



Drawing by an eight-year-old girl from Afghanistan, at the reception centre for refugees and asylum seekers (EAE) in Schweinfurt, Germany

Henrike Zellmann

LOW-THRESHOLD PSYCHOSOCIAL SUPPORT FOR REFUGEES AND ASYLUM SEEKERS

A project guide

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Collaboration: Anne Pillot, Alexandra Blattner

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Abbreviations

APA	American Psychiatric Association
ASG	Outpatient clinic for mental health St. Josef
BAFF	Nationwide working group of psychosocial centres for refugees and torture victims
BÄK	Federal Association of Doctors
BPTK	Federal Association of Psychotherapists
EAE	Reception centre for refugees and asylum seekers
GIZ	German Association for International Cooperation
GU	Shared accommodation
IASC	Inter-Agency Standing Committee (Permanent Interinstitutional Committee of the United Nations)
IFRC	International Federation of Red Cross and Red Crescent Societies
MHPSS	Mental Health and Psychosocial Support
MSF/DWB	Médecins sans Frontières/DOCTORS WITHOUT BORDERS
LÄK	State Association of Doctors
LPTK	State Association of Psychotherapists
PTSD	Post-traumatic stress disorder
SRQ-20	Self-Report Questionnaire 20
WHO	World Health Organization

1. Introduction

Alignment of the guide

The following guide is strongly practice-oriented and intended as an open resource when replicating similar methods of psychosocial care in other projects. It describes the steps in the development of our pilot project, 'Low threshold psychosocial support for refugees and asylum seekers' in Germany, from the initial idea of the project to its practical implementation. It is to be understood as a practical report for transferring the working methods of MSF from project countries to the German context. A particular focus is the training and working methods of psychosocial peer counsellors. They are at the heart of our approach to low-threshold psychosocial care.

Chapter 2 focuses on the scientific research and evidence that has informed the project and the development of references to specialist literature. This is a revised part of the psychological master thesis by Alexandra Blattner (University of Würzburg), which was developed as part of the pilot project's scientific support. I would like to thank Mrs Blattner for her kind permission to use the theoretical part of her work. I would also like to thank my colleague, Anne Pillot, who joined me in shaping the training of psychosocial peer counsellors and contributed important ideas to this guide.

We hope that our approach will raise interest as well as demonstrating new ways of providing psychosocial care for refugees in target countries. The work is intended to serve as a guideline for potential replicators.

Development of the idea for the pilot project in Germany

In MSF projects around the world, psychosocial care is an integral part of the healthcare package provided, especially in projects for refugees. The people who seek medical help in our facilities have usually lived through highly stressful, shocking and painful experiences. In these circumstances, it is just as important to provide mental health treatment for individuals and communities.

People need time to process their experiences. They need comfort and someone to listen to them, in order not to remain alone with their experiences. Trusting relationships are key in order for people to overcome their feelings of insecurity, sadness and fear. With support, they can look to the future with hope and strength. They need orientation in the here and now and assistance for self-help to gain a new feeling of control over the situation and to rediscover their strengths. They need to understand the connection between stressful events and the reactions of the body and soul, so they can cope with their symptoms. They need the reassurance that they are not going crazy or losing control, but that their fellow human beings react very similarly in the same situations.

In numerous reports, MSF has documented the massive psychological needs of people fleeing their homes, where lack of care has serious consequences for the general health of the individual. No one should seriously doubt this connection. If people are unable to sleep well for a longer period, due to particular stresses and worries, this has a damaging effect on their physical well-being. If people retreat due to their hopelessness and lack of motivation, this influences their mental well-being and physical performance.

There is no health without mental health (WHO, 2016b)

MSF provides medical care to refugees and displaced people in more than 40 countries around the world. For 15 years now, MSF has also been running projects for asylum seekers in Europe: in Greece, Italy, Serbia, Sweden and Belgium. The psychosocial needs of refugees must be urgently addressed not only in crisis areas and on transit routes, but especially in the target countries.

Due to special access barriers and the blatant shortage of resources, the provision of mental health care for refugees in Germany can currently be regarded as inadequate.

For this reason, MSF and the hospital St. Josef Schweinfurt implemented the pilot project 'Low-threshold psychosocial assistance for refugees' in an initial care facility and a community accommodation for refugees.

Objectives of the pilot project

With the pilot project, we want to show new ways of providing psychosocial care for refugees. We want to show that we can achieve a great deal with relatively little effort and means. If we meet the patient at a low-threshold, non-specialised level, with a respectful, resource-oriented attitude, we can provide support at an early stage. We want to ensure that the low-threshold approach to psychosocial care for refugees is implemented in further regions of Germany. To this end, we would like to inform stakeholders in Germany about our project and provide advice to those interested in implementing similar programmes.

Psychosocial care for refugees is an extremely important component of general health care and the integration of refugees, which must be incorporated regularly into the public health system – for both humanitarian and health economic reasons (see also Bozorgmehr et al. 2016).

Target group of the pilot project

People who have fled from war and crisis zones, and have only recently arrived in Germany, are among our primary target groups. In principle, however, all refugees arriving in Germany should have access to appropriate psychosocial support. It can be assumed that refugees are exposed to many different pre- and per migratory stressors. In addition, there are so-called post migratory stressors in the target country, such as insecurity about residence status and unclear prospects (see Ikram&Stronks, 2016; Boettche, Stammel et al., 2016), which have a negative reinforcing effect. The group of refugees is therefore more vulnerable to the development of mental health problems and requires our special attention.

In addition to direct work with the target group, the project is also aimed at specialist services. Intensive networking with migration and asylum counselling centres, as well as psychiatric-therapeutic services, is intended to create synergies; relieve the workload on specialist services; and provide beneficiaries with specific treatment at an early stage, if the respective indication is given.

2. References to theory

Needs and migration-specific stress

The health care system in Germany is insufficiently equipped to meet the considerable demand for treatment for mentally ill asylum seekers (Bajbouj et al., 2017) (Bozorgmehr, Nost, Thaiss, & Razum, 2016; BÄK & BPTK, 2015; BAFF, 2016b). In addition to the general lack of psychiatric care for the population, there is a particular lack of funding for language mediators, cultural sensitivity, as well as professional specialisation and integration (Bajbouj et al., 2017; LÄK & LPTK, 2015; Schneider, Bajbouj, & Heinz, 2017). So far, screening for mental illness among newly arrived refugees is not a standard practice (Steel et al., 2009).

Refugees are particularly mentally vulnerable (Boettche, Stammel, & Knaevelsrud, 2016; Crepet et al., 2017; Demir, Reich, & Mewes, 2016; Tinghög, Arwidson, Sigvardsdotter, Malm, & Saboonchi, 2016). In addition to PTSD and depression, anxiety disorders, substance abuse or somatoform disorders prevail (Crepet et al., 2017; Gäbel, Ruf, Schauer, Odenwald, & Neuner, 2006). Psychosomatic symptoms are significantly more frequent in refugees, especially from non-Western countries, than in the general population (Rohlof, Knipscheer, & Kleber, 2014; cf. also de Jong, 2011). General psychosocial burdens such as grief, social conflict or the destruction of property also play a major role in the spectrum of problems (IASC, 2017; Mundt, Wissche, Heinz, & Pross, 2011).

More generally speaking, we must refer to 'stress' in order to include any psychosocial burden: A distinction must be made between the stressful situations, i.e. the stressors, the stress response and the coping behaviour. Stress, in the sense of the stress reaction, manifests itself on an emotional level (e.g. sadness), a cognitive level (e.g. lack of concentration), a physiological level (e.g. sleep difficulties) and in behaviour (e.g. aggressive acts) (Almshosh, Mobayed, & Aljendi, 2016; APA, 2001; Wells, Steel, Abo-Hilal, Hassan, & Lawsin, 2016). In addition to 'normal' daily stressors and significant life events (cf. Anderson, 1991), forced migration causes additional psychosocial burdens, which are usually divided into pre-, peri- and post-migration stressors (cf. Ikram & Stronks, 2016).

The cumulative occurrence of post-migration stressors, i.e. stress in the target country, increases the psychological vulnerability of refugees in general, for PTSD and especially for depression (Bentley, Thoburn, Stewart, & Boynton, 2012; Lie, 2002; Nickerson, Bryant, Silove, & Steel, 2011; Steel et al., 2009). Central and typical post-migration stressors are: The separation of and concern for the family (Mohammadzadeh, Jung, & Leigemann, 2016; Schouler-Ocak et al., 2017; Wells et al., 2016), asylum status and uncertainty of the future (Demir et al., 2016; Gerlach & Pietrowsky, 2012; Gerritsen et al., 2006), the duration of the asylum procedure (Laban, Komproe, Gernaat, & de Jong, 2008), the financial burden of prohibition of work and problematic accommodation in large housing (Boettche, Heeke et al., 2016; Christ, Meininghaus, & Röing, 2015; Demir, 2015; Wells et al., 2016; Wöller, 2016), the loss of social status and a lack of daily activities (Christ et al., 2015; Crepet et al., 2017; Demir et al., 2016; MSF Italy, 2016; Wells et al., 2016), as well as language barriers and limited access to the health care system (Boettche, Stammel et al., 2016; Demir, 2015; Demir et al., 2016; Wöller, 2016).

Psychosocial care for refugees

In addition to these migration stressors, there are specific obstacles to the psychosocial care of refugees. Psychosocial problems, in the sense of general concerns (cf. IASC, 2017), are in the middle range of a continuum between mental illness and health (de Jong, 2011; de Jong & Kleber, 2003).

Therefore,

“the term 'psychosocial' [...] is intended to take up the relationship between the psychological (thought, feelings, behaviour) and social (reference persons, living conditions, culture) aspects of human experience and [...] understand them. The link between mental health and psychosocial well-being [...] makes it clear that it is never about social conditions on the one hand and psychological sensitivities on the other, but about the fact that social conflicts and psychological difficulties must always be seen in relation to each other and that neither of the two elements [...] may be neglected (Society for International Cooperation [GIZ], 2017).”

To achieve health in a positive holistic sense (see WHO, 2016b), psychiatric support, counselling and training of national staff ('psycho-'), on the one hand, and practical support, public education on common problems and the promotion of social structures and activities ('-social') on the other hand (de Jong, 2011) are therefore needed. Such an understanding is laid down in the guidelines of international psychosocial work for the so-called area of 'Mental Health and Psychosocial Support' (MHPSS) (IASC, 2017). Humanitarian MHPSS projects aim to reduce the consequences of mass violence through strengthening mental health and psychosocial well-being (de Jong, 2011).

Obstacles to psychosocial care for refugees in Germany

In current literature, the so-called 'healthy migrant' effect is often cited (e.g. Eggerth & Flynn, 2013; Salman & Weyers, 2010): It describes the fact that the health status of immigrants at the time of settlement is comparatively good. Since usually only the physically and mentally strongest, most motivated and financially well-situated people successfully master the challenge of flight or migration, the health advantage is based on a positive person selection. However, it shrinks over time in the target country in view of socio-economic disadvantages and insufficient access to the health system (Guruge, Thomson, George, & Chaze, 2015). Due to access difficulties, refugees make little use of health services in western countries (Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Gerritsen et al., 2006; Ikram & Stronks, 2016). Central barriers to the psychosocial care of refugees are considered below.

Language difficulties are particularly detrimental when accessing healthcare (Guruge et al., 2015; Ikram & Stronks, 2016; Schneider et al., 2017; Wöller, 2016). Admittedly, it is primarily the individuals (patients and specialist staff) who need help with communication (Salman & Weyers, 2010; Schneider et al., 2017). It is striking that this barrier in the healthcare system is not overcome by regular financing of professional interpreters (Boettche, Stammel et al., 2016; BÄK & BPTK, 2015; Richter et al., 2015). This hinders psychotherapeutic and medical treatment considerably in the case of anamnesis, ensuring compliance and awareness (BÄK, 2017). According to the BAFF, this often results in delayed or faulty supply and partial chronification (Kleefeldt, Wolff, & Carlo, 2016).

In the first (up to 15) months, the asylum process and residence status legally restricts the range of treatment offered for acute conditions (LÄK & LPTK, 2015; Schouler-Ocak et al., 2017). This also impairs psychotherapeutic care, since the asylum laws demand, for example, an assessment of applicants, which is often inadequate from a technical point of view (BÄK, 2017; BÄK & BPTK, 2015). Due to the over-presence of the topic 'residential status', there is often a lack of motivation to deal with topics that are detached from it, e.g. mental health (Demir, 2015).

Other practical problems arise from the asylum procedure, for instance unforeseeable transfers to different accommodation in Germany, making specialist services hard to reach from a distance (Guruge et al., 2015; Schneider et al., 2017). This also reflects a "low organisational flexibility of psychiatric institutions" (Schneider et al., 2017, p. 12).

A frequently cited barrier to healthcare is a lack of knowledge about what is provided by the German healthcare system (Demir et al., 2016; Kizilhan, 2014; Salman & Weyers, 2010; Schneider et al., 2017). Migrants are often unaware of the existence of services, especially in the psychological–psychiatric field (Guruge et al., 2015; Ikram & Stronks, 2016).

This is likely to be associated with the last obstacle to care: a different (psychological) understanding of disease and treatment, which is also influenced by educational background and culture of origin (Kizilhan, 2014; Kleefeldt et al., 2016; Salman & Weyers, 2010; Schneider et al., 2017). Reactions to traumatic experiences are often not even understood as 'disease symptoms' in the sense of western medicine," the BAFF confirmed (Kleefeldt et al., 2016). It can be ethnic–cultural customary to express distressing emotions in physical symptoms, which can lead to misinterpretations and unnecessary diagnostic processes (Kizilhan, 2014; Kraus, 2006). Psychological support services have little priority in many countries of refuge (Demir, 2015; Ikram & Stronks, 2016; Kleefeldt et al., 2016). There is often mistrust and stigmatisation of MHPSS in the social environment, so shame and guilt make it difficult to talk about symptoms (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014; Guruge et al., 2015; Kleefeldt et al., 2016; Schneider et al., 2017). It is important to differentiate between nationalities, for example: Somali refugees apparently used fewer health services than Afghans and Iranians (Gerritsen et al., 2006). Culturally conditioned are also excessive notions of the healing possibilities of Western medicine (Kleefeldt et al., 2016).

In view of the number of barriers to psychosocial care for refugees, it is necessary to identify which people (groups of people) do not make use of the services and why. Among other things, this question will be investigated within the framework of the scientific monitoring of the Schweinfurt pilot project.

Conceptual solutions for care barriers

The psychosocial component of care is an integral part of the humanitarian work of MSF (Ärzte Ohne Grenzen, 2017). It follows the principles of cultural sensitivity, integration, local capacity building and empowerment (help for self-help), with a low-threshold criteria (de Jong & Kleber, 2003). The Schweinfurt pilot project also uses these criteria to overcome the psychosocial obstacles to care that have been explained previously.

a) Use of consultants & cultural awareness

The heterogeneously used term 'peers' describes people who share similar professions, mental illness, social, ethnic or cultural backgrounds, or other similar living conditions (Jain, McLean, Adler, Lindley, & Ruzek, 2013; Wöller, 2016). The similarities make peers role pilots with special access to the target beneficiaries. They can effectively reduce stigmatisation in mental healthcare (Jain et al., 2013; Walker & Bryant, 2013). In the concept of the pilot project, the term refers to peoples with their own experience of flight and similar geographical origin as the beneficiaries (cf. Crepet et al., 2017).

A study of 240 veterans compared recovery groups under peerage, clinical management and standard treatment (Eisen et al., 2012). All three groups showed comparable improvements in the target criteria of depression, functionality, psychotic symptoms and overall health, so that peer use did not lag behind that of comparatively expensive specialist staff. The culturally sensitive trauma peer groups of Renner, Banninger–Huber and Peltzer (2011) achieved similarly good results. Peer work could therefore be a useful alternative for the shortage of psychosocial care for refugees in Germany (Jain et al., 2013; Salman & Weyers, 2010). The Federal Association of Physicians (2017) also demands: "Where the regulatory system is overburdened, innovative approaches to health care for migrants should be used and scientifically monitored in order to gain knowledge about their expansion and admission to regular care" (p. 129). The 'migrants for migrants' programs, for example, has been in existence since 2003 (Salman & Weyers, 2010), but is not specifically focused on the psychosocial problems of refugees, and is based solely on volunteer work.

In MSF projects, the use of peers as so-called 'psychosocial peer counsellors' is a key principle (de Jong & Kleber, 2003). The permanent consultants are not intended to replace psychotherapists (cf. Jain et al., 2013; Wöller, 2016), but rather to make a low-threshold, preventive offer that mediates to specialist services if necessary. Psychological supervision ensures the professional quality of peer work and also acts as a link to doctors, psychotherapists and social workers (Boettche, Stammel et al., 2016; Wöller, 2016).

