Long-Term Mental Health Support for Refugees after Resettlement: Assessment of Mental Health and Psychosocial Support Services for Refugees in Switzerland

Courtney W. Chan
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Long-Term Mental Health Support for Refugees after Resettlement:
Assessment of Mental Health and Psychosocial Support Services for Refugees in Switzerland

Courtney W. Chan

Fall 2019

SIT: School of International Training
Global Health and Development Policy
Academic Director: Alexandre Lambert

Washington University in St. Louis
Philosophy-Neuroscience-Psychology: Cognitive Neuroscience
“no one leaves home unless
home is the mouth of a shark
you only run for the border
when you see the whole city running as well...

...you have to understand,
that no one puts their children in a boat
unless the water is safer than the land...

...no one leaves home until home is a sweaty voice in your ear
    saying —
    leave,
    run away from me now
  i don’t know what i’ve become
  but i know that anywhere
  is safer than here.”

— Warsan Shire, excerpt from ‘Home’

Preface:

This research is inspired by and dedicated to my mom and her family, who are the most resilient people I know. Growing up hearing stories about their experiences as refugees during the Vietnam War, I could not fathom the inexplicable suffering my family had to endure as mere teenagers and children traveling by boat to escape their homeland. My mom would tell me stories about migrating to the U.S. and being thrown into her junior year of American high school with absolutely no background in English, working a full-time job along with school to support her family, and living with eight family members crammed into in a small house in Somerville, Massachusetts. She has since then gained a master’s degree in Computer Science after working full-time while completing her college studies. For all intents and purposes, she has achieved the “American Dream”. Nevertheless, the mental health repercussions by no means
Refugees after Resettlement

stop once “the dream” is achieved. Her stories about translating every sentence of her high school homework line-by-line, book-in-hand, from English to Vietnamese and back with no social services or academic support, still affect her now and just serve as further reminders of the lack of support for refugees after resettlement. Mental health remains a pertinent, yet hidden issue, especially in East Asian and other immigrant populations. It is swept under the rug for cultural reasons and selfless reasons – a culture where providing for one’s family and ensuring the next generation’s bright future are prioritized over one’s own emotional well-being.

I have always been interested in how culture, immigration, and trauma shape mental health. As a premedical student, I aspire to become a doctor who treats all patients – regardless of immigration status, race, religion, or background – with compassion and humanity. In this day and age, it is increasingly necessary to recognize that other people are just like us – human – and deserve care, support, dignity, and recognition of their suffering and trauma.

Recognizing cultural roots and the refugee experience are key components in providing culturally-relevant medical care to vulnerable populations. This research intends to expand the existing body of literature, as seeking mental health care after seemingly-ideal resettlement remains a stigmatized and invisible problem among refugees. I hope this research sheds light on the fact that refugee mental health not only should be talked about but needs to be talked about. Conducting research on this topic over the past few months has been both an eye-opening experience and a privilege. I hope that mental health continues to be studied in this population so that we can support this population, which has withstood so much unthinkable suffering that no human beings should ever have to endure.
Refugees after Resettlement

Abstract

By definition, refugees are people forced to escape their home countries, often as a result of persecution, war, or disaster. While abundant literature exists on the psychological effects of trauma and corresponding psychological treatment during or immediately following crises, we know little about how post-migration factors affect refugees’ psychological well-being after resettlement. Few such longitudinal studies have been reported; moreover, evaluations of current long-term mental health and psychosocial services (MHPSS) and refugee access to MHPSS in host countries remain sparse. This study presents an evaluation of MHPSS services for refugees currently implemented around the world, with a focus on services in Switzerland. Based on personal interviews with Swiss psychiatrists, policymakers, and humanitarian field workers while drawing on framing literature, we examine the causes of and types of psychiatric disorders that refugees experience, as well as discuss existing programs aimed to alleviate post-traumatic stress symptoms. We find not only that refugees endure traumatizing stressors before and during migration, but also that asylum-seeking and integration practices may further exacerbate PTSD, depression, and anxiety symptoms. Furthermore, we find that school-based interventions, migrant-specific mental health teams, and repeated exposure to cognitive-behavioral techniques are promising interventions to increase access to mental health services and provide sustainable care. Future mental health interventions must consider barriers to access, cultural differences, insurance-schemes, and politics during development and implementation.

Acknowledgements

This research would not have been possible without the support of staff in the SIT Switzerland: Global Health and Development Policy program. Thank you to Dr. Alexandre Lambert, Dr. Anne Golaz, Mrs. Francoise Flourens, and Mrs. Christina Cornes for your
Refugees after Resettlement

academic support and dedication to making us feel at home in Switzerland. Thank you especially to Dr. Golaz for your guidance and support for this project; your passion for humanitarian work and advice to “just listen” to other human beings is an important reminder in this chaotic world.

Thank you to all who agreed to be interviewed for this project: Dr. Ariel Eytan, Dr. Anne Golaz, Dr. Saskia von Overbeck Ottino, and Ms. Alison Schafer. Your passion for humanitarian work and medicine served as an inspiration for this project and my future endeavors. Thank you to Dr. Arnaud Perrier at the HUG for recommending me interviewees, as well as allowing me to shadow his patient rounds and learn about Swiss healthcare firsthand. Seeing him treat patients with such humanity and compassion is a breath of fresh air and reminds me of the doctor I aspire to be.

Most importantly, thank you to my family for supporting me through this experience: mom, dad, and Ryan. I would not have been able to explore Switzerland (and Global Health) without you. Thank you especially to my mom and her family, who raised me telling me gripping stories about refugee experiences escaping from the Vietnam War. Your resilience, toughness, and compassion for each other inspired this project and continue to motivate me through every difficult moment in my life.
Table of Contents

I. Introduction ........................................................................................................................................ 1

II. Research Methodology .................................................................................................................. 3
   i. Ethical Considerations and Study Limitations .............................................................................. 5

III. Background and Literature Review .............................................................................................. 6
   i. Stages of Migration, “Triple Trauma Paradigm” ........................................................................... 6
   ii. Child Development and Pyramid of Needs .................................................................................... 8
   iii. Debriefing and PFA ..................................................................................................................... 10
   iv. Remaining gaps ............................................................................................................................ 11

IV. Analysis and Findings ..................................................................................................................... 12
   i. Psychological effects of trauma on refugees after resettlement ................................................. 12
      On infants, children, adolescents, and adults .............................................................................. 12
   ii. From Asylum-Seeking to Resettlement: Associated Psychological Impact .. 14
      Asylum-Seeking Process and Obstacles ....................................................................................... 14
      Integration/Resettlement Process and Obstacles ........................................................................ 16
      Special Considerations for Children ........................................................................................... 16
   iii. Current Mental Health and Psychosocial Services Available to Refugees ... 18
      Classe d’Accueil; School-based Interventions .......................................................................... 18
      HUG Migrant Mental Health ...................................................................................................... 19
      Problem Management Plus, CETA Training, TFCBT ............................................................ 21
      From PFA to MHPSS: Lessons Learned ................................................................................... 24
   iv. Barriers to Care and Accessibility of Services .......................................................................... 25
      Factors Influencing Accessibility ................................................................................................. 25
      Politics and Legality ...................................................................................................................... 28
      Stigma and Cultural Differences ................................................................................................. 28
   v. Refugee-Centric Training and Tools for Providers .................................................................... 29
   vi. Strengths and Weaknesses of Existing System ........................................................................ 33
      Recommendations moving forward .............................................................................................. 33
      Comparison to other countries ..................................................................................................... 35

V. Conclusion ......................................................................................................................................... 36
   Limitations and Recommendations for Future Study ................................................................. 39
“No one becomes a refugee by choice; but the rest of us can have a choice about how we help.”

- Filippo Grandi, 11th UN High Commissioner for Refugees

I. Introduction

According to the United Nations High Commission for Refugees (UNHCR), the number of forcibly displaced people in 2018, 68.5 million, was the highest level of human displacement the world had ever seen. Of these 68.5 million, 25.4 million people were refugees (World Health Organization, 2019). From 2014 to 2015, Europe alone received an unprecedented increase in asylum seekers and migrants from Syria, Afghanistan, Iraq, and Eritrea by route of the Mediterranean Sea due to conflicts forcing people to flee. The 1.26 million asylum-claims in Europe during 2015 alone doubled that of claims in 2014. As globalization, conflicts, and violence continue, the number of migrants and refugees in the world is only expected to rise (Satinsky et al., 2019).

These millions of refugees per year are not just numbers, but people. Often traveling by foot or by sea in hazardous conditions, a refugee is defined by the United Nations 1951 Refugee Convention as “a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution...and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution” (National Center, 2003, p. 4). Refugees are markedly different from voluntary migrants, as they are forced to escape their home countries, often as a result of exceptionally traumatizing experiences, such as extreme violence, persecution, war, and disaster (National Center, 2003). The effects of trauma and forcible removal from one’s home are not small; they can have profound effects on one’s psychological well-being – not only before, during, and immediately following trauma, but in the months, years, and decades following.

Even during and immediately following crises, symptoms for mental health disorders can go undetected in the face more pressing physical needs for food, water, shelter, security, healthcare and contact with loved ones (World Health Organization, 2019). Consequently, humanitarian agencies
Refugees after Resettlement

have recognized a need for psychological first-aid (PFA), a first-aid technique used to psychologically evaluate and address affected individuals’ mental health in response to recent trauma. However, while PFA has proven relatively successful in the short-term, it still leaves an evident gap: after basic safety is restored, humanitarian workers leave site, and refugees are resettled into new countries, how are long-term psychological needs followed-up on and cared for? While experts recognize the need to evaluate refugees’ mental health after relocation, few such longitudinal studies exist (Fazel et al., 2012). Mental health disorders persist even after individuals are physically and temporally far from crisis; therefore, it is crucial to evaluate current programs that provide refugees with long-term psychological support following resettlement.

