Co-funded by
the Health Programme
of the European Union

Grant agreement number: 717319

Project acronym: EUR-HUMAN

Project title: EUropean Refugees-HUman Movement and Advisory Network

Work package number: WP5

Deliverable number: 5.2

Deliverable title: Model of integrated care

Funding: *This report is part of the project '717319/EUR-HUMAN' which has received funding from the European Union's Health Programme (2014-2020).*

Contents

Abbreviations

MH Mental Health

MHPSS Mental Health and Psychosocial Support

PFA Psychological First Aid

PHC Primary Health Care

PTSD Post-Traumatic Stress Disorder

Executive Summary

Objective. The purpose of this report is to describe a Model of Continuity of Psychosocial Refugee Care (MCPRC), which will tackle the challenge how to identify highly psychologically distressed refugees and migrants, provide Psychological First Aid (PFA), refer the refugee or migrant to specialised health services, if needed, and transfer the necessary information to other care providers, either within the same country or cross-border.

Background. Refugees and other migrants per definition have been exposed to adverse life threatening experience. Despite this, there is evidence that they are reluctant to seek help for psychological problems until they really become unbearable or make them dysfunctional. Therefore, there is a need to develop a model which will foster person-centred, integrated and multifaceted support for these groups of people. The Model is based on three key assumptions: (1) If highly distressed refugees and other migrants are identified early and receive initial care, they will be more likely to seek assistance for mental health (MH) problems later on; if needed (2) Refugees and migrants under elevated risk for developing MH conditions should receive appropriate, person-centred care over time, based on PFA principles; (3) Continuity of care should be fostered.

Model of Continuity of Psychosocial Refugee Care. The Model consists of three key components: identifying highly distressed refugees and migrants, providing brief and focused PFA interventions and fostering informational continuity of care. Identifying highly distressed refugees and migrants includes triage and screening for MH-problems. The purpose of triage is to recognise refugees and migrants who are dysfunctional and/or at immediate risk of harm to themselves or other, so they can be immediately referred to a specialist. Since MH issues can emerge at any point during refugee transit or the asylum seeking process, triage should be conducted at any point of meeting the refugee or migrant. MH screening aims to identify individuals who are experiencing heightened distress and who are more likely to develop more serious MH conditions, and is recommended to be conducted as a part of overall health check-up. Tools for conducting both triage and screening are presented as a part of the Model. Psychological first aid should be provided to all refugees and migrants, as it focuses on addressing basic needs, comforting and connecting people to information, services and support. A brief summary guide on possible PFA interventions during short, medium term and long term stay is presented. Finally, information on MH conditions of refugees or migrants, and information on the received interventions should be available to other care-givers, either in the same country of between countries. Two existing systems for information sharing are presented and a recording system for mental health of refugees and migrants is proposed.

Conclusions and next steps. The proposed Model of Continuity of Psychosocial Refugee Care should tackle the challenges of providing person-centred, integrated and multifaceted support for refugees and other migrants. It includes a protocol for identifying highly psychologically distressed refugees and migrants, a guide to PFA interventions and a

recording system for information sharing. The next steps in WP5 include piloting the proposed procedure, in close cooperation with IOM Croatia.

1 Introduction

Objective

The EUropean Refugees-HUman Movement and Advisory Network project (EUR-HUMAN) aims to enhance the capacity of European member states in addressing refugees' and other migrants' health needs, safeguarding refugees and migrants from risks and minimising cross-border health risks; both in the early arrival period and longer-term settlement. As a part of overall aim of the project, Work Package 5 (WP5) focuses specifically on mental health (MH) and psychosocial wellbeing of refugees and other migrants. The purpose of this report is to describe a Model of Continuity of Psychosocial Refugee Care (MCPRC). The Model will tackle the challenge how to identify highly distressed refugees and migrants, provide Psychological First Aid (PFA), refer the refugee or migrant to more specialised services, if needed, and transfer the necessary information to other care providers, either within the same country or cross-border. Best practices and existing guidelines for providing mental health and psychosocial support (MHPSS) to people who endured or witnessed possible shocking events (e.g. traumatized by destruction, organized violence or loss) will guide development of the model,[1–5] as well as previous work conducted as a part of EUR-HUMAN project.

Summary of previous work in EUR-HUMAN project

The previous work in EUR-HUMAN project highlighted several issues that need to be accounted in the development of Model of Continuity of Psychosocial Refugee Care.

