

The pains and gains of reception centres: How length of stay in reception centres is associated with Syrian refugees' mental health during early resettlement

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Abstract

In European countries, refugees await the approval of their asylum claim in reception centres. Scholars have repeatedly expressed concern about the consequences of a long reception period for refugees' mental health but the mechanisms that drive this negative relationship remain not fully understood. Using survey data from 481 Syrian refugees in the Netherlands, we show that the length of stay in reception centres was associated with an increasing number of forced relocations between reception centres, which weakened refugees' mental health during their resettlement up to 2 years later. In an attempt to improve refugees' mental health, reception centres now offer day-time activities. However, while we find that length of stay in reception centres was associated with more frequent participation in day-time activities, it did not substantially improve refugees' mental health. We call for policy makers to reduce the detrimental effects of a frequent forced relocations between reception centres.

INTRODUCTION

Since the summer of 2015, relatively high numbers of refugees from Syria were forced to flee their country and, consequently, have sought asylum in Europe. While awaiting the review of their asylum claim in the responsible country of arrival, refugees arriving in European Union member states are temporarily housed in assigned reception centres

(European Union, 1990). Refugees staying in reception centres often live in social isolation from the general population awaiting a discretionary decision over which they have little control, but which does determine their future. There is a significant body of qualitative studies illuminating the psychological stress and challenges while living in a reception centre. Refugees have described their experiences as 'humiliating' and 'a waste of time' due to limited access to the labour market, education or professional language training (Korac, 2003, p. 55). Experiences of passivity and uncertainty are common, and refugees describe feelings of boredom and excessive worrying about the future weakening their mental health (Boersema et al., 2015; Dupont et al., 2005). Additionally, quantitative studies have demonstrated that a lengthy reception period generally decreased resettled refugees' mental health, even many years later (Hallas et al., 2007; Hvidtfeldt et al., 2020; Laban et al., 2004, 2008). Hence, a prolonged length of stay in reception centres is viewed as 'anti-integrative' in that the combination of passivity, uncertainty and poor access to services can have long-term effects on mental health (Bakker et al., 2016, p. 7).

While length of stay in reception centres has been increasingly recognized as a significant factor in resettled refugees' future lives in the receiving society (Bakker et al., 2014), much less is known about exactly which organizational aspects of a long stay in reception centres determine longer-term outcomes. As mentioned in the title, we consider the following pains and gains of reception centres. Firstly, the potential pains of staying in reception centres: It has often been overlooked that as refugees spend more time waiting for an asylum decision, they are also more likely to experience multiple forced relocations between reception centres as the different stages of the asylum process are connected to different locations (Dourleijn & Dagevos, 2011). For example, in the Netherlands, it is standard for refugees to first stay in a central reception centre, then to be moved to another temporary location where their asylum request is processed, and from there to be moved to one or multiple longer-term but still temporary reception centres as the majority of municipalities is hesitant to accommodate more sustainable or permanent reception centres in their area (Unicef, 2013). Consequently, particularly during the peak of asylum applications in 2015 and 2016, this flexibility has led to even more relocations as the capacity appeared insufficient and more reception centres had to be opened (and later closed) to keep occupancy rates high (Wijkhuis & Van Duin, 2017). Despite studies demonstrating an adverse effect for frequent relocations between reception centres on the mental health of refugees and refugee children (Goosen et al., 2014; Nielsen et al., 2008), forced relocations have yet to be examined as a potential mechanism that could explain the detrimental effects of a long reception period. Secondly, the potential gains of staying in reception centres: In an attempt to improve living conditions in reception centres, refugees are increasingly encouraged to undertake day-time activities – particularly during a long stay in a reception centre. It has been argued that these activities are a way to improve wellbeing and offer opportunities to accumulate skills that facilitate integration into the receiving society (Engbersen et al., 2015). There is mostly qualitative evidence as to the positive relationship between refugees' mental health and participating in day-time activities, such as attending language classes and doing volunteer work (Boersema et al., 2015; Ingvarsson et al., 2016; Valenta & Berg, 2010), but these are typically descriptive, small-N studies situated in the context of the reception centre and are not designed to examine the extent to which undertaking day-time activities may facilitate mental health at a later date during early resettlement in the receiving society. Our contribution aims to fill these gaps in the literature by taking both the potentially negative (i.e. forced relocations between reception centres) and positive (i.e. participation in day-time activities) aspects of a (long) stay in a reception centre into account. Moreover, whereas previous studies mostly included refugees who have been living in the receiving society for many years or sometimes decades (e.g. Bakker et al., 2014; Hainmueller et al., 2016), we are able to examine the impact of the reception period more directly by focusing on refugees who arrived only recently (Diehl et al., 2016). Hence, the current study offers novel and important contributions to the refugee literature by examining why length of stay in reception centres deteriorates mental health, while focusing on Syrian refugees who have arrived during the great forced displacement of 2015.

