Good Practice in Mental Health and Social Care for Refugees and Asylum Seekers

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*The views expressed are purely those of the author and may not in any circumstances be regarded as stating an official position of the European Commission.*
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Introduction

1.0 Aims, background and structure of the project

Aims

The general aim of this project is to promote the international exchange of good practice, experience and expertise concerning interventions aimed at the psychosocial well-being of asylum seekers and refugees.

In recent years, EU Member States have been faced with the challenge of providing adequate (mental) health and social care for growing numbers of asylum-seekers and refugees. This group is particularly at risk for health and social problems. However, their access to services may be limited by a variety of factors, and the help offered by the services may be less than optimal. Professionals may feel themselves ill-equipped: their training and experience is unlikely to have prepared them to recognise the specific needs of this group and to offer effective solutions. Cultural and language differences may exacerbate problems of service delivery.

Confronted with these problems, agencies in many countries have devoted considerable effort to developing expertise in this area and devising interventions aimed at overcoming the problems mentioned above. To date, however, the development of interventions to help refugees and asylum seekers has mostly taken place within the borders of each country. There has been little systematic exchange of experience and good practice between different countries. This project examines the question of how ‘good practices’ can be identified and how they can be transferred between countries. It starts from the assumption that the best way forward is by sharing ideas developed in different countries. Innovations pioneered in one country may never have been considered in another; effort may be wasted in one country on developing interventions which in another country have been shown to be flawed.

The following steps are involved in transferring ‘good practices’ from one country to another.

- Identification of successful interventions
- Analysis of relevant differences between the context within which the interventions were developed and the context in which they will be applied
- Adaptation of the interventions to the new context
- Disseminating information and promoting interest among likely users
- Implementing the interventions

In order to meet the requirements of ERF funding, the project has to be limited to one year. Clearly, it is impossible to carry out all these steps in sequence within this space of time. We have therefore split the above trajectory into two sub-projects, referred to as the identification study and the implementation study. The first is concerned with gathering data on the interventions that have been developed in different countries; the second examines the practical problems of transferring interventions from one country to another.
Background

Since 1945, the number of armed conflicts in the world has increased relentlessly. It reached a peak of 56 in 1992, dipped slightly thereafter, but has started to climb again since 1995 (Gleditsch et al., 2001). Most of these conflicts are internal ones, causing great disruption to the lives of civilians. This is the main reason why there are currently (according to UNHCR estimates) around 45,000,000 people who have been forced to leave their homes in search of shelter.

Somewhat more than half of those uprooted remain within their country’s borders. According to UNHCR estimates there are at present as many as 25,000,000 of these ‘internally displaced persons’. Of the nearly 20,000,000 refugees who leave their country, most stay within the region, often in neighbouring countries. The major refugee burden is shouldered by non-Western countries (Middle East 46%, Africa 20% and Southern & Central Asia 18%). Relatively few of those seeking shelter are to be found in European countries (6.5%), while the combined total for the USA, Canada, Australia and New Zealand is lower still (3.9%). Those fleeing to the West are, almost by definition, a select and atypical group, able to plan, pay for and undertake a hazardous and uncertain enterprise. Nevertheless, in recent decades the proportion of refugees reaching Western countries has increased considerably, partly because of the steady improvement in transport facilities.

Asylum applications in Western Europe increased from 70,000 in 1983 to 700,000 in the peak year 1992. This particular surge was due to the Balkans wars; over the last ten years refugees also came (in order of numbers) from Romania, Turkey, Iraq, Afghanistan, Sri Lanka, Iran, Somalia, the Congo and many other countries. After the peak in 1992, the number of asylum seekers started to decline, reaching 245,000 in 1996. This decline was partly due to a lull in the Balkans conflict, but also to the adoption of increasingly stringent procedures for the admission of asylum seekers and the granting of refugee status.

During the last few years, there has been a tendency for countries of the industrialised world to vie with each other in developing the most restrictive asylum policy. This, however, seems to influence mainly the choice of which country to go to, rather than the decision to flee to the West in the first place. For example, between January and September 2002 asylum applications decreased in Denmark (-54%), The Netherlands (-38%), Belgium (-26%), and Spain (-26%), but increased in Finland (93%), Sweden (51%), Norway (31%) and the UK (20%). However, the total number of asylum applications in EU countries (335,000) remained stable. This demonstrates that relieving the pressure on one country mainly has the effect of passing it on to another, like a waterbed.

The provision of effective health and social care for asylum seekers and refugees is partly dictated by principles of human rights, and partly by pragmatic considerations.

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1 There are of course different ways of counting armed conflicts, but all observers agree on the underlying trend.
2 All percentages taken from World Refugee Survey, 2002 (Washington, D.C.: U.S. Committee for Refugees). This survey relates to “refugees in need of protection” defined as “asylum seekers awaiting a refugee status determination” plus “refugees who are unwilling or unable to return to their home countries because they fear persecution or armed conflict there and who lack a durable solution” (op. cit., p. 3).
The right to care is laid down in the Refugee Convention of 1951, but governments also have an interest in ensuring that this group is not neglected. Ignoring the problems people have usually leads to more serious problems at a later stage. For example, a refugee handicapped by psychosocial problems is likely to have difficulty getting a job and integrating into the host society, thereby becoming even more dependent on the state.

The provision of this care is a new challenge for many services and institutions. There are two arenas in which care may be provided: locally, within the conflict region (for example in temporary refugee camps), and in the host countries of the developed world. Help ‘in the field’ is mostly provided by internationally funded NGO’s. Although local services may be disrupted during armed conflict, they have the task of dealing with the problems of returned refugees and social reconstruction after the conflict ends. The present study is primarily concerned with the provision of services in host countries: in this case, services have to deal with problems and groups of clients with which they are unfamiliar. Giving refugees the formal right to care is one thing – but ensuring the care is accessible and effective is another. As we are dealing with a field which is still in its infancy, the exchange of experience and insights into good practice should have a high priority.

A note on terminology

In everyday usage, a refugee is “one who flees to a foreign country or power to escape danger or persecution” (Webster’s Ninth Collegiate Dictionary). Although the UNHCR statistics are based on this definition, many agencies reserve the term ‘refugee’ for those whose application for asylum under the terms of the Refugee Convention has been accepted. This is to distinguish them from ‘asylum seekers’, who still have to prove their right to asylum, and ‘illegal aliens’, who may be fleeing from danger or persecution, but have not entered the official asylum procedure or have been rejected by it. For convenience, we will generally use the term the term “refugee” to refer to asylum seekers, acknowledged refugees and refugees living in illegality. However, when the context requires, we will distinguish between these groups.

Sub-projects

i. The identification study

This study is concerned with identifying good practices and characterising the context in which they have been developed. We have chosen to study in detail two Northern European countries (the United Kingdom and The Netherlands) and two Southern European ones (Spain and Portugal). The number of asylum applications in these countries during 2002 was as follows (UNHCR, 2003). The right-hand column shows the ratio of the total population to this number, in other words how many inhabitants there are for each asylum seeker.
### Asylum Applications Ratio of Population

<table>
<thead>
<tr>
<th></th>
<th>Asylum Applications</th>
<th>Ratio of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>110,700</td>
<td>540</td>
</tr>
<tr>
<td>Netherlands</td>
<td>18,567</td>
<td>865</td>
</tr>
<tr>
<td>Spain</td>
<td>5,179</td>
<td>7,738</td>
</tr>
<tr>
<td>Portugal</td>
<td>245</td>
<td>41,160</td>
</tr>
</tbody>
</table>

**Table 1. Asylum statistics for the four European countries in the Identification Study**

The total for the Netherlands was much lower in 2002 than in previous years (less than half of the 43,895 asylum seekers in 2000), because of the introduction of stringent new procedures for excluding new arrivals from the asylum procedure. As mentioned above, the category of ‘illegal aliens’ probably harbours many fleeing from danger or persecution who are unwilling or unable to enter the asylum procedure, or who have been rejected by it. This applies to all the above countries, but in particular to Spain and Portugal, where many refugees are thought to by-pass the step of applying for asylum. The low numbers of asylum seekers in these countries may therefore be misleading.

As well as surveying the care provisions for refugees in each country, our study describes in detail the context in which these services have been developed. There are important differences between countries in this respect. These include social and political attitudes to issues of asylum and immigration, structures and traditions of care, and the size and composition of the refugee population. The suitability of an intervention for transfer depends not only on its quality, but also on its appropriateness in the context of another country. Often interventions will need to be drastically modified to suit the conditions obtaining in another country, while some may be simply non-transferable.

Besides these four ‘country reports’, a fifth survey deals with interventions developed in other European countries and in the rest of the world. Because of the limitations of the current project, this survey will necessarily be very limited and will focus on promising and original interventions from other countries.

**ii. The Implementation study**

This part of the project set out to gain concrete experience of the obstacles which may be encountered when attempting to transfer interventions between countries. For these purposes, we chose interventions which can be regarded as relatively successful in their country of origin. We also decided to transfer interventions between two countries offering similar contexts: the UK and The Netherlands. The resemblances between the mental health care services and professional philosophies in these two countries have been documented in Gijswijt-Hofstra and Porter (1996). New legislation which came into effect in 2000 means that both countries now practise *dispersal* of asylum-seekers and rely mainly on existing services to provide care.

In both countries we have selected (on the basis of consultations with experts in the field) an intervention which is highly regarded and has been positively evaluated, but has received little consideration in the other country.

We attempted to initiate the transfer of these practices and observed the difficulties which can arise in practice, when attempting to transfer practices which are highly promising in theory.
The British intervention to be considered for transfer to the Netherlands is the 'Breathing Space' project. This is a collaboration between the Refugee Council and the Medical Foundation, financed by the Camelot Foundation, which aims to address the different needs of refugees and asylum seekers in a co-ordinated way.

The Dutch intervention consists of a package of programmes for school-age children of refugees and asylum seekers, developed by the Pharos Foundation with the aim of facilitating integration and adjustment and helping to prevent psychosocial problems.

1.1 The notion of ‘good practice’ in the current setting

In the case of mental health and social care for refugees, defining ‘good practice’ is not simply a matter of evaluating the efficacy of a particular intervention in solving problems. Evaluation in this setting is much more complex and many-dimensional than, say, assessing different procedures for replacing hip joints. In the care for refugees, questions of accessibility, good communication and trust in the help offered are crucially important factors alongside the effectiveness, in purely clinical terms, of a given procedure.

As Watters (2001) has described, there are conflicting and competing paradigms or ‘schools of thought’ regarding the way in which refugees’ problems should be viewed and dealt with. Because we are dealing with a field which is complex and in certain respects contentious, we have decided to adopt broad definitions of problems and treatments and not to impose a fictitious consensus on the field when it comes to defining the ‘state of the art’. We could have taken as our starting-point the problem constructions and organisational structures of health service providers and simply asked the question “what services are available for refugees suffering from (for example) PTSD, and how adequate are they?” However, to do so would have been to align our research too closely with the frame of reference of the service providers themselves, which may be quite different from that of the users. We have therefore chosen broad definitions of problems, services, practices and criteria for ‘good’ practice.

Of course, the hope of some protagonists of ‘evidence based’ treatment was to create a single, uniform standard for ‘good practice’ which would make arguments between different schools of thought redundant, the only question being: “does it work?”. This might be a feasible goal for conditions defined in ‘disease’ terms, where success can be measured fairly objectively. When dealing with illness, however, interventions have effects on several different levels, so that the question of priorities arises.

How important, for example, is the removal of symptoms compared with the improvement of ‘quality of life’? How important are considerations such as ‘empowerment’ or ‘stigmatisation’? The answer to these questions will influence our assessment of whether a given procedure does or does not “work”.

Which problems?

To which problems are we looking for effective remedies? One option, again, is to define problems and needs in the terms in which they are constructed by professionals. Thus, workers in mental health and social care distinguish ‘psychosocial problems’ from material, social or political problems on the one hand, and somatic ones on the other.
Within these boundaries, the category still comprises a wide range of problems, ranging from psychiatric disorders to “normal reactions to abnormal situations”.

However, many users may not agree with the assumptions underlying the category of ‘psychosocial problems’, or even be familiar with it. They may not be in the habit of separating ‘internal’ problems from ‘external’ ones, or experiencing their mind and body as separate. Instead, they may stubbornly insist that psychological, material, social, political and somatic problems are inseparable. They may not locate problems ‘in’ the individual, or regard individual treatment as an appropriate response to them. To use Arthur Kleinman’s terminology, their ‘explanatory models’ may not match those of the professionals. Since the users’ perspective is important to us, so are these discrepancies.

However, since this research is concerned with improvements to the care system, it must take in to account professional notions as well. We have chosen for a pragmatic approach, in which attention is paid to the ‘explanatory models’ used by both professionals and users.

**Which services?**

Although the aims of the project are defined in terms of ‘mental health and social care’, we do not regard the only relevant service providers as mental health care organisations and social work departments. Sometimes, interventions aimed at psychological well-being are carried out by professionals working outside the mental health system (e.g. school counsellors). Interventions may also be carried out by non-professionals.

Since prevention is also a relevant activity, it is possible for many sorts of intervention not regarded as ‘psychological’ ones to have an impact on psychosocial problems. For example, recreational activities or language courses can have a valuable effect in improving refugee’s abilities to cope. This makes it sometimes difficult to know where to draw the line: the range of activities which can influence a refugee’s state of psychological well-being is theoretically enormous. Is the removal of a repressive regime by military means a form of ‘preventive mental health work’? Most would say no - but lobbying against stressful asylum procedures, unjustified detention and humiliating treatment does indeed, according to many, fall under the professional responsibility of those trying further refugee mental health.

Nevertheless, it would have made the scope of this research impossibly broad to examine everything, which could be regarded as a preventive activity. We have therefore confined this concept to activities, which define their own goals in such terms.

**Which practices?**

What counts as a ‘practice’? The most obvious level concerns ‘primary process’ – the actual treatment process. However, as we have seen, ‘treatment’ is not the term which many workers in this field use to define their own activities. Moreover, the accessibility of a service, its closeness to users’ culture and life world and the way it is organised, are also relevant to effectiveness.
In this study we are concerned with the following four major kinds of ‘practice’:

1. Organisational changes
These do not concern so much the type of help that is given, as the way service provision is organised. For example, where are services located? How are they financed? How are their activities coordinated? What is done to improve the standards of service on a national level? Do organisations exist to consolidate and disseminate existing knowledge and to develop new knowledge?

2. Training and education
‘Good practices’ may also consist in improving the expertise of health and social care workers. Training may be given as part of existing courses or separately. The duration of such activities may range from a single lecture or workshop to a two-year degree course.

3. Treatment
This refers to the ‘primary process’ activities referred to above, i.e. interventions designed to ameliorate existing problems. They may be undertaken within the context of regular care, or as part of a special facility.

4. Preventive activities
These activities (see discussion above) are especially important within a social medicine or mental health perspective.

Criteria for good practice

As already mentioned, assessing the quality of service provision in this area is a complex matter. Even if we reduce the issue to a simple question about the clinical effectiveness of a given treatment, there are many practical and methodological pitfalls involved. For example, many of the interventions studied involve small numbers and subjects who are difficult to follow up. Ethical, organisational or financial considerations often make it very difficult to set up controlled clinical trials with a sound experimental design. In addition, there are problems of access to the target group, resulting in biased sampling, and the cross-cultural validity of the instruments to be used. Although a ‘before-and-after’ design has the advantage that subjects form their own controls, thereby (hopefully) cancelling out whatever cultural bias there may be in the questions asked, it is another matter to be sure that these questions are properly understood, meaningful, and answered in a reliable way.

Other types of evaluation, however, may be more practicable. For example, process evaluation, in which information is gathered about the success with which a plan has been put into practice (whether it does what it sets out to do and whether it reaches, and holds, the target group). The satisfaction of both caregivers and users can be assessed, but these data are harder to interpret, for at least two reasons.
One is that answers may reflect strategic considerations (not wanting to ‘let the side down’ or to appear difficult; wanting to ensure that an activity is continued). The other is that it is quite possible for a genuine feeling of satisfaction to accompany a treatment which entirely fails to improve the condition it set out to improve - and vice versa.

Another, more *a priori* form of evaluation (plan evaluation) can be carried out even before an intervention has been put into practice.

To what extent does the intervention take account of well-known pitfalls and shortcomings of the type of activity in question? Does it appear to be informed by recent insights in the field in question - is it a ‘state-of-the-art’ intervention? As we saw above, however, there is no consensual definition of what the ‘state of the art is’, and it is impossible to impose a single standard on all the interventions studied.

Moreover, different ‘schools of thought’ may prioritise goals, which are actually in conflict with each other. A recent example is given by the reorganisation of youth services in The Netherlands. To improve the ‘professionalism’ of the services, systematic procedures were introduced based on the model of clinical practice. This entailed closing low-threshold, informal ‘walk-in’ centres where young people could drop in and air their problems discretely, as well as many ‘outreaching’ programmes. The result was a service with stricter standards and procedures, but one, which was effectively inaccessible to many of its intended users. By some standards, a ‘good practice’; by others, a totally inadequate one.

In this study, most of our effort has gone into *inventorising* practices. Where possible, we have included data on evaluation, but very little such information could be found. In our own selection of promising innovations, we have paid attention to questions such as these:

- How *accessible* is the intervention?
- How are the needs or wishes of users reflected in the intervention?
- To what extent have users influenced, directly or indirectly, the form of the activity?
- How much attention, and what kind, is paid to possible effects of cultural differences?
- Is the intervention *original*?
- Are attempts made to *evaluate* the success of the intervention?

### 1.2 Research strategy and outline of reports

**Research strategy**

**i. Identification study**

For each of the countries studied, an overview was made of the size and nature of the refugee and asylum-seeker population in each land, their particular needs, the services available for dealing with them, the problems arising in service delivery and the methods adopted so far for dealing with these problems.
This information was placed in the context of the distinctive political, demographic and cultural features of each country. Information was provided by the collaborating agencies in each land, as well as existing publications and other oral sources. The Canterbury team covered the UK & Spain, while the Utrecht research team carried out the same task for The Netherlands and Portugal. Both teams gathered information on non-EU countries.

In order to facilitate comparisons, information was be gathered in a standardised way (see section b ii below). The findings were presented for critical review to experts in each of the four countries and amended in accordance with their comments.

ii. Implementation study

Based on 2 selected practices. Steps.

a) Evaluate the experience to date with the two selected practices. This evaluation was based on existing reports, supplemented where necessary by interviews with professionals and clients who have been involved.

b) Identify the differences in the parameters of service provision and national context between the two countries which may make modification necessary (differences in refugee populations, financing of services, structure of service provision, treatment philosophy etc.)

c) Make proposals regarding the modifications which may be necessary to make practices transferable.

d) Produce a Manual summarising the results of steps a-c. This manual was submitted in draft form to selected experts familiar with the interventions for critical assessment and feedback. After revision it was handed over to the research team in the other country as a basis for taking the project further.

e) Expert Meetings were held with key stakeholders in the country to which the intervention was to be transferred, to discuss the best strategy for implementing it.

f) The research team in that country then developed a strategy for implementation and proceeded as far as possible with piloting and evaluating the intervention in question.

g) Finally, the success of the transfer was evaluated and recommendations were made about continuation, modification or termination of the innovation.

How this report is built up

i. General overview of the report

Part A. Introduction

Part B. Identification Study

1. UK
2. NL
3. Spain
4. Portugal
5. Further International Perspectives

Part C. Implementation Study

1. UK
2. NL
Part D. General conclusions from the study; continuation, dissemination.

ii. Results of the Identification Study

Surveys on the UK, The Netherlands, Spain and Portugal
These four surveys have the following standard structure, however this may vary slightly due to characteristics of the situation in specific countries:

Chapter 1. The context of interventions

1.0 Demographic
- Immigration and emigration in historical context
- Post-WWII migration: the main groups of immigrants.

1.1 Political
- Immigration policy since 1945. The politics of immigration: public attitudes, including representation in the media.
- Development of asylum policy. Representation of asylum seekers in the media.
- Current admission procedures
- Current reception and accommodation arrangements
- Rights and restrictions applying to asylum seekers (e.g. work, education)

1.2 Needs and problems of asylum-seekers and refugees
Particular sources of stress. Data (insofar as they exist) on needs for (psycho-social) care. This section combines official and professional views (e.g. epidemiological studies) with the perspective of the groups themselves, using published research, interviews with group members, and other informants.

Chapter 2. Mental health and social care provisions

2.0 Short sketch of the care system
- The health care system, with special attention to mental health services. Historical background, financing and organisational structure.
- Social and community care, focussing on the aspects particularly relevant to mental health (esp. social work).
- Health and social care outside the regular framework: NGO’s (including religious bodies), self-help organisations.

2.1 Multicultural care provisions
To what extent have efforts been made to improve care for members of ethnic minorities in general? The ‘state of the art’ in multicultural service provisions, with special attention to mental health. What problems have arisen in service provision for migrants, and what solutions have been offered so far?

2.2 Services for asylum seekers and refugees
- To what sorts of care are asylum seekers and refugees entitled?
- How accessible are these care provisions?
- What problems have arisen in service provision for asylum seekers and refugees?
Chapter 3. Practices developed for asylum seekers and refugees

This chapter follows on from the last one and contains an inventory of the practices that have been developed for these groups. What solutions have been developed so far? What are the philosophies underlying these innovations?

The approaches developed will be categorised under the following headings:
Organisational changes introduced to improve service provision for asylum seekers and refugees.
Training and education
Treatment
Preventive activities

Chapter 4. Good practices

Summary of strong and weak points of service provision
Case studies
Individual projects or approaches which are felt to be particularly innovative and promising will be singled out for more detailed attention here

World-wide Survey

This survey is necessarily more selective and summary in nature. In it, the researchers (in collaboration with the international bodies mentioned on p. 5) have identified a number of key initiatives that have been developed for asylum seekers and refugees in non-European countries. These were selected on the basis of the quality and availability of research and evaluation evidence. These interventions have been placed in the broader social and political contexts in which they have developed.

This involves, for example, considering the projects in the context of the particular laws and policies on asylum and immigration and the extent to which they are established primarily for refugees or asylum seekers or for migrants in general.

iii. Results of the Implementation Study
The results of the implementation study have been written up in the form of an account of the steps undertaken and the progress reached in each country.
1.3 Acknowledgements

The project was carried out jointly by the University of Kent at Canterbury (Tizard Centre) and the Utrecht University (Faculty of Social Sciences / ERCOMER), in collaboration with the bodies listed below. Detailed credits are given in the separate reports.

Eighty percent of the financing was provided by the European Council, European refugee Fund. The rest was provided by the University of Kent and Utrecht University.

The research team at Canterbury consisted of Charles Watters (project leader), Dominique Le Touze, Soumha Venkatesan and Mariola Bernal.

The Utrecht team comprised David Ingleby (project leader), Nina de Ruuk, Claudia de Freitas and Marlous van Leeuwen.

The project leaders gratefully acknowledge the collaboration of the following bodies in preparing and carrying out this project:

**UK**
1. Home Office
2. Department of Health
3. Department for Education and Skills
4. Refugee Council
5. Medical Foundation for the Care of Victims of Torture

**Netherlands**
- Pharos Foundation for the care of refugees and asylum-seekers
- ALTRECHT (mental health care conglomerate for the Utrecht region)
- GGZ-NL (organisation of Dutch mental health service providers)

**Spain**
- University of Barcelona
- SAPPIR (Servicio de Atención Psicopatológica y Psicosocial a los Inmigrantes y Refugiados)

**Portugal**
- Open University, Lisbon (CEMRI - Centro de Estudos das Migrações e das Relações Interculturais)
- Portuguese Refugee Council (Conselho Português para os Refugiados)
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- From the 1980’s to the present
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Report on the United Kingdom

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Introduction: Glossary of key terms and concepts

Terms pertaining to refugees and asylum seekers in the UK.

An asylum-seeker in Britain is a person who flees his/her home country and seeks refugee status in another, possibly because of war or human rights abuses. Under the Immigration and Asylum Act, 1999 (Part VI) the term asylum-seeker includes people who claim that their removal will breach Article 3 of the European Convention of Human Rights (ECHR) that prohibits torture, inhuman or degrading treatment or punishment. The recent Nationality, Immigration and Asylum Bill (2002) defines an asylum seeker as someone who is at least 18 years old and who has made a claim under the Refugee Convention or under Article 3 ECHR, which has been recorded by the Secretary of State but which has not yet been determined.

A person is recognised as a refugee when the government of the new country decides that they meet the definition of a refugee under the 1951 UN Convention Relating to the Status of Refugees. A person with refugee status is allowed Indefinite Leave to Remain (ILR) in the UK.

Asylum seekers who are not deemed to meet the criterion required for refugee status may, in some circumstances, be given Exceptional Leave to Remain (ELR) if it is deemed dangerous for them to return to their home countries. They may apply for settlement or ILR after 4 years.

A child asylum seeker or child refugee is any person who fits the above definitions in addition to being under 18 years of age or a legal minor.

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4 The definitions are all taken from the national report Another country: implementing dispersal under the Immigration and Asylum Act 1999 published by the Audit Commission, 2000.

5 The 1951 UN Convention Relating to the Status of Refugees requires signatories (including the UK) to offer refuge to a person who ‘...owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality, and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.'
Chapter 1: The Social, Demographic and Political Context

1.0 Demographics: An History of Migration into the UK

Migration prior to 1945

Immigration into the United Kingdom has taken place for hundreds, if not thousands, of years. In 250 BC as the Romans conquered the British Isles, a group of black legionnaires from Roman colonies in Africa were sent to guard Hadrian’s Wall. From the mid sixteenth century, with voyages to the New World, European traders began to enter into the slave trade that already existed in North Africa. Merchants returning to Britain brought with them wealth and goods, including slaves. As a result, by 1770 around 14,000 black people were living in Britain (www.bbc.co.uk).

Post World War II Migration

A large increase in immigration took place immediately following the Second World War, when small numbers of servicemen from the Empire, who had fought in both wars, remained in Britain. Large numbers of European immigrants were invited to come to Britain to fill massive work shortages. Although there appeared to be an official reluctance to invite immigrants from Commonwealth countries, work shortages were unable to be filled by Europeans, and the government turned to West Indians in particular. On the 28th June 1948 the ship, the Empire Windrush docked in London, bringing hundreds of men from the West Indies. That day can arguably be cited as hailing a new era of mass immigration.

Following this event, the increase in immigration was matched by a tightening of UK immigration law throughout the 1950’s and 1960’s. A series of increasingly restrictive laws resulted in the creation of legislation in 1972 that allowed individuals from overseas to work in the UK only if they had a work permit and could prove that a parent or grandparent had been born in Britain. Further policy making in the 1980’s continued to restrict entry to the UK. As a result the largest immigrant groups to enter the UK throughout this period were Americans for employment, mainly in the financial and industrial sectors, Australians, New Zealanders and South Africans with familial ties to Britain, and South Asians coming to work in medical professions.

Following 1989 and the end of Communism in much of Eastern Europe and the former Soviet Union, Britain experienced another rise in immigration as many individuals arrived in the UK (www.bbc.co.uk). The political upheavals and their consequences at that time also marked a substantial, and ongoing, increase in the number of refugees seeking asylum in Britain, as the next section examines.
Asylum seekers and refugees in Britain

Although Britain has long accepted refugees, as far back as 1560 and until 1575, Dutch Protestant refugees entered the UK fleeing persecution from the largely Catholic Netherlands (Refugee Council, 2002). Until the First World War the vast majority of immigration to the UK took the form of economic migration. However, from 1914, a growing percentage of migrants have been refugees.

During the First World War over 250,000 Belgian refugees arrived in Britain to escape fighting. Shortly before the Second World War when thousands of persecuted Jews were leaving their homes in Eastern Europe, the British government refused many Jewish refugees entry. Eventually however, around 50,000 refugees fleeing Nazi Germany, Czechoslovakia and Austria were admitted. In 1939, almost 100,000 Jewish refugees from France, the Netherlands, Denmark, Belgium and Norway arrived in Britain. Following the end of the Second World War, the vast majority returned to their home countries.

In 1972 the British government accepted around 28,000 Ugandan Asian refugees expelled by Idi Amin. From 1973 to 1979 around 3,000 Chileans arrived in the UK fleeing General Pinochet’s regime. Throughout the 1970’s and into the early 1990’s about 24,000 Vietnamese refugees entered Britain on a resettlement programme, they included Southern Vietnamese fleeing the Communist regime and ethnic Chinese people persecuted following the Chinese invasion of Vietnam in 1979. From 1992 to 1996 2,500 Bosnians escaping war in former Yugoslavia entered the UK and were given temporary protection status by the British government. By comparison, Germany accepted over 300,000 Bosnians during this time. From 1995 to 1999 over 4,000 Kosovan refugees were granted temporary protected status in Britain. Many more applied for asylum independently (Refugee Council, 2002).

Britain ranked second in Europe (after Germany) for the greatest number of asylum applications received in 2001. Nevertheless, if asylum applications are ranked by number of applications per thousand population, Britain comes seventh in Europe, with 1.5 applications per thousand (Home Office, 2001). Thus, the UK’s perceived popularity as a refugee destination is perhaps greater than is actually the case. Moreover, a large percentage of claims are refused, as is shown below. The very restrictive immigration laws that currently operate look set to continue in the current political climate, as the far right becomes increasingly influential.

Refugee Numbers Since 1980

In 1980, 2,352 new asylum applications were made. The 1980’s saw a slight rise in the number of applications, reaching 3, 869 new applications in 1988. Between then and the early 1990’s a massive increase took place, with 44,840 applications made in 1991. Which can perhaps be explained by the upheavals taking place throughout Eastern Europe at the time. Throughout the decade numbers fluctuated between 22,000 and 46,000, increasing again at the start of the millennium, with 80,315 applications made in 2000, and 71,700 made in 2001 (Home Office, 1998, 2001; Refugee Council, 2002).
Status Statistics

In 1988, of the 2,352 applications made, 1,385 were granted refugee status or Exceptional Leave to Remain (ELR). Around half of all applications made were granted throughout the 1980’s. During the 1990’s the number of positive decisions began to decrease rapidly as the number applications increased. Of all outstanding applications in 2001, 10,960 (9%) were recognised as refugees and granted asylum, a further 19, 510 (17%) were granted ELR, and 87,725 (74%) were refused.

Countries of origin

The numbers and nationalities listed above represent the largest groups of refugees arriving in the UK since the Second World War. However, thousands more have sought asylum in Britain, arriving from Ethiopia, Eritrea, Cyprus, Iran, Afghanistan, Iraq, Ghana, Sri Lanka, Pakistan, Somalia, Turkey, Congo, Burundi, Sudan, Angola, Sierra Leone, Rwanda, Kenya, Algeria, Nigeria, Zimbabwe, Colombia, the former Soviet Union and eastern European countries (Refugee Council, 2002).

In 2001, approximately 175 different nationalities made applications for asylum in the United Kingdom. Throughout that year the greatest number of applications for asylum were made by nationals from Afghanistan (9,190), Iraq (6,805), Somalia (6,500), Sri Lanka (5,545) and Turkey (3,740). Individuals from China, Zimbabwe, Pakistan, Iran and the Federal Republic of Yugoslavia also made a large number of claims in 2001 (Home Office, 2001). It is clear from the list of countries shown that many are experiencing civil unrest, are at war, or have large minority ethnic groups that are being persecuted. It is evident then, that far from being economic migrants, the large majority of claimants have strong bases for claiming asylum. Moreover, there is evidence to suggest that many asylum seekers are unaware of the asylum and social support systems in the UK before their arrival. A European Commission-funded study, Asylum Migration to the European Union: Patterns of Origin and Destination (1997), found that most asylum seekers don't choose their country of asylum. Those individuals who can choose are often influenced by knowledge of the language or familial or community ties rather than economic factors (Refugee Council, 2002).

1.1 Policy and Political Context

Asylum law stems from the United Nations Convention on the Status of Refugees of 1951, amended by the 1967 Protocol (see Glossary). Until 1993 however, no asylum legislation existed in the UK Very little was written down about the status and rights of refugees and it was not clear what status the UN Convention of 1951 had in British law.


The 1993 Asylum and Immigration Appeals Act incorporated the UK’s obligation under the 1951 UN Convention on refugees into UK law. It ensured that refused asylum seekers had the right to appeal negative decisions on their applications. However strict time limits were laid down. The 1993 Act required all asylum seekers including children to be fingerprinted.

* Figure excludes dependants.
It allowed for the detention of asylum seekers whilst their claims were being considered by
the Home Office.

The Asylum and Immigration Act 1996 introduced a 'white list' of countries which the
Home Office considered did not pose any serious risks of persecution. It introduced very
tight time limits for appeals for asylum applicants who came from countries in the 'white
list' or for asylum applicants who lacked credibility: if for example, they could not explain
why they used false documents or had none, or if their evidence was considered
questionable.

Under the 1996 Act, asylum applicants who were not even considered by the Home Office
because they had travelled through a 'safe third' country (this includes EU countries, USA,
Canada, Switzerland and Norway) could only appeal against such a refusal once they had
left the UK. The 1996 Act also introduced restrictions on employment and made it an
offence for employers if they knowingly employed someone who used false or no
documentation. The 1996 Act further restricted entitlement to housing for asylum seekers
and removed welfare benefit entitlement for all those who did not make a claim for asylum
immediately on arrival in the UK with an Immigration Officer.

**1999 Asylum and Immigration Bill: ‘Fairer, Faster and Firmer - A Modern
Approach to Immigration and Asylum’**

The Asylum Act 1999 heralded the third piece of immigration legislation in seven years,
and brought about radical changes in the support and appeal systems. As the title stated,
its aims were to make the new system ‘integrated…informed [and] fairer, faster and
firmer’ (Home Office, 1998). It attempted to do this by including measures that were
designed to ‘control the number of asylum seekers entering the country; to speed up the
decision-making process; and to support those who have no other means of support’ (ibid.: 2000)

**The National Asylum Support Service**

Before the 1999 Act was implemented, the Benefits Agency or local authorities provided
support to asylum seekers. From April 2000 that became the responsibility of the National
Asylum Support Service (NASS), a Home Office sponsored agency, made responsible for
providing support and accommodation for asylum seekers whilst their claim are being
considered and throughout the appeals process. Accommodation was provided under the
new scheme of ‘dispersal’, whereby, to receive support asylum seekers had to agree to be
housed in areas outside London and the South East. The aim was to reduce pressure on
those local authorities that received the largest number of newly arrived asylum seekers.
Support was provided in kind in the form of vouchers, equivalent to 70 % of Income
Support (£37.77 per week for individuals over the age of 25), that could be exchanged for
food, clothing and other goods.

NASS works with ‘reception assistants’ at ports of entry to ensure that destitute asylum
seekers are provided with emergency accommodation and vouchers to cover their
immediate needs.
Reception assistants are government funded agencies who assist individuals in making their initial claim for asylum, arrange emergency accommodation, and provide forms in order for them to access health care. After approximately two weeks NASS decide if the asylum seeker and his/her dependants are eligible for support. If so, the individual/s will be moved by NASS or the reception assistants to a dispersal area, and given support vouchers. Asylum seekers may also apply for a ‘vouchers only’ package if they are able to stay with family or friends.

Despite Government attempts to reduce the backlog of unprocessed applications, at the end of 2001 there were still 39,400 outstanding applications. The government aims to process most applications within six months, however some applicants may wait years for a final decision. Nevertheless, long term asylum seekers facing removal that have been waiting a substantial amount of time can appeal on humanitarian grounds under Articles 8 and 12 of the Human Rights Act 1998 (Janis et.al, 2000). During their long wait it is understood that asylum seekers may have established themselves within the community, their children may be enrolled in British schools, and as a result their claim may then be reconsidered.

2002 Asylum and Immigration Bill: ‘Secure Borders, Safe Haven’

Under the new Asylum and Immigration Bill a number of significant changes have taken place, and seeking asylum in the UK will become more similar to the Dutch system. Support arrangements are shown in Appendix 1. The main changes are as follows:

- The voucher system has been abolished, and replaced with vouchers that may be exchanged at the Post Office for cash. However, support levels for asylum seekers will remain at 70% of Income Support.

- Smart Cards will be introduced in order to identify asylum seekers through fingerprints.

- Perhaps the new measures likely to have the most impact are Sections 55 and 57: the withdrawal of support for in-country asylum applicants. Those arriving in the UK and wishing to claim asylum must apply ‘as soon as is reasonably practicable’. Those who do not will not be eligible for support from NASS (Refugee Council, 2003). The lack of definition in the term ‘as soon as reasonably practicable’ and new arrival’s lack of knowledge of the system could lead to large numbers of asylum seekers destitute with no access to support. The Act has also made it illegal for local authorities and voluntary agencies to provide support for asylum seekers.

**Induction Centres**

- Once they have claimed asylum, refugees will now be received in Induction Centres, while their initial claim for support is being considered. Each centre will provide full board accommodation for around 200-400 asylum seekers. There will be centres close to ports of entry and a small number in the regions (Refugee Council, 2002). It is thought that asylum seekers will remain in the Centres for around 10 days.
Asylum seekers will be briefed by staff about the asylum and support systems, and, if they are to be dispersed, information about their dispersal area. Staff will also run sessions on transactions such as a visit to the GP, or how to obtain legal advice.
Initial health screening will now take place at Induction Centres rather than at the Port Control Health Units (discussed below). This will help to initially determine special needs, including mental health problems.
Individuals will now be means tested for support.
Asylum seekers will be required to take a test on leaving the Centre to confirm that they have understood the asylum and support process (ibid.).

Non-governmental groups such as the Refugee Council have welcomed the move as part of a more integrated approach to induction. Indeed, it will create a more comprehensive method of providing general information, support and health care for new arrivals than is currently the case. Nevertheless, it remains to be seen how the system will operate in practice.

**Accommodation Centres**

Should NASS deem an asylum seeker eligible for support they will either be dispersed to an area outside London and the South East, or they will be sent to Accommodation Centre.
Centres will thus house only a limited number of asylum seekers. It is thought that three pilot Centres will hold 750 people each, and a possible fourth Centre will be slightly smaller. Accommodation Centres aim to provide all the support asylum seekers should require in one setting. This will include healthcare, education for children, language tuition and so on. NASS will aim to hold individuals no longer than six months, however as we can see with the Dutch system, this may not always be possible and asylum seekers may stay longer (Geuijen 2000)

The Refugee Council, and other national refugee groups, have expressed concern that such centres will hamper the integration of asylum seekers into local communities, and will encourage institutionalisation (Refugee Council, 2002).

**Current rights and restrictions applying to asylum seekers**

**Employment**
Asylum seekers whose claim has been registered for six months or more were, until recently, eligible to work. Asylum seekers who were engaged in an appeal process were also able to work. This status was not given automatically; asylum seekers who wished to work had to apply to the Immigration and Nationality Directorate (IND) at the Home Office. Permission to work was normally only granted to the asylum applicant, and not to the applicant’s dependants. Asylum applicants and their dependants were, and still are, automatically permitted to work once refugee status or exceptional leave to remain has been granted.

However, under new legislation, effective from 26th July 2002, asylum seekers are forbidden from working. Those who lodged an application prior to that date will be considered for permits. The Home Office has justified this move by claiming that asylum applications take 6 months to be processed.
In actual fact, the current average waiting time for a claim to be processed is 13 months and a further 26 weeks for an appeal (Refugee Council, 2002). The government also considers potential employment to be a ‘pull-factor’ among asylum seekers.

The Refugee Council, among others, has criticised the measures arguing that unemployment may hamper integration, that there is clear public support for asylum seekers contributing to the State, and that there is no evidence to suggest that employment opportunities encourage asylum seekers to come to Britain (ibid.). The government’s measures may also arguably drive asylum seekers to find employment on the black market. This has a number of implications; firstly employers may favour cheap labour in the form of asylum seekers over other employees thus creating tensions with local populations; secondly as illegal workers asylum seekers are not entitled to the health and safety precautions normally required thus potentially putting themselves and others at risk; and finally the state will be deprived of the taxes paid by legally employed asylum seekers.

A number of new employment schemes for migrants that have implications for refugees and asylum seekers have been introduced with the new White Paper (February 2002). The first of these is the Highly Skilled Migrant Programme that aims to enable those migrants with particular qualifications to work in the UK. Also promoted was the Seasonal Worker’s Agricultural Scheme that aims to meet the demands for short term casual labour, mainly throughout the summer. The new measures have been welcomed by refugee organisations such as the Refugee Council.

However the Refugee Council has criticised the lack of reform in permission to work procedures, which, they argue make it difficult for asylum seekers to enter the labour market.

**Education**

According to a Refugee Council estimate (1998), 20% of asylum seekers in the UK are children (1998: 6). A person is deemed a child if he or she is under 18 years of age.\(^7\) Refugee Council estimates that there are 63,000 refugee children in schools in Britain in 1999 (ibid.: 68). Unaccompanied children are those children who arrive in the UK and claim asylum without being accompanied by any members of their family. They may have been sent away by their families or may have been separated during the flight to the UK. The number of unaccompanied children entering the UK in 1998 was 2,833 (ibid.: 66). By April 2000 there were over 5,000 unaccompanied children in the care of local authorities, 80% were 16 or 17 years old. London boroughs supported the majority with major concentrations in Kent and West Sussex.

Refugee and asylum seeker children in the UK are entitled to free state education from preschool to age 16. Young people age 16 to 18 who are seeking asylum themselves, or are the dependants of asylum seekers and are receiving NASS benefits are often offered reduced rates for Further Education. Those young people with ELR or refugee status are entitled to free Further Education.

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\(^7\) For the purposes of the present Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/44/49 (1989), entered into force Sept. 2 1990, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.
In terms of Higher Education (18 years and above), asylum seekers are liable to pay the full fee rate for overseas students and are not entitled to government grants. Again those with ELR or refugee status are eligible for the same grants and pay the same fees as other UK students.

All children in the UK are legally required to go to school between the ages of 5 and 16. Local Education Authorities (LEA’s) are responsible for administering education through the local authority. Presently asylum seeking children, or dependants of asylum seekers are educated at their local school with other children from the local area. They are not schooled separately. However, the new White Paper’s proposal for Accommodation Centres includes educational provision for children that stay there. As detailed above there has been opposition to this suggestion as critics argue that school provides the best forum for addressing children’s various needs (Brewin and Demetriades 1998). School arguably offers one of the best sites for integration, language learning and acculturation.

Schools are legally required to offer places to asylum seekers, however not all children are enrolled. Some schools are loathe to take pupils that have needs, psychological and pedagogical, that may stretch resources. Similarly schools may be anxious that asylum-seeking children, new to the British schooling, could negatively affect results. For asylum seekers the added costs of education, such as transport, uniforms and books may discourage children from attending school. Finally, for children that have lived through traumatic circumstances, have been uprooted from their homes and may well uncertain about their permanence in the UK, high levels of anxiety may affect their school attendance and performance. Around 2000 children have not found school places (Refugee Council, 2000).

Public Attitudes

A recent survey by Mori Social Research Institute (June 2002) examined the public attitudes towards refugees and asylum seekers and their knowledge and understanding of media coverage. The survey asked respondents why someone might leave their own country to seek asylum in another country. Nearly two thirds (62%) spontaneously replied escape persecution, war or torture. The majority of participants however massively overestimated the number of refugees and asylum seekers in the UK, believing Britain to host nearly a quarter of the world’s refugees. The actual figure is 1.98%.

The study was also conducted with 15-18 year olds. This age group appeared to be less well informed; believing that Britain accepts 31% of the world’s refugees. Of more concern was that only 19% of respondents in this age group said they would welcome refugees into their community, compared with 26% of adults (Mori, 2002).

The survey went on to question public perception of the media in covering refugee issues. Over 85% of those adults questioned associated negative words with media coverage. Two thirds (64%) of these said the media most use the term ‘illegal immigrant’ when referring to refugees. Other words perceived to be frequently used in the media were ‘desperate’, ‘foreigners’, ‘bogus’ and ‘scroungers’. Phrases not commonly associated with media coverage were ‘persecuted’ (chosen by 20%), ‘skilled’, ‘talented’, ‘intelligent’, ‘hard working’, and welcome (chosen by 1-2%).
Kaye (1998) argues however, that far from the media informing public attitudes towards refugees and asylum seekers, discussions on the subject in some newspapers are directed by political agendas.

Kaye’s study looked specifically for the terms ‘bogus’, ‘phoney’, ‘economic migrants’ and ‘economic refugees’ in three broadsheets between 1990 and 1995, he concluded that despite some terms being used as part of a critique, the fact that newspapers were even discussing the issue of ‘genuineness’ validated its newsworthiness. Kaye argues that the agenda at that time was denigrating refugees and asylum seekers in the public opinion prior to introducing two pieces of immigration legislation in 1990-1 and 1992-3. This is perhaps pertinent at present; as newspapers report asylum seekers ‘flooding’ and ‘swamping’ our shores, the government are creating increasingly ‘tough measures’ to discourage asylum seekers from coming to Britain. Most recently for example the government have closed Sangatte, the Red Cross refugee camp in Calais, perceived by some as the gateway to Britain for asylum seekers.

1.3 Needs and Problems of asylum seekers and refugees

‘Refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity (Raj and Reading 1999). This reflects the view espoused by the Pharos knowledge centre in the Netherlands of refugees as:

‘ordinary people who have faced extraordinary situations. In their countries of origin, they have undergone extreme experiences, such as intimidation, persecution, (sexual) violence, imprisonment and torture. Sometimes, they have witnessed the murder of family members, narrowly escaping death themselves. Their escape has also been an anxious and uncertain time. [As asylum seekers], they are again confronted by a period full of insecurity, because the asylum process is prolonged and the outcome uncertain. In addition, they have to deal with language problems, unemployment and loss of status.’ (http://www.pharos.nl).

The pathologisation of refugee experience is a matter of concern (Raj and Reading 1999) as is the categorisation of refugees and asylum seekers as ‘victims’ not as ‘survivors’. How then is the difficult question of refugee health, and especially mental health, to be addressed? An effective clinical response to mental health issues faced by refugees should take into account the experiences of the individual and may need to conclude that the clinical role needs to to be cojoined with other positive strategies (Raj and Reading 1999). This view is echoed by Kramer (Kramer 2000), in his discussion on psycho-therapeutic interventions with refugees and asylum-seekers in the Netherlands (Boomstra 2000).

Common Health Problems

Causal Factors
The process of becoming a refugee is often divided into three stages: pre-flight, flight and post-flight. Van der Veer (1998) notes situations that are commonly associated with each stage, and the health problems that accompany them. Prior to flight an individual may be detained, and possibly tortured whilst in detention. He/she may also be subjected to other forms of terror such as witnessing violence, or taking part in combat.
During this stage, or perhaps during flight, a refugee’s relatives may disappear through violence or in the upheaval of migration. As a result of losing loved ones and their home refugees may therefore experience feelings of separation and loss. During flight refugees may also experience physical hardships such as hunger, exposure to extreme temperatures. During the final stage, that of exile, former experiences may manifest themselves as ongoing mental health problems. Poor housing, inadequate statutory resources, cultural isolation, and racism often compound these ongoing traumatic memories and feelings of loss and separation. It has also been argued that dispersal can be potentially damaging to the health and wellbeing of asylum seekers (Woodhead, 2000). Removal from London, and often therefore, from numerous support networks, can be very traumatic and lead to feelings of isolation and loneliness. Summerfield cites community support as a major protective factor, in terms of providing mutual support and solutions to problems (Summerfield, 2000: 2). These conditions can also worsen physical health problems sustained prior to or during flight (van der Veer, 1998).

**Common Illnesses**
Recent surveys showed that:

- Two thirds of refugees experience anxiety and/or depression (Carey-Wood, Duke et al. 1995).
- Refugees have a high incidence of post traumatic stress disorder, depression, anxiety, panic disorder and agoraphobia (Brent and Harrow Health Agency et.al., 1995).

According to the Medical Foundation (1999) the range of psychological problems experienced by torture survivors can include:

- Nightmares
- Hallucinations
- Panic attacks
- Sexual Problems
- Phobias
- Difficulty in trusting others and forming relationships
- Depressive illness/anxiety.

As a diagnosed condition Post Traumatic Stress Disorder (PTSD) is by far the most common mental health problem among refugees and asylum seekers. PTSD can be defined as ‘a prolonged reaction to intense stressors such as war or persecution’ (Watters 1999), and may include any of the symptoms indicated above. The term was first used in 1980 by the American Psychiatric Society in referring to Vietnam war veterans (Young 1995).

However, the concept of PTSD has been much criticised for a number of reasons. Firstly, that the experience of becoming a refugee is not necessarily pathologising. In other words, to suffer from one or more of the conditions outlined above, does not equate to a ‘traumatic reaction’. The significance of a symptom will relate to an individual’s own experience, and therefore the Post Traumatic Stress Disorder model is not universally applicable.
The second major criticism is that health professionals do not always acknowledge the fact that the model comes from an inherently Western view of mental health (Raj and Reading 1999). As Kleinman et. al. point out, illness and everyday life are part of one another, but when illness is compartmentalised as a medical problem these elements become fragmented, thus exposing the specifically cultural nature of biomedicine and the Cartesian dichotomies within in it (Kleinman, Brodwin et al. 1992).

Drug use is thought to be among one of the most common health issues for asylum seekers and refugees (www.harpweb.org.uk). Some users were already taking drugs before their arrival in the UK, while others begin perhaps as a response to the stressful situation they find themselves in on arrival. Asylum seekers may have language or cultural difficulties with attending drug user services and there are currently no national programmes specifically for asylum seekers with drug problems.

Khat (qat, kat, chat) is the green leaf of a shrub, chewed socially by people from the Horn of Africa and the Middle East (Cassanelli 1986). A number of asylum seekers and refugees in the UK chew the leaves, especially young Somali men, a stimulant that effects relaxation and reduces the appetite. Like other stimulants use may cause dizziness and lethargy. Khat is not thought to be physically addictive, however it is thought that regular use may lead to an emotional dependency or that sometimes khat may be replaced by other drugs and alcohol (www.drugscope.org.uk; Burnett and Fassil, 2002). Both the Medical Foundation and the Somali Welfare Association have claimed that khat use in young Somali men can exacerbate mental health problems and lead to suicide (Raj and Reading 1999).
Chapter Two: Mental Health and Social Care Provisions

2.0 The Healthcare System in Britain

Britain’s National Health Service is a state-run public service free to all those resident in the UK. The structure of the NHS in Britain can best be described using the diagram below.

![Diagram of the NHS structure in Britain]

Source: www.nhs.uk, 2002
The Department of Health

The Department of Health (DoH) is responsible for macro policy making and planning. It also manages, regulates and inspects the overall health and social care system. The DoH also has four Directors of Health and Social Care who work closely with the NHS and who manage strategic health authorities.

Strategic Health Authorities

From April 2002 many responsibilities of England’s 95 health authorities were passed to primary care trusts. The health authorities were replaced by 28 large strategic health authorities, which will come into effect in October 2002. Strategic health authorities are the link between local NHS trusts and the Department of Health. They will manage local services and ensure that government targets and policy plans are met.

Specialist Health Authorities

Specialist health authorities provide nationwide care. An example of a specialist health authority body is the National Blood Authority.

Primary Care

Primary care is the first line of healthcare, normally provided in General Practitioner’s surgeries. This line of healthcare not only includes GP’s but nurses, health visitors, dentists, opticians and a range of other therapists. Primary Care Trusts administer and plan local health services, and are responsible for maintaining and improving the health of the local population. Walk-in centres are open seven days a week from early morning to late evening, and provide fast access to health advice and treatment. NHS Direct is a telephone advice service that offers free medical advice 24 hours a day. Advice is also available on the Internet.

Secondary Care

Specialised care provided by hospitals. NHS trusts operate and manage hospitals, offering a broad range of services. NHS trusts employ the majority of the NHS workforce including nurses, doctors, midwives, dentists, pharmacists, physiotherapists, occupational therapists, podiatrists and psychologists and many more.

Current Trends in Mental Healthcare

Under growing recognition of the very problem focused nature of medical care in the West, more fluid practices have been adopted in the United Kingdom. Throughout the 1980’s, like most of the rest of Europe, Britain’s mental health provision shifted towards community care (Watters, 2002). Local Community Mental Health Team’s (CMHT’s) were established alongside primary care settings, offering a range of services including psychiatrists, psychiatric nurses, social workers, occupational therapists and psychologists in the community. The aim of the CMHT is to offer an integrated, ‘joined up’ approach to health care.
2.1 Multicultural care provisions

Ethnic minorities and mental health in the UK

It has been claimed that black and ethnic minority groups are ill catered for by the mental health service (Rogers and Pilgrim, 1996). As the 1999 National Service Framework for Mental Health points out, some black and ethnic minority groups have higher recorded rates of mental disorder than the rest of the population. Similarly, a recent study by the Sainsbury Centre for Mental Health, ‘Circles of Fear’ (2002) points out that Black and Afro-Caribbean people are over-represented in mental health services and ‘experience poorer outcomes than their White counterparts’ (SCMH, 2002). Moreover, young Afro-Caribbean men are more likely than others to be referred to through the criminal justice system rather than G.P’s. Young Asian women too, have high suicide rates compared to other young women (Aldous et. al., 1999).

Ethnic minority mental health patients are also more likely to be given ‘physical treatments’, such as drugs and electric shock treatment than their white counterparts (Fernando, 1995).

It has been commented that high rates of mental illness occur due to the specialised experience of ethnic minorities (Wilson and Francis, 1997). Racism may cause ethnic minorities to be disadvantaged in education, housing, work and other areas of life, which may impact on mental wellbeing. That lack of understanding may also continue once individuals enter the mental health system. However, some writers (Littlewood and Lipsedge, 1982; Fernando, 1988) have commented on the lack of cultural awareness in diagnosis and care, and the need to assess those methods and accepted models of mental illness.

Service Provision

The NHS

The NHS Modernisation Plan claims that ‘the NHS of the 21st century must be responsive to the needs of different groups and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality… the NHS must also be responsive to the different needs of different populations’ (www.doh.gov.uk).

In keeping with this aim, the Race Relations (Amendment) Act, 2000 required all Public Authorities, including the Health Service to ‘actively promote race equality’ through their ‘general duty’ to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good race relations between people of different racial groups.

To further these aims the NHS have established the Action on Health Equality Programme in order to develop ways of tackling health inequality in service provision.
The programme have begun to work with a number of projects across the country looking at good practice.

The Good Practice in Asian Mental Health Project at North Birmingham Mental Health NHS Trust is one such project. Arising from awareness days and a conference, the project aims to promote discussion around mental health issues among Asian communities in Birmingham and to improve standards of care for these groups. With the Council for Sikh Gurdwaras, two projects have developed; the Shanti project that gives mental health support to Sikh people, and the Dhandrusti project, that promotes complementary therapies to wider communities. Two videos have been produced, ‘Mann Ki Baat’ that aims to de-stigmatise mental illness, and ‘Talking About Suicide’ a drama that examines issues surrounding the subject.

The project has developed a Good Practice in Asian Mental Health guide, and delivers training on the subject. In development is a Resource Library and a Nurse Recruitment plan. The North Birmingham Mental Health Trust were winners of a Health and Social Care Award in 2001 for ‘improving the lives of people with mental health problems’ (www.doh.gov.uk).

A number of nationwide non-governmental mental health organisations in the UK have policies in place to provide multi-cultural mental health and social care (MIND, Rethink, SANE). MIND, for example, the largest mental health charity in the country, has established ‘Diverse Minds’, a body of policy makers and user groups that aim to ensure Black and Ethnic Minority policy is being effectively implemented. The group claim that the body has been successful in ensuring change both within and without MIND. MIND also have various localised projects offering counselling and care for Ethnic Minority clients.

The charity NASFIYAT provide counselling and therapy solely for people from black and ethnic minority communities. The organisation offers three services; counselling, training and outreach. Counselling aims to be culturally sensitive and includes provisions for clients to choose their own therapist. Each client receives a short-term contract of 12 weeks of therapy, which is then reviewed. Training seminars are held with community groups who request relevant topics. Training can cover a number of issues that can impact on mental wellbeing including familial disputes and feelings of isolation. Finally, NASFIYAT’s outreach work centres on mental health promotion and awareness raising and promoting the work of the organisation (Raj and Reading, 1999).

Many ethnic minority community groups also provide wellbeing services as part of a wider community care package. The Vietnamese Mental Health Service provides a number of culturally sensitive services to Vietnamese Communities in London and elsewhere, working with health and social care professionals and other organisations. Services include; development of mental health services for Vietnamese Community Organisations outside London, outreach work including counselling and day centres, support for carers (specifically for children of mentally ill parents), supported accommodation and training, education and health promotion. The Service receives clinical referrals and referrals from community groups and individuals.
Recommendations and Implementation

The high number of individuals from ethnic minorities to be diagnosed with mental illnesses is well documented and detailed above. In the light of this research, a recent report by the Sainsbury Centre for Mental Health, ‘Breaking the Circles of Fear’ seeks to explore and document black clients’ experiences of mental health care and analyse the service provision for those clients. With this research, the study hopes to generate an agenda for change (SCMH, 2002).

The Sainsbury Centre’s study makes a number of recommendations to combat this inequality. These include establishing ‘gateway functions’ to act as bridges between Black communities and mainstream mental health care; national mental health promotion ‘aimed at and owned by Black communities’; improved access to services through advocacy schemes; increased involvement of carers, and mental health workforce development through training in order to create sensitive services, and finally the study encourages the government and the National Institute for Mental Health to develop long term strategies to address inequality (ibid).

The Department of Health accepts that the mental health system is not meeting the needs of certain ethnic minority groups and that as a result, individuals may feel let down by the system. In order to tackle these problems the 1999 National Framework states that ‘All mental health services must be planned and implemented in partnership with local communities, and involve service users and carers’ (Department of Health, 1999). In practical terms this includes making NHS services (for example, NHS Direct) culturally sensitive, measures to create a register of transcultural psychiatrists, promotion of community mental health teams in rehabilitation of clients and a greater emphasis on the views of clients and their carers throughout the implementation process.

Like much British health and social care over the past two decades, a trend in health care for ethnic minorities has seen service provision becoming integrated and more culturally appropriate. A number of statutory services in London (most prominently Lambeth, Lewisham and Southwark, Brent and Harrow, Newham and Camden and Islington Health Authorities) and latterly the regions are building services that offer, among other things, interpreters, bi-cultural therapists and alternative therapies. Numerous non-governmental groups offer similar services and much expertise is exchanged between statutory and voluntary organisations. This is not to say that current mental health care for refugees is fully integrated and operating smoothly without problems. This is arguably far from the case in areas outside London, as the discussion of dispersal above demonstrates. However, there is a general move towards an exchange of knowledge and skills, and the various agencies that work with refugees are being encouraged to communicate more freely.

Fernando (1995) argues that much mental health care, and specifically psychiatry, suffers from ethnocentric and racist thinking that has been institutionalised in successive mental health acts (ibid: 35). For Fernando it is not policy changes that need to take place as much as a cultural shift in attitudes. In order to begin to combat this however, he advocates a “‘relativistic multi-systemic approach’ to identifying mental health problems [that] encompasses a wide range of dimensions but yet addresses the distress of individuals” (ibid: 203). Nevertheless, Fernando concludes that the mental health system in the UK still has a long way to go before it will provide services that are appropriate for all ethnic groups, or “multi-ethnic services for a multi-ethnic society” (ibid.: 214).
2.2 Services for asylum seekers and refugees

Mainstream Care Provision

Once an individual has lodged a claim for asylum, they and their dependants are entitled to the same NHS healthcare as any other UK resident (Aldous et.al., 1999:v). Officially refugees must be health screened at their port of entry by Port Health Control Units (PCHU), mainly for communicable diseases such as tuberculosis. However screening is somewhat sporadic and does not take place at some of the smaller ports (Clark et.al., 1998: 10). Health visitors too will sometimes take on the task of testing for communicable diseases, and are also required to visit all newborns. When reception assistants meet refugees to apply for NASS support they enquire into the health of the applicant.

According to a Social Welfare Worker (unnamed for reasons of privacy) at a reception organisation in Kent, questions cover both mental and physical health, and may include questions such as ‘do you have any mental health problems?’, ‘do you suffer from nightmares?’. However, the depth into which this is pursued depends largely on individual members of staff. As noted above, under the new White Paper (Secure Borders, Safe Haven 2002), health screening will take place in Induction Centres.

Alternative Health and Social Care

Watters (2001) points out that not all pathways to healthcare begin with GP’s consultation, arguing that much mental health care involves a much wider range of voluntary and user organisations (ibid.). As health visitors go to see most newly arrived families they can often act as important link workers between asylum seekers and primary care providers. Many health problems are linked to other issues such as poor housing, anxiety about a pending asylum case or racial harassment. Housing organisations, Citizen’s Advice Bureaux and reception assistants can therefore provide indirect care by resolving practical issues.

Refugee Community Organisations (RCO’s) too, can offer practical advice and support, providing access to mental health services. Many also provide their own therapies such as social events, Refugee Forum’s or alternative medical therapies such as massage. Finally, Watters points out the importance of religious centres in providing spiritual and social support that can again indirectly alleviate mental health issues (ibid.).

Complementary Healthcare

Over recent years there has been an increase in alternative healthcare provision for refugees and asylum seekers. Talking therapies are the most common alternative services for refugees and asylum seekers in the UK. Counselling is perceived to offer benefits to clients due to its often non-clinical setting, its links with practical advice giving and the fact that although clients may not be familiar with counselling in the Western sense, they may have talked through problems with a specific person in their country of origin, such as religious leader or relative (CVS Consultants, 1999).
However, counselling for refugees has been criticised as the discipline comes historically from a specifically Western perspective and still holds many of those biases. Fernando (1991) has commented on the difficulties in using orthodox methods to treat mental health problems with different cultural groups. In order to make counselling and other talking therapies more accessible to refugees and asylum seekers, a number of services now provide bi-cultural or trans-cultural counselling, where the session is held in the mother-tongue of the client. One such service is profiled in the next chapter. Nevertheless, clients prefer not to discuss intimate problems with members of their own community as they are concerned with issues of confidentiality or are embarrassed (CVS Consultants, 1999). Finally, the BMA warns that while the act of discussing traumatic events can be therapeutic, it is not necessarily so, and the negative and distressing effects can outweigh any benefits (BMA, 2002).

Perhaps less culturally bounded are non-verbal therapies such as massage, art therapy, physiotherapy and relaxation techniques. Such therapies may ease chronic pain and be used in psychotherapeutic exploration. For example, psychosocial therapists working with children who have experienced traumatic events have commented on the value of various arts as therapy (Nyuland, Legrand et al. 1999).

The therapists, in their work for UNICEF found that art, dance, music and drama enabled children to express their emotions in a safe and contained environment. Furthermore, they argue that culturally specific references can be used in art that provide children with a point of reference that is reified by the community around them (ibid). Non-verbal therapies are perhaps therefore particularly useful in treating refugees as they provide an alternative to the culturally loaded practices present in western mainstream medicine.

Problems in Service Provision for Refugees and Asylum Seekers

The needs and problems experienced by refugees and asylum seekers can impact on the success and effectiveness of their access to adequate healthcare services. Despite the fact that every asylum seeker is entitled to free healthcare from the NHS, there remain a number of barriers to healthcare for this group.

The British Medical Association (2002) perceives barriers to include; language and culture, time and continuity of care, information on health services, exemption from charges for healthcare.

Language and culture:
Often interpreters are not provided for refugees and asylum seekers in healthcare services, this can cause confusion and upset. Similarly, a lack of cultural understanding can offend clients and staff and hinder adequate care.

Time and continuity:
Due to the high mobility of asylum seekers, the large numbers of healthcare professionals that may treat them, the problems of communication and their often uncertain asylum status, continuity of care, and time in which to offer treatment can often be a massive barrier to care.
Information on health services:
There is often a lack of translated material on primary care services available to refugees and asylum seekers. In addition, many of those working with asylum seekers are unaware themselves of services available and of client’s right to access them.

Exemption from charges for healthcare:
Again, due to lack of information, many asylum seekers are unaware how to apply for free medical treatment. The form to fill out in order to claim is also only available in English and Welsh.

Barriers to healthcare in removal centres:
There are numerous problems associated with removal centres, many associated with mental health. However the BMA highlight other problems such as lack of translation services, poor treatment, lax record keeping and lack of agency on the part of clients in choosing treatment and practitioner (ibid.).

Levi (2002) in her study of asylum seekers and recently settled refugees in East Kent largely supports the BMA’s list of barriers to healthcare, but adds that some healthcare worker’s reactions to refugees and asylum seekers caused problems. The study found that staff were sometimes reluctant to register refugees, and could be impatient, irritation and anger in dealing with clients. The reasons given for this behaviour were lack of time, problems with communication and inappropriate service use. The study also found that although a number of refugee respondents had experienced some ‘overtly hostile’ behaviour from ‘nurses, midwives, dentists and ambulance crews’ that had upset them, none had made a formal complaint (ibid.).

Pathways to care and the effects of dispersal
The system of dispersing asylum seekers who receive National Asylum Support Service benefits away from the South–East of the UK has had a massive impact on the on the healthcare of those individuals. Many of the difficulties experienced by asylum seekers and refugees listed above are compounded through dispersal. For healthcare providers this has presented a massive organisational challenge.

The dispersal system aims to place people in areas where there are similar ethnic groups, however, in practice this is not always the case. The Breathing Space proposal (Griffin, 1999) argued that dispersed refugees would find themselves outside London in areas that had inadequate resources and little understanding of individual experiences or their impact. Furthermore, asylum seekers may face difficulties in accessing services due to their status. This has been highlighted recently by a case in which Barnet, Enfield and Haringey Mental Health Trust rejected an asylum seeker patient stating that the Trust was ‘not currently accepting referrals of asylum seekers’. In a letter to the GP who had made the referral the Trust argued that, ‘the stress of their uncertain status in this country confounds the multiple psychosocial problems that they undoubtedly already have and which we are not equipped to deal with in addition to the heavy volume of the more standard referrals’ (Carvel, 2002).
It is commonly assumed that accessing primary care generally depends on registration with a local General Practitioner (Goldberg and Huxley, 1980; The Refugee Health Consortium, 1998: 11; Audit Commission, 2000: 62).

However, there are a number of factors that hamper an asylum seeker’s access to GP care, factors that have been exacerbated by dispersal. Firstly, under the dispersal system many GP’s have found their resources overstretched as housing tends to be in already under resourced areas and GP’s may not be given extra funding (Williams, 2002). Secondly, communication problems may arise if interpreters are not available or if patient and doctor are coming to the consultation with quite different explanatory models of health and illness (Kleinman, 1980). Thirdly, asylum seekers are typically highly mobile, often causing care to be fragmented and inconsistent, that in turn can lead to the aggravation of existing health problems. Temporary residence in a number of regions may also mean that medical records are not maintained. Finally, all of the issues above raise the administrative costs for GP’s surgeries, causing some GP’s to actively discourage asylum seekers from registering. As a result, many asylum seekers have found it difficult even to register with a GP (Woodhead, 2000).

However, as dispersal areas are becoming accustomed to receiving large groups of asylum seekers so numerous resources have developed to offer sensitive health and social care. A number of these resources are detailed in Chapters 3 and 4, which examine examples of good practice in services. The work of the Breathing Space Project has gone a great way in promoting healthcare for refugees and asylum seekers in the regions.

The Breathing Space Project, a mental health programme, and collaboration of The Medical Foundation and The Refugee Council, has dedicated teams which train healthcare professionals and those working with refugees and asylum seekers and develop networks and expertise around the country.

**Recommendations**

The BMA (2002) has made a number of recommendations that go some way to prevent and allay some of these problems.

1) ‘Trained interpreters or advocates, rather than family members or friends, should be used wherever possible if language is not shared.

2) Healthcare professionals need to develop a greater understanding of cultural, social and other issues relating to asylum seekers.

3) While staying in induction centres, asylum seekers must be provided with health service information and accompanying forms in a language and format that they understand. Consideration should be given to develop systems to help illiterate asylum seekers also access this information’ (BMA, 2002).
Chapter Three: Practices Developed for Asylum Seekers and Refugees

3.0 Introduction

Mental wellbeing is an holistic concept, dependent on many factors. The mental wellbeing of refugees and asylum seekers then, could be said to depend on immigration status, accommodation, health, education, and social networks, among others. A vast array of service providers assist refugees and asylum seekers with issues in these areas, these are illustrated well in the diagram below from the Government’s 1999 report on dispersal that depicts the agencies involved in meeting the needs of asylum seekers and refugees.

National Agencies working with asylum seekers and refugees:

For the purposes of this short Good Practice study, UK researchers examined only two of the six local and national agencies detailed above, health care services and refugee community organisations.
agencies and community groups - specifically those that provided mental health programmes.

An area for future research might be the ways in which other agencies, such as housing providers, can improve the mental health and wellbeing of refugees and asylum seekers. Health care services included the Department of Health, Social Service authorities, GP services and primary care providers, Primary care groups, Port Health Control Units, NHS Trusts and Health Authorities. Refugee agencies and community groups included National Refugee Agencies, Refugee Community Organisations, Local Authority community development services and Religious and Voluntary Organisations.

3.1 Methodology

The analysis in this chapter is based on interviews (telephonic and face-to-face) with service providers based throughout Britain. A list of interviewees and contact details can be found in Appendix 2. Both questionnaire and interviews sought to highlight previously identified elements of good practice, which are outlined below. Each assessment followed the same semi-structured format that examined all the areas detailed in the project’s idea of good practice, a copy of the survey and interview can be found in Appendices 3 and 4.

The service providers were identified through a detailed survey of secondary literature on refugees and asylum seekers in the UK, including recent NHS and Department of Health reports, government funded documents and independent findings from Non-governmental refugee groups. A detailed literature survey was undertaken in order to establish which organisations and services might be approached to take part in the study (Burnett and Fassil (2002); Government (2000); Audit Commission(2000); Raj, M. and J. Reading (1999).

From this initial research, a list of 59 services perceived to be providing good practice was then compiled. About 80% of the organisations identified were in London. A three-stage process then began which started with a survey being sent out to all 59 services to further establish the nature of their work how it was funded, their role and position and whether the service had ever been evaluated. Of those 59, 26 replied and of those 26, 14 demonstrated particularly good practice, by the criteria detailed below.

Of those 14 we conducted telephone interviews with 10. With four services we undertook detailed extended face-to-face interviews. After completing this process, 11 services exhibited one or more of the good practice elements and 3 that proved to be examples of excellent good practice.

3.2 Elements of Good Practice

The World Health Organisation defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. The Good Practice Guide on the Integration of Refugees in the European Union, Health (Monaldi,G and Strummiello, 1999) emphasises the vital importance of health in the integration process as people’s quality of life and personal development is related to their physical and mental well-being. It adds that ‘focusing on refugee health means taking into account prevention strategies carried out by the country of asylum in order to alleviate refugee health
problems; reflecting societal aspects and the accessibility of appropriate treatment; and last…the setting up of special provisions tailored to refugee-specific needs and their expectations of care, if and when this is required.’ (ibid.: 5).

The Health of Londoners Project (Aldous, Bardsley et al. 1999) recommends that certain services be centralised. These include the work of health authorities in ensuring that clear guidelines on refugees’ rights to healthcare are disseminated to staff throughout the service and that there are provisions for the education and training of staff. An information service that can react quickly to changes in the nature of asylum seekers entering the UK and offer appropriate and timely advice to health workers is also critical.

The Refugee Council recommends that the establishment of a system for the automatic health assessment for new arrivals should begin an ongoing process of contact with the NHS. Asylum seekers should be given introductory information on UK health services and have their entitlements explained. A pilot health screening scheme for new arrivals, running in Kent, is currently exploring how best to assess the health of new arrivals.

Health professionals have commented that the most effective screening would be ongoing over a period of weeks or months, building the relationships and knowledge of the client to effectively feed them into mainstream healthcare (Breathing Space Conference, December 2002, personal communication).

On the basis of extensive literature reviews (Kos and Derviskadic-Jovanovic 1998; Aldous, Bardsley et al. 1999; Monaldi and Strummellio 1999; Raj and Reading 1999; 2000; Government 2000; Kramer 2000) including evaluations of projects (Watters 2002) and discussions with service providers and researchers, the following have been identified as important elements of good practices in the provision of services aimed at improving the mental well-being of refugees and asylum seekers in the UK. The elements identified in this section incorporate ‘macro’ as well as ‘micro’ issues and range from the level to which services are made maximally accessible to the extent to which service providers use learnings from their grassroots work to advocate at the policy level.

**Access and Promotion (planned and actual)**

- What are the ways in which information about the service are disseminated to potential users? How are barriers to the discussion of mental-health issues overcome?
- Range of languages in which literature on the project is available; numbers of multi-lingual staff/ availability of interpreters
- Geographic/ physical location – is the project/ organisations sited in such a way as to be easily accessible by public transport? Is there disabled access?
- Financial – what is the cost of the service?

**User involvement**

- Were users involved in the conception of the project/service?
- Are users involved in any part of the project/organisation apart from as clients?
- Is there any provision for the incorporation of users’ suggestions in the running of the project?
Multi-agency linkages

Closer working with different agencies – health authorities/trusts, statutory bodies and other agencies – can encourage

• Pooling skills, information and resources
• Tackling multiple needs
• Avoiding repetition

Additionally, contact between projects is important. As Grabher (op.cit.) points out, projects work in a milieu of recurrent collaboration that, after several project cycles, fills a pool of resources into latent networks; ‘know-how’ as well as ‘know-who’ become tacit knowledge.

Continuity:

of services

‘Strategies should aim to ensure that mainstream services at all levels can cater to for the whole population. The problem with short-term funding is that when it ends, refugees are at risk of isolation, with the system still unable to meet their needs.’ (Refugee Council, Good practice guide, health).

• Structural and financial embeddedness of projects. Can the project continue its work in some form after the funding period has come to an end?
• Is practice is consistent and/or formalised (for example in a constitution).
• Are there provisions for the education and training of personnel and staff so that the project is not dependent on one or two key persons and learnings are shared throughout the organisation?
• Is there availability of clear and jargon-free information regarding any changes to the existing system/practices.

for clients

• Do records exist, are they kept up to date and accessible?
• Are clients made aware of multi-agency links, are there records of how the different needs of the client are met by different agencies. Is there any forum for inter-agency discussions regarding cooperative efforts?
• The procedure and practice of onward referrals.