The purpose of this study is to assess the efficacy, access, and sustainability of mental health and psychosocial support (MHPSS) provided to refugees long-term, post-resettlement, with a case study focus on Switzerland. First, it will review current literature on a global scale and compare PFA during crisis to long-term MHPSS provided to refugees after resettlement. Then, using personal interviews with psychiatrists, humanitarian aid workers, and field experts in Switzerland, it will discuss the psychological effects of conflict and trauma on refugees, current MHPSS services available to refugees, and barriers to patient access and care. Next, it will evaluate the preparedness and training for medical providers caring for refugees, focusing on refugee integration and MHPSS services in Switzerland. Furthermore, this paper will examine the strengths and weaknesses of the existing mental health support system for refugees, as well as draw comparisons between Switzerland and other countries accepting refugees.

Mental health care for refugees relates to global health and development, as it concerns equity of health, including psychological health, for all people. The right to health transcends national borders and has global implications. Notably, refugees disproportionately affect developing countries, with nearly 85% of refugees coming from countries with little means to provide fiscal support or healthcare to vulnerable populations to begin with (Edwards, 2018). Mental disorders are of global importance
because they raise the risk for communicable (CDs) and non-communicable diseases (NCDs) alike; those affected by mental health disorders are at higher risk for shorter lifespans, alcoholism, and aggressive behavior, among a number of stress-related NCDs (Médecins Sans Frontiers, 2019).

Specifically, this study focuses on MHPSS services in Switzerland due to the fact that the country received a historic number of refugees in 2015. Due to the ongoing conflict in Syria, more than 39,000 asylum-seekers entered Switzerland from Eritrea, Afghanistan, Syria, Iraq, Sri Lanka and Somalia – a level not seen since the 1998 conflict in Kosovo (State Secretariat, 2015, p. 9). This led Switzerland to “accept resettlement of refugees directly from crisis regions”, putting their asylum system “severely to the test” (State Secretariat, 2015, p. 9). Thus, it is crucial to evaluate the provision, access, and sustainability of MHPSS for refugees in Switzerland, reflecting on whether mental health care has matched refugees’ needs in the four to five years following their resettlement.

II. Research Methodology

This study was constructed using a mixed approach of [1] secondary documents and [2] primary personal interviews. Preliminary search for peer-reviewed documents was conducted on Google Scholar. Official reports from intergovernmental, governmental and nongovernmental agencies regarding refugee statistics, asylum-seeking processes, and healthcare provisions were also examined. Journal searches consisted of three main categories using relevant key words: literature on [1] psychological effects of conflict and trauma, [2] psychological first-aid (PFA) history, development, implementation, and advice to providers, and [3] current mental health services available to refugees, with a focus on long-term migrant care in Swiss public hospitals.

Secondary literature was focused, but not limited to, studies conducted in Switzerland and surrounding European countries. For literature regarding psychological studies or development of intergovernmental/universal techniques (i.e. PFA), search criteria were not restricted to any country to increase the breadth and depth of literature. Findings of psychological studies are assumed to be
generalizable, and thus not country-specific. For psychological studies, studies examining refugees originating from areas affected by the Syrian conflict were selected when possible to ensure maximum continuity to refugees in Switzerland. For studies evaluating current mental health services, search criteria and personal interviews focused on resources in Switzerland; additionally, literature on MHPSS in peer countries were used to draw between-country comparisons. The author utilized the snowball approach, searching for references of previously cited articles to locate additional literature.

The target criteria for interviewees included experts based in Switzerland with academic expertise and/or firsthand involvement in mental health care for refugees, including psychological first-aid experts from humanitarian organizations, clinical psychiatrists, and field workers with experience in humanitarian crises. Experts were found via networking with other experts or online searches; they were recruited via email or through in-person conversations. All interviewees received an explanation of the objectives of the study, a preview of the interview questions, and email correspondence confirming their consent to the study. All interviews were semi-structured, with prompt questions interlaced with free discussion on topics of interest. Data was collected and transcribed during the interviews via notetaking on a personal laptop or by hand.

The interviews were conducted with: Dr. Ariel Eytan, Dr. Anne Golaz, Dr. Saskia von Overbeck Ottino, and Ms. Alison Schafer. The interview with Dr. Ariel Eytan, Associate Professor of Psychiatry at the Hôpitaux Universitaires de Genève (HUG) was conducted on Thursday, 17 October 2019 at the Warwick Hotel Lounge in Geneva. He was consulted based on his expertise in cultural psychiatry, migration, and mental health. Dr. Eytan served as a guest lecturer for SIT on Migration and Mental Health and was informally approached after the lecture for the possibility of a group interview, upon recommendation by Dr. Anne Golaz. His expertise provided firsthand perspective on refugee patients’ symptoms and his personal experiences providing care to refugees in a public Swiss hospital. Secondly, Dr. Anne Golaz, Coordinator of Health in Humanitarian Emergencies and Health Interventions in Humanitarian Crises at the Centre for Education and Research in Humanitarian Action
Refugees after Resettlement (CERAH), was interviewed on Friday, 18 October 2019 in the SIT Office in Nyon. Dr. Golaz was selected based on her teaching role at the CERAH, twenty years of field experience in humanitarian work, and former roles as a psychiatrist, medical epidemiologist for the CDC, Senior Advisor for UNICEF in Kathmandu and Geneva, and field experience with the WHO in Cairo and New Delhi. Her perspectives offered a firsthand look at what it was like to provide PFA to individuals during humanitarian emergencies, as well opinions on current MHPSS and PFA strategies based on her previous work with governmental and intergovernmental organizations. Thirdly, Dr. Saskia von Overbeck Ottino was selected upon recommendation from Dr. Arnaud Perrier, Chief Medical Director of the HUG. She was interviewed on Friday, 1 November 2019 at her psychiatry office at the HUG. Dr. von Overbeck Ottino served as a valuable resource due to her role as a child and adult psychiatrist, psychoanalyst at the HUG, and Vice President of the Association of Mental Health, Swiss-Rwanda, as well as V.P. of CAS: Migration and Culture Mental Health. She recounted her firsthand experiences consulting refugee patients, as well as personal experiences working in a migrant-care team within the HUG. Lastly, Ms. Alison Schafer was interviewed on Monday, 18 November via telephone. She was recommended by her colleague, Dr. Mark van Ommeren, WHO Public Mental Health Advisor and Policymaker. Ms. Schafer serves as Technical Officer at the WHO Department of Mental Health and Substance Abuse, with training in clinical psychology, research in cross-cultural mental health issues, involvement in developing PFA and MHPSS policies, and experience as Board Director of REPSSI to support children’s psychosocial needs in Africa. Her perspectives provided firsthand experience on development of PFA at the WHO and ongoing MHPSS efforts in developing and high-income countries alike to support individuals living in or fleeing from protracted conflict.

i. Ethical Considerations and Study Limitations

All primary interviews were conducted following verbal and email consent. Research design was IRB-approved by Human Subjects Review Standards and underwent expedited review. All
subjects were adults with significant expertise in humanitarian mental health. Interviews were conducted in English. Interviewees were informed of their privacy rights with full option to withdraw or remain anonymous prior to participation, as well as option to receive and review the paper prior to publication to avoid misinterpretation of data. When talking about experiences with refugee patients and children, no identifying patient information was disclosed. While initial research design included directly interviewing refugees, plans were changed due to sensitivity of talking to vulnerable individuals, time, and location restraints. Participant observation was therefore not conducted due to respect for the sensitivity of the issue and patient privacy. Additionally, the small sample of interviewees remained limited due to time and location restraints. Nevertheless, the study remained responsive to host community needs with sufficient quality, depth, and scope, as it consisted of a diverse range of experts speaking on patient, field, and policy experiences regarding long-term MHPSS for refugees.

III. Background and Literature Review

i. Stages of Migration, “Triple Trauma Paradigm”

In order to understand the psychological impact of migration on refugees, it is necessary to understand existing literature on the stages of migration. Scholars typically agree on classification of refugee migration into three steps: [1] pre-flight, [2] flight/transit, and [3] resettlement (National Center, 2003). At each stage, refugees may endure major stressors that put them at higher risk for mental disorders, coined as the “triple trauma paradigm” (Poulin, 2017).
During pre-flight, when individuals are still in their home countries but experience stressful triggers that cause them to flee, individuals may face anxiety, depression, anger, psychic numbing, paranoia, insomnia, and heightened awareness of death in response to witnessing extreme violence, loss of family members, persecution, chaos, threatened safety, or social upheaval (National Center, 2003). During transit or “flight”, refugees are often placed in refugee-camps described as “total institutions, places where...the inhabitants are depersonalized and where people become numbers without names” (National Center, 2003, p. 9). In these camps, many refugees witness violence and attempts at suicide, in addition to competition over inadequate food, water, and medical care. In a screening of unaccompanied Sudanese refugee children, researchers found that “virtually all” of the suffered from symptoms of post-traumatic stress disorder (PTSD) (National Center, 2003, p. 19). Additionally, children located in detention centers like those in the United States must navigate the asylum process and legal system, negotiating their rights without a guardian. Individuals in detention centers can be separated from family and held for up to two years; in one-third of cases, children are held in “juvenile jails” with lack legal representation as well as insufficient medical and psychological care (National Center, 2003, p. 10). Children held in postmigration detention centers are at higher risk
for psychological symptoms as well, due to exposure to fires, rioting, and other detainees engaging in self-harm (Fazel et al., 2012).

For those who are accepted for asylum, resettlement in the new country proves its own challenges. The loss of a familiar home, family and friends, material possessions, employment, and common language and culture frequently exacerbate symptoms of depression and PTSD; one study found that while time after relocation decreases severity of psychological symptoms, 92% of refugee children continued to experience some PTSD symptoms 2.5 years after relocation. Refugees may integrate to the new culture to varying degrees, ranging from only maintaining their original identities, balancing the integration of two identities, or entirely shedding their original identity. These varying levels of integration may result in feelings of anger, guilt, and ambivalence, as well as tension between the original cultural community or family and the refugee (National Center, 2003).

Dr. Jairam Ramakrishnan, a Médecins Sans Frontiers (MSF) psychiatrist working in Uganda, describes the refugee migration phases as the “perfect storm” for developing severe mental health problems (Médecins Sans Frontiers, 2019, para. 5). The combination of chronic conflict, lack of social support, and forced displacement being uprooted from one’s entire life and home make “fervent grounds” for developing mental disorders (Médecins Sans Frontiers, 2019, para. 8).

