

# Mental health and psychosocial support for resettled refugees



Facilitating the integration of resettled refugees  
in Croatia, Italy, Portugal and Spain

The opinions expressed in the Guidelines are those of the authors and do not necessarily reflect the views of the International Organization for Migration (IOM). The designations employed and the presentation of material throughout the document do not imply expression of any opinion whatsoever on the part of IOM concerning legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in the meeting of operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

The content of these Guidelines represents the views of the author only and is his/her sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

This publication was issued without formal editing by IOM.

Publisher: International Organization for Migration (IOM)  
IOM Coordination Office for the Mediterranean  
Casale Strozzi Superiore  
Via L.G. Faravelli snc 00195, Rome  
Phone: +39 06 44 23 14 28  
Email: [iomrome@iom.int](mailto:iomrome@iom.int)  
Internet: [www.italy.iom.int](http://www.italy.iom.int)

© 2021 International Organization for Migration

IOM Coordination Office for the Mediterranean



Some rights reserved. This work is made available under the:  
<https://creativecommons.org/licenses/by-nc-nd/3.0/igo/legalcode> (CC BY-NC-ND 3.0 IGO).

This publication should not be used, published or redistributed for purposes primarily intended for or directed towards commercial advantage or monetary compensation, with the exception of educational purposes e.g. to be included in textbooks.

Cover: © IOM 2016

**Mental  
health  
and psychosocial  
support  
for resettled  
refugees**

# Table of contents

<b>List of boxes and tables</b>	5
<b>Acronyms</b>	6
<b>About this guide</b>	7
HOW IS THE GUIDE STRUCTURED?	7
<b>Introduction</b>	8
1. REFUGEES AND RESETTLEMENT	8
2. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT	11
3. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT MATTER IN RESETTLEMENT	14
<b>SECTION 1. FIRST ASYLUM</b>	15
<b>Pre-migration</b>	16
OVERVIEW	16
<b>Travel to the country of first asylum</b>	18
OVERVIEW	18
<b>Living in the country of first asylum</b>	19
OVERVIEW	19
<b>SECTION 2. THE RESETTLEMENT PROCESS</b>	24
<b>Identification and selection</b>	25
OVERVIEW AND IOM'S ROLE	25
RECOMMENDATIONS	26
<b>Pre-departure activities and travel</b>	30
OVERVIEW AND IOM'S ROLE	30
RECOMMENDATIONS	35
<b>Post-arrival phase: reception and integration</b>	41
OVERVIEW AND IOM'S ROLE	41
RECOMMENDATIONS	51
<b>Conclusion</b>	62
<b>Annex 1.</b> Basic psychosocial skills for resettlement staff	63
<b>Annex 2.</b> Working with cultural mediators and interpreters	67
<b>Annex 3.</b> Key principles for promoting psychosocial well-being in the resettlement context	70
<b>Annex 4.</b> Key messages for refugees during the resettlement process	73
<b>Annex 5.</b> Key messages for host community members	75
<b>Glossary</b>	76
<b>References</b>	78

## List of boxes and tables

<b>BOX 1</b>	Mental health and psychosocial support: Key concepts and definitions	12
<b>BOX 2</b>	Intervention pyramid for mental health and psychosocial support in emergencies	13
<b>BOX 3</b>	Psychosocial approach to programming in displacement contexts	14
<b>BOX 4</b>	Understanding psychosocial reactions to adversity	17
<b>BOX 5</b>	First asylum phase and its common stressors and distress signs	21
<b>BOX 6</b>	Prevalence of mental disorders in post-conflict contexts and among refugees	21
<b>BOX 7</b>	The right of refugees to access mental health care	21
<b>BOX 8</b>	Strengthening the mental health assessment tool and protocol: a pilot study	31
<b>BOX 9</b>	MHPSS for pre-departure orientation (PDO) trainers	32
<b>BOX 10</b>	Best practices in PDO sessions: addressing mental health and psychosocial issues	33
<b>BOX 11</b>	Best practices for building the capacity of PDO trainers	40
<b>BOX 12</b>	Integration	39
<b>BOX 13</b>	Mental health and psychosocial support: a cross-cutting issue in the resettlement process	44
<b>BOX 14</b>	Identity and resettlement	47
<b>BOX 15</b>	Refugee resettlement and social integration	48
<b>BOX 16</b>	Barriers to access to mental health and psychosocial support for refugees in Europe	50
<b>BOX 17</b>	Best practices: Sensitization sessions on resettlement, mental health and psychosocial well-being (IOM Portugal)	60
<b>TABLE 1</b>	First asylum phase: summary of examples of stressors and possible psychosocial reactions	23
<b>TABLE 2</b>	Resettlement process: summary of example of stressors and possible psychosocial impacts	61

# Acronyms

<b>EEA</b>	European Economic Area
<b>EU</b>	European Union
<b>IOM</b>	International Organization for Migration
<b>MHPSS</b>	Mental health and psychosocial support
<b>NGO</b>	Non-governmental organization
<b>PDO</b>	Pre-departure orientation
<b>PEC</b>	Pre-embarkation checks
<b>PFA</b>	Psychological first aid
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>WHO</b>	World Health Organization

## About this guide

This document aims to inform decisionmakers and practitioners about the main psychosocial responses of refugees to each phase of the resettlement process. It also presents the role of the International Organization for Migration (IOM) in the process, and provides practical recommendations and resources for decisionmakers and practitioners to help them in providing mental health and psychosocial support to refugees in each of these phases.

### HOW IS THE GUIDE STRUCTURED?

The guide has three main parts and five annexes.

- ▶ The introduction gives an overview of the phases of resettlement; mental health and psychosocial support (MHPSS); and why MHPSS matters in the resettlement process.
- ▶ Section 1 covers the phase of 'first asylum' to help resettlement professionals understand the experiences and responses of refugees immediately prior to resettlement. It deals with reasons for initial displacement; travel to the country of first asylum; and refugee experiences on arrival and adaptation to that country. Section 1 explores the possible psychosocial reactions of refugees to events and adversity, including those that may have continuing impacts throughout the resettlement process.
- ▶ Section 2 describes each phase of the resettlement process – from application through arrival and integration – and related psychosocial impacts, providing key recommendations for all resettlement actors and host communities on improving mental health and psychosocial support for resettled refugees throughout the resettlement process.
- ▶ The five annexes provide more detail on basic psychosocial skills that can be used by all resettlement staff (whether or not they are MHPSS professionals); tips for working with cultural mediators and interpreters; and key messages for resettled refugees and host communities about the resettlement process.

# Introduction

## 1. REFUGEES AND RESETTLEMENT

A refugee is “a person who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.” (UNHCR, 1950)

Individuals and families who are displaced by armed conflicts, violations of human rights, torture, discrimination, persecution and abuse may seek protection and asylum in countries other than their own. Such events are increasing: the United Nations High Commissioner for Refugees reported that, at the end of 2019, 79.5 million people across the world were forcibly displaced, including 26 million international refugees and 45.7 million internally displaced people (IDPs).<sup>1</sup>

### Resettlement in Europe and the COMMIT Project

Worldwide, in 2019, IOM facilitated the resettlement of a total of 93,961 refugees, particularly to the United States of America, Canada, Australia, the United Kingdom and Sweden. Most of these refugees were originally from the Syrian Arab Republic, the Democratic Republic of the Congo, Iraq, Eritrea, Myanmar and took refuge in Turkey, Lebanon, Jordan, Uganda and Egypt.<sup>2</sup> Of these, a total of 29,309 refugees resettled in 18 countries implementing resettlement schemes in the European Economic Area (EEA)<sup>3</sup>, including the United Kingdom, Sweden, France, Germany, and Norway.<sup>4</sup> Most of these refugees were originally from the Syrian Arab Republic, Sudan, the Democratic Republic of the Congo, Eritrea and Somalia and were resettled from Turkey, Lebanon, Jordan, Egypt and Uganda.

In 2020, due in large part to the COVID-19 pandemic, resettlement programmes were restricted. IOM globally supported the resettlement of 30,966 persons, (with the largest proportions going to the United States of America, Canada, Sweden, Australia and Norway).<sup>5</sup> The majority of these refugees were originally from the Syrian Arab Republic, the Democratic Republic of the Congo, Iraq, Eritrea and Myanmar.<sup>6</sup> Among these, IOM facilitated the resettlement of 10,039 refugees in 18 countries implementing resettlement sche-

<sup>1</sup> UNHCR, 2020a.

<sup>2</sup> IOM, 2020.

<sup>3</sup> The European Economic Area (EEA) consists of the Member States of the [European Union \(EU\)](#) and three countries of the [European Free Trade Association \(EFTA\)](#) (Iceland, Liechtenstein and Norway; excluding Switzerland). (Eurostat, 2020). Europea Unione (EU): [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:European\\_Union\\_\(EU\)](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:European_Union_(EU))

<sup>4</sup> IOM, 2020a.

<sup>5</sup> IOM, 2021.

<sup>6</sup> IOM, 2021.



mes in the European Economic Area (EEA), including Sweden, Norway, France, United Kingdom and Finland. Most of these refugees were originally from the Syrian Arab Republic, the Democratic Republic of the Congo, Eritrea, Sudan, and Somalia and were resettled from Lebanon, Turkey, Uganda, Jordan and Egypt.<sup>7</sup>

UNHCR predicts that resettlement will continue to rise in 2021, with projected resettlement needs of 1,445,383 persons, of whom Syrian refugees make up 41%.<sup>8</sup>

Resettlement is not new to European countries: during and after World War II, thousands of European refugees were resettled to other continents. However, it was not until the early 1990s that UNHCR clarified the role of resettlement as an international protection tool and the United Nations, governments, non-governmental organizations (NGOs) and other stakeholders began to collaborate on resettlement policy, coordination and strategy.

As part of this process, in 2009 the European Commission (EC) issued a Communication on the establishment of a Joint European Union Resettlement Programme which called for:

- 1) an increase in the use of resettlement as a tool to provide better-targeted support to refugees in need of international protection;
- 2) the identification of common priorities to inform the resettlement activities of EU Member States; and
- 3) the establishment of common EU resettlement efforts, maximizing their cost-effectiveness.<sup>9</sup>

In 2015, the EC established a voluntary resettlement pilot project. In 2016, the EC proposed a Union Resettlement Framework Regulation as part of the European Agenda for Migration. This is still under negotiation with Member States at the time of writing. Nevertheless, in the last five years, EU resettlement initiatives in collaboration with key countries of origin and first asylum have significantly increased the number of resettled refugees.

Within this context, IOM plays a crucial role in resettlement in Europe, working closely with EEA governments and other stakeholders. IOM ensures that beneficiaries can move in a safe and dignified manner and provides support at the request of receiving/resettlement states, including with pre-migration health assessments and travel health assistance; movement and travel operations; pre-departure orientation; post-arrival integration support; capacity-building; and broader awareness and advocacy efforts.<sup>10</sup> IOM also manages the COMMIT project – Facilitating the integration of resettled refugees in Croatia, Italy, Spain and Portugal – funded by the European Commission (Directorate-General for Migration and Home Affairs) and co-funded by IOM. The transnational project runs from January 2019 to April 2021 and aims to facilitate the sustainable integration of resettled refugees in Croatia, Italy, Portugal and Spain. These countries are relatively new to resettlement (compared to ‘traditional’ resettlement countries such as Denmark, Finland, Sweden and the United Kingdom) and are in the process of strengthening their national resettlement schemes.

---

<sup>7</sup> IOM, 2021

<sup>8</sup> UNHCR, 2020d.

<sup>9</sup> European Resettlement Network, n.d.a.

<sup>10</sup> IOM, 2020a.

## The resettlement process

### *First asylum*

These guidelines define the ‘first asylum’ phase as the various stages of a refugee’s initial journey: the conditions which prompted displacement (pre-migration); travel to the destination country; and arrival and integration in the country in which refuge is sought (the country of first asylum).

### *Countries of resettlement*

In some situations, refugees who seek protection in a country of first asylum and meet certain criteria can voluntarily apply for resettlement to a third country at a later stage.

Resettlement is a durable solution involving “the selection and transfer of refugees from a State in which they sought protection to another State which has agreed to admit them with permanent residence status.”<sup>11</sup> Resettlement helps countries of first asylum share the burden imposed on social systems by the presence of many refugees. In some contexts, resettlement also allows refugees to aspire to a less precarious life by enabling access to greater social, economic, cultural, political, and civil rights.

The resettlement process consists of a number of different phases:

- ▶ *Decisions and quotas*
  - Countries have no obligation to accept refugees through resettlement. Each resettlement country voluntarily offers resettlement opportunities and support for the integration of refugees. Each resettlement country also sets its own yearly admission criteria and quotas in agreement with countries of first asylum.<sup>12</sup>
- ▶ *Identification and selection of refugees*
  - Once national quotas and admission criteria are established, refugees who meet both global<sup>13</sup> and country<sup>14</sup> resettlement submission criteria can apply for resettlement.
    - Refugees voluntarily apply for the process and are interviewed by UNHCR, which then submits the applicant dossiers to resettlement countries. The authorities of these countries are ultimately responsible for final decisions about each case, based on their criteria, capacity and laws.
    - The selection of refugees by resettlement countries may be made on the basis of the content of these dossiers alone.

<sup>11</sup> UNHCR, 2011.

<sup>12</sup> Some countries also accept refugees for resettlement on an *ad hoc* basis in response to specific appeals. (UNHCR, 2020c)

<sup>13</sup> UNHCR has seven resettlement submission categories: (1) legal and/or physical protection needs; (2) survivors of torture and/or violence; (3) medical needs; (4) women and girls at risk; (5) family reunification; (6) children and adolescents at risk; and (7) lack of foreseeable alternative durable solutions. For further information, see the UNHCR Resettlement Handbook (UNHCR, 2011).

<sup>14</sup> National criteria differ from those of UNHCR and may include quotas for certain nationalities; exclusions (such as very large families or very complex medical cases); or “integration potential”.

- Alternatively, resettlement countries may also organize selection missions to enable their representatives to interview the candidates in countries of first asylum and take final assessment and resettlement decisions. In some instances where and when UNHCR is unable to assist, IOM supports the organization of these missions. Recently this has included support for virtual missions and remote interviews, particularly in the context of COVID-19.
- ▶ *Pre-departure activities*
    - Once selected, refugees receive help to prepare for their travel to the resettlement country and the early stages of integration. This involves visa and travel document processing; pre-migration health activities, including pre-embarkation checks to establish fitness to travel; and pre-departure orientation (PDO) sessions.
    - In some contexts, IOM provides logistical support for refugees to process travel documents, as well as pre-migration health activities and pre-departure orientation. Elsewhere, resettlement countries are responsible for this support.
  - ▶ *Post-arrival phase*
    - Refugees are received by national authorities and stakeholders in the resettlement country. In some cases, IOM is also present at the airport to welcome refugees, while in others IOM's support extends to reception and integration measures.
    - During this phase, IOM works with local stakeholders and authorities to strengthen the reception and integration of refugees. IOM promotes activities to raise awareness of local actors about the resettlement process and about cross-cutting concerns for refugees, including mental health and psychosocial issues, during this process. IOM may also organize post-arrival orientation sessions with refugees.

## 2. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The psychosocial well-being and mental health of both individuals and communities can be threatened by many factors during one or more phases of their displacement journey, including:

- ▶ the nature of the events that prompted the decision or need to leave their home;
- ▶ the conditions of migration and displacement, including difficult journeys;
- ▶ isolation, stigma and discrimination;
- ▶ lack of access to basic services, including health care, education, security, food, and housing; and
- ▶ lack of access to other economic and social support.

Access to health care and to mental health and psychosocial support are crucial aspects of refugees' integration and inclusion. Insufficient access to mental health and psychosocial support services and related barriers (including administrative obstacles; a lack of familiarity with the health and social care system; and linguistic and intercultural issues) can have profound impacts on an individual's ability to integrate into their resettlement country.

In line with the 2020 EU Action Plan on the Integration and Inclusion of Migrants,<sup>15</sup> which recognizes the importance of mental health services for migrants and refugees, authorities and stakeholders in resettlement countries can strengthen assistance for resettled refugees and facilitate their integration by using a **psycho-social approach**. This involves:

- ▶ understanding the backgrounds of refugees and their possible psychosocial reactions during the different stages of migration and resettlement, and
- ▶ creating and implementing appropriate mental health and psychosocial initiatives for both refugees and host communities.

### BOX 1 | Mental health and psychosocial support: Key concepts and definitions

*Note: these are the definitions used for this document*

**Mental health:** A state of well-being in which an individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO et al, 2004)

**Mental health and psychosocial support (MHPSS):** Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. (IASC, 2007)

**Mental disorder:** Comprise a broad range of problems with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated. (WHO, n.d.)

**Psychosocial:** (adj.) Relating to the interrelation of social factors and individual thought and behaviour. (OED, 2020a)

**Psychological distress:** A set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. (APA, 2020)

**Vulnerability:** The limited capacity to avoid, resist, cope with or recover from a harm (e.g. discrimination, violation of human rights, violence, abuse, exploitation) as a result of the interaction of intersectional and co-existing personal, social, situational and structural factors. (IOM, 2019c)

Being subjected to negative life events and adversity such as forced displacement and human rights violations can cause social and psychological distress at the individual, family and community levels. These events can exacerbate pre-existing mental health conditions and/or induce new mental health and psychosocial problems, including:

- ▶ anxiety, depression, grief and post-traumatic occurrences at the individual level, and
- ▶ family separation, breakdown of social networks and the collapse of community structures at the social level.

The mental health and psychosocial impacts of adversity vary according to the event's nature and context, the population/community and the individual. Each person responds to a challenging situation uniquely: reactions depend on different bio-psychological, cultural and social factors, and each individual has different resources and coping capacities. This means that some people are at higher risk of experiencing social and psychological problems due to their vulnerability.

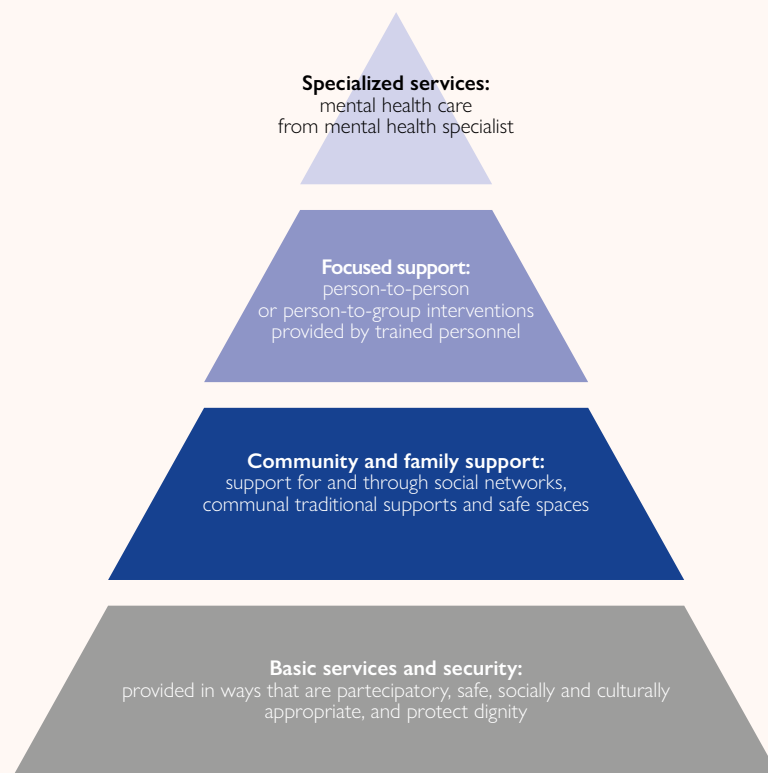
<sup>15</sup> European Commission, 2020.

