

Mental health policy for refugees in Europe

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Abstract

Europe is currently experiencing a huge influx of refugees, with many refugees coming from Middle Eastern conflicts as a result of war and violence. Refugees have been identified as a group with high risk for mental health problems due to daily stressors in pre-migration, migration and post-migration situations. Additionally there are some barriers that limit access to mental health services. Policy needs to be adapted to the new situation. In this thesis the role of policy in providing access to mental health services for refugees in Europe on EU, national and treatment level is researched, with the aim of identifying gaps between access to mental health services and needs of refugees. One important finding is that policy in this case is improvised by advocacy coalitions, who implement their own knowledge and strategies when providing mental health care.

Table of Contents

Abstract.....	2
Table of Contents.....	3
1. Introduction.....	5
2. Methodological framework: Understanding mental health problems of refugees.....	8
2.1 Understanding mental health.....	8
2.2 Framework.....	9
2.2.1 Pre-migration stressors.....	10
2.2.2 Displacement.....	11
2.2.3 Post-migration stressors.....	12
2.3 Conflicting ideas of mental health.....	13
2.4 Access to mental health services.....	14
2.5 The role of policy in creating access to mental health services.....	15
2.6 Conclusion.....	15
3. How has the EU responded to the mental health needs of Middle Eastern Refugees on institutional and service level?.....	17
3.1 Framework.....	17
3.1.1 Institutional level.....	17
3.1.2 Service level.....	17
3.2 Institutional level.....	18
3.2.1 Common European Asylum System (CEAS).....	18
3.2.2 Changes in EU refugee policy as a result of the current crisis.....	19
3.2.3 Mental health.....	19
3.3 Service level.....	21
3.3.1 Greece.....	21
3.3.2 The Netherlands.....	24
3.4 Conclusion.....	27
4. Do Middle Eastern Refugees have access to mental health services?.....	28
4.1 Treatment level.....	28
4.2 What barriers constrain access to interaction with a mental health worker?.....	28
4.2.1 Cultural concepts of mental health, illness and treatment.....	29
4.2.2 Accessibility.....	29
4.2.3 Trust and confidentiality.....	30

4.2.4 Working with interpreters	30
4.2.5 Engaging family and community	30
4.2.6 Mental health providers' style and approach.....	31
4.2.7 Advocacy – assisting young people with their priority areas	31
4.2.8 Continuity of care.....	31
4.3 Expectations of refugees.....	32
4.4 Traditional healing.....	33
4.5 Conclusion	33
5. What are remaining gaps, challenges and choices for the EU?	34
5.1 Conclusion	36
5 Conclusion	37
Reference List	38
Annex I – E-mail.....	44

1. Introduction

In recent years, forced displacement because of violent conflicts has led to a worldwide influx of refugees. At the end of 2015, there was an estimated 65,3 million forcibly displaced people across the globe, most internally displaced but also 21,3 million refugees and 3,2 million asylum seekers (UNHCR, 2016a). One out of four refugees is Syrian, with its civil war being seen as one of the worst humanitarian disasters of the past decade. Most of the refugees flee to neighbouring countries, but Europe also hosts 4,4 million displaced people, mostly in Germany and Sweden (UNHCR, 2016a). The reception of so many refugees is a huge challenge for European countries. It especially challenges the provision of health care, because health care is needed upon arrival as well as later on during the resettlement process. Therefore health care is at the centre of this humanitarian crisis (Permanand, 2016). Because most refugees go through a hazardous journey and face much difficulties both along the way and before departure, their disease profile and needs are different than the host population. The migration process particularly affects mental health (Pfortmueller et al, 2016). Not only the flight and departure factors affect health of refugees, also so called post-migration factors affect health, like fear of being sent back and being dependent on others.

Despite the fact that health services are available for refugees, refugees face barriers that restrict access or full use of provided health care. The main barriers are language barriers, inadequate information about rights, cultural barriers and fear of being reported (Permanand, 2016).

A good working health system works in two ways. On the one hand it provides health care for refugees who had a traumatic experience, which is in accordance with the human right 'to the enjoyment of the highest attainable standard of physical and mental health (OHCHR, 2008, p.1). On the other hand good refugee health is desirable for the host country because healthy (young) migrants with much ability to work can make a contribution to society in the context of ageing Europe (Permanand, 2016). From an economic perspective it is also much more cost effective to have a well-functioning health system.

