Returning with a health condition

A toolkit for counselling migrants with health concerns

Government of the Netherlands

PHAROS
CENTRE OF EXPERTISE ON HEALTH DISPARITIES

Return: not necessarily a step backward

IOM • OIM

This publication has been developed under the project ”Measures to Enhance the Assisted Voluntary Return and Reintegration of Migrants with a Chronic Medical Condition Residing in the EU (AVRR-MC)”, financed by the European Return Fund Community Actions 2011 and the REAN programme of the Dutch Ministry of Security and Justice.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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Contents

Terms and definitions

Assisted voluntary return and reintegration: This includes organizational and financial assistance for the return and, where possible, reintegration measures offered to the individual returning voluntarily.

Chronic medical conditions: These are conditions requiring permanent or long-lasting medical care, severe handicaps and substance abuse problems, e.g. mental health problems, diabetes, cancer, heart and circulatory problems, HIV/AIDS, or pulmonary problems (IOM, 2012). In Part 4 of this toolkit, the term disease is used for the physical (somatic) health problems and the term disorder is used for the mental health problems.

Country of origin: The country that is a source of migratory flows (regular or irregular) (IOM, 2011).

Health: Health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the objective of living. It is a positive concept emphasizing social and personal resources, as well as physical capabilities.[1]

Host country: The country that is a destination for migratory flows (regular or irregular) (IOM, 2011).

Medical conditions: These are physical and mental conditions requiring medical care. This toolkit uses the term for a range of conditions, including chronic medical conditions.

Mental health: This is the state of well-being in which an individual realizes his/her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community.[2]

1 Definition from the World Health Organization, 1946.
2 Definition from WHO, 2002.

Migrant: For the purpose of this toolkit and following IOM terminology, the term migrant means any non-national who has migrated to another country in order to establish him-/herself for a prolonged period or permanently. The term *migrant* is often used to distinguish those migrating for "economic" reasons from asylum-seekers or refugees who have migrated in order to find protection from persecution or violence. In this toolkit, we use the term migrant to encompass both groups. Where it is necessary to make a distinction between these groups (for example, when speaking about their legal status in the Netherlands), we specify this, for instance, by using the term *asylum-seeker or irregular migrant* (Mommers et al., 2009).

Psychosocial factors: Psychosocial factors, at least in the context of health research, can be defined as the mediation of the effects of social structural factors on individual health, conditioned and modified by the social structure contexts in which they exist (Martikainen, Bartley and Lahelma, 2002).

Return: Return refers broadly to the act of going back from a country of presence (either transit or destination) to the country of previous transit or origin. There are numerous subcategories of return which can describe the way in which it takes place or is implemented, for example, voluntary, forced, assisted or spontaneous return, as well as subcategories that can describe the individual returning, for example, repatriation (for refugees).

Sustainable return: Return is considered sustainable when approached in a comprehensive manner that takes account of pre-departure and post-arrival considerations encouraging the creation of new opportunities in the country of origin. This approach makes assisted voluntary return more attractive and acceptable to the migrants, and a growing number of countries of origin, transit and destination employ such a comprehensive approach.

Voluntary return: Voluntary return is based on a decision freely taken by the individual. A voluntary decision encompasses two elements: (a) freedom of choice, which is defined by the absence of any physical or psychological pressure; and (b) an informed decision, which requires the availability of enough accurate and objective information upon which to base the decision. The concept of "voluntary return" goes further than

simply an absence of coercive measures. In some cases, an assessment needs to be made of the extent to which a person is mentally and physically able to take such a free, informed decision, and who, if necessary, could legally take the decision on their behalf.

Note on gender: For ease of reading, the words return counsellor and migrant are used in this publication to refer to both males and females, unless the context demands further clarification. Where return counsellor and migrant are referred to through the use of words he, him *and* his*, this should be read to also include she and her.*

Chapter 1

Introduction

Chapter 1. Introduction

An increasing number of migrants availing themselves of the option of voluntary return may have medical concerns that need to be addressed. As vulnerable migrants, they require tailored assistance prior to, and during, the return travel and/or for their reintegration in the country of return. Looking at the individual level, different grades of vulnerability and resilience can be distinguished: some of these migrants find it difficult to imagine resuming life in their countries of origin, which may be characterized by health-care limitations; they need to be sure that proper health care is available and accessible to them at home; they may worry about becoming a burden to their families; or they fear marginalization due to their medical conditions. One way or another, these concerns play a role during counselling and the practical matters to be organized in view of the return.

1.1. About this toolkit

This publication is one of the outcomes[3] of the IOM project "Measures to Enhance the Assisted Voluntary Return and Reintegration (AVRR) of Migrants with a Chronic Medical Condition Residing in the EU". The project was funded by the European Return Fund Community Actions 2011 and co-funded by the Government of the Netherlands. The project brought together two European Union member States – Hungary and the Netherlands – and seven countries of origin – Afghanistan, Armenia, Azerbaijan, Ghana, UNSC resolution 1244-administered Kosovo,[4] Mongolia and Morocco.

The toolkit has been produced in partnership with the Pharos Centre of Expertise on Health Disparities in the Netherlands. The Centre's mission is to advance the quality and effectiveness of health care for migrants,

3 The project also produced the report *Challenges in the Reintegration of Return Migrants Suffering from Chronic Medical Conditions: Country Assessments Conducted in Afghanistan, Armenia, Azerbaijan, Ghana, Kosovo/UNSC 1244, Mongolia and Morocco.* The research examined the needs of migrants with chronic medical conditions upon and after their return to their countries of origin and the factors playing a role in the reintegration of this particular group of vulnerable migrants.

4 Hereinafter referred to as Kosovo/UNSC 1244.

refugees and people with limited health literacy. To achieve this mission, Pharos provides technical support to organizations working in the field of migration, including: training on the decision-making process and the psychosocial aspects of return migration; consultations on health-related aspects of return migration; and the development of approaches to psychosocial assistance to (former) asylum-seekers, refugees and undocumented migrants during the return process.

The purpose of this publication is to serve as a kit of basic tools for the use of return practitioners working with migrants with medical conditions in the context of AVRR programmes. In the development of the toolkit, the authors held consultations and meetings with several groups: IOM staff, including return counsellors working in the Field in different settings in the Netherlands; return migrants, before their departure from the Netherlands; and Dutch health practitioners. The finalization of the toolkit involved the active participation and contribution of IOM specialists in AVRR and in migration and health issues from the IOM Regional Office in Brussels, Belgium, and the IOM Headquarters in Geneva, Switzerland. The IOM counsellors indicated the difficulties encountered in communicating with migrants with serious health conditions, stating that they [the counsellors], more often than not, would need advice and guidance on handling medical return cases. The general practitioner and the psychiatrist consulted by the authors reported on the specific challenges of examining migrants with health concerns. Finally, the migrants who agreed to share their views elaborated on their personal experience as migrants and patients, and the many dilemmas and issues raised by the perspective of their return.

Pharos also built on its earlier publication, *Facing Return: An Approach for Psychosocial Assistance to (Former) Asylum Seekers and Undocumented Migrants* (2011), which provides practical tools to tackle the psychosocial aspects inextricably linked to the complex process of return migration.

The toolkit consists of five distinct chapters. Chapter 1 presents the context in which the toolkit has been developed and a brief overview of what constitutes AVRR. Chapter 2 looks into the factors and challenges that shape the migrant's return decision, and the interventions to be considered by the counsellor. Chapter 3 focuses on the communication with the migrant. Chapter 4 addresses specific aspects of counselling

migrants with chronic or protracted medical conditions in view of return. Chapter 5 presents a set of basic tools that may be used in the counselling process.

1.2. The European Union policy context

The Charter of Fundamental Rights of the European Union synthesizes the common values of the European Union member States, including civil and political rights as well as economic and social rights. The second paragraph of Article 19 of the Charter of Fundamental Rights states:

> No one may be removed, expelled or extradited to a State where there is a serious risk that he or she would be subjected to the death penalty, torture or other inhuman or degrading treatment or punishment.[5]

The return of "particularly vulnerable groups" is defined by the European Return Fund (ERF) 2008–2013 as a priority for the strategic interventions[6] of the European Commission. The Return Directive points to the importance of migrant counselling, stipulating that:

> An extension of the period for voluntary departure should be provided for when considered necessary because of the specific circumstances of an individual case. In order to promote voluntary return, Member States should provide for enhanced return assistance and counselling and make best use of the relevant funding possibilities offered under the European Return Fund.[7]

5 Charter of Fundamental Rights of the European Union (2000/C 364/01). Available from http://www.eucharter.org/home.php?page_id=26.

6 Article 18.2(e), Decision No 575/2007/EC of the European Parliament and of the Council establishing the European Return Fund for the period 2008 to 2013 as part of the General Programme "Solidarity and Management of Migration Flows". See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:144:0045:0065:EN:PDF.

7 Article 10, Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

The ERF Community Actions Call for Proposals 2011 outlines the policy context for this category of returns as follows:

> Reintegration assistance accompanying the return is one of the innovative tools the EU has introduced in the recent years to help people that have returned to their home country to rebuild their lives and to make their return sustainable. [. . .] Unfortunately, not all of the voluntary return programmes and almost none forced return programmes offer it. Especially challenged are vulnerable groups that often need more advice, guidance and resources to cope with the challenges of reintegration.

Furthermore, the 2011 Call makes specific reference to the recommendations of the "Comparative Study on Best Practices to Interlink Pre-Departure Reintegration Measures Carried out in Member States with Short- and Long-Term Reintegration Measures in the Countries of Return".[8] Recommendation 2 advises on the "involvement of specialised workers to psychologically prepare returnees – vulnerable individuals in particular – prior to departure" on the argument that "it is crucial to have trained social workers that can explain the voluntary return programmes and guide the migrants through the application process. Social workers should know the content of the programmes, be familiar with country of return information and aware of the different providers".

1.3. The Dutch context

This section provides a brief overview of the Dutch framework regulating the legal status of migrants with medical conditions in the Netherlands. Although it is not necessary for a return counsellor to have expertise in asylum and immigration procedures, it is important for him to be familiar with the main legal provisions applicable and the legal constraints faced by the migrant.

The Aliens Act 2000 regulates the admission and expulsion of aliens, the supervision of aliens who reside in the Netherlands, and border control of the country. The Act provides for the types of residence permit, including

8 Available from http://ec.europa.eu/home-affairs/doc_centre/immigration/docs/studies/ECHOMEREINTEGRATION_Final-January_2012.pdf.

those directly related to a migrant's medical condition. Leaving aside the case of foreign nationals applying for a regular residence permit for the purpose of undergoing medical treatment, whose applications are processed without taking asylum aspects into account, this overview focuses on the case of migrants with a medical condition, including former asylum-seekers and undocumented migrants, who are no longer entitled to stay in the Netherlands and have the obligation to leave the country.

Departure from the Netherlands can be temporarily delayed on medical grounds. According to Article 64 of the Act, "an alien shall not be expelled as long as his health or that of any of the members of his family would make it inadvisable for him to travel". If the migrant is confronted with a medical emergency expected to last longer than one year, Article 64 can be invoked to extend the permit.

In processing Article 64 requests, the Immigratie- en Naturalisatiedienst (IND, Immigration and Naturalisation Service) refers to the Bureau Medische Advisering (BMA, Medical Advisors Office). Based on information obtained from the migrant's treating physician, the BMA assesses the risk of a medical emergency within three months after arrival in the country of origin. Should the assessment confirm that there was no risk of such an emergency within that period of time, the residence permit would not be granted.

Medical emergencies are understood as situations whereby the person involved is suffering from a disorder with regard to which it has been decided, based on current medical and scientific opinion that the lack of treatment in the short term (i.e. three months) will lead to death, invalidity or another form of serious mental or physical damage.

