to even feeling like life is not worth living. It is common for many refugees and migrants to have these types of problems because of all the terrible things they have been through. What happens to us in life has an impact on our mind and on our body. The questions we are asking will help us find people who are having a hard time and who might need extra support. Your answers will not be shared with anyone else, without your permission.*

Box 5 MH screening and Refugee Health Screener 13 (RHS-13)

Identifying MH issues in refugees and migrants is a challenging task for a variety of reasons ranging from technical aspects of language barriers and accessibility, to problems such as defining mental illness across cultures.[47] Therefore, few screening instruments have been tested for diagnostic accuracy in refugee and migrant populations.[5] In general, a good screening tool should give consistent results with repeated tests (reliability) and should identify correctly those with and without condition (have good sensitivity and specificity). In addition, routine screening for exposure to traumatic distress should not be conducted, since it could lead to more harm than good in well-functioning individuals.[5] Finally, to be practical to administer, it should include symptoms that predict different common disorders, such as PTSD, anxiety and depression, in multiple refugee groups,[48] and should be short and easy to administer due to limited time for MH screening within the general medical screening.

Based on our review (Appendix I), the RHS-13 scale meets most of the specified criteria and can be recommended as the primary screening tool for refugees on arrival in host country. This instrument was specifically designed for and validated on newly arrived refugees and migrants with items derived from existing and valid instruments used on similar populations. It is translated in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); can be administered in relatively short amount of time; is easily understandable for people of different educational levels and can be administered for persons from age 14. Furthermore, it covers several relevant constructs related to emotional distress which are common in refugee populations.

RHS-13 scale consists of 13 questions assessing PTSD, anxiety and depression symptom intensity with five possible answers (0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely) with addition of a visual scale to facilitate understanding. It can be used as quick assessment of the probable risk of having or developing PTSD, anxiety or depression (cut-off score ≥ 11). It is important to emphasize that a positive screen on the RHS-13 does not automatically indicate that the person in question should be provided with clinical MH treatment but indicates the need for full assessment and follow-up.

Administering the screener. After the introduction, the care provider should remind the refugee or migrant that he/she will answer the questions by themselves, but that they can ask for help if they cannot read or find the questions confusing. The care provider should explain how to answer the questions (e.g. that one answer from 1 to 5 should be picked, depending on how he/she is feeling) and encourage again to ask for help if needed. It is important that the care provider and interpreter, if interpretation is needed, are highly familiar with the instrument and the purpose of the screening.

Evaluating the results and immediate assistance. Following the administration of the screener, the care provider should calculate the total score. For RHS-13 screening tool, the score of ≥11 indicates positive screen, and immediate assistance based on the PFA principles should follow. In order to help guide the intervention, it is helpful to assess refugee or migrant current resources, as described in the *Triage* section. It is recommended that the feedback and short intervention be provided by the same care provider who conducted the screening. Feedback following positive screen could start as follows:[49(p 22)]

> *"From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees and migrants experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. I would like to ask you what has helped you to survive so far?"*

Step 3: Referral

If a refugee or migrant has been screened positive, after providing PFA intervention appropriate referral should be made. Steps to successful referral will be discussed in the *Referral* section.

Otherwise, if the individual scores below cut-off, care provider should provide information about available services and encourage the person to ask for MH assistance for themselves or their loved ones if ever the need is felt. Even if there are no current indicative signs of distress, numerous resettlement stressors may worsen trauma-related MH symptoms, such as unemployment, unsafe housing, social isolation, discrimination, language and cultural barriers.[50] Screening should end with providing information on common MH issues and available services, orally and in the form of a leaflet for future reference.

ID#

DATE

REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

CHECK ONE: ☐ POSITIVE ☐ NEGATIVE ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

Figure 4 Refugee Health Screener 13 (RHS-13)

6 Psychological first aid

Rationale

Humanitarian aid organisations and other stakeholders working with refugees and migrants have long recognised the need to provide early interventions in order to avoid deteriorations in psychological wellbeing and MH status. Historically, a number of early psychological interventions have been proposed for working with refugee and migrant clients ranging from trauma-focused interventions to psychosocial approaches.

Trauma focused interventions such as *critical incident stress debriefing* (CISD) or *psychological debriefing* (PD) were developed to reduce initial psychological distress following a traumatic experience and to prevent the development of later psychological disorders by exploring facts, thoughts and reactions to a specific traumatic event.[51] However, these types of interventions proved to be ineffective. For example, recent reviews on single session PD showed that the use of PD after traumatic incidents does not reduce psychological distress or prevent the onset of PTSD, depression and anxiety,[32,51,52] and even suggest that debriefing can have adverse long-term effects.[52] Possible reason why such interventions are not suitable is that they can actually increase psychological distress by re-exposing individuals to traumatic event without sufficient time for therapeutic processing. For some individuals this can aggravate their condition because it interferes with normal recovery processes. In addition, research has shown that not everybody develops acute distress symptoms; some have temporary stress reactions and only a smaller number of individuals develop serious MH problems.[53] In that regard, trauma focused interventions, which put great emphasis on psychological distress, might even induce distress in those who otherwise would not experience it and make people more susceptible to developing psychological symptoms.

In contrast, psychosocial approaches are aimed at addressing the basic needs and reducing distress of people affected with adversity. International Federation Reference Centre for Psychosocial Support of the Red Cross and Red Crescent Societies defines psychosocial support as "a process of facilitating resilience within individuals, families and communities, enabling them to bounce back from the impact of crises and helping them to deal with such events in the future".[54] This approach emphasizes strengths and resources of individuals to recover from the impact of a crisis. Over the years a wide range of interventions were developed to provide psychosocial support among which particularly relevant for this context is psychological first aid.

Psychological First Aid (PFA) is a form of psychosocial support intended for people who have experienced mass violence, natural disasters and other types of distressing events. The term PFA is often used as an umbrella term for a range of different approaches, which resulted in different formal definitions in the literature. For example, National Child Traumatic Stress Network (NCTSN) and National Centre for PTSD (NC-PTSD) define PFA as „an evidence informed, modular approach for assisting people in the immediate aftermath

of disaster and terrorism to reduce initial distress and to foster short and long-term adaptive functioning."[34,38] The NATO guidelines on psychosocial care for people affected by disasters and major incidents usefully describe PFA as: "not a single intervention or treatment but an approach that is designed to respond to people's psychosocial needs after major incidents or disasters which comprises of a number of elements".[55] According to the Inter-Agency Standing Committee (IASC) PFA „…is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support".[3] Despite various formal definitions, the basic elements of PFA are universal and include:[33]

- Providing practical care and support which does not intrude;
- Helping people to address basic needs;
- Listening to people, but not pressuring them to talk;
- Comforting people and helping them to feel calm;
- Helping people connect to information, services and social support;
- Protecting people from further harm.

Main aims of PFA include reducing initial distress, meeting current needs, promoting flexible coping and building people's capacity to recover and adjust. PFA can be provided to anyone who has been exposed to a crisis event and anywhere where it is safe enough to do so (e.g. shelters, camps, transit centres, hospitals). Its implementation is not restricted to MH professionals but can also be delivered by trained lay persons. It should be emphasized that PFA is very different from clinical MH care, emergency psychiatric interventions or psychotherapy because it does not require clinical expertise or discussing the event that caused distress. Furthermore, PFA cannot be assumed to prevent long-term MH consequences of trauma or to reliably assist in identifying individuals at risk for developing MH disorders. Rather, it is an empathic and pragmatic approach to assist people in distress to stabilize and begin their own practical and emotional recovery.[33] Consequently, PFA does not presume that all survivors will develop MH problems but acknowledges that people who are affected by major life adversity may experience a wide range of negative psychological reactions. Some of these reactions may cause enough distress to interfere with adaptive coping for some people and these individuals can be helped by offering support from compassionate and caring providers.[55] Although there is no empirical evidence about the effectiveness of PFA interventions, there is an expert consensus that PFA can help people affected by extreme events to alleviate painful emotions and reduce further harm from initial reactions to a crisis. PFA is the approach recommended by many international expert groups, including National Centers for PTSD, National Institute for Mental Health, World Health Organisation, the Sphere Project, the Inter-Agency Standing Committee on Mental Health and Psychosocial Support, and other lead agencies such as the International Red Cross.

PFA interventions should be consistent with research evidence, applicable in various field settings, adjustable for different age groups and culturally informed. In order to ensure such conditions, an international panel of experts in the fields of mass trauma and disasters has

identified and recommended five empirically supported principles that should inform and guide all PFA intervention practices and programs:[6]

1. Promoting a sense of safety. Traumatic events such as wars, persecution, and natural disasters represent a threat to individual's psychological wellbeing and to subjective sense of safety which can increase the likelihood of developing MH problems.[56] Promoting psychological sense of safety can reduce post-traumatic stress reactions,[57] as well as cognitive distortions such as belief in a dangerous world and exaggeration of future risk.[58,59]

2. Promoting calming. Exposure to traumatic events also leads to an increase in emotionality, anxiety, hyperarousal or numbing responses, which can be normal and adaptive reactions to such events. However, if these responses persist for a longer period of time and remain at a level that disturbs eating, sleep and performance of daily tasks, this can lead to development of anxiety disorders (e.g. panic attacks, dissociation, PTSD), agitation, depression and somatic problems. For this reason, it is important to try to calm down and stabilise people who are overwhelmed and disoriented.

3. Promoting sense of self- and collective efficacy. Self-efficacy is the individual's belief that his/her actions are likely to lead to generally positive outcomes,[60] while collective efficacy represents a sense that one belongs to the group that is likely to experience positive outcomes.[61] After distressing events people can lose their sense of competency to handle new events which could be transferred even to situations that are not related to the original trauma.[62] In the context of mass trauma and violence, the most important aspect of efficacy refers to the subjective sense that one can cope with trauma related events.[63] This includes the perceived ability to regulate emotions and solve problems related to resettlement, restoration of property, job retraining, interpersonal relationships and other tasks after the crisis is over.

4. Promoting connectedness. Research on disasters and terrorist attacks has shown that social connectedness or social support is associated with emotional well-being and recovery following a traumatic event.[15,64,65] Promoting connectedness increases knowledge essential for effective response to a traumatic situation, provides opportunities for social support activities such as emotional understanding and acceptance, sharing of traumatic experiences, mutual instruction about coping, and practical problem solving. Therefore, it is important to identify individuals who lack strong social support or are socially isolated and those whose support system provides undermining messages such as blaming, minimizing problems and needs and unrealistic expectations.[66]

5. Promoting hope. Hope has been defined as a positive, action-oriented expectation that a positive future goal or outcome is possible.[67] However, for most non-Western societies hope has a religious connotation and is not action-oriented.[61] Retaining hope is crucial for people affected by mass trauma because it often provokes reactions of despair, futility, resignation, catastrophizing and a feeling that „all is lost“. Those who are optimistic, positive and confident that life is predictable are likely to have more favourable outcomes after experiencing mass trauma because they can retain a reasonable degree of hope for their future.

Procedures

This PFA procedure was conceived as a general guide for providing psychological care and support for refugees and migrants arriving in Europe. This framework is practically oriented, in line with the five basic intervention principles of PFA and adapted from or in some parts directly taken from existing PFA field manuals (*Psychological First Aid: Field Operations Guide*[34,38] *Psychological First Aid: Guide for Field Workers*[33]). The general framework comprises core PFA actions, which in the ideal case should all be provided to every individual in need of help. However, the choice of specific actions, the amount of time spent on each and the structure of the whole PFA procedure will depend on the specific context in which PFA will be provided (e.g. at the first point of entrance, during transit, in the host country) as well as the particular needs of the individual. In addition, the exact procedure will certainly differ depending on whether it will be provided within the short triage procedure or a more extensive MH screening. The guide is organised around a set of preparatory actions as well as eight core PFA actions.

Step 1: Preparation

PFA providers must be thoroughly prepared before entering the setting in which they will offer help. The preparation includes gathering all relevant information about the nature of the crisis event that forced people to leave their country, cultural specificities of their country of origin, and situation in which they are currently in, including the type of relief and support services that are formally available at their current location.

Cultural beliefs and practices affect the refugee understanding of the event, response to the crisis and the receptivity to PFA. For this reason, it is important to be familiar with the cultural background and social norms of the people being served. PFA providers should therefore learn cultural customs and norms regarding gender roles, family structures, religious practices, spoken languages, rules on emotional expression and other psychological reactions, customary ways of greeting and addressing people and norms for personal space and physical contact. In addition, provider should be aware of their own cultural values and prejudices so they don't interfere with the provision of assistance.

Probably the most important aspect of preparation includes gathering information about the situation in which the refugees and migrants are currently in. Specifically, the PFA providers should know which organisations are involved in help provision, who are the relevant authorities managing the situation and what are the security regulations in the specific country, so that help could be provided in an organised and coordinated way. Furthermore, it is important that they have accurate information about what is going to happen next, what medical and support services are available and where and how can people access these services. In the Table 4 we provide some general guidelines on what behaviours are appropriate and which ones should be avoided when providing PFA. [34,38,68] These basic "dos and don'ts" can help PFA providers to prepare before entering the setting in which they will offer help.

Table 4 General guidelines for providing PFA

Do	Don't do
Be prepared to be either avoided or flooded with contact and requests for assistance.	Avoid assuming everybody who was exposed to a crisis is traumatized or needs to talk.
Speak calmly, slowly, in simple, concrete terms. Be patient, responsive, and sensitive.	Avoid pathologizing the person's conditions, labelling their reactions as „symptoms" or using terms „diagnosis", „pathologies", „disorders".
Listen to people who wish to share their stories and feelings. Focus on hearing what they want you to understand and remember there is no wrong or right way to feel.	Don't force people to share their stories with you, especially very personal details Don't interrupt or rush someone's story.
Acknowledge how they are feeling and any losses or important events they tell you about, such as loss of their home or death of a loved one (e.g. "I'm so sorry. I can imagine this is very sad for you.").	Don't instruct people on what they should be feeling, thinking or doing now or how they should have acted earlier. Don't give simple reassurances (e.g. "everything will be ok" or "at least you survived" or "I know how you feel").
Acknowledge the person's strengths and efforts to help themselves.	Avoid patronizing the survivors and focusing on helplessness, weakness, mistakes, etc.
Provide information that is simple, accurate and appropriate for your audience.	Avoid offering inaccurate information. Always update the information.
Be honest about what you know and don't know. "I don't know, but I will try to find out about that for you.	Don't make promises that may not be kept.
Respect privacy and keep the person's story confidential (if appropriate).	Don't share the person's story with others or tell them someone else's story.
Respect people's right to make their own decisions.	Don't force help on people or judge them for their actions or decisions.
When they express fear or worry, remind people that more help and services are on the way (if accurate).	Don't talk about your own troubles.
Be friendly and compassionate even if people are being difficult.	Avoid expressions of approval and disapproval.
Help people meet basic needs for food and shelter, and obtain emergency medical attention.	Don't criticize existing services or relief activities in front of people in need of these services.
Help people to claim their rights and access available support while preventing discrimination.	Don't exploit your relationship as a helper (e.g. ask the person for any money or favour for helping them).
Make it clear to people that even if they refuse help now they can still access help in the future.	Don't take away the person's strength and sense of being able to care for themselves.
Find out the types and locations of government and nongovernment services and direct people to those services that are available.	Don't criticize existing services or relief activities in front of people in need of these services.
Keep families together. Keep children with parents or other close relatives whenever possible.	Avoid putting people at further risk of harm as a result of your actions.
Treat people with respect and according to their cultural and social norms.	Don't touch the person if you're not sure it is appropriate to do so.
Be aware of and set aside your own biases and prejudices.	Don't exaggerate your skills or act as if you must solve all the person's problems for them.

Step 2: Making first contact

The goal of this core action is to initiate first contact in a non-intrusive, compassionate and helpful manner or to respond to contact initiated by affected persons. The first contact with a refugee or migrant is very important because it creates a foundation for establishing a trusting relationship and increases the likelihood that a person will accept help. Since exposure to traumatic events can make people feel cut off from the world, social contact can provide a sense of connectedness with other people.

The contact can be initiated by making a nonverbal contact first (making eye contact, smiling, sitting or standing using the L stance, having an open posture, leaning forward). Even if the conversation requires an interpreter, provider should always look and talk to the person they are addressing, not the interpreter. PFA providers should then introduce themselves with their first or full name and title, tell for which organisation they are working for, describe their role in the present setting and explain their reason for offering assistance. It is very important to ask for the person's permission to talk to them and to ask how they would like to be called. Adults should be addressed with Mr./Mrs. and last name, unless given a permission to use the first name. After introduction, PFA providers should try to find a quiet, isolated place in order to ensure privacy for the conversation and invite the person to sit. The person should be given full attention and providers should avoid interrupting, rushing the person's story, looking around or being distracted. While communicating, it is also helpful to use a soft, calm tone of voice, positive language, words like „please“ and „thank you“, open and welcoming gestures, interested facial expressions, to let the person know that he/she is listened to (e.g. by nodding head or saying „hmmm..“) and to smile. If the PFA provider is not familiar with the culture of the refugee or migrant, it is best not to approach too closely or touch the person. When engaging in contact with female refugee or migrant, it is also important to pay attention to the gender of PFA provider because in some cultures it is inappropriate for women to discuss some issues with men. In addition, when approaching a family, it may be appropriate to ask who the family “spokesperson” is, and to address that person first. In any case, PFA providers should pay attention to nonverbal cues indicating discomfort.

When initiating first contact, PFA providers need to be prepared for the possibility that some people who have experienced crisis may avoid contact and refuse help. In such situations, help should not be forced and PFA providers should avoid being intrusive or pushy and just let people know where they can be found if necessary. In addition, some people may not need help, but may value a quiet presence from another person and the knowledge that if they need some practical support or just want to talk, someone will be there.