In this study, I want to explore what kind of mental health policy in Europe is implemented on country level and whether it meets the needs of refugees. This study will focus on mental health care because it is expected that in this area most challenges are present because of the underlying factors that affect mental health, as described above. This research should provide an insight in how mental health care is organized on the institutional level, the level of the care givers and the views of refugees themselves. This helps policy makers in their effort to include the views and needs of refugees in the provision of care, which will make care more effective. This study will focus on refugees of the Middle East, to be able to make better conclusions that are generalizable for this area. Countries in this region are Syria, Iraq, Iran, Jordan and Lebanon.

The objective of this research is to identify where there are gaps between access to mental health services and the needs of refugees. Because access is often an important aim of policy this will help policy makers in adjusting health care provision to the needs of the people receiving this care. The main question of this research is:

What is the role of policy in providing access to mental health services for refugees in Europe on EU, national and treatment level?

- Methodological framework: understanding mental health, access to mental health services and the role of policy.
- How has the EU responded to the mental health needs of Middle Eastern Refugees on institutional and service level?
- Do Middle Eastern Refugees have sufficient access to mental health services on treatment level?
- What are remaining gaps, challenges and choices for the EU?

In order to answer the research question literature is used from Google Scholar, PubMed, Web of Science and Global Search WUR. Additionally I have studied reports of NGOs and international organizations such as the World Health Organization (WHO), United Nations Refugee Agency (UNHCR) and the European Union (EU), as well as news articles.

The scope of this research is the European Union. Due to the limited time for this research I have chosen to focus mainly on Middle East refugees, because this is the major refugee group arriving in Europe during this crisis. Especially Syrians are the biggest refugee group. The definition for refugees used in this thesis is the definition of article 1(A)(2) of the UN Refugee Convention in 1951, which defines a refugee as someone who 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.' Although there is a difference between a refugee and an asylum seeker, in this thesis no distinction is made. Officially an asylum seeker is someone who has asked for asylum which means a legal permission to stay as a refugee (OSF, 2015). So when an asylum seeker has been given a legal status, he or she is recognized as refugee. In this research, the focus is on what happens upon arrival and right after arrival.

Europe is defined as all countries that are member states of the European Union. This thesis focusses on two countries: Greece and the Netherlands. These countries play a different role in the refugee crisis, which makes it an interesting to compare. Greece is a 'country of arrival', Middle Eastern refugees arrive Europe by crossing the sea from Turkey to a Greek island. From there, they continue their journey to Western Europe. One of the Western countries is the Netherlands a 'country of destination'. This thesis will use these countries as case study.

The second chapter provides a theoretical framework for this research. Firstly this chapter focusses on understanding mental health problems of refugees. What is mental health and what are stressors that affect mental health? The framework of Miller & Rasmussen (2010) is used to understand mental health related to conflict and post-conflict settings. The framework includes both war exposure and daily stressors as negatively affecting mental health status. This framework will be used in this research to address both pre migration stressors that influence mental health and post migration stressors and to identify whether current health policies are in line with this framework or only focus on war-related traumas. Secondly, the concept of access is explained. For this, the theory of access of Ribot and Peluso is used, who define access as 'the ability to benefit from things' (2003, p.153). In this thesis this means benefitting from mental health services. However, also little attention will be paid to

benefitting from other things like education and income, which influence mental health. Next to this Ribot and Peluso distinguish the ability to control access and the ability to gain or maintain access, which will also be used. Thirdly the concept policy will be defined and how this is used in the following chapters. Policy is understood as a set of decisions made by different actors through negotiation. Advocacy networks are important in this understanding.

The third chapter focusses on the EU and its policy about refugees' mental health. In 2001, Watters developed a framework for examining mental health services and identified three levels of interaction between services and refugees' own view on their needs. This places mental health in a broader context which is helpful to explain what barriers form a gap between health care providence and needs of refugees. Using this framework, different barriers will be explored as well as cultural differences and expectations at different levels.

- Institutional level: the context in which decision-making takes place in developing policy and financing mental health care.
- Service level: the organisation of health care at the local level, including interaction between different health care services and other organizations such as voluntary organizations and NGOs.
- Treatment level: where refugees have face-to-face contact with mental health professionals.

The institutional level and service level are addressed in chapter 3, while the treatment level is addressed in chapter 4. In chapter 4 the focus is on the refugees and their access to health services. Using the theoretical understanding from chapter 2 this chapter addresses the situation in the Netherlands and Greece. In the last chapter the former chapters are used to identify where there are remaining gaps and challenges for the EU.