Sensitivity

• Is there an attempt to develop culturally appropriate treatments in conjunction with patients and communities?
Communities are not stagnant and individual needs vary over time. Is reflexivity built into the system?

Gender sensitivity – is the environment sufficiently non-threatening for women? Is there any record of the number of female clients and reflexivity regarding any special needs that such clients may have?

Advocacy

This can be divided into ‘macro’ and ‘micro’ level advocacy and includes:

- Using knowledge on the ground to push for changes in the larger policy arena
- Ensuring that clients are aware of their ‘rights’ to services.

Evaluation

This too involves reflexivity – have there been any external/internal evaluations?

Research

Research is an important aspect of service provision. As the Refugee council points out (2001), more research on the client group and evaluation of projects need to be done before service providers can be proactive rather than reactive.

Distinguishing between statutory organisations and temporary projects

Before embarking on a discussion of elements of good practice, however, it is useful to briefly review the distinctions and interrelationships between temporary projects and permanent institutions. The term ‘permanent’ is intended to depict organisational structures which are planned to exist, if not forever, then for the foreseeable future. Projects, on the other hand are activity-oriented and have institutional termination. Projects have lately become subjects of academic analysis (see Grabher 2002). Previously used almost exclusively to refer to a proposed idea or object, the term project has now come to be used in social work and research to refer to standard organisational practices which emphasise the process of realising an idea or objective. An approach which recognises that projects and organisations as distinctly different yet interrelated recognises the strengths and limitations of each and argues that good practices in part are found where projects are structurally and financially embedded in permanent institutions which are, in turn, responsive to the learnings that projects bring in the course of their existence. A time-bound project may be initiated and run by a permanent organisation, for example the Breathing Space project (discussed in Chapter 2) which was started by the Medical Foundation for Victims of Torture and the Refugee Council.

Both projects and organisations are embedded in networks that facilitate skill and information sharing. Together they form part of a community of practice. When evaluating projects it is important to discuss their financial and structural embeddedness as well as any provisions for institutionalising and transferring findings from project to permanent organisations and to other projects. Similarly when discussing permanent institutions, the
responsiveness of the institution to issues raised in the work of other institutions as well as projects is important.

Certain categories emerged from the data collected through interviews, surveys and from secondary literature. The categories are as follows: structurally innovative projects; therapeutic approaches; training, education and advocacy; preventative activities; holistic and integrative health and social care. It is important to recognise that the categories are not watertight and that organisations which we highlight as pioneering good practice within a particular category, may, at the same time, be engaged in activities that fall into the other categories. To this extent the categories primarily serve an analytical purpose and are useful in conducting comparisons with services in the other countries addressed by our research project.

For the contact details of all the projects discussed below, please see Appendix 2.

**Structurally innovative projects**

Within this category are grouped projects that grow in response to needs of clients, build on existing structures and those which are able to react positively and constructively to changes in legislation and policy.

In this context it is illuminating to briefly outline the Personal Medical Service pilots introduced by the government as part of the National Health Service modernisation plan and to discuss the growing number of service providers throughout the country who have taken advantage of this scheme to create specialised services for particular groups of clients. These include the Newham Transitional Primary Care Team; the London based Health Support Team; Asylum Seeker Health, Sheffield; the Refugee Health Support Team in Barking, Essex; and, the Refugee Clinical Team in Vauxhall, London all of whom we interviewed for this study.

The NHS (Primary Care) Act 1997 allowed for the introduction of 'PMS pilots'. The term 'personal medical services ('PMS') refers to the same type of services as General Medical Services (GMS), but differentiates in that the services are being delivered under a pilot scheme. PMS pilot schemes are voluntary and are intended to give Primary Care Trusts, Strategic Health Authorities and providers - particularly GPs and nurses - the flexibility and opportunity to innovate by offering different options for addressing primary care needs. Doctors, nurses and PCTs that become PMS pilots, are able to negotiate directly with their commissioner to provide the services patients want, for example, varying surgery times to meet the needs of the local population, including addressing the needs of particular groups, for example, the homeless, populations with high mobility such as asylum-seekers and so on. Although not the sole purpose, one of the principles behind the flexibilities of PMS is to try and improve recruitment and retention of GPs within the NHS, especially in under-doctored areas, where it is difficult to attract and retain GPs. Linked to this is the attempt to distribute NHS financial resources more equitably to populations in need and to areas of deprivation.

The aims of PMS pilots are to:
• shape the primary and community health care services in their locality in partnership with PCTs, GPs, nurses, patients, Local Authorities and other voluntary organisations;

• address the problems of recruitment and retention of GPs, attracting more GPs to an area by offering GPs the opportunity of salaried employment. This could lead to the provision of a wider range of services which are more readily accessible to patients;
• encourage GPs and nurses to work more closely together, using the best of the skills available
• create more integrated services for patients;
• work to tackle health inequalities and the health problems of deprivation in parts of the country; and
• give doctors and nurses new flexibility in the way they provide care.

Over 30% of GPs are now working under the new contract, whereas when the NHS Plan was published in July 2000, only 4% of GPs were working to PMS Agreements. GMS delivers care to patients through a nationally determined contract. This suits most of the people most of the time. Under PMS the agreed range of services to be provided is specified in the locally negotiated contract. Payment to GPs under GMS is through a complex system of fees and allowances aligned to nationally agreed services without any local flexibility. The contract providers (GPs or Nurses) and the Commissioner (Strategic Health Authority (StHA)/Primary Care Trust (PCT)) agree a total price to be paid annually (most often in 12 monthly instalments) therefore increasing financial stability (www.doh.gov.uk/pricare/pca.htm).

The PMS pilot projects interviewed by us and discussed below serve to demonstrate how structural innovations pioneered by statutory organisations can act as catalysts for service providers to initiate time-bound projects (whose funding period may be extended) which act as pilots and seek to fulfill specific goals or to fill gaps in existing services. The Newham Transitional Primary Care Trust Project was set up on the basis of a persistent problem – that of GPs in the area not registering various populations. Following extensive research, consultations and evaluation (over five years) of the causes and possible solutions to this problem and the subsequent lack of access to mainstream health services for a proportion of the population. The team was set up in 2000 and provides access to primary health care for people who cannot otherwise access care. This includes people who form part of transient populations including refugees and asylum-seekers. The service, which includes a full-time General Practitioner, a Nurse Practitioner and a part-time Clinical Psychologist, aims to integrate patients into mainstream primary care in the borough between 6-18 months of their being with the centre. General Practitioners in the area and the transitional primary care team have what the team’s clinical psychologist described as a reciprocal relationship where the GPs know that the NTPCT will take the majority of new arrivals into the area and that they are expected to take them on after a 6-18 month period so that the team can work with more new arrivals. Currently members of the team are also engaged in liaising to provide similar services to a larger number of GP practices in the area.

**Therapeutic services**
There are a number of different approaches to providing therapy for refugees and asylum seekers. As detailed in Chapter 2 C, refugees and asylum seekers often experience a very specific set of circumstances, which can be addressed through conventional medical practices (both physical and mental) and complementary therapies.

Organisations examined in this study have tailored their work to the client population and have developed a range of services appropriate to those clients. Those organisations surveyed offered a wide range of therapies, sometimes providing multiple therapies in one service.

Personal Medical Services perhaps offer a good example of statutory services provided for disempowered, highly mobile groups, including refugees. Some PMS services offer psychological assistance such as the Newham Transitional Primary Care Team, where a full-time Clinical Psychologist is based in the multidisciplinary team and is also part of a primary care psychology service in the area. Another excellent example of innovative therapy in a primary health care setting is the Somali Counselling Service operated by Tower Hamlets Primary Care Trust. A needs assessment conducted by the Trust in the early 1990’s found that the general service was not appropriate for all clients and needed to be more equitable. In response to this the Somali Counselling Service was set up aiming to work with the large Somali refugee population in Tower Hamlets. The Counselling Service is staffed by one full time Somali speaking counsellor, assisted by a Somali speaking Psychologist. Most sessions are conducted in Somali. The service is being developed by the counsellor, who is running focus groups with young Somali men to gauge perceptions of mental health and illness. She is also currently producing a video targeted at the Somali community that aims to dispel myths surrounding mental health issues.

A non-governmental service offering complementary therapies and counselling to refugees and asylum seekers is Saheliya in Edinburgh. Saheliya is a Black and Ethnic Minority Women’s Mental Health Organisation, set up in 1992. The organisation aims offer a service that develops mental health and wellbeing in a safe and confidential setting. The group offer counselling, group support, complementary therapies and befriending to Black and Ethnic Minority women in Edinburgh who are experiencing stress and anxiety. The body therapies offered by the service have been particularly well received and evaluated by clients. Most clients are self referred, having heard about the service from friends or relatives. Started in 1997, the body therapies aim to explore feelings of mental ill health with clients that do not feel comfortable discussing those feelings in a counselling setting. An evaluation undertaken in 2000 by the Scottish Ethnic Minorities Research Unit noted that many clients interviewed commented that they ‘usually felt “comfortable”, “peaceful”, “relieved of pain” and “relaxed”’ in a body therapy session. Moreover clients also reported feeling that painkillers or anti-depressants did not offer the (mental) health benefits of massage (Hampton, 2000).

Complementary therapies such as these are becoming increasingly popular in working with refugees and asylum seekers.

As detailed in Chapter 2, complementary therapies offer an alternative to the typical Western clinical model, which might not be appropriate for refugees and asylum seekers. The Sanctuary PMS pilot practice in Hackney, North London is a primary health care
team, providing holistic care for asylum seekers and refugees focussing particularly on those newly arrived, awaiting dispersal, a large number of whom are emotionally distressed. The Sanctuary aim not to pathologise distress, and in doing so usually term presenting health issues as ‘emotional stress’, rather than labelling it as ‘PTSD’.

Clients have difficulty in accessing usual services due to their hyper-mobility and difficulties with obtaining interpreters. In response to this the Sanctuary offer counselling and other assistance that is easily available and has little or no waiting lists. The service offers half hour appointments, and focus very much on listening, as well as providing practical support with problems – for example referring to the Red Cross Family Tracing Service for those whose relatives are missing. Regarding mainstream psychological counselling, GP responsible for establishing the practice argues that a Western individualistic style of counselling is not very effective. Most clients have experienced, and are experiencing more external forms of stress, such as political or racial. Therefore the counselling service aim to listen and doesn’t ‘claim to do anything more than hold the situation’, until a client is dispersed. Staff at the Sanctuary Practice have found that the most effective form of mental health assistance has a practical element.

**Preventative Activities**

For the purposes of this research, preventative therapies are defined as any service that aims not only to treat the individual but also to work with the causes of illness. Some services surveyed offered preventative care as an ancillary part of their work, in other words, prevention of further illness occurred through offering other forms of therapy or assistance. Saheliya offers a good example of this type of prevention. The effects of treatment are long lasting, and the service endeavours to remain a presence in the lives of clients in order to offer long term social support.

The local authority asylum team for Humberside and Yorkshire Consortium, based in Wakefield, also offers preventative care in the form of advice and support for newly dispersed asylum seekers. The team is housing led, although there is a social care team within service. As detailed in Chapter 2C poor housing can be one of the largest sources of stress and physical illness for refugees and asylum seekers. In allocating in each new arrival a social care key worker, any problems that may arise to do with housing, education or health can be addressed in a personal and sensitive way. Clients are able to build a trusting relationship with their key worker that can prevent mental health problems from occurring. The Wakefield Asylum Team is examined in depth below, in the section concerned with integrative and social care.

The Comfrey Project, an allotment scheme for asylum seekers and refugees in Newcastle, is perhaps the only primarily preventative service examined in this study. The scheme’s main remit is to promote health and wellbeing among asylum seekers and refugees through horticultural activity and social interaction. Again, this project is detailed in Chapter 4 as a case study of particularly innovative and successful good practice.

**Advocacy**

The term advocacy can be used in three distinct ways when looking at services for asylum seekers and refugees; firstly for those organisations that campaign on asylum issues at a policy and local level, secondly those that promote their services to potential clients, and
finally those services that act on behalf of clients. Although, like a number of the services
detailed here, the services below do not have specific mental health remits, the promotion
and development of culturally appropriate health services is arguably beneficial to the
mental wellbeing of patients in the long term.

The Northern Ireland Council for Ethnic Minorities (NICEM) advocates in a number of
ways; from a parliamentary level in response to policy changes, to a local level as it
directly represents the interests of ethnic minority groups in Northern Ireland and
challenges discrimination at all levels. With specific regard to asylum seekers and
refugees, the organisation has been sub-contracted by the Refugee Council to operate a one
stop service. The service offers advice and support to destitute asylum seekers while they
apply for assistance from the National Asylum Support Service (NASS). It is a free and
confidential service and interpreters are available if required. NICEM also run a free
Immigration Advisory Service, which not only provides immigration related advice, but
will also, on behalf of clients, contact the immigration authorities and make referrals to
solicitors.

Jane Cook of the Refugee Clinical Team at Lambeth Primary Care Trust has been
particularly innovative in advocating for health care professionals working with refugees
and asylum seekers. Based on the experiences and needs of colleagues, Cook together
with two other health workers, Joan McFarlane from Sheffield and Susan Donnelly from
Newcastle, lobbied the Department of Health to establish the Asylum Health Team. The
Team is a nationwide group for nurses working with refugees and aims to look at
developing good practice at a national level. As a result, the group takes views from a
grassroots level right into the heart of developing policy.

Finally, a group that is particularly successful in improving access for potential clients is
the Minority Ethnic Health Inclusion Project in Edinburgh. The service aims to link black,
etnic minority and refugee communities with primary care services to improve
accessibility and appropriateness of services in the Lothian region. MEHIP works towards
these goals in a number of ways, firstly through providing advice and information to health
staff and minority ethnic communities. Information on resources is also translated into
minority ethnic languages and the group promotes the development of similar resources
elsewhere in the National Health Service. MEHIP advocate for increased patient
involvement in terms of patients actively taking part in their own healthcare. And finally,
the service attempts to bridge communication difficulties and cultural barriers between
patients and health services.

**Training and Education**

Education and training ensure that services remain relevant to their clients and allows staff
to continue to develop their skills. In this way projects have more likelihood of continuing
once funding ends as the expertise of staff can be applied to new projects. Moreover,
training in and an awareness of, the mental and physical health needs of refugees and
asylum seekers can create an environment of understanding among staff that improves the
quality of care.

The Health Support Team at Westminster Primary Care Trust have developed a
‘Lunchtime Learning Programme’ to encourage staff at the PCT to improve their
understanding of the health needs of asylum seekers and refugees. The Learning
Programme aims to provide multi-disciplinary training and the exchange of good practice, as well as increase multi-agency working, guest speakers are also invited to present various topics. The Programme has been running twice a year for three years, each course consisting of a 12-week session of 2.5 hours per week; in that time and the majority of staff at the PCT have taken part.

The Mental Health Awareness Project situated at South London and Maudsley NHS Trust is a group of mental health professionals and service users that offer training, support and advice to various communities. Training is adapted to each group and involves discussing the nature of mental health; viewing mental health as a continuum rather than polarising health and illness. Service users are fully involved in delivering and planning training, and are paid in the same way as healthcare staff trainers. The Project has plans to train the National Asylum Support Service in Lambeth, Southwark and Lewisham and are developing an ongoing relationship with the organisation in Croydon.

In addition to training, staff support and valuation may go some way to ensuring the success of a project. Less formalised than training, staff development can occur in the form of supervision and good working relationships for example. The Bayswater Family Centre, in Westminster, offers once such example, and is detailed in Chapter 4.

**Holistic and Integrative Health and Social Care**

All the services above offer more than the single service we have profiled. This is most prominently the case with organisations that work closely with a number of agencies. Over recent years there has been an increase in multi-agency working in health and social care in Britain. Many professionals working with refugees and asylum seekers actively advocate an holistic approach to mental wellbeing, that can only be effectively provided by agencies working collaboratively. As a result, a large number of services for refugees and asylum seekers in the UK are part of a wider package that encompasses a number of services, both statutory and voluntary.

The Government has developed a number of multi-disciplinary services for refugees and asylum seekers over recent years, partly in response to changes in legislation such as dispersal. For example, dispersed asylum seekers are able to attend ‘One Stop Shops’ – centres that can offer practical advice on issues such as accommodation, the asylum process, education and where to find English classes. One Stop Shop’s tend to be run by agencies contracted by the National Asylum Support Service (NASS). Asylum Teams, developed in regional consortia, offer help and support to newly dispersed asylum seekers. More recently the government have developed pilot Induction Centres in line with recent legislation. Induction Centres act as One Stop Shop’s for recent asylum seeker arrivals. Induction Officers take individuals through the asylum process and give them important information prior to dispersal.

As mentioned above, the Wakefield Asylum Team, part of the Humberside and Yorkshire Consortium, offers support regarding housing education, health and social service for newly arrived asylum seekers. Staff on the Team include four case workers, one of whom is an approved social worker. Working alongside the Asylum Team is an education worker, staff on an interpretation scheme, a health visitor and a police officer. The multi-disciplinary nature of the staff involved reflect the holistic nature of the service provided. On arrival into Wakefield dispersed asylum seekers are housed in emergency
accommodation before being transferred to NASS housing. On their second day, asylum seekers are allocated a permanent social care worker from the Asylum Team who can assist them with housing and other issues and link them with other local services.

As a model for multi-disciplinary working this operates very well, with one worker acting as a gatekeeper to other services, and who can provide ongoing support and continuity for clients.

Another excellent example of multi-agency working is the Bayswater Family Centre, where a range of services are offered within one centre and links with other services are strong. The Bayswater Family Centre is examined more closely in the next chapter, where three case-studies of excellent good practice are profiled.
Chapter 4: Case Studies of Good Practice

4.0 Introduction

Chapter Four aims to offer three in-depth case studies of good practice based on the surveys undertaken and described in Chapter 3.

Once organisations had completed questionnaires, researchers conducted face-to-face interviews with the services below. These services tended to exhibit particular innovation in their field and a number of the good practice elements detailed above. The case studies are both statutory and non-statutory and include a practice from outside the South-East. This reflects the increasing development of health and social care services for refugees and asylum seekers throughout the UK and the fostering of good practice within those services through innovation, networking, training and increasing expertise.

The examples below were chosen to give an example of the range and scope of services throughout the country, there are undoubtedly other examples of excellent good practice, however these projects were felt to be particularly innovative.
Dr Montgomery offers primary medical care in a general practice context to newly arrived and resident asylum seekers and refugees in Folkestone, Kent. Dr Montgomery works solely with refugees and asylum seekers, but is based in a practice serving both refugees and the host community. Her specialised service was established by Shepway Primary Care Trust in 1999, and is reviewed annually.

Dr Montgomery has also been involved in the pilot health screening programme for asylum seekers being run by the Department of Health in Kent.

There are a few particular areas in which the service exhibits excellent good practice:

- **Accessibility and multi-agency linkages**
  Arguably, the most beneficial aspect of the service for clients is the improved access it provides to health and social care. Montgomery pointed out that the existence of the service ‘means that new arrivals have facilitated access to full registration in the NHS…and provides a gateway to all other levels of care’. This gateway can include signposting clients towards agencies for assistance with non-medical problems such as housing or immigration issues. Dr Montgomery has build up a wide range of multi-agency linkages through her work in this area which is central to her role in welcoming asylum seekers to the UK.

  There is also good access to interpreters at the service. The surgery utilise Language Line, a service that can link callers to interpreters speaking most languages. However, perhaps more importantly, Montgomery has, over the years, build up a wide network of interpreter contacts, some of whom are former clients and who now work for local agencies as well as undertaking freelance work.

- **Translated materials**
  With translators Dr Montgomery has developed a large number of resources for patients and healthcare providers in Czech, Slovak, Albanian, Farsi, Sorani, Arabic, Romanian, and Russian, covering some fourteen subjects, such as health screening, childcare, staying healthy and appointment letters. She has also produced a very comprehensive ‘Medical Phrasebook and Resource’ for Czech and Slovak speaking patients and their healthworkers.

- **Ongoing support and specialised service**
  The longitudinal nature of Montgomery’s relationship with interpreters is indicitive of her relationships with other clients. In the years that the service has been running, Dr Montgomery has been able to build up rapport and trust with clients that undoubtedly has mental health benefits in terms of continuity of care. Moreover, as a specialised service, Montgomery is experienced in dealing with this particular client group, and is familiar with many of common health problems clients may present with. Non-specialist G.P’s working with individual asylum seekers might experience a strain on resources in terms of time and effort. A single G.P. offering a specialist service within a larger practice is arguably more efficient in providing care to refugee and asylum seeking clients than a mainstream service.
4.2 Case Study: Baywater Family Centre, Westminster, London

The Baywater Family Centre offers comprehensive family support for homeless and refugee families in Westminster. Baywater has the highest concentration of homeless families in the country, 85% of those are refugees and the majority are non-English speaking. The centre sees around 600 households a year and provides a service for 1,200 families. The service is funded by the NCH, Westminster City Council and Westminster Primary Care Team, and the service will continue once the current funding ends.

The Centre run a number of services deemed to be beneficial to client’s mental wellbeing, including: a drop in for carers and children under 5 years old; advice and information on housing, benefits and education; health assessment and GP registration; counselling in mother tongue languages; various body therapies; provision for laundry; an Early Years pre-school and English classes to name a few. This example is one offering a mental wellbeing service in its widest sense, providing a wide range of services that can practically assist vulnerable people and thus alleviate mental health problems. On visiting the practice, a number of elements of the service stood out as being especially good practice.

- **Access and promotion**
The Centre believes that providing holistic services under one roof is the way to work with families who have difficulty in accessing benefits and services, lack financial resources and often English skills. Several different languages are spoken at the Centre, the number and nature of which alter according to need as the client base changes. Interpreters supplement languages already spoken by multi-lingual staff and volunteers. Information for clients is also translated. The service offers a number of body and talking therapies. Key to the success of these is the provision of childcare which facilitates access to the service. Moreover, according to the Manager, clients find it easier and less stigmatising to come to the Centre for counselling as they come their anyway for other services.

- **Client centred service**
The service attempts to accommodate individual needs as they arise, and clients are actively involved in the day to day running of the Centre as well as long term planning, at regular Parent’s Meetings for example. The Centre operates with very clear guidelines and boundaries for staff and clients, whilst maintaining a strong sense of openness and approachability. Throughout the stress is on the fact that people are individuals with different individual needs. Staff are also valued highly and a great deal of emphasis is placed on providing staff support.

- **Wide range of multi-agency linkages**
The Centre has a vast list of multi-agency links including: a befriend a family project, a number of local refuges, other NCH family centres in the area and the multi-faith Baywater Refugee and Asylum Seekers Support Group. Aside from the good practice alluded to above, that multi-agency working instils in a service, the Baywater Family Centre is particularly innovative in utilising these resources for fundraising purposes. Local businesses and groups have been targeted, with great success, for donations of toys and other goods for the Centre. The Manager of the Centre commented, ‘we cannot afford to be a closed little project. There are ways of funding projects without spending any money.'
This [experience] is enriching in many ways’. For non-governmental projects funding is often a constant source of stress, by sourcing funding in this way, Bayswater is increasing both its structural embeddedness in terms of building relationships within the local community, and its financial embeddedness. Through ensuring embeddedness the Centre overcomes one of the central factors that can hamper non-statutory services, instability.
4.3 Case Study: The Comfrey Project, Newcastle

The Comfrey Project is an allotment scheme to promote health and wellbeing among refugees and asylum seekers in Newcastle. The Project uses gardening as a form of communication and a method of healing for asylum seekers and refugees experiencing mental distress. The emphasis of the project is on providing a safe and pleasant place for clients to meet rather than on maximising horticultural output. The Health Action Zone, Esmee Fairbairn Foundation and Allen Lane Foundation currently fund the Project, and it has just received a three year grant from the Community Fund.

A small group of asylum seekers and refugees meet with the project co-ordinator on the allotments. The Project rent two allotments and clients have their own key to the site and can come to allotment whenever they wish. The group mainly carries out horticultural activities and throughout the winter also attend training sessions on horticultural themes and hold discussion groups and social events. The Project not only offers space for relaxation, but also for group support and contact. In this way it can reduce the feelings of mental distress associated with seeking asylum. The Project also offers meaningful activity to unoccupied asylum seekers and provides opportunities for training and skill development.

Particular aspects of good practice include:

- **Innovation**
  Although there are well documented benefits to using horticultural therapy with mental health patients (Linden and Grut, 2002), there are relatively few projects working with refugees and asylum seekers in this way. In researching and planning the service, the Project Co-ordinator of The Comfrey Project worked closely with the Natural Growth Project, part of the Medical Foundation, and visited a similar project in Oxford. The Project Co-ordinator commented that attending the Project can reduce ‘feelings of loss of identity, feelings of isolation, feelings of dislocation and feelings of anxiety and frustration [about an asylum case]. People can talk about those feelings here, its very simple in many ways’.

- **User involvement**
  Users are involved in every aspect of the service, from choosing which plants to use, and undertaking work on site to being on the management committee. The Project Co-ordinator takes great pains to ensure that clients are involved and feel a part of the service. There are two greenhouses, separate flowerbeds and furniture on site, all constructed by clients and volunteers.

- **Access**
  New clients are always provided with a map and public transport details on how to get to the service. The Project Co-ordinator can also give clients gardening boots, to ensure that practical details do not prevent individuals from attending the service. Flowerbeds, too, are constructed in such a way as to enable them to be accessible to wheelchair users.

- **Positive evaluation**
  In a recent review of the service, conducted by an external researcher, the Project was very highly evaluated by clients. In particular clients commented that they benefitted from the social aspect of the service and the freedom and relaxation they experienced when working on the allotment away from their troubles. Clients also noted the sense of accomplishment they felt having completed small projects and how they found the sessions educational and a chance to learn new skills.
Appendix 1
Support Arrangements for Asylum Seekers under the 2002 Asylum and Immigration Bill

Flowchart:
- **Port of entry**
  - Asylum application, at port or in country
  - Sent to Induction Centre
    - **Positive decision**
      - Sent to Accommodation Centre
        - **Positive decision**
          - Given refugee status, Exceptional Leave to Remain
        - **Negative decision**
          - Sent to Removal Centre, to await departure or deportation
    - **Negative decision**
      - Sent to Removal Centre, to await departure or deportation

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**Time Line**
- Max. 7 days
- Max. 6 months
# Appendix 2

## Respondent Contact Details

<table>
<thead>
<tr>
<th>Service</th>
<th>Address</th>
<th>Telephone</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum Seeker Health, South East Sheffield PCT</td>
<td>Joan MacFarlane, Primary Care Nurse Consultant, Asylum Seeker Health, Park Health Centre, Duke St, Sheffield S2 5QQ</td>
<td>0114 226 1739</td>
<td><a href="mailto:joan.macfarlane@sheffielddse-pct.nhs.uk">joan.macfarlane@sheffielddse-pct.nhs.uk</a></td>
</tr>
<tr>
<td>Bayswater Family Centre</td>
<td>Shelagh Laslett-O’Brien, Co-ordinator, 14 – 18 Newton Rd, London W2 5LT</td>
<td>0207 229 8976</td>
<td></td>
</tr>
<tr>
<td>Breathing Space Project</td>
<td>Refugee Council and Medical Foundation</td>
<td>RC: 020 7820 3072</td>
<td><a href="http://www.refugeecouncil.org.uk">www.refugeecouncil.org.uk</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MF: 020 7813 9999</td>
<td><a href="http://www.torturecare.org.uk">www.torturecare.org.uk</a></td>
</tr>
<tr>
<td>Comfrey Project</td>
<td>Mandy Jetter, Project Co-ordinator, c/o The Rights Project, 292 Wingrove Ave, Newcastle upon Tyne, NE4 9AA</td>
<td>0191 273 1838</td>
<td></td>
</tr>
<tr>
<td>Health Support Team, Westminster PCT</td>
<td>John Burchill, The Medical Centre, 7E Woodfield Rd, London, W9 3X2</td>
<td></td>
<td><a href="mailto:Johnb@westminster-pct.nhs.uk">Johnb@westminster-pct.nhs.uk</a></td>
</tr>
<tr>
<td><em>Lambeth Mental Health Services, South London and Maudsley NHS Trust</em></td>
<td>Nicola Roberts, Mental Health Promotion Co-ordinator, South London and Maudsley NHS Trust, Lambeth Mental Health Services, Room 4604, Office Suite, Adult Mental Health, Oak House, 108 Landor Rd, Stockwell, London, SW9 9NT</td>
<td>0207 411 6568</td>
<td><a href="mailto:nicola.roberts@slam-tr.nhs.uk">nicola.roberts@slam-tr.nhs.uk</a></td>
</tr>
<tr>
<td>Minority Ethnic Health Inclusion Project (MEHIP)</td>
<td>Sana Sadollah, Refugee Linkworker MEHIP, Springwell House, Ardmillan Terrace, Edinburgh EH11 2JL</td>
<td>0131 537 7561</td>
<td></td>
</tr>
<tr>
<td>NAFSIYAT</td>
<td>278 Seven Sisters Rd London, N4 2HY</td>
<td>020 7263 4130</td>
<td></td>
</tr>
<tr>
<td>Newham Transitional Primary Care Team, Newham Primary Care Trust</td>
<td>Melinda Rees, Clinical Psychologist Church Road Health Centre, 30 Church Rd, London E12 6AQ</td>
<td>0208 218 7625</td>
<td><a href="mailto:Melina.rees@gp-f84740.nhs.uk">Melina.rees@gp-f84740.nhs.uk</a></td>
</tr>
<tr>
<td>Service Provider</td>
<td>Contact Person</td>
<td>Address</td>
<td>Telephone</td>
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<tr>
<td>---------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Northern Birmingham Mental Health NHS Trust – Asian Services</strong></td>
<td>Ms Lakhvir Rellon, Asian Service Development Manager, Northern Birmingham Mental Health NHS Trust, Asian Services Department, 1st Floor Morcom House, Ledsam Street, Ladywood, Birmingham, B15 8DN</td>
<td>0121 685 7120</td>
<td><a href="mailto:ranjit.senghera@nbmht.nhs.uk">ranjit.senghera@nbmht.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Northern Ireland Council for Ethnic Minorities</strong></td>
<td></td>
<td>3rd Floor, Ascot House 24/31, Shaftesbury Square Belfast Northern Ireland BT2 7DB</td>
<td>028 90 238</td>
</tr>
<tr>
<td><strong>Refugee Clinical Team, Lambeth PCT</strong></td>
<td>Jane Cook, Nurse Practitioner and Team Leader, The Refugee Clinical Team, Moffat Clinic, 65 Sancroft St, London, SE11 5NG</td>
<td>0207 411 5689</td>
<td></td>
</tr>
<tr>
<td><strong>Refugee Mental Health Project, Harrow MIND</strong></td>
<td>Refugee Mental Health Project Harrow MIND</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refugee Public Nurse Health Specialist, Barking and Dagenham PCT</strong></td>
<td>Sarah Savigar, Public Health Nurse Specialist, Barking and Dagenham PCT, Gasgoigne Rd, Barking</td>
<td>0208 594 2242</td>
<td></td>
</tr>
<tr>
<td><strong>Saheliya</strong></td>
<td></td>
<td>10 Union St, Edinburgh, EH1 3LU</td>
<td>0131 556 9302</td>
</tr>
<tr>
<td><strong>Somali Counselling Service, Tower Hamlets PCT</strong></td>
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<td>0207 790 7171</td>
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<td>Dr Sarah Montgomery Guildhall St. Surgery, Folkstone</td>
<td>01303 851 411</td>
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<td>Susan Donnelly 2 Jesmond Road West, Newcastle NE2 4PQ</td>
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</tr>
</tbody>
</table>
Appendix 3
Survey of Good Practice in Mental Wellbeing Provisions for Refugees and Asylum Seekers

- Title of Project:
- Address of Project:
- Service Provider:
- Briefly describe your project:
- How is your project funded?
- What is the funding period (please give dates)?
- Will the project continue once the current funding ends?
- Does your project have links with other agencies?
- From which agencies does the project receive referrals?
- Which agencies and organisations does the project refer clients to?
- To what extent are users involved in the project?
- Has the project ever been evaluated, internally or externally? If yes, please give details.
  - Are you happy to be contacted for further information about your project?

Please continue on further sheets if necessary
Thankyou for taking the time to fill in this questionnaire
Appendix 4
Interview for Good Practice Projects

First of all, can you describe the service/project to me very briefly in your own words?

1) Structural and Financial Embeddedness

Project
a) How is your project funded?
b) What is the funding period?
c) Will the project continue once this funding finishes?
d) What links does your project have with institutions? How strong would you say those links are?

Statutory
a) How was the department conceived?
b) What is the remit of your organisation?

e) Is training available to staff?
f) If yes, please give details (is it accredited, evaluated, how much does it cost).
g) What is the take up level, approximately, for training?
h) Is the organisation’s policy formalised (for example in a policy documents or a constitution)?
   If so, how?
i) How are these policies followed? What does this mean in day to day practice (please give examples)?
j) Are these policies publicly available (for example in text form, or on the web)?

2) Multi-Agency Linkages

a) Do you collaborate day to day with other agencies?
b) How are those links maintained?
c) How regular is your contact with other agencies?
d) How is information shared between these agencies?
e) Is this information shared with clients? If so, how?
f) From which agencies does the project receive referrals?
g) Which agencies and organisations does the project refer clients to?
h) How are clients informed of these referrals?
3) **Continuity for Clients**

a) Are records of clients kept? If so, how?

b) How are these records accessed and by whom?

4) **User Involvement, Flexibility and Sensitivity**

   **Project**

   a) *How was the department conceived? (i.e. needs led?)*

b) To what extent are clients involved in the day to day running of your department?

c) Are there measures in place to accommodate differential cultural and gender needs? Please give examples, including feedback from clients.

d) Are there provisions for the incorporation of user-led suggestions in the organisation’s work? Please give examples.

e) Does your service facilitate interactions between clients and co-ethnic groups and in a wider social context?

5) **Access and Promotion**

a) What are the opening times of the service?

b) Is there a registration/subscription fee for clients?

c) Is there disabled/pushchair access?

d) How close is the project to public transport?

e) Do you find that female clients prefer to talk to female workers? Are there provisions for this?

f) What languages are spoken at this practice/project?

6) **Advocacy**

a) Are clients made aware of their rights to services? If so, how?

b) Does your organisation advocate on asylum and immigration issues? If so, how?

7) **Evaluation**

a) Are there measures in place to assess the service internally? If so, please give details (by whom, regularity, funded by, are results published, are they publicly available).

b) Has your service ever been externally evaluated? If so, please give details (as above).

c) Can we contact the researcher, or have a copy of the evaluation?

d) Are there any mechanisms for staff support (e.g. regular supervision, staff room, staff social events)? Please give examples.

**Thank you very much for your time.**
References

Audit Commission

Identification Study:
Report on Spain
Mariola Bernal
Chapter 1. The Context of Interventions

1.0 Demographic

Immigration and Emigration in Historical Context

Spain, traditionally a country of emigrants, has become a recipient country during the last decades. The reasons for this shift are due to specific circumstances, which are a consequence of the prosperity period that Spain has achieved during the last decades. Prosperity which was undreamed-of only some decades ago, when other countries were those who offered opportunities to foreign workers. Then, many sectors of the population left their houses in search of a better life away from their country of origin. During the XIX and XX century, different exodus took place in Spain. The main recipient countries were Belgium, France, Germany and the United Kingdom. One of these migrations, the one which led thousands of Spanish day-labourers to the South of France for the vintage, has lasted until recent years.

Around two million Spanish people are still living abroad, more than double of the close to one million “foreign immigrants” – residents and nationalised - living at the moment in Spain. The term “foreign immigrants” includes economic migrants, refugees and asylum-seekers. Nevertheless, it is important to highlight that in Spanish the term *foreigner* refers to residents coming from first world countries while the term *immigrant* refers to those coming from third world or developing countries, usually in precarious conditions. This study is about those who have just been defined as *immigrants*.

Before going on, it is necessary to note that the largest ethnic minority group living in Spain for many years is the Roma, a group which makes up 1.4% of the total population. The first Roma migratory mainstream dates from the beginning of the XV century, arriving to the Iberian Peninsula through the Pyrenees. Since their arrival this population has been expelled constantly and resettled, eradicating any possibility of integration (San Román, 1997). Studies on this subject are very scant.

Even though they represent the largest ethnic minority I won’t refer to them in this study because they represent a different reality from that composed by the population which has arrived during the last years as a consequence of the current political and economic world situation.

European context

During the 50’s the countries of Western Europe which were devastated after WWII needed a huge amount of workers to carry out their economic reconstruction. Therefore, the migration of a mass of foreign workers, who came from southern countries such as Spain, Portugal, Italy and Turkey, was favoured. Also, those who came from the ex colonies were welcome.

Moreover, during those years the economic and political situation in Spain under Franco’s dictatorship - forced exile - meant that more than 3 million Spaniards had to leave their country.
In the 60’s the migratory movements and the increasing process of industrialisation altered the human geography of Spain. Apart from the process of emigration to other countries, an exodus began from rural to urban areas, a phenomenon that has lasted in different degrees until now.

Non-EU immigration in Europe kept increasing until the 1973 Oil crisis. Then the economic problems and the high rates of unemployment meant that many of the North-Western European countries started a restrictive policy before the issue of immigration. Despite this, immigration could not be stopped and this policy caused a significant change: the new immigrants became illegal and clandestine.

As a consequence of the establishment of strict controls in Northern European countries, immigrants changed their destination to Southern countries such as Spain, Portugal, Greece and Italy. These countries started to industrialise and become attractive for new immigrants. Another reason that made these countries so attractive was that they had a well-established black economy, which meant that new immigrants could find a job with little difficulty (Solé et al 2000).

It is at this time that the migration balance in Spain shifted, becoming finally an immigration country. However, this period did not last very long as the integration of these countries - Spain, Greece and Portugal - in the European Community during the 80’s meant the creation of control policies for the migratory streams. In spite of this, the situation of the labour market and the important presence of the black market were still the main reasons that made these Southern countries an ideal destination.

As I mentioned above, when Spain really became a recipient country was during the 80’s, and it is during the 90’s that it went through a rapid growth. The fact that Spain is a popular destination is due to various reasons, concerning, among others, its geographical situation as the Southern entrance to Europe, and the specific characteristics of the Spanish labour market. According to Solé et al, the most important features of this market are the quantitative loss of low qualified jobs in industry, the continuous decrease of jobs in agriculture, and the increase of tertiary industry.

Socio-demographic characteristics of the immigrant

According to the figures given by the Internal Affairs Ministry the number of immigrants has increased from 198,042 in 1981 to 1,109,060 in 2001 (AEE 2001). Presently, the immigrant residence rate in Spain is 2.74% (ibid) of the total population, which represents an insignificant figure if we compare it with other European countries such as England, with 4.5%.

Even though, this figure has grown very rapid during last years. We will make a brief summary about the main characteristics of the immigration collective settled in Spain through the study of socio-demographic indicators.

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8 Service sector has increased from 41% in 1976 to 60% in 1993.
Sex and age

The Socio-demographic profile of the immigration in this country is still characteristic of the first stage in the migratory cycle. This first stage is distinguished by the high amount of “primo-inmigrantes”, this is, those persons who have started a migratory chain that will be continued by other immigrants – relatives, friends, etc. – in most cases. The primo-inmigrantes are usually young adults, frequently single or not accompanied by their partners, couples or other relatives (Arango, 2002).

![Figure 1.1](image)


Therefore, the most extended model of immigration is the individual. This means, men who come alone in search of a job or formation and who look forward to applying for family reunification once they have settled down.

The reasons to return to their countries of origin are the same as the ones that have motivated them to emigrate. These reasons are mainly economic and related to the family.

However, a new tendency has been detected lately. Traditionally it has been said that men predominated in migration, but during the last years this situation has changed. Women are becoming the first income source of their families in their countries of origin and in the reception country. The high increase in the number of immigrant women is a phenomenon that has come to be called the “feminisation” of the immigration (Médicos del Mundo Annual Report, 2001). Also, it has been perceived an increase of pregnant women who are coming to give birth to their children in this country because this facilitates their application for a residence permit.
As Table 1.1 shows, concerning Latin American immigration, women are already the majority (57.68%). Moreover, they outnumber male immigrants in six Autonomous Communities of Spain.

Table 1.1. Foreigners with residence permit by sex and continent of origin (%).

<table>
<thead>
<tr>
<th>Continent of origin</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>European EC Area</td>
<td>48.38</td>
<td>51.62</td>
</tr>
<tr>
<td>Rest of Europe</td>
<td>44.09</td>
<td>55.91</td>
</tr>
<tr>
<td>Africa</td>
<td>30.85</td>
<td>69.15</td>
</tr>
<tr>
<td>Latin America</td>
<td>57.68</td>
<td>42.32</td>
</tr>
<tr>
<td>North America</td>
<td>49.35</td>
<td>50.65</td>
</tr>
<tr>
<td>Asia</td>
<td>40.12</td>
<td>59.88</td>
</tr>
<tr>
<td>Oceania</td>
<td>46.90</td>
<td>53.10</td>
</tr>
<tr>
<td>Stateless</td>
<td>26.62</td>
<td>73.38</td>
</tr>
<tr>
<td>Unknown</td>
<td>25.83</td>
<td>74.17</td>
</tr>
</tbody>
</table>

Source: AEE 2001, Internal Affairs Ministry

Nationalities

By 2001, foreign citizens with visa residence in force belonged to 185 nationalities, of which 23 represented the 83.22% of the total foreign population.

In a ranking based on countries the most numerous group of residents came from Morocco, and by the end of 2001 there were 234,937 Moroccans regularised in our country, which signifies an increase of 17.60% with respect to the previous year. The next country in the ranking is Ecuador with 84,699 regularised, representing an increase of 174.30% with respect to 2000.

The Ecuadorians are the collective that has grown the most in recent years, but especially during the previous year. This sharp increase may be due to the recent covenant signed between the governments of Spain and Ecuador. According to this covenant, in order to promote the voluntary return of thousands of Ecuadorian “paperless” who were living in Spain, the governments promised to provide their flight back and to give them preferential treatment when applying for work and residence permits before March 1st 2001.

However, four out of the five following countries in the ranking - United Kingdom, Germany, France and Portugal - are members of the European Union. Then Colombia, with 48,710 regularised in 2001, entails an increase of 97.19% with respect to the previous year.

Table 1.2. Foreigners with residence permit by continent of origin 31-12-01

<table>
<thead>
<tr>
<th>Continent/ Nationality</th>
<th>TOTAL 2001</th>
<th>%</th>
<th>% Variation 2000/2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>304,149</td>
<td>27.42</td>
<td>16.36</td>
</tr>
<tr>
<td>Asia</td>
<td>91,552</td>
<td>8.25</td>
<td>26.37</td>
</tr>
<tr>
<td>European Ec. Area</td>
<td>331,352</td>
<td>29.87</td>
<td>6.47</td>
</tr>
<tr>
<td>Latin America</td>
<td>283,778</td>
<td>25.58</td>
<td>53.44</td>
</tr>
<tr>
<td>North America</td>
<td>15,020</td>
<td>1.35</td>
<td>-</td>
</tr>
<tr>
<td>Oceania</td>
<td>944</td>
<td>0.08</td>
<td>4.66</td>
</tr>
<tr>
<td>Rest Europe</td>
<td>81,170</td>
<td>7.31</td>
<td>66.37</td>
</tr>
</tbody>
</table>

For further information, the annexe contains tables with detailed information about countries of origin of the whole immigrant population with residence permit living in Spain and the variation percentage with respect to year 2000.
Thus, in a ranking based on continents, the largest group of foreigners living in Spain come from European Union countries. This data contradicts public opinion, strongly influenced by the mass media, about the supposed invasion of immigrants coming from poor countries. According to the Anuario de Extranjería 2001 (Foreign Yearbook 2001) the total number of foreigner residents who came from European countries represented 37.19% of the total foreign resident population; this means that almost 4 foreigner residents out of 10 come from European countries.

Although we are talking mostly about an economic immigration, the colonial bonds are still a characteristic of the Spanish case. If we take as a reference the number of immigrants arriving from non-EU countries we find that six of the principal immigration groups – Morocco, Ecuador, Peru, Dominican Republic, Colombia, Cuba and Argentina - have had an historical bond with Spain. The two largest groups are Moroccans and Ecuadorians. The socio-economic problems of their countries of origin converge with the proximity of the destination: in the Moroccan case this proximity is geographical, in Ecuador’s cultural.

Other nationalities with a minor presence, but representing an important relative increase are Nigeria, Pakistan, Bangladesh, Bosnia-Herzegovina, Bulgaria, Ukraine, Armenia and Bolivia.

Concerning that part of the population in an undocumented situation, its number is estimated at around 200,000 according to official data. This figure is calculated on the basis of those applications rejected during the last process of regularisation, in which around 600,000 applications were processed\textsuperscript{10}. Other sources estimate about 300,000 or more, the number of undocumented immigrants living in Spain.

There exists powerful factors that generate irregularity; some of them are observed in all democratic countries but, no doubt, they are especially significant in Southern European countries due to their structure, culture, history and geography. These factors are summarised by Arango (2002) by the following:

- Clandestine entrance
- Irregular permanence/stay
- Existence of a high labour demand
- Difficulties in hiring foreign workers due to the rigidity of the labour legislation
- Bureaucracy, the slowness in the processing and renewal of residence and work permits
- Expansion of the \textit{Black economy}
- Insufficient work inspections
- Civic culture that does not confer a high priority to legality fulfilment
- Existence of unscrupulous employers that hire undocumented workers due to the advantages that this entails.

\textsuperscript{10} Including the last regularisation process in itself and its later extension.
Spain is one of the countries with the most undocumented immigrants in the European Union. The biggest section estimated are the magrebi (38% of the total) followed by the Latin-Americans (25%). Other groups in an undocumented situation with a minority presence are sub-Saharan (12%), Chinese (8%) and Eastern Europeans (8%) (Delegación de Gobierno para la Inmigración y la Extranjería).

The clandestine entrance into Spain

In recent years, the coasts of Southern Spain and the Canary Archipelago have registered a massive arrival of small, fragile crafts which hundreds of Africans use to get into Spanish territory putting their lives in danger. Some figures can give us an idea of the magnitude of this phenomenon and the dramatic situation at present.

In 1999 a total of 475 “pateras” (small craft) were detected in Cádiz, Málaga, Almería, Granada, Ceuta, Melilla and Canarias. 3,569 undocumented immigrants who came ashore were arrested. This number increased to 780 “pateras” during 2000 and there were 14,893 detentions. This is a devastating situation as the following figures reflect:

<table>
<thead>
<tr>
<th>Incident</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shipwrecked</td>
<td>30</td>
<td>54</td>
</tr>
<tr>
<td>Missing</td>
<td>23</td>
<td>47</td>
</tr>
<tr>
<td>Cadaver reclaim</td>
<td>29</td>
<td>55</td>
</tr>
<tr>
<td>Castaways rescued</td>
<td>387</td>
<td>1037</td>
</tr>
</tbody>
</table>

Source: Delegación del Gobierno para la Inmigración y Extranjería.

About a third of these 14,893 immigrants were women and, in many cases, came in an advanced state of pregnancy (www.elpais.es).

In 2000 the immigrants who used this way of getting into Spain were mostly from Nigeria, Ghana and Sierra Leone, whereas in 1999 they were mostly from Magreb.

It is expected that this method of entering Spain becomes less and less frequent as the Government puts into practice a new vigilance system for the coast of Andalucía and the Canary Islands. This new system, called SIVE (Integrated System for Exterior Vigilance), is a pioneer program in Europe to combat the entrance of illegal immigrants and prevent drug trafficking. The SIVE consists of radars and infrared cameras whose vision extends to 20 Kilometres. Although the system won’t be working fully until 2004, in the summer 2002 the watch tower was inaugurated in the Strait of Gibraltar. (El País, 14-08-02)

Another method, apart from the “patera”, used to get into Spain, is by truck or van. Usually the Mafia organises the clandestine journeys in vans and trucks which allows the immigrant to arrive to the Centre and North of the country. Moreover, the police have arrested around 300 people who tried to come to Spain by hiding inside vehicles used to transport fairground attractions during the summertime in Ceuta and Melilla.

The clandestine transport network has seen its economic benefits - that previously came from contraband and drug traffic - multiplied with this practice. This practice usually goes along with the illegal falsification of documents.
But apart from the small boats, trucks and vans, the most common way to enter the country is by plane – for those who have their documents in order for a three month stay, which can later be extended – or by bus, crossing the Pyrenees thanks to the advantages of the Schengen Pass.

The Comisaría General de Extranjería y Documentación (Foreign Office), together with the Police of the EU after RIO operation, outlines the following as the principal routes of entrance of immigrants into Spain, according to their origin. Whilst the Sub-Saharians would use a combination of all three ways - plane, shipment or transport by land – the Magrebi (eg. Moroccans) would be the principal customer of the “patera”; Latin-Americans and Asians use mostly the plane and, finally, Eastern Europeans come in vans or trucks (El País, 15-04-02).

Geographical distribution of the immigrant population in Spain

The immigrant population in Spain is not spread in a homogeneous form. It is concentrated mainly in the following areas: Madrid, Barcelona, the Mediterranean coast and both archipelagos, the Canary Islands and the Balearics. Interior areas of Spain – apart from Madrid - together with the Cantabrian Coast hardly signify 15% of the total immigrant resident population of the country.

In Andalucia the number of foreign residents makes up 14.17% of the total in Spain. In places near the coast the greatest number of foreigners are concentrated. Special mention

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should be given to cities like Málaga and Almeria where British and Moroccan residents are the largest groups respectively.

The Canary and Balearic Archipelago represent 12.18% of the immigrant resident population, with a major presence in The Canary Islands. But the composition between both Archipelagos is very different. Whilst The Canary Islands have become a destination for those who come from the African continent, the Balearics are chosen by a significant amount of European Union citizens, mostly Germans.

In the Autonomous Communities of Valencia, Murcia and Catalonia (excluding the province of Barcelona) are concentrated 18.27% of the immigrants, and special mention should be given to the provinces of Murcia, which has experienced an increase of 39.86% 1998-1999, and Aragón, whose immigrant population has increased 42.13% 2000-2001. Teruel (Aragón) is the Spanish city which has seen the largest percentage increase, 88.69%, in 2001.

Finally, in Madrid and Barcelona, the provinces which have the highest concentration of immigrant residents in Spain: The percentage of immigrant residents in Madrid is 20.86% of the population and has seen an increase of 2.58% with respect to the previous year 1999. On the other hand, immigrant residents make up 16.80% of the population in Barcelona which has seen an increase of 16.53% over the past year. It is important to point out the importance of the density of the immigrant population in Barcelona, taking into account that Barcelona has less than half the inhabitants of Madrid.

The composition of the immigrants on the basis of their country of origin is very different in both provinces. In the case of Madrid the largest groups are: Americans (43.18%), Europeans (27.14%), Africans (19.64%) and Asians (9.78%). In Barcelona the largest are: Africans (35.59%), Americans (27.54%), Europeans (20.59%) and Asians (16.07%). The distinct composition of both cities may be due to various factors concerning administration and language among others. Madrid has a capacity for attraction due its administration centrality. Language also may be one of the factors that brings a greater number of Latin Americans to Madrid, as in Barcelona the Catalan12 may be perceived as an obstacle for integration.

Labour situation of immigrants

The analysis of the labour trajectories of the non-EU immigrants points to a labour market strongly segmented, which places them at the lowest stratum of this structure and makes them victims of a strong discrimination. This is reflected both in access to employment as well as in their working conditions (Solé et al, 2000).

There are four principal areas of activity in which the immigrant population finds employment. These are agriculture, construction, catering, and domestic service. This labour market is characterised by instability, low wages, poor status and lack of regularisation. Immigrant workers have little choice because keeping their job is fundamental for the renewal of their residence permit.

The number of immigrants affiliated to the Social Security system increased by 44% for EC immigrants and 96% for non-EC between 1998 and 2000. According to the IMSERSO,

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12 Official language together with Spanish in Catalonia.
the number of foreign workers incorporated in the Social Security system before 11 January 2002 was 3.99% of the total working population. According to nationality, Morocco, Ecuador, United Kingdom, Germany, Colombia and France were the countries with the highest number of workers incorporated in the Social Security system at the beginning of the year.

On the other hand, undocumented immigrants presented a different distribution to the four activity areas. Besides working in the areas mentioned above, it is estimated that around 27% worked in itinerant commerce (street selling), and around 19% obtained money from drug trafficking and delinquency. Also close to 20,000 made a living from prostitution.

With regard to Spain, the immigrant women who exercise prostitution come mostly from Central and Latin America, Sub-Saharan Africa, Eastern Europe and Southeast Asia.

Demographic impact of the immigrant population on Spanish society

The incorporation of the immigrant population has helped to stem an ageing population, which Spain like other European countries suffers at present. According to the UN, Spain has one of the lowest birth-rates in the world, and has had an annual population growth rate of 0.09% between 1995 and 2000. In the short term, Spain would need an immigrant labour force to be able to keep the balance between the active population and the retired. Surveys carried out by the UN, World Bank and the National Statistical Institute (INE) raised the necessity of 4 million workers in 2020, which means an annual contingent of 240,000 to 300,000 immigrants in order to stop the demographic fall (CEAR White Book on labour insertion of Refugees and Immigrants, 2000).

The impact of immigration on those regions where immigrants have settled has caused the birth-rate curve to soar up compared with other regions which are still losing population. According to INE, 18,503 immigrant births (4.87%) balanced the demographic balance in 1999. To illustrate this point, the last Spanish Fertility survey carried out by the INE revealed that: 47% of Spanish women do not have any children while 42% of Central America women have 2 children, and more than 30% of African women have 3 or more. As a consequence, the birth rate of immigrants has helped Spain to avoid entering into a period of “negative growth”. However, nine Spanish regions have still presented these negative birth rates.

These births may presume a high cost in the short term concerning education and health care but in the medium and long term they will have very positive consequences for all. For example, these births will balance the demography, will supply the employment demand in a rising economy and will contribute in a decisive way to the maintenance of the pension system. (El País digital, 2002).
Asylum-Seekers and Refugees: Trends since 1970: Origins and Numbers

After the refugee exodus from Central European countries during World War II until 1978, Spain has been receiving refugees in a spontaneous way, coming first from communist countries such as the former USSR, Vietnam and Cuba, then from Latin American countries principally Chile, Uruguay and Argentina. Even some “Nazis” came fleeing from Germany (FISI\textsuperscript{13}-INSERSO, 1997). They received social and economic assistance directly from ACNUR, Cáritas and the Red Cross and some economic support from the Government. During this period the number of refugees was very small and the first steps for their social protection started to be given.

Spain became first a country of asylum and later an immigration country. Nevertheless, there is an important lack of exact statistical data from this time and the information available is not trustworthy.

\textsuperscript{13} Foro para la Integración Social de los Inmigrantes (Forum for the social integration of immigrants)
According to re-settlement history, the first quota of refugees who arrived in Spain, since the establishment of a democratic government, took place in December of 1979. As a consequence of ACNUR’s petition, Spain received 1000 refugees from Vietnam and Laos. After one year, and as a consequence of the problems which arose, these cases were remitted to the Red Cross who had to deal with their problems of integration and adaptation which had been caused by a lack of experience in the handling of non-Latin American refugees (ACNUR, 2002).

In the following years, Spain accepted, most of the time with ACNUR’s involvement, refugees from Cuba, Iran, Vietnam, Iraq, Bosnia, Ex-Yugoslavia, Albania and Afghanistan.

Most refugees re-settled obtained their Refugee Status, except in the case of the Iraqis in 1992 where only 25 out of 75 obtained it and the Bosnians in 1992-94, where 700 out of 1000 of the refugees did. The ex–Yugoslavians, who came in 1992, obtained a Temporary Protection Status and the Albanians in 1999 a different Status as displaced.

Reasons for the problems which have arisen during the different re-settlements that have taken place in Spain since 1978 (ibid, 2002):

- Lack of experience on behalf of the assistance personnel
- Consequences of the long stays of refugees in concentration camps
- False expectations / Lack of information on behalf of the refugees
- Lack of interest on behalf of the refugees who came to Spain because they had no other choice.
- Inadequate means of assistance due to the high number of refugees, and particularly, for trauma victims
- Overprotection (suffered in particular by the Bosnians)
- Important differences in relation to the level of welcome received and consequent integration in Spain in comparison with other countries.
- Co-ordination difficulties between Government Institutions and NGOs.
- Conflicts arising between people of different ethnic groups (as in the case of Serbs, Croats and Muslims) who were lodged in the same reception centres.
- Lack of translators specialised in refugees.

However, the Spanish NGO has been improving in the last years its ability to provide adequate assistance to the refugee population arriving to this country. They have specialised in working with this group (see Chapters 2 & 3).

According to ACNUR, Spain has attended positively to the urgent demands for re-settlement until 1999. Nevertheless, at the past Refugee World Day there was a demonstration by CEAR in which they criticised the fact that Spain had only accepted 17 refugees over the last three years. Although Spain does not have any specific legal regulation about re-settlement, the Asylum Law foresees the possibility of authorising the urgent move to Spain of those refugees whose life is thought to be at risk in the first asylum country (Art. 4.2. de la Aplicación del Real Decreto a la Ley de Asilo).
Therefore, until the mid 90’s Spain was basically a “springboard” where citizens from Iran, Iraq and Eastern European countries such as Poland or Rumania, stayed while their cases were being processed for their definitive re-settlement in other countries such as the United States, Canada, Australia and above all, Sweden. But this tendency has decreased considerably during the past decade. Looking at the data collected with regard to the number of asylum applicants from 1984 until 2000, it has to be said that trustful statistical data concerning asylum seekers and refugees in Spain is only available from 1988, and especially, from 1992 when the Ministry for Asylum Seekers and Refugees (OAR) was established.

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of applicants</th>
<th>Period</th>
<th>Number of applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>1,100</td>
<td>1993</td>
<td>12,615</td>
</tr>
<tr>
<td>1985</td>
<td>2,300</td>
<td>1994</td>
<td>11,992</td>
</tr>
<tr>
<td>1986</td>
<td>2,300</td>
<td>1995</td>
<td>5,678</td>
</tr>
<tr>
<td>1987</td>
<td>2,500</td>
<td>1996</td>
<td>4,730</td>
</tr>
<tr>
<td>1988</td>
<td>4,516</td>
<td>1997</td>
<td>4,975</td>
</tr>
<tr>
<td>1989</td>
<td>4,077</td>
<td>1998</td>
<td>6,764</td>
</tr>
<tr>
<td>1990</td>
<td>8,647</td>
<td>1999</td>
<td>8,405</td>
</tr>
<tr>
<td>1991</td>
<td>8,138</td>
<td>2000</td>
<td>7,926</td>
</tr>
<tr>
<td>1992</td>
<td>11,708</td>
<td>2001</td>
<td>9,490</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>117,861</td>
</tr>
</tbody>
</table>

Source: Data 83-91 from the Comisaría General de Documentación (C.G.D.)
Data 91-00, from Anuario Estadístico de Extranjería (Internal Affairs Ministry)

According to the Comisaría General de Documentación (Foreign Office), the distribution of these applicants by nationalities, placed Iranians and Iraqis as the majority until 1987. Then the Europeans took over from them, the biggest groups being from Poland and Rumania.

By 1992, Latin Americans were in first place, especially Peruvians, Dominicans and Cubans, while the Africans came third with the greatest proportion from Senegal, Angolia and Liberia.

In 2001, Spain had 7,606 asylum applications affecting 9,490 persons. The number of asylum-seekers in 2001 increased 19.73% with respect to 2000. According to continent of origin, most asylum-seekers in 2001 are American (52.27%), followed by Africans (29.44%), Europeans (10.84%) and Asian (7.23%). Those coming from Oceania and stateless persons make up 0.22% of the total.
In relation to gender, one should highlight that the number of men applying for asylum almost doubles that of women in the case of Latin America, and almost triples in the case of Asians.

While the Rumanians and Algerians were the two nationalities submitting the highest number of asylum applications previously, by 2000 and 2001 Colombians and Cubans were on top. Especially in 2001, the Colombians and Cubans represented more than half of the total of asylum-seekers (51.66%)\(^\text{14}\).

By Autonomous Communities, Madrid has the highest number of applicants (73.30%). This could be explained by its closeness to central administration and the belief that the application process could take less time. Far behind Madrid are the Communities of Valencia (5.97%) and Catalonia (5.49%).

\(^\text{14}\) For further information about the composition of asylum-seekers by nationalities over the last five years see Appendix.
### Table 1.5. Number of asylum-seekers in 2001 by Autonomous communities

<table>
<thead>
<tr>
<th>Autonomous communities</th>
<th>Number of asylum-seekers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalucía</td>
<td>381</td>
<td>4.01</td>
</tr>
<tr>
<td>Aragón</td>
<td>43</td>
<td>0.45</td>
</tr>
<tr>
<td>Asturias</td>
<td>9</td>
<td>0.09</td>
</tr>
<tr>
<td>Baleares</td>
<td>33</td>
<td>0.35</td>
</tr>
<tr>
<td>Canarias</td>
<td>243</td>
<td>2.56</td>
</tr>
<tr>
<td>Cantabria</td>
<td>92</td>
<td>0.97</td>
</tr>
<tr>
<td>Castilla - La Mancha</td>
<td>2</td>
<td>0.02</td>
</tr>
<tr>
<td>Castilla y León</td>
<td>35</td>
<td>0.37</td>
</tr>
<tr>
<td>Cataluña</td>
<td>521</td>
<td>5.49</td>
</tr>
<tr>
<td>Comunidad Valenciana</td>
<td>567</td>
<td>5.97</td>
</tr>
<tr>
<td>Extremadura</td>
<td>8</td>
<td>0.08</td>
</tr>
<tr>
<td>Galicia</td>
<td>60</td>
<td>0.63</td>
</tr>
<tr>
<td>Madrid</td>
<td>6,956</td>
<td>73.30</td>
</tr>
<tr>
<td>Murcia</td>
<td>15</td>
<td>0.16</td>
</tr>
<tr>
<td>Navarra</td>
<td>18</td>
<td>0.19</td>
</tr>
<tr>
<td>País Vasco</td>
<td>125</td>
<td>1.32</td>
</tr>
<tr>
<td>La Rioja</td>
<td>32</td>
<td>0.34</td>
</tr>
<tr>
<td>Ceuta</td>
<td>182</td>
<td>1.92</td>
</tr>
<tr>
<td>Melilla</td>
<td>36</td>
<td>0.38</td>
</tr>
<tr>
<td>Applications at embassies</td>
<td>132</td>
<td>1.39</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>9,490</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Source: AEE 2001, Internal Affairs Ministry. (Home Office)

According to the place the application was submitted:

### Table 1.6. Asylum-seekers by place of submitting the asylum application (%)

<table>
<thead>
<tr>
<th>National territory</th>
<th>Border post (puesto fronterizo)</th>
<th>Embassies</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61.94</td>
<td>36.67</td>
<td>1.39</td>
</tr>
</tbody>
</table>


And finally, in relation with the average acceptance of applications, UNHCR has grouped the data in intervals of five years:

### Table 1.7. Refugees: Average acceptance from 1982 to 2001

<table>
<thead>
<tr>
<th>Period</th>
<th>Applications submitted (Generally excludes repeat/reopened cases)</th>
<th>Recognition under the 1951 UN Convention (First instance decisions)</th>
<th>Asylum-seekers granted humanitarian status (First instance decisions)</th>
<th>Total granted refugee and humanitarian status (Convention humanitarian status in first instance and appeal/review) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982-1986</td>
<td>9,690</td>
<td>1,630</td>
<td>-</td>
<td>1,630</td>
</tr>
<tr>
<td>1987-1991</td>
<td>27,860</td>
<td>2,380</td>
<td>-</td>
<td>2,380</td>
</tr>
</tbody>
</table>

Note: These statistics do not include persons granted protection outside the individual asylum procedure (e.g. refugees granted temporary protection on a group basis), persons admitted under family reunification procedures or resettled refugees.

Source: www.unhcr.ch
It is a fact that asking for asylum in Spain is becoming harder every time. According to Boletín Estadístico de Extranjería (Foreign Statistical Bulletin), a half-yearly inventory for internal use in the Internal Affairs Ministry (Home Office), 3,748 asylum claims have been submitted during the first six months of 2002. Of these, only 243 were admitted, this means, only the 6.5% (El País, 19-09-02).

1.1 Political

Migration policies in Spain

Spain is a parliamentary monarchy. The 1978 Constitution followed a long period of dictatorship. Since then, the country has undergone a deep transformation of government, political structure and legal framework.

The 1978 Constitution bestows to the State the exclusive right to regulate the migratory flow, the concession of asylum to refugees, and of residence permits and nationality. Moreover, it creates the framework that guarantees the fundamental rights of immigrants.

The valid immigrant norm previous to 1985 was constituted by a wide collection of Laws-Decrees and lacked cohesion. Also, there were established some unique specifications within the laws which applied to foreigners of certain nationalities, and resulted from a compensation policy to benefit Spanish emigrants in former colonies, bearing in mind the historical responsibilities and the special bond that they wanted to maintain with the Hispanic Community (Forum for the Social Integration of Immigrants -INSERSO, 1997).

The 1985 Aliens Act on the Rights and Freedom of Foreigners arises as a response to the European petitions, which wanted Spain to prevent the possible avalanche of immigration that would signify this country becoming the port of entrance to Europe (Badosa & Subirats, 2002). At that time the immigration rate in Spain was 0.6% of the total population, and the immigration phenomenon was still not perceived among citizens.

The Aliens Act on the Rights and Freedoms of Foreigners became law in July 1985. Its principal characteristics were formed by a restrictive vision on fundamental rights and a strict visa policy for work, meaning that a previous offer of employment was necessary. The purpose of this was to obstruct the concession and renovation of work permits by a criteria based on the national employment situation (ibid, 2002).

The consequence was the establishment of a permanent undocumented population pocket, a situation that came out to be untenable. This is why the Government had to accomplish a regularisation process that took place in 1991, and moreover, started to develop a contingent\(^{15}\) policy to regulate the entrance of new immigrant workers. The purpose was to cover all those labour posts which were not covered by the indigenous population.

According Badosa and Subirats, the situation provoked a circular/”no way out” chain that will continue throughout the immigration policy evolution of this country: regularisation, irregularisation and regularisation of immigrants.

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\(^{15}\) Acceptance of contingent groups of immigrants as a way to regulate the migratory flows through the establishment of quotas depending on the number of jobs available which cannot be covered by any indigenous or resident foreigners.
This is because the establishment of restrictive practices facilitates the fall into illegality meaning that an extraordinary regularisation process would be needed. However, after a while the same problem starts again.

As the perception of the phenomenon increased due to the volume of the immigrant population\textsuperscript{16}, it became necessary to construct government policy to facilitate the social integration process of the new immigrants. The legal framework in force by that time was clearly insufficient for this purpose, and in 1996 a new Regulation was put into effect as a result of the negotiation between the Socialist Government\textsuperscript{17} and the social sectors implicated in the management of the migratory phenomenon.

The new 1996 Regulation tried to facilitate the legal stability of those immigrants in a regular situation. Some of its major contributions were:

- Legal establishment of “quotas”,
- Determination of different working permits,
- Creation of the figure of the permanent resident,
- Recognition of certain rights such as equality, education and legal assistance,
- Protection of children’s rights and
- Introduction of the family reunification permit.

To sum up, this new Regulation was mainly positive and created a benchmark for later legal modifications.

In 1998 a process was begun to reform the 1985 Alien Law. This process was characterised by the fact that it didn’t emerge from a government proposal but from three legal proposals presented by minority groups – Izquierda Unida (IU), Convergencia i Unió (CiU) and Grupo Mixto (a coalition of minority political parties) .

The process ended with the new Alien Act on the Rights and Freedom of Foreigners 4/2000 that was approved in July 2000. The Government announced that if they won the next elections, the reform of the recently approved law would be among its priorities. Indeed, they did win the elections and the recently approved law did not even last a year.

The positive aspect of the 4/2000 law was the desire to face up to the problem and to integrate the documented and undocumented population. For those regularised, the law facilitated family reunification and also the attainment of a permanent residence permit without it being necessary to prove 5 years of continuous residence in the country, instead just two years. It also permitted those foreigners who had a permanent residence permit to vote in elections. For those who were in an irregular situation, it offered a new way of automatic regularisation after two years of being registered in the census on condition of having sufficient means to subsist, and also it reduced the punishment for being undocumented\textsuperscript{18}. The law universalised the right to health assistance, education and free legal assistance, extending these rights to undocumented immigrants.

\textsuperscript{16} The immigration rate in 1996 was 1.2\% of the total population. Double the 1985 rate.

\textsuperscript{17} Last term of office of the Socialist party.

\textsuperscript{18} A fee would substitute the expulsion.
However, after the Popular Party won the elections, and this time with an absolute majority. The Government started the announced reform of the 4/2000 law. The permanent increase in the number of immigrants entering Spain and the events which occurred in El Ejido in that same year – events that had an international repercussion - were some of the reasons for the Government’s urgency to introduce some changes.

The reform carried out pointed to aspects concerning the sanctions/penalties and infraction system (reintroducing the expulsion for undocumented immigrants), the fight against illegal trafficking of immigrants, and the regulation of migratory flows. However, the Government’s migration policy was based on certain hypotheses that have been demonstrated false. These hypotheses concerned the existence of an impervious border, so that its policy actions focused on expulsion of illegal immigrants, establishment of quotas and bilateral agreements/treaties.

That aspect of the reform which has been most criticised by NGOs and other organisations working with immigrants, is the criminalisation of the undocumented immigrant, because it deprives them of their collective rights and does not resolve the situation of those whose expulsion order is still waiting to be processed. One of consequences of the new law 8/2000 was, therefore, the marginalisation of the undocumented immigrant who can not be effectively expelled. A situation that has become a serious problem in the Spanish case, with around 90,000 applications rejected in 2000. The access to certain social services, such as housing support or Higher education, which were guaranteed under the former law for any immigrant independently of their administrative situation, is now limited to those who have the residence permit.

However, the reduced integration possibilities not only affect the undocumented. Immigrants in a regular situation have now more obstacles to obtain the permanent residence permit, to apply for family reunification, and restricted rights concerning public/political participation. The permanent residence permit is obtained after a five year residence, and if at any point during those years the immigrant becomes undocumented (for example if he/she loses his/her job) he/she begins again from zero. The right for family reunification limits the number of members of the family to regroup, reintroduces the condition of presenting the previous requirements and does not incorporate the “administrative silence” as positive in the resolution. Finally, the new law eliminates the necessity of the establishment of democratic mechanisms to incorporate immigrants in the decision making process of local government, restricting their participation only to those issues which affect them directly (8/2000 Art 6.2). The right to vote was restricted to foreigners with residence permits but only in local government elections (8/2000 Art 6.1).

But the Execution Regulation of the new law softens some aspects and introduced the temporary residence permit to those who can prove a continuous residence of 3 years along with an accredited situation of rooting. To prove this root though, it is necessary to be incorporated in the labour market or to have family among foreigner or Spanish residents. Nevertheless, this situation of rooting has been suppressed during the elaboration of this report in 2002.

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19 For further information see pp 38-39.
20 Immigrants must prove residence for one year, provision of means and equivalent housing.
However, the lack of co-ordination between the competent entities and even between the different departments of each administration was practically absolute (Badosa and Subirats, 2002). The complex distribution of jurisdictions related to immigration has meant an added problem when putting into practice the political measures for immigrant integration (Informe España 2001). The following table shows the range of agents taking part in issues of immigration.

<table>
<thead>
<tr>
<th>Table 1.8. Agents involved in Migration policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conception</td>
</tr>
<tr>
<td>Chamber of Deputies</td>
</tr>
<tr>
<td>Central Government</td>
</tr>
<tr>
<td>Social workers, civil servants, police...</td>
</tr>
<tr>
<td>Governments, Autonomous Communities</td>
</tr>
<tr>
<td>Local organisations</td>
</tr>
<tr>
<td>NGOs</td>
</tr>
<tr>
<td>Immigrant associations</td>
</tr>
</tbody>
</table>

Source: Fundación Encuentro, CECS. (Informe España 2001)

These problems were tackled through the creation of the State Delegate for Migration\(^ {21} \) together with different mechanisms of co-ordination established in the 2000 Law.

The Spanish case has recently focused its efforts on a policy which controls the migratory channels. Its basic characteristic has been the centralisation of immigration policy in the Internal Affairs Ministry. The legislative and organisational reforms reaffirm this vision since the latest reforms were those made by the former Internal Affairs Minister instead of the minister for Labour and Social Affairs.

For example, organisations such as “The Forum for the Social Integration of Immigrants” (Foro), and the Permanent Immigration Observatory (OPI), which offers updated information about immigration and asylum, have passed from the Labour and Social Affairs to the Internal Affairs Ministry.

These two organisations – Foro and OPI - were set up as an initiative coming from the 1994 Interministerial Plan for Immigrant Integration. The Plan’s aim was to act as a reference for Administration, to help Autonomous Communities and local Administration, and, finally, as a channel to facilitate the active participation of civil societies in the integration of the immigrant population. Nevertheless, this Plan, still in force, stands out for its inequality between its objectives and fields of action stated in its contents and the resources provided for its development. While the legal field has been certainly improved, hardly any new administrative and human resources have been created, and even less economic resources (Informe España 2001).

Finally, the last action, which reflects centralisation, is the GRECO\(^ {22} \) program, the Global Regulation and Co-ordination Program for Immigration. It is directed by the Internal Affairs Ministry and represents the first Spanish initiative to tackle the immigration problem from all perspectives.

\(^ {21} \) RD 1449/2000 July 28\(^ {th} \) (28/07/00 BOE)

\(^ {22} \) Available at www.mir.es
This program strengthens the police vision of the migration phenomenon because the Internal Affairs Ministry monopolises the participation in most of the programs designed, even in those concerning Integration and Protection whose competence corresponds theoretically by nature to the Labour and Social Affairs Ministry. The following table presents the distribution by Ministries of the program’s measures planned for the period 2002-2004.

