

## Article

# The Interventions of a Mobile Mental Health Unit on the Refugee Crisis on a Greek Island

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**Abstract:** This present study concerns refugees and asylum seekers who have been referred to a Mobile Mental Health Unit (MMHU-Ch) in rural Greece on a Northeast Aegean Island during the refugee crisis in 2015. Our objective is the examination and recording of psychopathology characteristics, the presentation of the therapeutic interventions provided, and the difficulties. The sample is composed of 418 requests made by refugees, asylum seekers, adults, and children. The clinical and demographic data have been gathered from the MMHU-Ch's charts. The study is retrospective, descriptive with quantitative and categorical variables. The data has been analyzed with the utilization of SPSS. The dominant diagnosis in children involves anxiety disorders, developmental disorders, and PTSD. One noteworthy finding is the high percentage of suicide behavior regardless of psychiatric diagnosis, which should be further examined. As far as interventions are concerned, the conclusions which have arisen are the gradually stronger commitment of the referents, but also the high percentage of requests that dropped out. Further examination of the interventions and their efficiency is recommended as well as probing the features of psychopathology in the long term with a view to clarifying the patronizing and aggravating factors.

**Keywords:** MMHU; mental health; refugees; asylum seekers; PTSD; suicide behavior



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## 1. Introduction

People compelled or even forced to abandon their home country or their permanent residence and seek shelter in a foreign country experience a “culture shock”. Culture shock is conceived as a serious, acute, and sometimes chronic affective reaction to a new environment [1]. Refugees experience culture and language change and may experience family disruption, social isolation, and hostility from the population of the host country [2].

They are exposed to many risks pre-flight, during their flight, and upon arrival, which makes them vulnerable to the development of physical health issues, such as pneumonia and ear infections, in addition to mental health problems, such as anxiety [3]. After reaching the hosting country, the refugees and asylum seekers are physically exhausted, and the provision of somatic healthcare represents a major concern [3]. When refugees settle in their destination, they undergo a severe cultural alteration in means of communication, work, lifestyle, and language. When refugees arrive in the host country, they often face many difficulties, such as the frustration of their expectations, unemployment, personal fears, xenophobia. The influence of an utterly different culture, along with the racism and hostility they will encounter, may also lead to withdrawal, social exclusion, and mental instability [4]. Nevertheless, it should be noted that a substantial proportion of refugees have shown remarkable resilience to such circumstances [5,6].

It is estimated that approximately 1% of the world's population has been displaced either from their home or their home country. As a result, it is more likely for them to develop chronic mental health disorders [7]. Importantly, a refugee cannot be classified as an asylum seeker, as the former is regarded as a person who is already under the protection

of the country-destination. An asylum seeker is regarded as the person who seeks protection from persecution or severe danger in a country and is expecting the country's decision in order to be granted refugee status according to international and national regulations [8]. Asylum seekers have a higher level of PTSD and depression/anxiety symptoms compared to refugees. However, residence status appears to act as a marker for post-migration stressors [9].

Historically Greek people have been exposed to many migration and refugee experiences. The last wave of refugees comes predominantly from the east (mainly Syria and Afghanistan, through Turkey). The influx of refugees and asylum seekers making their way across the Mediterranean to Europe since 2014 has been estimated as the biggest since World War II. In November 2015, Hellenic Coast Guard reported that since the beginning of that year, as many as 650,469 refugees and asylum seekers had entered Greece, the main gateway to Europe [10].

The refugees and asylum seekers have landed mainly on the islands of the Aegean Sea: Lesbos, Chios, Samos, Leros, Kos, Simi, and Tilos. Landing on a Greek island is not the end of the story. The majority of asylum seekers and refugees do not want to stay in Greece. Many refugees and asylum seekers have relatives in Western Europe, and they want to join them. This was relatively easily achieved in the past, but, more recently, following the barriers set by many countries, it has become much more difficult [11].