Step 3: Ensuring safety and comfort

This core action includes several strategies to enhance a sense of immediate and ongoing safety, provide physical and emotional comfort and reduce psychological distress. This is important because psychological recovery begins with re-establishing sense of safety and satisfying basic needs, both of which provide comfort while dealing with distress. This includes:

1. Ensuring immediate physical safety. Ensuring physical safety for people who have lived through dangerous, life-threatening experiences is a priority. A sense of safety can be enhanced by making sure that the environment in which they are currently located is safe (e.g. removing sharp objects, unexpected noises), telling them that they are now in a protected and safe environment (if justified), addressing any obvious and urgent needs (e.g. providing food, clothes, blankets, protection from weather), ensuring special protection for people who are likely to be discriminated or persecuted based on their ethnicity, religion or some other characteristic and preventing any violence or conflicts with the help of appropriate authority. If there are indications that someone may hurt themselves or others, PFA providers should seek immediate assistance from a medical or security team.

2. Providing information about available services. Given that crises are often unexpected, shocking and confusing, the sense of safety and comfort can be strengthened by giving people simple and accurate information on what is going to happen next, what is being done to assist them, what are the available services and where can they be accessed. Such information should be presented only if a person appears to be able to comprehend what is being said and if the information is verified. It is also helpful to ask the person if he/she has any further questions or concerns and to answer them in a simple language while avoiding technical jargon.

3. Attending to physical comfort. Physical comfort can be reinforced by making the physical environment more pleasant (e.g. adjusting temperature, lightning, air quality, arrangement of furniture), encouraging people to actively participate in getting the things they need for comfort and helping people to soothe and comfort themselves. For many people, even the mere presence of a calm, supportive person can instil a sense of safety and protection.

4. Promoting social engagement. Besides providing a sense of connectedness with other people, social engagement can also promote a sense of security because proximity to other people is generally soothing and empowering, especially to children. In order to promote safety, PFA providers can help to connect family members or friends and encourage people who are calm and coping adequately to talk with others who are distressed or not coping well. If the person is alone, PFA providers can assist them in establishing contact to people from their own country or with similar experiences.

5. Protection from exposure to additional traumatic events and trauma reminders. Taking into account the amount of stress that refugees and migrants have already experienced, it may be important, depending on individual experiences, to protect them from any stimulus that can increase the sense of danger or remind them of a traumatic event. For example, they can be spared from scenes of other people's suffering in the immediate surroundings, exposure to distressing media news (television, radio, and internet), reporters and other media professionals inquiring about their traumatic experiences.

Step 4: Helping with stabilisation

People who experienced some kind of a crisis or drastic changes in social and living conditions may be emotionally overwhelmed. However, most expressions of strong emotions are expectable and normal reactions to distressing events and they do not require more than a supportive contact. Consequently, most people will not require stabilisation. They can be advised to get adequate rest and diet, to engage in positive distracting activities and to try to maintain a normal daily routine to the extent possible. But for individuals whose reactions interfere with their ability to function or respond to guidance, stabilisation may be needed. A detailed description of visible behavioural and emotional signs that can be used to identify such individuals can be found in Table 2 in *Triage* section.

Once they identify individuals in severe distress, PFA providers can use several simple strategies to stabilize them and help them function on their own. If the person is accompanied by family members of friends, they can be asked to help in comforting and providing emotional support. If the person is alone, he or she can be escorted to a quiet, private place. PFA providers should first give them few minutes alone while remaining close and available if the person requires help. During the intervention, it is important to try to address the person's immediate concern or difficulty, instead of just convincing them to calm down. To orient emotionally overwhelmed individuals, PFA providers should remain calm, help the person focus on specific manageable feelings and solvable problems, orient them to the surroundings, describe emotional reactions to traumatic events and explain simple strategies to cope with them (e.g. breathing deeply, stretching, going for a walk, practising muscle relaxation techniques). In such situations it should be assessed how much information is the person able to take in, and whether he/she is experiencing overly intense emotions and having difficulty to concentrate and understand what is being said. If the person appears extremely agitated, disoriented and seems to be losing touch with the surroundings, it may be helpful to refocus attention by asking the individual to listen and look at the helper, check whether the person knows where she is and what is happening, ask him/her to describe the non-distressing features of the current surroundings or to make contact with the environment or themselves (e.g. feel their feet on the floor, tap their hands on their lap).

In more severe cases of emotional distress a practical grounding technique, described in Box 3 in *Triage* section, can be used. If none of this helps to stabilize the person, the PFA provider should consult with or refer him/her to a MH professional.

Step 5: Gathering information on current needs and concerns

The goal of this core action is to identify immediate needs and concerns of the refugees and migrants and gather additional information on how to meet them. This core action is actually performed throughout all eight core actions of PFA, depending on the context of delivery.

During the conversation, it is useful to focus on concerns about immediate post-resettlement circumstances, separation from or concern about the safety of loved ones, death of a family member or close friend, personal losses in the adversity (home, school, business, neighbourhood, personal property, money), availability of adequate social support (family,

friends, community members) and extreme negative emotions (e.g. guilt, shame). If an individual shows signs of severe distress or adverse reactions that are stronger than those expected in the given situation (e.g. significant impairment in daily functioning), PFA provider should also check for any prior psychological problems or thoughts about causing harm to self and others, especially if the person has not previously gone through the process of triage. Although it is not advisable to pressure people to recount traumatic experiences and related emotions in detail, it can be useful to ask the person if he/she wants to talk about the nature and severity of the events that made him/her leave the country (especially if the person has a history of exposure to trauma). In doing so, it is really important to let the individual lead the discussion and reveal only what he/she feels comfortable with. If they don't want to discuss such experiences, PFA providers should respect that and only let them know that they can talk about it with a professional in the future. In the end, it is useful to ask a general open-ended question to make sure that no important information is missed (e.g. „*Is there anything else we have not talked about that might be important to know?*").

By asking these questions, PFA providers can gain insight into concerns and needs that require the most attention and modify other PFA core actions accordingly. In addition, this can help identify individuals who need immediate referral to a specialist, additional services or a follow-up contact. For example, persons who have thoughts about hurting self or others should be immediately escorted to a health care professional. Those who lack adequate supportive social network or have prior psychological problems can be linked with appropriate services and offered with a follow up meeting. While performing this activity, PFA providers should use their judgment about how to gather this information, how much information to gather, and to what extent to ask questions, while remaining sensitive to the needs of the person. If the survivor has multiple concerns, they should be ordered by priority.

Step 6: Providing practical assistance

Once the immediate needs and concerns have been identified, PFA providers can help refugees and migrants address them. Assisting survivors with current or anticipated problems is a central part of PFA considering that such problems can increase the level of distress and distract them from self-care.

In the prolonged crisis, people are often not aware what needs must be dealt with right away, and what can wait for a while. If the person has several needs or current concerns, they should be ordered by priority and handled one at a time. Basic needs such as providing food, water, clothes, sanitation and medical help or contacting a family member should be immediately addressed. For those needs and issues that cannot be rapidly solved (e.g. locating a missing family member or a friend, asylum claim, application for EU relocation program), PFA providers can discuss what the person has done so far, propose additional possibilities, explain the necessary procedures and help the person in taking concrete actions that address the problem (e.g. contacting family reunification services, helping them to complete the paperwork for asylum claim). In doing so, it is important to inform refugees and migrants what they can realistically expect in terms of potential resources, qualification criteria and application procedures. In addition, PFA providers should encourage people to as much as

they can for themselves in order to reduce the feeling of helplessness, unless the circumstances limit the person's ability to act on their own.

Step 7: Promoting social support

The resettlement process can undermine supportive links between family and community members. This core action focuses on helping people to establish ongoing contacts with primary support persons such as family members and significant others, and to seek out other sources of support. Social support is very important in the recovery process because it provides people with opportunities for a range of activities (sharing information, experiences and concerns, participation in joint activities), ensures practical and material assistance and gives people a feeling that they are needed and appreciated by others.

Most people will want to contact their family members, close friends and neighbours who are not currently with them, whether they remained in the country of origin, are already in the destination country or got separated during the journey. PFA providers can help people reach these individuals by phone, e-mail, through social media or services for tracing missing relatives. People who are completely alone should be encouraged to seek out other available sources of social support, such as other affected persons or relief workers. For example, elderly individuals could be connected with a younger adult or volunteer who can provide social contact and assistance with daily activities or they can be asked to assist families by spending time with their children. Similar-age children could be included in shared activities. Religious people can be connected with individuals from the same faith traditions and offered to pray together or participate in a religious service, if feasible. Some people may be unwilling to seek support because they are embarrassed, don't want to be a burden to others, think that others don’t want to listen or can’t understand them or even because they don't know what they need and where to seek help. Such individuals can be encouraged to think about the type of support that would be most helpful to them and to choose specific ways in which they would like to be involved with other people.

Step 8: Providing information on coping

Refugees and migrants have probably experienced many extremely stressful events in their country of origin or during resettlement. Consequently, they may feel overwhelmed, or distressed, and experience extreme fear and worries, outbursts of strong emotions such as anger and sadness, nightmares and other sleep problems. Many are affected by multiple losses and are grieving for people, places and life left behind. During their journey, some have been separated from family members, robbed, exposed to extremely harsh environmental conditions or have witnessed death of fellow travellers or family members. They may feel fearful or anxious, numb and detached. In addition, a lot of emotional suffering is directly related to current stresses, worries, and uncertainty about the future. Although PFA does not focus on treatment of psychological problems, it provides a good opportunity to strengthen coping behaviours of refugees and migrants. The goal of this core action is to provide information about stress reactions and coping in order to reduce distress and promote adaptive functioning.

Stress reactions caused by crisis events and resettlement process may be alarming for refugees and migrants. Some may be frightened by their own responses and others may view their reactions in negative and distressing ways (e.g. thinking that something is wrong with them, that they are weak or crazy). Some may have positive reactions such as appreciating life, family and friends, or strengthening of spiritual beliefs and social connections. It is therefore important to discuss the reactions they are experiencing, to describe common reactions to stressful events and to clarify that these reactions naturally arise from many stressors they face. This is particularly relevant for individuals who have had significant exposure to trauma or experienced loss of a close person. The detailed description of common reactions to stressful events is provided in Box 6 to orient PFA providers when providing information. When speaking about problematic reactions of refugees and migrants, PFA providers must take care to avoid pathologizing people's responses or use terms like "symptoms" or "disorder" because that might inflict unnecessary stigmatization. It is also crucial to inform them that if their reactions continue to interfere with their ability to function adequately for over a month, they should consider help from a MH professional.

In addition to providing information on stress reactions, it may be helpful to discuss ways of coping with stressful reactions and problems, distinguish between positive and negative coping actions and to encourage the positive ones. This may make people aware of the negative consequences of maladaptive coping actions, help them choose the appropriate strategy to cope and enhance a sense of self-efficacy. Positive coping actions are those that help to reduce anxiety, lessen other distressing reactions and promote adaptation to the situation. They include as talking to another person for support, getting adequate rest and nutrition, exercising, maintaining a daily routine, engaging in positive distracting activities, adapting expectations, setting and achieving goals, using relaxation methods and seeking counselling. On the other hand, negative coping actions such as using alcohol or drugs, passivity, social isolation or withdrawal, anger or aggressiveness, not taking care of themselves, risky behaviour, blaming of self or others can worsen the problem. When there is enough time to discuss coping strategies in more detail, PFA providers can demonstrate simple relaxation exercises, anger management techniques or sleep improvement guidelines if the person is interested.

Step 9: Linking with collaborative services

This core action links refugees and migrants with services needed at the time and informs them about available services that may be needed in the future. Linking individuals with collaborative services increases a sense of hope and safety. This includes immediate services that are available at the place where PFA is provided, as well as referral procedures for future specialised care. Because many refugees and migrants are reluctant to seek help on their own, this PFA component aims to increase the possibility of help seeking by offering early assistance and access to relevant services.

If the refugee or migrant during PFA contact states a need that requires additional help which goes beyond the competence of the provider or expresses needs for some additional service, the PFA provider should do all that is necessary to ensure that the person gets access to the

service (e.g. arrange a meeting with an agency representative who can provide the service, accompany the individual to the agency). For potential issues in the future, refugees and migrants can be provided with a list of resources and available services. If the individual has significant difficulties in daily functioning or prolonged and severe distress, he/she will need a referral to a specialised MH professional. Instructions on how to make a successful referral are described in more detail in the next section.

Box 6 Common reactions when terrible things happen[34,38]

There is a wide variety of positive and negative reactions that survivors can experience. These include:

	Negative responses	Positive responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviours
Physiological	Fatigue, headache, muscle tension, stomach-ache, increased heart rate, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

Common negative reactions that may continue include:

Intrusive reactions

- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again (“flashback”)

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being "on the lookout" for danger, startling easily, or being jumpy
- Irritability or outbursts of anger
- Difficulty falling or staying asleep, problems concentrating or paying attention

Trauma and Loss reminders

- Places, people, sights, sounds, smells, and feelings that remind you of trauma or loss
- Can bring on distressing mental images, thoughts, and emotional/physical reactions

Common examples include: sudden loud noises, destroyed buildings, the smell of fire, sirens of ambulances, locations where they experienced the trauma, seeing people with disabilities, funerals, anniversaries of the trauma, and television/radio news about the trauma

(Quoted directly, page 131)

7 Referral

Rationale

As the number of refugees and migrants increases, governments are struggling to improve current health care services. For example, the Centre for Disease Control and Prevention recent guideliness[39] include MH screening as a part of domestic medical examination for newly arrived refugees and migrants. However, questions emerge regarding the extent to which refugees and migrants are able to access MH services. Following the stepped model of care (Figure 5), for the majority of refugees and migrants ensuring basic needs and security will be sufficient. For a smaller number of individuals help in accessing key community (e.g. support groups, youth clubs, educational activities) and family supports (e.g. family tracing and reunification) will be sufficient to maintain MH and psychosocial well-being. Even smaller number of refugees and migrants will additionally require more focused, non-specialised support guided by PFA providers. Finally, the smallest number of refugees and migrants, who may have significant difficulties in basic daily functioning, will need access to specialised services. This assistance could include referral to specialised services, if they exist (e.g. psychological or psychiatric support) or initiation of longer-term training and supervision of primary health care providers[3] who will become competent to provide such services.

However, this "top layer" of stepped model of care might still encompass a large number of refugees and migrants. Based on previously mentioned research on high prevalence of serious MH problems in these populations, some authors caution that the assumption that majority of affected population will not develop mental illness might be wrong.[30] For example, about 30% of refugees and migrants screened with the Refugee Health Screener score above the scale cut-off, indicating that referral is needed.[69] Therefore, measures should be taken to ensure easy access to MH care for refugees and migrants in need.

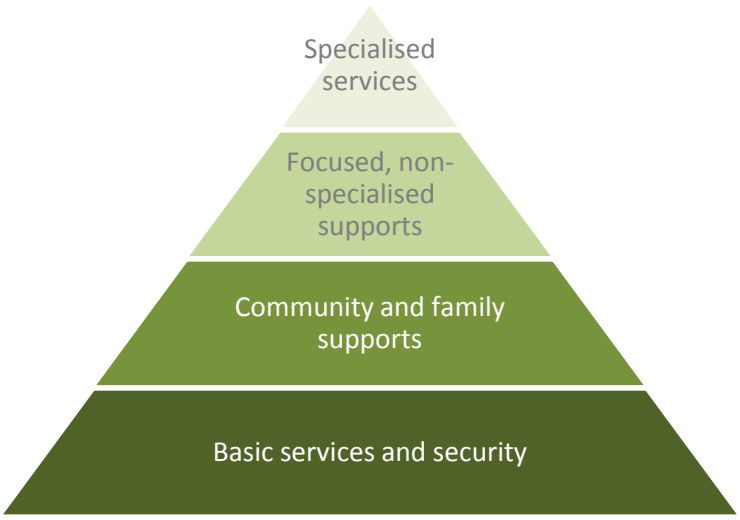


Figure 5 Stepped model of care[3]

Procedures

Even when MHPSS services are available, refugees and migrants may still be unable to access them. One important reason may be lack of financial resources to pay direct or indirect costs, such as treatment itself, transport or medication. There are also other factors that may influence access to MHPSS services, as language barriers, gender and help-seeking behaviour, lack of knowledge, and stigma around psychosocial distress and mental illness.[44,45,70] Therefore, referral should not be considered a routine issue; rather, special care should be given to remove potential barriers, having in mind that it is crucial to help the individual to access adequate care. Guided by the principles of successful referral shown in Box 7, we propose three main steps in referral:

1. Explaining the referral to the refugee or migrant.
2. Ensuring accessibility of services.
3. Continuity of care.

Step 1: Explaining the referral

The importance of referral should be explained in a non-stigmatising manner, focusing on the potential benefits for the refugee or migrant. In addition, procedure should be carefully explained: to who the care provider is referring the migrant or refugee, what information will be provided, and confidentiality should be emphasized. For example, the care provider could say:[49(p 23)]

> *"Sometimes people need help through a difficult time. I would like to connect you to a counsellor. This is a type of healthcare worker who will listen to you and provide help and support. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?"*

Step 2: Ensuring accessibility of services

In order to help refugee or migrant to access the available services, the care provider should proactively address potential barriers. The care provider who is referring the refugee or migrant should be aware of options for MH care services accessible to the individual, and preferably make the appointment herself/himself. In addition, the care provider should help the refugee or migrant tackle practical obstacles in accessing help, such as paying for the treatment, transport, child care options etc. Furthermore, the care provider should be well informed about available services in the local context. Referral paths and collaboration should be established with specialists who are able to offer evidence-based treatments (medication and therapy).

Box 7 Principles of successful referral[45]

Active care coordination

- Direct referral to MH provider (e.g. making appropriate referral on client's behalf, assisting with scheduling of the first appointment).
- Good communication between referring and receiving providers (e.g. discussing referral, case-specific education, sharing case files and assessment results, consultation and ongoing contact after initial referral).
- Good case management (e.g. help in identifying appropriate services, providing information on MH services and how to access them, coordinating discharge planning after psychiatric hospitalization).

Establishing trust and identifying mental health symptoms

- Trust developed through family or ethnic community leaders, health or non-health providers (e.g. referral made by non-MH providers, such as primary care providers, nurses, language learning programs, interpreters).
- Proactive identification of MH symptoms (e.g. accessing MH services through staff not directly involved with MHPSS delivery).
- Access to imbedded MH or referral coordinators (e.g. MH providers embedded in health or non-health settings).