**ii. Child Development and Pyramid of Needs**

While the psychological impacts of being a refugee are well-documented, it is necessary to look at the impact on children as well. The UNHCR reports that over half of the world’s refugees are children (UNHCR, n.d.a). Experiencing extreme amounts of violence and crisis during development only exacerbates risk for and severity of associated mental health disorders (Edwards, 2018). In a study measuring the extent of war trauma in Cambodian refugee adolescents living on the Thai border, researchers found through interviews that somatic complaints, social withdrawal, attention problems, anxiety, and depression posed as the most common mental health conditions. Both parents and children
Refugees after Resettlement

reported insufficient food, water, and shelter; meanwhile, children reported more emotional distress from manmade violence, such as shellings or bombings, than their parents, with the event staying pertinent in their memories (Mollica et al., 2010). In another study conducted in Mozambique, over 77% of the 500 children interviewed witnessed murders or mass killings (National Center, 2003). These studies concur that witnessing such disturbing acts of violence in childhood affects children’s’ psychosocial states in the long-term. One long-standing psychoanalytic theory of child development, Erikson’s development theory, proposes that at monumental stages of a children’s lives, children undergo “psychosocial crises” between two conflicting forces. Environment and learning result in children either developing the healthy or the negative psychosocial virtue. For example, infants up to two years old may develop a trusting virtue or feelings of abandonment based on whether their needs are met by their parents and caregivers early on (State Secretariat, 2015). Consequently, a meta-analysis of journals from 1990 to 2003 hypothesizes that wartime experiences may exacerbate the development of “mistrust, self-doubt, and inferiority” when children live in hazardous environments throughout development (National Center, 2003, p. 5). Since children and adolescents are dependent on adults’ decisions, when adults are subject to political upheaval and unpredictable violence during conflict, children may lose their basic sense of safety and trust, leading to the retention of the negative virtue (National Center, 2003). However, supporters of Erikson’s development theory have been criticized since the model may not be cross-culturally generalizable. Erikson’s, among other develop theories, are based on “Western, middle-class constructions of childhood and propriety”, and therefore may not be accurately applied to all children, especially since most refugee children come from non-Western regions (National Center, 2003, p. 6). As a result, some experts advise that child psychologists and psychiatrists be especially culturally-sensitive when treating child refugees, considering that children’s coping strategies, beliefs, and social relations may impact how they express their symptoms and respond to care. In particular, children’s chief complaints often manifest as somatic symptoms; some may report headaches and dizziness, which scholars believe to be cultural expressions of emotional
stress. Ways of reporting psychological stress can differ depending on culture of origin (UNHCR, n.d.a).

It is apparent that emotional stress in refugees is often not recognized, either due to differences in cultural expression or circumstances. Among the literature, one prevalent theory suggests that during and following crisis, mental health comes last in the list of priorities. Individuals, including children, instinctively prioritize basic needs first, leaving processing of trauma and coping with mental health as a need realized after basic safety is restored (National Center, 2003). The WHO recognizes this, recommending that in emergency settings, “the first level of intervention is to guarantee basic needs...food security and nutrition, accommodation and general subsistence should be provided as a minimum to refugees and migrants upon arrival in high-income countries” (World Health Organization, 2017, p. 8). For refugees who lack security, sustenance, and resources pre-flight, during transit, and even after relocation, mental health disorders become hidden under more immediate needs. These refugees “if symptomatic, function at very high levels”, making diagnosis and treatment even more difficult (National Center, 2003, p. 18).

iii. Debriefing and PFA

In response to recognizing the need for mental health support during emergencies, researchers in 1995 proposed that psychological debriefing should be widely used in the first few hours to days following traumatic events to reduce the incidence of PTSD. Debriefing is described as practitioners or hospitalists counselling and asking affected individuals for information about the traumatizing event, asking them to recount their distress and reactions to the trauma (Kenardy, 2000). The debriefing process typically lasts one to three hours, with a procedure that “encourage[s] and normalize[s] emotional expression” of the affected individual (Kenardy, 2000, p. 1032). Until 2003, debriefing was the most widely implemented intervention to potentially traumatic events (World Health Organization, 2012). However, in 2003, the WHO ceased recommending debriefing, as several randomized trials
found it not only ineffective, but with potential to do harm (Kenardy, 2000). Some research found that debriefing prolonged recovery from traumatic symptoms, suggesting that “debriefing ‘medicalizes’ normal distress by generating in an individual the expectation of a pathological response”, without taking into account individual differences in coping mechanisms and willingness to discuss trauma (Kenardy, 2000, p. 1033).

Instead, the WHO now suggests psychological first-aid (PFA), which is described as a nonintrusive strategy that addresses basic psychological needs by “listening, comforting, and protecting people” for recent serious crisis events. In contrast to debriefing, PFA is a “humane, supportive response to a fellow human being who is suffering and may need support...with respect to their dignity, culture, and abilities”, emphasizing being calm, showing understanding, making people feel safe, understood, and respected, and not pressuring people while allowing for silence (World Health Organization, 2011, foreword). PFA is preferred to psychological debriefing; rather than analyzing distress, it shifts the focus to listening to people’s stories without judgement or pressure (World Health Organization, 2011).

iv. Remaining gaps

PFA addresses individual’s mental health immediately following emergency events; however, it does not address psychological care in the long-term, years and decades after individuals have moved far from the source of trauma but still experience post-traumatic symptoms. Similarly, ample literature exists on the psychological effects of being a refugee, but long-term, longitudinal studies following refugee’s mental health years after relocation remain sparse. As a result, it is crucial to investigate this relatively unexplored area – whether services PFA, or MHPSS, is available to refugees and provided consistently and longitudinally after basic safety is restored. Investigation of MHPSS services were discussed in the context of Switzerland, given its historic influx of refugees four years ago and the study’s interest in exploring longitudinal results.
IV. Analysis and Findings

i. Psychological effects of conflict and trauma on refugees after resettlement

On infants, children, adolescents, and adults

While refugees undergo numerous stressors during all stages of the migration process, relatively little attention is given to how post-migration factors affect their mental health. Historically, the focus for refugee mental health issues has been on pre-migration trauma (Satinsky et al., 2019). MSF doctors explain that long-term problems for refugees are often concealed, noting that “despite the violence, people are resilient and survive without many of the tell-tale signs of PTSD. But over time, faced with being stuck in their current living circumstances, without any improvement in their lives, [they] feel hopeless” (Médecins Sans Frontiers, 2019, para. 7). Recent studies argue for more attention to be given to post-migration factors, as they “may moderate the ability of refugees to recover from pre-migration trauma”, proposing a “need for therapeutic intervention with psychosocial elements that address the broader conditions of refugee lives” (Hynie, 2017, p. 1). When discussing mental welfare for refugees after resettlement, it is important to note that the long-term psychological impacts from trauma differ based on a variety of individual factors. One such factor is age: patients receiving psychiatric care are typically categorized into four categories: infants, children, adolescents, and adults (Ottino, personal communication, November 1, 2019). According to the European Union of Medical Specialists (EUMS), child mental health differs because it refers to a different range of mental disorders, uses referral pathways based in family and school systems, works under specific legal frameworks, and varies in provider treatment preferences (European Union of Medical Specialists, n.d.).

This age classification system is particularly pertinent when discussing how refugees receive MHPSS after resettlement. When asked about the different types of mental health problems seen in different age groups, Dr. Saskia von Overbeck Ottino, a child, adolescent, and adult psychiatrist at the HUG, responded that for babies, children, and adolescents, their mental health often primarily depends
on the well-being of their parents (Ottino, personal communication, November 1, 2019). Several studies have found that child refugees’ stress levels are inversely related to their mothers’ ability to cope and ability to self-regulate depends on caregivers’ emotional state (Mollica et al., 2010). Babies of parents with PTSD, depression, anxiety, and post-partum depression have increased risk for developing adjustment disorder (Ottino, personal communication, November 1, 2019). According to the DSM-5, adjustment disorder is diagnosed when individuals show marked distress disproportionate to the stressor, that is to say overexaggerated or reduced emotional responses that impair functioning in daily life (Substance Abuse, 2016).

For children, the most commonly seen mental health disorders after resettlement are depression, school and behavioral problems, and somatic symptoms. Similar to babies, children may feel their parents’ anxiety and depression and develop similar symptomatology. For example, Dr. Ottino described a case where a child explained that seeing their mother cry made them feel sad. Additionally, mental health symptoms often present as somatic symptoms due to children’s limited communication abilities, in combination with cultural and language differences (Ottino, personal communication, November 1, 2019). As aforementioned, manifestation of mental health symptoms as somatic ones is a common theme seen in the literature as well (UNHCR, n.d.a).

In adolescents, Dr. Ottino reports that the most common mental health disorders she sees are depression, anxiety, suicidal ideation, and PTSD, which all can manifest as behavioral difficulties. Other issues include sleep disorders, concentration difficulties, and flashbacks of the trauma. Adults present with similar mental health problems, with the primary ones being depression, anxiety, PTSD, and substance abuse (Ottino, personal communication, November 1, 2019).

While knowledge on the most frequent mental health problems in refugees is necessary and valuable, Dr. Ottino asserts that “we should focus on strategies and treatments now, we know what the problems are, it’s common sense” (Ottino, personal communication, November 1, 2019). This comment recognizes that a gap exists in the literature – there is boundless information on types of
psychiatric disorders and stressors during migration, but less so on long-term strategies for follow-up and support of refugees. Dr. Ottino emphasized the need to shift the focus to longitudinal solutions to rather than symptoms of trauma (Ottino, personal communication, November 1, 2019).

ii. From Asylum-Seeking to Resettlement: Associated Psychological Impact

Asylum-Seeking Process and Obstacles

When considering refugee mental health care after resettlement, it is necessary to evaluate risks and propose solutions at the two key steps upon refugee entry to a host country: [1] the asylum-seeking process and [2] integration/temporary shelters and eventual resettlement. In Switzerland, the asylum-seeking process follows seven steps: application for asylum, preparatory phase, cancellation and inadmissibility decision or interview, substantive decision, appeal, or removal, as shown in Figure 2 (Swiss Refugee Council, n.d.)