There have been several reports considering the frightful consequences on the health, prosperity, and safety of the people stranded on the Northern Aegean Islands. The Medecins San Frontieres (MSF) has recorded that more than 180,000 people have crossed Greek Islands following the EU and Turkey Agreement in March 2016 [12]. The people arriving at the EU borders seeking asylum have already been exposed to violence and extreme conditions of aggression. Staying in camps called "Hot Spots" which are precarious and lacking decent accommodation, exacerbates the sense of vulnerability, helplessness, and mental instability [12]. Mental health professionals, in an effort to promote the refugees' psychosocial wellbeing, were confronted with trauma and post-traumatic stress disorder and were challenged due to the continuous change experienced by this population [13].

The increased migrant flow and the massive population movement from borders designate the refugee issue in the public opinion as prominent, including also the arrival of thousands of unaccompanied minors encumbered with and exposed to all sorts of perils [14]. The arrival of unaccompanied minors at the European borders, as well as the system of protective guarding, has challenged their mental health along with their already vulnerable condition [15].

Over the past years, according to the data gathered by United Nations High Commissioner for Refugees (UNHCR 2016), 51% of the migrating population to Greece is under 18 years old [16]. In any case, minors experience culture shock acutely due to their amputation from the society they lived in, the customs and habits, which are principal elements for the development of a child's identity.

An alarming percentage of children and adolescent refugees coming from war countries suffer from mental disorders such as depression, post-traumatic stress disorder, anxiety disorders, and personality disorders. A similar mental burden can also be detected in adult refugees [3,17]. The loss of parents and relatives triggers anxiety, bereavement, and deprivation well before a child's defense mechanisms are developed. Traumatized as children, they are exceedingly vulnerable to presenting depression, identity problems, low self-esteem, emotional regression, ambivalence towards relationships, and possible behavior disorders. Depression, which is all too often the case, is expressed with self-destruction and suicidal ideation, especially among vulnerable adolescents coming from single-parent families [18,19].

The number of studies that provide field data relevant to the mental health of refugees and asylum seekers during the first reception in Greece is still limited in the international literature [12]. According to the literature, refugees and asylum seekers are likely to experience poor mental health [20]. We assume that the refugees and asylum seekers in our

sample are at high risk of psychopathology too. The sample refers to refugees—asylum seekers who were in need of mental health services during the first period of their reception in a big camp on an island in the Northern Aegean over the reported Refugee Crisis.

The aim of the current study is the presentation of features and psychopathology of refugees and asylum seekers, as well as the therapeutic intervention provided by a community Mental Health Service, the Mobile Mental Health Unit of Chios (MMHU-Ch). The findings may highlight the hardships in the therapeutic approach of this special population group so as to underline the need for the formulation of specific prevention strategies.

## 2. Materials and Methods

### 2.1. Mobile Mental Health Unit of Chios (MMHU-Ch)

Mental healthcare service delivery in rural and remote areas in Greece is challenging due to socioeconomic and geographical reasons and distant facilities. To address the needs of the underserved areas, the Greek state has launched a number of Mobile Mental Health Units (MMHUs) in the mainland and on several of the numerous Greek islands [21].

The Mobile Mental Health Unit of Chios (MMHU-Ch) is being implemented by a nongovernmental organization, namely “Child and Adolescent Center”, and is financed by national resources. The MMHU-Ch delivers services in rural areas of the regional unit of North-East Aegean, more specifically on 3 islands on the borders: Chios, Oinousses, and Psara. The provided services include diagnosis and individualized treatment, such as pharmacotherapy and psychotherapeutic interventions, as well as enhancement of patients’ social skills, family support, and community-based programs. All services are free of charge. A total of 12 employees constitutes the workforce of the MMHU of Chios. The multidisciplinary team consists of one psychiatrist, who is also the team’s supervisor, one part-time psychiatrist, one part-time child psychiatrist, three psychologists, two nurses, two social workers, one part-time speech therapist, and one administrative officer.

