Locations of care: Meeting the mental health and social care needs of refugees in Europe

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1. Introduction: the study of mental health services for refugees

This article describes the results of a study (Watters et al., 2003) that was carried out for the European Commission (European Refugee Fund) during 2002 and 2003.\textsuperscript{1} The primary aims of the project were to identify mental health services for asylum seekers and refugees\textsuperscript{2} in four European countries, to identify examples of good practice in service provision, and to assess the potential for transferring good practice in the field from one country to another.

In focusing on the comparative study of mental health services for refugees, the study was a departure from the main areas of research in this field. In general terms, research has focused primarily on epidemiological studies within refugee populations, often aimed at formulating preventive strategies. Much, but by no means exclusive, emphasis has been placed on ascertaining the prevalence of Post Traumatic Stress Disorder within specific refugee groups. Ahearn has argued that “trauma and, in particular PTSD, is perhaps the most popular descriptor of refugee health or lack of health today” (Ahearn, 2000, p. 10). Emphasis has also been placed on assessing the impact of external stressors, such as displacement, on refugees’ mental health. These stressors have been grouped and categorized in a...
chronological sequence by Ager, who refers to the impact of pre-flight, flight, and post-flight experiences on mental health (Ager, 1993). As a counter to what some researchers see as an overemphasis on the mental health problems of refugees, researchers have drawn attention to the resilience of many refugees in facing highly stressful events (Muecke, 1992; Eastmond, 1998). Until the latter part of the last century there was overriding emphasis on the impact of traumatic experiences in refugees’ countries of origin and the impact these may have had on mental health status in the post-migration context (Beiser, 1999). In other words, the etiology of mental illness among refugees was frequently seen as rooted in past experiences, usually in distant lands.

More recent research has shifted focus somewhat to the impact of experiences in the post-flight environment noting, in particular, the correlations between specific policies of deterrence and the mental health of asylum seekers and refugees (Ahearn, 2000; Beiser, 1999; Ingleby, 2001). In a review of the research evidence, Silove, Steel, and Watters (2000) point to growing evidence that “salient post-migration stress facing asylum seekers adds to the effect of previous trauma in creating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms”. Silove and colleagues refer specifically to the impact of measures such as detention, restricted access to work, housing education and welfare as well as the effects of boredom, isolation and experiences of discrimination (Silove & Steel, 1998; Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997). The specific deleterious effects of detention of mental well-being have also been well documented (Pourgourides, Sashidharan, & Bracken, 1996).

A further range of recent studies may be described as Foucauldian in their orientation as they are concerned with the way in which state controls and processes act to categorize refugee populations in particular ways (Watters, 2001a). Ong (2003, p. 16), in her recent study of Cambodian refugees in Northern California, refers to the way in which refugees and immigrants are “subjected to a series of determining codifications and administrative rulings that govern how they should be assessed and treated, and how they should think of themselves and their actions”. Fassin (2001), in commenting on the situation of refugees and undocumented migrants in France, has drawn attention to the importance of a medical diagnosis as a rare avenue of legitimacy for asylum seekers at a time of significant decline in the numbers of asylum seekers being granted refugee status. Within the UK, Watters (2001b) has noted that a diagnosis of mental illness can have a significant impact on decisions to disperse asylum seekers outside of London, as there is thought to be too few appropriate mental health services outside the capital. These studies draw attention to the fact that the diagnosis of health and mental health problems in refugee populations is undertaken in a politically charged environment in which diagnosis could have a significant impact on crucial decisions regarding the right to stay. They also draw attention to the interrelation between state policies on migration and the contexts in which mental health services are delivered.

In a seminal paper, Zolberg (1989) drew attention to what he described as the “next waves” of migration, determined less by classical push pull factors than by the legal and policy mechanisms developed to restrict entry into countries. For the purposes of the study of mental health provision, this context is of fundamental importance. For example, in Southern European countries where there are relatively few asylum seekers (and low acceptance rates for those who do apply), and the main avenue of access is through irregular migration, there is likely to be little in the way of specialist mental health services (Watters, 2002a). In countries with relatively large numbers of asylum seekers and where they are held in induction or accommodation centers while their claim is processed (for example, Germany), mental health care is likely to be delivered in these formal settings and disengaged from mainstream health care. In countries where the emphasis is on the dispersal of asylum seekers so that no one part of
the country is seen as having a disproportionate “burden” (for example, in the UK), there are significant challenges in terms of the access to, and appropriateness of, mainstream services.

Consequently, underpinning the study described in this article was recognition that even within the countries of the EU there were widely differing approaches towards migration and mental health care. The different legal and policy frameworks operating within member countries have a critical impact on the avenues of access through which new migrants enter the EU. At the time of the study, the UK was encountering very substantial numbers of applications for asylum, with the UK exceeding Germany as the country receiving the highest number of applications in Europe. By contrast, the Southern European countries studied, Spain and Portugal, had dramatically lower numbers of applicants. However, recorded numbers of asylum seekers in Southern Europe disguise the realities of the extent of what is referred to as “irregular migration” with large numbers of people entering countries illegally and clandestinely.

The wide variation in immigration policies and significant differences in the configuration of mental health services in the countries studied could act as a deterrent to undertaking an international comparative study of the mental health care of refugees, such as that which this article describes. In Esping-Anderson’s seminal study into the regimes of welfare capitalism, the countries studied were categorized as providing different welfare regimes, with the UK welfare regime categorized as a liberal regime, the Netherlands a social democratic and Spain a conservative regime (Esping-Anderson, 1990). Mental health services are, as Goodwin notes, embedded in these distinctive historically determined contexts (Goodwin, 1997 p. 103). However, despite the potential difficulties, the comparative mapping of mental health services for refugees, and the attempt to identify and transfer good practice, is both timely and important.

