

VOLUNTARY RETURN WITH A SCHIZOPHRENIC DISORDER

**Research into points of consideration for working with
asylum seekers, rejected asylum seekers and refugees
with a schizophrenic disorder when voluntary return
to the country of origin is being considered**

RESEARCH REPORT

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**Researchers:
Mrs. Blanka Conze (MA)
Mr. Floris Müller (MA)**



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Publisher: International Organization for Migration
Mission in the Netherlands
PO Box 10796
2501 HT The Hague
The Netherlands
Tel.: + 31 70.318 1500
Fax: + 31.70.318 1501
E-mail: Missionthehague@iom.int
Internet: <http://www.iom-nederland.nl>

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1. EXECUTIVE SUMMARY

A number of experts in the asylum seeker and refugee mental health care sector have reported to IOM that they noticed that one kind of psychiatric patient occasionally expressed a desire to return voluntarily to their country of origin. These are asylum seekers, rejected asylum seekers and refugees with a schizophrenic disorder. The nature of this disorder presents the health worker with a number of specific problems. As of yet there is no literature on psychosocial support of asylum seekers, rejected asylum seekers and refugees with psychiatric disorders in the context of return migration. The present research was intended to cater to this hiatus in the literature and provide insight into the practice of assisting clients with a schizophrenic disorder when considering voluntary return to the country of origin.

This study aimed to provide health workers with a list of aspects that can be relevant when assisting schizophrenic clients in deciding whether or not to return voluntarily to their country of origin. The central research question was “Which points of consideration can be used by health workers to assess if, when and how the possibility of voluntary return to the country of origin can be discussed with an asylum seeker or refugee who is diagnosed with a schizophrenic disorder ?

An exploratory research was set up that sought to determine the considerations that were used by health care workers in the Netherlands when assisting in voluntary return with schizophrenic clients. The research also comprised a literature review in which points of consideration of the preliminary list were substantiated through an inventory of recent empirical and theoretical developments regarding return migration and schizophrenia.

In total 25 interviews were conducted for this research. These yielded 36 cases in which return migration had been considered, discussed with a client or realized. 21 of these cases concerned schizophrenic clients.

The analysis of the interviews that were conducted with health workers with experience in assisting schizophrenic asylum seekers, rejected asylum seekers and refugees yielded 17 main points of consideration. The points of consideration were elaborated on using insights gained from the cases that were mentioned by the respondents. The four most used considerations were:

If and what kind of social support was available for the client in the country of origin.

The extent to which the client has integrated in Dutch society.

Whether the client has a persistent wish to return.

Whether the client can be regarded as mentally competent to make the decision to return.

The list of considerations that was developed through this research can be used by both client and health worker as a checklist to see whether any important aspects of return with a schizophrenic disorder have been overlooked in discussions on the topic. The list developed will have to be tested

in practice by health workers that deal with schizophrenic asylum seekers, rejected asylum seekers or refugees and return. Another possibility for future research would be to see in what ways the results of this study will be applicable to asylum seekers, rejected asylum seekers and refugees with different psychiatric disorders such as anxiety disorders.

2. INTRODUCTION

Health workers that deal with asylum seekers and refugees are increasingly confronted with the possibility of their clients' return to their country of origin. In the cases of asylum seekers this is often related directly to the stricter government policy on asylum that causes more requests for asylum to be denied. Besides forced returns to the country of origin it is also the case that asylum seekers, rejected asylum seekers and refugees choose to return to the country of origin voluntarily. Voluntary return is defined by the International Organization of Migration as return that was not forced and also includes those returns in which asylum seekers or illegal people in the Netherlands only had the choice between returning voluntarily or risk being expelled by the government's Immigration and Naturalization department (IOM, 2004). It should be noted that this definition also includes people that had no other available alternatives but to return to their country of origin. According to IOM statistics 2,196 asylum seekers, rejected asylum seekers and refugees voluntarily returned to the country of origin in 2002 using IOM's facilitation services (which include a financial compensation and the arrangement of travel documents). In 2003 this number rose to 3,016 (IOM, 2004). The definition of refugees and asylum seekers used by IOM here is based on legal status only (i.e. refugees have a legal status that allows them to stay permanently in the host country and asylum seekers are in the process of awaiting the outcome of their request to be given this legal status) (Hondius, 2000). We will use this definition throughout this research report.

In the psychosocial care for asylum seekers, rejected asylum seekers and refugees return to the country of origin is always either implicitly or explicitly an issue because their stay in the host country is dependent on their official inability to return (Schell & Muller, 2000). When providing psychosocial support to refugees and asylum seekers, health workers can be faced with the question if, when and how the possible return to the country of origin should be discussed with a client. In recent years there have been some publications on this issue (Van Krieken, 2001; Schell & Muller, 2000; Mateman, 1999). As of yet there is no literature on psychosocial support of asylum seekers, rejected asylum seekers and refugees with psychiatric disorders in the context of return migration. This lack of research is understandable given the fact that voluntary return amongst asylum seekers, rejected asylum seekers and refugees with a psychiatric disorder remains minimal compared to other groups. One reason for this is that the majority of asylum seekers, rejected asylum seekers and refugees with a psychiatric disorder suffer from anxiety disorders that have their roots in experiences in the country of origin. Such a situation makes possible return a highly stressful topic for the clients that is often avoided (Mateman, 1999).

However, on the basis of clinical experiences from a number of experts in asylum seeker and refugee health care, it was concluded that one kind of psychiatric patient has occasionally expressed a desire to return voluntarily. These are asylum seekers, rejected asylum seekers and refugees with a chronic schizophrenic disorder. It can be anticipated that the nature of this disorder presents the health worker with a number of specific problems.

The present research was intended to cater to this hiatus in the literature and provide insight into the practice of assisting clients with a schizophrenic disorder in the consideration of a voluntary return.

3. PROBLEM DEFINITION AND CENTRAL RESEARCH QUESTION

Problem definition

The present research was intended to aid health workers in situations in which a voluntary return to the country of origin is an option for their schizophrenic clients. It was anticipated that two general scenarios could occur in this respect that might each carry their own set of problems. In the first scenario the client would express an interest in the possibility to return voluntarily or even decide he or she will return. In the second scenario the health worker would be the first to consider positive and negative aspects of a possible return to the country for his or her client. Although the two scenarios are quite different, in both instances the health worker would eventually have to do some kind of assessment of the positive and negative aspects of return (together with the client) if he or she wanted to assist their client in this process.

In the case of a schizophrenic client, some doubt can arise as to whether the client is sufficiently mentally competent to make the decision to return voluntarily to the country of origin. When a client expresses the desire to return, the health worker will need to assess that this expression is not the result of schizophrenic symptoms before deciding on a course of action.

Aims of the research

This study aims to provide health workers with a list of aspects that can be relevant when assisting schizophrenic clients in deciding whether or not to return voluntarily to their country of origin. It also aims to provide some basic guidelines for the usage of such a list in practice so that the chance of a successful, durable return could be maximized. The results of this study should thus be relevant to a large group of Dutch health workers that could potentially have to assist a schizophrenic asylum seeker or refugee in the process of voluntary return. The list of considerations could serve as a checklist of topics that might be worthwhile to investigate with a client for whom voluntary return might be an option. Although most health workers will probably discuss many of these as a matter of course, it is always possible that certain important issues are overlooked.

The present research was designed to expand on and empirically validate a preliminary list of considerations that was produced by mental health experts from Phoenix, DeVonk and Bureau Medische Advisering (BMA) of the state immigration and naturalization department (IND) (see Appendix I for this list). This list consisted of 15 points of consideration that these experts derived from their own clinical experiences and theoretical knowledge of issues that can be relevant when assisting schizophrenic asylum seekers, rejected asylum seekers and refugees in voluntary return. In using a checklist, both client and health worker can be more confident that the most important aspects of return have been considered in reaching a definite decision to return and making necessary preparations to ensure an optimal reintegration.

Research question

The central research question was formulated as follows:

Which points of consideration can be used by health workers to assess *if, when and how* the possibility of voluntary return to the country of origin can be discussed with an asylum seeker or refugee that is diagnosed with a schizophrenic disorder ?

These points of consideration cover both issues that were mentioned above (i.e. assessing the positive and negative aspects of voluntary return and dealing with the issue of a schizophrenic client's mental competence regarding voluntary return). An actual medical prognosis of the client's schizophrenic condition after return to the country of origin depends on many factors that cannot be assessed beforehand, and was therefore not included in this list. Instead, the research looks into medical and psychosocial issues of schizophrenia that could aid in the proper preparation of a client for a voluntary return to the country of origin.

4. METHOD

In order to expand on the list proposed by mental health experts from Phoenix, De Vonk and BMA, this study was set up as an exploratory research that sought to determine the considerations that were used by health care workers in the Netherlands when assisting in voluntary return with schizophrenic clients. The research also comprised a literature review in which points of consideration of the preliminary list were substantiated through an inventory of recent empirical and theoretical developments regarding return migration and schizophrenia. In this section the method of data collection and the method of analysis of the interview data will be presented.

4.1. Literature review: data collection

Based on a clustering of the preliminary list of recommendations the literature review focused on the following four different domains.

1. The individual medico-psychiatric and psychological characteristics of the client (i.e. type of schizophrenic disorder, severity of the disorder, cognitive functioning, strengths and weaknesses, etc.) that could be relevant for voluntary return.
2. The dynamics of return migration and effects of migration on schizophrenic symptomatology in particular.
3. The issue of mental competence in relation to a schizophrenic client's expression of a desire to return.
4. The cultural perspectives on mental illness in developing countries and the available health care facilities in those countries.

Given the amount of literature that exists on these topics and the limited time and resources that were available for this study, no attempt was made at an exhaustive review. The review was intended to summarize some of the recent theoretical and empirical issues that are relevant for health workers dealing with schizophrenic asylum seekers/refugees and voluntary return. The information contained therein should thus provide health workers with insights into which issues they themselves could investigate further if assessed to be relevant for their client.

The following themes were explicitly sought for:

- a. Determination of mental competence in schizophrenia
- b. Risk factors and theoretical models for developing schizophrenia and experiencing relapse once schizophrenia has been diagnosed.
- c. Prevalence and course of schizophrenia in various countries
- d. Aspects of the context that can influence prevalence and course of schizophrenia
- e. Aspects of migration that influence schizophrenic course and relapse which includes issues of reintegration in the country of origin.

4.2. Interviews

4.2.1. Interview data collection

Interviews were conducted to explore the various considerations that health workers actually make in practical situations in which voluntary return could be an option for their schizophrenic clients.

The interviews were conducted with health workers and facilitators of voluntary return at IOM. Inclusion criterion was that respondents had experienced a situation in which the possibility of voluntary return to the country of origin was at least considered with a client with a schizophrenic disorder. Only cases of asylum seekers, refugees and clients whose request for asylum had been denied were admitted as data in the analysis. The diagnosis of the clients had to be schizophrenia, schizophreniform disorder, and schizoaffective disorder. Given the fact that a considerable number of cases concerned chronic psychotic subjects of which diagnosis was not determined, these were also admitted for additional information but these cases have not been used in the final analysis. Cases that did not yield enough information for analysis were also excluded (i.e. cases on which too much data was missing because they had been mentioned only briefly or because respondents could not recall all aspects).

The main objective of each interview was to make an inventory of the knowledge and methods health workers apply when assisting schizophrenic clients in the process of return. In order to minimize the influence of interviewer bias, it was decided to carry out the interviews in an open, semi-structured format. Interviewees were asked to describe their experiences in the assistance of voluntary return per client separately. An interview protocol was set up in which a number of different questions were formulated that could be used to elicit case-bound narratives from the respondents (this protocol can be found in Appendix II).

As much as possible, health workers were requested to speak of recent cases (i.e. cases from the last two years) because the continuing changes in asylum and refugee politics and legislation in the Netherlands might make cases from different time periods hard to compare. The interviewer generally only asked questions to further explore the considerations that had been made by the health worker in a specific case. At the same time it was avoided where possible, to suggest considerations to the interviewees that they did not mention themselves in order to reduce the chance of bias. By discussing practical cases of assistance in voluntary return, the data could also give an indication of the specific problems that health workers experienced during this process. Such an open interview approach also leaves room for more general considerations regarding the health workers own subjectivity that may be relevant for understanding the dynamics of the process of assisting in voluntary return.

The validity of self-report cases

One of the most fundamental discussions in the literature on schizophrenia surrounds the validity of the concept itself (e.g. Sass, 1992; Boyle, 1993). This research limits itself to those cases in which the health worker has recognized that the client to have a schizophrenic disorder. Therefore it runs the risk of either including cases in which the client was not suffering from a schizophrenic disorder at all or excluding cases in which they were but were not recognized as such. Although the issue of what schizophrenia “really” is and which criteria should be used is an important one, it is beyond

the scope and interest of the present research. Since this research is concerned with the ways health workers assist people that they themselves recognize as having a schizophrenic disorder, the determination of what these clients might *really* be suffering from is beyond the scope of this research project.

Contacting health workers

After initial consultations with some experts in the field of refugee mental health care, a preliminary list of contacts was compiled. Possible respondents were then initially approached via email and after that contacted by phone when they expressed interest in the research. In a number of cases health workers did not respond and contact was sought over the telephone in order to inform them better on the importance of the research and their participation in particular. Participants in the research were also asked for additional contacts that could be useful for this research. About half of the participants were found through such a secondary “snow-ball” approach. Health workers were considered suitable for participation when they indicated that they had experienced situations with schizophrenic asylum seeking/refugee clients, in which voluntary return has either been contemplated, openly considered or had been realized. The participants in this study were not selected to be representative of health workers in general. They were selected because of their experience with this particular issue and considered as knowledgeable informants on the subject.

Participants were visited at their place of work and the interviews took about one hour. The entire conversation was recorded on tape and interviewers made additional notes both during and after the interview.

4.2.2. Interview analysis

The analysis of the interview data was carried out in six steps.

