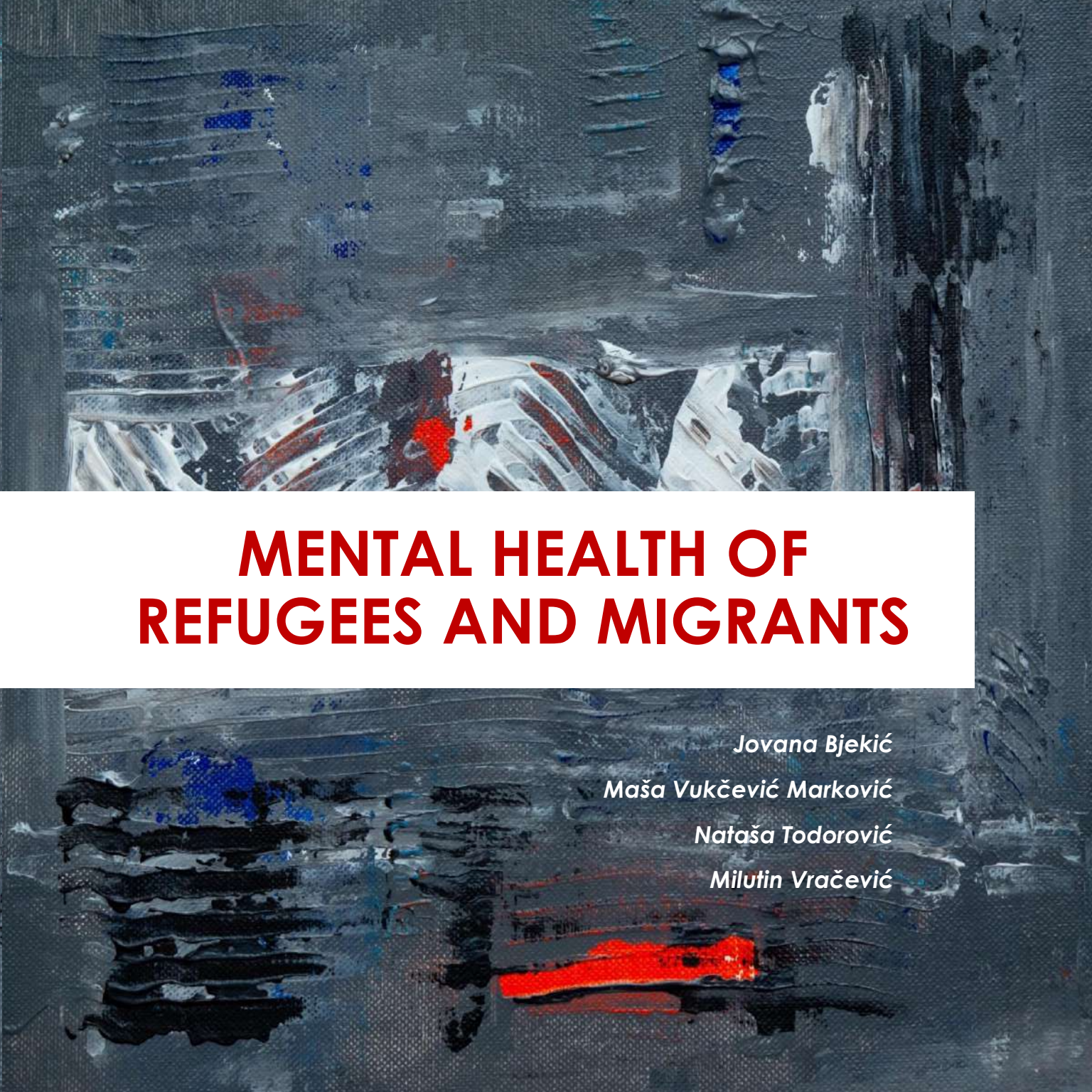

MENTAL HEALTH OF REFUGEES AND MIGRANTS

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Published by: Red Cross of Serbia
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Cover design: Jovana Bjekić

Printed by: Grafo IN

Circulation: 500

ISBN: 978-86-80205-74-8

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Mental health problems and disorders are one of the leading global public health problems. Refugees and migrants represent a particularly vulnerable group in that regard. Numerous traumatic experiences, both in their countries of origin and during their journeys, but also all the difficulties they face in the country of permanent or temporary residence are significant risk factors for problems and difficulties in the mental health area. This publication will focus on understanding mental health in the context of refugee related issues, with special emphasis on understanding post-traumatic stress disorder symptoms and manifestations, as well as depression and anxiety symptomatology. The results of the research on psychological vulnerability will be presented, as well as the frequency of different mental problems, but also positive aspects of psychological functioning and resilience among the refugee population in Serbia. Since difficulties in the mental health area represent an all-encompassing challenge in the context of refugees, both at the individual and the wider social level, this document will focus on mental health as challenge for achievement of refugee rights, but also on the way different social factors affect mental health of individuals. Finally, recommendations will be provided for further development of the psychosocial support programme of Red Cross of Serbia and other National Red Cross and Red Crescent societies and interventions focused on mental health and well-being of refugees and migrants.

MENTAL HEALTH

Mental health is a key aspect of public health – mental well-being is extremely important for the quality of life and capacity of dealing with life's ups and downs. Mental health protects us from physical ailments, social inequalities and unhealthy way of life.

Group for public mental health, 2018

Mental health problems and disorders are one of the leading global public health problems. A system analysis of over 300 chronic and acute conditions in 188 countries in the period between 1990 and 2013, indicates, as one of its conclusions, that mental health disorders are one of the leading global causes of disability (Vos et al 2013). Additionally, mental health problems and disorders often remain undiagnosed and without adequate treatment, especially in less developed countries. Thus, for example, the World Health Organisation (WHO) estimates that between 35% and 50% persons with serious mental disorders in developed countries do not receive treatment while this percentage is between 76% and 85% in developing countries (Demyttenaere et al 2004). Some of the main reasons include insufficient access to mental disorders related healthcare, inadequate and untimely diagnostics but also the stigma which accompanies people suffering from mental disorders – which still remains an obstacle for seeking help even in the most developed countries.

Difficult living conditions and stressful experiences in life have a negative impact on mental health of individuals, which is why refugees, asylum seekers and migrants represent a particularly vulnerable category in terms of mental health. Migration, and especially the refugee status bring about numerous mental health challenges – hard living conditions on one side and potentially traumatic events in the land of origin, then the process of leaving the country and difficulties people are facing during their journey as well as challenges of adaptation and setting up a new life in the country of destination, on the other side. Today, number of refugees is among the biggest ones in history (65 million displaced persons) and if this trend continues, we may expect that one out of 100 people is considered a refugee or a child from a refugee family (United Nations Refugee Agency, 2016), particularly having in mind that average time spent as a refugee is 20 years. Even though there are estimates that mental health problems are several times more frequent in refugee than domicile population, there are not enough reliable data about the epidemiology of mental disorders among refugees. Thus, as some studies estimate, the post-traumatic stress disorder prevalence (PTSD) among refugee population is approximately 9% (Porter & Haslam, 2005 Fazel, Wheeler & Danesh, 2005), other reviewed studies which also included refugees in less developed countries estimate the prevalence at about 30% (Steel, Chey &, Silove, 2009). One of the primary reasons for considerable variations in epidemiological indicators is absence of universal (and yet culturally adequately adapted) diagnostic criteria, and disproportion of studies in terms of used evaluation tools and monitoring periods. However, the one thing almost all studies agree on is that people who, for any reason, were forced to leave their homes, were exposed to significant stressors, went through different traumatic experiences, and experienced difficulties while adapting to new (often hard) living conditions, all of them being significant risk factors for mental health.

MENTAL HEALTH OF REFUGEES AND MIGRANTS IN SERBIA

The data from the Institute of Public Health of Serbia "Dr Milan Jovanović Batut" (periodic reports 2017-2018) demonstrate that mental health problems are the third most common cause of health interventions (after respiratory diseases and physical injuries) among the refugee, asylum seeking and migrant populations. It is indicated that healthcare workers register about 500 interventions a month related to mental health disorders among the refugee population in Serbia, which includes between 3.600 and 4.800 people. These data directly underscore the expressed needs of this population for timely support, mental health related interventions and specialised care, when necessary.

The most frequent mental health problems encountered in the refugee population include post-traumatic stress disorder, depression, and anxiety symptoms. Data collected during 2017 and 2018 on a sample of over 500 people, show that more than 80% of refugees residing in Serbia may be considered psychologically vulnerable – i.e. on a standardised questionnaire for initial mental health assessment, they receive a higher score than the cut-off score for being referred to a more detailed diagnosis and potential treatment (Vukčević Marković, Gašić & Bjekić, 2017, Vukčević Marković, Stankovic & Bjekić, 2018) . Here it is important to emphasise that presence of symptoms does not imply that a person needs to be diagnosed with a mental health disorder, but that he/she exhibits signs of psychological vulnerability at that moment, which may indicate an acute response to stressful and difficult living circumstances that, with adequate and timely support, could be completely overcome.

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[1]The presented data have been gathered in the scope of the UNHCR financed projects in Serbia.

The Red Cross of Serbia implements, as part of its activities and programmes aimed at supporting refugees and migrants, an initial mental health assessment with the aim of identifying the beneficiaries who need additional support, and tailoring programmes in terms of population indicators regarding psychological resilience and benefitiaries' vulnerability at different locations in Serbia.