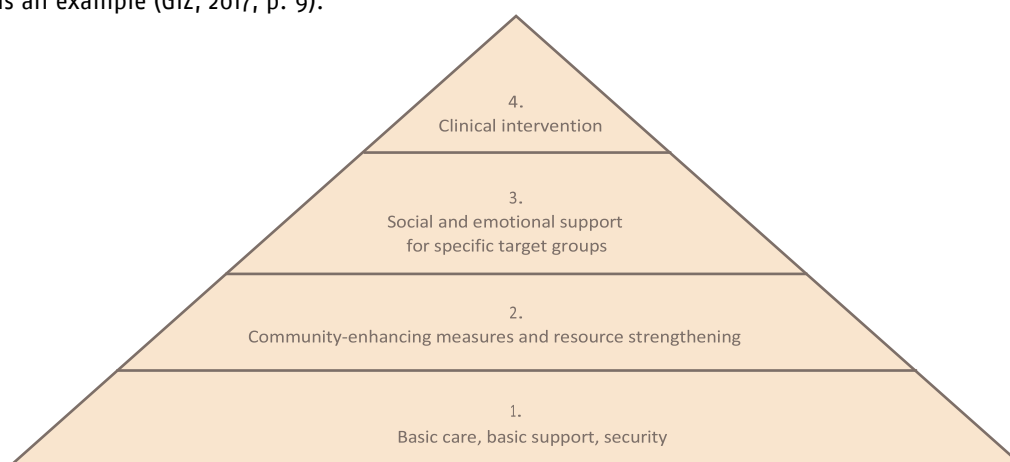
The use of peers increases the cultural sensitivity of psychosocial services and of local colleagues (Crepet et al., 2017), even if the same country of origin naturally does not guarantee a successful relationship between client and consultant (BAFF, 2016a). People from the same country of origin can also differ greatly, whether by educational level, more precise

region of origin or religious affiliation (Demir, 2015). The peers must therefore be empathic and culturally and communicatively appropriate (de Jong, 2011).

b) Low-threshold and graduated care pilot

Restrictive access to health care has long-term economic disadvantages, according to an analysis by Bozorgmehr et al (2016). Low-thresholds, on the other hand, are the "minimisation of access requirements [...] in order to counteract barriers to the use of the service" (Ulusoy & Grässel, 2010). The following are some concrete recommendations for adapting offers to the living environment of refugees: In view of deportations or the rapid redistribution to other accommodation, short-term programmes are a viable option (Demir, 2015). Waiting times should be short and opening hours should be more flexible, e.g. in Ramadan (cf. Lueger-Schuster, 2009). In addition, in the (frequent) case of low educational attainment (Bunge, Meyer-Nürnberg, & Kilian, 2006) as little prior knowledge as possible must be required for the use of the offer. Education should therefore be very basic and in the mother tongue (Joksimovic, Wöller, Happ, Tress, & Kruse, 2011). Bi-cultural personnel also have an advantage in terms of trust, acceptance and de-stigmatisation (Richter et al., 2015). Local embedding in existing familiar structures can also help to reduce concerns about use and facilitate contact (Ulusoy & Grässel, 2010). Judges and colleagues (2015), for example, recommend routine screening for all new arrivals in large-scale accommodation (ibid.). Finally, financial and bureaucratic expenditure must be kept to a minimum, which is often not the case with specialist offers for psychiatry and psychotherapy (ibid.).

Low thresholds in the health system are supported by so-called graduated care pilots (IASC, 2017); the following illustration is an example (GIZ, 2017, p. 9).



Graduated care pilot according to IASC guidelines

The higher the level in the care pyramid, the more specialised the measures, the more formal the training of the required specialist personnel and the smaller the target group that can be reached (GIZ, 2017). Depending on the stage of stress or disease, treatment is therefore initially carried out at the lowest level and is only replaced by a higher measure if it is not effective (IASC, 2017). A direct entry into each level is possible, e.g. through self-presentation or referral from other services (Bohus & Missmahl, 2017; Tol et al., 2014). According to Bajbouj et al. "the German health system is often overly focused on the fourth level of the care pyramid [...] and [...] easily available, low-threshold and broadly applicable interventions from the other three levels [are] not coordinated and only implemented irregularly" (Bohus & Missmahl, 2017, p. 4). The MSF pilot project is primarily on the second and third level, but has multidisciplinary links with the other levels. Through integrity and networking, for instance with psychiatrists, social workers or accommodation management, parallel structures are avoided, resources are spared and access to psychiatric psychotherapeutic services is made possible (IASC, 2017).

c) Prevention & Resource Orientation

A core concept for low-threshold care is resource orientation (Bajbouj et al., 2017). For example, they can be divided into extra-personal resources (e.g. financial resources) and intra-personal resources, which include physical resources (e.g. good health), psychological resources (e.g. optimism) and competencies (e.g. cognitive performance) (Lazarus & Folkman, 1984). In the uncertain circumstances immediately after flight, offers should not be deficit-oriented and trauma-confrontative, but should enable security and self-help (Jain et al., 2013; Wöller, 2016). Such resource promotion is part of disease prevention, i.e. the development of health-promoting behaviour (Lueger-Schuster, 2009). It is intended for vulnerable people such as refugees without symptoms (primary prevention), and with individual complaints without complete manifestation (secondary prevention) (ibid.). In the psychosocial field it includes for example education, strengthening social relations, psycho-education to cope with stress or promotion of physical activity (Busse, Plaumann, & Walter, 2006; de Jong, 2011; WHO, 2016a). The MSF guidelines call for preventive intervention as early as possible in the development of psychopathology (de Jong, 2011).

In an 18-month study with unaccompanied minor refugees in Belgium it became clear that their state of mental health did not improve (by itself) over time (Vervliet, Lammertyn, Broekaert, & Derluyn, 2014), so support offers are necessary. Ikram and Stronks (2016) found only a few studies for their review that tested the effectiveness of preventative intervention with refugees, and these with mixed results. The authors note, however, that especially community-focused prevention offers also aim at creating awareness and sensitisation, as well as a psycho-educative approach, which unfortunately has not been empirically recorded. Overall, the data situation does not appear to be sufficient.

Coping mechanisms

Many authors agree that the mental health of refugees depends on the psychological and social coping possibilities they use (e.g. Christ et al., 2015; Ikram & Stronks, 2016; Tempany, 2009). Positive coping is reflected in emotional well-being, appreciation of one's own life or self-confidence, while negative coping is reflected in hopelessness or social dysfunction (Ano & Vasconcelles, 2005; Prati & Pietrantonio, 2009).

In the Lazarus and Folkman stress pilot (1984), coping encompasses "all thoughts and behaviours that someone uses to meet inner and outer demands that are experienced as stressful" (quoted from Ringeisen, 2013, p. 257). Which coping strategies are used depends on the situation and personal characteristics, as well as on the subjective assessment of the stress situation (Lazarus & Folkman, 1984).

In cases of greater stress or more trauma, there are more coping strategies used simultaneously (Sachs, Rosenfeld, Lhewa, Rasmussen, & Keller, 2008; Snyder, 2001). Kaluza (2002) sums up that it is particularly helpful if a person has a broad, flexible repertoire of behavioural, cognitive and emotional strategies at his or her disposal. The following subdivision into three management dimensions naturally represents only one potential approach.

a) Problem-oriented coping strategies (PROB)

PROB strategies include a definition of the problem and the various possible solutions, the consideration of costs and benefits and the decision for an action and its initiation (Busse et al., 2006; Matheson, Jorden, & Anisman, 2008; Ringeisen, 2013). PROB strategies can also address the environment by seeking practical help from family or professionals, e.g. medical workers (Busse et al., 2006; de Jong, 2011). Such instrumental support, but also the emotional (cf. part c), shows a clear positive influence on mental health (an exact overview is provided by Hooberman, Rosenfeld, Rasmussen, & Keller, 2010).

b) Active-emotion-oriented coping strategies (A-EMOT)

Problem focusing is primarily favourable if a person takes advantage of opportunities for active processing (Reimann & Pohl, 2006). Without the possibility of situation control, however, cognitive-emotional strategies seem more effective for coping (ibid.; de Jong, 2011; cf. e.g. Strentz & Auerbach, 1988). A-EMOT covers strategies that do not reduce the problem of origin, but rather the resulting emotional stress. In doing so, a person actively confronts his or her emotions, unlike in avoidance coping (Busse et al., 2006). To be mentioned in concrete terms are positive reinterpretation ('reframing') and optimism with moderate to major effects (Al-Smadi et al., 2016; Kaluza, 1996; Prati & Pietrantonio, 2009), as well as humour and acceptance of the irreversible (Kaluza, 1996; Ringeisen, 2013). Busse et al (2006) also include sport, meditation or breathing exercises as active emotion management, as they reduce fear and help people to relax (cf. Koll-Krüsmann, 2016; WHO, 2016a). This is likely to also apply to personal rituals or visits to contemplative places (cf. de Jong, 2011; WHO, 2016a). Social emotional support through conversations is also effective, for which the expression of feelings is of central importance (Al-Smadi et al., 2016).

c) Avoidant coping strategies (VERM)

This category includes strategies that do not address the problem and that do not provide long-term relief (Busse et al., 2006). These include prolonged denial and distraction in the sense of cognitive ignorance and behavioural avoidance (ibid.; Kaluza, 1996; Matheson et al., 2008). Furthermore, it is negative to devalue/defame oneself or to withdraw socially, as this leads to loneliness and lack of activity in the long term (Kaluza, 1997; Kapsou, Panayiotou, Kokkinos, & Demetriou, 2010; Ringeisen, 2013). Passive resignation and the withholding of emotions are also avoiding (Matheson et al., 2008). To reduce avoidance, it is necessary to promote the maintenance of an active everyday life, whether domestic activities, work, personal care or caring for others (cf. WHO, 2016a). Unhealthy eating habits or medication and drug use in the sense of self-medication have an emotion-avoiding and negative effect; some of them affect the uninformed, others lead to crime or increased suicidal thoughts (Christ et al., 2015; Colder, 2001; de Jong, 2011; Leeies, Pagura, Sareen, & Bolton, 2010). Further to be mentioned is anger overcoming self- and foreign aggression (Kaluza, 1996; Salem-Pickartz, 2007). Religious practice can be described as negative-avoidant if it includes, for example, passive pleading for divine intervention or the idea of a punishing God (Ano & Vasconcelles, 2005).

3. Project development and phases of project establishment

Preparatory phase (July 2016 – January 2017)

Seeking a cooperation partner

After a sample-like Germany-wide needs assessment, in which the serious lack of mental healthcare (criticised by various psychosocial actors of refugee aid) was confirmed in our own view, we began to actualise the idea of a pilot design and initiate the search for a cooperation partner. We chose the initial admission facility (EAE) in Schweinfurt as the location for intervention, to help the refugees as early as possible: The St. Josef Hospital runs the medical ambulance for refugees on the premises of the EAE. The hospital management was very open and interested in collaborating with MSF. We were able to replicate the structure of our working methods in project countries in Schweinfurt: a close network of medical and psychosocial services under one roof. The treatment and counselling rooms are on the same floor as the EAE Schweinfurt, with short transfer paths and the possibility for beneficiaries to visit the outpatient branch of the hospital at low thresholds – whether for the use of medical or psychological help.

We drafted a cooperation agreement with an initial term of 12 months, in which MSF took responsibility for the professional development in the first seven months, and would then be available in an advisory capacity for the remaining period under the personnel management of St. Josef Hospital.

Provision of financial resources

To our regret, the project application of the St. Josef Hospital was not supported by the Bavarian state government. We therefore prepared our own budget plan, initially for a period of 12 months from February 2017 to February 2018. We agreed to split the costs between MSF and the St. Josef Hospital. In the meantime, St. Josef is making intensive efforts to continue financing the project via the Diocese of Würzburg and third-party funding sources. In addition, it is planned to approach responsible government agencies again, with the first interim results of the pilot project and with a request for support.

Seeking personnel

For our pilot project in Schweinfurt, we advertised for people with a migration background who have a secure residence permit in Germany. Further criteria were: They have lived in Germany for at least two years, have orientated themselves in the German system and, in addition to German language skills (at least B1), have interest and social skills for working with the target group. Relevant previous professional experience was desired, but not imperative (see Chapter nine Collection of materials: Job posting for psychosocial peer counsellors).

In terms of sustainability and appreciation for our team and the work to be done, it was important for us to provide our staff with German employment contracts right from the start. St. Josef created new job profiles and a suitable classification in the company's remuneration system for this very purpose. In line with our budget, three 75 percent positions (psychosocial peer counsellors), and from the seventh project month a 125 percent position (psychologist and project manager), were created. We tried to achieve the widest possible cultural and linguistic spread in the composition of the team. After the successful selection process, the team of consultants consisted of a social worker from Iran, a journalist from Somalia and a teacher from Syria (spoken languages: Persian, Arabic, Kurdish, Somali, English, German).

After the development of the project, which was carried out by the author in the context of her work with MSF Germany, the handover to St. Josef took place in the seventh project month. In this context, a search was made for a subsequent psychological management and project management position, which was employed by St. Josef on a 125 percent basis (divided into two positions). The job profile calls for a psychologist with a clinical background, preferably with previous experience in the clinical-psychiatric field for this position. (see Chapter nine Compilation of materials: Job posting psychologist).

Search for premises and equipment

The operators of EAE have shown themselves to be very cooperative and supportive in providing premises. In the immediate vicinity of the medical ambulance St. Josef, an office and two consultation rooms were set up on the same corridor. On a higher floor, we were given a large room for our training courses and groups. The furnishing of our consulting rooms traditionally takes a lot of effort and time; our beneficiaries should feel comfortable and welcome with us.

Development of intervention logic and treatment path

In the intervention logic, newcomers to the EAE should be able to benefit from the counselling offer as early as possible, so that the primary information of the beneficiaries is linked to the obligatory initial medical examination (see Chapter nine Compilation of materials: Treatment pathway). After the medical screening, residents are invited directly to the outpatient clinic for mental health. They get to know their psychosocial peer counsellors (who speak their language) and receive information about the services offered. In practice, we try to bring several beneficiaries together for an initial meeting. They also receive a flyer with written information about the ASG, as well as a photo and telephone number of their contact person (see Chapter nine Compilation of materials: Flyer Beneficiary).

Upon approval, an individual initial interview of approx. 60–75 minutes takes place, in which relevant aspects of their biography and flight history – as well as demographic data and current psychosocial situation – are recorded.

Furthermore, a questionnaire-based screening of psychological stress is carried out (see Chapter nine Compilation of Materials: Psychometric Screenings). The initial contact is pivotal for the successful cooperation between the consultant and the beneficiary – is it possible to establish a trust-based relationship? Is it possible to give the beneficiary an understanding of the possibilities and limitations of the service? To motivate him or her to participate in our group offer? We receive many different reactions from our beneficiaries during this initial meeting. The most beautiful moments are those when the person is visibly comfortable in our rooms, and feels appreciation: “You are the first person in months to ask me ‘How are you?’.”

This is followed by participation in the three-part group programme. This ideally happens with a closed group once a week for 90 minutes.

Approximately two to three weeks later, the participants are individually invited to a second interview, in which contents of the group are refreshed and individually deepened. A new psychometric assessment of emotional stress is also made. Depending on the individual situation and needs of the beneficiary, further contacts or referrals to other services may be made.

For economic reasons or the competence of the consultants, the focus of intervention lies in group intervention. Individual interventions are only offered in specific cases and under close professional supervision, as they are very resource-intensive. Nevertheless, the signal to the beneficiaries is: ‘Our doors are always open – come back when you need support.’

All protocol sheets used can be found in Chapter nine 'Compilation of materials'.

Functioning of the Schweinfurt pilot project

The pilot project was realised in cooperation between MSF Germany and the medical outpatient clinic in St. Josef Schweinfurt hospital, on the premises of the initial admission facility in Schweinfurt and the Geldersheim shared accommodation. With this structure, we tried to portray our working method in project countries, which always allows for close collaboration between medical and psychosocial services, under one roof. In August 2017, the management of the project was passed over to St. Josef Hospital. The costs were shared equally by the two partners in 2017. From 2018 onwards, the St. Josef Hospital will continue to finance the project.

The team consists of two psychologists and three psychosocial peer counsellors, who were trained in the first half of 2017 by two experienced clinical MSF psychologists. MSF Germany has held an advisory function in the project since August 2017. The entire team at the outpatient clinic for mental health in St. Josef, was equipped with employee contracts from St. Josef right from the start.

Working principles

Low-thresholds – the easiest possible way to reach the consulting service, available to everyone

We want to make access to psychosocial support as barrier-free as possible. A low-threshold offer must therefore be adapted as precisely as possible to the living environment and the needs of the target group in terms of time, location and content (Bunge, Meyer-Nürnberg, & Kilian, 2006). Since the work of counsellors takes place directly in the living environment of refugees in need of support, it also has a visiting social work component (Salman & Weyers, 2010).