![Figure 2. Flow chart of Swiss asylum-seeking process (Swiss Refugee Council, n.d.)](image)

Upon entry, asylum-seekers receive an N-permit permitting their stay in Switzerland during the asylum-seeking process (Murray et al., 2014a). They undergo a compulsory medical checkup upon entry (Shock et al., 2015). According to national law, all asylum-seekers are guaranteed basic and emergency healthcare during their stay at the processing center, which can last up to 90 days. It remains
unclear whether this encompasses mental health services (Swiss Refugee Council, n.d.a). After 90 days, they are assigned residence in a canton, waiting up to two to three years in flux before gaining official status, with limited health insurance based on canton (Ottino, personal communication, November 1, 2019). The asylum-seeking process itself can exacerbate psychiatric problems. Experts critique that asylum interviews, which can last up to six to eight hours, are designed to nitpick inconsistencies and “prove [asylum-seekers] wrong...ineligible or not trustworthy” (Ottino, personal communication, November 1, 2019, Eytan, personal communication, October 17, 2019). For example, Dr. Ottino explains that patients may be asked “When you were raped, what color were the walls?”. If the interviewee responds blue one time and red the other, he or she can be refused asylum on the basis of inconsistencies and lack of trustworthiness. This interrogative technique is the opposite of how one should treat traumatized patients, as dissociative amnesia is characteristic of PTSD, explaining why those in distress tend to confound or forget certain details of their trauma (Ottino, personal communication, November 1, 2019, Eytan, personal communication, October 17, 2019). Furthermore, the asylum interview may retraumatize patients by forcing them to recount distressing experiences. The adverse effects of asylum interviews are well-documented in the literature. In a study assessing asylum-seekers before and after interviews, asylum-seekers reported subjective worsening of their clinical symptoms for PTSD, anxiety, and depression after interviews. The researchers found that the asylum-seekers also showed significant increase in posttraumatic intrusions post-interview, reporting intrusive memories of war, torture, and feelings of helplessness (Shock et al., 2015).

Humanitarian players, health professionals, and researchers alike propose that those designing asylum-interviews must be aware of the specific needs of migrants who have faced trauma and be more sensitive to their mental health needs. One proposed solution is to provide decision-makers with “special training to gain psychological knowledge and sufficient understanding of the effects of PTSD...[to] reduce the effects of distress on memory performance, [which] could also enhance the asylum seeker’s perception of justice in the interview” (Shock et al., 2015, p. 3). These measures have
potential to significantly reduce severity and incidence of mental health disorders, as well as add humanity to the process.

Integration/Resettlement Process and Obstacles

After gaining approval for asylum, individuals are officially granted refugee status and begin their integration to the host country (UNHCR, n.d.b). While integration has no agreed-upon definition, the UNHCR frequently uses the term to mean “an alternative to voluntary repatriation and resettlement”, or the long-term process of becoming a member of the host society (UNHCR, 2013, para. 1). In Switzerland, integration programs vary by canton, with canton-dependent “programme cantonal d’intégration » (PIC). PICs follow similar objective and themes, encouraging refugee employability, social integration, protection against discrimination, language skills, and community engagement (Secrétariat, 2018).

One criticism of integration is that upon relocation, refugees are assigned to or tend to group among themselves into small, isolated communities. While it is crucial to have a support system and community that shares similar experiences and cultural backgrounds, Dr. Eytan notes that these isolated communities may experience an “epidemic of suicide”. Seen in prisons, shelters, and isolated cultural communities, the epidemic of suicide describes that once one person commits suicide, the incident increases the risk of others committing suicide, following suit. He remarks that psychiatrists and community workers need to pay more attention to this phenomenon, especially if they know the refugee’s place of residence and community conditions (Eytan, personal communication, October 17, 2019).

Special Consideration for Children

It is important to note that in recent years, over 40% of asylum-seekers in Switzerland were children, nearly 3% of them being unaccompanied minors. In 2014, conflicts in the Middle East yielded an influx in Geneva of many 16 to 17-year-old unaccompanied minors, posing an increased need for
Refugee mental health care. While nearly all migrants struggle with integrating into a new, unfamiliar culture, integration poses an even larger issue to pediatric populations because they have already grown up with a constantly changing environment during development (Ottino, personal communication, November 1, 2019). When thrown into a yet another completely new cultural domain after resettlement, children must choose how much to integrate their old and new cultures; yet, their “original” culture and childhood environment have changed so much during crisis that they struggle to find something experiences to anchor to (Ottino, personal communication, November 1, 2019). Dr. Ottino describes that adolescents typically need “something to hold onto and be held by” during “milestone developmental events [such as] puberty, marriage, etc” – that is to say, a stabilizing force in their lives during transitions (Ottino, personal communication, November 1, 2019). The migration process thus poses a unique problem to refugee children, who often do not have stable support systems, family structures, or places to call home to ground them.

The refugee migration process already poses an enormous strain on children and teenagers, who are at risk for suicide, sex trafficking, and forced labor during and after their journey. Child and adolescent refugees have undergone rapid changes in their lives without time for adjustment, increasing their risk for forming gangs and engaging in substance abuse, as well as displaying behavioral problems and emotional distress (Eytan, personal communication, October 17, 2019; Mollica et al., 2010). Once resettled into a host country, there is often no specific care organized for children; they are considered as adults in many regions (Eytan, personal communication, October 17, 2019).

Dr. Ottino remarks that health professionals generally agree that the system must be changed for child and adolescent refugee integration (Ottino, personal communication, November 1, 2019). Experts recommend several solutions: [1] programs for children to rebuild their “roots” after resettlement and [2] changes in laws differentiating minors from migrant minors. First, Dr. Eytan and Dr. Ottino recommend that in an ideal world, the best way to provide child refugees with long-term mental health support after resettlement is to restore family structures. Giving children and adolescents
mentors or foster families in refugee shelters could be beneficial for giving children “some sense of restored balance”, giving them individuals or mentor to turn to as their new roots (Eytan, personal communication, October 17, 2019).

Secondly, Dr. Ottino explained that all refugee minors are placed in the same shelter with other youths upon arrival and receive a “legal tuteur” to inform them of their legal rights (Ottino, personal communication, November 1, 2019). Minors are also placed on a government list upon entry and referred to mental health providers for assessment (Sirriyeh, 2013). While these measures are exemplary, there is still a need to distinguish minors from migrant minors both legally and medically. In Switzerland, migrant minors are legally obligated to attend Swiss schooling with often no French knowledge, employment, or means of support. Additionally, child psychiatrists are not used to treating migrant populations, which have different needs than non-migrant children. She suggests that special considerations should be for minors, especially unaccompanied minors, during integration (Ottino, personal communication, November 1, 2019).

iii. Current Mental Health and Psychosocial Services Available to Refugees

*Classe d’Accueil; School-based interventions*

In certain areas of Switzerland, “classe d’accueil” is one option for refugee children and adolescents to learn French and integrate into the Swiss lifestyle. Intended for “allophone pupils”, or newly arriving minors to Switzerland with little or no mastery of French, the class is intended to integrate language training into normal compulsory education (Unterhitzenberger et al., 2015). Among the literature, language skills and interpretation are one of the key social determinants of mental health; thus, the objective of class d’accueil is to accelerate language learning and cultural integration as the child adjusts to the host country (Satinsky et al., 2019). The class is intended for children and adolescents of all ages and consists of intensive French instructions for four periods per morning tacked onto their daily mathematics class. Advanced pupils have the option of adding German once they reach
advanced mastery of French and parents can receive free French classes, giving them skills for increased autonomy and chances for employment in Switzerland (Unterhitzenberger et al., 2015). Since school attendance is compulsory in major cities of Switzerland, including Geneva and Lausanne, integration of language into children’s regular classes is an accessible and efficient way to them to improve their skills (Ottino, personal communication, November 1, 2019).

In addition to class d’accueil, preliminary research has been conducted on school-based trauma and grief-focused group psychotherapy for child and adolescent refugees (National Center, 2003). Since refugee children are often thrown into a new school system quite suddenly, they sometimes experience racial discrimination, bullying, and difficulties with the curriculum due to language barriers and previous disrupted schooling. Having grown up in situations of long-standing conflict, they are more likely to have psychological difficulties and troubles adapting (Fazel et al., 2012). School-based, group psychotherapy can help children learn to process trauma better, as well as build “collective identities, support networks” and a sense of belonging (Satinsky et al., 2019, p. 4). This sense of group belonging can improve mental health and adjustment to the host country; previous research has found that perceptions of acceptance, sense of safety and connectedness to peers, and presence of people of the same ethnic origin are predictive of psychological functioning (Fazel et al., 2012). Studies thus far are promising; children participating in school-based mental health interventions display fewer psychiatric symptoms and more pro-social behavior (Murray et al, 2010). Stable settlement and social support in the host country is a key protective factor for better mental well-being after resettlement; thus, establishing stable social support systems, accelerating language learning, and encouraging healthy ways to cope with trauma are crucial first steps in minimizing mental health problems in child and adolescent refugees (Fazel et al., 2012).

_HUG Migrant Mental Health_
In addition to school-based mental health intervention, the HUG, a university hospital in Geneva, devotes a specific fund to their small team dedicated to migrant mental health. The four-person team was developed in response to a need for “migrant-specific services”, recognizing that mental health needs of non-migrants and those of migrants differ tremendously. Dr. Ottino serves as a psychoanalyst and psychiatrist for the team, specifically providing migrant-specific psychiatric care to children and adolescents. After opening a clinic during the Bosnia-Herzegovina conflict and witnessing the large influx of refugees from Syria and Middle East in Switzerland from 2014 to 2015, Dr. Ottino quickly realized the need for refugees to receive treatment for their trauma. While all migrant minors undergo a somatic assessment upon entry, specialized, long-term mental health care is necessary to address the abundant needs of the refugee population. Dr. Ottino explained four main components/services of the migrant mental health team: [1] maternity assessments, [2] family assessment, [3] consultation for unaccompanied minors, and [4] adult follow-up care (Ottino, personal communication, November 1, 2019).

