

MIGRANTS, REFUGEES AND MENTAL HEALTH CARE IN EUROPE

Charles Watters
University of Kent, UK

Abstract: This article focuses on the provision of mental health services to migrants and refugees in Europe. It draws in particular on two recent studies, a mapping of mental health services for migrants and a study examining good practice in the mental health and social care of refugees. It is argued that research examining mental health provision for migrants and refugees is both timely and vital in addressing not only the needs of these groups but also in ensuring that services are responsive to these needs. A preoccupation only with determining the nature and extent of mental health problems in these populations may inadvertently obscure salient issues relating to the interrelationships between service provision and the identification and treatment of mental health problems. It may also lead to an absence of attention towards important issues concerning the organisation and delivery of services. It is argued that not only should attention be given to services but that, further, these should be examined within the wider political, economic and social contexts in which they emerge and are sustained. Through placing services within these wider contexts realistic approaches towards the identification and dissemination of good practice can be developed.

Key words: Mental health care, Mental health services, Migrants, Refugees.

INTRODUCTION

Much recent academic research on refugees and mental health has focussed on examining the prevalence of certain mental health problems among refugee populations. A particular emphasis has been placed on Post Traumatic Stress Disorder (PTSD) which has been described by Ahearn (2000, p. 10) as «perhaps the most popular descriptor of refugee health or lack of health today». De Jong, for

Address: Charles Watters, European Centre for the Study of Migration and Social Care, School of Social Policy, Sociology and Social Research, University of Kent, Beverley Farm, Canterbury, Kent CT2 7LZ, UK. Phone: +44-1227-823086. Fax: +44-1227-763674. E-mail: C.Watters@kent.ac.uk

example, reports from a study undertaken in Sierra Leone that 99% of the population studied displayed «very high levels of disturbances, indicative of severe PTSD in Western Europe» (cited in Ingleby, 2005, p. 9). This claim was later modified and rates of PTSD have been elsewhere identified as ranging widely between 12% and 86% in refugee populations (Jaranson et al., 2004). The reported variations in the rates of PTSD are hardly surprising and what is really questionable are assumptions that uniform findings should be found in such diverse populations. Researchers have, for example, noted significant differences in rates of PTSD as influenced by sampling methods and the locations in which research has been undertaken (Silove, 1999).

In addition to the clinical orientation of much research in the field, an emerging body of work has sought to examine the interrelationship between clinical factors and the socio-political contexts in which asylum seekers and refugees are received in industrialised countries. A range of studies have demonstrated that mental health problems originating in a pre-migration context are often exacerbated within post-migration environments (Silove, Steel, & Watters, 2000). The effects of protracted periods of seeking asylum have been shown to be particularly detrimental to mental health. The presence of PTSD in refugee populations is likely to persist after resettlement (Weine et al., 1998). Pre-migration trauma has been associated with emotional disability in the post-migration environment with symptoms of PTSD and depression exacerbated by the hostile conditions faced by many asylum seekers (Silove et al., 2000). In a review of the research evidence, Silove et al. (2000) point to growing evidence that “salient post-migration stress facing asylum seekers adds to the effect of previous trauma in creating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms”. They refer specifically to the impact of measures such as detention, restricted access to work, housing education and welfare as well as the effects of boredom, isolation and experiences of discrimination (Silove et al., 2000; Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997).

Research revealing the mental health impact of policies directed towards asylum seekers has been instrumental in challenging and, in some cases, reversing the impact of severe policies of deterrence and detention. Moorhead, for example, cites the work of psychologists and psychiatrists in Australia in challenging the policies of detention, including the detention of children (Moorhead, 2005). This phenomenon challenges a perspective according to which the diagnosis of PTSD in refugee populations is seen solely in terms of a “psychiatric imperialism” seeking to impose a Western system and its products on vulnerable populations around the globe (Summerfield, 1999). Here the medicalization of the afflictions of refugee

populations is not so much a means of obscuring political realities but of challenging and resisting them. The author has introduced the concept of 'strategic categorisation' whereby those offering legal, health or social care to asylum seekers actively identify their problems in terms of socially and politically accepted medical categories. This approach should be characterised not as an attempt to deceive authorities but rather to place clients suffering within contexts where it can be recognised and engender support (Watters, 2001).