<table>
<thead>
<tr>
<th>MINISTRIES</th>
<th>GRECO TOTAL</th>
<th>CONTROL/REGULATION</th>
<th>ASSISTENCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DESIGN AND</td>
<td></td>
<td>INTER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COORDINATION</td>
<td>REGULATION</td>
<td>PROTECTION</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regulation</td>
<td>Subtotal</td>
<td>Subtotal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>channels</td>
<td></td>
<td></td>
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<tr>
<td>Internal Affairs</td>
<td>41</td>
<td>8</td>
<td>14</td>
<td>22</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Labour and Social Affairs</td>
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<td>4</td>
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<td></td>
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</tr>
<tr>
<td>Health and Consumption</td>
<td>3</td>
<td>0</td>
<td>2</td>
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<td></td>
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<tr>
<td>Education, Culture and Sports</td>
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<td></td>
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<tr>
<td>Public Administration</td>
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<tr>
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<tr>
<td>Autonomous Communities</td>
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<td>0</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>


One of the aspects contemplated in the GRECO program is the regulation regarding collaboration and bilateral agreements, in order to regulate the massive arrival of immigrants through the signature of covenants with their countries of origin. Labour necessities in our country are analysed to calculate the shortage of national, EC citizens and non-EC citizens with working residence permits, in order to cover the labour posts offered (GRECO, 2000). In actual fact, covenants of different modalities have been signed during 2001 with Colombia, Equator, Morocco and Dominican Republic, and during 2002 with Romania and Poland. Nevertheless, some of them have not been put into practice yet, like the covenant with Morocco, which due to a diplomatic conflict has been delayed for over a year. Polish and Rumanians have been the most fortunate because of their preferential option to be contracted in the 2002 contingents.

In general terms, the agreements try to establish, among other things, readily available information about work, travel and accommodation for immigrant workers and their rights and labour conditions during their stay (ibid, 2000).

However, this collection of good intentions has come up against several difficulties from the beginning. The contingent only focuses on the individual labour aspect, placing under contract/hiring workers instead of people. Also, the agreements are signed with countries that suffer significant deficiencies in their Administration and, moreover, it will not stop the attempts of getting into the country with a tourist visa (Trinidad, M. L., 2002). In fact, the reality confirms that these measures have not reduced the massive and clandestine entrance of undocumented immigrants. On the contrary, it has increased.

23 The Moroccan Ambassador has returned to his post in Spain at the beginning of February 2003.
The great amount of news appearing in *El País* newspaper during 2001 confirms that, since the new law was approved in January 2001, the number of illegal immigrants who have tried to enter the country has increased compared with the previous year.

In conclusion, the positive aspect of this centralisation is the possible co-ordination between the different entities, although it seems not to have become reality. On the other hand, there are two important negative aspects coming from this situation: first, it simplifies the issue to the point of reducing it to a police matter, and secondly, as a consequence of this, it deprives the autonomous and local governments from playing a more active role if the perspective was based more on social policies.

However, the Government made public in June 2002 their intention of reforming the current Immigration law again. According to the former Minister of Labour and Social Affairs, Juan Carlos Aparicio, the present law is not giving the expected results. Aparicio explained that the next reform should be based on the establishment of contingents and the hiring of immigrants from their countries of origin.

The insistence for controlling migratory flows through the establishment of contingents clashes with the failure that this mechanism has shown so far. The contingent approved by the Ministry Council in December 2001 offered 10,884 steady jobs for immigrant workers. Out of this total 2,243 were assigned to domestic service and only 27 were allocated. From the 8,641 posts remaining, Spain could only offer 353 jobs (*El País* 10-6-02). The Government ascribes these negative results to various factors such as: an increase in the labour force due to the resolution of the different processes of regularisation, the novelty of the system itself, the delay in the setting up of the offices to attend to employers (denied by Ecuador) and the lack of adequate managerial habits in the process. Non statutory bodies criticise that this failure is due to the lack in the Government’s operative capacity for contingents and the lack of will in implementing the policies.

The reform that the Government is considering would mean the end of any possibility to regularise the situation of those immigrants who are in the country and don’t have documents. The Executive has already implemented the denial of the documentation for rooting, independent of the time that the applicant is in the country. Also, it is trying to restrict drastically the right concerning family reunification, and to prohibit any extraordinary regularisation process (*El País*, 06-06.02).

If the Executive carries on with the reform announced before December 31st 2002, it would mean a change to the Law concerning immigration within three years. This continuous cycle of policy re-making gives an idea of the extreme importance of the issue in the political agenda at present.

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24 In July 2002 the Spanish President, Jose María Aznar, changed 8 of the Ministries. Eduardo Zaplana is now in charge of the Labour and Social Affairs Minister.
Asylum Policies in Spain

Since there was no legislation specifically for asylum before 1979, the majority of refugees (and immigrants) who were in Spain by that time had recourse to Law 118/1969, that offered privileged treatment concerning work permits to those who came from Latin America and the Spanish ex colonies. The former normative, which was abolished with the new law of asylum in 1984, presumed this regime to be more beneficial to them than asylum. Even though, some of them were really refugees in the sense that were victims of persecution for political reasons in their countries of origin (FISI-INSERSO, 1997).

At the end of the transition process, in 1978, Spain accepted the Geneva Convention of 1951 and became a member of EXCOM\textsuperscript{25} (Comité Ejecutivo del Alto Comisionado) in 1994. In December of that same year 1978, the Spanish Constitution was approved and article 13.4 made reference to the right of seeking asylum in Spain.

In 1979 the first Ministerial Order on the subject of asylum was approved. By that time, asylum was a constitutional and international law, but still needed its legal development.

From 1978 until the late 80’s, asylum seekers were getting economic and social assistance basically from the Red Cross, while recognised refugees did from the Spanish Refugee Aid Commission (CEAR). While Red Cross worked on the basis of a monthly monetary subsidy and a social-psychological orientation service, CEAR worked with little projects concerning the promotion of self-employment and grants (ACNUR, 2002).

During 1982, the Labour and Social Security Ministry\textsuperscript{26} started to assume officially a political commitment to give support to refugee and asylum-seeker programs. One year later, in 1983, the Social Service for Refugees, Asylum seekers and Displaced (SERAD) was created, dependent on the mentioned Ministry. It was about the first specific service for refugees, for which it was considered part of the National budget to be assigned to refugee and asylum-seeker’s support programs that would be mostly managed by NGOs (ACNUR, 2002; FISI-INSERSO, 1997).

It was in June 1984 that the first Asylum\textsuperscript{27} Law was put into effect. Taking into account the “asylum crises” in Europe this new and first asylum law presents very positive aspects giving more rights to asylum-seekers. Also, it was positive the fact that those persons whose asylum applications were rejected were not forced to leave the country but received instead a temporary residence permit, and were allowed to apply for regularisation according to the Immigration laws.

Among the negative aspects of this Law, two of them have special importance. Firstly, the establishment of two different statuses, one for asylum seekers and one for refugees. Secondly, the fact that it does not establish a clear line about the social protection of refuges and asylum seekers (FISI-INSERSO, 1997).

\textsuperscript{25} High Commission Executive Committee.
\textsuperscript{26} Nowadays Labour and Social Affairs Ministry.
\textsuperscript{27} Approved in March 1984.
The asylum was a “concession freely given by a sovereign state”, this means, that a person who does not fulfil the Geneva Convention’s requirements but whom the state conceded an equal protection to that of a refugee for reasons such as public interest or others. Its recognition had a constitutive value, while the refugee’s recognition had a declarative character according to 1951 Geneva Convention (ibid).

This statutory dualism led to ambiguity and delays. The main difference between both categories is that persecution suffered by an asylum-seeker had basically a legal/juridical nature.

Nowadays, after the modification of the 1984 Law, the asylum seeker doesn’t differ to the refugee. At present, the term asylum refers to the protection that Spain offers to those who have been recognised as having refugee status according to 1951 Geneva Convention²⁸.

In 1987 IMSERSO, the Institute of Migration and Social Care under the Labour and Social Security Ministry, was created and it began to take part in issues of asylum seekers and refugees. The first task assigned was to develop and manage a Reception Centre Network with Social Integration programs. In 1989, IMSERSO created the first “Reception Centres” for refugees and asylum-seekers (CAR). There exist four CAR in Spain: two in Madrid, one in Valencia and one in Seville, altogether offering a total of 396 places. The CAR are public establishments, managed directly by IMSERSO, and whose function is to provide temporary lodging, maintenance and psycho-social, urgent and primary care assistance. The main goal of these reception centres is to facilitate the social, cultural and labour insertion of this population (IMSERSO Journal Nº10, 2000).

Usually these centres were fully occupied until around two or three months ago, when the restrictions to enter the country were hardened and less and less applications from asylum-seekers were admitted. The decline of asylum applications has intensified since March 2002 due to the requirement of a transit visa for Cubans and an entrance visa for Colombians. According to CEAR²⁹, these measures have meant the suppression of these nationalities access to Spanish borders. The rapid decline of asylum-seekers during recent months has been noticed in CAR Vallecas, located in Madrid, where one of its workers (unnamed for reasons of privacy) confirmed that only the 70% of the places were taken in July 2002.

At that time, different NGOs began to concentrate their efforts in carrying out Reception programs and tried to collect money from the IMSERSO to open more of these centres. Nowadays, the IMSERSO finances 420 places, which are being managed by various NGOs, and are located all over the country, mainly along the East Coast and central plain.

From 1988, and, above all, in 1992 with the creation of the Office of Asylum and Refugees (OAR), trustworthy and fundamental data concerning asylum seekers and refugees became available. If we have a look at table 1.4, we can appreciate the marked decline in the number of asylum-seekers from 1995. While there were 12,615 asylum-seekers in 1993 and 11,992 in 1994, these figures decrease to 5,678 in 1995. This fall is explained by the new 1994 Asylum Law.

²⁸ “… owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing such fear, is unwilling to avail himself of the protection of that country…”. United Nations 1951. Convention relating to the Status of Refugees.

²⁹ Manifiesto de CEAR for World Refugee Day 2002.
As was stated in the Forum for the Social Integration of Immigrants (1997) the 1984 Asylum Law was modified 10 years later mainly because of the necessity for:

- The adoption of measures to restrain the abusive utilisation of asylum by “economic migrants”
- An accelerated procedure for inadmissible or “manifestly unfounded” asylum claims to avoid the collapse of the applications procedure and,
- The general situation in Europe, with the worsening economic crisis and unemployment, the deterioration of the situation in Third World Countries, and the beginning of the former Yugoslavian conflict. For these reasons, Europe asked for a harmonising of the Asylum policies of all member States.

The most important changes of the new 1994 Asylum Law were: unification of the double status of asylum and refugee in the Refugee Status, the creation of a new humanitarian statute that grants temporary protection, the establishment of an accelerated procedure for admission, and the reinforcement of certain procedure guarantees. Moreover, applicants who had been rejected would be forced to leave the country within a limited space of time.

The 1951 Geneva Convention lack of relevance to the actual world situation, where the reasons to escape are no longer limited to ideological reasons but to others such as corruption, inter-ethnic conflicts, etc, have obliged the governments to include these cases in their asylum law.

The Spanish law mentions these cases in its 17.2 article where it contemplates a special asylum for humanitarian or public interest reasons. It is applicable for displaced, vulnerable persons, and public interest cases. The State offers a temporary protection based on the non refoulment principle, and must be renewed annually.

There is to say that the displaced are shown as a separate entity, having a special mention in the Asylum Regulation. It refers to those persons who have had to leave their country as a consequence of political, ethnic or religious conflicts and do not fulfil the requirements to acquire Refugee Status. Thus, a specific legal cover is created which includes their right to the same assistance as asylum seekers and refugees. They are conceded temporary residence permits, due to exceptional circumstances, and a work authorisation without taking into account national employment situation. This Status is given mostly to Colombians (ACCEM, 2002). In practise, it has the same legal consequences as the Humanitarian Status.

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30 Reinforcement of:
- Legal and interpreter assistance
- Information and orientation services
- ACNUR special intervention
- Possibility of submitting reports by NGO specialised in this field

31 Disposición adicional primera.
Nevertheless, the consequences, when all this theory has been put into practise, have been - according to the Forum for the Social Integration of Immigrants (1997) - the following:

- In addition to Convention refugee status, Spain may extend temporary protected status to displaced persons that have fled their country of origin as a result of political, religious, or ethnic conflict. Recipients of temporary protection status receive yearly residence permits for the duration of the conflict in the country of origin. They are entitled to the same social benefits as recognised refugees. However, the article 17.2 of the Law that regulates the Humanitarian Status has an unfixed nature because there are no common norms of application. The interested party is subjected to different administrative practices and, sometimes, these are contradictory.

- The accelerated procedure for admission – established in order to eliminate those applications manifestly unfounded or abusive - is being applied with an excessive frequency. Certainly, it has existed an abuse in the application for asylum on behalf of the “economic migrants”, so that the implementation of this new procedure should be beneficial for refugees and displaced people. The Administration is now the one who’s carrying out an excessive application of inadmissibility without respecting the established guarantees. This practice is bringing about the rejection of some refugees and displaced.

- It also exists a tendency to treat in a generic way the applications that come from a specific country. There should be stricter control to accomplish an individual and personal examination of each application according to the Geneva Convention.

- Another issue to highlight with regard to guarantees is the re-examination at the border. Considered as the maximum guarantee of the procedure, in the practise what is really decisive is the first interview and allegations. In the first moment, most persons lack minimum information and are afraid because they are surrounded by policemen and administrative personnel. The second time, they are better informed and are more confident, but this re-examination has been devalued.

The effects of the Reform could not be noticed until 1995, with the sharp fall of asylum claims. This Law represented a deep legal change in the history of asylum in Spain.

Also, since October 1996 asylum-seekers may apply for asylum at two Spanish cities in North Africa, Ceuta and Melilla. The decision by the government is a consequence of a history of violent protests by asylum-seekers who were previously treated as clandestine immigrants and detained in the two cities.

In the same year, 1996, the Co-ordination Board between the IMSERSO and NGOs was set up. This Board has analysed and proposed new services to support immigrant groups.

Amnesty International (AI) have collected and analysed the restrictions that Spain imposes on those who flee from human rights violations, in its report “Asylum in Spain: an obstacle course” 2001. AI has detected serious barriers in accessing a fair asylum process.
Some of the barriers identified are: visa impositions on citizens coming from countries where there exists a systematic violation of human rights and where it is very difficult to get a visa\textsuperscript{32}, possibility of fining transport companies which bring undocumented persons to Spain, and the establishment of documentation controls before leaving the plane.

AI points out the absence of European and Spanish normative frames, and the existence of practices that could be obstructing access for many people claiming asylum. The sharp fall of asylum applications during recent years could be explained by those restrictions (AI, 2001).

\textbf{Current admission procedures}

\textbf{Immigrants}

The regularisation process is governed by 4/2000 Immigration Law, which was modified, as explained before, by the 8/2000 law. There are two different application regimes: Community Regime and General Regime.

\textit{Community Regime} is that applied to members of European Union countries and is much more favourable to the applicant than the General Regime.

According to the \textit{General Regime}, someone who comes to Spain, from a non-European Union country, in search of an improvement of his/her well-being and standard of living, mainly due to economic reasons, will be able to get a temporary residence permit on the basis of the following suppositions:

1) By contingents, this is, if the immigrant is not in Spain and (s)he has a job offer that can not be occupied by any indigenous person.
2) According to family reunification requirement
3) By extraordinary processes of regularisation\textsuperscript{33}
4) By “\textit{arraigo}”, this is, by proving a rooting situation. There are two possibilities to prove this situation:

\begin{enumerate}
\item a) Proving \textbf{three years} living in Spain \textbf{if} the immigrant has a job offer and children or Spanish parents, or if the children and parents have residence permit in this country.
\item b) Proving \textbf{five years} living in Spain \textbf{if} the immigrant has just a job offer
\end{enumerate}

When an undocumented immigrant marries a Spanish citizen, (s)he must prove at least one year of living together, whether before or after the marriage, in order to have the right to apply for a residence permit as a relative.

\textsuperscript{32}During the year 2002 new measures that restrain and prevent the access for claiming asylum to Colombian and Cuban citizens have been approved.

\textsuperscript{33}Extraordinary process of regularisation will be prohibited as a way of obtaining documents, if the Government approves the law reform planned for the beginning of 2003.
However, for an undocumented foreigner to get a legal job it is an arduous process, if not an impossible task. Immigrants without residence permits will be able to obtain one (apart from their regularisation derived from the contingent of 30,000 annual permits in Spain) with a pre-contract from a Spanish company; provided if the immigrant returns to his/her country of origin to get the residence and work visa in the Spanish consulate of that country. (S)he must take a risk, because everyone knows that the employer will not wait for unqualified labour (CEAR, 2002).

There exists two types of residence permit: temporary and permanent. Supposing that the foreigner fulfils the requirements mentioned above, (s)he will be able to get a temporary residence permit that lasts for one year. After this year, if (s)he still fulfils the requirements, the permit will be renewed for two years and then for two more. After five years of continuous legal residence the immigrant will obtain a permanent residence permit. To apply for nationality, ten years of continuous legal residence in the country is required for everyone except those who have refugee status, who require five years, and those coming from Latin American countries who need just two years.

The applicant must go to the Immigration Office or the Police Station in the town where (s)he plans to reside. The residence permit application will be formalised when the application sheet has been filled out and is presented together with the required documentation. The application form is only available in Spanish but Immigration offices have interpreters to give support. The specific documentation required in order to apply for a residence permit for the first time is the following:

- Valid residence visa
- Criminal record certificate
- Official medical certificate
- Except in outstanding circumstances, the applicant needs to prove sufficient means for living.
- In the case of applying for family reunification, the applicant must provide evidence of family bonds.

If a foreigner plans to prolong their stay in Spain, (s)he must renew the documents a month before their expiration.

**Asylum-seekers**

The Asylum procedure is governed by the Refugee Law 5/1984, modified by the 9/1994 Law and 1995 Real Decree. Asylum-seekers can submit applications to the Ministry of Interior’s Office for Asylum and Refugees (OAR), immigration offices, police stations at the border or within the territory, and at Spanish diplomatic and consular missions abroad. The process is divided into three stages:

First stage: **Presentation of the asylum application**

When applying, asylum-seekers must submit evidence of their identity and a “credible statement” asserting persecution along with the application form, passport or travel permit.
photocopy. If the solicitor is not contributing any type of personal documentation he will have to justify its omission.

The applicant receives a receipt for his/her application that needs to be accompanied by their passport. This receipt provides the authorisation for provisional residence in the country with a maximum allowed of 60 days.

As a measure of protection, if the solicitor lacks the documentation demanded to reside in Spain, the Ministry of Internal Affairs is able to permit residence to the interested party up to the definitive resolution of the process.

The Office for Asylum and Refugees (OAR) reviews all asylum applications submitted to the regular determination procedure. UNHCR submits an opinion on the admissibility of each claim to OAR.

As was mentioned above, Spain's 1994 asylum amendments introduced an accelerated procedure for inadmissible or "manifestly unfounded" asylum claims. Cases may be inadmissible if the person has sought or could have sought protection in a third country, if the applicant bases the claim on manifestly false or outdated information, or if the application is a mere reiteration of an earlier case denied by the Spanish authorities. The effects is the expulsion of the applicant from Spanish territory.

Spain began implementing the Dublin Convention on 1st September 1997, a European Union (EU) agreement that designates the country responsible for adjudicating asylum claims.

According to the UN High Commissioner for Refugees (UNHCR), the "safe third country" concept is not usually applied in itself, but is accompanied by other reasons when declaring an application inadmissible.

Second stage: Admission to process

It is at this stage that the figure of the asylum-seeker is created. If in the course of four days, the interested party has not been notified of non-admission, it will imply the admission of his/her request and the consequent authorisation of entry into Spanish territory. If, on the other hand, the application has been rejected, the interested party can ask for re-examination of his case within 24 hours after the resolution’s notification.

Non-admission means, in most cases, the expulsion from the country within 15 days. The person becomes immediately illegal. If the non-admission takes place at the border, entrance into the country is denied, except when the requirements to stay in Spain according to the Immigration Laws are fulfilled.

Admission signifies the following:

1) Authorisation to stay in the country during the time of the procedure.
2) Depending on means and personal situation, the provision of accommodation.
3) The asylum-seeker who lacks economical means, (s)he will benefit from social services, education and health, provided by local government or through NGOs, according to the budget available.
4) The time limit for the procedure is six months. After this time, if no decision has been reached, it is understood that the application has been rejected. But, if in six months the case has still not been resolved, the applicant can ask for a special authorisation to work. This authorisation differs from the regular work permit in the fact that this authorisation enables the asylum seeker to work only in the labour post that (s)he has been offered previously. This means, to apply for this authorisation, it is compulsory to have a job offer.

Immediately before writing the resolution proposal, the interested party is invited to an audience and they are given ten days to present documents and evidence that they consider appropriate.

Third stage: Final decision

OAR forwards all admissible applications to the Inter-ministerial Commission for Asylum and Refugee Status (CIAR), which includes representatives from the ministries of foreign affairs, internal affairs, labour and social affairs, and justice. Once Spain admits an asylum application to the regular determination process, UNHCR attends meetings of CIAR in an advisory capacity.

CIAR issues a decision, usually within four months, based on the information provided in the OAR file and the opinions provided by UNHCR and various non-governmental organisations. After evaluation, CIAR issues its proposed decision to the Ministry of Interior. If the ministry concurs with the CIAR decision, it becomes final.

OAR issues an identity document to accepted applicants, making them eligible for residency, work, and social benefits. But there are some restrictions like exceptions for family reunification. For example, when the marriage has been formed after the recognition of the Refugee Status, the reunification will be denied.

Denied asylum-seekers will be able to stay in Spain if they fulfil the requirements according to the 2000 Aliens Act on the Rights and Freedom of Foreigners, or they have an authorisation for humanitarian reasons or public interest. The granting of this sort of Status is dependent on the immigration authorities instead of the asylum ones since August 2001.

The applicant may appeal against decisions to the National Audience, which is a national court, within two months of notification. Appeals do not immediately suspend expulsion orders although asylum-seekers can request a suspension, which is usually granted.

For the granting of nationality by residence it is required ten years of proven residence, but five years is sufficient for those who have obtained asylum or refugee status.

Reception and accommodation

When arriving in Spain, the asylum-seeker must firstly go to the Asylum and Refugee Office (OAR), an organism which is under jurisdiction of the Internal Affairs Ministry. This organism is based in Madrid but it has seats over the country, usually at the
Delegación del Gobierno (government’s mission). The asylum seeker could go to other entities, such as Red Cross, to get advice.

If the application is accepted, the asylum-seeker is authorised to stay in the country during the time of the procedure. In the case that they lack economical means they are offered accommodation.

Each case is analysed on a global and individual basis, taking into account the different characteristics the application presents with respect to its composition, whether it consists of family units or individual cases.

The accommodation program provided is for stays lasting six months which can be extend up to a maximum of six more months in those family cases which present a vulnerable situation, and a maximum of three more months for individual cases.

The OAR, Red Cross, CEAR and ACCEM are the main bodies that propose which cases demand accommodation after having submitted their asylum application. Depending upon the social reality of each applicant and the vacancies at that moment, they decide which is the most suitable reception centre. OAR takes the final decision.

At a national level, the asylum-seekers accommodation service is under jurisdiction of:

**Governmental organisations:**

1- IMSERSO (Migration and Social Services Institute governed by the Ministry for Labour and Social Affairs): have four Refugee Reception centres (CAR) in different locations. Two of them are in Madrid, one is in Valencia and the other in Seville. Altogether they offer 396 vacancies.

**Non-governmental organisations:**

2- Spanish Red Cross.
3- Spanish Commission for Refugee Aid (CEAR).
4- Spanish Catholic Migration Commission (ACCEM): offering 148 vacancies in different flats, centres and residences in the following locations: Girona, Gijón, León, Madrid, Seville and Sigüenza.

The IMSERSO finances all places up to a total of 816, 396 being managed directly by the IMSERSO and the other 420, managed by the NGOs mentioned above.

The Psycho-social intervention in a CAR focuses on facilitating the living together and the integration of the refugee into Spanish society. However, these goals have to contend with the inevitable process of institutionalisation inside these centres. For example, in CAR Vallecas, the fact that a staff of 30 workers take care of 100 residents, persons who have had sufficient ability to flee their countries despite the obstacles, is a clear indicator of the overprotective character of the centre. “Real integration of residents would be much easier and better if the institution was more self-managed and self-responsible” (CAR Vallecas Annual Report, 2000: 87).
In cases of emergency, when reception centres are full or other special cases, Cáritas and the Red Cross provide emergency accommodation mostly in the form of vouchers for hostels. Red Cross has just started to create new places to give accommodation for those asylum seekers whose application is still waiting to be admitted or rejected to process. Other NGO – CEAR and ACCEM – will continue in this line.

Also, accommodation is provided by religious centres. Moreover the CASI in Madrid has recently established 145 vacancies for emergency accommodation for immigrants.

**Rights and restrictions applying to asylum seekers**

- (S)he can’t be expelled from the country, according to article 33 of the 1951 Geneva Convention, until the application’s resolution, which usually lasts from 6 months to over a year.
- (S)he can benefit from free legal assistance through the asylum claim process, applying for a lawyer at the National Law School or going to one of the NGOs that provide legal assistance for asylum-seekers (CEAR, ACCEM and COMRADE among others)
- (S)he will be attended by an interpreter if (s)he does not speak Spanish. This interpreter will be provided usually by ACCEM in the OAR and at Madrid-Barajas airport, and by COMRADE outside of the OAR.
- (S)he will get medical assistance if necessary and orientation about existing social services for refugees. This assistance is usually delivered by the Red Cross and the Social Work Unit at the OAR.
- In the case that they lack economic means, asylum-seekers will benefit from social services, education and health assistance delivered directly by public administration or through a NGO, according to available funds.
- Asylum-seekers are eligible to work if after six months of their claim’s submission their case has not yet been resolved. To obtain this [special authorisation to work](#) it is indispensable to have a previous job offer. Unlike the immigrant, the job doesn’t have to be limited by the national labour situation. The work permit will expire when the residence permit does, and both can be renewed at the same time.

**Public attitudes towards immigrants in general, and refugees in particular**

Before 1985, there existed in Spain a deep institutional and social indifference towards immigrants in general. The figure of the immigrant had still not been socially constructed. There only existed the figure of the “foreigner”, which had a positive connotation, referring to a population which came mostly from rich countries (Solé et al 2000).

With the 1985 Aliens Act on the Rights and Freedom of Foreigners, new juridical categories were created. These categories soon became symbolic categories that made the figure of the “immigrant” appear, referring to a population coming from Third World countries. Finally, institutional factors were those that made the figure of the immigrant visible in the public eye (ibid, 2000). By the term “immigrant”, Spaniards refer to “economic migrants”, refugees and asylum-seekers. Refugees and asylum-seekers are not perceived as a different immigrant group.

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35 Asylum-seekers can hold a job without any limitation, this means, independent to the national employment situation unlike those who have to resort to Immigration laws.
If we compare the attitude of the Spanish towards immigrants with that of other European countries, we can verify that Spain is, after Portugal, the country with most tolerant attitude towards immigration, having a very low Xenophobia index. The Xenophobia index has been constructed on the basis of questions that measure the level of agreement and disagreement with respect to five sentences describing attitudes towards immigrants.

Comparing the arithmetic average of the xenophobia index it is observed that, although maintaining always a very low level (less than 3, in a 0-14 scale), it decreased progressively until reaching its lowest point (1.9) in 1998. However since then, it increased to 2.0 in 1999 and 2.3 in 2000. The most xenophobic attitudes exist among the older and more conservative segments of the population, and also the ones with the lowest socio-economic status. These sectors see immigrants as direct competitors in the labour market and also have more possibilities of having them as neighbours (ibid, 2000).

The slight increase seen in the xenophobia index during 1999 and 2000 coincides with a blurred political climate along with an increase in racial violence, racist threats and crimes, some of which were committed by neo-Nazi organisations (EUMC Annual Report, 2000) which have caused a strong impact on public opinion. According to EUMC Annual Report 2000, the official statistics on racial crimes are challenged by human rights organisations in some Member States. In Spain, the NGOs recorded about four times as many racist attacks as the police authorities.

Among other events that took place during 1999 and 2000 some need to be pointed out:

- The polemic created concerning the 4/2000 Law,
- The electoral campaign – whose manifesto included the immediate reform of the recently approved Law –,
- The Regularisation plan to fight illegal immigration,
- The constant news coverage regarding the arrival of illegal immigrants at the coasts, and
- The events in El Ejido

The riot in the village of El Ejido (Almería) in 2000 had an international repercussion and was one of the most serious events of racist violence that year. On February 5th 2000 the murder of a Spanish woman by a Moroccan man – who was proved afterwards to have a mental illness - in the streets of El Ejido caused a unique racist uprising that lasted for three days. During that time different hordes armed with baseball bats, sticks and iron bars, plundered immigrants' trades, burned their houses and mosques, blocked highways and overturned cars with their occupants inside. This episode was known as the *caza del moro* (the hunt of the Moor). Some days before, there had been another murder of a local by one of his Moroccan employees.

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36 A) Foreign workers should only be admitted under the condition that there are no Spanish workers to cover those jobs.  
B) The economic situation of Spain is already too difficult to have to invest part of the National budget in helping immigrants.  
C) We would be annoyed if our children had classmates from other races at school  
D) Immigration will cause Spain to lose its identity.  
E) Citizens of any country should have the right to settle down in any other country, without any type of limitation.  
37 Data from 1991 to 1995 produced by CIRES  
Data from 1996 to 2000 produced by ASEP (Social, Economic and Political Analyses) and own by IMSERSO.  
El Ejido is a little town located in the Southwest of Almería, with nearly 54,000 inhabitants, and an immigrant population, mostly Moroccan, of 12,000 inhabitants (22.2%) during the busiest times (Martínez, 2001). The town lives mainly from agriculture. Immigration has been very profitable for the town economy, in the form of a cheap labour force.

Many of them work the land, most of them inside hothouses that can reach 45º during the day while they are using insecticides. The salaries they receive are under the minimum wage established by Law regarding country labourers (La voz de Almería, 10-02-00) and, according to the Report of the Ombudsman of Andalucía during the period of the incident, between 60 and 80% of immigrants didn’t live in proper housing (El País, 06-02-00).

One sentence pronounced by Juan Enciso, the Mayor of El Ejido, days after this episode, sums up what the popular point of view was. He said: "At eight o’clock in the morning there are too few immigrants, but at eight o’clock at night there are too many" (SOS Racism Annual Report, 2001)

In official surveys carried out during the 90’s we can see a shift in the opinion towards immigrants among the Spanish population. The year 1994 shows a shift, because it verified for the first time that about two thirds of Spanish people considered the number of foreign residents to be too many. The proportion of those who thought the number of foreign residents was “too many” increased from 12% in 1991 to 40% in 2000. This widespread opinion seems to be directly connected with age, right-wing ideology, and inversely connected with social position (Díez & Ramírez, 2001).

The monthly barometers of the State Central Survey Bureau (CIS), show that immigration has passed from the 8th place in November 2000 to 3rd place in July 2002 in a list of issues which the population perceives as national problems. The 3rd place reached in June and July 2002 barometers came after unemployment, terrorism or citizen safety. One should mention that it is only in the year 2000 when questions about regular immigration were included for the first time in the monthly barometers.

Independent to the objective increase in the number of this population during the last ten years, it also seems that the Spanish have become suddenly more aware of their presence. Until 1999, the immigration phenomenon was not among the principle problems of the Spanish population, but from that date on, political controversy and the mass media have converted it into one of the main problems concerning public opinion. Moreover, the mass media have played an important role in the direct association between immigration and delinquency. Already in 1995, a study carried out by SOS Racismo about the image of immigrants in the press concluded that a third of the articles published in the press concerning immigrants, related this group to criminal activities.

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39 A study of the death rate carried out in West Almería concerning agricultural day labourers, showed a high incidence of diseases related to the contact with pesticides (migraines, depressions, allergies) and an increase in intoxication rates. The study also suggested a possible relation between contact with pesticides and the increase in abortion and suicides rates (Ugalde, 1997)
40 Almería’s local newspaper
41 Quotations have been translated by the author.
42 Available at www.cis.es
43 SOS Racismo, “El racismo en el Estado español” (Racism in Spain, 1995 Report)
The assumed relation between illegal immigration and delinquency, an issue which is being used by the Government as a justification for their policy making, is not so clear as is often supposed. Some figures from the Ministry of Internal Affairs show that the percentage of immigrants who were apprehended during last January was 30.6%, of which only half were undocumented (El País, 23-05-02).

In Spain there exists very few studies concerning the role of the media in the formation of public opinion about immigration. Nevertheless, even at an international level there aren’t many studies based on systematic analyses of content and comparative investigations.

Among the studies in Spain, one which deserves a special mention is the continuous research carried out by the NGO CIPIE (Centre for investigation and Promotion. Latin America and Europe) during 1992-1994 and 1995-2000. During this second period, their work was published by the Immigration Permanent Observatory, an organisation that depended on the Labour and Social Affairs Ministry until 2000. With the new law, the OPI has passed to be under the management of the Internal Affairs Ministry and these publications have been cancelled. Their research covered radio, television and the Press.

Their last study on the Press, looked at the period of July, August and September of 2000. The objective was, as usual, to follow up news of immigration, racism and xenophobia in ten Spanish newspapers (national and regional). The total number of news items studied was 2,348. This total has been divided into 3 different groups, depending on the way the news affected the public image of immigrants and immigration in general. The results were the following:

Table 1.10. Press news selected during July, August and September 2000.

<table>
<thead>
<tr>
<th>Number of news</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive news</td>
<td>317</td>
</tr>
<tr>
<td>Negative news</td>
<td>1,470</td>
</tr>
<tr>
<td>Neutral news</td>
<td>561</td>
</tr>
<tr>
<td>Total selected news</td>
<td>2,348</td>
</tr>
</tbody>
</table>

Source: CIPIE Foundation journal.

Negative news is that which associated immigrants with exclusion and violence, being the immigrant either the agent or the victim. Also that which makes use of pejorative, confused and inadequate terms in its redaction, and could lead the reader to identify immigration with problems or criminal activities.

Positive news is that which shows a favourable position to immigrant integration.

Neutral news is that which cannot be considered either positive or negative because of the neutrality of its content or the ambiguity of its possible classification.

As we see in table 10, the percentage of neutral news is much higher than that of positive news. This could be explained by the clear presence of ambivalence in the media discourse.
The number of news items collected by CIPIE for the different studies during these years, shows the sharp increase in the appearance of this type of news in the Press since mid-1999. It reaffirms the idea supported by EUMC that the racist discourse is increasingly becoming implicit rather than explicit (EUMC Annual Report, 2000).

There is a scarcity or absence of minority voices compared to those from public institutions in the media. This fact contributes to the creation of an impression that migrants are passive or victims (EUMC Annual Report, 2000). The Spanish population does not receive objective information about the quantity and character of immigrants that reside in Spain. The replacement of this information by that propagated by the media leads to the formation of stereotypes (Pajares, 1998).

As Pajares explains “the result is the emergence of a psychology of invasion through which immigration phenomenon is perceived as something enormous due to the continuity and multiplicity of news referring to the immigrants. The propaganda of the invasion can be found in the justification of the recent restrictive policies. These policies keep the immigrant population in a situation of inferior rights which permits more exploitation, using, at the same time, the immigrants as a scapegoat for the current problems of society, such as unemployment and delinquency”44 (Pajares, 1998: 235).

Apart from the symbolic aspects that surround the social construction of the immigrant image and the institutional ones, the material conditions are essential to understand the impact of immigration on the recipient society. The fact that immigrants get the most precarious and socially devaluated jobs and live in deprived areas, with precarious housing conditions45, provokes their rejection by the rest of society. Rejection is based on the logic of exclusion and social marginalisation.

The immigrants groups which are most rejected are Arabs, Muslims and black Africans. However, despite being nationals, the Roma, are the most rejected. The Roma, with a population of around 400,000, is an ethnic minority which has lived in our country for 500 years. According to a survey carried out by CIERES46 in 1995, Arabs, Muslims and Roma were situated in the very last places in a ranking. Tolerance towards immigrants seems to increase when they are closer to “white race”, “western culture” and “Christian religion” (Solé et al 2000).

In relation to the younger sector of the population, a survey carried out by the Youth Institute in 200047 among 6,492 Spanish young people aged between 15 to 29 showed a third of the respondents considered the immigration phenomenon as detrimental for the future of the country. Also 24% thought that there would be negative effects on morality and Spanish customs.

There doesn’t exist any study about attitudes concerning refugees in Spain. The reason may be due to a cultural idiosyncrasy. The Spanish population perceives all “foreign

44 Quotations have been translated by the autor.
45 The conditions and treatment of immigrants and Roma in the labour market and housing are considered inhumane by human rights organisations reporting on Spain, among other countries (EUMC Annual Report, 2000).
46 Centro de Investigación de la Realidad Social.
immigrants” as economic migrants, that is, settled minority ethnic groups, and does not distinguish this category from that of refugees.

Information and education about refugees in Spain and their particular situation is very scarce. Some educational initiatives to raise awareness are being carried out by ACNUR by means of TV advertisements.

The demand for asylum in Spain does not mean a significant increase in the number of foreigners as happens in many other countries in Europe. As Professor Arango says, “the number of refugees who settle in Spain –less than 7,000- makes up an infinitesimal fraction of the total foreign population”. This is one feature that Spain shares with other Southern European countries, giving place to what has been called the “Southern immigration model”. The reduced number of asylum applications may be due to the very low proportion of favourable resolutions and the unattractiveness of the regime. Moreover, the lack of relevance that asylum has could be explained by the fact that in comparative terms, to enter, stay and work illegally is increasingly easier in Southern European countries (Baldwin-Eduards, 2002 op.cit Arango, 2002). The 1990 Dublin agreement that obliges asylum-seekers to present their application in only one country and the fact that Spain has not stood out for burden sharing are some of the factors influencing this downward trend.

1.2 Needs and Problems of Asylum Seekers and Refugees

Among all the changes a human being must face throughout his live, few are so wide and complex as those which take place during migration. Practically everything that surrounds the person who emigrates changes. Aspects ranging from diet, family and social relations to climate, language, culture, and status are subject to change.

The decision to migrate originates in a perceived lack of prospects that a person has in his own country. Every person who emigrates experiences affective loss, but is buoyed up in the hope of finding the first world paradise they know so little about.

In terms of psychiatric and psychological assistance, the singularity of the migratory experience lies in the fact that it is a psycho-social process of loss and change, which is known in the psychiatry of migration as a grief process (Calvo, 971, 1972, 1977; Tizón et al., 1981, 1983 y Gringberg, 1984, op. cit. Lurbe, 2002). Atxotegui, director of a pioneer organisation in Spain, which practices multicultural psychiatry, explains the process of migration through a model consisting of seven grieves (losses) causing anguish that a person will experience with time: family and friends, language, culture, homeland, loss of status, loss of the contact with their own ethnic group, and exposure to physical risks. The anguish consists in the reintegration of the personality which takes place when something very significant for the subject has been lost (Atxotegui, 2000).

Difficulties in expressing grief can cause psychological problems. SAPPIR is a psycho-social and psychological assistance service for immigrants and refugees located in Barcelona. According to the centre’s experience in refugee and immigrant assistance, “with the lack of development of the migratory project, more difficulties will appear in the expression of grief” (ibid, 2000).
These difficulties are accentuated when migration is accomplished under adverse conditions. Research about conditions which points to mental and psychosomatic disorders in immigrants living in Spain came up with the following factors affecting the mental health of immigrants: labour and economic instability, cultural and social marginalisation, family estrangement, pressures to send money to their families, racial discrimination and lack of statutory documentation.

Also, based on foreign literature and the scarce information available in Spain, Ugalde has suggested that the health conditions of immigrants in Spain are affected by (Ugalde, 1997):

- **High risk labour conditions**, long working day and, in general, labour exploitation. European Union positions Spain as the second country – only surpassed by Greece - with the highest black economy rate (El País, 06-08-01). One in three employers hire their labour force from undocumented immigrants.
- **Work and legal instability**.
- **Family estrangement and lack of psycho-social support**.
- **Drug abuse**
- **Hard living conditions and overcrowding**: For example, in El Ejido it was found that 80% of immigrants weren’t living in proper housing; surveys carried out in Barcelona arrived at the conclusion that almost all the houses are rented without the Cédula de habitabilidad from the Generalitat of Catalonia.
- **Existence of certain cultural values** that oppose hygienic rules and recommendable nutritional practices.

According to Kareem’s words, these “socio-political and economic factors, over which the individual may have little or no control, affect the inner world of us all” (Kareem & Littlewood, 2000).

Psychiatrists from the Psycho-pathological and Psycho-social Assistance Service (SAPPIR) team, located in Barcelona, have described the common symptoms that most immigrants present when attending the centre and have called it Ulysses syndrome, relating the risky and hard journey that the immigrants pursue in search of a better life with the odyssey of the mythical Greek character in his long voyage through the Mediterranean. Immigrants affected by this syndrome suffer from a depressive and chronic stress state that could lead to a mental disorder. The development of this condition occurs progressively as the immigrant encounters the obstacles that take place during the migration process: dangerous journey, distance from their own environment and family, difficulties to find a job and obtain documents, and the racism suffered in the reception country. Hence, the importance of a prompt intervention.

According to the opinion of the head psychiatrist, the current immigration policy, which is limiting immigrants regularisation possibilities, is increasing the number of “paper-less” heading for marginalisation and misery, which consequently increases the possibility of contracting this syndrome.

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49 Hygiene and health inspections on the behalf of the appropriate authorities.
50 Autonomous government.
51 Symptoms of Ulysses Syndrome include: anxiety, depression, sadness, fear, irritability, reclusion and psychosomatic disorders (migraines and abdominal pain or intense fatigue) and, in the worst cases, psychotic disorders.
Also, a psychologist from the Red Cross refugee assistance service have reported that from year 2000 patients present more serious diagnosis.

“Paper-less” or, undocumented migrants, are detained in a provisional way and lodged in an interment centre, Centros de Internamiento de Extranjeros\textsuperscript{52}\textsuperscript{52} (CIE) while they wait to be expelled. Residence in Spain without documents is not a crime but an administrative misdemeanour, so the interment could not take place in a penitentiary centre. In Spain there are six CIE in different cities: Madrid, Málaga, Melilla, Barcelona, Murcia, Valencia and Las Palmas, Canary Islands. In these centres the internees have undergone dreadful living conditions – lack of light and ventilation, visiting restrictions, lack of external communication, separation of children and parents - and insufficient legal guaranties. Access to these centres has been constantly denied to immigrant associations and the mass media. There is a lack of provision and information regarding health and social care assistance, and heavy restrictions with regard to the visiting regime. (Solana, 2002).

Some of these conditions surely affect refugees and asylum-seekers living in Spain as well, but their experience differs from those of “economic migrants”, in crucial aspects.

Refugees have had to flee to another country without having any migratory project, so the process of adjustment is much more difficult. Their only one project might be to return to their country as soon as the living conditions are more favourable. The fact of being unaware of the possibility of returning represents a loss – instead of a separation which occurs in the case of “economic migrants” – therefore their anguish is greater (Atxotegui, 2000).

Studies about the mental health of refugees often divide refugees experience into three episodes and consider the mental health implications of each (Ager, 1993). Firstly, there are the traumatic experiences refugees may have faced in their home countries such as war, famine and persecution. Secondly, there is the process of flight from the home country, which can be as hazardous and stressful as the problems that led to the initial decision to escape. The third and final episode, relates to all the problems a refugee must face when resettled in the asylum country or in a refugee camp (Watters, 2002).

The psycho-social consequences of displacement may be usefully considered with respect to distinct phases in the refugee experience, for each of which a range of characteristic stressors may be used (Baker, 1983; Ben-Porah, 1991, Felsman et al. 1990 op.cit. Ager, 1993). Ager identifies stressors as economic hardship, social disruption, physical violence, and political oppression during the first stage; separation and passage during the second; and settlement, cultural conflict, employment difficulties and intergenerational conflict during the last stage. As ameliorative factors, he points to family integration and attachment, social support, religious affiliation and political ideology.

The personal experience of these events and the way they will later damage in a psychological and physical level depends, among other factors, on the personal characteristics of each person, the length and intensity of the conflict, the violence and gravity of the crime, perception and interpretation of this gravity and the responsibility attributed to others.

\textsuperscript{52} Migrant Internment Centre.
Epidemiological studies across diverse cultures and contexts have detected high levels of trauma in displaced populations (Silove et al, 2000). Much recent debate in the field of refugee’s mental health has focused on the Post Traumatic Stress Disorder (PTSD) which is about the most common mental health disorder diagnosed among this group.

PTSD is recognised as a distinct psychiatric condition and is included in the DSM-III of the American Psychiatric Association in 1980. It arose in a particular social and economic context following the Vietnam war, and has gone on to be applied universally to victims of war and persecution regardless of cultural groups and places of origin (Young, 1995 op. cit Watters, 2000). However, PTSD is not only a disorder of victims of war. It affects all people who have undergone a traumatic experience which generates stress. These experiences provoke changes in their lives because they lack the necessary resources to deal with them, producing anxiety reactions. Examples of affected groups are: policemen, security guards, bodyguards, prisoners, and victims of accidents and rape.

The key to understanding the scientific basis of PTSD is the concept of trauma. According to DSM-IV, the person must have been exposed to a traumatic event in which both of the following have been present (www.ndpstd.org):

1. The person has experienced, witnessed, or been confronted with an event that involves real or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person’s response involved intense fear, helplessness, or horror. In children it may be expressed instead by disorganised or agitated behaviour.

People who suffer from PTSD often relive their experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person’s daily life (ibid, 2002). In those persons who were exposed to intense traumas in the past, certain posterior life events such as the loss of a job or a relative, retirement , etc., can cause the reappearance of the original symptoms (Westermeyer, 1989 op.cit Caballero, 2002: 23).

Asylum-seekers present diverse and changing demands as time passes. Some demands concern information, housing and economic resources, training and labour, psychological, schooling, leisure and cultural activities.

The first and most important thing to do is to provide the victims with a place where they can feel safe and protected, feelings they have lost during the stress situation, and which is an important factor to prevent serious physical and psychological problems. Working and schooling, in the case of children, should start as soon as possible, facilitating their integration and reducing anxiety. The information available identifies the period of time following their arrival until the asylum claim resolution, as the most vulnerable period, psychologically speaking.

Also, asylum-seekers demand psychological assistance to deal with the specific problems related to having to leave their country or move inside it in a forced way. These problems are associated with anguish, fear, suspiciousness, sentiments of guilt (if they have left their family behind) and depressive, anxious and psychotic clinical patterns (IMSERSO, 1998).
Research on the mental health needs of asylum-seekers and refugees highlights the importance of getting urgent reinforcement on a psychological level. This support should go along with the covering of possible health needs and the establishment of a day to day routine that leads to a normalisation of the abnormal situation. Moreover, leisure activities would contribute to their welfare and personal promotion while cultural knowledge of the asylum country is offered.

Interventions must not only be on a psychological level but also on a psycho-social level to enable the adequate confrontation of the subject with respect to family and community disintegration and the need of social support to overcome it. Psycho-social intervention takes into account the physical, psychological and social difficulties of the population in an interrelated way.

2.0 Short Sketch of the Care System

Main Stream Provision of Health Care

The Spanish health care system has been set up as an integrated National Health Service which is publicly financed, mainly through general taxation, and provides nearly universal health care free of charge at the point of use. Provision is mostly publicly owned and managed, and governance of the system has been recently decentralised to all the regions. In January 2002, transfer of sanitary jurisdictions meant an essential progress for the health in our country. The challenge now is to articulate a new connection system among the different health Administrations. Therefore, the just approved Cohesion and Quality of the National Health System Law comprises a group of measures addressed to the co-ordination and collaboration between public Administration, in order to preserve the cohesion of National Health System (Pérez-Santamarina, R., 2003).

Before the implementation of the General Health Act in 1986 the delivery of public health sector services in Spain was structured into three health care levels: primary health care, outpatient specialities and hospitals. After 1986, these levels were reorganised into two levels as primary health care was given an independent and reinforced status, which partly built on previous features and partly incorporated new ones that extended the role of the primary health care team. On the other hand, outpatient specialities formerly delivered at the local health centre were put under the responsibility of hospital services in order to guarantee improved co-ordination between secondary and tertiary care.

Primary Health Care

Primary health care (PHC) in Spain is an integrated public system with its own centres and staff. Management is primarily through specific PHC management bodies at the level of the health area, and organisation is based on the basic health zone, the smallest geographical unit of the health system.

In each health zone there is a Primary Care Centre within which a Primary Care Team (Equipo de Atención Primaria, EAP) delivers services working full-time on a salary basis since PHC is 100% publicly owned and staffed.

General practitioners (GPs) are the first contact the population has with the health system and have a gatekeeper role. They may refer patients on to specialised services if necessary. These patients are expected to return to the primary care physician who then assumes responsibility for follow-up treatment, repeat prescriptions, etc.

General practitioners conduct home visits and PHC is also responsible for the provision of around-the-clock emergency coverage either at the health centre or in the patient’s home. A dedicated emergency services team may provide it or, as is increasingly likely, by rotation of EAP personnel.
Functions formally assigned to primary care teams are health promotion and prevention, curative care and rehabilitation.

But despite progress in diagnostic support, primary health care centres still lack other basic infrastructure, such as that required to do minor elective surgery. Moreover, a national information system does not exist, which prevents the monitoring of the quality of the day-to-day clinical management of patients.

**Secondary and tertiary care**

Both secondary and tertiary care are included under the single category of specialised care in the Spanish National Health System. Organisation and planning is regionally based.

Most hospitals are publicly owned and the majority of staff are salaried employees. Access to hospital services is only through referral by other specialised health services and not general practitioners, except in emergency cases. This implies that the patients in need of hospital care have to go through three levels of care: GP, health care specialists and hospital physicians, which are not always well co-ordinated. All hospitals have 24 hours emergency services.

Alongside the hospital system there is an extensive network of outpatient health centres, which are responsible for the provision of outpatient care. Access to these health centres is only through referral by General Practitioners. Hospitals also maintain their outpatient clinics, which are targeted at patients referred to the hospital from the health centre clinics and, accordingly, usually correspond to a highly specialised type of care.

In the reformed model of provision, members of specialist teams in clinical departments of general hospitals rotate to cover outpatient care in health centres. In the old model, still in place in many regions, specialised doctors were fully dedicated to outpatient care, which made co-ordination between outpatient and hospital care difficult.

The main problems of this sector could be summarised as: co-ordination with PHC centres, waiting times, the number of people sharing each hospital room and the administrative procedures needed to obtain access to services.

**Social and Community Care**

**Social Services**

According to the law, Social Services are defined as “a public service that consists in a group of benefits orientated to prevent those factors that could lead to marginalisation, and to provide the attention necessary to overcome the causes” (Gaitán, 2002).

These services are managed partly by the Ministry of Labour and Social Affairs, and partly by the Autonomous Communities who plan and regulate local services, co-ordinate resources and oversee their assessment and control. Local governments are also involved in social care, especially in the planning and management of services. In contrast to practice in the health care sector, there are high co-payments for most social services.
The 1995 Royal Decree which defined the benefits package for the health care system established the need for co-ordination among the departments in charge of health care and social services when dealing with the social problems associated to mental health, but the advances made in this field are not yet visible, as is explained in the following page.

The key area of overlap between health and social services is in the provision of care for the elderly. Social services are responsible for elderly residential care but the number of places falls very short of demand.

According to the regulations, Social Service’s laws mention two types:

- General social services (or Community services)
  These services respond to a philosophy based on the conception of general, multipurpose, community services.
- Specialised social services
  These services adopt the former typology of the charitable institutions and help certain groups of people in need of help.

The combination of these two factors gives place in practice to a real structure of Social Services composed by two levels of attention:

- Primary attention
  - It is under municipal jurisdiction
  - It has a general character
  - It attends that part of the population which resides in a specific area
  - Facilities: Social Services Centres
  - Professional teams: mainly composed by social workers and other professionals who work together in Social Work Units and programs.

- Specialised attention
  - It is under autonomous jurisdiction
  - It attends sectors of the population through specific services according to the sort of problems they present.
  - Facilities: more diverse than that at the Primary attention level and are composed by Day Centres, Psychological Rehabilitation Centres, Orientation Centres and Residential Centres.
  - Professional teams: their composition is also more heterogeneous and no particular profession predominates.

This is a very general description since the social service model in force is very patchy across the territory.
Mental health care

Mental health care in Spain was traditionally one of the most neglected aspects of the Spanish system largely due to the division of responsibility for services among various public administrative bodies and the lack of co-ordination between parallel networks providing care. There was also a marked over-reliance on the hospitalisation of chronic psychiatric cases, inadequate provision of outpatient care and a notable lack of social resources (European Observatory on Health Care Systems, 2000). Mental health service provision is mainly the responsibility of the provincial authorities, which supply approximately half the mental hospital beds, while the Church and the private sector supply the other half (Comelles & Hernáez, 1994, op.cit. Goodwin, 1997).

Spain was a relative latecomer to the development of community-based mental health services. In the 1960’s and 1970’s, while other European countries began to develop community-based policies, Spain continued to rely upon a mainly institution-based psychiatric system. The reform of mental health services only became possible after the death of Franco and the transition to democratic government (Comelles and Hernáez, 1994, op.cit Goodwin, 1997). In 1985, a report of the Ministerial Committee for Psychiatric Reform laid out the guidelines for the future development of mental health services, arguing for the integration of mental health services with general health services.

The General Health Act (1986) confirmed that mental health patients were to be treated as users of equal worth and made provision for the integration of mental health within the general health care system. The psychiatric system was thus required to integrate its resources: to create mental health centres, to extend the number of psychiatric day units and allow for the hospitalisation of acute cases in general hospitals while reducing the number of beds in psychiatric hospitals. A study conducted by the Ministry of Health during the period 1991-1996 confirmed a shift in the system in order to achieve the mentioned goals, but it also showed the uneven development of these reforms in each of the Autonomous Communities. As a consequence, the quality of the services that a person receives depends to a greater or lesser extent on his/her place of residence.

In 1995, when the wider health system’s benefits were fully regulated, the content of mental health care and psychiatric care was defined and included the following: diagnosis and clinical follow-up; treatment; drug therapy; individual, group or family psychotherapy; and hospitalisation of acute cases.

The main challenges now facing the system are the lack of alternatives to institutionalisation and the shortage of community care resources. Available services and their use don’t fit into a community-based psychiatrist model.

Specific priority measures include:

- Training of PHC professionals in handling and evaluating mental disorders in order to guarantee the care of psycho-emotional disorders at this level
- Establishing co-ordination systems and integrating these with health and social services
- Encouraging general hospitals to admit cases of acute mental disorders
- Facilitating community care and rehabilitation of psychiatric patients in their normal environment

Regarding Mental Health services relation to Primary Health Care, it should be said that in five out of the seventeen Autonomous Communities, there exists an organic integration between both; in twelve of them integration is at least functional; and in fourteen the Primary Health and Mental Health Centre share the same premises. Thus, adequate conditions for establishing a closer relation are already set up (Salvador-Carulla et al., 2002).

With respect to co-ordination between mental health and social care services, things look a bit worse. In eight of the Autonomous Communities there exists an inter-constitutional commission, and only in two of them there are co-ordination and liaison commissions on an area level. According to Mental Health directors, in practice these commissions’ functioning is void or insufficient. On the other hand, the adopted policy of promoting private management in community services has contributed to the worsening of the communication between them (ibid, 2002).

This under-funding of mental health resources contrasts with an acceptable situation in the Spanish general health system according to recent international analyses (Rodriquez et al., 2000, op.cit. Salvador-Carulla et al., 2002).

Mental health services are included in specialised care, that is, in the secondary care level. The network is made up of interdisciplinary professional teams. All mental health services are structured into two levels, hospital and non-hospital, that work in co-ordination with the general health system, specialised social services, Council’s social services and any other care services in the district when needed.
The half-way resources consist in tertiary resources which are an alternative to hospitalisation that bring the therapeutic process into line with a more integrated social life. These comprise of day centres, assisted flats and other social services assistance.

The day centres offer a therapeutic and relational space located in the neighbourhood that complement the therapeutic process received at the Mental Health Centre.

Assisted flats consist in residential provision located inside the community with the aim of helping the patient to carry out a more independent life, living together with other patients under the supervision and assistance of social workers.

Theoretically, access to mental health services, like other medical specialities, is only through referral from the Primary Health Care level by a General Practitioner. Only for urgent cases, referral is not necessary. Moreover, no documentation is required so that most undocumented immigrants enter the system at this level, and afterwards they are referred onwards to a Mental Health Centre.

One of the psychiatrists interviewed in this survey, who works in a Psychiatric Urgency Unit, stated that most immigrant patients arriving to the service are not referred from a Mental Health Centre, and these cases don’t happen very often.
Apart from the National Health System, which is the principal provider of mental health services, depending on the Autonomous Community, additional services are provided by private organisations and charities, semi-autonomous services that are dependent or co-ordinated by the public health system, and NGO services that will be studied later on the chapter.

2.1 Multicultural Care Provisions

Access to Health and Social Care Public Services

The 4/2000 Alien Act on the Right and Freedom of Foreigners universalised the right to health assistance and extended this right to immigrants in an irregular situation through a registration procedure. This registration procedure, commonly named empadronamiento, is required as well to gain access to general social services.

To be able to consult a doctor it is required to be in possession of the “Sanitary Card”. To obtain this card the immigrant must have been previously registered in their municipality. For registration, it is essential to show their passport and a document that proves their residence in that municipality. Then (s)he would have to fill in a form for registering. Once the immigrant has been registered (s)he can apply for the “Sanitary card” through the Social Security network whose jurisdiction covers the Autonomous Communities, and it should arrive within a few days.

However, there is an important distinction between rights and accessibility. In numerous cases the obtaining of the Sanitary Card is being obstructed during the process of registration for different reasons such as fear (fear to be expelled if they contact with administration), ignorance (scarce information campaigns) or administrative obstacles (sometimes city councils obstruct the process demanding certain documents they do not have, or the form that they must fill in at the registration office is only available in Spanish).

In the case of asylum seekers, administrative obstacles may be the only one problem as fear and ignorance are usually combated because they are already in contact with administration in order to apply for asylum. Sanitary Card is usually managed from the centre they are living at or are in contact with.

Each of the Autonomous Communities has different peculiarities in the way one accesses the health assistance system. One can see that these differences range from the general position of providing the Sanitary Card to all immigrants (Andalucia’s case) to the other extreme of denying access even to Emergency Services. However, these extreme cases occur very rarely and usually happen in little towns where the Mayor may be afraid of attracting immigrants.

Moreover, these requirements do not take into account the situation of all those immigrants who arrive crossing the Strait of Gibraltar carrying no documents or those with no fixed abode or, even more, in the case of the Mafia gangs that deprive them of their rights and keep all their documents (Médicos del mundo Annual Report, 2001).
When the immigrant cannot be registered – with the exception of pregnant women and minors –, they will only be allowed to receive attention from the Social Security’s Emergency services, with the consequent collapse this service experiences. Moreover, if they are attended by the Emergency Services, the lack of the sanitary card prevents the doctor from prescribing the necessary medicines for treatment.

**Social Service Provisions**

While Central State has exclusive jurisdiction in the subject of control of migration flows and concession of work and residence permits, the Autonomous Communities assume the legislative and executive jurisdictions in the subject of immigrant integration. The municipalities constitute the territorial framework in which social care is given to immigrants, and hence the importance of local policies.

Until the beginning of the 90’s the majority of municipalities lacked any local policy on immigration. In practise, the attention given to immigrants had a charitable character and depended mostly on professional decisions.

After the 1991 Regularisation Process and the consequent increase of immigrant accessing social services, a Social Policy for immigration began to develop. This policy is normally executed through Community Social Services. These services have worked mainly through general projects and programs which avoid separating the immigrant and indigenous population. However, the indigenous population may perceive the immigrants as their competitors leading to a raise of xenophobic sentiments (Solana, 2002).

The general social services rendered can be divided into different spheres:

- **Information and legal orientation.**
- **Infancy and adolescence support:** book grants, nursery grants, refectory grants, etc.
- **Housing support:** information, economical support to pay the rent, applications for council houses, etc.
- **Labour:** work demand
- **Other demands for economical support:** in the case of food and clothes, immigrants are usually sent to churches and charitable institutions.
- **Demands for health care:** these were most demanded during the 90’s when many immigrants could not access the National Public Health System. After the 4/2000 Aliens Act on the Rights and Freedom of Foreigners, access to public health services has been universalised. Most tasks in this area concern information about registering and the resources available.

The *information and legal orientation* service has been given usually to immigrants who have registered. However, this service has lost much of its importance as these sort of demands have decreased significantly due to the growth of specific services in this field offered by other organisations such as trade unions, immigrant associations and NGOs. The legal orientation service has been the service most extensively developed and specialised during the last years by NGOs.
For the grant’s concession and participation in the program it is an essential requirement that the applicant has a residence permit.

Despite this, access to social services lacks uniformity across Spain. Some places have provided services to immigrants independent of their registration status or without having a residence permit.

Besides possible incidents during the registration procedure, Solana states the following factors as obstacles for the use of social care services:

*Ignorance of the language.* Only a few social services centres and public health centres have incorporated interpreters. Normally they are asked for in specific situations, with the consequent waste of time, and the disadvantages derived from the inefficient organisation of this provision. Usually, this service is carried out by volunteer interpreters with the ensuing problems associated to their availability.

*Problems related to cultural differences.* For example, the lack of attention and respect paid to Muslims’ diet has discouraged this group from using social services. Refectory grants do not guarantee that Muslims children’s food will be *halal*, meaning that it does not necessarily fulfil the precepts of the Muslim faith which govern eating habits.

*Lack of information about social services and difficulties concerning the understanding of service operation.* The importance of the social networks generated in the immigrants’ new environment are crucial for achieving this sort of information. The role of these networks - that are centred around bonds of family, race and nationality, work as oral transmission systems and play an essential role in access to social services, acting as mediators and interpreters during the first stages.

The fear of Public Administration and the believe that social/health services may be connected to the police

Preference for private and non-official centres

To fight some of these problems the Community of Madrid (CAM) has established Social Attention Centres for immigrants (CASI) during march 2002. The project was presented in the Regional Plan for Immigration for the period 2001-2003.

CASI tries to facilitate the social integration of immigrants offering a range of services which try to complement the action of General Social Services. Their staff is usually composed of a social worker, a psychologist, a lawyer and an administrative assistant.

It is a second level support service, since access to a CASI is only though referral by the corresponding Social Service Centre of the area in which the person lives.

**Health Care Provision**

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53 See Chapter 3 for further information.

54 CASI areas of activity: Specific Social Attention; Psycho-social attention; Legal Advice; cross-cultural and socio-educative integration; matters regarding employment and labour conditions.
The impact of non-EU proletarian immigration raises political, economic, cultural and, even, religious problems to the health sector (Clifford, 1999, op.cit Mascarella et al, 2002). The National Health Service is starting to deal with these problems in order to provide an adequate health care service for immigrants. Apart from the existent generic programs to which immigrants are entitled, local administration has created specific health programs aimed at immigrants. In some Autonomous Communities some of these specific programs have been the result of collaboration and agreements between areas of Social Services and Health.

The actions carried out by the municipalities with immigration programs throughout the 90’s dealt with prevention and health education activities, prevention and control of AIDS and other sexually transmitted diseases, control and treatment of tuberculosis, the making of didactic and audio-visual material to inform about health aspects and family planning (Solana, 2002). However the high increase of immigrants arriving to our country, especially during the last three years, has promoted the setting up of other health focused programs.

The Red Española de Ciudades Saludables has elaborated a study collecting information from those City Corporations (Corporaciones Locales Españolas) with more than 200,000 inhabitants in order to classify the typology of their specific programs for immigrants (Viñals, 2002). Some of these programs deal with:

- Information about immigrant rights regarding health assistance and about the health resources at the disposal of immigrants
- Raising awareness and information t aimed at National Health System workers
- Pharmaceutical assistance for immigrants without economic means
- Accompaniment and translation service
- Raising awareness of the importance of following medical treatment
- Reduction and abandonment of alcohol consumption
- Importance of breast-feeding in eliminating health risk situations in children of the immigrant population

As we can appreciate from the lack of psychological support programs, mental health is not among the priorities of the public health administration at present.

Rovira i Virgili University and Hospital Universitari Joan XXIII, both based in Tarragona, have jointly carried out a study -which is part of the project “Health for All, All in Health” and “Partners for Heath” led by the Italian NGO ALISEI -, about non-EU immigrants’ perception of health services. They have conducted various interviews and focus groups with members of different ethnic minorities. Among the information gathered stands out the poor attention paid to cultural differences (especially to gender issues and diet), especially controversial during the pregnancy, childbirth and puerperium period.

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55 According to Mascarella et al, multilingual information about disease prevention is not widespread. Just a few pioneering services in Madrid and Barcelona have been working on this material since 1996, being translated to a variety of languages including Urdu, Punjabi, Arab, Chinese and even some African languages. AID prevention leaflets can be found all over Spain in English, French and, in a lesser extent, in Arab and other languages (Rapporto, 2002).

56 RECS is a municipal movement that tries to strengthen and correlate urban projects concerning the administration of Spanish cities and towns in order promote favourable living conditions and surroundings (www.paciera.es/salutpublica).

57 Partners of the project are: Belgium, Italy, Netherlands, Spain, Sweden and the UK.
Immigrants from Pakistan and India pointed out that Spanish health services are technically very good but they also highlighted as main obstacles: problems of communication, the cold and distant attitude of the professionals, the slowness of bureaucracy, the lack of satisfaction with the scarce information received and the lack of correlation between services. Some of these are common complaints from the indigenous population as well, with the difference that some professionals consider that immigrants don’t have the right to protest if they don’t receive adequate attention. Mascarella et al have detected these kinds of episodes which they have called dormant discrimination, through the following-up of two immigrant patients.

The rigid structures of the institution, where sometimes other ways of behaving or other beliefs are found inadmissible by health personal, makes the delivery of health care more difficult for ethnic minorities (Mascarella et al, 2002).

With respect to treatment, Atxotegui\textsuperscript{58} has identified the following problems:

A) \textit{Deficit in assistance programs for the specific necessities of immigrants}. He proposes some areas that require more attention:

- \textbf{Mental disorders}, which have increased because of legal difficulties, rejection and social exclusion, labour exploitation, and others. These disorders show the difficulty in coming to terms with migratory grief and feelings of loss in a context of high stress accompanied by a lack of social support.
- \textbf{Reproductive Health}, in a population with a birth rate much higher than the indigenous one which often lives in very bad sanitary conditions.
- \textbf{Specific infectious illnesses} (like malaria, paludismo … etc)
- \textbf{Labour accidents}

B) \textit{Lack of co-ordination in health provision}. The work realised by the sanitary personnel, especially doctors, has an excessive bureaucratic component. Doctors have to spend half of the 5-7 minutes, the prescribed length of time for each patient visiting their G.P, filling in forms, applications for medical tests, labour reports, etc. This time is clearly insufficient, especially in the case of immigrants, where difficulties in linguistic and cultural communication are added.

C) \textit{Discrimination concerning access to treatment}. To suitably attend these new National Health System “users” there needs to be equality of access to all areas of treatment.

D) \textit{Lack of education of health professionals} when attending persons coming from different cultures.

This is reflected in:

- \textbf{Ignorance of the cultural conception of illness}. Traditional medicines are more alike to classify illnesses/disorders according to their origin, from a psycho-social and relational perspective – that many times is expressed

\textsuperscript{58} SOS Racismo Annual Report, 2001.
through magical referents. Western medicine pays more attention to the classification depending on symptoms, what can lead in many cases to misdiagnosis.

- **Lack of preparation in handling “counter transference”** during the therapeutic process. The immigrant tends to relate inadvertently the doctor or nurse with the police or an employer, usually indigenous, who could have been very hostile to immigrants. This situation leads the immigrant not to follow or to give up the treatment.

- **Problems of linguistic and cultural communication.** Interpreters only exist in some hospitals. As I.R. Marcos demonstrated in 1976, when a patient speaks a different language to that of the doctor, (s)he tends to overdiagnose the patient. The situation is made worse by the very short time available for the visit. As I mentioned before, the time established for a visit is 5-7 minutes, which is very little even for indigenous patients.

As a result, immigrants usually complain that they are overmedicated and receive low quality health assistance.

Solutions to these problems include – guaranteed information and orientation about health assistance to all immigrants, providing interpreters in Primary Care Centres, building up mental health services and hiring professionals specialised in migration, etc. Nevertheless, there exists some ethical problems that could obstruct their implementation. For example, one of the psychiatrists interviewed complains of the existent discrimination in private centres against hiring foreign staff and also, the racist attitudes among current staff.

The concept of racism is, “in one aspect, a psychological phenomenon, affecting whoever are its victims as well as its perpetrators, (…), but if its ultimate rationale is that of social power, racism, a two-way process operates through primitive feelings such as envy, hate, jealousy, greed, anger, violence, suspicion and fear” (Kareem & Littlewood, 2000:25). Most psychotherapists are supposed to have learned how to deal with these feelings, a difficult objective if we take into account that the issue of race is rarely absent from therapy even when one shares a client’s cultural and ethnic identity (ibid).

Moreover, in order to cover the increased demand for health assistance on behalf of the new population, a higher budget is required. The government policy of not increasing the national public budget, due to their policy of búsqueda del déficit cero (search for a zero deficit), is giving place to a quality decrease in health assistance.

Under these circumstances it must be taken into account that, firstly, Spanish health expenditure is lower than the European average (OCDE, 1999 op.cit Atxotegui, 2001) and, secondly, immigrants are workers who widely pay their access to health assistance and contribute to an important part of national welfare.

We must not forget that inadequate health assistance will generate a higher long-term cost (Atxotegui, 2001).

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59 Counter transference refers to the group of emotions that reflect the relationships of infants with their parents.
In Spain the collection of data about different health services is still very precarious. Most services have not even registered in their clinical files their patient’s country of origin, and it is only now that some centres are starting to quantify immigrant demand. Hence, the lack of general epidemiological studies and the consequent ignorance of differing mental health needs among the different ethnic minority groups.

Health and Social Care Provisions Outside the Regular Framework

Besides the National Health System and Social Services, which have been described beforehand, there exists other kinds of providers. In the beginning, faced with the incapacity, ineffectiveness and inhibition of public administration, the NGOs were the first entities which attempted to address the health and social needs of minority ethnic groups and refugees. The general tendency has been to establish collaboration agreements between the NGOs and municipalities on the subject of health and social services.

Since the mid 90’s, some NGOs began to take part in the health care provision of immigrants. These non-governmental organisations tended, therefore, to substitute mainstream services and cover those gaps in the National Health Service (Solana, 2002). Nowadays many NGOs, such as Médicos del Mundo, Red Cross, Médicos sin Fronteras and Karibu, among others, are providing primary care assistance for immigrants in vulnerable situations. Health care assistance includes, among other things, health promotion and prevention programs, and also some economic support for the purchase of medicines. Recently, these organisations are incorporating mental health services to the range of health assistance they offer. Also, other NGOs which are specialised in providing other kinds of services other than health assistance - full range of social care services that goes from accommodation and maintenance to practical advice and support of vulnerable groups - are now offering psychological assistance due to patient demand. Their staff usually includes social workers, psychologists, interpreters and, in some cases, cultural mediators.

Among various NGOs which have specialised services for migrants or which have set up specialised departments or social work projects, Solana classifies them and points out the following. He talks about denominational organisations, like Cáritas or local church associations, and lay entities, like the Unions or the Red Cross.

- **Cáritas** has been a pioneer entity in social work with migrants and in some municipalities it is still the main reference. With the intention of not duplicating services, there have been established different agreements between Cáritas and Social Services.

- **Local parishes** have developed diverse activities like the establishment of reception centres or the provision of facilities to immigrant associations or volunteers to carry out activities such as language courses and dispense humanitarian aid among other things. Their task is very important, above all, out with the city centre where access to services is difficult. They provide food, clothing, orientation and information, and training courses.
Nuns and priests are considered trustworthy persons and usually act as advisers to whom they can tell their problems, carrying out a sort of preventive mental health task.

- **The Unions** have opened new offices for immigrant consultation concerning residence and work permits, and also for labour issues. They have also offered occupational formation courses. In this area the CITE program of CCOO stands out.

- **Red Cross** is in charge of providing emergency first aid when immigrants arrive to the coasts, by means of primary care attention and medicines. Moreover, it has different programs to facilitate their social integration. These programs concern information and orientation about their rights, reception centres, insertion in the work force, attention to specific diseases, and psychological assistance, among other things. Other programs try to deal with cultural problems, which frequently occur in health assistance.

NGO financing comes mainly from the different public administrations (municipal, autonomous, national and European). The contributions of the affiliates and the donations coming from private entities cover just a minimum part of NGO expenditure. Many NGOs have hired professionals but an important burden of the activities is carried out by volunteers.

Other entities which are providing social and health care assistance are immigr**ant associations or mixed associations** – formed by immigrants and indigenous people-. Some of their main objectives have been: establishment of a network which acts as protection for persons without the means to live; reception activities, accompaniment, and information; labour and social advise; activities focused on propagating and maintaining their own culture in order to fight racism; protest actions to express immigrant’s problems. Some of these associations do provide health care assistance as well, having interpreters and doctors specialised in tropical diseases in order to assist those persons that are left outside mainstream care provision. A minority of them also offer psychological assistance.

The lack of facilities, economic means and professional staff are some of the difficulties these associations have to face.

NGOs and immigrant associations, being aware of the lack of adequate and specialised mental health care services for immigrant groups in mainstream care provision, are setting up psychological and psycho-social assistance services. In many cases, the establishment of these services has come as a direct result of patient demand, who were already making use of other services provided by the National Health Service.

The way in which NGOs and immigrant associations are incorporating mental health care services is, in some cases, through the contracting of an external psychologist who comes according to demand or, in most cases, providing a permanent psychology service.

Nevertheless, most of these immigrant and refugee health care services are located in main cities, mainly in Madrid and Barcelona.
Those immigrants in an irregular situation and who cannot register are attended by NGOs, while those who have been registered can access municipal public services. However, many of those regularised keep going to NGOs services because they are more efficient (Solana, 2002).

