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REVIEW OF MHPSS SERVICES FOR REFUGEES IN TRANSIT

2022

This review was made as part of work by Consortium on Refugees' and Migrants' Mental Health (CoReMH) through the project "*Heal and Connect: Towards the improvement of mental health protection of vulnerable groups through networking and evidence-based practice*" implemented by PIN – Psychosocial Innovation Network.

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The analysis, results and recommendations in this publication represent the opinion of the author(s) and are not necessarily representative of the position of the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

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CoReMH
CONSORTIUM ON REFUGEES' & MIGRANTS' MENTAL HEALTH

CONTENT

LIST OF ACRONYMS

CoReMH – Consortium on Refugees' and Migrants' Mental Health

CSO – civil society organization

EU – European Union

GIZ – Deutsche Gesellschaft für Internationale Zusammenarbeit

LGBTQI+ – lesbian, gay, bisexual, transgender, queer and intersex

MH – mental health

MHPSS – mental health and psychosocial support

PIN – Psychosocial Innovation Network

PSS – psychosocial support

PTSD – post-traumatic stress disorder

WG – working group

WHO – World Health Organization

SUMMARY

The aim of this review is to provide an overview of existing MHPSS practices for refugees, asylum seekers and migrants in the transit context. This review is made as part of work of Consortium on Refugees' and Migrants' Mental Health (CoReMH) consisting of organizations specialized in mental health protection of refugees in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Greece, Hungary, Italy, Kosovo, Serbia and Turkey.*

Data analysis has shown that there is a need for ensuring sustainability of MHPSS services along the transit route which would be equally accessible to all people on the move. Furthermore, there is a need for creating unique standards for the provision of MHPSS services for people on the move in the transit context. It is recognized that there is a need for including refugees' opinions and perspective while designing and implementing MHPSS services in transit. The need for establishing local, regional and international coordination mechanisms in order to facilitate cooperation between different actors, improve accessibility to services and enable continuity of care along the route is highlighted.

This review aims to be the first step in identifying existing gaps and good practices in the provision of MHPSS practices for refugees in transit. Furthermore, the review aims to pave the way for the development of unique standards for the provision of MHPSS services to refugees, asylum seekers and migrants in transit, ultimately leading to improved mental health protection for people on the move.

* This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.

CoReMH CONSORTIUM ON REFUGEES' & MIGRANTS' MENTAL HEALTH

ABOUT CoReMH

- The Consortium on Refugees' and Migrants' Mental Health (CoReMH) was founded in 2020 with the goal of improving mental health practices and policies for refugees, asylum seekers and migrants[1] in the transit context. In order to achieve this goal, CoReMH gathers experts for mental health protection of refugees operating in the wider area of South East Europe and focuses its work on identifying and addressing prominent issues in mental health protection for refugees through capacity building, evidence-based practice, research and advocacy work. CoReMH is a platform for exchanging experiences, challenges and good practices, which strives to create a common framework in the field of refugees' mental health protection.
- At the moment of writing this report, CoReMH gathers 25 members from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Greece, Hungary, Italy, Kosovo*, Serbia, and Turkey.
- CoReMH's work is organized in 4 Working Groups:
  1) Policy and Practice
  2) Research
  3) Advocacy and Networking
  4) Capacity Building
- This report is part of the CoReMH Policy and Practice Working Group.

[1] For better readability and simplicity, the term refugee will be used throughout the text, regardless of their legal status