The core principles of mental health and psychosocial support (MHPSS) are:

- ▶ *Human rights and dignity*: Promote and protect human rights, equity, and non-discrimination.
- ▶ *Participation*: Encourage the affected local population in the response, especially those who exhibit sufficient resilience.
- ▶ *Do no harm*: Reduce the potential for harm caused by interventions.
- ▶ *Accountability*: Holding actors accountable to the populations they engage with, thus contributing to the respect and fulfillment of their rights.<sup>16</sup>
- ▶ *Build on available resources and capacities*: Use local assets, self-help and strengthen existing resources.
- ▶ *Integrated support systems*: Avoid stand-alone services and fragmented care systems.
- ▶ *Multi-layered support*: Develop a layered system of complementary support that meets the needs of different groups and individuals (see [Box 2](#)).<sup>17</sup>

### BOX 2 | Intervention pyramid for mental health and psychosocial support in emergencies

In situations of adversity, affected people react in different ways and have diverse needs. To guarantee appropriate support and to meet these varied needs, MHPSS interventions should be part of a layered system of complementary support. All layers are equally important and should ideally be implemented concurrently.



Source: IASC, 2007 (adapted).

<sup>16</sup> IOM, 2020c.

<sup>17</sup> IASC, 2007.

### 3. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT MATTER IN RESETTLEMENT

Resettlement is a complex, multidimensional, continuing and dynamic process that requires a comprehensive and humane approach. Various factors can impact on the mental health and psychosocial well-being of individuals, and positively or negatively determine the extent of their integration in their new country.

Mental health and psychosocial support in protracted displacement and resettlement situations is therefore crucial to supporting the resilience, ability to cope with stress and social integration (see [Box 15](#)) of individuals and communities. Such support includes:

- ▶ making sure that all assistance provided during resettlement takes into account the psychological, social and cultural experiences of resettled refugees and promotes their dignity and agency (see [Box 3](#));
- ▶ community support activities (such as sociocultural, creative and artistic, sport and informal educational activities) aimed at promoting integration and strengthening communal response systems;
- ▶ self-help groups, support groups, individual and group counselling and other forms of person-to-person or person-to-group and peer support; and
- ▶ specialized mental health care for those in need.

#### BOX 3 | Psychosocial approach to programming in displacement contexts

The psychosocial approach is based on the interrelation of the following spheres:

- ▶ *Biopsychological*: feelings, emotions, thoughts, memories, behaviours, stress and stress reactions and the holistic understanding of the individual as a unique system of body and mind.
- ▶ *Cultural*: shared behaviours, beliefs, narratives, rituals, values, norms, customs (among other aspects), that are used by members of society to express and maintain their individual characteristics and to interact with others.
- ▶ *Social*: the interactions and interdependence between the individual and the communities to which s/he belongs. It consists of two complementary aspects:
  - *Socio-relational*: the quality of relations between individuals and the social system (communities, family, friends, wider social systems).
  - *Socioeconomic*: the availability of and access to resources that influence their living conditions (e.g. livelihoods, health care, information technology).

These spheres are interdependent and equally important and influence each other in defining the needs and resources of refugees and resettlement community members, as well as required responses.

Source: IOM, 2019a.

# Section 1.

## FIRST ASYLUM

**T**his section provides an overview of the “first asylum” phase and the possible psychosocial reactions experienced by refugees during this phase. Although it is not part of the resettlement process, the first asylum phase encompasses elements essential to understanding both the background of refugees and their potential psychosocial reactions throughout the process.

The first asylum ‘phase’ can be understood as the processes of:

- ▶ **Pre-migration** (experiences in the country of origin)
- ▶ **Travel to the country** of first asylum (the journey) and
- ▶ **Living in the country** of first asylum (experiences upon arrival and settling in the country).

# Pre-migration

## OVERVIEW

In the country of origin, refugees are exposed to abnormal stressors that force them to flee to another country seeking protection and asylum. These include war or other armed conflict; persecution and discrimination (e.g. on the basis of gender, race or nationality); torture and abuse; imprisonment; violations of their human rights; lack of safety and security; lack of access to basic services; loss of or separation from loved ones and homes; isolation; and uncertainty.<sup>18</sup>

### Psychosocial reactions<sup>19</sup>

These stressors, individually and cumulatively, may create symptoms of psychological and social distress, including:

- ▶ *Emotional*: sadness, grief, anger and fear
- ▶ *Behavioural and social*: social isolation, substance use, lack of self-care and hygiene and violent acts towards the self and/or others
- ▶ *Cognitive*: difficulties in concentrating, continual worry and helplessness
- ▶ *Physical*: changes in eating and sleeping patterns, fatigue, problems in sleeping, breathing difficulties and headaches.

These manifestations are *normal* reactions of the body and mind to unusual events and stressors and seldom lead to the development of a mental disorder. Moreover, every individual reacts differently to the same events and their impacts cannot be generalized. Some people may experience more intense and long-lasting reactions that can affect their functioning, in which case a specific and specialized assessment is required (for further information, refer to [Annex 1](#)).

Finally, it should be noted that exposure to adversity is never entirely negative from a psychological viewpoint. It can strengthen resilience and prompt individuals and groups to develop new skills and qualities to respond to negative events (through adversity-activated development) (see [Box 4](#)).<sup>20</sup>

---

<sup>18</sup> In the context of the COMMIT project, refugees supported through the resettlement process are originally from Syria, Sudan, Ethiopia, and Eritrea - countries affected by armed conflicts in recent years.

<sup>19</sup> For a summary of stressors and possible psychosocial reactions, see .

<sup>20</sup> According to Papadopoulos (2011), resilience is “not a result of individual strength but, often, of a relational process” and people “retain more resilient positive functions if they secure a collaborative and reciprocal support with others rather than when they struggle to overcome adversity on the basis of their own personal strength.”



**BOX 4 | Understanding psychosocial reactions to adversity**

Psychosocial reactions to adversity among refugees can be:

*Suffering* – responses that compromise a refugee’s well-being, cause various forms of social and psychological distress, and may include the aggravation or emergence of mental disorders.

*Resilience* – qualities, characteristics, behaviours, social relations and support *already* possessed by a refugee that s/he can use to respond to the challenges posed by adversity.

*Adversity-activated development* – includes *new* qualities, relations, skills and learning that refugees develop and learn to respond to adversity.

Such reactions are interlinked and occur simultaneously, varying with each individual and with each adversity experienced. While it is essential to recognize and understand the negative impacts of becoming a refugee and related human rights violations, these should not prevent recognition of people’s positive responses to adversity.

Source: Papadopoulos (2011)

# Travel to the country of first asylum

## OVERVIEW

This phase is the journey from the country of origin to the country of first asylum, which can be dangerous: refugees may experience a lack of safety, detention, infectious diseases, exploitation, human trafficking, physical harm, and other life-threatening events. They often have no access to essential services and are not in possession of legal documents. Fleeing the country of origin also means leaving behind part or all of their history, identity, social status, family and social support.

### Psychosocial reactions<sup>21</sup>

As in the pre-migration phase, the journey can provoke and cumulate distress, anger, fear, anxiety, a sense of loss of identity and grief and may entail experiencing and/or witnessing violations of fundamental human rights. Nonetheless, it can also strengthen resilience and the development of new abilities to face challenging situations, including through creating new social networks.

---

<sup>21</sup> For a summary of the stressors and possible psychosocial reactions, refer to [Table 1](#).

# Living in the country of first asylum

## OVERVIEW

Once in the country of first asylum, refugees are expected to adapt rapidly to new and different cultures, social dynamics and norms, languages, values, and environments – but they are often provided with little information and their status determination may take a long time. They may face additional stressors including: a lack of knowledge and information about their rights and entitlements and the bureaucratic procedures for receiving asylum; a lack of job opportunities or restrictions on legal work; lesser rights compared to the host population; and poor living conditions.

In many cases, too, countries of first asylum face their own internal social and economic crises, with impacts on the provision of essential services for nationals and refugees alike. Refugees may face constraints in accessing such services as do exist due to both formal and informal obstacles, including: national legal and policy frameworks that restrict access based on immigration status; criteria for receiving services (e.g. having national identification documentation); service costs and availability; language and cultural barriers; mistrust of service providers; and fear of discrimination.<sup>22</sup>

However, moving to and settling in a new place is not only negative: it can offer refugees an opportunity to restart their lives in a new community and enjoy security and safety they did not have in their country of origin. Such positive experiences can be strengthened with appropriate programmes and policies that focus on their integration. The reception of refugees can also have broader socioeconomic impacts as countries of first asylum benefit from their skills, culture and other contributions.

### Differences between living situations: refugee camps, urban areas and rural areas

The setting in which refugees live in the country of first asylum (camps or rural and urban areas) can influence their experience there and their future resettlement experiences.

#### *Refugee camps*<sup>23</sup>

Those living in refugee camps generally receive various essential services and may have closer/more regular interactions with humanitarian actors and other service providers due to being restricted to one site.

---

<sup>22</sup> International Federation of Red Cross and Red Crescent Societies (IFRC), 2016.

<sup>23</sup> Refugee camps are temporary facilities designed to protect forced displaced people by offering them assistance and services to meet their primary needs. Such sites are generally delimited spaces that allow closer coordination and assistance management by services providers and local authorities.

However, they may remain at risk if assistance is limited or if sites are overcrowded. In addition, despite the fact that refugee camps are meant to be temporary, in some contexts they host refugees for many years or even decades. This can result in refugees becoming dependent on external support and undermine their ability to be autonomous and to integrate. In some camps, refugees may experience additional stressors, including poor living conditions; insecure housing; and limited opportunities to participate in host community activities (e.g. employment and education).

#### *Urban and rural areas*

Generally, refugees living in urban and rural settings live autonomously and have the opportunity to contribute economically and socially to their host communities.

However, like those living in camps, some refugees in urban and rural settings can face challenges in accessing basic services. They may also suffer discrimination from host community members (including xenophobia); exploitation; detention; harassment; and economic difficulties linked to the lack of livelihood – all of which can impact on their integration and well-being. Refugees with mental health disorders and/or other medical conditions are at increased risk of facing additional barriers in accessing essential services and being discriminated against and marginalized.

Local authorities and stakeholders may face obstacles to locating, identifying and supporting refugees living in urban and rural areas because they have spread out across a wide area or have become 'invisible'. This can hamper the process of acquiring legal status; the identification and selection of refugees for resettlement; and referrals to appropriate services.

## **Psychosocial reactions<sup>24</sup>**

As in previous 'first asylum' phases, living in the country of first asylum can prompt positive psychosocial reactions among refugees, including strengthening and developing positive attitudes and abilities. However, the combined challenges of acculturation and of creating a new life in a place with new and unknown social, economic and other systems of meaning can also add additional stresses and affect refugees' functioning, daily activities, relationships and behaviours.

The long process of status determination and other bureaucratic barriers can be arduous, and contribute to discrimination and marginalization from parts of the host community. This may impact the well-being and identity of refugees, creating a sense of not belonging to a place, community or oneself – among other emotional challenges (see [Box 5](#)).

---

<sup>24</sup> For a summary of the stressors and possible psychosocial reactions, refer to [Table 1](#).

**BOX 5 | First asylum phase and its common stressors and distress signs**

Refugees can be exposed to many stressors at different stages of the first asylum phase, including: violence, insecure housing, lack of income, poor living conditions, work exploitation, unsafe travel conditions, limited access to essential services, family conflicts, separation from loved ones, detention, loss of social support and discrimination.

The psychological reactions to these stressors include: anger, grief, fear, frustration, aggression, social withdrawal, speech impediments, fatigue, psychosomatic complaints (e.g. headaches, stomachaches), and difficulties in sleeping.

- ▶ Studies focusing on the common stressors and distress signs of refugees from specific regions or countries of origin are important potential sources of information for actors involved in the resettlement process. For instance, many resettled refugees in Europe (and involved in the COMMIT project) are Syrians. Resettlement practitioners and policymakers wanting to know more about their specific needs and cultural paradigms influencing psychosocial suffering could read Hassan et al. (2015), Wells et al. (2016), International Medical Corps (2017b), and Save the Children (2017).

**BOX 6 | Prevalence of mental disorders in post-conflict contexts and among refugees**

According to a recent review (Charlson et al, 2019b), one in five people in post-conflict settings lives with some form of mental disorder – ranging from mild (e.g. anxiety disorder, depression, post-traumatic stress disorder) to severe (e.g. psychosis, severe depression). However, the high burden of mental disorders among conflict-affected population does not in itself prove that refugees are more vulnerable to developing mental disorders than any other population.

Rates of mental disorders in refugees vary across studies (see Fazel, Wheeler and Danesh (2005); Bogic, Njoku and Priebe (2015); and Kien et al. (2019)). The various methodologies used, the diverse target populations studied and the lack of consideration for cultural differences in the studies make it impossible to generalize the results. It is therefore recommended that resettlement (and other) actors avoid making assumptions about mental disorders among refugees before any individual assessment.

**BOX 7 | The right of refugees to access mental health care**

States have an obligation to promote and protect the rights of all persons, including access to mental health care and preventative interventions designed to counter the combined psychosocial effects of stressors and to provide appropriate support for improving individual and communal well-being. This obligation is bolstered by the recognition by world leaders of the importance of such measures and their inclusion in the health priorities of the Sustainable Development Goals (SDGs) Agenda.<sup>a</sup> SDG3, in particular, aims to ensure healthy lives and promote well-being for all at all ages.

Mental health and preventive measures for refugees include:

- ▶ Access to affordable, humane, dignified and culturally aware specialized mental health care;
- ▶ Access to community-based psychosocial support focused on strengthening resilience and integration through social networks and counselling; and
- ▶ Health, educational and social support from staff who have been informed appropriately about the various stressors that refugees may have experienced to avoid unintentional harm.

a) WHO, 2016.

As refugees commonly face distress during all of the various stages of the first asylum phase, all staff involved in assisting them should learn and use the principles of psychological first aid (PFA) – a humane, supportive and practical approach to help those suffering serious crisis events (see resources, below) – as well as supportive communication (see [Annex 1](#)). In addition, health and social care professionals should be aware of the services refugees benefited from – or not – throughout the first asylum phase and understand their background and help-seeking behaviours. Programme managers and other relevant actors should explore information on the specific challenges and circumstances of refugees who are being resettled: individually, if feasible, or as a group/population. These actions are crucial to ensuring general understanding among staff; identifying trauma-informed care measures; and providing appropriate mental health care and psychosocial support for resettled refugees.

### Resources

*How MHPSS is delivered in emergency settings*

[IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#) (IASC, 2007)

*How IOM provides MHPSS in emergencies and displacement settings*

[Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a)

*Psychological first aid*

[Psychological First Aid: Guide for field workers](#) (WHO, War Trauma Foundation and World Vision International, 2011)

[Psychosocial Support for Migrants](#) Free online training offered by IOM (available in English and Spanish)

*Cultural considerations in meeting the psychological needs of resettled refugees*

Note: In order to deal with the challenges of resettled refugees, it can be useful to read studies and articles about their psychological needs and their cultural approach to mental health. However, it is also important not to generalize because individuals can have different sets of values, behaviours and needs from those of their compatriots. The examples below relate to Syrian refugees.

[Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support Staff Working with Syrians Affected by Armed Conflict](#) (Hassan et al., 2015)

[Mental Health and Psychosocial Support Considerations for Syrian Refugees in Turkey: Sources of Distress, Coping Mechanism, and Access to Support](#) (IMC, 2017a)

[Understanding the Mental Health and Psychosocial Needs, and Service Utilization of Syrian Refugees and Jordanian Nationals: A Qualitative and Quantitative Analysis in the Kingdom of Jordan](#) (IMC, 2017b)

Table 1. First asylum phase: summary of examples of stressors and possible psychosocial reactions

	Stressors	Psychosocial suffering	Resilience	Adversity-activated development <sup>a</sup>
<b>Pre-migration</b>	Armed conflict Abuse Financial problems Loss of loved ones Loss of material possessions Persecution	Anger		
<b>Travel</b>	Abuse Detention Famine Infectious disease Physical harm Unsafe travel conditions	Anxiety Disorientation Fatigue Fear Grief Guilt Hopelessness	Value system Family and other social support networks Personal adaptive coping mechanisms <sup>b</sup> Activities (sports, arts, writing)	Creation of new social networks Increasing tolerance about other cultures Innovation Discovering new facets of the self
<b>Country of first asylum</b>	Difficulty in accessing essential services Discrimination Lack of documentation Poor living conditions Undefined legal status Unemployment/lack of livelihood	Low self-esteem Stress Substance abuse	Referring to traditional culture	Experiencing or accepting new gender, social and other roles

Note:

These examples are not comprehensive. Every individual reacts uniquely to events.

Based on WHO (2018a) and Ellis et al. (2019)

a) Papadopoulos (2007)

b) Adaptive coping mechanisms: the capacity to deal with adversity, adapting according to changing circumstances. Individuals can learn from previous experiences and adjust to new contexts.

## **Section 2.**

### **THE RESETTLEMENT PROCESS**

**T**his section covers the phases of the resettlement process; IOM's role in this process; potential psychosocial reactions experienced by refugees and host communities; and key recommendations. It aims to offer the essential elements to enable resettlement staff to understand the resettlement continuum through the psychosocial approach and to provide appropriate support to refugees.

The resettlement process is characterized by three key phases: the identification and selection of refugees; pre-departure activities and travel of refugees to the resettlement country; and reception and integration.



# Identification and selection

## OVERVIEW AND IOM'S ROLE

Identifying refugees who meet the criteria to participate in the resettlement process is a crucial step, requiring attention and appropriate knowledge about their protection risks and specific needs.<sup>25</sup> For resettlement to European countries, in most cases, UNHCR identifies refugees in countries of first asylum who are potentially eligible for the resettlement process through assessment and interviews. UNHCR eligibility criteria are based on seven categories: (1) legal and/or physical protection needs; (2) survivors of torture and/or violence; (3) medical conditions and needs; (4) women and girls at risk; (5) family reunification; (6) children and adolescents at risk; and (7) lack of foreseeable alternative durable solutions (see the [UNHCR Resettlement Handbook](#), UNHCR (2011)). Despite a common resettlement framework among EU countries, selection criteria and requirements for refugee resettlement vary for each country.