2. Methodological framework: Understanding mental health problems of refugees

In order to analyse how refugees have access to mental health services in the EU it is necessary to understand what kind of mental health problems refugees have and what causes those. Also attention will be paid on differences in defining mental health problems, the concept of access and the role of policy in accessing mental health services. Thus this is an introductory chapter that defines the different concepts used in this research.

2.1 Understanding mental health

WHO defines mental health as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO, 2014). Three main mental health diagnoses associated with refugees are Post Traumatic Stress Disorder (PTSD), anxiety and depression. PTSD and depression have had the most attention in the case of refugees.

Anxiety disorder is diagnosed when one's daily life-activities are interfered by feelings of anxiety permanently or frequently (NIMH, 2016). There are many types, such as generalized, panic and social anxiety disorder. Symptoms are restlessness, muscle tension, fatigue, fear attacks, fear for social performance. For refugees, events associated with anxiety problems are the witnessing of a massacre, being wounded and the experience of a traumatic event (Thomas & Thomas, 2004).

PTSD is an anxiety disorder that can develop after stressful, frightening or distressing events such as war, violence, (un)natural disasters or accidents (NHS, 2015). PTSD was first recognized as a formal disorder after the return of soldiers from the Vietnam War (Summerfield, 1999). PTSD can develop right after the event or up to years later. One often relives the traumatic event and may experience isolation, guilt and irritability (NHS, 2015). Other symptoms are sleeping and concentration problems. PTSD has had most attention in the research on mental health problems of refugees. Factors associated with this disorder are witnessing violence, disappearance of family members or facing death (Thomas & Thomas, 2004).

Depression can be a long lasting or recurrent mental disorder, which can be diagnosed and treated as a part of primary health care when it is mild (WHO, 2016a). When depression symptoms are more severe, more specialized care is needed. Symptoms are sadness, loss of interest, low self-esteem, feelings of guilt, fatigue, loss of concentration and sleeping disorders.

Important to note here is that in general refugees tend to explain their problems in somatic problems, such as headache or pain somewhere, while the underlying reason can be mental, however this remains often unexplained (Thomas & Thomas, 2004).

There are many factors that affect the mental health status of individuals. In the case of refugees these factors can be distinguished in three stages of the migratory process: pre-migration, migration and post-migration. Studies have shown that refugees face a relatively high risk of mental health problems. But there is a lot of variation between studies how high this prevalence rate actually is, ranging from 8 to 76 percent (Slewa-Younan et al., 2015;

Quosh et al., 2013). Differences can be due to methodological factors such as sample size, or country studied. A recent study in the Netherlands compared these different studies and concluded the study of Steel et al. (2009) had used the highest quality data and taken into account methodological factors (Ikram & Stronks, 2016). Their conclusion was 13-25% of the refugees in high-income countries are suffering from PTSD and/or depression (Steel et al., 2009). This is very high compared to 2,6-6% of Dutch citizens suffering from these mental health problems (Ikram & Stronks, 2016).

Refugees are vulnerable for mental health problems because they have been involved in or witnessed conflict and many experienced long-term psychological consequences as a consequence. Upon arrival, uncertainty, detention and bad circumstances may also impact mental health. However, mental health problems are not always occurring immediately. They may take time to evolve. While it used to be clear that war and conflict affect mental health, in recent years these post-migration stressors, so called daily stressors, have also become important for understanding refugees' mental health problems (Miller & Rasmussen, 2016; Permanand, 2016; De Schryver et al, 2015; Thomas & Thomas, 2004). This has been outlined in the framework of Miller and Rasmussen.

2.2 Framework

Miller and Rasmussen have proposed a framework for understanding and addressing mental health needs in conflict and post-conflict settings (2010). In their framework they have combined trauma and psychosocial approaches. Following a trauma approach, mental health problems are caused by exposure to violence. Following the psychosocial approach mental health problems are caused by stressful social and material conditions. Choosing one of these approaches influences the way a mental health problem is addressed. The first approach focusses on symptoms of war-related trauma while the second focusses on tackling stressful conditions in order to improve mental health status of an individual. The framework of Miller and Rasmussen acknowledges both factors and addresses exposure to armed conflict, daily stressors caused by armed conflict, displacement stressors and post-migration stressors. Because in this research we distinguish three different stages in the migratory process, the framework is slightly adapted to fit in these stages (fig.1). Daily stressors are highly stressful conditions such as poverty, uncertainty, discrimination, inadequate housing, dependency and social marginalization (Miller & Rasmussen, 2010). More studies have shown the effect of such daily stressors on mental health in diverse refugee settings (Miller et al., 2008; Panter-Brick et al., 2008; Fernando et al., 2010). The term daily stressors is not fully adequate, not all stressors occur daily, like sexual violence for example. But the term is chosen because these stressors lead to distress and a fear of recurrence. As Schryver et al (2015) have argued, not only can daily stressors be a predictor for mental health, but also a consequence of mental health. It thus works both ways. When one has mental health problems, how he or she acts may cause his or her own stigmatization or exclusion which creates experiencing daily stressors.

