Psychosocial support for Bhutanese refugees in Nepal

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For more than 20 years, thousands of Bhutanese refugees have been living in refugee camps in eastern Nepal, in an uncertain and challenging situation. Now, the possibility of resettlement is bringing even more challenges into their lives. In recognition of this situation, the nongovernmental organisation Transcultural Psychosocial Organisation Nepal provides psychosocial support to this group, in collaboration with United Nations High Commission for Refugees and other humanitarian agencies. This field report provides an overview of the psychosocial issues, interventions and implications, as well as lessons learned. It also includes the case study of a refugee. Direct psychosocial support, psycho-education and capacity development are major elements of the programme provided, not only to refugees, but also to the host community and aid workers as well. Recommendations include: continuing and strengthening services for both refugee and host communities, increasing attention to vulnerable groups (such as the elderly), and enhancing links and cooperation with local and international services and structures.

Keywords: Bhutanese refugees, multi-leveled support system, Nepal, protracted displacement, resettlement

Introduction

The relationship between the northern Bhutanese (Drukpa) and southern Nepali-speaking Bhutanese (Lhotshampas) populations was relatively free of conflict until the early 1990s. At that time, more than 80,000 Lhotshampas were forced to flee to Nepal following the introduction and enforcement of restrictive citizenship laws, and a '*One Nation, One People*' government policy (Hutt, 1996). Bhutan claims that this group left willingly and denies they were ever citizens. The refugees, however, claim that they were forced to leave Bhutan because of their ethnicity. As a consequence of this process, many people have lost their nationality and are currently stateless. The government of Nepal, concerned about the implications for national security, has not been willing to allow the refugees permanent residence. Yet, even though Nepal is not a signatory to the 1951 Refugee Convention, the government has allowed the refugees to live '*temporarily*' in refugee camps (Adelman, 2008). From 1993, until now, there have been 14 bilateral negotiations between Bhutan and Nepal to find a sustainable solution, but these have all been in vain (Sharma, 2009). Due to increasing international discussions on the '*warehousing*' of refugees (a situation where refugees are housed in one place for years on end due to lack of agreement or decisions on how to resolve the situation), as well as donor fatigue, some international community members have agreed to facilitate a process of resettlement to the United States, Canada, Australia, New Zealand, Norway, Denmark, the Netherlands and the United Kingdom (Loescher & Milner, 2005).

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Under the resettlement programme, which was launched in 2007, more than 50,000 refugees from Bhutan have now left Nepal to start a new life elsewhere. The United Nations High Commission for Refugees (UNHCR) and partner organisations continue to seek solutions for the remaining 60,000 refugees. According to UNHCR, more than 49,000 people among the remaining refugee population have expressed an interest in resettlement (http://www.unhcr.org/pages/49e487856.html).

Other refugees, however, do not want to leave the area and prefer to either repatriate to Bhutan, or stay in Nepal. The international community hopes that Bhutan and Nepal will allow these smaller groups to either remain or return, as humanitarian interventions are planned to be phased out after conclusion of the resettlement programme.

In the meantime, international and national humanitarian agencies continue to provide services related to health care, education and other needs within refugee camps in Nepal. There were originally seven camps, but due to the resettlement process mentioned above and the consequent decrease of the refugee population, camps are now being consolidated. Conditions in the camps remain challenging; they are overpopulated and there are security risks related to conflict and violence. Continuing uncertainty about the future and a protracted stay in the camps has also fuelled frustration and distress, which in turn impact psychosocial wellbeing. In order to offer the refugee community psychosocial support, the UNHCR has begun to work in cooperation with the Transcultural Psychosocial Organisation (TPO) Nepal. The involvement of TPO Nepal in the refugee camps began in the aftermath of a large fire that affected a major section of the refugee population in two camps, in 2008 (Prasad Dahal, 2011). Since then, TPO Nepal implements the *Psychosocial Support to Bhutanese Refugees in Camps* project, with the aim of improving psychosocial wellbeing and reduce psychosocial distress among Bhutanese refugees. In order to achieve this, TPO Nepal works in close coordination with UNHCR and camp based organisations (CBOs) from the refugee community[1] to provide a range of psychosocial support to address psychosocial distress, with attention to cultural values[2]. This report provides an overview of these psychosocial interventions over the last three years and reflects on achievements, the ongoing needs of the refugees, and lessons learned.