More specifically, in the current study, we ask: *To what extent is length of stay in reception centres associated with refugees' mental health 1–2 years later during their early resettlement in the receiving society?* We include the number of forced relocations between reception centres and participation in day-time activities while in a reception centre as mediating mechanisms. We analyse representative survey data from Rotterdam, the second largest city in the

Netherlands, which includes Syrian refugees who arrived in 2016 and were surveyed in 2017. The population of Syrian refugees in Rotterdam is highly similar to the broader population of Syrian refugees in the Netherlands (Dagevos et al., 2018), which makes Rotterdam a characteristic case within the Netherlands. Additionally, while there are differences regarding organization and regulations, the Dutch approach to the reception period is comparable to that of other European societies in terms of its duration and frequency of relocations between reception centres (AIDA, 2019; European Commission, 2019; Hvidtfeldt et al., 2020).

THEORY AND HYPOTHESES

A long stay in reception centres as a risk for mental health

Refugees might be spending years awaiting an asylum decision in poor living conditions and legal status insecurity, which places additional demands on the mental health of this already vulnerable group. In view of the dystopian notions of life in a reception centre, (predominantly epidemiologic) studies have regularly associated the reception period with mental health issues. Laban et al. (2004, 2008) showed that refugees in the Netherlands who waited more than 2 years for an asylum decision had higher prevalence rates of anxiety, somatoform and depressive disorders, and experienced lower quality of life and physical health compared to refugees who had arrived in the preceding 6 months. Hallas et al. (2007) demonstrated that referrals of refugees in Denmark for psychiatric treatment regarding mood, psychotic and nervous disorders increased with length of stay in reception centres. Bakker et al. (2014) found that having stayed in a reception centre for an exceptionally long period of more than 5 years weakened refugees' mental health during resettlement in the Netherlands. In a comparative study between the Netherlands and the UK, Bakker et al. (2016) concluded that staying in reception centres contributed to the deterioration of refugees' mental health, which, they suspect, is due to the lack of privacy and autonomy in reception centres. Hvidtfeldt et al. (2020) show that refugees in Denmark who waited longer than 1 year for an asylum decision faced an increased risk, even many years later, of being diagnosed with a psychotic or nervous disorder.

A long stay in reception centres has been argued to deteriorate refugees' mental health due to general feelings of isolation and alienation, the slow passing of time, and lack of meaningful day-time activities that are associated with life in a reception centre (e.g. Korac, 2003). These forms of psychological stress can additionally act as an important impediment to refugees' mental health at a later date while resettling into the host society: A prolonged stay in reception centres has been associated with steeper barriers to re-entering the labour market (Bakker et al., 2014; Hainmueller et al., 2016), difficulties with language proficiency (Damen, Dagevos, et al., 2021) and delayed access to (e.g. health) services that may further aggravate refugees' mental health (Jaschke & Kosyakova, 2021). Hence, we expect that *length of stay in reception centres is negatively associated with mental health during early resettlement* (H1).

The pains of living in reception centres: Frequent relocations

Refugees who have spent a longer duration of time waiting for an asylum decision, are also more likely to have experienced multiple relocations between reception centres. While relocations are driven by efficiency considerations regarding the occupancy rates of reception centres (Dourleijn & Dagevos, 2011; Wijkhuis & Van Duin, 2017), an (unintended) side effect of these forced relocations is that it demonstrates blunt forms of institutional power that keeps refugees in a dehumanized, transitory position in relation to those who exert power over them. This state of continuous instability has a destructive influence over refugees' lives in terms of disruption and inconvenience, and adds to feelings of unpredictability and powerlessness (Gill, 2009). However, studies have focused on relocations in the context of immigrant detention, but to our knowledge, only a handful of studies exist that have examined the mental health effects of forced relocations between reception centres. In a study among refugee children in