While a first group of studies can be identified that is oriented towards identifying the mental health problems of refugees (Ager, 1993; Ahearn, 2000; Beiser, 1999), a second group focuses on the study of mental health services for migrants and refugees. Research in this area is at a relatively early stage but has gained recent impetus from a substantial study of the mental health and social care of asylum seekers and refugees in Europe (Watters et al., 2003). The importance of research into mental health services for migrants and refugees may be identified as relating to several factors. Firstly, the development of governmental and non-governmental agencies operating in the field at a transnational level in Europe and elsewhere suggests the importance of developing a knowledge base of services that transcends national parameters. These agencies include the European Commission and the World Federation for Mental Health that has advisory status in relation to both the EU and the United Nations. A related issue is that many policies relevant both to migrants themselves and to mental health care are being developed at a European level. This is not least because, within Europe, issues of immigration and asylum have moved to the first pillar of policy making in the EU whereby the European Commission has a central role in developing policy (Dummet, 2001, p. 151). Policies include measures to seek to ensure the harmonization of standards of reception for asylum seekers across the EU. Within this process the European Commission Council Directive of January 2003 sets out minimum standards for the reception of asylum seekers in EU countries that were required to be incorporated in the national laws of member states by February 2005 (European Commission, 2003). These include standards with respect to health care, the needs of unaccompanied minors, and victims of torture and violence. With respect to the latter, Article 20 of the Directive requires countries to ensure that "persons who have been subject to torture, rape or other serious acts of violence" are accorded minimum standards of care.

Nevertheless, according to a report of a Red Cross working group on the Directive, in most EU countries, "access to mental health care and specialist treatment for victims of torture is not widely available and not easily accessible for asylum seekers who need special care" (Red Cross, 2004). The information

available on mental health care services is acknowledged by the Red Cross to be patchy and there is a need for in depth study of the situation in member countries. Additionally, the broad thrust towards harmonization across the EU makes it particularly timely for evidence of good practice in the mental health care of refugees to be presented with a view towards wider dissemination and implementation. Emphasis on “best practices” or “good practices” thus can act to counter concerns that, in seeking harmonization, services will simply resort to standards representing a lowest common denominator. These include laws and policies relating to labour migration and important directives relating to the reception and treatment of asylum seekers (European Commission, 2003).

Further issues relating to the provision of mental health services to migrants and refugees have grown in importance in the light of the accelerating numbers and diversity of migration in Europe. Besides the arrival of hundreds of thousands of refugees and undocumented migrants in the past twenty years, there is significant migration within the EU owing to the movement of populations from countries that have recently joined the Union to more prosperous countries in Western Europe. An implication of this is that service providers are progressively called to work with populations that are increasingly diverse in terms of ethnicity, culture, and language. This presents challenges to services that may be accustomed to cultural diversity largely within the context working with, and indeed alongside, people with family origins in former colonies. A further and related dimension is that many migrants live in contexts in which families and communities are simultaneously located in a number of different countries. In other words, family and community networks have a significant transnational dimension with issues of social support often involving family members located in a variety of countries. A recent example is the significant secondary movement of Somalis with EU citizenship from a number of Scandinavian countries and the Netherlands to the UK in the hope of increasing their opportunities. A consequence of this is that many Somalis have family members living in two or more European countries and family relations can only be properly understood by taking this transnational dimension into account.

In response to the emerging importance of this issue, a preliminary mapping exercise was undertaken to identify policies and practices relating to migrants’ mental health care in Europe. Drawing on a literature review of the field and discussions with key service providers and Non-Governmental Organisations, six broad areas for investigation were identified and these formed the basis for a survey of 16 countries. The areas identified were as follows: monitoring and research, specialist services, training, user involvement, talking treatments, and racism and discrimination in services. The results of the mapping exercise have been published

elsewhere and it is sufficient to outline briefly some of the salient issues here (Watters, 2002).

One feature of the study was the recognition that mental health services for migrants and the clinical picture that emerges from the work of these services were interrelated and, furthermore, were embedded within a wider social and political context. Within this context, the services that were developed were often informed by stereotypical and “common sense” views of specific migrant populations and their needs. In Foucault’s terms, the knowledge or “savoir” relating to migrants is interlinked with relations of power and the attendant positioning of migrant groups within socio-political contexts (Foucault, 1991). In undertaking the study, this relationship was implicitly incorporated in a methodology that examined both a top-down policy level and a “bottom up” examination of services at the grassroots.

