

Chapter 2. MENTAL HEALTH AND SOCIAL CARE PROVISIONS

A. SHORT SKETCH OF THE HEALTH CARE SYSTEM

A.1) MAINSTREAM PROVISION OF HEALTH CARE

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

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

A.1.1) Primary Health Care

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

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

General practitioners (GPs) are the first contact the population has with the health system and have a gatekeeper role. They may refer patients on to specialised services if necessary. These patients are expected to return to the

primary care physician who then assumes responsibility for follow-up treatment, repeat prescriptions, etc.

General practitioners conduct home visits and PHC is also responsible for the provision of around-the-clock emergency coverage either at the health centre or in the patient's home. A dedicated emergency services team may provide it or, as is increasingly likely, by rotation of EAP personnel.

Functions formally assigned to primary care teams are health promotion and prevention, curative care and rehabilitation.

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

A.1.2) Secondary and tertiary care

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

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

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

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

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

A.2) SOCIAL AND COMMUNITY CARE

A.2.1) *Social Services*

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

These services are managed partly by the Ministry of Labour and Social Affairs, and partly by the Autonomous Communities who plan and regulate local services, co-ordinate resources and oversee their assessment and control. Local governments are also involved in social care, especially in the planning and management of services. In contrast to practice in the health care sector, there are high co-payments for most social services.

The 1995 Royal Decree, which defined the benefits package for the health care system, established the need for co-ordination among the departments in charge of health care and social services when dealing with the social problems associated to mental health, but the advances made in this field are not yet visible, as is explained in the following page.

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

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

- General social services (or Community services)
These services respond to a philosophy based on the conception of general, multipurpose, community services.
- Specialised social services
These services adopt the former typology of the charitable institutions and help certain groups of people in need of help. Nevertheless, during last years there have been a tendency in the provision of these services to escape from practising an assistance approach, that does not encourage to strengthen the individual own possibilities.

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

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

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

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

A.2.2) Mental health care

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

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

guidelines for the future development of mental health services, arguing for the integration of mental health services with general health services.

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

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

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

Specific priority measures include:

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

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

With respect to co-ordination between mental health and social care services, things look a bit worse. In eight of the Autonomous Communities there exists

an inter-constitutional commission, and only in two of them there are co-ordination and liaison commissions on an area level. According to Mental Health directors, in practice these commissions' functioning is void or insufficient. On the other hand, the adopted policy of promoting private management in community services has contributed to the worsening of the communication between them (ibid, 2002).

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

Mental health services are included in specialised care, that is, in the secondary care level. The network is made up of interdisciplinary professional teams. All mental health services are structured into two levels, hospital and non-hospital, that work in co-ordination with the general health system, specialised social services, Council's social services and any other care services in the district when needed.

The following diagram shows all possible referrals within the public mental health care system.