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ŽENE SA UNE


Arct
QËNDRA SHQIPTARE E REHABILITIMIT
TË TRAUMËS E TORTURES


Amna


Care center for
refugees
TUZLA


BABEA
ΨΥΧΙΚΗ ΥΓΕΙΑ ΜΕΤΑΝΑΣΤΩΝ


aelle il punto


HRVATSKI CRVENI KRIŽ


ASOCIJACIJA
SRH.RS
Free to be me


HUMAN
RIGHTS360°


mavi kalem
SOSYAL YARDIMLAŞMA VE DAYANIŞMA DERNEĞİ


MSYD ASRA


Zeuxis


MÉDECINS
DU MONDE


RCT Zagreb


АСОЦИАЦИЯ
ЗА БЕЖАНЦИ
И МИГРАНТИ
БЪЛГАРИЯ
ASSOCIATION
ON REFUGEES
& MIGRANTS
BULGARIA


Ε.Π.Α.Ψ.Υ.
ΕΤΑΙΡΕΙΑ ΠΕΡΙΦΕΡΕΙΑΚΗΣ
ΑΝΑΠΤΥΞΗΣ ΚΑΙ ΨΥΧΙΚΗΣ ΥΓΕΙΑΣ

cesie
the world is only one creature


QKRMT
KRCT
Qendra Kosovare për Rehabilitimin
e të Mbijetuarve të Torturës
The Kosova Rehabilitation
Center for Torture Victims


PIN


SOLIDARITY
NOW
This is our common ground


Cordelia Foundation
for the Rehabilitation


ΕΛΛΗΝΙΚΟ ΦΟΡΟΥΜ ΠΡΟΣΦΥΓΩΝ

INTRODUCTION

INTRODUCTION

TRANSIT CONTEXT

- Despite the changes in sociopolitical views and policies that brought on the closure of European borders, people on the move from the Middle East and African countries are still trying to reach Western Europe (Kingsley, 2016; MSF, 2018; Paynter, 2019; UNHCR, 2017). According to the United Nation High Commissioner for Refugees, by the end of 2021 the number of global force displacements reached an astounding 89.3 million people (UNHCR, 2022).

- After the closure of the European borders, the three most frequent pathways of illegal border crossing to the European Union countries are the Western Balkan route, the Eastern Mediterranean route and the Central Mediterranean route (FRONTEX, 2021). These routes include the wider Balkan area, along with major Mediterranean reception points such as Greece and Italy. In 2020, more than 80.000 illegal crossings were registered in those three routes combined (FRONTEX, 2021).

- The migration from country of origin to destination country, frequently referred to as *transit*, can span across many *transit countries* (Düvell, 2014), which together form a so-called *transit route*, or a *transit context*. Although the term *transit* used in this context indicates a short and temporary stay, research has shown that the time spent in transit can last from a few days to even several years (Vukčević et al., 2014; Purić & Vukčević Marković, 2019). In addition to numerous harmful, traumatic and stressful experiences forced migration brings (Carswell et al., 2009; GIZ, 2018; Steel et al., 2009; Vukčević et al, 2016), transit context carries additional risks.

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- A research study from 2017 examining traumatic experiences refugees face during transit showed that refugees experience 10 traumatic experiences during transit, on average (Vukčević Marković et al., 2017). Similar results were obtained in 2021, confirming that refugees are still exposed to risks that can lead to physical and mental health difficulties (Vukčević Marković et al., 2021). The most commonly encountered traumatic experiences include life-threatening situations, lack of access to food, water or shelter during travel, as well as psychological and physical violence (Vukčević Marković et al., 2021; Vukčević et al., 2014; Vukčević Marković et al., 2017; Purić & Vukčević Marković, 2019). In addition, when compared to 2017, an increase was documented when it comes to the percentage of refugees who experienced separation from family members, death of a close person, sexual violence and serious bodily injuries during transit (Vukčević Marković et al., 2021). Furthermore, while trying to cross borders by-way-of smugglers, refugees are exposed to additional life-threatening risks including kidnapping and human trafficking, different types of physical and sexual abuse, torture and extortion (UNHCR, 2017). Finally, stay in transit carries additional prominent human rights violations risks, such as lack of access to health care, inadequate living conditions and lack of access to decent work (OHCHR, 2016).