The results from the study published in 2002 indicated that mental health services for migrants in Europe were both underdeveloped and under-resourced. In all of the countries studied there was a lack of both research and monitoring of the use of services by migrant groups. This absence made it virtually impossible to gain insight into which migrant groups were using which services and to judge whether services were appropriate and accessible. On this basis it was very difficult to develop an overview of problem areas and to construct responsive programmes for remedial action. There were few services offering specialist support and where services were available these typically existed in the form of short-term projects that occupied marginal positions in relation to mainstream mental health services. This marginality appeared to reflect the wider position of migrant groups in receiving societies. A feature of this was that those working with migrant and refugee groups were often on short-term contracts and received inadequate training and support. The study suggested, further, that there was very limited involvement with migrant users in mental health services. This omission is within a broader context in which user involvement in Europe exists «mostly in the virtual realm due to a lack of funding, and more generally, user involvement across Europe is very unevenly developed» (Rose & Lucas, 2007, p. 337). The findings also indicated that oft-cited concerns regarding some migrants groups’ lack of access to counselling and psychotherapy services were justified (Sassoon & Lindow, 1995). The broad view among respondents was that these services were available in theory but not in practice in that they did not make any specific accommodation for people from different ethnic, language and cultural backgrounds. There were some exceptions to this in the UK, Spain and the Netherlands. However, in general, even in these instances services were both piecemeal and poorly funded.

A further notable difference in the countries studied was in the nature and

extent of services to refugees and to settled migrant communities respectively. In some countries such as the UK and the Netherlands with long histories of migration from former colonies, there were examples of quite well developed services for migrant groups (Ingleby, 2005). However, in others services appeared much more developed for refugees than for other migrants. In general these were countries without significant colonial histories that had an established record in receiving refugees, such as Sweden and Finland. As noted above, a substantial study based on four EU countries attempted to examine the provision of mental health and social care services to refugees in more detail drawing on the methodological orientation of the preliminary study.

GOOD PRACTICE STUDY

Good Practice in the Mental Health and Social Care of Asylum Seekers and Refugees was a major study undertaken with the support of the European Refugee Fund (Watters et al., 2003). It sought to build on the findings of the preliminary mapping study by offering an in depth examination of services for refugees and asylum seekers in four European countries. To identify salient differences and similarities between countries researchers chose to study specifically two Northern European countries (the UK and the Netherlands) and two Southern European ones (Spain and Portugal). During 2002, the year in which most of the research was undertaken, the numbers of asylum applications in these countries, respectively, were as follows: UK 110,700; Netherlands 18,567; Spain 5,179; and Portugal 245 (Watters et al., 2003). As noted above, the low figures for Spain and (especially) Portugal may be deceptive: they conceal the fact that the category of “illegal aliens” (not included within the above numbers) probably harbours many fleeing from danger or persecution who are unwilling or unable to enter the asylum seeking procedure, or who have been rejected by it.

The major component of the study was what was termed the “identification” study, wherein we examined or “mapped” mental health services for refugees within the broad legal and policy frameworks within which these services were embedded. This included examining each country’s policy towards refugees and other migrants, the climate of public opinion and the service frameworks within which refugee services were contained. Assessment of service frameworks entailed examination of health and social care services in each country with reference both to mainstream statutory services and the role of voluntary and community organizations. As such, it reflected a broad conception of the health care system as

incorporating both formal and informal aspects (Kleinman, 1980). A common template was developed for all four of the countries examined to ensure that, as far as possible, the same framework for the collection of data in each country was applied and that no important areas for examination were overlooked. In developing the template, we sought to clarify the relationship between macro-levels in which policies on migration and mental health care were formulated and implemented and the micro-level in which specific services were offered to refugees. In the study we assessed mental health services in accordance with the following categories of activity:

1. *Organizational changes*. These did not concern so much the type of help that was given, as the way service provision was organized. Relevant issues were: Where are services located? How were they financed? How (if at all) were their activities coordinated? What was done to improve the standards of service on a national level? Were there agencies which consolidated and disseminated existing knowledge and developed new knowledge?

2. *Training and education* towards improving the expertise of health and social care workers in working with refugees.

3. *Treatment* within the context of regular care, or as part of a special facility.