In our projects, the medical service is the most important way to refer to our mental healthcare service. In the pilot project refugees are regularly invited by the medical ambulance St. Josef to the outpatient clinic for mental health. This is following their obligatory initial medical screening. The use of institutional/professional counselling services is not always a given either in our own or in other cultures. The beneficiaries receive information about our services and then

decide for or against receiving an initial mental health consultation. (see Chapter nine Compilation of materials: Beneficiary flyer, treatment pathway)

With this approach, we follow the stepped care pilot (IASC, 2017). We aim to reach and address a broad audience with our services, as far down the intervention pyramid as possible (Bajbouj et al., 2017). We want to reach as many people as possible with our preventive services based on psycho-education.

'Peer to Peer' and help for self-help – early 'basic help' through the use of psychosocial peer counsellors

Refugees best understand the situation of other refugees. In our psychosocial work, we therefore rely on consultants with similar backgrounds of experience as our beneficiaries. They are referred to as 'peers'. They have special access to our target group and thus help to reduce stigma in seeking mental healthcare (Walker & Bryant, 2013). If possible, these are compatriots, or people with similar linguistic and cultural backgrounds, who have been living in Germany for a long time and are able to converse with beneficiaries in a trustful way. We train psychosocial peer counsellors according to their own curriculum, and give them the opportunity to become more professional during their work through continuous professional supervision.

If we succeed in strengthening the refugees' resources and help them apply self-management skills when they first arrive, this can have a decisive effect on their psychological and physical well-being, as well as their ability to adapt to their new life. The focus of the approach is to strengthen individual coping mechanisms.

When working with refugees, the focus is on their resources and strengths. We know that it is awareness of our own strengths and resources that allows us to survive difficult situations – not orientation towards symptoms and deficits.

Participants are encouraged to reflect during group work: How did you manage to get here? What makes you who you are? What are your strengths, what are your sources of strength? How did you solve your problems before you fled? What are you proud of? Which people are close to you, what have you learned from them? How do you think you can survive the time in the initial reception facility as well as possible? Which pictures and symbols can help you to deal with difficulties?

Synergy instead of parallel structure – close co-operation and networking with other actors in refugee aid

With our projects, we do not want to replace or duplicate existing structures, but complement them in a meaningful way. We want to act where there are gaps in the supply system, working with existing structures in order to achieve synergies together. A careful analysis of the needs and the existing supply structure is of great importance for the planning of a successful intervention. In Schweinfurt, a so-called 'mapping' of existing aid providers was carried out and contact with relevant actors was sought. They described an urgent need for low-threshold help to relieve the psychological strain on and improve communication with refugees.

Building local capacities – strong emphasis on knowledge transfer and training local actors

The focus of our work is on training and further education as well as supervision of local staff. Based on the experience gained in our pilot project, we are convinced that the training and use of psychosocial peer counsellors can also represent an effective and meaningful supplement to the existing psychosocial care for refugees in Germany.

Psychosocial peer counsellors – key actors in low-threshold healthcare

In our aid projects all over the world, we often work with so-called 'peers' – people we recruit from the target population and who know the reality the refugees face, language and culture of the target group. We use local specialists wherever possible – however, only few national psychologists, social workers or psychiatrists are left in the world's crisis zones. MSF therefore works with people from a wide variety of professional backgrounds and trains them as psychosocial peer counsellors, according to internal training curricula. They are usually trained by clinical psychologists or psychiatrists and then supervised in their work. The supervisors ensure the professional quality of the work and act as a link between refugees and specialist services. Beneficiaries often find it less frightening and easier to trust a peer counsellor than to an 'expert'.

The idea of using psychosocial peer counsellors in humanitarian contexts is not new. The WHO, the International Red Cross and other non-governmental organisations rely on the use of 'peers' in their psychosocial work, who generally undergo internal training and education. There are numerous manuals and concepts for training psychosocial peer counsellors (e.g. IFRC, 2016: Lay Counselling – A Trainer's Manual; WHO: Problem Management Plus, 2016).

In Germany, too, the use of consultants is already being pursued by some actors, but so far only as part of individual initiatives and at a local level. In addition to specialists, there is a lack of language and cultural mediators for communicating with and understanding refugees in basic counselling. If a multiplier structure for the nationwide use of psychosocial peer counsellors can be established, the far-reaching needs of refugees could be met better and more

accurately. If possible, consultations with beneficiaries are always conducted in the refugee's native language (in our pilot project, three psychosocial peer counsellors can cover the following languages: Arabic, Kurdish, Somali, Persian, English and German). If required, interpreters can be involved in the consultation.

What are the tasks of psychosocial peer counsellors?

- Establishing a trustful relationship and communication with beneficiaries
- Addressing problems and providing advice on the beneficiary's side
- Psycho-educative services for refugees
- Orientation of refugees in the here and now
- First point-of-contact for the needs of refugees
- Early recognition of specific psychiatric and psychotherapeutic needs and assistance in the use of specialist services
- Networking with other local actors
- Language and cultural mediation in the German assistance system

Counselling content

What is effective in psycho-educative counselling work with refugees?

According to Demir, 2015; Kizilhan, 2014; Liedl et al., 2010; de Jong, 2011; Demir et al., 2016, the following aspects in particular can be assumed to be effective factors in psycho-educative counselling work with refugees:

- Establishing a trustful relationship and communication
- Communicating with a respectful and trusting attitude
- Conveying knowledge and disease concepts
- Normalisation and relief
- Raising awareness on coping possibilities
- Compliance
- Strengthening of resources and practical training
- Social support in group setting

Group level

The three-part psycho-educative group programme, developed for the German context, represents the core of our work with the target group. The aim of the intervention is to strengthen and expand one's own coping skills regarding stress management. Ideally, this deals with a reduction of the symptom burden and an improvement in everyday functionality. It is about giving the refugees a conclusive concept of why and how body and psyche react to stress, and how to deal with these reactions as well as possible. Beneficiaries are assigned to the groups in a detailed one-on-one interview and invited for a further individual feedback interview, after completion of the three-part group programme. In individual conversations, what has been learnt can be deepened and adapted even more to the individual's situation in life (see Chapter nine Compilation of materials: First meeting protocol, Group Manual Module I-III, Psychoeducation Stress I-III, Second meeting protocol).

Individual level

For individual consultation the following contents are predominant:

- Individual problem analysis
- Structured problem solving
- Promotion of individual opportunities for self-expression
- Promotion of processing

(See Chapter nine, Compilation of materials:

Individual counselling protocol; Follow-up protocol; drawing by eight-year-old Afghan girl)

Furthermore, the pilot project strives for the early recognition of mental illnesses, with appropriate indications for referral to specialist services. The psychosocial peer counsellors can also act as interpreters and thus considerably improve communication between the beneficiary and the specialist service. They can also be co-therapeutically effective if the beneficiary continues to receive support in the outpatient clinic for mental health.

The project activities are to be assigned to the intervention levels of primary and secondary prevention. In addition, we respond to the early recognition of clinical symptoms by referring patients to specialist services.

In terms of content, psycho-education and stabilisation are at the forefront of the measures taken. In an evaluation of MSF's own MHPSS projects, Shanks et al (2013) emphasise that the chosen work approach must always be adapted to new contexts.

Consulting formats

Group counselling

A group cycle consists of three 90-minute sessions with four to 10 participants (closed group) on the topics of 'social support', 'stress management' and 'resource strengthening'.

Individual counselling

- Initial meeting: detailed psychosocial anamnesis discussion with symptom screening
- Second meeting: detailed one-on-one interview after the group phase
- Follow-up: up to 20-minute brief contact
- Individual consultation: approx. 50-minute individual session

In the chosen approach, the use of individual sessions is only possible in specific cases and is generally linked to participation in the group offer, in which important psycho-educative basics are conveyed.

Development phase (February 2017 – June 2017)

Training of psychosocial peer counsellors

The quality and success of our work stands and falls with the attitude and training of our psychosocial peer counsellors, who are at the centre of the approach.

Together with my colleague Anne Pillot, also a clinical psychologist and long-time MSF employee, a three-part intensive training of the consultants was planned.

We asked ourselves: What makes our team good consultants? What attitude do we want to communicate? What are the relevant contents of the training, what are suitable techniques for conveying knowledge?

We made the following assumptions about the context:

- Refugees have a special need for psychosocial care
- There is a lack of psychosocial services for refugees
- An early intervention has a preventive and positive effect on the mental and physical health of refugees

We made the following assumptions about the psychosocial peer counsellors:

- The future consultants have little or no experience in the field of consulting
- They may have great difficulties with the German language
- They do not yet have a solid knowledge of the structure of the German aid system
- They have high social skills
- They have specific language skills
- They have similar backgrounds or experience to the beneficiaries
- They are highly motivated, interested and curious

We made the following assumptions about the group of refugees:

- They have no knowledge of German and are not integrated in the German system
- They are engaged with the experiences in their home country, on their flight and with the current living conditions and challenges
- They need someone to listen to them
- They need help classifying their physical and/or psychological complaints
- They can solve and/or control their problems
- They are independent individuals who are responsible for their own lives

These preliminary considerations led to a three-part training curriculum which was adapted according to the needs of each training unit. The concept was for three training modules with an initial training course of nine days each, and two continuing training courses after six and 14 weeks of five days each (see Chapter nine Compilation of materials: Training Curriculum Psychosocial Peer Counsellors I-III). At the end of the three-part training phase, the counsellors

received a certificate of participation (see Chapter nine Compilation of materials: Certificate Psychosocial Peer Counsellors). The supervision and training contents for the psychosocial peer counsellors cover the following areas:

- Consultant skills (e.g. verbal and nonverbal communication; general communication techniques; negotiation in difficult counselling situations; technique of 'psychological first aid' etc.)
- Consultant knowledge (e.g. German healthcare; counselling concepts and the role of the consultant; the relationship between mind and body; stress and stress management, problem conceptualisation and structured problem solving; basic knowledge of resources and coping mechanisms, family and education, family relationships and conflicts, addiction and drugs, violence, trauma and trauma consequences, dealing with thoughts of suicide etc.)
- Professional and personal self-awareness (e.g. biographical work; self- and group reflection on the topic of consultant personality)
- Continuous professional supervision by the project management ('on the job teaching')

Work on the project began immediately after the initial training. The project manager attended the first individual and group meetings. The so-called 'live coaching' (in which the counsellors are coached directly in their individual and group discussions – subject to the beneficiary's consent), proved to be a highly effective method of training, as in all my previous experience working with psychosocial peer counsellors. After each beneficiary meeting, debriefings took place either individually or with the entire team of consultants. A weekly case discussion (see Chapter nine: Collection of materials: Concept case study), a training meeting (see Chapter nine: Compilation of materials: Example for further training 'Asking helpful questions') and a weekly meeting with the staff at the St. Josef medical outpatient clinic were integrated into the schedule.

The naming of the programme was accompanied by many team discussions, but it was a highly exciting and insightful process. Each culture has its own understanding of the terms 'soul', 'psycho', 'social', and each language and culture its own fine connotations, which entailed further reflections and discussions in the team. After several weeks a name was chosen that suited everyone involved: The outpatient clinic for mental health St. Josef designed a logo, schedule sheet and a flyer for beneficiaries (see Chapter nine: Compilation of materials: Logo outpatient clinic for mental health St. Josef) and became more familiar on the AE premises.

Assignment to the group programme started shortly thereafter. After the initial discussion, groups of four to 10 participants with the same linguistic background were formed. The four groups then entered the three-part group phase. The psycho-education sessions were conducted by two counsellors each. This approach joins up resources, but also offers advantages in terms of collegial support and relief, as well as in controlling group dynamics. The group manual was adapted to the circumstances and gradually refined (see Chapter nine: Compilation of materials: Group Manual Module I-III). The team systematically and intensively discussed each group unit including counsellor behaviour. The consultants were thus able to quickly build confidence in their own behaviour in front of their group, and in their assessment of the group dynamics.

Consolidation and expansion phase (July 2017 – date)

Further differentiation

Further work on the project structure is required particularly in regard to the implementation of female-only groups (experience has shown that male presence in the groups means women tend to make only hesitant use of the programme), as well as special attention to the Somali group. The two groups use the programme less and have a more conditional understanding of the concept of 'counselling', which coincides with previous findings on this topic (Gerritsen et al., 2006). An attempt is currently being made to find a suitable solution for these groups, with an even lower-threshold devised (through general psycho-educative events in the waiting area of the medical outpatient clinic).

Expansion of consulting services to other locations

After the consolidation of work processes in EAE, the translation of the consulting work into the context of the shared accommodation Geldersheim, which is located approximately six kilometres away from Schweinfurt, followed. This is a large connecting accommodation with approximately 600 places, where refugees are transferred after their asylum status has been clarified. There are clear differences regarding the length of stay and psychological situation of the residents. A psychosocial counselling offer was urgently requested in advance. Close co-operation with the local actors (management, asylum counselling centre, voluntary medical ambulance) was established right from the start.

We are planning to expand our locations to Würzburg, in a new residential facility currently under construction for those in particular need of protection. Work is scheduled to begin in December 2017. The capacity limit for three 75 percent employees has thus been reached by far. The needs are obvious and the requests from outside are constantly increasing. With the appropriate counter-financing, the expansion of our team of consultants with new staff and additional language skills would be the right step.

Networking

Networking will continue, as described separately under 'Linkage with the existing range of services'.

Qualification of psychosocial peer counsellors on the German labour market

A major topic is the further qualification of our psychosocial peer counsellors. How can we combine their further training with the obtainment of an officially recognised qualification/certificate? To what extent can our own training program be certified?

Linkage with the existing range of services

From the very beginning, great importance was placed on linking the existing psychological-psychiatric and social care services. Networking is under constant development.

A collegial exchange could be established with all actors in the AE (facility management, St. Josef medical outpatient clinic, asylum social counselling, health office, police, etc.). Once a month there is a so-called authority meeting for a formal exchange of information; in addition, there are often beneficiary-related consultations and referrals, especially with the asylum social counselling centre. Foreign contacts are made as needed, e.g. to the addiction counselling centre, the migration service, the local helper circles or the providers of German language courses. In addition to its own consulting services, the pilot project also considers itself a competent contact point for beneficiaries. Who needs what, and where can it be found?

Regarding networking with specialist services, the pilot project focuses on co-operation with the local psychiatric network. At the time of first arrival in Germany, placement in specialist psychotherapeutic services is rarely a priority. In most cases, there is great uncertainty about the future and the unresolved asylum status, so the focus should be on the psychological stabilisation of refugees. Once the asylum status has been clarified, the implementation of a guideline for psychotherapy can be considered. The capacity limits in the German healthcare system become clearly apparent here.

The possibility of admission to stationary structures in the event of acute self- or external hazards must be prepared. The pilot project was therefore introduced to the Werneck district hospital (responsible adult psychiatry) right from the start. In the case of referrals, the consultants often act as interpreters, as there is already a relationship of trust between the consultant and the beneficiary, and in this way psychiatry is also relieved of the search for a suitable interpreter.

The situation in the field of outpatient psychiatric and psychotherapeutic care is much more difficult. An appointment with a psychiatrist or psychotherapist in private practice usually results in a waiting period of four to six months. Through intensive networking, it has now been possible to offer a weekly psychiatric counsel at the outpatient clinic for mental health St. Josef. This is for beneficiaries in urgent need of clarification, which is offered on a rotation basis by resident psychiatrists on the premises of the ASG. Results from this structural innovation and expansion of the range of services is to be waited on.

4. Scientific monitoring

The activities of the pilot project are scientifically accompanied by the Psychical Institute of the University of Würzburg. It is examined whether the mental state and stress management of participants of the psycho-educative group service improves in comparison to a control group. In addition, the psychological stress in the entire group of beneficiaries is recorded and characteristics of those who do not make use of psycho-education are analysed. The Self Reporting Questionnaire 20 (SRQ-20) of the WHO and the Letter-COPE, which covers strategies for coping with stress, serve as measuring instruments. In an initial interim evaluation, the psycho-educative intervention of participants in the qualitative survey was assessed very positively. On a quantitative level, intervention is expected to strengthen positive, active-emotional coping mechanisms. Since refugees have little control over many of their living conditions in Germany in the first period of arrival, this form of stress management (e.g. changing their own attitudes and perspectives, acceptance, exercising, anxiety-reducing and relaxing activities, expression of emotions) is highly relevant and purposeful for them.

Work is currently underway to expand the sample and the level of knowledge. First publications of the results are planned for the first half of 2018.

5. Costs and staffing

In the pilot project, three psychosocial peer counsellors (75 percent each), two psychologists and one project manager (150 percent in total) provide care to an average of 40–50 beneficiaries per month. In addition, interpreters are called in on an hourly basis if required. On average, 60–70 individual and 30–40 group sessions are held each month.

The monthly project costs, including personnel and material costs for the pilot project in Schweinfurt, amount to an average of approximately 20,000 euros.