1. Transcribing recorded interviews and notes

The interviews were not written out verbatim because of time restrictions. Instead the interviewer noted case by case which considerations and arguments were made and which factual information was given about clients and the course of the process of assisting in voluntary return. Notes made during and after the interview were included at the end of each interview.

2. Producing a case-by-case list from the rough interview transcripts

When all interviews had been carried out the cases were scored on a number of dimensions and placed in a table for a better overview. These dimensions were : Status or asylum seeker or illegal, diagnosis, land of origin, type of health worker, kinds of considerations made, kinds of difficulties encountered, whether return had eventually been assisted by the health worker and whether a return to the country of origin had been made (see Appendix IV for this table).

3. Inventory and condensation of list of considerations

All criteria and difficulties that were mentioned in the particular case were then taken together and were grouped into clusters of related points of consideration into a final “list of considerations”. Criteria were clustered with regard to whether they concerned aspects of the individual,

circumstances in the Netherlands or circumstances in the country of origin. Further clustering was made into more specific points of consideration.

4. Quantitative analysis

Although the data collection method of the research was not intended to yield a sample of cases that was representative, a number of quantitative aspects of the data were identified. It was for example determined how many considerations were generally made in situations of voluntary return and which aspects were mentioned most frequently.

5. Qualitative substantiation of list of considerations

The list of considerations was expanded on using the interview transcripts in order to provide accessible descriptions of each point of consideration. For each point a description was added with related difficulties that occurred in the process of return migration.

6. Thematic exploration

The final part of the analysis consisted of an exploration of the issues that came up during the interviews on the actual process of assisting clients with a schizophrenic disorder in considering voluntary return. Since this analysis was explorative, no clear guidelines were given, although themes that recurred over multiple interviews were investigated more thoroughly than those that were mentioned only once.

4.2.3 Interview participants

In total 25 interviews were conducted for this research. These yielded 36 cases in which return migration had been considered, discussed with a client or realized.

Of the 36 cases, 18 had refugee status in the Netherlands, 5 were asylum seekers, 7 persons were illegal whose asylum request had been denied and 6 were of unknown status (i.e. the health workers were not aware of the exact legal status of their asylum seeking/refugee clients).

The group consisted of 28 males and 8 females. The country of origin of the total set of 36 cases varied: 6 came from Iraq, 4 from Iran, 3 from Sudan, 3 from Bosnia, 2 from Russia, 2 from Congo, 2 from Armenia and 2 from Somalia. The other countries of origin were Ethiopia, Liberia, Colombia, Tanzania, Cameroon, China, Sri Lanka, Eritrea, Turkey, Togo and Algeria.

However, 15 cases had to be formally excluded from the analysis as they did not meet the inclusion criterion of a schizophrenic disorder (these cases had a chronic psychotic disorder that was not explicitly described by the interviewee as schizophrenia). In Tables 1 and 2 the above information is summarized separately for the schizophrenic group (Table 1) and the chronic psychotic group (Table 2). All subsequent results reported here concern only the cases of schizophrenic clients unless otherwise stated.

TABLE 1
SCHIZOPHRENIC CASES PER STATUS GROUP AND RETURN OUTCOME

Status of client (n=21)	Return realized	Return in process	Return tried & failed	Return not attempted
Asylum-seeker (n=4)	3		1	
Refugee (n=12)	8	3	1	
Rejected asylum-seeker (n=4)	1	2		1
Unknown (n=1)		1		

TABLE 2
EXCLUDED CHRONIC PSYCHOTIC CASES PER STATUS GROUP AND RETURN OUTCOME

Status of client n=15	Return realized	Return in process	Return tried & failed	Return not attempted
Asylum-seeker n=1				1
Refugee (n=5)	2	3		1
Rejected asylum-seeker (n=3)	1	1		1
Unknown (n=5)	4		1	

Voluntary return

12 schizophrenic people returned voluntarily to their country of origin.

In one case the process of return was not supported and facilitated by the mental- health worker because there was a high chance that the client would immediately be arrested and incarcerated upon return. The client however did return to the country of origin despite the lack of assistance. (In the excluded set of cases of people with psychotic disorders a further three such cases were noted: in one case mental competence was too low and in two other cases the clients symptoms were too severe to facilitate a return.)

Two schizophrenic people were not able to return successfully because of practical/medical limitations. One person did not have documents and could therefore not apply for a laissez-passer to enter the country of origin. In one case the parents refused to give permission for return.

Seven people did not want to return at all but the possibility of return was discussed in their treatment. In two cases return was mentioned by the health worker first because they suspected a better situation for their client in the country of origin. For five people return was discussed because of the juridical situation for them in the Netherlands (three were illegal, two were at the end of the procedure). The number of asylum seekers, refugees and illegals that are in the process of returning, have returned or whose attempts to return failed were shown in Table 1.

5. RESULTS

5.1. Literature review

The full 19-page literature review has been included in this report as Appendix III. It intends to provide mental health practitioners with some basic information on schizophrenia, psychosocial aspects of return migration, possible differences in medical facilities and treatment modalities in non-Western countries and the issue of mental competence. The four main conclusions that are relevant for the interpretation of the interview data are the following.

First, in a review of the state of the art of schizophrenia theory and research it was concluded that generally speaking a “vulnerability-stress” model is the most widely accepted model of the occurrence of the illness and the relapse into psychotic episodes. In relation to the specific situation of return to the country of origin, this underlines the need to assess the various stresses that clients are likely to face in different phases of the return process. A second important finding was that although popular academic knowledge suggests that prognosis of schizophrenia is statistically better in developing countries this applies only to the milder categories of the disease.

Second, the psychosocial aspects of return for migrants in general were listed. It can be concluded that these aspects may sometimes have to be considered more seriously with schizophrenic individuals because of the possibility that the associated stress will lead to an increase in symptoms.

Third, from a review of mental competence literature it was concluded that mental competence as a juridical concept that deals with the protection of the client or their context from harm, is not very useful when dealing with people returning to the country of origin. An alternative model of mental competence was considered more appropriate that does not define mental competence as a purely psychological property of the client. In this alternative model the client and health worker work together to increase the mental competence of the client with regard to the decision to return. This is done both through treatment of the disorder as well as through determining the meaning of return in terms of the client’s life, emotions and identity.

Fourth, it was found that although cultures differ in the ways they define mental illness, there is no reason to assume that the non-medical indigenous definition of mental illness always implies a more benign and less stigmatized existence for mentally ill persons. It was also concluded that attempts at psycho-education will have to be made in the knowledge that the medical perspective they offer on schizophrenia will have to compete with the various explanatory models that are available locally. In other words, psycho-education could sometimes have only a marginal effect if it does not connect in some ways with the existing local explanatory models of that particular mental illness.

5.2. Interview analysis

The points of consideration made by the respondents when return to the country of origin was an option for a schizophrenic client are outlined in the next paragraph. It was derived by taking all individual points made in the cases and grouping points per theme. In none of the cases from our interview more than seven points from this list were mentioned. Some points are self evident while others tap into multi-faceted problems and ethical issues that will be discussed below.

5.2.1. Points of consideration

Individual attributes

1. The persistence of the possible wish to return voluntarily
2. Mental competence of the client
3. Personality attributes of the client
4. The kinds and severity of schizophrenic symptoms
5. Expectations of client regarding return

Situation in NL

6. The degree of integration and acculturation in Dutch society
7. The prognosis of the client's disorder in the Netherlands
8. Relatives' opinions regarding client's voluntary return
9. The options left for achieving a refugee status in the Netherlands

Situation in country of origin

10. Availability of medication
11. Social support system in the country of origin
12. Safety risks
13. Health care facilities and treatment modalities in the country of origin
14. Local cultural practices and discourses regarding mental illness in the country of origin
15. Anticipated economic and social reintegration in the country of origin

Miscellaneous

16. Practical requirements
17. Opinions from other experts

In comparison with the list initially produced by the advisory committee, it is apparent that most of the points on the initial list are also mentioned by our respondents as a whole. It is also possible to provide a description of each point and anticipate some of the problems that may arise in assessing these criteria in practice.

Considerations of health worker

The number of considerations mentioned by the health worker in a specific case ranged from one to seven points from the list of considerations presented above. The consideration that was mentioned in most cases was whether the schizophrenic client would have social support in the country of origin (this consideration was made by 52.4% of the health worker).

The next three considerations were, in order of decreasing frequency: whether the client had a persistent wish to return (42.9%), whether the client had integrated in Dutch society (38.1%) and to what extent did the client have mental competence to make such a decision (33.3%). The complete list of the frequency of considerations made in different cases is shown in Table 2.

These numbers should not be seen as an indication of which considerations are more useful. Instead they show that in different cases different considerations will have to be made that are related to a client's specific individual situation. The distribution of frequencies could be taken to indicate that some considerations from the list apply to a broad range of cases of voluntary return of schizophrenic clients (i.e. those with the highest frequencies: social support, integration in NL, determination to return and mental competence). Given the small number of cases from different groups (e.g. 4 asylum seekers, 4 rejected asylum seekers and 12 refugees; 4 clients from Iran and 1 from the Democratic Republic of Congo), it is not possible to conclude which aspects of a case determine which considerations will be applied.

However, since each client always has to be approached individually by the health worker, it will become apparent only in practice which considerations are relevant for the client at hand.

TABLE 2
FREQUENCIES OF POINTS OF CONSIDERATION OF THE MENTAL HEALTH WORKER

Considerations	Frequencies	% of cases in which mentioned
1. Social support	11	52.4
2. Persistence of wish to return	9	42.9
3. Integration in NL	8	38.1
4. Mental competence	7	33.3
5. Safety risks	6	28.6
6. Reintegration in country of origin	5	23.8
7. Practical requirements	5	23.8
8. Health care facilities	5	23.8
9. Kinds and severity of symptoms	5	23.8
10. Prognosis in NL	3	14.3
11. Expectations regarding return	3	14.3
12. Personality attributes	3	14.2
13. Relatives' opinion in NL	3	14.2
14. Cultural practices	2	9.5
15. Availability of medication	1	4.8
16. Opinions of other experts	1	4.8
17. Options receiving status in NL	1	4.8

The list of considerations presented above was further elaborated on using the case descriptions from the interview data.

Individual factors

1. The persistence of the possible wish to return voluntarily

Description

Chronic psychotic persons can get very confused and may decide on things which they later regret. When they articulate a wish to return it is therefore often helpful to assess the stability of the wish to return. If a desire to return to the country of origin is made repeatedly over a certain time period, the health worker can be more confident that it should be taken seriously. Also preparations and effort extended will have been in vain if the client's wish to return later turns out to have been a passing fancy or the result of a thought disorder. Ambivalence on the other hand would be an indication that the health worker and client should discuss the expected consequences of staying or returning in greater detail.

Difficulties

It has been observed that a persistent wish needs to be taken seriously early on and discussed with a client. A person with the desire to return may often be very strongly motivated to return as quickly as possible. A number of cases were mentioned by respondents in which the client simply returned one day without making preparations that would have improved their chances of a successful return and continuation of the care for their condition.

It may be useful in such situations to discuss with the client which conditions need to be satisfied before the client can make a successful return.

2. The mental competence of the client

Description

As was noted in the previous point, chronic psychotic persons' expressions of a desire to return could in some cases be more a symptom of their disorder than of a genuinely felt desire. It can be useful to make a distinction between a merely repeatedly asserted wish to return and a truly felt and well considered decision to return home.

Such a decision depends in part on the absence of interference from a psychosis-related thought disorder or delusion and as such will become possible when the symptoms of the illness have been brought under some relative form of control. However, such a decision cannot be called well considered until client and health worker have concretized its place in the life and identity of the client. In the ideal case the desire to return would thus be in accordance with the emotions and identity of the client to the satisfaction of both client and health worker. In other words, it must be meaningful to the client in his or her life.

Difficulties

Some chronic psychotic persons with a persistent desire to return have been very resistant to the discussion of the subject in great detail. Others will be affected by the illness to such a degree that conversations on the meaning and place of their decision in their lives are difficult and will have to be postponed.

3. Personality attributes of the client

Description

Some attributes of a chronic psychotic person may be considered as either a protective or a risk factor when he or she returns to the country of origin. Skills that could be important are related to the task of acculturating and reintegrating in a community that they left (often a long time ago and in better mental health). Individual attributes that were mentioned by practitioners were intelligence and the development of social skills.

Difficulties

In one case a person's intelligence deteriorated with every psychotic episode, thus making her successful return (in combination with a number of other unfavourable conditions) even more unrealistic.

4. The kinds and severity of schizophrenic symptoms

Description

The specific category of the psychotic disorder (i.e. schizophrenia, schizoaffective or schizophreniform disorder) was not mentioned as a point of consideration by the respondents in this research. However, the severity of the symptoms was an often cited consideration. In an ideal situation, a return journey would be undertaken when the client is free of symptoms but in practice the stabilization of the condition is often considered to be necessary. For people with a chronic severe schizophrenic disorder it can be important to realize that literature has shown that the prognosis is usually not affected by mediating cultural factors. Other considerations are whether the symptoms include a thought disorder or other factors that impair functioning to a high degree.

Difficulties

In some cases it was noted that the health worker's inability to speak the clients native tongue and the client's insufficient command of the Dutch or English language caused problems in the diagnosis of the severity of the disorder. For example, the extent of incoherent speech runs the risk of not being detected by the health worker because the client's poor speech is erroneously attributed to his or her poor knowledge of the English or Dutch language. A solution to this problem would be to have a native speaker who is able to judge the content of the client's speech in his or her native language.

5. Expectations of client regarding return

Description

Clients' expectations regarding return are often intimately bound up with the reasons for their migration to the Netherlands in the first place. The expectation of success in the West, for example, may translate to the fear and shame of returning with a mental disorder. Asylum seekers, rejected asylum seekers and refugees have also experienced trauma in the country of origin and will thus be reluctant to discuss return at all. Other expectations regarding return may be based upon memories of the situation in the country of origin before migration, which may be many years ago. Awareness and anticipation of the possible changes in the situation in the country of origin may reduce stress upon arrival.