Proactive resolutions of access barriers

- Psychoeducation (e.g. about the process and benefits of accessing MH services, differences between Western and cultural specific MH concepts, roles of different health providers, payment for MH services).
- Interpreters (e.g. interpreter support available for MH appointments and referral).
- Transportation (e.g. providers help arrange transportation for MH appointment like medical taxi drivers).
- Follow up (e.g. reminders about the appointment, contacting the client after the initial appointment to ask how it went, offering additional help such as rescheduling when necessary).

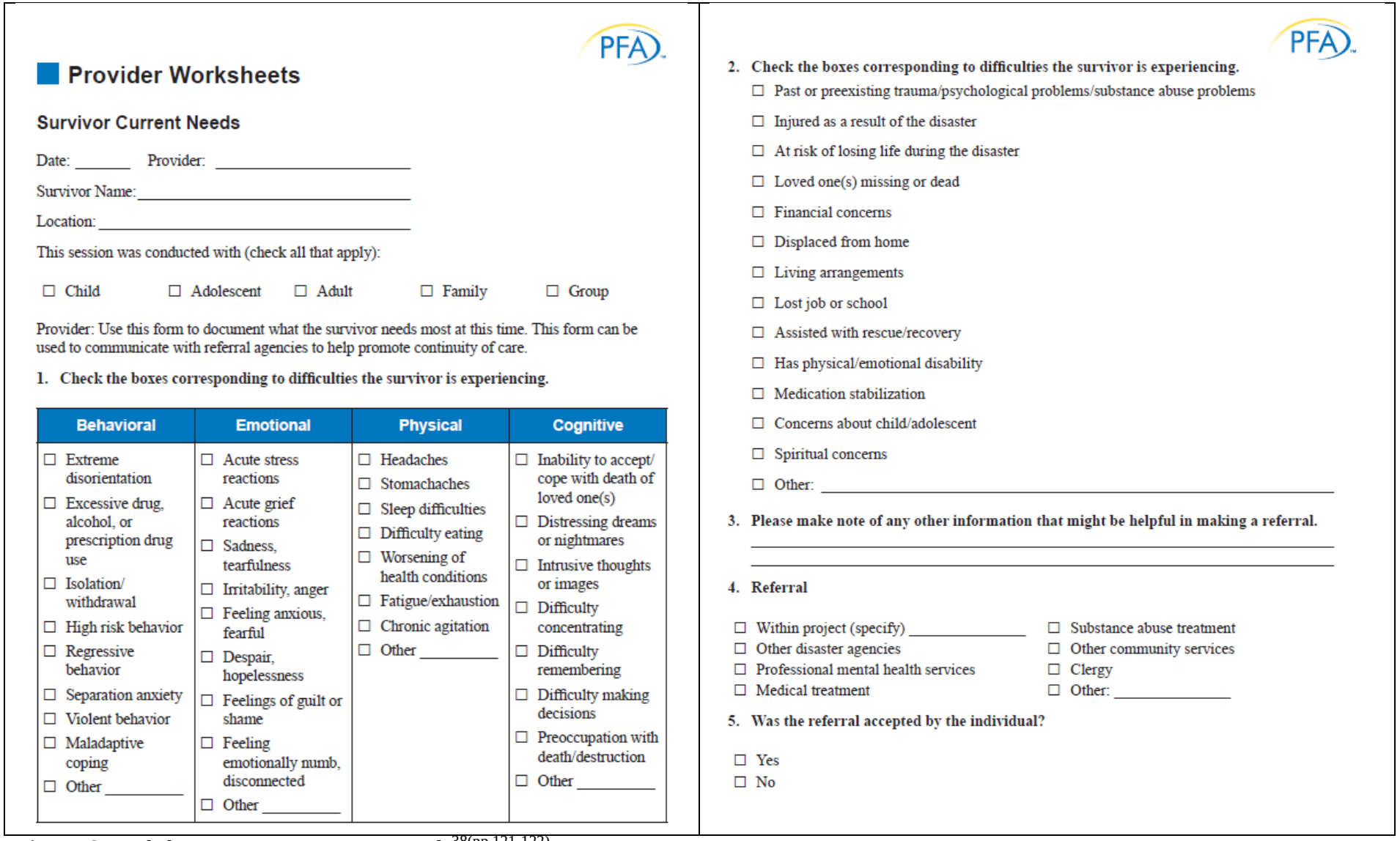
Culturally responsive care

- Knowledge of refugees' culture (e.g. adapting treatment to be culturally relevant, using appropriate language to discuss MH and wellbeing).
- Flexibility to meet in client's home (e.g. because of fear of being stigmatized).
- Multidisciplinary care (e.g. advocacy and assistance to receive additional services and resources, helping with paperwork for medical assistance).

Step 3: Continuity of care

Continuous care should be provided. In practical terms this means that it is important, to the extent possible, to minimize the need of refugees and migrants explaining their situation over and over again and telling their story to each care provider. With the permission of the refugee

or migrant, it would be best if results of assessment and other information gathered during the triage or screening, as well as information on provided support, be shared with the specialised MH care provider. For example, standardised worksheets explaining refugee or migrant needs and PFA components provided can be used (examples shown in Figure 6 and Figure 7). Informing the new provider about the individual is helpful and if possible, making introduction between the individual and helper facilitates the process.[38] It is also recommended that the referring care provider follows-up with the refugee or migrant after the first appointment with a specialised MH care provider.



Provider Worksheets

Survivor Current Needs

Date: _____ Provider: _____

Survivor Name: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
☐ Extreme disorientation	☐ Acute stress reactions	☐ Headaches	☐ Inability to accept/ cope with death of loved one(s)
☐ Excessive drug, alcohol, or prescription drug use	☐ Acute grief reactions	☐ Stomachaches	☐ Distressing dreams or nightmares
☐ Isolation/ withdrawal	☐ Sadness, tearfulness	☐ Sleep difficulties	☐ Intrusive thoughts or images
☐ High risk behavior	☐ Irritability, anger	☐ Difficulty eating	☐ Difficulty concentrating
☐ Regressive behavior	☐ Feeling anxious, fearful	☐ Worsening of health conditions	☐ Difficulty remembering
☐ Separation anxiety	☐ Despair, hopelessness	☐ Fatigue/exhaustion	☐ Difficulty making decisions
☐ Violent behavior	☐ Feelings of guilt or shame	☐ Chronic agitation	☐ Preoccupation with death/destruction
☐ Maladaptive coping	☐ Feeling emotionally numb, disconnected	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____		

2. Check the boxes corresponding to difficulties the survivor is experiencing.

☐ Past or preexisting trauma/psychological problems/substance abuse problems
☐ Injured as a result of the disaster
☐ At risk of losing life during the disaster
☐ Loved one(s) missing or dead
☐ Financial concerns
☐ Displaced from home
☐ Living arrangements
☐ Lost job or school
☐ Assisted with rescue/recovery
☐ Has physical/emotional disability
☐ Medication stabilization
☐ Concerns about child/adolescent
☐ Spiritual concerns
☐ Other: _____

3. Please make note of any other information that might be helpful in making a referral.

_____

_____

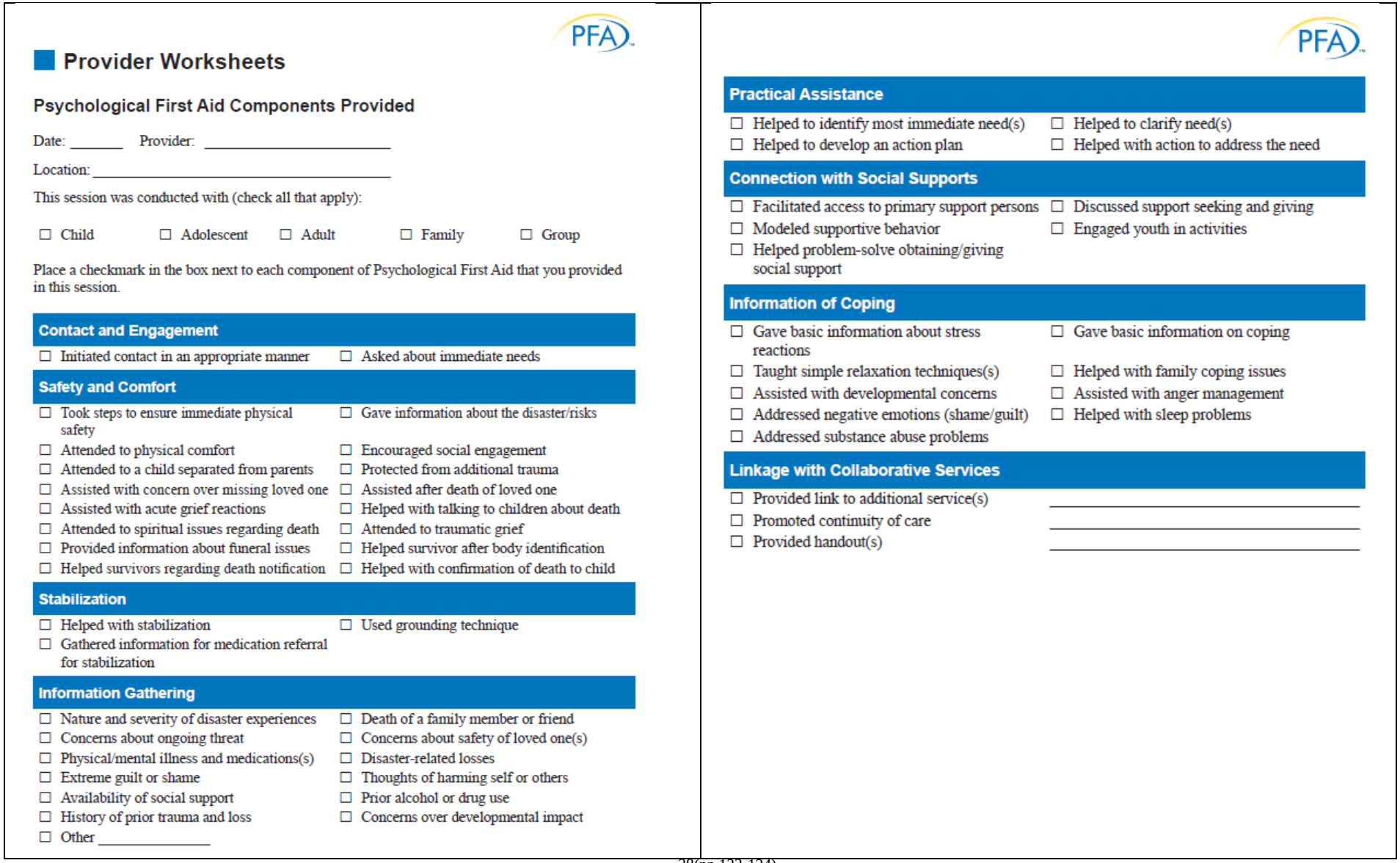
4. Referral

☐ Within project (specify) _____
☐ Other disaster agencies
☐ Professional mental health services
☐ Medical treatment
☐ Substance abuse treatment
☐ Other community services
☐ Clergy
☐ Other: _____

5. Was the referral accepted by the individual?

☐ Yes
☐ No

Figure 6 Worksheet on survivor current needs[38(pp 121-122)]



Provider Worksheets

Psychological First Aid Components Provided

Date: _____ Provider: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement

- ☐ Initiated contact in an appropriate manner
- ☐ Asked about immediate needs

Safety and Comfort

- ☐ Took steps to ensure immediate physical safety
- ☐ Gave information about the disaster/risks
- ☐ Attended to physical comfort
- ☐ Encouraged social engagement
- ☐ Attended to a child separated from parents
- ☐ Protected from additional trauma
- ☐ Assisted with concern over missing loved one
- ☐ Assisted after death of loved one
- ☐ Assisted with acute grief reactions
- ☐ Helped with talking to children about death
- ☐ Attended to spiritual issues regarding death
- ☐ Attended to traumatic grief
- ☐ Provided information about funeral issues
- ☐ Helped survivor after body identification
- ☐ Helped survivors regarding death notification
- ☐ Helped with confirmation of death to child

Stabilization

- ☐ Helped with stabilization
- ☐ Used grounding technique
- ☐ Gathered information for medication referral for stabilization

Information Gathering

- ☐ Nature and severity of disaster experiences
- ☐ Death of a family member or friend
- ☐ Concerns about ongoing threat
- ☐ Concerns about safety of loved one(s)
- ☐ Physical/mental illness and medications(s)
- ☐ Disaster-related losses
- ☐ Extreme guilt or shame
- ☐ Thoughts of harming self or others
- ☐ Availability of social support
- ☐ Prior alcohol or drug use
- ☐ History of prior trauma and loss
- ☐ Concerns over developmental impact
- ☐ Other _____

Practical Assistance

- ☐ Helped to identify most immediate need(s)
- ☐ Helped to clarify need(s)
- ☐ Helped to develop an action plan
- ☐ Helped with action to address the need

Connection with Social Supports

- ☐ Facilitated access to primary support persons
- ☐ Discussed support seeking and giving
- ☐ Modeled supportive behavior
- ☐ Engaged youth in activities
- ☐ Helped problem-solve obtaining/giving social support

Information of Coping

- ☐ Gave basic information about stress reactions
- ☐ Gave basic information on coping
- ☐ Taught simple relaxation techniques(s)
- ☐ Helped with family coping issues
- ☐ Assisted with developmental concerns
- ☐ Assisted with anger management
- ☐ Addressed negative emotions (shame/guilt)
- ☐ Helped with sleep problems
- ☐ Addressed substance abuse problems

Linkage with Collaborative Services

- ☐ Provided link to additional service(s) _____
- ☐ Promoted continuity of care _____
- ☐ Provided handout(s) _____

Figure 7 Worksheet on Psychological First Aid Components provided[38(pp 123-124)]

8 Children and adolescents

Rationale

Children and adolescents represent a vulnerable group in crisis situations due to their cognitive and socio-emotional development level. Beyond experiencing stressful events in their country of origin, they are at risk of being exposed to sickness, injury, violence, exploitation, trafficking and threats to life during their journey. Stressful events in childhood may cause severe short-term and long-term psychological issues,[71–73] so early prevention of these consequences has an important impact on children, their families and society in general.[74] Children's perceptions of traumatic events differ from adult's and depend on the child's age and characteristics of current developmental stage. In comparison with adults, children are less capable of introspecting and verbalizing their own thoughts and feelings, and can have difficulties understanding and explaining certain situations (e.g. that when someone has died, he/she will not come back), what can lead to confusion, sense of insecurity and mistakes in reasoning.[75] Furthermore, children and adolescent MH and well-being are greatly influenced by MH and well-being of their caregivers. On the one hand, the family can serve as a buffer against stress,[76] and family cohesion and adaptability and perception of high parental support predict good MH in refugee and migrant children.[77–81] On the other hand, poor parental MH has been predictive for MH problems in refugee and migrant children in a large number of studies.[82–85] In addition, studies show that parental exposure to trauma can be stronger predictor of children's MH problems then children's own exposure.[86,87] Therefore, providing information and support to parents and other caregivers is one of the most effective ways to support children.[88] However, for some children and adolescents this is not possible, since they have lost members of their family or become separated during transit.

Unaccompanied minor is a "a third-country national or a stateless person under eighteen years of age, who arrives on the territory of the (EU) Member State unaccompanied by an adult responsible for him/her whether by law or by the practice of the Member State concerned, for as long as he or she is not effectively taken into the care of such a person".[89] In most cases the decision to migrate is made by parents or family members, not by the minor himself/herself. From a legal point of view, unaccompanied children and adolescents who seek asylum must be allowed to enter EU territory while those who do not fulfil the conditions for asylum may be returned to their country of origin. Upon entrance into the EU country, unaccompanied minors are immediately referred to child protection officers, and asylum seekers are appointed with a representative.[90] EU states are also required to trace the families of minors with the assistance of international organizations, after an application for international protection is made. In addition to the risks all children and adolescents face during transit, unaccompanied minors face heightened or additional risks because they lack the protection and care of an adult. Research has shown that they often experience higher numbers of adverse events than accompanied children,[91–93] which can have serious consequences on their MH and well-being. For example, a review on MH issues among unaccompanied refugee minors suggests that they have higher levels of PTSD symptoms in comparison to general population and

accompanied refugee minors.[94] Moreover, they also report to have other difficulties, such as sleeping problems, concentration disorders, nightmares, withdrawal, anxiety, somatic symptoms, severe grief reactions and sadness, aggression, diminished interest, hyper-arousal, low self-esteem, severe guilt feelings, fatalistic view of the future, substance abuse, violent behaviour, suicidal acts, psychosis and delinquent behaviour.[92,95–97] Therefore, unaccompanied minors are particularly vulnerable group of children and adolescents and need special attention of care providers.

Procedures

General MH procedures for children and adolescents follow previously described procedures in this report, and consist of triage, screening, PFA and referral. However, these procedures need to be adapted to children's or adolescent's level of understanding and developmental stage, as well as to family context. In general, if children's or adolescent's family is present, we propose helping primary caregiver to support the child or adolescent. If not, the procedures will most likely be utilised by an appointed child protection officer or other representatives. In the text below we briefly outline some specific issues when working with children and adolescents.