Psychosocial issues in the Bhutanese refugee camps

A need assessment among Bhutanese refugees in the camps showed that they experience various contextual stressors related to basic needs and shelter, as well as resettlement opportunities and procedures (Luitel et al., 2009). According to this assessment: '*fear and insecurity, conflict in the family, confusion, substance abuse, stress and anxiety, worry about culture and religion, fear of separation and suicidal ideation are some of the key psychosocial problems prioritized by respondents in the focus group discussions*'. Another psychosocial needs assessment identified suicide as one of the major problems present, and confirmed that the number of suicides among Bhutanese refugees in Nepal is disproportionally high (Schininà et al., 2011).

Living in a refugee camp for 20 years, after having gone through difficult experiences and without any clarity in terms of the future, creates many challenges. For years, many refugees hoped to either return to Bhutan, or stay as residents in Nepal. However, given the complex relationship

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between Bhutan and Nepal, this has proved impossible to date. While there are educational and medical facilities in the camps, and refugees have been able to organise themselves within various forums and contribute to activities for others in the camps, giving meaning to life has proved to be difficult. Additionally, as refugees they are not officially allowed to work and therefore, unable to provide for their families. Even so, some of them do work as farmers, tradesmen, tailors or teachers in the informal sector, or within the camps.

Resettlement to third countries does provide an opportunity to study and work, and with that hope. This new dimension, however, has created complex situations for families. Young people are eager to start a new life and create a better future for themselves and their children. However, many elderly people have no wish to migrate again and prefer to wait for an opportunity to either return to Bhutan or stay in Nepal. Within families, this has created tension and conflict, resulting in some people either migrating or staying against their wishes. Families can be separated for years, because part of a family may be eligible to resettle, whereas others have to wait for completion of a long process due to complicating factors, such as: severe (mental) health problems, divorce, or mixed marriages between refugees and local people from Nepal or India.

Ongoing uncertainty and family conflicts may also lead to various psychosocial problems, such as depression, suicidal ideation or suicide. Sometimes, there are weekly reports of attempted or committed suicides by refugees who can see no other way out. Difficulty in giving meaning to one's life, or dealing with problems, can result in other negative impacts, such as substance abuse and/or an increase in domestic violence.

Psychosocial care programme

The psychosocial care programme aims to enhance community resiliency at grass root level with wider participation of the refugee community in the design and implementation of activities[3]. The programme includes: awareness raising to increase mental health literacy in the community, psychosocial counselling, classroom based interventions, and group interventions, such as women's empowerment groups. For interventions on specialised mental health care levels, people are referred to other specialised aid agencies. Interventions are assessed and adapted based on research (Figure 1).[4]

Fifteen psychosocial counsellors participated in a training course on psychosocial issues and support. They now provide psychosocial counselling in counselling centres in the camps, or in people's huts. The counsellors are supported and supervised by clinical psychologists. In order to strengthen early identification of psychosocial problems, ensure timely referrals and provide suitable care, members from the refugee population have also been trained to work as community psychosocial workers (CPSWs) and/or *Classroom Based Intervention* (CBI) facilitators. Eighteen CPSWs and 12 CBI facilitators provide basic psychosocial services. Their presence is advantageous as it creates a continuous presence of knowledgeable and supportive people within the camp.

Counsellors are involved with psychosocial counselling, psycho-education, and awareness raising campaigns, assisted by CPSWs. They help people to deal with their problems, and support them in finding new ways to cope. Main components of psychosocial counselling include: problem solving, symptom management, psychoeducation, emotional support in relationships, and development of personal skills.