The data gathered in the period between December 2018 and February 2019 on a sample of over 200 beneficiaries demonstrate that 72.5% of refugees and migrants are psychologically vulnerable, i.e. they obtain a score that is the same or higher than the cut-off score for identifying psychologically vulnerable persons in the Refugee Health Screener (RHS-15) instrument for an initial mental health assessment. In other words, almost 3/4 refugees demonstrate indicative levels of depression, anxiety and post-traumatic stress symptoms. It is important to note that among those who are psychologically vulnerable, every second individual may be considered extremely psychologically vulnerable, since he/she gets a score twice as high as the cut-off score on RHS-15. With regard to acute distress, 48.0% of refugees and migrants show acute signs of anxiety and other psychological issues, which is why they need to be provided with first psychological aid and then allow then be provided with access to adequate psychosocial support or interventions aimed at protecting and improving their mental health.

[2] Refugee Health Screener (RHS-15) is a short instrument for quick vulnerability assessment, linguistically and culturally tailored to refugee/migrant populations from over 20 countries of origin. This instrument has been used in different European countries and the USA for triage and referral of refugees to various services, as well as for monitoring their psychological condition during the various psychosocial support programmes. The questionnaire may be presented in interaction with the interviewer or the beneficiary may fill it in independently, depending on the mother tongue and availability of the questionnaire in a particular language as well as the level of literacy.

In terms of psychological vulnerability, there are also gender related differences. The results showed that 82.3% of female refugees and migrants are psychologically vulnerable, while this percentage is somewhat lower with the male population, i.e. 63.9%. With acute distress, 62.1% of women show obvious signs of current anxiety and psychological issues, while this percentage is almost twice as low in the male population, i.e. 35.8%. These findings clearly indicate the need for programmes specifically targeting psychosocial support for female refugees and migrants at the locations where the Red Cross of Serbia is implementing its programmes and activities. Apart from that, gender disproportion in the number of psychologically vulnerable people opens up the issue of availability of adequate services focused on the mental health of women from the refugee and/or migrant population. A special challenge in providing mental health services is the fact that only 26.2% refugees and migrants recognise signs of psychological vulnerability, and only 6.2% of them have thought about it or asked for help.

In other words, a significantly greater number of refugees/migrants experience mental health problems, but due to various reasons they fail to recognise the symptoms, and even the few of those who do recognise signs of psychological issues, rarely seek help actively. It is therefore necessary to work on development of effective systems for identifying psychologically vulnerable persons and providing information on available services and support systems in order to provide timely support so as to implement interventions at an early stage in development of mental health issues.

SYMPTOMATOLOGY AND SIGNS OF PSYCHOLOGICAL VULNERABILITY

Most of the refugee and migrant population members have the experience of various traumas in the countries of origin or during their journeys in common. Trauma is a medical term indicating injury – psychological trauma refers to a person's psychological injury and represents an individual perception i.e. a psychological consequence of a highly disturbing (traumatic) event. Defining the scope of events that could be considered "traumatic" is exacerbated by the fact that psychological consequences of the same event are not the same for all people, and that there are individual differences about which events are perceived as highly disturbing. Accordingly, psychological response to an event will depend on both the event itself and the perception and characteristics of the person who experiences it.

However, there are categories of events that can be considered traumatic for the majority of people, such as: events or series of events which directly or indirectly endanger someone's life or physical integrity, including experiencing serious bodily harm or sexual harassment; testifying of a violent death, grave physical injury or a situation which has endangered someone's life or physical integrity; knowing that such event happened to a family member or a very close person; and continuous exposure to frightening details or consequences of such events. Data about the traumatic experiences of refugees in Serbia show that over 80% of them experienced six or more traumatic experiences in the country of origin before they headed to Europe (Vukčević Marković, et al 2017, 2018).

Additionally, the long and often dangerous journey brings new hard experiences which include spending time in asylum centres, which often turn from temporary into permanent accommodation, improvised shelters and in the open, crossing the sea by unstable or overcrowded boats, staying in unhygienic conditions without access to food and water, but also individual traumatic experiences such as separation from family and/or friends, grave bodily injuries, detention, and being forced to commit sexual or criminal activities by smugglers. All these traumas represent significant risk factors with an acutely negative impact on mental health, but can also leave long-term consequences if timely response and support are missing.

Regarding traumatic experiences of the refugee population, the most common topic is collective traumatic experiences shared by most people coming from a certain country. Thus, special emphasis is placed on traumas related to wartime events (tearing down and destruction of settlements, exposure to armed conflicts, bombing, etc.), natural or humanitarian disasters affecting entire communities. However, it is important to keep in mind that there are also individual traumatic experiences – i.e. those that happened to one or several persons, which are not characteristic of the entire population. Thus, a person who began his or her journey to Europe with the purpose of achieving better quality of life in economically more favourable conditions can experience serious traumas such as sudden or violent death of a family member, forced stay in detention or grave bodily injuries. Therefore, from the mental health perspective, when assessing vulnerability of an individual, apart from the collective experience, one must also take into account individual experiences of each person, taking note of experience in the country of origin, as well as different experiences which a person could have undergone during the journey.

POST-TRAUMATIC STRESS DISORDER

During the day I deal with children, and manage, to some extent, not to think about the past. At night however it is different. I have trouble sleeping, and often have terrible nightmares where I seem to experience once again everything that has happened to me. Most of the times I wake up in the middle of the night, terrified, and can not go back to sleep again. I am mostly upset because of the children because I fear that sometimes I react too abruptly to little things, sometimes I will not let them go out, because I have a feeling that something terrible will happen again, occasionally I hear sounds which frighten me – I know they are not real, but I start to sweat nonetheless and need time to calm down..

Woman (29 years old) from Afghanistan

Post-traumatic stress disorder (PTSD) is a mental health disorder that occurs as a consequence of exposure to extreme stress, i.e. after experiencing one or more traumatic events. These traumatic events include, but are not limited to, being exposed to a war as soldier or civilian, exposure to threats of or actual physical attack, rape, terrorist attack, etc. PTSD is one of the most prominent mental health disorders in the refugee population, especially in those coming from war-affected areas, and PTSD symptomatology is up to 70 times more frequent in the refugee than general population. PTSD prevalence is slightly lower than 3% in most countries, for example the prevalence of this disorder is 2.3% in South Africa, 2.2% in Spain, 2.4% in Italy, 1.3% in Japan, etc. (Atwoli, et al. 2015). In the general population of European countries, PTSD prevalence is within the range of 0.56% to 6.67% (Wittchen, 2010), while with refugees it is up to 40% (Tekin, et al 2016).

PTSD symptomatology may differ depending on a large number of personal and situational factors, as well as the stage of development of the disorder i.e. trauma recovery phases, but, as a rule, includes:

Intrusions which are repeated, involuntary, intrusive memories of a traumatic event that a person is not able to control and which are disturbing. In the symptomatology, it is not unusual to experience repeated, disturbing dreams related to the trauma (nightmares) and dissociative reactions during which a person acts or feels like he/she is experiencing the trauma again (the so-called flashbacks). An individual feels as if memories of events are "attacking" him/her and that he/she can not get rid of them. Additionally, a person experiences intense or prolonged psychological anxiety and/or physiological agitation (sweating, rapid heartbeat, quick, shallow breathing) due to exposure to the stimuli associated with the trauma – these may be similar situations or details one remembers together with the traumatic experience.

Avoiding stimuli associated with a traumatic event. This aspect of symptomatology refers to trying to avoid or successfully avoiding memories, thoughts and feelings directly or closely related to the trauma (for example, one busies oneself with various activities to prevent the onset of thoughts and memories) as well as trying to or successfully avoiding people, places, activities and facilities that provoke disturbing memories, thoughts or feelings one associates with a traumatic event (in refugee and migrant populations, those can be river/sea, forest, basement/attic, small and poorly lit rooms, places where there is military or police presence, etc.). This way, people who have experienced severely traumatic experiences try to distance themselves from these events as much as possible and reduce their presence in their thoughts so as to establish a normal pattern of everyday functioning more easily.

At physiological level, this symptom most frequently manifests itself with sweating and rapid heartbeat upon coming into contact with a trauma related stimulus, so one consciously or implicitly avoids situations and stimuli which initiate such reactions..

Negative cognitions and emotions associated with a traumatic event. Negative cognitions are reflected as inability to remember important aspects of a traumatic experience (for example, a person can not remember the activities that preceded a traumatic event or key aspects of the event itself, such as the exact place, time of day, number of persons present, etc.), exaggerated negative opinions about oneself and the world (for example, "I am a bad person", "This world is a bad place"), as well as distorted thoughts about the cause and/or consequences of a traumatic event that, as a rule, lead to feelings of guilt due to attributing responsibility for certain events to themselves and their actions. Apart from guilt, negative emotions include other negative emotional states such as fear, anger, shame and are often accompanied by a visibly reduced interest in participating in important activities, and inability to experience positive emotions such as happiness, pleasure, love, and by a feeling of alienation from others. Thus, there is often an emotional "depravity" with people who suffer from PTSD – a constant feeling of emptiness and inability to experience a full spectrum of emotions, and provide an adequate emotional response to external stimuli. In other words, a person can act indifferently and "cut off" from events happening around him/her – for example, he or she can remain completely "cold" upon hearing bad news or not show signs of happiness and satisfaction upon hearing good news.

Increased excitement and reactivity related to a traumatic event which can be manifested through irritability caused by minimal or even non-existent provocations. Sometimes a person is aggressive and/or has outbursts of anger seemingly without a reason. Persons who suffer from PTSD often demonstrate increased caution and readiness to react, and have the appearance of someone "on the edge" (who is easily startled, scared and upset in contact with unthreatening stimuli from the surroundings). Also, reckless and self-harming behaviour may occur as well as trouble with concentration and sleeping. These symptoms are often developed as adaptation to being in highly uncertain and exposing conditions, such as hiding from the enemy army soldiers or police, or being under a sudden armed assault, attacks on personal and physical integrity, etc. That way, a person can seem tense, distrustful and ready to "escape", despite being at a safe place at that moment.