Triage

When working with refugees and migrants, care providers should pay special attention to children and adolescents who have serious distress reactions. In Table 5 common reactions to traumatic events by developmental stages are presented. It is important to stress that, if accompanied, further procedures need to include primary caregivers, and is often recommended to strengthen the family system which will in turn serve to protect the children.[66]

Table 5 Common children's reactions to traumatic events by developmental stages[98]

Growth stages (years)	Reactions to traumatic events
Infancy (0-4)	• Clinging more to their parents • Worrying that something bad will happen • Regression to younger behaviour • Changes in sleeping and eating patterns • Increases in crying and irritability • No interest in playing or playing in an aggressive way • Fear of things that did not frighten them before • Hyperactivity and poor concentration • They can be very sensitive to how others react
Early childhood (4-6)	• Clinging behaviour or over independence • Anxiety, fear of things and situations • Regression to younger behaviour • Sleeping and eating problems • Irritability • No interest in playing or playing repetitive games • Inactivity • Confusion or impaired concentration • Sometimes taking an adult role (tries to comfort the parents/siblings) • Stop talking • Physical symptoms like stomach aches
Middle childhood (6-12)	• Swinging level of activity • Confused with what happened • Withdrawal from social contact • Talking about the event in a repetitive manner • Fear • Negative impact on memory, concentration and attention • Sleep and appetite disturbances • Aggression, irritability or restlessness • Somatic complaints with no apparent cause • Concerns about other affected people • Self-blame and guilt
Adolescence (12-18)	• Feeling self-conscious, exposed and different from others • Guilt or shame • Sudden changes in interpersonal relationships • Major shift in views of the world and attitude • Attempt to make major life changes to become an adult. • Increase in risk-taking behaviour • Self-destructive behaviour (e.g. substance abuse) • Avoidant behaviour • Aggression • Intense grief • Feeling hopeless • Concerns about other affected persons • Becoming self-absorbed and feeling self-pity • Defiance of authorities/parents • Relying heavily on peer groups in socialising

Screening

Conducting MH screening is especially challenging with children. While most screening instruments developed for adults can be used with adolescents (for example, previously described RHS-13 screening tool), they are not usually appropriate for younger children. Because of undeveloped or limited verbal communication and less developed introspective and self-assessment skills, during infancy and early childhood parents or caregivers usually report child's symptoms; a procedure not applicable for unaccompanied children. In addition, cultural and language barriers might be more pronounced while working with children. Therefore, formal screening of children's MH needs might not be necessary. Rather, support should be given to all children and adolescents by enhancing parenting abilities and providing information on supporting children after traumatic events.

However, when working with unaccompanied minors, care providers can use different visual stimuli to assess children's distress. For example, a simple visual scale can help children recognise their emotions[99(p 63)] (Figure 8). Since emotions have visual character, this can be more appropriate for children's concrete way of thinking. The intensity of certain emotions or pain may be displayed by colored pencils, for example in different intensity of red color for anger. Care providers can also ask children to draw how they feel, psychologically (i.e. emotions) or physiologically.

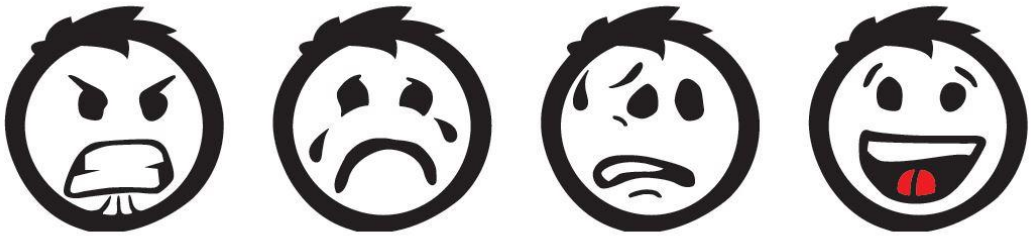
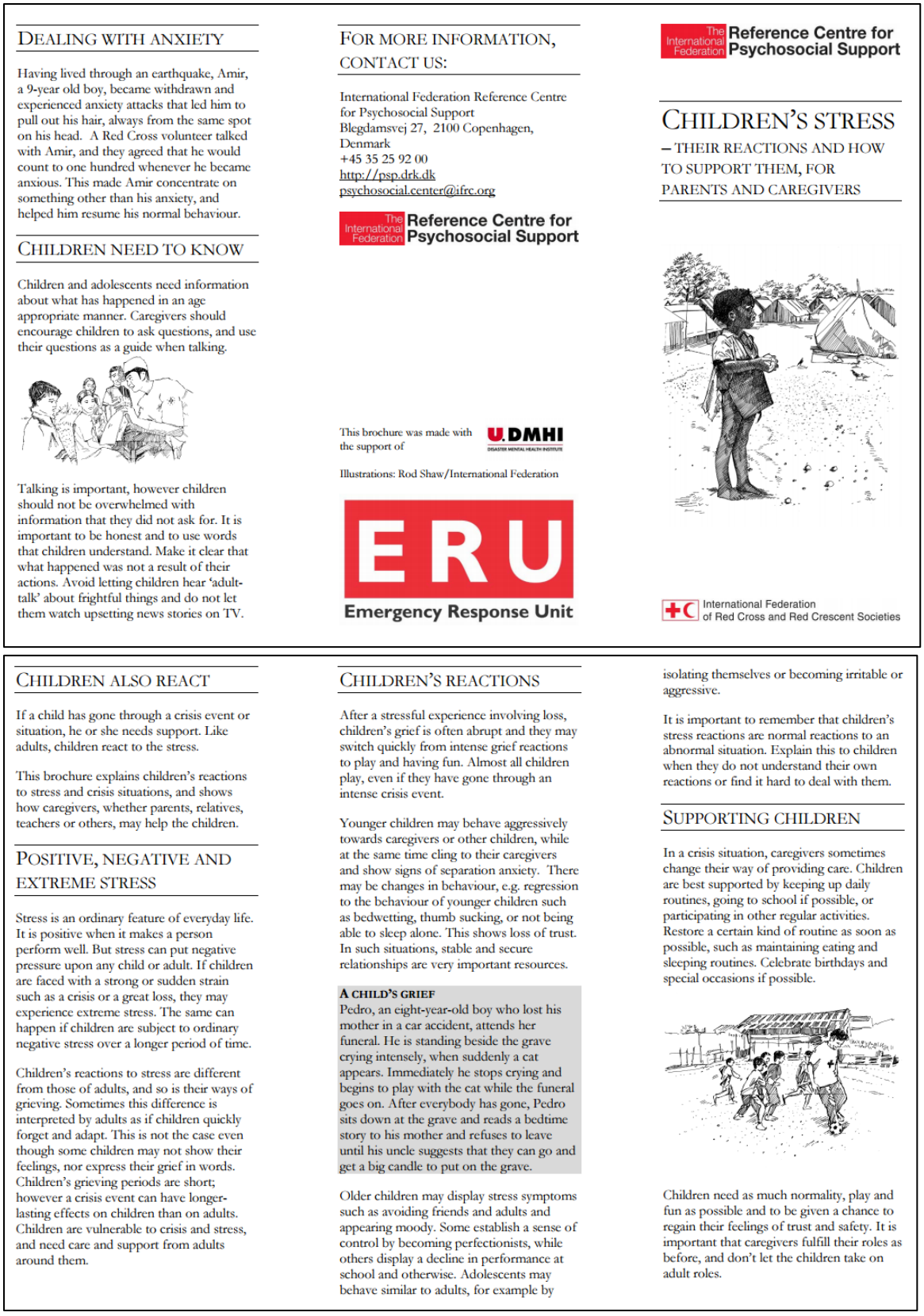


Figure 8 Visual scale for recognising emotions (from left to right: anger, sadness, worry, happiness)

Psychological first aid

Psychological first aid for children follows the same procedure as PFA for adults, while specific core activities need to be age appropriate. Hence, the language used by PFA providers needs to be modified to be understandable to children; activities can be developed for group-level use, and the emphasis in all activities has to be placed on specific developmental concerns and needs of children in different age groups. PFA for children is intended to be delivered primarily through parents and other caregivers, whenever possible, due to their previously mentioned importance in child welfare. Supporting caregivers with already outlined PFA core actions, helps to establish the adult protective shield which is the best possible way to reduce the children's level of distress in crisis situations.[100] In addition, PFA providers can further educate parents on children's reactions to stressful events and ways in which they can help their children stabilize and cope with such events. An example of a

leaflet that can be used for psychoeducation of parents and other caregivers can be seen in Figure 9.



DEALING WITH ANXIETY

Having lived through an earthquake, Amir, a 9-year old boy, became withdrawn and experienced anxiety attacks that led him to pull out his hair, always from the same spot on his head. A Red Cross volunteer talked with Amir, and they agreed that he would count to one hundred whenever he became anxious. This made Amir concentrate on something other than his anxiety, and helped him resume his normal behaviour.

CHILDREN NEED TO KNOW

Children and adolescents need information about what has happened in an age appropriate manner. Caregivers should encourage children to ask questions, and use their questions as a guide when talking.

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The International Federation Reference Centre for Psychosocial Support

This brochure was made with the support of U.DMHI DISASTER MENTAL HEALTH INSTITUTE

Illustrations: Rod Shaw/International Federation

ERU
Emergency Response Unit

The International Federation Reference Centre for Psychosocial Support

CHILDREN'S STRESS

– THEIR REACTIONS AND HOW TO SUPPORT THEM, FOR PARENTS AND CAREGIVERS

International Federation of Red Cross and Red Crescent Societies

CHILDREN ALSO REACT

If a child has gone through a crisis event or situation, he or she needs support. Like adults, children react to the stress.

This brochure explains children's reactions to stress and crisis situations, and shows how caregivers, whether parents, relatives, teachers or others, may help the children.

POSITIVE, NEGATIVE AND EXTREME STRESS

Stress is an ordinary feature of everyday life. It is positive when it makes a person perform well. But stress can put negative pressure upon any child or adult. If children are faced with a strong or sudden strain such as a crisis or a great loss, they may experience extreme stress. The same can happen if children are subject to ordinary negative stress over a longer period of time.

Children's reactions to stress are different from those of adults, and so is their ways of grieving. Sometimes this difference is interpreted by adults as if children quickly forget and adapt. This is not the case even though some children may not show their feelings, nor express their grief in words. Children's grieving periods are short; however a crisis event can have longer-lasting effects on children than on adults. Children are vulnerable to crisis and stress, and need care and support from adults around them.

CHILDREN'S REACTIONS

After a stressful experience involving loss, children's grief is often abrupt and they may switch quickly from intense grief reactions to play and having fun. Almost all children play, even if they have gone through an intense crisis event.

Younger children may behave aggressively towards caregivers or other children, while at the same time cling to their caregivers and show signs of separation anxiety. There may be changes in behaviour, e.g. regression to the behaviour of younger children such as bedwetting, thumb sucking, or not being able to sleep alone. This shows loss of trust. In such situations, stable and secure relationships are very important resources.

A CHILD'S GRIEF
Pedro, an eight-year-old boy who lost his mother in a car accident, attends her funeral. He is standing beside the grave crying intensely, when suddenly a cat appears. Immediately he stops crying and begins to play with the cat while the funeral goes on. After everybody has gone, Pedro sits down at the grave and reads a bedtime story to his mother and refuses to leave until his uncle suggests that they can go and get a big candle to put on the grave.

Older children may display stress symptoms such as avoiding friends and adults and appearing moody. Some establish a sense of control by becoming perfectionists, while others display a decline in performance at school and otherwise. Adolescents may behave similar to adults, for example by isolating themselves or becoming irritable or aggressive.

It is important to remember that children's stress reactions are normal reactions to an abnormal situation. Explain this to children when they do not understand their own reactions or find it hard to deal with them.

SUPPORTING CHILDREN

In a crisis situation, caregivers sometimes change their way of providing care. Children are best supported by keeping up daily routines, going to school if possible, or participating in other regular activities. Restore a certain kind of routine as soon as possible, such as maintaining eating and sleeping routines. Celebrate birthdays and special occasions if possible.

Children need as much normality, play and fun as possible and to be given a chance to regain their feelings of trust and safety. It is important that caregivers fulfill their roles as before, and don't let the children take on adult roles.

Figure 9 Psychoeducation leaflet on supporting children (*retrieved form: http://mhpss.net/?get=83%2F1305723318-2._Brochure_on_support_to.pdf*)

When children or adolescents are unaccompanied, or primary caregivers are temporarily unable to adequately take care of them (because of physical injuries or severe distress), PFA can be provided directly to children and adolescents. The key principle of PFA with unaccompanied minors is to reunite them with their caregivers whenever possible. If this is not possible, PFA providers should ensure that the child is never left unattended and should link him/her with appropriate child protection network or agency. In Table 6 we outline several specific activities within each of the eight PFA core actions that can be used with such children until they're linked with family members or appropriate services.

Table 6 PFA activities for children

Contact and Engagement	When making contact with children or adolescents, the PFA provider should get on the child's eye level (sit down, squat), smile, speak slowly, calmly and use developmentally appropriate language (concrete and in short sentences)., ask simple open ended questions while focusing on child's most immediate needs. Example: Hi, I'm ____ and I work with ____. I'm here to try to help you. May I ask your name? Nice to meet you ____. Is there anything you need right now?
Safety and Comfort	It is important to remove the child from any disturbing or stressful situations, (including very upset or suffering adults and exposure to distressing media information) and to create a child friendly-space with available calming, and reassuring activities (colouring books, art projects, building blocks). The child should be connected with adults who are calm and cope well with the situation. Physical comfort can be provided with toys or other age appropriate objects. For children whose family members or close friends have died, PFA providers can help them deal with acute grief reactions by comforting them acknowledging their emotions, engaging them in distracting and relaxing activities, establishing their daily routine and assisting with practical matters.
Stabilization (if needed)	Children who are very distressed, agitated and confused can be stabilized with the same relaxation and grounding techniques as adults with modifications to ensure age-appropriateness. For example, breathing exercises can be explained by blowing bubbles with a bubble wand, using chewing gum or blowing paper balls across the table. Child's attention can be refocused by asking them to name the colours in their surroundings, or imitate sound they hear.
Information Gathering	When working with children, it is important to gather information on name, age, country of origin, family and relatives (where they saw their parents last time, where they might be now, are there any other relatives) as well as their emotional and physical condition. This must done in a careful and thoughtful way because children have a limited understanding of the situation compared to adults and can misinterpretation events.
Practical Assistance	As with adults, PFA providers can help children identify and clarify their most immediate needs and do whatever they can to help them.
Social Support	PFA providers should first help children contact their primary caregivers or other close others who could take care of them. Social support can also be fostered by bringing unaccompanied children together, encouraging group events and facilitating fun activities (playing games, drawing, song singing, telling stories, and organising sport activities). Older children and adolescents can be asked to take care for and lead younger children in various activities.
Information on Coping	When talking about physical and emotional reactions to stress with children, PFA providers can describe different feelings and physical sensations and ask children to pick the ones they are experiencing or even draw an outline of the person to help them explain how they're feeling by themselves. To help children understand positive and negative forms of coping, PFA providers can write them on a paper, have the child pick the ones that he/she is currently using and discuss the ways the child can increase their adaptive coping strategies.
Linkage with Collaborative Services	Unaccompanied children should be linked with child protection officer and family reunification services immediately upon arrival. If deemed necessary, they should be further referred to a paediatrician or MH professional.

9 Additional topics

Training and expertise

Providing MHPSS to people in need requires specific knowledge. However, not all types of interventions require the same level of expertise; as the needs of the affected people increase, so does the need for training the care givers[54] (Figure 10). In the text below we briefly discuss training needs and expertise level for the proposed model of MHPSS care.

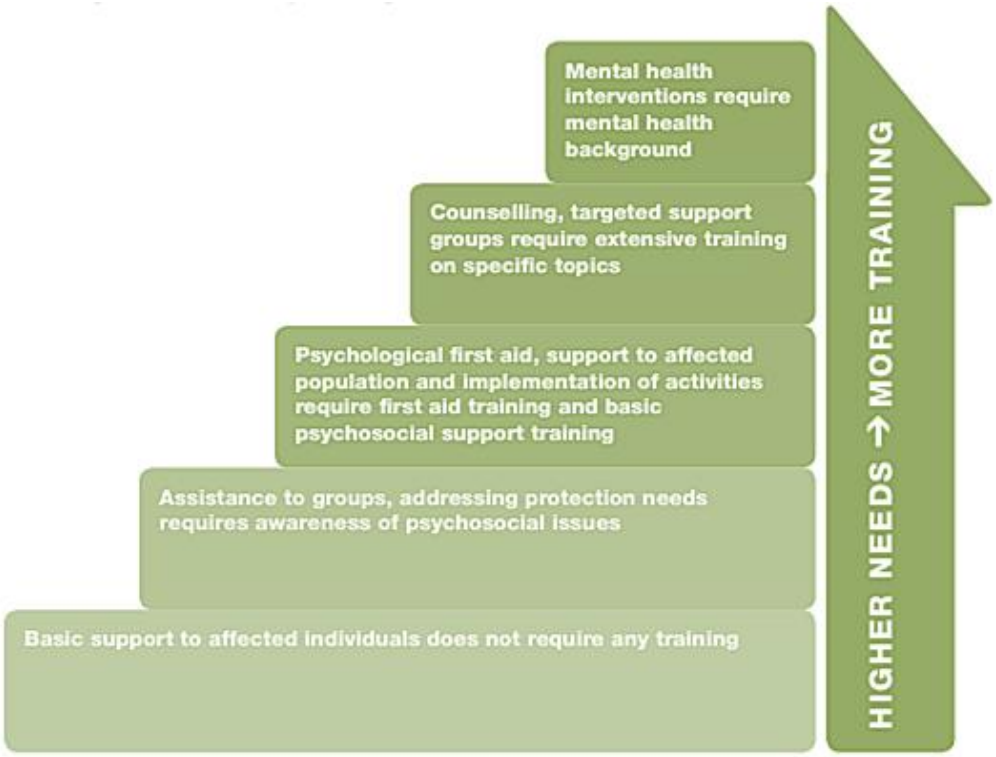

Figure 10 Needs for training for different levels of support[54]

MHPSS should be conducted in a multi-disciplinary setting, and integrated in all types of services offered (e.g. overall health system, shelters, water and sanitation, food and non-food item distribution, cultural immersion, language acquisition, social welfare). Therefore, every provider group working with refugees and migrants should have basic training in MHPSS, which should include the role of MHPSS in overall refugee services, and recognising behavioural signs of distress (Table 2).

Additional training should be provided for those care providers who will conduct triage. These care providers can be MH professionals (such as psychologists, psychotherapists, psychiatrists, psychiatric nurses), but also trained lay persons (emergency services or other psychosocial professions, as well as volunteers). Training should include: establishing confidential and trustful contact, assessing distress, resources and danger to safety (Table 3),

psychological first aid and supportive communication, and cultural framework for working with different groups of refugees.