Although daily stressors particularly used in this research as a factor in the post-migration phase, daily stressors and PTSD symptoms also influence how war events are experienced. It creates vulnerability, daily stressors makes them vulnerable for impact of war (Miller & Rasmussen, 2016). So daily stressors can also be an underlying condition of mental health problems. In Figure 1 all different sorts of stressors are put in a diagram. Examples of daily

stressors are visible in Table 1. In Figure 1, four different stressors are drawn as affecting mental health. Exposure to armed conflict and daily stressors caused by armed conflict together form pre-migration stressors. Then there are migration stressors that affect mental health and post-migration stressors. All three phases of migration and the corresponding stressors are explained below.

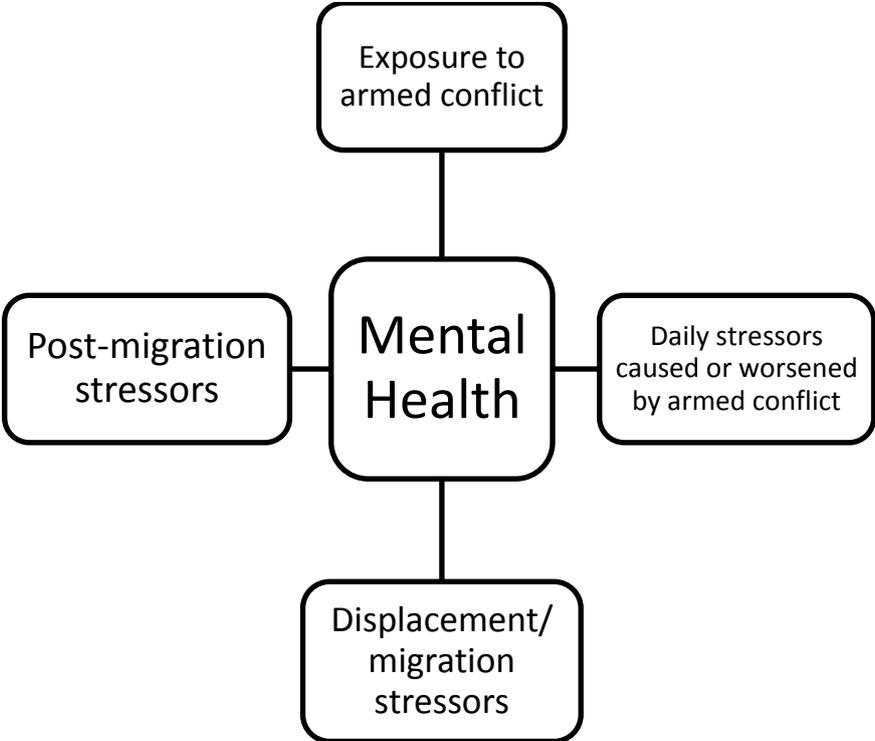


Figure 1. Mental Health Stressors
 (Source: Miller & Rasmussen, 2010, p.9)

2.2.1 Pre-migration stressors

In order to understand what pre-migration stressors can be, knowledge about the ongoing conflicts in countries where refugees come from is crucial. Because most refugees come from Syria, the Syrian war is explained as an illustration of the environment where refugees come from.

Syria is a small and poor country, about the size of Spain. It was densely populated, with 23 million inhabitants before 2011. Most of the land is desert, only a quarter of the land is arable, which was already a problem with regard to the population size. Islam is the main religion in Syria, but also other religious groups live together, such as Christians, Jews, Kurds. Since 1970, Syria is led by the first Assad regime, followed by the second Assad-regime in 2000. These were years of dictatorship where the regime claimed full authority. The climate is characterized by extreme temperatures which can cause dust storms and droughts. From 2006 until 2011 there was such a drought. Many farmers couldn't irrigate their land because of a lack of water. People lost their land and sometimes even their livelihood because of crop failures due to the drought. They fled to the urban areas to seek work and ended up in extreme poverty. Together with these 'climate refugees' also foreign refugees from Iraq and Palestine were living in the urban areas. (Polk, 2013)