4. *Preventive activities*. These activities are especially important within "public health" or "mental hygiene" perspectives.

The template used in the study reflected models developed by Duster and others that attempt to bring into relief the linkages between the macro- and micro-levels like "rungs in a ladder". In undertaking research on health screening programs directed towards black and ethnic minority groups in the USA, Duster suggests an appropriate approach to consist of identifying four levels which move from examination of policies at a federal and state level to "micro-observational" studies of services at a grassroots level (Duster, 1981). The framework was reflected in the use of a methodology comprised of four broad levels of examination. The first level included the political and policy context. This encompassed examination of each country's immigration policies since 1945, the development of current asylum and immigration policies, demographic data on the number of refugees and other migrants, and evidence of the needs and problems of refugees within each country. The second level placed services for refugees within the broader context of the health and social care system of the country, including the development of multicultural care provision for settled minority ethnic groups. The third level sharpened the focus to specific services and practices developed for asylum seekers and refugees, including organizational changes introduced to improve provision for refugees, training and education of staff, measures to prevent mental ill health and

initiatives in the treatment of refugees. A fourth and final level concerned the identification of good practices. This drew on advice on the identification of good practice from participating countries and from various international bodies including the World Health Organization and the Red Cross (World Health Organization, 1996, 2001; Red Cross, 2004). This final level of the study involved interviews and observational studies of selected mental health services.

The findings reflected some of the earlier observations from the preliminary mapping exercise described above, albeit here focussed specifically on asylum seekers and refugees. The data gathering for the study itself called attention to a general absence of specific data on the mental health and social care of refugees. In each country there were notable omissions both in terms of information and in the development of distinctive policies for asylum seekers' and refugees' mental health care. In the UK, for example, there was substantial evidence of research and policy developments in relation to "black and minority ethnic groups" and numerous official exhortations to improve services to this group. However, the emphasis was largely on settled communities with few references to the needs of asylum seekers and refugees in the most prominent policy documents. There were further challenges in relation to the provision of basic information on the use of mental health services by refugees. Monitoring tended to be virtually non-existent, as in Portugal and Spain, or composed of broad ethnic categorisations, as in the Netherlands and UK, which were of limited utility in such a diversified group. The problems here were twofold: general service monitoring did not capture the wide range of national and ethnic origins and, secondly, as ethnically based, it did not expose important legal distinctions between refugees, asylum seekers, and those granted forms of humanitarian status and undocumented migrants.

As in the earlier study, disarmingly simple questions such as "how many refugees use your service?" frequently led to high levels of consternation among mainstream service providers who attempted to guess or explained that monitoring systems did not accommodate this knowledge. In each country specialist NGOs including initiatives under the auspices of Refugee Councils had a vital role to play both in terms of service provision to this group and in their specialist knowledge about asylum seekers' and refugees' needs. They often had crucial co-ordinating roles in meeting a wide range of interrelated practical, social care and mental health needs.

However, the research drew attention to the fact that while such agencies provide important services, they normally existed in a marginal position in relation to mainstream health, mental health and social care. In findings that echoed closely the results of the preliminary mapping exercise, the latter services are normally

oriented almost exclusively to the majority population and were severely limited in education and training, monitoring and research in relation to the specific needs of refugees. Consequently, in general terms, the research team noted a significant polarisation between specialist services for refugees that frequently existed in a marginal position in relation to mainstream services, and mainstream health and social care agencies that lacked knowledge and awareness of the needs of refugees. There were consequently severe challenges for specialist refugee services in attempting to offer mental health and social care. In practical terms the establishment of such services relied on identifying mental health professionals and general practitioners within localities who were sympathetic to, and knowledgeable of, the needs of refugees and had the requisite skills and resources to address these needs. Thus mental health services for refugees normally involved partnership between at least two agencies with a commitment to the field.