This is not least because, within Europe, issues of immigration and asylum have moved to the first pillar of policy making in the EU whereby the European Commission has a central role in developing policy (Dummet, 2001, p. 151). Policies include measures to seek to ensure the harmonization of standards of reception for asylum seekers across the EU. The European Commission Council Directive of January 2003 sets out minimum standards for the reception of asylum seekers in EU countries that must be enshrined in the national laws of member states by February 2005 (European Commission, 2003). These include minimum standards with respect to health care, the needs of unaccompanied minors and victims of torture and violence. With respect to the latter, Article 20 of the Directive requires countries to ensure that “persons who have been subject to torture, rape or other serious acts of violence” are accorded minimum standards of care.

Nevertheless, in most EU countries, “access to mental health care and specialist treatment for victims of torture is not widely available and not easily accessible for asylum seekers who need special care” (Red Cross, 2003). The information available on mental health care services is acknowledged by the Red Cross to be patchy and there is a need for in depth study of the situation in member countries. Additionally, the broad thrust towards harmonization across the EU makes it particularly timely for evidence of good practice in the mental health care of refugees to be presented with a view towards wider dissemination and implementation. Emphasis on “best practices” or “good practices” could act to counter concern that, in seeking harmonization, services will simply resort to standards representing a lowest common denominator.

Alongside the development of EU-wide policies towards asylum seekers and refugees, there has been, more broadly, what Appadurai has referred to as the development of deterritorialization of ethnic groups and the formulation of transnational communities. Within a European context, major refugee
groups, such as the Somalis and the Kurds, have extensive family and social networks crossing numerous countries (Appadurai, 1996). While much emphasis has been placed in recent years on the importance of protecting the EU’s external borders, once inside the EU there are few practical impediments to crossing the borders of the Schengen countries including, since 1995, Belgium, France, Germany, Luxembourg, the Netherlands, Austria, Greece, Italy, Portugal and Spain (Lewis, Fink, & Clarke, 2001). Welfare services are increasingly concerned with the treatment of individuals whose significant family members are located in a variety of geographical settings and require coordination between agencies in a variety of countries. For this reason, comparative assessment of European agencies’ work is vital to their integrated servicing of refugee populations, particular with respect to refugees’ mental health needs.

2. Design and methodology

To identify mental health services for refugees in a variety of European contexts, we chose to study in detail two Northern European countries (the UK and The Netherlands) and two Southern European ones (Spain and Portugal). During 2002, the numbers of asylum applications in these countries, respectively, were as follows: UK 110,700; Netherlands 18,567; Spain 5179; and Portugal 245 (UNHCR, 2003). As noted above, the low figures for Spain and (especially) Portugal may be deceptive: they conceal the fact that the category of “illegal aliens” (not included within the foregoing numbers) probably harbors many fleeing from danger or persecution who are unwilling or unable to enter the asylum seeking procedure, or who have been rejected by it.

The major component of the study was what we have termed the “identification” study, wherein we examined or “mapped” mental health services for refugees within the broad legal and policy frameworks within which these services were embedded. This included examining each country’s policy towards refugees and other migrants, the climate of public opinion and the service frameworks within which refugee services were contained. Assessment of service frameworks entailed examination of health and social care services in each country with reference both to mainstream statutory services and the role of voluntary and community organizations. A common template was developed for all four of the countries examined to ensure that, as far as possible, the same range of data was collected in each country and that no important areas for examination were overlooked. In developing the template, we sought to clarify the relationship between macrolevels in which policies on migration and mental health care were formulated and implemented and the microlevel in which specific services were offered to refugees. In the study, we assessed mental health services in accordance with the following categories of activity:

1. Organizational changes: these do not concern so much the type of help that is given, as the way service provision is organized. Relevant issues are: where are services located? How are they financed? How (if at all) are their activities coordinated? What is done to improve the standards of service on a national level? Are there agencies which consolidate and disseminate existing knowledge and develop new knowledge?

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

3. Treatment within the context of regular care, or as part of a special facility.
Preventive activities. These activities are especially important within ‘public health’ or ‘mental hygiene’ perspectives.

The template used in the study described herein reflected models developed by Duster and others that attempt to bring into relief the linkages between the macro- and microlevels like “rungs in a ladder”. In undertaking research on health screening programs directed towards black and ethnic minority groups in the USA, Duster (1981) suggests an appropriate approach to consist of identifying four levels which move from examination of policies at a federal and state level to “micro-observational” studies of services at a grassroots level.

This framework was reflected in the use of a methodology comprised of four broad levels of examination. The first level included the political and policy context. This encompassed examination of each country’s immigration policies since 1945, the development of current asylum and immigration policies, demographic data on the number of refugees and other migrants, and evidence of the needs and problems of refugees within each country. The second level placed services for refugees within the broader context of the health and social care system of the country, including the development of multicultural care provision for settled minority ethnic groups. The third level sharpened the focus to specific services and practices developed for asylum seekers and refugees, including organizational changes introduced to improve provision for refugees, training and education of staff, measures to prevent mental ill health and initiatives in the treatment of refugees. A fourth and final level concerned the identification of good practices. This drew on advice on the identification of good practice from participating countries and from various international bodies including the World Health Organization (WHO) and the Red Cross (Red Cross, 2003; WHO, 1996, 2001). This final level of the study involved interviews and observational studies of selected mental health services.

3. Elements of good practice

Identifying criteria for the assessment of good practice in the mental health field is, of course, far from straightforward. Not least, any definition of good practice begs the question, “good practice according to whom”? Different stakeholders in services may present different benchmarks deriving from their own particular roles and perspectives. A psychiatrist may assess good practice as being demonstrated by rapid progress towards improved clinical outcomes. A service manager may add the element of cost effectiveness in treatments, while a service user may particularly value the quality of the interrelationship with service providers, including the extent to which s/he feels respected, listened to and understood. Refugees encountering mental health services are widely reported to have a range of needs that cross service boundaries between health and social care and require an integrated approach to service delivery (WHO, 1996, 2001). As such, the provision of a holistic assessment of needs and advocacy to help navigate through the wide range of services is of importance (WHO, 2001). An integrated approach involving the input of a range of service providers also reflects the extent to which refugees’ life worlds have been disrupted (Silove, 1999). A range of agencies, including the WHO, stress the importance of countering this disruption by empowering refugees, including through active consultation and participation in mental health programs (WHO, 1996).

