Good Practice Guide on the Integration of Refugees in the European Union

Health

Acknowledgements

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The six Good Practice Guides which make up this publication are as follows:

Good Practice Guide on Community and Cultural Integration for Refugees
Good Practice Guide on Housing for Refugees
Good Practice Guide on Health for Refugees
Good Practice Guide on Education for Refugees
Good Practice Guide on Vocational Training for Refugees
Good Practice Guide on Employment for Refugees

Consiglio Italiano Per I Refugiati

Good Practice Guide on Health for Refugees in the European Union

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Introduction

Background to the theme

"Refugee experience is essentially an experience involving loss. Loss of what is obvious, tangible and external such as possessions (e.g. a house), of a role in the work-place, status, a language, beloved members of the family or other close relatives); also a loss which is less obvious, internal and subjective: loss of trust in oneself and others, loss of self-esteem, self-respect and personal identity. You are suddenly stripped of things which link you with your community. The absence of all these links brings on stress, anxiety, depression and disorientation" (Refugee Health Panel)

According to the definition of the World Health Organisation (WHO) health is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". Refugees can suffer from a range of health problems relating to their experience of political persecution, imprisonment, torture and the conditions of flight from their country of origin. Once in the country of asylum, refugees' health can also be affected by a serious decline in their standards of living (housing conditions, unemployment or underemployment, social isolation and low income). Other external factors in the settlement phase such as insecurity of the asylum application, fear for the safety of family members, legal and bureaucratic difficulties in family reunification, adaptation to the new environment (e.g. new language, habits and culture) and hostile attitudes within the country of asylum might have an impact on refugee health, especially mental health.

Health is to be considered a vital element in the integration process as people's quality of life and personal development is related to their physical and mental well-being. Therefore 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 but not least the setting up of special provision tailored to refugee-specific needs and their expectations of care, if and when this is required.

Methodology

Since November 1997 NGOs, public institutions, practitioners, refugee community organisations and refugees have been involved in (i) analysing obstacles to refugee use of health care facilities and (ii) proposing solutions / ways to improving accessibility of health services, also tailoring prevention policies to refugees' experience and cultural background, as well as (iii) devising innovative ways of dealing with

traumatic events. CIR's main focus has been not only on identifying short-term projects but also mapping out the range of health activities (information, counselling, mediation and rehabilitation facilities) carried out in particular by NGOs and Local Health Authorities as part of their work[27].

A general questionnaire was devised by the ECRE Task Force partners to gather organisational information from NGOs and other organisations working in the field of integration (such as academic institutions, local authorities etc.). A thematic questionnaire on health was included with the general questionnaire, addressing key issues such as: (i) the main obstacles to accessing health care services, (ii) the main problems having an impact on refugee health and (iii) innovative and successful practices in dealing with refugee health. Suggestions for policy changes that could be advocated at EU level were also requested.

The first organisations / projects to be contacted were ECRE members and Pilot Projects. These and other contacts referred CIR names of other experts and organisations with appropriate contact details. During the two years of activities we have sent out 252 questionnaires. 72 organisations including NGOs, Local Authorities and Health Authorities responded. NGOs were the most responsive, as they were the special "target" of the ECRE Task Force Project.

Visits to projects / organisations (e.g. Belgium, Germany, Denmark, Italy, Portugal in 1998; France, Greece, the Netherlands and the UK in 1999) and interviews with refugee agency practitioners, researchers and public sector officers, were also carried out through a factual questionnaire, in order to look at a wide range of national traditions and practices in the health field. Major subject areas were progressively outlined: (i) health prevention; (ii) access to health care facilities; (iii) dealing with traumatic experiences (through counselling and rehabilitation programmes). The most widespread activity among European NGOs seems to be psychological counselling as well as information facilitating access to health care services (i.e. how the system works). On the contrary, activities mentioned to a lesser extent are: training of health professionals; preventive care activities; gender related attention and medical treatment and rehabilitation of traumatised refugees.

A first Health Expert Meeting was held in Rome on the 5th - 6th June 1998, its aim being to bring together health experts from EU countries. Eleven European countries were represented at the meeting to present different national contexts and discuss issues raised from the questionnaires, paving the way to the European Conference on Integration of Refugees (Antwerp, 1998).

From the results of the returned questionnaires and the discussion held at the Health Expert Meeting two major subjects were identified and considered at the Antwerp Conference (i) health prevention when

27 Inventory of Organisations working in the Field of Physical and Mental Health in the EU Countries CIR, 1999.

dealing with traumatic experiences and (ii) facilitating access to health care services. Two case-studies in the field were also provided: *Pharos Foundation* from the Netherlands and *Lambeth, Southwark & Lewisham Refugee Outreach Team* from the United Kingdom.

On 1st-2nd July 1999 a Health Refugee Panel was held in Dalfsen (the Netherlands) in order to involve refugees more directly in our work. Hearing their personal experiences and contributions was considered of the utmost importance in enriching and finalising the two years' work. An in-depth analysis of problems and a first draft of recommendations on specific obstacles / problems to integration (focusing on health) resulted from the Panel. It was the first such meeting to be organised in the EU in which refugees from different EU countries were asked to discuss the problems and propose recommendations to overcome them.

A second Health Experts Meeting was organised on 24th - 25th September to allow a few practitioners with a refugee background, researchers and also three representatives of the Dalfsen Panel to comment on the analysis carried out by the Health Refugee Panel and to define models of good practice through case studies in the three main areas (i.e. prevention, access, and rehabilitation), and to redraft final recommendations.

The outcome of this two-year consultation process is an overview of initiatives which seem to work out successfully in some EU countries and whose principles / key elements might be of inspiration to others working in the field and transferable to other countries. From national experiences and projects gathered, we chose some of the practices which address the major problem areas (i) **health prevention**, (ii) **access to health care facilities**, (iii) **dealing with traumatic experiences: counselling and rehabilitation programmes (through art and employment)**. A few models have been taken into account, which demonstrate elements such as: innovation, transferability, refugee participation during the planning and implementation stages, the role of refugee empowerment, the level of involvement of public institutions, long-term impact, multiplier effects. According to national contexts and policies these elements are more or less present: in Nordic countries the biggest share of financing comes from the State, thus public institutions are directly or by delegation involved in refugee health care. There is not so much room for grassroots initiatives. In southern countries NGOs and charitable organisations play a stronger role, supplementing State intervention, not only focusing on refugees but also on migrants. They often rely on EU funds, local financing and private donations, demonstrating a great deal of "flexiblity" in their initiatives but with long term survival difficulties. The UK deserves a special mention as it has a very long, well-established non-governmental tradition as well as for its very dynamic refugee community organisations carrying out valuable initiatives, sometimes in cooperation with Local and Health Authorities. Not all the

EU countries / projects are represented in the guide. This is in no way meant to be a criticism. In some cases we might not have been aware of successful initiatives, in others we have referred to examples illustrating the underlying principles of what is meant by "good practice". Reference to recent publications on the issue of health is also made, where relevant.

Section 1: The issue of entitlement; the right to health

The right to health is affirmed by articles of several treaties and international Conventions[28]. Notwithstanding, its substantive meaning is far from being assured as it also involves societal aspects and varying health care systems. If health and human rights are considered to be an interdependent phenomenon, they are especially at risk among the most vulnerable groups of society: children, immigrants, refugees, asylum seekers, persons deprived of liberty, the mentally ill, drug addicts and prostitutes[29].

According to article 23 of the 1951 UN Convention relating to the Status of Refugees, a Convention refugee is fully entitled to access to the NHS (National Health Service) on the same ground as nationals. On the other hand, asylum seekers' and humanitarian / de facto refugees' right to health varies according to national legislation. Some European countries, because of financial constraints, limit the access and treatment of asylum seekers and humanitarian refugees to necessary care only. Some of them provide asylum seekers with a health check-up on their arrival; some others neither entitle asylum seekers to access to the NHS nor provide them with any medical reception.

A. European practices: provision for asylum seekers and humanitarian refugees

There are differences in health provision for refugees in EU countries. In Austria, Belgium, Greece, Denmark, Germany, Finland and Sweden asylum seekers experience various restrictions with regard to accessing the NHS and are only entitled to emergency medical care and / or to a minimum standard of treatment except for children and pregnant women (Denmark, Finland, Germany, and Sweden). In

28 Art. 1 and 55 of the Charter of the United Nations; art.25 of the Universal Declaration of Human Rights; art. 2 and 3 of the European Convention on Human Rights; art 11 and 13 of the European Social Charter; art 3 of the European Convention on Human Rights and Biomedicine.

29 Proceedings from the European Conference on Health and Human Rights, Strasbourg 15-16 March 1999

other countries (France, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and the UK) asylum seekers and humanitarian refugees are entitled to access health services on the same grounds as nationals.

In Belgium, Denmark, Finland, Sweden a medical reception is provided for asylum seekers on arrival in reception centres (i.e. compulsory in Belgium and a free offer accepted by nearly all asylum seekers in Denmark, Finland and in Sweden); access to the NHS and medical treatment is provided if necessary.

