PART THREE
Planning for All

CHAPTER 3.1
Planning for Optimal Mental Health: Responding to Refugee-related Trauma

GOALS FOR INTEGRATION
(SEE CHAPTER 1.3)

ONE To restore security, control and social and economic independence by meeting basic needs, facilitating communication and fostering the understanding of the receiving society.

TWO To promote the capacity to rebuild a positive future in the receiving society.

THREE To promote family reunification and restore supportive relationships within families.

FOUR To promote connections with volunteers and professionals able to provide support.

FIVE To restore confidence in political systems and institutions and to reinforce the concept of human rights and the rule of law.

SIX To promote cultural and religious integrity and to restore attachments to, and promote participation in, community, social, cultural and economic systems by valuing diversity.

SEVEN To counter racism, discrimination and xenophobia and build welcoming and hospitable communities.

EIGHT To support the development of strong, cohesive refugee communities and credible refugee leadership.

NINE To foster conditions that support the integration potential of all resettled refugees taking into account the impact of age, gender, family status and past experience.


The focus of this Chapter


To keep in mind

Chapter 3.1
Planning for Optimal Mental Health: Responding to Refugee-related Trauma

Owing to their past experiences, resettled refugees are at risk of developing mental health problems. As indicated in Chapter 1.3, it is important that integration programs are provided in ways that support emotional and personal rebuilding. As well as promoting the optimal well-being required to deal with the stresses and adjustments involved in resettlement, this approach can help to prevent the development of more serious mental health difficulties. This goal underlies planning of the individual components of an integration program in Part Two of this Handbook.

This Chapter, however, is concerned with identifying and supporting those with more complex psychological problems. The impact of trauma and torture on physical health is addressed in Chapter 2.10.

Taking account of survivors of trauma

Integration program component (see relevant Chapter in Part Two for more detailed information)	Think about:
Placement	☑ availability of social support, health services and specialist trauma and torture services.
Settlement and social support	☑ more intensive early settlement support; ☑ support for survivors to access family reunification provisions.
Income support	☑ whether existing income support provisions for those outside of the paid labour force for reasons of disability, accommodate those affected by severe trauma.
Language training	☑ outreach and flexible delivery options; ☑ more intensive tuition for survivors of torture and trauma; ☑ offering a generous 'window period' for participation, as survivors of trauma and torture may not be able to benefit from language training soon after arrival.
Housing	☑ reviewing protocols guiding the allocation of housing on a priority or urgent basis to ensure that refugee-related trauma is considered in assessment criteria.
Employment	☑ intensive job search support for resettled refugees affected by trauma and torture.
Health care	☑ specialist services for trauma and torture survivors; ☑ culturally relevant approaches to addressing trauma and torture; ☑ professional development and awareness raising among mental health services concerning the needs of trauma and torture survivors with acute mental illness.
Welcoming and hospitable communities	☑ promoting understanding in the wider community of the effects of refugee-related trauma and the role of a welcoming environment in recovery; ☑ the need to take into account the impact of trauma on refugee communities in refugee community capacity building.
General	☑ professional development, training and awareness raising activities for key personnel and professionals to enhance their capacity to identify and support survivors; ☑ debriefing for relevant personnel; ☑ service provider networks to promote information exchange and coordinated support.

How common is exposure to traumatic experiences?

- It is estimated that up to 35% of the world's refugee population have been subject to severe physical torture and/or psychological violation[1].
- Routine assessment of refugees settling in the Victorian state of Australia in 1999 indicated that seven in 10 had experienced psychological or physical violence of some kind[2].
- A study of refugee and humanitarian entrants settling in the Australian state of New South Wales found that one in four had been subject to severe trauma and torture[3].

Why plan for resettled refugees with refugee-related trauma?

In the course of their refugee experiences, many resettled refugees will have been exposed to traumatic events. These may have included torture and/or trauma of a more generalised nature such as indiscriminate violence, forced displacement from their homes and communities, civil conflict and extended periods of deprivation. As a result of these exposures, resettled refugees are at higher risk of developing psychological problems, in particular, post traumatic stress disorders, depression, anxiety and grief[4].