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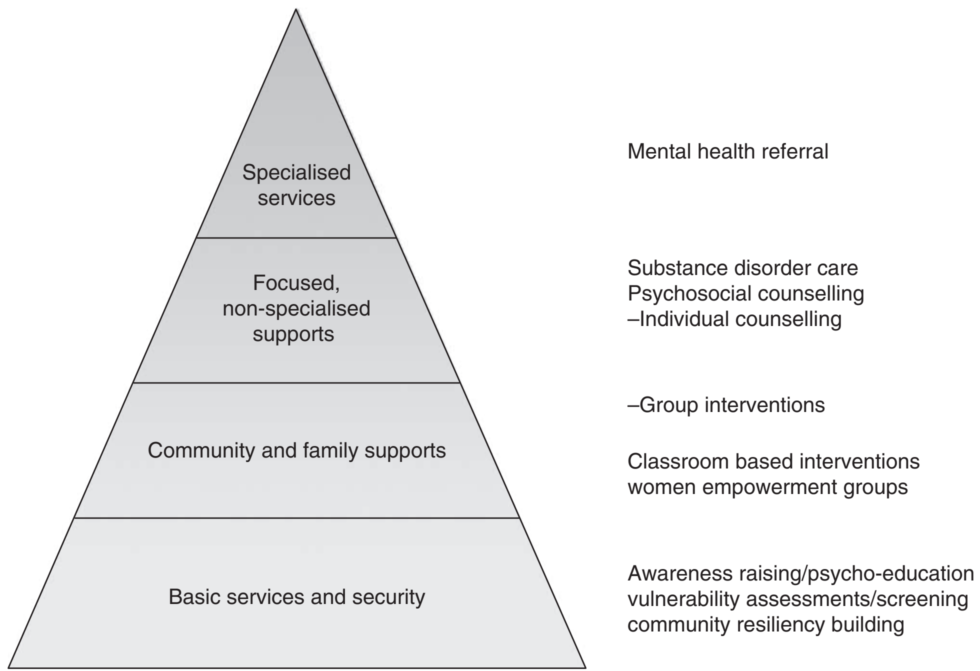

Figure 1: Psychosocial intervention framework for Bhutanese refugees in Nepal.

Family-oriented supportive counselling is provided through home visits, with the focus on parental capacities and psycho-education sessions, aiming to increase wellbeing at family level.

To better tailor psychosocial services for the target group, and assess family situations in the context of third country resettlement, TPO Nepal conducted a vulnerability and dependency assessment by visiting families at their homes. This assessment has led to recommendations to the humanitarian agencies that specifically address the needs of vulnerable families, through regular visits and referrals when necessary.

What works and what can be improved?

Awareness raising Awareness raising activities are important in order to draw attention to psychosocial problems as well as to available support services and ways to deal with problems. Various awareness raising activities focused on psychosocial issues are organised, such as street drama and spreading information through brochures and posters. On special days, such as World Refugee Day and World Suicide Prevention Day, humanitarian and refugee organisations arrange thematic awareness raising activities, such as essay competitions for students or street drama. People are invited to write down their memories, feelings and ideas on a *toran* (Sanskrit word for '*pass*', which may refer to a sacred or honorific gateway, or a decorative hanging in Hinduism or Buddhism, such as prayer flags). These writings can be spread by the wind, acting both as a memorial, as well as an awareness raising tool. These activities are used to increase awareness of, for example, suicide

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prevention, psychosocial support and services of aid agencies. It may be, however, that the most vulnerable people do not attend such events. Therefore, visits to potentially vulnerable families are also important. Additionally, TPO Nepal broadcasts a fortnightly regional radio programme, in Nepali, addressing psychosocial issues, such as mental disorders, family problems, stress, alcoholism, and suicide prevention. The programme targets refugees as well as the host community.

Psycho-education Psycho-education on psychosocial issues and coping strategies can contribute to enabling people to differentiate between positive and negative coping mechanisms, and help them find new ways to cope. For instance, when people are addicted to alcohol or drugs, psycho-education is one essential element, but severely addicted people will also benefit from the specialised care of rehabilitation centres. As many people may relapse, it is also important to continue with follow-up programmes and support, finding ways for these refugees to give new meaning to their lives. Family, CBOs and aid agencies can all contribute to this process.