According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) of the World Health Organization (WHO) and the Diagnostic and Statistical Manual for Mental Disorders (DSM-V) of the American Psychological Association (APA), the criteria for PTSD diagnosis are an experienced trauma (i.e. traumatic event is the condition for the diagnosis), followed by at least one of the symptoms from each of the four mentioned categories which last at least a month and results in great anxiety or worsening in social, business and other important areas of everyday functioning. However, it should be kept in mind that progression and recovery from this disorder can be very complex – thus, the expressed PTSD symptomatology can occur immediately after a traumatic event, and disappear completely relatively quickly, but it is also possible for a person not to exhibit any symptoms at first, only for them to appear after a while (the so-called delayed PTSD) and cause a relatively intensive and long-term problem.

An initial assessment of PTSD symptoms among beneficiaries of the Red Cross of Serbia psychosocial programmes and activities showed that 14.2% of them experience indicative levels of post-traumatic stress symptoms. Therefore, 25.1% of them, even though their lives are not in currently danger, experience the traumatic experience again (i.e. they have intrusive thoughts and memories of traumatic events); 26.2% have physical symptoms and reactions when encountering different aspects of a traumatic experience (excessive sweating, rapid heartbeat, etc.); 35.9% have difficulties with emotional functioning (they feel "empty", sad, but at the same time can not express those emotions adequately or cry, they experience difficulties with feeling positive emotions even when they are in a situation which should make them happy); 25.8% of them are tense and constantly "on the lookout" for something unforeseen that may happen.

Although different studies show that symptomology associated with the PTSD is more commonly present in men than in women (primarily due to the nature of traumatic experiences during wars or armed conflicts); in the refugee and migrant populations in Serbia, such gender differences in the PTSD symptomatology are not recorded. Thus, the post-traumatic stress disorder symptoms occur in 13.8% of men and 14.7% of women, with symptoms considerably more prominent in women, and they include nightmares and difficulties with emotional functioning.

For me, all this is new, I have never felt like this. I used to think that none of this would ever happen to me because I have always been mentally strong – whatever happens, I think of something, whatever the problem is, I solve it. And I never ran away from anything, because I knew I was strong. Now, it is as if I do not recognise myself, I am not able to explain what is wrong with me, sometimes I get irritated quickly, I am tense and I would just like to do something, anything – but I am not good at it and it is as if I can not focus.

Man (35 years old) from Somalia

When looking at the data about the PTSD prevalence among refugee and migrant populations obtained by different European countries during or immediately before the so-called refugee crisis, there seems to be a high demand for both specialised mental health interventions and long-term psychosocial support programmes. Namely, a study undertaken by the Swedish Red Cross (Tinghog, Arwidson, Sigvardsdotter, Malm & Saboonchi, 2016) showed that 30% of refugees who have been staying in Sweden for two years or less exhibit symptoms of PTSD. Furthermore, in Switzerland, 23% of refugees are diagnosed with PTSD (Heeren et al., 2012), while data from Denmark indicate that only 20% of refugees with PTSD symptomatology ask for help, despite there being various and highly accessible treatments for refugees who have survived trauma and/or are facing mental health problems (Acarturk et al., 2015; Stammel et al., 2017). This is supported by data from the Netherlands (Laban, Gernaat, Komproe & De Jong, 2007), according to which this number is even lower, i.e. about 9% of refugees with mental health problems visit one of the institutions where mental health services are being provided.

These data directly point to the need to identify obstacles and difficulties in accessing available services aimed at preventing and treating difficulties with regard to mental functioning. Namely, there is a question regarding actual extent of accessibility of mental health services and how tailored to the refugee population they actually are, even in the countries with the most developed systems for mental health preservation. Additionally, the fact that few refugees who need help actually ask for it opens up the issue of cultural adaptability of these services as well as general trust in institutions. Apart from that, there is a question regarding how the refugees are informed about available services, that is, whether information is transferred in an adequate, culturally-tailored manner. Finally, it seems that the main challenge lies in finding ways to establish trust at the individual and the system level, which will lead to greater number of those who need help actually receiving it.

How to make mental health services more accessible?

- ***Structured activities in the community –*** few persons will decide to have a preventive examination and an initial mental health assessment, therefore it is necessary to develop and implement community based preventive programmes which would be nonintimidating, allowing trust to be established, and identification of persons requiring additional support and enough room for people to ask for help on their own initiative.

- *Understanding and respecting cultural patterns* **–** establishing trust mainly depends on understanding and respecting cultural patterns and behavioural norms. Therefore, it is important that mental health services providers share the system of values with the people they are providing the services to. If, however that is not possible, they should be well acquainted with cultural norms and values of persons they are providing services to

- *Destigmatisation of mental disorders* **–** in order to decrease resistance to treatment of mental disorders, it is necessary to clearly communicate these difficulties as a normal response to stressful events, and avoid premature diagnoses and pharmacological therapy.

DEPRESSION

I feel like I can not do anything right. In the morning I find it very difficult to get out of bed, I do not have the will to do anything, and even when I do get up, I see no meaning anymore, nor do I have hope that this situation will ever change. They tell me I just need to make a little effort, but I have no strength to do anything. Nothing makes me happy anymore – people around me, or sport, or the movies I used to like watching – somehow it is as if everything has lost its meaning and the one thing left for me to do is to fall asleep and not wake up.

Boy (17 years old) from Afghanistan

Depressive disorders are an overarching term for a number of negatively polarised affective disorders which differ among themselves in terms of aetiology, symptomatology, duration and prognosis. A major depressive episode is the most common and best-known depressive disorder characterised by an apparent change in affect, cognition and neurovegetative functioning. The prevalence of various forms of depression in the world is slightly less than 5%, with depressive spectrum disorders in almost all countries more common in women than men (WHO, 2017). Prevalence of depression is higher in Western (> 5%) than in Asian countries, including the Middle East, where it is around 4% (WHO, 2017). Looking at the European countries, in the age group between 25 to 34 years, prevalence of depressive disorders ranges from 4% to 13% (ESE, 2017). On the other hand, prevalence of depression in the countries the most refugees who come to Serbia are from is generally less than 4%, e.g. in 2015 in Afghanistan, prevalence of 3.3% was registered (WHO, 2017).

Recent meta-analysis has indicated significantly higher depression rates in migrant population than in domicile populations in the territory of Western Europe, being as high as 20% (Janssen-Kallenberg, et al., 2017). Data which favour the notion that migration, and especially refugee status, have a strong influence on development of depressive symptomatology, indicate that prevalence of depression among refugees from Syria is about 44%, while the prevalence of depression in Syria before the war was 6.5% (Naja, et al., 2017). Risk of depression is also increased with tragic events such as loss of a close person or property, reduced or disabled contact with close people, but also difficult or impossible establishment of a normal everyday functioning pattern (e.g, inability to find a job, difficult financial situation, inadequate living conditions, etc.). Also, depression may be caused by social isolation and marginalisation, severe physical illness (usually cancer and physical disability). Finally, there is high comorbidity, i.e, joint reporting of depressive symptoms with symptoms of other mental health disorders such as PTSD, anxiety disorders, eating disorders, etc. Therefore, depression is one of the most common mental health problems in both general and refugee/migrant populations.

Unlike PTSD, which is caused by one or more traumatic events, depression often does not have a clear external cause, but is the outcome of prolonged unfavourable living conditions, including poverty, not being able to fit into society and the community, small number of social relationships and poor quality thereof, longer periods of unemployment or non-productivity. For this reason precisely, refugees and migrants are an especially vulnerable group with regard to development of depressive symptomatology, since they are often exposed to unfavourable living conditions for longer periods of time, unlike the majority of members of the domicile population.

Key symptoms of depressive disorder include manifestation of either **depressed mood** or **reduced activity levels** and **overall indifference**. Depressed mood can be determined on the basis of observation of someone (for example, a person cries almost every day most of the time or has a generally mournful disposition with occasional outbursts of crying or feeling "as if he/she does not care" about what is happening or what may happen in the future). It can also be determined based on subjective testimony of a person stating that he/she has been feeling predominantly sad, empty, dejected or hopeless for a long time. Markedly reduced interest or enjoyment in activities is manifested in all fields, and is especially evident in the activities and hobbies that have previously been a source of great satisfaction to that person and which he/she used to be highly invested in (for example, a woman who used to love preparing food and was known among friends and family as the "best homemaker", now cooks very rarely, does not have the will to go shopping for groceries, and when she does cook, she does it without paying special attention, routinely and indifferently). Here it is important to note that depression often implies both negative affective state and lack of interest in activities, but it is not unusual for only one of these two symptoms to be present, i.e. the depressed person does not have to be noticeably sad, cry or show negative emotions, because depression is often manifested as "emptiness in thoughts and evenness of affect".

Apart from the above mentioned symptoms, depressive symptomatology is characterised by drastic **decrease in energy** and **increased fatigue** due to which a person is forced to invest significantly more energy in performing activities which he/she has previously conducted with ease (e.g. a person finds it difficult to start activities, tires quickly and easily and has a feeling of constant fatigue and no strength to perform any activities).

Depressed people often experience **loss of confidence or self-esteem** that manifests itself in a person's impression of not being capable of doing things that he/she has performed successfully in the past with equal success (if at all), as well as unreasonable, exaggerated or inappropriate **attribution of guilt**. Low self-esteem and feelings of guilt are significant risk factors for onset of other depression symptoms, and they are under a considerable influence of different external and social factors. Thus, in migrant population, there are often reports of reduced self-esteem as a result of unsuccessful effort to reach the target country, inability to communicate in the local language or use one's own skills and knowledge in a new environment..

> *We led a hard life and did not have much, but I was still someone whom everyone respected and appreciated because I graduated from the Veterinary faculty in Kabul. Whenever someone had some problem with cattle, I was the one they called, since I always knew how to help. And they would always pay me, as much as they could. I like to help, I particularly like to take care of animals. Now I can not do that here, they say that nobody needs a veterinarian. There are no animals here at the camp, nobody has cattle and nobody needs my help.*
>
> *Man (24 years old) from Afghanistan*

Perception of refugees as persons in need of help in every aspect of daily functioning often contributes to the feeling of loss of confidence and low self-esteem. Therefore, it is often assumed that refugees have no knowledge and skills which could be useful to society, and that they are yet to acquire them in the new country, which has a further negative influence on mental health and psychological well-being of members of the refugee population.