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. Key finding from the perspective of WP5 is the recognition of unmet MH needs by the refugees and migrants themselves. These needs include distress related to shocking events before or during journey, depression, suicide risks, insomnia, fatigue, anxiety and uncertainty. Thus, the MCPRC needs to take into account early and accurate identification of refugees and migrants who are facing MH problems. In addition, lack of continuity of care was mentioned as a barrier to addressing health needs in general. This included lack of information on previous treatment, difficulty to obtain medication for chronic diseases during the journey and lack of knowledge among the health care workers on the care available in the next country. Although the specific circumstances have changed since the closure of "Balkans route", refugees and other migrants remain a highly mobile population, and the challenges to provide continuous care persist.

WP3 conducted systematic review of literature databases, online survey and expert interviews to identify success factors and obstacles in the implementation of health care tools and interventions for refugees and other migrants. The collected material points at recurring success factors and implementation obstacles, linked to characteristics of health care

interventions and measures, professionals, patient/refugee population, professional-patient interaction, incentives and resources, local capacity for organizational change, and social, political and legal factors. Key finding from the perspective of WP5 and this report was the identification of continuity of care as a cross-cutting obstacle in providing health care to refugees and other migrants.

WP4 conducted Expert Consensus Meeting (Athens, June 8th – 9th 2016), which aimed to reach consensus on the optimal content of Primary Health Care (PHC) and social care services needed to assess and address the health needs of refugees and other newly arrived migrants. Overall, nine areas were discussed, including mental health and continuity of care. The most important findings for this report support the central role of continuity of information about care, continuity in delivery of health care to migrants and other refugees, and the need for integration of MH care in primary health care.

WP5 (Deliverable 5.1) developed 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 conditions), immediate assistance based on the PFA principles and referral for full MH assessment and care as needed. Short, practical tools guiding these processes are included as a part of the comprehensive Model.

To sum it up, key findings from EUR-HUMAN project for development of Model of Continuity of Psychosocial Refugee Care point that:

- refugees are in need for compassionate psychosocial support related to distress following adverse or shocking events (WP2);
- there is a lack of information on previous treatment, hindering delivery of care (WP2);
- in general, (lack of) continuity of care is cross-cutting obstacle in delivery of care to refugees and migrants (WP3);
- informational continuity of care as well as integration of MH in primary care represent key challenges for delivery of care to refugees and migrants (WP4).

2 Background

Refugees and other migrants can be exposed to adverse life threatening experiences due to for example war and persecution, which made them decide to flee across international boarder in search of safety.[6,7] Data show that prevalence of mental health disorders leading to difficulties in family and work functioning, as well as problems of social integration in hosting societies is very high: up to 40% may have posttraumatic stress disorder (PTSD).[8] This is about 10 times higher than in the non-affected populations. [9,10] But this also shows that most refugees show remarkable resilience as they cope reasonably well in the aftermath of losses, traumatization and uprooting. [11] However, refugees are much more reluctant to seek help for mental health problems, than for physical health issues. Only when mental health problems become unbearable or have dysfunctional consequences, people are likely to reach out for support. There are estimates that it takes about 7 years of mental suffering for refugees hosted in Netherlands and Switzerland to reach out to care providers to seek assistance.[12,13] This increases the toll for the individual and family, as well as social and health costs for the host society. Therefore, there is a need to develop a model that would support early identification of highly distressed refugees and other migrants, provision of PFA, referral procedures, and continuity of care. Based on previous work in the EUR-HUMAN project, the Model is based on the following key assumptions.

Key assumption one: Refugees and migrants who are highly distressed and possibly dysfunctional should be identified early on and receive appropriate MH and psychosocial care. Moreover, it is assumed that if they find such interventions reassuring and helpful, they will be more likely to seek assistance for mental health problems at the point of their final destination and during resettlement, if needed. They will be motivated to do so if their positive experiences with health care and psychosocial personnel along the transit route, in hot spots or first reception centres helps to destigmatize suffering as a consequence of trauma and losses. Moreover, if the short and focused psychosocial support interventions help them deal better with adverse experiences, potentially traumatic events and losses, their coping capacity and resilience will be enhanced and the path to recovery will start early. Early identifying of highly distressed and possibly disrupted functioning refugees and migrants should be a two-step process which includes (1) triage and (2) screening.

Key assumption two: Those individuals with elevated risk for developing mental health conditions should receive appropriate, person-centred and compassionate care or support over time. This beginning of care should be based on principles of Psychological First Aid (PFA), approach which focuses on addressing basic needs while facilitating resilience within individuals, families and communities. The PFA approach is based on five basic principles:[5] promoting a sense of safety, promoting calming, promoting self- and collective efficacy, promoting connectedness and promoting hope. PFA can be provided to anyone who has been exposed to an adverse experience or crisis event, and anywhere where it is safe enough to do so (e.g. shelters, camps, transit centres, hot spots, reception centres, PHC, hospitals). Its implementation is not restricted to MH professionals but can also be delivered by PH teams,

allied health personnel, trained lay persons and volunteers. Therefore, PFA can be especially useful in situations where there is a large number of people in need of assistance and scarcity of MH and PH professionals.