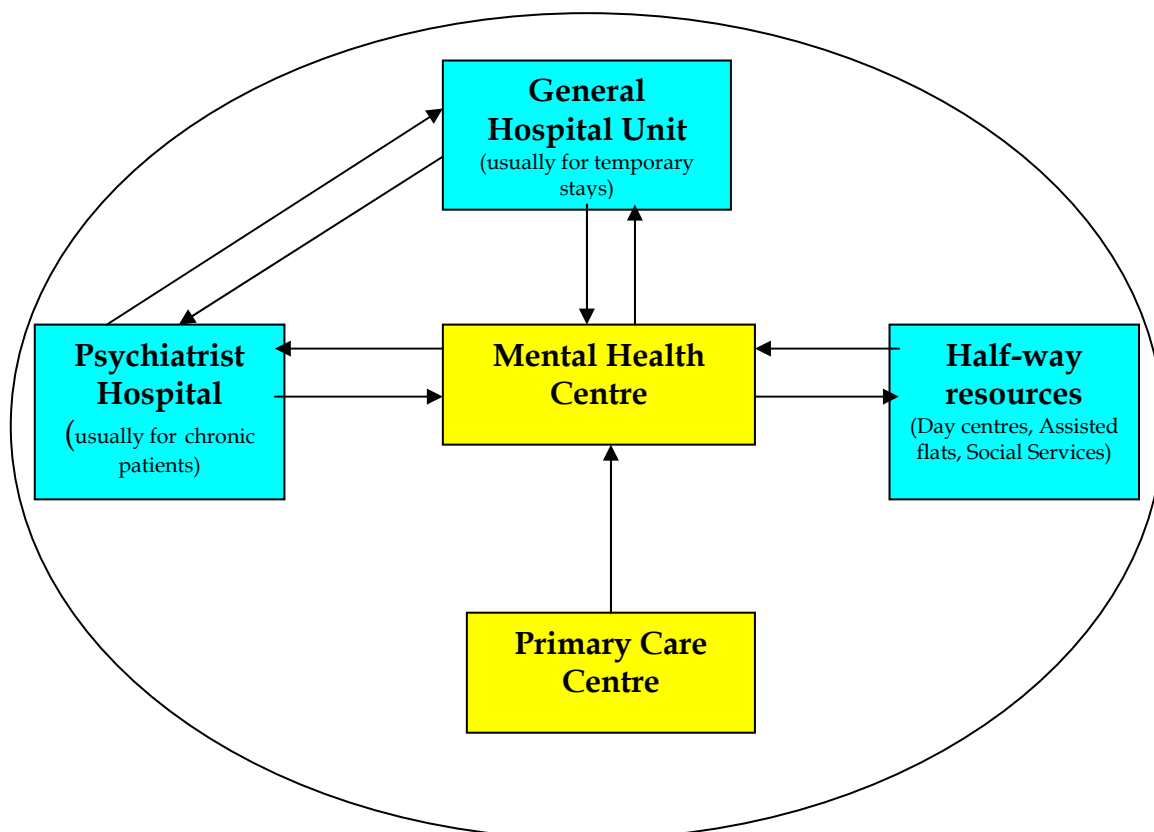


Figure 2.1. Referrals within the Mental Health System. (Self-elaboration)

The **half-way resources** consist in tertiary resources, which are an alternative to hospitalisation that bring the therapeutic process into line with a more integrated social life. These comprise of day centres, assisted flats and other social services assistance.

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

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

Theoretically, access to mental health services, like other medical specialities, is only through referral from the Primary Health Care level by a General Practitioner. Only for urgent cases, referral is not necessary. Moreover, no documentation is required so that most undocumented immigrants enter the system at this level, and afterwards they are referred onwards to a Mental Health Centre. One of the psychiatrists interviewed in this survey, who works in a Psychiatric Urgency Unit, stated that most immigrant patients arriving to the service are not referred from a Mental Health Centre, and these cases don't happen very often.

Apart from the National Health System, which is the principal provider of mental health services, depending on the Autonomous Community, additional services are provided by private organisations and charities, semi-autonomous services that are dependent or co-ordinated by the public health system, and NGO services that will be studied later on the chapter.

B. MULTICULTURAL CARE PROVISIONS

B.1) ACCESS TO HEALTH AND SOCIAL CARE PUBLIC SERVICES

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

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

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

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

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

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

B.2) SOCIAL SERVICES PROVISION

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

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

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

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

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

The information and legal orientation service has been given usually to immigrants who have registered. However, this service has lost much of its importance as these sort of demands have decreased significantly due to the growth of specific services in this field offered by other organisations such as trade unions, immigrant associations and NGOs. The legal orientation service has been the service most extensively developed and specialised during the last years by NGOs.

For the *grant's concession* and *participation in the program* it is an essential requirement that the applicant has a residence permit.

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

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

- ❑ *Ignorance of the language.* Only a few social services centres and public health centres have incorporated interpreters. Normally they are asked for in specific situations, with the consequent waste of time, and the disadvantages derived from the inefficient organisation of this provision. Usually, this service is carried out by volunteer interpreters with the ensuing problems associated to their availability.
- ❑ *Problems related to cultural differences.* For example, the lack of attention and respect paid to Muslims' diet has discouraged this group from using social services. Refectory grants do not guarantee that Muslims children's food will be *halla*, meaning that it does not necessarily fulfil the precepts of the Muslim faith which govern eating habits
- ❑ *Lack of information about social services and difficulties concerning the understanding of service operation.* The importance of the social networks generated in the immigrants' new environment are crucial for achieving this sort of information. The role of these networks - that is centred around bonds of family, race and nationality, work as oral transmission systems and play an essential role in access to social services, acting as mediators and interpreters during the first stages.
- ❑ The fear of Public Administration and the believe that social/health services may be connected to the police
- ❑ Preference for private and non-official centres

To fight some of these problems the Community of Madrid (CAM) has established Social Attention Centres for immigrants¹ (CASI) during march 2002. The project was presented in the Regional Plan for Immigration for the period 2001-2003.