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MENTAL HEALTH IN THE TRANSIT CONTEXT

- It is not surprising that experience of forced migration can have a negative effect on refugees' mental health. Several studies have indicated that there is a higher prevalence of mental health disorders among the refugee population when compared to the general population, principally when it comes to prevalence of PTSD and depression (Blackmore et al., 2020; Fazel et al., 2005; Giacco et al., 2018). Some results state that the refugee population settled in the West European countries can be as much as up to ten times more prone to developing PTSD (Fazel et al., 2005). A result of research exploring mental health of refugees in transit context, conducted from 2014 to 2021 showed high levels of psychological vulnerability, ranging from 79% to 89% of those in need for mental health support (Vukčević et al., 2014; Vukčević Marković et al., 2017; Vukčević Marković et al., 2018; Vukčević Marković et al., 2019; Vukčević Marković et al., 2020; Vukčević Marković et al., 2021). More specifically, high rates of depression, anxiety and stress-related symptoms were observed (Vukčević Marković et al., 2021). What is additionally concerning is that the measures of psychological well-being and resilience of refugees in transit are on a steady decline, implicating a general loss of hope and optimism (Vukčević Marković et al., 2021).

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- Bearing in mind numerous mental health risks that both forced migration and the transit context bring, the need for providing comprehensive mental health support to refugees in all phases of migration, including the transit route, is apparent. However, the task of ensuring mental health protection in transit has its own challenges:

  - There is a systemic lack of funding for refugees' mental health protection through the public health care systems on a global level (Amnesty International, 2020), despite the WHO recommendations that *"…in the long term, refugee and migrant health* [protection] *should be mainstreamed into existing services*" (WHO, 2022). This is in particularly challenging in low- and middle-income regions, such as those along the transit routes, that are already facing challenges and gaps in public health care systems.

  - There is a lack of publicly available information on MHPSS services along the transit route, and based on what we learned through the CoReMH work so far, the practices vary from region to region, as well as from city to city, depending on available funds, infrastructure and public health care policies. Crisis responses usually include ad-hoc interventions, urgent engagement of international organizations and local CSOs. There is a general lack of coordination mechanisms at the local, regional and international levels that would allow planning of sustainable mental health services equally available and accessible along the transit route.

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- In addition, a study has shown that the transit context itself calls in question traditionally conceptualized MHPSS services (Gargano et al., 2022). More specifically, it was shown that there is a need for introducing a more flexible model of care that would be catered to the needs of the refugee population and modified to fit the transit context with its specificities (unpredictable circumstances, lack of control, impactful life events, etc.) (Gargano et al., 2022).

- All of the above calls for action that would improve existing mental health practices and policies along the transit route, and ensure available and accessible MHPSS services to refugees in need. As a response, CoReMH has set a goal of creating an overview of existing MHPSS practices in the transit region. An overview is envisioned to be a first step in identifying main gaps and good practices, as well as providing data-driven recommendations for informed services planning, both quality and resource-wise, and creation of unique standards for the provision of MHPSS services in transit. This would improve practices, allow continuity of much needed mental health care for refugees in transit by facilitating international collaboration, and enable data driven advocacy work, both on local, regional and international levels.

CURRENT STUDY

CURRENT STUDY

- In order to provide information on existing MHPSS practicies and policies along the transit route, a survey assessing the overall availability, accessibility and quality of MHPSS services has been created by the group of CoReMH members, experts in MHPSS in the refugee context.
- The survey consisted of 28 questions in total, including multiple choice and open-ended questions aiming to assess both specialized services provided by mental health professionals and psychosocial services provided by non-mental health professionals, as well as main challenges and good practices in the refugees' mental health protection along the transit route.
- For the purpose of this study, MHPSS services were conceptualized as "*any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder*" (IASC, 2007). In addition, specific services were defined as follows:
  - **MH services** – counselling, psychotherapy, psychological interventions, etc., provided by psychologists, psychiatrists, or psychotherapists
  - **PSS services** – prevention programs, psychoeducational workshops, occupational activities, etc., provided by psychologists, psychiatrists, social workers, other humanitarian workers
  - **Psychiatric services** – psychiatric examinations, pharmacotherapy, check-ups, in-hospital treatment, etc., provided by psychiatrists

CURRENT STUDY

- CoReMH members participated in the study and provided information about their local contexts. The data was collected online from April 2021 until May 2022. In total, 10 surveys were obtained from:

  - Albania
  - Bosnia and Herzegovina
  - Bulgaria
  - Croatia
  - Greece
  - Hungary
  - Italy
  - Kosovo*
  - Serbia
  - Turkey

- Additional consultation meetings with members were held in order to collect additional information needed for developing this review.
- It should be noted that one of the most prominent characteristics of the transit context is that it is everchanging. Therefore, any comprehensive analysis of the services available in the field can only provide a current overview of the context. Furthermore, there is a lack of publicly available information and the obtained data are mainly based on CoReMH members' extensive data collection through desk research, field visits, communication with other relevant actors in the field and extensive experience and knowledge about refugees' mental health protection at the local level.