Migrants who have been denied a residence permit on the basis of the BMA report have the possibility to challenge the decision in court by using counter-expertise or a second medical opinion. The correctness of the information on the availability of medical care in the country of origin and the accuracy of the health risk assessment are at the core of such lawsuits.

As a general rule, applications for residence permit in the Netherlands may be rejected if the applicant does not possess a valid authorization

for temporary stay, a valid travel document and sufficient means of subsistence. However, the possession of a valid authorization of stay is not required for the application procedure if the state of health of the applicant makes it inadvisable for them to travel.

Aliens who cannot depart from the Netherlands for medical reasons are one of the three categories of foreign nationals who may become eligible for a residence permit on the grounds of the policy applicable to foreign nationals who are unable to leave the Netherlands through no fault of their own.[9]

1.4. Assisted voluntary return and reintegration

AVRR is one of the many services that IOM offers to its member States in the interest of efficient migration management within and between countries. It aims at orderly, humane and cost-effective return and reintegration of asylum-seekers, denied asylum-seekers, and other migrants currently residing or stranded in host countries, and who are willing to return voluntarily to their countries of origin. IOM considers AVRR an indispensable part of a comprehensive approach to migration management, which combines efficient border management, effective asylum processing structures and respect for human rights, by facilitating the safe and dignified return of migrants and encouraging their sustainable reintegration at home.

This area of IOM expertise has been developed through over 30 years of experience. Since 1979, IOM's AVRR activities have grown to include more than 100 projects, helping individuals return to some 160 countries worldwide. In the past decade alone, IOM has assisted more than 3.5 million migrants to return voluntarily to their home countries. IOM's rationale for its involvement in the facilitation of AVRR programmes has followed the changing migration realities. In the early years, the IOM programmes merely offered basic support to facilitate return transportation arrangements. They have since evolved into comprehensive programmes integrating a range of services in order to promote the sustainability of

9 According to the Aliens Act Implementation Guidelines, Section B14/3.2.2, the three categories are: foreign nationals who have tried to leave unsuccessfully; unaccompanied minor foreign nationals; and foreign nationals who have exhausted all legal remedies and who cannot leave for medical reasons.

returns. As migration has become more complex and circular, a more comprehensive approach to return has been required and implemented.

Currently, IOM carries out AVRR from and to an ever-increasing number of countries and supports reintegration activities in many countries of origin. The conditions in which assistance is provided, and the nature and extent of the resources made available to effectively return migrants and support their reintegration, vary from one country to the next. Beneficiaries of the AVRR assistance include individuals whose application for asylum was rejected or withdrawn, stranded migrants, victims of trafficking, and other vulnerable groups, including unaccompanied migrant children, or migrants with health-related needs.

Certain principles apply to AVRR. The first and most critical one for IOM is that it must be voluntary, as required by the IOM Constitution. IOM must ascertain whether returns are voluntary before return arrangements are made under the auspices of the Organization. As a rule, the migrants must receive return counselling to ensure that they are able to formulate an informed decision in choosing the AVRR option. IOM, or its recognized partners, must be able to perform return counselling independently and in an unhindered manner, and in conditions allowing migrants to express their views clearly, irrespective of their status or location.

All of IOM's AVRR programmes include the following stages:

- **Stage 1:** pre-departure assistance and travel preparations;
- **Stage 2:** assistance with the actual trip home;
- **Stage 3:** post-arrival assistance for the socioeconomic reinstallation and reintegration of returnees.

When organizing AVRR support for vulnerable migrants, the following recommendations should be considered in general:

- **Individual solutions:** Each vulnerable migrant has his specific needs. Therefore, an individual solution should be envisaged for each migrant.
- **Time:** An adequate time frame should be foreseen to plan proper travel assistance, arrange reintegration support and organize

specific support. All those involved in planning these assistance measures should allocate sufficient time for each task.

- **Communication:** It is essential to ensure a constant communication flow among the major parties (e.g. returnee, IOM, doctor or health provider including escorts, guardian, return counsellor, authorities) involved in the return and reintegration process in the host country and the country of return as well as between the two countries.
- **Cooperation:** It is crucial that there be cooperation with the principal parties involved in providing various kinds of assistance. The assistance to be provided in cooperation with several major stakeholders requires a clear understanding of the role of each actor so as to ensure that vulnerable migrants receive effective assistance and to avoid confusion concerning the information and counselling given to vulnerable migrants.
- **Confidentiality:** Returnees' personal information should be handled with utmost care (consent forms must be obtained from the migrants), as is the case for all AVRR beneficiaries. However, how to handle this issue among stakeholders should be agreed upon in advance.

The AVRR process always comprises arrangement of travel, post-arrival reception, information, referral, onward travel to the home location, and immediate reintegration assistance. It may also include information and counselling to potential returnees, medical assistance (if necessary) and longer-term reintegration assistance. Since the return of migrants with health needs is sensitive, the migrant's current conditions in the host country (for example, severity of medical condition, the medical treatment provided; the migrant's legal status; the availability of services in his or her respective country of origin) requires extensive information provision and counselling. Information about AVRR options and counselling is essential to ensure the informed consent of migrants.

1.4.1. Assisted voluntary return and reintegration in the Netherlands

In the Netherlands, IOM has been implementing the Return and Emigration of Aliens from the Netherlands (REAN) programme for over two decades. Since 1991, IOM has provided AVRR assistance to over 50,000 migrants departing from the Netherlands.

Through the years, IOM has been the main supporter of reintegration assistance for returning migrants, as a humanitarian intervention and also as a major sustainability factor. IOM expanded its reintegration services to returnees: more than ever before, migrants in the Netherlands are offered a variety of reintegration options. All AVRR projects running in 2014 include strong reintegration components. IOM The Netherlands offers individual cash and in-kind grants in support of reintegration plans in the countries of origin. Support from IOM can cover a variety of options, such as setting up of income-generating activities, housing and subsistence, or financing of educational or training projects. Tailored assistance is provided to specific vulnerable groups, such as migrants with health concerns, victims of trafficking, unaccompanied migrant children, families or single parents with underage children, elderly and irregular migrants. The number of migrants availing themselves of the services offered by IOM's medical programmes has increased significantly in recent years.[10]

The AVRR projects also include activities aimed at consolidating cooperation with partners in the Netherlands and countries of origin. Thanks to its global presence, IOM is ideally positioned to act as a facilitator and catalyst in strengthening links and cooperation with countries of origin. IOM's experiences show the many benefits of this approach, including: better reintegration results; effective communication and exchanges; increased visibility and awareness among stakeholders; and more comprehensive and effective project design and management, monitoring and reporting. IOM involves and works with a whole range of partners in the Netherlands and the countries of origin, namely the national governments, civil society or professional service providers, and actual and virtual diasporas.

10 Of the 2,489 migrants who departed from the Netherlands with IOM assistance in 2013, 270 (11%) were migrants with health concerns, or more than three times the caseload of 78 medical cases registered in 2009 when IOM started AVRR-medical activities.

Chapter 2

A methodology for return

Chapter 2. A methodology for return

This chapter looks at some of the key factors that need be taken into account in designing approaches to counselling of migrants with health conditions who are considering return. A migrant's decision on voluntary return may be shaped by a number of factors, ranging from the exhaustion of legal means to remain in the host country, to changing conditions in the country of origin, or the illness of a family member.

The extent to which migrants with health conditions are able to actively prepare their return and reintegration in the country of origin depends on the nature and severity of their illness, as well as their personal characteristics. Some are convinced that return will never work for them, and as such do not have any interest in preparing for it, mentally or practically. Others will only be living in the present, exclusively focused on their health issues and on meeting their immediate needs – in other words, they are surviving rather than working towards a future. Also, there will be migrants who strongly consider or have already made up their mind to return to their home countries.

Taking an initial inventory of options available enables the identification of constraints to return and reintegration. It is not possible to influence all of the circumstances that result in these constraints. An essential part of the assessment process, therefore, is to provide a realistic picture of those circumstances that cannot be altered and of the interventions that are possible. If unchangeable circumstances produce barriers that prevent return, they can lead to the end of the return process (unless the migrant readjusts his criteria for return). For those circumstances that can be influenced, interventions – in both the host country in the pre-departure stage and in the country of origin after arrival – need to be examined.

Use Tool 1

Migrant's perception of return migration

Many migrants would like to return home. This is also the case for chronically ill migrants. They can be motivated by a desire to be with their families, or to continue their lives in ways that they are not able to in the host country. The conditions that would have to be met for them to consider returning generally encompass:

- Sustainable access to suitable medical treatment (the **medical challenges**);
- Income to meet both costs of living and costs of medical treatment (the **economic challenges**);
- Successful reintegration in social networks (the **social challenges**).

2.1. Medical challenges

The most obvious concern of this category of migrants is the availability of suitable treatment, that is, whether treatment or medication exists (in public health systems, in local clinics, through private medical practitioners or through traditional healers) and whether it will continue to exist. The basis for the migrant's decision to return, however, is related to de facto accessibility to the treatment.

2.1.1. Nature and severity of medical condition

Different conditions impact differently on daily functioning. A chronic mental health disorder can lead to unrest, behavioural problems or conflicts. It can be a burden for the person's daily environment and the direct family. Most patients with serious mental health problems are impaired in different ways. Therefore, the possibilities of reintegration through work or through participation otherwise in society are often limited. Severity of the mental disorder is a crucial factor when predicting the chances for sustainable return.

For instance, someone with diabetes will need a balanced diet, as well as a stable day and night rhythm. Moreover, this person should be able to inject the necessary insulin and monitor his blood sugar level on his own. In case of insulin treatment, a refrigerator is indispensable. Someone with a heart disease can be impaired in functioning due to fatigue or the impossibility of doing physical activities. This means that living in a hilly area can lead to more impairments than living in a flat environment.

2.1.2. Accessibility of treatment

Even when adequate treatment is available, there are several factors that affect the individual accessibility of this treatment. These include affordability of treatment for an individual, as well as geographic and social factors that determine whether or not the individual can actually make use of the available treatment (Mommers et al., 2009).

- **Economic accessibility (affordability)** relates to, among others, transportation costs to access care, as well as treatment costs. The return migrant's medical condition and related medical expenditure may consume a large part of the household budget. Consultations, hospital visits and medication may be expensive and need to be paid directly in cash, considering the lack of health insurance schemes in many countries of origin. However, return migrants with medical conditions can often have low expectations of being able to earn enough money to sustain themselves and to cover all costs related to treatment (Mommers et al., 2009). They might need to live in an urban area in order to access treatment, but living costs are generally higher in the city than in a village. In some countries of origin, medication and services may be provided free of charge. However, informal payments to a nurse or a doctor are often a common practice in obtaining a better service quality. Also, patients turn to private pharmacies seeking to procure the exact same medicine as the one they used to get in the host country, since they do not trust generic brands.

- **Social accessibility** relates to discrimination on the basis of religion, gender, age and sexual orientation, among other things. Stigma can also be an issue for certain illnesses in some societies; in the case of HIV/AIDS or mental health problems, for example, stigma can be associated with visiting particular health-care facilities. These patients might feel a reluctance to use services where local community members are employed for fear that the confidentiality of their status would be compromised. Stigma and its dimensions of labelling, blaming and shame, and silence and secrecy are believed to be more pronounced in rural areas. The stigma attached to one's illness might also affect one's ability to get a job (Neves, 2008).

- **Geographic accessibility** relates to the distance between the living area and the treatment centre. This is especially important in the case of emergencies.

2.1.3. Adherence to treatment

This refers to the ability of individuals, once they have accessed treatment, to take this treatment consistently and continuously (Mommers et al., 2009). For this, it is important that the migrant has knowledge about the course of the illness and the skills or ability to manage his own illness, including healthy lifestyle choices. If a migrant is not able to comprehend his medical condition or if he is not able to follow the prescribed treatment on his own, help from an informal caregiver is crucial.