CASI tries to facilitate the social integration of immigrants offering a range of services² which try to complement the action of General Social Services. Their staff is usually composed of a social worker, a psychologist, a lawyer and an

¹ See Chapter 3 for further information.

² CASI areas of activity: Specific Social Attention; Psycho-social attention; Legal Advice; cross-cultural and socio-educative integration; matters regarding employment and labour conditions.

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

B.3) HEALTH CARE PROVISION

The impact of non-EU proletarian immigration raises political, economic, cultural and, even, religious problems to the health sector (Clifford, 1999, op.cit Mascarella et al, 2002). The National Health Service is starting to deal with these problems in order to provide an adequate health care service for immigrants. Apart from the existent generic programs to which immigrants are entitled, local administration has created specific health programs aimed at immigrants. In some Autonomous Communities some of these specific programs have been the result of collaboration and agreements between areas of Social Services and Health.

The actions carried out by the municipalities with immigration programs throughout the 90's dealt with prevention and health education activities, prevention and control of AIDS and other sexually transmitted diseases, control and treatment of tuberculosis, the making of didactic and audio-visual material to inform about health aspects³ and family planning (Solana, 2002). However the high increase of immigrants arriving to our country, especially during the last three years, has promoted the setting up of other health focused programs.

The *Red Española de Ciudades Saludables*⁴ has elaborated a study collecting information from those City Corporations (Corporaciones Locales Españolas) with more than 200,000 inhabitants in order to classify the typology of their specific programs for immigrants (Viñals, 2002). Some of these programs deal with:

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

³ According to Mascarella et al, multilingual information about disease prevention is not widespread. Just a few pioneering services in Madrid and Barcelona have been working on this material since 1996, being translated to a variety of languages including Urdu, Punjabi, Arab, Chinese and even some African languages. AID prevention leaflets can be found all over Spain in English, French and, in a lesser extent, in Arab and other languages (Rapporto, 2002).

⁴ RECS is a municipal movement that tries to strengthen and correlate urban projects concerning the administration of Spanish cities and towns in order to promote favourable living conditions and surroundings (www.paeria.es/salutpublica).

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

Rovira i Virgili University and Hospital Universitari Joan XXIII, both based in Tarragona, have jointly carried out a study -which is part of the project⁵ "Health for All, All in Health" and "Partners for Health" led by the Italian NGO ALISEI -, about non-EU immigrants' perception of health services. They have conducted various interviews and focus groups with members of different ethnic minorities. Among the information gathered stands out the poor attention paid to cultural differences (especially to gender issues and diet), especially controversial during the pregnancy, childbirth and puerperium period.

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

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

With respect to treatment, Atxotegui⁶ has identified the following problems:

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

- ***Mental disorders***, which have increased because of legal difficulties, rejection and social exclusion, labour exploitation, and others. These disorders show the difficulty in coming to terms with migratory grief and feelings of loss in a context of high stress accompanied by a lack of social support.
- ***Reproductive Health***, in a population with a birth rate much higher than the indigenous one, which often lives in very bad sanitary conditions.

⁵ Partners of the project are: Belgium, Italy, Netherlands, Spain, Sweden and the UK.

⁶ SOS Racismo Annual Report, 2001.

- *Specific infectious illnesses* (like malaria and others)
 - *Labour accidents*
- B) *Lack of co-ordination in health provision.* The work realised by the sanitary personnel, especially doctors, has an excessive bureaucratic component. Doctors have to spend half of the 5-7 minutes, the prescribed length of time for each patient visiting their G.P, filling in forms, applications for medical tests, labour reports, etc. This time is clearly insufficient, especially in the case of immigrants, where difficulties in linguistic and cultural communication are added.
- C) *Discrimination concerning access to treatment.* To suitably attend these new National Health System “users” there needs to be equality of access to all areas of treatment.
- D) *Lack of education of health professionals* when attending persons coming from different cultures. This is reflected in:
- *Ignorance of the cultural conception of illness.* Traditional medicines are more alike to classify illnesses/disorders according to their origin, from a psycho-social and relational perspective – that many times is expressed through magical referents. Western medicine pays more attention to the classification depending on symptoms, what can lead in many cases to misdiagnosis.
 - *Lack of preparation in handling “counter transference”⁷* during the therapeutic process. The immigrant tends to relate inadvertently the doctor or nurse with the police or an employer, usually indigenous, who could have been very hostile to immigrants. This situation leads the immigrant not to follow or to give up the treatment.
 - *Problems of linguistic and cultural communication.* Interpreters only exist in some hospitals. As I.R. Marcos demonstrated in 1976, when a patient speaks a different language to that of the doctor, (s)he tends to over diagnose the patient. The situation is made worse by the very short time available for the visit. As I mentioned before, the time established for a visit is 5-7 minutes, which is very little even for indigenous patients.