Denmark, Nielsen et al. (2008) found that staying in four or more different reception centres had an adverse effect on mental health. In a study in the Netherlands, again among refugee children, Goosen et al. (2014) showed that more than one relocation between reception centres per year was associated with an increased risk of mental distress. In line with these worrying outcomes for a younger demographic, Weeda et al. (2018) and Damen et al. (2021) support the negative relationship between the number of forced relocations and mental health using an adult sample of Syrian and Eritrean refugees in the Netherlands. Henceforth, we include the number of forced relocations between reception centres as a mediating mechanism that disrupts refugees' lives and herewith impacts their mental health. We aim to unravel whether length of stay in reception centres directly weakens mental health, or whether this is (in part) the result of an increasing number of forced relocations between reception centres associated with a long wait for an asylum decision. This leads to our next hypothesis: *Length of stay in reception centres is positively associated with the number of forced relocations between reception centres, which in turn weakens refugees' mental health during early resettlement* (H2).

The gains of living in reception centres: Day-time activities

As illustrated above, most studies have focused on the negative aspects of living in reception centres, such as the poor living conditions and restrictive policies. However, some scholars have started to contemplate the potential gains of living in a reception centre as a preparation period for the ensuing integration into the receiving society (Engbersen et al., 2015; Hainmueller et al., 2016; Hvidtfeldt et al., 2018). Instead of reducing refugees to passive victims of the asylum system, it should be acknowledged that various forms of agency and coping strategies exist within reception centres (Ghorashi et al., 2018). Particularly during a longer stay in a reception centre, refugees actively engage in various activities as a means of 'killing time' and counter the stress and uncertainty of waiting for an asylum decision (Dupont et al., 2005, p. 32; Geuijen, 1998). In an attempt to facilitate refugees' engagement and improve living conditions, reception centres have started to offer day-time activities to its residents, such as a language programme and volunteer work (Geuijen et al., 2020). Day-time activities may offer refugees opportunities to rebuild and accumulate social and cultural resources, including social relationships, language skills and familiarity with the receiving society's culture to ultimately benefit from better prospects and wellbeing (Engbersen et al., 2015; The Dutch Advisory Committee on Migration Affairs, 2013).

Recently, scholars have started to examine the outcomes of participating in activities while in a reception centre. In the Netherlands, participating in activities such as volunteer work and language classes has been found to increase social integration (Weeda et al., 2018) and Dutch language proficiency (Damen et al., 2021). Damen et al. (2021) demonstrate that the working mechanism behind this relationship is mental health; by counteracting passivity and offering distraction through activities refugees remain mentally stable, which in turn positively affects their integration in the receiving society. Qualitative work tends to support the optimistic expectations for participating in activities while in a reception centre. A study situated in Norway, maintains that organized activities in reception centres, such as language classes, contribute to the independence and empowerment of its residents (Valenta & Berg, 2010). Refugees residing in reception centres in the Netherlands felt that attending language classes and doing volunteer work was essential for their mental health and a way to temporarily escape their worries (Boersema et al., 2015; Geuijen, 1998). A study among refugees in Iceland asserts that doing volunteer work or attending language classes offers a simulation of 'normal life' and a way to both break their social isolation and practice their language skills (Ingvarsson et al., 2016). Based on the favourable effects of day-time activities on wellbeing during the reception period, we expect that day-time activities may also bolster mental health after the reception period during early resettlement. Henceforth, we include participation in day-time activities as a mediating mechanism to gain access to a more comprehensive understanding of how staying in a reception centre relates to refugees' mental health. We hypothesize that *length of stay in reception centres is positively associated with participation in day-time activities, which in turn advances mental health during early resettlement* (H3).

METHOD

Data and procedure

To test these hypotheses, we draw on the Bridge survey, an original representative survey conducted in 2017 among recently arrived refugees living in the second largest city of the Netherlands, Rotterdam. Using the Municipal Personal Records Database, respondents were recruited based on the following selection criteria: (a) refugee,¹ (b) at least 15 years of age, (c) received asylum status in the Netherlands since January 2016 and (d) living in Rotterdam since July 2016. In total, 575 Syrian refugees participated in the Bridge survey, but we excluded the portion of our sample ($N = 50$) who indicated never to have lived in a reception centre as this is the topic of this study. This resulted in a final sample of 525 respondents aged 15–75 years ($M = 32.33$, $SD = 11.33$) with 332 men and 193 women.

