

Chapter 3. PRACTICES DEVELOPED FOR ASYLUM SEEKERS AND REFUGEES

A. METHODOLOGY

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

The sample is composed by a wide range of professionals working in different fields of service provision to immigrants, asylum-seekers and refugees¹. Several interviews have been conducted in the two cities with highest immigration rates in Spain, Madrid and Barcelona.

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

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

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

It is important to make clear that we are talking about mental health services, located in Barcelona and Madrid, addressed to the whole immigrant population, including asylum-seekers and refugees. The reason for this extension is the scarcity of specific mental health services specialised in the treatment of asylum-seekers and refugees in Spain due to their reduced number when compared with the rest of the immigrant population² and, perhaps, also due to the lack of sensitivity shown to this group. Services that provide this sort of specific attention could be summarised as the Red Cross, CEAR, COMRADE, SAPPPIR and EXIL. Even though, these are not exclusive services for refugees, given that other immigrants are attended as well.

¹ List of the interviewed centres in the Annexe.

² Even though it is a fact that many "real" refugees end up getting residence and work permits through other ways different from asylum, this is through Immigration laws, due to the non-admission of their asylum claim or a negative resolution.

B. STATE OF THE ART

B.1) ORGANISATIONAL CHANGES (Structurally innovative projects)

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

But, certainly, some organisational innovations have taken place during recent years in order to provide a better care delivery for immigrants. Thus, a special medical service, Servei d'Atenció i Tractament de l'Inmigració (SATMI), was set up in Barcelona with the intention of supporting professionals working in the Public Health System.

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

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

Unlike in the National Health System, SATMI does not work with zoning³, differing in this way from the rest of the regular services. Patients are referred to this service from their mental health centre when a specific problem that cannot be solved by the usual doctor occurs, normally because they have not received any specific training in cross-cultural psychiatry. It is at this moment, which could be either at the beginning of the intervention or in the middle, when the patient is referred. There, the intercultural psychiatry team will help to overcome this step and, once resolved, the patient will be sent back to their own mental health centre where their treatment will continue. This mechanism is known as "*interconsulta*", since the normal doctor that can always consult with SATMI in order to get a more reliable diagnosis. Therefore, this service

³ Health area: each patient must address himself to the corresponding health centre depending on the zone where he lives.

aims not to establish a health assistance centre only for immigrants that will always separate them from the rest of regular services, thus promoting segregation, but a support service to facilitate immigrant integration. Their service is available only four hours a week, even though they are planning to extend these hours.

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

Collaborations between mental health services and universities come in the form of the formation of special programs to be implemented in the services. For example, the Universidad Autónoma of Madrid is drawing up a special program for the treatment of men in trauma, that is, who are affected by Post Traumatic Stress Disorder or sub-syndrome⁴. The therapy will have a cognitive-behavioural orientation, and it will be the only one group therapy in service at present.

On the other hand, in Madrid the CASI (Social Care Centres for Immigrants) could be another example of the setting up of special services in order to improve service provision for immigrants, asylum-seekers and refugees. CASI⁵ is a public device of private management that has sprung up from Madrid's Regional Plan for Immigration 2001-2003. Its pace of development has been slow, the negotiations lasting for nearly three years due to the lack of consensus on behalf of the different bodies.

CASI are not a medical service but a social care service focused on immigrant labour insertion. CASI consists in a second level support service

⁴ When the person has lived through traumatic experiences but the symptoms have not manifested yet.

⁵ There are 9 CASI in the Community of Madrid, and other 4 are expected. They are being managed by the Red Cross, CEAR (Spanish Aid Commission for Refugees), CIPIE (Centre for investigation and Promotion. Latin America and Europe), MPDL (Peace and Freedom Movement) and Pro-vivienda.

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

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

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

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

B.2) TRAINING AND EDUCATION

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

Training and education practices on the subject of understanding immigrant culture for mental health professionals working with immigrants, asylum-seekers and refugees are still at an early stage. However, a slight mobilisation of

resources has been detected in the form of an increase in the offer of new courses concerning this subject on behalf of certain universities and organisations. In spite of this increase, cross-cultural training is still very scant and does not reach the majority of mental health professionals working in the field.

Respondents working in the public health system criticised the scarcity of courses concerning mental health needs of minority ethnic groups and refugees, on behalf of the administration. The IMSERSO⁶ has internal training programs in all social care fields, but respondents pointed to the low quality of the training and the scarce number of courses related to asylum and refugees. Professionals perceive that there is a great imbalance between the training received and the social and cultural changes produced during the last year whose effects have not been met by the authorities.

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

In Catalonia, the Generalitat has asked various experts to make a guide that allows General Practitioners to identify mental disorders, so that they will be able to refer them, in case of necessity, to a psychiatrist. Already in 2000, the Institut Català de la Salut⁷ edited a basic lexicon guide for health conversation in different languages such as English, French, German, Russian and Arabic, as a work tool for health professionals. Moreover, in Barcelona, pharmaceutical firms have been financing the organisation of a series of talks given by health professionals trained in cross-culturality, and aimed at Primary Care doctors.

Some respondents have stated that the Public Health System is not training its professionals to be able to attend properly immigrants and refugees. The State, by means of financing certain NGOs, tries to cover this important specialised service. Even from public administration services, patients are referred to NGO mental health services instead of to regular ones, which are not well thought of.

Before this situation, most respondents - working in either the Public Health System, NGOs or immigrant associations - stated to have taken some external⁸ courses given by different universities or other entities, such as Grupo de

⁶ Migration and Social Services Institute.

⁷ Public health provider which manages different health services.

⁸ By external training I mean that which is not being provided inside the work place.