In Austria, Germany, Greece neither is medical reception provided nor is access to health care services granted to asylum seekers and humanitarian refugees except in cases of emergency.

In France, Ireland, Italy, Luxembourg, the UK, the Netherlands, Portugal and Spain asylum seekers and humanitarian refugees are fully entitled to access to the NHS. In the Netherlands medical reception is provided to asylum seekers on arrival, a compulsory check is carried out for Tuberculosis and all other medical checks are voluntary. The aim is to see all the asylum seekers (on a voluntary basis), with priority given to the 0-19 year olds, pregnant women, the disabled, those with a medical case history and other at risk groups. In practice 80-90% of the asylum seekers are seen. In Luxembourg and in Spain a compulsory health check is provided to asylum seekers on arrival in reception centres; (not everybody is granted access to reception facilities in Spain). In France a health check is offered in reception centres and accepted by nearly all asylum seekers (not everybody is granted access to reception facilities). In Portugal a health check is provided on a voluntary basis at the Institute of Tropical Medicine in Lisbon. In Italy and in Greece no medical reception is provided upon asylum seekers' arrival (except in cases of mass arrival). In Ireland a check up is provided, on a voluntary basis, by the Department of Public Health at the Refugee Application Centre in Dublin.

B. Analysis of problems

Refugees participating in the Health Panel stated that: "*The health of refugees is affected by many factors including their pre-refugee status, the cause of their flight, the displaced period, camp conditions, adaptation and final settlement in the host country. Therefore it is important not to generalise about health and disease problems of refugee communities.*" They also added that: "*Health needs associated with newly arrived refugees may include high levels of untreated illness, complications arising from war wounds or amputations and the treatment of resulting disabilities*".

People arriving at the border could be in poor health, having spent some time in a refugee camp, or as a result of coming from regions where health conditions are bad (e.g. war-torn countries). Unfortunately

host countries have the tendency to concentrate on immediate complaints only, whereas prevention would be an investment in future well-being. Therefore refugees participating in the Panel agreed on the need for a health check on arrival, both for refugees' own well-being and for the "safety" of the host society (e.g. to avoid the transmission of diseases to the new community).

As remarked at the first Health Expert Meeting (1998) there is a "continuum" as far as refugee health is concerned from the pre-asylum period through to the time asylum seekers get refugee status. Adequate reception schemes and a timely recognition of the consequences of violence and forced migration are extremely important for the realisation of an effective policy of health prevention.

The main question at stake is how the health check should be implemented and whether it should be compulsory or voluntary . For mandatory screening the major drawbacks are: people can be tested without being informed; public opinion could associate refugees / migrants crossing a border with diseases; screening could interfere with the asylum procedure. If care is a voluntary process, from a public health perspective things are obviously different. One hypothesis could be compulsory screening for some contagious diseases in reception centres and voluntary ones for others; not all Panel participants agreed on this point.

The second Health Expert Meeting (1999) confirmed the appropriateness of a health check for asylum seekers on arrival, the problems being: the risk of violation of their privacy, interference with the asylum procedure, and lack of follow up due to dispersal policies which mean asylum seekers are required to move from one reception centre to another. In fact some diseases have to be reported to the Health Authorities and the reports might end up being sent to the Asylum Authorities. If health is a *voluntary process*, the same goes for the health check. Crucial points in this phase are (i) information and (ii) reassurance of confidentiality to asylum seekers. Besides, there is a strong need to guarantee medical follow-up and treatment after the screening. In principle asylum seekers are not against a health check; but the respect for privacy is fundamental to promote it.

C. Identifying good practice

We have chosen some examples of good practice whose main purpose is not just *diagnosing* but *enhancing health prevention* on arrival (also allowing asylum seekers to access health care facilities). There are different models: the state can be directly responsible (e.g Ireland); the state can delegate an NGO to carry out the health check and medical assistance (Nordic countries). There is also a southern European model where NGOs and charitable organisations (such as Caritas in Italy, Médecins du Monde in

Greece, Le Comède in France, the Red Cross in Spain etc.) offer free medical care to migrants in general (especially those without documents) but also to asylum seekers and refugees who are not yet able or not allowed to access the system. Austria and Germany join the Southern model as they rely on NGOs to provide medical assistance and target migrants together with refugees.

The Netherlands are the only northern European country to grant full access to health care services to asylum seekers (except for in vitro fertilisation and treatment for transexuality), also planning the future involvement of the Municipal Health Services in the health care of asylum seekers in reception centres.

The COA (Asylum Seekers Reception Centre), the Netherlands

The Dutch government has delegated the responsibility for reception to a semi-governmental body: the COA (Asylum Seekers Reception Centre). The COA runs around 70 accommodation centres all over the country. In each of them there is a medical team (doctors & nurses) performing a health check on a compulsory basis. Asylum seekers are provided with medical treatment which also prevents the risk to public health. Medical doctors are responsible for the timely recognition of the consequences of violence and forced migration. When necessary, crisis intervention and short-term care are provided. *Asylum seekers who receive a permit to stay have to use the regular health service*. Before the year 2000, the medical care for asylum seekers in reception centres will come under the responsibility of the municipal Health Service.[30] (For more information about the COA, see Housing Guide, Section 1)

☺ Health check and prevention; timely recognition and treatment of health problems arising from after-effects of torture and forced migration
☺ Providing information on accessing the NHS to newly arrived asylum seekers
☺ **Full entitlement to health care facilities for asylum seekers and humanitarian refugees**
☹ Lack of continuity of care due to dispersal policy: moving asylum seekers from one centre to another
☹ Lack of medical follow up also due to a passive attitude of those who do not "choose" to have examinations performed
☹ Lack of staff expertise not only in the centres but also in the regular health care system, especially concerning mental health care

"Bosnian people in Denmark were separated from the rest of society for medical care, schooling, housing, just waiting, waiting and waiting. We stayed for a long time in a centre with a lot of other people,

30 The Construction of Health Policy for Refugees in the Netherlands. Kristel Logghe, University Maastricht, 1998

doing nothing, just waiting. My husband and I tried to keep alive, going out, visiting places, going sometimes to watch movies, but we were short of money so we couldn't afford it so much. At the end my marriage broke up, in such living conditions we could not anymore be a couple." (A Bosnian refugee living in Denmark, Refugee Health Panel)

Ireland was not until 1994, a traditional country of destination for asylum seekers. For the first time in the history of the Irish state a very heterogeneous and more culturally diverse population of individuals arrived in search of Convention Refugee Status[31] . The promptness of piloting a special "provision" for asylum seeker health care is remarkable even if some objections may have been raised.

Eastern Health Board Medical Unit, Refugee Application Centre, Dublin, Ireland

Since December 1997 the The Eastern Health Board has been offering a special refugee / asylum seeker health service at the Refugee Application Centre in Dublin. They carry out a public health screening, where people seeking asylum can, on *a voluntary basis,* receive medical tests, including a check for vaccination needs. The main focus of the activities is the detection of hepatitis B and tuberculosis. They also provide information about accessing the NHS and various support groups. When necessary they can refer people to a free psychological service which offers support to individuals and families who may be experiencing difficulties. The Unit also notifies the public health nurse of children under 6 living in the area and refer pregnant women to the public health nurse.

☺ Health check and prevention; timely recognition and treatment of health problems arising from after effects of torture and forced migration
☺ Providing information on accessing the NHS to newly arrived asylum seekers
☺ Full entitlement to health care facilities for asylum seekers and humanitarian refugees
☹ Lack of staff expertise in the regular health care system especially as for mental health needs
☹ The Medical Unit is in the same building as the Refugee Application Centre. It may engender fear and confusion in the users
😐 This initiative is quite recent and in need of some evaluation

An Algerian refugee living in Italy affirmed that: "*Refugees here, according to me the first thing, before starting the procedure should have a psychologist…he saw horrible things, incredible things…now you have seen some refugees: always their heads down, always thinking. (….). Emptying, talking makes you*

31 Asylum in Ireland: A Public Health Perspective, Department of Public Health Medicine and Epidemiology,University College Dublin, 1999.

feel good". (The Refugee Interviews).

In the UK the health check of asylum seekers on arrival is not done systematically: asylum seekers might have compulsory X-rays at ports of entry but this may not be the case if there are many of them entering at the same time. A nurse working both in the *Refugee Advice Centre* and in a Local Health Authority (London, UK) advocates a medical screening to be carried out at least for examinations such as: blood tests, hepatitis, HIV, TB. She suggests that: "*locally services might be set up carrying out this kind of check-up. These services should be expert on problems/symptoms of a given country*".