Once eligible refugees are identified, they can voluntarily apply for the resettlement process. If they do, UNHCR submits their files to the authorities of resettlement countries. These authorities can request an additional interview with refugees to provide further evidence for the claim-based assessment and, in some cases, for security checks. The authorities then take a final decision on each case, offering or denying permanent residence through resettlement.

Where the authorities of resettlement countries request additional in-person interviews with refugees during selection missions, IOM may be asked to provide logistical support (including transportation, accommodation, interview rooms, and provision of interpreters). IOM also facilitates virtual selection missions when resettlement country representatives are not able to travel to the country of first asylum.

### Psychosocial reactions<sup>26</sup>

The unpredictable timing and pace of the identification and selection process may create a state of 'suspension' for refugees – as if their lives are on hold in the country of first asylum. This can result in negative emotional outcomes, especially if the process is protracted or the application is ultimately rejected. The possibility of failure in the application process may also create tension and fear.

In some cases where refugees know they are being considered for resettlement, they believe that integrating in the country of first asylum is less important than the resettlement procedure. This limits their investment in settling in their current context, hindering their integration and future capacity to integrate. If refugees are not accepted for resettlement, they may reject the idea of continuing to live in the country of first asylum

---

<sup>25</sup> European Resettlement Network, n.d.b.

<sup>26</sup> For a summary of the stressors and possible psychosocial impacts in the resettlement process, see Table 2.

and face stronger psychological barriers to integration. These situations can lead to feelings of frustration, anxiety, helplessness, discouragement, disorientation and anger (among others).

Even though resettlement countries are generally considered by refugees to be 'better' than countries of first asylum, refugees commonly have preferences about which of these countries they want to be resettled in. Each country has its own characteristics, policies and structures that can influence the refugees' preferences – including culture, economics and politics; the services and opportunities offered to resettled refugees; residence status; and pre-existing social networks. These preferences, often based on information received by relatives and friends already living in resettlement countries or through social media, can result in frustration, anger and withdrawal if a refugee is accepted into a resettlement country different from the one they prefer.

The various interviews refugees are subject to during the resettlement process tend to focus on refugees' vulnerabilities and past adversity. They may therefore elicit negative psychological reactions, since they constantly remind refugees of painful and distressing past experiences. They also run the risk of reinforcing a 'victim' identity/mentality, and the perception that vulnerability is required from refugees, with potential negative impacts for their future attitudes and integration prospects.

In some cases, the application itself can be a source of family tensions. This is likely to happen when family members have different opinions about resettlement and they have to reach a common decision: as when grandparents would prefer not to resettle while their grandchildren wish to move. Family tensions in refugee contexts, where other social support networks are already limited and/or new, can have dramatic psychological consequences for family members.

Community tensions can rise among refugees due to perceived favouritism, persecution, unfair or uneven treatment in the process.

## RECOMMENDATIONS

### Programmatic recommendations

#### *The relationship between resettlement stakeholders and refugees*

- ▶ **Resettlement actors should create a professional and trustful relationship with refugees**

All actors involved in the identification and selection of refugees for the resettlement process must be trained to understand the possible impacts of refugees' experiences on their narratives, emotions, thoughts, behaviours, interactions and relationships with others, especially those in a position of authority. Such information can help interviewers, outreach teams and others to create a better relationship with the refugee and avoid harm.

To increase mutual understanding and trust, programme managers and other actors could:

- Contact local leaders (including authorities and religious and community leaders), individuals with relevant social functions in the community, families and diverse groups to gather information and build relationships.
- Identify MHPSS professionals and resources available in the context and engage with them to gain understanding of potential psychosocial and other issues experienced by refugees.
- Undertake focus-group discussions with various groups within each community to improve understanding of their needs, challenges, and resources
- Organize social events for refugees to share their stories.
- Create a committee and complaint mechanisms.

*For further information and examples on engaging with communities:*

Chapter 2 of the [IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a).

### **MHPSS support for refugees**

#### **► Provision of counselling sessions for refugees during the identification and selection process**

It is advisable to offer counselling to each refugee after the interview and selection processes, whatever the result of these processes. This can be done either as part of the protocol, through a dedicated professional on-premises, or through referral to existing services.

It is also suggested that the dedicated professional or outreach team staff make a follow-up call a few days after the interview to check on the refugee and, if needed, offer further referral.

*To create a referral system:*

Sections 2.6.3 and 4.1.3 and Annex 8 of the [IOM Reintegration Handbook](#) (IOM, 2019f).

### **Capacity building for resettlement staff**

#### **► All staff involved in the identification and selection processes must be trained in basic psychosocial skills**

The identification and selection process for resettlement tends to expose refugees to reliving negative and painful experiences, especially during interviews. All staff involved in the process must be trained in psychological first aid (see [Annex 1](#)), including supportive communication, identifying distress signs and supporting distressed people, so that they can provide humane assistance and do no harm whatever their function/role in the process.

*For further information on basic psychosocial skills:*

[Basic psychosocial skills for resettlement staff](#) (Annex 1 of this document)

[Psychological First Aid: Guide for field workers](#) (WHO, War Trauma Foundation and World Vision International, 2011)

[Psychosocial Support for Migrants](#) Free online training offered by IOM (available in English and Spanish)

### ► Interviewers should be adequately trained

Likewise, all relevant staff should be trained in interviewing skills, including how to collect and share relevant information properly. Such training should help strengthen staff adherence to ethical considerations and codes of conduct, and provide guidance on helping refugees to feel comfortable in sharing accurate information during the interviews.

*For information and tips on interviewing skills:*

[Guiding note for communication via interpreters](#) (EU-Frank, 2020a)

[Practical Guide for Planning and Conducting Resettlement Interviews](#) (EU-FRANK, 2020b)

[Trafficking in Persons: Victim Identification and Assistance](#) (chapter 4) (IOM, 2020b).

*Note: although this manual and chapter focus on victims of trafficking, the main principles and interviewing techniques are valuable and could be adapted for resettlement interviews.*

### ► Interviewers must explore the strengths and positive abilities of refugees

To minimize the creation or reinforcement of a 'victim identity' among refugees by focusing only on their vulnerabilities, it is essential wherever possible that interview protocols also include an exploration of their strengths, expectations and perceived added value.

*For detailed information on 'victim identity' in adversity:*

[Psychosocial support after adversity: A systematic approach](#) (IOM, 2019d)

### ► General recommendations

Cultural competence can be defined as a set of behaviours, knowledge and attitudes that enable the health professional to effectively work in cross-cultural situations. Cultural competence is the acceptance and respect of difference and a continuous self-assessment regarding culture.

"Culture" refers to integrated patterns of human behaviour, including language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups. Cultural competence involves awareness of the various ways in which culture, immigration status and ethnicity impact on psychosocial development, psychopathology and therapeutic transactions.<sup>27</sup>

<sup>27</sup> IOM, 2009.

▶ **Whenever needed, make use of trained interpreters or cultural mediators**

The help of these professionals may be required in some contexts to facilitate outreach, interviews and general interactions with refugees. They can help to encourage communication and facilitate understanding among refugees and resettlement staff, notwithstanding their cultural differences, thus creating a supportive environment and making refugees more comfortable in sharing information.

*For further information in working with interpreters and cultural mediators:*

[Annex 2: Working with cultural mediators and interpreters](#) (this document)

[Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Cultural Competence and Empower Practitioners](#) (IOM, 2009)

[Field Guide to Humanitarian Interpreting and Cultural Mediation](#) (Translators Without Borders, 2017)

*For information on the role of intercultural mediations in health care:*

[What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?](#) (WHO, 2019b)

# Pre-departure activities and travel

## OVERVIEW AND IOM'S ROLE

Refugees selected for resettlement then prepare to move from the country of first asylum to the resettlement country. This can include obtaining the necessary travel documents and visas, participating in pre-migration health activities and obtaining essential information and orientation on travel to and early integration in the resettlement country.

### *Processing of travel documents and visas*

Depending on the context, refugees will need to coordinate closely with UNHCR and/or IOM to determine and obtain the immigration and travel documentation required. Travel documentation requirements may include renewal of passports, obtaining ICRC travel documents, obtaining relevant visas and/or applying for exit permission. All decisions and coordination are made on a case-by-case basis and depending on location. IOM may provide support with booking travel and issuing tickets; helping with immigration documentation and visas (including collecting and filing the necessary preparatory documents; scheduling appointments; and providing transportation and accommodation, when needed); and coordinating travel plans with the authorities and stakeholders in departure, transit and destination countries.

### *Pre-migration health activities<sup>28</sup>*

Pre-migration health activities include health assessments and pre-embarkation checks (PEC). In most cases (and depending on agreements with countries of resettlement) these are conducted by IOM. Health assessments commonly take place following the refugee's selection for resettlement; less frequently, they are undertaken before or during the selection interview. They aim to assess a refugee's health conditions and provide treatment, if necessary, before departure and to ensure that the refugee, if affected by relevant health conditions, can travel safely and in a dignified manner and is linked to appropriate care services. The health assessment is based on the resettlement country's protocols, which do not necessarily offer a systematic evaluation of the refugees' mental health or use adequate mental health evaluation tools (see [Box 8](#)).

Practices with regards to the organization of comprehensive pre-migration health assessments vary between resettlement countries, but all programmes include a PEC. Up to 72 hours before departure, IOM conducts the PEC to confirm the refugee is fit to travel and gathers all necessary information for the follow-up of medical cases upon arrival by resettlement country authorities. The PEC also helps guarantee that

---

<sup>28</sup> It is essential to underline that a refugee's health status (including specific vulnerabilities such as urgent medical needs or treatments) is a criterion for UNHCR to submit cases for resettlement. However, it is the responsibility of the resettlement country to select the refugee, and its decision is made in line with the capacity of the national health system, availability of a medical team/hospital for a specific treatment and integration prospects.

refugees do not create risks for other travelers and resettlement communities and avoid in-flight medical emergencies or flight deviations.

The information gathered by IOM during these health activities is shared confidentially with the resettlement country health authorities before the refugee's arrival to ensure no disruption to the refugee's continuum of health care.

### **BOX 8 | Strengthening the mental health assessment tool and protocol: a pilot study**

As noted above, all selected refugees undergo a pre-migration health assessment (using protocols provided by the resettlement country's authorities) to identify any health issues and future treatment needs. However, such assessments generally focus on a refugee's physical health and may not systematically evaluate their mental health or use adequate tools. Insufficient or inadequate information about a refugee's mental health can impede referrals to appropriate mental health care services and hinder the refugee's integration in the resettlement country.

In order to strengthen the pre-migration mental health assessment, the United Kingdom (UK) Home Office and Public Health England, in collaboration with IOM, piloted a study using the Global Mental Health Assessment Tool (GMHAT). This clinically validated tool to assess and identify mental health problems in adults in various settings was used during the process of resettling Syrian refugees in the UK as part of the pre-migration health assessment. It helped to identify immediate mental health needs requiring urgent attention during the pre-departure phase and facilitate further assessments and referrals to specialized services in the UK. The information gathered through the GMHAT was shared with Home Office caseworkers and general practitioners as part of the pre-migration health assessment report.

The study suggests that the GMHAT has the potential to be useful for providing concise clinical information on a refugee's mental health prior to their arrival in the UK, helping local authorities prepare for the arrival of refugees with mental health concerns. It is also valuable for identifying refugees in need of specialized treatment and referring them to such services in a timely manner. This provides benefits for refugee integration.

However, the pilot study also raises concerns that should be taken into account by resettlement countries planning to use the tool. These include the need to: adapt and validate the tool according to cultural context; train caseworkers and practitioners in using the tool and existing referral pathways; improve the flow of GMHAT information between IOM and Home Office health staff; and ensure refugees can access culturally appropriate mental health care before departure whenever needed.

See 'The Global Mental Health Assessment Tool (GMHAT) pilot evaluation: Final report' (Home Office and Public Health England, 2019).

### **Pre-departure orientation<sup>29</sup>**

Pre-departure orientation (PDO) is generally conducted by IOM or another institution selected by the resettlement country and is mandatory for all refugees selected for resettlement.<sup>30</sup> It consists of one or a series of sessions that commonly take place close to the departure date. The recommended minimum

<sup>29</sup> For best practices in addressing MHPSS issues in PDO, see [Box 10](#).

<sup>30</sup> Under the COMMIT project, IOM is responsible for conducting PDO sessions for refugees resettling in Italy, Portugal and Spain. Refugees being resettled in Croatia receive PDO from another organization.

duration of a PDO 'course' is three days but, depending on resettlement country criteria, it can last up to ten days.

PDO supports early integration and can improve long-term integration outcomes by helping refugees to: reflect on their upcoming resettlement; make informed choices; enhance their safety and self-sufficiency; and understand the resettlement country's systems. By preparing refugees before their departure for some key aspects of their new lives, PDO can reduce the risk of unrealistic expectations and plans for resettlement, as well as tension between refugees and host communities.

In order to do this, PDO provides refugees with essential information about the resettlement country, including reception and integration support, refugee status, relevant laws, rights and responsibilities, health care and education systems, social norms, money management and housing. It also helps refugees to develop some of the practical attitudes, skills and tools they will need in the first months after their arrival as they adapt to their new communities. Some PDO sessions include video calls between refugees to be resettled and the reception authorities in the country of resettlement, helping refugees to establish contact with and build trust towards their new home. It also helps to ensure continuity in support by linking PDO and post-arrival orientation/assistance.

### BOX 9 | MHPSS for pre-departure orientation (PDO) trainers

PDO trainers may face challenging classroom situations due to one or more refugee's emotional difficulties, which can hamper the session and interactions between participants. By using basic psychosocial approach and support skills, trainers can identify and manage such situations, reducing negative outcomes and promoting well-being among those involved.

Many strategies can be used to help trainers, including providing them with capacity building and supervision and creating appropriate materials for their use. In collaboration with IOM Thailand, the Australian Cultural Orientation (AUSCO) Programme developed a guide on mental health and psychosocial support for PDO trainers. It aims to help trainers manage and provide basic psychosocial support for distressed refugees; enact strategies to reduce stressors; create a safe classroom environment. It also highlights the importance of staff welfare.

The guide provides key strategies for trainers to use in identifying and managing distressed people in each phase of the PDO session, including:

- ▶ **Before the session starts:** preparing a safe classroom environment and understanding the context and culture of the refugees participating;
- ▶ **During the session:** how to identify and manage distressed people; using a psychosocial approach in teaching skills; creating rapport and trust with and between refugees;
- ▶ **After class:** reporting and notifying relevant mission personnel for further referrals, if needed.
- ▶ The guide can be obtained by contacting [contactpss@iom.int](mailto:contactpss@iom.int).



### BOX 10 | Best practices in PDO sessions: addressing mental health and psychosocial issues

#### PDO trainers should:

- ▶ **Create a safe environment for the sessions**

Refugees will feel more comfortable in safe environments that are sensitive and respectful of each individual's characteristics (e.g. culture, previous experiences, gender, age etc.). Such environments can promote their inclusion and trust and help them to participate actively in the sessions.

- ▶ **Explore and identify refugees' strengths and resources**

PDO trainers are encouraged to explore and value the participants' strengths and resources to cope with possible challenges in the resettlement process. These may be related to the refugees' capacity to cope with stressors, as well as social and economic skills that can improve their well-being in adversity.

- ▶ **Provide psychoeducation session complementary to the PDO**

A dedicated and separate psychoeducation session should be conducted by a psychologist or creative therapist, aiming to raise refugees' awareness about possible mental health and psychosocial stressors linked to the resettlement process. It is essential to promote and recognize positive coping mechanisms to deal with such stressors and psychosocial reactions.

- ▶ **Promote gender equality in PDO sessions**

As well as sharing the cultural and gender values of the resettlement country, PDO trainers are encouraged to promote gender equality in the sessions by expecting and enabling women's participation in such sessions, and to be attentive to the specific needs of women refugees. If necessary, PDO trainers should create opportunities to address their needs in a separate discussion from male participants.

- ▶ **Provide key messages to support refugees during the resettlement process**

PDO trainers are encouraged to mainstream key messages on positive attitudes that can benefit refugees during the resettlement process, especially in their integration in a new context. (See Annex 4)

Adapted from 'Best practices: IOM's Migrant Training/ Pre-Departure Orientation Programs' (IOM, n.d.a)

#### *Travel to the resettlement country*

After preparing their travel documents, undergoing pre-migration health activities and participating in PDO sessions before departure, refugees travel from the country of first asylum to the resettlement country. Travel from one country to another requires refugees to be responsible for their travel documents and be attentive to travel procedures. It is also a moment in which refugees finally have a tangible experience of the resettlement process and come closer to starting their new life in a different context.

IOM provides assistance throughout the formal procedures for travel. It may conduct pre-embarkation sessions focused on pre-departure and arrival procedures; provide passenger assistance at departure and for immigration procedures; and receive refugees upon arrival, handing them over to responsible stakeholders and authorities for further assistance.<sup>31</sup> Operational escorts to travel with refugees are assigned to bigger groups and medical staff may accompany refugees with special medical requirements.

<sup>31</sup> IOM, 2020d.

## Psychosocial reactions<sup>32</sup>

### *Processing of travel documents and visas*

The process of preparing and arranging travel documents and visas, particularly combined with the application process for resettlement, can take time and result in frustration and exhaustion. Refugees may lack trust in border authorities and government officials due to previous experiences, possibly hindering the issuing of documents and visas and causing further distress.

### *Pre-migration health activities*

For some refugees, the pre-migration health assessment is the first comprehensive health check-up they have received in years – or ever. This can be a positive experience, as it provides refugees with information about any health conditions and referrals to the appropriate services or treatments when needed. However, it can also be distressing, as refugees are asked to disclose sensitive and private information about their bodies, habits and experiences, which they are often not used to doing. Where the assessment reveals one or more health conditions (which may include infectious diseases, chronic disorders and terminal conditions), the discovery can affect the individual's emotional well-being and create distress. In cases of family resettlement, the discovery of a family member's health condition can also have impacts on the entire family dynamic.

Protocols that focus on physical health and disregard mental health issues prevent a timely identification of such issues and referral to appropriate mental health care services both pre- and post-departure (see above). At the same time, however, it is difficult to complete the diagnosis of mental health conditions in the time allocated to pre-migration health assessments and doing so requires a revision of protocols and workload. Measures should be put in place to provide care and plan for referrals in both the country of first asylum and the resettlement country.

Health assessments for most non-EU countries can be exclusive in the sense that certain conditions mean that refugees may be excluded from the resettlement process, or their resettlement may be delayed. Although this is not the case for the EU, refugees who are being resettled there may have heard about this from peers and therefore believe that resettlement depends on being healthy. Conversely, they may believe that it depends on being psychologically traumatized. Underreporting or overreporting physical and mental health issues can result from these beliefs.