2.1.4. Quality of care

Recommendations from the medical adviser (i.e. BMA) of the IND, if made available to the counsellor, can give important information on the medical situation of the migrant and the requirements for travel and transfer of care in the country of origin. This does not mean that the actual transfer of care will be organized by the IND or other government agency. In the case of AVRR, this needs to be organized by the counsellor. It is important that the counsellors are able to do their own investigations, through IOM offices or other channels, to learn about the feasible option. This is a crucial and delicate aspect from a medical and humanitarian viewpoint. Helping a seriously ill person to return to a place where there is little chance of treatment does not contribute to sustainable return. It is important to acknowledge this tension and conduct an in-depth research on the availability of treatment as well as the costs involved. Only after a thorough and independent assessment of these factors can the counsellor provide sound advice, which enables the migrant to make an informed decision about a possible return.

2.2. Economic challenges

2.2.1. Conditions for economic reintegration

The extent to which return migrants can take part in daily life in the community back in the home country will affect their sense of well-being. Especially in lower-income or post-conflict countries, the lack of employment opportunities constitutes one of the key economic obstacles for return, even for healthy migrants. Within a setting which is often characterized by scarcity – of money, employment, accommodation and food – return migrants need to compete in many ways. They are in a disadvantageous position due to the fact that, in order to start afresh, they need to rely on a social network that they may have neglected during their stay abroad.

Economic reintegration is not easy. At the very least, therefore, a return migrant should have a good plan for attaining economic self-sufficiency. He should be aware of the steps that need to be taken, the assistance programmes that might be available and the kind of start-up capital that would be necessary. What opportunities for work or self-employment and/or training does the return migrant see for himself in the country of origin?

Living with a chronic medical condition in particular may place a considerable financial burden on the return migrant. Therefore, if economic reintegration would amount to merely living at subsistence level, this is unlikely to be sufficient for the return migrant with a medical condition to both meet his basic food, accommodation or education needs and pay for medical costs (Mommers et al., 2009). In case of return migrants unable to take up employment due to their medical conditions and receiving little or no family support, the sustainability of their reintegration becomes uncertain.

2.3. Social challenges

2.3.1. Social support networks

The importance of social support networks for sustainable return cannot be emphasized enough. It provides return migrants with both emotional

and practical/material safety nets. The availability of a social support network is dependent on a variety of factors. In some cases, this network might not exist at all, since family members have deceased, have left the country themselves, or the migrant has lost track of them.

Even if there is a support network available, are relatives and friends back home willing to provide the necessary care and support? This depends, to a large extent, on the frequency, nature and intensity of the contacts while the migrant was abroad. Did the migrant, for instance, send remittances during his absence, or did he render any other services that would justify some form of reciprocity? In other words, is the migrant perceived as being "entitled" to become a recipient of care? When the migrant comes back empty-handed, the willingness of relatives and friends to provide support may be diminished. Often family members are also struggling to make ends meet and the high medical expenses of the return migrant will affect the entire family. In such cases, the return migrant will probably be seen as an added burden, especially when carrying an illness that would reflect negatively on the family or circle of friends (Mommers et al., 2009).

2.3.2. Stigma and discrimination

Migrants who are living, for example, with HIV/AIDS, or who have a mental disorder may face stigma and discrimination upon return. This may be one of the biggest barriers to sustainable return. In many countries of origin, discrimination can have a highly negative impact on the ability of the return migrant to earn a livelihood, or to secure housing. More about stigma and discrimination of HIV-positive returnees can be found in *Health, Hope and Home* (Mommers et al., 2009).

Use Tool 2

Barriers and intervention possibilities

2.4. Assessment of intervention options

What are the preconditions for overcoming barriers to sustainable return and reintegration? The first of these is psychological in nature. Overcoming barriers to return requires a firm commitment to rebuilding a life in the country of origin. A positive, forward-looking attitude is crucial to have a chance of making return work. A migrant needs to have a large measure of mental readiness, as well as a proactive attitude in practically preparing for return.

2.4.1. Information gathering

When a clear picture of desirable interventions has been produced, the feasibility of implementing these interventions needs to be assessed. Again, this process will likely involve a lot of information gathering in the country of origin, and may also include further exploration of pre-departure assistance possibilities in the country or origin, for example, preparing the family for the reunion with their relative.

It is important to mention in this respect that many barriers to access services in the country of origin are difficult to tackle from the host country. Moreover, the resources at the disposal of the organization providing assistance, as well as its mandate, will play an important role in the feasibility of implementing certain activities. The assessment of intervention possibilities will likely lead to the conclusion that some interventions, though desirable, are practically unfeasible.

Here, again, the question needs to be asked whether return is still possible even in the absence of these interventions. The limitations and practical possibilities for intervention need to be communicated clearly with the migrant. It will then be up to the migrant to make a decision on whether to proceed with preparing his return. Although the “return decision” is described here as a specific point in time, in reality this is more likely to be a process, which already begins long before a request for assistance is made. Also, the voluntary nature of return would mean that this decision is not a “point of no return”. Even after the decision is made to go ahead with preparations for return, it should still be possible for the migrant to change his mind.

Whether the migrant will be able to support himself economically depends, apart from his health condition, on whether he has had the opportunity to learn and develop marketable skills while in the host country. As mentioned before, the extent to which the migrant has been able to send remittances to family members and/or to build up a "nest egg" to take home plays an important role (Mommers et al., 2009).

Use Tool 3

Personal action plan

2.5. Preparation of interventions

When a decision is made to try and realize return, interventions need to be prepared. As mentioned, the migrant himself has a key role in this preparation. However, return counsellors might complement the migrant's activities by, for example, mobilizing or providing resources. This stage would also include agreeing on clear terms about the extent to which assistance will be provided. Clear mutual expectations between the migrant and the return counsellor are crucial to avoid misunderstandings.

- **Implementation of pre-departure interventions**
  There needs to be a realistic time frame that is shared by both the migrant and the return counsellor. There might be a substantial time gap, for example, between starting the pre-departure interventions and the actual return. If, for instance, these interventions include skills training or treatment/stabilization, this may take a considerable amount of time.[11]

- **Implementation of post-arrival interventions**
  When the actual return takes place, it should also be clear which post-arrival interventions still need to be implemented. Is it the responsibility of the assistance provider (or a partner in the country of origin) or of the migrant to take the initiative? In some

11 The extent to which a migrant might actually have this time depends, among other things, on his legal status.

cases, the assistance provider can only refer the migrant to a local organization in the country of origin, without actually being able to influence the way in which this organization deals with the returnee. This also needs to be communicated clearly with the migrant before the actual departure.

- **Monitoring**
  The assistance provider and the migrant may make arrangements to monitor the way the migrant is getting on after his return. However, in practice, the effectiveness of such monitoring arrangements may be limited. More wide-ranging and comprehensive monitoring and evaluation of those who return under AVRR schemes is needed in order to better understand the risks and challenges faced by return migrants.

A research report[12] produced under the same project that funded this toolkit states that:

> Although returnees have to face the same health care-related problems and economic circumstances as the general population in the country of origin, they are, in many ways, more vulnerable than the average citizens. [. . .] this vulnerability is shaped by the stressful migration experience, the lack of real estate or land property (which may have been sold by the migrants to finance their migration), the social stigma attached to return migration in general and the high expectation among community members vis-à-vis the returnees.

12 M. van Schayk, *Challenges in the Reintegration of Return Migrants Suffering from Chronic Medical Conditions: Assessments Conducted in Afghanistan, Armenia, Azerbaijan, Ghana, Kosovo/UNSC 1244, Mongolia and Morocco* (Geneva, IOM, 2014).

Chapter 3

Communication

Chapter 3. Communication

Thinking about or making specific plans for returning to the country of origin can involve a lot of stress. It is important to realize that a migration plan that did not lead to the desired outcome can result in psychological reactions like confusion, emotional instability, a sense of loss, lack of trust, isolation, and a focus on the past or the future rather than on the present. Such reactions can be just normal consequences of the process of considering return and a sign that people are able to judge their predicaments. It can also be a result of the migrant's perception of his migration experience as a failure. Although such emotions are not necessarily symptoms of mental disorder, they can play a role in the decision-making process of the return migrant.

Evaluations from Pharos training sessions[13] have shown that, in general, return counsellors find it difficult to deal with the migrants' emotions, mixed feelings and thoughts. This is more so in the case of migrants with a known chronic condition. This chapter provides suggestions as to how return counsellors can handle emotional outbursts of return migrants.

3.1. Different emotions

As any act of life, talking, thinking and deciding about return may trigger different emotions, feelings, negative thoughts and behaviours in migrants. Even for people with no medical conditions, a decision about return may be accompanied by fear, anxiety, anger and sadness, a sense of failure, shame and disorientation. Migrants with medical conditions may be additionally worried about the course of the disease and the possibilities to receive continuity of care upon return. This may eventually translate into the decision not to return. In some cases, migrants may not be able to take stock of the situation with the result that they withdraw, hesitate strongly or appear apathetic. Communicating with such particular migrants may be challenging.

13 Training provided by the Pharos Centre of Expertise on Health Disparities in the Netherlands.

From the point of view of the return counsellor, feelings like the ones discussed above may hinder the assistance provided. In such cases, counsellors will not be able to carry on with the interview "plan" or "protocol". Things may not go as expected and could trigger a range of responses in return counsellors. Many of these responses stem from a sense of insecurity: "What can I do?"; "Will I cause the migrant harm if I carry on now?"; "He might hurt himself . . ."; "Should I refer the migrant to a health professional?"

Finally, the return counsellor should be aware that the relation between him and the migrant may be hindered by a lack of trust. Some migrants may question all the information provided to them and fear that there is a vested interest behind. This can be related to actual experiences they endured before and during their migration, including maltreatment from the police, discrimination in accessing services, stigma or experiences leading to suspicion towards reintegration officers in the country of origin. The latter is due to bad experiences they may have had as regards reliability of certain services. They may have experienced forms of corruption in their countries of origin, making them suspicious about free services and the trustworthiness of reintegration counsellors in particular.

While return counsellors are not psychologists or psychological counsellors, they can nevertheless acknowledge the emotional difficulties return migrants are facing, in order to create a supportive environment – to the extent possible within their functions and limited responsibilities – and do not harm further. A number of recommendations are listed below.

- Show respect to the migrant by accepting him. This means accepting that these emotions, feelings and thoughts exist and are motivated, without trying to push them away or downplaying them. Such feelings constitute the migrant's subjective reality and they are often linked with objective predicaments: they are very real to the migrant at that point in time.

- Consider the migrant a peer subject in the conversation, and not only the recipient of information. Do this by paying attention to any signals made by the migrant, for example, indicating his wish to stop talking for a bit, and take a little break. If the migrant is unable to express his needs or wishes, the counsellor may suggest to take

a break, for instance, to get something to drink or to go for a little walk and continue the conversation afterwards.

- In general, a counselling session on AVRR should not harm the migrant further from an emotional point of view and should be considerate of the emotional challenges the migrant may face at the moment. To achieve this, basic rules should be followed:
  - The session should take place in a quiet place to minimize distractions.
  - The counsellor should stay near the migrant but keep an appropriate distance, depending on the migrant's age, gender and culture.
  - The counsellor should let the migrant know that he hears what he is saying, for example, by nodding the head and saying, "Yes, go on," or just say, "Hmmm…."
  - The counsellor should provide factual information. He should be honest about what he knows and does not know. Say, "I don't know but I will try to find out". Avoid using terms that are too technical for the migrant.
  - The counsellor should give information in a way the person can understand. Keep it simple.
  - The counsellor should acknowledge the migrant's feelings, as well as any losses or important events they experienced, such as loss of home, the death of a loved one or possible abuse, by saying, "I'm so sorry…."
  - Respect privacy. Keep the person's story confidential, especially when he discloses very private information.
  - Conversely, the counsellor should acknowledge the migrant's strengths and how these have been supportive so far, when this emerges in the conversation.
  - The counsellor should not press anyone to tell his story and interrupt or rush someone's story.
  - The counsellor should not comment on the migrant's situation, but just listen.
  - The counsellor should not judge what the migrant has or has not done or experienced, or how he is feeling. Don't say, "You shouldn't feel that way" or "You should feel lucky you survived".
  - The counsellor should not talk about his own problems during the session, nor refer to someone else's similar experiences.