In March 2011, the already ongoing food and water issues turned into a political and later on also a religious conflict when a small group started an anti-government protest for democracy as a reaction on the arrest of teenage boys who wrote revolutionary slogans on a wall. The protests escalated when security forces fired at the demonstrators. This event triggered nationwide protests against the president, Assad. It turned even more violent when also rebel groups started using arms to expel security forces from their neighbourhoods. Eventually a civil war emerged when rebels formed various armed movements to battle the government forces for control of the cities. By August 2015, 250.000 people had been killed in this conflict. The conflict got more complex with the rise of the Islamic State (IS) and ethnic and regional groups fighting against each other. All parties involved in the conflict have committed war crimes, like murder, torture, rape and enforced disappearances (a person is deprived of his liberty by a state-official which is not acknowledged by the state). Another method of war used is targeting civilians by blocking access to food, water and health services. Many people were killed by bombs from government aircraft. IS has killed many people and imposes severe punishments on people when they don't listen to what IS and Islamic leaders say. The government is accused of using chemical weapons to kill people. All in all, the conflict turned into the biggest humanitarian crisis since World War II, with more than 4,5 million people fleeing from Syria since 2011. Most flee to neighbouring countries such as Lebanon, Jordan and Turkey. 10% fled to Europe. 6,5 million people are internally displaced inside Syria. About 70% of the population lacks access to adequate drinking water, one in three people are unable to meet their basic food needs, and more than 2 million children are out of school, and four out of five people live in poverty. Humanitarian agencies are often limited in their capacity to help and cannot reach all areas. IS has taken control of big areas in Syria and Iraq and proclaimed the creation of a caliphate in 2014. The international community responded to IS with air strikes, but also humanitarian aid. Many countries are involved in support of diverse groups: Russia, Iran and a movement in Lebanon support the Syrian government while US, UK, France, Turkey support one of the big opposition groups, the Sunni-dominated opposition. (Rodgers et al., 2016)

The conflicts in other countries are not the same, but cause similar stressors such as the experience of a traumatic event, poor living conditions and vulnerability factors (loss of homes or friends, religion, gender) which lead people to flee their country in search for a better and safer future. In 2015, over 1 million people left their countries to flee to Europe. So far in 2016, 205.000. Most refugees enter Europe by sea and arrived on islands of Greece and Italy. According to 500 interviews held by UNHCR (2016b), 94% of the Syrian refugees left Syria because of conflict and violence, compared to 75% Afghans.

2.2.2 Displacement

The displacement process is a difficult and uncertain process. It is a long way to flee to Europe that often does not happen in one journey. Most refugees first flee to neighbouring countries such as Jordan and Turkey but because of very bad circumstances in these countries they take the chance and travel to Europe. About 10% of all refugees choose to flee to Europe. The main routes are via Turkey and the Balkan, or via Turkey by boat to Greece and Italy. There are many barriers along the way. There are smugglers who can often not be trusted and ask a high price for a boat trip. There are weather related conditions and barriers on the borders. It is especially hard for vulnerable groups, the children, women and elderly. Risks for mental health include other health problems which can influence the

mental conditions of a refugee, such as infectious diseases and fatigue, and the lacking of basic needs such as food, shelter and water. There is no access to emergency health care and proper sanitation. Besides, the threat of not arriving or, for women, the threat for sexual abuse is present. Additionally there is grievance of what and who is left behind. Often not all family is joining, people lost beloved ones and their house, job and also social and cultural environment. All in all a flight is a very abnormal event that is very stressful and uncertain. (Thomas & Thomas, 2004)

2.2.3 Post-migration stressors

Where pre-migration stressors are mainly associated with PTSD, post-migration stressors are mainly related with depression, although also with PTSD (Thomas & Thomas, 2004). Stressors associated with post-migration are related to the situation where refugees end up. This can be in a refugee camp, which is the case in Greece. In the Netherlands, people are hosted in buildings which are often rapidly adapted for refugee housing. As such, much of the facilitations are improvised, in which the general needs are the most important things to be met, which are water, food and sanitation. The capacity of the government often plays a role in what can be provided (Thomas & Thomas, 2004).