Tuberculosis Screening and Health Information Project, The Refugee Council, London, the UK

This project offered information regarding TB screening to new arrivals also encouraging preventive and curative work at primary care level. Also information and guidance to accessing the NHS and registering with a GP were provided. All the asylum seekers entering at Heathrow or Gatwick airports and going on to live in pilot boroughs were supposed to be targeted (c.a. 1,200 April 97 - February 1998). This project was carried out in cooperation with Refugee Community Organisations, Local Health Authorities and the Port Health Units at Heathrow and Gatwick airports. Apart from TB screening, the main aim of the project was to raise awareness in Health Authorities of the importance of building links and working with Refugee Community Organisations.

☺ Piloting a systematic health check for asylum seekers on arrival and linking with the NHS
☺ Raising awareness of different actors: Port Units, Health Authorities and Refugee Community Organisations
☺ Networking of major actors: Refugee Community Organisations, Health Authorities and a Refugee Agency
☹ A more comprehensive approach to health prevention (not only TB screening) would be needed

As already mentioned, in southern European countries there is no medical "reception" (except in Spanish reception centres) on arrival and only a minority of asylum seekers are offered reception facilities. Charitable and voluntary organisations provide asylum seekers, together with migrants, with medical assistance and treatment. Only a small share of their funds comes from the state. In fact granting asylum seekers access to health care services but not providing them with any adequate interpreting facilities renders this right meaningless. In this sense it is highly remarkable to find that special provision for asylum seekers has been set up which carries out a first health check, which is not easily available

within the NHS. We have taken the following example from Portugal for its innovative dimension and its flexibility.

The Institute of Hygiene and Tropical Medicine, Universidade Nova, Lisbon, Portugal

The Institute of Hygiene and Tropical Medicine of the "Universidade Nova of Lisbon" carries out a medical consultation and tests on a voluntary basis. These examinations take place at the Clinical Laboratory within the Clinical department. The team is composed of five medical doctors and nurses. People are referred from the Portuguese Refugee Council (CPR). No psychological service is provided and patients in need of psychological support / evaluation are either referred to the CPR or, in an informal scheme to Hospital Psychiatric Units. Initially asylum seekers were sent on a personal and casual basis. It was only at the beginning of 1999 that a formal protocol was signed between the Institute and the Portuguese Refugee Council, also welcomed by the Health Minister. The service is funded by the University.

☺ **Health check and prevention; timely recognition and treatment of health problems arising from after-effects of torture and forced migration**
☺ **Full entitlement to health care services for asylum seekers and humanitarian refugees**
☺ Respect for privacy and confidentiality: complete separation of the medical consultation from the processing of the asylum application
😐 New initiative: still to find ways of promoting it among asylum seekers (except asylum seekers referred by the CPR); need for some kind of evaluation
☹ Lack of a psychological service for asylum seekers / refugees

There is a real necessity for a health check which should be offered freely and promoted among refugees. The majority of asylum seekers come from war torn countries and refugee camps where health conditions can be really bad. Sometimes they stay for a certain period in a second "safe" country not having any rights to health whatsoever. What is more 80% of children are not vaccinated according to European standards. Refugees are not against a health check up, the problem is how the host society looks at it. Italy is a sort of "entry point" for asylum seekers in Europe. In this sense there is a need for the harmonisation of the health treatment of asylum seekers in Europe. (A medical doctor working at CIR Rome, Italy)

It is necessary to carry out a medical check up on arrival because people in reception centres live very close to each other. Anyway people not willing to undertake an examination, once they get the refugee status, are nevertheless obliged to carry out a medical check up, in order to get the residence permit. (…) *It would be really important to have more psychologists in reception centres, also for the debriefing of the*

staff, but funds are not sufficient for this. Asylum seekers are not mentally ill but their past experience could engender related problems and depression. (The Director of Santé et Communication Paris, France)

Signposts to Good Practice[32]

- All asylum seekers and refugees should have full access to health care facilities independent of their legal status
- A policy of health prevention and early treatment of consequences of violence and forced migration should be pursued
- A medical check up for asylum seekers should be available on arrival
- The State should be responsible, either directly or by delegation, for the health check of asylum seekers, and should provide adequate funding for implementation.
- Medical screening should be accompanied by an information campaign to provide reassurance of the confidentiality of the screening
- Immediate psychotherapeutic help should be provided to traumatised asylum seekers / refugees
- The procedure for processing asylum applications should be fast and fair
- Networking should involve major actors: state agencies, national and local refugee or non refugee organisations and a core group should be responsible for co-ordination
- Follow up and treatment should be guaranteed, departing from a diagnostic framework and working towards a global approach to health
- Quality management of health services should be promoted including evaluation by users
- Training of health personnel at all levels should be a priority, also including personnel with refugee backgrounds
- Skilled members of refugee communities should be trained as health educators, because they know the best way to address other members of their communities and promote health prevention
- The NHS staff should be "brought" inside the special health check centres for refugees
- Interpretation services are fundamental, also including the presence of "friends" in a familiar atmosphere

Section 2: Access to health care services

Granting health rights does not necessarily imply a full enjoyment of such rights, especially for newly arrived refugees. Obstacles of different nature can hinder refugee access to health services: communica-

32 See Appendix 2: "ECRE Position on the Integration of Refugees in Europe": para:112

tion and language barriers can prevent refugees from accessing services as well as economic and administrative obstacles (see also Analysis of Problems). In this sense the need for some kind of provision helping refugees to access the system (e.g. interpreting services, cultural mediators, cross-cultural health personnel) is deemed to be advisable.

A. European practices: improving access to health care services

There are differences between EU countries with regard to the facilities available and special provision for accessing the NHS. In some countries interpreting services are provided (Finland, the Netherlands, Luxembourg, Sweden), but they are not always adequate especially in small and suburban areas. In Finland these services are provided by law and are government - financed: they also foresee preventive care information through brochures and booklets in various languages. In Sweden *Introduction Programmes* on medical rights and care are delivered by Municipalities for newly arrived refugees who possess a resident permit. Interpreting services are provided by law in medical examinations. In the Netherlands a special institution, *Pharos Foundation* has been created to bridge with mainstream health providers and trained migrants have been recently employed by Municipality Health Services as cultural mediators. In Denmark refugees do not have any formal right to interpreting services in the NHS (seldom are they offered), nevertheless each county or municipality may carry out some projects for specific groups of refugees, especially vulnerable ones. In practice it is a common experience that GPs sometimes prefer to rely on friends or children of refugee patients to avoid calling an interpreter, not to waste too much time or because of hospital budget constraints.

In other countries (Austria, Belgium, France, Germany, Greece, Ireland, Italy, Portugal, Spain) interpreting services are seldom provided (Italy, Greece, Portugal, Spain). Notwithstanding, NGOs play an informative role with regard to access and use of health care facilities. In the UK there is no statutory obligation to provide interpreting services for refugees but some Local Health Authorities might carry out refugee-orientated activities.

B. Analysis of Problems

According to our findings[33], the major problems with regard to accessing the health care services in the EU countries are: (i) communication problems (ii) language and cross-cultural barriers (iii) lack of information on how the NHS functions (iv) lack of training / awareness by health personnel about refugee issues, and their specific needs and care expectations (v) lack of understanding on both sides (vi) lack of trust on the part of refugees.

33 European Framework for Health Provision for Refugees. Analysis of Findings. CIR 1998

Refugees with a professional background in health are not allowed to practice in EU countries as their qualifications are not recognised (the exact situation may vary from country to country but the common end result is that refugees find it very difficult to practice their previous profession[34]). Nevertheless, the demand for health personnel with an ethnic background is high within national health services.

The need for special provision to bridge the gap between mainstream health facilities and asylum seeker / refugee clients is shared by the great majority of respondents: NGOs, practitioners and refugees. The idea is not to set up refugee health facilities but to make the existing ones accessible to newly arrived refugees. In fact if refugees are to be integrated in all aspects of society, setting up specific institutions for them could lead to their ghettoisation. On the other hand, health care providers might never come to know how to deal with refugee clients.

Refugees at the Health Panel stated that: "*Newly arrived refugees may not know how the system functions, as health care is organised differently in their country of origin. Mechanisms may be inadequate when communicating information to new arrivals about available health services (e.g. how to register with a General Practitioner - GP, how to fix an appointment to see a GP, how to call an ambulance, how to obtain prescribed medication, etc.). Doctors do not always know the different ways trauma can be released (i.e. when people cannot sleep, are nervous, feel pain in their stomach, etc.). Therefore, difficulties over diagnoses may occur if issues relating to traumatic experiences and different cultural background are not fully recognised.*"

Furthermore they confirmed that: "*Refugees do not necessarily need a refugee doctor. Some of them might not like seeing a refugee doctor and it would not be desirable to have different health systems. This would lead to a ghetto situation*".

As was the conclusion of the Health Expert Meeting (1999) there is a strong need for "link workers" to make services more accessible to refugees. In this sense it is important to empower refugees and refugee community organisations. However, facilitating equal access to "appropriate" services, especially in the first phase of arrival should never lead to the creation of special ghettos where "refugee doctors" are good enough for refugee patients. The retraining of health personnel with a refugee background has to be considered an important contribution to the host society as a whole, in terms of the promotion of a multicultural environment. This is the only way of fighting discrimination in the long run, the final goal being not only an equal access to mainstream health provision but also full social integration.