The first, maternity assessments, recognizes the need for mental health care for refugee mothers. Refugee mothers often present with different problems than non-refugee mothers, as they are tasked with having a child in a new country which comes with completely different concepts surrounding the medicalization of birth, rituals, and traditions for childbirth. They frequently arrive with lack of a support system or family; thus, obstetric and gynecological providers refer refugee mothers to the migrant mental health team for evaluation and assessment. Secondly, the team often counsels and assesses migrant families as a unit. Since many complications and mental health issues affect all members of the family. Dr. Ottino notes that it is easier to follow them as a whole unit to avoid losing individual members during follow-up appointments. Third, the migrant mental health team assesses unaccompanied minors when they arrive to communal shelters during resettlement. Unaccompanied minors frequently present with a bulk of mental health problems and behavioral problems. Without support systems or permanent caregivers, they are prone to skipping school, drinking, and starting
After resettlement, fights. While, years ago, they were originally only assessed if the mental health team received a referral from workers at the shelter, Dr. Ottino and the team recognized that at this point, it was too late to address the problems after they had already begun. Now, one psychologist aims to change that by visiting the shelter and psychiatrically assessing all unaccompanied minors on a regular basis, referring them to psychoanalysis when necessary. Fourth, the migrant mental health team sees adults on the basis of referral. While adult migrants receive mandatory somatic assessments upon arrival to Switzerland as well, they enter the migrant mental health team only if other doctors refer them (such as outpatient clinics, surgeons, etc.). For adults with chronic psychiatric problems, they are also referred to the team and receive follow-ups approximately once a month. Nevertheless, Dr. Ottino notes that once a month is “too infrequent” and “not enough for PTSD...[these patients] need more regular check-ins” to minimize psychiatric symptoms (Ottino, personal communication, November 1, 2019).

The HUG migrant mental health team functions on a referral-based system, partnering with pediatricians and other referring physicians. For example, when pediatricians at the main HUG building receive migrant minors, the minors are referred to the mental health team for a free first assessment. Patients are then referred to public outpatient follow-up care if necessary. This referral-based system is not standardized; it is dependent on connections between providers, relying on individual providers to be aware of and remember to refer patients to the migrant mental health team when necessary (Ottino, personal communication, November 1, 2019).

*Problem Management Plus, CETA Training, TF-CBT*

On a global scale, several longer-term MHPSS techniques have been developed targeting refugees and victims of trauma. Three of these are recommended by Alison Schafer, Technical Officer for the WHO Department of Mental Health and Substance Abuse, clinical psychologist, and author of the WHO Psychological First Aid pilot. These long-term interventions include: [1] Trauma-Focused

The first, Trauma-Focused Cognitive Behavior Therapy (TF-CBT), is an evidence-based treatment for children, adolescents, and their caregivers impacted by trauma. It consists of anywhere between 8 to 25 sessions between the child and their caregiver, with the objective of improving youth PTSD (TF-CBT, n.d.). There are eight components, termed “PRACTICE”: psychoeducation and parenting skills, relaxation, affective modulation, cognitive processing, trauma narrative, in vivo exposure, conjoint child/caregiver sessions, and enhancing safety and future skills (Unterhitzenberger et al., 2015). Professionals with advanced degree training in mental health disciplines (at least a Master’s) can become TF-CBT certified to provide long-term, repeated sessions to patients. Among 21 randomized control trials testing the efficacy of TF-CBT, research has shown that TF-CBT significantly improves children’s trauma symptoms. For example, a study assessing unaccompanied refugee minors from Somalia and Afghanistan in Germany found decreased PTSD symptoms after continued TF-CBT treatment in a German outpatient clinic for several months (TF-CBT, n.d.). Additionally, another study in Germany found concurrent results; Afghani refugee children who received 15 sessions of TF-CBT over a course of six months showed significant improvement in trauma-related symptoms (Unterhitzenberger et al., 2015).

Secondly, Problem Management Plus (PM+) is a WHO initiative developed in 2016. Like TF-CBT, the strategy focuses on providing long-term care to trauma-survivors over a course of several months to a year. PM+ consists of five, 90-minute individual sessions and is targeted toward adults. The sessions consist of problem-solving counselling or therapy options plus selected behavioral strategies depending on the individual’s problems. These problem-solving strategies focus on addressing stress, fear, and feelings of helplessness post-trauma, as well as propose strategies to cope with practical problems patients often have little control over, such as family conflicts, war, violence, and chronic poverty. Providers learn to validate patients’ feelings, communicate concern, praise
openness and sharing about traumatic experiences, and build confidentiality and trust. In contrast to TF-CBT, PM+ can be utilized by lay worker professionals with little to no prior mental health experience once providers undergo classroom and in-field PM+ training (World Health Organization, 2016). For example, PM+ sessions held in Guyana recruited general medical officers, psychologists, and social workers, as well as spiritual leaders and community health education workers (Pan American Health Organization & World Health Organization, n.d.). The PM+ technique has showed promising results, with Pakistani patients in one study showing lower levels of anxiety, depression, posttraumatic stress symptoms, and functional impairment after three months of treatment (Van Ommeren, n.d.).

The third, Common Elements Treatment Approach, or CETA, is an evidence-based treatment that aims on treating a general range of stressor-related psychiatric disorders, rather than focusing on one specific disorder. It takes common elements of treatment of common disorders, such as depression, PTSD, and anxiety, and combines them to treat post-traumatic victims regardless of specific diagnosis. This generalized approach is inexpensive and useful in low and middle-income countries; globally, this is crucial since 85% of refugees relocate to and from developing countries (Murray et al., 2014, Kenardy, 2000). CETA is conducted 8 to 12 times in 60-minute sessions, over the course of several months. CETA providers work with individuals to develop anxiety management strategies (meditation, deep breathing, and imagery), behavior activation techniques (active and mood-boosting activities), cognitive coping/restructuring (understanding associations and restructuring thoughts to be more helpful), techniques to talk about traumatic memories, gradual desensitization to trauma, and harm reduction techniques against substance abuse. Providers can be non-professionals, lay providers, or community health workers; CETA is designed to allow anyone to be trained through several weeks of practice sessions and supervised practice runs. Providers are trained to encourage participation, normalize, and validate individuals’ problems. CETA has been linked to significant improvement in trauma symptoms, anxiety, depression, and dysfunction, with successful studies conducted in Thailand, Ethiopia, Zambia, Ukraine, and Myanmar (Murray et al., 2014a). While CETA is limited because
Refugees after Resettlement

providers use a single-treatment approach and lack the training to handle comorbidities, it holds promise as an inexpensive, accessible way to scale-up delivery of mental health services in low and middle-income countries (Murray et al., 2014b).

**From PFA to MHPSS: Lessons Learned**

While this study focuses on long-term care provided to refugees after resettlement, it is helpful to note successful components of PFA and emergency mental health response strategies and integrate them into MHPSS care. Fittingly, Alison Schafer, author of the WHO PFA pilot, notes that PFA is enormously helpful in emergency situations, but “should not be done in isolation...[it] should be part of a broader response” (Schafer, personal communication, November 18, 2019). She asserts that:

PFA is not a panacea – you’re not covered in MHPSS just because you know PFA. It is just a tiny component of a bigger system that needs to be in place...people think it’s more than it’s meant to be. It was never intended to treat mental illness or prevent mental illness and doesn’t eliminate the need for specialists. (Schafer, personal communication, November 18, 2019)

By recognizing the need for a bigger system to be in place, it logically follows that MHPSS services can be adapted and translated into a sustainable, long-term system. Proponents of PFA also recognize that emergency situations offer the opportunity to build back on existing systems, especially if communities experiencing crisis had limited mental health services before. Dr. Golaz, CERAH coordinator with notable experience in psychiatry and field experience administering PFA, explains the idea of “Build Back Better”. The idea is that for communities with poorly developed mental health resources to begin with, they have the opportunity to build these programs from scratch after disaster. For example, Dr. Golaz explains that before the war in Afghanistan, they lacked proper mental health care systems, even chaining psychiatric patients to their bed. In humanitarian emergencies, aid workers worked to build back the system with community health workers and build a MHPSS system from scratch (Golaz, personal communication, October 18, 2019). The ICRC Guidelines on MHPSS develop
an organizational approach to MHPSS during and after conflict, suggest that building sustainable mental health systems requires close mentoring, supervision, follow-up, and gradual withdrawal of support systems to promote sustainability and independence. For example, humanitarian workers may train and supervise community worker, local psychologists, emergency care responders, hospital staff, and teachers to independently administer mental health counseling on their own (International Committee of the Red Cross, 2018). While lay workers can learn to offer basic psychological support, the guidelines also suggest that for more severe mental health problems, providers should refer patients to more specialized psychotherapeutic support. The objective is to weave long-term, sustainable mental health frameworks into already existing formal and informal support systems (World Health Organization, 2011).

Several other components of PFA have potential to be translated into long-term MHPSS. PFA training often includes roleplay or simulated training; these components have already been adapted into PM+, which includes around four days of role play out of the ten-day training, and CETA training, which is entirely roleplay based (Schafer, personal communication, November 18, 2019). Schafer notes that roleplay is a critical component in training both PFA and MHPSS provider – rather than online PFA or theory-based training, roleplay allows for skills-based learning. Roleplay allows the trainer to adapt the situation to the cultural context and change conversations on the go. As an experienced trainer, Schafer notes that “no two PFA trainings [she has] run have ever been the same”, allowing the trainer and mental health providers to adapt to their patients and adjust responses and support accordingly (Schafer, personal communication, November 18, 2019). This underlying theme of adaptability and flexibility to cultural context and individuals is very well applicable to long-term MHPSS services as well, especially when treating refugees after resettlement who come from starkly different backgrounds and countries.