This does not mean that all newcomers will develop mental health problems. As indicated elsewhere in this Handbook, resettled refugees generally have well developed personal survival skills and most go on to lead healthy and emotionally fulfilling lives in receiving societies.

However, for some, psychological symptoms will be sufficiently severe as to interfere with their day-to-day functioning[5]. This may be due to a number of factors, including the severity of the trauma to which they were exposed, individual predisposing factors and/or stresses in the resettlement environment[6]. Symptoms often persist after arrival in a safe country and in some newcomers may last for many years[7].

Studies have shown that a significant factor influencing psychological responses to trauma and recovery from its negative effects is the quality of the environment following traumatic experiences. While a supportive, stable environment

Is refugee trauma a mental health risk factor?

MANY of the effects of exposure to trauma and torture are difficult to measure and vary between refugee groups, depending on the nature and severity of their exposure and a range of individual and environmental factors. However, clinical studies have found:

- rates of post traumatic stress disorder ranging from between 39% and 100%[8] (compared with 1% in the general population)[9];
- rates of depression of between 47% and 72%[10].

PLANNING FOR OPTIMAL MENTAL HEALTH:
RESPONDING TO REFUGEE-RELATED TRAUMA

Are refugee children affected by trauma?

UNTIL recently it was commonly assumed that children were psychologically resilient and hence did not suffer long term effects from exposure to trauma. However, there is now a considerable body of evidence to show that children often experience a psychological reaction not dissimilar to that found in adults. There may also be important and far-reaching impacts on social, cognitive and neurological development, for instance, affecting the early formation of the capacity for attachment, sense of self, affect modulation, learning capacities and development of the child's social framework[11].

Reflecting on how I was a few years ago, I had practically lost trust and belief for anything in life, or even in myself...I knew that if I could get help, if people could understand and care for my experiences, I would start the belief again.
Resettled refugee

can help to prevent mental health difficulties, in contrast, exposure to further stresses in the resettlement period, such as housing problems, financial difficulties, isolation from family and community support or exposure to prejudice and hostility, can precipitate psychological symptoms or make them worse[12].

While countries of resettlement clearly have very little control over conditions immediately following exposure to trauma, they can both promote optimal conditions for refugee mental health in the early resettlement period and minimise exposure to further negative impacts. Strategies for achieving this in other components of an integration program are addressed in each of the Chapters in Part Two of this Handbook and are highlighted in the checklist on p. 232.

However, resettlement countries can also support those with more complex psychological problems by ensuring that they are identified and offered appropriate support at an early stage, when the prospects of recovery are generally better[13]. In an integration context, there are particularly compelling reasons for an early intervention approach, since psychological difficulties can serve as significant barriers to resettlement (see Table Eleven below).

Early intervention also has benefits for receiving countries helping to avoid the 'down-stream' social and health care costs which would otherwise be associated with addressing mental health problems which become more complex.

Supporting psychological rebuilding is important for future generations, with studies indicating that refugee-related trauma has effects on the mental well-being of the children of survivors which may persist into adulthood[14].

Table Eleven: The impact of trauma on resettlement

Possible behavioural and psychological responses to trauma	May impact on resettlement tasks by:
Guilt (particularly related to inability to secure the safety of other family members)	• undermining resettled refugees' capacity for self care and their belief in their worthiness of the support of others; • acting as a barrier to seeking support and to developing relationships with formal and informal support providers.
Lack of trust/disrupted attachments	• undermining supportive relationships within families; • affecting the formation of supportive relationships; • affecting relationships in the workplace and community; • increasing resettled refugees' vulnerability to anxiety, anger and suspicion when interacting with public officials, such as teachers, law enforcement officers, and personnel in government departments.
Impaired concentration, anxiety, flash-backs	• interfering with the process of learning new tasks, especially language acquisition; • increasing vulnerability to stress and anxiety when performing new tasks, having an impact on securing basic resettlement resources and participation in employment and education; • increasing vulnerability to stress during medical consultation, particularly if invasive procedures are involved.