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RESULTS

AVAILABILITY OF SERVICES

OVERVIEW

Although the general refugee context (circumstances, policies and practices) varies between CoReMH members, including both EU and non-EU members, much more similarities than differences in mental health practices were observed throughout the surveys. Therefore, conclusions and recommendation provided by this review are applicable throughout the South-East European refugee transit context.

- In general, MHPSS services are available, but their accessibility is often limited. Therefore, there is a need for overall increase of accessibility of MHPSS services to refugees.
- Availability and accessibility of MHPSS services depends on the population on the move in question, and there is a need for increased availability and accessibility of MHPSS services for migrants, those located in the border areas, and privately accommodated persons.
- MH and PSS services are mostly provided by CSOs through project funding, and their sustainability is in question, while psychiatric services are mostly funded and provided through the public health system. Nevertheless, their accessibility is often limited.
- Availability of services varies between different regions and facilities, and not all types of facilities have available MHPSS services. In the facilities that do have them, the availability drastically varies from "on demand" to 40 hours per week.

- MH and PSS services are mostly available in asylum centers and accommodation facilities for children. Reception centers, detention centers and other types of temporary accommodation facilities have less available MH and PSS services.
- Detention centers have limited or do not have available MH and PSS services. Those that are available are mainly provided by government institutions, while CSOs and other non-public institutions and organizations mostly have limited access to these facilities.
- Privately accommodated persons have available MH and PSS services provided by CSOs in urban areas where CSOs are mostly located. Accessibility to these services is however in question, since CSO capacities are limited and it can be challenging to inform privately accommodated persons on available services.
- MH and PSS services are not equally accessible to all people on the move. English, Persian and Arabic speaking people can access them significantly easier than others.
- The results showed difficulties in accessing in-hospital psychiatric treatment along the transit route, for both children and adults.

MENTAL HEALTH SERVICES THAT ARE BEING PROVIDED INCLUDE:

- Mental Health (MHPSS) Case Management
- Crisis interventions
- Psychological First Aid
- Trauma-focused treatments
- Harm Reduction Program
- Psychological counselling
- Psychotherapy

PSYCHOSOCIAL SERVICES THAT ARE BEING PROVIDED INCLUDE:

- Recreational activities (yoga / sport / relaxation techniques, "Baby Gym", etc.)
- Occupational activities (art workshops / creative workshops, etc.)
- Activities aiming to improve skills and/or knowledge (workshops for parenting skills, mother and child corners, CV (resume) writing workshops, informative workshops on various topics, including those that should facilitate integration, etc.)
- Psychosocial support (psychological first aid, psychoeducational group sessions, support groups targeting specific sub-population, self-help groups, etc.)
- Social counselling

PSYCHIATRIC SERVICES THAT ARE BEING PROVIDED INCLUDE:

- Psychiatric examinations
- Pharmacotherapy
- Check-ups
- In-hospital treatment

MENTAL HEALTH SCREENING:

- There are no predefined MH screening procedures, and MH screening is not being done regularly. The admission of screening instruments depends on practices of specific practitioners in question who choose to use them as part of their standard protocols.
- In locations where there are screening procedures, they are not being conducted in all facilities and the number of people being screened depends on the current availability of practitioners and interpreters.
- Instruments used:
  - **Refugee Health Screener (RHS-15)** (Hollifield et al., 2013)
    - Assessing psychological vulnerability, symptoms of depression, anxiety and PTSD
    - Administered in Serbia and Croatia
  - **Clinical Outcomes in Routine Evaluation (CORE-10)** (Evans et al., 2002)
    - Assessing subjective well-being, symptoms, life functioning and risk
    - Administered in Croatia
  - **Protect Questionnaire** (Mewes et al., 2018)
    - Assessing indications of PTSD and major depression
    - Administered in Kosovo*
  - **Hopkins Symptom Checklist-25 (HSCL-25)** (Hesbacher et al., 1980)
    - Assessing anxiety and depression
    - Administered in Albania
  - **Hamilton Depression Rating Scale (HDRS)** (Hamilton, 1960)
    - Assessing severity of depression
    - Administered in Albania
- MH screening of children and minors is not specified and according to the study results, it is not applied in practice.

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AVAILABILITY OF INTERPRETERS / CULTURAL MEDIATORS DURING THE PROVISION OF SERVICES:

- From 7 out of 10 surveys data on availability and usage of interpreters was obtained, showing that MH services are dominantly provided with the help of interpreters. PSS services are mostly provided with interpreters as well, although it is notable that the total percentage of PSS services being provided with interpreters is smaller when compared to the provision of MH services. This could be the case due to application of different non-verbal PSS activities.
- However, there is a huge gap in availability of interpreters during psychiatric in-hospital treatment, which represents an overall challenge in accessibility of in-hospital treatment for refugees along the transit route.
- In addition, availability of interpreters varies among different types of accommodation facilities – in general, they are mostly available in asylum centers, less available in accommodation facilities for children, and even less for privately accommodated persons. This set of information varies greatly from survey to survey, indicating a significant difference in practices across the transit route.
- The main obstacle for ensuring availability of interpreters is lack thereof, in particularly for certain languages (Persian and Arabic languages are most frequently present).
- Finally, interpreters are mostly funded by local CSOs and international organizations and are project-dependent. Therefore, the sustainability of this service is in question.

SPECIALIZED MH SERVICES

- Specialized MH services are to some extent available in the transit context. However, since the majority of specialized services in all regions along the transit route are available on demand, it is challenging to assess the real reach of these services. Further assessment is needed.

The results showed the following:

- 7 out of 10 surveys report having regularly available **specialized services for children and minors**
- 4 out of 10 surveys report having regularly available specialized services for **torture survivors**
- 2 out of 10 surveys report having regularly available specialized services for **LGBTQI+ persons**
- 3 out of 10 surveys report having regularly available **support during the asylum procedure**, including psychological assessment, preparation and support during the procedure.

Specialized MHPSS services recognized as needed, but not enough available or accessible:

- Specialized MHPSS services for children
- Regular in-hospital treatment including urgent care
- Specialized services for treating substance abuse
- Systematic MH screening
- Activities adjusted to adult males

CHALLENGES

The survey results showed several most prominent challenges in mental health protection along the transit route:

- Lack of MHPSS professionals adequately trained for working in the transit context and/or with specific groups
- High turnover of MHPSS staff in organizations providing services and the consequent lack of competences and experience
- Risk of burnout of staff and insecurity of work contracts of CSO staff (mainly project-funded with limited duration)
- Limited intercultural experience of MHPSS practitioners
- Lack of systemic MH screening procedure and lack of appropriate instruments for psychological assessment when more thorough or specific (clinical) assessment is needed (e.g., suspected intellectual disabilities)
- Availability of MHPSS services adapted to diverse cultural backgrounds
- Limited availability of in-hospital treatment, as well as language barrier during the in-hospital treatment due to limited availability of interpreters for these purposes
- Refugees' lack of motivation for participating in activities

CHALLENGES

- Inability to ensure continuity of care due to lack of human resources, short stay of beneficiaries in transit, and lack of international collaboration
- Complicated referral processes (leading to obstacles in accessing healthcare), interference of jurisdictions, and lack of efficient coordination mechanisms at local level
- Limited funding for MHPSS services, particularly for populations with pronounced MH risks such as torture and trauma survivors, unaccompanied minors, persons with disabilities
- Limited availability and accessibility of MHPSS services through the public health care system which makes mental health support along the transit context project-dependent and not sustainable. This was additionally limited during the COVID-19 pandemic
- Lack of availability of interpreters for languages other than Arabic and Persian

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS / RECOMMENDATIONS

- There is a need for **ensuring sustainable MHPSS services along the transit route** that would be continuously available, not project-dependent and equally available and accessible to all, regardless of the facility, geographical location, legal status or language of the person of concern. In addition to MHPSS services, this also refers to **interpretation services** that are required for ensuring quality of care.