34 For further information about recognition of qualifications see Education Guide, Section 3

C. Identifying good practice

There are a few examples of European good practice which involve facilitating access and use of health care services. Their major goals are: linking, informing, networking and empowering refugees and refugee community organisations. Key actors in this process are: public or delegated private institutions almost totally funded by governments (e.g. in northern Europe); Health Authorities (especially in the UK), and NGOs accessing national, local and/or EU funds.

The following example comes from the Netherlands which has a long tradition of reception of asylum seekers. The idea of a "bridging" institution was conceived when GPs (General Practitioners) began to feel powerless and unable to deal with refugees. "*This frustration helped them to look for solutions. Pharos has been one*" (Director of Pharos).

Pharos Foundation for Refugee Health Care, Utrecht, the Netherlands

Created in 1993 the aim of this Foundation is to act as a "bridge" to regular health care services and promote mental and social well-being of refugees, improving their access to regular health care. Refugees are considered "ordinary people with extraordinary experiences" to avoid labelling them as mentally ill people. Initially, *Pharos* was especially concerned with refugee assistance and treatment; the more refugees and health providers learned about each other the less *Pharos* dealt directly with refugees. At present *Pharos* mainly provides advice, information, consultation, training courses to health professionals and teachers and promotes the creation of networks and any other activity which may help refugees accessing health care services. Still refugees who do not find adequate care in regular health services can ask for a consultation with *Pharos*.

Pharos also runs (i) specific projects for children and teenagers to work through their experiences of stress (ii) training programmes for teachers and (iii) a mental health care activity (e.g. family therapy, body oriented group therapy and social care support).

- ☺ Integration philosophy: making the existing health care facilities available to refugees; avoiding isolation and stigmatisation
- ☺ Bridging to mainstream care facilities in the long run, by transfer of skills and knowledge (e.g. training of health staff, consultation, etc.)
- ☺ Holistic approach to health: physical, social, traumatic, psychiatric, cultural and family problems are taken into account in a holistic perspective

☺ Networking with local and regional institutions, transfer of knowledge and experience from *Pharos* professionals to health staff
☹ An integrated approach to health is not easy to practice in over-specialised societies where specific institutions deal with specific problems. GPs often tend to make medical diagnoses, forgetting the social and cultural aspects which may play a role in the illness
☹ In the short term, refugees could feel not at ease in regular health care services which are not necessarily tailored to their specific needs and care expectations
☹ A small percentage of refugees and ethnic minorities is employed
😐 Difficult to transfer to counstries where governments are less financially involved in refugee issues

A different model of "bridging" with health-care providers comes from the UK where Health Authorities are directly involved in facilitating access, especially to newly arrived refugees. Sometimes they also co-operate with refugee agencies and communities mutually exchanging knowledge and experience.

Refugee Outreach Team, Lambeth, Southwark & Lewisham Health Authority, London, the UK

This project is located within the Health Authority of one of the poorest area of South London, with a high concentration of refugees and high rates of unemployment and poor housing conditions. The objectives of the project are (i) facilitating registration with GPs (ii) supporting new arrivals through outreaching with refugee communities, (iii) raising awareness among health providers (especially GPs) and (iv) providing refugees with translated information on medical rights and health facilities. The main activities of the refugee outreach team are: raising awareness through refugee communities (i.e. explaining the importance of seeing a doctor); raising awareness among health service providers on refugees' needs and care expectations; providing information to health service managers on problems encountered; producing translated leaflets; giving support to newly arrived asylum seekers and enhancing health checks for those without access to welfare benefits.

☺ Direct involvement of a Health Authority in outreach to newly arrived refugees
☺ Integration philosophy: making the existing health care facilities available to refugees; avoiding isolation and stigmatisation
☺ Spreading information on both sides (i.e. translated leaflets on medical rights, availability of interpreting services)
☺ Facilitating understanding on both sides (i.e. through "outreach" visits and awareness-raising sessions)
☺ Empowering individuals and communities: helping users to develop their own resources

☺ Development role: involving refugee communities in the different stages of the project implementation
☺ Sustainability and long-term impact: the outreach team is based at the premises of an Health Authority
☺ Transferability: other Health Authorities could reproduce the underlying principles of outreach work through information, translating services and awareness raising sessions
☹ Financial problems: resources allocated for refugees are always minimal
☹ Outreach alone is not sufficient to tackle major refugee problems such as undiscovered mental health needs

Community Health Project, Refugee Advice Centre (RAC), London, the UK

A refugee support psychologist from the Forest Healthcare NHS Trust provides psychological support to refugees suffering from stress, depression and anxiety on the premises of *Refugee Advice Centre*; a nurse from a Local Health Authority assisted by 2 refugee medical doctors (one from Somalia, the other one from Tunisia) links up with local health services. The project is aimed at those refugees who are unable to access the NHS and/or are dissatisfied with it. It also liaises with the NHS in settling refugee complaints. Besides assisting refugees in accessing health services, the project offers refugees with medical background the opportunity of working with health services and the local community.

One of the main difficulties is accessing the system, above all in that part of London: GPs are oversubscribed.. The kind of reception refugees receive is also a barrier. If an interpreter is needed, the appointment is fixed when the interpreter can be there as well and it can take a long time for an appointment suitable for the GP and the intepreter to be found: "*People come here and ask for counselling; it might be that they went to see their GP but they don't understand the treatment, so here the staff give explanations. Sometimes GPs do not go through the hassle and refugees do not know how the system works".*

☺ Integration philosophy: making the existing health care facilities available to refugees; avoiding isolation and stigmatisation
☺ **Empowerment role: allowing refugee medical doctors to become familiar with the NHS, also lobbying for the recognition of their diplomas**
☺ Speaking about stress, anxiety etc… in a familiar and not stigmatising context such as a refugee "Advice Centre"
☺ **Involving health authorities and raising public awareness: the nurse and the psychologist working in RAC are also employed by health authorities. This could be seen as a mutual ex-**

change: an attempt by public institutions to go towards refugees and refugees attempting to understand and become familiar with Western care models

☺ **Transferability: other Health Authorities and/or NGOs could reproduce this practice**

☺ Sustainability and long term impact: involving a nurse of a Local Health Authority to liaise with mainstream provision

☺ Facilitating understanding on both sides (i.e. through "outreach" sessions, exchange of information)

☺ RAC is financed by the Waltham Forest Council, the local Health Authority and European funds: good financial interaction.

☹ Only one day a week is devoted to the Health Community project

Refugee mental health can also be affected by social and cultural factors in the new country of asylum. Therefore linking with mainstream mental health services as well is crucial. As was stated at the Refugee Health Panel: "*The cultural shock can be very severe from one country to another: the lifestyle changes, asylum seekers are not allowed to work. They remain isolated for a long time, passively waiting for a decision which will deeply affect their life. Their standard of living also declines*"

Refugee Support Service, Forest Healthcare Trust, London, the UK

This project is carried out in the borough of Waltham Forest where there is high level of social exclusion of refugees. Furthermore, there are many refugees living there who have physical and mental health problems. In 1997 a Refugee Support Psychologist was involved for the first time by the Trust in approaching refugee communities to investigate the problems they were experiencing. The seriousness of mental health needs was such as to justify the creation of a post of Refugee Support Psychologist within the Health Authority. The project aims at linking refugee organisations and mainstream health services, as well as empowering the effective coping strategies of the refugee communities i.e. what they used in their countries to face difficulties and incorporate them in the country of asylum (e.g. traditional healers, elders, "extended family", etc.). On the other hand the project provides informative material besides raising awareness among refugees about mental health needs. A leaflet produced in several languages explains stress and stress reactions; this is a useful tool for normalising refugee reactions to their situation i.e. normal reaction to abnormal situations. Also professionals are prompted not only to focus on PTSD (Post Traumatic Stress Disorder) but also to understand that exile engenders problems of adjustment which need to be dealt with.

☺ Integration philosophy: making the existing health care facilities suitable for the needs of refugees; avoiding isolation and stigmatisation

☺ Devising innovative techniques in dealing with refugee mental health needs

☺ Development role: empowering refugee community coping strategies
☺ Raising awareness among health professionals about mental health needs, focusing not only on PTSD but also on refugees' adjustment difficulties
☺ Transferability: other Health Authorities could implement a similar project after an assessment of refugees' health needs
☺ Sustainability and long term impact
😐 Difficult to evaluate the level of increased mental health awareness on refugee communities

Also some Italian Health Authorities are beginning to set up special provision for vulnerable groups, the target being immigrants, especially those without any legal residence permit. Of course asylum seekers and refugees may address these services as well in order to overcome bureaucratic difficulties when accessing health care facilities.