Planning for survivors of trauma and torture: Overall considerations

Identification through early assessment and settlement support

The processes of conducting assessment and offering early settlement support provide opportunities for early identification. Formal psychological assessment can be incorporated into these processes or resettled refugees can be provided with information for self identification and referral. In some countries, a formal psychological assessment is routinely offered. In others, identifying resettled refugees requiring more intensive psychological assistance is incorporated into the role of social support providers (see Chapter 2.3).

In several countries, specialist psychological support is made available to resettled refugees as part of the reception process. For example, in New Zealand, the Ministry of Health and the Refugees as Survivors (RAS) Centre offer a service at the Mangere Refugee Reception Centre where all resettled refugees are accommodated in the first six weeks following their arrival. In Australia, all resettled refugees are eligible for trauma and torture counselling in the first 12 months following their arrival and are informed about this service as part of assessment and early settlement support (see Chapter 2.3).

It is important to maximise opportunities for early intervention in the reception period. However, this is also a time when symptoms may be masked by the effects of the 'honeymoon' phase (see p. 25); suppressed in the context of other practical pressures; or given a lower priority while resettled refugees accomplish other tasks which are fundamental to their survival. It is not uncommon for psychological difficulties to be precipitated by the stresses associated with the confrontation and adjustment phases as resettled refugees begin to face the realities for the challenges before them (see p. 25).

For this reason, psychological support services will need to be made available well beyond the reception phase. Others who have contact with resettled refugees later in their resettlement (e.g. doctors, child care workers, teaching professionals, volunteer social support providers) should also be supported to identify and refer those requiring more intensive support and to deal sensitively with a disclosure of refugee-related trauma.

Support services may also be needed by resettled refugees as they age in the receiving society. The experience of countries with a long history of refugee resettlement has been that resettled refugees without a prior history of psychological problems may be vulnerable to developing symptoms as they age. The reasons for this are not well understood. However, they may be due to the increasing physical, social and psychological vulnerability associated with advancing age, age-related adjustment stress (in particular, adjustment to retirement) and the diminishing importance of other responsibilities (such as child care and career) which may serve as psychological defences in younger adults.

Approaches to providing support

While approaches to the treatment of refugee-related trauma have been the subject of considerable debate in receiving societies in recent decades, a broad consensus has developed among mental health researchers and practitioners that the optimal approach is one which combines:
—individual, family or group therapeutic approaches;
—support to address adverse environmental conditions which may exacerbate psychological symptoms (e.g. housing, lack of social support);
—pharmacological approaches where required.

In many countries, therefore, psychological support is usually provided in the context of an integrated approach, involving assistance with resettlement concerns, and in some cases general medical care.

Typically, support is provided by a multi-disciplinary team involving counsellors, social support providers, psychiatrists, general medical practitioners and in some cases other professionals such as natural therapists, physiotherapists and massage therapists. In some countries, this team operates from the one premises. In others, a team approach has been fostered through strategies to build co-operative relationships between support providers in existing generalist services (e.g. provider networks, referral protocols).

Counselling, which focuses on the individual, may be unacceptable in some cultures where greater emphasis is placed on whole families or communities working through a problem together[15]. For some resettled refugees this may be addressed by explaining the role and purposes of individual approaches to psychological support. However, a number of

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Men supporting men in Sweden

IN LULEA, Sweden, municipal social workers collaborated with the local psychiatry clinic to form the Neptune Group for refugee men affected by war-related trauma. Drawing on the fact that many of the men came from cultures with a strong bath-house tradition, the men were invited to join the group at the local public baths for a swim and sauna followed by coffee and discussion. The group enabled the men to share experiences that others might find difficult to understand. This was important as many of the men had previously felt they were alone with their problems. By discussing common symptoms such as forgetfulness and loss of concentration, the men came to recognise and understand these symptoms as common responses to torture. The men have also developed supportive links with one another through their participation in the group.

A good friend of mine, somehow noticing that I had reached that desperate stage, persuaded me to meet a group of women. It was a good beginning...
Resettled refugee

countries have developed alternative interventions such as the use of music, singing or dancing, art, natural and tactile therapies or traditional healing approaches (e.g. engaging faith healers). These have often developed in consultation with refugee communities.