3.2. Counsellor emotions

How can return counsellors remain alert to the needs of the migrant and ensure the quality of their services while remaining alert to their own well-being? In this chapter, we will discuss this and offer practical tools.

3.2.1. Balance between engagement and distance

Guiding migrants through the return process may provoke a variety of emotions, feelings, thoughts and behaviours in the return counsellors themselves. These may range from hope, satisfaction and (self-) confidence to feelings of anger and powerlessness. Such emotional responses may affect the personal well-being of the return counsellor and the quality of the work provided. For this reason, it is important that a balance is found between involvement with the migrant and keeping the migrant at arm's length.

> Mr and Mrs A. are from northern Iraq. With their four daughters, they sought refuge in the Netherlands four years ago. This couple has been through traumatic experiences in Iraq, and for that reason they are now under mental health treatment in the Netherlands. Their children have witnessed these traumatic experiences. They suffer from sleep disorders and are also in therapy. The family has exhausted all legal options a few months ago for their stay in the Netherlands, but all of them still have to return. The parents do not want their children to grow up as undocumented migrants, so they are cooperating with plans for their return. In the course of interviews, however, the couple appears to be at the end of their tether. They cry a lot and tell the return counsellor that their life has lost its meaning, but that they carry on because of their children. During the interviews, they indicate that they understand everything and that they will do everything they are asked to do. However, at the next interview, it always turns out that they have not done what they have agreed to do. Whenever the return counsellor asks them why, they indicate that they do not know why they have not done anything. The return counsellor does not know how to provide assistance to this couple. He feels powerless and frustrated and expresses this by getting angry. At the same time, he feels guilty because he knows that things were difficult for the family in Iraq and they do not really want to return. The counselling situation is caught in a deadlock.

Responses like the ones listed below may indicate that the return counsellor is tending to distance himself too much:

- Denial: “You have probably misunderstood, what happens is….”
- Downplaying: “I think you are exaggerating, it cannot be that bad.”
- Distorting: “Yes, I thought so, but it wasn’t like that, it….”
- Avoidance: “I heard you. Now we will discuss what you are going to do about it.”
- Indifference: “Oh well, we all go through things from time to time.”
- Withdrawal: “If you are mean to me like that, I won’t help you anymore.”
- Blaming the migrant: “It is your own fault, you didn’t do anything.”

Responses like the ones below may indicate that the return counsellor is tending to get overly involved:

- Taking responsibility from the migrant: “I am sorry things went this way, I will try my best to get you through this as best I can.”
- Getting caught up in the migrant’s story: “Oh, I am so sorry, that’s so bad. I understand you cannot do anything right now, that’s so dreadful.”
- Allowing the migrant’s responses to control you: “Please don’t get angry like that, I cannot help you when you get like that, please try your best for a change.”
- Tending to act like a saviour and action man: “I will make sure you get refugee status/that visa/the laissez-passer.”
- Feelings of guilt and embarrassment: “How terrible that my country is doing this to you, that is no way to treat people.”
- Suffering from feelings of loyalty and moral dilemmas: “Why are they sending innocent children back into another war?”
- Feeling victimized and falling ill: “Nobody recognizes how hard I work for them; they aren’t taking me into account at all.”

Both types of response may have an impact on the quality of assistance provided. Offering too much support and being overly involved can have an adverse impact on the migrant. To keep a good balance in providing assistance, it is important to be aware of your own responses. Try to take a position between engagement and distance. This will provide the working space where you move towards a more distant and formal

position if needed. For example, when you need to make a clear statement or when your migrant is asked to make a choice. Likewise, you may opt for a more involved position, for example, when emotions and anxiety are overrunning the migrant. It is the art of counselling not to be overly distant and not to be overly engaged. The position in between is the effective one, both for the migrant and the counsellor.

Use Tool 4

Impact of emotions on the ability to function as a professional

3.2.2. Most common reactions in counsellors

There may be a number of reasons why return counsellors are responding to the migrants the way they do.

Compassion

The return counsellor may feel touched by the migrant's story, out of sheer compassion. When working with asylum-seekers and refugees, one is inevitably confronted with sad, horrible and possibly traumatic stories. This can eventually lead to compassion fatigue, a phenomenon especially known among health-care professionals. It occurs when a person has heard so many tough and intense stories that he has become emotionally blunted and exhausted so to speak. To a certain extent, this can be the case with return counsellors as well.

Transfer and counter-transfer

Transfer and counter-transfer are concepts used in health-care settings in particular. However, these processes may also affect return counsellors to a greater or lesser extent. Transfer refers to the migrant projecting his emotions on the return counsellor. Migrants may project general feelings of anger and dissatisfaction on the return counsellor personally and take these out on him. They may be dissatisfied about living in a centre for asylum-seekers or angry because their application for asylum has been (once more) rejected. Counter-transfer relates to the counsellor's response to the migrant's behaviour. It has its origins in unprocessed emotions and subconscious problems affecting the counsellor himself.

If a return counsellor responds with counter-transfer, he may start shouting or become very anxious. If the return counsellor refrains from counter-transfer, he will quietly tell the migrant what he does not like about his behaviour. He may express some understanding, but he is aware of his boundaries. He will request that the migrant stay calm or that the conversation is continued some other time.

Working conditions

Working conditions may also lead to the counsellor responding emotionally to a migrant's story. Every individual will experience a certain degree of work-related stress. If a stressful situation continues for a long time, it can lead to physical and mental health problems. For this reason, it is important to keep listening to one's body.

Use Tool 5

Signs of stress among return counsellors

3.3. "Intervision" and preconditions from within the organization

It is any organization's responsibility to look after its employees and to monitor the quality of the services provided. Likewise, certain conditions are required which enable return counsellors to do their job well. One of the possible approaches is regular "intervision".

Intervision provides a valuable tool for allowing counsellors to discuss complicated cases with one another. Moreover, colleagues can reflect on possible emotional responses to migrants in a group context.

> *Intervision* is a problem-solving technique where employees in a team or group can request their colleagues to collectively think about problems. It is analytical more than solution-oriented, because the participants in intervision are not requested to bring solutions to the table but ask questions about the context, background and approach of the problem.

Tool 4 contains an outline for return counsellors to reflect on their possible emotional responses to migrants and their stories.

Tool 5 offers a list of stress-related symptoms. It also contains suggestions as to what individuals or organizations can do to reduce stress and pressure of work.

Tool 6 contains a second tool dealing with the emotional responses of counsellors. This intervision tool invites to a more in-depth consideration of the impact various factors may have on the counsellor's work satisfaction and on his general well-being.

Suggestions for organizations and supervisors/managers (Donk, 2000):

- Offer intervision and supervision. This will give return counsellors the opportunity to talk about possible emotional responses to the migrant's story.
- Tread carefully where the return counsellor's caseload is concerned. Ensure that a counsellor's caseload does not just consist of people who have been through traumatic experiences, because such a caseload is usually too heavy to carry.
- Show appreciation for the work done by your staff.
- Allow staff to influence their work (environment).
- Where necessary, offer training programmes or training courses to improve staff resilience.

Use Tool 6

(Personal) intervision

Chapter 4

Chronic conditions and voluntary return

Chapter 4. Chronic conditions and voluntary return

The return counsellor is not a health professional able to diagnose and treat medical conditions. Rather, the role of the return counsellor is to create an environment favourable to communication and advise without disregarding the challenges or difficulties that migrants are facing. For the return counsellor, basic knowledge about these disorders helps when discussing the possible consequences of a particular disorder for the return process. It enables return counsellors to better understand migrants with these disorders and to adapt their communication accordingly. It is important to realize that these disorders can lead to impairments for daily life or to a changed future perspective. These constraints are important aspects to consider in case of return.

Some basic knowledge of these diseases would help the return counsellor understand the main considerations to bear in mind when organizing the return of a migrant suffering from one of these conditions and when assessing the migrant's post-arrival situation. The return counsellor must be aware of the fact that migrants with a chronic condition may have tried to get a residence permit on medical grounds. In such cases, the medical adviser of the BMA would have already assessed the severity of the disease (see 1.3: The Dutch Context) and provided advice on medical needs in view of travelling. The BMA report, if available, can be an important source of information on the migrant's medical situation and on the requirements for travel and transfer of care. However, the BMA report does not consider the accessibility, affordability and efficacy of the treatment in the country of origin. Therefore, the return counsellor has the responsibility to assess all factors that my impact the continuation of the treatment in the country of origin and thus to be able to provide proper advice to the migrant. Such an assessment can be made through IOM offices, non-governmental organizations or other relevant entities in the country of origin.

Box 1. The migrant–physician–counsellor triad

When a migrant with a medical condition expresses the wish to return, the counsellor must function in a triad with the migrant and the migrant's health-care professional.

In order to discuss the migrant's case with third parties, including the migrant's general practitioner, the counsellor should have the migrant's informed consent. Once trust has been established between the migrant and the counsellor, it is easier for the counsellor to get the migrant's agreement to discuss the medical aspects of a possible return with the treating physician. Without this permission, it will be difficult for the counsellor to get a proper impression of the specific medical condition and the migrant's medical needs in the post-return phase. In most cases, it is useful to ask and motivate the migrant to first discuss his wish to return with his treating physician. Subsequently, the counsellor may contact the physician.

When contacting a treating physician, it is crucial to explain clearly the purpose of the inquiry and the particular circumstances of the return process. In some cases, the treating physician will ask for a written consent in which the migrant gives his explicit permission to the physician to discuss his case with the counsellor. In other cases, the migrant's verbal consent is sufficient.

The information in this chapter is organized in the following format:

- General information
- Treatment
- Complications
- Medical aspects to consider in the context of voluntary return
- Caveats regarding travel

4.1. Chronic physical conditions and voluntary return

This chapter describes three chronic physical groups of disease: diabetes, cardiovascular diseases and infectious diseases (hepatitis and HIV/AIDS). These diseases are most prevalent among the migrants assisted by IOM the Netherlands in recent years.

4.1.1. Diabetes

General

Diabetes mellitus (DM), or simply diabetes, is a group of diseases in which a person has high blood sugar which has to be treated with tablets or insulin. If left untreated, diabetes can cause many complications, including heart disease, kidney failure and damage to the eyes.

There are two main types of DM:

- **Type 1 DM:** This is a result of the body's failure to produce insulin. This form was previously referred to as "insulin-dependent diabetes mellitus" or "juvenile diabetes".
- **Type 2 DM:** This is a result of insulin resistance, often starting slowly at an older age. This form was previously referred to as "non-insulin-dependent diabetes mellitus" or "adult-onset diabetes".

Treatment

DM is a chronic disease for which there is no known cure except in very specific situations. Management concentrates on keeping blood sugar levels as close to normal as possible, without causing a too low blood sugar level (hypoglycemia). This can usually be accomplished with diet, exercise, and use of appropriate medications: insulin in the case of type 1 diabetes; oral medications, and possibly insulin, for type 2 diabetes. Blood sugar should be regularly monitored so that any problems can be detected and treated as early as possible. The risk of complications with diabetes can be reduced by adhering to medical advice and keeping diabetes under control.

Learning about the disease and actively participating in the treatment is vital for people with diabetes, since the complications of diabetes are far less common and less severe in people who have well-managed blood sugar levels. People with diabetes can benefit from education about the disease and treatment, good nutrition to achieve a normal body weight, and sensible exercise, with the goal of keeping blood glucose levels within acceptable bounds. In addition, given the associated higher risks of cardiovascular disease, lifestyle modifications are recommended to control blood pressure.