Additionally, depressed people often have problems with concentration and decision-making, which is recognised, in behaviour, as being indecisive or passive in decision-making. Also, changes in psychomotor activity occur and are exhibited as slow or anxious actions. Being slow implies slow thinking and speech, reduced movement and overall motor hypoactivity. Finally, there is a change in appetite (whether increase or decrease thereof) that leads to a visible change in body weight as well as sleeping disorders (inability to sleep, frequent waking up during the night, insomnia or hypersomnia – too much sleep, difficulty waking up, excessive drowsiness during the day) are all frequent symptoms of depression. In addition to the above, it is important to note that with depressed individuals there can be suicidal thoughts and behaviours present, as well as other self-destructive forms of behaviour such as self-harm for example. People can talk about suicidal ideas or intentions in a relatively subtle way (for example, one can say "one is tired of everything", "problems will come to an end", "one is powerless to deal with this life"), and therefore it is important to recognise them and respond adequately and on time.

How to act preventively?

• **Social support** – depressive symptomatology often goes hand in hand with social and emotional withdrawal, and it is often best to show the person that he/she has social support and understanding, but also provide them space to be on their own. It is important not to pressure a person to engage in various activities, talk about their feelings, or "cheer up".

• **Focusing on the strengthening and empowering of a person** – most refugees and migrants have knowledge and skills which can be useful to society and the community. They need to be identified and their expression must be enabled so that the person could preserve the sense of personal value and thereby improve resilience.

• **Refrain from pity** – empathy is often mistakenly replaced by pity, which can further exacerbate negative emotions and cognitions which a person has and make it difficult for him/her to recognise own capabilities and strengths.

Expressed levels of depressive symptomatology were recorded in 28.6% of refugees and migrants in Serbia, with considerable gender differences. Thus, depressive symptomatology is present in 41.7% of women refugees and migrants, while the percentage is 17.3% in the male population. This finding is in line with epidemiological studies showing that depression is more prevalent in women than men in the general population.

When data are observed at the symptom (i.e. indicator) level, it is evident that each of them occurs to a great extent in more than one third of refugees and migrants. Thus 34.1% of them report that most of the time they feel dejected, sad and unhappy, while 41.4% of them report that they feel helpless and hopeless. In addition, 36.2% of them report how they often start crying for no special reason. However, it is important to stress that these symptoms do not necessarily represent a person's permanent emotional state, but can rather be a natural and integral part of the normal grieving process due to loss or tragic event. It is therefore important for refugees and migrants to have different types of services available which could adequately respond to depressive symptomatology, taking into account and relying on its cause, duration, and capacities of the an individual to deal with current or chronic experience of negative emotions.

ANXIETY

I can not really explain what is wrong with me, but it is as if something is constantly creating pressure and discomfort. I feel anxious suddenly, even when nothing happens, as if I am trembling from the inside, as if I am shaking or I am cold all of a sudden. I can not calm down and I worry all the time. I am mostly concerned about crossing the border, but there are other things too – what if something happens, what if they do not let us pass through, what if someday somebody comes along and says I have to go back to Afghanistan, what if something happens to one of my friends, what if ... what if ... what if and it goes like than on and on and I do not know what to do with myself.

Man (22 years old) from Afghanistan

Anxiety disorders are an overarching term for a number of mental health disorders characterised by an unpleasant state of anxiety, fearful anticipation or intense fear. Prevalence of anxiety disorders worldwide is around 3.6%, and same as depression, it is more common in women than men (WHO, 2017). The highest rates of anxiety disorder are recorded in the most developed countries (e.g. Brazil - 9.3%, Norway - 7.4%, Australia - 7.0%, The Netherlands - 6.4%, United States of America - 6.3%, France - 6.2%, Germany - 5.8%), while the rates in the countries from which most refugees who come to Serbia originate are about 4%, i.e. Afghanistan - 4.0%, Pakistan - 3.5%, Syria 4.3%, etc. (WHO, 2017). However, among the refugee population, symptoms of anxiety are considerably more frequent than in the general population and appear in almost one third of refugees in Serbia (Vukčević Marković et al 2017, 2018).

Anxiety disorders differ among themselves based on a) objects (stimuli) which provoke fear, anxiety and avoidance behaviour, and b) cognitive processing (ideas) of the mentioned stimuli. Thus, a person can feel a fear of actual stimuli (e.g. water, forest, confined spaces) as well as more abstract all-encompassing things such as the future, family, emotional relationships, etc. It is important to keep in mind that the state of fear and anxiety, which often overlap, can still be distinguished from one another. Namely, fear is an emotional response to an incoming threat (real or perceived) which motivates the body for fight or flight reaction, while anxiety represents a reaction to an anticipated threat, i.e. a potential threat or an expected threat in the future, and is mostly manifested through muscular tension and increased alertness in preparation for future danger or through cautious or avoiding behaviour. Even though, as already mentioned, ideas differ in different anxiety disorders, symptoms of anxiety are often similar and include symptoms of vegetative irritability such as palpitations (short-term feeling of irregularity, stagnation, or skipping of the usual heart rhythm), rapid heart rate, sweating, trembling and drying of the mouth. Also, anxiety symptoms often include chest and abdomen, so that one often reports about difficulty breathing, feeling of suffocation, and nausea or discomfort (“fluttering”) in the stomach. General physical symptoms such as hot or cold flashes, burning sensation or numbness are often an integral part of anxiety disorders or anxiety attacks. These physical symptoms which form an integral part of anxiety (especially if they are intense and frequent) can often be misinterpreted as symptoms of various physical conditions and diseases and therefore an affected individual may more often turn to doctor for help or rely on medicines supposed to neutralize or alleviate the symptoms.

Apart from the above mentioned physical symptoms, there are often symptoms that involve an altered mental state, which can be manifested by dizziness, fatigue or disorganisation; one's experience that the surrounding objects are not real (derealisation) or experience of unreality, alienation and separation from one's own body (depersonalisation). Fear of losing control, or fear of "going crazy", fainting or dying can also be featured quite prominently.

In refugee and migrant populations, especially among those who do not yet have a clearly defined legal status, there are various forms of **anxiety regarding their uncertain future**. This form of anxiety is often exacerbated by external, changeable circumstances, unclear and unverified information, hints of negative outcomes from various procedures, etc. It is therefore of great importance for the information which is being communicated to be accurate, clear and consistent, as well as to avoid "subtle hints" regarding different potential negative outcomes (it is a frequent mistake of helpers who try to "prepare" someone for potential negative outcomes that way). It is also vital to keep in mind that every life change is naturally accompanied with a degree of anxiety, especially if this change is drastic (changing the country of residence, a new language, a new environment) and that it is possible that, with adequate support in adaptation, a person will be able to completely eliminate manifestations of an anxiety symptomatology, after stabilisation and a period of time spent in a new environment.

In a research by the Red Cross of Serbia, great levels of anxiety symptomatology were reported in 18.9% of refugees and migrants in Serbia, whereby there were pronounced anxiety symptoms in 22.9% of women refugees and migrants and 15.5% of men from this population. In other words, slightly less than one-fifth of them, in absence of adequate support, are at risk of developing an anxiety spectrum disorder. On the other hand, isolated anxiety symptoms are much more frequent, and are mostly related to current living situation and uncertain future. Thus, almost half of them (45.6%) reports they "think too much" – thoughts are swarming about in their heads; they can not stop thinking and relax, while 26.8% of them feel nervous and report how they often "shiver from the inside", and 37.2% of them say they "can not stay still" i.e. that they feel the nervousness they have to "expel" through continuous physical activity.

It is important to keep in mind that behavioural manifestations of internal anxiety which are common manifestations of anxiety symptomatology, in refugee population often represent a normal response to objective uncertainty and unpredictability of future events. This should not lessen the significance of these symptoms - namely, it is important to treat them appropriately, as in the case when symptoms are not the consequence of external circumstances - but an insight into the context in which they occur is of crucial importance for their understanding.

MENTAL HEALTH AND CHALLENGES OF A NEW BEGINNING

I want to leave the past behind me, it is a difficult and painful part of my life I do not want to think about. I am here now and I am starting over – I am waiting for all the procedures to be over and have regular talks with a lawyer who can help me get the papers. Uh, I just want this to be over ... Then I have to see where I am going to live, since I would like to leave the camp. Do not misunderstand me – everything is fine at the camp, I would just like to be in an apartment where I will be on my own, where I can come home whenever I want, and where I can eat what I prepare, if you know what I mean. I must find a job as soon as possible, any job at first, just to get back on my feet. The only thing that scares me now is whether I will succeed, for a moment I think I can do it, then I get the feeling I am no longer capable of doing anything. I said that I am trying not to think about the past, but sometimes thoughts come on their own and then I can not stop them. I just hope that in time everything will come together.

Man (25 years old) from Iraq

After leaving their country of origin, often preceded by painful and traumatic experiences, and facing different risks along the way, people in need of international protection reach the countries where they should start to build a new life. This phase, which mainly involves both solving existential issues, an attempt to regain control over one's own life, stabilisation of one's mental state and going through the stages of trauma recovery, brings new challenges and risks to preservation of mental health and psychological stability.