Psychological support may also be more acceptable to some resettled refugees if it is provided in the context of activities, such as craft or recreational groups. This may involve partnership arrangements between psychological support professionals and providers of other services.

Enhancing the availability of psychological support

In many countries psychological support may only be available on a fee-for-service basis (at a cost which is prohibitive for many resettled refugees) or there may be long waiting times for publicly funded services.

While the demand for support may be met to some extent by specialist services, most countries also recognise the importance of building the capacity of existing psychological support providers to work with resettled refugees. This has been achieved by:

—developing networks of professionals prepared to offer fee-free or affordable services to resettled refugees (e.g. psychiatrists, psychologists, counsellors);
—strategies to build the capacity of professionals in publicly funded primary health care services, such as counsellors and general practitioners, to provide psychological support to resettled refugees.

Specialist services for survivors of trauma and torture

A NUMBER of countries have established special services for survivors of trauma and torture.

Most of these services provide direct support to resettled refugees. However, for reasons outlined in Chapter 2.10, it is not intended that they will serve all resettled refugees requiring psychological assistance. Rather, most have the broader strategic objectives of:

- building an environment that promotes the psychological well-being of all resettled refugees;
- assisting others who have contact with resettled refugees to identify and refer those with more severe psychological problems;
- enhancing the capacity of existing psychological support providers in receiving countries to support resettled refugees.

They do this by:

- conducting awareness raising activities;
- providing professional development to raise awareness of the psychological consequences of the refugee and resettlement experiences and ways in which workers can contribute to psychological rebuilding;
- providing professional development and practice resources to workers who have contact with resettled refugees to assist them in identifying and referring those requiring more intensive support;
- supporting other psychological support providers through secondary consultation, professional development and debriefing;
- fostering partnerships with other services serving resettled refugees to enable psychological support to be provided in the context of other activities (e.g. craft groups) or settings (e.g. schools);
- network building.

Effective capacity building will depend on the identification of a lead agency with appropriate professional skills. In some countries of resettlement, specialist services for survivors of trauma and torture have been established for this purpose (see box).

Supporting resettled refugees to access psychological support services

A number of factors may influence resettled refugees' capacity to access and make use of psychological support, including:

—their perceptions of mental health services. Resettled refugees may lack familiarity with the role of mental health services in receiving societies or be fearful of contact with them. Mental health services are poorly developed in some refugee source countries. Conditions in in-patient care may be harsh and treatment options limited[16];

—their knowledge that their confidentiality will be respected;

—their familiarity with psychological support, in particular, counselling, and its benefits;

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An integrated approach to supporting survivors of trauma and torture

THE CANADIAN Council for the Victims of Torture (CCVT) offers an integrated approach to supporting the rehabilitation of survivors of torture and refugee-related trauma. A range of services are provided to clients and their families, including:

- support with resettlement issues such as housing and employment;
- crisis intervention counselling, often focussing on family issues;
- individual and group therapy;
- referral to medical, legal and social service professionals. This is facilitated through a network of professionals in the community developed and supported by the CCVT;
- a befriending program whereby survivors are linked with volunteers. The aim of this program is to assist survivors to rebuild their connections to other individuals and the wider community;
- a program linking survivors with volunteers who provide moral and practical support to attend appointments for medical, legal, health or settlement related matters;
- a language instruction and training program for survivors with trauma symptoms, such as impaired concentration or depression, which impede their participation in general classes.

The service emphasises the role of the wider community and service networks in supporting survivors. As well as engaging these networks through its volunteer programs and professional referral network, the CVVT provides public education to school communities, service clubs and other community groups to raise their awareness of the impact of torture and the ways in which communities can provide a supportive environment. Professional development programs are provided to personnel who have contact with survivors, along with secondary consultation to support them in their work with individual clients.

This approach recognises that while torture often has an impact on the physical health of survivors, it also affects the psychological, spiritual, and social domains. Consequently, a range of resources are required to support survivors and their families, including basic settlement resources such as housing and health care, as well as activities to build supportive social relationships between survivors and both the refugee and wider communities. It is based on the premise that a 'therapeutic bond' between survivors and these communities is essential for rehabilitation.

