12. MENTAL HEALTH AND SOCIAL CARE FOR ASYLUM SEEKERS AND REFUGEES
A comparative study

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1. INTRODUCTION

This chapter describes the results of a study (Watters et al., 2003) which was carried out for the European Commission (European Refugee Fund) during 2002 and 2003. The aim of the project was to promote the international exchange of good practice, experience and expertise concerning interventions aimed at the psychosocial well-being of asylum seekers and refugees. The project contained two elements. One, the ‘identification study’, was concerned with making an inventory of practices in selected countries. Alongside this, the ‘implementation study’ set out to transfer promising interventions from one country to another.

The following considerations motivated this project. In recent years, countries in Europe have been faced with the challenge of providing adequate health and social care for growing numbers of asylum-seekers and refugees. Despite the many problems for which the latter are ‘at risk’, their access to services may be impeded by a variety of factors. In addition, the help they receive may be less than optimal. Professionals often lack the training and experience necessary to recognize and deal with the specific needs of this group, while cultural and language differences may exacerbate problems of service delivery.

In response to such problems, agencies all over the world have devoted considerable effort to developing expertise and ‘good practices’ in this area. To date, however, this has mostly been done within the borders of each country: there has been little systematic international exchange of experience. This project examined the problems of identifying good practices and facilitating their transfer between countries. We believe that the best way forward in this field, as in most others, is through an international exchange of ideas. Innovations pioneered in one country may never have been considered in another; effort

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may be wasted in one country on developing interventions which elsewhere have been shown to be flawed.

Transferring good practices from one country to another involves the following steps. Firstly, successful interventions must be identified. Secondly, the differences between the context within which such ‘good practices’ were developed, and the one in which they will be applied, must be examined. Thirdly, in the light of this, the practices have to be adapted to the new context. Fourthly, information about the practices has to be disseminated; and fifthly, they must be implemented. Since it would have taken too long to carry out all these steps sequentially, we divided the process into two sub-projects. The ‘identification study’ dealt with the first two steps, while the ‘implementation study’ covered the last three.

1.1. Background of the study

Between 1983 and 1992 there was a tenfold increase in asylum applications in Western Europe (from 70,000 to 700,000). The surge in the early 1990’s was due to the Balkans wars; over the last ten years refugees also came from Romania, Turkey, Iraq, Afghanistan, Sri Lanka, Iran, Somalia, the Congo and many other countries. After reaching a peak in 1992 the number of asylum seekers started to decline, reaching 245,000 in 1996. This decline was partly due to a lull in the Balkans conflict, but also to the adoption of increasingly stringent procedures for the admission of asylum seekers and the granting of refugee status. Since the mid-nineties, countries of the industrialized world have vied with each other in developing the most restrictive asylum policy.

The provision of effective health and social care for asylum seekers and refugees is partly motivated by principles of human rights, and partly by pragmatic considerations. The right to care is laid down in the 1951 Geneva Convention on Refugees; more recently, the European Commission adopted on 27th January 2003 a directive laying down minimum standards on the reception of asylum applicants in Member States, including standards of health care. But apart from the question of human rights, governments also have an interest in ensuring that this group is not neglected. Ignoring the problems people have usually leads to more serious problems at a later stage. For example, a refugee handicapped by psychosocial problems is likely to have difficulty getting a job and integrating into the host society, thereby becoming even more dependent on the state.

There are two arenas in which care may be provided: locally, within the conflict region (for example in temporary refugee camps), and in host countries within the developed world. In conflict regions, help is usually provided by internationally funded NGO’s. The present study is primarily concerned with the provision of services in host countries. Here, the established services have to deal with problems and client populations with which they are unfamiliar. Our research shows that giving refugees the formal right to care is one thing: ensuring that the care is accessible and effective is quite another.