Servizio Medicina Internazionale ASL –Rome, Italy

This service has been set up following the enforcement of the new immigration law which entitles migrants even without legal residence to access health care services. Asylum seekers and refugees are not the main target, especially because they are legally entitled to full access to the NHS; but bureaucratic / economic difficulties lead them to resort to this facility. This service aims to provide a "bridge" to mainstream health providers especially in the first phase of migrant arrival, providing clients with information on how the NHS functions and the kind of medical treatment available, also referring patients to specialists when needed. "*It is important to empower people which means more than simply giving information. If a demand comes up, we start constructing a network to make people able to use services. Our department is a special service for migrants; doctors are not specially trained but since they have to deal with migrants they have to learn how to communicate.*"

☺ Direct involvement of a Health Authority in facilitating access
☺ Integration philosophy: making the existing health care facilities suitable to refugees
☺ Empowering refugees to find their own way in the system
☺ Transferability: other health authorities could foresee a similar targeted service for refugees
☹ Absence of translators / and cultural mediators
☹ Need of some training of health staff
☹ Financial problems: resources allocated for migrants are minimal

NGOs are also strongly involved in disseminating information and counselling activities, especially where governments do not provide any facility to asylum seekers and refugees. Austrian NGOs are very

active in this field the more so because asylum seekers and humanitarian refugees do not enjoy health rights, except in emergency cases. Therefore NGOs show a great deal of initiative despite the uncertainty of funding and long term state support.

Portobella Project, Omega, Graz, Austria

Omega Health Care Centre works for the improvement of the physical and psychological health of refugees and foreigners. Its main target is women as in many cultures it is women who are responsible for the well-being of all the members of their family. "*As at the very start asylum seekers and refugees might be afraid of going to private and public institutions it is important to find ways to reach these people and keep the initial fear as low as possible*". Omega provides individual and group counselling and psychotherapy to asylum seekers and refugees. A wide range of psychosocial care giving activities are also carried out.

A second hand shop "*Portobella*" was created in 1997, also serving as a meeting point for women (foreigners and Austrians) where women and their families can find information on institutions and organisations helping them with their new life in the country of asylum. Eight women from different countries are employed in "*Portobella*". A variety of creative workshops are held so as to reach a large number of women and alleviate their every day problems through common activities and the possibility of meeting other women in the shop. In the context of these activities the women started organising multicultural buffets at different public events, with the title "Culinary culture exchange". This initiative was received so well by the public that the idea of setting up a business was seriously undertaken. At the "Women's Café", informal sessions are held once a week where special topics are addressed such us: health, culture, etc... Also a brochure on how foreign women experienced their life in Graz was published. In the first half of 1999 "*Portobella*" was visited by 354 persons.

☺ Integration philosophy: making the existing health care facilities available to refugees; avoiding isolation and stigmatisation
☺ ***Addressing health topics in a relaxed and familiar context***
☺ ***Improving dialogue between Austrians and refugee groups***
☺ ***Enhancing prevention through informal dialogue and socialising activities***
☺ Reducing isolation and creating opportunities for work
☺ Easy to transfer in other national contexts, especially where NGOs are highly active in the field
☹ Uncertainty with regard to funding

Signposts to Good Practice[35]

- Mutual understanding between refugees and doctors should be promoted through training sessions, awareness raising campaigns, informal dialogue, books, etc.
- Interpreters and cultural mediators should be paid and work permanently within the NHS, and training programmes for cultural mediators should be provided;
- Refugees should be employed more often as cultural mediators making use of their specific background, skills and experience;
- Experience and knowledge of medical doctors with refugee backgrounds should be used and managers with different cultural backgrounds should be employed within the NHS
- Training programmes for cultural mediators should be provided
- Efforts should be made to raise the awareness of health providers about refugee issues (background, cultural differences)
- Specialised refugee services should form a permanent part of mainstream health provision and benefit from long-term public support. They should act as "bridges" to mainstream provision and focus on specific care and treatment needs resulting from experiences in the country of origin and during a refugee's flight to safety and reception in host country. These bridging services should be available for a s long as they are needed.
- The provision of health information to asylum seekers and refugees should be improved through leaflets, radio and television programmes and home visits by nurses, as well as information sessions in different languages;
- *Mutual cooperation should be established between NGOs and Health Authorities*
- *A clear legal framework should be established for access to health to avoid relying purely on the good will of providers*

Section 3: Dealing with traumatic experiences

Trauma is present at various stages of the asylum seeker's experience. It occurs when fleeing from the country of origin and also in the host country during the reception procedure. Some factors seem to have a strong negative impact on asylum seekers' psychological condition: a long waiting period; insecurity and great uncertainty concerning the future; lack of meaningful occupation and work; lack of control

35 See Appendix 2: "ECRE Position on the Integration of Refugees in Europe", para 113

over one's own life; being "stored" and not being seen as a person; lack of psychological support and treatment; deficiencies in accommodation; isolation from the majority of the population of the country; negative attitudes towards refugees among the majority of the population of the country of asylum [36].

A. European practices: (i) reception arrangements[37], (ii) counselling and social care activities, (iii) setting up specific rehabilitation centres

Asylum seekers are frequently accommodated in reception centres where they tend to spend quite a long time, especially in northern Europe. "*They are physically broken down during the time of waiting. Several of the asylum seekers whom I have met, I felt that the long time of waiting and uncertainty was another form of psychological torture. Sometimes they describe that their experience is even worse than that which they have experienced in their home country.*"[38] In the UK and in Ireland there are no reception facilities and asylum seekers may be lodged in Council accommodation. "*Refugees are often accommodated in cheap buildings located near busy, noisy roads with inadequate sound insulation. Dilapidated houses with structural defects and decaying walls predispose them to ill health. The level of hygiene in this dwelling is a very significant environmental health factor, due to overcrowding and insufficient sanitary conditions especially for those who spend most of their time indoors such as infants, young children and the elderly.*"[39]

Reception arrangements in Southern countries (Greece, Italy, Portugal, Spain) are very different: asylum seekers seem to experience the opposite problem. Reception facilities are not adequate (limited places) and the duration of stay permitted is not long enough. Only a minority of asylum seekers are offered reception facilities. Asylum seekers may undergo the experience of camping in parks, in the city centre and in central stations. The shortage of houses as well as the lack of welfare benefits make the lodging of asylum seekers and refugees an urgent issue.[40]

Refugees may have specific experiences related to persecution, imprisonment, torture, separation from their family and friends, uncertainty about their future. This may cause anxiety and mental stress.

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36 *Traumatised Refugees and the Refugees Reception Procedure in Nordic countries*. Summary of a report published by the Nordic Minister Council 1996. Paper presented at the European Conference on Integration of Refugees, Antwerp 1998 by Gunilla Björkqist, Psychologist at Stockholm University.
37 See Housing Guide
38 Idem
39 Health Panel Report, Dalfsen, The Netherlands, 1999
40 Reception and Accommodation of Asylum Seekers in Europe, FTDA 1997

As already mentioned one of the most widespread activities among NGOs is psychological counselling showing that there is a strong need for orientation and advice. A high percentage of respondents affirm that their activities /projects supply health care systems or test new practices in equal measure. They seem to promote and offer services which are not easily available within mainstream health provision, i.e. an integrated approach to health and cross-cultural counselling. Some studies show that when ethnic-oriented services are available they are highly used by asylum seekers / refugees. The main reason is obviously the opportunity of speaking their own language and getting in touch with a familiar atmosphere.

While testing new practices, activities such as non-verbal therapies (i.e. music, art, drawing and body relaxation techniques) are practised to a lesser extent.

There are not many rehabilitation centres for traumatised asylum seekers and refugees in European countries. In terms of provision there is a large gap between northern and southern Europe. According to our data[41], there are no centres for traumatised asylum seekers and refugees in Italy, Portugal and Spain. Furthermore, some rehabilitation centres (e.g. Danish Red Cross) only deal with recognised refugees for both financial reasons (medical insurance companies do not pay for asylum seekers) and therapeutic ones. There are also long waiting lists for those wishing to be treated.

B. Analysis of problems

All our respondents (NGOs, practitioners, experts and refugees) agreed on the negative impact on health of (i) the long waiting period for the processing of an asylum application (smoking, drinking, drug abuse and suicide attempts are also known to increase during such a period) (ii) a long stay in a reception centre and / or in bad housing conditions and (iii) prolonged inactivity.