Key assumption three: Continuity of care is important. Based on a multidisciplinary review of continuity of care,[14] there are three elements of continuity: informational, management and relational continuity (Box 1). Informational continuity links care from one provider to another and from one healthcare event to another. Both information on the condition and on patient's preferences, values and context are important to ensure services that are responsive to needs. Management continuity is achieved when services from several providers are delivered in a complementary and timely manner. This can be facilitated by shared management plans or care protocols, as well as flexibility in adapting care to changes. Relational continuity, emphasised especially in primary and mental health care, is often interlinked with informational continuity, as knowledge about the patient is accumulated in the memory of the provider. Even when there is no expectation of establishing an ongoing relationship, a consistent core of staff can provide a sense of predictability and coherence from the patient perspective. In the current situation informational continuity seems the most urgent element to ensure continuity of care. WP2 field work, reflecting the needs of refugees and other migrants, found that the lack of information is one of the most pressing barriers. In addition, at the Expert Consensus Meeting (WP4) in Athens (June 8th – 9th 2016), it was agreed that informational continuity is a minimum that should be established. Therefore, in this report we will focus on this aspect of continuity of psychosocial care for refugees and other migrants.

Box 1 Types of continuity of care[14]

Informational continuity. The use of information on past events and personal circumstances to make current care appropriate for each individual.

Management continuity. A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.

Relational continuity. An ongoing therapeutic relationship between a patient and one or more providers.

(Quoted directly, page 1220)

In the next section of the report, all three key assumptions of Model of Continuity of Psychosocial Refugee Care are described: identifying highly distressed refugees and migrants, providing brief and focused Psychological First Aid interventions and fostering informational continuity of care.

3 Model of Continuity of Psychosocial Refugee Care

Identifying highly distressed refugees and migrants

Identifying highly distressed and potentially dysfunctional refugees and migrants includes two separate but interlinked steps: triage and screening. The purpose of triage is to recognise refugees and migrants who are dysfunctional and/or at immediate risk, defined as a threat to personal safety of the possible affected person, or a threat to the safety of people around them. MH triage consists of recognising behavioural signs that indicate severe distress, conducting a rapid assessment of immediate risk and providing psychoeducation and referral if needed. Since MH issues can emerge at any point during refugee transit or the asylum seeking process, it is important that various groups of care providers/personnel working with refugees are familiar with the triage process.

The purpose of MH screening is to identify individuals who are experiencing heightened distress and who are more likely to develop more serious MH conditions. Screening should be based on using a reliable and valid measure of distress in refugee and migrant populations. Based on the review of MH screening tools (D5.1), the use of the Refugee Health Screener 13 (RHS-13) is recommended (Appendix I).[13] This instrument was specifically designed and validated on newly arrived refugees and migrants with items derived from existing and valid instruments used with similar populations. It is translated in several languages (Arabic, Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili); can be administered in short amount of time; is easily understood by people of various educational levels and can be administered to individuals from the age of 14. Furthermore, it assesses symptoms of Post-traumatic stress disorder (PTSD), anxiety and Depression Disorder, which are the most common MH conditions in refugee populations. It serves as a quick screener of probable risk of having or developing PTSD, anxiety or depression (cut-off score ≥ 11). It is important to emphasize that a positive screening on the RHS-13 does not mean that the person needs clinical MH treatment since it is not a diagnostic tool, but indicates the need for full assessment, referral and possible follow-up.

MH screening should be conducted as part of a comprehensive health check-up, at the first point of contact by primary care providers with refugees and other migrants. MH screening can be conducted by trained PC personnel, allied health professionals and volunteers with PHC background. If MH screening indicates a chance of developing more serious MH conditions ("positive screening"), care providers should make appropriate referral. Both triage and screening should be followed up by immediate brief interventions, based on PFA approach, such as psychoeducation.[16]

Tools to guide caregivers in the triage and screening processes are shown below and are briefly described in Table 1. These tools were developed for adult refugees and migrants. They can also be used with children and adolescents, if adapted to the appropriate level of understanding and developmental stage, as well as family context (*see Deliverable 5.1*).