In Western Europe, where the health system is based on care by general practitioners, treatment of diabetes typically takes place outside the hospital. Hospital-based specialist care is used only in case of complications and difficult blood sugar control.

Complications

All forms of diabetes increase the risk of long-term complications. These complications typically develop after many years (10–20), but may be the first signs or symptoms in those who were not discovered and diagnosed before that time.

The major long-term complications relate to damage to blood vessels. The primary complications of diabetes include damage to the eyes, kidneys and nerves. Damage to the eyes is caused by damage to the blood vessels in the retina of the eye, and can result in gradual vision loss and potentially blindness. Damage to the kidneys can lead to chronic kidney disease, sometimes requiring dialysis or kidney transplant. Damage to the nerves of the body is the most common complication of diabetes. Diabetes-related foot problems, such as diabetic foot ulcers, may occur and can be difficult to treat, occasionally requiring amputation. The other complications of diabetes include coronary heart disease and other vascular diseases, such as stroke.

There is a link between cognitive deficit and diabetes. Compared with those without diabetes, people with the disease have a greater rate of decline in cognitive function.

Medical aspects of significance in case of return

Box 2. Questions to ask a migrant with diabetes who is considering return

- Is the diabetes stable at this moment (e.g. stable blood sugar)?
- Are you able to do your daily routine?
- Do you have a good understanding about your condition?
- Are you under regular medical treatment? If so, where?
- Have you discussed with your treating physician the medical aspects of your return?
- Do you know how to handle your condition (i.e. control of blood sugar level, proper administration of your drugs or insulin)?
- Are treatment and medication available in your home country? How much do they cost?
- If treatment and medication are not available, are there appropriate alternatives? Are these medically acceptable? Take into account that insulin is produced in different strengths and that this cannot be considered an alternative.
- If you are using insulin, is there a fridge at your home to store it properly?

In order to answer these questions, the migrant needs to discuss these with his treating physician. In most cases, contact between the counsellor and the treating physician will be necessary.

Box 3. Travel and diabetes

For people with diabetes, it is necessary to plan the return trip well ahead. If the return migrant will travel by plane, he will need a doctor's letter to take insulin and/or syringes on board the flight. Proper food intake is also crucial. Regular glucose monitoring is important, to allow any adjustments in dose to be made safely. The counsellor needs to stress normal routine behaviour (e.g. intake of food, glucose monitoring) during travel. Extra attention

on signs of diabetes on the day of departure is also important. In case of doubt, organize a fit-to-fly examination.

For more travel information for persons with diabetes, see http://main.diabetes.org/dorg/PDFs/Advocacy/Discrimination/air-travel-and-diabetes.pdf.

4.1.2. Cardiovascular disease

General

Cardiovascular disease refers to any disease that affects the heart or blood vessels, principally cardiac disease, vascular diseases of the brain and kidney, and peripheral arterial disease. The causes of cardiovascular disease are diverse, but atherosclerosis and/or hypertension are the most common. In addition, with aging come a number of physiological and morphological changes that can alter cardiovascular function and lead to increased risk of cardiovascular disease, even in healthy individuals.

Cardiovascular diseases are the leading cause of death in the world. In 2008, 30 per cent of all global death was attributed to cardiovascular diseases. Since the 1970s, cardiovascular mortality rates have declined in many high-income countries. At the same time, cardiovascular deaths and diseases have increased at a fast rate in low- and middle-income countries.

Although cardiovascular diseases usually affect older adults, the antecedents of cardiovascular diseases, notably atherosclerosis, begin in early life, making primary prevention efforts necessary from childhood. There is therefore increased emphasis on preventing atherosclerosis by modifying risk factors, for instance, through healthy eating habits, exercise and avoidance of smoking tobacco.

Cardiovascular diseases consist of a wide range of conditions, such as coronary heart disease, hypertension and complications of the heart and other organs, abnormalities of heart rhythm, abnormalities of heart valves, stroke and heart structure malformations existing at birth. Most

of the time there is a history of high blood pressure, heart attack, chest pain and decreased exercise tolerance. As blood vessels are part of all organs and body parts, their functioning can be affected. An unstable situation presents itself as chest pain or other symptoms at rest, or rapidly worsening chest pain. The risk of artery narrowing increases with age, smoking, high blood cholesterol, diabetes, and high blood pressure. It is more common in men and those who have close relatives suffering from cardiovascular diseases.

Treatment

The main treatment options for cardiovascular diseases are drugs (e.g. medication to lower cholesterol, medication to lower blood pressure and normalize heart rhythm, medication to widen obstructed blood vessels and medication to prevent blood clotting), mechanical interventions (to widen obstructed blood vessels through dottering or by placing a stent) or heart surgery (e.g. bypass grafting, replacing heart valves).

Lifestyle changes, such as a whole-food plant-based diet, weight control, smoking cessation and avoiding consumption of certain types of fat, have shown to be effective in reducing the risk of having cardiovascular diseases. Exercise, such as walking, jogging and swimming, can help decrease blood pressure and the amount of blood cholesterol over time. Decrease of psychosocial stress is another factor to prevent cardiovascular diseases.

Complications

The most common complications of cardiovascular diseases are heart attack and heart failure. A heart attack usually occurs when a blood clot blocks the flow of blood through a coronary artery – a blood vessel that feeds blood to a part of the heart muscle. Interrupted blood flow to the heart can damage or destroy a part of the heart muscle.

Heart failure occurs when the heart cannot pump enough blood to meet the body's needs. Heart failure can be a result of many forms of heart disease, but it is mostly seen after a heart attack or in case of abnormalities of one of the heart valves.

Cardiovascular diseases may also cause a stroke, which happens when the arteries to the brain are narrowed or blocked and too little blood reaches the brain. A stroke is a medical emergency, as brain tissue begins to die within minutes of a stroke.

Medical aspects of significance in case of return

Box 4. Questions to ask a migrant with a cardiovascular disease who is considering return

- Is the disease stable at this moment?
- Are you under treatment at this moment?
- Did you discuss with your treating physician the medical aspects of your plan to return?
- Do you have a good understanding of your condition?
- Are you able to do your daily routine well? For instance, can you eat and perform personal hygiene tasks independently? Or do you need assistance to do so, partially or fully?
- Do you take your medicine(s) regularly?
- Are treatment and medication for your condition available? How much do they cost?
- If medication or treatment is not available, what appropriate alternatives are available for you? Are these medically acceptable and interchangeable?

In order to answer these questions, the migrant needs to discuss these with his treating physician. In most cases, contact between the counsellor and the treating physician will be necessary.

Box 5. Travel and cardiovascular diseases

In general, air travel does not pose great risks to most patients with cardiovascular diseases. Although the risk of a heart attack and irregular heartbeat or other major complications is low among people with a stable heart condition, heart-related problems account for a high percentage of all in-flight medical emergencies. Air travel carries certain risks for cardiovascular patients, which

deserve attention and preparations in view of the flight. Some heart patients need to avoid flying, at least temporarily, because of the increased risk posed by being confined in a high-altitude (and therefore low-oxygen) environment.

Patients should not fly if:

- They have had a heart attack (myocardial infarction) within the past two weeks;
- They have had a coronary artery bypass surgery within the past three weeks (longer if they have had pulmonary complications);
- They have unstable chest pains, poorly controlled heart failure or uncontrolled heart rhythm problems. Such patients can undertake air travel, after careful preparation and with special travel arrangements.

One significant risk faced by people with cardiovascular diseases when flying is *thrombosis*, or the formation of a blood clot in the vessels of the leg. Sitting long hours, dehydration and lower oxygen levels while on a plane cabin can all predispose a person to blood clots. This is in particular valid for flights longer than eight hours.

People with cardiovascular diseases should take precautions and discuss travel plans with their doctor before stepping on an airplane. The following pre-travel checklist is recommended for people with cardiovascular diseases:

- Carry a supply of all medications in hand luggage.
- Confirm aisle seating if at risk for thrombosis. This will allow a person to enter and exit the seat, walk around and stretch the legs without disrupting other passengers.
- Avoid alcoholic beverages on board and remain well hydrated.

For more travel information for people with cardiovascular diseases, see http://heartdisease.about.com/od/otherriskfactors/a/flyinghd.htm.

4.1.3. Infectious diseases – hepatitis and HIV/AIDS

Infectious diseases, also known as transmissible or communicable diseases, comprise diseases due to an infection or presence and growth of virus, bacteria or parasite in an individual. Infectious diseases are sometimes called contagious diseases when they are easily transmitted by contact with an ill person or their secretions (e.g. influenza). For the purpose of this toolkit, two infectious diseases are covered in this section: hepatitis and HIV/AIDS.

Hepatitis

General

Hepatitis is the general term for liver inflammation. It is characterized by an infection of the liver and the destruction of a number of liver cells. Hepatitis can be caused by viruses that primarily attack the liver cells. The most important types are hepatitis A and B. Chronic use of alcohol also can lead to a non-infectious form of hepatitis. Hepatitis can be divided into two subgroups according to duration: *acute hepatitis* and *chronic hepatitis*.

Hepatitis A is an acute form of hepatitis with often mild symptoms and little risk for a chronic course. The most serious chronic form is hepatitis B: about 600,000 people die every year due to the consequences of hepatitis B. It can only be diagnosed by blood tests. It can cause chronic liver disease and chronic infection, and put people at high risk of death from cirrhosis of the liver and liver cancer. Some people have no chronic infection but still carry the virus in their blood and body fluids and are thus highly contagious for others. Hepatitis B prevalence is highest in sub-Saharan Africa and East Asia. Most people in these regions become infected during childhood and between 5 per cent and 10 per cent of the adult population are chronically infected. Hepatitis B is preventable with the currently available safe and effective vaccine. All children in the Netherlands, including asylum-seeker children, are vaccinated against hepatitis B.

Treatment

There is no specific treatment for acute hepatitis. More than 90 per cent of healthy adults who are infected with the hepatitis A and B viruses will recover and be completely rid of the virus within six months. In some individuals, chronic hepatitis B can be treated with drugs, which can slow the progression of cirrhosis, reduce incidence of liver cancer and improve long-term survival. Treatment, however, is not readily accessible in many low-income countries. Liver cancer is almost always fatal and often develops in people at an age when they are most productive and have family responsibilities. In developing countries, most people with liver cancer die within months of diagnosis. In high-income countries, surgery and chemotherapy can prolong life for up to a few years. People with cirrhosis can undertake liver transplants, with varying success.

Complications

Without treatment, about a third of people with chronic hepatitis B infection go on to develop a disease of the liver, which can be very serious. It is estimated that 15–25 per cent of people with untreated chronic hepatitis B die of liver disease. Scarring of the liver (cirrhosis) affects around one in five people with chronic hepatitis, often many years after they first contracted the infection. Around 1 in 10 people with cirrhosis caused by chronic hepatitis B will develop liver cancer.

Medical aspects of significance in case of return

In Western Europe, hepatitis is often a stable disease. There are also individuals with hepatitis who only carry the virus in their blood and do not have an active infection. While they face little medical risks for themselves, they can infect others.

Box 6. Questions to ask a migrant with hepatitis who is considering return

- What is the type of hepatitis?
- Is there still an active infection?
- Are you under regular medical treatment? If so, where?
- Are you taking hepatitis medications?
- Are you able to do your daily routine well?
- Are there complications?
- Do you have a good understanding about your condition?
- Did you discuss with your treating physician the medical aspects of your return?
- Are treatment and medication available? How much do they cost?
- If medications are not available, are there appropriate alternatives? Are these medically acceptable?

In order to answer these questions, the migrant needs to discuss these with his treating physician. In most cases, contact between the counsellor and the treating physician will be necessary.

HIV/AIDS

General

HIV stands for human immunodeficiency virus. It is transmitted via body fluids through sexual contact, injected drug use, blood transfusion with infected blood, pregnancy or breastfeeding. The virus weakens the immune system by destroying important cells, the so-called CD4 cells, which are needed by the body to fight diseases and infections. A failing immune system cannot protect a person from infections. The human immune system cannot seem to get rid of HIV, which means that, once a person has HIV, it will be there for life.