A refugee client of CIR explained: "*The worst thing was the shock over where I ended up when I arrived, the reception centre, it made me feel bad…a refugee has made no plans, he is not prepared to find himself in those conditions…when he arrives he needs to have a dignified accommodation, otherwise he gets discouraged .*"[42]

Hosting refugees means being not only aware of their requirements, but preparing a welcome that can meet their primary needs and at the same time deal with a lack of mental well being (…). This means

41 Inventory of Organisations working in the Field of Physical and Mental Health in the EU Countries CIR, 1999.
42 Pilot Study on a Group of 60 Refugees, Clients of the CIR, Cirinforma, 1998.

that the centres which offer immediate assistance should be run by highly qualified personnel capable of perceiving at the outset the level of suffering which the refugee has brought with him or her. The staff ought to be able to take the measures necessary to prevent a lack of mental well-being from remaining untreated with the consequent danger that it may turn into a chronic, structured mental disturbance.[43]

"Refugee experience is essentially an experience involving a loss. Loss of what is obvious, tangible and external such as possessions,(e.g . a house) , a work role, a status, a language, beloved members of the family or other close relatives; also a loss which is less obvious, internal and subjective: loss of trust in oneself and others, loss of self-esteem, self-respect and personal identity. You are suddenly stripped of things which link you with your community. The absence of all these links brings on stress, anxiety, depression and disorientation" (Refugee Health Panel)

Being a refugee does not necessarily lead to mental troubles. "*The refugee experience is not, in itself pathological.*"[44] As already mentioned, major causes of trauma are due to human rights violations in the country of origin and to secondary traumatisation in the country of asylum. In this sense there is a need to prevent and alleviate those factors which could undermine refugee health in the long run.

At the Health Expert Meeting (1999) there was full agreement on the need to spread knowledge about trauma and rehabilitation to health care providers. The simple setting up of "special units" to help traumatised refugees leads to the treatment of a small privileged minority and a long waiting list for others. The real issue is *" to be where people are*". Different and more flexible ways of dealing with trauma are also desirable (e.g. self-help groups) the goal always being to avoid medicalization and stigmatisation. Restoring hope is crucial, also motivating people "to get back in to life"; in this sense secondary traumatisation could hinder this process.

C. Identifying good practice

Campaign to reduce the duration of stay in reception centres and promoting a suitable reception regime in the Northern countries: an example from the Dutch Refugee Council

The Dutch Refugee Council and the Pharos Foundation have recommended:

- To give asylum seekers who have stayed in the large-scale central reception system for a period of one

43 Idem.

44 *A Shattered World. The mental health needs of refugees and newly arrived communities,* CVS Consultants and Migrant and Refugee Communities Forum, London, 1999.

year and a half or longer a residence permit, for urgent humanitarian reasons. This permit would not be given for reasons of protection but simply because a prolonged stay in a centre is unacceptable on humanitarian grounds.

- To limit large-scale reception to six months for everyone. *This is the maximum permissible from a health perspective.*
- To make it possible, on the grounds of a medical indication, to provide decentralised housing to some asylum seekers.
- To offer a small-scale reception in municipalities when asylum seekers have not received a definitive decision with regard to their application for asylum. This type of reception could be set up under the responsibility of the central government."[45]

☺ Advocating a different kind of reception scheme on a small scale which could be applied in other countries in northern Europe.

ABRI Amsterdam, the Netherlands

Abri is a unique experience in the Netherlands: a small reception scheme compared to a large centre. It does not depend on the COA (Asylum Seekers Reception Service) . "*ABRI is something else*". *ABRI* accommodates people (asylum seekers and refugees) with serious behavioural problems, with PTSD, and traumatised people. Some of them are also minors. Guests are sent to *ABRI* from asylum seeker accommodation centres when they can not remain in large centres. The reception capacity of *Abri* is about 35 persons (asylum seekers and refugees). A social worker is employed and a medical team (GP and psychiatrist) is in constant contact with *ABRI*. There is a first interview for admission: if asylum seekers have serious psychiatric problems, they can not be admitted. Afterwards, asylum seekers / refugees are interviewed by the social worker. "*They can live here if they want to work with their problems*". ABRI does not accommodate alcoholics or drug addicts.

They always work with interpreters as "*it is important for people to express themselves in their own language*". The guests of the centre are called *residents*. Once here the *residents* talk with the staff and with the interpreter who explains all necessary and practical things to them. There are only single rooms and every floor has a kitchen and a living room. After about 8 weeks the situation is evaluated in a talk with the resident through the interpreter. *ABRI* encourages the *residents* do to something, to be active, they do not want them to do nothing: e.g. going to school, learning the language, voluntary work, etc., "*because*

45 Asylum Seekers – Don't Let them just sit and wait. Six months in a centre is a limit. Dutch Refugee Council, June 1997.

the more they live in their rooms, the more they think, think and think". If they do something "*they feel valid*". There is a special plan for everybody. After 8-10 weeks an evaluation is carried out by the staff.

"*The refugee issue is a frequent and hot one recently in the Netherlands. The possibility is under discussion of making asylum seekers work. For sure inactivity does not help, they become passive*". (see Employment Guide, Section 1)"*We don't do things for them, we do things with them*" (e.g. sometimes they ask the staff to make phone calls on their behalf to lawyers or doctors). "*We follow them all but like a helicopter*". The residents do not remain in the centre for more than two years. The organisation is financed by the government and ABRI which is an insurance company.

- ☺ A reception scheme tailored to asylum seekers with personal difficulties, behavioural problems and PTSD.
- ☺ Linking up the reception period with learning the language, volunteering, social events, warm atmosphere (i.e. cooking for themselves) to prevent people becoming passive and demoralised
- ☺ Education as a healing process (e.g. learning the language)
- ☺ Piloting a reception scheme on a small scale
- ☺ Paving the way to future integration by a progressive introduction to Dutch society

Rehabilitation means different things: (i) empowering people, (ii) regaining self-confidence and control over one's own life, (iii) feeling of wholeness (mental / physical / social / spiritual). Cross-cultural counselling seems to be very positively received by refugees. Trust is built up more easily and the language is no longer a barrier. It also empowers skilled people from ethnic minority backgrounds and provides an opportunity for them to be valued in the country of asylum. Nevertheless it is important not to leave refugee communities to deal alone with these issues, but to provide them with re-training and the necessary financial support.

The Bosnian Project, Welcare Community Projects, London, UK

The Bosnian project is one of the activities run by Welcare Community Projects. It started in March 1997 to assist Bosnian refugees to recover from their experience of war and imprisonment in concentration camps. In the framework of a resettlement programme for Bosnians funded by the Home Office, they were in the first phase assisted by the Refugee Council. When this programme ended Bosnians were still in need of help. This ongoing need led to the birth of the Bosnian project in 1997: a Bosnian development worker was appointed.

The first Bosnian group meeting was called the "coffee group": when they arrived at the Mosaic centre they were offered a Bosnian coffee. That it is to say that *"they started solving problems with coffee*".

In the framework of the project services are provided to different groups of Bosnian refugees: children, teenagers, the elderly and women. Services provided include counselling and therapy in a non direct way i.e. through playing for children, painting, drawing and drama workshops for the young. The women's group concentrates more on handicraft, also organising exhibitions. "*We try to keep the positive things in their culture in terms of coping mechanisms*".

A "social club" has been also set up and is run entirely by volunteers and clients. This club organises cultural events, outings and provides space to meet each other, also enjoying Bosnian television programmes and English classes.

These groups concentrate on "culturally" appropriate ways of dealing with trauma (i.e. experience of flight, loss of loved members of family, violence) and life in exile through keeping traditions, such as coffee, sewing and handicraft from their own country while also trying to readjust and integrate them into the country of asylum.

Mental health problems are explained as being a normal reaction to abnormal situations. More serious cases are referred to specialised centres.

☺ **Bridging with main health providers (information on how to register with a GP, to see a specialist, benefit rights, etc)**

Dealing with traumatic experiences in a non stigmatising way, through informal counselling and providing advice in a familiar environment

Cultural development through arts (e.g. drawing, handicraft)

Lack of funding is a major problem (e.g. the project can not rely any longer on a mental health social worker, due to lack of funds even if "such a figure would be necessary").

Tvaerkulturel Psykologisk Rådgivning (TPR) Cross-cultural Psychological Counselling, Copenhagen, Denmark

TPR is a non-governmental organisation which provides psychological counselling, treatment and social support to refugees and cross-cultural training to the personnel of NHS and other groups working with refugees. The staff is in large part made up of professionals from ethnic minority backgrounds. Research and awareness raising activities are also carried out.

The overall aim is to achieve social integration of refugees; by providing help and support to refugees and ethnic minorities, especially to those who have difficulties and psychiatric problems; they also carry out activities aimed at preventing suicide among ethnic minorities. Not being able to speak about everyday problems is a major source of concern to refugees and foreigners in general. TPR offers this opportunity, it "translates" cultures into the Danish language. The key to success is the respect for privacy and anonymity. "*Empathy with the users is crucial and cultural differences shouldn't be an obstacle to treatment*".

☺ Emphasising the contribution of ethnic minorities to the host society
☺ **Bridging with main health providers (information on how to register with a GP, to see a specialist, benefit rights, etc.)**
☺ ***Empowerment role: there is a significant presence of staff with ethnic minority background***
☺ Raising awareness and providing cross-cultural training of health officers
☹ Small organisation for a wide range of goals

Sometimes cross-cultural counselling only is no longer sufficient if the refugee is suffering from more serious medical aftermaths of torture or traumatisation, both primary and secondary ones (e.g. Post Traumatic Stress Disorder, depression, torture sequelae, etc.). For this purpose special rehabilitation units have been set up. The following project is an example of a clinic specially devoted to Bosnian asylum seekers/refugees.