However, many authors agree that providing information and support to parents and other caregivers is one of the most effective ways to support children.[15]

Table 1 Description of MH Triage and Screening Tools

	MH Triage	MH Screening
When	Any contact with the individual	Temporary or long term centres; as a part of comprehensive health check-up
Provider	Trained paraprofessionals and volunteers, professionals	Trained paraprofessionals and volunteers, professionals
Target group	14+	14+
Time to complete	20-30 min	15-20 min
Preconditions	(1) Creating a safe, comfortable and confidential setting; (2) Establishing basic trustful relationship (more information in D5.1, pp 14-15).	(1) Establishing trust (more information in D5.1, p 21); (2) Possibility to offer immediate assistance, if needed; (3) Possibility to offer referral, if needed.

MH Triage tool

1. Are there visible signs of distress?

Look for:

Physical/behavioural signs

- Looking glassy eyed and vacant, unable to find direction
- Unresponsive to verbal questions or commands
- Disorientation (engaging in aimless disorganized behaviour, not knowing their own name, where they are, or what is happening)
- Rocking or regressive behaviour
- Hyperventilation
- Experiencing uncontrollable physical reactions (shaking, trembling)
- Exhibiting frantic searching behaviour
- Self-destructive or violent behaviour

Emotional/cognitive signs

- Exhibiting strong emotional responses, uncontrollable crying
- Feeling incapacitated by worry
- Unable to care for themselves or their children
- Unable to make simple decisions
- Feeling anxious or fearful, overwhelmed by sadness, confused
- Physically/verbally aggressive
- Feeling shocked, numb
- Guilt, shame (for having survived, for not helping or saving others)

If NO

Usual procedures

If YES

2. Are there visible signs of danger to safety?

If YES

Immediate referral
(See referral script)

While engaging the person, look for:

- 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

If NO

3. Are there thoughts or plans for self-harm/suicide?

If YES

Immediate referral
(See Immediate referral)

Ask:

1. Some people with similar problems have told me that they felt life was not worth living. Do you sometimes go to sleep wishing that you might not wake up in the morning? (if YES, ask 2.)
2. Have you ever wanted to end your life or kill yourself? Have you made any plans to end your life? If so, how are you planning to do it?

If NO

Psychoeducation
(See Psychoeducation)

Immediate referral[1]

Inform

- ✓ Explain to the person that you are worried about him/her harming himself/herself and that you have a professional duty to act in the interest of preventing that.

Take precautions

- ✓ Remove means of self-harm.
- ✓ Create a secure environment while waiting – if possible, offer a separate, quiet room.
- ✓ Do not leave the person alone – assign a staff or family member to ensure safety.

Refer

- ✓ Immediately consult a mental health specialist and ensure escort to that specialist. If it is not possible to ensure immediate escort to specialist, ensure a safe environment and make an appointment as soon as possible.

Psychoeducation[2]

Normalise

- ✓ A lot of people experience sadness, worries, bad memories and feel stress when they go through terrible life events

Explain

- ✓ Experiencing stressful life events affects body and mind.
- ✓ Typical physical reactions ("body symptoms") are sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.
- ✓ Typical emotional and behavioural reactions ("mind symptoms") are anxiety, watchfulness and poor concentration, and negative feelings such as guilt, sadness and anger.
- ✓ Some people become disoriented, have intrusive memories and avoid being reminded of the thing that happened. Others may isolate themselves or increase intake of alcohol, medicine or drugs.

Encourage

- ✓ It is important to find ways of dealing with reactions to stressful life events.
- ✓ It may help to:
  Remember that these reactions are expected after terrible experiences.
  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.

Offer support

- ✓ If you start/continue feeling like this, and it persists over several weeks, seek help (*give contact where the person can do that!)*.

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[1] Based on http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
[2] Based on http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf

MH Screening tool

1. Are there visible signs of distress?

If YES → **Go to step 2 in MH Triage procedure**

Look for:

Physical/behavioural signs

- Looking glassy eyed and vacant, unable to find direction
- Unresponsive to verbal questions or commands
- Disorientation (engaging in aimless disorganized behaviour, not knowing their own name, where they are, or what is happening)
- Rocking or regressive behaviour
- Hyperventilation
- Experiencing uncontrollable physical reactions (shaking, trembling)
- Exhibiting frantic searching behaviour
- Self-destructive or violent behaviour

Emotional/cognitive signs

- Exhibiting strong emotional responses, uncontrollable crying
- Feeling incapacitated by worry
- Unable to care for themselves or their children
- Unable to make simple decisions
- Feeling anxious or fearful, overwhelmed by sadness, confused
- Physically/verbally aggressive
- Feeling shocked, numb
- Guilt, shame (for having survived, for not helping or saving others)

If NO →

2. Does the physical health screening indicate immediate assistance is needed?

If YES → **Attend physical health needs first**

When MH screening is conducted as a part of comprehensive physical health screening, conduct the MH screening at the end of the procedure. If physical health screening shows that immediate assistance is needed, solving this issue has priority over MH screening.