Usually the trauma recovery process and overcoming traumatic experiences go through several phases. In the first phase – **the stabilisation phase** – a person tries to establish a sense of security and safety, so as to overcome and manage difficult and threatening feelings. This phase usually lasts from several days to several weeks, but may also last up to several months and years depending on the circumstances of a particular person. Second phase – **recognition and grief** – includes active work on recognition and psychological treatment of traumatic experiences, and a person needs space for regret, acceptance of loss, and expression of feelings. During this phase, one will try to redefine oneself in the context of significant events, relationships and new circumstances, where often group or individual psychosocial support will be needed. The duration of this phase depends largely on personal capacities, available social support and overall living situation of that person. Finally, in the last phase – **the integration phase** – concrete steps are undertaken towards empowerment, and an individual actively takes responsibility for his/her own future. The aim of this phase is to restore one's self-esteem, belief in one's own abilities and capacities, and hope for a better future, not defined only by the events from the past.

The key to successful transition through these phases is a stable and nurturing environment, as well as strong social support. In the refugee population, however, there are a number of obstacles and aggravating circumstances which have a negative impact on integration of trauma and restoring of mental well-being. Namely, refugees, but also migrants, are, as a rule, facing not one but a great number of traumatic experiences – and while a person recovers from one traumatic event, his/her capacities are again disrupted by new unpleasant events, which leads to complex forms of psychological vulnerability.

Also, coming to a new country and trying to build a life there is accompanied by a multitude of stressors, among which are: the asylum procedure, resolution of existential issues, integration into the community and cultural adjustment. Each of them represents, in a specific way, a challenge to mental health, and mental health problems can be an additional obstacle for achievement of one's rights and integration.

MENTAL HEALTH RELATED DIFFICULTIES: CHALLENGE FOR THE COURSE AND OUTCOME OF THE ASULYM PROCEDURE

The asylum procedure, the way it is implemented in Serbia, but also in all other countries, as a rule, includes giving evidence of traumatic experiences that a person has undergone primarily in the country of origin. Since people often do not go through all the phases of recovery from trauma, this procedure on one hand carries the risk of re-traumatization (re-enactment of unprocessed traumatic experiences), while on the other hand it places demands before a person, who may not be able to fully fulfil them, due to his/her mental condition. Namely, one of the symptoms of PTSD is the inability to recall all relevant aspects of a traumatic experience (e.g. the exact place, time of the day, events that preceded or happened immediately after the trauma), which may have a negative impact on estimate of credibility of that person's testimony. Also, prejudices regarding how different psychological difficulties are manifested can lead to misleading conclusions about the psychological stability or readiness of a person to face the stressful and challenging, and at the same time highly relevant situations within the asylum procedure.

What psychological difficulties can negatively impact the course and outcome of the asylum procedure?

• **Intrusions** – during conversations unwanted images of events and disturbing scenes may flood the mind, and it is necessary to give space to an individual in order for him/her to calm down and/or end the conversation.

• **Avoidance** – a person may refuse to talk about the past events relevant to the procedure, especially if they provoke feelings of guilt and shame (e.g. unwanted sexual intercourse, physical abuse, torture, forced participation in actions that a person considers to be immoral and dishonest, etc.).

• **Forgetting and suppressing** – a person may be inconsistent in his/her statement, report that he/she can not remember the details of events or give contradictory statements during two relatively far apart conversations. All these forms of altered memories can be the result of that person's effort to recall and reconstruct traumatic events from the past.

• **Evenness of affect** – a person may have an inadequate emotional tone while presenting content that is tragic and deeply disturbing according to its characteristics. So a person can talk about traumatic experiences with an even tone (like telling someone else's or a made-up story).

• **Increased reactivity and agitation** – a person can react violently to seemingly irrelevant aspects of a situation, act nervously and tense during the whole conversation, or become verbally aggressive.

• **Indifference and increased fatigue** – a person can act as if he/she has no desire to initiate the asylum procedure, or may seem indifferent and tired during the interview or unable to invest energy in relevant aspects during the course of the procedure.

• **Anxiety and mistrust** - a person can act frightened and distrustful, and unwilling to openly talk about himself/herself and past events. In refugee population, there is often a lack of trust in institutions and the system, so one can disguise relevant information fearing that he/she may endanger the family due to "disclosing" certain information.

People are usually surprised when they realise for the first time that sadness and grief are not the only answers to trauma. Depending on different personal and situational factors, but also on the phase, i.e. the stage of overcoming and integrating trauma, an individual can show different emotions – he/she may be unable to talk about the event, may be cold and abrupt – almost mad and angry, able to speak without any emotions as if that event happened to somebody else, or may cry all the time. It is important not to rely on one's own convictions about how a "traumatized person" should behave when we are in a situation where we make important decisions for someone.

Mental health services supervisor

In order to make an adequate decision during the asylum procedure and to ensure that the procedure itself does not additionally endanger people who are often already psychologically vulnerable, it is necessary to additionally work on developing awareness and knowledge about manifestations of various mental issues as well as the trauma related symptomology. Also, it is important to raise awareness of all stakeholders about which psychological difficulties accompany the trauma related symptomatology, and can therefore be an obstacle to obtaining complete and accurate information from a person in the asylum procedure. Furthermore, it is necessary to carry out adequate assessment of a person's readiness to participate in the asylum procedure, as well as adequate preparation for potentially stressful and unpleasant situations which they can be subjected to during the procedure itself. Finally, before and during the procedure, it is necessary to provide continuous care and support to person's mental health so as not to disturb the capacity and positive aspects of psychological functioning.

When considering how trauma and PTSD can affect memory, it is important to keep in mind the complexity of this connection, or different factors that have been shown to make memorizing traumatic experiences more difficult. It has thus been shown that: 1) Repetitive and prolonged trauma more often lead to memory disorders than those that occur only once; 2) Traumatic experiences inflicted by another human being are to a greater extent related to memory disorders than natural or accidental disasters 3) Young people have more difficulty in recalling their traumatic experiences than older ones 4) Memory disorders are more likely to occur in persons who expect misunderstanding and judgement from their community, compared to those with available social support and community understanding (Sidran Institute, 1994).

Most refugees and migrants have suffered multiple traumas, or multiple traumatic experiences in their countries of origin, and then along their journey to a safe destination. The vast majority of the traumas they experience are related to experiences with members of paramilitary formations, police, smugglers and members of local communities in different countries (Purić & Vukčević Marković, submitted; Vukčević, Momirović, & Purić, 2016). Additionally, it is important to keep in mind that between 30% to 50% of refugees and migrants in Serbia are children. Finally, refugees and migrants often speak about their fear of openly talking about some traumatic experiences, due to judgement and stigmatization both within their community, and within local communities in the countries where they are trying to rebuild their lives.

MENTAL HEALTH AND CHALLENGES OF INTEGRATION INTO LOCAL COMMUNITY

Local community is the greatest resource for preserving one's mental health, but also poses specific challenges, especially for members of the refugee population. Namely, integration into the local community is often made difficult by language barrier, but also by prejudices which persist towards the migrant and refugee populations, and which can be particularly present in culturally and ethnically homogeneous communities. Such situation additionally has a negative effect on the feeling of isolation and loneliness among members of the refugee population. Since by leaving the country of origin, many of them have lost the social support one has when living surrounded by friends and family members, life in social isolation is one of the key obstacles to psychological well-being among refugees. This is supported by the data that refugees in Serbia indicate, as one of the main post-migration difficulties, feelings of loneliness, isolation and boredom (Vukčević Marković, et al. 2018). Integration and cultural adaptation often depend on a person's readiness to invest an active effort and struggle with daily frustrations. In order to learn about new customs, culture and behavioural norms, it is necessary to invest additional energy and be prepared for a number of failures and rejections. For those who are highly psychologically vulnerable and suffer from different symptoms of depression, anxiety and PTSD this can be a major challenge. Namely, it should be kept in mind that some of the major difficulties of such symptomatology is reduced capacity for overcoming stress, agitation and reduced threshold for reaction to negative stimuli.

Consequently, some of these difficulties which refugees and asylum seekers face, manifest themselves through social withdrawal or conflict with others, loss of confidence in the system, other people and themselves. This can be manifested as lack of trust in institutions, the state system, service providers they come into contact with, and who can provide assistance and support, as well as doubts in their own capacities and abilities to deal with current challenges. This may result in reduced motivation for the use of available resources, services and support systems, as well as in refusal to actively participate in decision making related to further course of one's life.

> *We only wanted to escape, then we were thinking only about how to get to Germany, so we waited and tried to be brave and strong – when we finally arrived there and managed to get the papers we thought that our problems were over, but now we know that the fight is just about to start. We are all learning the language, I will try to find a job as soon as possible, my wife is trying to decorate our house so that it is nice and we can receive friends. Still, it is harder for the children – they missed a lot in school, they do not know the language, so they are finding studying difficult. I notice they are laughing less than they used to before and they are quieter. In Serbia, there were many children in the camp and there were some activities for them, so they played and socialised much more. Here it is as if they are isolated and left to their own devices. We are trying and hoping it will get better once some time passes, but I am afraid how they will deal with all these changes.*
>
> *Father of three (35 years old) from Syria*

The fact that refugees and migrants in Serbia experience not only psychological difficulties, but that they also have significant capacities for overcoming stress is supported by the data about the presence of positive aspects of psychological functioning and resilience. Thus, 53.9% of them feel optimistic about the future, 56.2% think they have the capacity to achieve great things in life, and 52.8% see themselves as happy and content people. These data directly support the fact that great vulnerability is accompanied by exceptional capabilities for overcoming adversity, which, if adequately supported and activated, can be a significant protective factor against the onset of mental health disorders. In other words, the symptomatology occurring in the refugee population is more of a reaction to an acute living situation and previous traumatic events, than sign of a mental health disorder. Therefore, availability of various psychosocial programmes primarily focused on capacity building, overcoming adversity and empowerment of refugees and migrants is of crucial importance for preserving and further developing the existing psychological capacities so that the difficulties one experiences can be overcome as quickly as possible.