Refugees who are diagnosed with certain health conditions, such as tuberculosis and diabetes, tend to be treated before departure and receive multi-drug treatment which may cause adverse reactions, events or side effects, including depressive disorders. Refugees under such treatment may find their well-being compromised if they do not receive proper psychological follow-up.

Finally, health assessment personnel are usually from the country of first asylum and do not share the culture of the refugees being assessed. This may entail assumptions, prejudices, requests and expressions on the part of these personnel that may result in inappropriate or unclear interactions with refugees that increases their distress. Cultural competence, or the ability to understand interculturality in health care provision, among health care providers is therefore essential. Support from interpreters or cultural mediators can also be vital to strengthening such services, enabling better communication and understanding between refugees and medical practitioners (see [Annex 2](#)).

<sup>32</sup> For a summary of the stressors and possible psychosocial impacts in the resettlement process, refer to [Table 2](#).

### *Pre-departure orientation*

Refugees may not fully understand and absorb all of the information provided during PDO sessions. Their concentration and memory may be impaired for a number of reasons, including: the amount of information shared in the sessions; the fact that the sessions often happen close to the departure date, a time when refugees may be preoccupied, anxious and/or excited about their life-changing journey; and prior toxic levels of distress. Refugees may also ask practical questions about their resettlement that trainers are not able to answer. PDO trainers may also face challenges in managing refugees with mild or severe mental disorders, neurological and developmental disabilities, or who are under severe stress in the classroom. Where trainers are not trained to deal with these challenges, individual and group well-being and the effectiveness of the PDO sessions may be threatened.

Despite these possible negative situations and outcomes, PDO sessions provide one of the few opportunities during the resettlement process for refugees to spend extended periods of time with their peers, family members and even reception authorities (through video calls). These interactions can be crucial to increasing their knowledge, psychosocial well-being and support networks, and to managing expectations about resettlement. See [Boxes 9, 10 and 11](#) for best practices for MHPSS during PDO sessions.

### *Travel to the resettlement country*

Travelling from the country of first asylum to the resettlement country is a critical moment in the resettlement process: for refugees, it is the moment of transition to a new home and new possibilities of restarting their lives. They will face the usual anxieties about moving, including concerns about the journey itself (e.g. having responsibility for all of their documents and negotiating travel), as well as about their upcoming experiences in the resettlement country.

However, levels of excitement about the journey and transition often appear to be higher among refugees than stress levels. Refugees may take full advantage of their resources (e.g. by wearing their best clothes for the journey) and show their 'best selves' during travel and on their arrival.

Refugees with mild or severe mental disorders or neurological or developmental disabilities, or those experiencing extreme stress and/or trauma, may need a medical escort to reduce the risk of distress or harm during their journey.

## RECOMMENDATIONS

### Programmatic recommendations

#### *Processing travel documents and visas*

- ▶ **Offer appropriate support for refugees in processing their travel documents and visas**

Acquiring the necessary documents can be a stressful task for refugees – the process is lengthy and they often need to contact border authorities, in whom they may have little trust. In line with current IOM practice and programming guidelines, all resettlement staff should provide appropriate support, including:

- Prepare refugees for the process by:
  - Providing information on the steps and average duration of the process
  - Providing information on visa application procedures
- Logistical support (including providing accommodation and transportation)
- Support for the preparation of the required documents, if necessary
- In collaboration with national authorities, provide PFA and cultural competence training for border and other officials, developing their skills so they can work in cross-cultural contexts and respond to people in distress in a humane and supportive way.

*For further guidance on IOM support for the process:*

[IOM Resettlement](#) (IOM, 2020d)

[IOM Movements](#) (IOM, 2020e)

*For further information on basic psychosocial skills:*

[Basic psychosocial skills for resettlement staff](#) (Annex 1 of this document)

[Psychological First Aid: Guide for field workers](#) (WHO, War Trauma Foundation and World Vision International, 2011)

[Psychosocial Support for Migrants](#) Free online training offered by IOM (available in English and Spanish)

### **Pre-migration health activities**

#### **► Ensure the continuum of care for refugees (including mental health and psychosocial support)**

Programme managers, in collaboration with health authorities of the country of first asylum and the resettlement country, should create strategies and protocols to ensure the continuum of care throughout the resettlement process. Information on a refugee's mental health conditions and needs gathered during pre-migration health activities should be shared with the resettlement country authorities, respecting confidentiality measures, to guarantee that s/he receives appropriate care on arrival and the continuum of care is maintained.

#### **► Implement or strengthen systematic mental health evaluations as part of the pre-departure health assessment**

Protocols for health assessments should include a supportive and non-exclusive systematic mental health evaluation (see [Box 8](#)). This will enable the identification of refugees with moderate and severe mental disorders, neurological or developmental disabilities that may require specific care; their referral to appropriate services; and the provision of a medical escort during travel to the resettlement country if necessary. It will also strengthen follow-up, both before departure and upon arrival in the resettlement country.

In collaboration with resettlement country authorities, programme managers should implement or strengthen mental health evaluation protocols. Protocols and tools should be tested and adapted according to the cultural background of refugees. Health practitioners and caseworkers responsible for conducting health assessments should use the protocols in combination with their own professional expertise in diagnosis and referral. It should be noted that the inclusion of mental health components in the pre-migration health assessment will require additional time: depending on the protocol used, it could add five to 20 minutes per assessment (see [Box 8](#)).

*Strengthening mental health assessments in pre-departure activities:*

[The Global Mental Health Assessment Tool \(GMHAT\) pilot evaluation: Final report](#) (Home Office and Public Health England, 2019)

*Creating a referral system:*

Sections 2.6.3 and 4.1.3 and Annex 8 of the [IOM Reintegration Handbook](#) (IOM, 2019f)

*Complementary resource for health professionals conducting health assessments:*

[Handbook for Health Professionals - Health Assessment of Refugees and Migrants in the EU/EEA](#) (European Union, 2015)

► **Provide MHPSS for refugees facing health problems during the pre-departure phase**

Some refugees discover health problems during their pre-departure health assessment, including infectious diseases, terminal conditions and chronic disorders. These refugees (and their family members, if necessary) should receive psychosocial counselling by a psychologist on the premises or through referral.

Refugees who receive multi-drug treatments for specific health conditions (such as diabetes or tuberculosis) and run the risk of depressive symptoms as a side-effect should have access to counselling as necessary before and after resettlement.

► **Ensure health staff are trained in psychological first aid and cultural competence**

Health staff must receive PFA training to provide humane assistance and do no harm, and to improve their ability to talk to people and be empathetic to refugee concerns in sensitive circumstances.

*For further information on basic psychosocial skills:*

[Basic psychosocial skills for resettlement staff](#) (Annex 1 of this document)

[Psychological First Aid: Guide for field workers](#) (WHO, War Trauma Foundation and World Vision International, 2011)

[Psychosocial Support for Migrants](#) Free online training offered by IOM (available in English and Spanish)

In addition, health staff (including medical doctors and psychologists) should receive training in cultural competence to help them to work in cross-cultural contexts, respecting the background experiences, culture, beliefs, age, gender, language and literacy levels of refugees.

*For further information on cultural competence training, especially in mental health practice:*

[Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Cultural Competence and Empower Practitioners](#) (IOM, 2009)

IOM internal tool on [Cultural Competence in Migration Health Assessments](#). This tool can be obtained by contacting [contactpss@iom.int](mailto:contactpss@iom.int).

### Pre-departure orientation

► **Address psychosocial issues through complementary psychosocial counselling and psychoeducation activities**

In light of the stressors faced by refugees in this phase, it is recommended that:

- A separate, dedicated and complementary psychoeducation session is included in PDO curricula. The session would aim to explore refugees' fears and anxieties about the resettlement process and share tips on how to overcome them. It must be conducted by a psychologist or creative therapist.
  - The psychoeducation session should be adapted to the refugees' cultural background, and the psychologist should avoid using technical terms.
  - Complementary materials adapted to the refugees' context should be used to support the psychoeducation session.

The Self-Help Booklet for Men Facing Crisis and Displacement (IOM, 2014) was published to help Syrian men understand and cope with feelings and emotions in crisis times. This resource is available in [Arabic](#) and [English](#).

- Psychosocial counselling provided by a dedicated psychologist is offered on-premises to complement the PDO and psychoeducation sessions and protect or promote refugees' psychosocial well-being.

*For further information on psychosocial counselling in displacement and resettlement contexts:*  
Chapter 13 of the IOM 'Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement' (IOM, 2019a)

- Refugees with mild or severe mental disorders, developmental or neurological disabilities are referred to specialized care.

*Creating a referral system:*  
Sections 2.6.3 and 4.1.3 and Annex 8 of the IOM Reintegration Handbook (IOM, 2019f)

► **PDO trainers should be trained in PFA, cultural competence and how to manage distress in the classroom setting**

Like other procedures and activities in the resettlement process, the PDO sessions may trigger psychosocial distress in refugees. It is recommended that:

- PDO trainers receive PFA training, enabling them to identify distressed people, communicate with them appropriately and refer them to the appropriate services if necessary.

For detailed information on PFA:

[Psychological First Aid: Guide for field workers](#) (WHO, War Trauma Foundation and World Vision International, 2011)

[Psychosocial Support for Migrants](#) Free online training offered by IOM (available in English and Spanish)

- PDO trainers be prepared and trained to manage people in distress or with disabilities in the classroom to reduce negative outcomes and promote well-being at the individual and group levels.

The Australian Cultural Orientation (AUSCO) Programme/IOM manual on mental health and psychosocial support for PDO trainers. It aims to help trainers manage and provide basic psychosocial support for distressed refugees and create strategies to reduce stressors prior to, during and after the sessions (Box 10). The tool can be obtained by contacting [contactpss@iom.int](mailto:contactpss@iom.int).

- PDO trainers follow best practices for addressing mental health and psychosocial issues in the classroom (see Box 10). Such practices may vary according to the context.

## General recommendations

### ▶ Ensure pre-departure activities are culturally relevant and adapted to each group of refugees

Pre-departure activities, including psychosocial counselling and psychoeducation sessions, should take into account the different characteristics and contexts of participants (including culture, literacy and education levels, age, gender etc.). Resettlement staff should communicate and interact with each refugee group (and sub-group) according to these contexts and characteristics to reduce the risks of misunderstanding. Related capacity building materials, manuals and guidelines can be adapted or developed.

The COMMIT project's [Training Refugee Youth – Pre-departure orientation: Youth](#) (IOM, 2019e) is a guide for PDO trainers focused on PDO for youth refugees.

The COMMIT project's [Mainstreaming Gender in Pre-departure Orientation Sessions – Guidelines for Practitioners](#) (IOM, 2020f) provides PDO trainers with guidelines on gender mainstreaming.

Resettlement staff should receive capacity building in cultural competence to provide adequate assistance in cross-cultural settings.

### ▶ Provide interpretation and cultural mediation when needed

Programme staff and refugees often do not share a common language. In such cases, professional interpreters and/or cultural mediators may be essential to support communication between resettlement staff and refugees. They may help to promote the credibility of resettlement staff members and increase trust on the part of refugees. However, for this to work, resettlement staff need to understand the roles and limitations of interpreters and cultural mediators.

For further information on working with interpreters and cultural mediators:

[Annex 2: Working with cultural mediators and interpreters](#) (this document)

[Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Cultural Competence and Empower Practitioners](#) (IOM, 2009)

[Field guide to humanitarian interpreting and cultural mediation](#) (Translators Without Borders, 2017)

For information on the role of intercultural mediation in health care:

[What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?](#) (WHO, 2019b)

IOM internal tool on *Cultural Competence in Migration Health Assessments*. This tool can be obtained by contacting [contactpss@iom.int](mailto:contactpss@iom.int).

### **BOX 11 | Best practices for building the capacity of PDO trainers**

PDO trainers require specific skills to ensure the quality of sessions; to build the practical skills of refugees; and to help empower refugees with attitude and skills that benefit their integration in the resettlement country. They also need to have the knowledge to provide appropriate information about the resettlement country and answer questions from refugees related to the resettlement process.

PDO trainers come from a range of educational backgrounds – under the COMMIT project, for example, IOM trainers have university degrees in education, international relations and social sciences. Their specific skills should be valued and used, but it is also essential to prepare them specifically for their PDO role, including by:

#### **► Providing training opportunities in different skills**

PDO trainers should have the opportunity to participate in training on participatory and learner-centred methodologies; teaching adult learners; intercultural competence; communication competence; essential characteristics of refugees' countries of origin and resettlement countries (history, geography, culture, social manners etc.). They should also receive basic training in psychosocial support, psychological first aid and how to manage distress in the classroom (see [Boxes 9 and 10](#)).

#### **► Providing the opportunity to visit resettlement countries**

PDO trainers should have the opportunity to visit resettlement countries to widen their knowledge about local realities in the contexts in which refugees will be resettled. Where possible, they should also meet reception actors to create links between PDO and post-arrival orientation.

#### **► Ensuring teamwork and close coordination between resettlement staff in the country of first asylum and resettlement country**

Coordination between and teamwork in both countries are essential to the success of the resettlement process. PDO trainers can contribute to this collaboration by: addressing concerns and questions raised by refugees during the sessions, together with the relevant entities in the resettlement country (including through video calls whenever possible) and by reinforcing key messages.



# Post-arrival phase: reception and integration

## OVERVIEW AND IOM'S ROLE

This is the period following a refugee's arrival in the resettlement country and includes the integration process.

### BOX 12 | Integration

Integration empowers refugees to realize their full inclusion in society and promotes positive relations across diverse groups, thereby contributing to diverse yet inclusive and cohesive societies. IOM recognizes that successful integration is a dynamic, multifaceted process that is:

- ▶ Multidimensional – depending on multiple factors encompassing equitable access to resources and opportunities as well as respectful relations.
- ▶ Multi-directional – involving mutual adjustments by migrants and societies in which they settle.
- ▶ Inclusive of the whole-of-society – recognizing that both refugees and affected communities have a role to play in the process and a shared sense of responsibility to make integration work.
- ▶ Context-specific – requiring a tailored approach to refugees' characteristics, multiple identities and specific needs arising in particular contexts.

See IOM, *Integration and Inclusion of Migrants and People with a Migrant Background* (2020g).

Many factors contribute to the success of integration, including: the refugee's mental and physical health; access to social support; their previous experiences; and the host community's willingness to receive and integrate resettled individuals.<sup>33</sup> It does not require refugees to renounce their own cultural identity but involves a process of mutual adaptation.<sup>34</sup>

In many EU countries (including those covered by the COMMIT project), refugees are met by local authorities at the airport and then taken to central reception centres. Depending on the policies and systems of each resettlement country, these may be facilities managed by local authorities, agencies or non-governmental organizations, or private accommodation, located in urban or rural areas. Services provided to refugees during the reception phase include housing; food; local language courses; access to cultural mediators or interpreters; and legal, employment and education advice. These services aim to facilitate the integration of refugees into the host community and their access to essential social services, including mental health care (see [Boxes 7](#) and [15](#)). Reception services are generally offered for 12 to 18 months, depending on the resettlement country, but can be extended on a case-by-case basis.

<sup>33</sup> Strang and Ager, 2010.

<sup>34</sup> UNHCR, 2013.

Additional interventions may be undertaken by authorities and stakeholders at the national, regional and local levels to enable and support refugee integration. Initiatives combining livelihoods support, psychosocial support and access to health care and education can be designed to benefit both host community members and resettled refugees.

It should be noted that the diversity of resettlement structures and policies in European countries has an impact on the reception and integration of refugees, especially in countries that do not have much experience of resettlement. Refugees resettled in 'new' resettlement countries may therefore seek to move to another European country (generally those perceived to have stronger resettlement structures or to offer more interesting opportunities).

IOM works closely with governments and local stakeholders to strengthen the reception and integration processes by offering sensitization sessions on essential elements of resettlement, including refugees' mental health and the psychosocial aspects of these processes. For instance, IOM Portugal provides sensitization sessions to raise awareness among members of host communities and local integration actors on the resettlement process and related topics, including refugees' mental health and psychosocial well-being (see [Box 17](#)).

Ideally, many of the issues below will have been addressed during PDO (including changing family dynamics and gender roles). Depending on the resettlement programme, IOM may monitor the impact(s) of PDO during the first months of residence in the country of resettlement, cross-checking the relevance and efficiency of the key messages shared during the PDO sessions. Such monitoring ensures that the PDO curriculum is regularly updated and strengthens the link between the pre-departure and post-arrival phases, maintaining a continuum of services.

## Key aspects of integration

### *Social integration*

Social integration is a multidimensional process through which individuals participate in various social relationships, including social activities, building a sense of belonging and identification with social roles.<sup>35</sup> The integration of resettled refugees in host countries is a mutual process, requiring positive attitudes and adjustments from all actors, including the host community members, local authorities, and service providers as well as refugees (see [Box 15](#)).

Refugees and host communities first come into contact through experiences and activities in the reception/post-arrival phase, which is a crucial time to lay the groundwork for social integration. Social integration initiatives that promote and encourage the bridging of cultural, ethnic and social differences between refugees and host communities are essential to achieving positive gains for both populations.

The main psychosocial obstacles to effective social integration are the challenges for refugees in forming new social networks and relationships with host community members, which can include language barriers; cultural differences; and fear of rejection and discrimination (among others). Major facilitators include refugee

---

<sup>35</sup> Holt-Lunstad and Uchino, 2015.

peer-support networks (e.g. among national and ethnic groups) and efforts by host community members to welcome and include refugees in activities, basic service provision and employment.<sup>36</sup>

### **Economic integration**

Economic integration is essential to the integration of refugees in resettlement countries. Employment is the leading indicator of economic integration. It restores a sense of agency, autonomy and financial independence and builds refugees' confidence as productive members of society. It also enables social interactions, expands networks and communities and offers refugees opportunities to learn about the local culture, norms and language.

In the European context, the main barriers to the employment of refugees include: direct or indirect discrimination or prejudice in the labour market, lack of willingness by employers to hire refugees, a lack of social networks; level of education; limited knowledge of the local language; difficulties in qualification recognition; health conditions; a lack of childcare; and a lack of information.<sup>37</sup>

Many countries in the EU, including those under the COMMIT project, offer initiatives at the reception stage to promote livelihood and job opportunities to resettled refugees and strengthen their capacity and skills to access the local labour market (for instance, through local language courses and vocational training). It is important to bear in mind, however, that resettled refugees may be exposed to various sources of stress linked to their integration which might impact their participation in such initiatives. Indeed, some livelihood activities can actually lead to new or increased stressors rather than alleviating them.<sup>38</sup> Integrating livelihood programmes with MHPSS can reduce such risks of further harm. For instance, initiatives that focus on promoting food security, social integration and cohesion among refugees are expected to have a greater impact on their mental health than those focused only on boosting their income.<sup>39</sup>

### **Access to essential services**

Access to essential services – including health, education, housing, water, sanitation and hygiene – is both a human right and key to the integration process. Addressing the basic needs of refugees enables them to achieve well-being and live in a dignified manner. However, resettled refugees may face challenges in accessing such services.