6. Lessons Learned

The practical work on site

Challenges

Heterogeneity of the target population and rotation of countries of origin

In contrast to project countries, where the target population remains more or less stable and is relatively homogeneous, the collective shelters for refugees in Germany generally include people from very different countries of origin.

In the Schweinfurt initial admission facility, we are also confronted with a three to four month rotation of the countries of origin. The rotation has a direct influence on the possibility for our consultants to address the arrivals in their mother tongue. Whereas last year EAE was still occupied by Syrians, Iraqis, Somalis and Afghans, the main countries of origin are currently Ivory Coast, Somalia, Armenia and Algeria. In the shared accommodation, the composition of the inhabitants is further broken down by nation. Arriving asylum seekers can therefore often no longer benefit from our services in their native language, but nevertheless still with the help of interpreters. In these cases, the psychosocial peer counsellors still share important characteristics with the arrivals, namely the characteristics of 'flight experience' and 'similar cultural background'.

It would be highly desirable to expand our team of consultants to include people with the required language skills. However, this is not possible at the present time with the means available.

Lack of interpreters

The lack of interpreters on site is striking and creates problems. Asylum counselling, the police, the health department and the medical outpatient clinic are forced to resort to residents of the AE or the GU for interpreting services. Funds are apparently not available for the use of professional interpreters. Our consultants are therefore frequently requested by beneficiaries, or other interpreting, and regularly come under pressure in this respect. It is considered culturally unacceptable to turn down such requests – with the result that the actual counselling work falls behind, or that the counsellors and team leaders often must draw boundaries, which is often unpleasant and difficult.

Switching between the role of interpreter and the role of consultant is a challenging task. However, the team of consultants seems to be getting along better with this challenge.

Supply shortage for specialist services

Co-operation with the responsible psychiatry works (e.g. acute suicidal patients are referred and admitted directly; planned admissions are also possible in individual cases).

Outpatient psychiatric and psychotherapeutic care, on the other hand, is subject to considerable bottlenecks; it is virtually inaccessible to refugees. This often leads to enormous strains on our service; those beneficiaries who are not acutely suicidal but still need professional help remain in the ASG. As described above, we are currently testing a new care pilot with psychiatric consults in the outpatient clinic for mental health, which is intended to provide relief.

Due to the short duration of stay, the referral of beneficiaries to specialist psychotherapeutic services does not appear to be very helpful for residents of the EAE. For residents of the GU, however, this possibility should be examined in the case of appropriate indications. We are also experiencing considerable bottlenecks in this area of care; long waiting times for a therapy spot and the problem mentioned several times of a lack of interpreters, which makes many psychotherapists completely refrain from accepting refugees and often causes refugees to give up in their therapy efforts.

Feedback

Feedback from beneficiaries

The feedback from our beneficiaries about our services has been predominantly positive. In our work, however, we are not dealing with a homogenous group of people' – the group is extremely diverse.

Different cultural and individual backgrounds lead to completely different perceptions and opinions about our services. It is not always easy to deal with the different concepts of 'psychosocial help', to correct prejudices and fears. Again and again we have to explain the role of the psychosocial peer counsellor and the possibilities and limitations of our counselling services. We regularly seek feedback from our beneficiaries to learn from them and to develop an understanding of the different perspectives. The discussions with the three advisors about cultural habits and customs also give us better mutual understanding. During our third training session, for example, we were made aware of two Somali phrases in a discussion of different cultural perspectives on the use of counselling services by our Somali team member.

The one translates as: 'The silent mouth is gold.'

And the other: 'If you want something in your hand, talking doesn't help.'

We have since been able to explain in a much better way why the Somalis in the EAE are rather sceptical and cautious about our offer and we are trying to adapt our approach. The reactions of Somalis to simple and brief psycho-educative information events in the waiting room area remain to be seen. We are currently gaining positive experience in forming female-only groups and culturally mixed groups (e.g. Arab-speaking Somalis, Syrians and Algerians in one group).

Openness, flexibility and willingness to try out new things are essential prerequisites for the success of our work.

Feedback from our environment

The feedback from our environment has been very positive so far. By now, systematic interviews have been conducted with the facility management, with staff from the medical outpatient clinic and with the asylum counselling centre. In particular, the usefulness, relevance and appropriateness of the project has been rated as extremely good by these actors. The restricted advisory capacity and the rotation of countries of origin in the AU have been identified as limiting factors.

During a round table with different refugee actors in Schweinfurt, the participants spoke out in favour of further expansion of the approach. The use of psychosocial peer counsellors was predominantly assessed as positive and beneficial. The importance of supervisorial professional monitoring was emphasised.

Comparison initial reception facility vs. shared accommodation work setting

We are experiencing differences in the various work settings. In the initial period of arrival at the reception centre, asylum seekers are often completely absorbed by the many appointments and formalities that need to be complied with. There is a lot to be sorted out, they are active and full of hope. The suffering caused by the personal situation often fades into the background in this phase. In EAE, other appointments often overlap with our group appointments – meeting deadlines and providing reliability is a much greater issue than in shared accommodation.

Nevertheless, it seems important to introduce our offer to the arrivals right at the beginning. Even if a consultation may not be used until a later date, we can show support when people first arrive, gradually increasing acceptance of the psychosocial counselling service.

The psychological situation of the residents in the shared accommodation is completely different. The asylum status has been clarified for most of the refugees and other issues are at stake for the refugees. In our experience, people here are much more open and grateful for our services. The beneficiaries in the GU appear to be more burdened and the type of burden is more complex. For example, if there is a rejection combined with a deportation stop, which makes an integration course impossible and leads to lethargy and hopelessness; or if there is a positive asylum decision, but no housing can be found. Adherence to deadlines and reliability is much easier than in AE, and the offer is well received.

Structure

It has proven to be extremely useful to link the mental health outpatient clinic to the St. Josef medical outpatient clinic. The medical outpatient clinic St. Josef is the most important referral channel to the ASG. By linking our services to compulsory initial medical examinations, we can reach a particularly large number of people. We are also sending an important message. Psychosocial care is part of general healthcare and is a natural part of healthcare services. Short distances between the two outpatient clinics simplify consultations. A shared waiting area allows beneficiaries to visit us under the 'guise' of the medical outpatient clinic. This makes it easier for those beneficiaries who have reservations or fears about using our services.

Meanwhile, more and more people are reaching us directly through 'hearsay' without being referred by the medical outpatient clinic, which we regard as a positive sign regarding increasing acceptance and awareness of our services.

Working with psychosocial peer counsellors

Team dynamics and attitude

The group of psychosocial peer counsellors is heterogeneous in terms of professional, linguistic and cultural backgrounds. Although this heterogeneity of the group was sometimes a challenge in the training courses, it is a great advantage in practical work and an enrichment for all sides. From the very beginning, there was also a very good team cohesion and mutual support among colleagues.

The counsellors' attitude is one of the greatest resources in working with beneficiaries. The relationship experience of a respectful, human contact with the other person is of great importance for the beneficiaries, as well as the team itself. However, can you 'learn' the right attitude? In our example, there has certainly been a favourable selection process (only very specific people felt addressed by the job offer 'psychosocial peer counsellors'). On the other hand, we were able to further sensitise and strengthen the team towards its beneficiaries in helpful attitudes as consultants.

The motivation for the counselling work of all three psychosocial peer counsellors was very high right from the start. Time and again, team discussions are held about one's own role and actions. Our consultants report that they are proud of their work. They experience their task as meaningful and very important and want to 'give something back', as they say. It is also inspiring for all three to be able to make their first experiences in the German working context. The recognition of your professional qualifications acquired in your home country on the German labour market is complicated and only partially successful. They are aware that their position and further training as psychosocial peer counsellors could open up new professional opportunities and perspectives in Germany.

The professionalisation of 'peer helpers'

The most common concerns about the use of psychosocial peer counsellors relate to their professional inexperience in their role as counsellors. Above all, the consultants are not trusted with learning and maintaining a healthy, professional distance from the beneficiaries.

It is absolutely right that we expect a lot of our consultants: Every day they are confronted with extremely difficult, shocking or sad stories in their work. Beneficiary demands often cannot be met in the form in which they are addressed to the consultants. We therefore need close professional leadership, many opportunities for relief and consultation, as well as internal and external training and supervision opportunities for our psychosocial peer counsellors.

Another aspect mentioned refers to the similarity of the consultants with the beneficiaries. Can it lead to loyalty problems or mistrust when two people of different ethnic, political or religious affiliations, meet here? Processes that would not have been triggered with a neutral, distanced German consultant? In our work, we trust that the counsellors would inform us of such difficulties should they arise. Difficult examples of meetings in the consulting process were discussed with the team. So far, no such difficulty has ever occurred.

In our training courses, the contents of professional and personal self-awareness were of enormous importance. The feedback on the biographical work ('lifeline') of the team was extremely positive. It was also important to try out what had been learned in role-plays, as well as intercultural exchange in a discussion style.

Since work began, the consultants have been able to regulate their own expectations of their work. They could and can benefit from each other through numerous reflective discussions in the team; they learn to observe themselves and to look after themselves. All this helps the consultants to develop their role and to learn to distinguish themselves in a healthy way. These are ongoing processes of personal and professional development.

Formal recognition of the work of the psychosocial peer counsellors would be an important step, not only regarding existing needs, but also with regard to the self-image of the counsellors. During a specialist event at the Psychosocial Centre Düsseldorf on 21.11.2017, shortly before the completion of this guide, very similar questions were discussed. One extremely positive pilot project was 'in2balance' (see also <http://www.laienhelferprojekt-nrw.de/>), a joint project between the Ministry of Labour, Health and Social Affairs of North Rhine-Westphalia, the North Rhine Medical Association, the North Rhine Association of Statutory Health Insurance Physicians, the North Rhine-Westphalia Chamber of Psychotherapists and the Psychosocial Centre Düsseldorf. A comparable, low-threshold approach was also worked towards with psychosocial peer counsellors, and concluded that counsellors can make a valuable contribution to the psychosocial care needs of refugees, and must be further integrated into the German system. This example gives hope to the possibility of including the psychosocial peer counsellors in the German health system.

Overall, in our experience, the use of psychosocial peer counsellors in working with refugees in humanitarian contexts (not only in typical project countries, but also in the German environment), and considering the necessary structural and supervisory framework conditions, proves to be a functioning and goal-oriented working method that can and should be multiplied.

Role of psychosocial peer counsellors

The following aspects have proven to be particularly relevant in the practical work:

- Trustful contact and discussion possibilities for refugees
- Supportive relationship
- Provision of relevant information
- Orientation for refugees
- Referral function for the needs of refugees
- Cultural mediator between refugees and the German support system

Scientific monitoring

By 15 November, 2017, we had supported 263 beneficiaries in the pilot project, and 446 individual and 259 group meetings had been held.

Measuring the effectiveness of psychosocial interventions is subject to numerous challenges (e.g. early relocation of beneficiaries, untrained handling of psychometric questionnaires by beneficiaries, high personnel and time effort for the survey, etc.). Nevertheless, the systematic collection of quantitative and qualitative data is an important goal of our work on site. The first results will be published in the first half of 2018.

The following trends can be identified in our sample so far:

Overall, psychological and psychosomatic symptoms are reported in large numbers, particularly in the areas of sleep difficulties, nervousness, concentration, headaches and sadness. Our group programme leads to a strengthening of the individual's own stress management mechanisms. In particular, group intervention seems to have positive effects on active-emotional coping strategies. The positive-emotional coping is especially important against the background that many asylum-specific problems cannot be solved by the affected people themselves after their arrival. In terms of suitable coping mechanisms for beneficiaries, it is therefore more a question of reducing emotional stress than of solving the original problem.

Stressors, mentioned and experienced by refugees in the first phase of their arrival, are primarily related to their current life situation. The interviewees find the uncertainty regarding residence status and concern for family members particularly burdensome.

The psychological state is closely linked to an individual's own asylum status, which in turn determines one's future prospects: People with a refusal notice report many more symptoms than people at the beginning of their asylum procedure.

People from different countries of origin accept the psychosocial counselling support differently. Somalis, for example, use the service less frequently than members of other nationalities do.

7. Outlook

We have had many promising experiences with our pilot project in Schweinfurt and continue to do so. We have learned that our low-threshold approach to psychosocial support for refugees, using psychosocial peer counsellors, also works in the German context if the right professional and structural framework conditions are found. We hope to be able to interest German actors in our approach and promote further distribution in order to improve the – currently precarious – psychosocial care situation for refugees in Germany. We are interested in a continued exchange with refugee aid actors and political decision-makers.

The spreading of the job description 'psychosocial peer counsellors' in Germany seems to us to be the right approach. We will support a formalisation of the training course and a localisation in the German health care system.

The results of our accompanying scientific study are expected to be published in the first half of 2018.

8. Checklist project planning for interested parties

1. Thorough analysis of the target group and needs – who needs what?
2. Thorough analysis of the local supply structure – who and what is available on site?
3. Thorough analysis of stakeholders and expectations – who wants what?
4. Accurate analysis of means – money, time, personnel
5. Development of a realistic project plan – What is affordable and realistic under the given circumstances? What are the objectives?
6. In case of interest we offer a more detailed project consultation by MSF Germany
Contact: philipp.frisch@berlin.msf.org

9. Compilation of materials

Flyer - Beneficiary

Hello, my name is XY. How are you doing?

I am a psychosocial counsellor in the outpatient clinic for mental health St. Josef. I come from Iran and speak Dari, German, a little Pashto, Arabic and English. I will take care of the mental part of your health. We will talk about your current situation and how you are doing. In a one-on-one conversation I will simply listen to you, that does many people a lot of good. I have a duty of confidentiality, so our conversation will remain private and I will not pass on the information.

Together with my colleagues XY from Somalia and XY from Syria, I also offer groups on stress and stress management. We are sure you will find interesting and useful information on this important topic to take with you.

Please come by at the time agreed upon! We will then have tea and get to know each other.

Kind regards,

XY



Telephone: XY



Pilot Project

Low-threshold psychosocial support for refugees and asylum seekers

A pilot project emerges

In March 2017, MSF and St Josef Hospital in Schweinfurt began a pilot project for low-threshold psychosocial support for refugees and asylum seekers. The project has been independently continued by St Josef Hospital as of August 2017. Refugees and asylum seekers are approached with an information and counselling service from psychosocial peer counsellors with relevant backgrounds (regarding language, culture and refugee experience). The psychosocial peer counsellors undergo training with a specifically tailored curriculum and are supervised in their work by qualified staff.

Low-threshold support to close gaps in refugee care

To make access to the project as easy as possible, the information and counselling services are offered directly in the areas familiar to asylum seekers and refugees (in an initial reception centre in Schweinfurt and a secondary accommodation facility in the area). This pilot project should demonstrate new methods of providing psychosocial support with low-threshold access for refugees and asylum seekers in Germany. Existing barriers to access, as well as a glaring lack of resources in German health services, mean that the adequate provision of psychosocial support for refugees and asylum seekers is often impossible. Those who require psychosocial care are therefore often left alone with their concerns and problems and suffer an increasing deterioration in their mental health.

Goal: stabilisation, activation, easier integration

Approaching new arrivals early on and adequately in their totality can lead to a stabilisation of their mental health and to the activation of their own resources, which in turn eases integration efforts. The goal of the pilot project is also to try out the efficiency and effectivity of a low-threshold, resource-oriented approach in refugee support in order to initiate its wider implementation in Germany.

Target group: all refugees and asylum seekers

The project primarily targets those people who have fled war and crisis areas and who have only been in Germany for a short time. However, the project also targets all asylum seekers and refugees newly arrived in Germany and should enable them appropriate psychosocial support. Refugees and asylum seekers are generally people with a high level of psychological and emotional burdens through pre-, peri- and post-migration stressors that require specific attention.

The team: clinical psychologists and psychosocial peer counsellors

The pilot project is held in two locations: at the initial reception centre in Schweinfurt alongside the medical outpatient clinic of St. Josef Hospital; and a shared accommodation facility in Geldersheim. The team is made up of a clinical psychologist and three psychosocial peer counsellors who were trained and supervised by two experienced clinical MSF psychologists in the first half of 2017. This involved training and advisory talks in groups and individual settings. All members of the team have been employed as salaried employees of St. Josef Hospital. In August 2017 two psychologists were hired by St. Josef for everyday training and supervision of the peer counsellors.

Psychosocial peer counsellors: Essential actors in low-threshold care

The psychosocial peer counsellors are the central element of this pilot project. These counsellors are people who themselves have refugee experience and who have attained a secure residency permit. They have lived in Germany for at least two years, know the systems with which newcomers are confronted and bring their own interest and social ability to the work. Relevant professional experience is desirable, but not absolutely necessary.