If NO/N.A.

3. Does MH screening indicate positive screen?

If YES → **Referral offer** ***(See Referral script)***

Utilise reliable, valid screening tool, tested for diagnostic accuracy in refugee and migrant populations (*See Refugee health screener-13 in Appendix I*). Screening should assess current functionality or symptomatology. Routine screening for exposure to traumatic events is not recommended.

If NO → **Psychoeducation** ***(See Psychoeducation)***

Referral script[3]

- ✓ Offer referral. You can use the following script[4]:

"From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees 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. In *(state country)*, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. 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?"

- ✓ Make an appointment for the refugee.
- ✓ Proactively address potential barriers: ask the refugee if there are any obstacles that need to be addressed (e.g. money, transport, child care).
- ✓ Follow-up with the refugee after appointment.

Psychoeducation[5]

Normalise

- ✓ A lot of people experience sadness, worries, bad memories and feel stress when they go through terrible life events.

Explain

- ✓ Experiencing stressful life events affects body and mind.
- ✓ Typical physical reactions ("body symptoms") are sleeping problems, headaches, muscle tensions and bodily pains, fast heart beat and nausea.
- ✓ Typical emotional and behavioural reactions ("mind symptoms") are anxiety, watchfulness and poor concentration, and negative feelings such as guilt, sadness and anger.
- ✓ Some people become disoriented, have intrusive memories and avoid being reminded of the thing that happened. Others may isolate themselves or increase intake of alcohol, medicine or drugs.

Encourage

- ✓ It is important to find ways of dealing with reactions to stressful life events.
- ✓ It may help to:
  Remember that these reactions are expected after terrible experiences.
  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.

Offer support

- ✓ If you continue or start feeling like this, and it persists over several weeks, seek help (*give contact where the person can do that!)*

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[3] Based on http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
[4] Taken from http://www.lcsnw.org/pathways/pdf/RefugeeHealthScreener.pdf
[5] Based on http://mhpss.net/?get=83/1305723483-1._Brochure_on_stress_and_coping.pdf

Psychological First Aid

Psychological First Aid (PFA) is a form of psychosocial support intended for people who have experienced mass violence, forced displacement and other types of highly 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. Despite various definitions, the basic elements of PFA are universal and include:[17]

- Providing practical care and support which is non-intrusive;
- 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 and offering compassionate care and support.

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 organisations and expert groups, including National Center 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.[2,18–20]

As a part of the Model of Continuity of Refugee Psychosocial Care, the PFA procedure is conceived as guidance for providing psychological care and support for refugees and migrants arriving in Europe. 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 it 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. A detailed description of the PFA process is described in D5.1, while in Table 2 a summary of practical guidance on interventions that can be implemented in the short term, medium term and long-term stay is provided

Table 2 Summary of core Psychological First Aid actions

PFA CORE ACTIONS	Short term stay (up to 3 days)	Medium term stay (up to two weeks)	Longer term stay
Prepare	✓ Familiarise yourself with the cultural background of refugee of migrant groups you're most often in contact with ✓ At all times, be aware and up to date about: *The current situation regarding refugee movement, legal provisions and entitlements* *Types of relief and support services available at the current location*		
Make first contact	✓ Initiate first contact in a non-intrusive, compassionate and helpful manner *Make nonverbal contact first (eye contact, smile, open posture, lean forward)* *If using interpreter always look and talk to the refugee or migrant* *Introduce yourself and explain your role* *Avoid touching, since it may not be culturally appropriate*		
Ensure safety and comfort	✓ Improve immediate psychological safety: *Remove sharp objects/sources of noise* *Tell that this is a safe environment* *Address urgent needs (food, clothes, protection from weather)* *Attend to vulnerable groups (elderly, families with children, pregnant women, disabled)* *Provide information on what is going to happen next*	✓ Attend to physical comfort *Make environment more pleasant (adjust temperature, lighting, air quality, arrangement of furniture)* ✓ Provide information about available services ✓ Promote social connections *Help make contact with family and friends, connect with people who are coping well* ✓ Protect form additional exposure *Protect for scenes of people suffering, minimise exposure to distressing media (esp. for children), do not routinely enquire about traumatic experiences*	
Help with stabilisation	✓ Stabilise people in severe distress *Orient the person to the surroundings, use breathing relaxation techniques or grounding if necessary*	✓ Support people who are emotionally overwhelmed: *Ensure adequate space for rest* *Ensure adequate diet* *Engage in positive distracting activities* *Help maintain routine*	