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

Solutions to these problems include – guaranteed information and orientation about health assistance to all immigrants, providing interpreters in Primary Care Centres, building up mental health services and hiring professionals specialised in migration, etc. Nevertheless, there exist some ethical problems that could obstruct their implementation. For example, one of

⁷ Counter transference refers to the group of emotions that reflect the relationships of infants with their parents.

the psychiatrists interviewed complains of the existent discrimination in private centres against hiring foreign staff and also, the racist attitudes among current staff.

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

Moreover, in order to cover the increased demand for health assistance on behalf of the new population, a higher budget is required. The government policy of not increasing the national public budget, due to their policy of *búsqueda del déficit cero* (search for a zero deficit), is giving place to a quality decrease in health assistance. Under these circumstances it must be taken into account that, firstly, Spanish health expenditure is lower than the European average (OCDE, 1999 op.cit Atxotegui, 2001) and, secondly, immigrants are workers who widely pay their access to health assistance and contribute to an important part of national welfare. We must not forget that inadequate health assistance will generate a higher long-term cost (Atxotegui, 2001).

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

B.4) HEALTH AND SOCIAL CARE PROVISION OUTSIDE THE REGULAR FRAMEWORK

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

Since the mid 90's, some NGOs began to take part in the health care provision of immigrants. These non-governmental organisations tended, therefore, to substitute mainstream services and cover those gaps in the

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

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

- **Cáritas** has been a pioneer entity in social work with migrants and in some municipalities it is still the main reference. With the intention of not duplicating services, there have been established different agreements between Cáritas and Social Services.
- **Local parishes** have developed diverse activities like the establishment of reception centres or the provision of facilities to immigrant associations or volunteers to carry out activities such as language courses and dispense humanitarian aid among other things. Their task is very important, above all, out with the city centre where access to services is difficult. They provide food, clothing, orientation and information, and training courses. Nuns and priests are considered trustworthy persons and usually act as advisers, to whom they can tell their problems, carrying out a sort of preventive mental health task.
- **The Unions** have opened new offices for immigrant consultation concerning residence and work permits, and also for labour issues. They have also offered occupational formation courses. In this area the CITE program of CCOO stands out.
- **Red Cross** is in charge of providing emergency first aid when immigrants arrive to the coasts, by means of primary care attention and medicines. Moreover, it has different programs to facilitate their social integration. These programs concern information and orientation about their rights, reception centres, insertion in the work force, attention to specific diseases, and psychological assistance, among other things.

Other programs try to deal with cultural problems, which frequently occur in health assistance.

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

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

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

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

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

Nevertheless, most of these immigrant and refugee health care services are located in main cities, mainly in Madrid and Barcelona.

Those immigrants in an irregular situation and who cannot register are attended by NGOs, while those who have been registered can access municipal public services. However, many of those regularised keep going to NGOs services because they are more efficient (Solana, 2002).

B.5) EDUCATION

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

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

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

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

Some local administrations try to avoid this exodus by means of establishing quotas for foreign pupils per centre in order to plan their territorial distribution, but this is not a widespread measure. This distribution strategy is only possible if private schools get involved in the process (Solé et al, 2000). Moreover, there exists different opinions, as some professionals believe it is not a problem of the concentration of immigrants in certain schools but of lack of specific educational resources and autonomy that would allow adequate responses according to the specific reality of each school (Mascarella et al, 2002).

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

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

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

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

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

C. SERVICES FOR ASYLUM-SEEKERS AND REFUGEES

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

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

So that, when the asylum claim has been admitted, asylum-seekers and their dependants will be entitled to the National Health Service if they go through the registration⁸ procedure.

⁸ For further information see pp 54-55.

However, many asylum-seekers (and even official refugees) show preference for services outside the regular framework due to the lack of adaptation to the new demand perceived in the National Public Health System. Its resources are still very precarious, reflected mainly in the nearly complete absence of interpreters (above all, at a Primary Care Level), and in the lack of training of health professionals concerning the needs of ethnic minorities.

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

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

Problems arisen in service provision for asylum seekers and refugees coincide with those that apply to immigrants in general, which were discussed already in this chapter.