On the basis of extensive literature reviews incorporating the above policy documents, the views of advocacy bodies and the conclusions of academic experts (particularly the WHO, the European Council
on Refugees and Exiles, the International Red Cross and Pourgourides et al., 1996), certain factors were identified as important elements of good practices in the provision of services aimed at improving the mental well-being of refugees and asylum seekers. These factors were the following:

- Access and promotion;
- User involvement;
- Continuity of care;
- Multi-agency coordination;
- Cultural sensitivity;
- Advocacy; and
- Monitoring and evaluation.

These elements formed a basis for a series of questions posed by the researchers when examining services for purposes of the study described in this paper. The first set of questions, on access, concerned the relationship of the service to the wider environment in which refugees dwelt. For example, research subjects were asked whether the location of the service reflected areas where refugees would naturally congregate or were there filters to care that may inhibit refugees getting services they may need (Goldberg & Huxley, 1980). They were also asked what the service did to promote itself to refugee communities. The participation of service users in services is widely regarded as a cornerstone of effective and appropriate mental health care and is strongly advocated by international bodies such as the World Federation for Mental Health (Brody, 2002). In the UK, core policy documents issued by the National Health Service (NHS) emphasize the centrality of user involvement in good practice (NHS, 1999). Despite this, there are concerns about the extent to which members of black and minority ethnic groups are represented in the service user movement, and the role and representation of refugee communities among service users (Sassoon & Lindow, 1995).

Cultural sensitivity is widely accepted as a central component of good mental health services for refugees. Some agencies supporting practitioners towards this goal by developing “toolkits” to ensure that services are tailored to reflect the norms and values of diverse cultural groups (for example, the anti-discrimination “toolkit” developed by the non-governmental organization (NGO) Alisei in Bologna, Italy http://www.alisei.org). In the Netherlands, anthropologists sometimes work within community mental health centers to provide cultural knowledge and support to practitioners. One apparent way to improve cultural sensitivity is actively to recruit mental health center staff from appropriate ethnic and cultural groups. However, the achievement of cultural sensitivity is not straightforward and self-evident. As Ong (1995) has observed, in some contexts cultural sensitivity goes no further than the employment of a clinical assistant from an appropriate ethnic minority group who will help psychiatrists pigeon-hole symptomatology in relation to Diagnostic and Statistical Manual categories. The researchers in the study described in this article examined services to establish what cultural sensitivity meant in practice and how this linked to other elements, such as user involvement.

Advocacy was considered here both in terms of what may be described as “micro”- and “macro”-advocacy. The former refers to advocacy in the sense normally applied in health and social care, that is, providing support to clients to help them to achieve the optimum benefits from the range of services available to them. The conceptualization of advocacy was extended, in the research for the study described herein, to include the extent and manner through which service providers lobbied on behalf of refugee clients as a group. One example of such “macro” advocacy was advising government agencies of
the general mental health and social care problems experienced by refugees and the impact of governmental policies and practices on these. As such, this accords with the broader conceptualization of advocacy used by Ignatieff, who speaks of the “advocacy revolution” in the work of human rights organizations (Ignatieff, 2001).

Finally, services were considered in terms of the extent to which they routinely monitored and evaluated their work with refugees. Researchers asked questions regarding the content of monitoring and the extent to which evaluation included systematic reviews, intervention and observational studies. The role of service providers and user views in service evaluation was also examined.

4. Results of the identification study

The following is a brief outline of the results of the identification study including the identification of good practices.

4.1. United Kingdom

Historically, much of the immigration to the UK has been connected with the country’s imperial past. Substantial immigration took place in the second half of the 20th century, and much of this concerned inhabitants of the former colonies (the major groups being West Indians, Pakistanis and Indians). The UK also recruited cheap labor from the rest of Europe during the economic expansion of the 1950s and 1960s. At the present time, Britain’s major cities house large communities of immigrants, and around 8.4% of the total population is foreign born or born in the UK to foreign-born parents.

Since 1965, a series of Race Relations Acts have been passed to control racism and discrimination. Although immigration controls are tight, government policy is overtly multicultural and stresses the contribution made by immigrants to the nation. Nevertheless, racial tensions are a constant source of concern in British politics.

Up to the end of the 1980s, asylum applications numbered only 2000–3000 annually. In 1991 this total had increased to nearly 50,000, mainly because of the Balkans conflict; 2001 saw a total of 71,700 applications. Thus, Britain has become one of the major European countries receiving asylum seekers. In 2001, 74% of these applications were refused. Major legislative changes governing asylum policy were passed in 1993, 1996, 1999 and 2002, reflecting the difficulties the UK had in adapting to this relatively large influx. As we also noted in the Netherlands and Spain, the end of the 1990s ushered in a period of increasingly negative presentation of asylum seekers (and immigrants in general) in the British media.

After the reception phase, asylum seekers are dispersed to areas all over the UK. This policy of dispersal was introduced in 2000 to counter the large concentration of asylum seekers in the South East and in London. Accommodation arrangements are varied; there are few large-scale centers, but the use of detention in prisons or prison-like facilities has become a controversial feature of British policy.

Many of the needs and problems of asylum seekers in Britain are connected with government policy and public attitudes. The dispersal policy undermines informal support networks and hampers integration. Living conditions are often experienced as stressful. Discrimination and public hostility can also exacerbate these stresses. Quite apart from this, as already noted, many asylum seekers also have psychological problems as a result of their pre-flight experiences, as well as the worries and uncertainties associated with living in exile.
Health care in the UK is provided by the NHS and is free at the point of supply. The general practitioner (GP) functions as the main “gatekeeper” to the health care system. Asylum seekers are entitled to make use of the NHS, though the difference between rights and access is highlighted by the difficulty asylum seekers can experience in getting on to a GP’s list.

Mental health care services are provided by local Community Mental Health Teams (CMHT’s), which aim to offer an integrated, “joined-up” approach to health care in which social and practical problems are considered in relation to mental and physical ones.