PFA CORE ACTIONS	Short term stay (up to 3 days)	Medium term stay (up to two weeks)	Longer term stay
Gather information on current needs and concerns	✓ Focus on most pressing needs and concerns: *Need for medical assistance* *Look for signs of extreme distress (see Triage)* *Separation or concern for loved ones*	✓ Identify needs and concerns in the immediate future: *Inquire on the needs and concerns* *Address availability of social support* *Look for signs of extreme distress (see Triage)*	✓ Identify needs and concerns in the immediate future: *Focus on immediate post-resettlement circumstances* *Address availability of social support* *Screen for distress as a part of comprehensive health check*
Provide practical assistance	✓ Ensure meeting of basic needs (*food, water, clothes, sanitation, protection from weather*) ✓ Offer medical assistance, if needed	✓ Help establish contact with separated family members ✓ Ensure supportive session with a member of psychosocial support team ✓ Give detailed information on next steps and procedure, if possible ✓ Give information on coping (psychoeducation)	✓ Connect with family members ✓ Give detailed information on the asylum seeking process, entitlements and obligations ✓ Give information on coping (psychoeducation) ✓ Refer to specialised care providers, if needed
Promote social support	✓ Help establishing contact with family members, close friends and neighbours (*via phone, e-mail, social media*) ✓ If travelling alone, connect with a similar group of people (*e.g. of the same origin, gender*)	✓ Help establish contact with family members, close friends and neighbours (*via phone, e-mail, social media*) ✓ Encourage to seek support	✓ Connect with family members ✓ Engage in social activities (*creative workshops, camp/reception centre improvement groups, sports activities)*
Provide information on coping	✓ Provide information on stress and coping, verbally or via leaflets *(see pg. 9. Psychoeducation)*		
Link with collaborative services	✓ Refer to general practitioner, if needed	✓ Refer to general practitioner and members of psychosocial team, if needed	✓ Refer to general practitioner, members of psychosocial team or social services, if needed ✓ Refer to specialised health and MH services, if needed and possible ✓ Connect with free legal services

Informational continuity of care

At the Expert Consensus Meeting (Athens, June 8th – 9th 2016), a small group discussion was held regarding the issue of continuity of care (Deliverable D4.1 & D4.2). All participants emphasized the importance of ensuring, at minimum, information transfer on the health needs and provided interventions. There was a strong support for use of online electronic systems, since this would be a safer and faster way of data transfer, but if not possible, a password protected memory stick (USB) could be given to the refugee to carry with them during the migration/resettlement. Language barriers among EU member states were identified as an important issue, and two possible solutions were discussed: using English language, or using universal (international) codes for diseases/medication and vaccination. Two systems for fostering informational continuity of care emerged: the recently developed IOM personal health record[22] and The International Classification of Primary Care (ICPC-2).[23] The next two paragraphs briefly present both systems, stressing the parts of the systems that refer to mental health care.

IOM personal health record (PHR) aims to assess health status of refugees and migrants, regardless of their point of entry in EU countries and/or length of stay at the time of health assessment. It combines personal history, physical examination, basic laboratory tests and assessment of mental health status and aims to evaluate health needs regarding acute/chronic conditions, communicable or non-communicable diseases, immunisation status, injuries or mental health problems.[22] This procedure is expected to be followed up by immediate treatment, if needed, and follow-up. In the process of health assessment, examining physician/nurse/healthcare assistant takes patient's medical history including their known vaccination record. In case of indication of a need for immediate follow-up or further investigation, the patient will be referred to an appropriate health facility. IOM is currently developing an electronic personal health record and platform.

In the PHR, there are 4 questions concerning mental health:

- In medical history section, questions on previous/current mental illness/problems and on history of torture or violence (Y/N questions);
- In exam finding section, mental status should be assessed (including mood, intelligence, perception, thought processes, behaviour during examination) (Normal/Abnormal/Not assessed). Two assessment instruments are included in PHR: Mini-mental state examination - MMSE (only assessing cognitive impairment) and Assessment of activities of daily living – ADLs (assessing basic self-care functioning, e.g. ability to feed, dress and wash oneself);
- In summary findings section, significant mental health condition can be specified.