The fieldwork was carried out in correspondence with a sequential mixed-mode design: The respondents were initially requested by letter to participate online (i.e. computer-assisted web interviewing, CAWI), but upon nonresponse, were approached face-to-face by a well-trained surveyor (i.e. computer-assisted personal interviewing, CAPI). A mixed-mode design improves the representativeness of the sample, without problematic threats to the comparability of CAPI and CAWI modes of data collection in terms of data quality (Revilla, 2010). However, there are small differences between CAPI and CAWI modes; hence, mode of data collection is controlled for in the analysis.

The survey was administered in Syrian-Arabic, English and Dutch so that most of the respondents could participate using their native language. Additionally, for the CAPI mode of data collection, the surveyors were of the same ethnic background as the respondent which helped overcome any language and/or cultural barriers and was intended to increase response (Singer & Ye, 2013). Respondents were approached up to seven times by a surveyor on different hours of the day as well as different days of the week. The goal of this strategy was to minimize response bias and bring the response to a consistent level across typically underrepresented subgroups such as female and lower educated respondents (Laganà et al., 2013). This approach resulted in an excellent overall response rate of 84%, and the sample was representative for the 2016 cohort of Syrian refugees in Rotterdam with respect to sex and age.

Measures

Dependent variable

The dependent variable *mental health* was measured with a combination of four items derived from the Mental Health Inventory (MHI-5),² which detects mood and anxiety disorders (Rumpf et al., 2001; also see Damen et al., 2021, De Vroome & Van Tubergen, 2010, Spijkerman & Uiters, 2020, and Weeda et al., 2018 for a similar application among refugee samples). Respondents were asked “Over the past four weeks, how much of the time have you felt [nervous/calm/down/happy]?” (1 = constantly, 6 = never). The items measuring feeling happy and calm were reverse scaled so that for all items a higher score indicated better mental health.

Independent variables

The independent variable, *length of stay* in reception centres, was measured by asking “How long have you lived in different reception centres in total?” (in months). Responses to this item ranged from zero (indicating a stay shorter than 1 month, $N = 15$) to 26 months. Two variables are proposed as mediating mechanisms, namely number of relocations between reception centres and participation in day-time activities while in a reception centre. The *number of relocations* between reception centres was recorded by asking “How many different reception centres have you lived in?”. As only a small number of refugees stayed in more than six reception centres they were compiled into one

category, which resulted into responses to this item ranging from one to six or more reception centres. *Participation in day-time activities* while in reception centres was measured by asking “Which of the following activities have you undertaken during your time in a reception centre?”. The answer categories were: (1) attended language lessons, (2) learned Dutch on my own, (3) volunteer work, (4) paid work and (5) schooling. A sum scale was constructed to add up the answering categories ranging from 0 (no activities) to 5 (undertaken all activities). The sum scale indicated the extent to which an individual is participating in (a range of) day-time activities during their time in a reception centre, but should not be understood as a reflection of time investment (i.e. as a person who undertakes four activities does not necessarily invest more time than a person who intensively focuses on a single activity) or an attempt to evaluate the usefulness or meaningfulness of particular activities. Moreover, we do not wish to suggest that the day-time activities measured in the current study form a complete overview of the activities refugees may undertake during the reception period. Instead, we focus on those activities that are organizationally encouraged or set up within Dutch reception centres as especially these activities have been intended to improve mental health and better prepare refugees for their future in Dutch society in line with integration objectives, including learning the Dutch language and finding (paid) work (Engbersen et al., 2015).

Control variables

We use a variety of demographic characteristics as statistical controls in our model. These include age, sex, pre-migration education level (i.e. highest level of education achieved in country of origin, 1 = no education or did not complete primary school, 5 = higher education diploma), year of arrival in the Netherlands (i.e. 2015/2016 or 2017: 2015 and 2016 were merged, because few respondents arrived in the Netherlands in 2015), having a partner in the household, mode of data collection (i.e. CAPI or CAWI), and a measure of language proficiency. Language proficiency was assessed by asking “If you have a conversation in Dutch, do you often, sometimes or never have trouble with the Dutch language?” (1 = I do not speak Dutch, 2 = yes, often, 3 = yes, sometimes and 4 = no, never).

Method of analysis

After inspection of the descriptive findings, we tested our hypotheses using structural equation modelling (SEM). SEM combines scale construction (i.e. confirmatory factor analysis) and path analysis (i.e. regression paths among observed and latent factors) into a single, comprehensive analysis (Kline, 2010). The proposed model was fitted in Mplus 8 using a maximum likelihood estimator with robust standard errors. Because the missing rate was small across all included variables (i.e. 8%), we did not impute missing data and these cases were automatically excluded from the analysis (also see Bennett, 2001).