Traumatic Stress Clinic – Bosnian Project, London, UK

The project started in April 1997 following a survey of Somali and Kurdish groups. According to this survey it emerged that no one liked using interpreters and that there were communication barriers to accessing NHS services. The project was financed for one year by the King's Fund and has now been extended for a second year. It is carried out in the premises of the Traumatic Stress Clinic – Camden and Islington Health Authority whose aim is to provide a service for all people who have undergone severe traumatic experiences. The main users of this project are Bosnian adult refugees, although other refugees come from other regions of Former Yugoslavia and Kosovo. Two part-time workers were chosen to train as bicultural therapists; they come from former Yugoslavia and are specialised in psychology, PTSD and in psychiatric problems. It was the aim of the project to employ people of ethnic minority background. "*As for interpreters if he/she is a good professional interpreter, not a relative, it could be fine; but talking the same language and also having the same culture, it helps in establishing trust*". Preliminary work involved meetings with organisations, GPs and other actors targeting particular areas where there was a

high presence of Bosnian refugees in order to know what could be done for them. The basic criteria are that the users have the symptoms of PTSD, have experienced something traumatic in Former Yugoslavia and that there is a degree of severity in all cases. When refugees arrive, an initial psychological assessment is undertaken; practical needs are also taken into account as mental health problems are released after the primary needs like employment, housing, family reunion, welfare benefits, etc. are taken care of. Most users are referred by GPs. The main goal of the treatment is making refugees understand what their problem is and trying to develop coping strategies: the approach is largely problem-focused. They are asked to give a "testimony" of their history which is audio-taped; it is then transcribed and the final version is given to them to keep. This has been shown to reduce symptoms of PTSD. Most serious cases are on anti-depressants and are also seen by the consultant psychiatrist at the Traumatic Stress Clinic.

Within the activity of the project leaflets have also been produced in Bosnian and distributed among refugees, but also among GPs and health authorities. These leaflets aim at normalising reactions Bosnians might have experienced, difficulties, symptoms (e.g. nightmares) telling them that those reactions are normal and that they could get help. There are also sections devoted to problems with family and children. Furthermore there is a telephone line: Bosnians can call, leaving a message in their own language saying what their problem is (trauma-related), the staff then call them back. It seems that this is a positive feature as refugees are able to leave a message without their face being seen.

☺ Direct involvement of an Health Authority through the "adjustment" of its traditional tools to a particular situation: the Bosnian one
☺ Retraining of health staff with relevant ethnic minority background
☺ Health staff having the same language and cultural background as their patients.
☺ Special provision not originally available within the NHS
☺ Spreading communication and knowledge through leaflets and a telephone line
☺ Linking with GPs and health authorities
☹ Limited target of users
☹ Not easy to transfer in context where the "knowledge" on trauma is not widespread

The following example comes from Sweden where an Introduction Programme was adapted to the specific needs of traumatised people. In this case the issue of being "where people are" is taken into account.

Introduction Programme for Refugees - Trauma and Recovery, Botkyrka Municipality, Tumba, Sweden

This project is carried out in the municipality of Botkyrka, which is one of the most multicultural parts of

Sweden. In the municipality there is, in fact, an Introduction Unit for refugees, aiming at their integration through Swedish classes as well as introducing them to future work. The project is carried out with a group of 13 men from seven different countries, with different religions and languages. *"Sometimes refugees may suffer from severe concentration* difficulties due to their background situations. They went through traumatic events: many of them *suffer from post traumatic stress disorder". R*ather then supporting them, there has been a "*tendency of forcing people*" towards integration and it is here that the project comes into play: a social worker and psychotherapist, together with a Doctor of psychiatry and a group analyst work with this group, trying to find methods that can restore hope, helping refugees to handle their present and past experiences as well as motivating them to accept the treatment. The staff makes use of an integrated approach through body work (body-orientated group therapy such as yoga, shiatzu, bio-energetics), group analysis and psychodrama to help relaxing and concentrating. In this approach, the group is also used as a therapeutic/psychotherapeutic instrument itself: "*it is only through carrying each other that they work this out*". (For more information on the employment aspect of this project, see Employment Guide, Section 2)

☺ Adapting the Municipality Introduction Programme to traumatised refugees
☺ Emotional reactions to the triggering of events become less distressing
☺ **Holistic approach to health: physical, social, traumatic, psychiatric and cultural problems are taken into account in an overall perspective**
☺ Working with the body and using the group as a therapeutic instrument
☺ Mixing languages, religions and backgrounds
😐 Difficult to transfer where municipalities are less involved in the integration field

In Germany a big role in counselling and rehabilitation activities is played by the Evangelical Church, Caritas and the Red Cross which are partially financed by the State. Private donations also play a considerable role. It is important to stress that the absence of legal entitlement to health for asylum seekers and humanitarian refugees (see Section 1) makes these activities even more crucial.

Psychosocial Centre for Refugees, Diakonisches Werk der Evangelisch-Lutherischen Kirche in Bayern e.V., Nuremberg, Germany

The general objectives of the organisation are: supporting the integration process, general counselling and care for refugees and providing therapy to traumatised asylum seekers and refugees. They link with mainstream institutions helping refugees in their first steps to orientation in the new environment.

The project "Psychosocial Centre for Refugees" focuses on refugee mental health providing psychotherapy and social support which is not covered by the NHS. The staff has special knowledge in matters of psychological advice and care of vulnerable refugee groups. Also counselling for professionals and volunteers working with refugees is provided. The centre also produces informative material translated into several languages. The staff members consist of a sociologist, a social worker, a psychologist.

☺ Filling the gap providing those services which are not covered by the NHS
☺ Presence of personnel with ethnic minority background
☺ Counselling and therapy is open to everyone regardless of their legal status

In Italy there is no rehabilitation centre for traumatised refugees; CIR runs a project called "*Hospitality and Care for Victims of Torture*" which is a fixed-term project financed by the EU and the U.N. Voluntary Fund for Victims of Torture. A more structured approach would be needed given the high degree of vulnerability of traumatised refugees and the precarious living conditions shared by the majority of them. Nevertheless, this project deserves to be mentioned for its innovative dimension in a not very favourable context. As far as southern Europe is concerned two rehabilitation centres for traumatised refugees were set up in Greece. They share the same environmental difficulties as the Italian project such as offering therapy to refugees with many societal problems (e.g. those without accommodation, or without employment and / or social benefits).

Libre-Interactive Laboratory of Well Being and Restoration, CIR, Rome, Italy

A pilot-project of psycho-social integration and vocational training, in favour of a small group of traumatised refugees. Occupational therapy is the strategy adopted to help traumatised refugees to recover from a condition of psycho-emotional distress, while empowering them and guaranteeing sustainable benefits. Refugees are trained in furniture restoration, a field which is not much exploited in the job market. A psychologist also trained in this field and a pedagogue hold sessions combining counselling and training four times a week. These sessions take place in an antique shop thus also giving refugees the opportunity of selling their products.

☺ Devising innovative ways of dealing with trauma
☺ Education and training as a healing process
☹ Only a very small group of refugees is targeted by the project
😐 The employment rehabilitation programmes is at an early stage, difficult to evaluate in terms of effectiveness

At the opposite end of the scale is Denmark and its rehabilitation centres for traumatised people. The state is the main source of finance for these services which most of the time have a referral procedure. But only a minority of those who need help are actually treated. "*There is a real need to spread knowledge on trauma and rehabilitation among health staff*" to avoid long waiting lists and provide early treatment to anybody in need of it.

Vulnerable groups like children and the elderly are often neglected. The following practice deals with children's traumatic experiences.

Psychosocial Rehabilitation, CEPAR, Copenhagen, Denmark

Most of the work carried out by the organisation consists of the following activities: psychological counselling and treatment; rehabilitating psychotherapy as well as body therapy; providing individual courses of health education; developing methods for the relief of refugees and immigrant problems. There is a referral procedure to consult CEPAR: the referring agency describes the reasons and the client's situation. A special project is devoted to Iraqi children. The staff (3 psychologists, a body therapist and an interpreter) introduced a group of girls and boys to their new Danish life while their parents are educated on the effects of war, flight and trauma of their children.

The group activities included games, drawing, creative works with the contribution of an Iraqi painter. This inspired confidence in the children in relation to their own culture and thus helped to strengthen their sense of identity. The final aim is to prevent children from becoming marginalised also offering supervision and guidance to pedagogues and teachers who are in daily contact with the children. There is a regular supervision of the daily work of the staff.

☺ Devising innovative techniques in dealing with traumatic experiences
☺ Enhancing health prevention for refugee children by offering special support
☺ Raising awareness of parents and teachers about the vulnerability of children
☹ There is a tendency to introduce self-payment from clients which obviously undermines the continuity of therapy.