Over the past three decades, there has been a substantial number of reports and policy documents produced by or on behalf of the UK Department of Health aimed at improving the mental health care of black and minority ethnic groups. To take one recent example, a report titled “Breaking the Circle of Fear” drew on the experiences of black African and Caribbean people in mental health services to put forward 15 recommendations on ways through which services can be improved (Sainsbury Centre for Mental Health, 2002). The report called for local action across the country to build the capacity of mental health services to offer better care and treatment to black people. In general, while there has been an impressive body of critical studies examining services for settled black and minority ethnic groups and developing policy recommendations, there has been relatively little scrutiny of mental health services for asylum seekers and refugees. The problems of refugees may be exacerbated by the fact that in areas to which asylum seekers are often dispersed, service providers may be totally unused to dealing with clients of a different cultural background to that of the majority of the population. A further problem in services for both black and minority ethnic groups and refugees is that specialized services targeting these groups often take the form of short-term projects. These frequently exist in a marginal position in relation to mainstream services and lack sustained funding (Watters, 1996).

To identify good practices, the researchers for the study described in this article undertook a survey of service providers, identifying 59 which were active in developing mental health care for asylum seekers and refugees. Eighty percent of these were in London. Twenty-six services replied to a postal questionnaire in which they were asked about the elements of good practice described above. Fourteen of these showed elements of good practice, in terms of accessibility, user involvement, multi-agency linkages, continuity of services and care, cultural sensitivity, advocacy, evaluation and research. The research identified both structural innovations and innovations in the field of therapy. Training and education for professionals working with refugees and/or migrants is not widely available, but some such training programs existed. Preventive activities are organized by some local authorities and by NGOs such as the Refugee Council, which provide various support and advisory services.

The report singled out four especially promising innovations as examples of good practices. The first was a specialized GP service for newly arrived and resident asylum seekers and refugees, located close to a major port of arrival. The second, in London—the Bayswater Family Centre—provided comprehensive family support to homeless and refugee families. Both these services had a range of multi-agency linkages. A preventive project in the North of England, which used gardening as a means of recreation and social contact, was also featured as an example of good practice. This project had been highly rated by users. Finally, the Breathing Space Project was identified as having a number of elements of good practice including accessibility, multi-agency linkages, cultural sensitivity and micro- and macro-advocacy. It is beyond the scope of this article to describe all of these initiatives. However, a brief description of the Breathing Space Project is appropriate, as it was the example of good practice considered by the report as a prospect for potential transfer to the Netherlands.
The Breathing Space Project was established in April 2000 as a 3-year project funded by a grant of just under £1 million from a charitable foundation. The central aims of the project were as follows:

- To raise awareness of the mental health needs of asylum seekers and refugees through advocating for appropriate culturally sensitive services and training statutory and voluntary sector service providers;
- To gather information and offer advice on the provision of mental health services to asylum seekers and refugees; and
- To provide a specialized service for asylum seekers and refugees in the London area that could act as an example of good practice in the development of services for this group.

The project was established in response to growing evidence that, despite growing numbers of asylum seekers in the UK, services were generally ill equipped to meet their needs. This included evidence of the mental health problems asylum seekers and refugees faced as a result of experiences in the pre-migration environment, during flight and in the post migration environment. The initiators of the project drew on evidence, for example, of high rates of post-traumatic stress disorder, anxiety and depression among asylum seekers and refugees. The project initiated a unique partnership between the Refugee Council, a major provider of support to refugees in the UK, and the Medical Foundation for the Care of Victims of Torture, the major provider of health and mental health services to those who have experienced torture. Both organizations were London-based and, prior to the project, the Medical Foundation had limited interaction with services outside the capital. Project staff were based in both of these key agencies and the Project encouraged the development of close working relationships between the two agencies and between a wide range of service providers operating in the mental health and refugee service fields.

The tasks of the Project staff may be summarized as follows:

- The Project staff were to develop an advocacy strategy at a “macro” level that would highlight the mental health and social care needs of asylum seekers and refugees and seek to raise awareness and the responsiveness of agencies to these issues. A Development Co-ordinator based at the Refugee Council’s headquarters in London led this work.
- The Project staff were to develop the capacity of agencies providing mental health and social care services in regions outside of London to which asylum seekers were dispersed. The Regional Development Co-ordinator based at the Medical Foundation led this work.
- The Project staff were to assess training needs and provide training programs to mental health and social care staff working with asylum seekers and refugees. This training was of three types: Refugee Mental Well-being Awareness Training, Cascaded Training and In-depth Training. The first two types of training were targeted at staff working in a wide range of supportive roles while the latter was geared towards those working more specifically with victims of torture. The Regional Development Worker and Regional Training Co-ordinator based at the Refugee Council led the first two areas of work, while a Regional Training and Consultancy Advisor at the Medical Foundation led the In-depth Training.
- The Project staff were also to establish a culturally sensitive mental health service for asylum seekers attending the Refugee Council’s existing One Stop Service in Brixton, London. The service consisted of a full-time Bi-cultural Development Worker and four half-time Bi-cultural Support Workers.
Workers. The aim was to provide supportive, specialized service for asylum seekers attending the Refugee Council’s One Stop Service and assessed as having mental health needs.

The project was the subject of an intensive evaluation and, with the exception of the macro-advocacy work, which had limited impact, each aspect of it was considered to have been successful. A considerable amount of effective capacity building was achieved in the regions that mitigated effects of the dispersal program on asylum seekers with mental health problems. Evaluation of the training initiatives showed these to have been very useful and informative for those taking part and a “cascaded” process was initiated to widen its impact. The Bi-Cultural Team provided vital support to nearly 2000 asylum seekers including offering a holistic assessment of needs and working effectively with a range of agencies to develop an effective package of care for each client.

4.2. The Netherlands

The context of interventions in the Netherlands is in many respects similar to that in the UK. In the second half of the 20th century, the main immigrant groups consisted of people born in the former Dutch colonies and labor migrants, the largest groups being from Turkey and Morocco. Through family reunification and reproduction, the latter have come to number more than 600,000 (about 4% of the total population). Since the 1970s, Dutch policy on admitting non-Western labor migrants has been restrictive.