The services that were the focus of distinctive case studies often made a very significant impact on the lives of refugees. Examples cited here include Breathing Space in the UK, a partnership between the Refugee Council and the Medical Foundation for the Care of Victims of Torture; Pharos in the Netherlands that originated in a merger between the Social Psychiatric Service for Refugees and the Refugee Health Care Centre, set up in the Dutch Ministry of Health; and Psychopathological and Psychosocial Assistance Service for Immigrants and Refugees (SAPPiR) at the Hospital Sant Pere Claver, in Barcelona, Spain that grew out of a multi-disciplinary grouping of health professionals, the Health Assistance Service for Immigrants and Refugees. However, while the innovative nature of these services was inextricably linked to their ability to offer a distinctive approach that crossed traditional boundaries in service provision, it simultaneously was a source of potential weakness. With few exceptions mental health and social care services for refugees are rarely structurally embedded in mainstream mental health and social care services. In keeping with the profile of services for migrants identified above, services for asylum seekers and refugees had the following characteristics:

(a) Their funding base is not long-term and secure. These initiatives normally took the form of "special projects", or in larger organisations forums in which a number of special projects may be developed. They were established for a finite period during which they are normally subject to an evaluation initiated by the funding body. The long-term survival of special projects were thus often in doubt. This characteristic reflected the findings relating to services for migrants more generally.

(b) Their development followed a "bottom up" rather than a "top down"

approach. The projects identified in the study were typically the product of an initiative taken by an individual or group of individuals with an interest in the mental health and social care of refugees. After formulating a plan for a service, typically the group then sought funding from a government department, an international body or charitable organisation. The group had specialist interest in the field but had to balance this with employment within mainstream services. Thus time was divided between refugee and mainstream services, e.g., a psychiatrist who has commitments to a generic local team or psychiatric hospital. Projects directed at mental health and social care were thus rarely the result of top down policy development supported by appropriate resources. This has implications for the distribution of services. Some areas had dedicated professionals who secured resources for projects in their localities. However, this did not necessarily imply that these localities are the ones with the greatest level of needs. In Spain the majority of asylum seekers and refugees are based in Madrid while some very significant service developments in the field were recorded in Barcelona. In the UK some areas to which asylum seekers had been dispersed had good service infrastructures while others, with similar numbers of asylum seekers, had minimal facilities. The study suggested that a top down approach was necessary to ensure that there is an equitable distribution of services to areas of greatest need.

The challenges faced by EU countries

The study recognised that mental health and social care services for refugees existed within institutional contexts specific to the countries that were examined. As noted, results were presented within the structure of a template developed by the research team. This ensured that a complementary set of data was collected for each country. The uniformity in the basic structure of the reports also served to throw into relief significant similarities and differences between the countries. These may be summarised as follows:

(a) *Refugees and undocumented migrants.* For every country included in the study the issue of migration was prominent in political discourse and political and public debate. Within the two northern European countries, debate was often explicitly linked to perceived “problems” relating to asylum seekers or refugees. Within the UK, for example, there was by contrast a prominent discourse stressing the social inclusion of black and minority ethnic groups who were settled in the UK while, simultaneously a prevalent discourse of “otherness” in relation to refugees. In the southern European countries, debate was less explicitly focussed on “refugees” and more on illegal or undocumented migrants. This mirrored the fact

that, within these countries, there were relatively few asylum seekers and, of these, a very small proportion achieved refugee status. At the time of writing many EU countries are reporting a dramatic decrease in asylum applications. This is seen as a consequence of tougher border controls, more rigorous screening of applications, swifter deportation and further restrictions in welfare support. There is increasing concern that a consequence of these measures may be that people continue to enter EU countries but are disinclined to seek asylum when they arrive, thus swelling the numbers of undocumented migrants particularly in Northern Europe. It is important therefore to suggest further research drawing on the Southern European countries in the provision of health and social care to undocumented or "irregular migrants".

(b) Avenues of access. In relation to the above, the research drew attention to important differences in the pathways through which refugees enter countries and the impact this may have on the provision of mental health and social care services. This can be appropriately referred to as the avenues of access through which refugees receive services, and these have been identified as an important area for comparative study (Watters, 2001). The countries studied drew attention to at least three avenues of access.

Specifically, the UK operated largely a dispersal system in which asylum seekers were given social support on condition that they agreed to be dispersed to areas outside of the south east of England. Areas of dispersal were frequently ill prepared to receive asylum seekers and the early stages of dispersal were often fraught with problems. However, in some areas gradually innovative approaches to service delivery emerged typically in a "bottom up" fashion. Many of the innovations described in the report developed in this way and were the product of the vision and persistence of an individual or group of individuals with a commitment to the field.