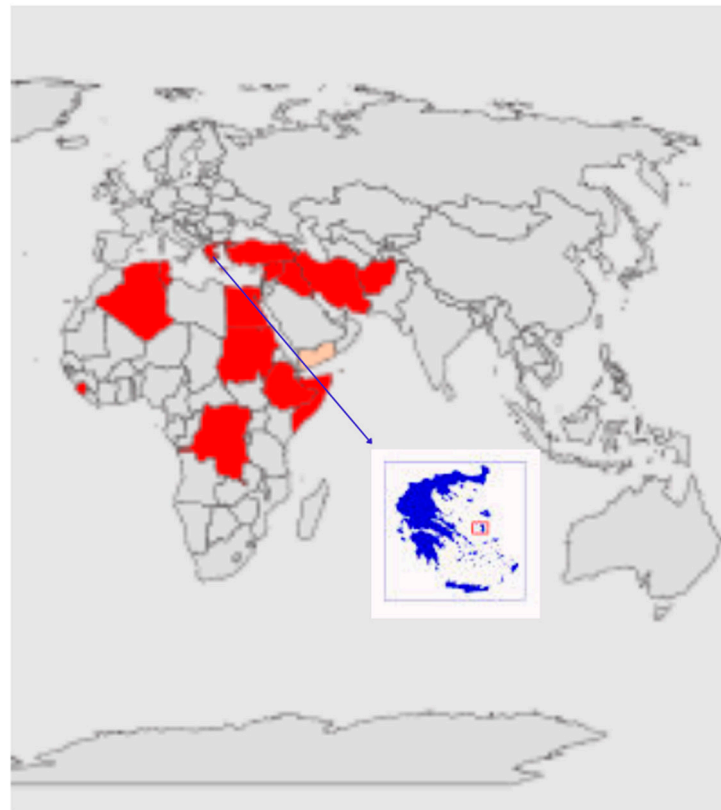
### 2.2. The Existing Circumstances at the Time of the Research

The Mobile Mental Health Unit of Chios (MMHU-Ch) is active in the Aegean on the borders of European territory (Figure 1). The refugee crisis, which began in 2015, brought unprecedented challenges for both the residents of the island and MMHU-Ch. The local health system on the islands was barely equipped to confront the additional strain of the large camps known as “Hot spots” which were formed.

The degradation of the Greek province due to the financial crisis showed that the health system lacked both mental health specialists and sufficiently skilled cultural mediators, such as interpreters. Therefore, all these difficulties have an impact on this vulnerable population, who needs specialized treatment and safe accommodation.

The increased number of requests for psychiatry and child psychiatry assessment could not be covered by the outpatient department in the local hospital in Chios, which was already under great pressure. There was equally a high number of requests by organizations that were active in the camps and in the unaccompanied minors’ hostel. The MMHU-Ch in an effort to respond to this new reality in the society, covering part of the needs which had arisen, cooperated with an improvised network of local entities and Non-Government Organizations (NGOs). The MMHU-Ch delivered psychiatric services and psychological assessment and counseling.

The current study pertains to refugees and asylum seekers who have been referred to MMHU-Ch during the period, which is extended from September 2015 to December 2020. Clinical and demographic information has been gathered from patient charts, which MMHU-Ch keeps. The Institutional board approved the present study, which is non-invasive, and waived the need for participants’ informed consent.



**Figure 1.** Immigration flows to Aegean Islands in 2015. Blue color: Country of Greece. Red circle in blue color: The catchment area of MMHU-Ch.

The research is retrospective, descriptive with quantitative and qualitative variables, involving the outcome of the request, the nature of the intervention, the gender, the diagnosis, the ethnicity, the suicide behavior as well as the existence of a psychiatric history for adults and the factor of accompaniment for minors.

The data were extracted from the patients' medical records (Real-World Evidence, RWE) addressed to the MMHU-Ch. The diagnoses are according to the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) [22]. More specifically, the variables of age, gender, ethnicity, and family status were collected by the referral forms. In addition to the referral forms, the variables of suicide behavior (death wishes, self-injuries, suicide attempts) and psychiatric history are also detected by refugees' and asylum seekers' claims during the psychiatric interview.