The number of asylum applications to the Netherlands increased by a factor of 20 (from 2603 to 52,570) between 1984 and 1994, and throughout the 1990s, the Netherlands remained (in proportion to its own population) one of the major European asylum seeker receiving countries, along with the UK and Germany. However, recent years saw the introduction of stricter admission policies: in 2002 the figure had dropped back to 18,667.

Historically speaking, Dutch attitudes to ethnic diversity were for a long time notably liberal. This tradition goes back to the 16th and 17th centuries: it was reinforced by the German occupation of 1940–1945, which strengthened hostility to racism and persecution. The Dutch Government formally adopted a policy of “multiculturalism” at the beginning of the 1980s.

In recent years, however—as in other European countries—a different wind has been blowing. Hostility has increased towards people of Turkish and (especially) Moroccan origin, who are accused of “backwardness” and inadequate integration. The populist politician Pim Fortuyn campaigned for the 2002 elections on a platform with included a complete ban on immigration. Since his assassination in that year, his ideas have formed the core of a xenophobic revival, leading to measures against immigrants and asylum seekers which have attracted complaints against the Netherlands by human rights organizations.

Asylum procedures were modified continually during the last 15 years, but the underlying principle has remained unchanged: most asylum seekers are accommodated in special centers that are spread over the whole country. Processing of asylum applications often takes several years, during which period rights to work and education are very limited. All these circumstances are reported by asylum seekers to give rise to considerable stress.

Dutch health care is based on a mixed system, run partly by the state and partly by private organizations. Alongside compulsory state medical insurance, one-third of the population is insured with private companies. As in Britain, the Government hopes that the operation of market forces will lead to increased efficiency and reduction of costs. Care provision in the Netherlands is characterized by a high
degree of professionalization, though some work is still carried out by voluntary organizations (in particular, the advisory services for refugees provided by Vluchtelingenwerk).

The GP plays a central role in Dutch health care, since he or she provides access to other parts of the health care system and is the point of referral. The mental health care system was strongly influenced by American models of “community care”.

For some 25 years, a small but active group of professionals has called attention to the problems of service provision for migrants and ethnic minorities. During this period, many initiatives have been sent up, mostly on a short-term, project-specific basis. Awareness of the issues confronting migrants is fairly widespread, especially in the big cities (where more than half of the young adult population is often of foreign extraction). However, it was not until 2000 that the Dutch Government acknowledged the need for structural measures to address the status, needs and concerns of migrants and refugees (Ministry of Health Welfare and Sport, 2001). As a result of a drastic shift to the right in Dutch politics observable over the past decade, official support for “interculturalization” has now been withdrawn.

Health care for refugees was originally provided mainly within the accommodation centers themselves, but there has been an increasing tendency to incorporate refugee service within the regular mental health system. From 2000 onwards, mental health care for asylum seekers has been entirely delegated to regular service providers. Since 1993 the Pharos Foundation for Refugees and Health, funded by the Dutch Government, has been responsible for furthering expertise in the care of this group. Refugees and asylum seekers enjoy virtually the same rights to health care as other inhabitants of the Netherlands; however, problems of access and effectiveness remain.

A large number of innovations (68) were identified in our search for good practices among Dutch service providers, according to the criteria outlined above. This reflects the fact that refugees have received systematic attention from professionals in the Netherlands, which—until recently—was one of the major destinations for asylum seekers. Expertise centers (Pharos and Mikado) have been set up for the care of refugees and migrants. Other organizational innovations have concerned unaccompanied minors and victims of sexual violence. Alongside this, networks or consultation schemes have been set up to improve and coordinate refugee health care.

Concerning treatment, seven specialized clinics, centers or programs for refugees were identified, as well as 12 other initiatives concerned specialized forms of treatment. A particularly large number of practices (27) concerned prevention, most being carried out by agencies or groups outside the regular health care system.

Our report concluded that in the Netherlands, “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”. Among the organizational innovations, we singled out expertise centers and attempts to improve holistic care by linking care-givers. The expertise center Pharos had exerted a positive influence on standards of care in the Netherlands, as well as performing group advocacy functions.

Lacking systematic evaluation studies, it was difficult to single out good practices beyond these organizational innovations. In the field of treatment, we focused on two methods that attempted to combine attention for physical, mental and social problems (“holistic care”). In the category “prevention”, we highlighted a program of creative and recreational activities for children in asylum centers. The Pharos Schools Program was identified as an example of good practice that could potentially be transferred to the UK. An outline of this program is presented below.
For refugee youth in secondary education, Pharos has developed the following programs:

- The Refugee lesson (De Vluchtelingenles). A series of eight ‘lessons’ focusing on the experiences refugee children have in common. The ‘lessons’ are conducted by a teacher, together with a mental health care professional, with a group of 8–12 children. Topics treated are: Living in the Netherlands, “Where do I come from?”, “Who am I?”, important things and days, friendship and being in love, prospects for the future.

- Refugee youth at school (Vluchtelingenjongeren op school). This is a training manual, accompanied by video tapes, for teachers and others involved with this group. The themes explored in this manual are: Backgrounds of refugee youth, coping with loss, dealing with traumatized children, preventive activities in the classroom.

- Welcome to school (Welkom op school). This is a series of 21 “lessons” emphasizing non-verbal techniques such as drawing and drama. Themes probed include: getting acquainted, “Where do I come from?”, my school, “Who are we?”, important days, living in the Netherlands, important people, friendship, being in love and marrying, leisure time, feeling excluded, on the road to the future.

The following activities have been developed for use in primary schools:

- F.C. the World (F.C. De Wereld). Like ‘The refugee lesson’, this program consists of eight ‘lessons’, using a variety of verbal and non-verbal methods. A small pilot study showed positive effects on the children taking part. Themes covered are: Me, school, where I live, family, celebrating, friendship, play and “Me, You and We”. During the program, each child makes a book about him/herself.

- The school as a healer (De school als headmaster). This is a training course for teachers, supported by video material (i.e., it is comparable to “Refugee youth at school”).