Practice-oriented training

The training programme for the participating psychosocial peer counsellors is practice-oriented in intensive training modules (three training modules make up a total of 20 days), and involves continual training during the work itself. The supervision and training content for the psychosocial peer counsellors covers the following areas:

- Counselling skills (i.e.: verbal and non-verbal communication; counselling techniques; counselling in difficult situations; counselling technique "psychological first aid" etc.)
- Counselling knowledge (such as of the German health system; counselling concepts and the role of the advisor; the relationship between body and mind; stress and stress management; problem conceptualisation and structured problem solving; basic knowledge of resources and coping mechanisms; family and parenting / child education; family relationships and conflicts; addiction and drugs; trauma and the results of trauma; how to deal with suicidal tendencies etc.)
- Professional and personal self-awareness and experience (biographical work; own and group reflection on the theme of counsellor personality traits etc.)
- Continual expert supervision from the project manager.

Counselling in the beneficiary's native language

Beneficiary peer counselling is generally conducted in the native language of the newly arrived migrant (the psychosocial counsellors speak Arabic, Kurdish, Somali, Persian, English and German). Where required, it is possible to involve interpreters.

Counselling content

- Confidential counselling
- Psycho-education regarding stress and functional stress reduction
- Strengthening resources
- Structured problem analysis and structured problem solving
- Activation in everyday life

Prevention and early detection of mental health issues

Besides the confidential counselling services and psycho-education concerning stress management, this pilot project aims to enable the early identification of mental health issues for further referral to expert care. The project activities are categorised at the intervention level of primary and secondary prevention.

Costs and staffing

In this pilot project, three psychosocial peer counsellors (each 75 percent) and a psychologist / project manager (100 percent) attend to an average of 40 - 50 beneficiaries per month. Interpreters are also brought into the project where required and employed on a freelance basis. 60 - 70 individual counselling sessions and 30 - 40 group counselling sessions are carried out each month. The monthly costs of this pilot project in Schweinfurt, including personnel and material costs amount to roughly 20,000 euros.

Feedback from beneficiaries and scientific insights (from end of 2017)

The activities of the pilot project are scientifically analysed. The goal of this analysis is to establish whether the mental health and stress management of the project's beneficiaries improve in comparison to a control group. In addition, the level of psychological strain across the whole group of beneficiaries is recorded and the characteristics of the people who do not accept psycho-education or counselling assistance is analysed. The Self Reporting Questionnaire 20 (SRQ-20) from WHO and the Brief-COPE from Knoll et al. (2000) are used as measurement instruments. In the first interim evaluation, the psycho-educative intervention was rated as being very positive by beneficiaries in the qualitative survey. On a quantitative level evidence showed an increase in positive, active emotional management mechanisms through the intervention. Since the refugees and asylum seekers have little control over their circumstances in Germany in the initial period of arrival, exactly this type of stress management is highly relevant. The scientific accompaniment of the project is continuing with the project, and a publication of the study findings is planned for the first half year of 2018.

Summary of working principles

- Low-threshold – the easiest possible and stigma-free access to counselling services
- "Peer to peer" and "helping people help themselves" – prevention through early basic help and psychosocial peer counsellors and easing the burden on expert assistance services.
- Referential resources – the focus of this approach is on the totality of the person and strengthening healthy coping mechanisms
- Synergy rather than parallel structures – close co-operation and networking with other actors in refugee support services

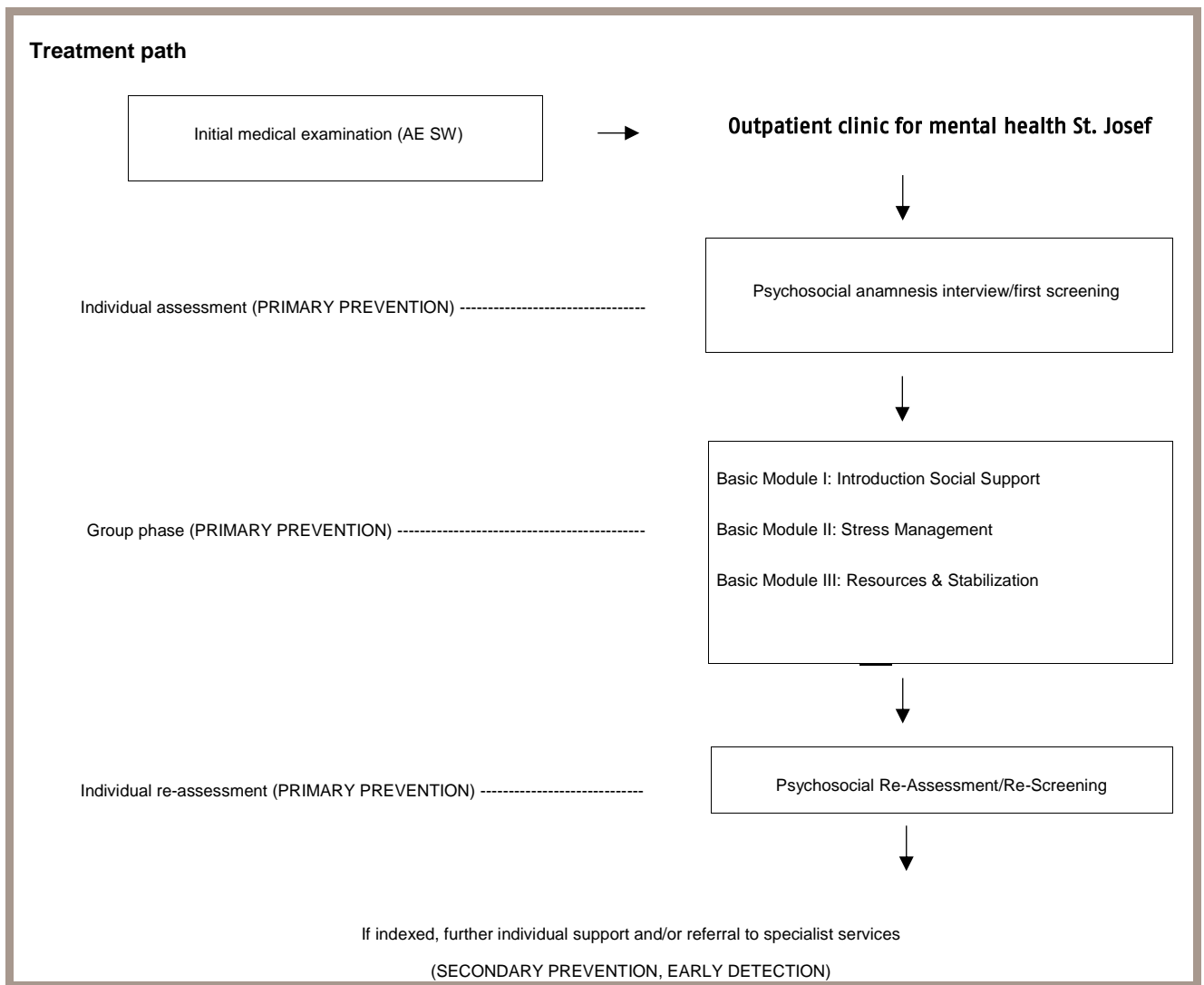
- Developing local capacity – capacity building, meaning the accentuation of knowledge transfer, training and further education of local employees

Contact



For further questions and information, please contact Dr. Henrike Zellmann (henrike.zellmann@berlin.msf.org) or Philipp Frisch (philipp.frisch@berlin.msf.org). For those interested, we offer expert assistance for the realisation of project ideas.

Treatment path



Data
tool

Leaflet/first meeting

Beneficiary No.:	Date:
Counsellor name:	Survey site:
MID:	Town, building, room, apartment:
Date of birth:

Disclosure: Confidentiality The counsellor role psychosocial services

Beneficiary data

Name: **Sex:** Male Female

..... **Age (Years):**

Telephone No.: **Marital status:**

single living in partnership

married divorced

widowed partner left behind

Information on family/children/relatives in Germany (Here alone? With the family? Who is 'missing'?)

.....

Work/Profession/Apprenticeship: **Number of school years:**

Asylum status: Application already filed? No Yes, on (D/M/Y):

- Waiting for reply Recognition Rejection
- 3 Years Appeal filed: Yes No
- 1 Year
- Toleration
- Deportation date (D/M/Y):

Country of origin: **Fellow travellers:**

Begin of flight (M/Y): **Arrival in Ger. (M/Y):**

Flight route (please note if stay in country lasted longer than six months):

.....

Medical anamnesis

“Do you have any relevant medical condition?”

“Are you in psychiatric care?” (*Diagnosis*):

“Are you currently taking medication?”

(*Drug, dose, since when?*)

Stress (Scale 1-10)

“How stressed did you feel before you fled your home country?”	
“How stressed did you feel during the flight?”	
“How stressed are you right now?”	

Current psychosocial situation

Problems: “Do you currently have worries or problems?” (*Underline the most important!*)

Coping: “What have you done about your worries and problems so far?”

Resources: “What are the current positive aspects of your life? What gives you strength?”

Notes:

Psychometric Screenings – SRQ-20

Self-reporting Questionnaire (SRQ-20)

SRQ Item	YES	NO
1. Do you often have headaches?		
2. Is your appetite poor?		
3. Do you sleep badly?		
4. Are you easily frightened?		
5. Do your hands shake?		
6. Do you feel nervous, tense or worried?		
7. Is your digestion poor?		
8. Do you have trouble thinking clearly?		
9. Do you feel unhappy?		
10. Do you cry more than usual?		
11. Do you find it difficult to enjoy your daily activities?		
12. Do you find it difficult to make decisions?		
13. Is your daily work suffering?		
14. Are you unable to play a useful part in life?		
15. Have you lost interest in things?		
16. Do you feel that you are a worthless person?		
17. Has the thought of ending your life been on your mind		
18. Do you feel tired all the time?		
19. Are you easily tired		
20. Do you have uncomfortable feelings in your stomach?		
SRQ-20 Total Score (total of yes)		

Brief COPE

These items deal with ways you have been coping with the stress in your life since you found out you were going to have to have this operation. There are many ways to try to deal with problems. These items ask what you have been doing to cope with this one. Obviously, different people deal with things in different ways, but I am interested in how you have tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you have been doing what the item says. How much or how frequently. Don't answer based on whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

- 1 = I haven't been doing this at all
- 2 = I've been doing this a little bit
- 3 = I've been doing this a medium amount
- 4 = I've been doing this a lot

1. I have been turning to work or other activities to take my mind off things.
2. I have been concentrating my efforts on doing something about the situation I'm in.
3. I have been saying to myself "this isn't real."
4. I have been using alcohol or other drugs to make myself feel better.
5. I have been getting emotional support from others.
6. I have been giving up trying to deal with it.
7. I have been taking action to try to make the situation better.
8. I have been refusing to believe that it has happened.
9. I have been saying things to let my unpleasant feelings escape.
10. I have been getting help and advice from other people.
11. I have been using alcohol or other drugs to help me get through it.
12. I have been trying to see it in a different light, to make it seem more positive.
13. I have been criticizing myself.
14. I have been trying to come up with a strategy about what to do.
15. I have been getting comfort and understanding from someone.

Psychometric Screenings – Stress Rating

Emotional stress

"You may experience psychosocial discomfort such as anxiety, sleep problems, strife with your family, or difficulties concentrating. Please briefly mention your most important psychosocial problem." (Please choose a problem!)

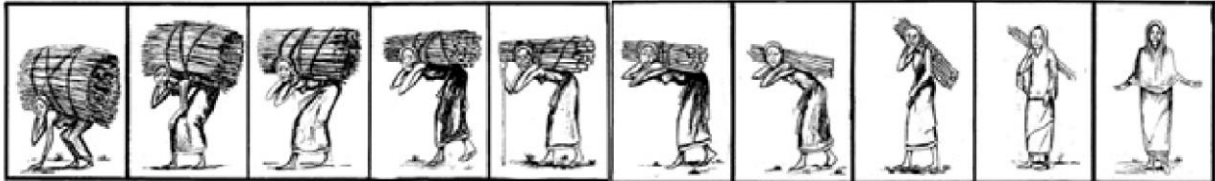
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"How emotionally burdened are you by this problem?" Please mark the image below (O) to indicate how severe this problem feels for you.

On the left "I feel completely overwhelmed."

Middle "It's hard. Sometimes I can handle it, sometimes I can't."

On the right "I'm getting along very well with it, it doesn't bother me that much."



O O O O O O O O O O

Functionality in everyday life

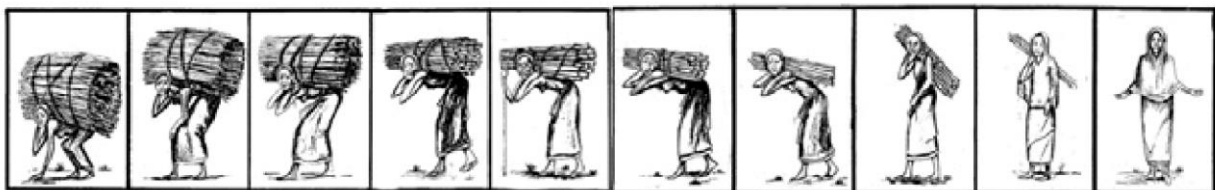
"This psychosocial problem may affect how well you can perform your everyday activities (e.g. household chores, meeting friends, personal hygiene). To what extent does this psychosocial problem affect the different tasks of your everyday life?"

Please tick the picture below (O), which most likely expresses how much the problem affects your daily functioning.

On the left "I can't do any of my daily activities."

Middle "Half - half, I can only perform part of my daily activities".

On the right "I have no difficulty in carrying out my daily activities as usual".



O O O O O O O O O O



Group module I: Introduction (15 + 90 min.)

The centrepiece of the hour: the participants get to know each other. Participants get an idea of the counselling services and the connection between stress and mental strain. The participants get an idea of the connection between thoughts and feelings. The participants are offered an opportunity to talk about their current situation.

0. Arrival of participants – Tea, coffee (15 min.)

1. Introduction of trainers and the structure of the program (5 min.)

- *Name and origin of the trainers, since when in Germany; explanation: role of the consultant*
- *3 groups of 90 minutes each, information about following appointments*
- *Closed and consecutive groups; regular participation is important*
- *The main topics are stress and stress management.*
- *Registration of participants in the group master data sheet; Explanation: Data will only be used for internal purposes and will not be passed on.*

2. Confidentiality (3 min.)

- *What does confidentiality mean? Why is it so important?*

3. Group rules (8 min.)

- *Which rules should apply in the group? Collect in group, write suggestions on flip chart. **Trainer makes additions / comments.** Communication rules, secrecy, turning off your mobile phone during meetings. Remove posters with group rules, hang them up again for the next two modules.*

4. Pair exercise: Presentation of the group participants (10-15 min.)

- *Trainer explains pair exercise. Groups of twos, one interviewing the other, then presentation in the group. (Name? Age? Country of origin? Who came to Germany with you? Profession? Are you already learning German? meaning of the name - who gave it, what does it mean, is there a family tradition to the name etc.)*
- *Presenting the partner to the group*

5. Introduction to the topic of stress (8 min.)

- *What is stress? How do I know I have stress? Collect in the group, write suggestions in keywords on flip charts. Trainer adds and comments. Stress is a normal reaction of the body to the challenges of everyday life. If a stress reaction lasts too long and/or is very intense, you should seek advice.*
- *It is normal to react with stress in a stressful time and with stressful memories. Next time more information about stress and dealing with stress.*

6. Introduction to the topic of health (8 min.)

- *There is physical and mental health*
- *When do you go to the doctor, when do you go to the counsel? What is the role of a consultant? What can a consultant NOT provide?*
- *Which situations and symptoms can lead to consultation? (Situations: e.g. conflicts between couples, difficult experiences on the flight or before the flight; symptoms: e.g. sleep problems - loss of interest, retreat - persistent sadness, fear - changing physical complaints, for which the doctor cannot find a cause - increased substance consumption)*

7. The power of our thoughts (15 min.)

- The trainer gives the example with a half full/half empty glass. Develop: People perceive situations very differently. People are able to gain more control over their feelings by changing their assessment and thoughts ('positive thinking'). **Give time for discussion in the group.**

8. Breathing exercise (8 min.)

9. End (What are you taking with you from the group?), Reference to next module, ratings EB/FA (10-15 min.)



Group module II: Stress Management (90 min.)

The centrepiece of the hour: strengthening helpful coping mechanisms - the emphasis is on a constructive exchange within the group and motivation for an active coping with everyday life.