Data was imported to IBM SPSS, version 22 (IBM Corp., Armonk, NY, USA), for analysis and interpretation. Continuous variables were expressed as means ( $M$ )  $\pm$  standard deviation ( $SD$ ). Absolute numbers ( $N$ ) and percentages ( $N\%$ ) were used to express categorical variables. In order to compare categorical variables, chi-square ( $\chi^2$ ) tests were used.

For the group of adults, the following comparisons of categorical variables were performed: (a) diagnosis with gender, ethnicity, and suicidal behavior (b) suicidal behavior with gender and psychiatric history. Regarding the group of children and adolescents, the following comparisons of categorical variables were performed: (a) accompaniment with diagnosis and outcome, (b) gender with the outcome. For all tests, statistical differences were determined to be significant at  $p < 0.05$ . All the procedures of the study had been approved by the institutional board.

### 3. Results

From September 2015 to December 2020, MMHU-Ch has received 418 refugee requests out of the total 2218 requests addressed (18.8%). Out of the 418, 232 (55.5%) involved adult refugees, asylum seekers, and 186 (44.5%) children. The NGOs active in psychosocial

support in the field of the camp and accommodation programs were the main source of reference, referring to 201 (86.6%) adults and 180 (96.8%) children. Far less were the cases of reference by Public Social Services, other Medical Services, or law enforcement agencies.

The dominant result as far as the outcome of the request in both adults (N: 103; 44.4%) and children (N: 88; 47.3%) was the dropout. There was a high percentage (20.7% adults and 21% children) where the request was canceled with no appointment ever taking place.

The large number of the appointments involved psychiatric assessment means medicine prescription and psychological support (N: 86; 37.1%) followed by diagnostic assessment (N: 71; 30.6%) and psychological counseling (N: 27; 11.6%) in cases where a psychotherapeutic framework could not be provided by other related services. Over the first years of the MMHU-Ch's involvement with this population, there was a limited number of sessions (one to two per request), which were mainly focused on the diagnostic assessment. Subsequently, the psychiatric assessment was the dominant therapeutic intervention and reached an average of five sessions per request.

The basic results from adults patients' characteristics and diagnosis depicted in Table 1. Analytically the results highlight that the references were young adults (90% up to 40 years of age), mainly men (N: 149; 64%). It is observed that men take the lead as far as references are concerned. However, there is a variation that is nationally defined (there were three times as many Syrian men, there were twice as many Afghans, and there were hardly any requests by African women). The countries of origin were Syria (N: 54; 23.3%), Iraq (N: 50; 21.6%), Africa (N: 53; 22.8%), and Afghanistan (N: 40; 17.2%). A percentage 34% (N:79) of the adults examined expressed suicide behaviors. The majority of them (N: 71; 69.4%) did not have a Psychiatric history. The main diagnosis concerned anxiety disorders, F40-49 to ICD-10 (N: 99; 42.7%) with an estimated percentage of Post Traumatic Stress Disorder 17.7% (N:41).

**Table 1.** Adults Patients' characteristics and diagnoses ( $n = 232$ ).

Age (mean $\pm$ SD)	29 $\pm$ 8.41
Diagnoses (%)	
Mental and behavioural disorders due to psychoactive substance use (F10–19)	2.6
Schizophrenia and related disorders (F20–29)	3.0
Mood(affective) disorders (F30–39)	27.2
Anxiety, dissociative, stress-related, somatoform, and other non-psychotic mental disorders (F40–48)	42.7
Others	16.8
Z-codes	7.8

Note: SD: Standard deviation.

The basic results from minors' characteristics and diagnosis are depicted in Table 2. In more detail, the majority of children involved boys (N: 131; 70.4%) in late adolescence (N: 81; 43.5%). The percentage of unaccompanied children was 31.7% (N: 59). The countries of origin were mainly Syria (N: 69; 7.1%) and Iraq (N: 53; 28%), and rarely Afghanistan (N: 26; 14%), and Africa (N: 23; 12.4%). The dominant diagnosis in children was anxiety disorders (N: 74; 39.8%), followed by developmental disorders (N: 47; 25.3%). The percentage of PTSD was 19.9% (N:37).