RESULTS

Descriptive findings

Table 1 shows the descriptive statistics for the variables included in our study. Firstly, pre-migration, our respondents had divergent educational backgrounds in Syria: Having obtained a higher secondary or vocational education diploma was mentioned most frequently (29%) but was followed by no (completed) education (22%). Post-migration, the majority had been living in the Netherlands for 1 year and more than half was currently living with a partner. As can be expected during early resettlement, the majority of our respondents indicated that they often have trouble to have a conversation in Dutch (37%). Secondly, we found that respondents spent on average 9 months in about three different reception centres, which is which is broadly similar to recent processing times of other European Union member states

TABLE 1 Descriptive statistics

	Range	Mean	SD
<i>Dependent variable</i>			
Mental health			
Nervous	1–6	4.01	1.53
Feeling down	1–6	4.43	2.11
Happy (reversed)	1–6	3.38	1.43
Calm (reversed)	1–6	3.57	1.42
<i>Independent variable</i>			
Length of stay in reception centre (in months)	0–26	8.72	5.37
<i>Mediators</i>			
Number of relocations between reception centres	1–6	3.19	1.71
Number of activities in reception centre(s)	0–5	1.40	1.24
<i>Control variables</i>			
Age (in years)	15–75	32.39	11.25
Female	0/1	0.36	0.48
Year of arrival (ref = 2017)	0/1	0.88	0.33
Language proficiency	1–4	2.21	0.82
Partner in the household	0/1	0.57	0.50
CAPI (ref = CAWI)	0/1	0.44	0.50
Pre-migration education	1–5	2.95	1.40

Note: Source Bridge survey 2017, N = 481.

(AIDA, 2019; European Commission, 2019; Hvidtfeldt et al., 2020), and underlined that relocations between reception centres are commonplace (for a similar finding see Dagevos et al., 2018). Secondly, during their stay in a reception centre, 28% did not participate in any of the day-time activities, whereas of the respondents who did participate in activities 51% attended language lessons, 43% learned Dutch on their own, 30% did volunteer work, 17% attended schooling, and 6% did paid work.³ Thirdly, as mentioned in the introduction, we expected that a refugee who has been in the asylum system for a longer duration of time has had more opportunity to participate in day-time activities or could have been relocated more often than a refugee who has been in the asylum system for a short amount of time. Indeed, low to moderate correlations were found between length of stay and the number of day-time activities ($r = 0.240$; $p < 0.001$) as well as length of stay and number of relocations between reception centres ($r = 0.612$; $p < 0.001$), but these correlations were not substantial enough to cause multicollinearity issues (Grewal et al., 2004). Lastly, when looking at our dependent variable mental health, we observed that, on average over the last 4 weeks, our respondents often (i.e. more than half of the days) felt happy and calm, but also sometimes (i.e. several days) felt nervous and down. Albeit not all significantly, all four items measuring mental health correlated in the negative direction with length of stay and number of relocations between receptions centres, while correlated in the positive direction with number of daytime activities. These results suggest that, when tested in multivariate analyses, the different aspects of a lengthy stay in reception centres could have diverging effects on refugees' mental health during early resettlement.

Structural equation analysis

As suggested by Byrne (2012), we used a two-step approach for our structural equation model (SEM): We first built and tested the measurement model before we included the hypothesized relations in the model. Confirmatory factor

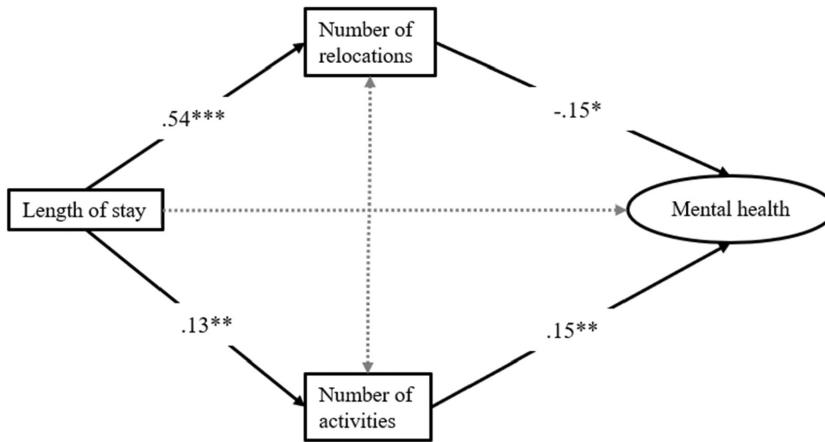


FIGURE 1 Path diagram of standardized direct effects of length of stay, number of relocations and number of activities on mental health. The grey dotted lines represent non-significant results.