  The survey results showed that MHPSS services along the transit route are to a large extent dependent on the funding available through international donors and CSOs. Therefore, its sustainability is in question. Furthermore, even though psychiatric services are mainly available through the public health care system, accessibility of these services is often limited due to lack of resources, difficulties in accessing in-hospital treatment and challenges in ensuring interpretation services for these purposes.

- There is a need for **creating unique standards for MHPSS services for people on the move in the transit context.** This would ensure quality of MHPSS services and enable continuity of care along the transit route for persons in need.

  The study conducted within the CoReMH Research Working Group revealed that there is a lack of consensus among MHPSS practitioners on some aspects of the mandate of MHPSS practitioners working in the transit context. This, among others, relates to whether the treatment of mental health disorders and the provision of support in processing traumatic experiences should be part of the MHPSS practitioner's work (for more, see Gargano et al. 2022). In addition, the survey results

CONCLUSIONS / RECOMMENDATIONS

showed different practices between regions concerning the type of MHPSS services that are available, in particularly mental health screening and specialized MH services (e.g. psychological interventions for LGBTQI+ persons, substance abuse treatments, etc.). Such standards could enable the standardization of activities, methods and tools used in practice, as well as evaluating the effectiveness of interventions (Nguyen et al., 2021), which is a priority.

- There is a need for **introducing culturally sensitive practices and including beneficiaries' opinions and perspectives in the design and implementation of MHPSS services** along the transit route.

Even though the need for culturally sensitive practices and more active involvement of beneficiaries' perspectives in MHPSS practices and policies is widely recognized and acknowledged by CoReMH members, there are no clear mechanisms for involving beneficiaries in decision-making concerning mental health practices and policies. There are some examples of good practices along the route but, as the survey results have shown, no capacity building activities conducted by MHPSS professionals from the region the beneficiaries are coming from were organized so far, apart from the good practice implemented by the practitioners from ARCT in Albania that have cooperated with the Amna Community and have organized a training from Amna experts for their staff. Furthermore, the involvement of beneficiaries in the decisions on MHPSS practices will mainly depend on the practitioner in question.

CONCLUSIONS / RECOMMENDATIONS

- There is a need for **establishing a coordination mechanism at a local level** to facilitate cooperation between government institutions, public and civil sector, as well as between civil sector organizations, which would coordinate the provision of MHPSS services to refugees in accordance to changes in the context and identified needs.

Example of good practice - There is a coordination mechanism in Serbia called Working Group for protection and improvement of mental health of refugees, asylum seekers and migrants, established in 2019 in collaboration between civil society (PIN), government institution (Commissariat for Refugees and Migration) and international agency (WHO). The MH WG gathers representatives from government bodies, international agencies, and CSOs who meet on a bimonthly level and coordinate the provision of MHPSS to refugees. After more than two years of successful work, the MH WG was adopted as an official coordination mechanism by the Ministry of Health of the Republic of Serbia in 2022. The WG continued to be an effective local mechanism for coordination of MHPSS, bringing together all relevant actors and facilitating cooperation and sustainable planning of services.

CONCLUSIONS / RECOMMENDATIONS

- There is a need for **establishing regional and international coordination mechanisms** which would facilitate international collaboration on mental health protection along the transit route. This would allow for the exchange of challenges and good practices, support continuous capacity building of MHPSS practitioners working in the transit context and facilitate reaching consensus on unique standards in MHPSS practices. This would further enable continuous care for people on the move which could access MHPSS services along the entire transit route that are being provided according to the same standards.