Health workers emphasized that the client's worries and general anxiety about a possible return can often be lessened by a direct phone call with relatives in the country of origin. Furthermore this can provide an impression of the recent developments in the region and the actual situation.

Difficulties

Some health workers suspected that their psychotic clients had actually emigrated because of their propensity to develop this illness.

Situation in NL

6. The degree of integration and acculturation in Dutch society

Description

A lack of integration and acculturation may be a reason to leave when a person is marginalized in the Netherlands. On the other hand, it can also be a reason to anticipate upon a number of problems when a person that was integrated and assimilated here decides to return.

Successful acculturation or integration will only be evident after a person has had a more lengthy stay in the new society. Poorly integrated chronic psychotic persons will suffer more from their mental illness and possibly develop more symptoms if this has resulted in a weak social support system or social isolation.

A poor command of the Dutch language is another important indicator of a lack of integration that is especially pertinent to a chronic psychotic person who is already having problems understanding the world around them. If many problems are evidently related to language difficulties, then return migration might lessen the associated suffering.

In some cases it was mentioned that homesickness was such a powerful negative force in the lives of clients that it was an important reason to help the client in returning.

Difficulties

People that have lived in the Netherlands for a long time will have adjusted to the situation in their own way and will probably have to readjust and acculturate anew in their country of origin. In the

case of families with young children the situation can thus arise that the “country of origin” is in fact a foreign country for the children. Whereas parents are, in most cases, not allowed to work, the children have sometimes been socialized in the Western school system for years. The resulting tensions in the family may obstruct the actual discussion of the subject.

7. The prognosis of the client's disorder in the Netherlands

Description

When the treatment for the psychotic symptoms is demonstrably working, this can be a reason to consider postponing return until the treatment has been finalized or the client has been stabilized to a certain degree.

When the treatment of the disorder is largely unsuccessful, this may be a reason to compare the social situation in the Netherlands with the possible social situation in the country of origin.

If the treatment is not reducing symptoms to a sufficient degree, medical treatment is not a reason to stay in the Netherlands and other factors might be given more weight or attention in discussions with the client.

Difficulties

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8. Relatives' opinions regarding clients' voluntary return

Description

The attitudes and opinions of relatives and close friends in the Netherlands can provide valuable information when concretizing the possibility of voluntary return to the country of origin with a psychotic client. If they are willing to share the burden of care for their relative or are already doing so, this could be seen as a contra-indication for return unless other factors weigh against it. It is also possible that support would be even better in the country of origin.

The opinions of relatives are especially pertinent in cases where psychotic persons are too symptomatic to discuss the desire to return personally, and in those where the legal responsibility rested with the relatives.

Difficulties

In some cases no relatives were living in the Netherlands or they refused to participate and discuss their psychotic relatives' wish to return voluntarily with the health worker.

9. The options left for achieving a refugee status in the Netherlands

Description

When a client has no more options to apply for a refugee status, this can be an additional motivation to look more seriously at the option of return. Conversely, in some cases, return migration remained impossible to discuss while an appeal to a negative court decision was still being processed.

Difficulties

When the final appeal has been denied, relatively little time remains to work with the client before the client-health worker relationship must be terminated. Since preparation could be said to be essential for return migration with a schizophrenic disorder, this is a problem that needs attention from both the side of the mental health sector and of the IND.

Situation in country of origin

10. Availability of medication

Description

Given the fact that pharmacological treatment is the pivotal element of most treatments for schizophrenia, it is often important to check whether the medication that is prescribed in the Netherlands can be continued in the country of origin. If it is not locally available an alternative must be found. Since side effects vary both from drug to drug and individually there is usually a period of trial and error until a suitable substitute is found.

The World Health Organization has a website that gives some global nation-level information as to the availability of a number of classic psychotropic drugs per country at the primary health care level (<http://www.cvdinfobase.ca/mh-atlas/>).

Difficulties

Some drugs require regular blood-checks or other maintenance by a professional health care worker. If these are not available in the country of origin, then the drug cannot be prescribed.

In some cases it was also not clear whether the client would be able to afford antipsychotic medication in the country of origin. Sometimes arrangements have been made where relatives in the Netherlands send prescription drugs back home. Most of the clients went back with a supply of medication for at least a few months.

11. Social support system in the country of origin

Description

It is crucial to determine what kind of social support system will be available for the client in the country of origin. If family or other reliable carers are present, then it needs to be investigated whether they are prepared to take on the burden of care for the client. This often includes supervising medication adherence. It also includes the availability of sufficient financial resources to provide for the psychotic relative and pay the cost of medication.

Cultural understandings within the social support system regarding mental illness, and in particular psychotic behaviour, can be relevant as well. In one case it became apparent that the family was not at all willing to respect the client's illness, which resulted in a very rapid decompensation upon return.

In such cases it can be useful to provide relatives with psycho-education as to the nature of the client's condition and the proper ways to interpret and deal with their psychotic behaviour. Psycho-education can have limited effects for asylum seekers or refugees returning to their country of origin. This will be further outlined in the discussion chapter.

Difficulties

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12. Safety risks

Description

For some asylum seekers, rejected asylum seekers and refugees, emigration was motivated by the danger of persecution in the country of origin. Voluntary return in such cases will have to include the calculation of risk that the client is taking when he or she makes the decision to return.

The Ministry of Foreign Affairs regularly publishes general information on the internet on political, social and economic situations in countries (called "Algemene Ambtsberichten"). These can be found on http://www.minbuza.nl/default.asp?cms_item=mbz257248. It is also possible to contact the Dutch embassy in the country of origin for more up-to-date information on safety risks.

More general information is also available at the Amnesty International website: Duran, N. [n.duran@bsd.rotterdam.nl] <http://www.amnesty.nl/landeninfo.shtml>. It needs to be emphasized here that the individual situation of the client should be discussed with the client him/herself or other people that are aware of his/her risks in the country of origin.

Difficulties

In one case the risk was high that the client would be arrested and taken to jail for a lengthy period of time. When this probability became apparent, his psychiatrist refused to help him further in his efforts to arrange return migration. Despite no further cooperation from the psychiatrist, the client himself eventually did arrange his own return. The outcome of this return journey remains unknown.

The difficulty here is thus that in such situations a client with a strong desire to go will return despite objections from health workers, leaving the worker with a sense of failure or responsibility.

13. Health care facilities and treatment modalities in the country of origin

Description

The continuation of mental health care after return migration depends to some extent on the availability of care in the country of origin. Issues that were considered by health workers were the actual presence of psychiatric care, the cost of psychiatric care and the kind of treatment that were available for the patient. In general it can be said that the state of health care systems is impoverished when compared to the Western health care systems such as that of the Netherlands. A strategy that is sometimes employed is to stabilize the client in the treatment in the Netherlands to such an extent that regular expert treatment is no longer necessary.

Global information regarding mental health care systems per country (i.e. number of psychiatrists per 100,000, number of hospital beds for psychiatric patients) can be found on the World Health Organization website: <http://www.cvdinfobase.ca/mh-atlas/>. The individual situation of the client should be discussed with the client himself or other people who have thorough knowledge of the specific area to which the person will return. IOM can assist the health worker in answering questions in this regard.

Difficulties

In some cases the health worker predicted that the client would either be locked away in a nineteenth century style mental asylum or receive no care at all. While for one client this was seen as a contraindication, with others it was merely concluded that good preparation was needed to mobilize the family in the country of origin to manage the care of their psychotic relative.

14. Local cultural practices and discourses regarding mental illness in the country of origin

Description

The ways in which people with a mental illness are viewed and treated can vary greatly from country to country and also between more localized areas in those countries. It can be useful to determine whether local views of mental illness are a risk for the reintegration of the client upon return. The symptoms of psychotic disorders are recognized practically universally as “abnormal” but the interpretation of this difference can vary with serious consequences.

For example, it is possible that certain kinds of disturbed behaviour are not tolerated locally and will cause the client to become stigmatized or even ostracized from the community. The number of homeless psychotic people in some developing countries attests to this possibility.

The medical model of Western science that sees people with chronic psychotic symptoms as suffering from an underlying mental disease can be transferred to a client’s close relatives through psycho-education. However it is important to realize that introducing such alternative ways of seeing “madness” is influenced by already existing views of disturbed behaviour.

It can be helpful to understand the culture-specific ways in which relatives are interpreting the client’s behaviour so that new understandings can be presented in a culturally acceptable way.

Difficulties

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15. Anticipated economic and social reintegration in country of origin

Description

The extent to which a returning refugee or asylum seeker can take part in daily life in the community of the country of origin will affect their sense of well-being. A factor that could be important to consider is whether the client will be able to find employment or a purposeful way to spend his or her time. A related point is how the client will be able to financially manage his or her life.

Difficulties

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Miscellaneous

16. Practical requirements

Description

Return migration of asylum seekers, rejected asylum seekers and refugees with a schizophrenic disorder was also found to be constrained by a number of practical issues. One of the most cited concerns is the arrangement of proper travel documents. This includes a laissez-passer which the client must procure at the embassy of the country of origin and a medical passport which can be arranged by IOM.

Other practical concerns are related to the client's ability to undertake the journey itself. If the client cannot travel alone because of his or her medical condition, IOM can arrange for and finance a chaperone. In the cases that our respondents reported, successful preparations often took a number of months, which they attributed in part to bureaucracy at both IOM and national embassies.

Difficulties

A frequently mentioned problem was that some asylum seekers did not have any form of identification or passport at all. Without such papers it can be very difficult to apply for a laissez-passer and the client is not able to return to his/her country of origin. Attempting return through an illegal border crossing would mean that IOM cannot give support for the remigration process.

17. Opinions from other experts

Description

For some health workers the opinions of others that are more familiar with the client are essential in reaching a decision regarding the client's return.

Difficulties

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5.2.2. Thematic exploration of the process of assisting in voluntary return

While the main analysis of the data has concentrated on considerations that were made in practical situations in which voluntary return of schizophrenic asylum seekers or refugees was a possibility, an additional exploratory investigation was also made into the actual process of assisting in voluntary return. We focused on the difficulties that were experienced during the process of assisting their clients and those points in the interviews where respondents reflected on the process and their own position within it. The following themes were found to recur in a number of the interviews. These points should not be seen as generalized aspects of every case of assistance in

voluntary return but rather as additional points of consideration that concern the process of assisting rather than the contents per se.

Lack of information

In many cases health workers indicated that their assistance to asylum seekers and refugees in regard to the possibility of voluntary return was being complicated by lack of information. This lack of information concerned a number of different areas. Respondents indicated that they were not well aware of the possible role that IOM could have in facilitating the voluntary return of their client. It was also stressed by a number of respondents that they lacked sufficient information about mental health care facilities and treatment modalities for schizophrenia in the countries of origin.

Communication problems between health worker, client's lawyer and Immigration and Naturalization Department (IND).

A considerable number of health workers with asylum-seeking clients indicated that communication patterns between themselves, their clients' lawyers and the IND were of a very poor quality. Many respondents observed that there was a mutual distrust between health workers and IND which expresses itself in reluctance on both sides to give out information about the client. These communication problems sometimes caused the abrupt termination of the preparation of a process of voluntary return because the health worker was not informed of the denial of a request for asylum.

It is possible that more information from the client's lawyer and IND regarding the status of pending asylum requests will allow for a better and more sustained assistance in the voluntary return of a client. Especially in the case of schizophrenic persons, some issues of the return process need a fair amount of preparation if they are to be carried out in a successful, sustainable and ethical manner (e.g. contacting family members, ensuring medication continuation, etc.).

Communication problems with IOM

In a number of cases contact with IOM was not considered optimal. The main complaint was that IOM services were not fast enough. Other respondents, however, indicated that they were satisfied.

Different views on the client-health worker relationship

Health workers that were interviewed for this study differed markedly in the way they defined their relation to their client. This difference is relatively unsurprising between workers of a different profession (i.e. social workers have a different relationship to their clients than psychiatrists). However, this variation was also seen amongst the group of psychiatrists that were interviewed for this study. While some were only concerned with the treatment of the client's disorder and refused to even discuss return options, others defined their responsibility as much broader, up to the point of not assisting in voluntary return on the grounds that they thought it was an unwise or dangerous decision.

Ethical dilemmas and contradictory treatment objectives

For some health workers the notion of assisting their client in making a voluntary return was incommensurable with their goals of activating and integrating their client in the Dutch society. This ambivalence was apparent in the way some people clearly delineated their responsibility for the client's well-being up to the border of the country of origin, making comments such as "I am only responsible that my client arrives there with the best chances of success. The rest is beyond my control".

Negative effects of long asylum procedures

Several respondents noted that their clients were suffering as a result of long periods of uncertainty as to whether or not they would be given refugee status in the Netherlands. It was emphasized that the stress that accompanied this uncertainty, and sometimes the contact with IND officials and lawyers, had a negative influence on the clients' schizophrenic symptoms, causing them at times to relapse into a psychosis. This stress and worsening of symptoms in turn made discussing return with the clients more difficult.

Diagnosis was less relevant than severity of condition

Health workers did not reflect on the differential influences of various kinds of diagnosis within the schizophrenic spectrum (such as schizoaffective, schizophreniform or chronic psychotic condition not otherwise described). Mostly the severity of symptoms and the prognosis were considerations that were regarded as much more relevant.

Essential notions of identity and culture

In discussions on the reasons for return migration a considerable number of respondents drew upon generalized notions of "the developing world" in which the culture and social system is more tolerant of difference and more supportive for weaker individuals. While this may be the case in many situations, examples also abound of the maltreatment and ostracism of psychotic persons in the developing world. It is thus more objective to avoid making assumptions and determine what the situation will be for the individual client.

Similarly, reintegration of clients that have been in the Netherlands for many years was assumed as unproblematic by health workers, despite the evidence in the literature to the contrary. In individual cases it can be essential to determine what their particular social situation will be like and not to take such a situation for granted.