By contrast, in the Netherlands most asylum seekers were more closely controlled within Accommodation Centres where specialised medical teams provided intake and referral to a range of mental health and social care services (van Willigen, 2005). The approach here is more uniform and systematic than in the UK, but is also, arguably, less innovative and dynamic. In Spain and Portugal the situation was again different. A significant majority of migrants entered the countries clandestinely and consequently were not entitled to immediate access to health, mental health or social care. Undocumented migrants only had access to the emergency services of public hospitals. The fact that few entered through officially recognised channels also had an impact on the severe lack of information experienced by service providers who lacked basic knowledge of the potential client group and migrants themselves who lacked knowledge of the services that may be

available. As noted in the report on Portugal, an absence of information may be seen as a serious source of stress and a threat to the well-being of this group.

(c) *Access*. The political and legal contexts of migration thus have a significant impact on access to mental health and social care services. However, the studies record also the impact of a secondary level of access. This is access through professional gatekeepers within the localities in which refugees are based. The report of the Netherlands highlighted the problems that may be faced by asylum seekers who may only access the support of a specialist after going through two professional gatekeepers in Accommodation Centres and then, subsequently, the general practitioner (GP) in the community (Van Willigen, 2005). The research point to barriers that may exist in gaining access to services through these gatekeepers arising from the latter's lack of knowledge and cultural competence in dealing with refugee clients. This may be compounded by the refugees' own lack of knowledge of the health care system resulting in her/his feeling "fobbed off" by the service (see for example de Frietas, 2006). In the UK dispersed refugees may be faced with a situation in which they have little knowledge of the health care system in their locality and where GPs may feel they have neither the time, nor expertise and resources necessary to treat refugees. This has, on occasions, resulted in explicit decisions being made by individual GP practices not to treat refugees. Thus, while entitlement to services may be present, actual access to services may not be.

The question of access may be addressed by agencies that act as brokers or advocates for refugees. For example, in Portugal researchers identified the critical role played by the Portuguese Refugee Council in acting as a "fundamental mediator between users and health care services". The UK case study highlighted the role of Breathing Space in acting as advocates in ensuring that refugees receive an appropriate range of mental health and social care services. In each of the countries studied, and in the broader international report, advocacy was widely viewed as a vital component of good practices in mental health and social care of refugees.

COMPONENTS OF GOOD PRACTICE

The report's findings suggest that, in broad terms, good practice in the mental health and social care services for refugees may be seen as including the following four components: (a) Cultural sensitivity; (b) Integrated approach; (c) Political awareness; (d) Accessibility. Those services that were identified as offering good practice have combined, to a greater or lesser degree, these four components.

Cultural sensitivity

Each of the examples offered in the report attempted to offer a service that was culturally sensitive. This went beyond a cultural sensitivity, which involved simply a reduction of cultural factors to standardised diagnostic systems of classification and, as such, viewing culture as a “mask” that professionals had to penetrate to reveal the “real” disease entity (see Rack, 1982). The form of cultural sensitivity recommended in this report refers to the development of mental health and social care services that were knowledge-based and reflected the cultures of the refugee groups with whom the service sought to engage. It directly challenged mono-cultural models of service provision and sought to develop systems of classification and treatment that reflected the problems identified by refugees themselves. The work of such services may result in the revision of categories to include “cultural bereavement” and, on the basis of the work of the SAPPPIR service in Barcelona, the “Ulysses Syndrome” resulting from the experience of migrating across the Mediterranean Sea. Cultural sensitivity also implies recognition of the dynamic nature of cultures and is aware of cultural heterogeneity and the development of new cultural forms over time. Thus the approach seeks to avoid the stereotyping and reification of refugee cultures that has dogged the development of mental health services to refugees and minority ethnic groups.

Integrated approach

An integrated approach implies the integration of mental health and social care services. It involves recognition that the problems experienced by refugees are rarely appropriately differentiated into the categories of mental health or social care. Within the post-migration context there is a crucial interrelationship between social circumstances and mental health with factors such as detention, bureaucratic processes, homelessness, poverty, loss of culture, loss of family and friends, social isolation having a discernible impact on mental health status (Silove et al., 2000). If services are to be effective they must therefore seek to identify the interplay of factors and function to ameliorate them at different levels. The services identified in this report recognised this interplay and, on some occasions, also, following Maslow (1943), a “hierarchy of needs” whereby it was appropriate to seek to address basic needs of, for example, food and shelter before effective treatment for mental health problems could commence fully. An integrated approach typically requires the crossing of institutional boundaries and the creation of partnerships between statutory services, intergovernmental bodies and Non-Government Organizations.