Since MH screening should most likely be conducted within primary health care units, it is recommended that specific care providers be appointed. These care providers can have different professional backgrounds (medical doctors, nurses, psychologists, social workers etc.), however, specific training should be organised to provide competencies for brief MH assessment and PFA. In addition to training for triage, these care providers should be trained in administering the screening instrument, making referrals and providing first psychological aid within the specific setting. Considering different professional backgrounds, training for professional care providers should take one day, while for other personnel and volunteers two day training programmes should be organized.

Finally, an important training topic for all providers working with migrants and refugees is self-care and burnout prevention. Training should include recognising signs of stress and burnout and self-help techniques. This training can be provided within one or two days, depending on assessment of needs of a specific target group.

Working with interpreters

Since care providers speaking the language of particular refugee or migrant group are scarce, interpreters are essential in provision of MHPSS. Working with interpreters should not only address language barriers, but also understanding the cultural, social and contextual variables of refugee and migrant difficulties and life circumstances that can provide vital information to the care provider and mitigate issues of discrimination or lack of acknowledgement of different cultural constructions and world views. Furthermore, it has been suggested that the use of qualified interpreters in early MH interventions is not only good clinical practice but may be cost effective as the costs of inadequate diagnosis and referral might be higher than hiring qualified interpreters.[101] Therefore, special care should be devoted to ensuring good communication between the care provider, interpreter and refugee or migrant. Some issues should be taken in consideration when having a mediated communication in any form of providing MH care:[41]

Knowing the language of the refugee or migrant. Although this sounds self-evident, many refugees and migrants come from areas that have multiple ethnicities and languages. For example, although Arabic is the official language in Syria several dialects are used, depending on the region. In addition, Kurdish is widely spoken in the Kurdish regions, and Armenian and Syrian Turkmen among Armenian and Turkmen minorities. Therefore, it is important to know the native language, and try to match the interpreter, ideally from the same country and, when necessary, the same dialect that the refugee or migrant speaks.[101]

Using a professional interpreter. It is best to use a professional, qualified interpreter. Using family, friends or community members as interpreters in not recommended, since it can hinder feelings of safety and confidentiality and lower the quality of communication.

Matching interpreter and refugee or migrant gender. Whenever possible, it is good that refugees and migrants can choose the gender of interpreter, but also of the care provider. Both men and women may avoid disclosing their adverse experiences to male care providers because of shame or fear of being judged.[26] This is of special importance when history of sexual assault is probable or if there are culturally specific gender norms of behaviour. This seems to be less critical for men who may be used to women being in a "helper" role than for women who may be forbidden from discussing certain issues in front of a male care provider.[41]

Matching interpreter and refugee or migrant age. An older refugee or migrant may not feel comfortable discussing confidential or personal matters with a much younger interpreter, especially in cultures where age equals authority and respect.

If there are more than one meeting with the refugee or migrant, **having the same interpreter** will make the process easier, facilitate communication and is likely to lead to better outcomes.[101]

Working with interpreters can be divided into three sections: before, during and after meeting.[41] Every part contains some specific topics that should be addressed so that the needs of refugees and migrants can be met.

Before the meeting. A few minutes before the meeting, care provider should meet alone with the interpreter to get an insight in usual customs (e.g. regarding touching people, using appropriate eye contact, or special topics to consider in terms of culturally appropriate approach to specific groups (e.g. elderly, children, women). The interpreter should also be aware if a distressing topic is expected to be discussed (i.e. traumatic experiences) so that he/she could be emotionally prepared. One of the most important topics to discuss before meeting the refugee or migrant is that the interpreter might be confused if the refugee or migrant appears or sounds unusual or the answers may not "make sense". In this case, the interpreter should interpret word for word and not "adjust" the message to make sense. It is essential in a MH assessment for care providers to know if the refugee or migrant is swearing, speaking emotionally, not answering directly etc. Discordant speech may help to diagnose a condition or indicate a reaction to a medication. Below is a sample script that care providers can use for briefing with the interpreter:[41(p 87)]

> *"Hi, my name is XY and I am a PO. I will explain the screening procedure to___, and then gather information about what is bothering him/her. If at any time I am misunderstanding what is happening in the conversation, or I am doing something wrong culturally, I encourage you to let me know. Because I want the refugee/migrant to understand everything in the room, it is important you let the person know that you are stopping to explain something to me. If I don't understand something, I will also stop and ask further questions. All of this will be interpreted for the individual so they do not think we are having a private conversation about him. Do you have any questions?"*

During the meeting. When using interpreter service, the conversation takes more time because everything has to be translated twice. The care provider should begin the meeting by

introducing everyone in the room, discussing confidentiality, and explaining that everything said in the room will be interpreted. By doing this, they set-up the meeting for the greatest success and pro-actively address the most common concern of refugee or migrant, which is privacy within the community. For example, care giver can say:[41(p 88)]

> *"Hi, my name is XY and I am a PO here. Mr. ZZ is a professional interpreter from Agency X. Both Mr. ZZ and I are bound by strict laws of confidentiality, meaning that if we talk about things without your permission, or tell people what was said in this room without your permission, we could get in a lot of trouble. Today Mr. ZZ will interpret what you say and what I say. He is going to interpret everything said in the room so both you and I can have a good understanding of everything that is happening. Please ask any questions you may have at any time."*

When communicating through an interpreter, care provider should look at and talk to the refugee or migrant, not at the interpreter. Providers and interpreters should be positioned side-by-side so that the refugee/migrant only has to look in one direction. Care provider should not say to the interpreter, *"Tell Mr. ____"* or "*Ask Mrs. ____".* Instead, he/she should talk to the refugee or migrant directly which helps develop both rapport and connection with the individual.[41]

To avoid misunderstanding, care provider should pay attention to a few things. It is recommended for care provider to speak in short sentences and pause frequently to give the interpreter time to process the concept and to interpret. He/she should avoid stopping in mid-sentence because the interpreter may not grasp the entire thought. Use of idiomatic speech and acronyms should be avoided. During the conversation the care provider should from time to time stop and ask the interpreter if he/she is speaking clearly enough, or speaking too fast. It should be kept in mind that not every word or concept has a direct equivalent in another language. Therefore, what the interpreter says may not match the length of time the provider spoke.

After the meeting. After the conversation, the care provider should make a brief follow up with the interpreter, asking for a feedback to improve his/her work with interpreters and asking whether there are specific cultural issues that might be relevant for the specific case. If a sensitive topic occurred during the conversation, care provider should ask the interpreter how he/she is doing and offer help if necessary. Many interpreters have shared experiences with refugees and migrants and some topics may trigger memories or difficult emotions. Provider should never ask the interpreter for opinion (e.g. asking the interpreter if the refugee or migrant is telling the truth, or what he/she thinks the real problem is). This is out of the job description of an interpreter and puts him/her in a difficult position, and is also disrespectful to the refugee or migrant. If the interpreter independently begins to give his/her opinion, it needs to be explained how important it is that only care provider analyses the content at face value, and that the only needed information is that one coming directly from the refugee or migrant. For example, the care provider can say:[41(p 89)]

> *"Thank you for your help today. Is there anything that I could have done better to make the interpretation go more smoothly? (Wait for answer) Is there anything I should know about the refugee's/migrant's culture that would help me serve the individual better? (Wait for answer) I know the refugee/migrant talked about _____. I know that was difficult to hear. Are you doing OK? (wait for answer and offer resources if necessary)."*

Including refugees and migrants in MH care

Refugees and migrants should be active participants in provision of MHPSS. To be able to make informed decisions on MH care, refugees and migrants should be given detailed information on MH difficulties and MHPSS in European context. They should be informed how to recognise early signs of MH problems and encouraged to seek help. Hence, it is important to raise awareness of common issues and symptoms experienced among refugees and migrants and provide information on available services. Handouts or flyers containing information about trauma, what to expect and where to get help among arriving groups should be offered at the entry points routinely.[32] Optimally, this educational information should be translated into the refugees' native languages and adjusted to the cultural framework and literacy level. For illiterate individuals, oral information should be provided. Distributed leaflets should be brief and contain essential information about common symptoms and reactions to stressful events, how to cope with them and details where to seek help. The location where to get assistance should be particularly pointed out (e.g. circle on a map of the ground plan of the location). An example of such leaflet is shown in Figure 11.

COPING WITH LOSS AND DEPRESSION

Bhuta lives close to the sea in Khao Lak, Phuket, Thailand. She lost everything, including her hope for the future, in the 2004 tsunami. Now she lives in a two-room barrack with no privacy. Her husband has a new job, but she does not.

She was depressed and felt that her life had no meaning. She had nothing to do, no dreams for the future and no-one to speak to. Then she decided to volunteer for the Red Cross, to interact with others, get sense of normality in her life and bring back a sense of purpose.

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This brochure was made with the support of U.DMHI

Illustrations: Rod Shaw/International Federation

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COPING

WITH STRESS AND CRISIS

International Federation of Red Cross and Red Crescent Societies

EXTREME STRESS

Everyone who has lived through a crisis situation will most probably experience extreme stress. Such stress usually causes unpleasant reactions.

This brochure highlights common reactions to extreme stress and gives suggestions on how to cope with them.

FEATURES OF STRESS

Stress is a state of pressure or strain that affects body and mind. It can be caused by any positive or negative change. Stress is an ordinary feature of everyday life and is positive when it makes a person perform optimally e.g. at an exam.

When faced with a strong or sudden emotional and physical strain, such as a crisis situation, most will experience extreme stress. Ordinary negative stress may accumulate over a period of time and become a negative spiral. Extreme stress can seriously affect a persons' health, working ability and private life.

REACTIONS TO STRESS

It is normal to react when experiencing an abnormal situation. This is important to remember when experiencing stress reactions.

Reactions to extreme stress vary. Typical physical reactions include sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.

Typical emotional and behavioural reactions are anxiety, watchfulness and poor concentration, and negative feelings such as guilt, sadness and anger.

Other common reactions include to become disoriented, have intrusive memories and try to avoid being reminded of the crisis situation. Some also react by not feeling anything at all, by having difficulties in making decisions or by isolating themselves from others. Some people increase their intake of alcohol, medicine or drugs to escape the pain they are feeling.

COPING WITH STRESS

Extreme stress reactions will most likely affect your health and daily life, both at work and privately. Coping with and recovering from the effects of a crisis situation can take a long time. Coping is the process of managing difficult circumstances and finding ways of minimizing or tolerating the effects of stress.

It is important to find ways of coping with the stress reactions. It may help to:

Remember that stress reactions are normal reactions to an abnormal situation

Allow yourself to feel sad and grieve

Maintain daily routines and do things that normally give you pleasure

Eat healthy foods, get sleep and exercise if possible

Socialize with other people instead of withdrawing

Seek support and assistance

Accept assistance that is offered

– Exercise if possible.

WHEN TO SEEK PROFESSIONAL HELP

The stress reactions described in this pamphlet may last several weeks. If the reactions persist and make it impossible to function normally over a long period of time, seek help. One option is to contact the local health facility or the Red Cross Red Crescent emergency response unit.

Figure 11 Psychoeducation leaflet on coping *(retrieved from http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf)*

10 Conclusions and implications for the EUR-HUMAN project

The aim of this report as a part of WP5 of EUR-HUMAN project was to develop protocol for rapid assessment of MH and psychosocial needs of refugees and other migrants, including tools, guidelines and procedures and interventions for provision of PFA. The protocol was developed using a hierarchical approach and is based on expert guidelines addressing overall approach to MHPSS, practical handbooks, manuals and reports, and a systematic search for validated tools. The proposed procedure consists of triage (identification of MH conditions requiring immediate specialist attention), screening (identification of individuals who are under increased risk for developing serious MH issues), immediate assistance based on the PFA principles and referral for full MH assessment and care as needed. These procedures are in line with the overall goal of the EUR-HUMAN project: to provide comprehensive person-centred and integrated care for refugees and other migrants.

In the overall structure of the EUR-HUMAN project (Figure 12), WP5 has several important links to other work packages. Therefore, the work conducted in other work packages has implications for WP5, and this report feeds into other work packages. In the text below we highlight these implications and summarise the next steps.

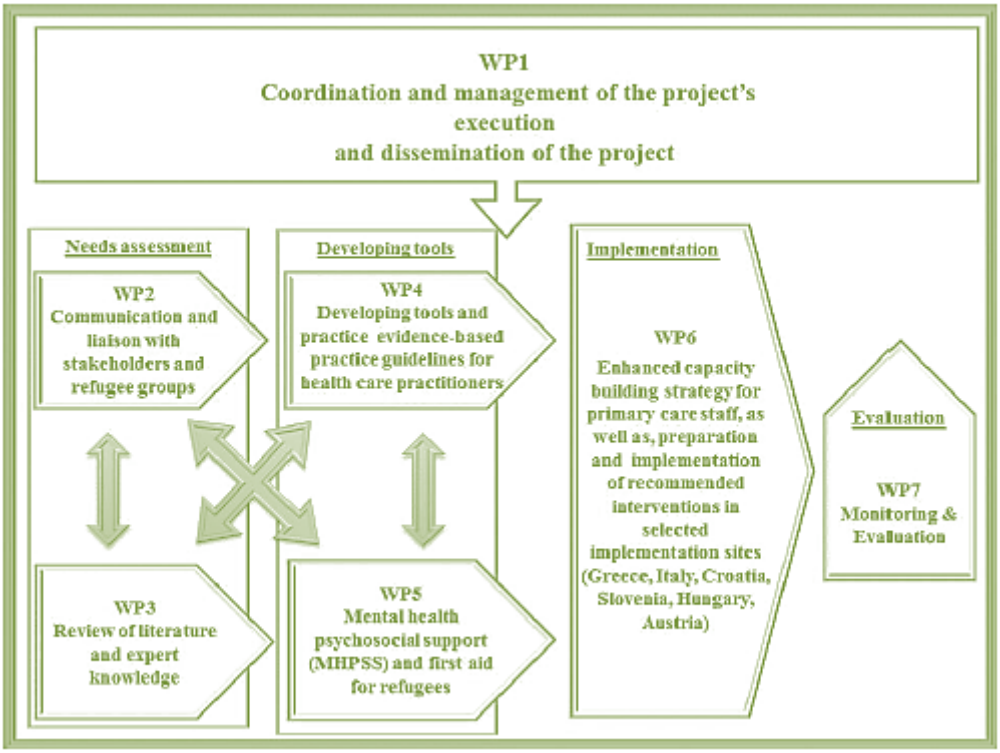

Figure 12 Overall structure of EUR-HUMAN project

WP2 assessed health needs and social problems, as well as experiences, expectations and barriers regarding accessing primary health care and social services of refugees and newly arriving migrants from hotspots via transit centres to longer-stay reception centres. In the

conducted fieldwork, refugees and migrants recognised unmet mental health care needs. Therefore, the procedures described in the present report can help meet these needs. The implications of WP2 fieldwork for procedures developed in WP5 are:

- Interventions for identifying and treating mental health problems should differentiate between hot spots (detention centres), transit centres and longer stay centres;
- MHPSS should start at the first point of entry to Europe and continue during transit and in the long-term stay locations;
- Lay personnel and volunteers should be able to conduct interventions (triage, PFA), especially at the hotspots and transit centres, due to time barriers and restricted resources;
- Since confidentiality issues and language are one of the main barriers in providing MH care, guidance should be provided to the care-givers.

WP3 conducted a systematic review of effective interventions to address health needs of and risks for refugees and other migrants in European countries, focusing on practical implications and implementation challenges. The main findings of WP3 have implications for adapting the protocol for provision of MHPSS to national and regional situations. Based on preliminary findings on the implementation of screening, assessment, and treatment of psychosocial problems, there are several core enablers and barriers for provision of MH care:

- At the professional level, core enabler is training of professionals in cultural sensitive aspects of MH care provision;
- At the refugee and other migrant beneficiary level, core enabler is including the refugees and migrants in organisation of MH care, for example, by making general health promotion programs available;
- At the organisation level, continuity of care should be promoted: MH services should be embedded in national health care organisations, and data on screening, assessment and treatment results should be collected systematically.

The aim of **WP4** is to define the optimal content of healthcare and other services needed to prevent infectious and chronic diseases as well as mental health damage, and to provide good care for those conditions in line with professional standards. These guidelines and tools will be developed and approved by international expert panel, which will be organised in June 2016. From WP5 the following questions arise that are relevant for the protocol for MH rapid assessment and psychosocial care (WP5):

- How can triage, screening and immediate assistance based on the PFA principles be implemented in various settings, from hot spots (detention centres), transit centres and long-stay locations? What resources, in terms of time and personnel are available in these settings in different EU countries?
- How can MH care be implemented in overall health care at the long-stay locations? Who are the care providers who will most likely provide MH care in a local primary health care unit (e.g. medical doctors, nurses, psychologists, social workers, trained volunteers)? Are there relevant national regulations which define what types of professionals can conduct MH screening and care?

- How can the continuity of care be supported, both in the same country and between countries? Are there already some systems for information exchange in place and how do they comply with data security standards and ethical confidentiality issues?

WP6 aims to enhance the capacity building of the primary care workers by assessing the existing situation and developing curriculum and training material for different health needs of refugees and migrants. WP5 will contribute to WP6 by developing the material for identifying mental health needs and providing MHPSS. The training should be adapted for different contexts and specific locations, but should include:

- At hot spots (detention centres) and during transit: triage and elementary PFA for individuals who are recognized as being at exceptionally high level of distress and potentially at risk to harm oneself or others. The hot spots (detention centres) at this time are in Greece and Italy, however triage should be available at all contact points on the transit route and at the locations of more permanent locations;
- At temporary or first hosting locations in EU countries where the contact with PHC is first established: screening for psychosocial and MH conditions, risks and resources, as well as PFA aimed at providing practical assistance;
- At more permanent locations where the refuges are settled: screening for psychosocial and MH conditions, risks and resources and more comprehensive PFA approach, as well as providing referral to specialised services for full MH assessment and care as needed for those refugees and migrants who have screened positive for MH conditions;
- Cross-site issues that were identified as relevant by current findings in WP2, WP3 and WP5: culturally sensitive care, providing continuous care and the issues of professional stress prevention, self- and mutual care of providers and burnout prevention for the care providers.