6. CONCLUSION

The results of this study can be summarized as follows. The analysis of the interviews that were conducted with health workers with experience in assisting schizophrenic asylum seekers, rejected asylum seekers and refugees yielded 17 main points of consideration. It was also found that in the majority of cases, the *client's wish* to return preceded the health workers consideration of the possibility of return and was central to the entire process of return. The points of consideration were elaborated on using insights gained from the cases that were mentioned by the respondents. The four most used considerations were:

1. If and what kind of social support was available for the client in the country of origin.
2. The extent to which the client has integrated in Dutch society.
3. Whether the client had a persistent wish to return.
4. Whether the client was regarded as mentally competent to make the decision to return.

However, in many cases these four points were not considered. This could be taken to illustrate the fact that the weight given to the different considerations will vary according to circumstances that characterize each individual case. It must be conceded that there is no way of knowing whether the health workers omitted these considerations on purpose or simply neglected them. In addition to these findings a number of recurring themes were noticed such as ethical dilemmas and possible obstacles when assisting in voluntary return.

We will now briefly assess how the results of this study can provide the answers to the central research question. This question was “which points of consideration can be used by health workers to assess if, when and how the possibility of voluntary return to the country of origin can be discussed with an asylum seeker or refugee that is diagnosed with a schizophrenic disorder?”.

The first part of the question, (i.e. “if the possibility of return can be discussed with schizophrenic clients”) can be answered positively. Our research yielded 21 cases in which the topic was discussed. The ways and extent to which it was discussed varied.

The second part of the question (i.e. “when can the possibility of return be discussed with schizophrenic clients”) corresponds with the fact that discussing return was usually integrated in the process of assisting the client in maximizing their mental competence and treating their symptoms in general. Generally speaking, discussions of the implications and meaning of a possible return will be most productive when the client’s symptoms have been stabilized to a certain extent.

The third part of the question (i.e. “how can the possibility of return be discussed with schizophrenic clients”) is answered by the list of considerations that was produced by compiling the considerations of health workers in each individual case. The model presented in the discussion could additionally serve as a tool for health workers that are looking for ways to discuss return with their clients.

The process of return: Stabilization-concretization-realization

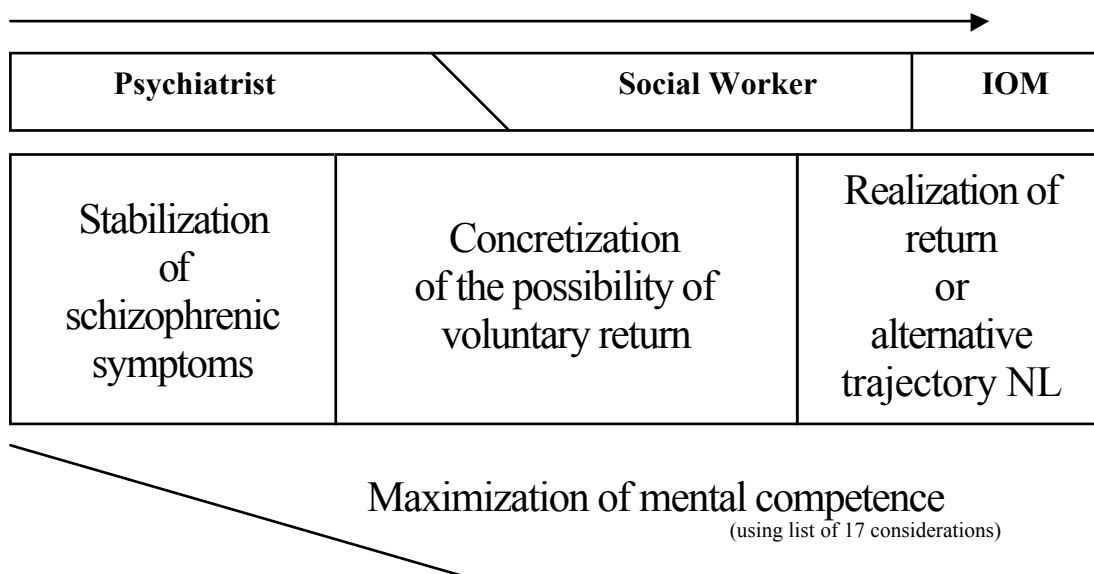
It could be argued that the list of considerations and the conclusions from the literature review can stand on their own to some extent. However, it became apparent through the thematic analysis of the interviews that the results can be meaningfully integrated into a preliminary model that can be used in practice by health workers.

The schematic model below (Figure 1) depicts the process of assisting asylum seekers, rejected asylum seekers and refugees with a schizophrenic disorder in dealing with the possibility of voluntary control and, in doing so, increasing their mental competence. On the basis of information gathered from the interviews on the common and the ideal scenarios of assisting clients, we have divided it into three related phases. These phases are:

1. “Stabilization”, in which the treatment of the client’s symptoms is given most attention,
2. “Concretization”, in which the possibility of voluntary return is discussed and concretized using both the client’s and the health worker’s relevant knowledge and
3. “Realization”, in which the outcome of the discussions and deliberations between client and health worker are put into practice through either realization of voluntary return or following up on an alternative trajectory.

The top bar of the schema (indicating “psychiatrist”/”social worker”/”IOM”) is included to indicate that the model does not necessarily assume that the client is assisted by a single health worker throughout the whole process. In practice it sometimes occurs that a psychiatrist delegates the discussion of return completely to a social worker. Clear and efficient cooperation between these entities can be beneficial for the return process. In the last stages of the process of return, practical issues can often be arranged by IOM district workers.

FIGURE1
THE PROCESS OF ASSISTANCE IN VOLUNTARY RETURN



In the initial “stabilization” phase the client may already express a desire to return. In some cases (i.e. when the client experiences periods in which symptoms are sufficiently moderate to allow a conversation on the topic) it may be possible to discuss considerations surrounding return. From the interviews it became apparent that it may be important to make agreements with the client in this phase so that the client will not return to their country of origin on their own before a number of conditions have been satisfied. These conditions will be determined by the individual case but one example could be that the symptoms of the illness have been stabilized to a satisfactory degree. The list of considerations presented earlier will be helpful mostly in the “concretization” and “realization” phases. These phases become possible when the client’s symptoms have been stabilized or when a period occurs in which the symptoms are sufficiently mild, to discuss the considerations that are relevant to the individual client’s situation.

One of the central features of the model focuses on maximizing the autonomy and increasing the mental competence of the client. We define increasing mental competence here as increasing the meaningful relation of the client’s desire to return to his or her emotions, identities and values. The creation of this meaningful relation is best seen as the responsibility of both the client and his or her health worker.

It should be noted that this model and the list of considerations is not intended to present health workers with an ideal picture of how assistance in voluntary return should be carried out. It has become very clear from the interview data that in most cases many considerations can be irrelevant for the client and practical constraints will require much creativity that cannot be anticipated by a simple theoretical model. As was mentioned earlier, it is also impossible to determine beforehand which considerations will be more relevant and which will be less, because this will depend on the individual case of the client. What is presented here is a way of charting the various issues that could be relevant in any particular case. We have decided to present a model for the situation in which both client and health worker wish to develop their thinking and opinions regarding return, using the knowledge that exists between them. The list of considerations that was developed through this research is thus intended for both client and health worker and could serve as a checklist to see whether any important aspects of return with a schizophrenic disorder have been overlooked.

7. DISCUSSION

The results of this study have thus not produced a tool for health workers to arbitrate whether or not they should facilitate their client's return to the country of origin. They rather give some information on how to proceed in the case that return is a possibility. Producing such a tool would focus too much on legal responsibility towards the client and would suggest that there is only one right way to deal with the situation. At the same time it should be made clear that the 17 points of consideration are mere recommendations that require testing in practice. Health workers should only take them to heart if they feel they make sense in the context of their own practice.

If a client expresses a desire to return to the country of origin this should never be dismissed by the health worker as a mere symptom of their illness because this cannot be known in advance. It is possible that the severity of symptoms precludes the client from evaluating the effects of such a decision on their life. It would therefore be more productive to treat the client's symptoms and discuss the issue with the client to increase their mental competence instead of dismissing it on the grounds that mental competence is too low.

A number of cases in our data concerned clients that returned without making any of the preparations that could have ensured a maximum chance of successful reintegration. This situation occurred because either the health worker refused to cooperate with voluntary return on the grounds that s/he considered it an unwise decision or alternatively because the issue of return had not been discussed and as a consequence the health worker was not aware of the client's desire to return.

We see this as a result of an overly paternalistic attitude through which health workers feel obliged or authorized to decide on the validity and viability of the client's possibility to return. It can be hypothesized that such an overextended sense of responsibility will lead to a situation where the health workers' own reservations about the clients' return, affect the ways in which they can assist their clients in this process.

We do not argue that health workers should simply go along with their clients' wishes irrespective of their own opinion. Instead we advocate that the health worker should discuss their opinion with the client without letting it preclude taking the client's desires seriously. Since non-schizophrenic people also make bad decisions, it is much more important to evaluate whether the client's decision is authentic and can withstand the test of deliberation and critique than whether one agrees with it per se. By working through the various ways in which voluntary return would affect the life of the client and the way in which he or she sees himself and the world, the mental competence of the client will be increased. In this view mental competence is a construct that is intimately related to the relationship between health worker and client. In the last instance both client and health worker will have to decide together whether the client has reached a sufficient level of mental competence with respect to the decision to return.

If this perspective is adopted, then working with the client towards return and maximizing the chance of successful reintegration is in the interest of the client, even if the health worker might not agree with the decision. Although the opinion of the health worker might still be different, he or she has made the client aware of the disagreement. It should therefore not conflict with assisting a client in giving their life shape and meaning autonomously based on their emotions, identifications and personal and cultural values.

It should be mentioned that those clients with the most severe cases of schizophrenia will present more difficulties to the health worker regarding the return process. If it remains impossible to have any form of meaningful discussion with the client because of the severity of the schizophrenic symptoms, then the health worker is left with the precarious task of finding out whether the consistent desire to return should be seen as authentic and based on deeply felt values and identifications or is influenced by the symptoms of the client's illness. The most important sources of information in such a situation will be the family and/or social group of the client. These people will usually also have the legal responsibility of the client and will thus be the ones that make the final decision. Several respondents noted that a total lack of effect of medication and treatment in the Netherlands took away one of the largest medical objections to return, since this was an indication that Western health care facilities did not have a positive effect on a particular client. However, it will depend on the opinion and information of the relatives in the Netherlands and/or in the country of origin how a health worker will deal with a severely disturbed schizophrenic client expressing a consistent desire to return to the country of origin.

The results of this research should, however, be followed by further study before any strong conclusions can be drawn. First of all, it is important to emphasize that this study was an exploratory study into the various aspects that were relevant in the process of assisting schizophrenic patients in return. Given this objective and the limited time that was available, the method of finding respondents through a "snowball" method was warranted and yielded a considerable number of cases and a wide range of approaches to the problem by different health workers. This method however also limited the generalizability of the results. Thus, we cannot make any statements about what usually happens in the Dutch mental health world when schizophrenic clients present a desire to return. What can be concluded is that many different perspectives are present amongst health workers and that voluntary return is considered in at least as many ways.

Second, although our recommendations are based upon interviews with experts that have experience with assisting schizophrenic clients in return and the state of the art of scientific literature, it remains to be seen whether the points of consideration are useful in practice. It is thus important that these results will somehow be presented to and used by practitioners in the field to determine their value and to find out which information is lacking further. Although we excluded the cases of non-schizophrenic chronic psychotic asylum seekers, rejected asylum seekers and refugees, the list of considerations could well be useful for this group as well. One indication for this is that specific diagnosis was almost never discussed and that the clients' problems were discussed at the level of symptoms (which can be the same for schizophrenics and non-schizophrenic chronic psychotic persons).

A number of other issues needed to be looked at closer in further research. One important topic that has not received enough attention is the follow-up of returnees to the country of origin. Systematic studies of the outcomes of voluntary return programmes will greatly help the development of methods and tools to assist persons that wish to return. A second possible avenue for future research would be to see in what ways the results of this study will be applicable to asylum seekers, rejected asylum seekers and refugees with different psychiatric disorders such as anxiety disorders. We can assume that their thinking about their country of origin is very different given the high incidence of traumatization in the land of origin amongst these groups.

Although in many cases it will be impossible for clients to return, research that aims to provide support for health workers must also consider the political climate in the Netherlands that is causing increased denials of applications for asylum. For those amongst the group of asylum seekers with psychiatric disorders, a return to the country of origin will have to be considered and compared with the alternatives of illegality in the Netherlands or migrating on to another country. As far as we know, health workers do not have any significant methods or tools available to deal with such situations at present.

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9. APPENDIX

Appendix I: Samengevoegde lijst van criteria van de Vonk, Phoenix en IND.

Elke organisatie stelde afzonderlijk een lijst samen op basis van hun respectievelijke kennis en ervaring op het gebied van terugkeer van asielzoekers en vluchtelingen met een psychiatrische stoornis.