- Just show who you are! (Laat maar zien wie je bent!). This program uses mostly non-verbal methods such as play, dance, movement, and drawing. A training manual for the teachers has also been developed. Themes dealt with include: Safety, identity, making contact with others, self-reliance.

Considerations relevant to the prospective implementation of this program in the UK are discussed below under Results of the implementation study.

4.3. Spain

Traditionally, emigration from Spain has far outstripped immigration: even today, some 2 million Spaniards live abroad. Between 1850 and 1970 many Spanish migrants went to work in the growth economies of Northern Europe and Latin America. Immigration into Spain started to grow in the 1960s but remained at a low level until the 1980s and 1990s, when the economy expanded greatly. It increased from 198,042 in 1981 to 1,109,060 in 2001. In that year, immigrants made up 2.74% of the total population; the largest group (30%) came from the EU, followed by Morocco and other African countries (27%), Latin America (26%), Asia (8%), and other European countries (7%).

Estimates of the number of undocumented migrants in Spain vary between 200,000 and 300,000, amounting to between 18% and 27% of the total of registered foreigners. This is one of the highest
figures in Europe. Spain has one of the lowest birth rates in the world, with a virtually static population, and immigrants help to offset the economic effects of this situation.

Since the establishment of Spain’s parliamentary monarchy in 1978, Spanish Governments have implemented various policies to regulate immigration and further immigration. Several amnesties have been offered to undocumented migrants. Legislation introduced in 2000, however, had the effect of criminalizing and (further) marginalizing this group. As in Portugal (see below), attitudes to immigrants among the Spanish public are relatively tolerant. However, in the last few years they have become more negative and immigration has become a controversial political issue.

As far as asylum seekers are concerned, the rate of applications for refugee status is very low (9490 in 2001) the rate of rejections high (around 90%). While the application is being processed, asylum seekers are accommodated in centers run by the Government or NGOs. The experiences of professionals working with asylum seekers and refugees suggest high levels of stress resulting from the flight itself and the living conditions on arrival. This applies even more to undocumented immigrants.

Before the transition to democracy in 1978, Spain has been an example of the “Southern European” welfare model, with the Catholic Church providing many health, education and welfare services and a strong emphasis on family as care provider. Since the transition, however, care provisions have come increasingly to resemble those in the rest of Europe.

The Spanish health care system has been set up as an integrated national health service, which is publicly financed and provides nearly universal health care free of charge at the point of use. Service provisions are mostly publicly owned and managed, while governance of the system has recently been decentralized to all the regions. The general practitioner functions as gatekeeper to the rest of the health system. Social services are managed partly by the Ministry of Labour and Social Affairs, and partly by the Autonomous Communities who plan and regulate local services, coordinate resources and oversee their assessment and control. As yet, there is relatively little interest among professionals in issues concerning multicultural service provision, but some research has been undertaken on this topic.

Since 2000, foreigners living in Spain have the right to health care and social services, even if their situation is irregular. However, they have to undergo a registration procedure and obtain a special card in order to actually use the services. Fear, ignorance and administrative obstacles prevent some from obtaining this document.

Asylum seekers and refugees form a very small part of the population and it is likely that many victims of political violence enter the country illegally. Asylum seekers are fully entitled to health and social care, and alongside the regular care system there are some specialized services provided by NGOs (religious or lay). Some of these services also offer help to irregular immigrants. These services tend to be concentrated in Madrid and Barcelona.

The research carried out for the present study located several organizations offering (mental) health care to asylum seekers, refugees and migrants (including irregular immigrants). A pioneer center is the Psycho-pathological and Psycho-social Assistance Service for Immigrants and Refugees (SAPPIR) in Barcelona, which deals with many new arrivals. In the same city, Servei d’Atencio Tractament de l’Inmigracio (SATMI) is a privately financed body offered support to professionals working with these groups. EXIL (derived from the founding organization EXIL established in Belgium in 1976) is a program of medico-psycho-social rehabilitation for immigrant victims of human rights violations and torture. In Madrid, similar organizations were not found, but some initiatives are working in that direction, such as CASI (Social Care Centers for Immigrants). The Red Cross has established
psychological assistance services for asylum seekers and refugees in March 2000, in different cities such as Madrid, Barcelona, Córdoba and Valencia.

Concerning professional education, although the attention to migrant problems in the regular courses is extremely scant, we located a fair number of initiatives in different sectors attempting to remedy this situation. Interest in these issues seems to be rapidly expanding.

Treatment methods used in the special centers mentioned above are very diverse. Preventive activities are organized by many NGOs working with migrants; they include legal advice, assistance in finding work, language and computer courses, and social or recreational activities.

4.4. Portugal

In many ways, the context of interventions to redress mental health care problems of refugees and asylum seekers in Portugal resembles that in Spain. Traditionally, Portugal has been a country of emigration, not immigration: in the 20th century, the main destinations were North America, Northern Europe and Brazil. As a nation, therefore, the Portuguese are very familiar with the phenomena of migration and ethnic diversity. Like all European colonial powers, Portugal experienced a wave of immigration after the transition of its colonies to independence. This took place abruptly and chaotically in 1975, following the revolution in 1974 which ousted the dictator Salazar. Post-colonial migrants came from the PALOP (Portuguese speaking African) countries: Angola, Cape Verde, Guinea-Bissau, Mozambique, Saint Tome and Prince.

Towards the end of the 1990s, as in Spain, labor migrants begin to enter Portugal in larger numbers, mostly from Eastern European countries (especially the Ukraine). The work available was mainly in the construction and service industries. Immigration control is less strict than in Northern European countries, and amnesties have been offered to irregular immigrants in 1992, 1996 and 2001. The Government has taken measures to combat discrimination and facilitate access to education and the labor market. As in Spain, however, the last few years have seen a tightening of immigration policy.