**Education**

The Ministry of Education, Culture and Sport’s advanced data affirms that the percentage of foreign students enrolled in Spanish schools during year 2000-2001 was 1.94% (133,684) of the total students. According to their continent of origin, the majority came from America (34.67%) followed by those coming from Europe (30.37%), Africa (28.02%) and Asia (6.79%). Their geographical distribution across the country is uneven, and whilst in Madrid the largest group comes from America (49.89%) followed by Africans (22.87%), in Barcelona the opposite occurs, Africans being the largest group (47.28%), followed by Americans (29.77%).

The Autonomous Communities with the largest percentage of foreign students are Madrid (28.86%), Catalonia (17.57%) and Andalousia (12.79%). With respect to the proportion of foreign students in relation to total pupils, Madrid is also at the top of the list with the highest proportion, 4.33%. Catalonia is in sixth position with a proportion of 2.37%.

Regarding the types of centre, 77.68% of foreign pupils enrolled in public schools while 22.32% did in private centres.

School zoning promoted by the government school system has led to school ghettos, which has been commonly interpreted as the flight of the majority of indigenous people to private schools or to different areas (Partners for Health, 2002), a fact that reinforces mutual ignorance and the persistence of negative prejudices and stereotypes. In this context, the concentration of immigrants in specific schools is regarded as a loss of quality and linked to the implementation of Educational Special Needs Programs, such as Programa de Educación Compensatoria (PEC) in Catalonia or Aulas Temporales de Educación Lingüística (ATAL) in Almería. These sorts of programs try to deal with the difficulties of pupils who present common problems such as being late for school, who come from a poor background, who present a high level of absenteeism and who belong to cultural and ethnic minorities with low economic possibilities (Moreras, 1999). In the beginning some compensatory educational programs originated to help assimilate immigrants in schools but after a time, these programs have incorporated an intercultural perspective.

Some local administrations try to avoid this exodus by means of establishing quotas for foreign pupils per centre in order to plan their territorial distribution, but this is not a widespread measure. This distribution strategy is only possible if private schools get involved in the process (Solé et al, 2000).

Moreover, there exists different opinions, as some professionals believe it is not a problem of the concentration of immigrants in certain schools but of lack of specific...
educational resources and autonomy that would allow adequate responses according to the specific reality of each school (Mascarella et al, 2002).

The EUMC 2000 Annual Report denounces that from the educational sector have come reports about children and young people in Spain from certain minority groups, in particular Roma, who have not received any education at all, or who have a high dropout rate.

A high level of absenteeism is noted among immigrant pupils, especially among girls. In the case of Moroccans, while at an early age the proportion between boys and girls attending school is very similar, at the high school this proportion plummets, despite the fact that schooling is compulsory until the age of 16.

The absenteeism can be the consequence of cultural differences in the role young people must play while of school age. Associations which work with Moroccans assure that the reason is that families do not consider school as a possibility for socio-economic promotion of their daughters (El Pais, 16-02-02).

The Muslim religion for Muslim students is taught by an Imam in their own associations. There are no classes of origin languages. In Catalonia’s schools the students learn both Catalan and Spanish, and one other foreign language. Families say it is very important to speak the languages of the reception country so that the children integrate more fully (Mascarella et al, 2002).

In spite of the efforts that are being made to facilitate immigrant integration at school by the setting up of specific programs, the training of professionals for cross-cultural education and a serious revision of education materials is a pending subject (Pajares, 1998).

### 2.2 Services for Asylum-Seekers and Refugees

When the asylum-seeker arrives to Spain and claims asylum, (s)he is sent to the Red Cross which is in charge of health screening in order to detect any contagious diseases.

Asylum-seekers will benefit from social services, education and health assistance delivered directly by public administration or through NGOs, according to the available funds (www.mir.es).

So that, when the asylum claim has been admitted, asylum-seekers and their dependants will be entitled to the National Health Service if they go through the registration procedure.

However, many asylum-seekers (and even official refugees) show preference for services outside the regular framework due to the lack of adaptation to the new demand perceived in the National Public Health System.

Its resources are still very precarious, reflected mainly in the nearly complete absence of interpreters (above all, at a Primary Care Level), and in the lack of training of health professionals concerning the needs of ethnic minorities.

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60 For further information see pp 54-55.
In relation to specialised assistance to mental health patients such as asylum-seekers and refugees, the Red Cross has long experience in refugee mental health care services. The existence of few other non-statutory entities providing this sort of assistance for victims of torture has been detected by NGOs such as COMRADE and CEAR in Madrid, and by NGOs such as EXIL in Barcelona. In Barcelona, we also find SAPPIR in the public health system, and SATMI which is a concerted service from a private and religious foundation.

Some of these NGOs, such as CEAR and the Red Cross, have signed state covenants with IMSERSO to manage social benefits for refugees and asylum-seekers. Most of them offer legal advice and help during the asylum procedure.

Problems arisen in service provision for asylum seekers and refugees coincide with those that apply to immigrants in general, which were discussed already in this chapter.
Chapter 3. Practices Developed for Asylum Seekers and Refugees

3.0 Methodology

In order to identify the practices that have been developed for these immigrant groups and to know better their contents, a qualitative study has been carried out.

The sample is composed by a wide range of professionals working in different fields of service provision to immigrants, asylum-seekers and refugees\textsuperscript{61}. Several interviews have been conducted in the two cities with highest immigration rates in Spain, Madrid and Barcelona.

In Madrid, 11 in depth interviews were carried out on a wide range of professionals including psychologists, psychiatrists, social workers and lawyers who work among different health and social care providers like the Public Health System, NGOs, a state refugee reception centre (CAR), a Regional Social Care Centre for Immigrants (CASI), the Immigration Regional Office (OFRIM) and an immigrant association.

In Barcelona, another 5 interviews were carried out with psychologists, psychiatrists, social workers and an anthropologist, this time in different NGOs which provide mental health care assistance, and in Private Sector and Public Health System centres.

The methodology used consisted in semi-structured face to face and telephone interviews. The fieldwork had taken place from June to November 2002, including the arrangement and conducting of the interviews. I would like to point out the splendid co-operation of all those professionals who collaborated and showed interest.

It is important to make clear that we are talking about mental health services, located in Barcelona and Madrid, addressed to the whole immigrant population, including asylum-seekers and refugees. The reason for this extension is the scarcity of specific mental health services specialised in the treatment of asylum-seekers and refugees in Spain due to their reduced number when compared with the rest of the immigrant population\textsuperscript{62} and, perhaps, also due to the lack of sensitivity shown to this group. Services that provide this sort of specific attention could be summarised as the Red Cross, CEAR, COMRADE, SAPPIR and EXIL. Even though, these are not exclusive services for refugees, given that other immigrants are attended as well.

3.1 State of the Art

Organisational Changes (Structurally innovative projects)

The great lack of co-ordination between refugee and minority ethnic groups, NGOs and Public Health Care institutions in the organisation of services, was criticised by the respondents and was also highlighted during the III National Immigration Congress held in Granada during the first week of November 2002. Speakers and attendants exposed how this lack of co-ordination affects negatively the development of their everyday work with migrants.

\textsuperscript{61} List of the interviewed centres in the Annexe.

\textsuperscript{62} Even though it is a fact that many “real” refugees end up getting residence and work permits through other ways different from asylum, this is through Immigration laws, due to the non-admission of their asylum claim or a negative resolution.
But, certainly, some organisational innovations have taken place during recent years in order to provide a better care delivery for immigrants. Thus, a special medical service, Servei d’Atenció i Tractament de l’Inmigració (SATMI), was set up in Barcelona with the intention of supporting professionals working in the Public Health System.

SATMI is not part of the public mental health system but it is a psychotherapeutic assistance unit financed by Sant Joan de Deu Foundation, which provides health care assistance in a co-ordinated way. This service arose at the end of 1997 and emerged from the proposal of the three cultural psychiatrists that currently make up the team, due to the sharp increase of immigrant patients in mental health centres. The Bi-cultural team comprises three psychiatrist, one psychologist and one nurse.

SATMI does not pretend to be a parallel service to existent mental health centres for the treatment of immigrants, asylum-seekers and refugees. Their objective and methodology are different from this conception.

Unlike in the National Health System, SATMI does not work with zooning, differing in this way from the rest of the regular services. Patients are referred to this service from their mental health centre when a specific problem that cannot be solved by the usual doctor occurs, normally because they have not received any specific training in cross-cultural psychiatry. It is at this moment, which could be either at the beginning of the intervention or in the middle, when the patient is referred. There, the intercultural psychiatry team will help to overcome this step and, once resolved, the patient will be sent back to their own mental health centre where their treatment will continue. This mechanism is known as “interconsulta”, since the normal doctor that can always consult with SATMI in order to get a more reliable diagnosis. Therefore, this service aims not to establish a health assistance centre only for immigrants that will always separate them from the rest of regular services, thus promoting segregation, but a support service to facilitate immigrant integration. Their service is available only four hours a week, even though they are planning to extend these hours.

In Madrid there isn’t any special medical service of this type like in Barcelona. But a first step towards the evaluation of current necessities in this field of provision has just started. A study to evaluate the situation of regular mental health care institutions has already been designed and will be carried out shortly. This study has been proposed by a psychiatrist working in the emergency services of a psychiatric hospital, who has detected that the percentage of admissions of the immigrant population exceeds that of the indigenous, being two or even three times higher. The study tries to measure the “assistance burden” (need for assistance) of immigrant patients in regular mental health services, that is in mental health centres, psychiatric wards in General Hospitals and psychiatric emergencies. The main objectives are to identify what is currently being delivered and what is not, the urgent lacks that need to be covered and moreover to investigate why members of certain ethnic minorities do not get to some sort of services while others get them in excess (for example Argentinians and Chileans). It will be the first study done in this sphere. The identification of problems and analysis of necessities will surely help towards the creation of special services or the reinforcement of the existing ones.

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63 Health area: each patient must address himself to the corresponding health centre depending on the zone where he lives.
Collaborations between mental health services and universities come in the form of the formation of special programs to be implemented in the services. For example, the Universidad Autónoma of Madrid is drawing up a special program for the treatment of men in trauma, that is, who are affected by Post Traumatic Stress Disorder or sub-sindrome. The therapy will have a cognitive-behavioural orientation, and it will be the only one group therapy in service at present.

On the other hand, in Madrid the CASI (Social Care Centres for Immigrants) could be another example of the setting up of special services in order to improve service provision for immigrants, asylum-seekers and refugees. CASI is a public device of private management that has sprung up from Madrid’s Regional Plan for Immigration 2001-2003. Its pace of development has been slow, the negotiations lasting for nearly three years due to the lack of consensus on behalf of the different bodies.

CASI are not a medical service but a social care service focused on immigrant labour insertion. CASI consists in a second level support service complementary to the attention given at Social Services Centres. Its team includes a psychologist, who provides psycho-social support for those problems that have arisen during the process of adaptation to the new social environment. But this service is not one which follows a clinical intervention, and the psychologist has only the task of handling the stress situation, detecting possible pathologies and referring on to mental health centres if necessary.

The state of the facilities for interpretation is still very precarious in the public health system. Interpreters have not been incorporated in Primary Care Attention Centres yet. Official full-time interpreter services are still a limited resource being available just in some hospitals like Hospital del Mar located in Barcelona. Normally, the rest of the hospitals have to ask for an interpreter in cases of necessity, and usually these are provided by NGOs, mainly by CEAR, ACCEM or COMRADE. Even though, hospital personnel believe they are necessary at all times. Respondents of the survey highlighted this way of accessing interpreters as problematic for different reasons such as problems of speaking their languages and the availability of the interpreters. One of the psychologists interviewed explained the impossibility of treating an Ethiopian patient due to the absence of Ethiopian interpreters in Madrid.

Before this situation, most immigrants have developed strategies like going to the doctor accompanied by a relative or friend who speaks Spanish, but we must not forget that this “solution” has an important limitation, above all in psychological or psychiatrist services, because the patient may not feel free to express himself.

NGOs have a better interpretation service because of their experience over many years of working with migrants, some of them being essential providers of interpreters. Even though, most psychologists interviewed spoke more than one language, mainly English and French.

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64 When the person has lived through traumatic experiences but the symptoms have not manifested yet.

65 There are 9 CASI in the Community of Madrid, and other 4 are expected. They are being managed by the Red Cross, CEAR (Spanish Aid Commission for Refugees), CIPIE (Centre for Investigation and Promotion. Latin America and Europe), MPDL (Peace and Freedom Movement) and Pro-vivienda.
Training and Education

Medical university education in Spain incorporates only in an anecdotal way specific training in sociology and anthropology of medicine. Moreover, these courses usually take place during the first university years and they are perceived by students as quite irrelevant to their training and personal interests. In the study of nursing, there exists a major sensitivity towards social and cultural questions, and student nurses make up the greatest number of students in the Social and Cultural Anthropology course. Nevertheless, there is no advance training in intercultural health in any of these university degrees.

Training and education practices on the subject of understanding immigrant culture for mental health professionals working with immigrants, asylum-seekers and refugees are still at an early stage. However, a slight mobilisation of resources has been detected in the form of an increase in the offer of new courses concerning this subject on behalf of certain universities and organisations. In spite of this increase, cross-cultural training is still very scant and does not reach the majority of mental health professionals working in the field.

Respondents working in the public health system criticised the scarcity of courses concerning mental health needs of minority ethnic groups and refugees, on behalf of the administration. The IMSERSO has internal training programs in all social care fields, but respondents pointed to the low quality of the training and the scarce number of courses related to asylum and refugees. Professionals perceive that there is a great imbalance between the training received and the social and cultural changes produced during the last year whose effects have not been met by the authorities.

With the objective of fighting this serious training gap, efforts are coming from the service level. Specifically in Madrid, through the initiative of a psychiatrist, a course in Cultural Psychiatry was recently designed and will be given by the public administration. The course’s subject will not be entirely psychiatric but will contain important social dimensions. It will be addressed to public administration workers, and its main aim is, according to its promoter words, “to be a training course for trainers, in the sense that the pupils are expected to be like germs that will impregnate their social environment causing the proliferation of these practices”.

In Catalonia, the Generalitat has asked various experts to make a guide that allows General Practitioners to identify mental disorders, so that they will be able to refer them, in case of necessity, to a psychiatrist. Already in 2000, the Institut Catalá de la Salut edited a basic lexicon guide for health conversation in different languages such as English, French, German, Russian and Arabic, as a work tool for health professionals. Moreover, in Barcelona, pharmaceutical firms have been financing the organisation of a series of talks given by health professionals trained in cross-culturality, and aimed at Primary Care doctors.

Some respondents have stated that the Public Health System is not training its professionals to be able to attend properly immigrants and refugees. The State, by means of financing certain NGOs, tries to cover this important specialised service.

66 Migration and Social Services Institute.
67 Public health provider which manages different health services.
Even from public administration services, patients are referred to NGO mental health services instead of to regular ones, which are not well thought of.

Before this situation, most respondents - working in either the Public Health System, NGOs or immigrant associations - stated to have taken some external\textsuperscript{68} courses given by different universities or other entities, such as Grupo de Acción Comunitaria\textsuperscript{69}, and which are usually financed by their employers. However, in some cases (NGOs) there is no financing and the professionals must pay for it, which is not always possible for them. Courses in “Mental Health and Psychological interventions with immigrants, refugees and minorities” - in Barcelona -, and “Psycho-social interventions under political violence situations” - these course take place in the cities of Madrid, Barcelona and Bilbao, which require a lot of flexibility on the part of the attendants - are available among few others. The decision to take these courses comes mainly from the worker’s personal interest.

A significant number of respondents in Madrid had taken a course in the EMSI, and showed themselves quite satisfied with it. The EMSI is a public school for the formation of Social Mediators in Immigration (EMSI) that was set up in the Community of Madrid in 1995\textsuperscript{70}, with the objective of providing education and training for professionals working in public administration, associations and NGOs working with migrants. The school is a public service with private management, promoted by the Social Services Council and it is a project framed in the URBAN II European Union’s initiative, which seeks the improvement of the quality of life in urban areas of European Union member states. Born with the vocation of being an instrument of training immigrants and indigenous, the EMSI provides “technical formation necessary to understand the different aspects of life immigrants have to deal with, along with the abilities, values and attitudes essential for social work in that field” (\url{www.comadrid/EMSI}). EMSI aims to be the catalyst of the training necessities of the immigrant assistant network, being in charge of the collection, elaboration and proposal of those necessities. Since 1999 there has existed the figure of the Social Mediator as a civil servant in the City Council.

Among the courses given, there is one for training in socio-sanitario mediation (social health mediation), whose aim is to provide the knowledge, abilities and tools appropriate to optimise this kind of work in the health service.

The difference between an interpreter and a cultural mediator lies in the fact that while the first one translates literally the conversation, the cultural mediator is, as well as an interpreter, an expert in the symbolic and cultural universe of the user, and also explains to the user about the organisation and functioning of the health system. Most cultural mediators are members of ethnic minorities. Moreover, when they receive specific socio-sanitary training they become health agents, which enables them to carry out health promotion and preventive campaigns (Lurbe, 2002).

\textsuperscript{68} By external training I mean that which is not being provided inside the work place.

\textsuperscript{69} Organisation based in Madrid, which documents and reflects about mental health and human rights. It has centred its efforts in the development of training programs in psycho-social work and mental health in violent or catastrophic situations.

\textsuperscript{70} From 1995 to 1998, the EMSI was under management of Universidad Autónoma de Madrid (UAM) which had a covenant with Instituto para la formación de la Comunidad de Madrid (IMAF) and Social Services Council. From 1998 onwards, the management was transferred to Red Cross and Social Services Council.
In Barcelona, CEAR-ACSAR is carrying out specific programs for the training of health agents in specific subjects such as sexually transmitted disease prevention or Eastern women. The figure of the health agent has been incorporated into Catalan hospitals since 1994. As well, Barcelona City Council launched in spring 2002 a intercultural mediation program, to prevent possible conflicts with immigrants and hired 20 intercultural mediators (El País, 04-03-02, Ed. Catalonia). But their incorporation is still slow and, above all, very controversial referring to mental health services.

In conclusion, the general tendency of the respondents was to point out the need for training, above all, in the mental health needs of minority groups and refugees, the “unknown sphere” of migration. They expressed feelings of isolation with respect to their work, of which there is little or no monitoring.

Derived from this situation, in Madrid, professionals working with asylum-seekers and refugees have felt pushed to meet periodically as a means of support. These bi-monthly meetings stem from the proposal of Red Cross psychologists based in Madrid, who searched to set up a working group among the professionals working in psychological intervention. It brings together professionals working in either public administration – as OAR, CARs - or NGOs – such as ACCEM, CEAR, COMRADE among others -. It arose with the intention of being a self-help group, but later on it became more a reflection and self-training group through the sharing of expertise, and recently members are also planning to publish the group’s work. For some respondents, these meetings mean their only contact with other psychologists working in the field.

**Treatment**

The organisations examined in this survey offered a variety of therapies, all developed in order to meet the needs of immigrant and refugees. Some organisations operate with more than one therapy, depending on the specific characteristics of each case, that is, from an eclectic approach.

Individual and family counselling and psychotherapy were reported to be available in most organisations contacted. However, these talking treatments were only available in Spanish, Portuguese, English and French, as the most common languages encountered, and therefore excluded some groups. Moreover, one respondent argued that psychotherapeutic interventions were very limited and were only selected those interventions which were less culturally conditioned. It follows the idea that the Western style of intervention isn’t very effective among specific populations.

Complementary therapies propose an alternative to the Western clinical model. In the cases reported, psychotherapy was complemented with alternative therapies such as relaxing techniques - like yoga or massages - hypnotic techniques, group support, befriending and art therapy – noticed just in one centre -. Art therapy aims to explore, outside the counselling setting, aspects of mental ill health and, in this way, to complement main treatment. The advantages of art therapy, particularly when applied to foreign patients, is that it overcomes the possible obstacles due to linguistic problems.

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71 Asociació Catalana de Solidaritat i Ajuda als Refugiats. ACSAR and CEAR (Spanish Refugee Aid Commission) are united in Catalonia.
These complementary therapies do not pursue a clinical intervention in themselves, therefore these activities not necessarily have to be conducted by a psychologist or psychiatrist.

At other centres examined, the psychological assistance service was being managed by social-psychologists, and deemed group intervention more beneficial. These centres combine advocacy services and programs for labour insertion, thus acting as a crucial social support. When the psychologist detects possible pathologies, for instance PTSD symptoms, clients are referred to other organisations offering clinical treatment.

For PTSD it was observed that cognitive therapies are preferred among victims of trauma, combined with a psychopharmacological treatment. EXIL centre, unlike the others, have developed different programs to treat war trauma, all based on an integral systemic approach according to a medical-psycho-social model, that is, taking into account the person’s biological, psychological and social situation.

**Preventative Activities**

Most of the common mental health disorders that present themselves amongst the immigrant population are caused by problems related to adaptation to their new environment and with the precarious situation in which they find themselves on arrival. Instability in their legal situation, uncovered basic necessities such as food, housing, work and health, and the lack of social support are without doubt factors which lead to mental health problems. Prevention is feasible in order to reduce the impact on mental health. Disorders must be treated within a clinical framework, but preventative care seems essential for the prevention of further illnesses.

Prevention is being given in the form of other types of therapy and assistance. An example of preventative activities are those developed by the surveyed Refugee Reception Centre (CAR) in Madrid where children’s excursions, cultural raffles and party celebrations are organised at the same time as languages courses are being given. Training in healthy habits, such as Hatha Yoga courses or education for health, are carried out during specific psychotherapy sessions, having a positive impact on resident’s social integration and mental health. Moreover, the psychologist has set up a self-help group that aims to promote the creation of a support network between persons that share similar characteristics and necessities. In this way, identification and personal empathy processes can emerge so that the participants are able to develop their own ways of coping with their problems.

Most NGOs examined offered preventative care in the form of legal advice. The Social Care Centres for Immigrants (CASI) network in Madrid and the Cultural Association for Colombia and Latin America (ACULCO) have centred their efforts in combining different services such as the insertion of immigrants in the work place, legal advice and psychological assistance.

Moreover, there exists numerous immigrant associations that, apart from promoting intercultural living together through their cultural diffusion, facilitate the creation of social networks for those who lack social support.
Common activities include the organisation of language and computer courses, school reinforcement, and the accomplishment of cultural excursions, sports, conferences, exhibitions and the editing of magazines among other things. Also, many of them offer advice, labour insertion and housing demand support.

3.2 A Critical Reflection on the State of the Art

It is a fact that Spain is a *latecomer* – according to Gerschenkron terminology - as an immigration country in relation to our North Eastern neighbours. The first and main feature of the Spanish case is its recent character. Although there doesn’t exist essential data to prove it, some experts hold that a very high proportion of the immigrants settled in Spain, have come during the last five years. The institutional system faces a new challenge, derived from the new necessities that have arisen due to the immigration phenomenon. Some changes have already taken place, but still significant institutional changes, mainly in the social and health care sphere, are demanded for the adequate service provision that our society requires at present.

The institutional system has not been sufficiently developed and, therefore, it is not ready to attend to people coming from different cultures. This is because it has been created for a mono-cultural system, which is rigid and closed. The need to establish specific mental health services mainly out with mainstream health provision but also within it, in order to address ethnic minorities needs, reveals the mono-cultural character of the public health system. This mono-culturalism derives from the provision of sanitary resources according to not only the ethnic but also the social position of the users. Hence, that Spanish health system has come to be described as ethnocentric and socio-centric (Pereda et al, 1997, op.cit. Lurbe, 2002).

Next, there is a summary of those weak points that demand short-term solutions:

Most respondents have reported an *absence of monitoring* in the services. Monitoring on the use of mental health services is a necessary tool that would help towards a positive development of the existing services, as evaluation is a crucial aspect of the methodology in psycho-social intervention. Most respondents requested the implementation of good-quality external auditing that could analyse and evaluate the work that is being done. Apart from the intervention in itself, monitoring and evaluation have other positive effects as they would motivate the team members of these services, who are vulnerable to suffer from burn out syndromes.

Existant *racism* in public institutions was reported, as other ways of behaving and other beliefs are being found inadmissible by the health personnel. This problem could be fought through the adequate training of professionals in intercultural subjects together with the realisation of systematic monitoring tasks, as mentioned above.

The *lack of qualifications of social and health professionals* working with immigrants and refugees may create different forms of racism and a mistaken assessment of users, leading to misdiagnosis. The scant offer of external courses and the absence of training inside workers’ organisations seems to be a sign of a lack of motivation on behalf of potential providers and of workers in the field. Courses available have emerged from doctors’ personal initiatives working directly with immigrants and refugees.
The administrators should be more aware of the situation and take part in the qualification of their workers by offering courses, adjusted to new social demands, and given at every health and social centre.

In relation to financial resources, running of most programs has an annual duration even though there exists a certain acceptance of the project’s continuity, except in the case of psychological support projects. It was reported that some psychological and psycho-social support projects submitted by various NGOs have been rejected funding on the basis that this sort of assistance is already covered by the National Health Service. This is certainly true, however, as it was found and reported throughout this survey, there exists groups who have no access to the National Health Service – the undocumented afraid of the administration, homeless, etc – and moreover, the system is still not prepared and has not been adapted to treat minority ethnic groups. As a sign of this, respondents have reported the common referral of immigrant or refugee patients from the National Health Service to NGOs with mental health services, and also the preference these patients show for NGOs services. In spite of this, the mental health services of the NGOs are the programs with the least guarantee of continuity whereas their advocacy or labour insertion programs are much more established and numerous.

Short-term projects, in general, have disadvantages arising from their marginal position in relation to mainstream services. Among the disadvantages there exists the pressure on the new service that has to prove itself successful in a short time, the difficulties in recruiting appropriate staff on short-term contracts and the difficulty in influencing mainstream mental health service policy from a marginal position. The majority of psychological support services for migrants established in Spain have to deal with these limitations.

The inadequate funding given is clearly shown by the necessity to have volunteers working in these services and by the lack and condition of the facilities in which they work, among other things. For example, there is a lack of adequate therapeutic space in psychological consulting rooms of many of the services visited for this survey, where, in some cases, the psychologist was attending patients inside the rooms of the advocacy service, and was, therefore, surrounded by other workers and users. Respondents have also pointed out problems of accessibility to the psychologist of some users owing to their lack of availability, as they usually only work part-time. Interpretation services are insufficient, and almost absent in the National Health System.

Distribution of information about services and how potential users could gain access to them, have demonstrated to be insufficient. Although efforts are being carried out by different NGO’s, associations and city councils, information is not reaching the whole target population.

Consultation with users’ group is not a general methodology, and was only found in those organisations equipped with primary health care and/or advocacy services, which have reported that the establishment of a psychological assistance service had emerged directly as a demand from the users of the service, through the setting up of focus groups with the objective of assessing their needs by means of active listening. The idea appeared from personal contact with the users who often suffered from anxiety when they were informed of any negative administrative resolutions.
Nevertheless, there is almost no evidence of further users’ involvement in the development of services, as the general lack of service evaluation hinders the measurement of their grade of satisfaction and the possibility to make their own suggestions. It has been proved therefore that ethnic minorities and refugees themselves, rather than those who see their role as articulating their needs on their behalf, must be central to this practice. In spite of this, it has been reported that services across Europe rarely provide opportunities for consultation with minority ethnic groups about the type of mental health services they receive in order to identify on a broader level what they want from mental health services (Watters, 1998b, op.cit. Watters, 2001).

Another weak point is the absence of general epidemiological studies. During all this time National Health System records have not registered the patient’s nationality, but only if the patient is national or foreigner. Some efforts have just begun in order to start collecting this sort of data in the communities studied for this survey, Madrid and Barcelona, but the process is still at an early stage. Whereas specific health care services for minority ethnic groups and refugees have been collecting this data since their origin, and they use it to elaborate the organisation’s annual report - confidential in some cases -, which permits specific epidemiological to be conducted. It is very important to carry out systematic and complete data recording that will allow the construction and use of statistics, which is essential to argue for resources in order to develop preventive activities and particular programs of treatment.

If culturally sensitive services are those which include the deployment of health and social care workers from similar cultural backgrounds as those of ethnic minorities or refugees themselves, for the provision of interpreting services, advocacy services and specific training in cultural issues for mental health staff, we could say that Spain is still a long way from achieving these goals. Some services visited are working along these lines, but, in general, there exists a great lack of workers coming from similar cultural backgrounds to members of ethnic minorities or refugees, and they are only being demanded at present as cultural mediators. The School of Social Mediators for immigration (EMSI) based in Madrid, functions on this basis, training new mediators. Currently in Madrid 80% of cultural mediators are foreigners.

However, other voices against state that the appointment of workers coming from similar backgrounds does not necessarily entail an effective means of responding to the needs of minority ethnic groups and refugees in the sense that, for example, a bilingual therapist’s role is not to translate patient’s experience in their own terms but to construct parameters that fit experiences into predefined biomedical categories. In this way, bicultural therapists may be seen as agents of de-culturalisation and de-politisation in that they transfigure the patient’s account into individualised pathology (Ong, 1995, op.cit. Watters, 2001).

In Spain, the specific demands of different migrants are not being considered, like, for example, the issue of gender awareness. Due to cultural reasons some patients prefer to be attended by a woman instead of a men, and vice-versa, but in practice this option is still very limited when referring to services involving psychological assistance, mainly due to staff limitations.
3.3 Conclusions

As mentioned previously, the recent history of Spain as a reception country combined with the sharp increase of immigration during the last three years and the state of Spain’s economy explains much of the present situation of immigrants in this country. Spain’s high level of unemployment and the weakness of the welfare system compared with other European countries, explains why this regime was not an attractive destination for immigrants in the past.

Health care institutions have taken a long time in addressing culture diversity, probably because of institutional difficulties. In the meantime, NGOs have been taking a leading role in immigrant health and social care assistance, even though their scope is still limited. Through experience and the passage of time they have specialised in the provision of specific services. However, as NGOs stand outside the mainstream mental health and social care provision and, despite the fact that their work has unquestionable positive effects on the state of service provision, this system is promoting the separation of immigrants from the rest of population. This can be a short-term solution, but efforts should be focused on endowing the National Health System with the human and material resources necessary so that it can provide an efficient service that meets the needs of all its clients. Meanwhile, the funding of NGOs by the government must also be increased in order to improve the quality of their service provision, as with inadequate financial support, NGOs cannot effectively carry out their role. It will be only when all these measures have been carried out that we will be able to say that health assistance is truly universal for all people living in Spain.

It is essential that workers, within the mental health and social care systems, also provide welfare advice and act as advocates for immigrants and refugees in that institution. As Watters says, “an ideal approach may be the combination of advocacy services addressed to ensure that immigrants and refugees gain maximum benefits from existing services together with the provision of specific holistic services, which respond to the social care and mental health needs of immigrants and refugees” (Watters, 2001:1715).

To carry this out, one has to struggle against the present lack of co-ordination between the National Health System, NGOs and ethnic minorities, and furthermore, it is essential to raise awareness about health issues. This is clearly indicated by the fact that during the last National Immigration Congress held in Granada in November 2002, which 700 professionals of different backgrounds attended, the subject of health had very little prominence.72

Policy makers should pay more attention to health issues – facilitating access to services and improving provision - a basic initial need for physical well-being and, therefore, integration, instead of focusing so much on control and regulation policies that strengthen the police vision of the immigration phenomenon, and have a dramatic impact on the mental health of immigrants, asylum seekers and refugees. One should bear in mind that the psychological and social consequences of the law have a deep impact on mental health.

72 Specifically at the “communication table” – assigned not for reading papers but as a place for discussion – which dealt with health issues in general, and mental health in particular, there were just two listeners apart from the speakers (persons who gave the papers).
Chapter 4. Good Practices

4.0 Good Practices

This chapter will show two in-depth case studies of good practice based on the survey carried out and explained in Chapter 3.

The chosen case studies are one statutory and the other non-statutory, and both are located in Barcelona. These cases have been chosen because they comprise a range of good practice elements – easy access and promotion, user involvement, personal and cultural sensitivity, the co-operation between different agencies, continuity of services and clients, advocacy work, evaluation and research tasks - and were also found particularly innovative.

4.1 Case Studies

SAPPIR. Psycho-pathological and psycho-social assistance service for immigrants and refugees

Introduction

The first and unique Pla de Salut Mental (Plan for Mental Health) in Catalonia was approved in 1994 and it does not conceive ethnic difference as a criteria for screening users who require professional care for their mental disorder. Hence, it didn’t make any reference to the need to establish specific services addressed to non-EU immigrants or specific policies aimed at ethnic minorities. However, it did refer to immigration, its cultural impact and racism, as life events that could alter the psychological balance of a person.

The socio-political scene characterised by the will of the EU to close its borders, and the demographic concentration of the immigrant population, together with the major attention paid by the media to this phenomenon, favoured the appearance of a specific mental health service partly integrated in the public health system and directed towards non-EU immigrants and refugees. This is SAPPIR.

On a micro-social level, other factors that promoted the establishment of this service were the incapacity, expressed by health professionals, of attending patients from different cultural backgrounds, and the complaint, on the behalf of certain NGOs and health professionals, regarding the problems of accessing health services by an important sector of the non-EU population.

SAPPIR was established in 1994 and set out to provide mental health assistance to undocumented immigrants, asylum-seekers and refugees in Barcelona. The centre is a specialised service inside a wider group, the Health Assistant Service for Immigrants and Refugees (GASIR). The GASIR was established to help the health problems that these groups have. The GASIR was founded in 1990 by a cross-disciplinary team that comprises doctors, psychiatrists, psychologists and anthropologists. Among its objectives were the development specific psycho-social and mental health programs for immigrants.
SAPPIR was established with the objective of setting up a free assistance service specialised in psycho-pathological and psycho-social assistance for immigrants and refugees. The centre is situated in Hospital Sant Pere i Claver Foundation, near the city centre. It receives funding from the Servei Catalá de la Salut and the City Council annually. This private hospital, which is a pioneer in working with immigrants, generously provides its infrastructure – reception, rooms, administration personnel and technological equipment -. SAPPIR is linked to the Association for the Study of the World Refugee Problem (AWR) located in Rome.

The centre comprises a multicultural team formed by a head psychiatrist – member of GASIR -, a child psychiatrist, two psychologists - one of whom carries out art therapy sessions, a cross-cultural mediator and interpreter, a sociologist and an administrator. Most of the staff are volunteers so that we can say the volunteers play an important role in the functioning of the service. Members of staff carry out periodical meetings in order to share their expertise and to discuss aspects of the day to day running of the centre. The team carries out different activities according to the following realms:

- The Bi-cultural team. Psycho-pathological and psycho-social assistance (first visits, treatment, psycho-social evaluation and art therapy)
- Administration
- Promotion and training
- Research

Other elements of the project include the elaboration of a standard inter-cultural psychiatry questionnaire on behalf of the head psychiatrist. This questionnaire is currently in progress, and the objective is to obtain a standard questionnaire that could be used by any psychiatrist treating patients from a different culture.

The objectives of SAPPIR are:

- Independent of the patient’s clinical and social situation, psychological and social attention will be given.
- Psychological attention is provided from a psychological and psychiatric intercultural perspective.
- To offer training to other professionals
- The promotion and diffusion of their work to other institutions that work with migrants
- To achieve external recognition based on the high level of quality offered

**Project users**

- Immigrants suffering from problems deriving from adaptation to their new environment, independent of their legal situation.
- Asylum-seekers and refugees. GASIR signed a covenant in 1998 with Red Cross Barcelona, by which SAPPIR assumes responsibility for the psycho-pathological and psycho-social attention given to asylum-seekers and refugees in Catalonia.

Clients are referred mainly from immigrant associations, Red Cross, Social Services and other health services.
The Bi-Cultural team

The staff consists of two bi-cultural psychiatrists, one of them being the team leader, who has responsibility for 2 bi-cultural support workers, both of whom are clinical psychologists. The availability of the service is two days per week by appointment.

Languages available are Spanish, English, Arab, Berber, German and Russian.

The work consists of:

⇒ **First visits.** The first visit is carried out in two parts, first with the psychiatrist and then with one of the psychologists, and focuses on assessing patient need. Firstly, the psychiatrist gathers information mainly about symptoms, stressors and the grade of resilience. Other data collected in the clinical record is: name, age and age that the patient looks, sex, civil state, country of origin (specifying rural or urban area), time of residence in Spain, previous migrations, labour situation before and after migration, legal situation, housing conditions, level of education, languages spoken, religion and grade of practice, migration characteristics (reasons, projects, if (s)he came alone, family relations, children, if any relative has died since they arrived, etc.), dreams of returning to their homeland, number of persons they can count on if they find themselves in a difficult situation and existence of an alternative system of believes. This data will be collected throughout different visits. The patient is asked to explain what they think are the causes of their mental disorder.

During a second stage, the psychologist tries to gather complementary information through the conducting of an interview based on the questionnaire of the “seven grievances of migration”. This questionnaire has been drawn up by a psychiatrist who states that the patient will get better sooner if information is abundant and reliable.

⇒ **Treatment.** It consists in the application of the treatment according to Pla d’Atenció i Seguiment (Attention and follow up Plan). The cross-disciplinary team are experts in diverse psychological and psychiatric treatments and techniques such as psychoanalytical psychotherapy, systemic, cognitive and psychopharmacological, among others. Their methods are based on an eclectic approach.

Generally, SAPPIR offers a psychotherapeutic treatment that tries to relieve superficial symptoms, provides medication for anxiety or acute depressions and develops a psycho-dynamic therapy with the objective of re-organising the relational and social life of the person in the reception country.

The treatment of PTSD is done through psychopharmacological treatment combined with a psychotherapeutic cognitive-dynamic intervention.

**Art therapy.** SAPPIR is the only centre at the moment which offers free of charge this type of therapy for immigrants in Spain. The University of Barcelona has pioneered in Spain the offering of a Master in Art Therapy since 1999 and Madrid University has followed its steps offering this degree since 2001.
Art therapy has the advantage that patients do not need to speak the language of the recipient country. Although from art creation we could arrive at a verbal process, art plays down the importance of the verbal part of communication and provides an alternative model of treatment.

The art therapist in the centre is a foreigner, and has been trained in multicultural psychology. One hour sessions take place in a classroom made available by the Secondary School right next to the hospital.

The results achieved so far are positive, even though only a very small minority of patients agree to participate on these sessions.

According to the psychiatrist, “art therapy helps in the collection of information about the patient, and the success of the intervention depends to a great extent on the quality and quantity of the information collected”.

**Administration**

The tasks of the secretary are those of reception, arrangement of visits and management of the postgraduate course offered by the University of Barcelona, which is given at the centre.

**Promotion and Training**

**Promotion**

Members of staff have given briefings to the media – TV and radio - on the work of SAPPIR. The team leader has published various articles in national newspapers – e.g. *El País* - , medical magazines, and has also participated in the SOS Racismo 2001 Annual Report, with the objective of raising public awareness towards the situation of immigrants.

Moreover, he has just published a book titled “Depression in immigrants. An intercultural perspective”.

**Training**

Training is given in the form of a postgraduate course in “Mental health and psychological interventions with immigrants, refugees and minorities” run by the psychiatrist, who is a university professor.

The course is given by the University of Barcelona, in collaboration with Sant Pere i Claver Hospital, where some of the normal classes are given, and where those of a practical nature take place.

The course centres on the study of the prevalence of mental health disorders in immigrants. Experts from different backgrounds – psychologists, psychiatrists, sociologists, anthropologists and journalists among others - are invited throughout the academic year to give lectures about the subject on which the students are working. The course is addressed mainly to psychiatrists, psychologists, G.P’s, nurses, social workers, sociologists and other professionals working with migrants.

Apart from this, the team leader has given some talks for health professionals working in Primary Care Centres in Barcelona. These talks have been financed by pharmaceutical firms.
Research
Records exist and are kept up to date. The sociologist, trained in multicultural psychology, is in charge of the data for the elaboration of the Annual Report. The data collected in the questionnaires has three parts:

- Socio-demographic data: sex, age, country of origin, civil state, education level, legal situation, year of arrival in Spain, etc.
- Data concerning the migratory process: reasons for migration, situation in the recipient country, expected activities, etc.
- Clinical record: child history, personal record (previous psychological problems, personality type etc).

Through the use of a computerised SP/SS data base, research is carried out and reported on every year.

During 2001, SAPPIR attended patients of 26 nationalities. Most of them were Moroccan (38.2%) followed by Ecuadorians (11.8%) and Pakistanis (5.3%). The majority were men (53.9%), aged between 19 and 30, who had gone to secondary school and who didn’t have a job.

Most of these patients presented a combination of symptoms related to depression and anxiety, together with some psychosomatic symptoms, ranging from migraine and sleep disorders as the most common, to abdominal, joint and chest pain. Also, SAPPIR treated cases in which stress caused sexual dysfunction, the most common problems being impotence and premature ejaculation.

Future projects aim to enlarge the service through the establishment of a social attention service - incorporating a social worker in the team -, and to carry out further and deeper research about what its director has called “Ulysses syndrome” - using the service data base that contains more than 170 cases – with other European partners.
Introduction
The EXIL centre was established in 2000 in Barcelona and is a program of medico-psycho-social rehabilitation for immigrants who are victims of human rights violations and torture. It receives funding from the United Nations centre for Victims of Torture, from the EXIL centre based in Belgium and other institutions. It doesn’t receive Government funding, apart from a small grant from Barcelona City Council.

The centre’s activities and services will be enlarged when funding increases. One of the workers explained that to get higher funding it is necessary to offer guarantees that the centre is working with success. During the first two years of existence, they have dedicated all their efforts to the task of promotion and contact with other organisations in order to set up a co-ordinated network to provide a widespread and better service.

The first EXIL centre was founded in Belgium in 1976 by refugees who came from Latin America and had been victims of organised violence in their countries of origin. The director of the centre is a Chilean exiled in Belgium during the Pinochet dictatorship. In this country he administered psycho-social support for victims of torture and persecution. Later on he became specialised in the treatment of victims of organised violence – for political, religious or ethnical causes – and intra-familiar violence – like sexual abuse, sexual mistreatment, child violence, etc.

Barcelona, was the chosen city to establish the Spanish EXIL centre for three main reasons, the favourable geographical situation, closest to other European countries – the director keeps regular contact with other organisations across Europe and, of course, with Belgium-, the high density of immigrant population living in the city and, finally, the higher sensibility concerning public health issues and the strong network of associations in relation with this field in comparison with the other regions he visited.

The project is made up of three services: psychotherapeutic, psychiatric and social. Its opening hours are from 10.00 a.m. to 17.00 p.m. and the assistance offered is free. Unlike the rest of services visited, EXIL counts with the availability of an adequate space for treatment. The centre is based in an ample flat, bright and quiet, divided into different rooms, one of which is conditioned for children.

Project users

- Immigrants victims of human rights violations or torture. Even though, other immigrants are attended if they ask for assistance.
- Specialist treatment for women and children who are victims of torture

Clients are referred mainly from ACSAR-CEAR, Cáritas, Médicos Sin Fronteras, and Resident Associations that know of its existence due to the promotion campaign that Exil has carried out during its first two years of existence.
The Bi-Cultural team

The Bi-Cultural team is made up of a psychiatrist, a psychologist and a social worker as regular staff. They are all clinically trained in multicultural psychiatry and psychology and work full time. One should point out that all members of staff have been living in different countries for a considerable period of time, something that will surely have a positive effect on their work. Moreover, there are voluntary staff working part time, mainly psychologists, whose number varies depending on availability.

Languages spoken are English, French and Spanish. According to centre’s experience, most patients speak one of these languages, even though in case of necessity they can ask for translators from other associations.

The centre’s assistance focuses on an integral systematic approach in accordance with a medical-psycho-social model. The bio-psycho-social approach means an intervention which takes into account at the same time biological (heredity, neuro-endocrine disorders, biological susceptibility…), psychological (personality structure, the capacity to face life, ways of relating to others…) and social (influence of the environment that surrounds us, family, work and economic pressures…) factors. Mental or physical pathology is not perceived as something separate to a person’s situation. According to EXIL’s director’s words, “We try to offer victims of torture rehabilitation through a process of medical-psycho-social support that it is done according to a type which relates to integration in the community, that means, putting those persons in contact with other survivors and supportive persons who will support them and help them rediscover their trust in humanity.”

During the first visit the principle objective is to identify the person’s basic necessities. The social worker is in charge of assessing needs and acts as a key worker in assisting refugees to access those services that will allow them to maximise their potential. His main tasks are those of accompaniment and orientation.

The centre has developed specific programs to cure the consequences of war trauma, organised violence and torture. Currently, there exists three different programs:

- **Children-Families’ program**: is a program of medical-psycho-social support destined to support the “parent role” of families in exile. Work is done through individual and group support for children and families, and through a network with other members.

- **Adolescent’s program**: is addressed to unaccompanied minors. It is integrated into a network of social workers who are in contact with adolescents. Activities are based on a personal and group approach.

- **Women’s program**: is a medical-psycho-social accompaniment program for women victims of organised and gender violence. Work is carried out through individual and group support.

Moreover, the centre organises periodically some *discussion groups* with patients. However, the aim of these groups is completely therapeutic, in the sense that they are not set up only as a way of collecting qualitative information from patients, but to put them in contact with each other.
While members of the team act only as mediators, patients get in contact with each other with the objective of helping each other in their therapeutic process and to rediscover their trust in humanity. This is what the centre calls “the therapeutic content of solidarity”.

**Promotion and training**

Promotion has been scarce due to the short life of the service. Even though, one of the workers has been invited to a local radio station to speak about EXIL, in order to tell specifically what the program is about and what service they are offering.

The director, a specialist in child violence, has written books related to this field and has participated in various conferences on Child Protection – e.g. the last European conferences on Child Protection organised by the Diputación de San Sebastián.

Training, during the first two years of existence, has been given in the form of the organisation of two conferences on the consequences of torture, to which professionals/experts of different countries were invited.

The EXIL team remarks that training in this field has a strong demand. Recently, they were asked to participate in a seminar organised by two Algerian associations dedicated to victims of torture in Algeria.

**Research**

On a therapeutic level, evaluation of the service is given through team meetings where demands are assessed and suggestions made about the most humanitarian way of dealing with the problems which arise.

The director carries out the centre’s general evaluation, but research is still not among the centre’s main priorities.
Red Cross

**Introduction**

Red Cross established the psychological assistance service for asylum seekers and refugees in March 2000, in different cities such as Madrid, Barcelona, Córdoba and Valencia. Lately, other cities are incorporating this type of service – Alicante, Torrelavega… -.

Their main objective is to provide with an integral assistance. Therefore, IMSERSO has come to contemplate this psychological assistance service for asylum seekers and refugees as part of the global assistance program for this population at a level state.

**Project users**

- The project was conceived for asylum seekers and refugees so that majority of users comprises this population. Even though, if an immigrant (with or without documents) requires this service, will be also assisted.

**Bi-Cultural Team**

The Bi-Cultural team is made up of one psychologist, one social worker and one lawyer.

The service aims to offer psychological support and psychotherapeutic intervention when necessary. Their work contemplates evaluation, diagnosis and trauma intervention, apart from providing accompaniment and psychological support throughout the asylum process, which is arduously long and has different inflection points every time the applicant receives a response.

Other important feature of their work, apart from trauma intervention, is the task addressed at mental hygiene prevention. Adaptation to the new country, cultural difference, loss of references and the complication of the asylum process could lead to the appearance of psychological problems. Therefore, prevention tasks and precocious detection of first symptoms will facilitate possible intervention.

Red Cross’s psychological assistance service for asylum seekers and refugees comprises the following programs:

- Psychological assistance to adult asylum seekers and refugees
- Psychological assistance to asylum seekers and refugee’s children
- Family therapy and pareja
- Psychological assistance to pregnant asylum seekers and refugee women

**Promotion and training**

- Labores de difusión de su trabajo: escribir, participar en conferencias, salir en msm….
- Formación específica de los trabajadores
Existe evaluación de su trabajo? Cómo, quién la hace?

Análisis de datos de las historias? Son publicadas? Algo importante a resaltar de las últimas?
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Lurbe i Puerto, K. (2002). Incursión sociológica sobre la enajenación de l@s otr@s. Estudio sobre el tratamiento de la diferencia étnica en la salud mental. Trabajo de investigación. Dir: Dra. Carlota Solé. Universitat Autònoma de Barcelona.


Mascarella et al, (2002). “Estudio sobre la percepción de los colectivos no comunitarios de los dispositivos de salud en España” (Health for All, All in Health). Non published [www.salutepertutti.org]


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- www.cruzeroja.es. Red Cross Spain.
- www.eumc.eu.int. European Monitoring Center on Racism and Xenophobia.
- www.msf.es. Médicos sin Fronteras
- www.ncptsd.org. National Centre for Post-Traumatic Stress Disorder
- www.reicaz.es/extranjeria. Web del Área de Extranjería del Real e Ilustre Colegio de Abogados. Zaragoza
- www.salutepertutti.org.
- www.sosracismo.es. SOS Racismo.

Special acknowledgements to Ignasi Pons i Antón, Arancha García del Soto, Maria Requena, Maria Jesús Sastre, Esther González Alonso and Immaculada Hernández for sharing their knowledge and for their support throughout the elaboration of this report.
Annexe (Appendix Section)

Foreign residents by continent and country of origin in 2001 and the percentage difference compared to 2000.

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**EUROPEAN ECONOMIC AREA**

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### Asylum seekers on the last five years by country of origin

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1 Tables show the ten nationalities on top.
INTERVIEW

Context of the practice: Political and financial feasibility.

♦ How is the project funded?
♦ What is the funding period?
♦ What will happen if the funding finishes?
♦ Specific policies.
♦ Organisational innovations.
♦ Do links exist with other agencies?
♦ How are these links maintained?
♦ Does there exist a connection with social services and/or with other medical services?

Target Group

♦ Traumatised persons / Illegal Immigrants / Children / Rejected asylum seekers / All
♦ Profile of users: sex, age and country of origin.
♦ How do users arrive to the service? Do they come by themselves, with their families? Are they referred from other agencies or organisations?
♦ Which agencies does the project receive referrals from?
♦ Which agencies does the project refer users to?

Access and Promotion

♦ What are the opening times of the service?
♦ Do clients have to pay any subscription fee for the services offered?
♦ Are there any problems of accessibility to the service due to physical distance or lack of information?

Professionals

♦ How many workers comprise the staff of the service?
♦ Professional’s background. Is it an interdisciplinary team?
♦ Have they received specific training?
♦ Where have they received specific training?
♦ What professionals do about the current opportunities for intercultural training in Spain?
♦ What it is the importance/role of the volunteers in the service?
Practice

♦ Methodology, specific practices and therapies used.
♦ Particular techniques used
♦ Are there specific programs?
♦ What do you think about working with interpreters and cultural mediators? Who do you prefer to work with?
♦ What are the languages spoken at the service?
♦ How is attention paid to cultural differences? Are there measures to assist/provide differential cultural and gender needs?
♦ Does the service keep records of clients? If so, how?
♦ Has the service been internally evaluated? If so, by whom, regularity, are results published, etc...
♦ Are clients consulted about their assessment of the service?
♦ In which way are clients involved in the conception and functioning of the service?
♦ Has the service been externally evaluated? If so, describe as above.
♦ Are clients made aware of their rights to services?
♦ Does the organisation advocate on immigrant and asylum issues?
♦ Problems which have arisen in service provision and ways to deal with them.

CENTRES INTERVIEWED

In Madrid:

• ACULCO: Cultural Association for Colombia and Latin America
• CAR Vallecas: Refugee Reception Centre
• CASI Centre District: Social Care Centres for Immigrants
• CEAR: Spanish Aid Commission for Refugees
• COMRADE:
• Puerta de Hierro Hospital. Psychiatry Unit (Special Unit for acute cases)
• Red Cross Madrid

In the following centres, which did not have their own specific psychological assistance service, a modified interview script was applied in order to obtain useful information about state-of-the-art mental health and social care provision:

• ACCEM: Spanish Catholic Association for Migrants
• OFRIM: Regional Office for Migration.
• Mental Heath Central Services.

In Barcelona:

• ACSAR-CEAR: Catalan Association of Solidarity with Refugees and Spanish Aid Commission for Refugees.
• EXIL: Programme of medical-psico-social rehabilitation for immigrant victims of human rights violations and torture.
• Red Cross Barcelona
• SAPPIR: Psycho-pathological and psycho-social assistance service for immigrants and refugees.

SATMI: Service of Treatment and Attention for Immigrants

Identification Study
Report on Portugal
Chapter One: The Context of Interventions

1.1 Demographic

Immigration and emigration in historical context

Emigration

Portugal has traditionally been a country of emigration. This phenomenon is believed to have started as early as the fifteenth century when departures to Ceuta, in North Africa, and to the Archipelagos of Azores and Madeira began. In the years thereafter, the Portuguese travelled through the Indian and the Atlantic Oceans reaching Africa, India
and Brazil – the Expansion Period had started and by 1600 more than 100,000 people were spread throughout the newborn Empire (Rocha-Trindade, 1995).

Emigration was a consequence of the need to protect conquered lands and to assure self-sufficiency to the newly installed communities. The scale of emigration to the colonies remained high throughout the sixteenth, seventeenth and eighteenth centuries. An estimate of the Portuguese population across the world in the year 1820 presented the following figures:

- 3,352,180 in Portugal, Algarve, Madeira, Azores and Cape Verde;
- 1,100,000 in Africa;
- 580,000 in Asia;
- 5,300,000 in Brazil.

(Serrão in Rocha-Trindade, 1995).

The massive emigration to Brazil was to continue. The state’s independence in 1822, and later on the end of slavery, led the Brazilian government to adopt a policy of immigrant labour. This need to replace sources of manual labour, together with the prevalent myth of ‘getting rich quick’ and the poor economic situation in Portugal, created the conditions for an emigration stream that kept up until the first decades of the twentieth century. Meanwhile, other destinations within the American continent began to attract Portuguese workers. Among them were Venezuela, Canada and the United States of America. At the beginning of the twentieth century the number of departures to the USA made up 16.7% of the national emigration (Garcia, 2000).

The two World Wars and the Great Depression in America, as well as the increasing emigration restrictions at home, diminished significantly the Portuguese flow overseas. At the same time, emigration within Europe became possible. In combination, these factors set a new trend of migration and in 1964 Portuguese emigration to Western Europe exceeded the flows to Brazil – France alone received 800,000 Portuguese in just a few decades.

By the third quarter of the twentieth century the volume of Portuguese emigration was out of all proportion to the country’s population. The low profitability of agriculture, the fragile process of industrialization and the poor development of the services sector contributed to extremely low per capita incomes, contrasting strongly with the salaries offered in other European countries.

The colonial war and the opposition to Salazar’s political regime provided more motivation for a massive exodus from Portugal. Between 1950 and 1975 more than 1,300,000 left out of a population of ten million, creating a severe social and economical crisis (Rocha-Trindade, 2000).

The year 1974 proved to be a turning-point. The military coup that took place in that year (the “April Revolution”) triggered fundamental social and economic changes. Portugal became a democratic state and the political and ideological reasons that once motivated departure then became strong stimuli for a significant return movement. Together with the world oil crisis of 1973-74 and the subsequent restrictions on immigrants’ admittance to European receiving countries, this event ushered in a drastic
cut in Portuguese permanent emigration and an increase in temporary migration in the years thereafter (Ferreira and Viegas, 1999).

In 1997, the number of Portuguese people living abroad extended to over 4 million, of which 54.3% were in America, 31.3% in Europe, 12.4% in Africa, 1.3% in Oceania and 0.7% in Asia. Currently, an average of 35,000 people leave the country every year\footnote{The main destinations are France (25.6%), Germany (24.3%), Switzerland (22.7%) and the United Kingdom (8.8%). These figures come from 1999; in that year, 85% of the total emigration was temporary.} (Falcão, 2002).

**Immigration**

The history of immigration in Portugal in ancient times is inevitably incomplete, as no quantitative data exist (Rocha-Trindade, 2001). Nevertheless, there is qualitative evidence proving a first settlement of Roma gypsies in Portugal approximately five hundred years ago. According to the Portuguese Constitution of 1822 and the Constitutional Charter of 1826, which eliminated the inequalities regarding ‘race’ and conferred Portuguese citizenship on those born in Portuguese territory, the Roma are national citizens. Their presence has increased substantially to almost 40,000 and they are currently considered an important minority (Franqueira, 2002).

In the sixteenth century another group of migrants was established as a consequence of the smuggling of African slaves. Although there was a significant number of Africans, particularly in Lisbon, the end of slavery in the eighteenth century and the miscegenation that then occurred came to eliminate this group as a distinct community.

The arrival of Western European immigrants started in the nineteenth century. They were predominantly from Spain (mostly from Galicia), the United Kingdom, Germany and France. Together with the Brazilian immigration, these flows were active through the twentieth century, expanding specific professional activities connected with the commerce of wine and the exploitation of mines (Rocha-Trindade, 1995).

**Post-WWII immigration**

**From the 1960’s to the 1980’s**

There are no specific statistical data concerning the number of immigrants living in Portugal until 1960 (Fonseca, 1997 in Ferreira e Viegas, 1999). The foreign resident population is believed to have been stable during the 1950’s at a level of around 25,000 (Pires, 1999).

The 1960 Census recorded 29,428 immigrants in Portugal. Of these, 22% were Brazilians and 67% Europeans. Of the latter, 40% were Spanish, mainly refugees of the Civil War and mostly settled for more than ten years; 7% were English, 6% French and 5% German. Brazilian immigration represented by then a reverse current to the emigration flows. The end of the decade came to favour European immigration as a consequence of national attempts to industrialize, incentives to foreign investment and the development of tourism in the Algarve. Also during this period, return immigration from some of the African colonies began\footnote{Mostly, these migrants arrived with the purpose of study, or as unqualified labour recruited (mainly from Cape Verde) to}. Mostly, these migrants arrived with the purpose of study, or as unqualified labour recruited (mainly from Cape Verde) to
replace local workers who had emigrated to Europe or been drafted for the colonial wars (Ferreira e Viegas, 1999; Pires, 1999; Rocha-Trindade, 2001).

As a result of the political, social and economical changes initiated with the 1974 Revolution, ‘traditional’ (i.e. European and South American) immigration decreased. However, in the following five years the foreign population almost doubled, due to the arrival of 28,000 Africans from the ex-colonies. By 1981 there were 58,526 foreign residents in Portugal. The percentage of immigrants in the total population of the country rose from 0.33% in 1960 to 1.10% in 1981, representing an increase of 313% in the number of immigrants. Several qualitative changes occurred during these two decades:

- The proportion of Europeans in the total immigrant population dropped to 33%, while that of Africans increased from 1.5% to 44%.
- The proportion of youth (under 15 years old) increased substantially from 15% to 42% while that of the elderly (above 64) halved (7%).
- The proportion of active youth remained more or less stable around 36%.
- The proportion of immigrants integrated in commercial activities halved (17%), while the proportion of immigrants employed in the construction sector rose from 3% to 22% (Pires, 1999).

Decolonisation and its effects

Portugal’s African colonies were granted independence during 1975. This process plunged Guinea, Mozambique and especially Angola into a situation of political chaos and extreme insecurity, forcing half a million repatriates and other migrants to move to Portugal (Rocha-Trindade, 2001).

In a first phase, both labour migrants (mainly Cape Verdians) and refugees (particularly Mozambicans and Angolans) characterized the post-1974 African migration. The partial overlap between the first streams of African immigrants and the massive influx of ‘retornados’, together with an irregular component of those streams gaining admittance to Portugal with the help of fellow nationals already in the country, makes it difficult to give an accurate account of the size of these flows at the beginning of the 1980’s. Estimates range between 27,287 according to the Aliens and Border Service, and 45,222 according to the Census of 1981 (Pires, 1999).

From the 1980’s to the present

The 1980’s ushered in a marked rise in the number of immigrants to Portugal, which until then had never exceeded 50,000. By 1997 there were 175,000 legal immigrants, an increase of more than 200% compared to the 58,000 in 1980. These figures increased to 208,198 in 2000 and to 350,503 in 2001 (see Table I).

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Table I: Number of Foreign Residents, 1980-2001

74 Numbers concerning these flows are difficult to establish. During the colonial period, movement to and from the African colonies was considered inter-regional and was therefore not included in the statistics (Pires, 1999).

75 This group of repatriates is commonly designated ‘retornados’.
From the mid-1980’s until the end of the 1990’s the development of immigration was
caracterized by the consolidation of the African immigration\textsuperscript{76} and, simultaneously, by
a diversification of origins through the emergence of new streams or the revival of old
ones. The 1980’s were particularly marked by a resumption of European immigration,
especially from the United Kingdom, and by the emergence of new Brazilian
immigration (+165%). During the 1990’s, African immigration intensified once more.
Between 1990 and 1997, the number of legal foreigners grew on average by 63% while
the number of immigrants from Portuguese Speaking African Countries (PALOP)
increased by 79%. This boost was mainly the outcome of the substantial increase in
immigration from Guinea-Bissau (+221%), Angola (+207%) and Saint Tome and Prince
(+112%). Cape Verdian and Mozambican immigration remained below the general
average (Pires, 1999).

This evolution indicates a significant change in the composition of the top ten
nationalities between 1980 and 2000 (see Table II). In terms of the total rate of growth,
Guinea-Bissau and Angola present an outstanding increase of 2,350% and 1,376%
respectively. By contrast, Spain registers the smallest growth rate (185%). In 1980 the
nationalities most represented, in descending order, were Cape Verde (41%), Spain
(13%), Brazil (7%), USA (6%) and the UK (5%). In 1990, Spain and USA drop to the
fourth and fifth positions, respectively, and Brazil rises to second. By 2000, the two lead
positions are stable (Cape Verde, 23% and Brazil, 11%) but Angola (10%) and Guinea-
Bissau (8%) rise considerably to the third and forth places. The UK (7%) drops to fifth.
These developments account for variation within the streams, strengthening the
heterogeneity of the immigrant population.

\textsuperscript{76} In this context, African immigration refers to the Portuguese Speaking African Countries (Países Africanos de Língua Oficial Portuguesa, PALOP) – Angola, Cape Verde, Guinea-Bissau, Mozambique, Saint Tome and Prince.
While in 1990 only one African country appears within the five main nationalities, in 2000 there are three – Cape Verde, Angola and Guinea-Bissau. Additionally, the total of the immigrants from the top ten nationalities as a percentage of all immigrants drops from 84.7% in 1980 to 76.53% in 1990, rising to 81% in 2000 (SEF).

On a much smaller scale but still worth mentioning, due to its special nature and its rapid increase in recent years, is Asian immigration. Two groups are commonly singled out for attention: the Chinese and the ‘Indians’. The latter designation refers to the initial group of immigrants who arrived from India, Pakistan, Bangladesh and Mozambique\footnote{This stream of immigration increased in the period post-1975 mainly as a consequence of the repatriation of Indians from Mozambique (Ávila and Alves, 1993 in Pires, 1999), which settled there during the period of colonization.} prior to 1975. Students and descendants of the Luso-Goese elites composed these groups, which meanwhile increased and diversified towards greater social and religious heterogeneity (Pires, 1999). Altogether, immigrants from the Indian subcontinent made up 1.2% of the total foreign residents in 2000.

Chinese immigration has increased recently as a consequence of political developments in Macao. By 2000, there were 3281 Chinese residents (1.6% of the total number of foreign residents).

The year 2001\footnote{During the year 2001 a regularisation campaign took place allowing for several thousands of irregular immigrants to obtain permanent residence permits. It should therefore be taken into account that the given numbers may reflect the presence of groups of immigrants settled years before that presence was recognised.} showed a substantial increase (69%) in the total number of immigrants, mainly due to the granting of 126,901 permanent residence permits (see Table II). Despite the sustained growth of Brazilian immigration, the most significant increase has been among Eastern Europeans. Ukrainians alone accounted for 36% of the total permanent residence permits, followed (although on a much smaller scale) by Moldavians (7%), Romanians (5%) and Russians (4%). Asian immigrants, in particular the Chinese (3%), ‘Indians’ (2%) and Pakistani (2%), have also registered a significant increase.

According to several authors (Esteves, 1991; Rocha-Trindade, 1995; Machado, 1997; Eaton, 1999), Portugal’s migration pattern has undergone in a remarkably short period of time a shift from being one of Europe’s major sources of emigration to become a receiving society. Nevertheless, a discussion has arisen about whether or not this shift can immediately be interpreted in these terms.

On the next page, Table III gives a detailed breakdown of the origins of foreign residents at the end of 2000.
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Source: SEF
**Profile of immigrants**

Immigration in Portugal has been developing in a systematic way as a consequence of several factors. Among these, the most prominent are the economic growth of recent years and the inability of the national labour market to respond to increasing levels of production. The rate of national unemployment is very close to the rate of natural unemployment and, therefore, labour needs are not easily satisfied (Falcão, 2002).

The economically active immigrant population is basically employed in two segments of the labour market. The largest group comprises unskilled workers who undertake the most unpleasant and low-paid jobs in construction, transport, cleaning and domestic service. At the other extreme of the socio-professional hierarchy are directors, management staff and self-employed professionals (Fonseca, 2001).

The largest numbers of immigrants are concentrated in the Metropolitan Area of Lisbon, followed by the region of Algarve. Their profile varies according to nationality and three particular situations can be recognised.

1. PALOP immigrants are mainly concentrated in the districts of Lisbon and Setúbal, although a significant presence of Guineans is found in Faro.
2. EU immigrants are equally distributed between Lisbon and Faro, though greater numbers of Dutch and English are settled in the Algarve.
3. The settlement of immigrants from North and South America has occurred mainly in the regions of the country where emigration to those destinations had taken place.

These variations indicate different types of migration (Pires, 1999):

1. In 1998, the rate of labour activity among PALOP immigrants was close to the national rate (50%) at 54.6\(^79\). Among these workers, 79\% were construction workers. According to the General Labour Inspection (IGT) in 1999, 80\% of the Cape Verdians and Guineans were in the field of public works, comprising 10\% of the cheap labour in that sector. This occupational pattern is reflected in the geographical disposition of these immigrants, who settle mainly in urban areas.
2. EU immigrants are commonly characterized as professional immigrants, occupying predominantly technical and scientific positions or engaging in activities connected to the tourism sector. In 1998, 56\% of these immigrants were active.
3. Immigrants from the Americas represent a mixture of return migration and qualified migration. The former is more evident among Canadians and Venezuelans, the latter among immigrants from the USA or Brazil. Of these groups, Brazil has registered the highest growth in recent years and by 1998 it was the second largest nationality in the total of immigrants, which seems to confirm the tendency for a new stream of migration. Although a large number of immigrants integrate scientific and technical occupations (46\% in 1997), an increase in the number of workers in the service and commercial sector has been taking place (19\% in 1997) (Rato, 2001; Pires, 1999; SEF).

\(^79\) There is reason to believe that this rate is underestimated, as the informal labour performed by housewives is not included.
As we noted above, Asian migration (particularly from the Indian subcontinent and from China) has been increasing. These groups of migrants are characterised by a substantial activity within small businesses. In 1997, 80% of the Pakistanis, 78% of the Bangladeshis and 38% of the Indians were employed in commercial activities, mostly in Lisbon’s Metropolitan Area. Chinese migrants have settled mainly in Lisbon although a small outpost has been established in Porto. In the same year, 22% of the Chinese engaged in commercial activities while 52% were in domestic services or self-owned businesses (Pires, 1999).

Eastern European immigration attained prominence during the year of 2001, outstripping the previous leading group (PALOP) in numbers, and altering the composition of the total of legal migrants. Nevertheless, evidence suggests that the first influx of these immigrants took place in mid-1990s, some being attracted by Expo-98 building sites or trying to benefit from less restrictive policies. Initially, the only sending country was Romania. After the 1996 regularisation campaign the number of sending countries increased (Peixoto, 2002). This group is essentially characterised by labour migrants distributed mainly through the regions of Lisbon and Algarve. Despite the high degree of education of most of these immigrants, their many occupations range between the different activities of the following sectors: public construction, processing industries, accommodation, restaurants and, commerce (Falcão, 2002). Although male workers mainly comprised most of the first wave of immigration, some female immigration is now developing. Services like restaurants and domestic cleaning are the main occupations targeted (Peixoto, op. cit.).

Irregular Immigration

The number of irregular immigrants has been estimated at between 25 and 40,000 for the period immediately after the regularisation campaign of 1996. In the first half of the 1990’s, Internal Security Reports typified irregular immigrants as foreign citizens from PALOP who had entered Portugal legally and remained after their visas expired. Meanwhile, the application of the Schengen Convention furthered the rise of immigration from Eastern Europe. Later on, Decree Law 244/98 of 1998 was discovered to be promoting Portugal as an attractive country for the settlement of human labour trafficking networks. Together, these factors led to structural changes within irregular immigration, which became predominantly associated with trafficking networks established in the sending countries and particularly representative among Eastern European immigrant communities (Malheiros and Baganha, 2001).

The regularisation campaign undertaken until November 2001 seems to confirm the pattern described above. Of the 126,901 illegal immigrants who attained a “permit to stay”, more than half were Eastern Europeans.

---

80 According to the law, an immigrant is found irregular when entering and remaining in Portuguese soil undocumented or carrying false identification; when remaining in the country after the expiry of the visa or residence permit, or after being expelled by the authorities.
81 With the application of the Schengen Convention in 1995, Eastern Europeans did not need to apply in advance for a visa.
82 Decree Law 244/98 states that foreign citizens who do not conform to all the required criteria may be granted a residence permit under exceptional conditions of national interest or for humanitarian reasons.
83 “Permit to stay” is here also referred to as “permanence permit”. See the subsection concerning Immigration Policy.
These figures also indicate a substantial increase on the phenomenon of irregularity when we take into account the fact that not all the requests were approved. These cases should be added to those who did not apply for legalisation.

Several reasons have been adduced to explain immigrants’ reluctance to apply for regularisation. First, they may be unwilling to emerge from the ‘comfort zone’ provided by the safe houses and supportive communities in the shanty towns (Eaton, 1998). However, the main reason is that official recognition may jeopardise their comparative advantage as cheap and flexible labour to employers. After being issued a permanence permit the immigrant becomes liable to income tax and the employer is legally responsible for social security payments. This situation increases the costs, rendering the immigrant less attractive as cheap labour (Eaton, 1999). Furthermore, the efficacy of the regularisation processes has been questioned and its procedures have been found to be manifestly inadequate. On the one hand, through lack of information or excessive bureaucracy they excluded a significant number of irregular immigrants. On the other, they were responsible for attracting new (irregular) immigrants as expectations on obtaining legal status in a EU country rose (Peixoto, 2002).

According to the Aliens and Borders Service’s Union, the number of irregular immigrants in Portugal “will not be far from 200,000”. This number, which is based on the last regularisation procedure and on the number of family members of legal migrants entering the country, is significantly higher than the official estimates and the numbers given by immigrant associations. The government and the Alien and Border Service’s administration estimate the number of irregular migrants at 50,000, while immigrant associations argue for 100,000 (in Público, 13/02/2003).

Asylum Seekers and Refugees

Asylum Claims

Even though Portugal ratified the 1951 Geneva Convention in 1960 and the additional 1967 New York Protocol in 1975, the set of norms postulated in these documents were not applied or regulated until April 1974 (Costa, 1996).

The years immediately after the fall of the regime did not register a substantial amount of asylum claims (16 in 1974; 87 in 1975; 16 in 1976; 7 in 1977). In 1978 the number of asylum seekers increased considerably to 528 and kept growing until 1980 (when the first legal diploma on asylum was granted), when it reached 1633 claims. Despite a significant decrease in the two years thereafter, the number of asylum claims remained substantial until 1983. This intensification is closely linked with the internal conflicts lived in the former colonies at the time and the subsequent large numbers of migrants seeking security and employment.

Many of these claimed asylum in order to benefit from the provisional permit to stay and to work, but in the end most applicants gave up their claims as many were able to keep or acquire Portuguese nationality, or were simply given a residence permit.
The following period, between 1984 and 1990, showed a decrease in asylum applications and in 1990, these figures were as low as in the middle of the 70’s (60 claims).

The year 1991 came to signify the beginning of an exponential rise in the number of asylum seekers that more than doubled in 1992, attaining its highest peak in 1993 when 1659 asylum applications were launched, to which should be added 355 family members. In fact, the number of claims in 1993 exceeded the total of applications for the period between 1985 and 1992.

This sudden increase is related to the profound political, economical and social changes undergone in Eastern Europe, which led large numbers of people to seek asylum all throughout Western Europe. In the specific case of Portugal, Romanians amounted for the highest number of arrivals (1035). Nonetheless, two other groups from Africa presented a substantial number of applications – the Angolans (312) and the Zairians (86). This situation came to a rapid halt in 1994 and onwards due to changes in the law, increasing the restrictions on granting refugee status. The decrease in the number claims continued until 2002, with a slight exception for the year of 1998 (Costa, 1996; CPR, 2002; and SEF).

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Source: SEF
Within the European Union, Portugal is the country with the lowest number of asylum applications in recent years. According to the Portuguese Refugee Council (2002), several factors might be contributing to this situation:

- the country’s geographical position\(^{84}\)
- a lower rate of development within the EU
- the expectation of an inferior set of reception conditions when compared with those from countries such as the Netherlands, Sweden or the United Kingdom.

Adding to this, Portugal is considered, rightly or wrongly, to be a relatively tolerant country concerning irregular immigration. Finally, the number of regularisation opportunities that have been granted during the past decade\(^{85}\), together with legislation offering other alternatives of legalisation\(^{86}\) in national territory, might have had an impact on the drop in asylum claims.

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\(^{84}\) Apart from the distance from Asia and Eastern Africa, there are few direct air connections with these areas.

\(^{85}\) Two regularisation campaigns took place during 1992/93 and 1996.

\(^{86}\) Article 55, Law 4/2001, 10\(^{th}\) January exempts from visa a whole a series of situations, namely, all those: 1) holding a working contract proposal from the General Work Inspection (IGT), 2) who have not been judged and condemned with a prison penalty over six months, 3) who have not been coerced to abandon national territory and remain in the subsequent period of entrance interdiction, and 4) who are not indicated in the Integrate System from SEF of non-admissions. When fulfilled, these conditions allow for the application of a permanent residence permit for a period of one year, renewable for equal periods, which in total must not exceed five years.
Refugee Status and Humanitarian Protection

Quite apart from the low number of asylum claims, the percentage of asylum seekers obtaining refugee status under the Geneva Convention is conspicuously small (Table VI, next page). From 1993 to 2002 refugee status was only granted to 126 persons. Weighed against the number of applicants for the same period of time (4076), this is equivalent to 3% of all asylum claims (CPR, 2002). If a more detailed analysis is considered, this percentage drops below 2% in the years 1994 (1.5%), 1997 (1.6%) and 1998 (1.2%).