Criteria voor gewogen medisch-psychiatrische eindafweging:

- Wilsbekwaamheid
- Consistente wens tot terugkeer
- Motieven t.a.v. terugkeer
- Aard van de stoornis
- Prognose van de stoornis
- Mening naaste familie of steunsysteem
- Culturele attitude t.a.v. stoornis in LvH
- Mate van te verwachten psychosociale stress in LvH
- Politiek Juridisch risico dat patiënt bij terugkeer loopt
- Aanwezigheid van sociaal steunsysteem in LvH
- Aanwezigheid van minimaal vereiste zorgvoorziening
- Welke behandelingen kan cliënt in LvH verwachten ?
- Effectiviteit behandeling NL vs. LvH
- Financiële middelen toereikend voor situatie LvH
- Mate van Integratie hier vs. te verwachten herintegratie in LvH
- Is therapeut bereid over het verbreken van het therapeutisch contact na te denken

Appendix II: Interview protocol

De interviews met hulpverleners en maatschappelijk werkers krijgen een semi-gestructureerde vorm, wat inhoudt dat een aantal kernvragen altijd gesteld zullen worden. Het verloop van het interview zal echter niet gestructureerd worden zolang het thema niet te ver van de aandachtspunten afwijkt. Het wordt opgenomen per dictafoon om later passages terug te kunnen luisteren. De interviewer maakt tijdens het interview daarnaast ook beknopte aantekeningen. Direct na het gesprek zondert de interviewer zich af en werkt hij/zij de gemaakte aantekeningen uit. Daarbij worden ook de gedachtes die de interviewer zelf had tijdens het interview opgeschreven omdat deze later nog belangrijk kunnen zijn voor de interpretatie van het verloop van het interview. Van elk interview wordt op een later tijdstip een kort verslag gemaakt dat bij de analyse van de resultaten en de synthese van alle interviewdata gebruikt kan worden. Interviews zullen tussen de 45 minuten en ander half uur duren en bij voorkeur afgenomen worden in de werksetting van de ondervraagde.

Aan het begin van het interview introduceert de onderzoeker zich en bespreekt hij het onderwerp van het onderzoek, het belang van het onderzoek en de participatie van de ondervraagde. Daarnaast wordt duidelijk verteld dat het interview ten alle tijden mag worden onderbroken zonder opgave van redenen en dat alle informatie over derden voor zover nodig volledig geanonimiseerd wordt. Het is belangrijk dat de ondervraagde in deze fase duidelijk inziet wat het belang van zijn/haar medewerking aan dit onderzoek is. Aangezien IOM en “terugkeer van asielzoekers” in de sommige contexten geen onbeladen thema’s zijn moet er voor een vruchtbaar interview duidelijk gemaakt worden dat er aanbevelingen mee zullen worden opgesteld die de *hulpverlener* in de praktijk van dienst zullen zijn, juist in situaties waar ethisch geen eenduidig antwoord gegeven kan worden. Een voorbeeld dat ook in het interview kan worden voorgelegd is de situatie van de uitgeprocedeerde asielzoeker die slechts de keus rest tussen repatriëring of de illegaliteit.

Als deze punten besproken zijn wordt het eigenlijke interview begonnen met de volgende vraag:

“Er wordt wel gezegd dat terugkeer in elke fase van het bestaan van een asielzoeker of vluchteling een rol kan spelen. Op wat voor manieren heeft U hier zelf ervaring mee in Uw werk met asielzoekers of vluchtelingen met een psychotische stoornis?”

De interviewer probeert hierbij de ondervraagde zoveel mogelijk concrete voorbeelden uit de eigen ervaring te laten gebruiken. Bij voorkeur worden daarbij de volgende punten integraal *per casus* nagelopen;

- *Hoe gaat de ondervraagde om met een cliënt met een psychotische stoornis die gedachtes uit over een mogelijke terugkeer naar het land van herkomst?*
- *Op wat voor manier speelt het begrip wilsbekwaamheid een rol bij de terugkeer van cliënt en met een psychotische stoornis en aan de hand waarvan stelt de ondervraagde dit vast ?*
- *Op wat voor manier speelt de diagnose en prognose na repatriëring een rol in het denken en handelen van de ondervraagde in deze context ?*
- *Op welke kennis en vaardigheden beroept de ondervraagde zich in zulke momenten en wat denkt hij/zij te ontberen ?*

- *Wat voor gedachtes heeft de ondervraagde zelf wel eens gehad over de mogelijke terugkeer van zijn cliënten met een psychotische stoornis?*

Tijdens het interview zouden aan de hand van deze vragen (zoveel mogelijk van) de volgende onderwerpen aan bod kunnen komen (deze zijn afgeleid van de werk-lijst criteria in Appendix I). Het is echter niet de bedoeling om deze lijst af te lopen tijdens een interview. Wanneer een ondervraagde bepaalde onderwerpen in een casus niet noemt wordt er van uitgegaan dat deze niet relevant waren voor de besluitvorming in dat specifieke geval.

- Het vaststellen van wilsbekwaamheid
- Het vaststellen van aard en prognose van de stoornis in NL en LvH
- Het belang van co-morbiditeit met andere stoornissen
- Het vaststellen of een stoornis in het land van herkomst reeds (latent) aanwezig was bij de cliënt en het belang daarvan
- De plaats van familie of steunsysteem in dit proces
- Het inschatten van psychosociale stress in het land van herkomst
- Bepalen van de invloed van de politiek juridische situatie op de cliënt
- Bepalen van de aanwezigheid van minimaal vereiste zorgvoorziening
- Inschatten van mogelijke behandelmethoden en de effectiviteit daarvan in land van herkomst
- De rol van financiële middelen in het repatriatieproces
- Het belang van en methode van het inschatten van de mate van integratie hier en te verwachten herintegratie in land van herkomst
- De geobserveerde relatie tussen stress rond het thema terugkeer (bijv. dreigende uitzetting) en de mate van decompensatie van een cliënt.
- Het mogelijke taboe op meewerken aan repatriatie door hulpverleners dat een objectief oordeel in de weg kan staan

Wanneer de ondervraagde geen gevallen uit de eigen ervaring kent van cliënten met een psychotische stoornis maar wel met cliënten andersoortige problemen heeft gewerkt waarbij terugkeer een relevant thema was, wordt bezien in hoeverre deze informatie bijdraagt aan het inzicht in de bovenstaande punten.

In het geval dat men uit de eigen praktijk en ervaringen niet genoeg voorbeelden kan oproepen om al deze thema's rond terugkeer met een psychotische stoornis te bespreken kunnen vragen hypothetisch worden gesteld in de vorm van bijvoorbeeld de volgende herkenbare situatie van een uitgeprocedeerde asielzoeker.

- *“Stel U hebt een cliënt met een psychotische stoornis die uitgeprocedeed is en het land moet verlaten. U krijgt te horen dat U Uw hulpverlening moet afbouwen en vervolgens afsluiten. Hoe ziet U dan Uw eigen rol in deze laatste fase van Uw professioneel contact en hoe weegt U de mogelijkheid van vrijwillige terugkeer af tegen de andere mogelijkheden van Uw cliënt, zoals de illegaliteit van Nederland of doormigreren?”*

Bij afronding van het interview wordt de ondervraagde bedankt voor de medewerking en de mogelijkheid voorgelegd om het uiteindelijke verslag van het onderzoek en de lijst met aanbevelingen toegestuurd te krijgen in December.

Appendix III: Literature Review

In the following the results of the literature review are presented. The review was intended to summarize some of the recent theoretical and empirical issues that are relevant for health workers dealing with schizophrenic asylum seekers/refugees and voluntary return. In the first chapter general information on schizophrenia is discussed that is relevant for return migration. In the second chapter psychosocial aspects surrounding return are discussed including cultural differences in perceptions of mental illness. In the third chapter the concept of mental competence is explored in relation to the expression of the decision of a schizophrenic client to return to the country of origin. No attempt was made at an exhaustive review and the following should be seen as an exploration of the various issues that could be relevant for health workers in this situation. The specific situation of clients will always have to be assessed individually and information presented here should be followed up on and further investigated before applied to the situation of any client.

1. Schizophrenia Symptoms and Classification

The psychiatric category “schizophrenia” has a relatively short history. It was only in the beginning of the twentieth century that psychiatrists like Bleuler and Krapelin proposed that one disorder (“schizophrenia”) was the common cause for a number of symptoms that in many non-Western or non-medicalized settings are often associated with the more ambiguous terms “mental illness” or even “madness”. These symptoms were hallucinations, sustaining bizarre ideas, attention deficits, inappropriate emotional responses and stereotyped motor behaviour (Birchwood & Jackson, 2001).

Symptoms of schizophrenia are generally grouped in two categories. In the first category, the so-called “positive symptoms” are considered to be an addition to a person’s repertoire of behaviour and thoughts. These thus include hallucinations, delusions and disordered speech. In the second category, so-called “negative symptoms” are those changes in mental and social functioning that are evidence of a diminishing of a person’s capacities. These include lack of energy and initiative, poverty of speech and social withdrawal (ibid.).

Some researchers have recently proposed that two categories may not be the best way to group the symptoms and, for example, a three-factor model may be more appropriate (Malla, Ashok, Norman, Williamson, Cortese & Diaz, 1993). The symptoms associated with “schizophrenia” would be categorized better by the factors “psychomotor poverty”, “disorganization of thought and affect” and “reality distortion” (as evident in delusions and hallucinations) (ibid.; Walker, Lewis, Loewy & Palyo, 1999). Combined with the fact that prognosis of schizophrenia has been shown to vary very widely (Birchwood & Jackson, 2001; see below) such a perspective has led some researchers and theorists to conclude that the syndrome view of schizophrenia might be flawed. It has been proposed that the various symptoms might not always have the same common cause in each individual after all. As an alternative it has been proposed that it would be more productive to study symptoms separately (Bentall, Jackson & Pilgrim, 1988).

In everyday clinical practice, however, such theoretical considerations are obscured by the widespread use of relatively straightforward categorical classification systems DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1992). In Europe the DSM-IV is mostly used (Birchwood et al., 2001). A person gets diagnosed with schizophrenia by the DSM-IV when, during a one-month period, two or more of the following symptoms are present: delusions, hallucinations, disorganized speech, disorganized/ catatonic behaviour or negative symptoms such as affective flattening. Other requirements for the diagnosis include a six-month period of social and/or occupational dysfunction and the absence of a medication or drug use (APA, 1994).

Because of its categorical design the DSM-IV prohibits the diagnosis of schizophrenia in people whose psychotic symptoms are related to a mood disorder. In practice it has often proved difficult to make this distinction (Birchwood & Jackson, 2001). One way out of this has been the concept of the “schizo-affective” disorder in which elements of a mood disorder and schizophrenia are combined (APA, *ibid.*). A consensus is emerging that in fact the categorical perspective might have to be abandoned in favour of a continuum view in which no clear cut natural boundaries exist between the disorders that in the DSM are considered unrelated. As such, unipolar affective illness would occupy the one end of the spectrum; the middle would contain bipolar affective disorders, followed by schizo-affective disorders. The far end would then be reserved for full-blown schizophrenia (Crow, 1986).

Other possible diagnostic alternatives are so-called “co-morbidities”, such as a depression produced by the effects of a schizophrenic disorder. Discriminating between comorbidities and schizophrenic affective disorders is based on the duration and onset of both the affective and the schizophrenic symptoms and whether there are periods in which one occurs without the other (Selten, 2002).

Biomedical considerations

Schizophrenia is relatively common and is estimated to affect about 1% of the population both in Western and in non-Western settings (Birchwood et al., 2001). In the field of schizophrenia research it is widely accepted that the illness is a universal phenomenon that is not linked specifically to Western culture (WHO, 1979; Jablensky, Sartorius & Ernberg, 1992; Waxler, 1979; Ogawa, Miya & Watarai, 1987). The core symptoms of delusions and hallucinations have proven to be robust in cross cultural research, although their contents do vary depending on the culture and context of the person (White, 1995; Bhugra, 2000).

Schizophrenia is seen as an illness that has a strong biological substrate. It has been shown that people diagnosed with schizophrenia show a number of abnormalities in brain structure and biochemistry, such as enlarged ventricles and overactive dopaminergic neurological systems (Videbeck, 2003).

Treatment thus invariably includes some kind of pharmacological intervention. This is usually in the form of anti-psychotic medication (also known as “neuroleptics”). It is important to note that medication is prescribed to manage the symptoms of the illness and reduce relapse rates and but is not known to cure schizophrenia or prevent psychotic relapse altogether (Leucht, Barnes, Kissling, Engel, Correll & Kane, 2003; Birchwood et al., 2001). Neuroleptic medication is given either

temporarily as a treatment for acute symptoms or continuously to decrease the risk of relapse in people whose symptoms are absent or under control (this is called “maintenance therapy”). Generally the dosages given for acute symptoms are higher than those for maintenance therapy (Birchwood et al., 2001).

There are two kinds of antipsychotic medications. The older are usually referred to as conventional antipsychotics and operate as dopamine antagonists. They reduce positive symptoms (e.g. Hallucinations, delusions) but not the negative ones (e.g. lack of volition, anhedonia or social withdrawal) (Marder, 2000; Videbeck, 2003). Common conventional antipsychotics are: Haloperidol, Chlorpromazine, Trifluoperazine, Fluphenazine, Thioridazine, Mesoridazine, Thiothixene, Loxapine, Molindone, and Perphenazine (Videbeck, 2003). Antipsychotic medications can cause serious neurological and non-neurological side effects. Neurological side effects include (sometimes irreversible) movement disorders, involuntary movements of head, neck and tongue, seizures and the sometimes fatal “Neuroleptic Malignant Syndrome”. Non-neurological side effects include excessive weight gain, sedation and anticholinergic symptoms such as dry mouth, blurred vision or constipation. These side effects can be very frightening and discomforting to a patient and often constitute a primary reason for discontinuing or reducing the prescribed dosage of medication (Videbeck, 2003). For patients that require medication adherence over longer time periods (in maintenance therapy for example), it is sometimes possible to administer the drugs in the form of depot-injections that last 2 to 4 weeks. Depot medication is currently only available with the conventional antipsychotics haloperidol and fluphenazine (Videbeck, 2003).

More recently the so-called “atypical” antipsychotic drugs have become available in Western countries. These work as both dopamine *and* serotonin antagonists and reduce negative symptoms as well as positive symptoms. Most used atypical antipsychotics are Risperidone, Clozapine, Olanzapine, Quetiapine and Ziprasidone (ibid.). One of the advantages of atypical neuroleptics is that they tend to produce fewer side-effects and thus increase the likelihood of medication adherence. This adherence in turn has been hypothesized to lower the risk of relapse (Leucht et al., 2003). The determination of the kind of drug to be used must be done separately for each individual and often takes the form of a trial-and-error procedure. As side effects differ from person to person and some people respond better to certain kinds of drugs than others, patients can sometimes try a number of drugs before an acceptable alternative is found. It has also been noted that a significant percentage of people diagnosed with schizophrenia do not respond favourably to neuroleptic treatment at all (Birchwood et al., 2001).