ICPC-2 was published for the first time in 1987 by World Organisation of Family Doctors (WONCA), and is designed to help primary health care providers to classify three elements of the health care encounter: reasons for encounter, diagnoses or problems, and process of care.[23] ICPS is linked to existing classifications such as ICD-10 (International Classification of Diseases) and is included in the WHO-FIC (WHO Family of International Classifications).

The system consists of symptoms codes, diagnoses and process codes referring to tests or actions undertaken per encounter. Since code thesaurus is universal, it bridges the language barrier: GP's in different countries can see the patient information in their own language.

In ICPC-2, there are 29 codes for psychological symptoms, and 17 codes for psychiatric diagnoses. In addition, there is a process code regarding intervention in the area of psychosocial assistance: therapeutic counselling/listening. Among the 29 symptoms, there are 5 that can refer to expressions of distress usually found in the refugee populations: feeling anxious/nervous/tense, acute stress reaction, feeling depressed, feeling/behaving irritable/angry and sleep disturbance. Furthermore, there are additional 29 codes for different social problems, some of which are very relevant for refugee and migrant population, for example poverty, housing problem, unemployment, legal problem or health care system problem.

Although psychological symptoms are better represented in ICPC-2, both systems lack what we believe are important pieces of information concerning MH status of refugees and migrants. Neither of these systems proposes a way to assess the intensity of distress which would indicate that action is needed. Proposing a standardised and valid procedure to screen people in distress is especially important in refugee populations, since identifying MH issues in refugees and migrants is a challenging task for a variety of reasons, ranging from cultural aspects of language barriers and accessibility, to problems such as defining and understanding mental illness across cultures.[24] In addition, these systems do not propose a way to record psychosocial interventions provided to the refugee or migrant. Therefore, we propose a recording format which would be based on a validated screener for psychological distress (RHS-13, Appendix I) and on a checklist of interventions that are recommended under the PFA approach. This recording system can be integrated in PHR and ICPC-2 systems, and can be used in a paper or electronic version.

The recording system for mental health of refugees and migrants which is proposed here includes results of MH screening, in terms of "positive" (above-the-cut off) screen on RHS-13 scale.[21] Individual symptoms could be described in a comment (PHR format), or entered as a symptom code (ICPC-2 format). In addition, the system would include a list of interventions, where care providers can mark and comment on interventions they have provided (PHR format) or enter the interventions as a process code (ICPC-2 format). This recording system would serve two purposes: first, to describe psychological state of the refugee or migrant based on the most relevant symptoms, and to provide information on the relevant areas of interventions that have been provided or deemed important. In the text bellow, the two recoding formats for MH issues that can ensure the continuity of refugee psychosocial care are illustrated: PHR format on pages 16-18 and ICPC format on pages 19-20.

Psychosocial Health Record I (PHR format)

Section 1 PROVIDER INFORMATION

Family name

Last name

Profession

Contact information City, Country

Email

Phone

Section 2 CLIENT INFORMATION

Family name

Last name

Date of birth

Country of origin

Language

Gender ☐ Male ☐ Female

Section 3 CURRENT NEEDS

Screening above cut-off on RHS-13 ☐ Negative ☐ Positive

If positive, please briefly comment on the most prominent difficulties (screener questions with the highest score):

Referral to MH specialist for full assessment and care provided ☐ Yes ☐ No

Are you aware of other difficulties the client is experiencing?

☐ Thoughts of harming self or others *Add comment*

☐ Alcohol or drug abuse *Add comment*

☐ Concerns about ongoing threat *Add comment*

☐ Physical/mental illness and medication(s) *Add comment*

☐ Extreme guilt or shame *Add comment*

☐ Concerns about safety of loved one(s) *Add comment*

☐ Availability of social support *Add comment*

Section 4 PSYCHOLOGICAL FIRST AID COMPONENTS PROVIDED

Safety and Comfort

☐ Attended to physical safety and comfort *Add comment*

☐ Attended to a child separated from parents *Add comment*

☐ Assisted with concern over missing loved one *Add comment*

☐ Assisted with grief reactions *Add comment*

☐ Assisted after death of loved one *Add comment*

☐ Gave information about the current situation *Add comment*

Stabilisation

☐ Helped with stabilisation *Add comment*

Practical assistance

☐ Helped to identify most immediate need(s) *Add comment*

☐ Helped to address immediate need(s) *Add comment*

Connection with Social Supports

☐ Facilitated access to social support *Add comment*

☐ Helped to engage in activities *Add comment*

Information on Coping and Psychoeducation

☐ Gave information about stress and coping *Add comment*

☐ Taught simple relaxation technique(s) *Add comment*

☐ Addressed negative emotions/anger management *Add comment*

☐ Addressed substance abuse problems *Add comment*

☐ Helped with sleep problems *Add comment*

Linkage with Collaborative Services

☐ Provided link to additional services *Add comment*

Section 5 OTHER

Do you have any other comments?