**Table 2.** Children Patients' Characteristics and diagnoses ( $n = 186$ ).

Gender (male) (%)	70.4
Age (mean $\pm$ SD)	12 $\pm$ 4.72
Children's escort (%)	
Accompanied	68.3
Unaccompanied	31.7
Diagnoses (%)	
Mental and behavioural disorders due to psychoactive substance use (F10–19)	0.5
Schizophrenia and related disorders (F20–29)	0.5
Mood (affective) disorders (F30–39)	10.8
Anxiety, dissociative, stress-related, somatoform, and other non-psychotic mental disorders (F40–48)	39.8
Disorders of psychological development (F80–89)	25.3
Others	15.6
Z-Codes	7.5

Note: SD: Standard deviation.

Variables have been crossed for possible relations. For the group of adults, no statistically significant differences were observed concerning: (a) diagnosis in relation to gender ( $\chi^2(5) = 7.64, p = 0.177$ ), ethnicity ( $\chi^2(20) = 26.22, p = 0.159$ ) and suicidal behavior ( $\chi^2(5) = 8.16, p = 0.147$ ), (b) suicidal behavior in relation to gender ( $\chi^2(1) = 0.38, p = 0.540$ ) and psychiatric history ( $\chi^2(1) = 3.49, p = 0.062$ ).

For the group of children and adolescents, no statistically significant differences were observed concerning: (a) accompaniment in relation to diagnosis ( $\chi^2(6) = 7.23, p = 0.300$ ) and the outcome ( $\chi^2(3) = 5.52, p = 0.137$ ), (b) gender in relation to the outcome ( $\chi^2(3) = 3.92, p = 0.271$ ).

#### 4. Discussion

This is one of the few studies in insular Greece that addresses the mental healthcare of refugees and asylum seekers in a large Hot spot. The dominant result of this study in both adults and children is the dropout and the cancels of requests. The refugee population is rarely accustomed to receiving mental health services since, for instance, in the Arabic world, a small amount of the annual governmental budget is spent on mental health. Usually, access to such services have only people with severe psychopathology because of the fear of the mental health stigma [23,24]. Refugees and asylum seekers may maintain a negative attitude towards mental health services because of dissuasive experiences in their country of origin [3]. Moreover, according to Hynie [25], asylum seekers, while waiting for their application to be examined, are confronted with restrictions regarding their access to employment, education, accommodation, and in some cases, they face detentions even in their freedom. These parameters should be noticed and taken care of from the beginning. The high percentage of the drops out possibly reflects these parameters, which have been mentioned in the literature. The “Hot Spot” in Chios, like many other refugee camps, is located in a remote area, far from the town center, and therefore there is a considerate distance away from the mental health services, which according to the literature, holds back their access to them [12,24]. The requests for support are often canceled because the refugee population is ghettoized. The factors that lead to this marginalization are lack of organization and infrastructure, which seem to make them feel isolated and helpless.

The increase in the appointments per request may indicate the gradually stronger commitment and consistency of the referents to our services. To that end, the contributing factors that led to this direction seemed to be the cultural adjustment of the MMHU-Ch's professionals and the cooperation with better-qualified interpreters. According to Hebebrand et al. [3], it is important for interpreters, inter-cultural workers, and mental health professionals to pursue ongoing training and cooperate with local cultural groups in order to enhance their cultural awareness. They should also reconsider and redefine the familiar psychotherapy models in order to enrich them with the different meaning concepts

such as mental health, trauma, etc. A mental health professional should meet the needs of people from different backgrounds. The vast majority of the referrals, 86% in adults and 96.8% in children came from NGOs which were active in psychosocial care within the camps. The cooperation of such services with local entities as the MMHU-Ch facilitated refugees and asylum seekers' access but is not sufficient to ensure continuity of care.