Access to education may be complicated by language and administrative barriers,<sup>40</sup> financial difficulties and a lack of documentation/proof of existing qualifications and course completion. This may hinder integration by compromising a refugee's ability to continue their studies, increase their education level and gain employment.

<sup>36</sup> UNHCR, 2013.

<sup>37</sup> UNHCR, 2013.

<sup>38</sup> Lund, et al., 2011.

<sup>39</sup> IOM, 2019a.

<sup>40</sup> The acquisition of local language is a cross-cutting issue that can affect their integration.

Similar difficulties can impede access to health care, including mental health care (see [Box 16](#)). In addition to a lack of information, discrimination, language and communication barriers, refugees may also find it difficult to receive culturally sensitive care that respects their background, culture, and beliefs.<sup>41 42</sup> A lack of support may result in the deterioration or complication of existing health conditions, or a failure to diagnose new conditions.

Refugees may also encounter difficulties in accessing affordable, appropriate and secure accommodation, including because of their legal status or when they are unemployed or lack secure income.<sup>43</sup>

Meeting refugees' basic needs is crucial to their successful integration across many dimensions of the process. For example, if a refugee has a health condition but cannot access health care, s/he may find it difficult to be productive and, as a result, face challenges in contributing to and participating in community activities.

### **BOX 13 | Mental health and psychosocial support: a cross-cutting issue in the resettlement process**

Mental disorders are determined not only by individual attributes – such as the ability to manage one's thoughts, emotions, behaviours and interactions with others – but also by social, cultural, economic, political and environmental factors, such as national policies, social protection, standards of living, working conditions, and community support.<sup>a</sup> Mental health and psychosocial support must be considered a cross-cutting issue throughout the resettlement process and in all related sectors (e.g. education, health, protection and shelter).

Every resettlement stakeholder – government authorities and agencies as well as international and national organizations – should advocate for and integrate multilayered MHPSS approaches and activities into their responses (including in the national health system), and establish coordination and referral mechanisms across different levels of interventions and sectors.<sup>b</sup> This will increase the likelihood that resettlement programmes will be successful and ensure the sustainability of mental health and psychosocial services and the continuum of care for resettlement refugees.

a) WHO, 2019a

b) IASC, 2007

<sup>41</sup> WHO, 2018a.

<sup>42</sup> WHO, 2018b.

<sup>43</sup> UNHCR, 2013.

## Psychosocial reactions<sup>44</sup>

### *Arrival and reception in the resettlement country*

Refugees have their first experiences of their new country at arrival at the destination airport and through contact with reception staff, and these may influence their first impressions of the country and affect their expectations of resettlement.

They may be facing genuine distress due to arriving in an unknown place, with strange local culture and social norms, as well as anxiety about their immediate and longer-term future. They may be tired from the journey, and overwhelmed or disoriented by new and detailed information provided by reception staff, triggering feelings of anxiety and fear. However, they may also or instead be feeling excitement about arriving in their new place of residence and their new life there.

### *Adjustment*

The initial weeks and months in the resettlement country are crucial, as these are when expectations and plans are confronted with reality. Resettled refugees may have a range of responses and reactions, including excitement, happiness and euphoria – and/or grief, fear and concern. Many of these emotional reactions are considered 'normal' in the face of demanding circumstances and life changes.<sup>45 46</sup>

Resettled refugees are expected to adjust quickly to the social, cultural, economic and political aspects of the resettlement country. However, adaption and integration involve actions that require longer time investments – such as learning a new language, creating bonds and social connections, finding a job and housing, and learning the local culture and traditions. The expectation for a quick adjustment can therefore cause fatigue, pressure, isolation and low self-confidence, among other impacts. When refugees are resettling in family units, such reactions may be multiplied, with potential negative results for the family's well-being and dynamics.

On the other hand, adjustment can have positive impacts for both refugees and host communities. For instance, resettled refugees can create or transform life aspirations based on new opportunities in the resettlement country; adapt coping mechanisms and resources based on previous experience (resilience) to deal with stressors; learn new skills; and break boundaries.

### *Changes in family roles and dynamics*

Families that have moved as a unit may face internal conflicts due to changes in roles for family members from different generations. For example, older generation members may become dependent on their children or grandchildren in certain aspects of their lives where children are more easily able to learn the new language.<sup>47</sup>

<sup>44</sup> For a summary of the stressors and possible psychosocial impacts in the resettlement process, refer to Table 2.

<sup>45</sup> WHO Europe; UNHCR; IOM; MHPSS.net., 2015.

<sup>46</sup> American Psychiatric Association, 2020.

<sup>47</sup> Robertson, 2020.

Younger refugees may be given more responsibilities than in their country of origin or first asylum, such as finding a job to support their families financially. These role changes and new responsibilities have different impacts on the identities (see [Box 14](#)) and well-being of family members. Younger refugees may feel stress and anger at the pressure to support their families, while older adults can develop low self-esteem and a sense of not belonging to the community or feel frustrated. Conversely, these changes in dynamics may stimulate members of the younger generation, leading them to be proactive in learning new skills needed in the household, flexible and adaptative to changes.<sup>48</sup>

Changes in gender roles can also occur in resettled families. For instance, in some cultures, men are responsible for providing financially for their family, while women are expected to take care of the house and children. In the country of resettlement, women may have to start working to support the family. In such cases, discomfort and even conflict may occur as family members confront their traditional values and culture. Depending on the context, women may feel empowered by their new role(s) and by having the same rights as men.<sup>49</sup>

### **Identity changes**

During resettlement and integration, when refugees are expected to adapt to the culture and norms of the resettlement country and host community, they may experience changes in personal and community relationships that affect their sense of self and well-being (see [Box 14](#)).<sup>50</sup> These may be exacerbated by tensions around changes in family roles and dynamics that affect not only the individual but the identity of the family unit. The process can also affect the professional and occupational identities of refugees, who often have to work in a different area than in their country of origin or of first asylum, requiring a change of roles and possibly learning new skills.<sup>51</sup>

Moreover, as identity is characterized by continuing evolution and change, it may also be affected by other factors related to context, culture, tradition and social norms. Adversity faced by refugees in both the first asylum phase and resettlement process – including forced displacement, violence, human rights violations and the need to adapt to different cultures – has impacts for both individual and community identity and well-being. As a result, resettled refugees may experience disorientation, a sense of not belonging and confusion, among other emotions.

At the same time, the arrival of resettled refugees can affect the individual and community identities of members of host communities. Refugees bring new cultural elements, traditions, needs and demands to host communities, which may fear the loss of their own identity. However, such changes are not necessarily negative: they can result in positive outcomes such as the creation of a new collective identity (or identities) and increased respect and consideration for different cultures and traditions.

<sup>48</sup> See the COMMIT project's [Training Refugee Youth – Pre-departure orientation: Youth](#) (IOM, 2019e) for more information.

<sup>49</sup> See the COMMIT project's [Mainstreaming Gender in Pre-departure Orientation Sessions – Guidelines for Practitioners](#) (IOM, 2020f) for more information.

<sup>50</sup> Bergquist, Sozil, Everhart, Braithwaite, and Kreimer, 2019.

<sup>51</sup> Steimel, 2010.

**BOX 14 | Identity and resettlement**

Identity can be defined as the characteristics determining who a person is.<sup>a</sup>

Identity is central to individual and collective well-being, and remains so after adversity, disruptions and displacement. It can be considered as an interrelated system of three components that continuously feed back on each other:

- ▶ The self-concept, or who I am according to myself (e.g. self-attribution and individual differences)
- ▶ Internalized social factors (e.g. gender, sexuality, culture, race, nation, age, class and occupation, traditions, traditional roles)
- ▶ The relational component, or how others perceive me.
- ▶ The identity of an individual or community is in a continuing process of change and evolution, directly affected by experiences, encounters, education, environment, context, culture, traditions etc.

For further information, see the [IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a; pp. 16-17).

---

a) OED, 2020b

**Social integration**

The initial contacts and interactions between members of host communities and resettled refugees are important to the process of integration. Members of both groups may find their expectations have been confirmed, or that reality does not match their hopes.

Both individual and community well-being can be affected by such experiences. Social integration initiatives can do much to guide and support initial interactions. Where these are positive, refugees and members of host communities may create bonds and increase their tolerance and understanding of other cultures, which in turn encourage new relationships and new ways of thinking, break traditional boundaries and increase a sense of belonging. They can also result in job opportunities for resettled refugees, providing them access to a livelihood and expanding and diversifying the local economy.

However, where social integration is not promoted, does not occur or goes poorly, refugees can face stigma and discrimination from host community members, affecting individual and communal well-being and preventing their economic integration. Individuals may suffer distress as a result, with impacts on their self-esteem and self-efficacy.<sup>52</sup>

**Livelihoods and the economy**

In addition to the socially and culturally positive outcomes of integration, host communities and refugees can also benefit economically from expansions and innovations of local labour markets. Such economic benefits can have positive knock-on effects on individual and community well-being.

---

<sup>52</sup> Holt-Lunstad and Lefler, 2020.

Initiatives that provide both livelihood and psychosocial support can have particularly positive impacts for individuals and communities. Such initiatives benefit from the interrelations between these two dimensions: psychosocial improvements are necessary for the success of economic activities, and when refugees participate in livelihood activities it helps them support both their families and the community, contributing to social integration and helping to reduce stigma and discrimination (among other impacts).<sup>53</sup>

Vocational training, livelihood activities and other initiatives offered by local authorities and stakeholders during the reception stage can empower refugees and strengthen their work-related skills, including through exploring their existing abilities and experience. These resources and skills can be valuable to old and new members of the host community by expanding its economic activities.<sup>54</sup>

### BOX 15 | Refugee resettlement and social integration

A number of studies show the relationship between promoting social integration and the success of refugee resettlement (see, for example, Correa-Velez et al. (2020) and Spicer (2008)). Social connections between refugees and host community members play an important role in the integration of resettled refugees by:

- ▶ creating emotional support networks and reducing feelings of isolation among refugees
- ▶ creating a sense of belonging to and trust in the host community
- ▶ enhancing the sense of life satisfaction and
- ▶ facilitating access to basic services and job opportunities.

Where social integration is weak or lacking, refugees may be marginalized or stigmatized, and may even be perceived as 'problems' in the community (or refugees may believe this to be true).

## Access to basic services

### Education

Access by both children<sup>55</sup> and adults to education can play an essential role in social integration and improvements to their well-being.

Access to education for adult refugees can improve their chances of employment and their economic situation, while supporting acculturation and socialization processes. In some contexts, refugees may face challenges in receiving recognition for their existing education and qualifications (for example, due to a lack of documentation), which can cause anger, frustration and demotivation.

Children can also benefit positively from attending schools which have the appropriate initiatives and structures to receive them. The combination of their capacity for rapid language acquisition and the opportunities

<sup>53</sup> World Bank, 2014.

<sup>54</sup> Studies suggest that, although refugee integration is expensive, its medium- to long-term socioeconomic benefits outweigh the costs (see, for example, Kancs and Lecca (2017)).

<sup>55</sup> Horswood, Baker, Fazel, et. al, 2019.



offered in and by school environments can help them to create new social networks<sup>56</sup> and develop a sense of belonging in the community.

### *Health*

Health is a cross-cutting issue that can influence various aspects of the integration process. Maintaining the highest standard of physical and mental health is crucial for enabling refugees to realize their potential and to participate and contribute actively to their new community.

A lack of access to health care systems (including mental health care – see [Box 16](#)) can be a stressor that negatively affects refugee well-being, dignity, safety and integration. For instance, lack of health care can mean that health conditions are exacerbated; they may suffer discrimination, feel frustrated, and even develop distrust towards the resettlement country and its systems. Such impacts cause distress among individuals and can directly impede the integration process.

### *Housing*

Accommodation is an essential aspect of integration. When refugees encounter barriers to accessing housing and/or poor living conditions, this can have impacts on their well-being and integration. Inadequate housing size and sanitary conditions, or an inappropriate housing location, can affect the mental and physical health of refugees, including through the effects of stress.<sup>57</sup>

### **Resettlement settings (urban and rural areas)**

Under the COMMIT project, each resettlement country has its own criteria for resettling refugees in urban or rural areas. Every setting may have specific cultural traditions; access to livelihoods, health and education; language; and weather conditions, all of which influence refugees' opportunities to integrate. For instance, those living in rural areas may only have access to a limited labour market, while those living in an urban centre may have more opportunities to match their skills to jobs, but face higher living costs. In either case, refugees are required to adjust to and integrate into the community where they have been resettled. However, refugees may not like the community and/or it may not meet their expectations, which can cause feelings of frustration, anger, stress and worry.

In addition, the setting in which a refugee lived in the country of first asylum can influence how they integrate into the resettlement community and, consequently, their well-being. For example, those living in an urban area in the country of first asylum may well have been able to live autonomously,<sup>58</sup> which can mean they are more experienced in finding their own ways to meet needs and access essential services and as a result are more proactive in the resettlement country. Those who lived in a refugee camp, on the other hand, generally received services directly from providers and were not required take an active approach to meeting their own needs. In the resettlement country, they may also be more passive. For further information on these settings in the country of first asylum, see [Chapter 1 - Differences between living situations: refugee camps, urban areas and rural areas](#).

---

<sup>56</sup> ICMC, 2013.

<sup>57</sup> UNHCR, 2013.

<sup>58</sup> Dick and Kuhnt, 2019.

### Previous integration experiences

As the above example demonstrates, although the resettlement country may be unfamiliar in terms of culture, values, politics and economics, it is not the first new environment that resettled refugees have had to adapt to. They will already have experience of adjusting to and integrating in their country of first asylum – and they can use this experience to their benefit by using the lessons they learned and positive coping mechanisms they developed in the resettlement context. However, if these experiences were detrimental to a refugee's well-being, the refugee may be less able to deal with new challenges in the resettlement country.

#### **BOX 16 | Barriers to access to mental health and psychosocial support for refugees in Europe**

Studies have identified a number of barriers that restrict the provision and access to mental health and psychosocial services for migrants, including refugees (see, for example, Bradby et al. (2015), Priebe et al. (2016) and O'Donnell (2018)). The main obstacles for refugees are:

- ▶ A lack of information about the local health system
- ▶ Conflicting cultural beliefs about mental health
- ▶ Difficulties in speaking the language of the resettlement country
- ▶ Distrust towards mental health services and staff
- ▶ Stigma and discrimination
- ▶ Cultural stereotypes about the roles and functions of health care staff.

Local authorities and stakeholders can minimize these barriers by:

- ▶ Raising the awareness of refugees about mental health conditions and encouraging their engagement in treatment if necessary
- ▶ Providing language courses to refugees and using cultural mediators or interpreters when necessary, including in health care services (see [Annex 2](#))
- ▶ Guaranteeing confidentiality in mental health and psychosocial activities
- ▶ Mapping MHPSS services providers and establishing referral and coordination mechanisms
- ▶ Ensure ongoing dissemination of information about the services available
- ▶ Training health care and resettlement staff to:
  - recognize people in distress and provide basic emotional support and referrals to appropriate care (see [Annex 1](#))
  - improve cultural competence and understand and respect refugee cultures, including beliefs about mental health.

## RECOMMENDATIONS

### Programmatic recommendations

#### Strengthening MHPSS initiatives

► **MHPSS initiatives must be mainstreamed**

MHPSS initiatives for resettled refugees are essential if the resettlement country is to respect their right to mental health care (see [Box 7](#)).

Resettlement countries should minimize the barriers to accessing mental health services (see [Box 16](#) and below). It is recommended that MHPSS initiatives be mainstreamed across different sectors (see [Box 13](#)).

► **MHPSS initiatives should facilitate access to mental health care for resettled refugees**

Programme managers should advocate with resettlement country authorities and stakeholders to ensure that mental health care services are accessible for resettled refugees. All essential services, including mental health care, should be:

- mainstreamed and advertised in all relevant sectors ([Box 13](#))
- systematically provided throughout the resettlement process
- non-discriminatory (segregated mental health care services specifically for migrants should be avoided<sup>59</sup>)
- culturally and linguistically sensitive
- physically accessible and economically affordable.

*For further information on strategies to facilitate refugee access to mental health care in the European context:*  
 Mental health promotion and mental health care in refugees and migrants (WHO, 2018a)  
 Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe - A Multi-Agency Guidance Note (UNHCR, IOM, MHPSS.net., 2015)  
 Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Cultural Competence and Empower Practitioners (IOM, 2009)

*Examples of best practices for facilitating refugees' access to MHPSS in the European context:*  
 A civilised society: mental health provision for refugees and asylum-seekers in England and Wales (MIND, 2009)  
 Mental health support for refugees and asylum seekers (Refugee Council, 2020)  
 STRENGTHS: Scaling up psychological interventions with Syrian refugees (STRENGTHS, 2020)  
 FOCUS: forced displacement and refugee-host community solidarity (FOCUS, n.d.)

To minimize barriers to resettled refugees accessing specialized mental health care, it is recommended that governments and health authorities:

- Grant refugees access to primary, secondary and tertiary health services, including mental health care (do not create separate services for refugees)

<sup>59</sup> Many refugees can benefit from the same interventions that are offered to host community members. (WHO, 2018a)

- ▶ Mainstream mental health and the needs of refugees in all relevant sectors: education, social care, health care, religious settings, security and law enforcement and community services
- ▶ Promote multi-layered mental health and psychosocial interventions, focusing on strengthening community support
- ▶ Map available services at the local, regional and national levels, and establish coordination and referral mechanisms. If needed, set up new services
- ▶ Guarantee the availability of cultural mediators and interpreters trained to work in mental health services
- ▶ Provide capacity building/training on cultural competence and how to work with refugees to resettlement staff and mental health professionals.

*For further information on mental health care for refugees in Europe:*

[Mental health promotion and mental health care in refugees and migrants](#) (WHO, 2018a)

*For further information on mental health systems and multi-layered interventions:*

[Mental health action plan 2013-2020](#) (WHO, 2013)

[The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response](#)

(Sphere Project, 2018)

[The Inter-Agency Standing Committee \(IASC\) Guidelines on MHPSS in Emergency Settings](#) (IASC, 2007)

- ▶ **MHPSS initiatives should strengthen local multi-disciplinary support systems and community-based activities**

MHPSS programmes must include community-based activities to strengthen multi-disciplinary support systems and social integration.<sup>60</sup> A coordination mechanism will increase synergy among MHPSS stakeholders, reduce the duplication of activities and avoid gaps in meeting the needs of refugees.

*For further information on community-based mental health and psychosocial support for refugees:*

[Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a)

*For further information on community-based MHPSS and coordination mechanisms:*

[Community-Based Approaches to MHPSS Programmes: A Guidance Note](#) (IASC, 2019)

- ▶ **MHPSS initiatives must be tailored to the needs of resettled refugees and host communities and to local response capacity**

Needs assessments should be conducted to establish both the needs of refugees and host communities and local capacity to respond. This will help to avoid 'one-size-fits-all' models of MHPSS.