The results of the evaluation of the programmes implemented by the Red Cross of Serbia in the asylum and reception centres indicate that more than half of refugees and migrants (52.0%) feel that their everyday life here is filled with activities of interest to them.

Apart from that, it is important to keep in mind that mental health issues often have a "delayed onset" and that psychological vulnerabilities can be demonstrated in their full capacity only when a person successfully resolves the basic existential needs. A recent study on mental health of asylum seekers in Germany supports that notion. It demonstrated that the number of people diagnosed with PTSD was lower during the initial psychiatric examination than six months later, as well as that the PTSD symptoms such as increased activation and avoidance had intensified after six months in Germany (Richter et al, 2018). These data indicate that the needs for psychosocial support are not diminished with time spent in the new environment, but that it may actually be the opposite. **Namely, the challenges a person faces after receiving permanent or temporary international protection, sometimes become more complex and more difficult to overcome.**

It is also important to keep in mind that psychological difficulties which occur as response to trauma do not represent someone's permanent patterns of functioning, but that these conditions are dynamic and change depending on a wide range of personal and social factors. In other words, once identified psychological difficulties, may completely disappear, with adequate support and timely interventions, while persons where no difficulties have been noted may begin to demonstrate intense signs of a mental health disorder over time, without an apparent reason. It is therefore important to provide ongoing psychosocial support programmes in the community in order to make mental health services more accessible and less selective.

Finally, the fact that people with mental health problems are still highly stigmatized in society should not be neglected and that they are often regarded as unstable and potentially dangerous for themselves and others. Asylum seekers and migrants with psychological functioning disorders can often be exposed to **twofold stigmatization** – both because of their origin (culture, religion) and their disrupted mental health. Stigmatization and personal beliefs about the nature of mental disorders have great influence on the community's attitude toward people with mental disabilities, especially if these people, apart from that, have different cultural patterns and beliefs. However, it is important to keep in mind that negative prejudices against people with mental issues affect not only the attitude of the community towards individuals, but also professionals working with asylum seekers and migrants. Thus, there is more readiness to help and provide adequate services to people who are psychologically stable, highly functional and motivated to participate in different programmes, than to those who are less emotionally stable, frequently agitated, occasionally aggressive or constantly indifferent. In order to avoid the situation where those who are among the most vulnerable ones are not receiving adequate assistance and support, it is necessary to develop measures aimed at adapting services to refugees with psychological issues, both specialised and unspecialised, strengthening social cohesion and sense of community belonging.

CONCLUSIONS AND RECOMMENDATIONS

Taking into account the results of research on mental health of refugees and migrants in Serbia, as well as rich experience of the Serbian Red Cross and other organisations in providing psychosocial support services in asylum and reception centres, and relying on the strategic document Guidelines for protection and improvement of the mental health of refugees of asylum seekers and migrants in the Republic of Serbia (WHO, 2019), it is necessary to undertake the following activities in order to improve the well-being and protection of refugees and migrants:

- It is necessary to regularly collect the data related to mental health and well-being of refugees and migrants (while respecting dignity, autonomy and confidentiality), both those who reside in asylum and reception centres, as well as those located in different/specialised types of accommodation/institutions. When collecting data, one must take into account gender, age and cultural tailoring of methods and instruments. These data will enable better understanding of the needs and consequently informed planning of psychosocial support activities for migrants, asylum seekers and refugees, and also provide basis for evidence-based advocacy at national and regional levels.
- Actively advocate and strive for consensus about the need to ensure availability of psychological assessment as an integral part of the asylum procedure in order to reduce the risk of asylum seekers being discriminated against and rejected due to wrong evaluations or lack of psychological evaluations (e.g. partial loss of memory or inability to remember certain information may be a consequence of PTSD, which may be misinterpreted without information about one's psychological status).

- It is necessary to introduce, along the migrant route, an adequate way of monitoring the health of refugees and migrants, both physical and mental, respecting their privacy and their right to healthcare (e.g, health cards that the refugees and migrants will carry with them, which will enable availability of necessary services and medicines and reduce the risk of unnecessary repeated or multiple diagnoses; postponement of treatment or suspensions of treatment and therapy).
- All those who work with refugees and migrants, regardless of their profession and education (volunteers, police, employees of the Commissariat for Refugees, NGO sector and humanitarian organisations staff, etc.) should undertake psychological first aid trainings and apply them in an appropriate manner when needed.
- Special attention should be paid to training of translators who, in addition to the training focused on psychological first aid techniques, should also undergo trainings aimed at providing translation services in the area of mental health, with special emphasis on clarifying professional roles and responsibilities.
- Ensure adequate access to information regarding available psychosocial support and mental health related services. Keep in mind that the information and the way of delivering the same must be tailored to children, the elderly, people with disabilities, illiterate people, representatives of different cultures, etc.

- Particular attention should be paid to groups at risk: unaccompanied children, young men, pregnant women, the elderly, victims of sexual and gender-based violence, victims of human trafficking, victims of torture, etc. when providing protection and psychosocial support.
- Educational programmes for refugees and migrants need to be provided with the purpose of strengthening specific knowledge and skills (e.g. psychological first aid, psychological well-being, self-help, etc.), which will enable individuals to better deal with and overcome the stress and challenges they face.
- It is necessary to provide programmes that will improve support within the refugee/migrant community, as well as peer support so as to empower and use the existing resources. Additionally, it is necessary to empower migrants and refugees to take on an active role in helping and supporting themselves and people close to them, as well as to recognise when it is necessary to contact qualified persons for assistance.
- Close cooperation and coordination of all stakeholders working with refugees and migrants should be established in order to distribute the available resources in a realistic and coordinated way, avoiding overlap of activities/services and responding to identified needs in the best possible way.
- It is necessary to actively involve the beneficiaries (refugees and migrants) in the decision making process, creation and implementation of psychosocial programmes and services in order to adequately adapt these services to their needs.

- Special attention should also be paid to continuing education of volunteers and employees related to both the referral procedures and the broader picture of how the overall support and assistance system are functioning.
- Continuous exchange of experience, knowledge and information on mental health of refugees and migrants between the National Red Cross and Red Crescent Societies is necessary as well as their increased cooperation in monitoring, reporting and providing support.
- Based on the mental health data, National Red Cross and Red Crescent Societies could advocate, both nationally and globally, for improvement of the situation of refugees and migrants from the law-based approach point of view.
- National Red Cross and Red Crescent Societies have to continuously take care of their staff and volunteers by means of regular meetings, supervisions, support and training programmes related to assistance to supporters.

WELL-BEING WALK – AN EXAMPLE OF GOOD PRACTICE

In the context where there is a large number of persons in need of humanitarian assistance, adequate selection of the most vulnerable and prioritisation of assistance are a specific challenge. One of the proposed forms of informal psychosocial assistance, which aims to improve the protection and focus of psychosocial support on the most vulnerable members of the population is the *Well-Being Walk*. This activity involves one or more volunteers who would be physically present at the location where the affected population is located and who would conduct triage through direct contact with vulnerable persons, relying on visible signs of distress. More precisely, the aim of the triage is to identify the urgent needs, in a short period of time, and provide timely access to adequate services available in the field..

Assessment and triage:

After observing the physical signs of anxiety, but also gender, age and other characteristics of a person, and after brief conversations, a triage should be classified as:

1. Non-urgent: people whose basic needs have been satisfied but who need additional information

2. Priority – persons who show clear signs of anxiety and need to be provided with psychosocial support

3. Emergency – persons who need immediate assistance and protection (often those are the people who have suffered physical injuries or need immediate medical care, victims of violence or human trafficking, or persons with severe psychological difficulties).

As a result, an increase in availability of services is expected (with physical presence the volunteer enables the people in need of help to ask for it, and uses his/her own judgement to direct the person showing signs of distress to adequate support); improvement of protection services (continuous physical presence of volunteers is the basis for creating trust between members of humanitarian organisations and vulnerable populations, and increases the chance of identifying especially vulnerable people who often do not have an opportunity to actively seek help – for example, victims of domestic violence, human trafficking victims, etc.); finally, physical presence of volunteers increases the number of people who receive first psychological aid or relevant information, and influences the capacity to overcome adversity in vulnerable population.

Positive effects of this type of response in a humanitarian context are manifold. However, in order for such responses to be carried out in an adequate and effective manner, it is necessary to undertake trainings of volunteers and professionals which would also include the way of identification and triage of vulnerable persons, as well as adequate responses to the needs for different levels and types of vulnerabilities.

Adapted from the manual by Maya Tucker

INITIAL MENTAL HEALTH ASSESSMENT – AN EXAMPLE OF GOOD PRACTICE

In a humanitarian setting where there are numerous people in need of urgent help and support, and resources are often very limited. One way of responding to mental health needs as best as possible is a systematic initial mental health assessment of the vulnerable population.

The aim of the initial mental health screening assessment is a relatively fast and effective triage of people based on their psychological vulnerability. In order to undertake an initial assessment, it is necessary to rely on short, but reliable instruments, which are primarily adapted to work in a specific setting. Refugee Health Screener (RHS-15) is one such instrument which can be used for initial assessment of mental health in the refugee/migrant population.

This instrument has been developed and adapted to the refugee population so that it contains a relatively small number of questions (a total of 15), and enables both self-administration and administration by helpers, it does not contain complex claims and statements, and it is culturally and linguistically adapted to be applied in over 20 languages including Arabic, Farsi, Cuban Spanish, French, Somali, Kurdish, etc. This questionnaire consists of 13 statements describing the most frequent mental health problems that occur in the refugee population - symptoms of PTSD, depression and anxiety, and one question for assessment of capacities to overcome stress, and a question in the end related to acute distress, or current anxiety of an individual.

This instrument has been developed under the *Pathways to Wellness programme* and it is necessary to obtain permission before using it.