Psychosocial counselling Psychosocial counselling can include individual, family or group counselling. For many people, counselling provides an opportunity to share their experiences, feelings and problems in a constructive way. Especially when it concerns family issues, refugees perceive it as very helpful for a neutral person to listen and assist in the search for ways to deal with problems. However, offering psychosocial support can be challenging, as people fear their family matters may be discussed with others within the community. Sometimes counsellors are requested not to visit them in their huts out of fear that people may talk about it. Therefore, the office in the camp often offers the quiet space required for people to freely discuss their issues.

When there are internal family conflicts, family members may join in on a counselling session. In such a counselling session, attention is focused on mediation and psycho-education including information on, for example, alcoholism, suicide prevention and/or mental disorders. Additionally, relaxation exercises, to address anxiety or stress, can also be included.

On average, people attend between five and ten counselling sessions. While some may need more (specialised) support, in general, the counselling sessions provide the necessary knowledge and skills to cope differently with the challenges they face. It was found when a person is depressed and has suicidal thoughts because other family members have already resettled, combined with their not knowing if and when they can resettle, it may take a lot of effort to motivate the client to look at the situation from a different perspective. However, counselling and sharing experiences with others facing comparable situations may be quite useful.

People who face multiple, complex problems often require a variety of support from different caregivers, for example, in cases of severe mental disorders such as schizophrenia or severe depression, medical support[5] is necessary. Referrals to psychiatrists and community mental health prescribers (MHP) (refugee staff trained in recognising mental health disorders, and providing medication) can offer additional mental health care to these refugees.

Challenges to providing psychosocial counselling Practical problems and daily stressors are often very challenging, not only for the refugees but also for the counsellors providing support. Additionally, most psychosocial counsellors and CPSWs are quite young, often in their mid 20 s. While on the one

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hand, dealing with complicated cases may not only require input from a psychologist or psychiatrist, but may also require some life experience, especially when clients are much older. On the other hand, young psychosocial counsellors may also demonstrate a flexible, open-mind and ease in interacting with young clients, as within such a large population, it remains a challenge to reach all those in need of support. Another challenge is the fact that most refugee staff members who have been trained will resettle at some point, so that experienced people leave and new staff have to be trained.

Case study: an example of a psychosocial intervention

Kunja is a 23 year old, female refugee. She is married, but has no children. Kunja had been abused by her husband and other family members, including both physical and mental forms of abuse. Her husband was unsupportive. She presented with complaints of anxiety, fear, restlessness, flashbacks, feelings of loneliness, suicidal ideation, and dizziness. When she could no longer bear her situation she sought help with a psychosocial counsellor. Kunja moved in with her parents during the therapy sessions, even though she is not legally divorced. Staying with her parents was good for Kunja and helped to reduce her symptoms.

In the psychosocial counselling sessions, cognitive behaviour therapy was used (explained below) in order to offer her support to become stronger. For her, it was fortunate that her parents were the direct caregivers, as her husband and in-laws were unwilling to help. Additionally, although her abusers were not arrested or removed, there was a legal process in progress.

The first few sessions focused on allowing Kunja to identify her problems, while creating an atmosphere where she could feel comfortable to share them. She began to vent her problems and emotional difficulties, as well as the abuse experienced in the family. The counsellors frequently intervened with the family, especially with her husband. However, her husband continued to side with his family (especially with his parents) and, therefore, disregarded Kunja's feelings and the problems she wanted to share with him. He even ignored her when she tried to share good, or positive feelings with him.

By the seventh session, Kunja had strengthened her level of confidence and her mood symptoms had drastically improved. She was given daily homework assignments, and taught to challenge intrusive thoughts, one at a time. By regularly challenging negative thoughts, she was able to feel stronger.

Notes of the daily events made in a diary were helpful to observe her thoughts in different situations, and to then correct them. Muscle relaxation therapy was used to relax her mind and body, and improve coordination. Within each session, positive changes were observed, both in her daily activities, such as meeting people or sharing feelings and in her coping mechanisms. She is now more hopeful and motivated.

In the course of the therapy, Kunja was happy to join English language class, attend the beauty-parlour, and was also motivated to receive 'alternative to violence' training sessions conducted in the camp. She learned to remain independent and be decisive to make her life meaningful. The intervention was discontinued when there was a marked reduction in symptoms. In the end, Kunja declared herself happy and said; 'this is my new life, and I want to continue it'.