**Barriers to Care and Accessibility of Services**
Factors influencing accessibility

While in an ideal world, MHPSS services would be available to all refugees who need mental health care without question, certain barriers to care exist that make it difficult for refugees to seek out and receive care after resettlement. According to Dr. Ottino, 50% of those who experience war and conflict should have some form psychiatric disorder, whether that be PTSD, anxiety, or depression. However, migrant mental health teams do not see that 50% enter their doors (Ottino, personal communication, November 1, 2019). Recognizing that there are missing patients that need care but are not receiving it, Dr. Ottino and her team realized that medicine needs to “revamp its health strategy”, as “surely it is not that these patients are not experiencing problems, but our strategy [needs to be revamped] to make sure we’re providing access” (Ottino, personal communication, November 1, 2019). A systemic review conducted in 2019 on mental healthcare utilization and access in Europe finds similar results: while there are low rates of MHPSS service utilization in Europe, there remain high rates of mental health morbidity. Notedly, the review found that in Switzerland, asylum seekers incurred higher annual healthcare costs and number of general practitioner visits than Swiss residents but used relatively lower mental health services. Among the 41% of asylum-seekers who need psychiatric care in Switzerland, only 26% receive it (Satinsky et al., 2019).

Research cites that other barriers to access include limited availability or regular staff to build trusting relationships with refugees, long wait times, limited accessibility to schedule or find transportation to appointments, lack of interpreters, lack of childcare options, and problems with acceptability of treatment. Stigma, lack of awareness, and reluctance to seek help for mental health related problems are also cited. For example, the study found that Kurdish refugees in the United Kingdom were more comfortable visiting hocas, or traditional healers, than English doctors (Satinsky et al., 2019). Traditional healers may also be preferred since clinicians in host countries may not speak the refugees’ language; moreover, refugees may lack ability to pay for Western services and have low priority to their mental health over other basic physical needs (Mollica et al., 2010).
Dr. Ottino explains that another factor might explain the “missing patients” – that mental health disorders are sometimes mistaken for behavioral problems. In communal resettlement shelters, PTSD is often overlooked because it presents as “bad behavior”, manifesting in individuals drinking, starting fights, or shouting at other residents at the shelter. There is a need for increased education, that is, making shelter supervisors aware that PTSD might be the cause of problematic behaviors. Rather than shouting at individuals or disciplining them, workers need to refer them to help and support them (Ottino, personal communication, November 1, 2019).

**Politics and Legality**

Furthermore, the current political environment is one where few want to help refugees, making it difficult to bring attention to refugee healthcare (Ottino, personal communication, November 1, 2019). Dr. Ottino describes working for refugee mental health as “a fight against the wind”. She cites that years ago, individuals could seek asylum from their home country prior to being resettled in Switzerland. Now, asylum-seekers must enter illegally, frequently through hazardous Mediterranean routes that further traumatize individuals prior to undergoing long asylum interviews upon entry. After asylum interviews, which pose their own adverse effects on mental health, asylum-seekers wait up to two to three years with limited support before gaining official status. Changes in administrative and legal processes regarding refugees are influenced by the political environment, which has become more and more strict against refugees in recent years (Ottino, personal communication, November 1, 2019). Dr. Eytan adds to this perspective, remarking that “refugees may have access, but most people on the move are not refugees...they are illegal and in the process of seeking asylum without being granted refugee status” (Eytan, personal communication, October 17, 2019). In the years that asylum-seekers must wait for a decision, asylum-seekers endure the stress of transition in addition to limited access to care, existing neither as a refugee nor as a citizen with full rights (Eytan, personal communication, October 17, 2019). The literature concurs, stating that “legal status (often) determines the level of
Refugees after Resettlement

access, as appropriate within national insurance schemes and health systems”; moreover, “refugees and migrants may fear detection, detention, or deportation and may be subject to tracking or slavery”, only further driving them away from accessing the services they need (World Health Organization, 2019). Consequently, Dr. Eytan recommends that public health needs to move toward providing not only resettlement services, but transitory services as well, as asylum-seekers and refugees are affected by unpredictable party politics outside of their control (Eytan, personal communication, October 17, 2019).

Stigma and Cultural Differences

Lastly, stigma and cultural differences in expressing mental health symptoms play a large role in underusage of MHPSS. In numerous countries, there is a stigma against mental health that deters people from seeking help for their symptoms. Rambo, a South Sudanese refugee, explains to MSF that “people do not understand what mental health is...some associate it with witchcraft...yet there is a huge need...many have experienced physical assault, some have seen relatives killed” (Médecins Sans Frontiers, 2019, para. 11). In the Middle East especially, there is an enormous amount of stigma around mental illness; as a result, even if refugees from those areas know they have access to care, they still will not use the service (Golaz, personal communication, October 18, 2019). Cultural differences and gender stereotypes also impact usage of care; for example, Dr. Golaz explains that when she conducted field work in Kyrgyzstan during the ethnic clashes, she interviewed the chief of the village. When asked about the needs of his people, he responded that “our women need psychosocial support”, but when asked about the men, he retorted, “No, no, no, our men are strong!” . These gender stereotypes influence individuals seeking and receiving care. Relatedly, she found that individuals would prefer to go the general practitioner rather than a mental health specialist to avoid admitting that they may have a mental illness (Golaz, personal communication, October 18, 2019).
Furthermore, mental health symptoms are sometimes expressed differently by those of different cultures. Some individuals express mental health issues through somatic channels, opting to say “my heart hurts” rather than indicating sadness or depressive symptoms (Golaz, personal communication, October 18, 2019). Literature shows that expressions of somatic distress to indicate mental health problems are common – and if physicians are not aware of it, they may misdiagnose refugees and delay mental health treatment onset (Satinsky et al., 2019). From her field experience, Dr. Golaz learned that it was important to be cautious with language, adapting it to the context. For example, when working in Myanmar, a Buddhist country, instead of using the words “mental health” or “psychiatric support”, she would gently remind individuals “I’m here if you want to talk about your feelings”, taking away pressure and encouraging open conversation only if desired. In Buddhist monasteries in Nepal, she explains that Buddhist individuals would remark that they “did not understand why people with mental health issues were put in asylums...you just need to meditate...Buddha is helping us overcome the experience, we accept it.” Recognizing that religion can be a good coping mechanism, Dr. Golaz recognized that mental health can be overmedicalized in the West and that drugs are not always necessary for mental health issues. While she did not force MHPSS on these individuals, she instead provided the option to receive care if individuals desired, stating, “if Buddhism is your culture, that’s fine, but if it’s very serious – we know from studies that there are physiological changes to trauma, then the option to receive care is important” (Golaz, personal communication, October 18, 2019). Thus, it is important for practitioners to recognize that refugees may be underutilizing services due to stigma, differences in language expressing symptoms, or cultural differences in coping mechanisms in response to trauma.

**Refugee-Centric Training and Tools for Providers**

There is a need for practitioners treating refugees to recognize that migrant care is different; therefore, the must adapt their professional styles consider refugee patients’ specific needs (Ottino,
personal communication, November 1, 2019). While stigma does play a role in refugee underutilization of MHPSS services, Dr. Ottino argues that “people say that discrimination and stigmatization is the reason why refugees don’t seek mental health care...but I believe the problem is on the side of the professionals” (Ottino, personal communication, November 1, 2019). She asserts that professionals need to agree on how to treat refugees as a collective body; she gives an example to illustrate the problem: imagine a 15-year-old refugee patient who would never go to appointments unless his parents forced him to go. While educators would advise the boy “if you don’t want to go, don’t go”, Dr. Ottino argues that sometimes educators and providers are not on the same page. From a clinical standpoint, minors sometimes avoid appointments to avoid talking about the problem, as is it painful and retraumatizing to talk about their previous traumas. While she recognizes that it is important not to force refugees to rehash their trauma, she also emphasizes that if patients don’t come, providers cannot help them. There is a careful balance between sensitivity and providing necessary care (Ottino, personal communication, November 1, 2019). The literature restates the same idea, emphasizing that when interacting with refugees, practitioners are “forced to start rethinking a familiar model of psychotherapy”, as the dynamics of mental health are completely different if the refugee patient comes from an entirely different background from the provider (Murray et al., 2010).

Along the same lines, experts suggest that providers need to recognize that people have different coping mechanisms, which vary depending on culture. There is no prescribed treatment or “correct” coping mechanism. Dr. Golaz recounts one conversation in particular with her driver for UNICEF in Haiti. After the earthquake, he told her that he was “happy today because after weeks, [he had] found the bodies of [his] mother and child in the rubble”. Shocked, Dr. Golaz asked him why he didn’t take a vacation, in which he responded “No, I prefer to work, listening to religious readings and music helps me”. For the Haitian driver, his coping mechanism was using work as a distraction and relying on religious groundings. Differences in coping mechanisms such as these are not only cultural, but personality-related too (Golaz, personal communication, October 18, 2019). Thus, it is crucial for
providers to be sensitive to every individual’s specific needs and coping mechanism, responding accordingly in a personalized and nonintrusive way.

Among all providers, the common lesson for all healthcare professionals treating refugees can be summarized in one word: “Listen” (Golaz, personal communication, October 18, 2019). Patients vary on willingness to open up, so experts recommend that advisors recognize that it is especially important to respect refugee patients’ will and feelings (Eytan, personal communication, October 17, 2019). In the very beginning stages of resettlement, refugees may find it difficult to talk about their feelings if safety and basic needs are still not restored – safety is prioritized over emotions, and individuals tend not to talk about feeling sad if they cannot get food on the table, have no reliable shelter, etc. (Eytan, personal communication, October 17, 2019). The basic principles of treating a trauma-affected vulnerable are to “not tell people what to do, be aware that some people might have to be listened to, and not do all the talking” (Golaz, personal communication, October 18, 2019). This is especially applicable to providing MHPSS after resettlement, as healthcare workers dealing with migrants should be aware of differences in approaches in healthcare; they should work on making refugee patients comfortable and bridging cultural gaps rather than forcing assimilation (Golaz, personal communication, October 18, 2019).

Moreover, experts recommend that refugee health providers be sensitive about their language use and behavior, which may differ in cultural acceptability depending on the population. For example, when training community health workers on PFA in Gaza, Schafer advised them not to make promises or give victims of disaster false hope about things they didn’t know. She advised against telling a person with a missing child that they will be okay, that the child will be found, etc. However, she quickly learned from the health workers participating in the training that in their culture, it is considered “ungodly and rude” to not reaffirm people with some sort of hope. She accordingly had to adjust her training to account for that (Schafer, personal communication, November 18, 2019). Furthermore, experts advise that healthcare professionals be cautious about language and behavior when helping
children, as children need to be communicated with in simpler, kinder, and more human terms (Ottino, personal communication, November 1, 2019). These nuanced considerations for refugees are just small adjustments in language and vocabulary but make a large difference in how healthcare is perceived by refugees.