Apart from the evident practical value of this instrument, there are a number of empirical findings that support its foundation and usefulness in working with refugees and migrants. Thus, a normative study has shown that a cut-off score of 11 points represents a cut-off value which is sufficiently inclusive to enable detection of persons with psychological problems, and at the same time sufficiently specific to detect those who need additional care and support in terms of mental health (Hollifield, et al 2013). Verifications of this instrument on the population of refugees who reside or have resided in Serbia in the period from 2017-2018 have shown that, apart from the proposed cut-off score of 11, in situations where the population at risk surpasses in many ways the available human and professional capacities, it is justified to use the "double cut-off score" to acutely identify the most vulnerable persons; and that there is an empirical justification for the use of separate scores to express the symptoms of PTSD, depression and anxiety (Vukčević Marković, Stojadinović, & Bjekić, 2019). Finally, for administration of RHS-15, there are accompanying materials such as the suggestion of a text used to present the instrument to an individual, as well as the suggestion of the text to be used for further referral of someone (see page 49), which can be adapted to the local context if necessary.

The results presented in this publication are based precisely on the application of RHS-15 as an instrument for initial assessment of mental health and further referral of psychologically vulnerable persons.

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

Refugee Health Screener-15 (RHS-15)

Farsi Version

Bilingual versions of the RHS-15 have been translated by an iterative process involving experts in the field, professional translators, and members of the refugee community so that each question is asked correctly according to language and culture. The English text is provided for reference only; using the English alone negates the sensitivity of this instrument.

DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

Developed by the *Pathways to Wellness* project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The *Pathways* Project at 206-816-3253 or pathways@lcsnw.org.

PATHWAYS to WELLNESS

غربالگری سلامت پناهنده-(آر اچ اس 15)

REFUGEE HEALTH SCREENER-15 (RHS-15)

/ID: شماره شناسایی:

/DATE: تاریخ:

دستورالعمل: لطفاً با استفاده از مقیاس مندرج در هر ردیف، مشخص نمایید این علایم جسمی یا روحی در یک ماه گذشته تا چه اندازه شما را آزار داده است. در ادامه، متناسب با حال روحی خود علامت ضربدر بگذارید. اگر نشانه یا علائمی وجود دارد که در یک ماه گذشته با آن مواجه نشده اید روی گزینه «اصلاً» ضربدر بگذارید.

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

علائم جسمی یا روحی SYMPTOMS	اصلا NOT AT ALL	کم A LITTLE BIT	بطور متوسط MODERATELY	تا حدی QUITE A BIT	بسیار شدید EXTREMELY
1. دردهای عضلانی، استخوانی یا مفصلی Muscle, bone, joint pains	0	1	2	3	4
2. احساس بی حوصلگی، اندوه، یا افسردگی در اکثر مواقع Feeling down, sad, or blue most of the time	0	1	2	3	4
3. زیاد فکر کردن یا افکار زیادی در سر داشتن Too much thinking or too many thoughts	0	1	2	3	4
4. احساس درماندگی Feeling helpless	0	1	2	3	4
5. ترس ناگهانی و بی دلیل Suddenly scared for no reason	0	1	2	3	4
6. سستی، سرگیجه، یا ضعف Faintness, dizziness, or weakness	0	1	2	3	4
7. عصبیت یا لرزش درونی Nervousness or shakiness inside	0	1	2	3	4
8. حس بی قراری، آرام و قرار نداشتن Feeling restless, can't sit still	0	1	2	3	4
9. به آسانی به گریه افتادن Crying easily	0	1	2	3	4

Developed by the Pathways to Wellness project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The Pathways Project at 206-816-3253 or pathways@lcsnw.org.

PATHWAYS TO WELLNESS

غربالگری سلامت پناهنده-(آر اچ اس 15)

REFUGEE HEALTH SCREENER-15 (RHS-15)

/ID: شماره شناسایی:

/DATE: تاریخ:

علائمی که در ذیل می آید باید مرتبط با اتفاقی در دوران جنگ و مهاجرت باشد که سبب آسیب روحی شده است.
در ماه گذشته تا چه اندازه با موارد ذیل مواجه شده اید:

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

علائم جسمی یا روحی SYMPTOMS	اصلا NOT AT ALL	کم A LITTLE BIT	بطور متوسط MODERATELY	تا حدی QUITE A BIT	بسیار شدید EXTREMELY
10. آیا با این تجربه روبرو شده اید که اتفاق منجر به آسیب دیدگی دوباره برایتان زنده شود و طوری رفتار کنید یا احساس نمایید که انگار آن اتفاق دوباره برایتان رخ داده است؟ Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. آیا با یادآوری آن اتفاق واکنش های جسمانی (مثلاً خیس غرق شدن، یا ضربان تند قلب) داشته اید؟ Been having physical reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. آیا با کرختی احساسی مواجه شده اید (مثلاً احساس کنید غمگین هستید اما نمی توانید گریه کنید، یا نمی توانید احساسات دوستانه خود را نشان دهید)؟ Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. بیشتر از جا می پرید یا سریعتر دچار هراس می شوید، (مثلاً وقتی کسی پشت سر شما راه می رود)؟ Been jumpier, more easily startled (for example, when someone walks up behind you)	0	1	2	3	4

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ID/ شماره شناسایی:

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غربالگری سلامت پناهنده-(آر اچ اس 15)

REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS

14. در زیر دور بهترین جواب دایره بکشید. آیا احساس می کنید که:
Circle the one best response below. Do you feel that you are:

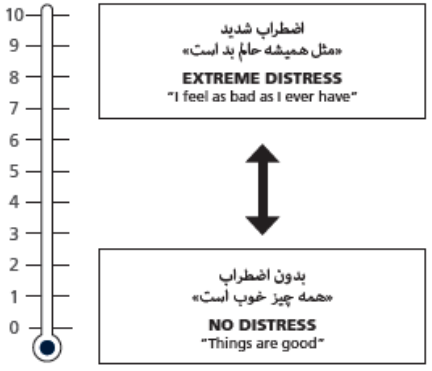
0	می توانم با همه چیز روبرو شوم (با آن کنار بیایم) Able to handle (cope with) anything
1	می توانم با بیشتر چیزها روبرو شوم (با آن کنار بیایم) Able to handle (cope with) most things
2	می توانم فقط با بعضی اتفاقات زندگیم روبرو شوم (با آن کنار بیایم)، ولی نه با هر اتفاقی Able to handle (cope with) some things, but not able to cope with other things
3	نمی توانم با اکثر اتفاقات زندگیم کنار بیایم Unable to cope with most things
4	نمی توانم با هیچیک از اتفاقات زندگیم کنار بیایمر Unable to cope with anything

Add Total Score of items 1–14 ☐

سنجش میزان پریشانی
15. Distress Thermometer

لطفاً دور عدد (۰ تا ۱۰) که میزان اضطراب شما را در هفته گذشته، شامل امروز، به بهترین شکل توصیف می نماید دایره بکشید.

Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.



SCORING SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

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

RHS 15 INTRODUCTION (Proposal)

"Some people suffer from physical and mental problems due to all they have been through and because moving to another country is very stressful. The questions we are asking help us find the people who are in distress and who might need additional support. Everything we talk about here is confidential and will not be disclosed to anyone without your explicit permission."

REFERRAL OFFER (Proposal)

"Based on what you have said, it seems that you are currently in distress. You are not alone in this. Many people in your situation are sad, worry a lot, have horrible memories or are stressed out due to everything they have been through and because it is hard to adapt to life in a new country. Here, people who experience such difficulties can get additional support. This does not mean that something is wrong with them and that they are sick, sometimes people need additional help in overcoming distressing times. I can connect you with an advisor – that is a person who will talk to you, listen to you, and provide you with support and help. Everything you say to this person is confidential – it means he/she can not share the information you provide with anyone without your permission. Do you want me to connect you with that person?"

IF THE CLIENT AGREES TO A REFERRAL (Proposal)

"Can we have a couple of minutes now to fill in the referral form? I will refer you to an organisation that provides counselling services. There they will explain to you all about the available programmes, and then you can decide if you want to use their services."

*Adapted from the RHS-15 manual

Apart from the instrument for assessing the difficulties in psychological functioning and identification of persons who need additional attention and care, in the context of refugee status, and especially long-term stay in collective centres for accommodation of refugees and migrants, evaluation of positive aspects of functioning is also recommended, i.e. psychosocial well-being thereof.

For that purpose, a short questionnaire was designed to assess the benefits through indicators such as optimism, self-confidence, satisfaction with life, happiness, etc. Additionally, this questionnaire includes indicators of disrupted well-being often associated with psychological difficulties and/or having implications on successful everyday functions, such as sleep and eating disorders, excessive drinking, social withdrawal, or difficulties in performing daily activities.

WELLBEING QUESTIONNAIRE MAN/WOMAN

Name and surname _____ **Age** _____ **Gender** _____ **Date:** ..../...../..... **Interpreter** _____ _ **Interviewer**_____ **How long have you been attending Red Cross activities**_____	
1. I have felt cheerful and in good spirits	5 □ 4□ 3□ 2□ 1□
2. I have felt calm and relaxed	5 □ 4□ 3□ 2□ 1□
3. I have felt active and vigorous	5 □ 4□ 3□ 2□ 1□
4. I woke up feeling fresh and rested	5 □ 4□ 3□ 2□ 1□
5. My daily life has been fi lled with things that interest me	5 □ 4□ 3□ 2□ 1□

1. I feel optimistic about the future	5 □ 4□ 3□ 2□ 1□
2. I believe I have the capacity to achieve great things in life	5 □ 4□ 3□ 2□ 1□
3. All in all I see myself as a happy and content person	5 □ 4□ 3□ 2□ 1□

1. I often feel tired and week even if I dont do anything	5 □ 4□ 3□ 2□ 1□
2. I have thought of hurting myself	5 □ 4□ 3□ 2□ 1□
3. I have difficulties falling asleep or eating lees/more than usual	5 □ 4□ 3□ 2□ 1□

1. I feel that I am taking care for my family/children the most in these circumstances	5 □ 4□ 3□ 2□ 1□
2. I have difficulties to fulfil all things that are expected of man / husband / father / son / brother woman /mother / sister	5 □ 4□ 3□ 2□ 1□
3. In last weeks have you: ☐ drunk too much ☐ get into fights/quarrels ☐ use psychoactive substances / drugs ☐ spent less time with children / family members ☐ avoid talking to other people in the center ☐ thought about seeking help/support from doctor/psychologist/other professionals (if yes – why?)	