<sup>60</sup> IASC, 2007.

*For further information about MHPSS needs assessments:*

[Psychosocial Needs Assessments in Emergency Displacement, Early Recovery, and Return](#) (IOM, 2010)

[Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings](#) (WHO and UNHCR, 2012)

### ***MHPSS initiatives at the reception and integration phases***

#### **► Provide post-arrival orientation**

It is recommended that local authorities, in collaboration with other key stakeholders, provide post-arrival orientation sessions to enable refugees to ask questions and clarify information about the resettlement country, the process of integration and any upcoming steps they need to take. The information shared in post-arrival orientation must be aligned with that provided in PDO to ensure continuity and consistency of support.

Like PDO trainers, post-arrival orientation trainers should receive training in PFA and cultural competence and cultural mediators and/or interpreters should be involved if needed.

#### **► Implement community based MHPSS activities to promote psychosocial well-being among refugees and integration**

In light of the possible challenges and stressors refugees can face during the reception and adaptation phase, it is essential to support the implementation of activities that promote the well-being of refugees and facilitate their integration in the new community.

Activities should be based on skills among refugees and host community members and focus on common interests.

#### **► Celebrations and rituals**

- Celebrations and rituals are crucial for the promotion of well-being and self-care. They can help refugees to overcome isolation, share their culture and reconnect with themselves, their family, their community of origin and host communities.
- Examples: personal, cultural, traditional, religious social celebrations and rituals – at both the collective and individual levels.

*For further information on these activities:*

Chapter 7 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a)

*For further information on the relevance of cultural, religious and spiritual practices as forms of community engagement and mental health-care services:*

Action Sheets 5.3 and 6.4 of the [IASC Guidelines on MHPSS in Emergency Settings](#) (IASC, 2007)

▶ Psychosocial counselling

- Distressed refugees should have access to psychosocial counselling conducted by a dedicated psychologist. Such support can promote well-being at both the individual and community levels.
- Refugees with mild or severe mental disorders or developmental or neurological disabilities should be referred to specialized mental health care.

*For further information on these activities:*

Chapter 13 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a)

▶ Creative and art-based activities

- Structured art-based and creative activities facilitate personal expression, relaxation, symbolic re-elaboration, relationships and problem-solving through social communication and metaphors.<sup>61</sup>
- Examples: art and other creative workshops, theatre and drama, community events with narration.
  - In Portugal, for instance, local stakeholders offered resettled refugees a radio station to share their culture with other community members through music from their country of origin and radio programmes to discuss their various traditions. Stakeholders also supported initiatives using dramatic performances and culinary skills.

*For further information on these activities:*

Chapter 6 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement](#) (IOM, 2019a)

▶ Integrated MHPSS and livelihood support

- MHPSS actors and local economic development stakeholders can offer combined livelihood and psychosocial support activities for refugees facing financial hardship, as well as MHPSS community-based social integration activities for host community members and refugees.
  - The design of livelihood programmes should take into account the cognitive capacity of people experiencing toxic levels of distress; limit environmental reminders of past trauma; and recognize the psychological and cultural difficulties refugees may encounter.
  - Livelihood support programmes should include counselling, psychoeducation sessions, and peer support groups.
  - The programme structure and staff should encourage horizontal constructive-collaborative dialogues between host community members and refugees to improve social and interpersonal relations, cultural exchanges and mutual acceptance and to create a new community identity.

<sup>61</sup> IOM, 2019a.

*For more information on the socio-economic dimensions of integration:*

[Socio-economic dimensions of integration: what does the literature say? \(FOCUS, 2020\)](#)

*To learn more about establishing integrated MHPSS and livelihood support:*

Chapter 11 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement \(IOM, 2019a\)](#)

[Restoring Livelihoods with Psychosocial Support \(World Bank Group video series\)](#)

*For more information about education in the displacement context:*

Chapter 9 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement \(IOM, 2019a\)](#)

[Improving Well-being Through Education – Integrating Community Based Psychosocial Support into Education in Emergencies \(FCA, 2018\)](#)

*For information on refugee education and integration in the European context:*

[A New Beginning: Refugee Integration in Europe \(UNHCR, 2013\)](#)

▶ Socio-relational and cultural activities

- These activities aim to support individuals and groups by enhancing resilience and mitigating distress. They can also provide evidence of the positive outcomes of adversity (such as gaining skills, reflection, creativity) and promote a sense of belonging at the individual and community levels.
- Examples: Support groups, informal groups, problem-based groups, peer-support, mentoring.
  - In Italy, peer-support and mentoring networks are part of COMMIT project activities aiming to strengthen community support. These activities promote supportive relationships between peers with similar experiences and backgrounds, and are bolstered by training for mentors.

*For more information on these activities:*

Chapter 5 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement \(IOM, 2019a\)](#)

▶ Sports and games

- Sports and games as structured or recreational activities are potent tools for promoting and enhancing social integration, a sense of community, self-confidence and resilience (among other benefits).
- From a psychosocial perspective, structured sports and games activities should include discussions with participants about the changes the activities have brought about at the community and individual levels.

*For more information on these activities:*

Chapter 8 of the [Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement \(IOM, 2019a\)](#)

► **Create a hotline for resettled refugees to provide information, orientation and basic psychosocial support**

Hotlines at the national and/or local level in resettlement countries should be established to provide easy access for refugees to orientation and key information about specific services and processes, and to offer basic emotional support.

► **Conduct sensitization and awareness-raising for host communities and local stakeholders**

Sensitization and awareness-raising sessions for host communities and resettlement/integration actors (e.g. reception personnel, social workers, health service staff members of the host community etc.) are essential to strengthening the resettlement process. They can also be an important tool for reducing the risks of discrimination and marginalization of refugees by host community members. Finally, they can help to ensure that service providers at the local level are equipped with the knowledge and skills required to integrate refugees' needs in existing services or tailor services to address these needs.

Such sessions can introduce participants to the background and characteristic of refugee groups (including culture and social norms) and their specific integration needs, including mental health and psychosocial needs.

See [Box 17](#) for best practices on the provision of sensitization sessions on resettlement refugees' MHPSS for local stakeholders.

See [Annex 5](#) for key messages for host community members about the importance of refugee integration.

► **Develop complementary MHPSS materials for resettled refugees and host community members.**

The promotion of initiatives on developing self-paced MHPSS informed integration tools or self-help tools based on the refugees' and host communities' needs is essential for strengthening the sense of well-being at individual and community levels. Still, it enhances the refugees' integration in the new context.

The tools should consider both population background and be culturally adapted.

The [Self-help book for men facing crisis and displacement](#) (IOM, 2014) aims to help Syrian men understand and cope with their feelings in times of crisis. It is also available in [Arabic](#).

It is suggested that a new tool be developed, based on [Preparing for Return](#) (IOM, n.d.b). The tool should focus on preparing refugees for the post-arrival process and coping with associated distress, and could be used during PDO, counselling and other settings.



### *Involving resettled refugees as key MHPSS actors*

- ▶ **Map MHPSS professionals in refugee and other migrant communities**

Recognizing the skills of refugee and migrant MHPSS professionals and using these to support others in the community can be beneficial for both individual and communal well-being. Those whose professional qualifications are valid/recognized in the resettlement country can benefit from integrating into the local labour market and assisting others with similar experiences.

### *Technical capacity building for relevant actors in the post-arrival phase*

- ▶ **Provide empathetic and appropriate reception services for refugees on arrival**

Local actors who provide information to refugees on or just after their arrival often fail to consider the physical and mental distress caused by the journey and their genuine concerns about moving to a new country. Reception staff need to ensure that they pay attention to signs of distress and display empathy. They should be aware that the quantity of information shared, and the ways in which it is shared, may be overwhelming, and act on that awareness. Training in psychological first aid, communication skills and the principle of 'do no harm' for reception staff is strongly recommended. See [Annex 1](#) for more guidance.

- ▶ **Provide capacity building for mental health professionals working with interpreters and managing cultural diversity in therapeutic settings**

Culture can affect how people approach mental health services, understand mental disorders and interact with mental health professionals. Cultural and language barriers are among the obstacles faced by refugees in accessing and using mental health services.

To mitigate such stressors and address these barriers, mental health professionals should receive training and capacity building in cultural competence and working with interpreters in therapeutic settings.

*For further information on cultural competence, especially for health professionals:*

Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Cultural Competence and Empower Practitioners (IOM, 2009)

What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region? (WHO, 2019b)

- ▶ **Provide capacity building in psychological first aid and cultural competence for resettlement staff and community leaders**

The arrival and adaptation phase can trigger worry and distress among refugees and exacerbate existing mental health conditions. Training in PFA and cultural competence helps resettlement staff and community leaders to provide humane, supportive and culturally adapted assistance to refugees and reduces additional stressors (such as discrimination).

*For detailed information on PFA:*

[Basic psychosocial skills for resettlement staff](#) (Annex 1 of this document)

[Psychological First Aid: Guide for field workers](#) (WHO, War Trauma Foundation and World Vision International, 2011)

[Psychosocial Support for Migrants](#) Free online training offered by IOM (available in English and Spanish)

### ▶ Facilitate the creation of peer support networks

Refugees can benefit from new social networks created through peer-mentorship programmes or community groups made up of people from the same country of origin or region. They can receive emotional, cultural and social support through exchanging experiences with others of the same nationality or from similar backgrounds. Seeing that other refugees/migrants have had similar experiences but been successful in resettling and integrating can help newcomers trust the process and encourage and motivate them to persevere despite difficulties.

### *Communicating effectively with refugees*

A key part of helping to ensure that refugees retain a sense of control over their situation (which can help to mitigate negative psychosocial reactions) is to communicate with them effectively and appropriately. Resettlement actors should:

- ▶ **Develop an information communication strategy** outlining what type(s) of information should be shared when, how, and by what means. This should be adapted according to context and in consultation with specific refugee groups. The risks of sharing information should be identified and minimized. It is particularly important to understand and use the communication platforms and media that refugees themselves use.
- ▶ **Prepare standardized and consistent messages** for meetings with refugees, which include explanations of what constitutes fraud, abuse, exploitation and misconduct and the rights of refugees to ask questions if they do not understand the information provided; to confidentiality; and to report and complain where they feel that their rights have been violated (and how to do so).
- ▶ **Establish a two-way complaints and feedback mechanism** to manage expectations and actively monitor the concerns that refugees may have about the resettlement process, and to ensure that they receive an adequate and timely response.
- ▶ **Demonstrate empathy and understanding at all times, but particularly where a refugee is in extreme distress** (for example if their resettlement application has been turned down).
- ▶ **Dispel misinformation:** Where recurrent questions arise around the same issues, or incorrect information and rumours proliferate among refugees, additional and correct information should be shared.
- ▶ **Coordinate messaging on complex issues in advance with key partners.**

*For detailed guidance on effective communication please email [contactpss@iom.int](mailto:contactpss@iom.int).*

## General recommendations

### ▶ Ensure all assistance provided to resettled refugees is systematic and sustained

All support provided to resettled refugees, including MHPSS activities, language courses and livelihood initiatives, must be systematic and sustained in order to avoid further challenges and stressors for refugees caused by unreliable or fragmented assistance.

### ▶ Make use of interpreters or cultural mediators whenever needed

The use of professional interpreters and cultural mediators can be essential to supporting communication and understanding between service providers and refugees. It can increase the credibility of service providers and help ensure trust on the part of refugees.

All mental health professionals, interpreters and cultural mediators involved in the post-arrival phase should receive appropriate training in working together in cross-cultural therapeutic settings.

*For further information in working with interpreters and cultural mediators:*

[Annex 2: Working with cultural mediators and interpreters](#) (this document)

[Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Cultural Competence and Empower Practitioners](#) (IOM, 2009)

[Field guide to humanitarian interpreting and cultural mediation](#) (Translators Without Borders, 2017)

*For information on the role of intercultural mediations in health care:*

[What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?](#) (WHO, 2019b)

### ▶ Additional good practices for health professionals during the resettlement and integration phase

- Provide training for community members in basic psychosocial support that does not require specialized professionals (e.g. PFA, peer counselling)
- Ensure the integration of mental health care with other health and social provision
- Ensure all staff are aware of refugee entitlements to care.

### **BOX 17 | Best practices: Sensitization sessions on resettlement, mental health and psychosocial well-being (IOM Portugal)**

As part of the COMMIT project, IOM Portugal provides sensitization sessions focused on refugee mental health and psychosocial well-being for multisectoral stakeholders across the country. Between August 2019 and April 2020, 18 sensitization sessions were delivered to 370 participants in 11 regions. These sessions complement others organized under the Resettlement Protocol with the Government of Portugal.

The sessions aim to help multisectoral stakeholders to assist refugees in a humane way, promote good mental health among refugees and to do no harm by:

- ▶ Increasing their knowledge about the psychosocial well-being of refugees
- ▶ Deconstructing myths about the mental health of refugees
- ▶ Raising awareness about the importance of promoting the resilience and psychosocial well-being of refugees at the community level and
- ▶ Providing useful information, resources and contacts.

The participants are professionals from different sectors involved in refugee reception and integration, including local authorities, service providers, social workers, NGOs, civil society organizations and health professionals providing education, social support, health care, employment services and vocational training. They include hosting institutions and professionals who work directly with refugees providing care or who otherwise work with them regularly.

Each session is adapted to the context and stakeholders' needs and covers a core set of information:

- ▶ The resettlement process and the role of IOM
- ▶ Activities that complement the National Resettlement Programme, including the COMMIT project
- ▶ Mental health, psychosocial well-being and resilience
- ▶ Psychosocial processes in forced migration and among refugees
- ▶ Practical considerations for service providers and community actors working with refugees
- ▶ Promotion of mental health: community-based approaches and
- ▶ MHPSS aspects of the COVID-19 pandemic (in 2020).

The sensitization sessions prepare local actors and professionals to support resettled refugees in their integration, and to understand both the different types of MHPSS activities and the importance of strengthening community networks among local stakeholders. They also help to reduce the risks of discrimination and marginalization of the refugees by host community members.

- ▶ The design and implementation of sensitization sessions requires organizers to:
- ▶ Take into account the context (the country, region, community)
- ▶ Ensure the activity is appropriate and targeted to the context and different participants
- ▶ Ensure communication with stakeholders along the resettlement continuum
- ▶ Carry out a needs assessment before fine-tuning/adapting session contents
- ▶ Encourage the participation of local stakeholders in the design and implementation of the sessions
- ▶ Develop and implement feedback mechanisms for the sessions (e.g. feedback questionnaires, reports) to improve future sessions.

**Table 2. Resettlement process: summary of example of stressors and possible psychosocial impacts<sup>a</sup>**

	<b>Stressors</b>	<b>Psychosocial suffering</b>	<b>Resilience</b>	<b>Adversity-activated development<sup>a</sup></b>
<b>Identification and selection phase</b>	<ul style="list-style-type: none"> <li>Timing and pace of the process</li> <li>Possibility of failure of application</li> <li>Different expectations/wishes among family members</li> </ul>			
<b>Pre-departure phase</b>	<ul style="list-style-type: none"> <li>Concerns about resettlement outcomes</li> <li>Difficulties in understanding and absorbing information</li> <li>Travel to resettlement country</li> <li>Responsibility for all documents</li> <li>Immigration process concerns</li> </ul>	<ul style="list-style-type: none"> <li>Anxiety</li> <li>Apprehension</li> <li>Disorientation</li> <li>Distrust</li> <li>Fatigue</li> <li>Fear</li> <li>Frustration</li> <li>Grief</li> <li>Hopelessness</li> <li>Isolation</li> <li>Low self-confidence and self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>Adaptive coping mechanisms</li> <li>Creation of new life aspirations</li> <li>Creation of new relationships</li> <li>Flexibility</li> <li>Patience</li> </ul>	<ul style="list-style-type: none"> <li>Independence</li> <li>Innovation</li> <li>New ways of thinking and breaking traditional boundaries</li> <li>Non-traditional economic activities</li> </ul>
<b>Post-arrival phase Reception</b>	<ul style="list-style-type: none"> <li>Social adjustments</li> <li>First contact with the resettlement country</li> <li>Planning future steps</li> <li>Acculturation challenges (e.g. language, social norms, etc.)</li> <li>Changes in social roles and family dynamics</li> <li>Discrimination</li> <li>Financial problems</li> <li>Finding jobs and housing</li> <li>Identity conflicts</li> <li>Lack of social integration</li> <li>Stigma</li> </ul>	<ul style="list-style-type: none"> <li>Negative coping mechanisms</li> <li>Sense of instability</li> <li>Sense of hopelessness</li> <li>Feeling of not belonging to the community</li> <li>Stress</li> <li>Worry</li> </ul>	<ul style="list-style-type: none"> <li>Revival of traditional ceremonies</li> <li>Self-confidence</li> <li>Social cohesion</li> <li>Tolerance of other cultures</li> </ul>	<ul style="list-style-type: none"> <li>Non-traditional lifestyles</li> <li>Rights-oriented thinking and behaviour</li> <li>Transformative renewal of life aspirations</li> </ul>

<sup>a</sup> Based on WHO (2018a) and Ellis et al. (2019).

These examples are not comprehensive. Every individual reacts uniquely to events.

## Conclusion

This guide highlights the importance of understanding each migration phase and the possible psychosocial responses experienced by refugees throughout the integration process. Understanding these responses is vital to providing the services required to ensure that refugees receive the mental and psychosocial support they need.

Refugees experience different (positive or negative) psychosocial reactions depending on the stage of resettlement. Initially, refugees who meet the criteria to participate in the resettlement programme are identified and can voluntarily apply for the process. Refugees may face a number of challenges, including the unpredictable timing and pace of the resettlement process; interviews; and family tensions arising from different opinions about the choice between staying or resettling. Actions should focus on strengthening mental health and psychosocial support for refugees during this phase.

At a later stage, refugees selected for resettlement prepare to move from the country of first asylum to the resettlement country and go through various procedures, acquiring travel documentation and participating in pre-migration health activities and pre-departure orientation. Activities should focus on strengthening pre-migration activities using a psychosocial approach.

The third stage, or post-arrival phase, includes the reception of refugees in the resettlement country and their integration into host communities. At this stage, psychosocial reactions to the changes involved may take place at both the individual and community level and among both refugees and host community. Support for such populations should again be strengthened through a psychosocial approach to post-arrival assistance.

Understanding these phases, and the potential psychosocial impacts involved in each stage, enables providers to design and implement tailored initiatives and activities to meet the needs of refugees (and host communities) and foster effective and successful resettlement integration.

# Annex 1.

## Basic psychosocial skills for resettlement staff

This annex will briefly present the basic psychosocial skills essential to **all staff** involved in the resettlement process, whether or not they are MHPSS providers.<sup>62</sup> These skills are fundamental to supporting refugees regardless of the type of assistance provided.

Disclaimer: This material is not intended or designed to provide the skills required by a certified mental health professional.