For health workers dealing with non-Western patients it is important to realize that drug metabolism is affected by a person’s genetic make-up. In practice such differences will often overlap with a person’s ethnicity. Videbeck (2003) notes for example that Asian American clients need lower doses of drugs such as haloperidol (a conventional antipsychotic) to obtain the same drug level in the blood stream as compared with African, Caucasian and Hispanic Americans. It has been reported that Ashkenazi Jews have an increased risk of developing a blood disorder as a result of certain antipsychotic medication (Burroughs, Maxey & Levy, 2002) Such information can be especially important when dealing with people whose genetic make-up might be considered to differ from the usual patient population. Given the severe side effects that these drugs can cause, it points to the need to individualize psychopharmacological treatment.

Linking biological and psychosocial issues: stress vulnerability models

The development of schizophrenia is considered to be the result of an interaction of biological and genetic vulnerabilities on the one hand and psychosocial stressors on the other. Zubin and Spring posited a “vulnerability-stress” model in the 1970s that remains central to the way the onset and particularly the relapse of persons diagnosed with schizophrenia is conceived (Zubin & Spring, 1977; Neuchterlein et al., 1994; Schuldberg, Karwacki & Burns, 1996; Yank, Bentley & Hargrove, 1993). At present a number of different “vulnerability-stress” models are in use that differ mostly in what is considered vulnerability and what is considered a stressor. The models provide clinicians with a framework that allows them to integrate the relatively unrelated (neuro-) biological and psychosocial approaches to schizophrenia in their treatment strategies (Yank et al., 1993). Although the stress-vulnerability model is also given as an explanation for the onset of the illness, this is more controversial than its application to the prediction and theorization of subsequent relapses into psychotic episodes (Jablensky, 1986).

Vulnerability is usually conceived of as a biological (and possible genetic) propensity to develop the psychotic symptoms of the disease when faced with a certain amount of psychosocial stress. For individuals with a high vulnerability, the threshold for stress is lower and they will decompensate at correspondingly lower levels of “objectively measured” stress (Neuchterlein et al., 1994; Schuldberg et al., 1996; Yank et al., 1993).

Many theories have been put forward to define what constitutes vulnerability in the above sense (Yank et al., 1993). These include cognitive defects, chronic overarousal of the autonomic nervous system, disruptions of basal hypothalamic-pituitary-adrenal rhythmicity, cortisol concentrations and abnormalities in the immune- and central nervous system (e.g. Gispen-de Wied, 2000; McGrath, 1999; Walker et al. 1999; Birchwood et al., 2001; Yank et al., 1993; Moeller, Bottlender, Wegner, Wittmann & Strauss, 2000). Depending on the theory, a number of different interventions proposed vary similarly, ranging from social skills training to neuroleptic medication (ibid.).

A similar amount of hypotheses have been proposed to define what factors constitute the stressors that induce relapse (and possibly first onset) in vulnerable persons. These are usually described in psychosocial terms of stressful “life events” (i.e. the death of a relative, the loss of a job or, as will be discussed below, stress concerning migration) or chronic environmental stressors in the shape of interpersonal difficulties or a lack of social support (ibid., Birchwood & Jackson, 2001; Neuchterlein, 1994; Yank et al., 1993; Freeman, 1994).

Prevalence

In contrast to the prevalence of schizophrenia (which has been shown to be around 1 per cent around the world), the course and outcome of schizophrenia has repeatedly been shown to differ in different geographical, social and cultural locations (e.g. Fenton, Blyler, Heinssen, 1997; Geabel & Frommann, 2000; Jablensky, 1992; WHO, 1979; Waxler, 1979). Moreover, epidemiological studies have repeatedly found that rates of psychosis and schizophrenia are higher in urban areas than in rural areas (Freeman, 1994; Marcelis, Navarro-Mateu, Murray, Selten & van Os, 1998; Marcelis, Takei & van Os, 1999). Similarly it has been observed that incidence of schizophrenia is higher in migrants and certain ethnic groups in Western countries. For example, a higher risk for schizophrenia

has repeatedly been reported for Afro-Caribbean immigrants in England (e.g. Bhugra, Leff & Mallet, 1997; Brekke & Barrio, 1997) and for Surinamese, Dutch Antilles and Moroccan born immigrants in the Netherlands (e.g. Selten, 2002). These heightened incidence rates range from 1.7 to as much as 13.2 (Eaton & Harrison, 2000). Heightened risk of schizophrenia has also been reported for second-generation immigrants and is sometimes found to be even higher than in first-generation immigrants (Bhugra, 2000).

Interestingly enough it has also been reported that the “sending countries” of these immigrants have rates of schizophrenia that are similar to the lower rates for majority-group native born individuals in Western countries (Selten, 2002; Cantor-Graae, Pederson, McNeil & Mortensen, 2003; Bhugra, 2000).

These findings are consistent with a large body of research building upon a multinational and longitudinal WHO study (e.g. WHO, 1979; Jablenski et al., 1992, Waxler, 1979). A second and more controversial outcome of most of these studies is that the prognosis of schizophrenia could be more benign in developing countries (Jablenski et al., 1992; Hopper & Wanderling, 2002). This has also been reported for some ethnic minority groups in Western countries compared to the white majority (Eaton & Harrison, 2000).

Although these findings are often treated as if their scientific validity has been proven, some writers remain sceptical and point to widespread shortcomings in the research designs on unresolved theoretical issues in this body of literature (e.g. Cohen, 1994; Edgerton & Cohen, 1992). Prognosis of schizophrenia, for example, is actually not better for all cases of schizophrenia but only for a subgroup with “mild” symptoms. For those suffering from severe schizophrenic symptoms (about one-third both in the Western and developing countries) prognosis was poor, irrespective of country or culture (ibid.). Furthermore, it has been pointed out that in developing countries the number of patients whose schizophrenia had an acute onset was twice as great as in the Western sample. Given the fact that these are predominantly hospital based studies and that in developing countries fewer hospital beds are available for mentally ill patients, it is possible that only acute cases needing immediate attention were seen in the hospital. If this were the case there would be no way of knowing if the better prognosis of these acute cases is representative of the many schizophrenics that never entered the hospital (ibid.)

Explanations for higher incidence amongst migrants

As was mentioned above, the factors that actually make a person schizophrenic in the first place should not be confused with the factors that induce relapse in already schizophrenic persons (e.g. Freeman, 1994). Although it is not impossible that factors responsible for onset also induce relapse and severity of symptoms, it remains important to distinguish explanations for the differences in occurrence from differences in prognosis. Differences in occurrence are generally derived from the number of people in a population that present with the symptoms of schizophrenia as defined by a classification system like the DSM-IV. In these studies correlations between social markers like gender, socio-economic status or ethnicity and the occurrence of schizophrenia are taken as the empirical data on which conclusions about the incidence are based. Differences in prognosis on the other hand can be found only in longitudinal studies in which the severity of symptoms and the amounts of relapse are also investigated (such as the WHO- “determinants of outcome study”,

(WHO, 1979; Jablenski et al, 1992; Hopper & Wanderling, 2002; Goater, King & Cole, 1999). Generally, however, explanations for occurrence and prognosis of schizophrenia are not always clearly separated in the literature (Edgerton & Cohen, 1994) and causes of the actual occurrence of the illness are given more attention than prognosis.

To explain the heightened incidence of schizophrenia in inner city and migrant populations, a number of causes have been proposed that can be categorized as either a version of the “drift” hypothesis or the “breeder” hypothesis (Freeman, 1994). The “drift” hypothesis holds that people that already started to develop schizophrenia will experience more stress in their social environment because of their pre-morbid maladjustments and deficient social skills. As a result they will be more inclined to migrate or to move into inner city areas where low-skilled work is more readily available, social control is less stringent and housing is cheaper.

The poor conditions in which inner city residents and migrants eventually develop schizophrenia are thus not seen as causing the disease but simply sought out by these individuals because of their condition. However, it has also been noted that, for first-generation immigrants, health problems are much more likely to occur in a secondary phase of migration in which their stay takes on a more permanent character (i.e. a stay of multiple years; Bhugra, 2000).

The “breeder” hypothesis contends that there are factors associated with the process of migration and subsequent reintegration itself and inner city life that do influence the incidence of schizophrenia in these populations. Some of these are non-social, such as exposure to infectious diseases, air pollution, toxic wastes and heavy metals such as lead. Others environmental factors that are thought to produce an increased incidence in these populations are social, such as an increase of stressful life events in urban or Western contexts, increased social isolation, lack of control over the living environment and “over stimulation” due to overcrowding (Lewis, Andreasson & Allsbeck, 1992; Freeman, 1994).

Although the “drift” hypothesis can explain higher incidence, it has shown that it cannot explain fully the incidence of schizophrenia in migrants coming to Western countries such as England and Holland. It has, for example, also been found that, in second-generation immigrants, an even higher incidence of schizophrenia can occur in some circumstances (ibid.; Bhugra, 2000). It is therefore considered plausible that a number of social factors associated with migrant and minority status *after migration* induce schizophrenia in genetically vulnerable persons as well (ibid.). Social and economic disadvantage (expressed in real life problems such as unemployment, poor housing, poverty and low socio-economic status) have been proposed as the most obvious long-term environmental stressors that could eventually lead to the development of schizophrenia in vulnerable persons. This social and economic disadvantage has been linked to institutionalized and individual racism in Western countries such as England and Holland (ibid.). Other less easily measurable factors that are hypothesized to produce prolonged stress in long-term migrants are a marginalized cultural identity and the culturally specific demands on personal autonomy in Western societies (ibid.; Harrison & Eaton, 2000).

For an individual faced with a specific choice in a specific context, it is important to be careful not to jump to conclusions when faced with statistics of increased incidence among migrants and better

prognosis for some cases of schizophrenia in the developing world. As of yet, no literature has been published dealing with the case of schizophrenic migrants returning to their countries of origin and, as such, we have no way of knowing whether such statistical findings would have any relevance for schizophrenics with a history of migration. Given the fact that relapse is associated with stress, it is important to realize that successful return and reintegration of schizophrenics depends on more than merely medical preparations.

2. Psychosocial aspects of return

Psychosocial problems of migration in general

In order to understand what the psychosocial aspects of return migration are, it is necessary to have a good understanding of the clients' situation in the host country. As was noted in the previous chapter, some studies show migrants can suffer from worse mental health (Bhugra, 2000).

We will now discuss some theories and findings in this field of research so that a better understanding can be gained of the psychosocial problems that asylum seekers, rejected asylum seekers and refugees in the Netherlands have to deal with. With a better knowledge of the psychosocial stressors in the Netherlands it will become possible to compare them to the psychosocial situation in the country of origin.

In much of the literature it is assumed that health problems result from migration because migration is a life changing event in which all aspects of a person's health (i.e. physical functioning, mental functioning and social functioning) are exposed to stress (Hondius, Willigen, Kleijn & Ploeg, 2000). Knipscheer & Kleber (1998) describe migration as a process in which people are first uprooted from their place of original residence, then go through a liminal phase in the host country and eventually settle down and reintegrate into the new society. In the liminal phase, migrants have to come to terms with a number of different changes in their life. These changes take place on the physical level, the biological level, the cultural level, the social level and the psychological level (Berry, 1992).

Characteristic transitions faced by migrants are, for example, the separation from family and partner and associated homesickness and concerns about their relatives' well-being (Knipscheer et al., 1998; Hondius et al., 2000). The transition from a rural to an urban situation and associated problems with housing and housing conditions are also considered important (ibid.). Other potential changes include a different climate, different nutrition, new cultural patterns of behaviour and difficulties in partaking in one's religion (Arowolo, 2000). Yet other issues that have been mentioned are problems with discrimination, racism and the sense of being a second-class citizen. The situation for refugees and asylum seekers is complicated by an unclear legal status that by definition increases the liminality of the person. Long stays without legal status and the associated passive waiting can be great stressors in themselves (Knipscheer, 1998).

It has been estimated that up to 40 per cent of all health-related complaints of migrants are actually related directly to aspects of the specific post-migration situation of many asylum seekers, rejected asylum seekers and refugees (Hondius et al., 2000; see also Sundquist, Bayard-Burfield, & Johanssen, 2000). For South American refugees in exile, for example, the best predictor of

depression was poor social support and not the fact that many had also suffered torture and abuse (Hondius et al., 2000).

Mediators of migration-related stress

It must be emphasized that not all migrants (or all asylum seekers, rejected asylum seekers and refugees for that matter) suffer from poor health because of these transitions. It is therefore necessary to understand under which condition these transitions become stressful and cause health problems.

The notion of “acculturation” proposed by Berry (1992) can be useful to understand how these migratory experiences can affect migrants in different ways. Acculturation is defined as the changes that occur when two distinct cultural groups come into prolonged first-hand contact with each other (ibid.). For the individual migrant in a new society, acculturation is unavoidable but the ways in which the person adapts to the new situation can vary.

When acculturation is accompanied by reduction in the individual’s health (as broadly defined above) this is termed “acculturative stress”. The occurrence of such “acculturative stress” can be influenced by a number of factors. For example, less stress is experienced when the host society is tolerant of difference, if the migration was undertaken voluntarily and when migrants have adequate coping strategies at their disposal. Acculturation theory also posits that there are different ways in which people acculturate to a new society and this can be important for understanding the stress that is experienced (ibid.).

The kind of acculturation depends on whether a migrant considers it of value to maintain relationships with other cultural groups in society and whether he or she wants to maintain pre-migration cultural identity and characteristics. With these two dimensions four different types of acculturation can be distinguished. When cultural identity is preserved and contact with other groups is maintained, a person is considered “integrated”, but when cultural identity is given up and contact with other groups is maintained, eventually a migrant will be indistinguishable from native cultural groups and is thus named “assimilated”. When cultural identity is preserved but contact with other groups is avoided, this is considered “separation” and when this cultural identity is lost or given up, a person will become “marginalized”. This notion of differential acculturation has proven very popular with researchers in pluralist multicultural countries. Not surprisingly it was clearly stated in the original theory that “integration” was the best way to acculturate while remaining healthy (ibid.).