In comparison, the proportion of asylum seekers attaining residence permit for humanitarian reasons\(^\text{87}\) is considerably higher (see Table VII, next page). Nevertheless, it comprises a small number of asylum seekers when measured against the total number of claims. Between 1998 and 2002 175 persons were granted this permit, 1.7% of those applying for asylum during the same period. Sierra Leone is the country of origin with the greatest number of asylum seekers being granted this status (63.4% of the total) followed, to a much smaller extent, by Guinea-Bissau (4%), and Algeria and Angola both with 3.4% (CPR, 2002).

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\(^{87}\) Law 15/98 of the 26th March, Article 8 issued the category of humanitarian protection.

### Table V. Entry of asylum seekers into EU countries, 1998-2000 (thousands)

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<td>38.6</td>
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<td>390.8</td>
<td>389.6</td>
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Source: OCDE-SOPEMI in CPR, 2002
| Year | Angola | Algeria | China | Colombia | Cuba | Guinea-Conakry | Guinea-Bissau | India | Iran | Iraq | Kazakhstan | Liberia | Mauritania | Mozambique | Nigeria | Pakistan | D. R. Congo | Romania | Rwanda | Sierra Leone | Sri Lanka | Togo | Total |
|------|--------|---------|-------|----------|-----|----------------|--------------|-------|------|------|------------|---------|------------|------------|--------|---------|-------------|----------|------|--------|
| 1993 | 0      | 0       | 1     | 0        | 0   | 1              | 0            | 0     | 0    | 2    | 0          | 24      | 0          | 0          | 1      | 0       | 4           | 3        | 0    | 39     |
| 1994 | 2      | 2       | 0     | 0        | 2   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 8          | 0          | 1      | 0       | 1           | 3        | 0    | 9      |
| 1995 | 3      | 0       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 12     |
| 1996 | 0      | 0       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 4      |
| 1997 | 1      | 1       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 2      |
| 1998 | 2      | 1       | 0     | 0        | 0   | 1              | 0            | 0     | 0    | 5    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 16     |
| 1999 | 2      | 1       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 4      |
| 2000 | 0      | 0       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 16     |
| 2001 | 0      | 0       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 14     |
| 2002 | 0      | 0       | 0     | 0        | 0   | 0              | 0            | 0     | 0    | 0    | 0          | 0       | 0          | 0          | 0      | 0       | 0           | 0        | 0    | 7      |

**Total** | **39** | **9** | **12** | **5** | **4** | **16** | **16** | **7** | **14** | **126** |

Source: SEF in CPR, 2002

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</tr>
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<td>Nigeria</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Rwanda</td>
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<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>19</td>
<td>42</td>
<td>34</td>
<td>13</td>
<td>3</td>
<td>111</td>
</tr>
<tr>
<td>Sudan</td>
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<td>0</td>
<td>0</td>
<td>1</td>
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</tr>
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<td>West Sahara</td>
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<td>Zimbabwe</td>
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<td>0</td>
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<td>4</td>
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<tr>
<td>Total</td>
<td>28</td>
<td>50</td>
<td>46</td>
<td>33</td>
<td>18</td>
<td>175</td>
</tr>
</tbody>
</table>

Source SEF in CPR, 2002

**Asylum Seekers – Origins and Profile**

Considering the origin of asylum seekers per continent for the period 1974-1996, Africa occupies the leading position with a total of 6278 claims (to which 2393 family members should be added). Reaching their highest numbers at the beginning of the 80’s and 90’s, African asylum seekers are mainly from the Portuguese Speaking African Countries (with a total of 5430 claims), of which Angola (3454) and Mozambique (1720) are the most representative, followed by Zaire (458) and Ghana (118). Europe follows with a total of 1582 claims (adding 258 family members), occurring especially at the beginning of the 90’s. Romania is the main country of origin with 1256 requests. Poland comes after this, although to a much smaller extent, amounting for 70 requests. In the mid-80’s Iran (90 claims) became the most representative country from the Asian continent, with 255 asylum claims (plus 56 family members). The Americas is the less representative continent, totalling 132 asylum claims and 30 family members, mostly in consequence of the political conflicts experienced in South America (Costa, 1996).

For the period between 1998 and 2002 (February), the Portuguese Refugee Council (2002) gathered information allowing the creation of a database concerning the profile of asylum seekers in Portugal (see Table VIII). This database includes 727 persons, 70% of the total of asylum applications made during the same period, distributed according to arrival through the following dates: before 1998 (3), 1998 (165), 1999 (211) 2000 (150), 2001 (158) and Jan-Feb 2002 (34). 6 persons arrived on an undetermined date.
The population analysed is predominantly composed of males (87%) and young persons (73% are below 35 years old). In successive years, the age of asylum seekers tends to decrease. Up to 1998, 8% of asylum seekers were below 25 years old. By 2001, this proportion had risen to 56%.

Despite the diversification of geographical origins, African asylum seekers were the most predominant, namely Sierra Leoneans (212), Angolans (69) and Nigerians (62). Throughout the period analysed, a significant shift in the main origins occurred. The prevalence of natives from Western Africa decreased considerably. In contrast, Southwest Africans, Latin Americans, Subcontinental Indians and, Central Asians confirmed a growing tendency. Eastern Europeans increased substantially from 1998 until 2000 lessening down in 2001\textsuperscript{88}.

\textsuperscript{88} According to the Portuguese Refugee Council (2002), the pattern of applications within each of these groups is found related mostly to political and socio-economic situations of these countries. Yet, a knock on effect, that is, the dissemination of information of news by those who left in the country of origin, appears to be taking place.
<table>
<thead>
<tr>
<th>Nationality</th>
<th>Total</th>
<th>Nationality</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eastern Europe</strong></td>
<td></td>
<td><strong>Maghreb</strong></td>
<td></td>
</tr>
<tr>
<td>Albania</td>
<td>21</td>
<td>Algeria</td>
<td>40</td>
</tr>
<tr>
<td>Belarus</td>
<td>7</td>
<td>Egypt</td>
<td>1</td>
</tr>
<tr>
<td>Bosnia</td>
<td>12</td>
<td>Mauritania</td>
<td>5</td>
</tr>
<tr>
<td>Bulgaria</td>
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<td>Morocco</td>
<td>2</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>2</td>
<td>Western Sahara</td>
<td>1</td>
</tr>
<tr>
<td>Fed. Republic of Yugoslavia</td>
<td>26</td>
<td>Sub-Saharan Africa - NW</td>
<td></td>
</tr>
<tr>
<td>Lithuania</td>
<td>3</td>
<td>Benin</td>
<td>3</td>
</tr>
<tr>
<td><strong>Letonia</strong></td>
<td>1</td>
<td>Cameroon</td>
<td>8</td>
</tr>
<tr>
<td>Macedonia</td>
<td>3</td>
<td>Ivory Coast</td>
<td>2</td>
</tr>
<tr>
<td>Moldavia</td>
<td>16</td>
<td>Gambia</td>
<td>20</td>
</tr>
<tr>
<td>Poland</td>
<td>14</td>
<td>Ghana</td>
<td>49</td>
</tr>
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<td>Romania</td>
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<td>Guinea-Bissau</td>
<td>33</td>
</tr>
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<td>Russia</td>
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<td>Guinea-Conakry</td>
<td>19</td>
</tr>
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<td>Liberia</td>
<td>28</td>
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<tr>
<td>Ukraine</td>
<td>17</td>
<td>Nigeria</td>
<td>77</td>
</tr>
<tr>
<td><strong>Central Asia and the Middle East</strong></td>
<td></td>
<td>S. Tomé</td>
<td>1</td>
</tr>
<tr>
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<td>274</td>
</tr>
<tr>
<td>Armenia</td>
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<td>Togo</td>
<td>10</td>
</tr>
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<td>Kazakhstan</td>
<td>8</td>
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<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>12</td>
<td>Angola</td>
<td>118</td>
</tr>
<tr>
<td>Iran</td>
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<td>Democratic Republic Congo</td>
<td>61</td>
</tr>
<tr>
<td>Iraq</td>
<td>6</td>
<td>Gabon</td>
<td>2</td>
</tr>
<tr>
<td>Libia</td>
<td>1</td>
<td>Congo</td>
<td>6</td>
</tr>
<tr>
<td>Palestine</td>
<td>4</td>
<td>Africa - Other</td>
<td></td>
</tr>
<tr>
<td>Tajikistan</td>
<td>1</td>
<td>Burundi</td>
<td>1</td>
</tr>
<tr>
<td>Turkey</td>
<td>3</td>
<td>Chad</td>
<td>1</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>1</td>
<td>Eritrea</td>
<td>1</td>
</tr>
<tr>
<td><strong>Indian Subcontinent</strong></td>
<td></td>
<td>Niger</td>
<td>1</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>1</td>
<td>Kenya</td>
<td>2</td>
</tr>
<tr>
<td>India</td>
<td>5</td>
<td>Rwanda</td>
<td>14</td>
</tr>
<tr>
<td>Pakistan</td>
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<td>Somalia</td>
<td>5</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>21</td>
<td>South Africa</td>
<td>3</td>
</tr>
<tr>
<td><strong>Rest of Asia</strong></td>
<td></td>
<td>Sudan</td>
<td>11</td>
</tr>
<tr>
<td>China</td>
<td>4</td>
<td>Uganda</td>
<td>3</td>
</tr>
<tr>
<td>Mongolia</td>
<td>5</td>
<td>Zimbabwe</td>
<td>3</td>
</tr>
<tr>
<td><strong>Latin America</strong></td>
<td></td>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>9</td>
<td>France</td>
<td>1</td>
</tr>
<tr>
<td>Cuba</td>
<td>22</td>
<td>Germany</td>
<td>1</td>
</tr>
<tr>
<td>Peru</td>
<td>1</td>
<td>Spain</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>1184</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source CPR, 2002 and SEF
The educational level of asylum seekers is relatively high when compared, for instance, to some of the most representative groups of immigrants in Portugal such as the PALOP. The distribution of asylum seekers per educational level is as follows:

- 19% are illiterate
- 24% have completed primary school
- 21% have between 5 and 9 years of schooling
- 18% have between 10 and 12 years of schooling
- 11% have a technical education
- 8% have a higher education.

Higher levels of education are found among Latin Americans and Eastern Europeans. Africans, with the exception of Maghrebians, who have relatively good educational levels, are the most common group at the opposite end.

Only 12% of the asylum seekers master Portuguese reasonably well: of these, the majority are Angolans. About two thirds are able to communicate in English, namely West and East Africans and Subcontinental Indians. 23% can communicate in French, particularly Maghrebians and South Western Africans. 15% of the asylum seekers are not able to use any of these languages. This situation occurs predominantly among Eastern Europeans and Central Asians of the Middle East.

Concerning religion, Muslims and Catholics are represented in almost identical proportions (36% and 35% respectively). 18% are non-Catholic Christians, of which Orthodox are the most predominant. Yet there is a substantial number of Protestants and Jehovah’s Witnesses represented, mainly by asylum seekers coming from Angola and Nigeria.

42% of the asylum seekers used several means of transportation. Nevertheless, the aeroplane was the most frequently used transport to get to Portugal.

The great majority of applicants passed through third countries. Only 22% took a direct route. Africans, in particular from Western Africa, usually pass through neighbouring countries before coming to Portugal. Among Eastern Europeans, Latin Americans and Maghrebians, a passage through other EU countries is frequently made. 23% of the asylum seekers have applied or had the intention to applying for asylum in third countries. This percentage is substantially higher among Maghrebians (66%).

Most asylum seekers (93%) arrived alone. Arrival with family is most frequent among Eastern Europeans, Central Asians of the Middle East and Latin Americans. A significant number of South Western and Eastern Africans arrived with their children. 90% of the asylum seekers have no family either in Portugal or in any other EU country.

Slightly more than half of the asylum seekers arrived without documents (54%) and 13% had a false passport. These conditions at arrival were most prevalent in the case of West Africans (67% had no identification papers and 13% had a false passport) and East Africans (64% and 14%, respectively). In contrast, Latin Americans (95%) and Maghrebians (81%) mostly arrived in possession of a passport and visa (74% and 75% respectively).
In an attempt to find a pattern in the data concerning the characteristics of asylum seekers, the Portuguese Refugee Council (2002) has produced a typology of asylum seekers in Portugal. This typology is based on a multiple correspondence analysis\(^\text{89}\) (identification of the main factors out of a matrix of Individuals x Modalities of each variable), followed by a hierarchical classification (cluster) analysis based on the scores of each of the six main factors (position of each individual in the factor) and by the description of the most stable groups in the cluster. The variables used in this analysis are listed in the Appendix.

The results allow for the identification of four main types of asylum seekers:

**Type 1 (148 individuals)**
These come, firstly, from Eastern Europe and, secondly, from Central Asia and the Middle East. In many cases, they passed through other countries of the EU. Many used land transport to reach Portugal; most came in 2000.
Members of this group are usually more than 34 years old and married. The arrival of nuclear family (spouses and children) carries significant relative weight in this group. They do not speak English.
The majority of these persons are Orthodox Christians. They have completed a course in higher education or technical training. They were in technical or scientific professions in their countries of origin.

**Type 2 (137 individuals)**
Having an entrance visa and communication skills in Portuguese are the unifying traits of this group. About half of these persons also speak French and a relatively small proportion is able to communicate in English.
There are various geographical origins, from which Southwest Africa, Maghreb and Latin America stand out the most. Furthermore, they have already applied or intend to apply for asylum in another country.
Most persons in this group are between 25 and 34 years old. The proportion of those who have family in Portugal or in another EU state is of great significance.

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\(^{89}\) Multiple correspondence analysis allows for the synthesis of initial data into a set of factorial axis, which expresses the common characteristics of the universe under analysis. After building a matrix of individuals X modalities of each variable, a factorial analysis technique is applied, taking into consideration the categories of the active variables (the ones that contribute to the definition of the factors). Results of the applied factorial technique correspond to:
1) Identification of the explanatory capacity (% of the variance) that is associated with each factor (factor’s own value);
2) Identification of the relationship between each variable and each factor (loadings);
3) Identification of the relationship between each individual and each factor (scores).
The hierarchical classification, corresponding to a numerical taxonomy that synthesizes distances between one individual and the remaining individuals (measured from the factorial analysis sores’ values), allows the distribution of the individuals into groups that share identical categories.
Type 3 (218 individuals)
What unites this set of persons is the fact that they come to Portugal by aeroplane and, consequently, applied for asylum at the airport and remained there for some days. They came from the year 2000 onwards. The majority came from Western Africa and passed through other countries, mainly African ones, before arriving to Portugal. They did not hold an entrance visa. They are, in most cases, very young (19-24) or even minors. Women carry considerable relative weight in this group. Many of these persons speak English.

Type 4 (224 individuals)
Almost all persons that constitute this group arrived in Portugal by ship and took a direct course. They came, mainly, in 1998 and 1999. They are, like the previous group, natives of Western Africa. They do not hold, either an entrance visa, or identification papers. They speak English and almost none speak Portuguese. Their educational level is very low. In their countries of origin, they were farmers, fishermen or vendors. The proportion of women, in this group, is very small. They have no family in Portugal or in any other EU country.

1.1 Political
Immigration Policy

Government policy on issues of immigration and ethnic minorities is based on the constitutional principles of equality and non-discrimination of citizens in relation to ‘race’ (Article 13 of the Portuguese Republic Constitution, PRC) and to the principle of equalisation of rights between nationals and foreigners (Article 15 of the PRC), with the exceptions provided for in the Constitution and in law. Nevertheless, problems in the practical implementation of these principles exist due to a late recognition of the need to introduce measures for integration, as well as the aggravation of the effects of processes of social exclusion (Franqueira, 2002).

The last twenty-five years of democratic rule in Portugal brought about several changes in naturalisation and immigration policies. As a consequence of the decolonisation in Africa, a new law on nationality was issued in 1975 (Decree-Law 308-A/75, of the 24th of June). This law restricted nationality to those people of Portuguese ancestry resident in the ex-colonies. In the same manner, immigrants of non-Portuguese origin living in the Republic of Portugal at the time of their country’s independence needed a five-period residence in Portugal prior to the 25th of April 1974 to obtain citizenship (Ramos, 1976 in Mendoza, 2000). In 1981 a new nationality law was approved (Law 37/81, of the 3rd of November). The main change introduced by this law was the abandonment of the *jus soli* principle. In 1994 the nationality law was once again revised (Law 25/94, of the 19th of August) establishing tougher criteria for the naturalization of nationals of non-Portuguese speaking countries (Mendoza, 2000).

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90 This law extended nationality to some special cases as those of people with special links with Portugal.
91 After 1981, children of non-Portuguese nationals born in Portuguese territory were considered foreigners.
92 Up until 1994 naturalization was possible after six years of legal residence in Portuguese soil. After the approval of the new law, this requirement was kept for nationals of Portuguese speaking countries but enlarged to ten years for nationals of any other countries.
Although the rising wave of immigration to Portugal started in the mid-eighties, only ten years later did the Portuguese government publicly accept the label of ‘immigration country’ and set about designing an institutional and juridical framework (Marques, Santos, Ralha and Cordeiro, 1998).

As a consequence of the Treaty on European Union and the Schengen Convention, two immigration laws were issued in 1993 in order to bring the Portuguese legislative framework in line with the country’s international agreements. The first was aimed at non-EU nationals (Decree-Law 59/93, of the 3rd of March). The second was directed at EU citizens (Decree-Law 212/93, of the 3rd of March). Finally, to give legal status to previously irregular residents, two legalisation processes were passed (Mendoza, 2000) and, recently, a great number of temporary permanence permits was issued (Peixoto, 2002).

The first legalisation process of irregular immigrants issued by the Decree-Law 212/92, of the 12th of October, was one of the measures undertaken to cope with the migration phenomenon and it aimed at fighting immigrants’ social exclusion. This law had a retroactive effect of six months meaning that all those immigrants entering the country after the 15th of April could not benefit from it (SOS Racism, 2003). The following table translates the main nationalities which benefited from regularisation:

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Number of regularisations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>12525</td>
<td>32</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>139</td>
<td>0,4</td>
</tr>
<tr>
<td>Brazil</td>
<td>5346</td>
<td>13,6</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>6778</td>
<td>17,3</td>
</tr>
<tr>
<td>China</td>
<td>1352</td>
<td>3,5</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>6877</td>
<td>17,6</td>
</tr>
<tr>
<td>India</td>
<td>261</td>
<td>0,7</td>
</tr>
<tr>
<td>Morocco</td>
<td>98</td>
<td>0,2</td>
</tr>
<tr>
<td>Mozambique</td>
<td>757</td>
<td>1,9</td>
</tr>
<tr>
<td>Pakistan</td>
<td>286</td>
<td>0,7</td>
</tr>
<tr>
<td>Saint Tome and Prince</td>
<td>1408</td>
<td>3,6</td>
</tr>
<tr>
<td>Senegal</td>
<td>1397</td>
<td>3,5</td>
</tr>
<tr>
<td>Other</td>
<td>1942</td>
<td>5,0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39166</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: SEF in SOS Racismo, 2003

Four years after the first regularisation process and under a new elected government, a second “extraordinary process of immigrants legalisation” was issued (Law nº 17/96, of 24th of May). This law also comprised a retroactive effect differentiating between two categories of immigrants. Those coming from the Portuguese Speaking Countries93 (PSC) were allowed to apply for regularisation as long as they had entered the country before December 1995. The remaining aliens could only make the same application if

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93 Included in this category are: Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique and Saint Tome and Prince
they had been in Portugal before the 25\textsuperscript{th} of March of 1995 (SOS Racism, 2003). The following table shows the number of regularisation requests by nationality:
Table X. Regularisation Campaign 1996 – Number of Requests per Nationality

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Nº of Requests</th>
<th>Nationality</th>
<th>Nº of Requests</th>
</tr>
</thead>
<tbody>
<tr>
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<td>9255</td>
<td>Russia</td>
<td>54</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>6872</td>
<td>Mali</td>
<td>54</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>5308</td>
<td>Ecuador</td>
<td>34</td>
</tr>
<tr>
<td>Brazil</td>
<td>2330</td>
<td>South Africa</td>
<td>31</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1754</td>
<td>Mauritania</td>
<td>28</td>
</tr>
<tr>
<td>China</td>
<td>1608</td>
<td>Hungary</td>
<td>26</td>
</tr>
<tr>
<td>S. Tome and Prince</td>
<td>1549</td>
<td>Switzerland</td>
<td>25</td>
</tr>
<tr>
<td>India</td>
<td>915</td>
<td>Ghana</td>
<td>22</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>752</td>
<td>Nigeria</td>
<td>19</td>
</tr>
<tr>
<td>Senegal</td>
<td>672</td>
<td>Nepal</td>
<td>18</td>
</tr>
<tr>
<td>Morocco</td>
<td>520</td>
<td>Gambia</td>
<td>16</td>
</tr>
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<td>461</td>
<td>Argentina</td>
<td>16</td>
</tr>
<tr>
<td>Mozambique</td>
<td>416</td>
<td>Croatia</td>
<td>16</td>
</tr>
<tr>
<td>Zaire</td>
<td>352</td>
<td>Peru</td>
<td>16</td>
</tr>
<tr>
<td>Egypt</td>
<td>161</td>
<td>Yugoslavia</td>
<td>15</td>
</tr>
<tr>
<td>Guinea-Conakry</td>
<td>131</td>
<td>Poland</td>
<td>13</td>
</tr>
<tr>
<td>Venezuela</td>
<td>106</td>
<td>Ukraine</td>
<td>10</td>
</tr>
<tr>
<td>USA</td>
<td>101</td>
<td>Colombia</td>
<td>10</td>
</tr>
<tr>
<td>Algeria</td>
<td>65</td>
<td>Other</td>
<td>1268</td>
</tr>
<tr>
<td>Canada</td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35082</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SEF in SOS Racism 2003

The 1992/1993 regularisation campaign allowed a total of 39,166 immigrants to regularise their legal situation by obtaining a residence permit. This figure is similar to the 35,082 obtaining legal status in 1996. In both cases, African nationals from the PALOP constituted more than half of all regularised immigrants (72.3% in 1992/1993 and 66.7% in 1996), with Angolans being the most representative category in both processes.

The third regularisation campaign took place during the year of 2001 (Decree-Law 4/2001 of the 10th of January) and it allowed a total of 126,901 immigrants to obtain a permanence permit. Contrary to the tendencies observed in 1992/93 and 1996, more than half of the regularised immigrants were Eastern Europeans. This was so far the regularisation process with the higher number of applicants and beneficiaries of regularisation in Portugal (SEF, 2002).

Other measures were undertaken in the meantime, of which one instance concerns a new law approved in 1998 (Law nº 20/98, of 12th of May). This recognises the right to family reunification, provided that the applicant is legally residing in Portugal and can furnish proof of housing and sufficient economic means to support the family. It also enables children born in Portugal to parents who are legal residents to be covered by the same residence card granted to the parents, provided that they present a request within six months of the child’s birth (Fonseca, 2001).
In addition, this law eliminates the restriction imposed by the former one (Decree-Law 97/77, of the 7th of March) which forbade the hiring of foreigners in firms having less than five employees and prohibited the number of foreigners from exceeding 10% of the total firm labour force (Marques et al., 1998). According to Marques et al. (1998), this legal constraint became, in the ten years previous to the new law, a stimulus to the rapid growth of a vast informal economy of clandestine work, particularly in the building and public works sector.

**Permanence Permit**

Decree-Law nº 4/2001, of the 10th of January, altered Decree-Law nº 244/2001, of the 8th of August, concerning the juridical regime of entrance, permanence, departure and removal of alien citizens from national territory. The main shift involved the introduction of the permanence permit in the legal system, creating for the first time, a legal notion of temporary work stays. According to the previous law there was only one administrative condition possible – the residence permit. The new law introduced the possibility of applying for a “permit to stay” which is conferred for a year, and renewable until a maximum of five years. In order to obtain it some conditions are required, including the possession of a work contract and the absence of criminal record in the country. As long as these conditions are met, the possession of a permanence permit allows for (temporary) family reunification. At the end of the five-year period immigrants can apply for a residence permit (Peixoto, 2002).

**The Immigration Law**

The second clause of Article 36 from Decree-Law nº 244/98, of the 8th of August (juridical regime of entrance, permanence, departure and removal of alien citizens from national territory), as amended by Decree-Law nº 4/2001, of the 10th of January, provided for the introduction of a system of contingency to the alien labour force authorized to work in Portugal. This contingency is dependable on the annual calculation of work opportunities, accordingly with the sectors of activity where they take place. The government shall issue an annual report taking into consideration the opinion of the Employment and Professional Training Institute (IEFP) and social partnerships (employers associations and unions).

The Ministry Council (RMC) created the Inter-ministry Commission to Accompany Immigration Policy (CIAPI), determining its competency to “approve the report on the annual calculation of working opportunities (…), which shall be issued in collaboration with IEFP, after auditing the social partnerships”. Furthermore, the RMC established that the admission of non-EU citizens in national territory, will be determined according to the needs for labour defined in the report, considering the juridical regime of concession of labour visas, with a maximum limit of 20,000 admissions, distributed by sectors of activity: 50% in public construction, 23% in tourism and commerce, 12% in agriculture and 15% in the remaining sectors (SOS Racismo, 2003). At the same time, the employment of irregular immigrants and the trafficking of migrant workers became severely punishable offences (Peixoto, 2002).

**Legal Instruments Promoting Immigrant Integration**

94 By resolution nº 14/2001, of the 14th of February.
Legislative initiatives aimed at promoting immigrant integration and combating discrimination and racism began to be developed in 1995. Among them are:

- **Law 50/96, of the 4th of September (the Reciprocity Law)** – which concerns the enhancement of political participation by allowing citizens from the European Union, and also Cape Verde, Brazil, Peru and Uruguay, to vote and participate as candidates in local elections. This law as been later extended to Argentina, Norway and Israel.
- **Law 19-A/96, of the 29th of June** – which attempts to promote professional and social integration by guaranteeing all individuals with legal residence a source of income that contributes to the satisfaction of their minimum needs.
- **Law 79/96, of the 20th of June** – which aims at the eradication of slum neighbourhoods by creating legal support for the acquisition or the renovation of family housing (including that of legal immigrants) covered by the PER programme (Special Plans of Relocation).
- **Law 20/98, of 12th May (the Foreigners’ Labour Law)** – which aims at fighting employment on the informal economy by enhancing access to the labour market through the implementation of the principle of equality both in recruitment and working conditions, independently of national origin (Franqueira, 2002).

**Non-Governmental Organisations**

A large number of non-governmental organisations are active on matters concerning immigration. The NGOs operating at a national level function as pressure groups, promoting immigrants’ rights and fighting racial discrimination. Three types of national NGOs can be distinguished:

1) **organisations dedicated to immigrants’ rights in general** (e.g. **Obra Católica para as Migrações** - a Catholic charity institution, and trade unions which focus particularly on immigrant labour rights)
2) **organisations addressing the rights of the main ethnic minorities** (e.g. Cape Verde Association, Guinea Association, and the **Casa do Brasil**)
3) **organisations aiming at promoting equality and fighting racism** (e.g. **SOS Racismo** and **Olho Vivo**).

Nevertheless, most NGOs working on immigration issues are located primarily in ‘problem areas’ and neighbourhoods where the percentage of immigrants is high. Overall, local NGOs, such as **Associação Unidos de Cabo Verde** (Cape Verdian United Association), establish as their main goal the promotion of immigrant integration into Portuguese society (Baganha, Marques and Fonseca, 2000 in Franqueira, 2002).

**Asylum Policy**

Portugal ratified the 1951 Geneva Convention on the 1st of October 1960 and its additional 1967 New York Protocol in 1975. Regardless the commitment imposed by these documents, its norms were not implemented until the approval of the Constitution of the Portuguese Republic (CRP) in 1976. Article 22 of CRP granted, in a first stage, the right of asylum to all those persecuted as a consequence of activities in favour of democracy, social and national liberation, peace
among peoples, freedom and, rights of the human person, ascribing the law with the definition of political refugee. In 1977 UNHCR opened its first delegation in Portugal and, for a period of three years the grant of refugee status was under its jurisdiction (Costa, 1996). It was also UNHCR that pushed forward national legislation of asylum.

In the years following the 25th of April 1974 Revolution, not only did the number of asylum requests increase, but also a massive flow of people arrived as a consequence of the de-colonisation process. The need to make a distinction between these two streams lead to the creation of the first Asylum Law 38/80, of 1st of August, which granted asylum under humanitarian reasons. Despite the initial generosity of this document, three years later, Decree-Law 415/83, Article 15-A introduced the ‘refusal of asylum’ postulate (Morais, 2001).

The 1990’s were marked by a sudden increase of asylum requests. In 1993 the number of claims rose to 1659. This placed great pressure on the national reception system leading to the revocation of the former Law 38/80 by the Law 70/93, which implied a logic of control and restriction through the introduction of concepts such as ‘third country’ and ‘safe country’.

The rapid shifts experienced on the context of forced migration led to another revision of the legal regime in the space of only five years. In 1998, new legislation was published (Law 15/98 of 26th of March) and is still in force at present. This law does the following: it

- enlarges the definition of a refugee according to the Geneva Convention (article 1, nr 1);
- extends the scope of protection (e. g. Residence Permit for Humanitarian Reasons and Temporary Protection, articles 8 and 9, respectively);
- grants the right of family reunification (article 4), the right to health (article 53), the right to social care (article 50), the right to work for asylum applicants on the hold of a provisional residence permit (article 21);
- and acknowledges the suspensive effect of the appeal to the Supreme Administrative Court.

Two government bodies take part in the asylum procedure: the Aliens and Borders Service (SEF) and the National Commissioner for Refuges (CNR). SEF is the competent authority, which receives all asylum requests in Portugal, decides on the admission or refusal of the application and on the acceptance and, acts within the eligibility phase of the asylum procedure. CNR is the first instance of administrative appeal, within the Ministry of Home Affairs, which decides on the reappraisal requests of the non-admissibility decisions taken by the Aliens and Boarders Service.

In addition, the Portuguese Refugee Council (CPR), created in 1991 with the goal of promoting and defending the right of asylum, and still the only NGO in Portugal that deals with refugees and asylum seekers, was recognised as a ‘partner’ in the asylum

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95 As a consequence of the rapid political transition in Eastern Europe.
procedure alongside the Aliens and Borders Service (SEF) and the National Commissioner for Refugees (CNR). According to the Asylum Law, CPR provides free legal advice to asylum applicants throughout the asylum procedure and can present information and opinions on the individual cases. CPR is the operational partner of UNHCR in Portugal since 1998, the date of the closing of its office in this country.

**Residence Permit for Humanitarian Reasons**
This form of permanence is granted to persons to whom Article 1 of the Asylum Law is not applicable and who feel unable to return to their country, or are prevented from doing so, as a consequence of serious insecurity due to armed conflicts or the systematic violation of human rights. The residence permit for humanitarian reasons is valid for a maximum period of five years and only renewable after the analysis of the situation’s evolution in the country of origin.

**Temporary Protection**
Temporary protection is granted for a period no longer than two years to persons displaced from their country as a consequence of armed conflicts or natural disasters, which generate large scale migratory flows\(^{96}\).

The Portuguese Refugee Council has shown concern that residence permits for humanitarian reasons might be a weaker form of protection, which administrative entities might have recourse to. Additionally, the law determines extensive application only for the former and not in situations of temporary protection. Finally, the law does not provide in family reunification and the issue of a travel document (CPR, 2002).

Despite the breakthroughs which this law represents, practice is still catching up with theory. Injustices arise such as the lack of suspensive effect in the case of refusal, when in the phase of admissibility, in cases in which requests are presented on the border.

**Current Admission Procedures**
According to the Asylum Law, the asylum seeker must submit his/her application to any police authority, who is obliged to remit the request to SEF within eight days upon the date of entry into national territory, either verbally or in writing (Article 11). In the case of those already residing in the country, the application must be issued on the date of knowledge of the facts on which the request is based. The application may be submitted beyond the prescribed deadline with due justification.

The Asylum Law makes a distinction between applications made at the border and those made in national territory. The legal regime is identical, but the deadlines are much shorter in the case of the requests presented at border points, since the asylum seeker has to stay confined in the ‘Temporary Installation Centre’ located at the airport, during the admissibility phase. This circumstance also represents the only detention-like situation in the national asylum procedure.

One other consequence of the requests presented at border points, when the asylum application is considered non-admissible, is that the asylum seeker is returned directly

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\(^{96}\) Temporary protection was granted so far to two groups of persons: in 1998, to a group from Guinea-Bissau and in 1999, to a group from Kosovo.
to the country of origin or to the country where he/she came from, because the appeal to the Administrative Circle Court has no suspensive effect (cf. above).

The asylum procedure is divided in two main parts: Admissibility and Eligibility. Once the asylum application is submitted, the SEF must inform the Portuguese Refugee Council (CPR) of the submission of the request. In cases where the application has been made at border points, the CPR must be informed immediately. When the application is made within national territory, the SEF must decide on the admissibility of the application within a maximum of 20 days. At border points this deadline corresponds to 5 days. Within these deadlines, the Director of the SEF can decide for or against the admissibility of the application. The decision is based on the reasons outlined in article 13 of the Asylum Law. It can be deemed groundless if the allegations that the applicant fears persecution do not meet any of the criteria defined by the Geneva Convention and by the NY Protocol, or because the request is made by an applicant who is a national or habitual resident in a country likely to be considered as a safe country or as a third host country or to fall within the situations mentioned in article 1-F of the Geneva Convention.

In the case of a non-admissibility decision, the applicant can request a reappraisal within 5 days (if the request was made in national territory) or 24 hours (if it was made at a border point). This request is addressed to the National Commissioner for Refugees, who may interview the applicant personally. The reappraisal with the NCR will have a suspensive effect. In this procedure, there is one aspect of great importance. According to the law, the expiration of these deadlines by the administrative entities determines tacit admission of the application. If the decision against the admissibility still stands, the applicant can appeal before the Administrative Circle Court, with no suspensive effect.

If the application is admitted, a provisional residence permit is issued. In the case of applications made at border points, the decision on admissibility determines entry into national territory. This provisional residence will allow the applicants to have access to the labour market. Within 60 days from the moment of admission, the SEF will proceed with the eligibility phase that investigates every fact conducive to a fair and quick decision. At the end of the procedure the SEF must prepare a report for the CNR, who has 10 days to present a proposal project granting, or not, the right to asylum. The applicant and CPR must be informed of this proposal project and can express their opinion within 5 days. If the decision is positive and either refugee status or residence permit for humanitarian reasons is granted, an identity card will be issued attesting to the protection due to the applicant. In the case of a negative decision, the applicant has 20 days to appeal against the referred decision to the Supreme Administrative Court which has a suspensive effect.

**Reception and Accommodation**

The period of asylum application entails two phases of reception. The Portuguese Council for Refugees (CPR) to whom asylum applicants are referred by the Aliens and Boarder Service ensures the phase of initial reception.
During this stage, accommodation usually takes place in CAB – Reception Centre of Bobadela. Applicants are allowed to stay until the issuance of a provisional residence permit, which can take between one and two months. An exception is made for cases found vulnerable (women, one-parent families, sick persons, elderly and minors) who are placed in the care of Santa Casa da Misericórdia (SCM).

After the issuance of a provisional residence permit, asylum applicants enter the final phase of reception – waiting for a grant of refugee status or of a residence permit for humanitarian reasons. During this period, they are under the protection of Instituto da Solidariedade e Segurança Social (ISSS). Accommodation is then paid by this entity. Despite the possibility of choice, asylum applicants are usually sent to boarding houses in Lisbon. The amount of money allocated for accommodation is 175 EUR per month. Support is given for at least four months with a possibility of extension, depending on the length of the evaluation process.

When an asylum application is considered non-admissible, an appeal to the Administrative Circle Court is lodged. This appeal has no suspensive effect and applicants find themselves in a situation of ‘absence of status’, losing the right to receive support from ISSS. If the application is considered admissible but refugee status or humanitarian protection are not granted, an appeal to Administrative Circle Court also takes place but this time with suspensive effect. Applicants are therefore allowed to stay in the country and entitled to a provisional residence permit that allows them to work.

Apart from the designated accommodation providers, non-governmental organisations such as the “Exército da Salvação” (Salvation Army), “AMI-Porta Amiga” and “Abrigo da Graça” and the Jesuit Service for Refugees (JRS) have been supportive on accommodation issues. The first two provide temporary accommodation and meals, which are essential for the applicants waiting for the appeal results. JRS intervenes on a later phase of the reception process helping on the search for flats to rent or purchase and often working as guarantors.

The Portuguese Refugee Council has expressed concern with the poor conditions in the boarding houses in which asylum seekers are accommodated and the lack of effective supervision by the entities that subsidise them. This lack of supervision also applies to vulnerable cases. SCM disposes of accommodation only for minors below six years old. Consequently, others are sent to boarding houses and left to their own devices.

SCM is trying to cease its support for vulnerable cases. So far, these persons are taken in CAB where they wait to be sent to other places. SCM, in collaboration with CPR, is trying to contact other entities in order to solve the problem of minors’ accommodation.

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97 Under the management of CPR, the Reception Centre of Bobadela was created in 1999 with the purpose of ensuring decent conditions of accommodation for asylum seekers. Until then, they were being allocated in boarding houses, often with poor conditions. CAB is located on a parish of the Lisbon Council, Loures, and it has a capacity for twenty-three residents. At present, the centre is undergoing several improvements such as the creation of a leisure room, a kitchen and dining area, a launderette, a classroom and office rooms. The main appointed problems regard security requirements (Portuguese Refugee Council, 2002).

98 When there are no vacancies asylum applicants are sent to boarding houses in Lisbon.
Another concern regards the rejected asylum seekers that are undocumented. Their right to any sort of support is lost and they remain in a legal ‘limbo’, nearly always unemployed, with no possibility of regularisation.

**Rights and Restrictions**

**Family Reunification**

The Portuguese Asylum Law establishes the right to family reunification of recognised refugees in clear and non-restrictive terms. This law includes the spouse, minor children, adopted or disabled, and the parents of asylum applicants who are less than 18 years old. The Portuguese Refugee Council (2002) believes that the case of parents who are dependant of full age asylum applicants should also be included.

Family reunification of beneficiaries of a residence permit for humanitarian reasons is regulated not by the referred Asylum Law but by the Aliens Law, that recently entered into force (Decree-Law 34/2003, of 25th of February). According to article 56 of this law, and contrary to recognised refugees, beneficiaries of a residence permit for humanitarian reasons have to prove they can provide proper lodging and enough means of subsistence to maintain their family members.

**Employment**

According to the Constitution of the Portuguese Republic, the Asylum Law (Law 15/98) and the Foreigners Law (Decree-Law 244/98), refugees are entitled to access the labour market. This applies also to persons under humanitarian protection. In relation to temporary protection the Asylum Law applies criteria according to each situation (Article 9, nº 2)\(^99\) (Seabra, 2000). As for asylum seekers, Article 55 of the Asylum Law states their right to access the labour market from the moment they are granted a provisional residence permit\(^100\).

Article 17 of the Geneva Convention the most favourable treatment accorded to nationals of a foreign country shall be accorded to refugees in the same circumstances. In Portuguese Employment Law the most favourable employment treatment applies to citizens from the European Union. Formally at least, asylum seekers and refugees are in a position of formal freedom, which means they are able to make a verbal or written contract and to be registered on the personnel list of an employer, without being required to deliver a copy of the contract to, or depend on, the authorisation of the Institute of Development and Working Conditions Supervision (IDICT).

\(^99\) The Ministers Council Resolution nº 94/98 that granted protection during the initial period of one year to citizens of Guinea Bissau issued them with the same rights as those of foreigners legally residing in Portugal, i.e., access to the labour market (Seabra, 2000. Forthcoming).

\(^100\) The provisional residence permit has a limited validity of one up to two months. After expiry it may not always be renewable. During the waiting time for renewal asylum seekers loose the right to engage in economic activity.
Several bodies provide re-qualification programmes, training courses and vocational support, in particular:

- Centres of Integration into Active Life (UNIVA)
- Employment Clubs (active in various social solidarity associations)
- Employment Centres of the Employment and Professional Training Institute (IEFP)
- Temporary Employment Agencies (CPR, 1998)
- High Commission for Immigration and Ethnic Minorities (ACIME).

Additionally, the CPR has its own employment department (CPR, 2002).

**Centres of Integration into Active Life (UNIVA)**

The UNIVA’s are services under the auspices of the Ministry of Social Solidarity and Work whose main goal concerns the promotion of information, professional guidance and support in the search for training programmes and/or employment.

**Employment and Professional Training Institute (IEFP)**

The IEFP is a public entity created in 1979 (Decree Law nº 519-A2/79 of 29th of December) under the auspices of the Ministry of Social Security and Labour. Its main task concerns the implementation of employment and professional training policies defined and approved by the government.

IEFP’s headquarters are located in Lisbon. Regional delegations are distributed through the country, including Employment Centres. Applicants must contact the Centre of their area of residence in order to be registered. These Centres process the supply of jobs, i.e. they immediately integrate those qualified into the labour market. The Centres also provide guidance, training and/or professional qualifications for those not yet qualified to perform an activity.

IEFP’s activities in the field of professional training are carried out through Professional Training Centres with either a Direct Management, which is directly involved in the training, or a Shared Management, in which case the Training Centres do not belong to IEFP but are connected with it and this institute has a share funding on it (CPR, 1998).

In July 2001 the IEFP implemented the programme “Portugal Acolhe” (“Portugal receives”). This programme is addressed to aliens living in Portugal and it concerns the learning of Portuguese language and acknowledgement of the basic rights of citizenship. Asylum seekers have access to this programme as soon as their asylum claim is made.

According to CPR (2002), difficulty in accessing other IEFP programmes arises from problems related to the recognition of qualifications and validation of diplomas. One of the limitations is that the IEFP is only able to give support for the recognition of qualifications up to the 9th school year.
Temporary Employment Agencies

Temporary employment agencies work as intermediaries between employers and employees, thus between job supply and demand, providing employment for a limited period. Applicants with legal status can make contact with these organisations in two ways. Firstly, the applicants can present themselves in person to these companies. Secondly, they can contact the agency as a result of an advertisement. In order to be registered the applicant must provide the residence permit, academic and professional qualifications certificates, tax contributor card and social security card.

The labour agreement is a regular contract (in accordance with the Aliens Law regime), restricted to the area where the individual made the application and for a limited period of time. The renewal of the labour agreement for more than one year is not allowed. Employees are allowed to take other jobs while they are not working through the temporary employment company (CPR, 1998).

High Commission for Immigration and Ethnic Minorities (ACIME)

This body was set up in 1996 under the auspices of the Presidency of the Ministries Council (Decree Law nº3-A/96 of 26th of January and Decree Law nº 39/98 of 27th of February) in response to the recognition of the ‘new challenges faced by Portugal as a country of immigration, which require social integration measures for migrant families and ethnic minorities in general, in order to avoid situations of social exclusion that generate racism and xenophobia’.

ACIME serves as an interdepartmental structure of support and consultation for the government in questions concerning immigration and ethnic minorities. In collaboration with social partners, social solidarity institutions and other public and private bodies working on this sphere, ACIME is also responsible for conducting studies on the integration of immigrants and ethnic minorities. Its main tasks are:

- to contribute to the improvement of the living conditions of immigrants in Portugal, in such a way as to ensure their integration into society, without prejudice to their identity and culture;
- to ensure that all citizens residing legally in Portugal enjoy an identical degree of dignity and opportunities, eliminating discrimination and fighting racism and xenophobia;
- to support the action of the various bodies on the field of entry, exit and residence of aliens in Portugal, respecting their powers;
- to collaborate in defining and ensuring the supervision and stimulation of policies intended to actively combat exclusion;
- to propose measures, in particular those of law-making, to assist immigrants and ethnic communities.

To ensure the participation and the collaboration of the above-mentioned bodies in defining social integration policy and combating exclusion, a Consultative Council on Immigration was created (Decree-Law 39/98, 27th of February). In situations of violation of the Anti-Discriminatory Law, and in accordance with the opinion of Committee for Equality and Against Racial Discrimination, ACIME holds the power to impose fines (Carlos, 2002).
Among other projects, the ACIME has created two National Centres of Immigrant Support (CNAI) in Lisbon and Porto. This service exists in partnership with other institutions (SEF, IEFP, Social Security, Ministries of Heath and Education, etc) and its main aim is to answer to immigrants’ problems concerning legalisation, employment, social security, education, health, housing, recognition of qualifications and validation of diplomas. These Centres bring together a number of services, all located in the same place and run by different teams of experts.

ACIME will also set up Regional Centres of Immigrant Support (CRAI) and Local Centres of Immigrant Support (CLAI). The former will be established in regional capitals at locations shared with municipalities. The latter will be distributed among cities and villages in offices shared with municipalities, parishes or NGO’s.

The ACIME has also implemented an SOS Immigrant Telephone Line which makes information available for immigrants and institutions working with immigrants and can also provide advice in cases of discrimination, labour exploitation, abuses connected with housing provision, or physical assault.

**The Portuguese Refugee Council’s Employment Department**

CPR’s employment department was created in December 2001. Its main purpose is to facilitate the integration of refugees and asylum seekers into the labour market. Actions are undertaken on two levels: on one hand it attends to asylum seekers and refugees (e.g. providing information about job vacancies, preparing a curriculum vitae and contacting employers when the potential employees do not master the Portuguese language), on the other hand it establishes contacts with institutions and employers.

In 2002 CPR developed a partnership with the Employment and Professional Training Institute (IEFP). IEFP intervenes in areas such as the recognition of qualifications, integration into the programme ‘Portugal Acolhe’ and access to Employment Centres. According to CPR (2002), there is a strong legal restriction in the involvement with IEFP which relates to the fact that support for persons without a regularised legal situation (absence of a residence permit) cannot be provided. This situation excludes all asylum seekers without a provisional residence permit and all those to whom the application is refused but who remain in the country undocumented.

A second domain of cooperation between CPR and IEFP relates to the programme ‘Portugal Acolhe’. As mentioned above, from the moment the asylum claim is presented applicants are entitled to access this programme. The participants receive a lunch subsidy (3.49 Euros) and a monthly transportation pass. The course consists of a total of 62 hours of which 12 hours correspond to an individual block relating to citizenship. Subsequent instruction concerns the teaching of Portuguese language at three levels: basic, intermediate and advanced. Persons from the PALOP are not included in this programme. According to the IEFP, they already have knowledge of the Portuguese language and have an organised community and UNIVA’s in some of their associations.
According to CPR (2002) it is impossible to know how many refugees attend professional training courses as no distinction is made between refugees and other immigrants in the statistics of IEFP.

‘Companies for integration’ is another IEFP programme relevant to the professional integration of refugees. This programme exists for non-profit making private bodies that intend to implement new values for integration but cannot meet the costs. These entities, in order to perform the necessary services, would hire persons with additional integration difficulties (i.e. populations in risk of exclusion), in this manner performing a social service and, for that reason, being paid by the IEFP for the investment costs (except for repairs) and maintenance costs (minimum wage + 80% of the deductions to the social security system). These companies can encompass various areas of activity as long as they are within the ambit of social utility. They are obliged to contract a group of 5 to 20 persons for a period up to two years. These ‘companies for integration’ are required to have a team that supports this integration (e.g. a psychologist, a social worker, etc) which can be shared with other companies. Up till now, the foreign citizens included in the companies for integration have been mainly from the PALOP (CPR, 2002).

**Minimum Guaranteed Income (RMG)**

An alien with a legal right to residence in Portugal can apply for the Minimum Guaranteed Income. RMG is not just a benefit, it is part of a social assistance programme intended to help its beneficiaries and their households in vocational and rehabilitation training, employment, health, education, housing and justice areas (CPR, 1998).

**Education**

According to the Asylum Law, “asylum seekers of school age to whom a provisional residence permit has already been issued, shall have access to public institutions of compulsory education under the same conditions as national citizens” (Article 57, Law 15/98). Persons of school age whose legal situation has been regularised must be integrated into the national education system (CPR, 2002).

In practice, schools usually also accept children who do not have a residence permit. This situation can apply in cases where asylum has been refused and people remain in the country without documentation (CPR, 2002).

In 1991 the government developed the first explicit action to promote interculturalization of the educational system, creating the Secretariat for the Coordination of Multicultural Education Programmes (Secretariat for the Coordination of Programmes of Multicultural Education, SCOPREM). SCOPREM has come to be designated ‘Secretariat Entreculturas’ (Intercultural Secretariat) since 2001. Its main goal consists of “coordinating, encouraging and promoting, within the educational system, programmes meant for the education towards values of companionship, tolerance, dialogue and solidarity between different peoples, ethnicities and cultures”.

Activities developed by the Secretariat Entreculturas since 1991 include the following:
• implementation of a database of annual statistics concerning the educational achievement of minority students between the school years 1992/93 to 1997/98;
• development and support of projects promoting intercultural education at the level of basic and secondary teaching, as well as the organisation of seminars on this topic;
• publication of supporting material for teachers.

In 1993 the Secretariat Entreculturas developed another project designated Project of Intercultural Education (PREDI). This project was intended to “stimulate equality of access to the benefits of education, culture and science” and to “consider and valorise the different knowledge and cultures of the populations present on the schools” where the project was implemented. It also promoted training for interculturalization among teachers, which until then had been absent. Between 1993 and 1995 this project comprised 30 public primary and secondary schools, to be extended to other 22 schools between 1995 and 1997. At the end of these two pilot phases the project was to be implemented in all public schools. So far, this has not been the case.

Additionally, under the scope of the Secretariat Entreculturas and following on from PREDI, the Association of Teachers for Intercultural Education (APEDI) was created in 1993. Since then, this association has come to develop training programmes for teachers in this field.

Other institutional actions have been developed at the central level, including:

• the initiative developed by the Direcção Geral do Ensino Básico (General Directorate of Primary Education) in 1990 promoting the project “The School on an Intercultural Dimension” (A Escola na Dimensão Intercultural) (PEDI). This project was implemented in 30 primary schools in Lisbon and its main focus lay on providing training to teachers and encouraging pedagogic alternatives to help minority socio-cultural groups characterised by low schooling achievement;
• the creation of the Working Group for the Equality and Integration of Gypsies. This project was developed in order to “produce a set of proposals allowing the elimination of situations of exclusion”;
• the institutionalisation of religious diversity in public schools through the possibility of including classes on different religions101;
• the creation of the project “For the Minorities”. This project is a result of a protocol developed between the Ministry of Science and Technology (MCT) and the High Commission for Immigration and Ethnic Minorities (ACIME). Its main purpose consists of fighting information exclusion among less privileged members of society, by promoting access to information and communication technologies;
• the creation of the Working Group for Cultural Mediators, the main goal of which consists of defining the conditions through which Cultural Mediators will be implemented at an institutional level (SOS Racism, 2003).

101 According to SOS Racism, this situation seems to have suffered a setback as in August 2002 the government approved a Decree Law stating that the course of Moral and Religious Education shall be part of the curricula of primary schools on a weekly basis (SOS racism, 2003).
Health

According to the Dispatch nº 25.360/2001 of 12th of December, concerning “Immigrants’ access to health”, all alien citizens legally residing in Portugal have access, in equal circumstances to those for nationals, to the health care and medication assistance provided by the institutions and services which are part of the National Health System (SNS). A user card is needed for this effect. In order to request it, alien citizens must go to the health services of their area of residence and present a residence permit or a working visa for national territory. Alien citizens not in possession of these documents may access SNS’s services by presenting a document issued by a particular administrative body in their area of residence, stating their presence in national territory for more than 90 days. These alien citizens may be charged for medical expenses, except in cases endangering public health (SOS Racism, 2003).

Undocumented aliens only have access to the emergency services of public hospitals.

According to SOS Racism (2003) the need for an appointment to access Health Centres’ services might constitute a bureaucratic barrier undermining frequent use of these centres. Additionally, difficulties in communicating with professionals of this field and the geographical distance from Health Centres (as most aliens live in the periphery) might be contributing to aliens’ preference for pharmacies and emergency services of public hospitals.

Concerning the specific case of asylum seekers, access to SNS’s services is granted on the same conditions as those mentioned above from the moment a provisional residence permit as been issued.

At the beginning of 2001, the CPR established a protocol with the Instituto de Higiene e Medicina Tropical (Hygiene and Tropical Medicine Institute) (IHMT) which allows for free medical check-ups. The check-up takes place usually two weeks after arrival, but it is not compulsory. A clinical interview is held, followed by a number of various examinations and medical tests. The results of these examinations are sent to CPR and delivered to the applicants. Psychological evaluation is not made, due to lack of specialized staff. Until May 2002 little more than one hundred applicants had medical check-ups. This corresponds to less than half of the target population for that period (CPR, 2002).

Media representation and public attitudes towards immigrants and refugees

Only limited information is available on public attitudes towards immigrants and their representation on the media. Nevertheless, interest in such studies seems to be on the rise. Concerning asylum seekers and refugees no published scientific information was found. According to the Portuguese Council for Refugees, the categories of asylum seekers and refugees appear merged with that of immigrants in terms of public opinion. In other words, generally speaking, the ‘public eye’ makes no specific distinction between these categories.

\[102\] In Portugal, immigrants have been commonly addressed as ‘foreigners’. Lately, there seems to be a growing tendency to employ the terms ‘immigrants’ and ‘ethnic minorities’. For the studies analysed here, the original terms used by the authors will be kept.
Five studies on media representation and public attitudes towards immigrants have been located. A first study, undertaken by Pires (1991), focused on Portuguese public opinion towards ‘foreigners’ through press analysis. This study was followed by an investigation focused on how Africans are portrayed by the Portuguese press (Cunha, 1996). In 2002, three other studies were conducted. One examined immigrant and ethnic minorities’ media representations (Cádima, 2002). A second consisted of an opinion poll concerning the way in which immigrants are viewed by the host society (Lages and Policarpo, 2002). A third study focused on racism and cultural diversity on the media (Franqueira, 2002).

In his study, Cunha (1996) concludes that like any other professional, the journalist is subject to informal and formal processes of socialisation and the production of news obeys to mechanisms of manipulation, which are naturalised in the journalistic practice. Furthermore, discourses produced by politicians and the mass media reflect the interests, stereotypes and prejudice of the majority group. Politicians and journalists therefore make the opinion leadership.

Press news on immigrants was rather scarce fifteen years ago and adopted a ‘social report’ approach, leaving aside political views. Contrary to other EU countries, newspapers in Portugal published exclusively isolated articles and no special issues could be found. A global designation for the ‘resident foreigners’ could not be found either. Instead, immigrants were referred to on the basis of their nationalities or the category of ‘foreigners’ was matched with specific occupations or traits (e.g. student, Islamic community). Nevertheless, one category stood out from others as being most often in the news: the Africans. Within this category, Cape Verdiain immigrants were the most frequently mentioned and, in practice, the term ‘Cape Verdiain’ seemed to be used as a synonym for ‘African’. Newspapers portrayed Cape Verdians as denizens of an ‘unknown world’: living precariously, removed from the city centre, facing high rates of unemployment, lacking legal documentation and neglecting their children. Inside their own community they were depicted as extremely social and out-going. However, their integration was seen as weak due to spatial segregation, lack of language skills and low educational achievement among their children.

Regarding the attitudes of Portuguese towards this category, the existing information expressed, on the one hand, the attitudes of the journalists, and on the other, the attitudes observed by them in the population. Two topics dominated in analyses of such attitudes: criminality and racism. Concerning criminality, the Portuguese population tended to express a certain amount of fear. Journalists, however, characterised this feeling as irrational. Racism was never written about from the point of view of the host population: articles always focused on statements made by Africans themselves.

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104 This research was based on the analysis of eight newspapers: four dailies (Público, Diário de Notícias, Jornal de Notícias and Diário Económico) and four weeklies (Expresso, O Diabo, O Independente and Semanário) during 1993-1995.
105 This study took place during January of 2001 and March 2002.
106 This study was conducted during November 2002. A random sample was used and the respondents were interviewed at their homes.
107 Unexpectedly, difficulties with the Portuguese language were found as a big part of the Cape Verdians had as a mother tongue the ‘crioula’.
Opinions varied between the absence of racism and the presence of subtle racism in Portugal. In general, journalists tended to express curiosity, sympathy and complicity, attempting to establish a parallel between the viewpoints of Portuguese and Africans. Thus, up to the end of the 1980s, ‘foreigners’ were not constituted as a problem in public discourse. Portuguese public opinion lacked interest in the topic of immigration and it did not figure on the political agenda as a problem deserving attention (Pires, 1991).

In the mid-1990’s, this situation changes substantially. In his analyses of ‘Africans in the Portuguese press’, Cunha (1996) came across constant references to people and bodies in power, particularly political and governmental institutions. Contrarily to the earlier tendency, limited attention was devoted to the citizen, the immigrant, the lay people. News which was focused on their position within society appeared less important, less extensive and was soon abandoned to make way for news on political decision-making and institutional processes. Furthermore, the use of sensationalist headlines and leads, which could easily provoke alarm and fear, began to be observed. Despite the almost total absence of images of Africans, when depicted as a citizen or immigrant the African appeared as a complement of the ‘Portuguese self’. However, this image was complemented by stereotypes of marginality, poverty and exoticism.

In 2002, a survey focusing on press releases on the topic of immigration/integration no longer detected an imbalance between references to the political structure and the immigrants and host society, and registered a significant increase in the variety of themes discussed. These themes could be grouped into three main categories:

- ‘achievements’ (e.g. reception, willingness to co-exist, fights against mafias, the legalisation process, culture, education and so on);
- ‘difficulties’ (e.g. offences, exploitation and mafias, difficulties on legalisation process, racism and xenophobia, and so on); and
- ‘debate’ (e.g. data and information, ethnic and cultural differences and racism, immigration law and legalisation, multiculturalism and human rights, labour market and work conditions).

The ‘achievements’ concerning immigrant and ethnic minorities’ integration made up the greatest amount of news (44%)\textsuperscript{108}. Nevertheless, when broken down into sub-themes the main focus of attention appeared to be on offences (12%), reception (9%), co-existence (6%) and exploitation and mafias (6%). Reference to immigrants’ origin occurred in 66% of the news, with Eastern Europeans being the most quoted category (32%), followed by immigrants from the PALOP (13,7%) and immigrants from the American continent (5%), of which Brazilians make the biggest part (Cadima, 2002). Thus, there seems to be an increase in news focusing on immigration, with particular attention for issues related to integration. The focus has become much wider than the early emphasis on ‘African’ immigrants.

Nevertheless, an opinion poll on the attitudes of Portuguese and immigrants towards each other, commissioned in 2002 by the High Commission for Immigration and Ethnic Minorities (ACIME), revealed a negative attitude among the Portuguese towards the arrival of new immigrants.

\textsuperscript{108} The themes ‘difficulties’ and ‘debate’ amounted for 40% and 16% respectively.
The majority of respondents agree that Portugal should not receive more immigrants, with small differences for the three main categories of origin: Africans (74%), Eastern Europeans (73%), and Brazilians (72%). However, these attitudes are related to background variables such as educational level. Negative attitudes to immigration tend to be expressed by respondents with lower education levels. When asked about security, three out of ten respondents believe that ‘immigrants commit more offences than the Portuguese’; three out of four agree that undocumented immigrants ‘should be kept under surveillance in order to avoid criminal activity’. Regarding protection, however, most respondents believe that immigrants should be treated equally in law. 80% are in favour of the legalisation of undocumented immigrants and 90% agree that ‘immigrants should be protected against labour exploitation’. Most respondents (72%) share the opinion that immigrants ‘do the work the Portuguese don’t want’ and that both Eastern Europeans (66%) and Africans (57%) ‘earn less than the Portuguese for doing the same work’. Concerning the type of work and educational qualifications, 66% of the respondents believe that Eastern Europeans are over-qualified for the kind of work they perform (this percentage drops to 16% for Brazilians and 12% for Africans).

In terms of attitudes of tolerance, most respondents answered positively to the question ‘would you accept an immigrant boss’?. Similarly, a question about ‘sending your children to a school with more than 50% immigrant children’ got a favourable response although a preference for Brazilians (66%) was noticeable (Africans, 58%; Eastern Europeans, 58%). The majority did also not see intermarriage as a problem, but again Brazilians (88%) enjoyed more acceptance at this level, followed by Eastern Europeans (77%) and Africans (76%).

The perception of ‘cultural differences’ places the Africans in the most different category concerning to habits (62%), child-rearing (51%), religious practices and beliefs (50%) and values and sexual behaviour (32%). Only in terms of language do Eastern Europeans (72%) appear as the ‘most different’. Brazilians are perceived as the most similar to the Portuguese. Finally, when inquired whether ‘immigrants should set aside their habits in order to be part of the Portuguese society’ 61% responded negatively. According to the majority (60%) ‘the presence of immigrants enriches the cultural life of the country’ (Lages and Policarpo, 2002).

Considering the issue of racism, Portugal may be characterised as a society which is formally anti-racist, in which racist attitudes however persist (Vala, Brito and Lopes in Franqueira, 2002). This paradox is explained by the different concepts of racism, reflecting different positions in relation to the anti-racist social norm that emerged in western societies after World War II, which condemns expressions of traditional racism. A distinction is made between prejudice, or flagrant racism, and subtle racism. Those who are subtly racist accept the anti-racist norm as a way of being socially correct and avoiding punishment for their actions in public life. In Portugal, as in the rest of Europe, an anti-racist social norm exists for flagrant racism, but not for subtle racism. It can also be noted that in Portugal, not only are racist attitudes frowned on, but militant racism is extremely rare (Baganha, Marques and Fonseca, 1999 in Franqueira, 2002). Nevertheless, in the past years, several public actions have been developed to promote cultural diversity and combat racism, including conferences, workshops, forums,
monitoring of the media, television programmes and an anti-discrimination law (Law 115/99, of the 3rd of August)\textsuperscript{109} (Franqueira, 2002).

We can conclude that in recent years, the representation of immigrants in the media has been subjected to shifting trends, varying from an initial focus on the ‘African’ immigrant in the 1980s, to a significant input on the political discourse on immigration by the mid-1990s, and engaging recently in more diversified reporting with significant attention for issues related to immigrant integration. Additionally, Portuguese people seem to be unfavourable to the arrival of new immigrants. However, those who are already in the country are regarded as deserving protection and equal treatment before the law. No relevant attitudes of intolerance were observed. In view of this, it is striking that so many actions have been undertaken to combat racism.

\textsuperscript{109} See Franqueira, A. (2002).
1.2 Needs and Problems of Asylum Seekers and Refugees

Interviews with Refugees and Asylum Seekers

As no research appears to have been carried out on this topic, an interview study was carried out under the supervision of Mrs. Ligia Ferreira of CEMRI (Centro de Estudos das Migrações e das Relações Interculturais, Open University). The sample consisted of 15 subjects from the following countries: Liberia (2), Ghana (1), Cuba (2), Angola, (2), Albania (2), Romania (1), Yugoslavia (1), Colombia (1), Kenya (1), Sierra Leone (1).

The average mean age is 34, with a standard deviation of 8.45. Five of the subjects are female and ten male. The length of stay varies between 11 years (male, 42 years old, 4th grade) and two months and two weeks (female, 33 years old, 4th grade). The level of education ranges between the 3rd grade of primary school and university. The most representative educational level in this sample is the 4th grade of primary school. 50% of the subjects are unmarried, 49% are married and 1% is a widower. 26% are illegal, 27% are asylum seekers, 27% are refugees, and 20% have a permanent residence permit, of whom 13% have a permit for humanitarian reasons.

Sources of stress

The sources of stress most frequently mentioned are connected to the following factors:

1. traumatic or harrowing experiences in the country of origin due to political or family reasons.
2. language/ idiom
3. legal status/ documentation
4. employment/ work

1 - A strong relationship was found between the length of stay in the host country and the sources of stress. Subjects with a shorter length of stay (2-3 months up to one year) tend to point traumatic events experienced on the country of origin as the main source of stress. Problems relating to language, employment, or documentation might not be acknowledged straight away, as subjects might still be under severe emotional distress. Additionally, the period between the request for asylum and the final decision is usually spent at the CAB, which limits the subjects to the particular dynamics of accommodation centres and deprives them of a thorough contact with the hosting society.

In this early stage, the sources of stress most commonly indicated are:

- the period of travelling and the journey’s route;
- health problems
- difficulty of the access to health care provisions
- ignorance among professionals concerning the rights of refugees.

In the specific situation of pregnant women, feelings of anxiety and uncertainty of care previous to and during the journey as well as after arrival were stated.
2 – Most of the subjects had many worries about the lack of Portuguese teaching classes for refugees. There is a general belief that good jobs can only be found if full proficiency in Portuguese is obtained. Furthermore, language is considered an instrument to combat labour exploitation. It is also understood as essential for the establishment of relationships within the local community and therefore, for integration. And it is found particularly necessary in the access to health and social care services and in the update of developments regarding the asylum request as it favours a certain independence from CPR and other NGO’s.

3 – The lack of documentation undermines access to employment. Undocumented persons only have access to the emergency services of public hospitals. This situation assumes particular significance when a response to the first phase of the admission procedure extends beyond its usual time, and in situations of appeal (after refusal) when a provisional residence permit has not been issued or is on hold for renewal. Substantial stress arises out of feelings of fragility and defencelessness carried on as subsequent exploitation takes place through the absorption by informal markets.

Non-recognition of diplomas and professional experience also generates substantial distress as subjects find themselves constricted by occupations with a degree of demand below their competencies and out of their scope of interests.

4 – Concerning employment, a great deal of stress is experienced due to:

- long-term unemployment
- lack of payment after completion of the job (interpreted as a consequence of employers’ “bad faith” and the inability to claim rights as a result of deficient language skills)
- communication problems with the employer
- low payment and subsequent lack of money to ensure basic needs
- discrepancies between academic qualifications and job opportunities.

Most of the subjects share the belief that a solution for great part of their problems would be found if they had steady work.

**Access to Information**

The majority of the subjects said they had not been provided with any sort of information concerning the rights of asylum seekers or refugees, and social care provisions upon arrival. One of the subjects claimed to have found information only three months after arrival. Another said he had slept in a garden for three days before he was able to find a place to ask for asylum.

SEF (Aliens and Border Service) is generally the first organisation to which asylum seekers are referred. Once the asylum claim is submitted, contact with the CPR (Portuguese Refugee Council) is arranged. The majority of the subjects said they had received the first set of information at the Bobadela Accommodation Centre and in the CPR’s juridical/ employment office. Some were also provided information in other institutions such as AMI and local churches. Some of the subjects named the lack of awareness about services able to provide information when the asylum request is refused, as a substantial source of stress.
When a problem arises, where can help be sought?

Most of the subjects answered that they had sought support at CPR, both in its juridical/employment office and through CAB’s social worker. Santa Casa da Misericórdia and Jesuit Refugee Service were also contacted.

One of the subjects claimed it was impossible to find any sort of help in Portugal: “no one is interested in providing us information and no one wants to help”. Asking for help is perceived as a problem by some of the subjects. A number of them said they had never asked the police for help, as they feared not being understood.

Many subjects stressed the importance of CPR as a fundamental organisation that guaranteed accommodation and sustenance after arrival and where they felt they were treated as ‘family’.

Accessibility of services

All the subjects had made use of the health care services at least once. Among these services are: Health Centres (family doctors) and Hospitals (S. José, Santa Maria, Maternidade Alfredo da Costa, Instituto de Higiene e Medicina Tropical110).

CPR is considered a fundamental mediator between users and health care services. A first contact with health care professionals is often established through CPR. Expenses with medication and other prescriptions are fully subsidized by this organisation. Santa Casa da Misericórdia is also mentioned as an intermediary organisation establishing contacts with health care services and providing support on the formalities regarding the access to those services (e.g. user card).

All subjects share the belief that in the use of health care services problems will most certainly arise. Several instances have been reported in which irregularities were encountered. Despite the right of free access to health care during the asylum process (acknowledged as Portaria 30/2001, de 17 de Janeiro, which regulates article 53 of Law 15/98, de 26 of March – Asylum Law), users are frequently asked to pay for those services due to misinformation among providers. In situations in which the users were not in possession of a valid user card, assistance has been completely denied. Furthermore, periods of excessive waiting for appointments have raised feelings of victimization, disregard and suspicions of institutional racism111. The lack of information sometimes extends to the non-recognition of the refugee identity card (issued when an asylum applicant is recognised as refugee in Portugal), forcing the users to do a great deal of explaining regarding their status. This proves the lack of knowledge of most services concerning the specific status of refugees.

Concerning the issue of employment, Santa Casa da Misericórdia and the Jesuit Refugee Service are mentioned as a possibility of help in that they collect curriculum vitae and try to seek for professional opportunities.

Nevertheless, the majority of the subjects consider networking, establishing personal connections, as the most reliable and accessible way to get help in finding a job.

110 In 1998, CPR established a protocol with Instituto de Higiene e Medicina Tropical (Hygiene and Tropical Medicine Institute), which allows each asylum seeker to have a check-up after presenting the request for asylum.

111 It should be noted that in Portugal long waiting periods for appointments in the health care services are a national problem that affects the general population.
The inability to speak the language arises as one of the main obstacles when in contact with any sort of services. This situation is particularly acute when the user addresses health care services. Unable to fully describe their symptoms, users might run the risk of not having their needs properly met.

**How could services be improved?**

The subjects saw a need for the following:

- improvement of the service provided through the department of employment of CPR\(^{112}\)
- information and contacts concerning special deals for renting rooms/housing
- a canteen serving meals daily and free of charge, particularly during the period of absence of money and employment
- an informative leaflet setting out the rights and obligations of both refugees and asylum seekers in their own language.
- adequate Portuguese language courses\(^{113}\)
- training to develop professional competencies (e.g. carpentry, etc.)
- the organisation of recreational events (e.g. football matches).

Concerning health problems, a need was felt for establishing in CAB a weekly service provided by voluntary medical doctors, in order to assure medical examinations and treatment for all residents, as well as a specific mental health service able to provide psychological counselling particularly in situations of emotional distress.

**Public Attitudes\(^{114}\)**

“Portuguese are good people, friendly and pleasant although the same can’t be said about the employers”. Mostly, “people living side by side with refugees have no idea who they are”. The government is found to have done little concerning the situation of illegals. “When accidents take place at work, the employers do not notify the Social Security (Segurança Social). Workers involved get no help and a big part of their salaries is not paid”. This is identified as a serious problem, justifying a strong need for new policies and eventually the help of the European Union. “Living in Portugal is not bad but we lack legal documents and employment”. One respondent said: “although friendly, Portuguese people always have their doors closed when it is time to help. They say they will help but then nothing happens”.

Most subjects agree there is a widespread lack of information and knowledge regarding the significance of the refugee status, its legal and social implications, and the conditions under which this type of migration is undertaken.

“Immigrants can always go back to their country. The same is not true for us. In Portugal, refugees tend to be seen as immigrants and not as refugees”. Despite this, there is a general feeling of acceptance and non-discrimination “maybe because Portuguese people were

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\(^{112}\) This service has been functioning since January 2002.
\(^{113}\) At the moment the interviews were undertaken CPR was the only organisation providing Portuguese language courses for refugees.
\(^{114}\) Two of the interviewed subjects said they had not been long enough in Portugal to have formed an impression of public attitudes.
migrants themselves”. Subjects believe this situation to be different in other European countries.

Two of the subjects stated that “The Portuguese are cold and closed people, with the exception of the CPR’s professionals. Contact is very difficult. People don’t speak to each other in the streets. In our country is not like this. Maybe it would be better to go somewhere else. Here it takes too long to solve things. There is too much bureaucracy and corruption which makes integration ion this society difficult”. The inability to communicate in Portuguese leads most people “to be afraid of us and to refuse involvement with refugees. People fear what they don’t know”.

Among the subjects interviewed there is a general tendency for the family and legal situation in the receiving country to be linked to the perception of public attitudes. The greater the degree of family and legal stability, the greater the tendency to report positive attitudes of acceptionation from the subject towards the Portuguese society and vice-versa.

One other aspect deserving attention regards the emergence of a sort of continuum of perceptions about the Portuguese society in which Africans, Eastern Europeans and South Americans seem to succeed each other from more negative to more positive representations of the host society. However, a larger sample would be needed to confirm this trend.
Chapter Two. Mental Health Care and Social Provisions

2.0 The Health Care System\textsuperscript{115}

Mainstream Health Care

The Portuguese health care system is constituted by three co-existing systems of health care coverage: the National Health Service (NHS), special insurance schemes for certain professions and voluntary private health insurance schemes.

The central government, through the Ministry of Health, holds the main responsibility for the regulation, organization and direction of the health care system as a whole. The Ministry of Health is responsible for developing health policy, overseeing and evaluating its implementation, and for the coordination of health-related activities of other Ministries, such as social services, education, employment, sport, housing, town planning, the environment and the economy. Its core function is that of regulating, planning and managing the National Health Service.

In addition to the cover provided by the NHS, about 25% of the population are covered by health insurance schemes for which membership is based on professional or occupational category. These are often designated as health subsystems and they form part of the historical remnants of the social welfare system of the 1970’s. Most of the schemes are compulsory for employees but they do not prevent the beneficiary from seeking services directly from the NHS. However, the health subsystems usually allow for more freedom of choice than beneficiaries would enjoy within the statutory system. Most people covered by these schemes use the private sector for ambulatory care and the NHS for non-elective surgical interventions.

The private health care sector has mainly a supplementary role to that of the NHS, rather than posing an alternative to it. Despite the establishment of the NHS, this sector prospered and now it mainly provides diagnostic, therapeutic and dental services as well as some ambulatory consultations, rehabilitation and psychiatric care services. Overall, the private sector amounts for 30\% of all medical consultations. The main private actors are the private health insurance companies which cover approximately 10\% of the population, mostly under the form of group insurance provided by the employer.

The National Health Service – historical background

The establishment of the National Health Service (NHS) took place in 1979. Up until then the Portuguese government had left the responsibility of paying for health care to the individual and his or her family. Care for the poor was under the accountability of the charity hospitals\textsuperscript{116} and out-of-hospital care remained the responsibility of the Department of Social Welfare. The government was liable only for the costs of health care for civil servants.