However, according to several studies, the services in the host countries should prioritize non-specific psychosocial interventions until some emotional and social stability is achieved. Non-specific psychosocial interventions target basic safety, education and employment. Further research is required in order to clarify the most suitable interventions for the refugee population [26].

As far as expressed psychopathology in adults is concerned, our findings are in line with international literature, according to which refugees and asylum seekers show signs of depression, anxiety, and PTSD [12,27,28]. The percentage of mental disorders varies depending on the specific features of the research. The increased risk of poor mental health among the refugees and asylum seekers seems to be closely linked with anxiety before and after emigration but also with the procedure for seeking asylum itself [29]. Further, Hynie [25] mentions that the post-emigration circumstances have a great impact on refugees' and asylum seekers' mental health. She also supports that refugees and asylum seekers who stay in refugee camps in lower-income countries show signs of anxiety and depression, reflecting the exceedingly stressful conditions encountered in camps. Other studies report an aggregate prevalence of depression among international migrants, while in the present study, depression is not the dominant diagnosis [30]. We assume that the differences between these findings depend on the focus of our study on the ICD-10 diagnosis rather than on particular symptoms [22]. Depressive symptoms are detected in our sample, but they do not meet the criteria for the depression diagnosis according to ICD-10 [22].

Suicide behavior, which includes suicidal ideation, suicide attempt, and complete suicide, is often observed in adult refugees, a fact which is also confirmed by this study. According to Procter [31], being a refugee and an asylum seeker constitutes a stressful and distressful experience that correlates with suicide and self-harm. According to Bhugra, Craig, and Bui [32], a percentage from 3.4% to 34% of refugees and asylum seekers seem to be more vulnerable to the risk of suicide behavior. The finding of the highest percentage expression (34.1%) in our study is possibly related to the living conditions in the "Hot Spot". The confinement of refugees and asylum seekers in the camps triggers further mental distress [12,28]. The hotspots, such as the camp in Chios, are not safe places for people who seek asylum. They are overcrowded, have security issues with an additional lack of access to adequate healthcare, sanitation, and food [12]. In our study, the cross-overs of the variables diagnosis and suicide behavior were not statistically significant, indicating that there is no relation between diagnostic category and suicide behavior. Suicide is human behavior and, as such, can have multiple causes [33]. However, the examinations of this relationship (psychopathology-suicidal behavior) could be the subject of future research since it has not been conducted as it should have been for this specific group [33].

According to literature, gender is a factor that seems to be related to refugees' and asylum seekers' adverse mental health [12,34]. Specifically, women refugees appear to score higher in developing depression and PTSD [35]. In the current study, there have been no findings that indicate any relationship between gender and psychiatric diagnosis. This might arise from the fact that the sample is fairly small, and the majority of the participants are men. The fear of being stigmatized as mentally ill is very common among refugee populations. The fear that anyone who is referred to mental health services might be characterized as "mad" or even be rejected by their own family may make people who are already labeled as refugees-asylum seekers avoid any further stigmatization [26,28]. Possibly the cultural barriers are even more difficult to overcome by women's populations. Additionally, while the intense expression of many young men's psychopathology might have been a reason for referral to a mental health service, refugee women with mental and withdrawal problems are probably undetected by our services.

According to recent research data, minor refugees at a mental health level do not seem to have a single symptom in common rather a combination of symptoms that does not necessarily indicate a specific disorder [36]. That is possibly expressed in a preponderance of the neurotic, stress-related, and somatoform disorders, anxiety, and depressive disorders in our sample. There is a sizable percentage of developmental disorders (25.3%) diagnosed for the first time in MMHU-Ch. We can justify an increased reference of children with severe developmental disorders if we consider that when a family has to take care of a child with these kinds of difficulties, it has greater possibilities for better living conditions (transference to an apartment). Furthermore, a child with such problems faces hardships in living in a camp.