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Suicide prevention and intervention Because of the high level of suicide attempts and those committed, UNHCR, Asian Medical Doctors Association (AMDA) Nepal and TPO Nepal decided to design a suicide prevention and intervention protocol. This protocol aimed to: increase coordination and cooperation, reduce the amount of suicide attempts and those committed, and to give more clarity in terms of which agency should intervene, and at which stage. Staffs from both offices in Damak and Kathmandu, as well as field based staff, were consulted. Furthermore, community consultations were organised in order to guarantee the views of the refugee community were also represented in the process. This last consultation was very important, as front line workers from the refugee community are often the first ones expected to give support to victims and families, especially during nights and weekends when there are limited agency staff present in camps. The protocol has now been completed, its use will be monitored and reviewed, and a suicide prevention group will be created. Their work will include commemorating World Suicide Prevention Day on 10 September at the camps, every year. Additionally, consultant psychiatrists who visit the camps once or twice a month have agreed to involve counsellors in their consultations with refugees so that the counsellors can learn from these sessions about mental health issues, and cooperation between psychiatrists and counsellors can be increased. Even with resource constraints and the challenge to find time for these consultations, this cooperation should contribute to increased linkage and care related to mental health and psychosocial support.

Classroom Based Intervention (CBI) CBI is a five week long structured group intervention, with the combined aims of reducing psychosocial problems of children while contributing to their communication skills, self-esteem and skills for cooperating with others. Children participate through playing games, dancing, singing and drawing, which stimulate cooperation, interaction, and sharing of feelings and ideas. One challenge to address is that the children are from vulnerable family backgrounds where problems related to substance disorders, domestic violence and various other issues are all quite prevalent. The CBI supervisor and facilitators, as well as counsellors, also arrange activities for parents, addressing issues like good parenting and communication, as well as providing psychoeducation on issues such as substance abuse and creating a safe place for children at home. Schools, school counsellors and teachers are also involved in activities, and take part in training on psychosocial problems and support related to behavioural disorders, bullying, and the school as a protective place, among others.

Women's empowerment group (WEG) Group interventions where people with the same challenges can share their experiences and ideas, can contribute to feelings of solidarity, increase self-confidence, and create changes in attitude and coping strategies. In the camps, there are many single women who have lost their husband through either death or divorce. The Bhutanese Refugee Women Forum (BRWF) and TPO Nepal initiated WEG classes with the aims of supporting women to find new ways to cope with family problems, share experiences and feelings, and to increase self-esteem. There are also classes for women affected by domestic violence. Some groups are running very well, and the feedback from participants is very positive. Other groups lack continuity due to the high level of absence of participants who are either too busy taking care

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of their families, or are reluctant to share their feelings. Another challenge is that problems shared can sometimes be quite severe or difficult, and therefore also challenging for counsellors to facilitate the sessions.
Group harm reduction (GHR) GHR activities have been introduced in order to address problems related to substance disorders, like alcoholism. An assessment in two camps showed that substance use rates were not alarming, but hazardous drinking was present. As a result, special care and awareness campaigns were recommended (Luitel et al., 2010). Group harm reduction is an approach where people who are facing the same type of problems participate in groups, and awareness is raised through psychoeducation. Participants can share their experiences and write a contract with themselves in which they can address their will to stop using alcohol. For some refugees this approach worked well. For psychosocial counsellors, the challenge remains to stimulate people to participate in the sessions and to keep them involved.