CONTINUOUS SUPPORT PROGRAMME EVALUATION – AN EXAMPLE OF GOOD PRACTICE

The refugee crisis in its early stages, when several thousands people would come to Serbia every day, required an urgent, humanitarian response and basic care of refugees and migrants who arrived to Serbia. New circumstances have resulted in involvement of a large number of professionals and volunteers who provided protection, assistance and support to people in distress. In the coming months and years, as the number of people coming to Serbia daily decreased and the length of their stay in Serbia prolonged, it was necessary to build systematic, sustainable solutions and support programmes that would be focused on providing continuous support which will constantly be adapted to changes within the context, on one hand and individual needs, challenges and strengths of refugees and migrants in Serbia, on the other hand.

In order to be able to adequately respond to complex working conditions, the Red Cross of Serbia carries out a continuous evaluation of the activities it conducts, actively including the beneficiaries of services in designing and adapting programmes that are conducted in asylum and reception centres.

Evaluation of activities includes feedback from the participants immediately after an activity has been implemented, as well as on monthly level. Thus, the beneficiaries on the four-level Likert scale assess the extent to which the programme is beneficial to them, or pleasant, interesting, empowering, adapted to their needs, knowledge, gender, age and culture. Also, the programme participants regularly have an opportunity to answer an open question regarding whether some part of the programme was particularly useful to them, or if there was something they did not like. They can also provide their suggestions and comments on how the activities could be changed or improved. It is important to note that evaluation forms are gender and age tailored.

WEEKLY EVALUATION FORM

Age _____; Gender_____

How long have you been participating in the *(name of activity)?* _____

Please mark the extent to which *(name of activity)* was:

	Not at all				To a large extent
	1	2	3	4	5
Useful					
Pleasant					
Interesting					
Empowering					
Adjusted to your needs					
Adjusted to your knowledge					
Adjusted to your gender					
Adjusted to your age					
Adjusted to you culture					

From which activities did you benefit the most? _____

Please explain _____

_____

_____

Do you have any suggestions or recommendations on how we could adjust/ improve our services/ our work? _____

_____

Do you have anything to add? _____

_____

_____

THANK YOU FOR OPINIONS, SUGGESTION AND PARTICIPATION!

INTERVIEW EVALUATION FORM

1. Was this interview tiring, hurtful or pointless for you? NO YES
2. Do you think this interview was beneficial for you and in which way? NO YES

_____

3. Were the questions clear? NO YES
4. Do you have any questions or suggestions? NO YES

_____

5. Do you have anything to add? _____

WEEKLY EVALUATION FORM FOR CHILDREN

Mark the one that looks like you the most

Mark your age

7	8	9
10	11	12
13	14	15

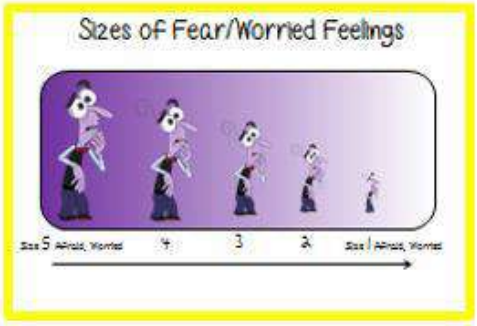
How do you feel at the Red Cross activities? Could you please mark it?

How do you feel after the games during Red Cross activities?

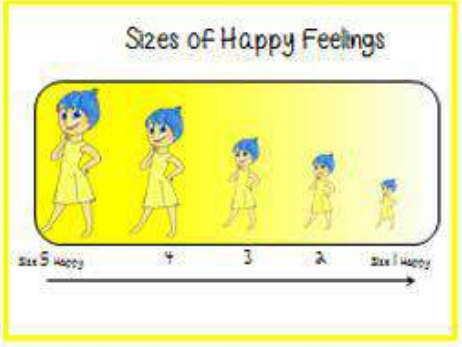
Could you please draw the activities that you like the most? (an empty paper should be provided)

How does it make you feel that you have friends at the Red Cross activities from different countries?

Could you please mark the extent of your fears, worries and concerns after you participate in the activities and events of the Red Cross?



Could you please mark the extent of your happiness after you participate in the activities and events of the Red Cross?



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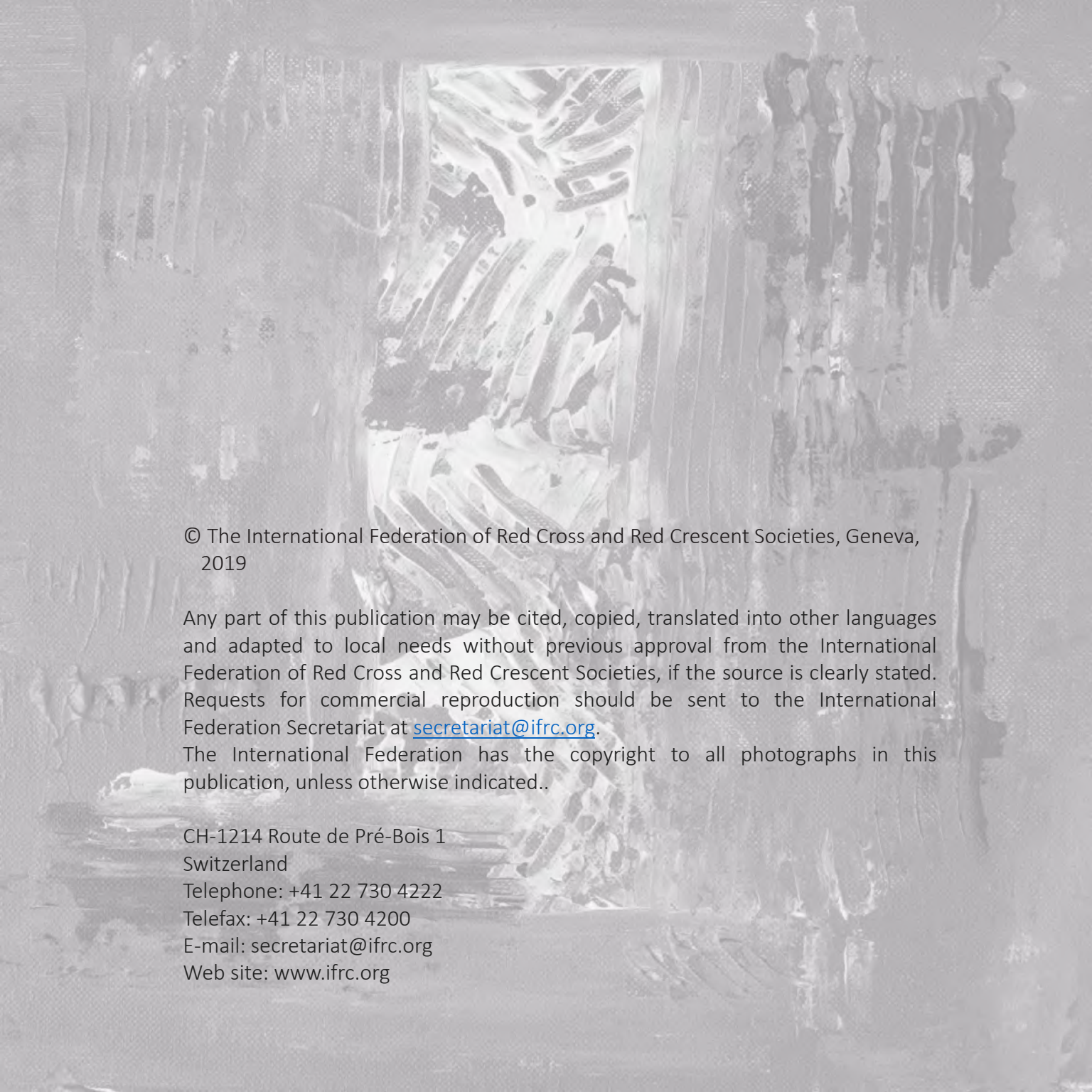
Acknowledgement

We owe special gratitude to employees and volunteers of Red Cross Pirot, Red Cross Šid, Red Cross Sombor, Red Cross Belgrade, Red Cross Kikinda and Red Cross Subotica, who have participated in data collection, as well as to beneficiaries of psychosocial support services who took part in the research.



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CIP - Каталогизација у публикацији
Народна библиотека Србије, Београд

342.726-054.73:613.86(497.11)
341.231.14-054.73:613.86(497.11)

MENTAL Health of Refugees and Migrants / [Authors Jovana Bjekić... [et al.]]. - Belgrade : Red Cross of Serbia, 2019 (Belgrade : Grafo IN). - 61 str. : ilustr. ; 21 x 21 cm

Prevod dela: Mentalno zdravlje izbeglica i migranata. - Upitnik na engl. i farsi jeziku. - Tiraž 500. - Authors: str. [62]. - Bibliografija: str. 57-61.

ISBN 978-86-80205-74-8

1. Bjekić, Jovana, 1988- [аутор]
а) Мигранти -- Ментално здравље -- Србија б) Избеглице -- Ментално здравље -- Србија

COBISS.SR-ID 276754956

International Federation
of Red Cross and Red Crescent Societies

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Црвени крст Србије
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The book was published with the financial support from the International Federation of Red Cross and Red Crescent Societies and the Norwegian Red Cross.