1. Welcome, Registration (group master sheet) (5 min.)
2. Flash round (8 min.)
 - *How are you today? With which feelings are you joining the group today? Trainer begins, involves feelings, passes on to group participants*
3. What is stress? How do you know you have stress? (8 min.)
 - *Definition of 'stress': The stress reaction of our body is a normal reaction to the challenges of life. The stress reaction is initially something positive because it releases energies in us to tackle and solve problems. Usually a stress reaction is temporary and subsides when the stressful situation is overcome. However, if our body's stress reaction lasts too long, it can make us sick and cause symptoms such as persistent insomnia, nervousness, body aches, etc.*
 - *The stress posters are clamped to the flip chart one after the other. Which situations lead to stress? What reactions are there? What can we do to deal with the situation? Important: Trainer involves the group, asks for own experiences, reactions and coping mechanisms. **The focus is on the third poster!** Emphasize overall **active coping and daily structure**. Acceptance is another topic: what can I change, what can I not change?*
 - ***The participants should talk more than the trainers!***
 - *Summary by the trainers: Every person has his individual, typical stress pattern and his individual coping mechanisms. Everyone reacts differently to stress, everyone finds his own way to deal with his stress. The trainers motivate the participants to try out new coping strategies.*

4. Mindfulness exercise: self-observation (3-minute exercise)/breathing exercise (8 min.)

- Trainer refers to exercise from the last hour. Now observe more specifically: with closed eyes 1 minute on the environment, 1 minute on the own body, 1 minute on the own feeling pay attention; only observe, do not evaluate. Group feedback, if desired.

5. End, reference to next module, ratings EB/FA (10-15 min.)



MEDECINS SANS FRONTIERES
ÄRZTE OHNE GRENZEN e.V.



KRANKENHAUS
ST. JOSEF
SCHWEINFURT

Manual for counsellors

Group module III: Resources (90 min.)

The centrepiece of the lesson: Each participant is given the opportunity to reflect on their own personal resources and coping strategies and to present them to the group.

1. Welcome, Registration (group master sheet) (5 min.)
2. Flash round (5 min.)
3. Introduction to the topic of acceptance (10 min.)
 - *Problems cause us stress. There are problems that can be changed (e.g. communication - language course). Here it is important to take action and try to change the situation. But there are also problems that cannot be changed (e.g. reply to asylum application). If you can't change things, you should try to accept the situation and save energy for your everyday life in order to survive the difficult time as well as possible. Changeover to the topic of resources*
4. Introduction to the topic of resources (15 min.)
 - *What are resources? There are external and internal energy sources/power sources.*
 - *External resources e.g.: relationships, family, friends, work, money, education etc. The trainers make examples that the participants complete.*
 - *Internal resources e.g.: valuable experiences and memories, "treasure" memories, knowledge, faith, feelings, values, thinking, the "I", healthy lifestyle, patience, will, personal goals, the ability to think positively, hope etc. The trainers make examples that the participants complete.*
 - ***Focus on inner resources and personal coping strategies*** - *what can help you to survive this difficult time?*

5. Tree of resources (40 min.)

- *The trainers paint a tree with roots, trunk, branches and leaves on the flip chart. They make a few very personal examples of inner and outer resources (e.g. that I have a good relationship with my son gives me strength, that I can be funny and make others laugh is special about me, the song "XY" because it reminds me of a beautiful situation with my wife etc.)*
- *Helpful questions for the participants: What is good for me here in everyday life? What can I believe in? Which inner values give me support and strength? What can I do if I am sad? What am I good at? What about myself am I proud of? What am I grateful for? Who am I in contact with? The content of the resource tree should be as personal and individual as possible!*
- *The trainers hand out painting materials. Each participant should paint his own personal resource tree, introduce it to the group (voluntarily) and take it home. The presentation of resource trees is the centrepiece of the hour! The trainers give the participants a lot of time and attention during the presentation in the big round.*

6. Imagination Exercise (Imagination of the own resource tree) (5 min.)

7. Conclusion, acknowledgement, final round ("What do I take with me from the group?"), reference to second interview in approx. two weeks, ratings EB/FA (10-15 min.)



Stress: Causes, Signs and Coping Strategies

Stress is normal part of our everyday lives, and is not an illness itself, However, if signs of ongoing stress are not managed it can result in physical and mental health problems.

Causes Of Stress To Women, Men and Children



WAR/CONFLICT



DEATH OF FAMILY MEMBER



DISPLACEMENT



SEPARATION OF FAMILY MEMBER



LACK OF FOOD



JOBLESS



DEPENDENT ON OTHERS FOR SURVIVAL



FAMILY CONFLICT



LIVING AMONGST STRANGERS



SOCIAL ISOLATION



UNCERTAIN FUTURE



OTHER CAUSES OF STRESS



Stress: Causes, Signs and Coping Strategies

When we experience ongoing stress in our lives, there are various ways our body and mind reacts to these tensions and pressures.

Below are a selection of the signs of ongoing stress.

SIGNS OF ONGOING STRESS



GENERAL BODY ACHES / PAIN



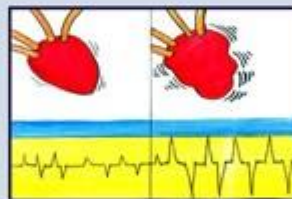
LACK OF APPETITE



SLEEPLESSNESS



PROFUSE SWEATING



POUNDING / IRREGULAR HEARTBEAT



SADNESS / CRYING FREQUENTLY



SELF-ISOLATION



ANGER / AGGRESSION TOWARDS OTHERS



ANGER / AGGRESSION TOWARDS SELF



POWERLESSNESS



OTHER SIGNS OF STRESS



Stress: Causes, Signs and Coping Strategies



WHY DOESN'T MEDICATION ALWAYS WORK?

Medication help us feel better for a short time from what is upsetting us. It will not provide a permanent cure, because what is upsetting us comes from something bad that has happened or an unhappy time. These unhappy events have caused an emotional wound to our minds. Like all wounds, time is the real healer. Unless the "emotional wound" is allowed to be healed, then we remain stressed. The best way to heal is to share our memories, feelings and worries with someone we trust, someone in our family or a close friend.



TRY TO EAT



AVOID DRINKING TEA AFTER SUNSET



SHARE YOUR WORRIES WITH SOMEONE YOU TRUST/FAMILY



EXPLORE SUPPORT NETWORKS WITHIN THE COMMUNITY



SPEND TIME WITH CHILDREN / PLAYING



PARTICIPATION IN CULTURAL ACTIVITIES



SPORTS / GAMES



PHYSICAL EXERCISES



BREATHING EXERCISES



NEEDLEWORK / CARPET WEAVING



SPIRITUAL ACTIVITIES



ANY OTHER WAYS

Second meeting

Data
tool

Beneficiary No.: **Date:**

Counsellor name: **Survey site:**

Telephone-No.: **Building, room:**

Asylum status: Application already filed? No Yes, on (D/M/Y):

Waiting for reply

Recognition

Rejection

3 Years

Appeal filed: Yes No

1 Year

Toleration

Deportation date (D/M/Y):

“Are you currently taking medication?”

“How stressed are you currently?” (Scale 1-10):

Current psychosocial situation

Problems: “Do you currently have worries or problems?” (*Underline the most important!*)

Coping: “What have you done about your worries and problems so far?”

Resources: “What are the current positive aspects of your life? What gives you strength?”

Psychoeducation groups

„How satisfied are you with the psychoeducation groups?“



Not satisfied at all

Very satisfied

"What exactly about the groups helped you? What exactly did you personally find useful?"

"What suggestions, criticism or wishes do you have for the groups?"

Notes:

Individual counselling

Data
tool

Beneficiary No.:	Date:
Counsellor name:	Survey site:
Telephone-No.:	Building, room:

Asylum status: Application already filed? No Yes, on (D/M/Y):

- Waiting for reply Recognition Rejection
 3 Years Appeal filed: Yes No
 1 Year
 Toleration
 Deportation date (D/M/Y):

Brief reminder on last meeting

„How stressed are you currently?“ (Scale 1-10):

Current situation:

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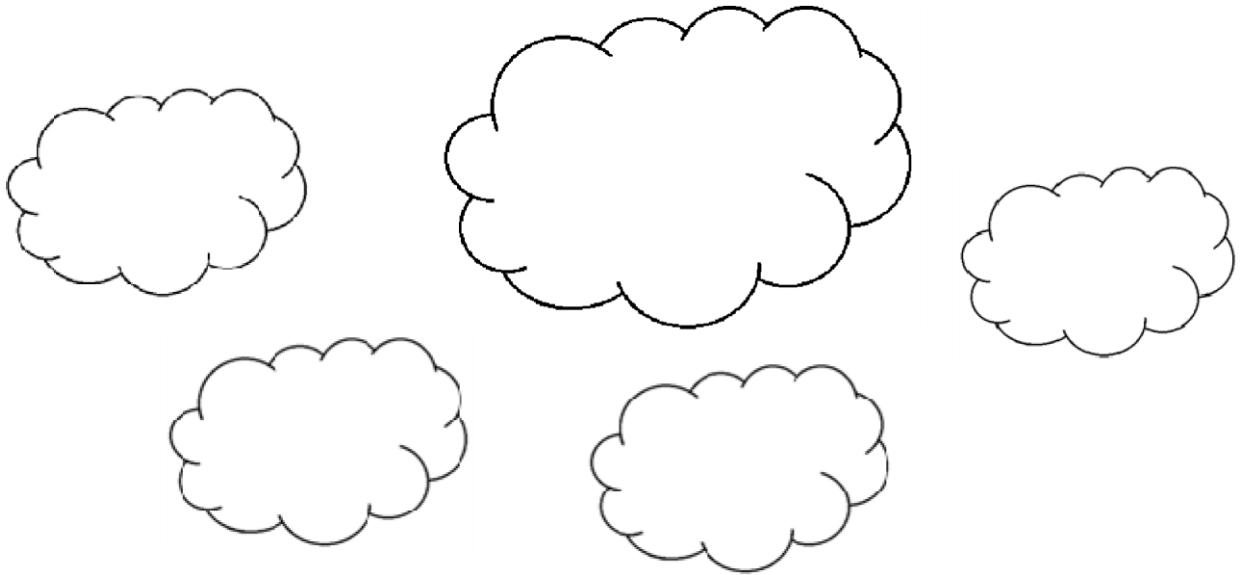
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Problem exploration



These are the points the beneficiary wants to talk about today:

What intervention took place today?

- Sort problems
- Develop alternative solutions and encourage their use
- Strengthening resources
- Acquire new perspectives
- Asking helpful questions
- Practice
- Other:

What does the beneficiary take home/concrete task:

.....
.....
.....

Data
tool

Follow-up

Project name: German Refugee MH DE003

Beneficiary No.:	Date:
Counsellor name:	Survey site:
Telephone-No.:	Building, room:

Asylum status: Application already filed? No Yes, on (D/M/Y):

- Waiting for reply
- Recognition
- Rejection
- 3 Years
- 1 Year
- Toleration
- Appeal filed: Yes No
- Deportation date (D/M/Y):

„How stressed are you currently? “(Scale 1-10):

Current situation:

.....
.....
.....
.....

What was discussed/agreed on?

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Drawing by an eight-year-old girl from Afghanistan



Brief description:

The project "Psychosocial support for asylum seekers: Low-threshold preventive care at the reception center "Schweinfurt" is a pilot project for newly arrived refugees in Germany and aims to facilitate access to low-threshold psychosocial assistance for asylum seekers by installing a psychosocial counselling center based on the internationally proven MSF model. The psychosocial advisors come from a similar or the same cultural and linguistic background as the refugees and work under professional guidance and supervision.

Early, low-threshold help contributes to an appropriate processing of stressful events, to an increase in one's own resistance and psychological stability, counteracting a chronology of psychological suffering.

Within the scope of the project, a psychosocial counselling center will be installed in the Schweinfurt reception facility, which is operated by the St. Josef Hospital. Moderated discussion groups (women, men, young men, young women, etc.) are offered with the aim of psycho-education and relief discussions for families and individuals. In the sense of an outreach approach, the surrounding asylum shelters are also looked after psychosocially by a mobile team. Furthermore, close cooperation and networking with local refugee aid actors is planned.

Aim:

Promotion of the mental health of refugees/asylum seekers by providing low-threshold psychosocial support and early addressing of psychosocial needs.

Areas of responsibility under professional supervision:

- Preparation and implementation of low-threshold psycho-educative offers in individual and group settings in the initial reception facility in Schweinfurt, in the St. Josef Schweinfurt Hospital and in surrounding asylum shelters
- Implementation of low-threshold psychosocial activities and counselling interviews in individual and group setting in the Initial reception facility in Schweinfurt, in the St. Josef Schweinfurt hospital and in the surrounding asylum shelters
- Information, contact management and networking in the vicinity of the facilities
- Information and support for employees and residents of refugee institutions on health, psychiatric and psychosocial issues (pilotage)
- Establishment of contacts with refugees with mental disorders and, in the event of illness, placement in psychiatric treatment or the psychiatric help system (case management)
- Initiation of suitable psychosocial measures for the refugees and/or connection to existing offers outside the shelters

Requirement profile:

- Relevant migration background (Afghanistan, Syria, Iraq, Iran, Somalia, Eritrea, Algeria) and/or precise knowledge of the regions
- Relevant language skills: native language(s), German (min. B2), English (desirable) with exact description of the respective language level
- School diploma, completed apprenticeship
- Migrated persons/refugees with residence title/secured residence status with social work/social pedagogic/pedagogical/psychological training or other suitable vocational training
- Relevant work experience
- Intercultural competence/cultural sensitivity
- Driving license class III (desirable)
- Computer proficiency
- Good knowledge of the local psychosocial / psychiatric help system in Schweinfurt and the surrounding area (desirable)
- Living in Germany for at least 2 years

We offer you:

- Independent working
- A many-sided and responsible task
- A salary according to the employment contract guidelines of the German Caritas association, with all social benefits of the public service; the amount of the salary depends on your professional, state-recognized qualification



Psychologist (m/f) with clinical background

The employment is initially limited until 15.02.2018; there is a prospect of contract extension. The work takes place in the outpatient clinic for mental health St. Josef in the rooms of the reception facility in Schweinfurt.

Brief description:

The project "Psychosocial support for asylum seekers: Low-threshold preventive care at the reception center "Schweinfurt" is a pilot project for newly arrived refugees in Germany and aims to facilitate access to low-threshold psychosocial assistance for asylum seekers by installing a psychosocial counselling center based on the internationally proven MSF model. The psychosocial advisors employed in our pilot project come from a similar or the same cultural and linguistic background as the refugees and work under the professional guidance and supervision of the sought-after psychologist. The psychosocial advisors receive intensive training and continuous further education as part of their employment. Early, low-threshold support and offers contribute to an appropriate processing of stressful events, to an increase in one's own resistance and psychological stability, counteracting a chronology of psychological suffering.

Within the scope of the project, a psychosocial counselling center (outpatient clinic for mental health) was installed in the reception center in Schweinfurt, which is operated by the St. Josef Hospital. Moderated discussion groups (women, men, adolescent men, young women, etc.) are offered with the aim of psychoeducation and relief discussions for families and individuals. In the sense of an outreach approach, the surrounding asylum shelters are also looked after psychosocially by a mobile team. Networking with local refugee aid actors is part of our approach.

Aim:

Promotion of the mental health of refugees/asylum seekers by providing low-threshold psychosocial support and early addressing of psychosocial needs.

Areas of responsibility under professional supervision:

- Professional supervision of psychosocial consultants (team and individual supervision, personnel development according to the MSF model)
- Support of psychosocial advisors in the preparation and implementation of low-threshold psycho-educative offers in individual and group setting in the initial reception facility in Schweinfurt, in the St. Josef Schweinfurt hospital and in surrounding asylum shelters
- Initiation of suitable psychosocial measures for the refugees or connection to existing offers outside the accommodations
- Information, contact management and networking in the vicinity of the facilities
- Information and support for employees and residents of refugee institutions on health, psychiatric and psychosocial issues
- Establishment of contacts with refugees with mental disorders and, in the event of illness, placement in psychiatric treatment or the psychiatric help system (case management)
- Documentation and evaluation of the measures and activities carried out, reporting
- Participation in public relations work
- Participation in the further development of the project approach

Requirement profile:

- Completed studies in psychology
- Relevant work experience, in particular work experience in psychosocial-consulting and/or clinical-psychiatric settings as well as in international/intercultural cooperation
- Experience in team supervision and case supervision
- Intercultural competence/cultural sensitivity

- Driving license class III (desirable)
- Computer knowledge
- Good knowledge of the local psychosocial / psychiatric help system in Schweinfurt and the surrounding area (desirable)

We offer you:

- One-month training by a MSF specialist
- Working independently
- A many-sided and responsible task
- A salary according to the employment contract guidelines of the German Caritas association, with all social benefits of the public service; the amount of the salary depends on your professional, state-recognized qualification

Dr. Henrike Zellmann will be happy to answer any professional questions you may have under the telephone number 0163 8808 418

If we have attracted your interest, please send your detailed application documents (including cover letter, motivation letter, CV and all relevant training and work certificates) by **15.06.2017** at the latest in written form to the

Hospital St. Josef, Ludwigstr. 1, 97421 Schweinfurt, Germany, Mr. Norbert Reuther, Head of Human Resources

Training curriculum psychosocial peer counsellors Block I

Training block I psychosocial peer counsellors, February 2017 – MSF Pilot project ,Psychosocial support for refugees			
Day 1 16.02.2017	Introduction Pair exercise interview Group rules What does consulting mean? What does it mean to be a consultant? What is the role of a consultant? Confidentiality	What does counselling mean? (Zellmann)	9-12 a.m.
	Theory: What is mental health? Physical versus mental health Theory of personality Introduction Salutogenesis Relationship between body and mind Humanistic perspective Embodiment theory	The relationship between body and mind (Pilot)	1-4 p.m.
Day 2 17.02.2017	Flash round and morning circle Presentation of the functioning of the psychosocial counselling centre Consulting stages Consulting center Schweinfurt and Geldersheim Initial interview and survey instruments	Work approach and structure in the pilot project (Zellmann)	9-12 a.m.
	Verbal and non-verbal communication Behavioral observation What is empathy? Conversation according to Rogers Paraphrasing, summarizing, restarting Active listening	Communication I (Pilot)	1-4 p.m.
Day 3 18.02.2017	Flash round and morning circle Verbal communication Helpful and less helpful questions Leading questions	Communication II (Pilot)	9-12 a.m.
	My values and perceptions Life lines	Self-awareness I (Pilot)	1-4 p.m.
Day 4 20.02.2017	Flash round and morning circle First meeting (role plays) Use of survey instruments (role plays)	Use of survey instruments (Zellmann&Blattner)	9-12 a.m.
	Trauma and trauma effects	Trauma (Zellmann)	1-4 p.m.
Day 5 21.02.2017	Flash round and morning circle What are resources? What are coping mechanisms? Case studies	Resources and coping mechanisms (Pilot)	9-12 a.m.
	Flash round and morning circle Psychological first aid (role plays)	Psychological first aid (Zellmann)	1-4 p.m.