The shift towards greater public provision of health care and commitment to universality was embodied in legislation passed in 1971.

\textsuperscript{115} Source: European Observatory on Health Care Systems (1999)
\textsuperscript{116} These hospitals were owned and managed by religious charities designated Misericórdias. Mesiricórdias exist to this day, but they no longer provide acute hospital care.
Although never implemented to its full extent, this law gave priority to prevention over cure and sought to integrate health policy in the context of wider social policy, that is, to include protection of the family and disabled persons and other social welfare activities connected to health. After the revolution of 1974, a process of health service ‘nationalization’ began, culminating in the establishment of the NHS. Initially, district and central hospitals were taken over by the government. Later, local hospitals and health units followed.

Citizens’ right to health was embodied in the Portuguese constitution in 1976 and was to be delivered through a ‘universal, comprehensive and free of charge’ National Health Service. However, legal implementation did not take place until 1979 when the NHS was formally inaugurated. The 1979 law laid down a unified publicly financed and provided health care system under the principles of centralized control but with decentralized management. To this end, central, regional and local bodies were established. It brought together public health services and the health services provided by social welfare, leaving the general social security system to provide cash benefits and other social services.

**Health Care Finance**

The health care system is a combination of public and private financing. The NHS, which provides universal coverage, is predominantly funded through general taxation. The health subsystems are sponsored mainly through employees/employers contributions, including state contributions as an employer. A large proportion of funding is private, taking the form of direct payments by the users and, to a less extent, t premiums to private insurance schemes and mutual institutions, which cover respectively 10% and 7% of the population.

Concerning the total health expenditure, taxation accounts for the largest amount. In 1997, 61.6% of health expenses was financed in this way. This includes expenditures on direct provision within the NHS and in the form of subsidies to the health subsystems which operate for public sector employees. The share attributed directly to social insurance schemes was only 4.8% in 1996. Out-of-pocket payments accounted for 44.6% of the total health expenditure in 1995 making it one of the highest within the European Union.

The proportion of total health care expenditure in Portugal measured as a share of GDP has been rising steadily. In 1970 it amounted for 3% of the GDP. This figure increased to 8.2% in 1996. Portugal spends slightly less than the Western European average of 8.4% (1996). Compared to other Southern European countries, it appears that Portugal has not contained health expenditure growth as successfully. In 1996, Portugal spent more than both Spain and Italy, despite having spent considerably less than both these countries in 1970. Only Germany, France, Switzerland and the Netherlands spending a higher percentage of their GDP on health care.

117 Nevertheless, some aspects of the 1970s system persisted, namely, the health subsystems which offered better services and greater choice of providers to a variety of public and private employers than the NHS did and which, for that same reason, were forcefully defended by trade unions.

118 Out-of-pocket expenditure includes cost sharing and direct payments to providers.
The Health Care Delivery System

Primary Health Care

In Portugal a combination of public and private health care providers deliver primary health care (PHC). PHC covers all health care provided out-of-hospital by both generalists and specialists, and other non-specialist care and services such as dental care services, physiotherapy, radiology, and diagnostic services.

Within the public sector, primary health care is mostly delivered through publicly funded and managed health care centres (HCs). These centres have no financial or managerial autonomy but are directly run by the regional health administrations (RHAs). The Ministry of Health allocates funds to the RHAs which in turn determine the budget attributed to each centre based on historical and activity costs.

The first point of contact within the public system are the general practitioners (GP) at a health centres. All users must register with a GP. In theory, people have no direct access to secondary care and GPs are expected to act as gatekeepers. Yet, in practice, most people go directly to the emergency department in hospitals if they have any acute symptoms. A very large amount of attendees at hospital emergency units however do not need immediate care.

General practitioners (GPs) deliver most primary health care. However, some of the health centres also allow for a limited range of specialized care. This is the end result of the integration of social welfare medical services into the NHS at the end of the 1970s. Specialists working in HCs belong to the ambulatory specialties such as mental health, psychiatry, dermatology, paediatrics, gynaecology and obstetrics and surgery. Services provided by GPs include: general medical care, for the adult population and the elderly; prenatal care; child care; women’s care; family planning and perinatal care; first aid; certification of incapacity to work; home visits; and preventive services, comprising immunization and screening for breast, cervical and prostate cancers.

According to OECD (1998), the average number of contacts with physicians per person for the years of 1996/1997 in OECD countries within Europe was 5.7. Portugal had, thus, one of the lowest scores - 3.2, only surpassed by Sweden (2.9). Yet, the number of medical appointments per capita rose from 2.9 in 1980 to 3.3 in 1996 (Department of Health Studies and Planning, 1997 in European Observatory on Health Care Systems, 1999).

Portugal also has a vast independent sector that provides diagnostic and therapeutic services to NHS beneficiaries under contracts designated ‘convenções’. These medical contracts cover medical ambulatory health facilities for laboratory tests and examinations such as diagnostic tests and radiography, being usually scarce on medical consultations. In order to obtain such a contact providers must meet the criteria established by NHS for service provision and agree with the prices the same body is willing to pay. A list with all providers who have registered and meet the basic quality standards is published annually. Yet many users chose to go directly to the emergency departments of hospitals where all necessary tests can be obtained within a much shorter time.

Very few home visits are done by GPs – less than 48 per health centre, when each of these health centres cover on average 28 000 people.
Several problems accompany this type of health care. Among these are: inequitable distribution of health care services, lack of quality control programmes, lack of coordination between primary health care, hospitals and private doctors, difficult access to primary health care, lack of motivation of general practitioners, shortage of qualified ancillary staff in health centres, weak reputation of public primary health care system. A number of health care reform proposals have been developed aiming at increasing accessibility, improving continuity of care, identifying quality, increasing GP motivation and stimulating home care services.

Secondary and Tertiary Care

Secondary and tertiary care is mostly provided in hospitals although, as mentioned above, some health care centres make available specialist ambulatory services via their own staff. Nevertheless, these positions have been gradually diminishing in number.

In 1996, of a total of 211 hospitals about 58% were publicly owned. Almost half of the private hospitals belong to for-profit organisations. Trends in hospital numbers have been similar to those in other European countries, showing a decrease over the past thirty years (67%).

Most hospital services are provided according to an integrated model, that is, directly by the NHS. However, non-clinical services have for some time been assured by the private sector. Diagnostic and therapeutic services in the ambulatory sector are also mainly provided by the private sector through all-willing provider contracts.

One of the main problems which hospitals are confronted with in Portugal is the excessive use of emergency departments in situations of non-urgency for treatment. This problem and others have been the focus of attention of the 1998 National Health Strategy which was planned in order to reduce waiting lists, increase patient-friendly services, reorganise emergency departments and contracting-out of activities and projects considered to be priorities. A fundamental change within hospital services has been the shift in their funding from allocation based on historical budgets to contracted budgets. Regional Agencies contract with the hospital board who in turn contacts with a multidisciplinary team of health professionals for the delivery of services in fulfilment of the contract.

Social and Community Care

Very little state provision of community care services exists in Portugal. Despite the strong traditional and cultural reliance on the family as the first line of care, demographic changes such as the increase of female employment and a breakdown in the extended family due to migration to urban centres have meant that many people can no longer rely on such informal care. Additionally, Portugal faces a growing elderly population and the pressure to provide social as well as medical care is increasing.

120 Examples of such services are maintenance, security, incineration, catering and laundry.
The existing social services are provided in each region through the Ministry of Social Security. Nevertheless, *Misericórdias*, the independent charitable organisations, are the main providers of social care services.

The state continues to encourage *Misericórdias* to invest in social care and develop the basic infrastructure of services and facilities through the reinvestment of money obtained from the NHS and which was made available during the process of ‘nationalization’ of hospital facilities on the 1970s.

Several general obstacles have been pointed to the development of social care in Portugal: the lack of provision, lack of trained personnel, no tradition of community care which is regarded as a family responsibility, and lack of tools and skills to develop social care (e.g. few education courses).

**Mental Health Care**

Mental health services are run under the aegis of the General Directorate of Health. With the exception of large cities, mental health centres (MHC) are administered on a district basis. These centres are closely linked with regional health administrations and district hospitals relying on the connections with all health services in the community.

Mental health centres provide the following services: ambulatory care provided by mental health teams (usually at the centre itself), psychiatric services for patients in crisis and psychiatric services for patients with long-term problems. Every MHC has a staff member responsible for child mental health.

In recent years, a massive reduction of acute psychiatric and long-term beds has taken place as part of a process of de-institutionalization. Most mental health services have been integrated in general hospitals. Nevertheless, when compared to other European countries, this reduction has been less pronounced, since services in this sector are less developed in Portugal.

**2.1 Multicultural care provisions**

As already noted, there are so few asylum seekers and refugees in Portugal that they tend not to form a salient category for policy makers, service providers, professionals and the general public. Accordingly, the distinction between provisions for immigrants and those for asylum seekers and refugees is not a relevant one in this context. We therefore discuss multicultural care provisions in the following section.

**2.2 Services for asylum seekers and refugees**

Only one special service has been identified which is particularly relevant to the needs of asylum seekers and refugees, and even that does not cater for them as a group, but is concerned with victims of torture.
Centre of Support to Victims of Torture in Portugal – CAVITOP

CAVITOP is a Non-Governmental Organization integrated in the Coalition of Latin-European Centres for Victims of Torture (Latin-European CCVT). It was implemented in 2002 with the main goal of supporting and rehabilitating victims of torture, violence and cruel or inhumane treatment at a national level. In order to accomplish this goal the CAVITOP sets out to:

- promote the rehabilitation of victims of torture, violence and cruel or inhumane treatment by referring to and providing for individual medical assistance (e.g. psychiatric and psychological assistance) and social, juridical and moral support;
- collaborate with entities such as health administration, social security, justice, police and local autarchies and other NGO’s and humanitarian institutions on the defence and enforcement of torture victims’ rights;
- promote social solidarity through the creation and management of networks of voluntary collaborators and social agencies;
- encourage and sponsor research concerning the victims’ problems, namely how these problems develop and which solutions are adopted;
- promote and participate in programmes, projects and information actions as well as to make the public opinion aware of the problem;
- promote the creation of a documentation centre or library with literature concerning the problems of victims of torture;
- contribute to the implementation of legislation for the defence, protection and support of victims of torture;
- establish contact and collaborate with other international organizations with the same goals.

The installing commission of CAVITOP includes a national coordinator, a lawyer, two psychiatrists, two psychologists and a social assistant. CAVITOP has been planned to work within an inter-institutional and multidisciplinary network. As the organisation is not yet well known among the general public, most cases so far have been referred by other organisations. Nevertheless, the organisation assures the possibility for spontaneous and personal contact daily via its secretary.

Specific contact with the General Practitioners Association was established in order to make doctors sensitive to potential victims of torture. The media have also been contacted and informed about the organisation’s purposes and scope of intervention.

Users are provided with a range of services namely: medical, psychiatric, psychological, social and juridical. In general, the first contact is made with a psychiatrist. After evaluation, the person is either assisted by CAVITOP (provided that the case is found to fall within the scope of the organisation’s intervention), which establishes an accompanying plan or referred to other N.G.O.s/ professionals.

The services provided always regard the person’s best interests. Attention is put to each person’s timing and willingness to receive treatment. Confidentially is assured at all stages of intervention and referral.

Concerning service provision, the main difficulties experienced by professionals relate to the kind of problems the organisation attempts to target.
It is believed that the same circumstances that lead to the need for help might also undermine a direct contact with the organisation (e.g. feelings of reprisal by the aggressor).

Other problems relate to financial matters. So far, these problems have been overcome through the collaboration and donations made by institutions and individuals.

Prior to the formal implementation of CAVITOP two training activities for voluntary staff were organized. The first, undertaken in December 2001, consisted of a seminar entitled “Torture as a challenge to the health professions”. The second, carried out in July 2002, entailed a course under the theme “Healing the wounds”.

New volunteers will be trained both through the use of videos of previous seminars and the promotion of other conferences and discussion sessions.

In April 2003, a protocol of cooperation between CAVITOP and the Portuguese Council for Refugees was signed. So far, all the individuals referred for and in counselling are asylum seekers or refugees.

**Results of interviews with service providers**

To investigate the extent to which regular services are oriented towards the needs of asylum seekers and refugees, a survey of service providers in the Lisbon’s region was carried out under the supervision of Prof. Natália Ramos of CEMRI (Centro de Estudos das Migrações e das Relações Interculturais, Open University).

The data of this survey was drawn from a set of interviews conducted with qualified professionals from institutions and services such as General Hospitals, Psychiatric Hospital, Health Centres, Town Halls and NGO’s. Among the interviewees were: medical doctors, nurses, psychologists, technical staff and civil servants. These subjects were recruited via an informal network of friends and colleagues who then were interviewed and referred other professionals. Formal contact with services and institutions (e.g. via letter soliciting collaboration on this study) would most likely have led to delays for the study, given the low probability of reply which generally characterizes this kind of services. This last aspect is felt to be one of the main obstacles to the development of such studies. Due to time limitations the selection of services was restricted to Lisbon’s Metropolitan Area.

**Summary of main findings.** Most of the subjects interviewed commented on the difficulty of answering the posed questions due to a lack of statistical data concerning migrant users. There is a general view among these services which sustains the idea that all users should be treated as equals. Therefore, reference to a user’s nationality is found unnecessary and even counter-productive, even if it is intended as a form of “positive discrimination”. The lack of governmental action addressing professionals’ needs when providing services to such diversified populations (e.g. the need for translators and training programs) was referred by most interviewees. However, despite the structural disorganization and lack of specific orientation and training, all efforts are made in order to satisfy migrant users’ needs. Most professionals referred the creativity and generosity of their fellow colleagues in attempting to find solutions for such cases. They also note that mostly such solutions are found and users’ needs satisfied.
The more detailed results of this study were as follows.

- Hospitals and Health Care Centres do not develop specific practices for immigrants and refugees. These groups are provided with the same kind of services as Portuguese residents. Professionals acknowledge migrants’ need for more information and therefore provide information about the health care system, current legislation and the social care services that can be accessed. This, together with general information about health matters, can be regarded as a general preventive activity. More specific support can only be found within the Social Service department of these institutions. Together with other private institutions (Jesuit Refugee Service and Portuguese Catholic Work for Migrations (OCPM) and immigrants and refugees’ support associations, the Social Service departments offer social, legal and educational support. Other private institutions and city halls provide specific support on the following levels: social, juridical, educational, employment and professional training, Portuguese language courses, housing, health.

- In recent years, the number of requests for help has been rising, particularly with Eastern European (Ukraine, Romania and Moldavia) and Brazilian immigrants. Altogether, immigration from the African Countries of Official Portuguese Language (PALOP - Angola, Cape Verde, Guinea-Bissau, Mozambique and São Tomé and Príncipe) is still the most representative.

- The services respond to the general population without differentiating between target groups. When users’ needs cannot be satisfied within these services, they are referred to other specialised services. In the case of mental health needs, there are no special facilities to which users can be referred. For example, if migrants need psychiatric help they are referred to the psychiatric hospital in their own residential area. Although Miguel Bombarda Hospital has a transcultural mental health team, there is no separate department for multicultural mental health care.

- There is collaboration between all the contacted services. Some of these collaborations are sparse. Others take the form of a support partnership and training and information exchange. Communication between professionals tends to appear mainly within private services. On a public level, interdisciplinary communication is stimulated according to the needs. Difficulties tend to arise due to the bureaucratic and hierarchical traits that characterise these services.

- Evaluation is done through reports on activities. These are conducted each three months and/or annually and delivered to the supervising ministries.

- Activities outside the health care system are promoted by private entities such as Associations, NGO’s and specific services developed by municipalities and the Church.

- Public services are financed by the Portuguese state through the charge of taxes for Segurança Social (Social Security) but within these, City Halls are financed by the ‘autarquias’. Private institutions are financed by collections, private and business donations, members’ contributions and the state.

- The most commonly reported problems of immigrants and refugees are: difficult accessibility to health care, financial, legal and housing problems. Despite of this, they appear to the professionals interviewed to be pleased with the help they get.

- According to those interviewed, the biggest problems arising are:
  - language-related problems (in particular with Eastern European immigrants);
  - the lack of staff members to provide individualised service.
the lack of specific training on issues concerning the health of immigrants and refugees. Because there are no official translators, longer-established members of the migrant communities are often asked to accompany other migrant users.

- Service providers are waking up to the existence of the special needs of refugees and other immigrants. Immigration is a recent reality in Portugal. So far there are no solid and organised structures in the existing institutions. Everything that has been done depends on the means at the disposal of the institutions/services and is the result of some professionals’ sensitivity to interculturality and to the mobility of the arriving populations.
- The social and health care system seems to be blur for migrants. No specialised information centres exist so far. It is also a difficult task for researchers to access professionals. Constraints of time and availability necessitate great perseverance in seeking out information.
- There is a need to improve the organisation, coordination and enlargement of care services for these populations and to provide training to the professionals working with them.
- At the moment, there is a significant number of immigrants and refugees distributed through the country’s different regions. It would be important to study the needs of other institutions (outside Lisbon) that provide for these populations in Portugal.
Chapter Three: Practices developed for asylum seekers and refugees

3.0 Conclusions of the study

As explained in Chapter Two, the category of asylum seekers and refugees is numerically very small in Portugal and hardly any special services of any kind exist for this group. These that do exist are mostly organised by the Portuguese Refugee Council (CPR). However, the emphasis in the activities of both the CPR and the Portuguese Government lies on matters more directly concerned with practical problems and integration (housing, training and employment). In these areas, we noted a relatively large number of interventions.

Concerning health and social care, attempts to provide multicultural services in Portugal still seem to be in a fairly rudimentary stage. A number of initiatives we had been told about proved impossible to reach, and we were led to the conclusion that they had ceased to exist. The only innovation which we succeeded in locating was CAVITOP, the centre for victims of torture set up in 2002 (see p. 47).

At the level of training and education, a two-year Masters Course is offered for professionals working in the field of health care at the Open University, Lisbon, on “Communication and health”. In this course, attention is paid to problems of multicultural service delivery.

Since 1998, a course on “Asylum and Refugees in the International System” has been part of the programme of the degree on International Relations (4th year, university). This course is coordinated by Dr.ª Maria Tito de Morais Mendes, president of Portuguese Council for Refugees.

Because there are so few practices to describe in this area, we have omitted Chapter 4 of the report.
References


Web sites

http://www.acime.gov.pt  Alto Comissariado para a Imigração e Minorias Étnicas - High Commissioner for Immigration and Ethnic Minorities (ACIME)
http://www.cpr.pt/  Conselho Português para os Refugiados – Portuguese Refugee Council (CPR)
http://www.who.dk/observatory  European Observatory on Health Care Systems
www.ercomer.org  European Research Centre (ERCOMER)
http://www.iom.int/  International Organization for Migration (IOM)
http://www.iefp.pt  Instituto do Emprego e Formação Profissional – Institute for Employment and Professional Training (IEFP)
http://www.mfh-eu.net/  Migrant-Friendly Hospitals
http://imigrantes.no.sapo.pt/  Migrantes
http://www.mai.gov.pt  Ministério da Administração Interna (MAI)
http://www.obercom.pt/  Observatório da Comunicação
http://www.oecd.org  Organisation for EconomicCo-operation and Development
http://www.publico.pt/  Público Online Newspaper
http://www.refugeenet.org/  Refugee Net
http://www.sef.pt/  Serviço de Estrangeiros e Fronteiras – Aliens and Borders Service (SEF)
http://www.sosracismo.pt/  SOS Racismo – SOS Racism
### Appendix

Variables analysed for the Asylum Seekers Typology in Portugal

<table>
<thead>
<tr>
<th>Variables</th>
<th>Modalities</th>
<th>Variables</th>
<th>Modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>1 – Male</td>
<td>1 – Scientific and technical professions, artistic and similar professions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Female</td>
<td>2 – Directors and upper management</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>1 – 18 or less</td>
<td>3 – Administrative Staff and similar workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – 19-24</td>
<td>4 – Trade workers and vendors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 – 25-34</td>
<td>5 – Protection/Security staff, personal services, domestic staff and similar professions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – 35-49</td>
<td>6 – Farmers, animal breeders, farm labourers, fishermen, hunters</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 – 50 or more</td>
<td>7 – Workers in mining/natural extraction and transformation industry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 – NA</td>
<td>8 - Civil construction workers, machine operators and drivers</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>1 – Eastern Europe</td>
<td>9 – Students</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Central Asia – Middle East</td>
<td>10 – Pensioners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 – Sub-Saharan Africa-SW</td>
<td>11 – Housewives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – Indian Subcontinent</td>
<td>12 – Unemployed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 – Sub-Saharan Africa-NW</td>
<td>13 – Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 – Africa Other</td>
<td>Place of Asylum Claim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 – Magreb</td>
<td>1 – National territory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 – Latin America</td>
<td>2 – Portela Airport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 – Rest of Asia</td>
<td>3 – Other Airport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 - Others</td>
<td>4 – Land Border</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Sea Border</td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td>1 – Reception Centre/ Shelter</td>
<td>Route</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Airport</td>
<td>1 – Direct</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 – Lisbon Metropolitan Area</td>
<td>2 – through EU</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – Boarding-house</td>
<td>3 – not through EU</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 – Other</td>
<td>4 – NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 – NA</td>
<td>Date of Arrival to Portugal</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>1 – Single</td>
<td>1 – Before 1998</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Married</td>
<td>2 – 1998</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 – Divorced/ Separated</td>
<td>3 – 1999</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – Common – Law Marriage</td>
<td>4 – 2000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 – Widow/ Widower</td>
<td>5 – 2001</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 – 2002</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 – NA</td>
<td></td>
</tr>
<tr>
<td>Arrival in Family Group</td>
<td>1 – Spouse</td>
<td>Came by Aeroplane</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Spouse and children</td>
<td>1 – Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 – Children</td>
<td>2 – No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – Did not come with family</td>
<td>3 – NA</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>1 - Atheist</td>
<td>Came by Train, Bus, Car</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Catholic</td>
<td>1 – Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 – Other Christian</td>
<td>2 – No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – Muslim</td>
<td>3 – NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 – Other non-Christian</td>
<td>Holds an Identification</td>
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</tr>
<tr>
<td></td>
<td>6 – NA</td>
<td>1 – Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 – Illiterate</td>
<td>2 – No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 – Primary School</td>
<td>3 – NA</td>
<td></td>
</tr>
<tr>
<td>Educational Level</td>
<td>3 – 5th up to 9th school year</td>
<td>Holds a Visa</td>
<td>1 – Yes</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------</td>
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<td>---------</td>
</tr>
<tr>
<td>4 – 10th up to 12th school year</td>
<td></td>
<td></td>
<td>2 – No</td>
</tr>
<tr>
<td>5 – Technical Education</td>
<td></td>
<td></td>
<td>3 – NA</td>
</tr>
<tr>
<td>6 – Higher Education</td>
<td>Applied for Asylum</td>
<td></td>
<td>1 – Yes</td>
</tr>
<tr>
<td></td>
<td>or Intends to Apply in Another Country</td>
<td></td>
<td>2 – No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 – NA</td>
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<table>
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<tr>
<th>Speaks Portuguese</th>
<th>1 – Yes</th>
<th>Has Family in Portugal</th>
<th>1 – Yes</th>
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<tbody>
<tr>
<td></td>
<td>2 – No</td>
<td></td>
<td>2 – No</td>
</tr>
<tr>
<td></td>
<td>3 – NA</td>
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<td>3 – NA</td>
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<th>Speaks English</th>
<th>1 – Yes</th>
<th>Family in Another EU State</th>
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<td></td>
<td>2 – No</td>
<td></td>
<td>2 – No</td>
</tr>
<tr>
<td></td>
<td>3 – NA</td>
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<td>3 – NA</td>
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<tr>
<td></td>
<td>3 – NA</td>
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Identification Study
Report on The Netherlands

Nina de Ruuk

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Chapter One. The context of interventions

1. Demographic

Immigration and emigration in historical context

Immigration, considered over a longer period of time, is anything but a new phenomenon in the Netherlands. The ‘Low Lands by the sea’ formerly had a great attraction to immigrants, particularly during the 17th century. During this ‘golden century’ the Republic, of which the present-day Netherlands was then a part, was the most flourishing country in Europe. Apart from its wealth, the country was known for its relative tolerance. Immigrants came in waves: thousands of French protestants sought refuge here, which is why the Republic acquired the name la grande arche des fugitifs (‘the great refugee arch’). But not only refugees came to the Republic: many labourers from the neighbouring countries also came in search of seasonal work. From about 1820 onwards, however, relatively little migration to the Netherlands took place, primarily because of its weak economy. During the First World War the country took in temporarily around one million refugees from Belgium.

From the beginning of the 17th century thousands of Portuguese Jews came to the Republic, followed by Jews from middle and eastern Europe from 1635 to the 1920’s. The persecution of the Jews in Nazi Germany and Austria after 1933 brought another 16,000 and 7,000 other political refugees to the Netherlands.

Penninx (1996) has pointed out that the percentage of new immigrants in the Netherlands during the seventeenth century was actually higher than it is now. However, during the more recent past – between 1820 and 1960 – immigration was very limited.

Post World-War II Migration

Labour migration from Mediterranean countries

The rapid economic growth during post-war reconstruction soon led to a structural shortage of labour. Between the mid-1950’s and 1970’s labourers were recruited as ‘guest labourers’ (gastarbeiders) from the Mediterranean countries: Italy, Spain, Portugal, Yugoslavia, Greece, Turkey, Morocco and Tunisia. These people were mostly semi- or unskilled workers. In the 1970’s many of these labour migrants returned to their country of origin, in particular the Italians, Spaniards, Portuguese, Greeks and Yugoslavs.

Many Turks and Moroccans, however, stayed in the Netherlands, as their homelands did not offer them opportunities for a better life. Recruitment came to a halt after the oil crisis in 1973, but the first-generation immigrants acquired the right to bring family members and wedding partners to the Netherlands and numbers have continued to increase. In September 2002 there were 330,709 immigrants of Turkish origin and 284,124 Moroccans in the Netherlands (Centraal Bureau voor de Statistiek, 2002).
Decolonisation and its effects

Decolonisation, a worldwide process, also determined the pattern of post-war immigration. In 1949, the Netherlands handed over the Dutch East Indies to Indonesia. As a result, some 273,000 repatriates and other migrants came to the Netherlands. A second colony, Dutch Guyana (now Surinam), became independent in 1975. Consequence was the migration of one third of the Surinamese people to the Netherlands. Family members came over later, which resulted in a total number of 315,177 Surinamese in the Netherlands in September 2002 (Centraal Bureau voor de Statistiek, 2002).

The migration of Antilleans has not been restrained by international regulations, as the Antilles are still officially part of the Netherlands and its inhabitants have Dutch nationality. There are 124,870 Antilleans living in the Netherlands in September 2002 (Centraal Bureau voor de Statistiek, 2002).

Other migration flows

Alongside the migration flows mentioned above, a steady stream of migrants from other countries has come to the Netherlands over the years. The number of migrants from other EU countries grew to 188,000 in 1994, of which Germans, British and Belgians formed the largest nationality groups. The number of migrants from the industrialized countries like the U.S.A. and Japan has also grown. However, in the last 15 years, most labour migrants have come from third world countries, for example China. In addition, large numbers of refugees have arrived in this period (Vietnamese, Ghanaians, Ethiopians, etc.) (Penninx, 1996).

Asylum-seekers and refugees: trends since 1970

Numbers

The late 1980s – early 1990s saw an increasing number of refugees arriving every year. In 1985 there were 5640 persons requesting asylum in the Netherlands. Five years later the figure had risen to 21,210, reaching a peak of 45,220 in 1998. From then on a decline has been noticeable, leading to 32,580 requests in 2001 and 18,670 in 2002121. This is a direct result of stringent new procedures set up to exclude asylum applications deemed to have a low chance of success. The organisation Human Rights Watch has recently claimed that the Dutch “accelerated determination procedure”, limited to 48 hours and used to process 60% of all incoming cases (including 30% of child asylum seekers), is a violation of fundamental rights (see http://www.hrw.org/press/2003/04/netherlands0409.htm).

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121 These numbers have been obtained from the official web page of the Centraal Bureau voor de Statistiek (CBS). http://www.cbs.nl
Illegal immigrants

Because of the increasingly restrictive policy for admitting both labour migrants and refugees, there exists a large group of illegal immigrants in the Netherlands. The number of illegals is estimated around 100,000, but no hard figures are available. The four largest cities in the Netherlands house around 40,000 illegals from non-European countries (excluding Turkey). It has been estimated that 55% of these illegals are here because of labour migration and only 5% because of a refused asylum application.

Origins of asylum seekers

Although there are more than 70 registered countries of origin, in 2001 the largest groups of asylum seekers came from the following countries: Angola (4,111), Afghanistan (3,614), Sierra Leone (2,405), Iran (1,519), Guinea (1,467), Turkey (1,400), Somalia (1,098), Bosnia Herzegovina (1,026) and the former U.S.S.R. (911). Among other countries, the unaccompanied minors have come from Angola (1,991), Sierra Leone (728), Guinea (668), China (344) and Somalia (248) (Immigratie en Naturalisatie Dienst, 2002).

In 2002, most asylum applications still came from Angolese refugees (1,891). However, fewer applications came from Afghans. Second place was taken by Sierra Leone, with 1,620 applications. Guinea, Bosnia Herzegovina and the former U.S.S.R. have disappeared out of the top ten list. Instead, FR Yugoslavia, Nigeria and China have entered (IND, 2003). The most important countries of origin of unaccompanied minors in 2002 were: Angola (854), Sierra Leone (392), Guinea (199) and China (177).

1.1 Political

Sketch of immigration policy since 1945

Because the Second World War had left the Dutch economy in a very weak condition, there was a surplus of labour and the government devoted considerable effort to stimulating emigration (Penninx, 1996). Between 1946 and 1972, some 481,000 emigrants left for countries such as Canada, the United States, New Zealand, Australia and South Africa. When the Dutch Indies (now Indonesia and New Guinea) gained independence shortly after the war, many who had been identified with the Dutch regime were granted admission to the Netherlands. The same phenomenon could be observed after independence was granted to Surinam (1975).

Labour migration to the Netherlands only reached significant levels during the 1950’s, when the economy started to pick up. Right up until the end of the 1970’s, however, government policy was dominated by what Penninx (op. cit.) calls “the illusion of temporariness”: the notion that The Netherlands was not an ‘immigration country’ and that labour migrants would sooner or later go back where they came from (despite the fact that many of them had already brought their families over to join them). No attention was paid to problems of integration and some groups of ‘guest workers’ were actually segregated from the host population in old housing complexes or disused barracks.

Towards the end of the 1970’s, however, a shift in policy took place. The presence of migrants had become inescapable and government advisory bodies voiced concern about the
social marginalisation of many groups. In 1983 a bill was published (the “Minderhedennota”) which marked a formal change to a multicultural or pluralistic policy: special programmes were set up to combat the disadvantaged position of minority groups, and ‘integration without giving up one’s own culture’ became the official goal of government policy.

Almost from its inception, however, this multicultural policy was subject to criticism by those who favoured an approach based on assimilation. Extreme right-wing political views were hardly to be found in the Dutch political spectrum (the Dutch tradition of tolerance and respect for human rights and, in particular, the backlash from the Nazi occupation saw to that), but some politicians cautiously toyed with this theme up to 2000, when an often very heated public debate started about the multiculturality of Dutch society was set off by the newspaper article ‘The Multicultural Drama’ by Paul Scheffer (Scheffer, 2000). In this article, the author blamed the government for being too ‘soft’ towards all types of migrants with regard to the demand for assimilation. Some points made were the relatively high criminality among second generation Moroccan boys, the fact that many (older) migrants still are not able to speak Dutch, and the questionable messages of Imams in Mosques. Politicians took this debate over.

As in other Western countries after “9/11” the phobia for Muslims came to the fore. Pim Fortuyn, leader of a new Dutch party, stated in the run-up to the general election in 2002, that (among other things) the borders should be closed for all migrants, including asylum seekers. He also declared Islam an inferior religion. These statements led to an increasing polarisation within Dutch society. Fortuyn was assassinated on May 6th, 2002 and with this murder the polarisation in society became tangible. Many Dutch people declared that Fortuyn had finally put into words what they had been thinking all along. In the elections a week later his party, the LPF, became the 2nd in parliament. A right wing government including the LPF was formed. The government lasted only 58 days, but many parties took quite a few ideas over from the LPF, or from what is called “the legacy of Pim Fortuyn”.

Nevertheless, the “chicken-and-egg” question remains: what made the xenophobia start? In 1986, 29% of the Dutch public said they were happy with the diversity in society because it brought them in touch with other cultures. In 2000 this proportion had risen to 44% (Heij & van Weezel, 2002). In 2001, migrants and refugees said they felt more comfortable in Dutch society than before. However, in recent public surveys the phobia against Islam has become more apparent (ibid., p. 3).

**Development of asylum policy**

Dutch asylum policy is complex and has gone through many stages of evolution. In order to appreciate its present form, it is necessary to follow the story of its transformations over the last four decades. The following account distinguishes between the periods 1965-1987, 1987-2002 and 2001-2003.

**Asylum policy and practice in the Netherlands, 1965 – 1987**

In 1956 the Dutch government ratified the UN Refugee Convention of 1951, amended by the Protocol of New York of 1967. The Aliens Law, in which the asylum law was embedded, came into force in 1965. This law and related administrative instructions hardly changed between then and 1987 (Selm, 2000).
The resettlement of ‘quota refugees’

For many years the focus of asylum policies in the Netherlands lay on the country’s contribution to the refugee resettlement program of the UN High Commissioner for Refugees. Until 1977 on an ad-hoc basis, and subsequently by quota regulations, various groups of refugees were invited to resettle in the Netherlands, the first non-Europeans being the Ugandans in 1972, followed by Chileans, Argentineans, Uruguayans, Brazilians (1974 -1981) and Vietnamese (1977 - 1985). In the 1980’s the national annual budget also provided for admitting around 800 individual refugees, who sought asylum in the Netherlands on their own initiative. However, the number of persons seeking asylum in the Netherlands exceeded this figure increasingly. In an attempt to control the number of spontaneous arrivals of asylum seekers, the quota for resettlement was doubled in 1987. The regulation for ‘quota refugees’ of 1987 has not changed since. In practice, however, since the end of the nineties the numbers of invited refugees lay far behind the official quota. The figures were: in 2000, 83; in 2001, 284 and in 2002, 159 (IOM, 2002 & 2003).

On arrival, quota refugees immediately receive the refugee, or A- status, which meets all the standards set out in the Refugee Convention (Selm, op. cit. p. 5). With the new Aliens Law of 2000 this status changed into a permanent residence permit for those who had already received A-status. New arrivals receive a status which can be withdrawn within the first three years (see ). Quota refugees mostly arrive in groups and are housed in a reception centre for around three months, after which they usually receive housing in moderate-sized municipalities.

Individual refugees

Until the mid-1980’s asylum seekers, assisted by the Dutch Refugee Council, found housing in private accommodation without much difficulty. In 1984 – 1985, however, city authorities faced with the arrival of relative large numbers of Tamil asylum seekers expressed reluctance to house them out of concern for their safety and for public health. The government decided upon a special regulation, through which the Tamils were housed in small hotels and boarding-houses rented for the purpose. This led to a request of the parliament to develop a general regulation for the central reception of asylum seekers. The ‘Regeling Opvang Asielzoekers’ (ROA) (Regulation for the Reception of Asylum Seekers) came into force in 1987. Initially, asylum seekers who were unable to find housing independently, were housed, like the quota refugees, for a period of around three months in reception centres, after which they moved to special asylum-seekers houses (ROA houses) offered by municipalities. In these ROA houses the asylum seekers could await a decision on their asylum request. If positive they received regular housing dispersed over the country.

Until 1988 three types of residence permits could be granted to an asylum seeker: the Refugee, or A status; the B-status, a permission to stay as ‘asielgerechtigde’; and the C-status, granted for humanitarian reasons. Since the Council of State considered the B-status the same as the A-status, the B-status was abolished. As said, the A-status gave all rights as described in the Refugee Convention of ’51, meaning the same passive rights as Dutch citizens, with the addition of special assistance in finding housing and employment and the right to family reunification without any conditions. The C-status meant a residence permit, which had to be renewed each year, no special assistance with housing and employment, and family reunification only if a regular income of 70 % of the minimum social security and adequate housing could be guaranteed.
A negative decision on an application for asylum could be appealed against, in the last resort to the Council of State.

**Asylum policy and practice in the Netherlands, 1987 – 2001**

Since 1987, both the laws and the official procedures governing asylum seekers have been subject to many changes. Asylum policy concerning *quota refugees* did not change in this period, although the number of refugees invited for resettlement in the Netherlands decreased considerably from the end of the nineties. But the specific reception centres for quota refugees, in which they started directly with language classes, an introduction in Dutch society and an orientation on employment possibilities, were closed in 2000. Since that time, quota refugees are temporarily housed together with asylum seekers in the central reception centres for asylum seekers.

For other groups, the story is a lot more complex, as we shall now describe.

**The ‘watershed’**

The implementation of the ROA in 1987 was seen as a ‘watershed’ in the asylum policy. In the nineties many were to follow.

The number of asylum seekers arriving in the Netherlands increased steadily, while the outflow of asylum seekers from the central reception to municipalities stagnated. At the beginning of the 1990’s the government decided to link the reception scheme to the asylum procedure. Asylum policy started to be characterized by restriction and control. The Netherlands joined “the European race to the bottom”, in the words of Meurs and Broeders (2002), “to avoid becoming the most attractive country for asylum”.

Up until 1994, however, the national budget for the asylum policy proved every year to be too low, which meant that every summer the government announced cuts in other budgets because of the high number of persons seeking asylum. In 1994 the “Liberal party broke with the tacit taboo on raising the asylum issue during election times” (Selm, op. cit., p. 5). Asylum and migration issues became part of public and political debate, in which the correct terms for asylum seekers, (illegal) migrants and refugees often were confused. Nevertheless, politicians continued to declare that ‘real refugees’ should be welcomed and admitted wholeheartedly.

New measures were taken. (Semi-)detention centres were created: the ‘grenshospitium’ for asylum seekers not admitted to the asylum procedure, and the 'return' centre at Ter Apel for those rejected who did not leave the country on their own initiative. With the arrival of asylum seekers from former Yugoslavia, many of them invited by the Dutch government, a special temporary permission to stay was created for this group. This temporary status was generalized into a ‘F-status’, a provisional residence permit (VTm – Voorwaardelijke Vergunning Tot Verbleven), in the Asylum Bill of 1994, for those asylum seekers coming from selected countries including Bosnia (until 1995), Somalia, Iraq, Afghanistan and Rwanda. The list of those selected countries changed in accordance with the situation in the country of origin, as determined by the government. The F-status gave graduated and cumulative rights
to employment and education in three years time. If the situation in the country of origin had not changed after those three years, the F-status was changed into a C-status.

The rights of persons granted an A- or C-status stayed the same. The C-status was divided, though, in a status for humanitarian reasons (C-hum) and a status for medical reasons (C-med). The C-med status was ended when there were no more medical reasons, a measure which presented dilemma’s of medical ethics. The A-status was granted to a decreasing percentage of asylum seekers.

Besides the list of ‘unsafe countries’, lists of ‘safe third countries’ (mainly to implement the Dublin Convention) and ‘safe countries of origin’ were introduced in 1995, although the government stated that each individual case still would be considered on its own merits. The Dublin Convention, of 1990, to which the Netherlands is party, means that asylum seekers who could have applied for asylum in another country that is party of the Convention, should return to that country. The asylum seeker in question is allowed to remain until the so-called Dublin claim is granted by the other country, but has no right to reception, including medical care, except in exceptionally difficult humanitarian situations.\(^{122}\)

At all stages of the asylum procedure, asylum seekers could appeal against a negative decision. The use of appeal procedures was stimulated by the fact that they were quite often successful. Another reason for appeal was that the different statuses gave different rights (for instance: C-status: no family reunification without income demands). The capacities of the Immigration and Naturalisation Service (IND), an agency of the Ministry of Justice, and the courts were unable to deal with the number of cases. The procedure became increasingly lengthy for many. Although the government aimed at a procedure lasting an average of 9 months, in 1998 the average length of stay in the central reception was 19.9 months, a figure that included those asylum seekers who left the central reception with ‘unknown destination’ (MOB - Met Onbekende Bestemming), often at an early stage (Centraal Plan Bureau, 1999). In 1999 around 6500 asylum seekers had stayed longer than 3 years in the central reception. The outflow of persons with an A-, C- or F-status to regular housing in municipalities, and of persons who received a (final) negative decision on their asylum request but could not be removed, stagnated gradually as well. In December 2001 almost 83.000 asylum seekers, persons with a permit to stay and rejected asylum seekers were housed in the central reception (De Haan & Althoff, 2002).

All parties concerned agreed that the asylum policy had failed, although for diverging reasons. In 1997 and 1998 the Dutch Refugee Council and Pharos initiated a public campaign to protest against the lengthy asylum procedure. They signalled an increase of mental problems among asylum seekers due to the too lengthy, passive stay in the central reception. On the other hand, the Medical Advice Service of the Immigration and Naturalisation Service (for example) complained that too many asylum seekers tried ‘to enter through the back door’ by presenting mental problems and requesting a C-status for medical reasons (Van Willigen, 1998).

At the same time, politicians started to become concerned about rejected asylum seekers not leaving the country. The Dutch government’s policy regarding removal and return was based on the notion of co-operation and consensus. In most cases, asylum seekers whose asylum request had been rejected in the highest court received a notification that they had to leave the

\(^{122}\) This changed in October 2002, when so-called 'Dublin claimants' got reception until their return to the country of claim.
country. After a month, the alien police checked if the person or family in question had left their last address. Some of these rejected asylum seekers were brought to the border. Others received a notification that they had to go to the (semi-) detention centre in Ter Apel where they were supposed to wait their deportation. This last measure proved not to be effective, and extremely costly. A ‘facilitated repatriation’ pilot program for people from Angola, Ethiopia and Eritrea, also extremely expensive, resulted in the return of only a very few persons.

The asylum policy was in crisis. The ‘front door’ to the asylum procedure was stuck as well: the Immigration and Naturalisation Service did not have enough capacity to admit all new asylum requests. In the course of 1998, tents were hastily set up as provisional reception centres, and waiting lists were made for the application of asylum. The Prime Minister openly expressed the failure of the asylum policy by remarking on television: “If you know any better, let us know” (“Wie het weet mag het zeggen”). After many heated discussions in public and parliament, a new Aliens Law was prepared.

Asylum policy and practice since 2001

The main changes in asylum policy and practice concern the Aliens Law 2000, the policy regarding repatriation, and the policy regarding unaccompanied or separated asylum seeking minors (UAM). Because of the last-mentioned change attention is also given to numbers and nationalities.

The Aliens Law 2000

In September 1999 the draft new Aliens Law was sent to parliament. Many amendments were made. The main concern which the new Aliens Law gave rise to was the absence of a definition of a refugee according to the 1951 Convention, although in the explanatory notes it was stated that the definition of the Convention will be used. Despite initial reluctance, the UNHCR agreed with the new law. The aim of the law is to simplify and accelerate the asylum procedure.

The basic principles of the new Aliens Law are:

- There are two residence permits: one for a defined period of three years in which the permit can be withdrawn, followed by a permanent residence permit.
- Every person with a residence permit for a defined period receives the same rights: access to the labour market, financial support for education, access to housing, the right to employment and the right to family reunification on the condition of realisation within three months after permit granting; after that one ought to have an income of 100 % of the minimum social security123.
- The possibility for appeal at the Immigration Service (IND) on against a negative decision is cancelled.
- The decision to grant or reject an asylum request will be taken within six months (formally; this period can be extended for six month due to research outside); an appeal can be made against a negative decision in court.

123 The ‘demissionary’ (departing) government planned to raise the condition of 100 % to 130 % of the minimum income.
• After three years\textsuperscript{124} the situation in the country of origin will be assessed; on the basis of this assessment a decision will be taken about changing the residence permit for a defined period into a permanent one.

• Only when the decision to grant a permanent residence permit is negative will the motives for the temporary permit be clarified\textsuperscript{125}.

• The permanent residence permit can only be withdrawn if the person in question forms a danger for to public order.

The decision period of six months can be lengthened to 1½ years if the situation in the country of origin is uncertain, or expected to improve, or if the number of asylum requests is too high for the IND to assess within 6 months. The latter shows an overlap with the guidelines of the EC regarding the mass influx of displaced persons.

The government aims at an acceptance of the asylum requests of around 20 %, instead of the 50 % under the former Aliens Law (Centraal Plan Bureau, 1999, p. 14).

On 1\textsuperscript{st} April 2001, the new Aliens Law came into force. As before, the new measure in asylum policies showed effect directly afterwards, as most probably other European countries have experienced as well: “Europe is a waterbed” with regard to asylum – when one country suppresses the numbers, they rise in other countries. The number of asylum seekers admitted to the procedure decreased drastically (see section c below).

However, the low figures for 2002 cannot be explained only by a reduction of the persons wanting to apply for asylum in the Netherlands. In April 2002, 31% and at the end of 2002, 60% of those requesting admittance to the asylum procedure were rejected in the so-called ‘accelerated determination’ (AC) procedure (Spijkerboer, 2002). The present, demissionary Minister for Immigration and Integration has declared a target of 80 % rejections (Heijmans & Oñorbe, 2002a). Despite all the laudable intentions of the government to accelerate the asylum procedure with the new law, according to the Dutch Refugee Council only 43 % of the admitted asylum seekers receive a decision on their request within six months (Heijmans & Oñorbe, 2002b).

\textit{Policy on repatriation}

In 2000 the policy regarding repatriation of those people whose asylum request is rejected has become stricter. Central to the policy is the person’s own primary responsibility to return. Within the reception centres, so-called return centres have been created in which the International Organisation for Migration (IOM) informs asylum seekers about the organisation’s social and financial assistance with voluntary repatriation. The employees of the Central Agency for the Reception of Asylum Seekers (Centraal Orgaan Opvang Asielzoekers - COA), an independent administrative organ of the Ministry of Justice which is responsible for the reception of the asylum seekers, also play a role in preparing asylum seekers for return.

When an asylum seeker receives a (final) negative decision on his asylum request s/he is notified by the IND and COA to leave the central reception within 28 days after which housing, financial subsistence and medical insurance will be stopped. If the person in question

\textsuperscript{124} The demissionary government has sent a proposal to parliament to change the three years into five.

\textsuperscript{125} The motives might be a permit as a Convention refugee, for humanitarian or medical reasons or for family reunification.
has not left the central reception, s/he is removed by force. In 2002 quite a number of rejected people, including families with children were removed from the central reception. Initiatives were taken by municipalities, churches and other private organisation to provide those people with shelter. Among those are people who are – often in vain – awaiting a laisser-passez from the authorities of their country of origin or who have applied for asylum for the 2\textsuperscript{nd} time. They stay legally in the country, but do not have a right to governmental facilities.

**Numbers and nationalities**

The numbers of asylum requests in the Netherlands since 1994 are as follows\textsuperscript{126}:

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</thead>
<tbody>
<tr>
<td>Asylum requests</td>
<td>52,570</td>
<td>29,258</td>
<td>22,870</td>
<td>34,476</td>
<td>45,217</td>
<td>39,29</td>
<td>41,306</td>
<td>32,579</td>
<td>18,667</td>
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</tbody>
</table>

The majority of applicants are men and between 20 and 45 years old.

The numbers of unaccompanied or separated minors rose both absolutely and proportionally:

<table>
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<tr>
<th>Year</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of UAM’s</td>
<td>2,660</td>
<td>3,504</td>
<td>5,547</td>
<td>6,681</td>
<td>5,951</td>
<td>3,232</td>
</tr>
<tr>
<td>Percentage of total influx</td>
<td>8 %</td>
<td>8 %</td>
<td>14 %</td>
<td>15 %</td>
<td>18 %</td>
<td>17 %</td>
</tr>
</tbody>
</table>

An increasing number of UAM’s arrive as a so-called ‘child family’. Child families are single teenage mothers with their child(ren), and minors accompanied by their younger siblings, nephews and nieces or other younger children they are taking care of.

If the IND doubts the given age of an UAM and the UAM cannot show valid documents indicating his / her age, the age is determined with an X-ray test\textsuperscript{127}.

In the period 2000 – 2002, most asylum seekers originated from Afghanistan, the Federal Republic of Yugoslavia, Iraq, Turkey, Angola, Iran, Sierra Leone, Somalia and Guinea. Almost half of those coming from Angola were UAM’s. In addition, during 2000 – 2002 most UAM’s came from China, Guinea, Sierra Leone, Somalia and Afghanistan.

**Policy on unaccompanied minors (UAM’s)**

In 2001, because of the increasing number of UAM’s seeking asylum in the Netherlands, the government decided upon a policy of deterrence. The main principles of the new policy regarding UAM’s are\textsuperscript{128}:

\textsuperscript{126} According to various publications of the Ministry of Justice and the Immigration and Naturalisation Service
\textsuperscript{127} Excluding the number of people from Kosovo who received temporary protection in the Netherlands
\textsuperscript{128} Since the introduction of the age determination the methodology in use has been questioned several times. In December 2002 the Ombudsman stated that the IND can only conclude that the asylum seeker is older than 20 years when the clavicle is closed. After that the court in Arnhem has asked experts to advice about the reliability of the investigation method the IND uses.
\textsuperscript{129} Letter from Staatssecretaris van Justitie to Tweede Kamer, vergaderjaar 2000-2001, 27 062, nr 14
Children younger than 12 years of age will now be interviewed by IND personnel, specially trained for that purpose.

On the asylum request of a minor a decision has to be taken as soon as possible.

In the first period (6 – 9 months) all UAM’s older than 14 years are housed in the so-called return model (‘terugkeer variant’), until a decision is made about their asylum request. When they are granted for asylum they are housed elsewhere. UAM's younger than 15 years are housed under the responsibility of Nidos (the organisation for guardianship).

If a minor is not being considered for a residence permit on grounds of asylum, the repatriation possibilities will be investigated at the earliest stage.

Those who do not have a right on asylum have to return to their country of origin. This rule will be applied to UAM’s without a residence permit, to UAM’s who are fabricating evidence\(^{130}\) and to UAM’s who have a temporary permit to stay.

If return is not directly possible initially the UAM will receive a temporary permit. This permit is valid till the moment adequate reception in the country of origin is available or at maximum till the moment the UAM will be 18 years old.

If a child family consists of a mother becoming an adult and her child(ren), they will have to return as a unity. If the child family consists of child becoming an adult and his or her minor siblings, the eldest has to return with the younger ones.

UAM’s who are granted asylum will be housed in the so-called integration model.

All UAM’s older than fifteen are housed initially in the ‘return model’ in which the education is focused on return. This type of housing falls under the responsibility of the COA. Children younger than 15 are placed in foster families who have to prepare the children for return as well. The organisation Nidos is responsible for the guardianship of all UAM’s. Nidos is also responsible for the housing of UAM’s in the integration model, focused on the integration of UAM’s in Dutch society.

In the fall of 2002 the COA started a pilot project of a campus model using the education methodology of Glen Mills. The campus is a living and learning in one institution (semi closed) with a strong focus on the return perspective. In short time many UAM’s left the campus because of the strict regime. It caused public and political debates about the humanity of this model. At the time of writing the model is reconsidered, but will be operational in 2003 until the evaluation.

**Reception and accommodation of asylum seekers**

**The reception centres**

As described in section c above, the number of asylum seekers housed in central reception facilities increased steadily in the 1990’s. The reception scheme was also linked to the asylum procedure. The reception scheme became the following (cf. Figure 1):

On arrival an asylum seeker has to apply for asylum in one of the four Application Centres (Aanmeldcentrum - AC) at the Dutch border (including the ‘Grenshospitium’ when arriving at the airport Schiphol). IND personnel will conduct the first interview in the AC. The asylum

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\(^{130}\) UAM’s who are fabricating evidence are those who are telling contradictory or fantastic (implausible) stories which frustrate the investigation of the possibilities for return.
seeker is asked for his identity, nationality and itinerary. On the basis of this so called first interview the IND reviews whether the request can be dealt with quickly or not. If so, the asylum request will be dealt with within 48 hours or a maximum of five working days. This is called the accelerated procedure. All steps in the asylum procedure (the extensive interview, the intentional procedure and the decision) are worked through quickly. There is little room left for thorough investigation. The asylum seeker is legally assisted and has the right to an interpreter during the interviews. If an asylum request is rejected within the accelerated procedure an appeal can be made in court, which will be dealt with within about two weeks. In the mean time the asylum seeker has no housing of other facilities.

When it appears impossible to make a decision in the short time of the AC the asylum seeker is referred to an Investigation Centre (Onderzoek Centrum - OC) where there is more time for the processing of a request for asylum. The further interview is the basis of the asylum procedure. During this interview, the asylum seeker explains to the civil servant of the IND why he has fled. Based on this information, the IND will then take a decision regarding the request for asylum. If the IND is not convinced the story is genuine, it will apprise the asylum seeker of its intention to reject his application. The asylum seeker and his lawyer may respond to this with a 'point of view', in which they can add extra information. When this has been done, the IND will take a definitive decision.

After a limited period of stay in the OC's where the first phase of the asylum procedure is handled and the asylum seeker gets a medical check-up for tuberculosis, an asylum seeker goes to an AZC, an accommodation centre housing an average of 400 persons. If not, he will be housed in the AVO, which stands for additional reception, mostly housing less than 100 people. In addition, because of lack of places in the central reception, for some years an asylum seeker could be housed with relatives or friends. This possibility was stopped in 2001. Another form of small-scale reception are the Central Reception Houses (Centrale Opvang Woningen - COW’s). At the end of 2002 the government announced that the AVO’s and COW’s would be closed as well. The COA announced at the beginning of 2003 a major reduction of places in central reception facilities because of the decrease of number of people seeking asylum in the Netherlands. The OC’s will be turned into AZC’s, meaning that there will be no longer be a distinction between phases in central reception.

Since the Aliens Law 2000 came into force, priority has been given to the processing of new asylum requests. For that reason, in January 2003 there were still some 70,000 persons remaining in the central reception facilities, of whom 28,000 had been there longer than 3 years (Vluchtelingenwerk Nederland, 2003). It is calculated that this backlog will be removed by 2005.
Facilities and limitations

Since the mid-1990’s the independence and self-reliance of asylum seekers has been central to the policy of the central reception facilities. In most centres, asylum seekers can cook for themselves. They receive pocket money on their bank account for food, clothing and recreation (€ 39,- a week for an adult and € 7, - for a child: see Gastelaars et al., 2002, p. 38). In some cases and centres, extra money is given for travel to hospital or membership of a sport or other recreational club outside the centre. Within the centres, hardly any recreational facilities are left. Dutch language classes are given in the AZC’s, but only to those who have not received an initial negative decision on their asylum request. Asylum seekers are not supposed to work more than 12 weeks per years during their procedure. This mostly concerns agricultural work. They can also do odd jobs in the reception centre for € 0,45 – 0,50 per hour.

In the centres all nationalities live together. In some centres families can have their own housing unit; in others they have to share housing with others, including bathrooms and kitchens. Privacy, hygiene and safety for (single) women and children are often absent (see Inspectie Jeugdhulpverlening en Jeugdbescherming, Regio Noordoost, 2002).
Many conflicts within and between families and nationalities occur in the centres, sometimes resulting in injuries or even death (Koppenaal, Bos & Broer, 2003). In fact the situation in the centres gives rise to many tensions. In 2001 the Scientific Board for Government Policy (Wetenschappelijke Raad voor het Regeringsbeleid) concluded that the reception centres have an institutionalising effect: “they create dependency instead of making use of the skills of asylum seekers” (WRR, 2001, pp. 68-69). In addition Meurs and Broeders (2002, p. 9) write: “The system aims at leaving the asylum seekers in a sort of waiting room, outside of regular Dutch society”. In line with these observations in a study about the ‘high criminality among asylum seekers’ – a disputable allegation made by the mayor of Groningen in January 2001 - de Haan and Althoff concluded that the centres have almost all the characteristics of a total institution as described by Goffman (De Haan & Althoff, 2002, p. 15). These authors signal many sorts of deprivation:

- the predominately isolated location of the reception centres;
- the types of building in which asylum seekers mostly have to share space and facilities with others;
- the lack of meaningful activities, creating impotence, boredom and lack of perspective;
- the insecurity about the length of stay;
- the regime in the centre (breaking rules is for example is punished with a cut in pocket money or expulsion from the reception centre for a period of time);
- the climate – for instance bad hygiene - and composition of the population;
- and the interaction with staff, who have the task not only to assist the asylum seekers but also to prepare them for return.

The authors relate the ‘criminal’ behaviour of the asylum seekers who had committed an offence (usually shoplifting and fighting or other forms of aggression, mostly within the reception centre) to these factors of deprivation and the stress stemming from them.

**Education**

Asylum seekers in central and decentralised reception have access to all forms of education. Primary education facilities for refugee and asylum seeker children differ between cities. Some accommodation and asylum seeker centres have their own primary school, where full-time or part-time education is given. These schools offer newcomers intensive ‘Dutch as a second language’ education, after which (mostly one year) the children can move on to regular primary schools. Placement in these projects is compulsory in some cases, but it can also be optional. At other locations there are no such schools and the children are placed directly in regular schools.

Around 10,000 refugee children attend primary schools in the asylum seeker centres where they are placed, or in the neighbourhood. 80% of these children stay in this school for one to two years. Others that have to live in the reception centres for more years, stay longer.

As is the case in the United Kingdom, attending school in the Netherlands is compulsory for children up to the age of 16. Refugee youngsters are educated in special departments and classes for newcomers, so-called ‘international bridge classes’ (ISKs). These classes are meant for students from 12 to 16, who have not yet mastered the Dutch language and

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131 Part time education for newcomer children in the Netherlands usually means that they attend the special school in the morning and go to a regular school in the afternoon.
therefore cannot follow regular education. The bridge classes prepare them for regular Dutch secondary schools and vocational training and give them an intensive course in Dutch language. The youngsters receive full-time education from 6 months up to 3 years. The classes are completely different from regular schools in the Netherlands. They are small and contain students of different age groups and different levels. Because of the constant registration and moving up of students, the composition of these classes often changes (Tuk, 2000). Furthermore, these classes differ from regular classes in their climate, accommodation, staff and programme.

Young asylum seekers from 16 to 22 years old attend classes in the ROCs (Regional Education Centres). This is also the place where adult newcomers complete their integration trajectory.

1.2 Needs and problems of asylum seekers and refugees

A study by Hondius et al. (2000) among refugees and asylum seekers from Latin America and the Middle East, interviewed in the eighties, showed that having suffered torture in the country of origin and/or being an asylum seeker is a risk factor for presenting a Posttraumatic Stress Disorder (PTSD)132. In addition, asylum seekers present significantly more psychosocial problems than refugees with a residence permit. The interviewed refugees and asylum seekers related their physical complaints partly to the violence they suffered in their country of origin, but they also related both their physical and psychological problems to worries about family and friends left behind, developments in the country of origin, worries about the future and worries about the asylum procedure. These findings were confirmed by more recent, qualitative studies among groups of refugees, in which the interviewees also blamed the lengthy stay in the reception centres for asylum seekers and unemployment as cause of their a-specific medical problems (Logghe, 1998).

In a study of mortality among asylum seekers (Vera, 1998), this group showed a significantly higher mortality caused by unnatural deaths than the average Dutch population of the same age, and mostly among males: in the age 5 – 19 especially by drowning, in the age of 20 – 39 by murder, manslaughter and suicide (op. cit., p. 36).

Adult asylum seekers and refugees seek the promotion of their health in:

- a shorter, more transparent asylum procedure;
- more privacy and safety in the reception centres;
- employment;
- more social-cultural activities and possibilities for social gatherings;
- language classes and better information about the norms and values of Dutch society, including those of the Dutch health care;
- a better image of asylum seekers and refugees in society.

In a study (Hullegie& van Ravenzwaay, 1999) among children in a reception centre for asylum seekers, including some UAM’s, 77% of the children interviewed said they had 5 or more health problems. Most problems involved “worrying a lot”, “homesickness”, “physical complaints” and “feeling tired”. They could score their perceived health on the Cantrell scale,

132 NB: these interviews took place before the restrictive and deterrent measures in asylum policy were taken.
a scale from 0 – 10. Dutch children score an average of 8 on that scale. The asylum seekers children scored an average of 4,3. The reasons for their distress were:

- lack of a residence permit;
- lack of money and housing;
- the boring environment
- missing their family
- having too few activities.

A study by Bean (2000) among schoolchildren in The Hague showed that UAM’s present more PTSD than other refugee, migrant and non-migrated children, and refugee children more than non-migrated children. Significantly more UAM’s than the other interviewed children said to have thoughts about suicide. In a recent qualitative study among UAM’s they said they mostly suffered from headaches, stomach aches, eye problems, sleeplessness, colds and flu (Van Willigen, 2002). They related their colds and the flu to the wet, cold climate in our country and some related their stomach ache to unhealthy food. Most adolescent UAM’s related their health problems to their experiences in the country of origin, to the absence of their parents and relatives and to the lack of perspectives for the future.

Asylum seeker children express their need for receiving attention, respect, and being understood. They would like to have possibilities for sport and recreation, besides good food, good sleep, friendships and social support. They also would like to have information about the prevention of a variety of health problems (Van Willigen, 2003).

**Policy on integration**

During the 1990’s, integration courses were given in most municipalities to ‘newcomers’, who were mostly people arriving for marriage or reunification with established immigrants, as well as refugees with an A- or C-status. In 1996 this practice became government policy and in 1998 the Law on Integration of Newcomers (Wet Inburgering Nieuwkomers) came into force.

With the passing of this law, the courses became compulsory for all specified categories of newcomers including persons with an A- or C- status, and (since 2001) with a residence permit for a definite period on asylum grounds. The course aims at a certain level of self-reliance. Three forms of self-reliance are distinguished (see Odé & Brink, 2002):

- **social** – the newcomer should become able to function in society independently;
- **educational** – the newcomer should be able to follow further training;
- **professional** – the newcomer should be able to be find his or her way to the labour market.

To this end, 600 hours of classes on Dutch language and orientation on society and professions are given. The course finishes with a test to determine the level the newcomer has reached. Often follow-up training is given subsequently. During the course the newcomer is supervised, in case of refugees mostly by a worker of the local association of the Dutch Refugee Council.

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133 In fact by the study the MOA and COA realized that the pocket money for both UAM’s and adult asylum seekers had not been indexed for some years: it had become inadequate for buying healthy food.
In 2001, the effects of the integration course were evaluated and found to be poor. Among the refugees many start later than the prescribed 4 months after arriving in the municipality, or cannot be reached; they often ‘drop out’ for medical and psychological reasons, and mothers with young children often cannot follow the course because of lack of child care facilities. In addition, the content of the courses seems not to be geared to the level and demands of the individual newcomer. Only a few newcomers can be guided towards the labour market. Most have to continue following Dutch language classes.

Of course many reasons can be given for these results. For instance, as Meurs and Broeders write (op cit, p. 9): “When asylum seekers receive a status, the system turns 180° and the holder of a status is expected to start as quickly as possible with acculturation and integration.” The question arises of whether the course should not be combined with work. The unemployment of all newcomers is 4 times higher than that of the average Dutch population (Koopmans, 2002), which formed one of the reasons for developing the Law. Because the course starts only after the lengthy asylum procedure is completed, many of the refugees have lost touch with the developments in their profession. The majority of them are not able to find work in their original profession and on their own level, or even to find work at all.
Chapter Two: Mental Health and Social Care Provisions

2.0 Short sketch of the care system in the Netherlands

Health policy

Health policy in The Netherlands is aimed at ensuring that the population has access to necessary health care. The main policy goals of universal and equitable access to health insurance and good quality health care have translated into comprehensive health insurances and a wide range of health care services accessible to the entire population.

The Health Inspectorate is responsible for monitoring the quality of health services and health protection measures. In 1997, it published an extensive report on the quality of health care in The Netherlands. One of the main conclusions of the report is that, compared to other countries, the quality and efficiency of Dutch health care is good (Ministry of Health, Welfare and Sport, 1997).

A resident of the Netherlands has traditionally been insured from the cradle to the grave under the generous, but costly, socialised welfare state. Private health care plays a minimal role in the Dutch system. Private companies, however, play an important role and the state is keen to use market forces to increase efficiency and reduce costs, without compromising the basic tenets of equal access to (affordable) health care for all citizens.

Important trends are emerging to affect the nature of the Dutch health care system:

- increasing demand for medical services;
- growing pressure to contain associated costs;
- an ageing population;
- shifts from institutional towards out-patient care;
- a move from curative towards preventative care;
- the ongoing emergence of new technologies.

The Dutch Central Bureau of Statistics (CBS) forecasts that by 2020, one third of the population will be over 50 years of age. This ‘greying’ of the population will result in an increase in chronic and degenerative diseases and disorders with a corresponding increase in the demand for appropriate health care services.

The Netherlands has developed a mixed health care system, which combines social and private elements. The system traditionally has three types of insurance, four layers and comprises two sectors.

Three types of insurance:

Statutory general health insurance for long-term diseases (AWBZ)

The Exceptional Medical Expenses Act (AWBZ) which came into force in 1994, was created in order to ensure that all the inhabitants of the Netherlands have insurance cover against serious medical risks. This refers to risks which cannot be covered on an individual basis, since, in many cases, it is a question of a chronic condition. In brief, it refers to areas such as
nursing homes, care for the handicapped, home care, and care for the mentally ill. The AWBZ provides insurance for every Dutch citizen against exceptional medical expenses with regard to long-term diseases. AWBZ insurance is obligatory and premiums are income-related, up to a fixed maximum basis of assessment. Premiums are paid by the employer on behalf of employees. Self-employed persons pay the premium themselves, and retired persons are exempt from payment. The original goal of the AWBZ was to finance care for patients with serious and long term illnesses. The scope of the law has been extended to cover other costs to the extent that the care covered by the AWBZ does not have sufficient financing. The provisions of the AWBZ Act are implemented by health insurance funds as well as public and private insurers.

Statutory health insurance for acute diseases (ZFW): The Social Health Insurance Act (ZFW).

This insurance covers expenses with regard to acute diseases, and is obligatory up to a certain income level. Approximately 63 percent of the Dutch population is insured via the statutory health insurance fund. The insurance covers basic medical care, such as general practitioners and medical specialists, hospital care, medicines, physiotherapy and dental treatment for children. Premiums are income-related and paid by both employers and employees. In addition, employees pay a fixed rate related to household size. Retired persons pay reduced premiums. The Government and the private insurance funds also contribute to the ZFW. Private insurers contribute to the ZFW to compensate for the disproportionately high number of retired persons in the ZFW. The provisions of the ZFW are implemented by health insurance funds. Contribution rates for the AWBZ and ZFW are fixed annually by the Government.

Private health insurance

Persons whose earnings exceed the income level for obligatory insurance with the ZFW may take out a private health insurance policy, though insurance is not obligatory for this income group. Approximately 33 percent of the population is insured through a private health insurance fund. Civil servants (5 percent of the population) are insured via a special fund. These insurance providers determine, together with the government, which medical treatment is reimbursable.

Four layers:

As health professionals and organisations integrate their services and change their organisational and contractual relations, it has become difficult to provide an exact overview of the four layers. The traditional layers are listed below.

Zero-line health care

Zero-line health care consists of collective disease prevention, including immunisation, school health care, mother and child care and health education. This sort of care is provided by the local GGDs (public health services of the local authorities).
Primary health care

Primary care in the Netherlands has traditionally included the services provided by general practitioners, dentists, physiotherapists and other therapists, ambulatory mental care, home nursing, home care as well as related medical and social services. Primary care in the Netherlands embraces a rather wider concept than in many other European countries, including as it does both an ambulatory mental health care sector and also the so-called Cross or Home Care Organisations. These organisations provide services covering aspects of both nursing and welfare.

In the system of public medical insurance (ziekenfonds), a patient must first consult a general practitioner before going to a specialist, except in special circumstances. Almost all private insurance companies also demand a formal referral by the general practitioner to the medical specialist. The general practitioner therefore determines access to other parts of the health care system and is the point of referral. Users are free to choose their own general practitioner, subject only to distance and the willingness of the doctor chosen to offer a full range of medical services. For users covered by the public medical insurance agency (ziekenfonds), the general practitioner must be recognised by the agency.

Second-line health care

Second line health care comprises acute hospital care.

Long-term care

Psychiatric hospitals, convalescent centres and nursing homes.

Two sectors:

Intramural

Including acute hospital care, care for the mentally ill, care for the disabled, and residential and nursing homes.

Extramural

Including specialist practices, general practices, dental institutions and practices, midwifery and paramedical practices, supply of medicines, and public health institutions.

Mental health care in the Netherlands134

Mental health care has expanded rapidly over the last decades. Some recent studies estimate that every year, over 500,000 residents seek support from mental health professionals and institutions (Ministry of Health, Welfare and Sport, 2001). Apart from these providers, other

134 This information was taken from the official web page of the Trimbos Institute
health care and social care professionals and voluntary organisations provide support, including general practitioners, nurses and social workers. Government policies have encouraged a rapid process of integration of ambulatory and institutional care on the regional level. The key principles are the provision of flexible, integrated, patient-friendly and effective care, with an emphasis on ambulatory rather than institutionalised treatment of mental disorders (Ministry of Health, Welfare and Sport, 2001).

Mental health care in the Netherlands in its present form dates back to the seventies and eighties, when it was set up as a separate sector. At the time the view prevailed that it had to be accessible to everybody. There were already in-patient facilities such as psychiatric hospitals, but in 1983 the Regional Institutes for Out-patient Mental Health Care (RIAGGs) were founded and in the late eighties facilities for sheltered accommodation and part-time treatment were added. The aim was to evenly spread the options all over the country.

The organisation of mental health care was shaped according to the principle of echelons. The Regional Institute for Out-Patient Mental Health Care constituted the first echelon. The second consisted of semi-residential care – sheltered accommodation and part-time treatment -, and the third of in-patient treatment and care. The aim was and still is to limit the number of long-term hospital admissions, shorten their duration and promote social reintegration.

In recent years the distinction between these layers is disappearing. Mental health care institutions are rapidly merging, thus transforming themselves into local and regional agencies providing a wide range of facilities. Help is increasingly organised in circuits and programmes for various target groups and extending to facilities outside the mental specialisation such as general health care, informal care and legal institutions.

As mental health care is rapidly changing, it is hard to present a clear picture of the new situation in the Netherlands. Therefore, the traditional distinctions between out-patient, semi-residential and in-patient care are maintained in this report.

**Out-patient care**

Out-patient mental health care in the Netherlands includes psychiatrists and psychotherapists with their own practices, Regional Institutes for Out-patient Mental Health Care (RIAGGs), the out-patient clinics at hospitals and out-patient addiction care centres.

Independent psychiatrists and psychotherapists mainly treat adults, while RIAGGs help both young people and adults, including the elderly, by providing treatment, guidance, prevention and advice and a 24-hour crisis service.

At the out-patient clinics, of which some are specialised, the emphasis is on guidance and treatment. Addiction care has also undergone enormous changes. A number of the former Consultation Bureau for Alcohol and Drugs have merged into larger institutions.

Together, all the facilities for out-patient care cater to 450,000 new patients every year (Trimbos, 2002).
**Semi-residential care**

Semi-residential facilities house people for whom out-patient care is not appropriate but who do not or no longer qualify for in-patient admission. They include sheltered accommodation places, psychiatric part-time treatment centres, day activity centres and medical day nurseries.

People who can manage reasonably enough but still need support and guidance in everyday life are housed in sheltered accommodation, which register 1,300 new clients a year.

Child and adolescent psychiatry, addiction care and forensic psychiatry all provide part-time treatment. Medical day nurseries offer part-time treatment for children in the age of 2 to 7 and their parents. There are an annual 17,000 new registrations for part-time treatment.

Day activity centres are run for people with a long psychiatric past. The centres give these people an opportunity to socialise with each other, organise useful day activities and can provide relevant opportunities for clients who are ready for regular work.

**In-patient care**

In-patient care is provided at a wide range of institutions and facilities. In addition to the psychiatric hospitals, there are fourteen independent institutions for child and adolescent psychiatry and seven departments for child and adolescent psychiatry, thus amounting to twenty-one specialised clinics. Some fourteen addiction care facilities provide in-patient as well as outpatient care. Around seven psychiatric hospitals have special departments for addiction care.

The number of admissions to in-patient mental health care institutions exceeds an annual 90,000 (Trimbos, 2002).

**Child and youth care**

Child and youth care is divided into three categories. First, the clinics for child and adolescent psychiatry and the youth departments of the RIAGGs. Second, the Child Protection Agencies (councils for child protection, guardianship agencies). Third, the child care system (youth counselling centres, residential homes, etc.). Efforts are being made to reverse the fragmentation of these three types of services.

**Care circuits and programmes**

Institutions sometimes work together in care circuits to target specific groups. Care circuits have been developed for children and adolescents, adults, the elderly, et cetera. The circuits consist of care programmes where the care for people with a specific disorder like depression, anxiety or schizophrenia is integrated. The aim of this approach is to provide evidence-based tailor-made care that encompasses all the echelons and is specified in guidelines and protocols. Recently, the five professional associations for psychiatrists, psychotherapists, clinical psychologists, general practitioners and social-psychiatric nurses have installed a joint committee to look at common protocol development.
Financing the mental health care sector

Since 1989, mental health care has been financed via the Exceptional Medical Expenses Act (AWBZ) except for outpatient addiction care, which is mainly paid for via the Welfare Act. After one year, the Exceptional Medical Expenses Act requires a contribution from the patient for in-patient treatment, sheltered accommodation and psychotherapy.