Over time, HIV can destroy so many of the CD4 cells that the body cannot fight infections and diseases anymore. When that happens, the HIV infection can lead to acquired immunodeficiency syndrome or AIDS,

which is the final stage of an HIV infection. Individuals with AIDS need medical intervention and treatment to prevent death. Being HIV-positive usually has a strong psychological impact. Stress, fear, stigma, fatalism and depression may all be experienced by a person with HIV.

Treatment

Not everyone who has HIV progresses to AIDS. Just because someone is HIV-positive does not mean he must take HIV medications, also known as antiretroviral treatment. Whether – or when – HIV treatment has to be started and which type of treatment is needed will depend on many factors, including the CD4 count and the number of viruses in the blood. With proper treatment, the level of HIV virus can be kept low. It involves taking a combination of HIV medicines every day. With these HIV medicines, someone can live a longer and healthier life and reduce the risk of transmitting HIV to others. HIV has become a manageable chronic disease and with proper treatment, people living with HIV/AIDS can lead full and active lives.

Starting treatment means regular visits to an HIV specialist. Following the directions for the medications is very important. Not taking the HIV medications exactly as directed creates the risk of drug resistance, which could make the HIV medications stop working. For many people, starting treatment for their HIV disease means they have to make significant changes in the way they live. Some of the life changes are related to the way the HIV medications work. For instance, some medications may require eating at certain times of the day. Other HIV medications have to be taken more than once a day at specific times and taking them with food may make them more or less effective. Stopping treatment can make the virus multiply quickly and cause medications to lose the ability to control HIV and make someone ill at the same time. It is important to never change the treatment plan without consulting the health-care provider first. In Western Europe, treatment of HIV/AIDS is done in specialized centres.

Complications

AIDS is a syndrome rather than a single disease. It is a complex illness with a wide range of complications and symptoms. The first complications to be mentioned are the side effects of the HIV medications. Almost all HIV

medicines have side effects. While the HIV medications are controlling the virus, they may also cause anaemia, diarrhoea, dizziness, fatigue, headaches, nausea and vomiting, pain and nerve problems. Often these are temporarily, but dealing with medication side effects can be a huge barrier to starting and continuing HIV medications. Some long-term side effects of HIV treatment are fat storage at the abdomen and neck, development of diabetes and bone weakness.

All kinds of infection can occur with a declining immune system. These infections are the most common cause of death for people with HIV/AIDS. One of the goals of HIV treatment is to lower the risk of getting infections and other complications. Antiretroviral therapy can help by increasing the number of CD4 cells, which will help protect from infections. Taking medications is also used to prevent disease from occurring (this is known as HIV prophylaxis). Other complications are hepatitis B and tuberculosis.

Medical aspects of significance in case of return

Box 7. Questions to ask a migrant with HIV/AIDS who is considering return

- Are you under regular medical treatment? If so, where?
- Are you taking HIV medications?
- Is the HIV stable at this moment?
- Are you able to do your daily routine well?
- Are there complications?
- Do you have a good understanding about your condition?
- Did you discuss with your treating physician the medical aspects of your return?
- Are treatment and medication available? How much do they cost?
- If medications are not available, are there appropriate alternatives? Are these medically acceptable?

In order to answer these questions, the migrant needs to discuss these with his treating physician. In most cases, contact between the counsellor and the treating physician will be necessary.

In case of an AIDS diagnosis, which is the final stage of this complex disease, a sustainable return to many countries of origin must be thoroughly considered, as discontinuation of treatment rapidly leads to dramatic consequences.

Travel of migrants with infectious diseases

Travel assistance for migrants with infectious diseases like hepatitis B or HIV cannot proceed without a doctor's clearance. Treating medical doctors may not be travel specialists and cannot be expected to advise on the consequences of travel by air; therefore, the proper clearance would be a fit-to-fly examination. It should be noted that for tuberculosis patients who would like to travel, a medical clearance will always be required. Therefore, return counsellors of patients with tuberculosis shall make the necessary arrangements for the clearance before initiating other travel arrangements.

Box 8. Travel of migrants with infectious diseases

Hepatitis
With proper treatment and in stable condition, migrants with hepatitis can travel without problems. In case of doubt, it is recommended that the migrant contact the treating physician and request that a fit-to-fly examination be done.

HIV/AIDS
There are no obstacles to travel of migrants with HIV/AIDS, provided they are under proper treatment and in stable condition. In case of doubt, it is recommended that the migrant contact the treating physician and request that a fit-to-fly examination be done.

4.2. Chronic mental disorders and voluntary return

This chapter presents three mental disorders: depressive disorder, post-traumatic stress disorder (PTSD) and schizophrenia. In this section, some special points of interest are discussed in relation to return counselling of migrants with mental disorders. These three mental disorders have been the most common mental conditions in the medical return caseload of IOM The Netherlands in the past few years. Some basic knowledge of these disorders helps the return counsellor to better understand the way a chronic ill migrant usually behaves or communicates. It is also crucial when preparing the actual return and when assessing the post-arrival situation.

4.2.1. Depressive disorder

General

Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behaviour, feelings and sense of well-being. Depressed people can feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt or restless. They may lose interest in activities that once were pleasant, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions, and may contemplate, attempt, or commit suicide. Sleeping problems, fatigue, loss of energy, aches, pains or digestive problems may also be present.

Depressed mood is not always a psychiatric disorder. It may also be a normal reaction to abnormal life events. A prolonged or severe depressed mood may lead to a diagnosis of a depressive disorder, which can be treated. This diagnosis can only be made by a mental health professional. Not all people with depressive disorders experience the same symptoms. Severity, frequency and duration of symptoms vary depending on the individual and his particular illness.

Treatment

Depressed mood may not require any professional treatment. Support from family and friends, positive lifestyle changes and emotional skills building can help against depressed mood. But when this is not helping,

seeking the help of a mental health professional is necessary. Depression is highly treatable, even in its most severe forms. The sooner a person is treated, the more effective that treatment will be. Studies have also shown that prompt treatment reduces significantly the likelihood of recurrence.

Medications often effectively control the serious symptoms of depression. However, people living with depression must also learn to recognize their individual patterns of illness and must develop ways to cope with them. Taking medication prescribed by a doctor is just one way to manage a major depression. Psychotherapy is another way to help manage depression. Research demonstrates that a combination of medication and psychotherapy is often the most effective treatment. Education, support from people who have "been there," supportive relationships, physical exercise and attention to co-occurring conditions are also useful in supporting recovery.

Complications

Untreated depressive disorder can result in emotional, behavioural and health problems that affect every aspect of a person's life. Depressive disorder has a strong link to many physical conditions. It can aggravate the pain, distress and disability from physical health problems. Many depressed people are in much poorer health than the rest of the community. Complications associated with depressive disorder may include: excess weight or obesity, which can lead to heart disease and diabetes; alcohol or substance abuse; anxiety; family conflicts; relationship difficulties; work or school problems; social isolation; and self-mutilation, such as cutting and suicidal attempts or a suicide. Depression is often chronic, with episodes of recurrence and improvement. Even newer antidepressants have failed to achieve permanent remission in many patients with depressive disorder. The standard medications, however, are very effective in treating and preventing acute episodes.

Communication with someone who has a depressive disorder

Following is a general advice on how to communicate with a person having depressive disorder:

- A person suffering from depression feels extremely isolated, like a glass wall separates them from the rest of the world. There is also an overall feeling of "wrongness" that may make them respond negatively to everything being said to them. Do not get discouraged and do not take things personally if they are hostile or withdrawn.
- You do not have to understand what the depressed person is going through in order to be helpful. In fact, attempts to show that you understand can run the risk of making you sound insincere. As depression tends to rob us of the ability to articulate effectively, remember that the conversation may be fairly one-sided. Do not feel that you have to fill up the silence.
- If you think that someone has suicidal thoughts, express your concern and seek professional help. Talking openly about suicidal thoughts and feelings can save a life.

Box 9. Constructive and helpful remarks

Acknowledge the depression and do not trivialize it. Let the individual know that he is recognized not just as lazy or feeling sorry for himself.

You might say:

- "I'm sorry you're in so much pain."
- "I can't imagine what it's like for you…."
- "I can't really fully understand what you are feeling, but I'm here to support you."
- "Do you feel like talking? I would be glad to listen to you."
- "Is there anything I can do for you?"

Box 10. Unhelpful remarks

Any of the following remarks is less helpful or even counterproductive in communicating with a person suffering from depression. Although some of these approaches may seem helpful – after all, you are trying to make the individual feel better – they almost always have the opposite effect.

These tactics frustrate the depressed person because they make it clear that you do not understand what depression is about. Many counsellors fall back on remarks like these simply because they have not had any experience with depression and do not know how else to handle the situation.

Do NOT say:

- "Cheer up!" or "Just smile more!"
- "Get off your behind and stop feeling sorry for yourself!"
- "What you need is to be more active, find something to do or a significant other!"

Do not trivialize depression by saying something like, "Well, everyone has a bad day now and then."

Do not try to "fix" the situation unless the person has asked for your help in some specific way, for instance, reminding them to take their medication or finding a doctor.

Do not talk about how the person's depression is affecting your work. You will only make them feel more guilty and defensive.

4.2.2. Post-traumatic stress disorder

General

When in danger, it is natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or

to avoid it. This "fight or flight" response is a healthy reaction meant to protect a person from harm. But in PTSD, this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they are no longer in danger.

The traumatic events that lead to PTSD are usually so overwhelming and frightening that they would upset anyone. Following a traumatic event, almost everyone experiences at least some of the symptoms of PTSD. When your sense of safety and trust are shattered, it is normal to feel crazy, disconnected or numb. It is very common to have bad dreams, feel fearful and find it difficult to stop thinking about what happened. These are normal reactions to abnormal events.

For most people, however, these symptoms are short-lived. They may last for several days or even weeks, but they gradually lift. But if you have PTSD, the symptoms do not decrease. A normal response to a possibly traumatizing event may evolve in PTSD when symptoms are protracted over time, and above a certain threshold (quantity of symptoms and their intensity).

The main characteristics are:

- Reliving traumatic events in nightmares and flashbacks, and on triggers;
- Avoiding situations that remind the person of the event;
- Negative change in personal beliefs and feelings;
- Extreme alertness.

Treatment

There are good treatments available for PTSD. The two main types are psychotherapy and medication. These are often combined.

There are many types of psychotherapy to be used in PTSD treatment. All these treatments can bring positive and meaningful changes in symptoms and the quality of life for the people who use them. "Getting better" means different things for different people, and not everyone who gets one of these treatments will be "cured". But they will likely do better than people with PTSD who have not been treated. The medications

used are mainly antidepressants with a decreasing effect on anxiety. This medication works at the biochemical level in the brain. If a person has had a good response to medication, there is a great chance that he will need to be on the respective medication for a long time.

Complications

PTSD can disrupt a person's whole life, including his job, relationships, health and enjoyment of everyday activities.

Having PTSD may also increase the risk of other mental health problems, such as depression and anxiety, issues with drugs or alcohol use, eating disorders, and suicidal thoughts and actions. Rates of depression are especially high in people with PTSD. Someone with PTSD is at high risk for alcoholism, smoking and other forms of addiction. Some people with PTSD may use alcohol or drugs to self-medicate. Heavy smoking is common in people with PTSD. PTSD can have negative effects on work, social behaviour and relationships. PTSD is also associated with different physical illnesses like high blood pressure and heart disease.