—their acceptance of western style approaches to psychological support;
—attitudes to seeking psychological support in refugee communities. There may be a stigma attached to mental health problems in some refugee communities;
—their trauma symptoms and the extent to which these impact on help-seeking (see Table Eleven);
—the availability of language assistance;
—whether psychological support is geographically and practically accessible to them.

Various strategies have been adopted in resettlement countries to address these issues, including:

—building bilingual work force capacity in key clinical and client contact positions, particularly in mental health and support services;

—deploying bilingual workers to undertake individual and community outreach and provide cultural consultancy to mental health professionals;

—providing language assistance (see Chapter 2.5). Professionally trained interpreters will be particularly important to overcome resettled refugees' fears that their privacy will not be respected;

—awareness raising and education in refugee communities to enhance mental health literacy, understanding of mental health issues and knowledge of the role and purpose of mental health services;

—awareness raising and professional development activities to support settlement and other workers to assist resettled refugees to better understand and access mental health services;

—developing models which enable psychological support to be provided in the context of other group or individual activities;

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Resettled refugees with underlying mental illness

Exposure to refugee-related trauma may complicate the condition of those resettled refugees with existing mental illness, such as schizophrenia. Underlying mental illness may also serve as an additional barrier to accessing care. It is important that professional development and work force development and awareness raising activities are also targeted to professionals providing acute mental health care.

—service level strategies to support access (e.g. home visiting, appointment reminder calls, flexible appointment systems, assistance with child care and transport);
—exploring alternative approaches in consultation with refugee communities (e.g. spirits, faith healing, natural and tactile therapies).

Building capacity in the wider resettlement environment to support refugees affected by trauma

As indicated above, many symptoms commonly experienced by trauma survivors may interfere with important resettlement tasks and hence more intensive assistance may be required.

If services are sensitively provided this can have a powerful therapeutic effect. For example, a sensitive consultation with a health care provider can help to re-establish resettled refugees' trust in others, affirm their worthiness to receive care and provide reassurance to those who fear that they have been irreparably harmed by their experiences.

Professionals and volunteers also have an important role in identifying resettled refugees requiring more intensive support and offering to assist them with a referral to a psychological support agency.

The checklist outlined on page 232 outlines steps that can be taken to ensure that the needs of those affected by trauma are taken into account by personnel in integration services and in the wider society.

Caring for children and young people affected by trauma and torture

Capacity building initiatives will be particularly important in those settings serving refugee children and young people, such as child care centres and schools. Early intervention offers this group the benefits of assisting both at an early stage of resettlement as well as early in their development (see Chapter 3.3).

'One-to-one' therapeutic assistance may not always be possible or appropriate for refugee children and young people (see Chapter 3.3). However, child care and school facilities can be supported to adopt strategies to respond sensitively to affected children and young people, strengthen family support and offer an environment which offers the very best prospects for rebuilding.

The role of professional debriefing

CARING FOR highly traumatised clients can evoke emotional reactions in workers, which may influence the provision of appropriate support as well as leading to personal stress. Experience suggests that those working with resettled refugees are better able to deal with this stress if they have opportunities to talk with others[17].

The need for professional debriefing will be influenced by:

- the nature and level of professionals' contact with resettled refugees. More structured arrangements will need to be made for those seeing large numbers of refugee clients or in roles which involve a high level of disclosure of trauma;
- the extent of access to day-to-day peer support. Particular efforts will need to be made for sole practitioners such as general practitioners;
- whether the professional is from a refugee background themselves. Interpreters and bilingual workers may share many experiences in common with refugee clients or may have friends and relatives in unsafe circumstances in their countries-of-origin or refuge. This can be a source of additional stress.

Consider making arrangements for professional debriefing for the following professionals and volunteers who have extensive contact with resettled refugees:

- interpreters and translators;
- teaching professionals in adult and basic education settings;
- health care providers;
- specialist trauma and torture counsellors and other practitioners;
- child care professionals;
- social support professionals and volunteers, in particular, those from refugee communities.

Established resettlement countries have adopted a number of approaches to providing professional debriefing, including:

- building case discussion and review into the work practices of relevant providers;
- offering regular professional debriefing on an individual or group basis.