However, it has also been criticized for a number of reasons. For one, the theory assumes that people either hold on to their cultural identity completely or otherwise assimilate completely. The possibility of a bi-cultural identity is thus not acknowledged. It has also been proposed that some people have an “orthogonal” cultural identification in which they identify with both cultures in different aspects of their lives. The result of such differential cultural identification sometimes extends so far that the culture of some migrants is at least as removed from the culture of their country of origin as from the dominant culture in the host society. In such cases it has been proposed that acculturation actually results in a new hybrid “migrant culture” (Meurs, 1996; Knipscheer, 1998). Such a culture can superficially resemble the culture of the country of origin (for

example, the culture of Chinese immigrants in Holland) but in effect it has been influenced by the culture in the host country in a profound way and has become incommensurable with the original culture (Knipscheer, 1998).

Psychosocial aspects of return migration

Problems with return migration increase with a longer stay in the host country, a younger age at migration, a more extensive assimilation into the host country's culture while away and less contact with the people back home while away (Arowolo, 2000). An example of problems with return is that rural people that have acquired a city lifestyle while they were away must be "ruralized" when they return home in order to function in the community (ibid.). It could thus be argued that, for migrants that have been away for a considerable amount of time (i.e. years), return to the country of origin will often take the shape of a return *migration*. In the light of problems such as the need to be "ruralized" after a lengthy stay in an urban area it could be argued that return migrants face the same trials of acculturation and (re-)integration as migrants do (Mateman, 1999).

There are very few frameworks available for theorizing the dynamics of re-integration after return to the country of origin (Arowolo, 2000). However, three points can be made at this juncture that can be useful in assisting potential returnees.

First, psychosocial problems surrounding return are related to the changes that migrants have undergone while they were abroad. Second, after years of foreign residence the situation in the country of origin will usually have undergone changes as well (even if it is only because family and friends have aged). Especially when people have been away longer and continuously, such changes can be dramatic and come as a surprise to the returnee. A third point on return migration is that reasons for return to the country of origin are often intimately connected with reasons for migration to the host country in the first place (Mateman, 1999; Schell & Muller, 2000).

To illustrate, Meurs (1996) describes the case of an elderly Moroccan immigrant in the Netherlands. This man had worked for 30 years in France while his family lived in Morocco. He had recently retired and, although he had planned to retire in his native village, neglected to do so. He had developed some serious mental problems that caused him to be admitted to a psychiatric hospital. Meurs shows how the notion that he was working for a better future for his children and the promise that he would eventually retire in his village as a successful and respected man enabled him to withstand 30 years of isolation from his family and village. Upon retirement, however, he discovered that both he and his idealized home had undergone too many changes to make such a triumphant and unproblematic homecoming possible. His children had moved to the city and developed an "urban" lifestyle, while he himself had clung to his "rural" identity even in an urban French context. Also, he did not feel like he fitted in his old village anymore because what he had preserved as his authentic way of life was very different from the way village life had developed there.

Meurs (1996) proposes that this Moroccan man was in fact trying to return to the situation from which he thought he had emigrated 30 years ago. He proposes that the stress and psychological breakdown that the man suffered as a result of his confrontation with reality upon return would

have been considerably less if he had been assisted in interrogating his expectations surrounding his return and effortless reintegration.

Psychosocial support for return migrants

Although most attention surrounding return migration has concerned the actual repatriation and not subsequent reintegration, some methodologies have been designed to guide health workers in supporting returnees on a psychosocial level. Schell & Muller (2000) describe the process of reintegration in four consecutive steps. At first arrival, return migrants experience mostly euphoria over their reunification with family and friends. After this initial period, a gradual awareness starts to develop that behaviour and values of family and friends on the one hand and oneself on the other have developed in different ways during the period of migration. After this, feelings of homesickness can develop, which must be resolved in a final phase through renewed acculturation to the situation of the country of origin. If the returnee does not succeed in this, he or she risks isolation in the community (ibid.).

Reintegration is further complicated if there are difficulties securing a new residence, employment or a social network. For children who have spent the largest part of their lives in another country, the parents' country will be completely alien and reintegration will thus be an even more difficult task (Arowolo, 2000).

Mateman (1999) has summarized that all return migrants can be confronted with nine different kinds of psychosocial challenges upon return in their country of origin.

First, it is important for returnees to feel safe in their country, region and city when they return. Second, changes may have occurred in the social environment while the returnee and his/her relatives and friends were separated. If the returnee does not expect these changes, return may be more stressful. Third, when a returnee is very well integrated into the host society it will be difficult to leave because of the investment that has been made in the host society. Fourth, it is important to discuss with returnees that return migration is in a very strong sense a new start. It is not possible to simply pick up where one left off and it is important to realize the effort that will go into resettling in the country of origin. Fifth, living conditions in the country of origin may dictate to what extent it is possible to secure employment, housing, health care and education. The political climate is also an important point to consider before returning. Sixth, it is possible that the country of origin is idealized during the stay in the host country. The realism of these expectations are often better tested before returning to prevent disappointment upon arrival. Seventh, the relatives in the country of origin may expect the returning person to take up certain responsibilities and this can result in conflict and uncertainty during the first period after return. Eighth, a social network is often very helpful in aiding a person in reintegrating into society but may not be present. Sometimes it can be useful to assess which people can be asked for help in the first period before the return journey. Ninth, the stresses and challenges of return and reintegration can lead people to question themselves in a manner that could be called an identity crisis. They can become highly aware of missed opportunities and limited options for the future (ibid.).

Mateman distinguishes six further psychosocial issues that can affect only specific kinds of return migrants (such as children or refugees). First, trauma experienced in the country of origin will often

cause the returnee renewed anguish upon return. Second, if country of origin was left to escape ethnic conflict, it is highly probably that the society will have undergone marked changes for which it is better to be prepared. Third, some returnees may feel guilty about having left (especially refugees). Fourth, returnees can behave and be received with a considerable amount of distrust because of what happened before they left. Fifth, children that have lived in the host society for the largest part of their lives will be very reluctant to migrate to their parents' country of origin. This can lead to conflict and stress within the family. Sixth, asylum seekers that have waited for years until their application was decided on will sometimes have developed passivity and lowered sense of self esteem that will have its consequences when efforts have to be made at reintegration in the host country (Mateman, 1999).

Discussing return

An important issue for health workers is how and when such aspects of return migration should be discussed with clients. Mateman (1999) and Schell & Muller (2000) propose that assisting migrants psychosocially can occur in three different phases of the return process. In the first phase, called the orientation phase, return is considered by the client but sometimes not openly discussed. The second phase is entered when a decision is made to return. At this point the health worker and the client can begin concretizing the return and discussing the different aspects that may be relevant to prevent stress and lead to good integration. The third phase of return occurs when the client has returned to the country of origin and must face the challenge of reintegrating. Although it is most important that agencies in the country of origin provide support for the returnee, it can also be helpful to anticipate the problems of reintegration with the client so that he or she comes prepared. Schell has elaborated this method beyond the scope of this literature and we thus refer the reader to the original text if they are interested (Schell & Muller, 2000)

Culture in the country of origin

It is important to be aware of the possibility that mental illness and schizophrenic symptoms in particular are sometimes interpreted very differently in different non-Western cultures.

According to Castillo, there are five ways in which culture affects mental illness (Castillo, 1997). First, it can influence the patient's subjective experience. In the case of schizophrenic disorders this is usually taken to mean that the contents of delusions and hallucinations are influenced by culture. Second, the ways in which people can express their psychic discomfort is determined by so-called "idioms of distress". This means that people from different cultures will sometimes have very different ways of dealing with and exhibiting their psychic discomfort. Third, some categories of mental illness may actually be found only in certain cultural groups. As was discussed earlier, this is generally not the case for schizophrenia which is found in all cultures. Fourth, as was noted before, traditional treatment of mental illness is embedded within cultural perspectives on mental health. Fifth, outcomes of disorders have sometimes been shown to vary in different cultural settings (see the previous section for a discussion of this finding in relation to schizophrenia) (Castillo, 1997).

One important difference between the Western culture in which biomedical practice is embedded and many non-Western cultures is the individualism of the former and the collectivism of the latter (Ritts, 1999). In many non-Western cultures from which traditional healing is derived, interdependence and maintaining harmony of one's social group is valued much more than the

Western values of autonomy, self reliance and individuality of individuals (ibid.). Such values can also play a part in the cultural ways in which mental illness is perceived. For example, conceptions of schizophrenia have been shown to vary along these dimensions between first-generation Mexican immigrants in America and the majority white population (Jenkins, 1988). Whereas a large part of the Americans described schizophrenia using medical terms and used a biomedical explanatory model, the Mexicans often referred to the concept of “*nervios*” when asked how schizophrenic symptoms should be interpreted. *Nervios* can be defined as the loss of control over one’s life through stressful circumstances and has a parallel with the Western notion of a nervous breakdown. Jenkins argues that it is understandable that individuals from each group use different explanations of the illness because these explanations reflect their cultural values. Given that in Mexican culture the maintenance of family bonds is highly valued, the concept of *nervios* has two effects that the medical label “schizophrenia” may not have. On the one hand the concept of *nervios* absolves both the individual and their family from blame because it posits an external cause for the illness. On the other hand a notion of “nerves” is less stigmatizing and thus avoids the possibility that a schizophrenic family member will be seen as experiencing something so different and disturbing that the family can no longer identify with him or her. Through interpreting the relative’s symptoms as an extreme case of a condition that anyone can come to suffer from, the acceptance of the individual is increased and criticism is diminished (ibid.).

Better social support in some developing countries is sometimes thus related to a more benign view of mental illness and a more empathic attitude in general in developing countries (e.g. Okasha, 1999; Jenkins, 1988). However, such generalized assumptions must be made carefully given the fact that within all cultures schizophrenia can take a great variety of courses and many examples of maltreatment and ostracism of mentally ill in developing countries exist as well (Giel, 1984).

Moreover the link between a better social support system and the prognosis of a schizophrenic disorder is not yet explained by such a finding. One operationalization of the effects of a more supportive social climate for schizophrenics is the so-called “expressed emotion” hypothesis. Research in this field was initially based on the observation that relapse rates were often higher for subjects that returned to live with their family after discharge from the psychiatric ward than those that did not. It was similarly found that people living with their extended families in developing countries had a somewhat better prognosis than those that did not (El Islam, 1979). In subsequent research it was found that high levels of critical comments, emotional over-involvement and sometimes even hostility among the close relatives of schizophrenic patients were predictive of a higher likelihood of a psychotic relapse in the first 9 to 24 months after discharge from the hospital (Neuchterlein, 1992). These interpersonal attitudes and behaviours are referred to as “expressed emotion” and are said to result in an “over stimulating environment” for the subjects (Tarrier & Turpin, 1992).

It is hypothesized that a severe illness such as schizophrenia increases the burden that is placed on the caregiver, especially when they lack a proper understanding of the nature of the disease. The caregiver might then eventually become frustrated and critical of their psychotic relative because of the difficulties they experience in coping with the situation (Birchwood et al.; 2001, Tarrier & Turpin, 1992).

Thus it can be concluded that in some cases it can be important to determine what cultural definitions of mental illness and schizophrenic symptoms in particular are being used in the country of origin because these can influence the treatments that will be considered relevant and will be applied to a client on the basis of his or her individual symptoms. Cultural understandings of mental illness can also influence the ways in which families will be able to assist and live with their schizophrenic relative.

The notion of different cultural understandings is also important in the context of psycho-education which is often practised with relatives of patients with schizophrenia in Western countries. While psycho-education is often practised with the patient himself, it is often also offered to his or her immediate family. In both instances it is important to realize that psycho-education is an attempt to manipulate the symbolic framework of a person by introducing new ways of understanding the patient's behaviour that are in line with the tenets of scientific medicine (Stein, 2001). In some instances the difference between this medical discourse and the ways in which people make sense of the symptoms of schizophrenia in their own culture can be very large. In many countries incommensurable traditional conceptions of mental illness exist alongside Western medical discourses. Stein (2001) reports examples from Morocco in which patients became dissatisfied with the conceptualizations offered by both traditional healers and psychiatrists and were effectively faced with the challenge of finding a middle ground between these two institutionalized discourses.

In one instance she gives an example of how this can be effected in practice when she describes a situation in which a traditional healer actually accompanies a patient to the hospital because he suspects an organic mental illness to be the cause of the symptoms. The psychiatrist in turn included the traditional healer in the process by suggesting he could ensure the patient's medication compliance (ibid.).

In the direct context of return of schizophrenic clients such arrangements will often be impossible to make but these illustrations point to the necessity to at least be aware of the fact that Western biomedical psycho-education and treatment occur in a cultural context. When the client returns to the country of origin biomedical notions of mental illness will have to compete with other discourses of mental illness and behaviour of people involved may similarly undergo changes.

A number of interventions have been suggested in order to lower the risk for relapse that is produced by these psychosocial risk factors. These include giving both patient and their significant others information on schizophrenia, how to deal with its symptoms and information about the vulnerability-stress model in particular (this is usually referred to as "psycho-education"). It has also been advocated to teach problem-solving approaches to minimize escalation and impact of expressed emotion in daily life (Neuchterlein, 1993; Schuldberg et al., 1996; Yank, 1993).

Mental health care in the country of origin

In light of the possibility and desirability of the continuation of mental health care for a schizophrenic client, a number of medical issues in the country of origin can be important.

First of all, it is important to realize that official state mental health care provision in the Netherlands is considered to be of a very high standard compared to developing parts of the world

(see WHO, 1979; Rudaleviciene, 2000) and that it is unrealistic to expect the same level of Western medical care to be available in most developing countries in the world. According to the World Health Organization, most middle- and low-income countries devote less than 1 per cent of their health expenditure to mental health. As a result resources are often lacking acutely for the implementation and maintenance of mental health policies, legislation, community care facilities and treatments (ibid.).