The next steps in **WP5** include adapting the developed protocol to respective national and regional context in collaboration with local stakeholders (Task 5.3) and developing model of integrated Chain of Psychosocial Refugee Care from Early Hosting and First Care Centres to Psychosocial Advice and Support Points for Refugees (PASR) in communities of refugee and migrant destinations (Task 5.4).

Appendix I Mental health screening tools

The purpose of this systematic search was to identify tool(s) that are simple, short and culturally appropriate for MH screening of refugees and migrants in the context of current refugee crisis. Therefore, we aimed to identify screening instruments which were constructed and (or) validated specifically on refugee and migrant populations. In short, our aims were to:

- Identify existing instruments for MH screening and their target population;
- Assess the measurement properties of these measures;
- Discuss feasibility and applicability of identified tools.

The search strategy, identified scales and their use are described in more detail below.

Assessment of screening tools

To identify existing tools for MH screening of refugees and migrants, PsycINFO database was searched using the following search strategy:

Step 1. (Migrant OR DE "Immigration" OR DE "Refugees") OR KW (migrant* OR immigrant*OR refugee*) OR AB (migrant* OR immigrant*OR refugee*)

Step 2. (DE "Psychological Screening Inventory" OR DE "Screening" OR DE "Screening Tests" OR DE "Test Construction" OR DE "Test Validity" OR DE "Questionnaires") OR KW (screen* OR instrument OR test* OR identification OR questionnaire)

Step 3. (E "Acute Stress Disorder" OR DE "Post-Traumatic Stress" OR DE "Posttraumatic Stress Disorder" OR DE "Anxiety" OR DE "Major Depression" OR DE "Mental Disorders" DE "Emotional Adjustment" OR DE "Mental Health" OR DE "Distress") OR KW (mental health OR mental illness OR anxiety OR distress OR PTSD or post-traumatic stress OR posttraumatic stress OR depression)

Step 4. S1 AND S2 AND S3

In addition, Internet search was conducted for key words “refugee screening” and “distress in refugees” using Google and Google Scholar engines, and two previous systematic reviews were assessed.[5,102] For all tools identified, the search was then further expanded; tool names were used to search for additional studies that utilised and validated the respective tools on refugee and migrant populations. Authors were contacted for further information on the studies that were not available for download (via E-mail contact or Research Gate requests).

Overall, 21 tools were identified. The description of all the tools can be found in Table 7. The table contains basic information about the tool (name, author, mode of completion, purpose of the measure, number of dimensions and items), description of measurement characteristics (target population, validation sample and measurement properties: reliability, sensitivity and specificity), example of items and the source of data for further research. In some instances,

further development of measures led to reduced or redefined versions of the same scale (for example HSCL-25, HSCL-37). In these instances, results/characteristics are presented separately for each version of the scale.

Some of the 21 identified tools were developed specifically for refugee populations while the others were already existing instruments adapted for use on refugee populations. The scales in general were used on a wide range of refugee populations (Asian, Iraqi, Burmese, Bhutanese, Sudanese, Vietnamese, Bosnian, Albanian, Croatian, Albanian, Somali, Hmong, Namibian, Rwandan), even though most of them individually were administrated on two to three groups of refugees. The number of items on all identified scales ranged from 4 to 49. The mode of completion for most of the measures was self-report with the exception of 4 measures that require administration by MH care professionals. The majority of instruments do not have a predetermined cut-off score which could be used to identify individuals who are likely to develop more serious MH problems. From all of the tools found in our search, below we outline the ones that meet the current needs the most. The first section contains scales that are developed specifically for refugee populations while the second section gives an overview of the scales that are not originally constructed for refugees but were later adapted for this purpose. Other measures, that are not listed below were too long (too many items), have insufficient validation data on refugee samples or need to be administered by clinicians in the form of (in-depth) clinical interviews.

Tools developed for refugee and migrant populations

Harvard Trauma Questionnaire

The Harvard Trauma Questionnaire (HTQ) is a four-part self-report questionnaire.[103] The first and fourth part of the questionnaire are most widely used PTSD measures in refugee and migrant populations.[104] *Part 1* consists of 17 war-related traumatic experiences determined to have affected Southeast Asian refugees. The scale was constructed using expert consensus and clinical experience, and was designed to allow respondents to check as many of 4 responses for each experience that apply to them ("did not happen," "experienced," "witnessed," or "heard about).[105] Part 4 contains a list of 30 trauma symptoms, 16 generated from the DSM-III-R/DSM-IV criteria for PTSD, and 14 which are, culture-specific symptoms related to refugee trauma.[106] Possible responses are "not at all," "a little," "quite a bit," or "extremely."[107] The criterion validity study showed sensitivity of 0.78 and specificity of 0.65 for a cut-off point of 2.5.[103] On a sample of 68 Sudanese refugees the internal consistency reached a high value of α=.87.[108] This questionnaire was frequently used in refugee research focusing on experiences with trauma (e.g. Cambodian refugees in US, Sri Lankan internally displaced refugees, and Burmese refugees in Australia) but it does not address anxiety, depression or other mental issues common in refugees.

The Vietnamese Depression Scale (VDS)

Vietnamese Depression Scale was developed using a well described consensus approach from extensive clinical experience.[109] The measure consists of 15 items and each item is assessed on a scale from 0 ("sometimes") to 3 ("often"). Culturally appropriate terms were added to the

existing Western symptoms of depression so the scale measures three types of symptoms: physical symptoms associated with depression in Western countries, Western psychological symptoms of depression, and symptoms unrelated to Western concepts of depression.[102] The cut off score of 13 out of a possible 34 points is recommended, but no data about sensitivity and specificity are available. Internal consistency in a sample of 180 Vietnamese refugees living in USA for approximately 9 years is α=.88 (subscales range .80-.92).[70] The advantage of this scale is that it includes culturally sensitive symptoms of depression but they are primarily adapted for Vietnamese refugees and may not be appropriate for other refugee populations.

The Posttraumatic Symptom Scale (PTSS-10-70)

The Posttraumatic Symptom Scale (PTSS-10-70) is a modified version of the self-report instrument PTSS-10.[110] The scale was used to assess the level of posttraumatic stress disorder (PTSD) symptoms among refugees from Bosnia (N=206) compared to a group of Swedish patients in health care centres (N=387). The PTSS-10 showed high internal reliability (Cronbach's alpha = .92).[110] This short measure of PTSD symptoms has good psychometric characteristics but it would be appropriate in the current context only if used in combination with measures of other mental disorders.

The Refugee Health Screener-15

The Refugee Health Screener-15 (RHS-15) was designed to be a short, neutral language measure of common mental disorders in refugees (15 questions) that does not directly address issues of violence, torture, or trauma.[69] The screener has three sections. The first part consists of 13 questions of symptoms with five possible answers (0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely) with addition of a visual scale to facilitate understanding (variably full jars of sand). The second part consists of one item assessing coping on a scale from 0 to 4 (Generally over your life, do you feel that you are: „Able to handle (cope with) anything that comes your way - 0 to "Unable to cope with anything"- 4). The last section is a graphic distress thermometer (0 - no distress - things are good, to 10 - extreme distress - I feel as bad as I ever have). The RHS-15 was empirically developed to be a valid, efficient and effective screener for common mental disorders in refugees. Symptoms that are included in the validated version of RHS-15 were derived from twenty-seven New Mexico Refugee Symptom Checklist-121 items (NMRSCL-121), the Hopkins Symptom Checklist-25, and the Posttraumatic Stress Symptom Scale Self-Report because they were found to be most predictive of anxiety, depression, and PTSD across the target samples of Iraqi, Nepali, Bhutanese, and Burmese refugees.[69] The internal consistency of the scale on a sample of 190 refugees from Bhutan, Burma and Iraq is excellent α=.95. The recommended cut-off score for the first 14 items is ≥ 12, which yields sensitivity of 0.94, 0.95, 0.81 and specificity of 0.86, 0.89, 0.87 for anxiety, depression and PTSD respectively. The recommended cut-off score for the distress thermometer is ≥5. It has already been translated into eleven languages, including Arabic, and Farsi.[69] The RHS-15 has been integrated into standard physical health screenings for newly arrived refugees at Public Health Seattle & King County and in a number of other places across the U.S.[48] The RHS-15 is open access tool and may be obtained through Lutheran Community Services Northwest (LCSNW).

In further research, the same authors tested a shorter version of the same instrument; RHS-13. This version is without the coping item and the distress thermometer. Authors report that the coping item is the most time consuming and difficult for many refugees to understand. It has been tested on 179 refugees from Bhutan, Burma and Iraq. This short form showed excellent internal consistency (α=.96) with sensitivity ranging from 0,82-0,96 and specificity ranging 0,86-0,91 with a cut-off point of ≥11.[29] The 13-item scale may be more efficient in daily use and effective for case identification.

Tools adapted for refugee and migrant populations

The Hopkins Symptom Checklist-25

The Hopkins Symptom Checklist-25 (HSCL-25), is a widely used and validated screening tool for measuring symptoms of depression and anxiety, originally designed to measure changes in 15 anxiety and 10 depression symptoms in psychotherapy.[111] The participants rate every item on a 4-point severity scale (from 1='not at all' to 4='extremely'). An average-item score >1.75 indicates "clinically significant distress," and is used as a diagnostic proxy in general U.S. studies and in several refugee studies as well (Sri Lankan internally displaced refugees, Burmese refugees in Australia, Bhutanese and Iraqi refugees in the US, Cambodian refugee women, Tibetan refugees).[112] Although this measure is widely even on refugee samples, it has no information about sensitivity and specificity and it should be administrated only by health care professionals.

The Impact of Event Scale

The Impact of Event Scale (IES) has been used in a handful of refugee studies.[102] The 22-item scale (IES-R) has been validated on a small sample of treatment seeking patients with refugee background, while the 15-item measure has been validated on a large refugee sample of Croatian and Bosnian Children (N=1,787). The scale assesses seven intrusion and eight avoidance items on 3-point descriptive scales measuring intrusive thoughts, body sensations and avoidance behaviours after trauma. It has been proven valid and reliable, and its development is well described.[113] The internal consistency for the two subscales are satisfactory (α=.82 and .74 for the two subscales).[102] However, this is another unidimensional measure more suitable for use in combination with other indicators of mental distress in this setting.

Summary

Most refugee and migrant studies have been conducted after the resettlement and included refugee samples that were already in a primary health care system. The specific circumstances (e.g. available time) and characteristics of those samples are probably different from the refugees and migrants that are currently arriving to Europe. There is evidence that the predominantly used instruments on refugee and migrant samples are Harvard Trauma Questionnaire (with questions about trauma), Hopkins Symptom Check list (symptoms of anxiety and depression), Vietnamese Depression Scale (depression symptoms only) and IES

(symptoms of PTSD). Most of these instruments contain a substantial number of items, measure one or two constructs and directly ask about trauma-related experiences.

It is important to keep in mind that MH screening of refugees and migrants (a highly vulnerable population by definition) is conducted in a very specific situation and many requirements need to be met to avoid harm and potential problems. Professionals who deal with such sensitive issues are aware of this but empirical evidence to guide conducting the screening in such settings are still lacking.

Through this systematic search several caveats and gaps were identified:

- Most of the assessments tools available are not comprehensive, but rather assess specific experiences and/or symptoms and disorders. There are not many instruments that measure several common MH problems of refugees and migrants;
- Majority of data available is derived from research conducted after the resettlement;
- A large number of prevalence studies have been conducted on clinical populations, refugees and migrants who were already enrolled in a MH or general health programme, which introduces a selection bias;
- Finally, it should be noted that for some refugees and migrants post-migration living difficulties might be equal or even stronger factor of emotional distress than migration related difficulties. Poverty and unemployment, for example, are factors that may be a source of distress either immediately or months after arrival in the new country.

Recommendations

The goal was to find a simple, short and culturally appropriate screening measure to assess emotional distress in refugees and migrants during their resettlement. Ideally, the scale would assess PTSD, anxiety and depression as the most common MH issues in the refugee and migrant populations, it would be validated on refugee and migrant samples and would be brief in administration. Furthermore, it should not evoke trauma experiences because there is not enough time during the screening to deal with it appropriately. According to information available in the literature we conclude that the RHS-13 measure meets most of these criteria. Therefore, RHS-13 instrument can be recommended as the primary screening tool for refugees and migrants upon arrival in destination country. This instrument was specifically designed for and validated on newly arrived refugee samples with items derived from existing and valid instruments used on similar populations. It is available in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); it can be administered in relatively short of time and is easily understandable for people of different educational levels. Furthermore, it measures several relevant MH constructs related to emotional distress typical for refugee and migrant populations. RHS-13 can be used as a quick assessment of the probable risk of having or developing PTSD, anxiety or depression (cut off score ≥ 11). It is important to emphasize that a positive screen on the RHS-13 does not automatically indicate that the person in question should be provided with clinical MH treatment but simply points out the need for full MH assessment and follow-up.

Table 7 Tools for MH screening in the refugee and migrant populations

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
The Refugee Health-Screener-15 (RHS-15)	Hollifield et al. (2010)	PTSD, anxiety and depression	Self-report	13 symptom items, 1 coping item + distress thermometer Total : 15 items Time of administration: 4-12 min.	Developed in a community public health setting for detection of emotional distress in refugee groups	Bhutan, Burma, Iraq (N=190) Refugee women (Iraqi, Burmese, Somali) (N=26)	α=.95 Sens: 0.81-0.95[69] Spec: 0.86-0.89[69] Cut-off: ≥ 12 on 14 items or distress thermometer score ≥5	Feeling helpless (from 0 – not at all to 4 – extremely)	[48,69,48,114]
The Refugee Health-Screener-13 (RHS-13)	Hollifield et al. (2010)	PTSD, anxiety and depression	Self-report	13 symptom items		Bhutan, Burma, Iraq (N=179)	α=.96 Sens: 0.82-0.96 Spec: 0.86-0.91 Cut-off ≥11	Feeling helpless (from 0 – not at all to 4 – extremely)	[29]
Harvard Trauma Questionnaire (HTQ)	Mollica et al. (1992)	War related trauma and PTSD	Self-report	Part I: 17 items on traumatic life events Part IV:16 items generated from the DSM-III-R criteria for PTSD and 14 symptoms related to refugee trauma Total: 47 items	Adult refugees and Bosnian and Croatian war veterans	Sudanese refugees (N=68) Sri Lankan refugees (N=1448)[115] Cambodian refugees in U.S. (N=490)[116]	α=.87[108] Cut-off = 2.5 Sens: 0.78 Spec: 0.65	Part I: Lack of food or water (experienced, witnessed, heard about, did not happen) Part IV: Feeling on guard (from 1 - not at all, to 4 - extremely)	[102, 104,107, 108, 105,111, 115, 116, 117, 118, 119]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Vietnamese Depression Scale (VDS)	Kinzie et al. (1982/87)	Depression	Self-report	Depressed affect (8) Somatic symptoms associated with depression (7) Culture specific symptoms (3) Total: 18 items	Developed for use with Vietnamese refugees in the US	Vietnamese refugees living in USA approx. 9 years (N=180)	α=.88 subscales =.80-.92[70] Cut-off >13	Feel that the future is hopeless (from 0 – sometimes to 3 - often)	[102, 70]
Hopkins Symptom Checklist (HSCL-25)	Derogatis et. al (1974)	Depression, anxiety	Health care professionals	Anxiety symptoms (10) Depression symptoms (15) Total: 25 items Separate scores for anxiety, depression and total	Originally for use in primary care and non-clinical settings. Validated on US general population and Indochinese refugees.	Sri Lankan internally displaced refugees (N=1448)[115] Old and new patients with a refugee background (N=61)	Cut-off >1.75 for each of 2 components[112]	Suddenly scared for no reason (Not at all to Extremely)	[102, 112, 111 115, 117, 119, 120, 118, 121, 122, 123]
Hopkins Symptom Checklist (HSCL-37)	Derogatis et. al (1974)	Depression, anxiety, internalizing and externalizing trauma related reactions	Health care professionals	10 anxiety 15 depression 12 externalizing behaviour (trauma-related) Total: 37 items	General population in a family practice or a family planning service	Sudanese refugees (N= 68) Adolescent refugees from 48 countries in Netherlands and Belgium (N= 3890)	Subscales: [108] anxiety = .83 depression = .89 somatisation = .82 α=.90 (.84-.95)[124]	Bullies, steals things (1-not/never to 4-always)	[108, 124]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Impact of event scale (IES)	Horowitz et al. (1979)	PTS symptoms	Self-report	2 scales: 7 intrusion 9 avoidance measuring intrusive thoughts and body sensations after trauma Total: 15 items	Study of bereaved individuals and exploring psychological impact of trauma	Croatian and Bosnian children (N=1787)	α=.82 and .74[102] If the score on either subscale is >19, medium for scores of 8.5 to 19, and low-level for scores of 1 to 8.5.[125]	I thought about it when I didn't mean to (from 0 – not at all to 4 – often)	102,125
IES-R (Norwegian version)	Eid et al. (2009)	PTS symptoms	Self-report	3 scales: 8 items Intrusion scale 8 Avoidance scale 6 hyperarousal items Total: 22 items		Old and new patients with a refugee background (N=61)	α =.99[126] Cut-off ≥33[126]	I found myself acting and feeling like I was back at that time (from 0 - not at all to 4- extremely)	112, 126
Health Opinion Survey (HOS)	MacMillan (1957)	General mental health	Self-report	16 items	Adults in rural communities	SE Asian refugees Vietnamese refugees	Have not been tested for validity in refugees	Do you have loss of appetite? (often to never)	102,127