Not only do medical providers need to be trained in culturally sensitive medical care, but interpreters need to be culturally sensitive as well. Especially for children, mental health interpreters must be aware of small changes in nonverbal communication and tone of voice, as children tend to communicate in simpler, less verbal terms. In her migrant mental health team, Dr. Ottino emphasizes that the ideal migrant mental health interpreter should not pressure children to talk, especially about traumatic experiences. She asserts that refugee children need to be treated differently, with more sensitive considerations than non-migrant children. Additionally, interpreters must be aware of cultural taboos, which differ by language (Ottino, personal communication, November 1, 2019). For instance, death and sexuality are taboo in many cultures – when talking to a non-English or French-speaking patient, it is important to translate the question “Do you have any ‘dark thoughts’ or ‘pensées noires’?” to the language spoken (Ottino, personal communication, November 1, 2019). These anecdotes coincide with the literature, which is best summarized by the following:

When treating refugees for mental health problems associated with trauma, it is crucial to account for their it is crucial to account for their culture, history, experiences traveling from their country of origin, and coping mechanisms when evaluating their mental state, making diagnoses, and considering treatments. (Mollica et al., 2010)

There is therefore a need for access to regular, expert interpreting services, cultural liaison officers, and cultural training for interpreters. Research suggests that culturally sensitive medical care should also shift the emphasis away from actual experiences of trauma and PTSD, and more toward encouraging patients to find strength, capacity, and resilience moving forward from their pasts (Murray et al., 2010).
When refugees themselves were asked about how they would like physicians to ask about their mental health, they responded that providers should focus on making refugees comfortable, advising them, “Don’t cut us short, let us speak...joke with us” (Shannon, 2014, p 464). They also recommended that providers ask about the historical context of symptoms, reminding them not to “just focus on the pain...connect [it] to our problems back home” (Shannon, 2014, p 464). Lastly, refugees advised that providers ask direct questions about mental health instead of skirting around the issue to avoid making patients feel like they’re complaining. They preferred that providers “show [them] that it’s curable, otherwise [we] won’t tell” providers about the issue for fear that there is no solution (Shannon, 2014, p. 464).

**Strengths and Weaknesses of Existing System**

Mental healthcare, especially for migrants and refugees, has come a long way in the past decade. While humanitarian players and physicians alike used to prioritize somatic symptoms and physical ailments over mental ones, little by little, mentality has changed in recent years. Dr. Golaz describes mental health as coming from a neglected area to a “super addressed area”, especially after experts realized that conflict exacerbates pre-existing mental health conditions. The effect is shocking: she recounts that recently, in Gaza, most of the funding requested by humanitarian organizations was for mental health and psychosocial assistance, and not enough funding was requested for physical health (Golaz, personal communication, October 18, 2019).

On a smaller scale, it is considered a success that migrant mental health programs, such as the 4-person team at the HUG, even exist. Despite their limited staffing and funding, the HUG migrant mental health program sees nearly six times more patients now than when they started and has an expansive referral-based network system with physicians and other contacts (Ottino, personal communication, November 1, 2019). Concurrently, research on refugee mental health has shifted from a sole focus on pre-flight factors, to recognition that resettlement factors, preventative interventions,
and resettlement factors play a large role in well-being (Murray et al., 2010). The shift in research and mere existence of migrant health programs shows the importance that mental health is gaining in the public eye.

Nevertheless, refugee mental health still faces its challenges. For the HUG migrant mental health team, Dr. Ottino remarks that every year, they “fight to renew their funding”; as a result, most staff stay for about two years (Ottino, personal communication, November 1, 2019). There is a need for more permanent staff, as short-term staff require additional resources, time, and energy to train and transition knowledge. She also notes that if the team were more confident in their stability, instead of rallying for funding year to year, they would most likely be able to pursue more long-term, ambitious projects, as well as increase drive and motivation among staff. Nonetheless, Dr. Ottino is grateful for the existence of such team, despite small and temporary, and “doesn’t think [they] need much more, just more permanent staff and a better provider network” (Ottino, personal communication, November 1, 2019). She also points out that the team trains healthcare providers, but it is a sector that still needs substantial growth. The team provides around eight hours of training per year during medical training for competencies, equivalent to about a day dedicated specifically to migrant health. In an ideal world, Dr. Ottino would recommend more intensive and regular trainings for providers interacting with refugees and migrants (Ottino, personal communication, November 1, 2019).

Globally, refugee mental health and cross-cultural medicine are topics that draw little political attention (Ottino, personal communication, November 1, 2019). Since the political environment shapes administrative and legal policies, experts call for politicians to improve the asylum-seeking process to minimize their damaging effects on migrant mental health (Eytan, personal communication, October 17, 2019). Some comment that politicians tend to be short-sighted, so little services are provided for mental health now despite the long-term impacts on economic and social progress. Furthermore, Dr. Ottino suggests that there should be more “transversal” positions in hospitals that span several specialties. For her, she worked in maternal care, psychiatry, and migrant services, fitting perfectly
with her role on the migrant mental health team; however, she suggests that an official role should exist that ties together cross-cultural psychiatry and mental health, not one that arose out of happenstance. Additionally, she notes the need for more standardized processes; for example, she may be referred a patient because a surgeon she knows connects her to them, but the referral system is entirely based on professional and personal connections rather than a standardized method. Lastly, experts indicate that transitioning children from pediatric to adult care poses a challenge. For Dr. Ottino’s adolescent psychiatry service, she notes that they continue to follow about 50% of their patients personally instead of referring them to outside services out of fear of losing them in the transition (Ottino, personal communication, November 1, 2019). Dr. Eytan notes the same issue in patient retention and suggests that a smoother model for continuity of care should be enacted to retain as many patients as possible (Ottino, personal communication, November 1, 2019).

**Recommendations moving forward**

Recognizing the benefits and drawbacks of the existing refugee mental health system, experts agree on several recommendations moving forward. All interviewees mentioned the desire for more needs-assessments, or studies that document not just diagnoses and psychiatric pathologies, but ones that determine the needs, gaps, and current coping mechanisms refugees already work (Golaz, personal communication, October 18, 2019). There was agreement among all interviewees that needs assessments are more important than statistics, as they evaluate the current situation and “what works and what doesn’t”, as opposed to merely stating that an obvious problem exists.

Secondly, a common theme among interviewees was recommending that mental health care be integrated into primary healthcare. By incorporating a specialized field into general practitioner visits, this strategy would provide increased access to refugees, as well as assess psychosocial well-being during their regular somatic checkups (Golaz, personal communication, October 18, 2019). Integrating
mental health into primary care is also predicted to increase patient retention, decrease stigma, and improve access to appointments (Eytan, personal communication, October 17, 2019).

Finally, experts suggest that while attention toward sustainable mental health measures has increased in recent years, there is still a need for more research on long-term mental health. It is a legitimate question to ask how refugees “fare 10, 20, 30 years later”, whether they have access to care, whether services meet current needs, and what coping techniques helped them resettle and adapt (Golaz, personal communication, October 18, 2019). Yet, it is a question that still lacks ample research, as it is difficult to track down refugees years after resettlement and successful integration into host countries.

**Comparisons within Switzerland and versus the United States**

For Switzerland in particular, the mental health system is cantonal, with integration and healthcare procedures differing across the 26 cantons. While experts note that major cities like Geneva, Lausanne, Zurich, and Bern, are well-equipped to treat migrant mental health, other cantons may be less so equipped. In particular, some cantons continue to place minors in adult shelters and do not provide children and adolescent refugees with specialized care. Additionally, Geneva and other major cities compel mandatory school attendance, but this differs by cantons as well. Fortunately, all of Switzerland functions under Universal Health Coverage (UHC) (Ottino, personal communication, November 1, 2019). Basic health insurance is compulsory for all individuals residing in Switzerland for more than three months (Confédération Suisse, n.d.), with residents opting for supplementary private insurance coverage for services not covered by basic insurance, if desired. All Swiss residents with basic insurance are granted access to outpatient psychiatric treatment within their canton with a 10% copayment for services. Psychiatric inpatient hospitalization is covered by cantons and basic insurance plans; additionally, providers emphasize holistic treatment of the patient by encouraging
rehabilitation and complementary forms of therapy (exercise therapy, art and music therapy) to accelerate healing (Trotta et al., 2013).

Experts note that insurance policies can determine difficulty of accessing mental health care (Ottino, personal communication, November 1, 2019). The U.S. functions under a hybrid public-private patchwork of insurers, with no Universal Health Coverage. Access to outpatient psychiatric care is highly dependent on type of health insurance plan; those without insurance do not have access to treatment unless they pay out-of-pocket. Additionally, insurers often limit the number of outpatient psychiatric visits per year. This fragmented system leads to increased rates of inpatient hospitalization in the long-run. For inpatient psychiatric hospitalization, different insurance policies cover different lengths of stay, with some only covering treatment at certain prespecified hospitals (Trotta et al., 2013)

Differences in insurance policies are a major factor in determining level of access to services (World Health Organization, 2019). Consequently, it is necessary to consider all larger global factors – political and country-specific – when evaluating refugee access to MHPSS.

**Conclusion**

Through an evaluation of the psychological effects of the refugee migration process, current immediate and long-term mental health services available, barriers to patient access and care, and recommendations for refugee-centric mental health care in the future, this study addressed why MHPSS for refugees is a pertinent issue in the global health sector now. Moreover, this study assessed strengths and weaknesses of the existing MHPSS system in Switzerland, comparing and contrasting it to current global strategies to address mental health, as well as strategies with varying degrees of success in other countries.