Capacity development
Schininà et al. (2011) found that attention to knowledge and skills on mental health and psychosocial support was limited among most of the humanitarian agencies working with Bhutanese refugees in Nepal, and therefore recommended that the *mhGAP Intervention Guide* (WHO, 2010) be used to address these gaps among the agencies. To achieve this, TPO Nepal provided training with the *mhGAP Intervention Guide* for the doctors and nurses of the International Organisation for Migration (IOM) who perform medical screening of refugees, before they are resettled to third countries. As a result, medical staff are now able to better identify those refugees who would benefit from a psychological assessment and/or psychosocial support, and refer them accordingly. The training resulted in a cooperation and referral system between IOM and TPO Nepal. Similarly, TPO Nepal provided training for the CMOs and MHPs of the nongovernmental organisation (NGO) Asian Medical Doctors Association (AMDA). These interventions have also strengthened cooperation at camp level, between medical staff members and psychosocial counsellors.
Another recommendation resulting from the assessment related to lack of attention paid to psychosocial aspects of the cultural orientation that refugees receive from IOM, prior to their resettlement to third countries, about these respective countries. As it was found that some refugees commit, or attempt, suicide after their arrival in their new country, it is essential to prepare refugees. This preparation should include what they can expect, which psychosocial issues they may face, and how to support each other in their new setting. IOM and TPO Nepal decided to jointly develop training modules on these issues, for both aid workers and refugee representatives.

Conclusions and lessons learned

TPO Nepal and partner organisations have sensitised refugees to psychosocial issues, contributed to capacity building of staff and refugees, and provided counselling services to refugee and host communities. The resultant recommendations and lessons learned follow below.

Continuous psychosocial services for refugees and hosting community
For the coming years, it is recommended to continue the psychosocial services at camp level and to create or link these to existing psychosocial services for host communities as well. This will ensure attention is given

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to psychosocial support during, and after, the reduction phase for humanitarian interventions for this group of refugees.

Those refugees remaining in Nepal can then also benefit from the shared psychosocial facilities. Continuation of care for remaining refugees is also important, as the ones who stay behind are often the most vulnerable, such as the elderly and people with severe illness or mental disorders. Involvement of the host community can contribute to the creation of a social care network for both communities. Developed psychosocial interventions for the refugee community can ideally be integrated and embedded in existing care interventions and structures in the region, taking into account both culturally acceptable and international standards (Jordans & Sharma, 2004).

Strengthening of refugee community

Involving the refugee community, by either consulting them on needs and ideas or training them as CPSWs, aids in strengthening self-esteem and improves psychosocial wellbeing within the community. When preparing for the World Suicide Prevention Day, one of the CPSWs said; "*we are so proud to organise this together. This will be our day*."

Vulnerable groups

Vulnerable groups such as senior citizens, refugees with a disability, and single headed households need extra attention. Elderly refugees had been through a lot, some of them experienced horrible events in Bhutan then fled to Nepal and spent decades in a refugee camp. Often, their children and grandchildren may want to resettle, whereas they would rather go back to Bhutan or stay in Nepal.

Enhance links and cooperation

It is important to enhance cooperation between international and national NGOs in this humanitarian programme. At camp level, meetings are already held but these need to be accompanied by joint capacity development for staff from different agencies in order to increase cooperation and improve referral between agencies.

Follow-up

It would be helpful to explore possible linkages with psychosocial organisations in the countries where refugees resettle, in order to develop a system of handing over cases and sharing experiences, as well as psychosocial support. This is of particular importance in terms of suicide prevention and strengthening the psychosocial situation for vulnerable refugees who might need support in the process of becoming new citizens and how to fully engage in their new country.

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[1] Including, among others, the Camp Management Committee (CMC), the Bhutanese Refugees Women Forum (BRWF), the Bhutanese Refugees Children Forum (BRCF) and the Youth Friendly Centres (YFC).

[2] TPO Nepal developed a multi-level and multi-component care package, compatible with recommendations made by the *Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007).

[3] Needs of the refugee community are reflected in vulnerability assessments and specific studies, such as on the resilience of refugees in Nepal (Thomas et al., 2011). TPO Nepal participated in the study to develop the Humanitarian Emergency Settings Perceived Needs (HESPER) Scale, for which information was collected among the Bhutanese refugees (Semrau et al., 2012).

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[4] This is provided by the Asian Medical Doctors Association (AMDA), Nepal.

[5] The *Classroom Based Intervention* (CBI) was adapted, and implemented, in 14 districts in Nepal (2006–2007). Based on the results of a research study (Jordans et al., 2010), the CBI package was further adapted and implemented with refugee children in the camps from 2009.

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