In Nigeria, for example, social welfare programmes have been officially implemented for the mentally ill and community rehabilitation programmes are similarly present (ibid.). However, in practice, the shortage of personnel and funding is so great (for example, only one psychiatrist per 10 million people is available) that such programmes cannot be compared with the Dutch situation on the practical level. It has been estimated that 70 per cent of the population does not have access to health care in Nigeria (Ritts, 1999). In Nigeria the burden of care for the mentally ill rests with the individual's family (Ohaeri, 2001). The financial burden is also larger for the families in such a situation because they receive less support from the government. Costs of antipsychotic medication in Nigeria can constitute up to 52% of the expenses made for the client's schizophrenic disorder, whereas in a Western country medication typically constitutes only 2-5% of expenses made (ibid.).

The availability of antipsychotic medication can similarly be a problem in some areas. However in individual cases it can be important to assess the availability of some drugs at the local level, even when no expert psychiatric care is available. In Nigeria, for example, antipsychotic drugs fluphenazine, haloperidol and chlorpromazine are available at the local primary health care level despite the absence of functioning state mental health facilities. The World Health Organization website offers information per country on the availability of some common antipsychotic drugs at the primary health care level (<http://www.cvdinfobase.ca/mh-atlas/>). Treatment modalities may also differ from the Western norms. In Nigeria, for example, possible treatments not only consist of Western medical practices but are mixed with traditional practices and religious healing practices. In rural areas treatment is often not carried out by mental health experts trained in Western medicine but is the domain of traditional healers (Ritts, 1999). Nigerian traditional methods of treatment of mental disorders are based on conceptions of demonology and possession. These methods include flogging the patient and making ritual offering sacrifices. Restless or aggressive patients are sometimes restrained using ropes, handcuffs and leg chains (Ritts, 1999).

However, these examples of rural Nigeria should not be seen as typical of the whole of the country or even of all developing countries. In Ethiopia, for example, three cultural influences determine the ways in which mentally disturbed persons are treated in society outside of the sphere of Western medicine (Jacobsson, 2002). These are a traditional African culture, the Coptic Church and the Muslim culture. Although a general opinion regarding mental illness is that it is caused by evil spirits or bewitchment, the forms of treatment can vary to some extent. The Coptic Church, for example, offers spiritual healing practices that include priors, reading from holy texts, drinking holy water. In some monasteries people can stay for weeks or months to participate in these healing practices. In the traditional African context healers contact the spiritual world from which directives for treatment are derived. In the Moslem culture spiritual leaders similarly engage in religious healing practices but also practice healing through herbs and surgery. In Ethiopia (as in many other developing countries) these traditional healing practices are much more accessible than Western

medical facilities. It has been estimated that there are only ten psychiatric specialists for the country's 60 million inhabitants, which are almost all working in the capital Addis Ababa (Jacobsson, 2002). Further Western mental health services are available through specially trained nurses that work at most of the district hospitals of the country. These professionals only get to see the most severe cases of mental illness and in particular those suffering from psychotic illnesses. The milder cases usually seek out traditional healers and are treated by them (ibid.; Okasha, 1999; Raguram, 2002).

Thus in the Ethiopian situation on the one hand the concentration of Western medical services in the Addis Ababa capital limits its use in the countryside. On the other hand the severity and kind of mental disorder may play a role in the kind of help that is needed and sought after. Furthermore it has been noted that despite the mental health care situation in Egypt being slightly better of the outpatients at the Cairo university mental health clinic, 60% had been to traditional healers before coming to a psychiatrist.

However, in some developing countries mental health care is in a relatively better state. In Egypt, for example, 19 of the 24 governorates have their own psychiatric clinics and outpatient units for mental health patients. The country has 13 psychiatric beds per 100,000 population and this is considerably more than 0.7 beds per 100,000 that are available in, for example, Ethiopia. In contrast, however, the difference with the Netherlands remains vast, since 187 psychiatric beds per 100,000 are available (WHO, 2003). As was stated before, such a shortage generally means that much of the care for the patient falls on the shoulders of the family and treatment is often exclusively traditional.

3. Mental competence

In the previous section it was noted that the return to the country of origin is a process that can be divided into three phases (orientation, concretization and reintegration upon return). For the specific case of schizophrenic asylum seekers, rejected asylum seekers and refugees that is the topic of this research, all of these phases are complicated by their mental illness. In the orientation and concretization phases it is necessary for the health worker to know whether the expressed interest in a voluntary return on the part of the client is an expression of a genuine desire or merely symptomatological of the schizophrenic disorder. This so-called "mental competence" (in Dutch: "*wilsbekwaamheid*") of clients to make adequate and well informed decisions has received considerable attention in the literature.

When concerned with mental health care, this literature is usually concerned with the protection of either the client himself or other parties from harm that may come from his or her decisions or actions. In many cases the issue revolves around the client's consent for treatment, organ donation or participation in experiment (Biesart & Hubben, 1997).

The definitions of what this "mental competence" actually is that enables people to make adequate decisions varies a lot. One of the few points on which nearly all conceptions converge is that "mental competence" is never a global indication of a person's ability to pass judgement. It is

always related to a certain area of a person's life or even a single decision (Welie, 1999). As such, a person can be seen as perfectly capable of handling their finances but be considered unfit to decide on whether or not to go through with a certain life threatening medical procedure.

In juridical terms "mental competence" is considered absent when a person is unable to come to a "reasonable appreciation of his/her interests on a subject matter" (Berghmans & Widdershoven, 2002; translation mine). In the Dutch health care legislation this definition is central to the "Wet geneeskundige Behandovereenkomst" (WGBO) and the "Wet Bijzondere opnemingen in psychiatrische ziekenhuizen" (WBOPZ). These are laws that are designed to protect the interests and autonomy of clients. Much of the literature on the subject is similarly motivated towards maximizing autonomy and therefore focuses on the ability of clients to make independent decisions without influence from other parties (Welie, 2002; Berghmans & Widdershoven, 2002).

Generally four different types of criteria are proposed to assess mental competence to make decisions. These are:

1. The ability to make and express a choice,
2. The ability to comprehend relevant information,
3. The ability to appreciate the nature of the situation and the possible consequences and
4. The ability to process information in a rational way.

With the exception of the first (which separates those people that cannot express their wishes in any way from those that can) these criteria are strongly focused on cognitive abilities and rational thought and reasoning processes (ibid.).

Such a singular focus runs the risk of discriminating against psychiatric patients and especially those with a schizophrenic disorder since they often have impaired cognitive skills and problems with maintaining a rational train of thought (Jonker, 2002, Berghmans & Widdershoven, 2001). In order to maintain the schizophrenic client's autonomy in regard to his or her decision and prevent an unwarranted disqualification of their utterances on purely cognitive grounds, it is important to acknowledge the role that emotions have in decision making. Emotions can be expressions of deeply felt preferences and will motivate a person to take action in accord with these preferences (Frijda, 2001). One strategy for assessing the meaning of a client decision is to determine whether the emotions that have informed it are deeply and personally felt or based on more contextually based fear or uncertainty. Frijda has proposed to make emotions as important in the assessment of mental competence as cognitive considerations. As such, mental competence could be impaired when either:

1. The client lacks the ability to take into account the emotional and factual consequences of an emotion,
2. The client lacks the ability to determine which alternatives carry the most subjective weight,
3. The client lacks the ability to foresee future emotions and
4. The client lacks the ability to endure immediate negative emotional consequences to achieve some future goal (Frijda, 2002).

Which emotions are informing a decision can sometimes be unclear even to the client himself. It can therefore sometimes be helpful to discuss these with a client if they are capable of that (ibid.; Berghmans & Widdershoven, 2002).

However, this general focus on a person's "decision making capacity" (or more correctly person's lack thereof) has been criticized for its individualism. The notion of independent decision making is said to lack appreciation for the fact that decisions are never made in a vacuum but are always contextually and relationally produced. Such a "decision making capacity" approach simultaneously implies a specific relation of the health worker with the client in which the need to decide on matters in the life of the client lies either completely with the client or is alternatively in the hands of his carer.

It also obscures the fact that a judgement of mental competence by a psychiatrist is in practice a normative verdict that determines the extent to which a client's decisions can or should be considered meaningful and have moral implications. The assertion of someone's mental competence is thus not in the first place the stating of a fact but rather implies that the person will be treated in a certain way from then on. It has also been found that the judgement of "mental competence" is highly subjective up to the point that in one study 47% of health workers disagreed on whether their mutual client was mentally capable of making certain decisions (Biesaart & Hubben, 1997). Furthermore it was found that someone judged "mentally incompetent" is often not even consulted in small inconsequential matters like the choice of clothing despite the general tendency in Dutch health care to allow patients a maximum of autonomy.

Some approaches to "mental competence" therefore advocate to focus more on the process in which decisions are made than on the actual decisions and their outcomes per se (Berghmans & Widdershoven, 2002; Welie, 2002). From such a perspective the health worker is given responsibility not to simply determine the level of mental competence and either refrain from discussing a client's decision at all or paternalistically make their decisions for them. Instead he or she should help the client improve his or her competence and also aid in the decision making process in a number of ways.

The emphasis on providing the client with all necessary information and making sure he or she decides autonomously is thus reduced. Instead the capacity to make decisions is seen as a function of the client's ability to make his or her decision meaningful in his or her own life. Thus, while the symptoms of the schizophrenic disorder can influence a person's mental competence and need to be treated, an absence of symptoms therefore does not by definition constitute a sufficient condition to assume a client is completely mentally competent in this area of their life. Enabling clients to evaluate their decision and make it meaningful in their own life is possible by paying attention to three different domains of the interaction with the client. These are emotions, identity and dialogue (Bergmans & Widdershoven, 2002; Helle, 2001) which will now be discussed briefly.

Although emotions are not entirely neglected in cognitive approaches they are usually seen only as a secondary aspect that either enables or distorts rational cognitive thought. However, they can also be seen as an indication of the way a person is interpreting the world around them and the values that are implied in such an interpretation. In order to assess whether a person can competently judge

a situation, it pays to look at their emotional and affective reactions (and this is especially true in the case of clients with impairments in cognitive functioning such as is often the case for schizophrenic persons). The meaning of these reactions within the context of a particular decision can be interrogated and the question can thus be made what consequences such an emotional state should be given. When a client exhibits unexpected emotional responses in reaction to a certain proposal, then this could be a reason to investigate why they do so (ibid.; Frijda, 2002).

Such an investigation would also look into the second point on identity. The more conscious forms of decision making are preceded by a person's personal identity, their self-perception and identifications (ibid.). These identity-related concepts also determine the direction and shape of the more conscious forms of decision and are thus implicated in them. For people who have difficulty with lower mental competence, certain decisions can be problematic because they do not have a clear idea of where they stand as a person in relation to the decision. Helping them enlarge their decision making capacity in such cases translates in aiding in their quest for (re)discovering their identity in this respect and offering them possibilities of identification (ibid.). Increasing a client's mental competence is not an issue of providing a client with sufficient objective information about alternatives but much more the creation of a relationship between health worker and client through whom the client can find or create his or her position in this concrete situation, based on emotions, history and desires.

The test of mental competence is thus made by assessing whether a decision fits in the life of the client and this assessment should be made by both the health worker and the client together. A mentally competent person could thus be described as making authentic choices, which means that choices reflect the identity of the person. The third point made on dialogue emphasizes that there should be sufficient attention and discussion around the values and emotions of the client with the client him- or herself (Berghmans & Widdershoven, 2002). However, this does not mean that these values should be assumed as an unchangeable given. The values on which the client bases their decision should be resistant to a reasonable and healthy amount of deliberation and critique for the health worker. Through such critical dialogue the client is required to take a more deliberate stand on issues and question his or her own adherence to certain values. It is possible that the client thus changes his or her mind on certain issues because of discussions with the health worker (ibid.). However, unlike the cognitively oriented "decision making capacity" paradigm in which proper decisions are made without influence from others, this perspective does not see this as an indication that mental competence has been compromised merely because the decision was reached in cooperation with a health worker.

The point here is not that health workers should simply go along with their clients' wishes irrespective of their own opinions but rather that such considerations deserve to be given a place in the contact with the client (Welie, 2002; Helle, 2001; Berghmans & Widdershoven, 2002). Since non-schizophrenic people also make bad decisions, it is much more important to evaluate whether the decision is authentic and can withstand the test of deliberation and critique. By working through the various ways in which voluntary return would affect the life of the client and the ways in which return is related to the way he or she sees him/herself and the world the mental competence of the client in regard to this decision will be increased. In this view, mental competence is a construct that is intimately related to the relationship between health worker and client. In the last instance both

client and health worker will have to decide together whether the client has reached a sufficient level of mental competence with respect to the decision to return.

**Appendix IV:
Schematic example of case data**

C A S U S	Status/ verblijf in NL	Diagnose	*Land van herkomst * sekse * leeftijd	Soort hulp- verlener	Criteria	Knelpunten	Terug keer gefaciliteerd	Terug gekeerd ?
1	*Uitgeproc- edeerd 3..5 jaar in NL	*Chro- nisch psychto- tisch *gedrags proble- matiek, (ontrent)	*Somalië *Vrouw *38 jaar		* familie/ steunsysteem * gezondheids- zorg * mate van integratie * intelligentie * vaardigheid om te overleven * leeftijd * kans op decompen- satie door stress bij terugkeer en gebrek aan structuur	* Cliënt: blokkade, weerstand, ontwijking, vermijding * Dilemma: weerstand niet te doorbreken dus slechts symptoom- behandeling. * gebrek info over terugkeer * ethische dilemma's: - machteloos, - slechte prognose maakt het pijnlijk voor behandelaar, - schuldgevoel door mede werking aan terugkeerproces	Is nog in behandeling	nee