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Posttraumatic Symptom scale (PTSS-10-70)	Holen, Sund, and Weisaeth (1983)	PTS symptoms	Self-report	10 items	Clinical follow-up of psychotherapy treatment for refugees	Bosnian refugees (N=206) Swedish adults (N=387)	Among refugees α=.92 In compared group α=.90	Indicate the extent to which you had experienced each of the following: sleeping problems, nightmares about the trauma (from 1 – no problems to 7 – very severe problems)	[102,110]
Beck Depression Inventory (BDI)	Beck et al. (1961)	Depression	Self-report	21 symptoms of depression Time of administration: 5-10 min.	Derived from clinical observations on attitudes and symptoms displayed by depressed psychiatric patients	Vietnamese refugees Somali refugees living in Helsinki, older adults (N=128) Albanian refugees in UK (N=842) Hmong refugees N=97[128]	α=.89[129] <9/10 = no depression 10-18 = mild to moderate depression 19-29 = moderate to severe depression 30-36 = severe depression[15] among refugees α=.93 Sens: 0.94 Spec: 0.78[104]	Sadness (0 – I don't feel sad to 3 – I am so sad or unhappy that I can't stand it)	[15, 102,129]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Norbeck Social Support Questionnaire (NSSQ)	Norbeck et al. (1984)	Dimensions of support	Self-report	3 dimensions of support: Social network size Emotional support Esteem support	Measurement of social support in general population	Namibian refugees (N=88)[130]	α=.83[102] No further reliability testing among refugees	How much does this person make you feel liked or loved?	[102,131]
Primary Care Posttraumatic disorder (PC-PTSD)	Prins et al. (2003)	PTSD	Self-report	4 items	PTSD-screen in Veterans using VA health care		Cut-off=2/3[129] Sens: 0.78 Spec: 0.87 Unknown cultural validity	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? (yes/no)	[5, 129]
Short screening scale for DSM-IV posttraumatic stress disorder	Breslau et al.(1999)	PTSD	Interview	7 symptom screening scale for PTSD Time of administration 5 min.	Representative US sample in Detroit (N=2,181)	Participants from general medical and women's health clinics at a VA Healthcare System (N=134)	Cut-off= 4/5[18] Cut-off: 4-most sensitive option) Sens: 0.85 Spec: 0.84 Unknown cultural validity	Did you begin to feel more isolated or distant from other people? (yes/no)	[5, 132]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Self-Report Questionnaire (SRQ-5)	WHO (1994)	common mental disorders primarily in primary health care settings in developing countries	Self-report	Total: 5 items	Created for Congolese women (short version of SRQ-SIB)[14]	Displaced women living in refugee camps in Rwanda (N=810)	Not yet implemented. further research needed[14]	Do you sleep badly? Do you often have headaches? Do you find it difficult to enjoy daily activities? Are you able to play a useful part in life? Is your daily life suffering? (yes/no)	14, 38,133
Mini International Neuropsychiatric Interview (MINI)	Sheehan (1990)	PTSD, depression	Clinical instrument	Time of administration 15-30 min.	Psychiatric evaluation and outcome tracking in clinical psychopharmacology trials and epidemiological studies	Adapted for different immigration groups Old and new patients with a refugee background (N=61)		Since X, do you feel tired or without energy? (yes/no)	112, 134

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
The Posttraumatic Symptom Scale (PSS-SR)	Foa et al. (1993)	PTSD	Self-report	3 subscales: re-experiencing, avoidance, and arousal, as well as a total score Total: 17 items	PTSD symptom severity and caseness in trauma affected population	Kurdish (N=48) and Vietnamese (N=32) refugees in the U.S.	α =0.95 cut-off: 13	Have you had upsetting thoughts or images about the trauma that came into your head when you didn't want them? (0-not at all or only one time to 3 -5 or more times a week / almost always)	[135]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
Post-traumatic Stress Diagnostic Scale (PDS)	Foa, (1997)	PTSD	Self-report	49 items (10–15 min)	Patients identified as victims of a traumatic event or to assess symptoms when already PTSD	Arab Muslim immigrant women (N=453)	α= 0.93. Diagnosis only when DSM IV criteria A to F are met cut offs for symptom severity rating : 0 no rating, 1–10 mild, 11–20 moderate, 21–35 moderate to severe and .36 severe.	Having upsetting thoughts or images about the traumatic event that came into your head when you did not want them to. (0-not at all or only one time to 3 -5 or more times a week / almost always)	[136, 137]
General Health Questionnaire (GHQ- 28)	Goldberg and Hillier (1979)	General mental health	Self-report	4 subscales: Somatic symptoms (7) Anxiety and insomnia (6) Social dysfunction (6) Severe depression (6) Time: 5 minutes	Individuals likely to have or to be at risk of developing psychiatric disorders	Albanian refugees in UK (N=842) Albanian refugees, refugees in Kosovo (N=1358)	General cut-off point: >7 traumatised people: > 12-13 No cut-off scores published for refugee populations[138]	Have you recently found at times you couldn't do anything because your nerves were too bad ? (Not at all, to Much more than usual)	[117, 138, 139]

Name	Author (year)	Purpose of the measure	Mode of completion	Number dimensions (items) Time	Context of initial development and use	Refugee sample (N)	Reliability Sensitivity Specificity (cut-off)	Item (example)	Sources
General Health Questionnaire (GHQ-12)	Goldberg et al. (1997)	General mental health	Self-report	2 factors: 'psychological distress' and 'social dysfunction' Total: 12 items	Short version of GHQ-28	Somalian refugees living in Helsinki, older adults (N=128)	α=.95 Cut-off point of 3/4, with scores above 3 suggesting high probability	Lost much sleep (less than usual, to much more than usual)	[15, 138, 140]
25-item psychiatric symptom checklist	Dawn Noggle (1999)	Depression, anxiety and PTSD (DSM-IV based)	Self-report	25 (all the symptoms required for a diagnosis of depression, most items required for a diagnosis of PTSD, and two symptoms of panic attacks)	Refugees aged >18 years (not designed for children)	Refugees from 24 countries in the Denver health screening (N=1,058; 128 screened positive)	Reliability and validity have not been established No cut-off point because of cultural factors influencing symptom endorsement	Intrusive memories of the bad things that happened in your country or refugee camp (yes/no)	[141]

References

1. Norredam M, Mygind A, Krasnik A. Access to health care for asylum seekers in the European Union - a comparative study of country policies. *The European Journal of Public Health*. 2006;16(3):285-289. doi:10.1093/eurpub/cki191.
2. National Collaborating Centre for Mental Health, Royal College of Psychiatrists' Research Unit. *Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care.* London: Gaskell and the British Psychological Society; 2005. http://guidance.nice.org.uk/CG26/Guidance/pdf/English. Accessed March 30, 2016.
3. Inter-Agency Standing Committee. *IASC Guidelines on mental health and psychosocial support in emergency settings.* Geneva; 2007.
4. Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J., Bevan, P. *Guidance for responding to the psychosocial and mental health needs of people who are affected by disasters or major incidents*. https://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf.pdf.
5. Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*. 2011;183(12):824-925. doi:10.1503/cmaj.090313.
6. Hobfoll SE, Watson P, Bell CC, et al. Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry*. 2007;70(4):283-315.
7. United Nations High Commissioner for Refugees. *UNHCR Statistical Yearbook 2014.* 14th ed. Geneva, Switzerland; 2014. http://www.unhcr.org/statistics. Accessed March 17, 2016.
8. United Nations High Commissioner for Refugees. *Mid-Year Trends 2015*. Geneva, Switzerland; 2015. http://www.unhcr.org/statistics. Accessed March 17, 2016.
9. Laban CJ, Gernaat H, Komproe IH, Van Tweel, I., De Jong, J.T.V.M. Post migration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of nervous and mental disease*. 2005;193(12):825-832. doi:10.1097/01.nmd.0000188977.44657.1d.
10. Kirmayer LJ, Narasiah L, Munoz M, et al. Common mental health problems in immigrants and refugees: general approach in primary care. *Canadian Medical Association Journal*. 2011;183(12):E959. doi:10.1503/cmaj.090292.
11. Gerritsen, A. A. M., Bramsen I., Devillé W, van Willigen, L. H. M., Hovens JE, van der Ploeg, H. M. Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social psychiatry and psychiatric epidemiology*. 2006;41(1):18-26. doi:10.1007/s00127-005-0003-5.
12. Mann CM, Fazil Q. Mental illness in asylum seekers and refugees. *Primary Care Mental Health*. 2006;4:57-66.
13. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*. 2005;365(9467):1309-1314. doi:10.1016/s0140-6736(05)61027-6.

14. Bell SA, Lori J, Redman R, Seng J. Development of a brief screening tool for women's mental health assessment in refugee settings: A psychometric evaluation. *International journal of nursing studies*. 2015;52(7):1202-1208. doi:10.1016/j.ijnurstu.2015.04.003.
15. Mölsä M, Punamäki R, Saarni SI, Tiilikainen M, Kuittinen S, Honkasalo M. Mental and somatic health and pre- and post-migration factors among older Somali refugees in Finland. *Transcultural psychiatry*. 2014;51(4):499-525. doi:10.1177/1363461514526630.
16. Smith H. Shocking images of drowned Syrian boy show tragic plight of refugees. *The Guardian.* Updated September 2, 2015. http://www.theguardian.com/world/2015/sep/02/shocking-image-of-drowned-syrian-boy-shows-tragic-plight-of-refugees. Accessed March 17, 2016.
17. Leen-Feldner EW, Feldner MT, Bunaciu L, Blumenthal H. Associations between parental posttraumatic stress disorder and both offspring internalizing problems and parental aggression within the National Comorbidity Survey-Replication. *Journal of Anxiety Disorders*. 2011;25(2):169-175. doi:10.1016/j.janxdis.2010.08.017.
18. van Ee E, Kleber RJ, Mooren TT. War trauma lingers on: Associations between maternal posttraumatic stress disorder, parent-child interaction, and child development. *Infant Ment. Health J.* 2012;33(5):459-468. doi:10.1002/imhj.21324.
19. Lauterbach D, Bak C, Reiland S, Mason S, Lute MR, Earls L. Quality of parental relationships among persons with a lifetime history of posttraumatic stress disorder. *J. Traum. Stress*. 2007;20(2):161-172. doi:10.1002/jts.20194.
20. Schauer M, Schauer E. Trauma-focused public mental-health interventions: A paradigm shift in humanitarian assistance and aid work. In: Martz E, ed. *Trauma Rehabilitation After War and Conflict*. New York, NY: Springer New York; 2010:389-428.
21. Teicher MH, Samson JA, Polcari A, McGreenery CE. Sticks, stones, and hurtful words: Relative effects of various forms of childhood maltreatment. *Am J Psychiatry*. 2006;163(6):993. doi:10.1176/appi.ajp.163.6.993.
22. Mueller-Bamouh V, Ruf-Leuschner M, Dohrmann K, Schauer M, Elbert T. Are experiences of family and of organized violence predictors of aggression and violent behavior? A study with unaccompanied refugee minors. *European Journal of Psychotraumatology*. 2016;6:168. doi:10.3402/ejpt.v7.27856.
23. Hoge C, Terhakopian HA, Castro CA, Messer SC, Engel CC. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *Am J Psychiatry*. 2007;164(1):150. doi:10.1176/appi.ajp.164.1.150.
24. *EU-Turkey statement, 18 March 2016*; 2016. http://www.consilium.europa.eu/en/press/press-releases/2016/03/18-eu-turkey-statement/. Accessed June 4, 2016.
25. The Assessment Capacities Project (ACAPS) and MapAction. *Refugee/migrant crisis in Europe, situation update*. Greece; March/2016. Accessed 11-Apr-16.
26. Hassan G, Kirmayer LJ, Mekki-Berrada A., et al. *Culture, context and the mental health and psychosocial wellbeing of syrians: A review for mental health and psychosocial support staff working with Syrians affected by armed conflict*. Geneva; 2015.
27. Jensen NK, Norredam M, Priebe S, Krasnik A. How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. *BMC Fam Pract*. 2013;14(1):17. doi:10.1186/1471-2296-14-17.

28. Blount A. Integrated primary care: Organizing the evidence. *Families, Systems, & Health*. 2003;21(2):121-133. doi:10.1037/1091-7527.21.2.121.
29. Hollifield M, Toolson EC, Verbillis-Kolp S, et al. Effective screening for emotional distress in refugees: The Refugee Health Screener. *The Journal of nervous and mental disease*. 2016. doi:10.1097/NMD.0000000000000469.
30. Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P. Mental health in complex emergencies. *The Lancet*. 2004;364(9450):2058-2067. doi:10.1016/S0140-6736(04)17519-3.
31. Burkle FM. Triage. In: Antosia RE, Cahill JD, eds. *Handbook of bioterrorism and disaster medicine*. Boston, MA: Springer US; 2006:11-17.
32. Litz BT, Gray MJ, Bryant RA, Adler AB. Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice*. 2002;9(2):112-134. doi:10.1093/clipsy.9.2.112.
33. World Health Organization, War Trauma Foundation and World Vision. *Psychological first aid: Guide for field workers*. Geneva; 2011. http://www.who.int/mental_health/publications/guide_field_workers/en/. Accessed March 23, 2016.
34. Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A. et al. *Psychological First Aid: Field operations guide*,. 2nd ed. Los Angeles: National Child Traumatic Stress Network and National Center for PTSD; 2006. Accessed 01-Apr-16.
35. U.S. Department of Veterans Affairs. Common Reactions After Trauma. http://www.ptsd.va.gov/public/problems/common-reactions-after-trauma.asp. Accessed April 6, 2016.
36. Substance abuse and Mental Health Services Administration. Coping with traumatic events. http://media.samhsa.gov/MentalHealth/TraumaticEvent.aspx?from=carousel&position=1&date=3112011. Updated August 25, 2011. Accessed April 6, 2016.
37. Broadbent M, Moxham L, Dwyer T. The development and use of mental health triage scales in Australia. *Int J Ment Health Nurs*. 2007;16(6):413-421. doi:10.1111/j.1447-0349.2007.00496.x.
38. Brymer M, Jacobs A, Layne C, et al. *Psychological first aid: Field operations guide.* 2nd edition; 2006. www.ptsd.va.gov/professional/manuals/psych-first-aid.asp. Accessed March 24, 2016.
39. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases, Division of Global Migration and Quarantine. Guidelines for mental health screening during the domestic medical examination for newly arrived refugees. http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html. Updated May 8, 2014. Accessed April 4, 2016.
40. World Health Organization and United Nations High Commissioner for Refugees. *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies.* Geneva; 2015. http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf. Accessed April 7, 2016.

41. Lutheran Community Services Northwest. *Walking Together: A mental health therapist's guide to working with refugees*; 2015.
42. Burkle F. Acute-phase mental health consequences of disasters: Implications for triage and emergency medical services. *Annals of Emergency Medicine*. 1996;28(2):119-128. doi:10.1016/S0196-0644(96)70051-3.
43. Schick M, Zumwald A, Knöpfli B, et al. Challenging future, challenging past: the relationship of social integration and psychological impairment in traumatized refugees. *European Journal of Psychotraumatology*. 2016;7. doi:10.3402/ejpt.v7.28057.
44. Lamkaddem M, Stronks K, Devillé WD, Olff M, Am Gerritsen A, Essink-Bot M. Course of post-traumatic stress disorder and health care utilisation among resettled refugees in the Netherlands. *BMC Psychiatry*. 2014;14(1):90. doi:10.1186/1471-244X-14-90.
45. Shannon PJ, Vinson GA, Cook TL, Lennon E. Characteristics of successful and unsuccessful mental health referrals of refugees. *Adm Policy Ment Health*. 2015. doi:10.1007/s10488-015-0639-8.
46. Giacco D, Priebe S. *WHO Europe policy brief on migration and health: Mental health care for refugees*. http://www.euro.who.int/en/media-centre/events/events/2015/11/high-level-meeting-on-refugee-and-migrant-health/documentation/background-documents/whoeurope-policy-brief-on-migration-and-health-mental-health-care-for-refugees. Accessed April 12, 2016.
47. Zimbrean P. Risk factors and prevalence of mental illness in refugees. In: Annamalai A, ed. *Refugee health care*. New York, NY: Springer New York; 2014:149-162.
48. Rhema SH, Gray A, Verbillis-Kolp S, Farmer B, Hollifield M. Mental health screening. In: Annamalai A, ed. *Refugee Health Care*. New York, NY: Springer New York; 2014:163-171.
49. Pathways to Wellness: Integrating Refugee Health and Wellbeing. *Refugee Health Screener-15 (RHS-15). Replication packet*; 2013.
50. Miller KE, Rasmussen A. War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*. 2010;70(1):7-16. doi:10.1016/j.socscimed.2009.09.029.
51. Rose S, Bisson J, Wessely S. A systematic review of single-session psychological interventions ('debriefing') following trauma. *Psychother Psychosom*. 2003;72(4):176-184. doi:10.1159/000070781.
52. Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *The Cochrane database of systematic reviews*. 2002;(2):CD000560. doi:10.1002/14651858.CD000560.
53. Summerfield D. Addressing human response to war and atrocity: Major challenges in research and practices and the limitations of Western psychiatric models. In: *Kleber B, Figley C, Gersons B (Ed.) 1995 – Beyond trauma*.
54. International Federation Reference Centre. *Psychosocial interventions: A handbook*. Copenhagen; 2009. http://pscentre.org/wp-content/uploads/PSI-Handbook_EN_July10.pdf. Accessed March 23, 2016.
55. North Atlantic Treaty Organisation. *Psychosocial care for people affected by disasters and major incidents: A model for designing, delivering and managing psychosocial services*

for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO; 2008. Accessed 11-Apr-16.
56. Balaban VF, Steinberg AM, Brymer MJ, Layne C.M., Jones RT, Fairbank JA. Screening and assessment for children's psychosocial needs following war and terrorism. In: Friedman MJ, Mikus-Kos A, eds. *Promoting the psychosocial well–being of children following war and terrorism*. Amsterdam, The Netherlands: IOS Press; 2005:121-161. Accessed 07-Apr-16.
57. Friedman MJ, McEwen BS. Posttraumatic stress disorder, allostatic load, and medical illness. In: Schnurr PP, Green BL, eds. *Trauma and health: physical health consequences of exposure to extreme stress*. Washington, D.C.: American Psychological Association; 2004:157-188.
58. Smith, Kerrie, and Richard A. Bryant. The generality of cognitive bias in acute stress disorder. *Behaviour Research and Therapy*. 2000;28(7):709-715.
59. Warda G, Bryant Richard A. Cognitive bias in acute stress disorder. *Behaviour Research and Therapy*. 1998;36(12):1177-1183.
60. Bandura A. *Self–efficacy: The exercise of control*. New York: Freeman; 1997.
61. Antonovsky A. *Health, stress, and coping*. San Francisco: Jossey–Bass; 1979.
62. Foa EB, Meadows EA. Psychosocial treatment for posttraumatic stress disorder: A critical review. *Annual Review of Psychology*. 1997;48:449-480.
63. Benight CC, Harper ML. Coping self–efficacy perceptions as a mediator between acute stress response and long–term distress following natural disasters. *Journal of traumatic stress*. 2002;15(3):177-186. doi:10.1023/A:1015295025950.
64. Hobfoll SE, Canetti-Nisim D, Johnson RJ. Exposure to terrorism, stress-related mental health symptoms, and defensive coping among Jews and Arabs in Israel. *Journal of consulting and clinical psychology*. 2006;74(2):207-218. doi:10.1037/0022-006X.74.2.207.
65. Bleich A, Gelkopf M, Solomon Z. Exposure to terrorism, stress-related mental health symptoms, and coping behaviors among a nationally representative sample in Israel. *Journal of the American Medical Association*. 2003;290(5):612-620. doi:10.1001/jama.290.5.612.
66. Ruzek JI, Brymer MJ, Jacobs AK, Layne CM, Vernberg EM, Watson PJ. Psychological first aid. *Journal of Mental Health Counselling*. 2007;29(1):17-49.
67. Haase JE, Britt T, Coward DD, Leidy NK, Penn PE. Simultaneous concept analysis of spiritual perspective, hope, acceptance and self-transcendence. *Journal of Nursing Scholarship*. 1992;24(2):141-147. doi:10.1111/j.1547-5069.1992.tb00239.x.
68. World Health Organization, War Trauma Foundation and World Vision. *Psychological first aid: Facilitator's manual for orienting field workers*. Geneva; 2013. http://apps.who.int/bookorders/anglais/detart1.jsp?codlan=1&codcol=80&codcch=196. Accessed March 23, 2016.
69. Hollifield M, Verbillis-Kolp S, Farmer B, et al. The Refugee Health Screener-15 (RHS-15): Development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General hospital psychiatry*. 2013;35(2):202-209. doi:10.1016/j.genhosppsych.2012.12.002.