Note: Entries are the results of a SEM analysis in Mplus 8. Reported are the standardized coefficients using STDYX standardization (β). $N = 481$. Rectangles are observed variables, ovals are latent factors. Not presented in the path diagram are factor indicators, error terms, and control variables. The standardized control variables are displayed in Table 3. *** $p < 0.001$ ** $p < 0.01$ * $p < 0.05$.

analysis was used to test the factorial validity of the latent variable mental health. All items loaded significantly on their matching latent construct, confirming the measurement validity of the latent variable (the standardized factor loadings varied between 0.41 and 0.81, $ps < 0.001$). As the fit of the original model proved to be insufficient, $\chi^2(32) = 189.82$, $p < 0.001$; CFI = 0.830, RMSEA = 0.101, the model fit was improved by adding correlated measurement errors for the latent factor mental health between the two items measuring feeling down and nervous. The final model proved to be adequate: $\chi^2(31) = 59.58$, $p = 0.002$; CFI = 0.969, RMSEA = 0.044. In our final model, the dependent variable mental health was predicted by length of stay, number of day-time activities, number of relocations, and the control variables. The mediators number of day-time activities and number of relocations were predicted by each other, length of stay, and the control variables.

Figure 1 and Table 2 provide an overview of the SEM results with standardized regression weights. As we formulated in H1, we expected that length of stay in reception centres is negatively associated with mental health during early resettlement. However, we found no direct relationship between length of stay and mental health ($\beta = -0.082$, $p > 0.05$, not shown), and H1 was rejected. Instead, we found that length of stay affects refugees' mental health indirectly as we formulated in H2 and H3. Regarding H2, we expected that length of stay in reception centres is positively associated with the number of relocations between reception centres, which in turn weakens mental health during early resettlement. The analyses showed that length of stay was indeed positively associated with the number of relocations

TABLE 2 Specific relations between the predictors and mental health

Path		β	SE	
Length of stay →	Mental health (total)	-0.145*	0.059	
Length of stay →	Mental health (direct)	-0.082	0.068	
Length of stay →	Number of relocations →	Mental health	-0.082*	0.035
Length of stay →	Number of activities →	Mental health	0.019 [†]	0.010

Note: Entries are the results of a SEM analysis in Mplus 8. Reported are the standardized coefficients using STDYX standardization (β) and their standard errors (SE). $N = 481$.

[†] < 0.10 , * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

TABLE 3 Standardized coefficients of control variables for mental health, number of relocations and number of activities

	Mental health		Number of relocations		Number of activities	
	β	SE	β	SE	β	SE
Age (in years)	-0.09	0.06	0.04	0.04	-0.01	0.04
Female	0.03	0.12	-0.17*	0.08	-0.36***	0.09
Pre-migration education level	-0.06	0.05	0.09*	0.04	0.14**	0.04
Year of arrival 2015/2016 (ref = 2017)	-0.02	0.17	0.15	0.12	0.15	0.14
Language proficiency	0.07	0.06	0.04	0.04	0.21***	0.04
Partner in the household	0.08	0.11	-0.15	0.08	-0.19*	0.09
CAPI (ref = CAWI)	0.51***	0.10	-0.03	0.07	-0.35***	0.08

Note: Entries are the results of a SEM analysis in Mplus 8 using STDY standardization for dichotomous variables and STDYX standardization for continuous variables. Reported are the standardized coefficients (β) and their standard errors (SE).