Acción Comunitaria⁹, and which are usually financed by their employers. However, in some cases (NGOs) there is no financing and the professionals must pay for it, which is not always possible for them. Courses in “Mental Health and Psychological interventions with immigrants, refugees and minorities” - in Barcelona -, and “Psycho-social interventions under political violence situations” - these courses take place in the cities of Madrid, Barcelona and Bilbao, which require a lot of flexibility on the part of the attendants - are available among few others. The decision to take these courses comes mainly from the worker’s personal interest.

A significant number of respondents in Madrid had taken a course in the EMSI, and showed themselves quite satisfied with it. The EMSI is a public school for the formation of Social Mediators in Immigration (EMSI) that was set up in the Community of Madrid in 1995¹⁰, with the objective of providing education and training for professionals working in public administration, associations and NGOs working with migrants. The school is a public service with private management, promoted by the Social Services Council and it is a project framed in the URBAN II European Union’s initiative, which seeks the improvement of the quality of life in urban areas of European Union member states. Born with the vocation of being an instrument of training immigrants and indigenous, the EMSI provides “*technical formation necessary to understand the different aspects of life immigrants have to deal with, along with the abilities, values and attitudes essential for social work in that field*” (www.comadrid/EMSI). EMSI aims to be the catalyst of the training necessities of the immigrant assistant network, being in charge of the collection, elaboration and proposal of those necessities. Since 1999 there has existed the figure of the Social Mediator as a civil servant in the City Council.

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

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

⁹ Organisation based in Madrid, which documents and reflects about mental health and human rights. It has centred its efforts in the development of training programs in psycho-social work and mental health in violent or catastrophic situations.

¹⁰ From 1995 to 1998, the EMSI was under management of Universidad Autónoma de Madrid (UAM) which had a covenant with Instituto para la formación de la Comunidad de Madrid (IMAF) and Social Services Council. From 1998 onwards, the management was transferred to Red Cross and Social Services Council.

In Barcelona, CEAR-ACSAR¹¹ is carrying out specific programs for the training of health agents in specific subjects such as sexually transmitted disease prevention or Eastern women. The figure of the health agent has been incorporated into Catalan hospitals since 1994. As well, Barcelona City Council launched in spring 2002 an intercultural mediation program, to prevent possible conflicts with immigrants and hired 20 intercultural mediators (El País, 04-03-02, Ed. Catalonia). But their incorporation is still slow and, above all, very controversial referring to mental health services.

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

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

B.3) TREATMENT

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

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

¹¹ Associació Catalana de Solidaritat i Ajuda als Refugiats. ACSAR and CEAR (Spanish Refugee Aid Commission) are united in Catalonia.

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

These complementary therapies do not pursue a clinical intervention in themselves; therefore these activities not necessarily have to be conducted by a psychologist or psychiatrist.

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

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

B.4) PREVENTATIVE ACTIVITIES

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

Prevention is being given in the form of other types of therapy and assistance. An example of preventative activities are those developed by the surveyed Refugee Reception Centre (CAR) in Madrid where children's excursions, cultural raffles and party celebrations are organised at the same time as languages courses are being given. Training in healthy habits, such as

Hatha Yoga courses or education for health, are carried out during specific psychotherapy sessions, having a positive impact on resident's social integration and mental health. Moreover, the psychologist has set up a self-help group that aims to promote the creation of a support network between persons that share similar characteristics and necessities. In this way, identification and personal empathy processes can emerge so that the participants are able to develop their own ways of coping with their problems.

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

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

C. A CRITICAL REFLECTION ON THE STATE OF THE ART

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

The institutional system has not been sufficiently developed and, therefore, it is not ready to attend to people coming from different cultures. This is because it has been created for a mono-cultural system, which is rigid and closed. The need to establish specific mental health services mainly out with mainstream health provision but also within it, in order to address ethnic minorities needs, reveals the mono-cultural character of the public health system. This mono-

culturalism derives from the provision of sanitary resources according to not only the ethnic but also the social position of the users. Hence, that Spanish health system has come to be described as ethnocentric and socio-centric (Pereda et al, 1997, op.cit. Lurbe, 2002).

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

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

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

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

In relation to *financial resources*, running of most programs has an annual duration even though there exists a certain acceptance of the project's continuity, except in the case of psychological support projects. It was reported that some psychological and psycho-social support projects submitted by various NGOs have been rejected funding on the basis that the National Health Service already covers this sort of assistance. This is certainly true, however, as it was found and reported throughout this survey, there exists groups who have no access to the National Health Service – the undocumented afraid of the administration, homeless, etc – and moreover, the system is still not prepared and has not been adapted to treat minority ethnic groups. As a sign of this, respondents have reported the common referral of immigrant or refugee

patients from the National Health Service to NGOs with mental health services, and also the preference these patients show for NGOs services. In spite of this, the mental health services of the NGOs are the programs with the least guarantee of continuity whereas their advocacy or labour insertion programs are much more established and numerous.

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

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

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

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

identify on a broader level what they want from mental health services (Watters, 1998b, op.cit. Watters, 2001).

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

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

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

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

D. CONCLUSIONS

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

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

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

To carry this out, one has to struggle against the present lack of co-ordination between the National Health System, NGOs and ethnic minorities, and furthermore, it is essential to raise awareness about health issues. This is clearly indicated by the fact that during the last National Immigration Congress held in

Granada in November 2002, which 700 professionals of different backgrounds attended, the subject of health had very little prominence¹².

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

¹² Specifically at the “communication table” – assigned not for reading papers but as a place for discussion – which dealt with health issues in general, and mental health in particular, there were just two listeners apart from the speakers (persons who gave the papers).