Concerning asylum seekers, Portugal operates an exceptionally restrictive policy, rejecting around 97% of applications. Only a few hundred asylum seekers are admitted annually. However, these figures conceal the fact that many victims of political violence probably enter the country as irregular immigrants. Many probably also come from PALOP countries and fall in the category of “post-colonial” migrants. Our research included interviews with asylum seekers and refugees in Portugal concerning their difficulties. Many reported problems of access to services, caused by bureaucratic obstacles and language difficulties.

Like Spain, Portugal was formerly an example of the “Southern European” welfare model, but since the 1974 revolution, care provisions have followed the model of other European countries. Health care is covered by three overlapping systems: the Portuguese National Health System (SNS), special insurance schemes for certain professions, and voluntary private health insurance schemes. Although the general practitioner is supposed to act as the gatekeeper to secondary care, in practice many people report directly to the emergency department in hospitals.

All aliens legally residing in Portugal have the same rights as nationals to use the SNS. However, multicultural health care is not yet officially recognized as an issue, though there are sporadic signs of interest among professionals. We conducted an interview survey among service providers, which revealed that professionals often go to considerable efforts to find ad hoc solutions to the problems of
helping immigrants, at the same time adhering strongly to the principle that all users should have access to the same kind of care.

As we have seen, 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. Those that do exist are mostly organized 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 for refugees, the one innovation which we managed to locate is described in the following section.

This study found hardly any initiatives directed at improving mental health and social care provision for refugees and asylum seekers. This has partly to do with the small numbers in these categories, but it also reflects the lack of attention to issues of cultural diversity in service provision generally.

The only initiative which might qualify for the category of “good practices” is CAVITOP, the Portuguese Support Center for Victims of Torture in Portugal. CAVITOP is an NGO which forms part of the Coalition of Latin-European Centers for Victims of Torture (Latin-European CCVT). It was established in 2002 with the main goal of supporting and rehabilitating victims of torture, violence and cruel or inhumane treatment at a national level. However, the organization was not specifically set up for refugees.

Users are provided with a range of services (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, or referred to other NGOs or professionals. Since the organization was being set up at the time the present research was being carried out, we were unable to carry out any kind of appraisal of its activities.

5. Results of the implementation study

A third component of the study concerned assessing the potential for the transfer of good practice from one country to another. This part of the project was “action research” aimed at gathering concrete experience of the obstacles which may be encountered when attempting to transfer interventions between countries. We chose programs which could be regarded as relatively successful in their country of origin. To increase the chances of success, we also chose a pair of countries offering similar contexts: the UK and the Netherlands. The many 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 introduced in Britain in 2000 meant that both countries had a policy of dispersing of asylum-seekers nationwide. They have also relied mainly on existing services to provide care.

In both countries, we selected a project which was highly regarded by experts in the field and had been positively evaluated, but had 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 which was considered for transfer to the Netherlands was the Breathing Space Project (see Watters, 2002b). As described above 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 coordinated way.
The Dutch intervention consisted of a package of programs 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 (see Ingleby & Watters, 2002).

Firstly, the experience gathered on the two selected practices was summarized. Next, differences in the context of service provision were analyzed which might make modification necessary. Proposals were made for the modifying the practices to make them suitable for transfer.

After this, a manual summarizing the results of these steps was produced. Drafts of this manual were submitted for critical assessment and feedback to selected experts familiar with the respective programs. After revision, they were handed over to the research team in the other country as a basis for taking the project further.

This team then organized expert meetings with key stakeholders to discuss the best strategy for implementing the selected program. On the basis of this, a strategy for implementation was outlined and the researchers proceeded as far as possible with piloting and evaluating the intervention in question. Finally, the success of the transfer was evaluated and recommendations were made about continuation, modification or termination of the innovation.

6. Transfer of “breathing space” project from the UK to the Netherlands

The most suitable component of the Breathing Space Project for transfer to the Netherlands was the Bi-Cultural Team: a low-threshold, culturally sensitive, “one-stop” service for referring those in need to the appropriate mental health or social care agencies. After the Kent-based members of the team working on this study had produced a manual describing the British project, a strategy for implementation in the Netherlands was worked out in a series of meetings by a team of experts drawn from Pharos and mental health service providers.

One important problem concerned the target group. The Breathing Space Project was developed against the background of a large and fairly static concentration of asylum seekers and refugees in London. In the Netherlands, on the other hand, asylum applications, investigations and accommodation are located in different places, spread all over the country. The majority of asylum seekers are accommodated in centers and moved around the country at the behest of the Government. However, in the Randstad (Rotterdam, The Hague, Amsterdam and Utrecht) some 10,000–20,000 asylum seekers live outside the centers, and for this group a service like the Bi-Cultural Team would definitely be useful. The service would also be helpful for refugees with a residence permit who experience difficulties in accessing regular care providers. At the same time, the project could also create opportunities for refugees to obtain work in the care sector, something which is otherwise extremely difficult for them to realize.

The scheme would in principle have to be paid for from the regular sources of health care financing. However, there were doubts as to 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.

A special fund was located which could finance a small-scale pilot version of the project, but applications to this fund could only be made by mental health service providers. Unfortunately, none were interested in doing this. Because of strict new rules, numbers of asylum seekers were shrinking rapidly; they were expected to be halved within a year. Many facilities would be closed and the new
policy was to keep all asylum seekers in accommodation centers. At the same time, service providers were being affected by a serious financial squeeze.

To sum up, the project was overtaken by rapid changes in the context for intervention—in particular, the sharp decline expected in the target group. 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.

7. Transfer of the pharos school program from the Netherlands to the UK

The Dutch research team working on this study prepared a manual on the schools program. Six different programs were described, three for refugee children in primary schools and three for those in secondary schools. Some programs could also be used for “newcomers” in general.

After receiving this manual, the UK researchers met with representatives of schools in Britain which had indicated that they might be interested in implementation, in order to discuss a strategy for implementation. The most obvious problem concerned the differences between the British education system, in which refugees and children seeking asylum attend regular schools, and the Dutch system, in which they attend special schools. A second problem concerned financing: staff had to be trained and some programs even required two teachers for each session. Thirdly, there was no agency in Britain comparable to Pharos which might provide organizational support. In spite of all these practical problems, responses to the content and philosophy of the Pharos programs were extremely positive.