Box 11. Advice for communication with someone who has PTSD

- Avoid pressure as it can trigger stress and re-experiencing the traumatic events that caused the disorder, and, thus, PTSD symptoms.
- Accept that people experience trauma differently and will have their own various coping and healing mechanisms.
- Realize the factors that induce stress and trigger traumatic events that can lead to PTSD, so that you are less surprised by it and can anticipate properly.
- Accept that avoidance of triggers is part of the disorder and that it will be difficult to talk about situations or subjects that act as a trigger.
- Use positive language, as it encourages trust and empowerment.
- Express that you have met other people of his country with some bad experiences and that you know something about the situation over there.

- Ask what will make him most comfortable, and respect his needs.
- Be tolerant if the person repeats his stories and experiences, and avoid interrupting the person.
- In a crisis, remain calm, be supportive and remember that the effects of PTSD are, to a certain extent, normal reactions to an abnormal situation. Ask how you can help the person, and find out if there is a support person you can contact (such as a family member or a professional with whom he is in contact). If appropriate, you might ask if the person has medication that he needs to take.

4.2.3. Schizophrenia

General

Schizophrenia is a mental disorder characterized by a breakdown in thinking and poor emotional responses. People with schizophrenia lose touch with reality. Two of the main symptoms are delusions and hallucinations. *Delusions* are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. *Hallucinations* are false perceptions, such as hearing, seeing or feeling something that is not there. Schizophrenia causes significant social and work problems. Alcohol and drugs are mostly aggravating psychotic symptoms.

Treatment

Mostly, there is no cure for schizophrenia. Medicine can help control the symptoms. Often, more medicines are tried to see which works best. Most of the time treatment is lifelong. Additional treatment can help to deal with the illness from day to day. These include therapy, family education, rehabilitation and skills training. The mainstay of treatment is antipsychotic medication, which primarily suppresses certain parts of the brain. Therapy, job training and social rehabilitation are also important in treatment. In more serious cases – where there is risk to self or others – involuntary hospitalization may be necessary, although hospital stays are now shorter and less frequent than they once were.

Complications

Schizophrenia has a chronic course and is seen as a serious illness. As a major cause of disability, schizophrenia has great human and economic costs. Approximately three-fourths of people with schizophrenia have ongoing disability with relapses and over 16 million people globally are deemed to suffer moderate or severe disability from the condition.

Some people do recover completely and others function well in society. Most people with schizophrenia can live independently with community support. Outcomes for schizophrenia appear better in the developing than the developed world. These conclusions, however, have been questioned.

There is a higher-than-average suicide rate associated with schizophrenia. Schizophrenia and smoking have shown a strong association. People with schizophrenia are likely to have additional mental diseases, including depression and anxiety disorders. Social problems, such as long-term unemployment, poverty and homelessness, are common. The average life expectancy of people with the disorder is 12–15 years less than those without. This is the result of increased physical health problems and a higher suicide rate.

Box 12. Advice for communication with someone who has a psychotic disorder or schizophrenia

Effective communication with schizophrenic patients is particularly important because they are so easily overwhelmed by the external environment and their inner thoughts and emotions.

To get along well with a person living with schizophrenia, it is important to act naturally and treat him with respect. As a general rule for effective communication, speak kindly, clearly and simply.

It is important to speak slowly and clearly to persons with schizophrenia – make the sentences short so that they are not too complicated, and wait to make sure that what has been said is understood by the person.

Here are three tips you can try when speaking to someone with schizophrenia:

- **Listen actively.**
  It is just as important to understand as it is to be understood. Active listening means paying close attention to what a person is saying and repeating back to him what you have heard to confirm your understanding. By doing this, you show the person that you are really listening, make sure there are no misunderstandings, and demonstrate your respect.

- **Acknowledge the person's experience.**
  It is important to show sensitivity to what someone is feeling. Seeing things from his perspective will help to better understand and communicate. Denying or dismissing what the person is going through is destructive. Remember that at times, a patient may believe things that are not real to you, but seem very real to him. Acknowledge that these beliefs are real, without supporting the actual delusions.

- **Uncover what motivates the person.**
  Many times an individual with schizophrenia may say or do something that does not make sense to you. If this happens, ask thoughtful questions to uncover his motive. You may be able to leverage the motive to encourage desired behaviour.

Box 13. What to avoid when communicating with someone with schizophrenia

- Being patronizing;
- Being critical;
- Pushing the migrant into situations he is not comfortable with;
- Being gloomy;
- Arguing with the migrant, or with others while they are present;
- Giving the migrant a lecture, or talking too much;
- Getting yourself in difficult situations with the migrant.

Box 14. Other helpful tips

- Maintain a low-stress environment;
- Have one person speak at a time and keep voices down;
- Use language that is positive and supportive instead of critical;
- Be encouraging and understanding;
- Keep conversations short and simple;
- Do not argue, even if someone argues;
- Use "I feel" statements rather than "I think" statements.

Sooner or later, when a person has schizophrenia, a crisis will occur. When this happens, there are a number of things you can do to reduce or avoid the potential for disaster. Here are a few pointers:

- Remember that you cannot reason with acute psychosis.
- Remember that the person may be terrified by his own feelings of loss of control.
- Do not express irritation or anger and do not shout.
- Do not use sarcasm as a weapon.
- Avoid direct continuous eye contact.
- Avoid touching the person.
- Sit down and ask the person to sit down also.

4.2.4. Points of special attention on mental health and return counselling

Referring to a health professional

There are situations in which the return counsellor feels that professional care is needed. One is when the migrant is self-harming or suicidal, or when the migrant is unable to state simple facts of life or attend to basic routines. When a migrant becomes violent, there can also be a need for referral, or, in severe case, even ask the police to interfere.

For referral, the family doctor is the first one to refer to. When the migrant is getting mental health treatment, there can be referral to his treating mental health professional (e.g. psychiatrist, psychologist or nurse). It can be useful to share the worries with the professional the migrant is referred to.

Mental competence

In most national legislation, there is a law – usually called mental capacity act – that regulates under which mental condition a person is deemed unable to take a decision about his hospitalization and treatment so that treatment can be forced on them. The same applies to any form of consent.

In some cases of mental disorder, there are doubts about the mental competence of the migrant. Return counsellors should be aware that according to the mental capacity legal acts, they are not allowed to discuss return options with migrants who are deemed unable to take a decision or give consent. There is risk of being mentally incapable in cases of schizophrenia; also, among migrants with severe depression or PTSD, this doubt can rise. In such cases, the expression to return can be more of a symptom of the disorder than of a genuinely felt desire. Risk factors for assessing further mental competence or lack of thereof are: a mental disorder with no stability; many psychological complaints; bizarre behaviour; intense emotions; or signs of hallucinations (hearing non-existing voices or seeing non-existing things).

In such a case, the general practitioner may refer the case to a psychiatric evaluation for mental capacity determination. Only after a migrant has been declared mentally capable on deciding on his return can the counsellor proceed with the return counselling.

Suicide

Suicide is defined as ending one's own life. A suicide attempt means trying to end one's own life. Somebody is said to be suicidal when he expresses that he wants to kill himself. The situation is even more serious if the person has already made several attempts to end his own life.

Depressive feelings are the cause of up to two thirds of all suicide cases. Depressed men are more likely to commit suicide than depressed women. Suicidal preoccupation or threats of suicide should always be treated seriously.

Risk factors for suicide include prior suicide attempts, history of experienced violence (abuse in family or in society), chronic physical illness, including chronic pain, and exposure to the suicidal behaviour of others. Warning signs that someone may be thinking about or planning to commit suicide include having a depressive disorder, talking or thinking about death, losing interest in things one used to care about, or making comments about being hopeless, helpless or worthless.

Return counsellors may be confronted with migrants who threaten to commit suicide or who actually attempt suicide. Suicide is a behaviour that can generate, by a conscious decision in the given circumstances, an impulse related to strong negative emotions and feelings of powerlessness, or a mental disorder and most often by a combination of those. The assessment of whether someone is in fact suicidal can only be done by a mental health professional. Suicide threats should always be taken seriously by the return counsellor, regardless of the counsellor's perceived level of well-being and distress of the migrant, and the migrant should be immediately referred to a mental health professional for assessment and eventual follow-up.

Box 15. What to do if the migrant threatens to commit suicide

- Acknowledge the problem. Tell the migrant what you notice about him. Take him seriously.
- Tell the migrant what you can and cannot do. Be clear and indicate what your boundaries are.
- Tell the migrant you are not authorized to deal with this problem and that he should see his family doctor. The family doctor can decide what steps to take next.
- If the migrant refuses to see a doctor, you need to seek advice from a health professional for crisis referral.

4.2.5. Importance of mental health aspects in case of return and travelling

Encouraging a migrant with a mental disorder to take an active part in the return process is essential, but this can be hard as the return counsellor is not a mental health professional. For instance, migrants who are seriously depressed are not always able to respond appropriately. Sometimes it may take the migrant a long time to answer a question or he may start to cry in response. It can be difficult for the migrant to take any initiative, such as visiting an embassy himself to obtain travel documents. It might not be a matter of him not willing to take action but a matter of not being able to take action due to his mental disorder.

Migrants suffering from PTSD or schizophrenia may also pose serious challenges to the return counsellor. Even the thought of returning may remind people suffering from PTSD of earlier traumatic experiences in the country of origin. They may have painful "flashbacks" because they are reminded of the reason they migrated in the first place.

Migrants suffering from a psychotic disorder such as schizophrenia cannot be counselled when they have an active psychosis. People with active psychosis may not be capable of making well-informed decisions, including decisions on return migration. Counselling for people with active psychosis should not be organized in the first place.

Box 16. Questions to be answered when a person with a mental health disorder is considering return

- Are you under regular psychiatric treatment? If so, where?
- Are you taking medications?
- Is the mental health disorder stable at this moment?
- Are you able to do your daily routine well?
- Are there complications?
- Do you have a good understanding about your condition?
- Did you discuss with a mental health professional the medical aspects of your return?
- Are treatment and medication available? How much do they cost?

- If medications are not available, are there appropriate alternatives? Are these medically acceptable?

In order to answer these questions, the migrant needs to discuss them with his treating physician. In most cases, contact between the counsellor and the treating physician will be necessary.

Box 17. Travel and mental disorders

People with a psychiatric disorder can usually travel safely, but may at times require an escort. Passengers with mental illness are required to be in a stable condition to travel alone. In other cases, an appropriately trained health professional – usually a nurse or doctor – should be provided as an escort, with access to medication to calm the patient if necessary.

People whose mental state or behaviour is disturbed are not fit to travel until stability has been achieved. Suicidal or homicidal behaviour by those so disposed are rare but can be catastrophic in outcome. Psychiatric assessment is necessary, also just before the flight. This fit-to-fly examination is often done by a physician or nurse specialized in travel medicine.

Chapter 5

Practical tools

Chapter 5. Practical tools

Tool 1

Migrant's perception of return migration

Tool 2

Barriers and intervention possibilities

Tool 3

Personal action plan

Tool 4

Impact of emotions on ability to function as a professional

Tool 5

Signs of stress among return counsellors

Tool 6

(Personal) Intervision

Tool 1

Migrant's perception of return migration

How to use this overview

Score each notion, ranging from –1 to –3 in the left hand column for factors that prevent return, and from +1 to +3 in the right hand column for factors that promote return.