Day 6 22.02.2017	What are my personal resources? Working with life lines	Self-awareness II (Pillot)	9-12 a.m.
	Presentation of the group concept Group module I (role plays)	Group module I (Zellmann)	1-4 p.m.
Day 7 23.02.2017	Flash round and morning circle Group module II (role plays)	Group module II (Zellmann)	9-12 a.m.
	Group discussion: What does it mean in my culture to take your own life? What words are there for that? Case studies Critical counseling scenarios	Suicidality and other critical counseling scenarios (Zellmann & Pillot)	1-4 p.m.
Day 8 24.02.2017	Flash round and morning circle Group module III (role plays) Use of the group data sheet	Group module III (Zellmann)	9-12 a.m.
	Self-care	Self-awareness III (Pillot)	1-4 p.m.
Day 9 25.02.2017	Flash round and morning circle The German health system, especially the Mental Health System (SPD, JA, School Psychology Service, PT, KJP etc.; financing systems etc.) Referral system	The German health system (Zellmann) 90 Min.: flexible, consolidation, e.g. group dynamic	9-12 a.m.
	Revision Clarification of questions Completion	Completion	1-4 p.m.

Training curriculum psychosocial peer counsellors Block II

Training block II psychosocial peer counsellors, February 2017 – MSF Pilot project ,Psychosocial support for refugees

Day 1 03.04.2017	Flash round and morning circle	Professional/case-related self-experience (Zellmann)	9-12 a.m.
	Resumé of the first working weeks What is easy for me, what is difficult for me? What are difficult situations, difficult beneficiaries for me - and why? Case-related self-experience		
	Maslow's needs hierarchy What problems and worries do beneficiaries face? Problem typification and forms of interventions	Problem conceptualization and helpful forms of interventions (Pillot)	1-4 p.m.
Day 2 04.04.2017	Flash round and morning circle	The second meeting (Zellmann)	9-12 a.m.
	Structure and contents of the second meeting The IES-R and TSQ questionnaires The further treatment pathway Indication and structure of Individual counselling The safe place		
	Paraphrasing, summarising, reframing (Theory & role plays, case studies)	Imagination exercise (Pillot) Conversation techniques (Pillot)	1-4 p.m.
Day 3 05.04.2017	Flash round and morning circle Troubleshooting - How do I find out what my beneficiary's main problem is? Introduction to structured problem solving Questions as a consulting technique Case study	Conversation techniques (Pillot) Case conceptualisation (Pillot)	9-12 a.m.
	Suicidality Conversation with suicidal clients Case study	Impulse lecture (Zellmann) Case conceptualisation (Pillot)	1-4 p.m.
Day 4 06.04.2017	Flash round and morning circle The objectives of our psychosocial counselling When do we do/ask what - and why? Grief	Capturing the meta-level (Zellmann&Pillot) Impulse lecture (Zellmann)	9-12 a.m.
	The unstructured/logorrheic client The dissatisfied/demanding client Case studies of the team Sleep disorders	Conversation in difficult consulting situations (Zellmann) Case presentation, supervision and case conceptualization (Zellmann&Pillot) Impulse lecture (Zellmann)	1-4 p.m.
Day 5 07.04.2017	Flash round and morning circle		9-12 a.m.
	Case studies of team Family conflicts	Case presentation, supervision and case conceptualization (Zellmann&Pillot) Impulse lecture (Pillot)	
	End and completion of second training phase	Psychological first aid (Zellmann)	12-2 p.m.
	Discussion and evaluation	Debriefing (Zellmann&Pillot)	3-5 p.m.

Training curriculum psychosocial peer counsellors Block III

Training block III psychosocial peer counsellors, February 2017 – MSF Pilot project ,Psychosocial support for refugees

Day 1 19.06.2017	Flash round and morning circle Where does the project stand? A look at the past, into the present and into the future.	Reflection and intermediate resumé (Zellmann)	9-12 a.m.
	Where do I stand? What are my topics? Self-reflection and self-perception as development opportunity for counsellors Stress management & self-care for counsellors	Professional self-experience (Zellmann & Pillot)	12.30-3.30 p.m.
Day 2 20.06.2017	Flash round and morning circle Reflection on the role of the counsellor Conversation according to Rogers role play Problem conceptualization Stress management for counsellors	Conversational guidance in the individual counselling situation (Pillot)	9-12 a.m.
	Drugs and addiction Role play	Impulse lecture (Zellmann) Case work (Zellmann & Pillot)	12.30-3.30 p.m.
Day 3 21.06.2017	7-step problem solving pattern Family & Education Developmental tasks and psychology of the life span Family relationships and dynamics Family conflicts and counselling approaches	Structured problem solving (Zellmann) Thematic impulses (Zellmann&Pillot) Family (Zellmann&Pillot) Discussion (Pillot&Zellmann)	9-12 a.m.
	Case study and practical exercises Role play: A demanding, dissatisfied client	Case study (Zellmann & Pillot)	12.30-3.30 p.m.
Day 4 22.06.2017	Flash round and morning circle Repetition from the previous day: Structured problem solving Domestic and sexual violence Role play: problem analysis, problem conceptualisation, problem solving pattern	Repetition: Structured problem analysis, structured problem solving (Zellmann) Impulse lecture (Pillot) Case study (Zellmann&Pillot)	9-12 a.m.
	Work management	Work management (Blattner)	12.30-3.30 p.m.
Day 5 23.06.2017	Flash round and morning circle Role play: The role of the consultant The first data has been evaluated - feedback to the team Evaluation of the questions and topics of the team of day 1 Conclusion, feedback round, farewell to Anne Pillot	The role of the consultant (Zellmann&Pillot) Reflection and intermediate resume (Zellmann&Blattner) Wrap Up (Zellmann) Outlook and conclusion (Zellmann&Pillot)	9:00 a.m. -1 p.m.
	Final discussion and evaluation (trainers only)	Completion of training (Zellmann&Pillot)	2:00 -4:30 p.m.



Certificate

Herewith it is confirmed that XY participated with great success participated in a 20-day full-time training course (advanced training as a psychosocial lay counsellor* - 3 training blocks of 9 or 5 training days respectively each) of MSF Germany.

The training took place within the framework of the pilot project 'Low-threshold psychosocial support for refugees and asylum seekers', a cooperation project between MSF Germany and the St. Josef Schweinfurt Hospital. In addition, Dr. Henrike Zellmann, project manager of the pilot project in the initial admission facility in Schweinfurt and the Geldersheim joint accommodation in the period 15.02.-31.07.2017, continuously supervised and trained Mr. XY. From 01.08.2017, the professional supervision of qualified staff of the St. Josef Schweinfurt Hospital will be continued.

The following topics were taught in theory and practice:

1. consulting skills (see description overleaf)
2. consulting expertise (see description overleaf)
3. professional and personal self-awareness (see description overleaf)

The following techniques were used to impart knowledge: Work in small groups, frontal lectures, role plays, group discussions, short presentations of the participants.

We wish Mr. XY all the best for his future career.

Dipl.-Psych. Dr. Henrike Zellmann
Project manager MSF Germany

Dipl.-Psych. Anne Pillot
Co-Trainer MSF Germany

*Note: At a later date, we changed the vocational title 'psychosocial lay counsellor' to 'psychosocial peer counsellor'. In our opinion, the term 'lay counsellor' is misleading and does not express enough of the existing professionalism of the counsellors.



- **Consulting skills**
 - Communication - theory and practice
 - Conversation techniques
 - Conversation in difficult consulting situations
 - Conversational techniques of 'Psychological First Aid'

- **Consulting expertise**
 - What is consulting? Consulting concepts and the role of the consultant
 - The relationship between mind and body
 - Salutogenesis
 - Problem conceptualization and structured problem solving
 - Impulse lectures on the topics: German health care, stress and stress management, resources and coping mechanisms, developmental tasks and psychology of life span, family and education, family relationships and family dynamics, family conflicts, domestic and sexual violence, sleep disorders, trauma and trauma consequences, drugs and addiction, dealing with suicidality

- **Professional and personal self-awareness**
 - Biographical work
 - Self- and group reflection on the topic of consultant personality
 - Continuous supervision by the project management





Ambulanz für Seelische Gesundheit

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Structure of case study

1. Formulation of the consultant's question to the group/supervisor
2. Description of the main problem and the beneficiary's objective
3. Basic information (gender, age, country of origin, special features)
4. Background information (social and family situation, escape history)
5. Particularities in the biography (e.g. serious illnesses, deaths in the family, special family constellations etc.)
6. Individual resources of the client
7. Questions of the group
8. Brainstorming in the group
9. Determining the next steps in the consulting process

Questions as an instrument of consulting

Questions for researching the beneficiary's state of health

- When did this feeling start?
- When did this symptom start?
- What happened during that time?
- Tell me more about it.
- How exactly does this manifest itself?
On a scale of 0 to 10, how strong is the feeling at the moment? How strong is the symptom?
- Are there moments when the symptom/feeling is not there? What's different then? What do you do differently then?

Questions about exploring and changing thoughts and/or the way someone thinks

- How or what do you think in this particular situation?
- Does it make sense to think like this? What feelings do your thoughts trigger?
- Is there another way to think about this situation?
- What personal resources can help you to overcome this situation? What can be helpful for you?

Questions about the formulation of goals

- What would you like to discuss with me today? What is your goal for today's interview?
Is there something we should not talk about/ you don't want to talk about? What have you done to solve the problem? What was helpful, what was less helpful?

Questions about differences and exceptions

This type of question makes exceptions noticeable and reduces the tendency to generalization.

- When are the complaints fewer, when are they greater?
- What is different when the symptoms are fewer?
- Are there moments when the problem is not present?
- What's different then?
- How can you ensure that there are more moments without the problem? What personal strengths and/or resources can you use?

Hypothetical questions

These kinds of questions make solutions possible.

- If your fear would fade, what would be your next step?
- How could you increase your pleasure in X?
- If you had a day off from your problem, what would you like to do?
- How did you manage to do this (something positive)? How did you find the courage to do what you have done so far? What helped you?

Circular questions:

- What would your mother/father/wife/ husband recommend to you?
- What would your best friend say about your strength?
- What good qualities about you would your friends name?
- What do you think would be a good outcome for your mother/father...etc.?
What would your mother/your friends say about your strengths?
- What do you want to keep as it is today? What should not be changed under any circumstances? What should be preserved?

Scaling Questions

These questions are helpful to see how close the beneficiary already sees himself at his destination.

- On a scale of 1 to 10 (1 very bad, 10 very good) - where do you stand today?
- What do you need to get from X to X? (advise small steps!) - What can I support you (as a counsellor) so that you get from X to X?
- Who else can support you?

Questions about resources or competences

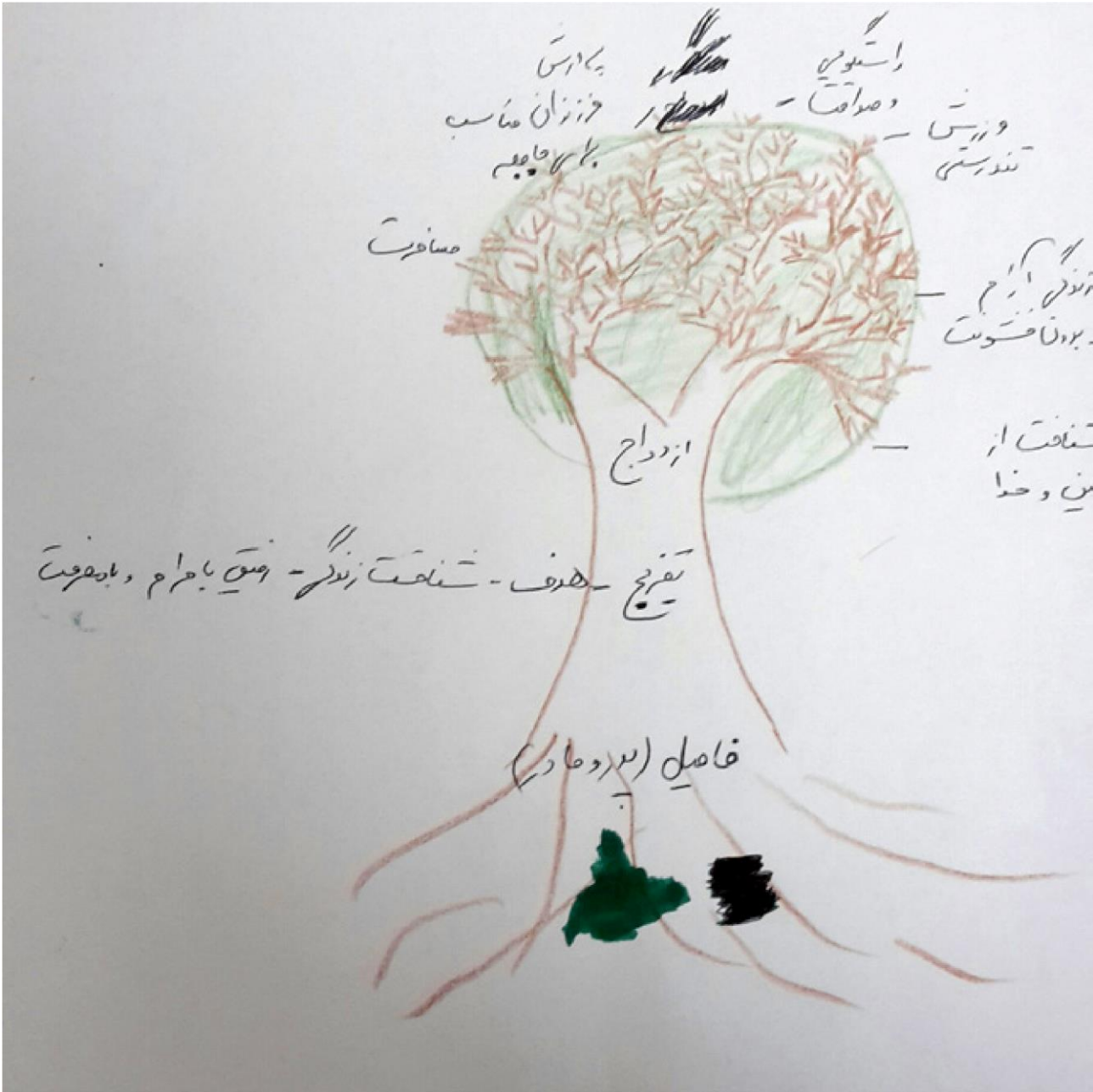
- What problems have you solved in your life? What did you do to get there?
What helped you do this? What was helpful?
- How did you do that?
- How have you dealt with other people/other situations so far? What experience have you had? Which can you use for your current situation?
- What are you particularly good at? What do you enjoy most?
- Is there someone in your life who can help you?
- Name 5/10 things you like about yourself.
- Name 5/10 things you've done well in your life so far.
- Name 5/10 things you are thankful for.