Political awareness

The services examined here demonstrated that while “integration” and “cultural sensitivity” were central to the development of good practice, these features were necessarily augmented by a further factor. They displayed what may be defined in broad terms as “political awareness” and this was an important feature of their effectiveness. This may be seen as operating at both a macro- and a micro-level. At a macro level this involved awareness of the situations refugees were fleeing from and developing as up to date knowledge as possible of the volatile situations within countries of origin. It also included knowledge of the political situations in the countries refugees passed through en route to Western Europe. This included changes in laws and policies within countries developed at a national or supra national level, e.g., through new EU policies. These macro-changes were viewed by astute service providers, not as mere background knowledge, but as having a direct and substantial impact on the lives of refugees they were supporting. Changing conditions in one country – for example, Afghanistan or Iraq – had a considerable impact on relatives and friends living there and on refugees’ perceptions of their future lives. On some occasions a host country’s perception of improving conditions led to anxieties about being forced to return to a situation in which refugees may continue to feel very unsafe. Consequently, macro-level changes may have a very direct impact on the lives and mental health of refugees. Political awareness was also of vital importance in relation to the changing laws and policies of the host societies and the pressures that arise from public perceptions of refugees. As noted above, the living conditions and position in the asylum process have a direct bearing on mental health status in the post-migration environment. Public hostility in particular localities can greatly increase anxiety, isolation and depression.

Accessibility

The fourth fundamental component of services identified here is accessibility. Access should be viewed as operating at different levels. Each of the services identified in the study were innovative in seeking to improve the access of refugees to services. They often sought to create “user friendly” environments in which there was a celebration of multi-culturalism evident through the use of images in posters and design and, on occasions, the promoting of multi-cultural events designed to promote harmonious relations between refugees and the host communities. It is important that policy makers draw a distinction between entitlement and access. The former is achieved by legal and policy rules and procedures. Access, however, is a less tangible and more

complex phenomenon. Here we refer to access in terms of refugee clients receiving the support and treatment of mental health and social care services that meet their needs. By definition, access here is preceded by an assessment of needs that is receptive to clients' own perceptions and concerns. It also recognises the importance of various "gatekeepers" in either facilitating or preventing access and the critical importance of training and education in this process. The UK study, for example, cited evidence of various training initiatives that sought to ensure that gatekeepers within health and social care services were appropriately trained in meeting the needs of refugees. There was also further evidence of the importance of the skills and knowledge of gatekeepers in each of the studies.

Drawing on the examples examined in this study the above components are present in services offering good practice in the field. For many services, however, these may represent somewhat idealistic goals and the immediate and more basic challenges of addressing statutory minimum requirements may themselves be daunting.

CONCLUSION

On the basis of the findings of the Good Practices report a specific list of mental health service "accomplishments" are suggested which may be realisable even for services at an early stage of development. These are as follows:

- An assessment of mental health needs is undertaken at an early stage of the asylum seekers' application.
- The assessment is sensitive to the particular culture and language of asylum seekers and includes interpreters and translated materials where required.
- Advocacy services are available to help meet the range of mental health and social care needs asylum seekers and refugees may have.
- Key service providers, including those acting as gatekeepers, receive training modules to develop their skills and awareness in dealing appropriately with this client group.
- Asylum seekers and refugees are consulted about the sort of services they would find helpful.
- Mental health and social care services are responsive to the stages of the asylum process and provide support at key phases during which clients may be most vulnerable.

The research described above has demonstrated that there are complex local variations in the context of care provision, which lead to widely divergent solutions, but exchange of ideas and practices can still be of great value. Those working in this

field can gain new insight into their own situation by comparing it with that of others. The examination of mental health and social care services for migrants and refugees in Europe is still at an early stage but work to date has demonstrated that there have been significant developments across the EU. However, these examples are localised and the context of care still varies markedly from country to country, region-to-region and even town-to-town. The above studies suggest that there is tremendous scope for fruitful exchange of good practice between localities. By placing practices within the broader social and political contexts from which they emerge, the foundations can be laid for a realistic appraisal of the potential for spreading good practice in this vital area from country to country within the European Union and more widely in the international community.

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