Psychosocial Health Record I (ICPC-2 format)

Psychological symptoms

PXX Severe distress (*coded if patient scores above cut-off on RHS-13*)

- PXX.X Muscle, bone, joint pains *(coded if intensity is at least "1")*
- PXX.X Feeling down, sad or blue most of the time *(coded if intensity is at least "1")*
- PXX.X Too much thinking or too many thoughts *(coded if intensity is at least "1")*
- PXX.X Feeling helpless *(coded if intensity is at least "1")*
- PXX.X Suddenly scared for no reason *(coded if intensity is at least "1")*
- PXX.X Faintness, dizziness, or weakness *(coded if intensity is at least "1")*
- PXX.X Nervousness or shakiness inside *(coded if intensity is at least "1")*
- PXX.X Feeling restless, can't sit still *(coded if intensity is at least "1")*
- PXX.X Crying easily *(coded if intensity is at least "1")*
- PXX.X Had the experience of reliving the trauma; acting or feeling as if it were happening again? *(coded if intensity is at least "1")*
- PXX.X Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma? *(coded if intensity is at least "1")*
- PXX.X Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings) *(coded if intensity is at least "1")*
- PXX.X Been jumpier, more easily startles (for example, when someone walks up behind you) *(coded if intensity is at least "1")*

PXX Thoughts of harming self or others

PXX Alcohol or drug abuse

PXX Extreme guilt or shame

Social problems

ZXX Concerns about safety of loved one(s)

ZXX Availability of social support

Process codes

XX Attended to physical safety and comfort

XX Attended to a child separated from parents

XX Assisted with concern over missing loved one

XX Assisted with grief reactions

XX Assisted after death of loved one

XX Gave information about the current situation

XX Helped with stabilisation

XX Helped to identify most immediate need(s)

XX Helped to address immediate need(s)

XX Facilitated access to social support

XX Helped to engage in activities

XX Gave information about stress and coping

XX Taught simple relaxation technique(s)

XX Addressed negative emotions/anger management

XX Addressed substance abuse problems

XX Helped with sleep problems

XX Provided link to additional services

Conclusions and next steps

The Model of Continuity of Psychosocial Refugee Care includes identifying refugees and migrants in need of psychosocial help and offering brief, focused PFA support. This support should be compassionate, person-centred and based on needs and wishes of refugees and migrants. Information about assessment of the mental and psychosocial status and the following PFA interventions provided to an individual refugee or migrant should be stored, with full and informed consent of each individual, and in a way so that only care-providers authorized by the patient can access it at all points of contact and at the final refugee destination. This can be done as a paper health record booklet or stored on a transferrable media (e.g. USB stick) or in a secure data base, with passwords known only to the patient. For this process, it is of paramount importance to obtain bioethical approval from the relevant institutions. Information transfer such as this would enable the care-provider to quickly understand the history and status of the refugee patient who reached out avoiding repetition of asking questions about the symptoms, see what PFA interventions were provided, and to provide a next "dose" of interventions that are consistent with the previous ones. Upon doing this, the care-provider should enter simple information about the interventions, so that there are cumulative, continuous records on one client/patient. Refugees and migrants should be encouraged to access the designated mental health psychosocial support care-providers and be informed how to do this at the next point of contact.

The next steps in WP5 include piloting of the screening procedure, including using RHS-13 scale in the Reception Centre Porin in Zagreb, for which ethical approval was obtained from the relevant body of the University of Zagreb on 5 July, 2016. The screening procedure will be piloted with approximately 120 asylum seekers. The results of those who score above the cut-off on the screening tool will be shared with the psychosocial support team in the Reception Centre and with the GP who is responsible for providing health care in the Centre, with the consent of the individual. In this way the feasibility of conducting mental health screening and of the information sharing protocol previously described will be tested.

In addition, cooperation has been established with IOM Croatia, who will be conducting physical health screening and collecting data for PHR in the next months. Therefore, experiences from WP5 piloting of the screening procedure will be shared with IOM PHR, but not the individual data. Upon this piloting, we will provide recommendations on integration of mental health screening in overall health screening for refugees and migrants with the hope that more relevant set of information on asylum seeker mental health needs will be included in the PHR.

Appendix I Refugee health screener 13[6]

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

[6] can be obtained at: http://www.lcsnw.org/pathways/

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