These problems were further discussed by the British team of experts and a joint meeting with Dutch experts was held in Brussels, at which participants from education authorities in Gloucester, Manchester and Kent agreed to take the program further in their localities. An e-mail discussion group was also set up. It was decided to proceed towards implementation at a “grassroots” level, involving initially one or two schools and education authorities, and then move towards wider implementation. The team felt that the primary school programs would be the easiest to implement. Finally, the need was recognized to involve refugees themselves in the running of the programs.

The process of implementing the Pharos programs in the UK has made a very promising start. Following the meeting in Brussels, a delegation from Manchester visited the Netherlands to view the programs first hand and have been impressed with the results. This was followed up in 2004 by a visit of Dutch experts to Manchester, where plans to implement some of the Pharos programs are in an advanced stage.

8. Discussion and conclusions

The comparative study of mental health services for refugees is at an early stage and the present research represents a further, cautious step into that field. However, by mapping the mental health care of refugees in four countries, it is possible tentatively to discern some common features of services and issues to be addressed. Further research may determine to what extent these are common features of service provision throughout the industrialized world. The study suggests that these are some of the interrelated key challenges facing services.
8.1. Disparities between “top-down” and “bottom-up” approaches

The Dutch mental health services for refugees were more stratified, systematic and hierarchically organized than the British. As such, our research suggested that the Dutch mental health regime represented offered a relatively “top-down” approach. British services were less systematic and there were considerable differences in the range and quality of the services in different parts of the UK. A positive aspect of the British experience was that there were a very wide variety of service initiatives, including services offered by hundreds of refugee community organizations (RCOs).

The British approach was so organic and grassroots oriented that policy making by central Government would often be preceded by work by advisory groups such as the Audit Commission. The Audit Commission is an influential public body responsible for ensuring that public services deliver value for money, who surveyed the variety of services around the country and, on the basis of this, made recommendations for policy development (Audit Commission, 2000). A negative feature of this was that the organization of services was sometimes chaotic and there were severe problems for service providers trying to organize programs of care for asylum seekers dispersed from London.

Spain and Portugal also demonstrated some of these problems with the location and content of services not necessarily following from an overarching view of the demography or needs of migrant and refugee populations. The research suggests that an optimum arrangement may be one in which there is “top down” planning of services to ensure, as far as possible, an appropriate distribution of resources. This might be best combined with measures to ensure that community based initiatives are supported in the localities where refugees are based.

8.2. The ad hoc nature of service provision

Many of the examples of good practice cited in the report have been the result of initiatives taken by determined professionals with a deep concern for the welfare of refugees. These professionals often doggedly sought funding to build up a service by working through personal and professional networks and their respective health and social care agencies. The reason why there was a particular mental health initiative in, say, Barcelona or Glasgow, was often less to do with top down planning than with individual initiative. On this basis, many commendable organizations have developed. A weakness of such ad hoc strategies, however, is that they may rely on the personal skills and resources of a founder and may be highly dependent on this person’s ongoing involvement. Because mental health services for refugees were often delivered in the form of special short-term projects, these services often experienced problems in terms of continuity and integration into mainstream health care provision.

8.3. Continuity of care

Many of the services, both in their reports and in comments made to the researchers, expressed concerns about being able to provide long-term care to refugees. The aspiration to provide comprehensive care, particularly to asylum seekers, was undermined by policies of deterrence that resulted in measures such as dispersal, detention and rapid deportation. Individuals often moved from place to place speedily making it difficult or impossible for care-givers to develop and
implement appropriate interventions. The Breathing Space Project’s Bi-cultural Team operated, for example, in a One Stop Service, which managed social support arrangements for in the region of 70,000 asylum seekers in a year. Many of the clients were dispersed, while others led itinerant lifestyles between forms of emergency accommodation. Their geographic dispersal and transience posed significant challenges for the effective treatment of those with particular mental health needs.

8.4. Refugees and undocumented migrants

At the present time, many EU countries are reporting a dramatic decrease in asylum applications. This is seen by observers such as the European Council on Refugees and Exiles as a consequence of tougher border controls, more rigorous screening of applications, swifter deportation and further restrictions in welfare support (http://www.ecre.org). As a consequence of these measures, it is likely that people will continue to enter EU countries, but be less inclined to seek asylum when they arrive, thus swelling the numbers of undocumented migrants. 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.

8.5. Access

The right to care is one thing; good access to care may be quite another. Usually, access to services is via professional gatekeepers. Barriers may arise from the gatekeepers’ 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. “Brokers”, “advocates” or “mediators” thus have an important role to play in ensuring good access and appropriate referral.

9. Recommendations for the development of minimum standards in the mental health and social care of refugees

Our findings led us to conclude that, in broad terms, good practice in the mental health and social care services for refugees includes the following components: cultural sensitivity, an integrated approach, political awareness and accessibility. Those services that have been identified as offering good practice have combined, to a greater or lesser degree, these four components. In the main report (Watters et al., 2003) we have elaborated this argument further.

As noted above, a landmark European Council Directive, dated 27 January 2003, has laid down minimum standards for the reception of asylum seekers by EU member states. As a complement to these guidelines, we would suggest the following guidelines for the provision of mental health and social care services to asylum seekers and refugees:

- An assessment of mental health needs should be undertaken at an early stage of the asylum seekers application;
- The assessment should be sensitive to the particular culture and language of asylum seekers and include interpreters and translated materials where required;
- Advocacy services should be 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, should receive training modules to develop their skills and awareness in dealing appropriately with this client group;

- Asylum seekers and refugees should be consulted about the sort of services they would find helpful; and

- Mental health and social care services should be responsive to the stages of the asylum process and provide support at key phases during which clients may be most vulnerable.

Our research has shown that there are complex local variations in the context of care provision, which lead to widely divergent solutions. Nevertheless, exchanges of ideas and practices can still be of great value. Those working in refugee service and mental health care fields may gain new insight into their own situation by comparing it with that of others. The authors sincerely hope that the report described in this article marks the beginning of an extensive program of development in this field.

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References