Impedes return –1 to –3	Starting point	Promotes return +1 to +3
	1. Outcome of immigration procedure General asylum procedure/extended asylum procedure/temporary residence/undocumented migrant/refugee	
	Use this space for any comments relating to this factor:	
(Perception of) Health		
	2. Physical health	
	2a. Actual medical treatment	
	3. Mental health	
	3a. Actual medical treatment	
(Perception of) Opportunities in the country of origin		
	4. Perception of safety in the country of origin	
	5. Children	
	6. Accommodation	
	7. Employment	
	8. Training	
	9. Family/social network	
	10. Health-care services	
	11. Social norm with regard to return migration	

Impedes return –1 to –3	Starting point	Promotes return +1 to +3
(Perception of) Opportunities in the host country		
	12. Perception of safety in the host country	
	13. Children	
	14. Accommodation	
	15. Employment	
	16. Training	
	17. Family/social network	
	18. Health-care services	
	19. Social norm with regard to remaining in the host country	
Total –		**Total +**

Tool 2

Barriers and intervention possibilities[14]

Barrier to return	Consideration for intervention
Medical issue	
Appropriate medication not available	• No intervention is feasible, unless broader treatment services and broader medication options become available. Advise the migrant not to return.
Other crucial medical facilities (qualified health-care staff, testing, treatment, etc.) not available	• No intervention is feasible. Advise the migrant not to return.
Appropriate treatment available elsewhere in the country of origin, but not near the preferred location of return	• Is the migrant willing and able to settle closer to a treatment site? Does he have economic opportunities and a social support network there? (See below.) • Will migrant have the financial means to travel to the treatment site? (See Economic Issue.)
Essential care from friends or family as one of the pillars for effective treatment not available or not yet guaranteed	• Have relatives or acquaintances been traced and asked about their willingness to provide informal care? • Are there alternatives for this kind of support?
Appropriate treatment and monitoring available but (parts of) treatment are not free	• What are the migrant's short- and long-term economic prospects? (See Economic Issue.) • Is it reasonable to assume that the migrant will be able to afford treatment if he has a sustainable income?
Appropriate treatment available but treatment centres have waiting lists	• Gather information on the state of waiting lists. When will the migrant be able to enter the treatment programme? • Are there other treatment sites reasonably accessible to the migrant without waiting lists?
Concerns about the continuity of the availability of treatment at the treatment site	• Gather information about the history of the treatment site (start of provision of treatment, interruptions in supplies, etc.).

14 C. Mommers et al., *Health, hope and home? The Possibilities and Constraints of Voluntary Return for African Rejected Asylum Seekers and Irregular Migrants Living with HIV in the Netherlands* (Geneva, International Organization for Migration, 2009).

Economic issue	
High levels of poverty and/or unemployment in the country of origin	• No intervention is feasible.
Migrant needs income-generation strategy	• Can the migrant rely on his family to sustain him? • Does the migrant want to find employment? • Does the migrant want to become self-employed?
Migrant wants to find employment	• Information gathering: Are there job opportunities that match the skills, experiences and physical possibilities of the migrant? • Are there opportunities for training (before departure or in the country of origin) to improve the employability of the migrant? • Is some kind of mediation with potential employers possible (e.g. job placement)? • Information gathering: What protection is there against workplace discrimination of persons living with HIV or disabilities? Is legal assistance available and do effective remedies exist?
Migrant wants to become self-employed	• Can the migrant be advised on developing a viable business plan? • Information gathering: Are there particular activities that are more likely to generate a sustainable income? • Does the migrant have the skills and experience to engage in these activities? • Is skills training (in the host country or the country of origin) available? • Are there possibilities for micro credit or other financial assistance for business start-up?
Social issue	
Migrant has no social network in the country of origin	• Can lost family be traced and contact re-established? • Are there alternatives for social support? • Do these provide sufficient levels of support?
Other issues	
Fears of violence or persecution in the country of origin	• Discuss with the migrant to what extent his fears are based on facts. • Investigate, together with the migrant, the current security situation in the country of origin. • If necessary, advise the migrant to call in a lawyer to look into his case.

Tool 3

Personal action plan

General information

Organization

Name of return counsellor	
Organization	
File number	
Date	
Persons present	

Migrant's personal details

Name	
Date of birth	
Telephone number	
E-mail	
Address	
Country of origin	

1. Personal background information: What have you done to date and what are your interests?

	Country of origin	Host country
Education and training		
Work experience		
Interests/hobbies: What gives you pleasure in life? What do you enjoy doing?		
Talents: What are you good at?		

2a. Personal goals: accommodation, employment, education, health.

What sort of work and/or education would you like to do/would you be able to do if you were to live in your country of origin?
Where (house, accommodation) would you like to/would you be able to live in your country of origin?
What goals, as regards your medical condition, would you like to achieve if you were to live in your country of origin?

2b. Personal goals: Think about what you would need in order to achieve your goals. Think about money, facilities, opportunity, training and time.

Employment/Education
Accommodation
Health

3. Think what people/organizations might be able to do to help you and how (both in the country of destination and in the country of origin).

	Who?	How?
Family members		
Friends		

Organizations		
Religious communities		
Online groups/social media/chat rooms		
Other		
Will it be necessary to rekindle previously existing contacts or to find new contacts? For instance, with family members, organizations or online groups. With whom? How will you go about this?		

4. Children: school, education and training, child care, facilities, future development, safety.

(Where) Will children be able to attend school? Has there been contact with the school as yet?
Are the children able to speak and write the language spoken and written in the country of origin? How will children be able to learn the language better?
Are there big differences in social etiquette between the country of destination and the country of origin that you would like to prepare your children for?
How can children get in contact with age group peers in the country of origin? What activities might children be able to participate in?

5. Safety: Are you worried about your safety or that of your children/ family if you were to return to your country of origin?

What are you worried about?
Would it be possible to reduce your concerns for your safety? What would it take for you to feel safer? Think of five things that might make you feel safer.
What would be the most realistic ways/solutions to make you feel safer?

6. Information: How can you get information about what is in store for you after your return to the country of origin (informal sources of information, Internet, TV, newspaper)?

Sources of information:
If possible, think of some other sources of information together with the migrant.

7. Expectations from those who stayed behind in the country of origin.

Did your friends and relatives in your country of origin harbour certain expectations when you fled/left as to what you would achieve in the country of destination? What were those expectations?

Do they still harbour these expectations? Why or why not?
What do these expectations mean for you (e.g. embarrassment, fear of losing face, feelings of guilt)?
If applicable: Think of what you might be able to do in order to modify these expectations.
If applicable: Think of what you might be able to do in order to reduce your feelings of embarrassment, guilt and fear of losing face. Are any practical solutions possible? Think of who might be able to assist.

8. Your own expectations with regard to returning.

Name five things which you would be looking forward to/which would make you happy if you imagine being back in your country of origin.
Name five things which you would not be looking forward to/which you are scared of, if you imagine being back in your country of origin.
For each of these, think of five things which you might do to be able to cope with these/respond to these. In other words, think of solutions for problems you expect/ fear or for unpleasant situations.

Think of who might possibly be able to help you cope with the problems you anticipate or fear or with these unpleasant situations.

9. Practical matters: laissez-passer, accommodation, employment, flight.

What practical matters need to be taken care of?
Who is going to do that?

10. Organizations involved and the handover.

Which organizations are involved in your return?
Which organization is responsible for what?
How does handover occur from one organization to the next? What is your role in the handover between organizations?

11. Monitoring following return migration.

Do you wish to receive assistance following your return?
Do you mind if we get in touch with you to find out how things are going at various points in time following your return?
For what period and at which points in time?

12. Appointments.

Our next appointment is for: 1. 2. 3. 4. 5.
What actions will you undertake between now and our next appointment in order to realize your plans for return migration? Who will you contact? What will you try to find out?

Tool 4

Impact of emotions on ability to function as a professional

This instrument contains an exercise which can be done by return counsellors either on their own or together with colleagues. This exercise asks return counsellors to think about possible emotional responses to migrants and their stories. It also invites return counsellors to think about the impact such responses might have.

Exercise

Have you ever been faced with migrants who provoked intense feelings in you or whose stories really affected you? What kind of emotions did they provoke?

Give examples for one or more of the key words listed below.

- Feelings of annoyance
- Powerlessness and frustration
- Anxiety
- Abhorrence and disbelief
- Anger
- Alarm/shock
- Low mood/sadness
- Caution
- Uncertainty
- Respect
- Feelings of guilt
- Satisfaction

How did this feeling impact:

1. Your contact with and assistance provided to the migrant?
2. You personally?

Signs

The signs listed below may be an indication that your professional actions (or those of a colleague) are affected by emotional responses. The signs below may also indicate a general sense of dissatisfaction with the work you do. These signs of emotional responses at the professional level may have an impact on the quality of service given to the migrant. See to what extent these signs appear familiar.

General signs:

- Deteriorating performance
- Exhaustion
- Irritability and increased conflict
- Avoidance of troublesome assignments
- Withdrawal
- Feelings of abhorrence
- Low morale (less interest in work)
- Increased absenteeism

Signs in contact with the migrant:

- Tipping the balance in favour of either too much distance or being overly involved
- Not sharing and discussing information in order to avoid difficult situations

Signs within the team and within the organization:

- Withdrawal and not sharing things with one another
- Decline in output and creativity
- Complaining a lot and whispering in corners
- Conflicts spiralling out of control
- Inability to put things in perspective
- Feeling victimized; feeling unable to have any influence
- Angry reactions towards supervisors or third parties
- Viewing management as being at odds with the person's own role
- Sabotaging management decisions

Tool 5

Signs of stress among return counsellors

This instrument offers a list of stress-related symptoms. It also contains suggestions as to what individuals or organizations can do to reduce stress and pressure of work.

Below you will find an extensive list of signs which may give you some clues in trying to objectively interpret these signs. This may assist you when you suspect that professional help may be required.

This list is intended to help you recognize stress. If you recognize more than one sign, do consider:

- Seeing your family doctor
- Discussing these signs with your employer
- Asking for intervision, supervision and coaching

Signs of stress:

- Sleeplessness
- Anxiety
- Palpitations
- Headache
- Shortness of breath
- Unease
- Fatigue
- Muscle tension
- Indecision/indecisiveness
- Reduced concentration
- Constant worrying
- Not feeling like having sex
- Smoking a lot
- Drinking a lot of alcohol
- Crying easily

Preventive measures aimed at reducing stress at the personal level:

- Physical self-care: nutrition, sport, rest and relaxation
- Emotional self-care: inspiration, friendship, love, being alert to emotions, receiving therapy if need be
- Improving skills such as assertiveness, stress reduction techniques such as meditation, time management, resilience training

Preventive measures aimed at reducing stress at the professional level:

- Varied duties at work
- Work breaks
- Earmark time to create overviews and to organize yourself: having an overview reduces stress
- Keeping an eye on time: no unlimited overwork, fixed amount of time for each migrant
- Supervised team intervision or intervision with professional colleagues outside the organization
- Supervision (independently from the organization)
- Network of professional peers, also in other organizations

Tool 6

(Personal) Intervision

This intervision tool invites to a more in-depth consideration of the impact various factors may have on the return counsellor's work satisfaction and general well-being. Ask yourself whether the following factors have an impact on your work in general or on the counselling you are offering a specific migrant.

Factors related to society:

- Political ideas on migrants
- Ideas within society on migrants
- National legislation
- International legislation

Factors related to the work environment:

- Way in which the work needs to be done (e.g. the number of people to be seen in one day)
- Manner in which supervision is provided
- Extent to which people can have a say in their work
- Degree of support from supervisor
- Degree of support from colleagues

Factors related to the return counsellor's personality/personal life:

- Your personal well-being, aside from work
- Your way of dealing with stress
- Level of enjoyment and satisfaction obtained from work
- Quality of your leisure pursuits and satisfaction you gain from your leisure pursuits
- Your personality: Are you a perfectionist?
- Balance between involvement and distance: Where do you find yourself on the continuum? How do you respond to migrants? What are your own attitudes towards and perceptions of migrants and return migration?

- Perceptions about migrants held by your family and friends
- Extent to which you possess the knowledge and skills to do your work

Factors related to the migrant's life:

- The migrant's life history: What has he been through up until the point in time you talk to him in your role as a return counsellor?
- How long has he been in the country of destination? How did he get there? (Did he pay a lot of money?)
- In the case of asylum-seekers, how did their asylum procedure go until now? What sort of experiences have they been through in the centre for asylum-seekers?
- Is the migrant single or does he have a family?
- What is his physical and mental condition like? Is he receiving help, if required?
- Is he in touch with people or agencies within the host society (and is he aware about the perceptions which exist about migrants)?

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