70. Dinh TQ, Yamada AM, Yee, Barbara W. K. A culturally relevant conceptualization of depression: An empirical examination of the factorial structure of the Vietnamese Depression Scale. *The International journal of social psychiatry*. 2009;55(6):496-505. doi:10.1177/0020764008091675.
71. Fazel M, Reed RV, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*. 2012;379(9812):266-282. doi:10.1016/S0140-6736(11)60051-2.
72. Ehntholt KA, Yule W. Practitioner review: assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of child psychology and psychiatry, and allied disciplines*. 2006;47(12):1197-1210. doi:10.1111/j.1469-7610.2006.01638.x.
73. Shaw JA. Children exposed to war/terrorism. *Clinical Child and Family Psychology Review*. 2003;6(4):237-246. Accessed 18-Apr-16.
74. Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P. Mental health in complex emergencies. *The Lancet*. 2004;364(9450):2058-2067. doi:10.1016/S0140-6736(04)17519-3.
75. Berk LE. *Development through the lifespan.* 4th edition. Boston, MA: Allyn and Bacon; 2008.
76. Garmezy N, Rutter M. Acute reactions to stress. In: Rutter M, Hersov L, eds. *Child and adolescent psychiatry, modern approaches*. 2nd ed. Oxford: Blackwell; 1985.
77. Almquist K, Broberg AG. Mental health and social adjustment in young refugee children y 3½ years after their arrival in Sweden. *Journal of the American Academy of Child & Adolescent Psychiatry*. 1999;38(6):723-730. doi:10.1097/00004583-199906000-00020.
78. Thabet AAM, Vostanis P. Post-traumatic stress reactions in children of war. *Journal of Child Psychology and Psychiatry*. 1999;40(3).
79. Laor N, Wolmer L, Mayes LC, et al. Israeli preschoolers under scud missile attacks. *Arch Gen Psychiatry*. 1996;53(5):416. doi:10.1001/archpsyc.1996.01830050052008.
80. Kovacev L, Shute R. Acculturation and social support in relation to psychosocial adjustment of adolescent refugees resettled in Australia. *International Journal of Behavioral Development*. 2004;28(3):259-267. doi:10.1080/01650250344000497.
81. Rousseau C, Drapeau A, Platt R. Family environment and emotional and behavioural symptoms in adolescent Cambodian refugees: Influence of time, gender, and acculturation. *Medicine, Conflict and Survival*. 2004;20(2):151-165. doi:10.1080/1362369042000234735.
82. Ajduković M, Ajduković D. Psychological well-being of refugee children. *Child Abuse & Neglect*. 1993;17(6):843-854. doi:10.1016/S0145-2134(08)80014-2.
83. Almqvist K, Brandell-Forsberg M. Refugee children in Sweden: Post-traumatic stress disorder in Iranian preschool children exposed to organized violence. *Child Abuse & Neglect*. 1997;21(4):351-366. doi:10.1016/S0145-2134(96)00176-7.
84. Qouta S, Punamäki RL, Sarraj EE. Mother-child expression of psychological distress in war trauma. *Clinical Child Psychology and Psychiatry*. 2005;10(2):135-156. doi:10.1177/1359104505051208.

85. Ekblad S. Psychosocial adaptation of children while housed in a swedish refugee camp: Aftermath of the collapse of Yugoslavia. *Stress Med.* 1993;9(3):159-166. doi:10.1002/smi.2460090306.
86. Montgomery E, Foldspang A. Validity of PTSD in a sample of refugee children: can a separate diagnostic entity be justified? *Int. J. Methods Psychiatr. Res.* 2006;15(2):64-74. doi:10.1002/mpr.186.
87. Rousseau C, Drapeau A, Rahimi S. The complexity of trauma response: A 4-year follow-up of adolescent Cambodian refugees. *Child Abuse & Neglect*. 2003;27(11):1277-1290. doi:10.1016/j.chiabu.2003.07.001.
88. Norris FH, Friedman MJ, Watson PJ. 60,000 disaster victims speak: Part II. summary and implications of the disaster mental health research. *Psychiatry: Interpersonal and Biological Processes*. 2002;65(3):240-260. doi:10.1521/psyc.65.3.240.20169.
89. Papademetriou Theresa. *European Union: Status of unaccompanied children arriving at the EU borders*; 2014. https://www.loc.gov/law/help/unaccompanied-children/status-of-unaccompanied-children-arriving-at-the-eu-borders.pdf.
90. European Migration Network. *Policies, practices and data on unaccompanied minors in the EU Member States and Norway: Synthesis Report for the EMN Focussed Study 2014*; 2014. http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/emn_study_policies_practices_and_data_on_unaccompanied_minors_in_the_eu_member_states_and_norway_synthesis_report_final_eu_2015.pdf. Accessed April 19, 2016.
91. Derluyn I, Mels C, Broekaert E. Mental health problems in separated refugee adolescents. *Journal of Adolescent Health*. 2009;44(3):291-297. doi:10.1016/j.jadohealth.2008.07.016.
92. Derluyn I, Broekaert E. Unaccompanied refugee children and adolescents: The glaring contrast between a legal and a psychological perspective. *International journal of law and psychiatry*. 2008;31(4):319-330. doi:10.1016/j.ijlp.2008.06.006.
93. Wiese, Elizabeth B. P., Burhorst I. The mental health of asylum-seeking and refugee children and adolescents attending a clinic in the Netherlands. *Transcultural psychiatry*. 2007;44(4):596-613. doi:10.1177/1363461507083900.
94. Huemer J, Karnik NS, Voelkl-Kernstock S, et al. Mental health issues in unaccompanied refugee minors. *Child Adolesc Psychiatry Ment Health*. 2009;3(1):13. doi:10.1186/1753-2000-3-13.
95. Felsman KJ, Leong FT, Johnson MC, Crabtree FI. Estimates of psychological distress among Vietnamese refugees: Adolescents, unaccompanied minors and young adults. *Social Science & Medicine*. 1990;31(11):1251-1256. doi:10.1016/0277-9536(90)90132-C.
96. Derluyn I, Broekaert E. Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents. *Ethnicity & health*. 2007;12(2):141-162. doi:10.1080/13557850601002296.
97. Fazel M. The mental health of refugee children. *Archives of Disease in Childhood*. 2002;87(5):366-370. doi:10.1136/adc.87.5.366.
98. Save the Children Denmark. Psychological first aid for children: Toolkit and manual. http://resourcecentre.savethechildren.se/sites/default/files/documents/4633.pdf. Accessed April 19, 2016.

99. Terlonge P. *Psychological first aid training manual for child practitioners*; 2013. http://resourcecentre.savethechildren.se/sites/default/files/documents/final_pfa.pdf. Accessed April 15, 2016.
100. Pynoos RS, Nader K. Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stres*. 1988;1(4). Accessed 20-Apr-16.
101. Tribe R, Lane P. Working with interpreters across language and culture in mental health. *Journal of Mental Health*. 2009;18(3):233-241. doi:10.1080/09638230701879102.
102. Hollifield M, Warner TD, Lian N, et al. Measuring trauma and health status in refugees: A critical review. *The Journal of the American Medical Association*. 2002;288(5):611-621.
103. Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *The Journal of nervous and mental disease*. 1992;180(2):111-116.
104. Rasmussen A, Verkuilen J, Ho E, Fan Y. Posttraumatic stress disorder among refugees: Measurement invariance of Harvard Trauma Questionnaire scores across global regions and response patterns. *Psychological assessment*. 2015;27(4):1160-1170. doi:10.1037/pas0000115.
105. Shoeb M, Weinstein H, Mollica R. The Harvard Trauma Questionnaire: Adapting a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Iraqi refugees. *International Journal of Social Psychiatry*. 2007;53(5):447-463. doi:10.1177/0020764007078362.
106. Refugee Health Technical Assistance Center. Assesments for Trauma and Mental Health in Refugees. http://refugeehealthta.org/physical-mental-health/mental-health/adult-mental-health/assessments-for-trauma-and-mental-health-in-refugees/. Accessed March 21, 2016.
107. Young P, Gordon MS. Mental health screening in immigration detention: A fresh look at Australian government data. *Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists*. 2016;24(1):19-22. doi:10.1177/1039856215624247.
108. Schweitzer R, Melville F, Steel Z, Lacherez P. Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *The Australian and New Zealand journal of psychiatry*. 2006;40(2):179-187. doi:10.1111/j.1440-1614.2006.01766.x.
109. Kinzie JD, Manson SM, Vinh DT, Tolan NT, Anh B, Pho TN. Development and validation of a Vietnamese-language depression rating scale. *AJP*. 1982;139(10):1276-1281. doi:10.1176/ajp.139.10.1276.
110. Thulesius H, Håkansson A. Screening for posttraumatic stress disorder symptoms among Bosnian refugees. *Journal of traumatic stress*. 1999;12(1):167-174. doi:10.1023/A:1024758718971.
111. Vonnahme LA, Lankau EW, Ao T, Shetty S, Cardozo BL. Factors associated with symptoms of depression among Bhutanese refugees in the United States. *Journal of*

immigrant and minority health / Center for Minority Public Health. 2015;17(6):1705-1714. doi:10.1007/s10903-014-0120-x.

112. Teodorescu D, Heir T, Hauff E, Wentzel-Larsen T, Lien L. Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian journal of psychology*. 2012;53(4):316-332. doi:10.1111/j.1467-9450.2012.00954.x.
113. Zilberg NJ, Weiss DS, Horowitz MJ. Impact of Event Scale: A cross-validation study and some empirical evidence supporting a conceptual model of stress response syndromes. *Journal of consulting and clinical psychology*. 1982;50(3):407-414.
114. Johnson-Agbakwu CE, Allen J, Nizigiyimana JF, Ramirez G, Hollifield M. Mental health screening among newly arrived refugees seeking routine obstetric and gynecologic care. *Psychological services*. 2014;11(4):470-476. doi:10.1037/a0036400.
115. Husain F, Anderson M, Lopes Cardozo B, et al. Prevalence of war-related mental health conditions and association with displacement status in postwar Jaffna District, Sri Lanka. *The Journal of the American Medical Association*. 2011;306(5). doi:10.1001/jama.2011.1052.
116. Marshall GN. Mental health of Cambodian refugees 2 decades after resettlement in the United States. *The Journal of the American Medical Association*. 2005;294(5):571. doi:10.1001/jama.294.5.571.
117. Cardozo BL. Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. *The Journal of the American Medical Association*. 2000;284(5):569. doi:10.1001/jama.284.5.569.
118. Sabin M, Sabin K, Kim HY, Vergara M, Varese L. The mental health status of Mayan refugees after repatriation to Guatemala. *Rev Panam Salud Publica*. 2006;19(3). doi:10.1590/s1020-49892006000300004.
119. Schweitzer RD, Brough M, Vromans L, Asic-Kobe M. Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Aust NZ J Psychiatry*. 2011;45(4):299-307. doi:10.3109/00048674.2010.543412.
120. Jamil H, Farrag M, Hakim-Larson J, Kafaji T, Abdulkhaleq H, Hammad A. Mental health symptoms in Iraqi refugees: Posttraumatic stress disorder, anxiety, and depression. *Journal of Cultural Diversity*. 2007;14(1):19-25.
121. D'Avanzo CE, Barab SA. Depression and anxiety among Cambodian refugee women in France and the United States. *Issues in Mental Health Nursing*. 2009;19(6):541-556. doi:10.1080/016128498248836.
122. Peltzer K. Trauma and mental health problems of Sudanese refugees in Uganda. *Central African Journal of Medicine*. 1999;45(5):110-113. doi:10.4314/cajm.v45i5.8465.
123. Holtz TH. Refugee trauma versus torture trauma: A retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous and Mental Disease*. 1998;186(1):23-34. doi:10.1097/00005053-199801000-00005.
124. Bean T, Derluyn I, Eurelings-Bontekoe E, Broekaert E, Spinhoven P. Validation of the multiple language versions of the Reactions of Adolescents to Traumatic Stress questionnaire. *J. Traum. Stress*. 2006;19(2):241-255. doi:10.1002/jts.20093.

125. Horowitz M, Wilner N, Alvarez W. Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*. 1979;41(3):209-218. doi:10.1097/00006842-197905000-00004.
126. Eid J, Larsson G, Johnsen BH, Laberg JC, Bartone PT, Carlstedt B. Psychometric properties of the Norwegian Impact of Event Scale-revised in a non-clinical sample. *Nordic journal of psychiatry*. 2009;63(5):426-432. doi:10.1080/08039480903118190.
127. Macmillan AM. The health opinion survey: Technique for estimating prevalence of psychoneurotic and related types of disorder in communities. *PR*. 1957;3:325-339. doi:10.2466/pr0.3.325-339.
128. Westermeyer J, Vang TF, Neider J. A comparison of refugees using and not using a psychiatric servce: an analysis of DSM-II criteria and self-rating scales in cross-cultural context. *Journal of Operational Psychiatry*. 1983;14:36-41.
129. Prins A, Ouimette P, Kimerling R, et al. The primary care PTSD screen (PC–PTSD): Development and operating characteristics. *Prim Care Psych*. 2004;9(1):9-14. doi:10.1185/135525703125002360.
130. Shisana O, Celentano DD. Relationship of chronic stress, social support, and coping style to health among Namibian refugees. *Social Science & Medicine*. 1987;24(2):145-157. doi:10.1016/0277-9536(87)90247-4.
131. Norbeck JS. The Norbeck Social Support Questionnaire. *Birth defects original article series*. 1984;20(5):45-57.
132. Breslau N, Peterson EL, Kessler RC, Schultz LR. Short screening scale for DSM-IV posttraumatic stress disorder. *AJP*. 1999;156(6):908-911. doi:10.1176/ajp.156.6.908.
133. Chipimo PJ, Fylkesnes K. Case-finding for mental distress in primary health care: An evaluation of the performance of a five-item screening instrument. *Health*. 2013;5(3):627-636. doi:10.4236/health.2013.53A083.
134. Durieux-Paillard S, Whitaker-Clinch B, Bovier PA, Eytan A. Screening for major depression and posttraumatic stress disorder among asylum seekers: Adapting a standardized instrument to the social and cultural context. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*. 2006;51(9):587-597.
135. Hollifield M, Warner TD, Jenkins J, et al. Assessing war trauma in refugees: Properties of the Comprehensive Trauma Inventory-104. *J. Traum. Stress*. 2006;19(4):527-540. doi:10.1002/jts.20137.
136. McCarthy S. Post-traumatic Stress Diagnostic Scale (PDS). *Occupational medicine (Oxford, England)*. 2008;58(5):379. doi:10.1093/occmed/kqn062.
137. Norris AE, Aroian KJ. Assessing reliability and validity of the Arabic language version of the Post-traumatic Diagnostic Scale (PDS) symptom items. *Psychiatry research*. 2008;160(3):327-334. doi:10.1016/j.psychres.2007.09.005.
138. Goldberg DP, Hillier VF. A scaled version of the General Health Questionnaire. *Psychol. Med.* 1979;9(1):139-145. doi:10.1017/S0033291700021644.
139. Turner SW, Bowie C, Dunn G, Shapo L, Yule W. Mental health of Kosovan Albanian refugees in the UK. *The British Journal of Psychiatry*. 2003;182(5):444-448.
140. Montazeri A, Harirchi A, Shariati M, Garmaroudi G, Ebadi M, Fateh A. The 12-item General Health Questionnaire (GHQ-12): Translation and validation study of the Iranian version. *Health Qual Life Outcomes*. 2003;1(1):66. doi:10.1186/1477-7525-1-66.

141. Savin D, Seymour DJ, Littleford LN, Bettridge J, Giese A. Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Reports*. 2005;120(3):224-229.