### RECOGNIZING SIGNS OF DISTRESS AND PEOPLE REQUIRING SPECIALIZED CARE

When providing any kind of assistance, it is crucial to be attentive to the person and carefully observe their reactions to understand how they feel. Distressed people often express common responses or signs of their inner state, such as:

- ▶ Abrupt changes in mood
- ▶ Aggression
- ▶ Apathy
- ▶ Change of sleep or eating patterns (e.g. eating/sleeping too much or too little)
- ▶ Crying
- ▶ Difficulty to concentrate
- ▶ Feeling forgetful
- ▶ Lack of energy
- ▶ Lack of self-care
- ▶ Loss of self-esteem and self-confidence
- ▶ Poor personal hygiene
- ▶ Social isolation.

These are natural reactions to unusual situations and may vary over time. However, some people may experience and communicate more intense and long-lasting reactions. They may:

- ▶ Attempt or have attempted suicide or self-harm or announce their intention of doing so
- ▶ Be violent towards themselves and/or others
- ▶ Not be able to remember elementary facts about their life (e.g. their name) or attend to basic routines (e.g. waking up, eating)
- ▶ Report drug use
- ▶ Report having been a recent victim of rape, torture, personal violence or trafficking and/or having witnessed tragic situations
- ▶ Report pre-existing psychiatric conditions, especially if they did not have access to medications for a prolonged period.

---

<sup>62</sup> For further information in this topic, refer to the [HYPERLINK https://www.who.int/mental\\_health/publications/guide\\_field\\_workers/en/](https://www.who.int/mental_health/publications/guide_field_workers/en/) World Health Organization (WHO), War Trauma Foundation and World Vision International (WVI), 2011.

In such cases, the person may be severely distressed, which can impact their ability to function in daily life. The person should immediately be referred to medical or professional psychological care.

## HELPING DISTRESSED PEOPLE TO FEEL CALM AND IN CONTROL OF THEIR SITUATION

When facing a person in distress, it is essential to help them relax, feel calm and regain their sense of control over the situation. The following tips and techniques can be helpful.

- ▶ Stay close to the person (if culturally appropriate)
- ▶ Offer a quiet place to talk and a non-alcoholic drink
- ▶ Avoid leaving the person alone
- ▶ Listen carefully
- ▶ Do not pressure the person to talk
- ▶ If the person feels or appears dissociated from reality, remind them where they are and ask them to take notice of things in their surroundings and/or to focus on their breathing.
- ▶ Supportive communication

Communication with a person in distress must be clear, respectful, and create or strengthen the interpersonal relationship while providing basic support to the individual. In the resettlement process, staff should consider the following techniques and approaches to promote supportive communication:

- ▶ Active listening

Active listening is an essential technique to help people listen and communicate appropriately and be supportive. It requires the listener to be attentive, focused and open to receiving and understanding information; to encourage the other person to participate actively in the conversation; to help them to feel calm; and to offer appropriate support.

- ▶ Empathy and attentive behaviour

Empathy is the ability to recognize, be sensitive towards, understand and share the feelings of another person, without judgment. Understanding a refugee's context and the challenges of resettlement help resettlement staff to be more empathetic, in turn helping the refugee feel more comfortable and willing to talk and to share her/his thoughts and feelings.

Specific techniques include asking questions to clarify what has been said, and paraphrasing and summarizing what has been said. These techniques ensure both that the listener understands and that the speaker knows s/he has been heard and understood.

It is also crucial to create and maintain a positive relationship with the speaker by paying attention to what s/he is saying – and by demonstrating empathy.

- ▶ Non-verbal communication

It is also possible to convey messages of support in a non-verbal way, such as through facial expressions, gestures, eye contact, and other physical behaviours. When providing any kind of support, resettlement staff should follow the behaviours outlined by the mnemonic SOLER.<sup>63</sup>

---

<sup>63</sup> IOM (2019f).



*S – Sit facing the person*

*O – Open posture, non-defensive body position*

*L – Lean forward a little (if culturally appropriate)*

*E – Eye contact (if culturally appropriate)*

*R – Relax.*

- ▶ Consider cultural aspects

It is essential to take into account cultural differences among refugees and resettlement staff during the provision of support. The acceptability and appropriateness of certain gestures and forms of courtesy – such as shaking hands and making eye contact – as well as physical distance between people vary between cultures. Moreover, in some cultures and religions, communication between men and women may not be acceptable.

### **Tips for communicating with resettled/refugee children**

Use appropriate, clear and understandable language (avoid using technical terms).

Make sure that you and the child are positioned at the same level (eye level).

Keep your tone of voice soft and calm, but do not infantilize your voice.

Create a friendly atmosphere that encourages trust.

Consider the child's cultural background.

Focus on positive reactions and thoughts rather than deficiencies or difficulties.

Do not force the child to talk.

Avoid physical contact.

## PROVIDING BASIC INFORMATION

It is essential to understand each person's needs by asking them (not by making assumptions) and to provide appropriate and tailored information about the services available to meet these needs. Such information should be reliable and communicated simply (staff should avoid using technical terms) to ensure the person understands fully. If necessary, resettlement staff should ask for the support of a cultural mediator or interpreter.

## LINKING THE PERSON TO AVAILABLE SERVICES

It is recommended that resettlement staff not only inform individuals about available services, but also refer them whenever needed and possible. Staff members should recognize their own limits in assisting a person

in distress and take responsibility where necessary by referring them to appropriate support. Resettlement staff should, if possible, link people in distress directly to support services or give them the contact information and instructions to obtain additional help.

Do	Don't
<p>Acknowledge the person's strengths and positive skills</p> <p>Allow moments of silence</p> <p>Be attentive to the other person</p> <p>Be empathetic</p> <p>Consider and respect the person's age, culture, gender, customs, and religion</p> <p>If the person does not speak the same language as you, ask for support from a cultural mediator or interpreter</p> <p>Introduce yourself and your role</p> <p>Keep an open and relaxed posture</p> <p>Keep eye contact with the other person (if culturally appropriate)</p> <p>Talk slowly, using a soft tone of voice</p> <p>Listen carefully to what is being said</p> <p>Link the person to appropriate available services</p> <p>Help the person to gain control of the situation</p>	<p>Don't be judgmental about the individual's experiences and choices</p> <p>Don't make false promises</p> <p>Don't provide false or unverified information</p> <p>Don't share your personal opinion</p> <p>Don't make assumptions about the other person</p> <p>Don't multitask while talking to the other person (e.g. texting, using a computer)</p> <p>Don't pressure the other to talk</p> <p>Don't share information shared by beneficiaries with other colleagues or beneficiaries</p> <p>Don't speak fast and/or loudly</p> <p>Don't use gestures and forms of courtesy that are not culturally appropriate</p> <p>Don't ask for unnecessary information about the person's experiences</p> <p>Don't speak or do things on the person's behalf</p>

## Annex 2.

# Working with cultural mediators and interpreters <sup>64 65</sup>

The support provided to resettled refugees can be strengthened using the cultural competence approach, including the use of cultural mediators and interpreters. This annex briefly presents the importance of using these professionals, their roles and tips for working with them in the resettlement context and on psychosocial activities.

Given the different backgrounds of resettled refugees, in many instances they cannot initially communicate in the language(s) of the first asylum and resettlement countries. They also need time to learn and adapt to the local culture, manners and traditions. Local authorities and service providers in host communities should therefore consider using cultural mediators and interpreters to assist individuals and strengthen the integration process.

Cultural mediators facilitate relations and communication between host community members and resettled refugees to enhance mutual understanding in situations involving people from different cultural backgrounds (which influence attitudes, behaviours, social manners and beliefs). Interpreters, on the other hand, are responsible for orally translating from one language to another, and are not trained to ‘translate’ or take into account cultural elements. The table below provides examples of the differences between the roles of these professionals.

In mental health and psychosocial support activities, understanding refugees and their mental health situations requires an understanding of their needs, and of their cultural background and its ways of expressing and understanding mental disorders. A cultural mediator’s assistance can be essential to avoiding assumptions and misunderstandings, with interpreters providing linguistic support.

Role	Cultural mediators	Interpreters
Improving cultural competence	Assists individuals/institutions/organizations in providing culturally appropriate care	No involvement
Addressing language barriers	Mediates spoken messages between people speaking different languages, focusing on ensuring messages exchanged between care providers and refugees are understood	Mediates spoken messages between people speaking different languages <i>without adding, omitting or distorting meaning or editorializing</i>

<sup>64</sup> For further information on this topic: EU-FRANK, 2020a and 2020b; IOM,2009; Translators Without Borders, 2017; WHO, 2019b.

<sup>65</sup> In Europe, cultural mediators can be accessed through associations and professional networks.

Addressing sociocultural barriers	Focuses on cultural brokering to bridge, link or mediate between groups or persons of different cultural backgrounds for the purpose of reducing conflict or producing change <sup>66</sup>	Uses cultural knowledge only to interpret speech accurately
-----------------------------------	---	---

There are a number of essential conditions for working with cultural mediators and interpreters:

- ▶ These roles must be undertaken by specialized professionals, who are further trained in the area of mental health and psychosocial activities.
  - It is also recommended, in the context of these activities, that such professionals receive specific training in how to work with refugees.
- ▶ In the resettlement context, it is suggested that interpreters or cultural mediators are carefully assessed and selected on a case-by-case basis, taking into consideration possible conflict triggers between the interpreter/cultural mediator and refugee. These may include political, religious and other differences that may hamper communication and create conflict.
- ▶ Decision- and policymakers must have or develop systems to ensure quality and effective support from these professionals. Notably, these systems should:
  - recognize and certify the professional skills of interpreters and cultural mediators;
  - provide them with any necessary additional technical training;
  - provide them with technical supervision;
  - provide them with support.

Cultural mediators and interpreters must also adhere to a number of main principles:<sup>67</sup>

- ▶ Accuracy

They should provide a reliable and complete interpretation of the source language and should preserve the tone and spirit of the message in the source language. Interpreters should not omit, change or add information.

- ▶ Compensation

They should never accept or charge additional money, compensation or favours.

- ▶ Confidentiality

They must not release information acquired during or through assignments, including information obtained via written documents or other materials. They should never publicly discuss, report or offer opinions on topics they are or have been engaged in, even when such information is not considered by law to be confidential.

<sup>66</sup> Jezewski, 1990.

<sup>67</sup> WHO, 2019b; Translators Without Borders, 2017.

- ▶ Cultural sensitivity

They must respect different cultural norms and be attentive and careful of the cultural sensitivities of the individuals or groups they serve.

- ▶ Non-discrimination and conflict of interest

They must remain neutral, unbiased and impartial in all situations. If they feel their performance will be compromised in any way by any bias, or if there is any conflict of interest that may affect their professional conduct or performance, they must resign from the assignment. It is therefore not recommended that community and family members act as cultural interpreters/mediators.

- ▶ Proficiency

They must meet at least a minimum level of proficiency, proven by certification, test/examination results, demonstrable experience and competence (where available in the resettlement country).

- ▶ Professional conduct

They should act appropriately during the assignment, including by observing dress codes and social courtesies.

<p style="text-align: center;"><b>What resettlement staff should and should not do</b></p>	<p style="text-align: center;"><b>What cultural mediators or interpreters should and should not do</b></p>
<p><b>DO:</b></p> <p>Ask the cultural mediator for clarification on cultural differences if/when necessary</p> <p>Avoid using technical terms</p> <p>Brief the cultural mediator/interpreter on the assistance to be provided (including: general rules and specific/relevant aspects of the work)</p> <p>Check the interpreter/cultural mediator status after the assistance is provided to take stock of what might be improved or reinforced and provide positive reinforcement on what went well.</p> <p>Maintain eye contact (if culturally appropriate)</p> <p>Provide the cultural mediator or interpreter appropriate background information ahead of time</p> <p>Speak directly to the refugee as if s/he could understand you</p> <p>Speak at a normal pace or slowly</p> <p>Speak loudly and clearly</p> <p>Say only one or two sentences at a time</p> <p><b>DO NOT:</b></p> <p>Do not rush the process or individuals involved.</p> <p>Do not use directive phrases (e.g. "Tell him...", "Ask her...")</p>	<p><b>DO:</b></p> <p>Ensure information is accurate</p> <p>Ensure the information shared and interpreted is kept confidential</p> <p>Speak directly to the person to whom you are conveying messages</p> <p><b>DO NOT:</b></p> <p>Do not add to, omit, substitute or summarize what has been said (interpreters)</p> <p>Do not answer questions on behalf of the assistant or refugee</p> <p>Do not explain questions</p> <p>Do not express your feelings</p> <p>Do not participate in side conversations</p> <p>Do not provide personal advice or opinions</p> <p>Do not use the third person (e.g. "She told you...")</p>

## **Annex 3.**

# **Key principles for promoting psychosocial well-being in the resettlement context<sup>68</sup>**

### TREAT ALL REFUGEES WITH DIGNITY AND RESPECT AND SUPPORT SELF-RELIANCE

Every refugee has the right to be treated with equity, dignity and respect, and without any discrimination. Services should be provided in ways that respect the autonomy, privacy and right to self-determination of refugees, and that make refugees part of the decision-making processes that affect their lives. Any psychosocial support should enable refugees to choose how they prefer doing things so that they maintain a sense of personal control, including by consulting refugees to assess their capacities and needs and to build assistance solutions around their suggestions.

### RESPOND TO REFUGEES IN DISTRESS IN A HUMANE AND SUPPORTIVE WAY

All staff involved in supporting refugees during the resettlement process should know how to assist people in acute distress and to alleviate their stress where possible, and should follow the principle of “do no [more] harm”. Psychological first aid (PFA) is a set of simple techniques to respond to someone in distress, usable by anyone, whether a professional and non-professional.<sup>69</sup>

### PROVIDE INFORMATION ABOUT SERVICES, SUPPORT AND LEGAL RIGHTS AND OBLIGATIONS

A lack of information can be a source of stress and distress for refugees. Staff assisting refugees in the resettlement process should provide relevant and accurate information where possible, and refer refugees to other places where it is possible to obtain accurate information. The information provided should be easy to understand by all refugees (including children, adults, elderly people, people with disabilities and those who are illiterate/sub-literate).

### PROVIDE RELEVANT PSYCHOEDUCATION AND USE APPROPRIATE LANGUAGE

Providing psychoeducation – education and information on mental health issues, including the psychosocial impacts of resettlement – helps refugees understand their feelings when facing stressful situations. It can also be useful for reassurance; normalizing certain reactions to abnormal conditions; and sharing positive coping mechanisms for situations of distress.

---

<sup>68</sup> Adapted from WHO Europe, UNHCR, IOM, MHPSS.net (2015)

<sup>69</sup> For more detailed information see WHO Europe, UNHCR, IOM, MHPSS.net (2015)

Sessions must be offered in language that refugees can understand (in their mother tongue) and should be facilitated by psychologists. Facilitators should avoid using clinical terms and, if necessary, seek the support of an interpreter and/or cultural mediator.

Note: Do not make generalizations labelling refugee populations as 'traumatized' by their experiences or using other terms, such as 'post-traumatic stress disorder' and 'trauma'. Individual refugees are affected differently.

## STRENGTHEN FAMILY SUPPORT AND PROMOTE SOCIAL INTEGRATION

Family and social support are often essential components of positive coping mechanisms and successful integration. However, the resettlement process can undermine family relationships and supportive links within families and communities. The design of psychosocial assistance should take into account the importance of strengthening refugee family relationships and promoting social integration, including links between host community members and refugees.

Make interventions culturally relevant and ensure adequate interpretation

It is crucial to adapt psychosocial initiatives to the actual needs of the resettled refugees. Psychosocial workers should familiarize themselves with the background, culture, and values of refugees to ensure the support offered is appropriate.

In many cases, the use of interpreters or cultural mediators is crucial to guarantee efficient support. Interpreters and mediators should receive training and supervision. Using community or family members in these roles is not recommended due to ethical concerns. (See [Annex 2](#)).

## IDENTIFY AND PROTECT REFUGEES WITH SPECIFIC NEEDS

Identifying vulnerable refugees and referring them to the appropriate services can be lifesaving and strengthen the protection of refugees throughout the resettlement process. People who may be more at risk than others include: older people, children, people with disabilities, pregnant women, survivors of torture and sexual and gender-based violence (SGBV), and people with non-majority gender identities and sexual orientations. It is essential to protect and offer psychosocial support to children, particularly those with special needs (survivors of violence; those with disabilities; those exposed to abuse and exploitation).

## PROVIDE TREATMENT FOR REFUGEES WITH SEVERE MENTAL DISORDERS

Treatment for severe mental disorders must be provided only by professionals (certified clinicians) and in accordance with national regulations. Refugees with pre-existing conditions; with psychotic symptoms; who cannot function; who use substances; and/or who are at risk of harming themselves or others should be referred immediately to specialized mental health care.

## DO NOT WORK IN ISOLATION: COORDINATE AND COOPERATE WITH OTHERS

Many organizations and individuals provide support to resettled refugees. To avoid duplicating activities or creating significant gaps in services, these actors must coordinate with each other. Mental health professionals assisting resettled refugees should connect with existing organizations and groups. Professional mental

health and psychosocial support must not be provided outside a supportive organization environment and government-endorsed structure.

#### MONITORING AND MANAGING THE WELL-BEING OF STAFF WORKING WITH REFUGEES

Staff should be trained to identify signs of stress in themselves and their teammates and be referred to the appropriate service(s) when necessary. It is essential that staff work in an inclusive, supportive and transparent environment to protect them and promote their well-being.



## **Annex 4.**

# **Key messages for refugees during the resettlement process**

### PREPARE AND BE OPEN TO NEW OPPORTUNITIES

When moving to a new context, it is crucial to have an open and flexible approach to your expectations. It may help you to identify and benefit from opportunities when they arise.

### CHANGE TAKES TIME

Dealing with change and unpredictability is part of life. Set small goals and achieve them step by step.

### BE POSITIVE ABOUT YOUR SKILLS

Remember your strengths and achievements and be confident in your ability to solve problems.

### BE FLEXIBLE

Accepting changes and learning to adapt to them make you more prepared to face challenges.

### BE OPTIMISTIC AND REALISTIC

Positive thinking does not mean ignoring problems and reality. It means focusing on positive outcomes. Even when it is difficult to be optimistic when facing challenges, it is important to be hopeful and confident about the future. Focus on the options you have now and how you can move forward by using your abilities to deal with problems and your strengths.

### DEVELOP YOUR PROBLEM-SOLVING SKILLS

Developing problem-solving skills will allow you to identify what is happening, what needs to change and the steps to make those changes. When facing a problem, make a quick list of ways to solve it. By practicing this, you will be better prepared to manage challenging situations.

### USE POSITIVE COPING MECHANISMS

Using positive coping mechanisms means practicing healthy methods to manage stress when facing difficult situations. Positive coping mechanisms are tools and approaches that increase well-being and improve the effective handling of problems. Examples include: practicing sports, reading, listening to music, talking to a friend, and engaging in a hobby you enjoy.