Evidence supports that during all stages of the refugee migration process, extreme stressors and traumatic events increase the risk for refugees to develop severe, post-traumatic mental disorders. A common theme supported by both secondary and primary sources was that mental health appears to be
Refugees after Resettlement

a more hidden need that is often swept under the rug; refugees tend to prioritize basic needs and safety before considering their emotional ones. As a result, nearly all studies concurred that the most common psychiatric disorders in refugees – depression, anxiety, and PTSD – frequently go undetected and ignored for many years even after resettlement. Evidence also suggests that psychiatric symptoms are commonly ignored due to lack of provider awareness and psychoeducation; PTSD can present as behavioral problems, substance abuse issues, or acting out in schools or shelters, and thus it can go unrecognized for extended periods of time. This evidence further highlights the need for more attention and services targeted toward refugees after resettlement.

All interviewees noted that legal, administrative, and political barriers pose one of the greatest threats to refugee mental health. The asylum-seeking process is criticized among the literature and experts alike for retraumatizing patients with its interrogative practices. One pattern noted is that all sources vouched that child and adolescent refugees need to be given special consideration to ensure healthy psychological development in the face of adversity. These considerations indicate that current asylum-seeking and integration processes need to change to protect refugee mental health.

This study originally proposed that an imminent need exists for expansion and growth of long-term MHPSS services offered to refugees. Evidence from expansive literature, as well as from personal interviews from experts in the field, provide support that there is a need for more research on long-term MHPSS services. Fortunately, evidence indicates that MHPSS is gaining traction in the field, as several promising, long-term MHPSS strategies are currently being developed and implemented, such as PM+, CETA training and TF-CBT. In Switzerland specifically, several support measures for refugees and migrants are in place, such as school-based intensive language acquisition courses and migrant-specific mental health teams at the HUG. Among all sources, they indicated that integrating mental health into primary care or school-based interventions prove promising first steps, as incorporating mental health into pre-existing systems can reduce barriers such stigma and lack of access. Moreover, all sources noted that refugees must be treated with the utmost cultural sensitivity and humanity, with providers
Refugees after Resettlement

being aware of cultural differences, variations in coping mechanisms, and different ways patients may express their psychiatric symptoms.

These findings have implications on how MHPSS continue to evolve and support refugee mental health. While the existing body of knowledge sufficiently details the psychological symptoms that refugees experience, few studies to-date exist that evaluate refugee mental health in the long-term. An evaluation of current successful measures in Switzerland, such as school-based interventions, different long-term therapies, and migrant-specific departments at hospitals, could serve as a model for the development of similar MHPSS services in the future.

Limitations and Recommendations for Future Study

This study was limited due to time restraints, with research being conducted over a period of only several months, and location restraints, with all interviewees being located in the Geneva/Canton of Vaud area. One shortcoming was the small sample size of interviewees (four experts); much of this was due to the busy schedules of experts at major humanitarian and medical organizations, as well as difficulty contacting numerous experts in a short amount of time. Additionally, the author was unable to directly interview refugees due to patient sensitivity and IRB concerns over privacy for vulnerable populations. However, this would serve as an interesting avenue for continued research.

In the future, the field could benefit from more longitudinal and in-depth studies evaluating existing long-term MHPSS services and their clinical efficacy in reducing and preventing the incidence of psychiatric disorders. In addition, future research could investigate development of proactive MHPSS treatments children of refugees, as they are at an increased risk of developing psychotic disorders compared to peers of non-immigrant parents (Fazel et al., 2012). Lastly, research on the effects of climate change on immigration and asylum-seeking is especially relevant, given that forced coastal and seaside migrations have been elevating in recent years (Eytan, personal communication, October 17, 2019). There are currently few preventative interventions to address climate-based mental
Refugees after Resettlement

health problems, with most interventions serving as reactive political and government responses instead of proactive, preventative aid. While the focus on mental health in the medical and humanitarian community has grown exponentially in recent years, escalating migration and push-factors driving people out of their homes call for increased attention on refugee mental health.
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Refugees after Resettlement


Refugees after Resettlement


Refugees after Resettlement


Refugees after Resettlement


**Primary sources**


Appendices

A. Abbreviations List ................................................................. A1
B. Summary of Research Provided to Interviewees ......................... A2
C. Interview Questionnaires Provided to Interviewees .................... A3-A6

Appendix A: Abbreviations List

Organizations/Institutions

CDC: Center for Disease Control
CERAH: Centre for Education and Research in Humanitarian Action
EUMS: European Union of Medical Specialists
HUG: Hôpitaux Universitaires de Genève
ICRC: International Committee of the Red Cross
IRB: Institutional Review Board
MSF: Médecins Sans Frontiers
UNHCR: United Nations High Commission for Refugees
UNICEF: United Nations Children's Fund
WHO: World Health Organization

Health Terminology

CETA: Common Elements Treatment Approach
DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
MHPSS: Mental Health and Psychosocial Support
NCDs: Noncommunicable Diseases
PFA: Psychological First-Aid
PIC: Programme Cantonal d’Intégration
PM+: Problem Management Plus
PTSD: Post-Traumatic Stress Disorder
TF-CBT: Trauma-Focused Cognitive Behavior Therapy
UHC: Universal Health Coverage
Appendix B: Summary of Research Provided to Interviewees

An Assessment of Long-Term Mental Health Support for Refugees
How current psychological first aid (PFA) techniques address the refugees’ long-term, post-traumatic mental health needs

Brief summary:

The goal of this ISP is to evaluate current techniques in psychological first aid (PFA) in providing refugees psychological support in the long-term, following traumatic events. By definition, refugees are people forced to escape their home countries, often as a result of persecution, war, or disaster. The effects of trauma, exposure to violence, and forceful removal from one’s home can have profound effects on psychological well-being – not only during and immediately following trauma, but in the months, years, and decades following.

While PFA is applied during and immediately after emergency situations, this ISP aims to investigate:

[1] The definition, strengths, and weaknesses of PFA
[2] Whether long-term care like PFA is provided to refugees post-relocation

Main question:

How do current psychological first aid (PFA) techniques address the refugees’ long-term mental health needs after traumatic events?

Objective:

To evaluate the opinions of [1] governmental PFA policymakers on the efficacy of current strategies and [2] clinical psychiatrists and humanitarian doctors. To evaluate similarities and/or discrepancies between Swiss policymakers’ and physicians’ opinions on efficacy and access of long-term PFA in refugees post-relocation.

Thank you for agreeing to be interviewed for this ISP. Your time and consideration are greatly appreciated. This project would not be possible without you!

Please feel free to contact me at courtneychan@wustl.edu or 076 628 05 50 if you have any additional questions, or would like a copy of the final report.

Courtney W. Chan
Washington University in St. Louis
Appendix C: Interview Questionnaires Provided to Interviewees

Interview 1 – Dr. Ariel Eytan

1. From a clinical standpoint, what are the psychological impacts of conflict refugees (PTSD, anxiety disorders, phobias, etc)? What differences do you see in the impact on children vs. adolescents vs. adults?

2. When refugees enter a host country, what clinical screenings do they undergo? Are mental health assessments incorporated into their transition, and if so, how?

3. What mental health services are available to refugees post-conflict and trauma? Long-term?

4. From a clinical standpoint, how do you see refugees actually accessing and using mental health services?

5. After refugees are relocated and integrated into their new countries, do you see staff at these institutions sufficiently equipped with the right training and tools to provide long-term mental health care? What is your experience like working at the HUG?

6. What barriers to accessing mental health services, if any, do you see in refugees after relocation?

7. What is your opinion on the efficacy/strengths/weaknesses of mental health services available for refugees now?

8. In an ideal world, how do you think we can best provide refugees with long-term mental health support after relocation? What improvements would you suggest to the existing system?

9. How do you think the focus on mental health in the medical community has evolved? How do you think it will continue evolving?
Interview 2 – Dr. Anne Golaz

1. What is your…
   a. Name?
   b. Position?
   c. Role(s)?

2. From a clinical standpoint, what are the psychological impacts of conflict refugees (PTSD, anxiety disorders, phobias, etc)? On children vs. adolescents vs. adults?

3. What mental health services are available to refugees post-conflict and trauma?

4. From a clinical standpoint, how did you see refugees actually accessing and using long-term mental health services?

5. After refugees are relocated and integrated into their new countries, do you see staff at these institutions sufficiently equipped with the right training and tools to provide long-term mental health care?

6. What current mental health services are available to victims of trauma during humanitarian emergencies? Can you talk a little bit more about PFA?

7. Do you see psychological services similar to PFA being provided to refugees in the years following relocation?

8. What is your opinion on the efficacy/strengths/weaknesses of PFA?

9. What improvements would you suggest for PFA?

10. How do you think we can best provide refugees with long-term mental health support after relocation?
Interview 3 – Dr. Saskia von Overbeck Ottino

1. What is your…
   a. Name?
   b. Position?
   c. Role at the HUG and relevant experience to mental health and migrants?

2. From a clinical standpoint, what are the psychological impacts of conflict refugees (PTSD, anxiety disorders, phobias, etc)? What differences do you see in the impact on children vs. adolescents vs. adults?

3. When refugees enter a host country, what clinical screenings do they undergo? Are mental health assessments incorporated into their transition, and if so, how?

4. What mental health services are available to refugees post-conflict and trauma? Long-term?

5. From a clinical standpoint, how do you see refugees actually accessing and using mental health services?

6. After refugees are relocated and integrated into their new countries, do you see staff at these institutions sufficiently equipped with the right training and tools to provide long-term mental health care? What is your experience like working at the HUG?

7. What barriers to accessing mental health services, if any, do you see in refugees after relocation?

8. What is your opinion on the efficacy/strengths/weaknesses of mental health services available for refugees now?

9. In an ideal world, how do you think we can best provide refugees with long-term mental health support after relocation? What improvements would you suggest to the existing system?

10. How do you think the focus on mental health in the medical community has evolved? How do you think it will continue evolving?

11. How does Switzerland compare to other countries, especially the U.S., in terms of providing refugees with mental health care? What are the influencing factors?
Interview 4 – Ms. Alison Schafer

1. What is your…
   a. Name?
   b. Position?
   c. Role(s)?

2. What current mental health services are available to victims of trauma during humanitarian emergencies? Can you talk a little bit more about PFA?

3. Do you see psychological services similar to PFA being provided to refugees in the years following relocation?

4. What is your opinion on the efficacy/strengths/weaknesses of PFA?

5. What principles of PFA you would translate to refugee MHPSS after resettlement?