10. References

- Almohmash, N., Mobayed, M., & Aljendi, M. (2016). Mental health and psychosocial needs of Syrian refugees and the role of Syrian non-governmental organisations. *BJPsych*, 13(4), 81–83.
- ÄRZTE OHNE GRENZEN Deutschland. (2017). Pilotprojekt für psychosoziale Hilfe für Asylsuchende in Schweinfurt gestartet. Retrieved from <https://www.aerzte-ohne-grenzen.de/modellprojekt-psychosoziale-hilfe-asylsuchende-deutschland>
- Al-Smadi, A. M., Tawalbeh, L. I., Gammoh, O. S., Ashour, A., Alzoubi, F. A., & Slater, P. (2016). Predictors of coping strategies employed by Iraqi refugees in Jordan. *Clinical nursing research*, 26(5), 592–607.
- American Psychiatric Association (APA). (2001). *Diagnostic and statistical manual of mental disorders (DSM-4-TR)* (4th ed.). Washington, DC: American Psychiatric Pub.
- Anderson, L. P. (1991). Acculturative stress: A theory of relevance to black Americans. *Clinical Psychology Review*, 11(6), 685–702.
- Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of clinical psychology*, 61(4), 461–480.
- Anstiss, H. d., Ziaian, T., Procter, N., Warland, J., & Baghurst, P. (2009). Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research. *Transcultural Psychiatry*, 46(4), 584–607.
- Bajbouj, M., Alabdullah, J., Ahmad, S., Schidem, S., Zellmann, H., Schneider, F., & Heuser, I. (2017). *Psychosoziale Versorgung von Flüchtlingen in Deutschland: Erkenntnisse aus der Not- und Entwicklungshilfe*. Der Nervenarzt, published online.
- Bentley, J. A., Thoburn, J. W., Stewart, D. G., & Boynton, L. D. (2012). Post-migration stress as a moderator between traumatic exposure and self-reported mental health symptoms in a sample of Somali refugees. *Journal of Loss and Trauma*, 17(5), 452–469.
- Bohus, M., & Missmahl, I. (2017). Zur Umsetzung alternativer Behandlungsmodelle für Flüchtlinge in der BRD: Was können – was sollten – wir aus Afghanistan lernen? *Der Nervenarzt*, 88(1), 34–39.
- Böttche, M., Stammel, N., & Knaevelsrud, C. (2016). Psychotherapeutische Versorgung traumatisierter geflüchteter Menschen in Deutschland. *Der Nervenarzt*, 87(11), 1136–1143.
- Böttche, M., Heeke, C., & Knaevelsrud, C. (2016). Sequenzielle Traumatisierungen, Traumafolgestörungen und psychotherapeutische Behandlungsansätze bei kriegstraumatisierten erwachsenen Flüchtlingen in Deutschland. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, 59(5), 621–626.
- Bozorgmehr, K., Nost, S., Thaiss, H. M., & Razum, O. (2016). Die gesundheitliche Versorgungssituation von Asylsuchenden: Bundesweite Bestandsaufnahme über die Gesundheitsämter. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, 59(5), 545–555.
- Bundesärztekammer. (2017). 120. Deutscher Ärztetag – Beschlussprotokoll. Retrieved from http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Ordner/120.DAET/120DaetBeschlussProt_2017-05-26.pdf
- Bundesärztekammer (BÄK), & Bundespsychotherapeutenkammer (BPTK). (2015). *Vorschlag der Bundespsychotherapeutenkammer und der Bundesärztekammer zu den Eckpunkten eines Pilotprojektes zur Verbesserung der Versorgung psychisch kranker Flüchtlinge*. Retrieved from http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Ordner/Modellprojekt_Versorgung_psychisch_kranker_Fluechtlinge_BPtK_BAEK.pdf
- Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer (BAFF). (2016a). Ein Jahr nach dem „Sommer der Solidarität“ – Was bewegte sich? Ehrenamt in der psychosozialen Arbeit mit Geflüchteten: Zwischen praktischer Unterstützungsarbeit und politischer Verantwortung. Stellungnahme. Retrieved from http://www.baffzentren.org/wp-content/uploads/2016/09/BAFF_Ehrenamt-in-der-psychosozialen-Arbeit.pdf
- Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer (BAFF). (2016b). *Versorgungsbericht: Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland*. Berlin. Retrieved from Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer website: http://www.baff-zentren.org/wp-content/uploads/2017/02/Versorgungsbericht_3-Auflage_BAF.pdf
- Bunge, C., Meyer-Nürnberg, M., & Kilian, H. (2006). Gesundheitsfördernde Angebote für Menschen mit Migrationshintergrund: Sonderauswertung der Projektdatenbank „Gesundheitsförderung bei sozial Benachteiligten“ www.gesundheitlichechancengleichheit.de. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, 49(9), 893–897.
- Busse, A., Plaumann, M., & Walter, U. (2006). Stresstheoretische Modelle. In Kaufmännische Krankenkasse & Medizinische Hochschule Hannover (Eds.), *Weißbuch Prävention 2005/2006: Stress? Ursachen, Erklärungspilotle und präventive Ansätze* (pp. 63–77). Berlin: Springer.
- Christ, S., Meininghaus, E., & Röing, T. (2015). *All Day Waiting: Konflikte in Unterkünften für Geflüchtete in NRW*. Retrieved from Bonn International Center for Conversion website: <https://www.bicc.de/publications/publicationpage/publication/all-day-waiting-konflikte-in-unterkuenften-fuer-gefluechtete-in-nrw-697/>

- Colder, C. R. (2001). Life stress, physiological and subjective indexes of negative emotionality, and coping reasons for drinking: Is there evidence for a self-medication pilot of alcohol use? *Psychology of Addictive Behaviors*, 15(3), 237–245.
- Colucci, E., Szwarc, J., Minas, H., Paxton, G., & Guerra, C. (2014). The utilisation of mental health services by children and young people from a refugee background: A systematic literature review. *International Journal of Culture and Mental Health*, 7(1), 86–108.
- Crepet, A., Rita, F., Reid, A., van den Boogaard, W., Deiana, P., Quaranta, G., Di Carlo, S. (2017). Mental health and trauma in asylum seekers landing in Sicily in 2015: a descriptive study of neglected invisible wounds. *Conflict and health*, 11, 1.
- de Jong, K. (2011). Psychosocial and mental health interventions in areas of mass violence.: A community-based approach (2.th ed.). Amsterdam: Médecins Sans Frontières. Retrieved from https://www.researchgate.net/profile/Kaz_Jong/publication/263198639_Mental_Health_Guidelines_A_handbook_for_implementing_mental_health_programmes_in_areas_of_mass_violence/links/02e7e53b6b95beb6ee000000.pdf
- de Jong, K., Ariti, C., van der Kam, S., Mooren, T., Shanks, L., Pintaldi, G., & Kleber, R. (2016). Monitoring and Evaluating Psychosocial Intervention Outcomes in Humanitarian Aid. *PloS one*, 11(6), e0157474.
- de Jong, K., & Kleber, R. (2003). Early psychosocial interventions for war-affected populations. Reconstructing early intervention after trauma innovations in the care of survivors, 184–192.
- Demir, S., Reich, H., & Mewes, R. (2016). Psychologische Erstbetreuung für Asylsuchende: Entwicklung und erste Erfahrungen mit einer Gruppenpsychoedukation für Geflüchtete. *Psychotherapeutenjournal*. (2), 124–131.
- Demir, S. (2015). Beratung nach Flucht und Migration: Ein Handbuch zur psychologischen Erstbetreuung von Geflüchteten. Potsdam: WeltTrends.
- Eggerth, D. E., & Flynn, M. A. (2013). Immigration: Implikationen für Stress und Gesundheit. In P. Genkova, T. Ringeisen, & F. T. L. Leong (Eds.), *Handbuch Stress und Kultur* (pp. 343–359). Wiesbaden: Springer.
- Eisen, S. V., Schultz, M. R., Mueller, L. N., Degenhart, C., Clark, J. A., Resnick, S. G., Sadow, D. (2012). Outcome of a randomized study of a mental health peer education and support group in the VA. *Psychiatric services*, 63(12), 1243–1246.
- Gäbel, U., Ruf, M., Schauer, M., Odenwald, M., & Neuner, F. (2006). Prävalenz der posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. *Zeitschrift für klinische Psychologie und Psychotherapie*, 35(1), 12–20.
- Gerlach, C., & Pietrowsky, R. (2012). Trauma und Aufenthaltsstatus: Einfluss eines unsicheren Aufenthaltsstatus auf die Traumasymptomatik bei Flüchtlingen. *Verhaltenstherapie & Verhaltensmedizin*, 1, 5–19.
- Gerritsen, A., Bramsen, I., Devillé, W., van Willigen, L., Hovens, J., & van der Ploeg, H. (2006). Use of health care services by Afghan, Iranian, and Somali refugees and asylum seekers living in The Netherlands. *European journal of public health*, 16(4), 394–399.
- Gesellschaft für Internationale Zusammenarbeit (GIZ). (2017). Psychische Gesundheit und Psychosoziale Unterstützung (MHPSS) im Kontext der Syrien- und Irakkrisen: Orientierungsrahmen für die Entwicklungszusammenarbeit. Anforderbar bei judith.baessler@giz.de, Leiterin des Regionalvorhabens „Psychosoziale Unterstützung für syrische/irakische Flüchtlinge und Binnenvertriebene.“
- Gurge, S., Thomson, M. S., George, U., & Chaze, F. (2015). Social support, social conflict, and immigrant women's mental health in a Canadian context: a scoping review. *Journal of psychiatric and mental health nursing*, 22(9), 655–667.
- Hooberman, J., Rosenfeld, B., Rasmussen, A., & Keller, A. (2010). Resilience in trauma-exposed refugees: the moderating effect of coping style on resilience variables. *The American journal of orthopsychiatry*, 80(4), 557–563.
- Ikram, U., & Stronks, K. (2016). Preserving and Improving the Mental Health of Refugees and Asylum Seekers: A Literature Review for the Health Council of the Netherlands. Amsterdam.
- Inter-Agency Standing Committee (IASC). (2017). A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings. Retrieved from IASC website: <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings>
- Jain, S., McLean, C., Adler, E. P., Lindley, S. E., & Ruzek, J. I. (2013). Does the integration of peers into the treatment of adults with posttraumatic stress disorder improve access to mental health care? A literature review and conceptual pilot. *J Trauma Stress Disor Treat* 2, 3, 2.
- Joksimovic, L., Wöller, W., Happ, M., Tress, W., & Kruse, J. (2011). Gruppentherapeutische Interventionen bei traumatisierten Flüchtlingen. *Gruppenpsychotherapie und Gruppendynamik*, 47(3), 192–210.
- Kaluza, G. (1996). Belastungsbewältigung und Gesundheit. *Zeitschrift für Medizinische Psychologie*, 5, 147–155.
- Kaluza, G. (1997). Evaluation von Stressbewältigungstrainings in der primären Prävention—eine Meta-Analyse (quasi-) experimenteller Feldstudien. *Zeitschrift für Gesundheitspsychologie*, 5(3), 149–169.
- Kaluza, G. (2002). Förderung individueller Belastungsverarbeitung: Was leisten Stressbewältigungsprogramme. *Prävention und Gesundheitsförderung*, 2, 195–218.
- Kapsou, M., Panayiotou, G., Kokkinos, C. M., & Demetriou, A. G. (2010). Dimensionality of coping: An empirical contribution to the construct validation of the brief-COPE with a Greek-speaking sample. *Journal of health psychology*, 15(2), 215–229.

- Kizilhan, J. I. (2014). Migration aus psychologischer Perspektive. Retrieved from <http://www.dgvt-fortbildung.de/interaktivefortbildung/archiv-der-fachartikel/archiv/jan-ilhan-kizilhan-2014-migration-aus-psychologischer-perspektive/>
- Kleefeldt, E., Wolff, B., & Carlo, L. d. (2016). Flüchtlinge in unserer Praxis: Information für ÄrztInnen und PsychotherapeutInnen. Berlin. Retrieved from Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer (BAFF) website: http://www.baff-zentren.org/wp-content/uploads/2016/03/BAFF-Fluechtlinge_in_unserer_Praxis.pdf
- Koll-Krüsmann, M. (2016). Trauma-Awareness und Psychoedukation. Bonn. Retrieved from Deutscher Akademischer Austauschdienst (DAAD) website: <http://www.daad-akademie.de/medien/ida/traumalast.pdf>
- Kraus, M. (2006). Somatisierung im kulturellen Kontext. In E. Wohlfart & M. Zaumseil (Eds.), *Transkulturelle Psychiatrie – Interkulturelle Psychotherapie: Interdisziplinäre Theorie und Praxis* (pp. 363–376). Berlin: Springer.
- Laban, C. J., Komproe, I. H., Gernaat, H. B., & de Jong, J. T. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social psychiatry and psychiatric epidemiology*, 43(7), 507.
- Landesärztekammer (LÄK), & Landespsychotherapeutenkammer (LPTK). (2015). 2. Versorgungsbericht – Ambulante medizinische, psychosoziale und psychotherapeutische Versorgung von traumatisierten MigrantInnen in Baden-Württemberg. Stuttgart. Retrieved from <http://www.aerztekammer-bw.de/10aerzte/05kammern/10laekbw/20ehrenamt/3oausschuesse/menschenrechte/versorgungsbericht/versorgungsbericht-2015.pdf>
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Berlin: Springer.
- Leeies, M., Pagura, J., Sareen, J., & Bolton, J. M. (2010). The use of alcohol and drugs to self-medicate symptoms of posttraumatic stress disorder. *Depression and anxiety*, 27(8), 731–736.
- Lie, B. (2002). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica*, 106(6), 415–425.
- Liedl, A., Schäfer, U., Knaevelsrud, C., & Maercker, A. (2010). *Psychoedukation bei posttraumatischen Störungen: Manual für Einzel- und Gruppensetting*. Stuttgart: Schattauer.
- Lueger-Schuster, B. (2009). *Psychosoziale Versorgungssysteme – institutionelle und gesundheitsrechtliche Rahmenbedingungen, Beschaffung von Information: Skriptum zur Vorlesung*. Retrieved from <http://docplayer.org/12538133-Psychosoziale-versorgungssysteme-institutionelle-und-gesundheitsrechtliche-rahmenbedingungen-beschaffung-von-information.html>
- Matheson, K., Jorden, S., & Anisman, H. (2008). Relations between trauma experiences and psychological, physical and neuroendocrine functioning among Somali refugees: mediating role of coping with acculturation stressors. *Journal of immigrant and minority health*, 10(4), 291–304.
- Mohammadzadeh, Z., Jung, F., & Lelgemann, M. (2016). Gesundheit für Flüchtlinge – das Bremer Pilotl. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, 59(5), 561–569.
- MSF Italien. (2016). *Neglected Trauma: Asylum seekers in Italy: An analysis of mental health distress and access to healthcare*. Retrieved from MSF website: <https://www.aerzte-ohne-grenzen.de/sites/germany/files/attachments/2016-neglectedtrauma-report.pdf>
- Mühlig, S., & Jacobi, F. (2011). Psychoedukation. In H.-U. Wittchen & J. Hoyer (Eds.), *Klinische Psychologie & Psychotherapie* (pp. 477–490). Berlin: Springer.
- Mundt, A., Wunsche, P., Heinz, A., & Pross, C. (2011). Traumatherapie in Krisenregionen und Katastrophengebieten – Eine kritische Auseinandersetzung mit standardisierten Interventionsverfahren am Beispiel der Narrativen Expositionstherapie. *Psychiatrische Praxis*, 38(6), 300–305.
- Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*, 31(3), 399–417.
- Prati, G., & Pietrantonio, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma*, 14(5), 364–388.
- Reimann, S., & Pohl, J. (2006). Stressbewältigung. In B. Renneberg & P. Hammelstein (Eds.), *Gesundheitspsychologie* (pp. 217–227). Berlin: Springer.
- Renner, W., Banninger-Huber, E., & Peltzer, K. (2011). Culture-Sensitive and Resource Oriented Peer (CROP)-Groups as a community based intervention for trauma survivors: A randomized controlled pilot study with refugees and asylum seekers from Chechnya. *The Australasian Journal of Disaster and Trauma Studies*. (1), 1–13.
- Richter, K., Lehfeld, H., & Niklewski, G. (2015). Warten auf Asyl: Psychiatrische Diagnosen in der zentralen Aufnahmeeinrichtung in Bayern. *Das Gesundheitswesen*, 77(11), 834–838.
- Ringeisen, T. (2013). Stressbewältigung im Kulturvergleich. In P. Genkova, T. Ringeisen, & F. T. L. Leong (Eds.), *Handbuch Stress und Kultur* (pp. 255–278). Wiesbaden: Springer.
- Rohlf, H. G., Knipscheer, J. W., & Kleber, R. J. (2014). Somatization in refugees: a review. *Social psychiatry and psychiatric epidemiology*, 49(11), 1793–1804.
- Ruf, M., Schauer, M., & Elbert, T. (2010). Prävalenz von traumatischen Stresserfahrungen und seelischen Erkrankungen bei in Deutschland lebenden Kindern von Asylbewerbern. *Zeitschrift für klinische Psychologie und Psychotherapie*, 39(3), 151–160.



My tree of resources – Drawing by a 37-year-old Afghan man, made during the group program module III, EAE Schweinfurt