## DEVELOP A STRONG SOCIAL NETWORK

Find support groups and peer groups where you can connect with people with similar experiences, backgrounds, and interests. Participate in community activities to meet new people and build a social network. Having supportive people around can help you during difficult times.

## BE INVOLVED IN YOUR COMMUNITY

Participate in activities that are meaningful to you in your new community. It can help you to find new social relationships, goals and projects.

## ASK FOR AND ACCEPT HELP

Asking for and accepting help can be difficult and hurt our pride, especially if we think it makes us appear weak. But this does not have to be the case. There is no shame in asking for help or accepting the support of professionals, friends or family members when we face difficulties. It can help us face challenges and create better outcomes.

## BE AWARE OF YOUR RIGHTS AND RESPONSIBILITIES

Every country has its laws and refugees should benefit from them. You also have the responsibility to uphold these laws.

## BE OPEN TO LEARNING NEW SKILLS

Being open to new cultures and learning new skills (especially the local language) will help you to deal with challenges, integrate into the community and create new opportunities.

Adapted from IOM, n.d.b.

## **Annex 5.**

# **Key messages for host community members**

### BE OPEN-MINDED

When meeting resettled refugees, have an open, welcoming and flexible approach. They may be facing challenges in adjusting and adapting to the new culture, social mores and behaviours and language.

### BE OPEN TO CULTURAL DIVERSITY

Resettled refugees carry their culture with them, and this may be different from that of the host community. Having different traditions, behaviours, customs and beliefs does not mean that a person is better or worse than another. It is important to understand and respect others and their culture. Indeed, learning about different cultures and traditions from resettled people can be a fun way to make new friends!

### CREATE OPPORTUNITIES FOR RESETTLED REFUGEES

When arriving in a resettlement country, refugees may face difficulties in establishing new social networks, finding jobs or having their work-related skills recognized. Participating in social activities with refugees and creating job opportunities for newcomers can be an excellent way to establish new personal and professional relationships and even strengthen the local labour market.

### BE SUPPORTIVE

Understanding, respecting and supporting resettled refugees is essential for their successful integration. Be open and supportive when a resettled refugee expresses the need for help.

### BE AWARE OF POSITIVE CONTRIBUTIONS BY REFUGEES TO THE COMMUNITY

Refugees often contribute positively to their new community, using their different experiences, skills and competences. You and your community can benefit from the cultural diversity of refugees, and the added value they can bring to the local economy and its development.

# Glossary

Note: These definitions are those that apply in the context of resettlement and in this document. Some terms may have different meanings in other contexts. The glossary is not exhaustive.

**Acculturation:** The progressive adoption of elements of a foreign culture (ideas, words, values, norms, behaviour, institutions) by persons, groups or classes of a given culture. The partial or total adaption is caused by contacts and interactions between different cultures through migration and trade relations. (IOM, 2019c)

**Cultural competence:** A set of behaviours, knowledge and attitudes that enable the health professional to effectively work in cross-cultural situations. (IOM, 2009)

**'Do no harm' approach:** Minimum standard of practice to avoid causing inadvertent harm to beneficiaries of aid. (Global Conflict Sensitivity Community Hub (CSC-Hub), n.d.)

**First asylum country:** State which grants protection on its territory to persons outside their country of nationality or habitual residence, who are fleeing persecution or serious harm or for other reasons. (IOM, 2019a)

**Health:** A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO, 1946)

**Mental disorder(s):** A broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated. (WHO, n.d.)

**Mental health:** A state of well-being in which an individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO et al, 2004)

**Mental health and psychosocial support:** Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. (IASC, 2007)

**Psychosocial:** Relating to the interrelation of social factors and individual thought and behaviour. (OED, 2020a)

**Psychosocial approach:** Considering the fundamental interrelation of biopsychological, cultural, and social factors in defining the needs of migrants, displaced and crisis-affected populations, as well as the responses to these needs. (IOM, 2019a)

**Psychological distress:** A set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. In some cases, however, psychological distress may indicate the beginning of major depressive disorder, anxiety disorder, schizophrenia, somatization disorder, or a variety of other clinical conditions.” (APA, 2020)

**Refugee:** A person who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. (United Nations High Commissioner for Refugees (UNHCR), 1950)

**Resettlement:** An international protection tool and durable solution to meet the specific needs of refugees, involving “the selection and transfer of refugees from a State in which they sought protection to other State which has agreed to admit them with permanent residence status.” (UNHCR, 2011)

**Resettlement country:** A country that agrees to admit refugees and grant them permanent residence status. (UNHCR, 2011)

**Resettlement process:** The selection and transfer of refugees from a State in which they have sought protection to a third State which has agreed to admit them – as refugees – with permanent residence status. The status provided ensures protection against refoulement and provides a resettled refugee and his/her family or dependents with access to rights similar to those enjoyed by nationals. Resettlement also carries with it the opportunity to eventually become a naturalized citizen of the resettlement country. (UNHCR, 2011) The process is composed of different phases: identification and selection, pre-departure, travel, reception and integration.

## References

American Psychiatric Association

2020. *Mental Health Facts on Refugees, Asylum-seekers, and Survivors of Forced Displacement.*

American Psychological Association (APA)

2020. *APA Dictionary of Psychology.* See <https://dictionary.apa.org/psychological-distress>.

Bergquist, G., J. Sozil, K. Everhart, D.O. Braithwaite and L. Kreimer

2019. Investigating Layers of Identity and Identity Gaps in Refugee Resettlement Experiences in the Midwestern United States. *Western Journal of Communication*, 83(3):383-402.

Bogic, M., A. Njoku and S. Priebe

2015. Long-term mental health of war-refugees: a systematic literature review. *BMC Int Health Hum Rights*, 15(29).

Bradby, H., R. Humphris, D. Newall and J. Phillimore

2015. *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region.* Copenhagen, WHO Regional Office for Europe.

Charlson, F., M. van Ommeren, A. Flaxman, J. Cornett, H. Whiteford and S. Saxena

2019b. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet*, 394:240-248.

Correa-Velez, I., A. Green, K. Murray, R. Schweiter, L. Vromans, C. Lenette and M. Brough

2020. Social Context Matters: Predictors of Quality of Life among Recently Arrived Refugee Women-at-Risk Living in Australia. *Journal of Immigrant and Refugee Studies*, 18(4):498-514.

Dick, E. and J. Kuhnt

2019. The neglected role of cities in the Global Compact on Refugees. *Deutsches Institut für Entwicklungspolitik (DIE).*

Ellis, B., J. Winer, K. Murray and C. Barrett

2019. Understanding the Mental Health of Refugees: Trauma, Stress and the Cultural Context. In: *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health* (R. Parekh and N. Trinh, eds.). Switzerland, Springer Nature Switzerland.

EU-FRANK

- 2020a. *Guiding note for communication via interpreters (Tool 5)*. Sweden.
- 2020b. *Practical Guide for Planning and Conducting Resettlement Interviews*. Sweden.

European Commission

2020. Action Plan on Integration and Inclusion 2021-2027. COM(2020) 758.

European Resettlement Network

- n.d.a. *The Policy Framework*. Brussels.
- n.d.b. *The Resettlement Process - Identification Phase*. Brussels.
- n.d.c. *National Resettlement Programmes*. Brussels. See <https://www.resettlement.eu/country>.

European Union

2015. *Handbook for Health Professionals – Health Assessment of Refugees and Migrants in the EU/EEA*. Brussels.

Eurostat

2020. *Glossary: European Economic Area (EEA)*. Luxembourg City.

Fazel, M., J. Wheeler and J. Danesh

2005. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet*, 365(26):1309-14.

Finn Church Aid (FCA)

2018. *Improving Well-being Through Education – Integrating Community Based Psychosocial Support into Education in Emergencies*. Helsinki.

FOCUS

2020. *Socio-economic dimensions of integration: what does the literature say?* Copenhagen. See [www.focus-refugees.eu/wp-content/uploads/FOCUS\\_Brief-3\\_Socio-economic-factors\\_Oct2020.pdf](http://www.focus-refugees.eu/wp-content/uploads/FOCUS_Brief-3_Socio-economic-factors_Oct2020.pdf).
- n.d. FOCUS: forced displacement and refugee-host community solidarity. See [www.focus-refugees.eu/about/](http://www.focus-refugees.eu/about/).

Global Conflict Sensitivity Community Hub (CSC-Hub)

Hassan, G., L.J. Kirmayer, A. Mekki-Berrada, C. Quosh, R. el Chammay, J.B. Deville-Stoetzel, A. Youssef, H. Jeffrey-Bahloul, A. Barkeel-Oteo, A. Coutts, S. Song and P. Ventevogel

2015. *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflicts*. Geneva, UN-HCR.

Hendrickx, M., A. Woodward, D. Fuhr, E. Sondorp and B. Roberts

2019. The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees in neighboring countries: a systematic review. *European Journal of Public Health*, 42(3):299-310.

Holt-Lunstad, J. and M. Lefler

2020. Social Integration. In: *Encyclopedia of Gerontology and Population Aging* (D. Gu and M. Dupre, eds.). Switzerland, Springer, Cham.

Holt-Lunstad, J. and B. Uchino

2015. Social Support and Health. In: *Health behavior: theory, research, and practice*. (K. Glanz, B. Rimer and K. Viswanath, eds.). San Francisco, Jossey-Bass.

Home Office and Public Health England

2019. *The Global Mental Health Assessment Tool (GMHAT) pilot evaluation: Final report*. Home Office Research Report 108. London.

Horswood, D., J. Baker, M. Fazel, L. Heslop and D. Silove

2019. School factors related to the emotional wellbeing and resettlement outcomes of students from refugee backgrounds: protocol for a systematic review. *Systematic Reviews*, 8(107).

Inter-Agency Standing Committee (IASC)

2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva.
2019. *Community-Based Approaches to MHPSS Programmes: A Guidance Note*. Geneva.

International Catholic Migration Commission (ICMC)

2013. *Welcome to Europe: A comprehensive guide to resettlement*. Geneva, ICMC Europe.

International Federation of Red Cross and Red Crescent Societies (IFRC)

2016. *New Walled Order: How barriers to basic services turn migration into humanitarian crisis*. Geneva.



## International Medical Corps (IMC)

- 2017a. *Mental Health and Psychosocial Support considerations for Syrian Refugees in Turkey: Sources of Distress, Coping Mechanism, and Access to Support*. Los Angeles.
- 2017b. *Understanding the Mental Health and Psychosocial Needs, and Service Utilization of Syrian Refugees and Jordanian Nationals: A Qualitative and Quantitative Analysis in the Kingdom of Jordan*. Los Angeles.

## International Organization for Migration (IOM)

- 2009. *Cultural Competence and Training in Mental Health Practice in Europe: Strategies to Implement Competence and Empower Practitioners*. Brussels.
- 2010. *Psychosocial Needs Assessments in Emergency Displacement, Early Recovery, and Return*. Geneva.
- 2014. *Self-Help Booklet for Men Facing Crisis and Displacement*. Geneva.
- 2019a. *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement*. Geneva.
- 2019c. *International Migration Law - Glossary on Migration*. Geneva. See [https://publications.iom.int/system/files/pdf/iml\\_1\\_en.pdf](https://publications.iom.int/system/files/pdf/iml_1_en.pdf).
- 2019d. Psychosocial support after adversity: A systematic approach. In: *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement (IOM)*. Geneva. See [www.iom.int/sites/default/files/mhpss/annex/iommhpssannex3\\_20200512.pdf](http://www.iom.int/sites/default/files/mhpss/annex/iommhpssannex3_20200512.pdf).
- 2019e. *Training Refugee Youth: Pre-departure orientation – Youth*. Rome.
- 2019f. *Reintegration Handbook - Practical guidance on the design, implementation and monitoring of reintegration assistance*. Geneva.
- 2020a. *IOM Resettlement Support 2019 - European Economic Area*. Geneva.
- 2020b. *Trafficking in Persons: Victim Identification and Assistance (Training Guide)*. Geneva.
- 2020c. *Accountability to Affected Populations Framework*. Geneva.
- 2020d. *IOM Resettlement*. Geneva.
- 2020e. *IOM Movements*. Geneva.
- 2020f. *Mainstreaming Gender in Pre-departure Orientation Sessions – Guidelines for Practitioners*. Rome.
- 2020g. *Integration and Inclusion of Migrants and People with a Migrant Background*. Brussels.
- n.d.a. *Best practices: IOM's Migrant Training/ Pre-Departure Orientation Programs*. Geneva.
- n.d.b. *Preparing for return Handbook*. Geneva.

Jezewski, M.

1990. Culture brokering in migrant farmworker health care. *Western Journal of Nursing Research*, 12:497-513.

Kancs, D., and P. Lecca

2017. Long-term Social, Economic and Fiscal Effects of Immigration into the EU: The Role of the Integration Policy. *JRC Working Papers in Economics and Finance 2017/4*.

Kien, C., I. Sommer, A. Faustmann, L. Gibson, M. Schneider, E. Krczal, R. Jank, I. Klerings, M. Szelag, B. Kerschner, P. Brattström and G. Gartlehner

2019. Prevalence of mental disorders in young refugees and asylum seekers in European Countries: a systematic review. *Eur Child Adolesc Psychiatry*, 28(10):1295-1310.

Lund, C., M. De Silva, S. Plagerson, S. Cooper, D. Chisolm, J. Das, M. Knapp and V. Patel

2011. Poverty and Mental Disorders: Breaking the Cycle in LowIncome and Middle-Income Countries. *The Lancet*, 378(9801):1502-1514.

MIND

2009. *A civilised society: Mental health provision for refugees and asylum-seekers in England and Wales*. Stratford.

O'Donnell, C.

2018. Health care access for migrants in Europe. In: *Oxford Research Encyclopedia of Global Public Health* (D.V. McQueen, ed.). Oxford University Press, Oxford.

Oxford English Dictionary (OED)

- 2020a. *Psychosocial*. See [www.lexico.com/definition/psychosocial](http://www.lexico.com/definition/psychosocial)

- 2020b. *Identity*. See [www.lexico.com/definition/identity](http://www.lexico.com/definition/identity)

Papadopoulos, R.

2007. Refugees, trauma and Adversity-Activated Development. *European Journal of Psychotherapy and Counselling*, 9(3):301-312.

2011. *A psychosocial framework for with refugees*.

Priebe, S., D. Giacco and R. El-Nagib

2016. *Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekrs and irregular migrants in the WHO European Region*. Copenhagen: WHO Region Office for Europe.

Refugee Council

2020. *Mental health support for refugees and asylum seekers*. Stratford.

Robertson, A.

2020. *'A New Life for Me' - Integration experiences of Syrian refugee children and their families*. Barnardo's Northern Ireland, Belfast.

Save the Children

2017. *Invisible Wounds: The impact of six years of war on the mental health of Syria's children*. London.

Sphere Project

2018. *The Sphere Handbook - Humanitarian Charter and Minimum Standards in Humanitarian Response*. Geneva.

Spicer, N.

2008. Places of Exclusion and Inclusion: Asylum and Refugee Experiences of Neighbourhoods in the UK. *Journal of Ethnic and Migration Studies*, 34(3):491-510.

Steimel, S.J.

2010. Refugees as People: The Portrayal of Refugees in American Human Interest Stories. *Journal of Refugee Studies*, 23(2):219-37.

Strang, A. and A. Ager

2010. Refugee Integration: Emerging Trends and Remaining Agendas. *Journal of Refugee Studies*, 23(4):589-607.

STRENGTHS

2020. *Scalable Psychological Programmes*. Amsterdam.

Translators Without Borders

2017. *Field Guide to Humanitarian Interpreting and Cultural Mediation*.

United Nations

1950. United Nations General Assembly resolution 428 (v), adopted on 14 December 1950. (A/RES/428(V)).

United Nations Children's Fund (UNICEF)

2018. *Operational Guidelines: Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-Tiered Support for Children and Families [Field Test Version]*. New York.

United Nations High Commissioner for Refugees (UNHCR)

2011. *UNHCR Resettlement Handbook*. Geneva.
2013. *A New Beginning: Refugee Integration in Europe*. Bureau for Europe, Brussels.
2018. *Lisbon's first Syrian restaurant*. See [www.unhcr.org/news/videos/2018/4/5addceff4/lisbons-first-syrian-restaurant.html/](http://www.unhcr.org/news/videos/2018/4/5addceff4/lisbons-first-syrian-restaurant.html/).
- 2020a. *Global Trends: Forced Displacement in 2019*. Geneva.
- 2020b. *The History of Resettlement*. Geneva.
- 2020c. *Partnership in Resettlement*. Geneva. See [www.unhcr.org/partnership-resettlement.html](http://www.unhcr.org/partnership-resettlement.html).
- 2020d. *Projected Global Resettlement Needs 2021*. Geneva.
2021. Resettlement Data Finder. Accessed on 8 February 2021.

United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM) and MHPSS.net

2015. *Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe: A Multi-Agency Guidance Note*.

Wells, R., Z. Stee, M. Abo-Hilal, A. Halim Hassan and C. Lawsin

2016. Psychosocial concerns reported by Syrian refugees living in Jordan: Systematic review of unpublished needs assessments. *The British Journal of Psychiatry*, 209(2):99-106.

World Bank

2014. *Invisible Wounds: A Practitioners' Dialogue on Improving Development Outcomes Through Psychosocial Support*. Conference proceedings. Washington D.C.

World Health Organization (WHO)

1946. Preamble to the Constitution of World Health Organization, adopted at the International Health Conference (19 June - 22 July 1946) and entered into force on 7 April 1948. See [www.who.int/about/who-we-are/constitution](http://www.who.int/about/who-we-are/constitution).
2013. *Mental health action plan 2013-2020*. Geneva.
2016. *Mental Health included in the UN Sustainable Development Goals*. Geneva.

- 2018a. *Mental health promotion and mental health care in refugees and migrants*. Regional Office for Europe, Copenhagen.
- 2018b. *Report on the health of refugees and migrants in the WHO European Region*. Regional Office for Europe, Copenhagen.
- 2019a. *Mental Disorders: Key Facts*. Geneva. See [www.who.int/news-room/fact-sheets/detail/mental-disorders](http://www.who.int/news-room/fact-sheets/detail/mental-disorders).
- 2019b. *What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region?* Regional Office for Europe, Copenhagen.
- n.d. *Mental disorders*. See [http://158.232.12.119/mental\\_health/management/en/](http://158.232.12.119/mental_health/management/en/).

World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR)

2012. *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings*. Geneva.

World Health Organization (WHO), Victorian Health Promotion Foundation and the University of Melbourne

2004. *Promoting mental health: concepts, emerging evidence, practice (Summary Report)*. Geneva.

World Health Organization (WHO), War Trauma Foundation and World Vision International

2011. *Psychological first aid: Guide for field workers*. Geneva.

This project is funded by  
the Asylum, Migration and Integration  
Fund of the European Union



Facilitating the integration of resettled refugees  
in Croatia, Italy, Portugal and Spain