Changing health care: boundary erosion

In the 1990s, encouraged by changing market conditions, government policies and modern management models, providers of primary care sought collaborations and forms of horizontal and vertical integration with secondary and tertiary care. They extended their activities far beyond their traditional borders (Okma, 1997). Institutions and organisations for ambulatory care agreed to cooperate in providing consumer-oriented and efficient services. Hospitals, nursing homes and home care organisations created formal and informal alliances and regional networks. This also blurred the traditional borderlines between the different sub-sectors or ‘echelons’ in health care and related social services. As a consequence, traditional definitions of health care services no longer easily apply. For example, ‘primary care’ in the Netherlands traditionally included the services by general practitioners, dentists, physiotherapists and other therapists, ambulatory mental care, home nursing, home care and related medical and social services. But as health professionals and organisations integrate their services and change their organisational and contractual relations, it has become difficult to provide an exact overview of ‘primary’ or ‘secondary’ care. Instead the Regeerakkoord 1998 introduced three funding segments or ‘compartments’ of health care and funding (see Ministerie van WVS, 2001).

In this report, however, the traditional classification is used as much as possible.

Care for the elderly

Care for the elderly includes home care, related social services and care provided by nursing homes and retirement homes. Developments in the care for the elderly are similar to those in other sectors: the borderlines between traditional categories of services have faded and the emphasis has shifted from special care for special categories of patients to integrated care providing a wider range of services to a wider range of users (Ministry of Health, Welfare and Sport, 2001).
2.1 Multicultural care provisions in the Netherlands

In 2000, the Council for Public Health and Care published an advisory report on multicultural health care in the Netherlands. For this report, a study had been carried out on the adequacy of care provisions for ethnic and cultural minorities. The Council concluded that the process of ‘interculturalising’ Dutch health care has so far taken place too much on a temporary, noncommittal base. According to the report, a more effective and coherent policy is needed to structurally, integrally and permanently deal with deficiencies in care provision for migrants, including education of professionals.

The Council’s advice states that the role of the general practitioner/family doctor is of great importance, as migrants more often visit their GP than autochthonous Dutch people. The GP could function as a gatekeeper, who guides them further into/through the health care system. However, there are indications that this gatekeeper role has not yet lived up to its promise.

Although allochthonous clients do visit their GP more often, they do not receive health education as much as autochthonous clients. Also, their consults last shorter, which contradicts the remarks of the doctors who say that allochtonous clients take more time (Van Wieringen et al., 1999). Finally, allochtonous clients also receive more pharmacological treatment than autochthonous clients.

After more than twenty five years of investigating the problems that exist in health care for migrants, recent studies still encounter the same difficulties. Migrants complain about language problems, lack of information and claim that professionals do not take their complaints seriously. Professionals say that they have the following problems: expressive complaining behaviour, simulation, presenting of vague complaints, a taboo on psycho-social problems, difficult consultations with women, resistance to certain examinations, medical ‘shopping’, incorrect use of medication (van Dijk & van Dongen, 2000).

2.2 Services for asylum seekers and refugees

To what sorts of care are asylum seekers and refugees entitled?

a. The situation before 2000

When, at the beginning of the seventies, the first groups of non-European refugees arrived in the Netherlands, the Dutch government assumed that regular health care was equipped to provide health care to this new target group. However at the end of the seventies, it was recognized that the refugees presented specific health problems, related to their backgrounds of violence, deprivation, uprooting and acculturation, for which they could not find adequate help. Based on the experiences with the victims of Second World War and hijackings in the Netherlands in the seventies, some specific health care provisions for refugees were created. Others were to follow.

In 1978 the Social Psychiatric Service for Latin American refugees was founded, which later also started to offer psychosocial, psychological and psychiatric care to refugees of other nationalities. In 1979 the Refugee Health Care Centre was established as part of the Ministry of Health with the following tasks: to offer a first medical reception to invited...
refugees, and since 1987 also to asylum seekers; to give assistance and counselling to refugees already settled in the Netherlands and to serve as a bridge to regular health care by giving advice, consultation, courses and training.

The medical teams of the former Refugee Health Care Centre offering medical reception to invited refugees and later to asylum seekers as well consisted of medical doctors and nurses, supported by administrative staff, working in all the reception centres for invited refugees and asylum seekers. Their task was to take preventive measures against tropical and other infectious diseases and they were responsible for the timely identification of the consequences of violence, forced migration and uprooting, as well as other health problems. Nurses at the centres offered health education both individually and in group sessions as well as information about the health care provisions and structure. If necessary the doctors carried out crisis intervention and they offered short-term care to refugees and asylum seekers whose medical problems were related to the traumatic experiences in their native country, forced migration and uprooting and the often traumatic asylum procedure in the host country. Child health care was provided by the medical team in cooperation with the regular local child health care service, or exclusively by the latter. Screening for tuberculosis is compulsory, while general screening is voluntary.

The aim of the medical reception was (and is) to increase the accessibility of regular health care for the target group by functioning as a bridge to the regular health care institutions and by informing the GP and other primary health care workers in the municipality, in which the refugee is housed, of his health problems and their social and violence-related background, and giving them advice about further support and assistance.

At the beginning of the 1990s, the Inspection for Health Care reported a number of bottlenecks in the medical care for asylum seekers. Doctors and nurses who worked in the accommodation centres were isolated from the other ‘regular’ care. The quality of care was difficult to guard and monitor. Therefore, embedding this medical care into the regular care system seemed to be of great importance. However, when the Refugee Health Care Centre became independent in 1992 – 1993 (see Pharos), the Medical Reception became part of the organisation (the department of Welfare of the former Ministry of Welfare, Health and Cultural Affairs, responsible for the reception of respectively quota refugees and asylum seekers). The need for medical reception had increased due to the growing number of asylum seekers in the Netherlands. In 1993, the Dutch parliament passed a law which made the COA an independent body with one main task: the reception and housing of asylum seekers. Other tasks were supposed to be taken over by external services like the regular care providers. The act specifically referred to GPs for curative care and to GGDs for preventive care (van Schijndel).

That same year, however, the Inspection for Health Care concluded that the quality of medical care in the accommodation centres was lacking. Medical responsibilities were unclear and the expertise of the care givers was lacking (van Schijndel). Also, cooperation with regular care providers did hardly take place: only few arrangements were made, the MOA had more tasks than previously agreed and the care for asylum seekers differed between the centres (van Duijn, 1999). The centres were too much self-oriented and had been isolated from the regular care providers. Central organisation became more and more difficult.
In 2000, GGD Nederland, the COA and the Ministries of Justice and Public Health agreed that asylum seekers must receive medical care from regular (mental) health care institutions, instead of being treated in the reception centres. The benefits of this new health care for asylum seekers would be numerous: they would be given more responsibility over their own medical care (which is believed to be beneficial), and the medical reception in the centres could give more attention to prevention and education.

b. The ‘covenant’ between health insurers and service providers

To cater for the mental health care aspects of this new approach, GGZ Nederland (the umbrella organisation of mental health service providers in the Netherlands) drew up a covenant with VGZ (the health insurance company which covers asylum seekers). According to this agreement both parties committed themselves to providing nation-wide, comprehensive and accessible mental health care for asylum seekers.

To implement this agreement the notion of a ‘care pyramid’ has been introduced, consisting of basic, (supra)regional and national care. The first level of basic care has to be available via every mental health care institution. The second level, (supra)regional care, is based on (supra)regional co-operation (within acceptable distance). Finally, specialist mental health care is offered on a national level. The operationalisation of this ‘pyramid’ concept may differ per region.

16 mental health cooperatives were formed, each one having its own care coordinator. In this way, the size and specific problems of the target group are taken into account, experts can be utilised more efficiently and the care on offer can be adapted to the needs of users. In practice, the most important partners of mental health care are primary health care and social services, plus the GGD/MOA’s.

Criteria for quality have been made up for the care for asylum seekers, on the basis of which member institutions of GGZ Nederland are certified. The certification functions as a guarantee for good quality mental health care for this target group.

c. The situation from 1/1/2000: embedding medical care for asylum seekers within the regular health care system

As a result of the new system, health for asylum seekers has undergone drastic changes. For example, in contrast to the old situation, curative and preventive care are now quite strictly separated. In the past, workers of the MOA were charged with somatic as well as psychiatric and youth care. According to van Duijn (1999) this was the result of the unwillingness of GPs and other care institutions. Nowadays, the MOA teams, under the responsibility of the GGD, work in several centres at the same time. The teams are now differentiated: youth care nurses, social nurses, health education nurses and others work in one team. Furthermore, preventive care is now given by the MOA foundations in the centres, while all curative care has been taken over by regular care institutions like GPs and(ambulatory) mental health care institutions. Directors of centres can also contract local Social Work service providers. Since the medical reception has primarily been focussed on preventive tasks, regular care providers have seen a growing influx of asylum seekers.
The MOA foundations

The medical teams of the MOA foundations usually consist of public health doctors, social nurses (as mentioned above) and administrative workers. The nurses offer an walk-in consultancy in which they try to settle most of the complaints by giving health education or a self-help remedy. If found necessary, referrals are made to regular institutions. The following preventive tasks take place in all the centres: health screening, pregnancy care, referral to regular care, combating of health threatening factors, and health education. In the larger accommodation centres extra attention is given to education and information, for example about the Dutch health care system, birth control, STD and AIDS, and oral hygiene. According to Somers (19??), the smaller centres do not have enough personnel to give this extra attention.

In the screening and reception centres (OC’s) where asylum seekers arrive, the tasks of the MOA are somewhat different. Here, the focus is on the screening of health problems. Only urgent medical problems are dealt with; all other (somatic and/or psychological) problems must wait until the asylum seeker is placed in a more permanent accommodation centre.

Asylum seekers with a status (‘refugees’) must find housing outside the accommodation centre. From now on, they also have to look for a GP. The municipality or the Refugee Council often assist in the settlement of these new status holders. Refugees with status now receive an allowance and are insured by the public medical insurance scheme (AWBZ).

Developments in mental health care following the covenant

Recently an evaluative study has been conducted on the mental health care for asylum seekers since the covenant in 1999. The most important findings were the following (Stants e.a., 2002):

- Nowadays mental health care for asylum seekers conforms for the most part to the covenant of 1999: basic care is accessible via every mental health institution, the organisational structure is functioning, 16 mental health cooperatives were formed and care coordinators were assigned, care networks have been set up and activities to further expertise have taken place.
- However, on the regional level in the care pyramid there are some gaps: psychotherapy, part time treatment and day activities are not yet fully accessible or adapted for asylum seekers.
- User orientation and professionalism are key aspects in improving mental health care for asylum seekers.
- Co-operation and coordination with intern and extern partners have to improve, especially with Addiction and Youth Care.
- The accessibility of mental health care still remains the most important aspect to work on. Waiting lists have to be prevented, professionals have to be taught to work with interpreters, education has to be given to the target group and good co-operation with the MOA is of great importance.

Even though the covenant has initiated many positive developments, mental health care still does not match the needs of the target group sufficiently. Causes can be sought in the
lack of knowledge and insight in these needs. This knowledge is of crucial importance and has to be studied. Also, a specialised care package has to be developed, as well as specialised working methods.

The conclusion of the study is that mental health care still needs to undergo crucial changes to be accessible and provide user-led care for asylum seekers (Stants e.a., 2002).

Other relevant services:

VluchtelingenWerk Nederland: the Dutch Refugee Council

The Dutch Refugee Council is an independent, broadly-based organisation that represents the interests of refugees and asylum seekers from the moment they arrive in the Netherlands until their integration in Dutch society. The organisation was founded in 1979 by several societal organisations.

The work, carried out by about 9,000 volunteers coached by professionals in local groups, entails personal support and the protection of refugees’ interests during admission, reception and social participation, primarily in the Netherlands. Specific support, for example, is giving information about the asylum procedure, and offering help during the preparation of the interviews with the Immigration and Naturalisation Service (IND) of the Ministry of Justice. The council advocates a fair asylum procedure and works hard to ensure that refugees will be fully integrated in Dutch society.

Also, the refugee council has contacts with the authorities and holds national campaigns, for example to remove prejudices about this group.

The refugee council works in 94% of the municipalities and in all accommodation centres in the Netherlands. It is the only organisation that helps refugees during all stages of their stay. The national organisation receives structural subsidies from the Ministries of Justice, Public Health and Welfare & Sports. Also, financial support is given by the National Postcode Lottery and by its 15,000 members and 32,000 donors. The local groups of Vluchtelingenwerk are organised in regional independent departments that rely for the most part on their own financial sources. Funds for integration provided by the municipalities are an important source of income.

From official web page: www.vluchtelingenwerk.nl

The Red Cross

The Dutch Red Cross offers help in tracing lost family members. Also, the Red Cross has a special UAM department, organising preventive activities for unaccompanied minors.

Churches

The church plays an important role in the life of many asylum seekers and therefore cannot be overlooked in this report. Many churches offer help and support to this group, also organising activities and events for both adults and children.
Labour rehabilitation projects/programmes for refugees

There are several labour rehabilitation projects and employment offices for (traumatised) refugees, like Emplooi, a free employment office for refugees with over 80 advisors. 3300 refugees are signed up.

Accessibility of care provisions

The accessibility of the MOA depends on the size of the accommodation centres. While larger centres have constant MOA staff 7 days a week, in the smaller centres MOA workers are only present a few days a week (with weekly consultation times). As a consequence, referrals to medical care can only be obtained once a week. The rest of the week, urgent medical complaints can be reported to the MOA reporting room, which can only be reached by telephone via the reception office. At night, medical help is even more difficult to get, which does little for the sense of safety of the asylum seekers. In a recent study among inhabitants of 3 accommodation centres, Gastelaars et al. (2002) found that asylum seekers are not satisfied with the medical care, except for those who live in COW (central reception) houses scattered over the municipality. These asylum seekers do not need the intervention of the MOA to obtain medical care. However, this group is relatively small.

Requests for referral are screened by the MOA for their necessity, to unburden GPs as much as possible. In some centres, there is a daily or weekly limit to the number of patients who can be referred to the GP.

Another factor influencing the accessibility of medical care concerns the expectations of the asylum seekers of the medical care they receive. Asylum seekers are often unfamiliar with the Dutch health care system and have different expectations. As a consequence, they may feel they are not treated properly and sometimes even discriminated. The pain-killer pill (paracetamol) can be seen as a symbol in this matter. The starting point of Dutch health care is “confidence in the self-healing capacity of the human body” (Somers, 2002). Therefore, GP’s try not to refer too quickly, in order to prevent ‘somatic fixation’. In particular, to curb the development of resistant bacteria antibiotics are prescribed conservatively. In the asylum seeker centres paracetamol is routinely prescribed for a wide range of complaints - but asylum seekers who are used to getting antibiotics and other medicines for minor infections feel they are not taken seriously.

Problems in service provision for asylum seekers and refugees

Many asylum seekers only get in touch with two small parts of the Dutch health care system: the MOA and the general practitioner. Therefore, most complaints heard concern these two parts. However, little research has been done on the concrete experiences of asylum seekers with the medical reception.

According to van Dijk et al. (2000), health problems of asylum seekers must be seen in the context of their difficult life experiences. In general, asylum seekers distinguish three different causes of health problems: physical failing, consequences of their recent situation, and consequences of life before the flight. Most seen are health complaints resulting from the distress of living in an accommodation centre with no or little perspective on the future (van Dijk et al. 2000).
Three central themes can be discerned in the experiences of asylum seekers with the Dutch health care system. The first complaint of many asylum seekers is not being heard, or being heard too late. Referrals have to be asked for at the MOA and are sometimes turned down. People ask for medical examination or specific medication, which they do not get.

Another complaint is that they are often turned down or sent away by the general practitioner. Many asylum seekers expect to receive the same medical care for their somatic complaints as they did in their country of origin. However, due to the different, less somatic approach of Dutch health care, they may feel not taken seriously and fobbed off with a painkiller. Also, the ‘gatekeepers’ of the Dutch health care system seem to pose a problem for asylum seekers. When confronted with one, asylum seekers may feel they are being refused help. In many countries, a specialist can be contacted directly. Therefore, the MOA and GPs are experienced as obstacles to health care.

Finally, asylum seekers say that they feel they are sometimes treated badly, ignored and let down by health care professionals. In contrast, refugees with status do not experience this. They seem to have other problems. Most heard is the complaint of not being understood by the general practitioner (van Dijk et al., 2000). According to the latter authors, health care professionals lack knowledge and cultural competence to provide proper care for asylum seekers. Prejudices and discrimination do exist in Dutch health care: asylum seekers are often seen as time and help consuming patients with only small or non-medical problems.

Even more important for the quality of care for asylum seekers, is the idea many health care professionals have of the (cause of the) problems of this group. Non-somatic complaints are often believed to be reactions to the past and almost always result in trauma treatment. Sometimes the care professionals do acknowledge the role of the actual distressing life in the accommodation centre, but they do not feel it is in their power to change anything about that. In both cases, asylum seekers do not feel acknowledged in the seriousness of their difficult position in society.

To sum up: problems in service provision for asylum seekers have become evident, even though recent policy is aimed at ensuring good medical care for this group. Particular problems have arisen in the contact with general practitioners.
Chapter Three: Practices developed for Asylum Seekers and Refugees

As described in the Introductory chapter, we have collected information about four basic kinds of practices or innovations: organisational changes (11 interventions located), training and education (11), treatment (19) and preventive activities (27). We will now describe the activities found in each of these categories.

3. Organisational interventions

Coordination of policy, pooling of information

1. **Pharos: Knowledge Centre for Refugees and Health**
   
   www.pharos.nl
   
   Formerly known as the Pharos Foundation for Refugees and Health, this centre supports professionals in the health care field who work with refugees, by providing information and documentation, education, consultation and training programmes. The organisation has also developed prevention and health education programmes, books, an information and advice line, an information and documentation centre and a magazine (*Phaxx*). It is a WHO collaborating centre and a member of ECRE (European Council on Refugees and Exiles).

   Funded by the government, Pharos has the task of furthering improvement of the accessibility and quality of health care for refugees and asylum seekers. Nowadays the focus of the activities of Pharos lies on supporting regular health care services by providing consultation, training, courses, and any other activities which may improve knowledge and skills. In addition, Pharos develops preventive and health promoting activities. Research is initiated and documentation in this field collected.

2. **Mikado: Intercultural Mental Health Expertise Centre**
   
   www.mikado-ggz.nl
   
   Mikado is a recently established (2000) expertise centre that aims to support the development of intercultural mental health care in the Netherlands in the context of increasing diversity within the care system by means of transfer of knowledge, promotion of expertise and initiating research. As such, Mikado does not confine itself to refugees as a target group, but it does not exclude them either. In July 2002 the centre is financed by the Dutch Department of Health Care, Welfare and Sports and it has been fully operational since January 2003.

3. **TransAct: Expertise Centre for Sex Specific Care and Sexual Violence**
   
   www.transact.nl
   
   Following the trend in the Netherlands of pooling expertise, another expertise centre was set up in the 1980’s. TransAct is the Dutch centre for gender issues in health care and the prevention of sexual violence. It offers advice, courses and training, and information for counsellors, institutions and policy makers in this area. It is funded by a subsidy from central government.
Together with two Dutch organisations providing aid to refugees and victims of war (Pharos and ICODO), TransAct offers training and advice to service providers and assistance organisations in former Yugoslavia coping with the trauma produced by sexual violence. This work is organised in a foundation called Admira and is funded by the Dutch Ministry of Foreign Affairs. In the past TransAct has also set up the Tarquia Project for black, migrant and refugee women.

Recently a study was conducted by TransAct on service provisions within regular Dutch mental health care for asylum seekers and refugees with psychological problems resulting from sexual violence (Cense & Kuijer, 2002)

4. **SAMAH: The National Foundation for Unaccompanied Minors**
   [www.samah.nl](http://www.samah.nl)

Samah was set up in 1999 as an independent foundation under the auspices of Humanitas[^135]. It is the only organisation in the Netherlands that exclusively focuses on unaccompanied minors. Aims are:

- Advocacy on behalf of UAM’s
- National coordination of activities for UAM’s
- Project development

Samah organises activities for both professionals and unaccompanied minors. These activities are on the areas of mediation, advocacy, referral, education and organising & supporting relevant projects. Samah has pooled expertise in the field of unaccompanied minors and provides the public authorities with relevant information on the practical consequences of their policies. It also offers a helpdesk for both unaccompanied minors themselves and professionals. Furthermore, the foundation stimulates and coordinates local and national networks, makes inventories of projects for unaccompanied minors existing nation-wide, monitors and refers. Samah develops and initiates methods and projects for unaccompanied minors and keeps in contact with collaborating agencies who may take over these projects. To promote and sustain the social participation of unaccompanied minors in the Netherlands, Samah has set up the UAM Council, as well as guest parent and buddy projects.

The foundation receives financial support from several funds and from the government.

**Attempts to provide holistic care by linking care givers**

5. **Local and Regional Care Networks (Zorgnetwerken)**

These networks were set up by Pharos, in collaboration with other agencies, during the 1990’s. A wide variety of care professionals who deal with the problems of refugees participate in these networks. The care networks aim to make service providers more sensitive to the complex problems of refugees, to exchange information, to make referral easier, to coordinate the care provided and to fully utilize each others’ expertise. Also,

[^135]: Humanitas is a national organisation aspiring to a society with full and equal participation of all its members. The organisation draws attention to problem areas in Dutch society and develops various activities in the broad area of welfare, health and social care, and housing.

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bottlenecks can be pointed out and efforts can be made to solve these by mutual consultation and coordination, discussion of cases and adapting policy.

6. **Platform for Mental Health Care and Asylum Seekers**

For mutual consultation and coordination a national platform was set up in which mental health care institutions and knowledge centres dealing with asylum seekers participate: Pharos, MIKADO, GGZ-Groningen, GGZ Drenthe, GGZ Den Bosch, Sinai, De Vonk, De Gelderse Roos and RIBW. The managers of these institutions participate in the Platform. Its objective is mainly mutual information exchange, coordinating institutional policies and commenting national policy on asylum seekers. The Platform meets six times a year.

**Other organisational innovations**

7. **Committee for Innovative Projects in Mental Health Care**

In the course of integrating health care for asylum seekers into the regular care system (see Chapter 2), the health insurers set up a ‘Committee for Innovative Projects in Mental Health Care’. This committee assesses proposals for innovative preventive and curative projects undertaken by the mental health care institutions using ZRA funds. To date, ten projects have been approved by the committee and financed by the ZRA.

8. **Ethical/moral committee of the Riaggs**

The ethical committee of the Riagg Midden-Gelderland (Community Mental Health Centre) was set up to discuss how to deal with ethical issues such as the treatment of illegal immigrants. However, not many cases have been treated (only 6 or 7 in the same number of years). The practical relevance and effect are unclear and the committee is to all intents and purposes dormant.

9. **Hotline for extreme cases (GGZ Nederland)**

GGZ Nederland, the umbrella organisation of mental health institutions in the Netherlands, has set up a hotline for reporting acute situations resulting in extreme hardship, which arise as a result of the tightened policy for asylum seekers (for example, suicidal behaviour of rejected asylum seekers). However, lack of financial support has impeded the success of the plan to fail so far. New possibilities are being investigated.

10. **Intervision Group on Migrants (Utrecht)**

This group is unique in The Netherlands. In it, representatives of various professional organisations dealing with migrants and refugees meet each month to discuss specific issues. The group was set up in the 1970’s by the Dutch Centre for Foreigners (NCB). The goal is to keep each other informed about local developments, to improve care and expertise and to provide help as quickly as possible (Van Rooijen, 2000).
Among the organisations participating are the local ambulatory mental health service, local authority health service (GGD), social work department, the Refugee Council, the municipal social Service, and child protection service.

11. Consultation projects

The nationwide consultation projects provide individual and group consultation for GP’s and mental health workers who have questions about working with the target group. Pharos has set up a research project on these projects.

3.1 Training and education

Centres and organisations providing training and education

1. **Pharos**
   www.pharos.nl

The Pharos knowledge centre (see above) provides training for professionals in the field of refugees and health care. Pharos has developed training material (education and training manuals), so that others can give training as well. For care providers, teachers and others who work with refugees and asylum seekers, Pharos offers an information and advice line, which is open 4 days a week. The staff have knowledge and experience in the field of refugees and health.

2. **ICODO: Information and Coordination body for Service to Victims of War**
   www.icodo.nl

ICODO is an advice centre for both victims of war and professional workers. It was set up in 1980 for victims of World War II. However, since 2001 the organisation has broadened its target group to include war victims in general, including refugees. ICODO offers training (diagnostics, treatment and personal integration); a multidisciplinary study group on psychotrauma; information; consultation; and referral. It has close links with Centrum ‘45/De Vonk, a specialised clinic for victims of war.

3. **TransAct: expertise centre for sex specific care and sexual violence**
   www.transact.nl

TransAct offers training and information for professionals who are involved in combating sexual violence and improving sex-specific care (see next section).

4. **Centrum ’45 Foundation: National Centre for the Treatment of Victims of War**
   www.centrum45.nl

Centrum ’45 is primarily a treatment facility for victims of war. In 1995 the unit ‘De Vonk’ was set up especially for the treatment of traumatised refugees. However, it also functions as an expertise centre on mental health care for survivors of organized violence. Education and training is offered to professionals working in mental health care for
refugees. The focus is on post-traumatic stress disorder (PTSD). Centrum ’45 cooperates closely in this respect with Pharos and ICODO.

5. **The Sirius Foundation: Training and Education for Creative Therapists working with Refugees**
   The Sirius Foundation aims to deepen and transfer knowledge about creative therapy for refugees and to mediate between supply and demand. It provides training, advice and support for creative and art therapists. The foundation is run by a group of 5 experienced creative therapists who work together with Pharos.

**Specific training and education programmes**

6. **Pharos Training modules**

Several modules are offered for mental health, social and youth workers:

For mental health workers:
- *Refugees and asylum seekers in mental health care*
- *The intercultural working/professional attitude*

For social workers:
- *Refugees and social work*

For youth workers:
- *Refugee youth aged 0 to 20*
- *Training Vitamin C*
- *Sex education for Unaccompanied Minors*
- *Training theatre play For example...love*

For MOA workers:
- *Introductory course*

7. **Trainings offered by the RINO (Regional Institute for Retraining and Education, the Dutch Institute for Psychologists (NIP) and mental health care institutions**

The RINO, NIP and some mental health care institutions (for example GGZ Drenthe) offer in-house training for staff members. Examples of training courses are:
- *Mental health care for asylum seekers and refugees*
- *Intercultural communication with refugees and asylum seekers*
- *Psychosocial stress and trauma with asylum seekers and refugees*
- *How to assess traumatized asylum seekers*
- *Trauma from war, violence, flight: backgrounds, diagnostics and treatment*

8. **European Masters Degree (Utrecht School of Governance)**

The Utrecht School of Governance offers, in collaboration with the Universities of Kent, Örebro (Sweden) and universities in Portugal and France, a two-year part-time course
entitled “Interculturalisation of service provision”. This interdisciplinary course is aimed at professionals, managers and policy makers working in the field of care for migrants and refugees.

9. Female Circumcision Project (EFSAN)

In the Female Circumcision Project of EFSAN, trainers are shown how to make the subject of female circumcision discussible.

10. TransAct Workshops

TransAct offers two workshops that are of use for professionals who offer sex specific care after sexual violence for migrants or refugees.

- Culture specific care after sexual violence
- Ethnicity and sex specific care

3.2 Treatment

Specialized centres

1. De Vonk, clinic of Centrum ’45
   www.centrum45.nl/vonk

In 1994 De Vonk, a special pavilion of Centrum ’45 (which provided clinical psychiatric care to victims of Second World War), was opened for traumatised refugees from the age of 16 in need of clinical psychiatric assistance. It offers both clinical, day-clinical and policlinic treatment. The clinic is trauma-oriented: focus is on dealing and coping with trauma. Methods used are conventional psychotherapeutic and psychiatric approaches, but also creative, psychomotor and mindfulness therapy (Centrum ’45, 1998; Van Emmerik & van den Heuvel, 1999).

Centrum ‘45/De Vonk offers special outpatient treatment methods for asylum seekers and refugee children and adolescents. It currently also functions as an expertise centre in the field of mental health care for survivors of organized violence. As a knowledge centre, it also offers training and supervision.

In October 2001 the team of ambulatory mental health care professionals of Pharos has been added to The Vonk. There is close collaboration with Pharos and ICODO.

2. Phoenix, part of De Gelderse Roos (regional mental health organisation)
   www.phoenix.nl

Phoenix, a pavilion of the psychiatric clinic in Wolfheze, which since 1982 provided clinical psychiatric care for Vietnamese refugees, broadened its target group by accepting all nationalities among the refugees in the beginning of the nineties. It offers accommodation and in-patient treatment to refugees and asylum seekers with more complex psychiatric problems who cannot be adequately helped by a regular psychiatric
hospital. Treatment is given by a multidisciplinary team and consists of three stages: observation and diagnostics, treatment, and resocialisation. Clients receive individual Dutch language lessons along with treatment (Kooyman, 2000).

3. **Sinaï Centrum**  
   [www.sinai.nl](http://www.sinai.nl)

The Sinaï Center was originally a Jewish general psychiatric hospital. However, its focus has shifted to research & therapy for all traumatized victims of war, i.e. refugees and asylum seekers. The focus is also on psychotrauma.

4. **GGZ Den Bosch: Day treatment for refugees and asylum seekers**

   GGZ Den Bosch is a regular mental health care institution in the city of Den Bosch. It offers outpatient treatment to refugees and asylum seekers with post traumatic stress disorder (PTSD). Aims are to learn to cope with and to restructure stressful/traumatic experiences, to repair or set up a daily structure and to orientate on or integrate into society. Several kinds of group therapy are offered, each of them for men and women separately, sometimes per nationality: creative and music therapy, swimming, psychomotor therapy and desensitisation. Examples are the structured psychotherapy group for men from Iraq, Iran or Afghanistan and the international trauma group for women. Also, when needed individual therapy and pharmacotherapy is offered (GGZ ‘s Hertogenbosch, no date).

5. **PTSD expertise centre of GGZ Groningen**

   The PTSD expertise centre at Winschoten (in Groningen, the northern part of the Netherlands) offers outpatient and day treatment to asylum seekers and refugees who have suffered from trauma. Forms of therapy used are both group and individual therapy, pharmacotherapy, psychomotor therapy and short-term trauma therapy (exposure, REM). Treatment focuses on stress and fear reduction; coping with the experiences of war and flight; culture-specific coping mechanisms; culture-specific reactions to sexual violence (see TransAct, 2002); the role of religion; the context of violence; and life in the accommodation centres.

6. **De Evenaar: day treatment for refugees of GGZ Drenthe**

   De Evenaar is part of GGZ Drenthe and offers a specialised day-clinic mental health care programme for refugees and asylum seekers.

7. **Bavo RNO group**

   From April/May 2003 the Bavo RNO group in Rotterdam starts with a specialised care programme for refugees and asylum seekers. This programme consists of a basic day-clinic programme for groups of men and groups of women; a policlinic for refugees and asylum seekers; and a consultation team for mental health care professionals. Day clinic services include group discussion, support of the Dutch language, psychomotor therapy and creative and art therapy.
Innovative methods and therapies

The following innovative methods and therapies are specially applied to refugees and trauma. They existed before, but are not usually found in mainstream practice.

8. **Body-oriented integrative group therapy**

Many therapies for refugees and asylum seekers include body oriented-methods and group therapy. The philosophy behind body-oriented therapy is that the focus on the body fits in better with the non-western explanatory models of many refugees. Approaching problems psychologically and talking about them individually in that sense is typically western. Therefore group therapy with less focus on talking and more focus on the body, has become a popular approach when it comes to giving treatment to traumatized refugees (Zwart, 2001).

9. **Creative and art therapy**

Creative therapy is becoming a popular therapy method with refugees and asylum seekers in the Netherlands, because of the non-verbal component. When language skills are lacking or emotions or memories are too intense or difficult to discuss, creative activities form a way to express them (Wertheim-Cahen, 1995). Creative therapy consists of such creative activities like drama, painting, drawing, etc. A special form of creative therapy is music therapy, offered by Phoenix (De Gelderse Roos) and other agencies.

Creative and art therapy is mostly offered by individual creative and art therapists at schools or as part of (mostly preventive) projects organised by mental health care institutions. GGZ Friesland, GGZ Groningen and GGZ Enschede currently run such projects. The Bavo RNO group also offers creative therapy as part of its care programme for refugees and asylum seekers, in day care and intramural settings.

10. **Eye Movement Desensitisation and Reprocessing (EMDR)**

EMDR is an emerging and popular method in the Netherlands, focused on trauma. It was specifically designed for clients who have experienced one intense trauma and keep living through this experience over and over again. This method is believed to be less damaging than regular therapies and gives quicker results.

11. **Mindfulness**

Another therapy used for refugees and asylum seekers, but not yet widely spread, is Mindfulness: a regular therapy with Buddhist influences.
12. **Little dolls in therapy**

This contextual, psychoanalytic approach to trauma is used in only a few settings. It involves working with little dolls, to visualize the unbearable. Dolls of all sizes, colors and ages are used to play situations in the past, present and future (Diekmann Schoemaker, 2001).

13. **The CFD: Cultural Interview**

The CFD is a structured interview which is used by mental health care professionals, set up along the lines of the Cultural Formulation of Diagnosis. Aim of this interview is to gather information about the cultural background of refugee patients. For more information see Borra et al. (2002).

14. **The UAM Booklet (AMA boekje)**

The UAM booklet is a project of the asylum team of the Riagg Rijnmond Zuid in Rotterdam. This little book contains information (preventive care) and writing space for the unaccompanied minor to write down personal notes about his or her experiences and contacts with Dutch (mental) health care. After referral the book can be used by the UM to inform future caregivers about his or her previously received care.

**Holistic services**

We use this term to refer to innovations in which an effort is made to coordinate different types of help, such as social work and therapy.

**Within asylum-seeker centres**

1. **PIT-projects (Preventive Intensive Home Care)**

PIT-projects, an outreaching part of mental health care, are not specifically designed for asylum seekers, but have been applied inside the accommodation centres. The PIT nurses prevent psychiatric hospitalisation by supporting asylum seekers intensively at home in the centre. Activities: promoting self support and medication intake, providing open office hours once a week, etc.

2. **The ‘Crailo Team’**

An outreaching part of mental health care, the Crailo Team is a multidisciplinary team that is working inside the accommodation at Crailo. It consists of social nurses, doctors, intensive psychiatric nurses and a psychomotor therapist. Benefits of this multidisciplinary team are believed to be: the high attendance of clients (99.9%), breaking down taboos, and the fact that the team is on location, seeing the problems and difficulties of this group with their own eyes. Also, more women are reached, a group that often does not leave the centre (Mensinga, 2000).
Another multidisciplinary team (a doctor, psychiatrist, social nurse and psychologists) can be found in the accommodation centre at Amersfoort.

**Projects for migrants which may benefit refugees**

3. **Intercultural Mobile Team (Parnassia Mental Health care, The Hague)**

Parnassia, the mental health care institution covering The Hague, provides intermediaries who are deployed by social nurses and general practitioners to give information about the Dutch mental health care system and to do house visits. The aim is to make mental health care more easily accessible for migrants.

4. **Project Nieuwe Sporen (New Tracks)**

Also in The Hague, a 2-year experiment was set up by the STIOM (Foundation for promotion of Health Care and Social Service) with 15 confidential advisors. These advisors are key figures in help for the migrant communities in The Hague and form bridges between their communities and regular Dutch mental health care. The project is based on the notion that these groups, because of other help-seeking behaviour, often do not reach mental health care (May, 1999).

5. **Quatro Project**

The Quatro Project is a cooperation between intermediaries and (social psychiatric) nurses with the aim of providing care support to migrants and refugees. It was first set up only for migrants as a supportive service, but is now also offered to refugees.

**3.4 Prevention**

In this section, we will categorise projects according to the different groups they are aimed at.

**For refugees in general**

1. **Self-help groups**

Self-help groups for migrants and refugees are widespread in the Netherlands. Pharos has developed a manual for setting up such groups.

2. **Project Healthy Thinking: psychosocial support (Gezond Denken), GGD, AMW & Pharos**
Signals from several reception centres have made clear that there is a need for non-problematising, non-therapeutic methods, which are preventive and have a group approach. A method was developed by the GGD (MOA) of Flevoland, the AMW and Pharos.

3. **Abri**

Abri is a residential service for asylum seekers from the age of 16 with problematic behaviour (e.g. aggression and self-neglect) of which the cause is not yet clear, but which causes too many problems to permit staying in the reception centre or at an independent housing location. The service offers counselling and housing guidance. Problems are mapped, skills are taught to handle these problems and a suitable housing advice is formulated. The service does not offer social-psychiatric help, but has a more preventive objective. If necessary, professional social-psychiatric help is offered by the local mental health centre.

This service is not for refugees with a residence permit.

4. **Annual festival of ‘Unlimited Encounters’ (Onbegrensde Ontmoetingen)**

Festivals are popular in the Netherlands, which is also true of the annual Festival of Unlimited Encounters, set up to promote a positive self-image and the integration of refugees. A wide range of festive activities is offered to refugees and Dutch visitors like music, dancing, art, food, sports, information, discussion and a youth programme.

5. **Stichting Canvas (Canvas Foundation)**

The Canvas Foundation aims to promote social integration of traumatized refugees. Activities are social, cultural and family days, sports activities and education. It is run by volunteers.

6. **The Worldwide Project (Project Wereldwijd), RIAGG Maastricht**

The Worldwide Project in Maastricht offers sheltered workplaces where asylum seekers can learn a skill, for example bicycle maintenance. This project was set up because asylum seekers asked for it. It is now a self-supporting project and receives financial support from churches.

**For refugee women**

7. **Self-help groups for women**

Self help groups have been set up for many groups, including refugee or asylum seeker women. Pharos has played a role in setting up self help groups for refugees, by offering support and producing a manual. An example of a self-help group for women is the one for Bosnian and Somali women with war experiences, set up by the Centre for Foreign
Women in Tilburg. The Centre also offers accessible activities like coffee hours, sewing, cycling and traffic lessons.

8. **Psycho-education for women**

Responding to the need for separate psycho education groups for men and women, some municipalities now offer special psycho-education for women. An example of a women’s group is that in Zeewolde and Dronten.

9. **Support groups for black, migrant and refugee women (7 womens organisations in Drenthe)**

The groups aim to make experiences of sexual violence and abuse discussable with women, so that they will be more able to find their way into (mental) health care. Information is provided, non-verbal and creative methods are used and experiences are exchanged by means of themes. The group also aims to provide warmth and has a social function. Women are trained to support other self-help groups.

9. **PRIME: monthly dinner for illegal women**

PRIME organizes a monthly dinner for women whose application for asylum has been rejected. During this meal the women are informed and mobilised for projects to improve their situation.

**For refugee men**

11. **Psycho-education for men**

As separate psycho-education groups were set up for women, men also became a specific target group. Several psycho-education groups for refugee men were set up as well. An example is the group for Iraqi men in the asylum seeker centre, in which the men learn how to cope with stressful situations.

**For refugee families**

12. **A course for parents: Dealing with adolescents in the refugee situation (Parnassia, The Hague)**

In Parnassia, the regional ambulatory mental health care provider in The Hague, a course is offered for refugee parents who need information and support in raising their teenagers and to exchange experiences and ideas with other parents.
For refugee children and youth

13. Pharos Prevention programmes for refugee children and youth

Pharos has developed many preventive methods for refugee and asylum seeker youth. The philosophy behind these methods is that refugee children exhibit normal reactions to abnormal circumstances. Therefore, the children are treated as ordinary children and the programmes are mostly carried out at school (De Ruuk, 2003).

For children in primary school, the following programmes have been developed:

- ‘Just show who you are!’ (Laat maar zien wie je bent!)  
  A non-verbal teaching method for strengthening the competence of refugee children in an early stage of reception.
- ‘F.C. The World’ (F.C. De Wereld)  
  A more verbal teaching method for strengthening the competence of refugee children in primary education.

For adolescents in secondary school, these programmes have been set up:

- ‘Welcome to school’ (Welkom op school)  
  A programme for newcomers in secondary education, for class use.
- ‘The Refugee Lesson’ (De vluchtelingenles)  
  A teaching method for groups of refugee adolescents in secondary education.
- ‘Vitamin C’ (Vitamine C).  
  A less verbal prevention method with creative methods, to improve well-being, trust, social and behavioral skills.
- ‘What are you doing tonight?’ (Wat doe je vanavond?)  
  Social support project, in which adolescents with a small social network are stimulated to take part in an activity outside the school.

14. Creative prevention projects: the National Foundation for the Propagation of Cheerfulness (Stichting BV)  
www.vrolijkheid.nl

The satirically-named ‘Stichting BV’ founded in 1999, initiates and promotes creative prevention projects for children and adolescents in accommodation centres throughout the Netherlands. Aims are to offer young people a chance to use their own capacity to work through their experiences with activities like music, theatre, arts and stories. The purpose is to strengthen self-esteem, self-respect, resilience and the ability to work together (Zuijdegeest, 2000).

BV organises pilot projects that are carried out by local organisations. The foundation works together with the accommodation centres, the Dutch Refugee Council, universities and welfare organisations in the region where the workshops are being held. A thorough evaluation of the activities of BV has been started in 2002, the results of which will be known in 2004.
15. **Theatre workshops: Beestenbende (‘Animal farm’)**

‘Animal farm’ organises 5-day educational theatre workshops for children and young people who need extra attention, e.g. refugee children. During the workshops, which are based on the natural elements and universal themes without the use of language, children from different cultural backgrounds rehearse a theatre play. Aspects are learning to cooperate in a safe environment, escaping from reality for a moment, mutual respect, promoting imagination, building self-confidence, etc. Since the founding of ‘Animal farm’ in 1995, over 8000 children in accommodation centres and schools have attended the workshops. The foundation also organizes ‘train-the-trainer workshops’ for (future) teachers, concerning the development of self-image, self-respect and identification in children. The project receives structural financial support from the Dutch Ministry of Education, Culture and Science.

16. **Buddy Projects for unaccompanied minors and young asylum seekers**

Nation-wide buddy projects have been set up for unaccompanied minors and young asylum seekers in the age range 18-26. The youngsters are matched with a Dutch (volunteer) peer, and encouraged to do voluntary work. Aims are enlarging the social network, learning new skills, and participating in Dutch society and the labour process, thereby breaking the negative spiral of boredom, low self-esteem, isolation and apathy. An example of a buddy project is Free Ned Work, set up by SAMAH, the unaccompanied minor organisation of Humanitas.

17. **Guest Parents Projects**

Another form of social support projects for unaccompanied minors and children in asylum seeker centres are the nation-wide host family projects. These projects provide host families or parents in the weekends.

Goals of these guest parents projects are:
- decreasing isolation of young asylum seekers
- enhancing the social network of friends
- assisting and improving conditions for the integration and participation in Dutch society

SAMAH (Humanitas) has played an important role in setting up local, regional and national host parent networks. The organisation developed a method so that others can start guest parent projects more easily.

18. **Social Support Projects for children**

In the social support projects for children, asylum-seeker or refugee children with a small social network are stimulated to take part in a wide range of leisure activities outside the school, similar to the Pharos programme ‘What are you doing tonight?’. Goal of these projects is to fill in spare time, to make contacts and to find one’s way into Dutch society. An example of these projects is the one in Arnhem, organised by mental health care service provider De Gelderse Roos (Huijbregts, 2001; Van den Boer, 2001).
19. **Prevention projects of Youth Care**

In Gouda, the local youth care service organises meetings for unaccompanied minors every two weeks to discuss certain themes of their recent situation, for example the procedure, education and integration, social contacts, friendship, relationships and sex, racism and discrimination. The service also organises training in domestic skills for unaccompanied minors who are not independent enough to live on their own.

The prevention group in Gouda is an example of the many projects that exist nationally for different groups: boys, mixed, primary school age, secondary school age, young adults, etc.

20. **Prevention project “Asylum seeker’s children in primary school with social-emotional problems”**

This is an ‘outreaching’ project set up by the Prevention Department of the mental health service provider Parnassia, together with the Haags Centrum voor Onderwijsbegeleiding (HCO). Primary school teachers are encouraged to identify children with social or emotional difficulties that may be related to their refugee background. In such cases, after seeking permission from the parents, the problems are further investigated and a series of counselling sessions with the child is organised, which may include visits to the child’s house. Where necessary, the child and/or the family will be helped to access other service providers.

21. **Peer education for Unaccompanied Minors**

A mental health care institution in Noord Holland has initiated a peer education programme for unaccompanied minors. In this programme UAM’s are trained to carry out education activities and psycho education for their peers in the accommodation centres.

22. **‘For example … love’: a sex education programme for refugee adolescents**

Pharos has developed a sex education programme for adolescent refugees and asylum seekers: *For Example… Love (Bijvoorbeeld De Liefde)*. In this programme forum theatre is used as an educational method.

23. **Helpdesk for unaccompanied minors**

SAMAH has set up a help desk (advice phone line) for unaccompanied minors who need someone to talk to or who need an answer to their questions. The line is open two days a week and has a call-back service to reduce the costs to a minimum. It is anonymous. Examples of questions that are being asked are:
- “I have problems with my social worker. With whom can I talk about that?”
- “I would like to do sports! How do I have to arrange this?”
- “Someone was calling me bad names because I am an asylum seeker. I was very sad and so I called you.”
24. National Unaccompanied Minor Festival (SAMAH & The Red Cross)

A popular festival, the national unaccompanied minor festival contains shows, movies, theatre, workshops, information, etc. Aims of this festival are to reduce social isolation by meeting peers, and to familiarise the refugees with the Dutch facilities and organisations (Amsterdams Netwerk AMA’s, 2002). However, because of recent political changes this festival will not take place in 2003.

25. Summer camps: Red Cross, SAMAH, the Refugee Council & Church foundations

Several organisations organise summer camps (up to a week) for refugee children and unaccompanied minors in the Netherlands. Especially during summer holidays, when school has stopped, there is very little for these children and youngsters to do. Activities on location are diverse: sports, beach, disco, barbecues, etc. Alongside offering some distraction and diversion, the camps aim to reduce social isolation (ibid.).

26. Leisure activities for unaccompanied minors and asylum seeker children

Throughout the country, organisations like the Dutch Refugee Council, the Red Cross and several churches offer activities to unaccompanied minors and children in the reception centres. These activities work in a preventive way as they offer some distraction, counteract boredom, improve skills and provide social contacts. Examples are: painting and drawing, surfing the web, dance & music workshops, cooking, pottery, visiting the zoo, swimming, etc.

Not specific to refugees

27. Migrant Women Phone Line

The Migrant Women Phone Line offers anonymous contact in various languages to discuss child-raising, financial issues, residence permits, relationships etc. Although Moroccan, Turkish and Antillean migrant women mostly use this line, the languages spoken (like Farsi and Arabian) make it suitable for asylum seeker or refugee women too. There are lines in three cities.
Chapter Four: Good Practices

4. Introduction

Reading through the long list of interventions located in the Netherlands (the previous chapter listed no less than 68), it is not easy to obtain a clear idea of which ones qualify for the term ‘good practice’. What is clear is that in this country, the challenge of providing care to asylum seekers and refugees has stimulated a great deal of innovative activity at all levels - from government departments and service providers to voluntary organisations.

It is ironical that this activity seems to be getting off the ground just at the moment when Dutch government policy on asylum seekers has become repressive to the point of ruthlessness. For many workers in the mental health and social care field, it has become ‘mopping up with the tap on’ (dweilen met de kraan open) to try to promote mental well-being among a group subjected to increasingly harsh measures that affect every aspect of their lives.

In the introductory chapter of this report we discussed the difficulty of assessing the quality of interventions in this field, where controlled clinical trials are virtually impossible to carry out and are sometimes (e.g. when discussing organisational innovations) an irrelevant form of evaluation. A list was given of some characteristics of interventions which, in the view of the researchers, should be regarded as positive criteria:

- demand-oriented rather than supply-oriented
- consultation with users’ groups
- attention to questions of cultural difference
- successful operationalisation (does the intervention do what it sets out to do and does it reach the target group?)
- subjective assessment of users and/or care givers
- original and inspiring

Given the scope of this research project, it was not possible to make conclusive judgements about the success or failure of the innovations studied. However, on the basis of the information available, we have been able to identify some practices which display some of the characteristics mentioned above. This is not to say that other practices are not ‘good’: in many cases, the information available was simply insufficient to assess them. The necessity of choosing among a very large number of promising interventions means that many deserving cases have had to be passed over.

In what follows, we have selected examples of promising innovations in the fields of organisational change, treatment, training and prevention. We will give a short history of each practice, describe its specific and unique features and discuss evaluations or views on the practice held by experts in the field. The practices are then discussed on the basis of the criteria mentioned above.
4.1. Organisational interventions

Two types of organisational interventions are of particular interest in the list in Chapter 3: *expertise centres* and *attempts to improve holistic care by linking care givers*.

**Expertise centres**

In recent years, several expertise centres have been set up in the Netherlands to provide knowledge and expertise for workers in the field of (mental) health and social care for refugees, asylum seekers and migrants. A good example of a successful service is Pharos, offering expertise in the field of refugee health and (health) care. Another recognised centre is Mikado, which provides expertise on the interculturalisation of mental health care. In this chapter we have chosen to highlight the work of Pharos in more detail, because of the unique role this organisation has played in service provision for refugees in the Netherlands.
Case Study of Good Practice: Pharos, the National Knowledge Centre for Refugees and Health

Short history

Pharos recently celebrated the tenth anniversary of its existence. Originating from a merger between the former Social Psychiatric Service for Refugees (established in 1978) and part of the Refugee Health Care Centre (set up within the Dutch Ministry of Health in 1979), the “Pharos Foundation for Refugee Health Care” was created in 1993. In the first phase of its existence, Pharos provided treatment for refugees and asylum seekers and supported professionals in the health care field working with this group, by providing information and documentation, education, consultation as well as training programmes. The organisation also developed prevention and health education projects, books, an information and advice line, an information and documentation centre and a magazine (Phaxx). It also played a key role in international networking in the nineties, and was designated a WHO Collaborating Centre for Mental Health and Refugees in 1995.

In 2000 a reorganisation took place as a consequence of the wider reorganisation of health care for asylum seekers, whereby this care was integrated into regular services. In October 2001 the Pharos team of ambulatory mental health care professionals was incorporated in a specialised clinic, De Vonk (see Chapter 3 under ‘Treatment’). Although critics of this reorganisation felt that Pharos should continue to maintain the link between theory, training and practice, the existence of a treatment facility outside the regular health care system was seen as incompatible with the new structure of service delivery. Nowadays, advantages of the reorganisation are seen. According to René Grotenhuis, director of Pharos between 1998 and 2003, “having ties with practice is necessary, but not having our own treatment section stimulates a more active search for partners in practice. In this way, a broader influx of experience from several institutions and paradigms is possible. Furthermore, an in-house treatment facility may lead to the risk of seeing one’s own practice as the measure of all things and of being blind to developments elsewhere in the field.”

Aims, activities and philosophy

In its new form, Pharos continues all its previous activities apart from treatment. It remains a WHO collaborating centre and a member of ECRE (European Council on Refugees and Exiles). Funded by the government, Pharos has the task of furthering improvement of the accessibility and quality of health care for refugees and asylum seekers. Nowadays the focus of its activities lies on support for regular health care services by providing consultation, training, courses, and any other activities which may improve knowledge and skills. In addition, Pharos develops preventive and health promoting activities. Research is initiated and documentation in this field collected.

Pharos aims to promote the health of refugees by improving the quality of care. Its general philosophy is based on the notion that most refugees show normal reactions to an abnormal experience. Therefore Pharos aims to promote emancipation and empowerment, rather than medicalisation and stigmatisation. The introduction of PTSD has promoted recognition of the problems of refugees. When, however, this concept started to monopolise the attention of professionals and public, corrective influence by stressing that complaints may also
be caused by the lengthy asylum procedures, life events accompanying migration, uprooting and acculturation. With this approach, Pharos has distanced itself from the mainstream in many other countries, where the emphasis has remained on trauma caused by war and torture.

In the development of knowledge for improving refugee health care services, both the groups concerned – the refugees and the professionals who work with them - are systematically involved, so that products and services are demand-oriented and culture-sensitive and respond to the latest developments in the field.

Evaluation

Over the years, Pharos has become an expertise centre known by health workers throughout the country. Consequently, Pharos has been quite successful in directly and indirectly reaching the target group. We could not find evaluative studies on the functioning of Pharos as a whole, but many evaluations have been carried out on the individual prevention and training programmes the expertise centre has developed. Effect studies have not always found long term effects, especially with children. However, no very adequate research instruments have been developed yet for studying the effects on this special target group. Those who work with refugees, for example teachers and social workers, have been generally enthusiastic about the Pharos programmes and training material. Especially the Pharos philosophy that refugees are normal people with abnormal experiences, connects well with their own ideas and experiences.

So far, the main criticism from outside experts has been that the link-up between general practitioners and Pharos has never fully worked. The reason for this may lie in the strong focus on mental health care and second-line services in the early years. Another missed opportunity was the merger between Centrum ’45, ICODO and Pharos. This merger would have linked up treatment, training and expertise, but it failed because of problems concerning financing.

When assessing Pharos in terms of the criteria listed above, the general impression is positive. To start with, the whole concept of an expertise centre in this field is original and may be inspiring for many other countries. It has become clear that it is quite a unique formula, with no real counterparts in other countries.

Secondly, the expertise centre can be seen as demand-oriented rather than supply-oriented: user groups and workers in the field are involved in the development of its programmes. A social worker comments: “Unique to this expertise centre is that its methods follow from the needs of the refugees themselves. Before, patients had to adapt to methods the therapist were taught a long time ago”. Furthermore, Pharos has employed refugee programme developers to profit from their knowledge, experience and social network, so that programmes become culturally sensitive and oriented more towards the wishes of the refugee community. In its personnel policy, Pharos places strong emphasis on recruitment from the target group.

Although the last year or two have difficult for organisations working with refugees, Pharos has maintained its position and activities and is still seen as an indispensable source of information by workers in the field of mental health and social care for refugees.
Attempts to provide holistic care by linking care givers

Several attempts, not all of them successful, have been made in recent years to provide ‘holistic’ (integrated) care for refugees in the Netherlands. Care givers are linked in care networks or otherwise brought together, to improve the care for this vulnerable group, that often involves many-dimensional problems.
Case Study of Good Practice: Local and Regional Care Networks (Zorgnetwerken)

Short history

In the 1990’s, when it became evident that the care for refugees was too fragmented and segregated, local and regional care networks were set up throughout the country. This initiative was stimulated by Pharos, acting from the conviction that joining up organisations is the key to providing good quality care for refugees. Furthermore, for Pharos these networks had an important function as a source of information from the field.

Aims, activities and philosophy

The problems of refugees are often complex, as medical, social, psychological and legal problems tend to be interwoven. Therefore, co-operation between the institutions involved is regarded as essential to improving the accessibility and quality of the care for this group. A wide variety of care professionals dealing with the problems of refugees participate in these networks.

Care networks aim to make service providers more sensitive to the complex problems of refugees, to exchange information, to make referral easier, to coordinate the care provided and to fully utilize each others’ expertise. Also, bottlenecks can be pointed out and efforts can be made to solve these by mutual consultation and coordination, discussion of cases and adapting policy.

Some networks function at local level, others at regional level. In most cases, one organisation chairs the network and Pharos provides help in the setting it up.

Evaluation

Care networks entail a diffuse process of working together, getting to know each other, and fine-tuning of perspectives and standpoints. In them, people come and go. The difficulty is that not every organisation acknowledges the importance of care networks. Some organisations lack time or staff, or simply claim they do not need such a network. In the past, some networks have collapsed after one year with the withdrawal of Pharos. If only a few participants are enthusiastic, the network is vulnerable. Consultation has to take place during working hours and often no extra money is set aside for it. According to those involved, care networks take some time to become successful.

Nevertheless, successes have become visible lately. Organisations connected to the networks have become more sensitive to the problems of refugees. This was found in a study at the University of Maastricht in 2000 (Meijerman & Sneekes, 2000). The care networks have led to a larger informal network within the care system. Also, the pathways to care have become clearer and care givers now know better where to go with specific questions. Service provision is running more smoothly nowadays. The key to success appears to be a custom-made network, tailored to the needs, roles and possibilities of the participating care organisations. To promote this, Pharos has brought out a manual for setting up successful care networks.
4.4 Training and education

With the relatively large number of expertise centres, quite a lot of training material has been developed for working with refugees. However, we have been unable to determine the success or quality of the interventions listed in this area in Chapter 3. The fact that the project leaders are involved in the European Masters Course mentioned on p. 34 makes it inappropriate to offer an evaluation of this course here.

4.5 Treatment

In recent years, mental health care for refugees in the Netherlands has undergone some important changes. In the beginning, no special care provisions for this group existed. With the large numbers of refugees coming from former Yugoslavia in the 1990’s and the growing focus on trauma and PTSD, specialized clinics were set up for this group. These clinics still exist, like de Vonk and Phoenix, mostly treating severe psychiatric complaints and PTSD.

However, mental health care for refugees is now mostly provided by the regular care system. Recent trends include innovative forms of trauma therapy, better adapted to the ‘idioms of distress’ and explanatory models of refugee clients. In Den Bosch, a city in the south of the country, a unique day care programme is offered to refugees at the local mental health organisation. Also, attempts have been made to offer holistic services, to respond to the often complex problems of refugees.

Innovative forms of therapy

Amongst recent popular forms of trauma therapy, body oriented integrative group therapy is considered to be the most innovative practice in this field. Because this is a therapeutic approach used in several mental health services in different ways, we restrict this example of good practice to only a short description (for more information see Roig et al., 1999).
**Specialized clinics**

With the most recent developments in the integration of mental health care for refugees into the regular care system, specialized clinics have become, according to some people, an outdated form of service. An innovative and unique practice which combines the best of both forms of service provision (a specialised clinic and a regular mental health centre) is GGZ Den Bosch, with its day-care programme for refugees. The mental health centre offers outpatient care, combining many different forms of trauma therapy.

**Holistic Services**

Holistic services have been developed as an answer to the often complex problems of migrants in general, but especially of asylum seekers and refugees. In these services a multidisciplinary team is providing more integrated care, based in one office, mostly inside or not far from the accommodation centre.

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**Case Study of Good Practice: Body oriented integrative group therapy**

Body oriented integrative group therapy sees the individual as one whole and does not differentiate between physical, psychological, intellectual, relational or social aspects. All sides of the human being are addressed by using very different techniques. Especially for refugees who do not yet master the Dutch language, or who have stored their traumas in their body, this appears to be an effective method.

Innovative in this intervention is that it is holistic, thereby fitting in better with the explanatory models and idioms of distress of non-western refugees. Skills in putting feelings into words are not required and physical complaints are taken seriously. This approach claims to me more culturally sensitive than most other forms of trauma therapy.

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**Case study of Good Practice: The Crailo Team**

**Short history**

In 1999 a project was initiated by the Riagg Gooi en Vechtstreek, to offer a more outreaching form of mental health care. For years, the medical reception in the centre (MOA) had been aware of symptoms of stress or PTSD among asylum seekers, but they found that the step towards the regular mental health care system, towards the local Riagg, was too big for many users. Something had to be done to lower the threshold. A multidisciplinary team was then set up: the Crailo Team.
4.8 Prevention

Prevention has traditionally been a strong field in the Netherlands. It is therefore not surprising that prevention nowadays is a popular form of care for refugees, although the dividing line between prevention and therapy is not always clear, with some prevention...
programmes showing a resemblance to therapy sessions. With the large numbers of prevention projects in the Netherlands, the image is created of a well functioning preventive care system for refugees. However, the provisions are patchy and many of the projects are not structural, only running as long as donations or voluntary efforts can support them. These projects have a short half-life and unfortunately do not get much chance to contribute to structural preventative care for refugees.

Even though there are good practices in prevention for many different target groups (men, women, national groups, children, unaccompanied minors, etc.), we have chosen to describe only one, which is aimed at children and adolescents. This example of a good practice in prevention does try to offer structural prevention. It is the National Foundation for the Propagation of Cheerfulness (BV).

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**Example of Good Practice: The National Foundation for the Propagation of Cheerfulness (BV)**

**Short history**

The satirically-named ‘Stichting BV’ was founded in 1999. It had become apparent that little attention was being paid to the prevention of mental health problems for children in the many accommodation centres throughout the country. Trauma therapy seemed to be the only service available to help children cope with their experiences. Fronnie Biesma, founder of BV, felt there must be other ways to help these youngsters giving meaning to their experiences. Her conviction was that children are resilient human beings, who are very much able to cope with difficulties themselves. The only thing children need is a safe place, where they can be themselves and play or be creative. With this idea in mind, and supported by many professionals in the field, Biesma set up the foundation and creative workshops were initiated in several accommodation centres and for different age groups.

**Aims, activities and philosophy**

BV initiates and promotes creative prevention projects for children and adolescents in accommodation centres throughout the Netherlands. Aims are to offer young refugee people a chance to use their own capacity to work through their experiences with activities like music, theatre, arts and stories. In the activities self-esteem, self-respect, resilience and working together are stimulated.

The foundation organises pilots of creative workshops in the accommodation centres, executed by local organisations who want to cooperate in creating a happy future for asylum seekers children in the Netherlands. Examples of these organisations are the Dutch Refugee Council, universities and welfare organisations in the region. With the pilot projects, new methods and tools are developed or improved and a structure is left behind in which enthusiast and inspired people can structurally set up a local or regional project.
BV is a network organisation with a small, flexible head office. The board consists of experienced people with expertise and a network in the fields of communication, management, marketing, non-profit organisations considering refugees and asylum seekers. Professionals with experience in the field of asylum seekers and children and in working with creative methods execute the workshops working together with volunteers. The foundation has a forum of experts in the field of refugees; creative therapy, child development and psychology, traumas, coaching and training, welfare and the practical organisation around asylum seekers and refugees. These experts volunteer to think, brainstorm and discuss in this forum.

Evaluation

In 2000 and 2001 five pilots were set up. For two months theatre makers, musicians, storytellers, artists, writers and volunteers organised activities with children from refugee centres. The workshops were evaluated and in 2002 new workshops were developed to address better to the needs of the children. That year, transferable methods were developed, in the form of manuals. In 2002, 1700 children, youngsters and adults were reached with the activities of BV. At this moment, a thorough evaluation is carried out on the activities of BV, of which the results will be known in 2004.

BV is a good practice, when comparing it to the Criteria for Good Practice. The foundation aims to work demand-oriented. In the beginning, methods were created particularly on the basis of ideas of its (experienced) employees and professionals like creative therapists. Lately however, the foundation has been giving more attention to the needs of the children and youngsters themselves. Needs assessment forms a major part of the thorough study that is taking place during the writing of this report.

BV thinks it is important that refugee artists lead the workshops, as they share experiences with the children and can serve as a source of inspiration and as a role model. The foundation also involves parents and other adults from the centre in the projects. In this way, workshops become more culturally sensitive and also have positive effects on the adults involved.

The activities of BV are outreaching, as they come to the accommodation centres where the children live. It is known that refugee children do not often leave the terrain of the accommodation centres, except for going to school. Most children have friends inside the centre and do not have hobbies outside, for the simple reason that these are often too expensive. Activities outside the centre also mean using public transportation, which is costly and therefore avoided. The choice for activities inside the centres seems to be working well.

Finally, the activities and especially the philosophy of BV are seen as original and inspiring. Their idea is that we must not be fooled that children and youngsters cannot cope with their experiences on their own. Children are resilient human beings, they just need a safe environment and a little help to give meaning to their experiences and to achieve the happiness they deserve. This concept inspires many others in the field and has received a lot of attention in the media.
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Further International Perspectives

Charles Watters
David Ingleby
Dominique Le Touze
Mariola Bernal
Further International Perspectives

Introduction: Good Practice in Australia, Canada and Guatemala

The research on good practices in the mental health of refugees indicates that mental health work with refugees may be seen as governed two paradigms. These may be described as the ‘clinical’ and the ‘psychosocial work’ paradigms. Research in the field indicates that these paradigms normally exist side by side in countries with mainstream government resourced mental health services being largely dominated by a clinical approach, while services offered by NGO’s are predominately governed by the psychosocial approach. However, while there are differences in relation to the orientation of the agencies delivering mental health care, from an international perspective there are also some differences between countries and between groups of countries.

In relatively affluent, Western countries with a high level of service provision, a clinical paradigm tends to dominate: mental health workers aim to alleviate the symptoms of individual psychological disorders (in which the category PTSD plays a prominent role). Reflecting the way in which service provision is structured in these countries, there is a systematic distinction between physical, psychological and social problems. Political issues are seldom regarded as relevant to the agenda of the mental health care worker.

This paradigm tends to dominate in the U.S.A., Canada, Australia and Europe (especially Western European and Scandinavian countries). It is also often used as the basis of local relief programmes undertaken in conflict areas by NGO’s operating from these countries.

A slightly less ‘clinical’ approach is represented by the notion of ‘psychosocial work’, which often informs projects directed at the reconstruction of post-conflict communities (e.g. in the Balkans, Latin America and Southern Africa). Here, there is less emphasis on individual pathology and more attention to day-to-day problems of social functioning, especially the task of coming to terms with the legacy of conflict (bereavement, ethnic conflicts, the necessity for justice and for reconciliation). Health care is seen through a public health perspective rather than a clinical one; human rights and political issues (for example the role of ‘truth commissions’) are very much on the agenda.

Examples are the numerous ‘psychosocial’ projects undertaken in the Balkans in the aftermath of the conflicts during the 1990’s (see http://www.ishhr.org/conference/). Another example of this broader approach can be found in the work of the Trauma Centre for Victims of Violence and Torture in Cape Town, South Africa (see http://www.crls.org.za/trauma/Index.htm), which deals not only with victims of the apartheid era, but also with refugees from other conflicts in Africa (and recently, with victims of criminal violence). Despite the clinical overtones of its name, this Centre adopts an explicitly multi-level approach, in which an attempt is made to link personal, familial and political issues. Therapy at the Centre consists of trying to construct a ‘thinking space’ in which a narrative can be created to contain the hardships that have been experienced (Kramer, 2000) Advocacy is also an important part of the Centre’s work, involving practical, outreaching interventions in the users’ communities.
We set out below case studies of the mental health and social care of refugees in Australia and Canada. These countries have been selected because academic research has indicated that they have both a wide range of initiatives for refugees and these include significant innovations in the field. In each country specific examples of good practice are highlighted. Another example, this time from Guatemala in Central America, takes us even further from the ‘medical model’. We have chosen to present a more detailed discussion of these projects, which contain an explicit religious dimension, because they differ markedly from North American and European approaches. (We are grateful to Mattanja Beunder of Utrecht University for this summary of the Guatemalan interventions).
1.0 Demographic

Immigration to Australia

Indigenous Aboriginal inhabitants of Australia, are thought to have arrived in the country from South East Asia 60,000 years ago. Until Europeans arrived in the Eighteenth Century, it is thought the Aboriginal population numbered around 300,000.

In 1787 the British began to use Australia as a penal colony, and in 1788 the first fleet of eleven ships containing convicts arrived in New South Wales. Many of the convicts and other settlers such as prison wardens did not have the skills necessary to survive such as farming or carpentry and many residents were often at risk of starvation. Due to the massive need for skilled migrants, the British began to offer these ‘Free Settlers’, ‘assisted passage’, whereby their fare was paid for by the British government. Some settlers who arrived and laid claim to large areas of land in order to farm, became known as the ‘Squatters’.

The discovery of gold in 1850 caused a massive increase in migration. Immigrants arrived from Europe, China and America in the hope of finding gold, and cities in Australia decreased in population as residents moved to the gold fields. The Irish potato famine throughout the 1850’s also brought large numbers of Irish migrants (www.ozramp.net.au).

Since the Second World War, over six million migrants have settled in Australia. Following the war, arrangements were made with a number of European countries and the International Refugee Organisation to accept displaced people from war-torn countries. From October 1945 to 30 June 1960 1.6 million migrants were accepted (DIMIA, 2003). This number rose to approximately 1.3 million in the 1960’s due to large numbers of European workers arriving in Australia to work as unskilled labourers in new factories and civil engineering projects as rapid industrialisation took place (www.ozramp.net.au; DIMIA, 2003a). Throughout the 1970’s, 80’s and 90’s, nearly three million more migrants arrived, and now, in 2003, nearly one in four of Australia’s 19 million population was born overseas (DIMIA, 2003a).

Refugees

After the Second World War, the next influx of refugees took place in the late 1970’s when Vietnamese people were fleeing their country, which continued until the early 1980's. In 1989, following the Tiananmen Square massacre, Chinese citizens staying in Australia were permitted to remain, and in 1990 visitors from Sri Lanka, Lebanon, Iraq and Kuwait were also permitted to stay in Australia due to unrest in their countries of origin. Similarly in 1992, visitors from Croatia, Slovenia and former Yugoslavia were given extended periods of stay (DIMIA, 2002).

The number of refugees currently arriving in Australia remains low by world standards. The table below indicates asylum applicants in Australia since 1995.
Asylum Applicants in Australia, 1995/6 – 2000/1

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<tr>
<td>No. Asylum Applicants</td>
<td>7</td>
<td>11,135</td>
<td>8,128</td>
<td>8,390</td>
<td>12,185</td>
<td>13,105</td>
</tr>
</tbody>
</table>

*Source: Australian Refugee Council, 2003*

By comparison, below is a table demonstrating the ratio of refugees to other host country populations:

**Ratio of Refugees to Host Country Populations as of December 31, 2000**

<table>
<thead>
<tr>
<th>Host Country</th>
<th>Ratio of Refugee Population to Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1: 1,130</td>
</tr>
<tr>
<td>Canada</td>
<td>1: 572</td>
</tr>
<tr>
<td>Germany</td>
<td>1: 456</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1: 681</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>1: 22</td>
</tr>
</tbody>
</table>

*Source: Australian Refugee Council, 2003*

The nine most popular countries of origin for those refugees arriving by boat between 1998 and 2000 were, Afghanistan, Iraq, Iran, Palestine, Sri Lanka, People’s Republic of China, Pakistan, Syria, Kuwait (ibid). The countries represented reflect much of the world’s conflicts taking place at that time, suggesting that such arrivals in Australia felt a real need to flee their home country, rather than seeking economic gain.

**1.1 Political Immigration Policy**

Perhaps the most influential immigration policy of the Twentieth Century in Australia was the ‘White Australia’ Policy. In 1901 the new Federal Government passed the Immigration Restriction Act that prohibited many groups from migrating to Australia, included were the insane, anyone likely to be a threat to the public, those suffering from infectious diseases, and those of ‘loathsome character’ (DIMIA, 2002). Another restriction took the form of dictation test, whereby potential immigrants had to pass a written test in a European language chosen by an immigration officer. The test is arguably similar to the tests the British government is currently seeking to bring in for new immigrants. Despite its Draconian measures, the White Australia policy received a great deal of public support, and remained in place for the first half of the twentieth century. Following the Second World War in 1949, 800 non-European refugees were permitted to stay, as were Japanese brides of army servicemen; the move was one of the first steps towards a less discriminatory policy. After a series of similar small concessions, the Labor government finally went some substantial way to abolishing the policy in 1973. These included three steps:

1) Legislation that permitted all migrants to apply for citizenship after three years.
2) Australian Immigration posts overseas were instructed to disregard race as a factor in migrant selection.
3) All international agreements on race and immigration were ratified.

A slow increase in non-European migrants took place over the next few years and in 1978, annual migration population targets were abolished in favour of a planned Migration Programme (to accommodate skilled workers and family ties) and a Humanitarian Programme (for refugees and those suffering human rights abuse) which still exists today (ibid.).

**Asylum Policy and Process**

Australia is a signatory to the United Nations Convention and Protocols regarding the Status of Refugees, and is bound by UN regulations to protect all those who seek asylum.

Australia’s Humanitarian Programme is divided into Offshore and Onshore programmes. The Offshore programme is for those who apply for refugee status in Australia while still abroad, and the Onshore programme is for those already in Australia ‘who arrived on a temporary visa or in an unauthorised manner’ (DIMIA, 2003b), or who, once in Australia on valid travel documents, then apply for asylum.

The programme recognises three refugee status:

- **Refugee**: for those recognised as in need of protection by the UNHCR.
- **Special Humanitarian Program**: for those who have experienced serious human rights abuse, hardship or have been displaced, and who have support from a single Australian citizen or community group.
- **Onshore Protection Visa Grants**: those who have been assessed and recognised as refugees and granted protection visas in Australia.

The Humanitarian Program has a set number of places each year; in the year 2002-03, there are 12,000 places on the whole programme, comprising of 7000 places for those on the Special Humanitarian Program, 1000 places for refugees found onshore and 4000 places for offshore refugees (DIMIA, 2003b).

**The Offshore Program**

In August 2001 the MV Tampa picked up a group of 400 refugees who’s boat had sunk while trying to get to the Australian coast to claim asylum. The MV Tampa was refused entry into Australian waters, and the passengers remained aboard ship for several days, during which time many of the male refugees aboard took part in a hunger strike. Eventually, the refugees aboard were transferred from the MV Tampa to a Royal Australian Naval ship; 131 were taken to New Zealand and the remainder sent to Nauru (DIMIA, 2003c; Barkham and Bowcott, 2001).

Following this incident, new Offshore Processing Facilities were developed in Nauru and Papua New Guinea, in the so-called ‘Pacific Solution’. The new measures mean that any refugees attempting to arrive in Australia by boat, or via an ‘excised territory’ (the Ashmore and Cartier Islands, Christmas Island; Cocos (Keeling) Islands; and any offshore sea and resource installations) will be taken to an Offshore Processing Facility for their asylum claim to be assessed by Australian officials or the UNHCR.
If applicants receive a positive decision they will be resettled. In February 2003 (17 months after the Program began) 318 applicants had been awarded Temporary Protection Visas\textsuperscript{136} by the Australian government, and 352 had been resettled in New Zealand. Others had been resettled in Sweden, Denmark and Canada, or had taken part in the Australian government’s Assisted Return Scheme (DIMIA, 2003d).

**The Onshore Program and Detention**

Any individual who is already in Australia when they make their claim for asylum becomes part of the Onshore Program. Those who arrive without valid travel documents are ‘unauthorised arrivals’ and are detained in one of seven detention centres around the country. Those who make an application having held a valid visa, are deemed ‘legal’ and permitted to reside in the community while their asylum claim is being processed.