> *Survey results showed that MHPSS practitioners working in the transit context find different networks and associations they are currently involved in to be valuable and useful. However, the need for a more specialized approach, specifically focused on MHPSS practices and policies, such as the one applied through CoReMH, was identified. Furthermore, survey analysis showed that MHPSS practitioners working in the transit context identified international collaboration that would allow continuity of care for people on the move as a priority.*

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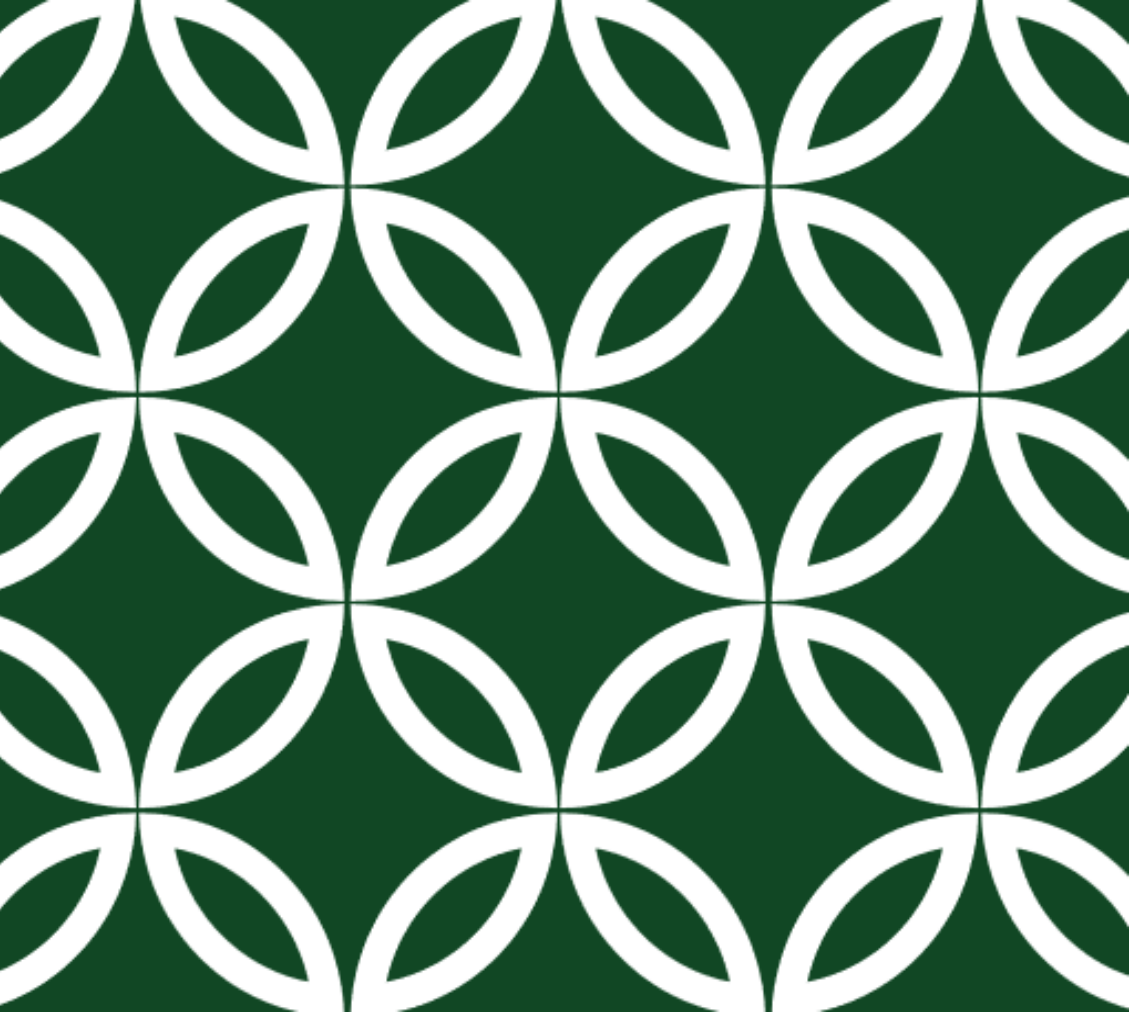

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