$N = 481$.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

($\beta = 0.541$, $p < 0.001$), and the number of relocations was negatively associated with mental health ($\beta = -0.151$, $p = 0.018$). Furthermore, there was a significant indirect effect of length of stay via the number of relocations between reception centres for mental health, in the expected direction ($\beta = -0.082$, $p = 0.020$). Thus, the findings support H2; the number of relocations between reception centres increased in tandem with length of stay, which in turn negatively affected refugees' mental health. Regarding H3, we hypothesized that length of stay in reception centres is positively associated with the number of activities, which in turn advances mental health during early resettlement. The analyses showed that length of stay was indeed positively associated with the number of activities ($\beta = 0.127$, $p = 0.006$), and the number of activities was positively associated with mental health ($\beta = 0.151$, $p = 0.005$). However, even though the indirect effect of length of stay via the number of activities while in reception centres for mental health was in the expected direction, it was only borderline significant and small in magnitude ($\beta = 0.019$, $p = 0.056$). Therefore, we conclude to have found only partial support of H3: A longer stay in reception centres increased the number of day-time activities, which advanced refugees' mental health, but participation in day-time activities did not substantially mediate the relationship between length of stay in reception centres and refugees' mental health during early resettlement.

Lastly, Table 3 summarizes the standardized effects of the control variables for the key variables included in the structural equation model. When inspecting the control variables, we found additional meaningful results. We show that participating in a larger number of day-time activities was positively associated with language proficiency ($\beta = 0.206$, $p < 0.001$), which supports the call for an early start to increase refugees' chances of a successful integration into the receiving society (Engbersen et al., 2015). However, women undertook fewer day-time activities than men ($\beta = -0.171$, $p < 0.001$), which is a caveat of note for those concerned with developing policies on refugee integration. Furthermore, we did find some support that particular subgroups of refugees were relocated between reception centres more frequently than others: We found small significant associations between the number of relocations and the demographic characteristics sex ($\beta = -0.080$, $p = 0.047$) and pre-migration education level ($\beta = 0.086$, $p = 0.018$), but not for language proficiency, refugees living together with their partner in the household, and age (all $ps > 0.05$). Hence, refugees are generally relocated due to administrative reasons, but, occasionally, exceptions are made upon request (Dourleijn & Dagevos, 2011; Goosen et al., 2014). Moreover, the mode of data collection was associated with two of our key variables, showing that respondents who participated in the CAPI mode reported better mental health ($\beta = 0.252$, $p < 0.001$), and participated in fewer activities while in reception centres ($\beta = -0.171$, $p < 0.001$). The literature on survey methodology suggests there may be small differences between CAPI and CAWI modes for sensitive subjects caused by the presence of an interviewer (Voogt & Saris, 2005), as well as differences with regard to the representation of different age groups, ethnic groups, and education levels (Hox et al., 2015). These aspects underline the importance of including mode of data collection as a control variable.

DISCUSSION AND CONCLUSION

Previous studies have demonstrated a negative correlation between a long reception period and refugees' mental health, in some cases even some time later during early resettlement (Bakker et al., 2014; Hallas et al., 2007; Hvidtfeldt et al., 2020; Laban et al., 2004, 2008). However, by focusing exclusively on the mere duration of the reception period, scholars were unable to identify which aspects of a longer stay in reception centres would shape refugees' lives in the receiving society. In the current study, we offer new insights into why the reception period is often found to take a toll on refugees' mental health. We investigated two underlying mechanisms of the relationship between length of stay in reception centres and refugees' mental health during early resettlement in the Netherlands, namely forced relocations between reception centres and participation in day-time activities. Using recent survey data collected among Syrian refugees after obtaining asylum status, our research has revealed a combination of negative and positive outcomes of living in reception centres for mental health during early resettlement.

Two central findings emerge from this study. Firstly, we shed light on the pains of living in reception centres: Results show that as length of stay in reception centres increased, refugees experienced an increasing number of forced relocations that in turn weakened their mental health 1–2 years later during early resettlement in the receiving society. These findings suggest that the damaging feelings of unpredictability and powerlessness that are associated with forced relocations (Gill, 2009), were more disruptive to refugees' mental health than the feelings of boredom and passivity (e.g. Korac, 2003) related to the mere duration of living in reception centres. Herewith, we add to previous studies by showing that length of stay exerts an indirect rather than a direct influence on mental health via the number of relocations between reception centres. Particularly the harm caused by forced relocations between prison-like facilities has started to receive more attention in studies concerning immigrant detention (Peterie, 2021). However, in the current study, we show that even in regular settings inherent to the reception period in European Union member states, forced relocations between reception centres cause harm to refugees' mental health. Nevertheless, it is likely that similar mechanisms apply, such as feelings of uncertainty and unpredictability or the experience of loss after a forced relocation has separated refugees from their social and professional support networks within the facility (Gill, 2009; Peterie, 2021). Secondly, we address the gains of living in reception centres: Results show that as length of stay in reception centres increased, refugees participated in more day-time activities, which was positively related to refugees' mental health 1–2 years later during early resettlement in the receiving society. However, the mediating effect for participation in day-time activities was small and only borderline significant as it was overshadowed by the negative impact of frequent relocations between reception centres.