All applicants go through the same basic asylum process:

- Individuals apply to the Department of Immigration and Multicultural Affairs (DIMIA) for a Protection Visa.
- If the claim is not successful, the applicant is able to appeal the an independent tribunal, either the Refugee Review Tribunal (RRT) or the Administrative Appeals Tribunal (AAT). If a claim is not successful the failed applicant is liable to pay A$1,000 to the RRT.
- The final avenue of appeal is through the Minister for Immigration, who may turn over the decision, should it be ‘in the public interest’.
- If all of these channels fail, the individual must leave within 28 days or risk deportation (DIMIA, 2003c; Smith, 2001).

Since 1999, however, distinctions have been made between authorised and unauthorised applicants. Authorised applicants are eligible to apply for Permanent Protection Visas, which permits the holder to live in Australia permanently. Unauthorised arrivals however, are only eligible for a Temporary Protection Visa, which is valid for three years. At the end of that time, the situation in the individual’s home country will be assessed, to establish whether the visa should be renewed (ibid.).

**Permanent Protection Visas (PPV’s)**

Those applying for a PPV are living in the community and eligible for the Asylum Seeker Assistance (ASA) Scheme. This meets the most basic needs for food, accommodation and healthcare, and is administered by DIMIA. To be able to access the scheme, asylum seekers must have had a PV application lodged for six months, and not be eligible for any other benefits. Support ceases as soon as a final decision is made on the applicant’s case. Those receiving ASA benefits who cannot access Medicare (State provided healthcare) can access some support with healthcare costs and can be referred to counselling services.

PPV applicants are granted ‘Bridging Visa’s’ which allows their original travel documents to remain valid while their asylum claim is being processed. The Bridging Visa allows some applicants to work, depending on their original visa.

\textsuperscript{136}See ‘The Onshore Program and Detention’.
All those applying for Protection Visa’s (Temporary or Permanent) have free access to the Immigration Advice and Application Assistance Scheme administered by DIMIA (ibid.).

**Temporary Protection Visas (TPV’s)**

TPV’s are short-term visas, valid for three years. Once granted a TPV the holder is permitted to work, and to the same benefits as unemployed Australian citizens, including special benefits, rent assistance, maternity allowance, family tax benefit and access to Medicare. TPV holders, however, are unable to access many settlement services such as English language classes (Smith, 2001).

After 30 months, TPV holders may apply for a PPV, if they are deemed to still be at risk in their home country. However, following a new ruling in September 2001, those who en route to Australia have stayed in another country for seven days or more ‘where they could have sought and obtained effective protection’ will not be eligible for a PPV, and must remain on a TPV (DIMIA, 2003: 2.).

**Detention**

Those making TPV applications are normally held in detention centres. Those in detention are termed ‘unlawful non-citizens’, and include those who have overstayed their visa and those who have worked illegally. However, around 80% of those are asylum seekers (Smith; 2001).

In November 2002, 1,282 people were being held in detention in Australia. Detention centres are administered by the Australasian Correctional Services Pty Ltd through their company Australasian Correctional Management. Immigration officials are present at each centre, but management and administration is largely left to prison officers.

This includes medical care, administered by health workers employed by the ACM, larger centres also employ psychologists. Certain religious provisions are also made, such as prayer rooms and attempts to meet the very diverse dietary needs of detention centre populations. Some English classes and sports activities are also provided.

Most detention centres are in very remote areas, without access to refugee and immigrant support networks, mainstream services or legal advice. Furthermore, centres are surrounded by razor wire and detainees are not permitted to leave the compound. If a detainee travels from one area of the centre to another they may have to go through a strip search performed by guards; each person over ten years old is subjected to this scrutiny (Gray and Crabb, 2001; Ethnic Communities Council of Western Australia; 2001).

Detainees are kept for as long as it takes to process their asylum claim and sometimes longer, which can take months or even years. Asylum seekers do not know how long their detention will last, and this uncertainty can lead to massive mental health problems.
1.3 Needs and Problems of Asylum Seekers and Refugees

Asylum seekers and refugees can develop numerous health problems associated with pre-flight, flight, and post-flight experiences, some of which are detailed elsewhere in this research. It is also important to note that the experience of becoming or being a refugee is not necessarily pathologising. Nevertheless, research has shown that many detainees experience severe mental distress. Uncertainty about the outcome of an asylum case, closely shared and heavily guarded accommodation, perhaps sharing with oppositional ethnic or religious groups, can lead to a lack of mental wellbeing. A report by the UN Working Group on Arbitrary Detention (2002) found numerous incidents of self-harm and suicide (including lacerations from jumping onto razor wire; lips sewn together in hunger strike; head hitting against walls), some of which were witnessed by researchers. From interviews the group also concluded that certain other behavioural problems existed such as ‘affective regression and infantilism’ and ‘aggressivity’. Other stressors that were noted by the UN Working Group included constant surveillance by security camera, frequent handcuffing, up to four roll calls per day and routine calling detainees by their registration number not their name.

Steel and Silove (2001) and others (Sultan and O’Sullivan, 2001; Becker and Silove 1993) have noted that the experience of being in a detention environment, and the surrounding stressors that accompany it, such as uncertainty about length of stay can serve to diminish the mental wellbeing of asylum seekers, especially if individuals have experienced torture or trauma before their arrival in Australia. Moreover, an inquiry by the Human Rights and Equal Opportunity Commission (an Australian governmental body) found that large numbers of asylum seekers in detention experience mental distress (HREOC, 1998).

Human Rights Watch in a 2002 report concluded that the ‘blanket policy of indefinite and non-reviewable detention had been found to be “arbitrary” and therefore a violation of international human rights law’ (HRW, 2002). The UN Working Group also concluded that it hoped that the Australian Government ‘will take the initiative to review the laws in order to bring them into compliance with international standards’ (UN, 2002).

In response, the Minister for Immigration and Multicultural Affairs, Phillip Ruddock, rejected the report by the UN Working Group, on the grounds that it gave an erroneous representation of detention centres.

The same grounds in fact on which the government also rejected a report made earlier in 2002 by Justice Bhagwati of the UN Commission for Human Rights, that came to similar conclusions (DIMIA, 2002b).

2.0 Healthcare in Australia

Healthcare in Australia comprises of a mixture of public and private healthcare. The Medicare system offers subsidised healthcare for all Australian citizens. There is also a degree of private healthcare, some running alongside public healthcare in shared hospitals others in separate hospitals and clinics. Non-governmental religious and charitable organisations have also traditionally played a role in public and private health services, and continue to do so (Commonwealth of Australia, 2000).
Health services

Health services are provided through a range of public and private care.

General Practitioners and Hospital Doctors

Most doctors are self-employed. Some General Practitioners take part in the Medicare system and some hospital doctors contract their services to public hospitals. Other hospital doctors are salaried employees of the Commonwealth, State or local governments; they may have rights to treat private patients, with a percentage of the fees going to the hospital.

Hospitals

Public Hospitals

Public hospitals were established by the government or by charitable or religious organisations, but are now funded by the government. There are also small numbers of privately run hospitals owned by independent firms that have arrangements with State governments to provide public services. Most emergency outpatient clinics are provided by public hospitals. Complex medical care such as surgery also tends to be carried out by large urban public hospitals.

Private Hospitals

Private hospitals are owned and run by independent corporate firms and charitable and religious organisations (the latter on a largely not-for-profit basis). Private hospitals tend to offer elective surgery only, although there is increasing provision for complex care.

Mental Health

Mental health care tends to be provided away from mainstream care in psychiatric hospitals and community settings. However the Commonwealth, State and Territory Governments are working to mainstream these services. As in Britain, there is also a move to replace psychiatric hospitals with community based care.

Medicines

Independent drug companies provide pharmaceutical drugs. Prescriptions are subsidised by the Commonwealth Pharmaceutical Benefits Scheme.

Other services

The Australian healthcare system has also developed a number of nationally specific services, in response to the country’s unique geographic and social make-up.

- The Royal Flying Doctor Service, which provides care to remote areas of the country.
- The Aboriginal and Torres Strait Islander peoples community controlled services, which seek to meet the needs of indigenous communities.
- Regional Health Services, which provides care with an accent on the specific needs of rural and remote areas (ibid.).
Medicare

Medicare offers comprehensive medical care to all people ‘residing in Australia who are Australian citizens, New Zealand citizens or holders of permanent visas’ (Commonwealth of Australia, 2000). Medicare is funded through taxes and a Medicare levy on all taxable income.

Medicare covers:

**Out of Hospital**
- consultation fees for doctors; tests and examinations, for example, x-rays; eye tests; most surgical and therapeutic procedures performed by doctors; some dental surgery; specific action under the Cleft Lip and Palate scheme.

**In Hospital**

All hospital patients in Australia can choose one of three options for the delivery and payment of their care:

1. **Public care:**
   Care is delivered in public hospitals under the Medicare scheme; meaning all surgical procedure and care is paid for.

2. **Private/public combination care:**
   Patients eligible for Medicare can opt for private treatment in public hospitals. Medicare can pay for 75 per cent of surgical costs; the patient pays for the remainder of the surgical costs, cost of accommodation and other related costs. Health insurance can cover the extra costs the patient incurs.

3. **Private care:**
   Private patients in private hospitals pay for all surgical and other care costs. Again private health insurance can contribute towards payment of these costs.

Private Insurance

The Australian government is keen to develop private health insurance schemes in order to reduce the costs of public healthcare. In 2000 private health insurance funded around 11 per cent of national healthcare funding (Commonwealth Government, 2000).

The government have started a number of schemes to promote private health insurance to individuals, and through these schemes aim to ensure that insurance is a possibility for all sectors of society, not just those who can afford it.

To this end, the government offers a 30 per cent subsidy to anyone who buys a health insurance policy. In addition, those who acquire a life-long policy before they are 31 years old will benefit from lower premiums than older buyers (ibid.).
2.1 Multi-cultural Care Provisions

Australia has a comprehensive range of governmental and non-governmental services for ethnic minorities. Many of the largest organisations are government funded. A number do, however, have links to smaller organisations in their local region, as the next chapter demonstrates. Perhaps the most well-publicised ethnic minority in Australia are the indigenous people. Finally, after a long history of government oppression, recent government policy sees the health and welfare of indigenous people higher on the agenda.

**Case Study: Office for Aboriginal and Torres Islander Health**

Indigenous residents in Australia (Torres Strait Islanders and Aborigines) have a life expectancy that is some 15-20 years below that of other Australians. The infant mortality rate among this sector of the population is also much higher than for other groups. To address these inequalities, the Australian government established the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in 1994. The aim of the Office was to bring the health needs of Indigenous Australians into the mainstream of health care (www.health.gov.au/oatsih).

The OATSIH cites some of the factors contributing to the poorer health of Indigenous Australians as:
- Financial barriers in accessing healthcare
- The inability, through lack of training and knowledge, of the healthcare workforce to operate cross-culturally
- The lack of a comprehensive primary healthcare approach
- The need for better linkages between various parts of the healthcare system
- Poor access to healthcare in remote locations (ibid.).

The OATSIH aims to tackle these issues through a combined package of measures including improved access; more flexible funding; improved partnerships and communications and health promotion and research.

The Office is largely based around strategic policy making and planning. However, one area where the Office have implemented policy is through the government’s execution of recommendations in the *Bringing Them Home* report (see below). As part of a programme which aims to work with Aboriginal communities affected by former child removal policies, the OATSIH manages counsellors and co-ordinators, education and training activities, some parenting programmes and ‘culturally sensitive approaches to healing for families and communities’ (ibid.).
Recommendations from ‘Bringing Them Home: Report of the National Inquiry into the separation of Aboriginal and Torres Strait Islander Children from their families’

Recommendation 33c: That all government-run mental health services work towards delivering specialist services in partnership with Indigenous community-based services and employ Indigenous mental health workers and community members respected for their healing skills.

Recommendation 35: That all State and Territory Governments institute Indigenous mental health worker training through Indigenous-run programs to ensure cultural and social appropriateness.

Recommendation 36: That the Council of Australian Governments ensure the provision of adequate funding to relevant Indigenous organisations in each region to establish parenting and family well-being programs.

Source: Human Rights and Equal Opportunities Commission, April 1997

Aboriginal and Torres Strait Islander Co-ordinated Care Trials ran between 1997 and 1999, aiming to alter the emphasis of healthcare onto specifically designed community-based programmes. A national evaluation summary (Commonwealth of Australia, 2001) of these programmes indicated that the trials had a positive outcome. It was found that the trials had produced enhanced service access, improved service appropriateness, improved individual empowerment in the development and delivery of care plans, and a greater understanding of the importance of community empowerment (ibid.).
3.0 Good Practice Examples

3.1 Methodology

An extensive web and literature search, and discussion with service providers and academics, contributed to an initial list of possible sites of good practice. These sites were then assessed against the criteria for good practice established in the last section of this research. Of the many possible sites of good practice, three stood out as offering comprehensive, innovative and well-managed care.

In a similar way to the study conducted in the UK, all of the services detailed below are large organisations. There appear to be a large number of government funded organisations of this kind that display good practice, through their innovation, skill and multi-agency links.

It is worth noting that many Refugee Community Organisations are missing throughout this research, arguably due to difficulties with establishing constant and ongoing funding sources, that, in turn, impact on the efficacy and proficiency of management. Future research could address the reasons for that phenomenon and explore the possibility that there is a gap in services due to financial and structural instability.

3.2 Case Study: Australian Transcultural Mental Health Network

In 1997, more than 20 per cent of the adult Australian population (those aged 15 years and over) were born in non-English speaking countries, and a large proportion of those are not proficient in the English language (Open Mind Research Group, 1997). Research has shown that language can prove to be a massive barrier to accessing healthcare (BMA: 2002; Levi 2002).

The Australian Transcultural Mental Health Network (ATMHN) was established in 1995 as part of the National Mental Health Strategy. The ATMHN calls itself a ‘network of networks’: a web of all the national, regional and local organisations that offer transcultural mental health support. It aims to link up these organisations with a view to improving mental healthcare for ethnic minorities across the country through; working in partnership with communities and healthcare services; promotion of mental health issues; ensuring high quality health care provision; promoting and supporting network members to be active in policy development; encouraging mainstream development of transcultural services and through promotion of research (www.atmhn.unimelb.edu.au).

The ATMHN possesses a management unit that promotes service and policy development through consultancy and advice and by working to develop good practice with its member organisations. It also runs annual conferences to highlight issues and developments and publishes a tri-annual magazine on the same subject. The ATMHN’s website and library also hold an extensive amount of research on transcultural mental health.
Elements of the ATMHN found to be exhibiting good practice were:

- **Multi-agency Links:**
  With its nationwide network to multi-cultural mental health centres, both governmental and non-governmental, the ATMHN provides an excellent resource. The government funding of the programme also indicates good practice on the behalf of the state in promoting a broad range of good quality, integrated healthcare.

- **Access and Promotion:**
  ATMHN’s library in Melbourne contains a large number of mental health journals, papers, multi-media resources. The website also has a library, with a number of the resources duplicated there. The organisation also publishes a quarterly magazine that examines topical mental health issues, and provides a forum for reader’s discussion. The ATMHN also holds conferences annually, again to discuss relevant issues and enable members to network. This range of mediums ensures the transparent working of the organisation and affords individuals various opportunities to gain insight into the field of multi-ethnic healthcare.

- **User Involvement:**
  The organisation is keen to work in partnership with small organisations and communities to promote them stakeholders in policy and decision making. Local partnership’s and fora enable this process, and the organisation also offer consultancy to assist and facilitate policy, planning and development.

(http://www.atmhn.unimelb.edu.au)
### 3.3 Case Study: New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

<table>
<thead>
<tr>
<th>The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors was established in 1988 as a response to the inadequacies of mainstream healthcare in dealing with this group of clients. The STARTTS programme is mainly funded through the NSW Department of Health with extra funding from the Federal Department of Health and Family Services, and independent funding for individual projects.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STARTTS aim to assist survivors of torture and trauma in the healing process through a variety of therapies and community projects. Clients are largely refugees receiving therapy, and service providers to whom STARTTS provides consultancy and training. The ethos of the organisation is one of client-focused, appropriate services and many staff are bi-cultural.</td>
</tr>
<tr>
<td>The range of services that STARTTS provide is impressive: counselling and therapy; physiotherapy and bodywork (such as massage); group work and self-support groups; assistance in seeking employment and training; referral and case management; community liaison and consultation; community development projects; training of mainstream service providers; lobbying, advocacy and research. STARTTS offers mental wellbeing care in its broadest sense, providing services that not only treat, but also aim to prevent mental health problems such as employment advice and respite youth programmes. The services provided manage to blend traditional Western medical care services like counselling with other practices such as community work that serve to empower individuals and communities and enhance wellbeing. STARTTS’ role in case management ensures continuity for clients and staff through a longitudinal relationship.</td>
</tr>
<tr>
<td>Specific elements of good practice include:</td>
</tr>
<tr>
<td>Staff support: Body therapies are available to all body therapists experiencing difficulties with clients.</td>
</tr>
<tr>
<td>Community Development: STARTTS work from the premise that just as individuals bring their experiences of trauma with them as refugees, so do communities. The organisation work with some 20 refugee community organisations and other groups, and counsellors are required to spend 30% of their time in group work. Community development takes three forms: social networking – including social support such as the FICT programme (see below); refugee community work – assistance and advice with establishing community groups; mainstream society and institutions – advocacy, education and training with the wider community. STARTTS is keen for communities to be involved in all stages of development, and regular forums and informal consultations are held to ensure that this takes place. This not only allows for user involvement, but also a large degree of transparency in policy making.</td>
</tr>
</tbody>
</table>
Families in Cultural Transition:
The FICT is a group programme, aided by an FICT kit that covers various issues associated with the transition phase that many refugees experience. The kit includes information and guidance on the migration and settlement process; support systems for new arrivals; trauma and healing; and parenting and gender issues. The groups run regularly and are facilitated by counsellors. The inclusion of families in therapy is particularly innovative and may encourage family members to become involved that might not normally receive assistance, such as mothers. Young people often adjust to new lifestyles more quickly than their parents; through this scheme family members can work with one another to come to terms with their new situation.

Youth Program:
The youth program works with young survivors of torture and trauma in order to allow them space and time to express themselves as growing young people, and to develop social and personal skills. The youth program offers an annual camp and ongoing activities throughout the year, some including parents. Counsellors refer participants onto the program, and it then uses early intervention strategies to assess the needs of specific individuals. The aim is not only to give participants the opportunity to explore psychotherapeutic issues, but also to gain positive experiences through activities with peers. Some evaluation of the program has shown that participants experienced significantly reduced stress levels.

3.4 Case Study: The Victorian Foundation for Survivors of Torture Inc. (VFST)

The Victorian Foundation for Survivors of Torture was founded in 1988 to provide care and rehabilitation to individuals who have experienced torture or trauma before, during or after fleeing their country of origin.

The VFST provides counselling, support, advocacy, family support, group work and natural therapies for clients. It also conducts training for healthcare professionals working with refugees and asylum seekers; evaluation of services and research; collation of resources and advocacy on state, governmental and commonwealth levels.

Professional training is provided for healthcare workers wishing to improve their skills. There are two levels of training; a general module for workers with some experience, covering, counselling, safety issues, loss and grief and working with families; and a more specialised program designed for specific organisations. The training program is similar to that offered by the Breathing Space Project in the United Kingdom, and thus indicates possibilities for future collaboration.

The VFST also conducts Project Development Work that have a number of mental health benefits:

The Food and Nutrition Project
The project promotes the positive potential food and lifestyle have on the ability to recover from distressing experiences. This can be by reducing mental distress, such as insomnia; through promoting independence over food purchasing, preparation and consumption (something denied to detainees) and through reaffirming cultural practices.

The Refugee Health General Practice Development Program
The General Practice Development Program has created a network of G.P.’s with a particular interest in refugee healthcare that serves as a forum for debate and the exchange of ideas and information. The organisation has put together a series of clinical guidelines, which are currently being piloted in 18 general practices. The VFST also runs training sessions for G.P.’s.

The Health Access Pathways for New Arrivals Project
The Access project recognises that good physical and mental health are essential for settling successfully in a new country, and that health services can act as a gateway to numerous other wellbeing services. To this end the Project has produced a collection of resources for both new arrivals and healthcare providers.

An example of particularly innovative work is the:

School-based Program for Children and Young People from Refugee Backgrounds and their Families
The program is an intervention scheme for young refugees that aims to strengthen coping factors, through personal development, counselling and group work. School is seen as an ideal site for the programs to take place as it is the main source of contact between refugee families and the host society, and one that provides safety and continuity for children.
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http://www.survivorsovic.org.au

Canada

1.0 Demographic

History

Canada has earned in recent years a reputation as a welcoming country towards refugees. This reputation is certainly deserved, but it bears no relation to Canada’s policies towards refugees in the first half of the twentieth century.

During most of the past century Canadian immigration policies were unambiguously racist. Some did exclude some groups, imposing certain restrictions or a Head Tax, as it was to Chinese and other immigrants of “any Asiatic race”. Moreover, the fact that people were refugees also made them unwelcome. For example, Armenians refugees who were seeking for a new home in the 1920’s were categorised as Asiatic and had to face admission impediments and hostility from the immigration department because they had no home country they could be deported to if Canada later wanted to deport them (Canadian Council for Refugees, 2002).

During the Nazi regime’s years, anti-Semitism marked Canada’s policies and its door remained close on Jews who desperately seek asylum. It is well known and illustrative of the political position, the response given in 1945 by an official to the question on how many Jewish refugees Canada would take, he said, “none is too many” (ibid, 2002).

It will be a few years after the Second World War, when Canadian policy took a different turn so that between 1947 and 1952, 186,154 displaced persons came to Canada, but it wasn’t until the 1960’s when explicit racial discrimination was ended.

In 1948, 987 Estonian refugees became perhaps the first refugee claimants arriving by boats on the east coast of Canada. Most of them were accepted.

Groups of Hungarians were admitted in 1956, Czechs in 1968, Tibetans in 1970 and Ugandan Asians in 1973. Refugees from Chile were also admitted even though less enthusiastically welcome by the government due to political considerations following the coup d’état. Moreover, around 30,000 – 40,000 US draft dodgers and deserters fleeing the Vietnam War were accepted.

The 1978 Immigration Act created the private sponsorship program, which had a dramatic popular response to the crisis of the “boat-people” from Vietnam, Cambodia and Laos. Between 1978 and 1981 refugees were around the 25% of all immigrants to Canada. For all that, in 1986 people of Canada were awarded with the Nansen medal by the UNHCR in recognition of their major and sustained contribution to the cause of refugees.

The 1978 Act also provided a refugee claim determination system that was put into effect in 1980. In 1985 the Supreme Court of Canada recognised that refugee claimants are entitled under the Canadian Charter of Rights and Freedoms to fundamental justice. April 4th, anniversary of the judgement, is celebrated each year as the Refugee Rights Day.

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In 1989 important changes were made to the law creating a new Refugee Determination System. On June 28th 2002, a new Immigration and Refugee Act came into force replacing the 1978 Act. One of the changes brought has been the transferring of competences in jurisdiction over the determination of refugee claims in Canada from the Convention Refugee Determination Division of the IRB to the Refugee Protection Division of the Board. Although the new Immigration and Refugee Act has brought many other changes that affect to refugees – as it will be explain later -, its impact still has to be seen.


<table>
<thead>
<tr>
<th>Year</th>
<th>GAR</th>
<th>PSR</th>
<th>Refugees landed</th>
<th>Dependants of refugees abroad</th>
<th>Refugee Claims</th>
<th>Total refugee</th>
<th>Percentage refugee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>7,712</td>
<td>2,658</td>
<td>10,624</td>
<td>3,223</td>
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<td>1998</td>
<td>7,382</td>
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<td>10,179</td>
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<td>2,805</td>
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<td>2,905</td>
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<td>2001</td>
<td>8,693</td>
<td>3,570</td>
<td>11,891</td>
<td>3,740</td>
<td>44,726</td>
<td>27,894</td>
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<tr>
<td>TOTAL</td>
<td>38,599</td>
<td>13,605</td>
<td>57,430</td>
<td>16,211</td>
<td>163,215</td>
<td>125,845</td>
<td>61'3</td>
</tr>
</tbody>
</table>


Being:

**GAR:** Government assisted refugees, this is, refugees selected abroad and resettled in Canada with assistance from the Government. Includes people in Humanitarian Designated Classes and Joint Assistance Sponsorship.

**PSR:** Privately Sponsored Refugees, this is, refugees selected abroad and resettled in Canada under the sponsorship of a private group. Includes people in Humanitarian Designated Classes.

**Refugees landed:** refugees granted permanent residence within Canada.

**Dependants of Refugees abroad:** grants of permanent residence to immediate family members abroad of refugees landed in Canada.

**Percentage Refugee:** total refugee as percentage of total immigration.

In 2001:

1. 211 refugees arrived under the Urgent Protection Program
2. 396 refugees arrived under the Women at Risk program
3. 48% of GAR were women or girls
4. 48% of PSR were women or girls
5. 40% of the claims were made on average by women or girls
6. Of 28,418 refugee claims finalised by the Immigration and Refugee Board, 13,383 (47%) were found to be refugees.
7. Out of a total of 28,317 decisions made in refugee claims, 2,798 (almost 10%) were decisions to declare a refugee claim to have been abandoned. The abandonment of a refugee claim is an aspect of refugee determination that has received little attention under international law.
In 2002, from January 1st to September 15th, 22,143 claims were made. Of these, 35% were made at USA-Canada border (CCR, 2002).

1.1 Political

Recent Changes in policies

On June 28th 2002 a new Immigration and Refugee Act, Bill C-11, was going to replace the 1978 one, which had been amended over 30 times. Mainly, new measures focus on enhancing the overseas resettlement program and to make a faster and fairer inland process. Some of the most significant changes relating to refugee protection are the following (Citizenship and Immigration Canada, 2003):

- New selection criteria will take into account economic and social factors in determining whether an applicant will successfully settle. The method for application to Canadian Missions abroad for refugee resettlement has changed and under the new Act, a permanent resident visa application for resettlement is required to be accompanied by:
  - A referral from the UNHCR or
  - An undertaking for private sponsorship

(Except for countries having a direct access)

- New regulations will ensure faster family reunification for refugees by allowing dependants to be process as part of the same application for a period of one year after the principal applicant has acquired permanent resident status.

- Grounds for protection that are currently assessed through three separate procedures – refugee determination, post-determination risk review and risk-related humanitarian review – will be consolidated into one procedure at the IRB, so fastening the process.

- Decisions on refugee eligibility will be made at CIC within three working days.

- Bill C-11 requires the Refugee Protection Division to take into account a claimant’s lack of identity papers, inability to reasonably explain the lack of papers and failure to take reasonable steps to obtain them, when it considers the credibility of the claimant.

- The UNHCR now have a right to present written submissions to the Refugee Appeal Division, in addition to its past right limited to observe hearings.

- The Bill fights the “revolving door syndrome” not allowing anymore those persons whose refugee claim had been refused, to make a new one if they return to Canada at least 90 days following their departure. Current Act allows previous claimants to apply for a pre-removal risk assessment to CIC if they return to Canada six months after departing.

- Foreign minor children do not require anymore an authorisation to study at the pre-school, primary or secondary level, unless (s)he is the minor child of a temporary resident not authorised to work or study.

- Members of organised crime, security threats and violators of human or international rights and persons found inadmissible by the Immigration Division, on grounds of a conviction in Canada for an offence for which ten years or more imprisonment may be imposed and for which at least two years was imposed, will be ineligible to make a refugee claim.

- Bill C-11 contains authority to prescribe safe third countries for the sharing of refugee responsibility, as it was before, adding that any safe third country must comply with the Convention Against Torture.
Canada and the USA are negotiating an agreement affecting refugee claimants who make a claim at the USA - Canada border. According to this agreement, the USA will be designated a “third safe country” and as a result, most refugee claimants who pass through the USA on their way to Canada would be ineligible to make a claim in Canada, but forced to make it in the USA. The Canadian Council for Refugees does not agree with the deal and denounces that:

- Some refugee claimants that would be accepted in Canada would be refused if forced to apply in the USA, as both countries have different ways of interpreting the refugee definition.
- The USA is not necessarily a safe country for refugees and their situation there may be about to get worse.
- The agreement does not ensure that refugee claimants turned back at the Canadian borders will have a hearing in the USA, as USA could sign a similar agreement with another country and bounce claimants back.
- Closing door at the Canadian border for examination creates a situation that it is likely to be exploited by smugglers and traffickers.
- The goal and the effect of the agreement are to reduce the number of refugees who can claim refugee protection in Canada.

**Overview of the Canadian Refugee System**

Canada’s refugee protection system consists of two main components:

1. **The Refugee and Humanitarian Resettlement Program, for people seeking protection from outside Canada**

   Citizenship and Immigration Canada (CIC) is the federal department responsible for selecting refugees overseas. For refugees being resettled to Québec, the government of Québec also plays a role.

   The Canadian resettlement program is composed by two categories:

   - **Government-assisted refugees**, who receive financial assistance on their arrival from the government for their first year in Canada, or until they are able to support themselves financially, whichever comes first.
   - **Privately sponsored refugees**, who receive support from private groups. Private sponsorships groups may be faith communities, ethnic associations, unions or any other group of individuals that decides to help to offer a new home to a refugee family. Usually the sponsorship period is one year, but the government can ask for a sponsorship up to three years.

   To qualify for resettlement in Canada, the person must be found to be at risk by meeting one of the following definitions:

   - **Convention refugee**, are those people who fulfil the requirements of the 1951 Geneva Convention. Individuals selected under this class are eligible for government assistance or may be privately sponsored.
- **Country of asylum class**, are those people who are outside their country of citizenship or habitual residence, and are “seriously and personally affected by civil war, armed conflict or massive violation of human rights”. Individuals selected under this class must be privately sponsored or have adequate financial means to support themselves and their dependants.

- **Source Country Class**, are those people who meet one of the two preceding categories, but who are still inside their country of citizenship or habitual residence and this country is designated by Regulation\(^\text{137}\). Individuals selected under this class are eligible for government assistance or may be privately sponsored.

2. **The In-Canada refugee Protection Process, for persons making refugee protection claims from within Canada.**

CIC receives claims to refugee protection in Canada and decides whether they are eligible. However, it is the Immigration and Refugee Board that is responsible for deciding on claims.

In addition to refugees, in recognition of Canada’s other international obligations, as a party to the 1984 Convention Against Torture and to the International Covenant on Civil and Political Rights, Canada’s Immigration and Refugee Protection Act also offers protection to people in Canada who, if sent back to their country of origin would:

- face a substantial danger of torture
- face a risk to their life or a risk of cruel and unusual treatment or punishment.

Refugees who are resettled from overseas usually become permanent residents as they arrive in Canada, while refugees who make a claim in Canada and are granted protected person status must make a separate application for permanent residence. Application for permanent residence must be done within 180 days after notification from IRB or CIC that you are a protected person (CIC, 2003).

The “protected person” status gives them certain rights in Canada – for instance to work and study - however, the rights that go with “protected person” status are quite limited. In order to acquire other rights, such as the right to family reunification, permanent residence must be achieved (CCR, 2003).

After three years, permanent residents are entitled to apply for Canadian citizenship.

**Refugees and Immigrants**

Refugees are people who are forced to flee from persecution, whereas immigrants are not forced to move, but make a choice to immigrate to a new country. This distinction is recognised in the name of the Immigration and Refugee Protection Act, the current law that came into force on June 28th 2002, replacing the former Act.

\(^{137}\) Current countries that fall inside this category are: Colombia, Democratic Republic of the Congo, El Salvador, Guatemala, Sierra Leone and Sudan. This list of countries is subject to change.
Although the law distinguishes between refugees and immigrants, there are many provisions that apply to both. For example, both refugees and immigrants are inadmissible to Canada on grounds of criminality, security risks or danger to public health and safety. The rules about detention or loss of permanent residence apply alike to refugees and non-refugees. Furthermore, refugees may go to Canada as independent immigrants and therefore, they are not classified as refugees.

Canada’s total population in 2002 was 31.414.000. During last decade, the average of total immigration – this is, immigrants and refugees granted permanent residence in Canada – has been of 200.000 immigrants per year. At this pace, it is estimated that total population will soon surpass the 40 million. In 2006, Toronto will be more multiethnic than New York or London. At present, main immigrant nationalities are China (16’1%), India (11’1%) and Pakistan (6’1%). Moreover, the aboriginal population amounts to a 3’3% of total Canadian population. The government’s policy of immigration based on the idea that people should reinforce their identity at the same time that “experiments a feeling of belonging to Canada”, as Canada’s Prime Minister pointed, is making of Canada a world-wide reference for immigration (La Vanguardia Journal, 2-03-2003).

**Women at Risk Program**

The area of gender persecution is an example of changing interpretation on refugee reasons over time. Canada was the first country in the world to issue guidelines recognising that women can be persecuted because of their gender and the Convention should be interpreted to include this persecution (CCR, 2002).

In 1988, the Government of Canada created the Women at Risk Program (AWR) for refugee women in desperate circumstances. The program’s aim is to address the special needs of refugee women. Canada has give over 2.250 women and children a safe home since the beginning of the program.
2.0 Short sketch of the health care system

Canada has a predominantly publicly financed and privately delivered health care system. The Canada Health Act establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer. Canada has 13 interlocking health insurance plans and 13 separate delivery systems (Health Canada, 2003).

There is a shared responsibility in which the Federal Government’s role includes the setting and administering of national principles, providing funding assistance to provincial services, delivering direct health care services to specific groups and fulfilling other functions such as health protection, promotion and disease prevention. The administration and delivery of health care services is the responsibility of each individual province (ibid, 2003).

Canadian’s health care system relies extensively on primary care physicians who account for about 51% of all practising physicians. They are usually the first contact with the formal health care system and arrange for access to most specialists, hospital admissions, diagnostic testing and prescription drug therapy.

Most doctors are private practitioners who work in independent or group practices, enjoy a high degree of autonomy, and are generally paid on a fee-for-service basis.

Over 95% of Canadian hospitals are operated as private non-profit entities run by community boards of trustees, voluntary organisations or provincial health authorities.

Mental Health

Mental health services, broadly defined, include a mix of health, social, vocational, recreational, volunteer, occupational therapy, and educational services, as well as housing and income support (Health Canada, 2003). At the provincial level, mental health services are provided through a variety of means: primary care, general hospital care, community service, specialized treatment facilities, psychiatric hospitals, community providers, NGOs and consumer-run organizations. The extent to which all these are organized under a single administration differs from one province to another (Atlas WHO, 2001).

In Canada the planning and delivery of mental health services is an area in which the provincial and territorial governments have primary jurisdiction. The Ministry of Health in each province is responsible for the bulk of mental health costs, paying for hospitals and other services (Bigelow & McFarland, 1994 op.cit. Goodwin, 1997). Canada has never had the federal programme of community mental health centres, and consequently there is more variation in service provision between the provinces.
Mental health is a part of primary health care system. About the 50% of medical treatment for mental and emotional disorders are provided through the primary care system. It can be defined as a “shared care” system where primary practitioners provide care while in collaboration with a psychiatrist. However, serious patients are often referred to the psychiatrist and the primary care practitioner treat stabilized and less serious patients. Regular training of these primary care professionals is carried out in the field of mental health (ibid, 2001).

Canada has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children.

**Mental Health Policy**

Since 1970s a policy of developing community-based mental health services has been clearly established in all Canadian provinces. Mental hospital bed space has declined rapidly, and a range of new services such as psychiatric units, day hospitals, residential units and community support services has been developed (Department of Health and Welfare, 1990).

Nowadays, the components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Each of Canada’s 13 provinces has the legal authority to make laws in relation to the establishment and maintenance of provincial health care systems, and to provide of health and mental health services.

There are few national policies relating to mental health, but Federal Government regularly releases National Action Plans, strategies and discussion documents that, despite are not policy statements per se, are meant to stimulate thinking and guide provincial service developers (Atlas WHO, 2001).

**Access to health care**

To apply for a health card it is necessary to take the birth certificate, Canada Immigration Visa and passport to the provincial ministry of health where the person is staying. Some provinces also request further information as showing name, address and signature (CIC, 2003).

Canadian citizens and permanent residents are eligible in all provinces. Persons in Canada for a Temporary period of time – as temporary workers, foreign workers, holder’s of a Minister’s permit and refugees, whose status has been confirmed by the Immigration Refugee Board - are eligible in some provinces.

Newcomers\(^{138}\) have been found to under-utilize health services for which they are eligible. Barriers to services are several, but Gagnon divided it into three broad categories. The first is fear of accessing the system mainly because they think it could be detrimental to their immigration applications or they could be considered a burden on the system; second, relates to culturally inapt care and language; and third concerns difficulties navigating the system.

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\(^{138}\) For Gagnon, newcomers are specifically those with a precarious immigration status such as asylum seekers, and those with a high-risk profile such as refugees arriving in Canada from conflict areas.
Refugee claimants are not covered under provincial plans but rather under the Interim Federal Health Program (IFHP) at Citizenship and Immigration Canada, created as Government response to certain needs for access. However, serious difficulties with accessing this program remain (Gagnon, 2002).

**The Interim Federal Health Program**

The program it is not meant to substitute provincial health plans and does not provide the same extent of coverage as for permanent residents. Eligibility is determined by a demonstrated lack of funds. IFHP benefits are limited to essential health services for the treatment and prevention of serious medical/dental conditions, essential prescription medications, contraception, prenatal and obstetrical care, and the Immigration medical examination.

Even with the IFHP, certain asylum seekers have no health insurance for some periods of time due primarily to delays in processing their asylum claims. Health and social services provision during this waiting period varies according to services available through local NGOs and community health centres. Inland claimants have the most difficulty, in some cases waiting up to one year to obtain coverage (Gagnon, 2002).

Canada has answered certain needs for access to care by implementing the IFHP. However, there remain serious difficulties with accessing services through this program including: delays in immigration processing times, limitation to coverage of essential services, errors in completing forms, language barriers, and the administrative burden placed on service providers (ibid, 2002).

**Role of NGO**

Non-governmental organizations play a key role in welcoming and protecting refugees in Canada. As service-providers, community-builders and advocates, they offer refugees practical, emotional and moral support. The NGO sector-serving refugees in Canada is mostly made up of local community-based organizations. Immigrant and refugee communities, organizing to help themselves, created many of these. Some organizations were formed to address the needs of particularly vulnerable refugees, such as survivors of torture (CCR, 2002).

The Canadian Council for Refugees highlights among the activities of refugee-serving NGOs the following:

- providing shelter to newly arrived refugee claimants
- assisting refugee claimants in securing refugee protection in Canada
- sponsoring refugees from abroad
- visiting refugees in detention
- offering information and referrals
- assisting refugees in finding housing, employment, schools for children, etc.
- educating the public about refugees
- providing language training for refugees
- informing the government about the impact of their policies and practices on refugees
- advocating for policies that protect and welcome refugees
Most NGOs strive with inadequate financial support and so are limited in the accomplishment of their work. On the other hand, funding also brings challenges to NGOs’ independence putting into risk their advocacy role.

3.0 Good Practices

There are several examples of “best practice” at a provincial level. Groups focusing on immigrant resettlement issues carry out advocacy and networking activities, other agencies focus on culturally appropriate mental and physical health services, concerns with female immigrants or guidelines for practices among others.

In a federal level, it can be pointed out the existence of the Metropolis Project. This project brings together policy makers from three levels of government, NGOs and researchers in an effort to examine the effects of migration on Canadian cities. It has an international component and was awarded the Public Service Award for Excellence in Policy Development in 1999-2000.

Other initiative to highlight is the Multilingual-Health-Education Network that was funded by Health Canada and Heritage Canada with the goal of improving service delivery by making translated documents easily available to providers and the public.

The following cases were chosen because they comprise a range of good practice elements – personal and cultural sensitive, the existence of multi-agency linkages, continuity of services and clients, advocacy work, evaluation and research tasks - and were found particularly innovative.

3.1 Case Studies: Canadian Centre for Victims of Torture

**Introduction**

The CCTV is a non-profit, registered charitable organisation, founded by several Toronto doctors, lawyers and social service professionals associated with Amnesty International. They started to see victims of torture in 1977 and it is in 1983 when it is incorporated as the Canadian Centre for the Investigation and Prevention of Torture. The name was changed to CCVT in 1988, becoming the second such facility in the world to be established after Copenhagen in 1982. It receives funding from Federal, Provincial and Municipal governments, the United Nations Voluntary Fund for Torture Victims, foundations, religious organisations, and individuals. In 1998 CCVT became a member agency of the United Way.

**Structure and Provision**

The CCVT has 15 member volunteer board which sets policy and guidelines for the operation of the Centre. There are 17 paid staff members whose job descriptions correspond to the areas of service provided by the Centre. These areas are:

*Co-ordinated Professional Services:* The CCVT provides the link between the survivor of torture and a network of professional services which include doctors, lawyers, social service workers and volunteers as well as crisis intervention, counselling, Children’s program and Art therapy. There is a reciprocal referral service for legal and social assistance services when required.
The medical network includes experienced physicians, psychiatrists and other medical specialists. The CCVT staff will assess a survivor’s physical and psychological condition and refer him/her for appropriate medical attention and treatment with CCVT’s associated physicians. The Centre offers a new service through which doctors examine torture survivors and document their experience, something very helpful if requested by the survivor’s lawyer to support a refugee claim before the IRB. The Centre acts as an advocate when requested to do so by the survivor.

**Support and Group Programs:** Group programs include a drop-in program that assists survivors to access services available in Toronto and helps them to overcome isolation, as it allows clients to meet in a comfortable atmosphere. A bilingual staff member composed by a volunteer physician – member of the Centre’s medical group – and a volunteer nurse with a speciality in mental health are some of the resources available.

**Public Education:** Aimed at enhancing awareness and sensitivity to the particular needs of survivors, they conduct seminars, workshops and research, and they also publish in academic journals.

*Apart from the areas described above, CCVT also provide with an English as Second Language Program (ESL) and Art Therapy Program.*

**Edmonton Centre for Survivors of Torture and Trauma**

**Introduction**

The Edmonton Centre for Survivors of Torture and Trauma is a community-based mental health program providing specialized services and support for immigrants and refugees who have suffered from physical and/or psychological torture. ECSTT has a strong financial base through funding from the UN Voluntary Fund for Victims of Torture and the United Way of Alberta. Part of its founding comes from individual donors.

**Structure and provision**

ECSTT is staffed by a small, interdisciplinary team of eight individuals, including two psychologists who specialised in treatment of trauma. There exists a professional referral network comprising psychiatrists, physicians, public health nurses, dentists, occupational therapists, nutritionists and a specially trained team of Multi-Cultural Community Health Developers. ECSTT relies extensively on volunteers.

Among Centre’s main activities stand out:

**Treatment:** The Centre provides crisis intervention, therapeutic counselling, and more in-depth therapy to adults, children and families. It organises support and community-based self-help groups. Also, it provides of a preventative and early intervention program named “Securing Hopeful Futures”. This program is addressed to refugee children and youth. Support services for helping parents work effectively with the school system are also in place.

The staff, practicum students and volunteers also provide information referral, escort and advocacy.
**Training:** ECSTT’s education and training focuses on two great necessities. On one hand, its aim is to develop the capacity of survivors and ethno-cultural communities for self-help and mutual support. On the other hand, it is addressed to service providers, professionals and institutions in order to develop awareness, skill and sensitivity. Currently, ECSTT staff together with Catholic Social Services has developed a 40-hour training program for professionals, service providers and volunteers named “Supporting the healing of survivors of torture and catastrophic trauma”.

ECSTT has published brief articles about its work and about the effects of torture and trauma in several local and national publications.

**Research:** Staff and practicum students are involved in various research papers and
### 3.2 Case Study: Intervention Network for people having subjected to organized violence (RIVO)

#### Introduction

The RIVO network was formed in 1990 by a group of health and social services providers working with people who have been subjected to the effects of torture. RIVO was recognized as a non-profit organization on March 4, 1993.

RIVO’s members come from various backgrounds such as social workers, mental health specialists, doctors and lawyers among others.

#### Objectives and services

RIVO’s main objectives are:

- To intercede with people having suffered the effects of organized violence and to facilitate the integration of their traumatic experience.
- To sensitize the host community and its health and social services providers to the realities of the target population.
- To develop links with the agencies and organizations concerned with this population.

For its consecution, the services offered by RIVO are the following:

- Psychosocial and psychotherapeutic services, medical follow-up, accompaniment, art therapy, music activities, massage therapy among others.
- Awareness and sensitization tasks in the form of training for workers in front-line agencies, non-profit and community organizations and educational systems among others.
- Organization of special meetings related to a particular theme or a specific group of providers.
- Links with other organizations working with refugees across Canada.
- Facilitates the setting up of working groups to study specific subjects, or to produce reference documents pertaining to its objectives.
- Promotion of international exchanges with groups in countries, which have been subjected to organized violence, who wish to put into place measures to prevent repression and torture.
- Organize research activities.
3.3 Case Study: Victoria Immigrant and Refugee Centre Society

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<th>Introduction</th>
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<tr>
<td>The Victoria Immigrant and Refugee Centre (VIRCS) is a non-profit society that has helped immigrants and refugees settle and adapt to life in Canada since 1989. Its aim is “to assist in the settlement and adjustment of immigrants and refugees in Canada and to provide services designated to increase the newcomer’s participation in Canadian society by assisting the newcomer to overcome barriers”.</td>
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<th>Service provision</th>
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<tr>
<td>Services VIRCS provide could be summarized in settlement, job and training services, and an English as Second Language Program (ESL).</td>
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</table>

**Settlement services**: settlement workers assist with emergency needs, housing, education, health care, refugee, immigration, and citizenship procedures, legal issues, day care, transportation and travel, finance and benefits, and the many stresses that the refugee and migration experience put on individuals and families. They provide assessment, orientation, information, referrals, adjustment support and service linking and bridging including accompaniment. Services are provided in an individual or family basis. Regular workshops are held to provide information about family class sponsorship. A community kitchen is being organized to help parents provide non-expensive appropriate meals for their families.

The services are client-driven and are provided with sensitivity to the immigrant and refugee experience.

**English as Second Language**: classes are offered on a continuous basis at the Beginner and Intermediate levels and classes’ size does not exceed from 14 students in order to allow for a maximum participation. There is a Community Bridging Program for adults, and a Home Tutoring Program.

**Job**: the Job Coach Program has been helping immigrants and refugees to find employment since 1991. They have built up connections with local employers and help clients through counselling and teaching. The program offers: employment counselling, experience and skill assessment, Victoria labour market information, educational and training opportunities and job search workshops among others. Eligibility for the program lays on the basis of being a landed immigrant or refugee, legally permitted to work in Canada and actively looking for work. Priority is given to Income Assistance and Employment Insurance Recipients.

VIRCS sponsors various educational workshops and it’s television and video production unit “Ethnivision” had produced informational programming for newcomers and the whole community.
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  - The Canadian Refugee System
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- Health Canada [www.hc-sc.gc.ca]
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- Metropolis Canada (2002) [canada.metropolis.net/frameset_e.html]
- Refugee Asylum Law Canada UNHCR [www.e-refugee.com]
- Refugee Review Tribunal [www.rrt.gov.au]
- Victoria Immigrant and Refugee Centre Society [www.vircs.bc.ca]
- WHO Atlas Project, A Project of the Department of Mental Health and Substance Dependence. WHO, Geneva [mh-atlas.ic.gc.ca]
- Winnipeg Refugee Education Network [www.web.net/~wren]

Information was sought from journals, ministries of health, of immigration, regional health and social services agencies, and non-governmental organizations. Yahoo and Google were employed as search engines.
Social-cultural restoration and reconstruction of social memory in the Mayan communities of post-war Guatemala: the contribution of the Catholic church

Post-war Guatemala is a country that is struggling to find its way towards peace and democracy after a 36-year civil war in which 200,000 civilians were murdered or disappeared. As a result of government led counterinsurgency practices, many Mayan communities in the interior had to seek refuge in nearby mountains, while a minority fled over the border with Mexico. A 83% majority of the victims were of indigenous Maya origin.

1.0 Exhumations

At present, teams of forensic anthropologists are working to exhume the clandestine graves where the bodies of the victims remain hidden, which gives the families and communities involved the opportunity to restore the dignity of their loved ones. Mental health teams of the Catholic church accompany the Maya population during these exhumations, which take place within a still unstable human rights situation and a persisting climate of juridical impunity. Therefore the exhumations often result in renewed intimidation by local war offenders and an intensification of fear for possible acts of retribution acts. This is especially the case among war widows.

After the practical work of exhuming the clandestine graves is carried out, a vigil is organized in the local church to ensure the arrival of the spirits of the deceased in the other world. Once these transition rituals are completed the souls of those left behind can also find peace, "because the spirits have come to rest and aren't troubling them anymore in their dreams."

1.1 The impact of the civil war on communal life

Besides the personal losses, the civil war has had severe detrimental effects on social structures, cultural practices, collective memory and the shared cultural beliefs. One of the main objectives of the military oppressors had been to show that "a universe culturally constructed according to indigenous beliefs was not strong enough to guarantee basic survival, and that in the last instance, this was powerless in the face of the will of established power. The idea was to defeat any expectation of social and economic change." (Flores, 2000, 194) The military largely succeeded in imposing a culture of terror, which undermined existing social structures and the giving of meaning to the events, by deploying civil patrols to control the rural areas.

1.2 Psychosocial assistance in post-war Guatemala

How can one provide psychosocial assistance in these cases of collective human suffering and how can social-cultural healing in the affected communities be fostered? This was the central question in the research I carried out in cooperation with the Guatemalan Archdiocesan Human Rights Office (ODHAG) and their Mental Health Team (Equipos de Salud Mental). My main interest was in seeing what kind of psychosocial interventions the diocesan NGO's offered to the largely illiterate, monolingual, rural and marginalized indigenous population and how the culture-specific explanations of the experienced violence believed in by the population, resulting in marked self-blaming, are dealt with.
In summary, six key elements were distinguished that make psychosocial assistance based upon the ideology of liberation theology into a holistic and integrated approach to human suffering, that goes far beyond a psycho-bio-medical trauma perspective:

1. The psychosocial assistance is action-orientated, linking reflection to the promotion of community development initiatives.
2. The raising of political and historical awareness is the key to reframing of war experiences with the purpose of restoring a feeling of collective agency.
3. A religious framework for giving meaning to the past and present suffering is offered.
4. Restoration of community structures and reconciliation are priorities for enhancing collective psychological well-being, whereas individual problems are of secondary importance and are regarded as derivatives of communal problems.
5. Cultural revitalization is seen as an important communal concern.

The majority of the staff providing this psychosocial assistance identifies with the past suffering and the continuing struggle of the Maya population. The population has accepted the staff to some extent as 'catholic co-workers' in their struggle, because of the structural social assistance offered by the church through emancipatory pastoral work. In some dioceses this assistance continued under wartime conditions, when the pastoral worker themselves were threatened, because of their vision of social development and their involvement in helping the communities to organize themselves.

2.0 Problems encountered

- The emphasis on reconciliation between civil patrols and victims (who often live in the same or nearby communities) as a way to social reconstruction, is premature, because of the national climate of impunity for war crimes and the continued intimidation of those seeking truth and justice. Until the protection of human right is secured, 'truth' is revealed and the military responsible for the genocide are prosecuted, local reconciliation will be very difficult to achieve.
- A fostering of idealization of victims through identification with religious and political figures can hinder the construction of integrated memories and working through of mourning processes.
- The Catholic church is limited in the scope of cultural revitalization and restoration it can achieve, because:
  - In the past, as a representative of colonial power, it contributed to the decay of cultural traditions.
  - At present, the psychosocial methodology still provides an alternative or competing religious conceptual framework to the traditional conceptual framework for giving meaning.
  - It remains the choice of the Maya population whether or not to restore cultural practices. Cultural values and meanings cannot be 'given back to them' by actors who do not share the same discourse.
2.1 Conclusions

The collective, integrated and holistic perspective to psychosocial assistance is worthwhile, because the Maya population experiences the social-cultural effects of war as highly detrimental to their daily lives. Moreover, this perspective offers a bridge between psychosocial healing and community development. Instead of promoting a restoration of cultural practices, psychosocial assistance could be directed at discussion of local cultural concepts that distort and negatively influence the process of giving meaning to the violent experience. The emphasis on recovering social memory and truth is important in re-establishing positive Maya identities. For the time being, 'reconciliation' remains a moral-religious ideal that cannot be achieved within the short term, because of the continuing climate of political denial and impunity.

Reference

PART C: IMPLEMENTATION STUDIES
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A preliminary assessment by the members of the Dutch research team concluded that the most suitable component of the Breathing Space project for transfer to the Netherlands was the ‘Bi-Cultural Team’. The activities ‘Training and Advocacy’ and ‘Research’ are already carried out on a reasonable wide scale in the Netherlands. A Bi-Cultural Team for asylum seekers and refugees would, however, be innovative (although the use of intermediaries in mental health services is not unknown).

In July and August 2002, two Expert Meetings were held in Utrecht, attended by Rob van Dijk (Bavo RNO Group, Rotterdam), Ronald May (Altrecht, Utrecht), Wim Amtmeijer (Pharos), as well as the researchers (David Ingleby and Nina de Ruuk). At the first meeting, the Breathing Space project was critically examined with a view to seeing how useful it would be in the Dutch context, and how it might have to be adapted.

In the Manual prepared by the University of Kent, it was unclear how successful the project was in terms of reaching those in need and referring cases to the regular mental health services. It seemed that only a very few of those seen (5%) were actually referred to mental health agencies. Clarification was required on this point. (It turned out later that the percentage of referrals is actually much higher than stated, because referrals to the Medical Foundation had not been included). It was in any case clear that many clients do not go beyond the Bi-Cultural Team, raising the question of whether the team should be seen as a form of mediation (a referral agency), or a new form of service provision in its own right. Experiences in the Netherlands with similar services in general mental health care have shown a tendency for intermediaries to adopt an autonomous role and ‘hold on’ to their clients.

One source of experience on mediation is Project Apoio, set up in Rotterdam for the benefit of the Cape Verdian community. (As it happens, en evaluation of this project was been carried out for GGZ Nederland by Nina de Ruuk.) Many problems were identified in this evaluation, but the principle of the intervention remained a promising one.

In relation to the target group of asylum seekers and refugees, there are important differences between the Dutch and British contexts. The Breathing Space project was developed against the background of a large and fairly static concentration of asylum seekers and refugees in London. Specialised services are provided by the Medical Foundation and Refugee Council, but there was also a perceived need for a low-threshold, culturally sensitive, ‘one-stop’ service to refer those in need to the appropriate agencies.

In the Netherlands, asylum applications, investigations and accommodation are located in different places, spread all over the country. The majority of asylum seekers are accommodated in centres and moved around the country at the behest of the government. In these centres, the MOA functions as a gateway to the regular health and social care system. However, in the four major cities of the Randstad (Rotterdam, The Hague, Amsterdam and
Utrecht) there are some 10,000 – 20,000 asylum seekers living outside the centres, and for this group a service like the ‘Bi-Cultural Team’ would definitely be useful.

These asylum seekers fall into two categories:

ZZA: zelfzorg arrangement. These are asylum seekers living self-sufficiently, renting their own accommodation.
COW: centrale opvang in woningen. This form of accommodation is organised by the COA, the agency responsible for running the accommodation centres.

Apart from these groups of asylum seekers, a bi-cultural team would also be useful for refugees with a residence permit who experience difficulties in accessing regular care provisions.

The question arose, in fact, of whether the target group should not be expanded to include all categories of immigrants. There are good arguments for this, but the possibility would have to be explored on another occasion, because the terms of reference of the current project are clearly limited to asylum seekers and refugees. In fact, there already exists a rather similar project at Parnassia (The Hague), set up for the benefit of all users from cultural or ethnic minorities: the Multicultural Team.

At the first expert meeting, the possibility was discussed of focusing the intervention on one specific group (e.g. asylum seekers and refugees from Somalia, Afghanistan or Eastern Europe). During the 1990’s Pharos had positive experiences of working with Vietnamese bi-cultural workers. It seemed desirable not to restrict the focus too much, though with a small number of workers some limitation would be inevitable.

The project could also create opportunities for refugees to obtain work in the care sector, something which is otherwise extremely difficult to realise: Dutch health care forms a ‘labour market shelter’ (to use Eliot Freidson’s term) which is exclusive to the point of protectionism. Against this background, it seemed highly desirable to try to recruit from the target group.

The second expert meeting discussed the question of how to finance a bi-cultural team. In principle, it would have to be provided for by the regular sources of health care financing – the AWBZ national insurance system for refugees with a residence permit, and the ZRA insurance scheme (initiated in 2000) for asylum seekers. However, doubts arose about whether it would be seen as an eligible form of service provision.

A more suitable source of finance might be the public health budgets of local authority health services, which also provide the funding for the MOA’s (‘zero-line’ referral agencies within the accommodation centres). A ‘bi-cultural team’ might run the risk of falling between two stools, because it performs both a public health function (screening, referral) and a treatment function (advice, counselling). Both the budget for public health and the financing of treatment facilities are currently under great pressure.

The meeting decided that in all probability, it would ultimately be the GGD’s which would have to provide structural financing for a bi-cultural team. Mental health service providers might be persuaded to collaborate in such a project as stakeholders. In this model of implementation, the service would be seen as complementary to the MOA: it provides the care for asylum seekers outside the accommodation centres which the MOA provides for...
them *within*. There would be a further, practical advantage in a close relationship with the MOA, because that agency possesses asylum seekers’ medical records. For a bi-cultural team to also offer services to asylum seekers residing *inside* the accommodation centres would certainly be meaningful in terms of users’ needs, but it would be seen as a duplication of the services offered by the MOA - perhaps even as a form of ‘poaching’ on that agency’s territory.

There was, however, one possibility for obtaining finance from the ZRA scheme which finances health care for asylum seekers. The Committee for Innovative Projects (see Identification Study on the Netherlands, Chapter 3) was set up to distribute annually 1% of the total budget for asylum seekers’ mental health care, in order to stimulate the development of new interventions for this group. Within the funds currently available, a small-scale pilot project could perhaps be set up, to be financed from this source. If the experiment was successful, negotiations could later be begun with local authorities to persuade them to provide financing on a structural basis.

The meeting decided to try to organise an application to the Committee for Innovative Projects in time for the next round, which was in October. Ronald May offered to describe the project to the national meeting of regional mental health coordinators for asylum seekers, due to take place in the middle of September. We would hope to be able to obtain an expression of their support for the experiment. To this end, David Ingleby subsequently prepared a one-page project description, which was distributed to the participants in this meeting.

The main problem remaining was to find a mental health service provider willing to submit the project application, since this is a precondition of financing by the Committee for Innovative Projects. Such an agency would have to be located in one of the four big cities, where the target group mostly resides. Ronald May agreed to investigate the response of Parnassia in The Hague and Altrecht in Utrecht. However, he warned the meeting not to expect too much enthusiasm, because it was a relatively small target group and these agencies already felt severely overworked.

After the second Expert Meeting, a concerted effort was made to find a service provider who would be prepared to submit the project application. However, the responses were unanimously negative. The most important reason for this lay in the political and policy developments taking place around asylum seekers. Because of strict new rules, the numbers of asylum seekers were shrinking rapidly; they were expected to be halved within a year. Many facilities would be closed and in particular, the ZZA and COW options would be terminated, which meant that in future, all asylum seekers would have to live in accommodation centres. At the same time, the financial squeeze affecting service providers intensified, against a background of increasing signs of economic recession. The events of 11th September only increased this atmosphere of pessimism. Because no service provider could be found who saw any future in the proposal, no project was submitted to the Committee for Innovative Projects.

To sum up, it would appear that the project was overtaken by rapid changes in the context for intervention – in particular, the sharp decline expected in the target group. It might be possible to try to promote the idea of a bi-cultural team for the general migrant population, but this would not count as a genuine innovation since there already exists a Multicultural Team in The Hague. Defining the target group as ‘asylum seekers and (recognised) refugees’ would run into the objection that Dutch policy since the mid-1990’s has been to integrate as much as possible of the care for refugees into regular service provision.
Despite the disappointing outcome, valuable lessons were gained in this project about the complex considerations involved in transferring even the most promising interventions from one country to another.

**Report on the Feasibility of Implementing the Pharos Schools Programme in the UK**

The research team in the UK examined the feasibility of implementing the Pharos Schools Programmes into British schools. The Dutch research team prepared a manual on the schools programme documenting its social and political background, the theoretic framework for the programmes, the content of each programme, and ideas for the implementation of the programme in the UK. As described in the manual, Pharos developed 6 different partially complementary, programmes to be implemented in the special schools and bridge classes for newcomers in the Netherlands and Belgium. Three of these programmes were aimed at refugee children in primary school and three were made for refugee youngsters in secondary school. Some of the programmes could also be used for ‘newcomers’ in general (asylum seeker and migrant children).

The programmes were as follows:

**For primary school children:**

- **School as a Healer** (‘De school als heelmeester’, 1998) – a training course for teachers in primary education
- **Just Show Who You Are!** (‘Laat maar zien wie je bent!’, 2001) – a non-verbal teaching method for strengthening the competence of refugee children in an early stage of reception

**For secondary school children:**

- **The Refugee Lesson** (‘De vluchtingenles’, 1997) – a teaching method for groups of refugee adolescents in secondary education
- **Welcome to school** (‘Welkom op school’, 2000) – a programme for newcomers in secondary education, for class use
Following receipt of the manual, the UK researchers met with representatives of schools in Britain that had indicated that they may be interested in the implementation of these programmes. A response highlighting some of the specific challenges that would be faced by schools in Britain was prepared. In this the following comments were made:

The differences between the British education system, where refugee and children seeking asylum go to regular mainstream schools, and the Dutch system where they attend special schools is one of the most critical points to consider when evaluating the Pharos schools programmes with a view to possibly implementing them in the UK.

The responses to the content and philosophy of the Pharos programmes have been extremely positive. Nicky Odgers an educational psychologist with the Hertfordshire LEA emphasised that: it is definitely a good idea to have structured opportunities to address some of the issues refugees have to cope with especially considering the fact that nobody talks about feelings / emotions in secondary schools in England though there are more opportunities in primary schools. She also added that working within groups, as these programmes do, provides opportunities for children to develop a sense of belonging within their new country and to establish relationships with teachers whom they felt understood them. However, based on existing research, she stressed the importance of involving locally settled peers in any such programme as external social support identified as an important protective factor includes acceptance by peers. This would help stop bullying and harassment in playgrounds and allow for relationships to build up between different groups of students. Many of the Pharos programmes, are, she adds, capable of being adapted for use by all children – not just refugee children. The other question is that of costing and time allocation. Staff training is an important aspect of the programmes and the programmes themselves are labour intensive; some needing two teachers for each session. However, detailed costings are yet to be made.

The recently announced plan to build large accommodation centres for asylum seekers where the children are educated on site is relevant in any discussion on the implementation of Pharos in the UK. The Refugee Council’s alternative model of accommodation centres housing around 100 people where children are educated in local schools but have access to specially appointed facilitators in the accommodation centres with whom they can work is also relevant.

An initial expert group meeting was convened to consider the Dutch report and held at the Institute of Community Studies in London in July 2002. The participants included members of the Dutch research team and Bram Tuk from Pharos who is a key figure in the development of the schools programme. The meeting was chaired by Charles Watters and included Soumhy Venkatesan and Dominique Le Touze from the UK research team and a group of experts including Professor Gundara from the Institute of Education, Augustine Akinwolere from the Midlands Refugee Council and Neil Remsbury from the National Children’s Bureau. The issues explored in the meeting included the applicability of the programme in Britain given the fact that asylum seeking children were educated in mainstream schools and were not placed in separate classes. The following further issues were raised:
• The need for organisational support towards the introduction of the programmes. The Dutch schools have support from the Pharos organisation but, at this time, British schools had no equivalent organisation to provide support and one should be identified
• The funding that would be required to implement the programmes in Britain. These would need to be assessed thoroughly and would include estimates of preparation time, space, numbers of staff required, translation of workbooks and staff training sessions.
• It was proposed that the best approach towards implementation would be to pursue this at 'a grassroots level' involving initially one or two schools and education authorities and then move towards wider implementation.
• Experts felt that the primary schools programmes would be more easily implemented.
• The possibility was raised of using spaces other than schools for the implementation of the programmes e.g. museums.
• There was concern to ensure that those with refugee backgrounds themselves should have opportunities to facilitate the programmes.
• Experts recognised the need to involve refugees themselves in the programmes

Following the initial Expert Meeting opinions continued to be sought on the implementation of the programme in the UK and a range of experts provided further detailed comments. These included the educational consultants Jill Rutter and Bill Bolloten, Sheilagh Crowther from Gloucester Local Education Committee, Nicola Odgers an educational psychologist from Hertfordshire, and Mei May Thong from the Ethnic Minorities Achievement Service in Manchester. The research team organised a second Expert Meeting in Brussels and invited a wider range of experts from the UK and the Netherlands to address issues of implementation.

The second expert meeting was held on January 20th 2003 at the Kent Partnership Office in Brussels. The participants at the meeting were as follows:

Participants:

Charles Watters, University of Kent (Chair)
Jan Baan, Pharos Knowledge Centre (J.B.)
Mary Blanche, Kent Social Services (M.B.)
Bill Bolloten, Consultant for new arrivals and refugees, Lewisham (B.B.)
Sheilagh Crowther, Centre for Intercultural Resources and Language Education, Gloucester (S.C.)
Nina de Ruuk, Utrecht University (N.d.R)
Joe Flynn, Ethnic Minorities Achievement Service, Manchester (J.F.)
David Ingleby, Utrecht University (D.I.)
Dominique Le Touze, University of Kent (D.L.)
Neil Remsbery, Formerly of the National Children’s Bureau (N.R.)
Glenn Page, Kent Social Services (G.P.)
Daffydd Pugh, Policy Officer, Kent Brussels Office (D.P.)
Mei May Thong, Ethnic Minorities Achievement Service, Manchester (MM.T.)
Bram Tuk, Pharos Knowledge Centre (B.T.)
Soumhya Venkatesan, University of Kent (S.V.)

The meeting included a detailed presentation from two of the programme initiators from the Netherlands Bram Tuk and Jan Bram including video material of the Dutch programme in
action. The University of Kent researcher Soumhya Venkatesan provided an update on progress on implementation in the UK followed by a wide ranging discussion on the feasibility of running the programme in the UK that drew on and developed the themes identified at the previous meeting. The discussion centred on the following themes;

- Integrated versus segregated schooling
- Dispersal and the ‘hyper-mobility’ of refugees
- Staff support and development
- Funding and resources

At the conclusion of the meeting participants from education authorities in Gloucester, Manchester and Kent said they wished to take the programme forward in their localities. A proposal was also put forward to initiate an email discussion group on the programme.

**Conclusion**

The process of implementing the Pharos programmes in the UK has made a very promising start. There has been wide ranging consultation with key service providers and experts in the UK including two expert meetings. Following the meeting in Brussels, a delegation from Manchester has visited the Netherlands to view the programmes first hand and have been impressed with the results. Kent County Council Education Department have invited Charles Watters and the Pharos team to offer a presentation of their work in September with a view towards implementation in Kent schools. There has also been a strong interest in taking matters forward in Manchester. Charles Watters was invited to a meeting with representatives from the Education Department in July 03. this is to be followed up by a proposed meeting in September at the Department of Education and Skills in London. The aim is to introduce a pilot programme in schools in Manchester in January 04.
PART D: CONCLUSION
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Conclusion

In this section of the report the authors reflect on the lessons that have been learned from the study and the implications of the research for the development and transfer of good practices in the mental health and social care of refugees in Europe. The section will consider the following topics:

- Problems and opportunities presented by the study
- The challenges faced by EU countries
- CIPA Approach
- Recommendations for the development of minimum standards in service provision

Problems and opportunities presented by the study

As noted in the introduction, this is the first study of the mental health and social care of refugees in Europe. As such, the study faced an immediate challenge in that it could not draw on previous research on this specific topic. Rather, the authors had to draw on knowledge from a wide variety of fields, including statistical data on immigration to the four selected countries and those included in the broader international report, historical and legal data on the evolution of asylum and immigration policies in the selected countries, policy documents on the development of health and social care in selected countries, interviews with selected service providers and, where practicable and appropriate, interviews with asylum seekers and refugees.

The research process 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 absences in information and policy development. In the UK, for example, there is 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 here is largely on settled communities in the UK and there are 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, that are 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, those granted forms of humanitarian status and undocumented migrants.

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. The reference to mainstream services is of importance here because a distinction must be drawn between specialist refugees services and the general health, mental health and social care services for the general population. In each country specialist NGO’s and Refugee Councils had a vital role in terms of service provision to this group. These agencies hold specialist knowledge about asylum seekers and refugees needs and often have a crucial co-ordinating role in meeting a wide range of practical, social care and mental health needs.
However, the research draws attention to the fact that while such agencies provide important services, they normally exist in a marginal position in relation to mainstream health, mental health and social care. The latter services are normally oriented almost exclusively to the majority population and are 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 services to refugees. 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 partnerships identified in this study 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 SAPPIR in Spain that grew out of a multi-disciplinary grouping of health professionals the Health Assistant Service for Immigrants and Refugees. However, while their unique institutional development is inextricably linked to their ability to offer distinctive services that cross traditional boundaries in service provision, it can also be a source of potential weakness. With the possible exception of the Dutch example, mental health and social care services for refugees are rarely structurally embedded in mainstream mental health and social care services. By this we refer to the fact that they tend to have the following characteristics:

- **Their funding base is not long term and secure.** These initiatives normally take the form of ‘special projects’, or in larger organisations forums in which a number of special projects may be developed. They are 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 are thus often in doubt.

- **Their development follows a ‘bottom up’ rather than a ‘top down’ approach.** The projects identified in this study are 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 seeks funding from a government department, an international body or charitable organisation. The group will have specialist interest in the field but may have to balance this with employment within mainstream services. Thus time may have to be 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 are thus rarely the result of top down policy development supported by appropriate resources. This has implications for the distribution of services. Some areas have dedicated professionals who have secured resources for projects in their localities. This does not necessarily imply that these localities are the ones with the greatest level of needs. We noted that in Spain the majority of asylum seekers and refugees are based in Madrid while significant service developments in the field are recorded in Barcelona.
In the UK some areas to which asylum seekers have been dispersed have good service infrastructures while others, with similar numbers of asylum seekers, have minimal facilities. A top down approach is necessary to ensure that there is an equitable distribution of services to areas of greatest need.

The challenges faced by EU countries

As noted in the Introduction to the project, the authors recognise that mental health and social care services for refugees exist within institutional contexts specific to the countries that have been examined. The results have been 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:

- **Refugees and Undocumented Migrants**

For every country included in the study the issue of migration was currently 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 a prominent discourse stressing ‘inclusivity’ in relation to black and minority ethnic groups who were settled in the UK while, at the same time, there was a 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 examine the lessons from the Southern European countries in the provision of health and social care to undocumented or ‘irregular migrants’.

- **Avenues of Access**

In relation to the above, the researchers 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. The countries studied drew attention to at least three avenues of access.

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 often 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. In the Netherlands most asylum seekers were more closely controlled within Accommodation Centres where specialised medical teams provide intake and referral to a range of mental health and social care services. The approach here is more uniform and systematic than in the UK, but is also, arguably, less innovative and dynamic. Since the mid-nineties, the Dutch government has actively discouraged the setting up of categorical facilities for refugees and asylum seekers, on the grounds that adequate services must be provided in the regular care system.

In Spain and Portugal the situation is again different. A significant majority of migrants enter the country clandestinely and consequently are not entitled to immediate access to health, mental health or social care. Undocumented migrants only have access to the emergency services of public hospitals. The fact that few enter through officially recognised channels also has an impact on the severe lack of information experienced by service providers who lack basic knowledge of the potential client group and migrants themselves who lack 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.

• 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 highlights 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 the form of the MOA in the Accommodation Centre and then, subsequently, the GP in the community. The researcher points 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. 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 GP’s may feel they have neither the time, 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. The report on Portugal identifies the critical role played by the Portuguese Refugee Council in acting as a ‘fundamental mediator between users and health care services’. The UK report highlights 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.
CIPA Approach

On the basis of the reports findings it is concluded that, in broad terms, good practice in the mental health and social care services for refugees include the following components:

- Cultural sensitivity
- Integrated approach
- Politically aware
- Accessible

Those services that have been identified as offering good practice have combined, to a greater or lesser degree, these four components.

Each of the examples offered in the report has attempted to offer a service that is culturally sensitive. This went beyond the cultural sensitivity, commented on in the report on Spain, that simply implies a reduction of the cultural factors to standardised diagnostic systems of classification. The form of cultural sensitivity recommended in this report refers to the development of mental health and social care services that are knowledge-based and reflect the cultures of the refugee groups with whom the service seeks to engage. It directly challenges mono-cultural models of service provision and seeks to develop systems of classification and treatment that reflect 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 SAPPiR service in Barcelona the ‘Ulysses Syndrome’ resulting from the experience of migrating across the Mediterranean Sea. Cultural sensitivity also implies a 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.

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, 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 NGO’s.
The services examined here demonstrated that good practice must move beyond the frequently accepted criteria of being integrated and culturally sensitive. Services examined here also displayed political awareness and this was an important feature of their effectiveness. Political awareness functioned at a macro and a macro level. At a macro level this involved awareness of the situations refugees were fleeing from and developing as up to date a 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 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.

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.

As noted in the reports 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.
Recommendations for the Development of Minimum Standards in the Mental Health and Social Care of Refugees

Drawing on the examples examined in this study, the authors suggest that the above components are present in services offering good practice in the field. However, it is important to recognise that, at the time of writing, the EU is engaged in formulating minimum standards for the reception of asylum seekers, including asylum seekers experiencing mental health problems.

While we would encourage services to draw on the experiences of care providers referred to in this project and ensure that all services are culturally sensitive, integrated, politically aware and accessible, we recognise that there may be limitations on the achievement of these objectives for asylum seekers in some current EU destinations. We would, however, argue on the basis of our findings that it is essential that all EU countries work towards these objectives and, as a preliminary to their full incorporation adopt the following minimum standards:

- 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 has shown that there are complex local variations in the context of care provision, which lead to widely divergent solutions, but that 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 study has demonstrated that there have been significant developments in the mental health and social care of refugees across the EU. However, good practice tends to be localised and situations vary markedly from country to country, region to region and even town to town. The project has demonstrated that this is tremendous scope for fruitful exchange of good practice between localities. The authors sincerely hope that this report marks the beginning of an extensive programme of development in this field.