Disabled refugees like children and elderly refugees are often the most vulnerable groups as no provision is made specifically for them. The following example emphasises these institutional deficiencies at the same time showing that something can be provided which is better targeted towards this particularly disadvantaged group.

Supporting the Integration of Disabled Refugees, AVRE, Paris, France

This project provides specialised training to disabled refugees, helping them to adopt a dynamic physical and psychological attitude with regard to their disability. The disability might be due to consequences of poliomyelitis, amputation, chronic diseases or ill treatment in the country of origin. Refugees are picked up in the morning for a full day of activity. AVRE provides medical assistance, rehabilitation (e.g. kinesitherapy) and psychological support. Also language and computer courses are provided. Videos are shown as an introduction to French culture. In France there is no special centre to deal with refugees with disabilities, as they are a minority. Before receiving a formal assessment of their disabilities which would entitle them to some state benefits and assistance, refugees might wait for two or more years. Furthermore they might have a passive attitude towards dealing with their disability in order to be recognised officially as a disabled person. "*They will be officially impaired people*". On the contrary, the philosophy of the project is recovering or at least learning to lead a normal life despite their disability. This project is supported by EU budget line B3-4113.

- ☺ Devising innovative ways of dealing with disabled refugees
- ☺ Enhancing health prevention, early treatment of psychomotor deficiencies, consequences of poliomyelitis and chronic diseases
- ☺ Filling the gap in welfare provisions (refugees might wait for two or more years before receiving a formal assessment of their disabilities)
- ☺ Education as a healing process: learning the language and the culture, "keeping busy with tasks"
- 😐 Pilot experience still to be evaluated, especially with regard to its long term sustainability

Also linking rehabilitation with personal independence and cultural development is an important asset of integration. There are only a few examples of activities in this field, even if there is a general agreement on the importance of combining rehabilitation and employment, the latter being considered as the main element for successful integration. Also a successful strategy to deal with trauma seems to be "*keeping busy with meaningful occupations*" which gives back to the refugees control over their own lives in terms of personal fulfilment and economic independence.

*When starting a new life in the country of asylum one of the major obstacles to personal well-being and to social integration is unemployment. At the Refugee Employment Panel it was generally felt that: "*Finding employment is crucial, if not the single most important factor assisting the integration process. Having a job not only brings a degree of economic independence but also self-esteem and a sense of contributing to the host society.*"*[46]

46 Report from the Refugee Employment Panel, Dalfsen, 1999

Unemployment causes deprivation of financial and material resources. Studies on unemployed people show that they suffer from bad health and chronic illnesses. Those who cannot practice their previous profession get frustrated and this may affect their health, especially their mental health[47] .

Mental Health Centre & Canvas – Employment Rehabilitation of Refugees, GGZ's-Hertogenbosch, Vught, the Netherlands

This project was established by GGZ's-Hertogenbosch in 1996 to provide "early" treatment of psychotrauma to asylum seekers and refugees in the region of Vught and to develop a network of outpatient facilities. The organisation provides medical care and rehabilitation, psychotherapy, psychological counselling and social support especially through an out-patient treatment centre for traumatised asylum seekers and refugees and a day treatment centre for refugees. The treatment is provided with the aid of methods such as: art therapy, music therapy and psychomotor therapy. There is one year of intensive treatment based on a five phase model. Afterwards a programme of after care and a self-help group is planned. A special insurance agreement has been made with ZRA-Insurance to cover the health insurance of asylum seekers. The client capacity of this Day Treatment Centre for Asylum Seekers and Refugees is about 60, whereas currently 120 clients are in out-patient individual treatment.

The staff includes one psychiatrist, one psychologist, one social psychiatric worker, two socio-therapists, two creative/art therapists, one music therapist, and one psychomotor therapist.

Besides treatment, another important element in refugees' lives is a successful integration and the feeling they are useful members in the society; one of the means to achieve this is through employment. "*Good trauma treatment is not only being busy with what happened*". With this aim GGZ-Mental Health Centre has planned a project called CANVAS: centre for employment-rehabilitation of newcomers. This foundation has been set up mainly by refugees who in future want to help newly arrived traumatised refugees to find a job. The aim is to accomplish their integration, because they will no longer be patients. "*Only then the treatment of the traumatised refugee can be called successful when this person involved is integrated in society as much as possible and has a job*". "*There will be an end to trauma when they are integrated*".

☺ The organisation offers a specialist provision to asylum seekers and refugees which is not provided by the NHS (therapy and non-verbal interventions in an outpatient setting)

☺ **The starting of trauma treatment at an early stage, before receiving refugee status**

☺ **Multidimensional aspect: paving the way to integration through after care programmes and employment research in the long run**

☺ **Devising innovative ways of dealing with trauma**

☹ The premises of GGZ's-Hertogenbosch - Mental Health Centre are located in a Psychiatric Hospital which might give the impression of stigmatisation of the clients

😐 The employment rehabilitation programmes is at an early stage and therefore difficult to evaluate in terms of effectiveness

Susret/Encounter Project, Frastanz, Austria

In 1992 an Austrian psychoanalyst began counselling war-exiled Bosnian women in the non-profit Susret-Encounter refugee centre in Frastanz, Austria. The majority of them came from a region near Sarajevo and had worked as shepherds, farmers, factory managers, engineers and university professors. As part of the therapy, the psychoanalyst encouraged the Bosnian women to write about their war experiences in order to be able to release guilt and regain self-esteem and emotional balance. As the women's therapy continued, the psychoanalyst identified another form of self-expression - weaving and needle arts - that suited their backgrounds and utilised their skills. Through arrangements made by a famous Austrian textile designer and a teacher at the Academy of Supplied Arts of Vienna, a partnership was established with the academy and the workshop thus set up. Leading artists and designers from 22 nations donated highly graphic, contemporary designs that were then hand-crafted by the Bosnian women into limited editions (only six per design) for the international textile-art market. The finished works have given these women a hope for their future as well as the means to financial independence.

Susret's agreement with the Austrian government ran throughout 1998. It subsidises up to 15 refugees each year as members of the workshop. At the end of the year, the group obtained Austrian work permits to live and work on their own. The first group of 13 women are now all supporting themselves. The Susret integration programme has been financed since 1995 by the non profit organisation Susret and the Austrian government and, during 1997 was supported by the EU Budget line B3-4113.

The psychoanalyst: "*The arts are a great healer and any form of craft and artisanry occupies and focuses the mind*". (…) "*One of the biggest problems to develop the Susret Project was to rebuild the trust and the belief of the refugees in new ideas. This needs a long process of human relationship with them.*" (…)*"People bought the first items out of charity"* the psychoanalyst said: *"But then the business started*". (See Community and Culture Guide, Section 4B).

47 Report from the Refugee Health Panel, Dalfsen, 1999

☺ **Multi-dimensional aspect: the project combines rehabilitation with cultural development and economic and social integration**

☺ **Empowerment role: the project has given the women a sense of pride and accomplishment besides personal financial independence**

☺ **Raising awareness of refugee issues and of the cultural and economic contribution refugees can make to the host society**

☹ It is a very "special" project linked to the managerial capacity of the psychoanalyst who started the therapy.

☹ Sales are limited, because the museum-quality quilts, carpets, tapestries etc. are quite expensive.

Signposts to Good Practice[48]

- Innovative ways should be devised to deal with trauma and promote refugee mental health
- Care providers should shift from a diagnostic framework to a more integrated approach to health
- Rehabilitation centres should be set up to help traumatised refugees to overcome their traumas
- Immediate psychotherapeutic help should be offered to traumatised asylum seekers / refugees
- The need to alleviate cultural shock should be taken in to account
- Help centres should be set up to orientate refugees to appropriate services
- A holistic approach should be taken to health and the tools used by the NHS should be adapted to the special needs of refugees
- Health promotion should be seen as an active process which entails making people feel that they are part of the society. This includes the absence of diseases, personal commitment to start a new life and inclusion in the host society (e.g. acceptable delays in the asylum procedure to avoid separation and isolation from the host society)
- Medical / psychological follow up should be ensured through home visits by nurses of Local Health Authorities
- Human rights violations and the effects of torture should be part of any medical doctor's education
- Outreach work should be used to "go where people are"
- Treatment should be flexible and creative; adapting western-oriented therapy by using body-oriented methods, music / creative therapy; using self-help methods; avoiding medicalization
- Practical help/solutions should also be provided to everyday problems, and consideration given to finding a suitable location for treatment (near by/ neutral environment)
- Clients should not be made to feel they are victims, but should be helped to develop coping strategies (normal reaction to abnormal situation)

48 See Appendix 2: "ECRE Position on the Integration of Refugees in Europe", para. 118

- A shift should be made from specialised centres to an improvement of expertise in regular services through “knowledge centres” and building intercultural competence
- Rehabilitation programmes should be adapted to different cultures and major sources of concern should be looked at and worked through
- Rehabilitation should be considered as a “transversal process” not separable from social / economic status

Health: CIR

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