In some studies, stress experienced by children-refugees is mentioned more as a symptom that is intensified during their voyage to the host country and the time spent there, rather than a symptom that emerges as a traumatic experience back in their country of origin [37]. In the literature, this period is mentioned as a period of “secondary trauma”. Therefore, there is some skepticism on the use of the prefix “post” with the PTSD diagnosis in this particular group of disorders. In agreement with the above, the diagnosis of PTSD (19.9%) in the minor group of our study, which is based on the development of the basic symptoms (nightmares, flashbacks, aggressiveness), requires diachronic monitoring in order to be stabilized.

Concerning the unaccompanied, a minor refugee having been separated from their parental figures is in no condition to form a sense of “belonging” and thus is highly more probable to show signs of anxiety or depression even if they are being taken care of [38]. Bowlby hypothesized that the theory of bond is activated when children are confronted with threat or stress [39]. According to the child’s developmental stage at the time of the emigration, the separation from the family seems to be experienced as “trauma” which possibly is not followed by typical symptomatology of post-traumatic stress but by behaviors that indicate intense anxiety as irritability, withdrawal, restlessness and so on [17].

In our sample, there is a high percentage of unaccompanied minors who were referred (31.7%) to MMHU-Ch. However, the findings do not suggest a statistically significant difference between the existence of accompaniment with the outcome of the request and the diagnostic category. We think that the developmental stage of the majority of the minors in our study who were mainly in their late adolescence influences the result. On the other hand, the co-existence of psychiatric morbidity in the caregivers, such as maternal depression, PTSD symptoms, the sense of “helplessness” of the parents, may also lead to mental health problems in the accompanied minor’s sample. Further analysis of more specific factors is needed in order to lead to a better understanding of the aggravating factors of children’s vulnerability.

Our study has several limitations. First of all, the size of our sample is relatively small for the generalization of our findings to the population of refugees and asylum seekers. Furthermore, the fact that the referrals were made by people working in the camp may have a significant impact on the referents. An additional limitation is that the study was conducted analyzing the requests for intervention addressed to the MMHU-Ch. The sample tested is self-selected, and this may have introduced the bias. Furthermore, pathological conditions could be both above and below reported in relation to the greater or lesser propensity of people to ask for help.

Despite its limitations, this study is one of the few Greek reports discussing the clinical manifestations of mental disorders in this population at the time of the refugee crisis in 2015 and may contribute to a better understanding of mental health in this group.

## 5. Conclusions

Emigration constitutes a significantly mentally stressful condition that influences people’s mental health, increasing the possibility of presenting mental problems. The



findings of our study are in line with international literature, according to which refugees and asylum seekers show signs of depression, anxiety, and PTSD.

However, the high percentage of suicide behavior regardless of psychiatric diagnosis, which comes up in all relevant research, is an important finding which should be further researched and understood. Designing special interventions seems to be important. Further research could focus on the development of a culturally suitable tool in order to assess suicidal behavior among refugees and asylum seekers and to form appropriate prevention and interventions.

The present study highlights the complexity of the factors which influence the existence of mental problems in minor refugees. Long-term monitoring and reporting of this group are imperative in order for conclusions to be drawn concerning the appearance of psychopathology and the protective and aggravating factors. More specifically, future research could examine the way that factors as the developmental stage of a minor, the co-existence of pathology in caregivers, and the existence of accompaniment influence the diagnostic category and the outcome of the intervention.

Finally, the interventions to this group, alongside mental healthcare services to the residents, constituted a great challenge for the MMHU-Ch. The multidisciplinary team was burdened with more patients of different cultures and needs and, at the same time, needed to cooperate and support many entities in an unorganized and unstable environment. The high percentage of cancellations and drops out, which is expected in such camps, creates additional adversities and frustrations in a health service. What seems to be important is that services that are at the forefront of resettlement give priority to non-expert psychosocial interventions aimed at basic security, education, and employment. The services' staffing with mental health professionals, further education of the interpreters and the intercultural workers, as well as their cooperation with the local social work and health services, constitute crucial elements of efficient practice in refugee and asylum care.

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**Informed Consent Statement:** Not applicable.

**Data Availability Statement:** The clinical data which were used for the study are kept in the Institutions' Medical charts and are confidential.

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