We would like to mention some general reflections on the present research. To our minds, the present study is particularly valuable because of the sample used and the detailed insights into the aspects of a (longer) stay in reception centres that until now have been largely neglected. Herewith, the current study provides nuance to previous studies that found direct effects of length of stay in reception centres (Bakker et al., 2014, 2016; Hainmueller et al., 2016; Hallas et al., 2007; Laban et al., 2004, 2008; but see Hvidtfeldt et al., 2018), by showing that the effect of length of stay on mental health is mediated by frequent relocations between reception centres. However, our findings are also subject to some limitations, which we encourage for future research to overcome. Firstly, we did not distinguish between particular day-time activities and further research is encouraged to unravel whether the general participation in day-time activities improved mental health, for example as a means to break the cycle of passivity and boredom, or whether specific activities were more useful than others, for example by increasing psychological resilience. Secondly, while the reception period took place before our respondents reported on their mental health in our survey, our study does not make any causal inferences with regard to whether participation in day-time activities improved refugees' mental health or whether refugees with better mental health were more inclined to participate in day-time activities. The connection between mental health on the one hand and being inactive on the other is likely a two-way street – a longitudinal approach using panel data would be needed to establish causal order or shed light on potentially reciprocal relationships. Thirdly, practical constraints meant that we relied on self-report measures of mental health which may be susceptible to social desirability effects.

Whereas one can argue that self-report measures may underreport vulnerabilities regarding mental health, it is possible that the current effects are underestimated. Future research could supplement or replace self-report measures with more objective indices like psychiatric hospital contact (see Hvidtfeldt et al., 2020) or referrals for mental disorders (see Hallas et al., 2007). Lastly, we focused specifically on Syrian refugees who now form a large refugee group in many European countries, but it would be interesting if similar relationships can be found for other refugee groups to examine whether the reception period is experienced similarly across groups. Relatedly, as the current study is a single-case study, it would be important to establish whether our findings can be generalized to other countries. However, the Dutch approach to the reception period is not exceptional when compared to the approaches in other European societies (Asylum Information Database, 2019; European Commission, 2019). Reception facilities exist in many European countries, and although there are differences in its organization and regulations, it is plausible that mechanisms of length of stay, relocations, and activities also play a role in other countries (see Bakker et al., 2016).

The findings of this study have important implications for policies aiming to promote the resettlement of refugees into the receiving country. The reception period is considered a vital starting point for the integration process during which early experiences can determine long-term outcomes in the host society (Diehl et al., 2016), and mental health is considered a crucial resource during (early) resettlement (Phillimore, 2011). Previous studies have stressed that a lengthy stay in reception centres affects resettled refugees' labour market integration (Bakker et al., 2014; Hainmueller et al., 2016) and language proficiency (Damen et al., 2021), which, they argue, is mostly driven by psychological discouragement arising from the prolonged stay in isolation. Organizing activities during the reception period contribute to strengthening refugees' mental health and may form a springboard for their further integration into the receiving society, but only if forced relocations will at least be limited. In other words, the pains currently outweigh the potential gains of the reception period. Taken together, our findings support recommendations to further reduce the length of stay in reception centres in order to cut back the number of relocations between reception centres, while guarding against the (further) entrenchment of the reception period.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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ENDNOTES

- ¹ A refugee is "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UNHCR, 2010, p. 2).
- ² The item 'How much of the time during the past four weeks have you felt so down in the dumps that nothing could cheer you up?' was excluded from the Bridge survey after extensively testing its validity among our target sample in a pilot study. Respondents had difficulty in understanding this item as intended due to the visual language that was used. In a previous study by De Vroome and Van Tubergen (2010), a similar adaption was made to the MHI-5 to assess refugees' mental health resulting in similar levels of internal consistency (Cronbach's $\alpha = 0.75$ in the current study, Cronbach's $\alpha = 0.78$ in De Vroome & Van Tubergen's study).
- ³ Chi-square tests showed that many different combinations were possible for respondents who were active in more than one day-time activity. The most common combination of day-time activities was participating in Dutch language classes as well as volunteer work $\chi^2(1, 525) = 40.56, p < 0.001$.

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