Immediately after arrival the most vulnerable groups for mental health problems are the people already suffering from mental health problems in the pre-flight and displacement phase (Miller & Rasmussen, 2010). One stressors that is associated with post-migration is social isolation because often the social network is lost and disconnected due to the flight. People lost their job and are not allowed to directly find a new job which may also lead to depressive feelings. Another stressor is discrimination by the host-population or related to people from different nationalities living together. Violence within the family might increase because of stress and in camps there is sometimes a lack of safety, there is a risk to sexual violence. On top of that there is uncertainty about the legal status, fear of being sent home or of detention being prolonged. These detention centres are associated with mental health problems because there is much uncertainty about the asylum procedure and whether refugees can stay in Europe, because refugee camps are full since the closing of the border to Macedonia (Stemerding, 2016). This uncertainty is a very important post-migration stressor, because when a legal status changes from temporary to permanent, mental health problems are diminished in many cases (Raghaven et al., 2013).

<i>Pre-migration factors</i>	Potentially traumatic events (PTEs) in home country <ul style="list-style-type: none"> - Single or multiple - Discrete event or continuing situation Living conditions <ul style="list-style-type: none"> - Socioeconomic circumstances - Family situation - Situation of membership group (ethnic, religious, etc.) Personal history <ul style="list-style-type: none"> - Vulnerability factors - Protective factors (resiliency)
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<p><i>Transit factors</i></p>	<p>Direct trip to destination country vs. stays in transit locations <i>If transit through other locations</i></p> <ul style="list-style-type: none"> - Refugee camps (internal or in transit country) - Stays in transit countries <ul style="list-style-type: none"> Clandestine (non-status) or with status Economic situation, access to care, etc. Detention linked to migratory status <p>Travel with official documents or false documents <i>If obtained from a smuggler</i></p> <ul style="list-style-type: none"> - Cost and impact on the person's finances <p>Exposure to PTEs during transit</p> <ul style="list-style-type: none"> - Exploitation by smugglers - Poverty - Protracted experience of marginalization, helplessness, being stuck (e.g. refugee camp) - Physical injuries or mental stress linked to clandestine entry (e.g. exposure to the elements, hunger, confinement) <p>Strengths acquired during transit</p>
<p><i>Post-migration factors</i></p>	<p>Obstacles upon arriving in destination country</p> <ul style="list-style-type: none"> - Interviews by immigration officers - Detention - Challenges to admissibility <p>Ongoing threat: fears for the future, feeling of not being safe</p> <ul style="list-style-type: none"> - Protracted uncertainty about legal status - Anxiety about testifying at refugee status hearing - Fear of being sent back to country of origin - Fears about safety of family members back home - Fear that their membership group (ethnic, religious, political, or other) is under threat in country of origin <p>Current living conditions</p> <ul style="list-style-type: none"> - Loss of social identity (role as provider, community member, member of extended family, social recognition of competence, etc.) - Limited access to employment, health care, social services, education, etc. - Separation from family - Poverty - Limited social support - Marginalization or discrimination linked to migratory status, ethnicity, language, etc. - Settlement challenges: finding a place to live, a job, adapting to a different culture, learning a language, etc.

Table 1. Factors affecting refugee mental health and well-being.
(Source: Cleveland et al., 2014, p.249)

2.3 Conflicting ideas of mental health

Although this understanding of mental health is widely acknowledged by state institutions and non-governmental organizations (NGO's) some authors are critical and warn for the risk to immediately label refugees with PTSD when they are coping with stress from war and conflict. Many refugees themselves do not perceive their behaviour and feelings as a disorder; they just see it as coping with the situation. Therefore they may overcome this stress on their own since they have are used to this stress feelings and see it as a normal part of their life. Summerfield (1999) wrote a critical piece on Western assumptions on traumas resulting from war and conflict. His main critique is that there is a tendency to apply Western cultural ideas to refugees which results in the medicalisation of stress and the rise of psychological therapies (p.1449). This means that social distress has become something

bio-psychomedical (in the form of PTSD) and thus can be treated in a medical way, medicalization. From a western point of view, trauma is individual-centred. War is directly related with trauma, even when affected people themselves do not admit and experience the problem. Refugees just attribute it to be an inevitable part of the war but psychologists and researchers do not acknowledge that.

Summerfield argues that suffering arises from and is resolved in a social context shaped by the meanings and understanding applied to events. Therefore it is important for an effective assistance to not only focus on European knowledge but also the voices and knowledge of the refugees must be heard and used to frame the experiences and stressors refugees are facing and how to cope with it. Refugees also help each other to overcome their trauma, for example through religion.

What Summerfield does not incorporate are the daily stressors in the post-migration circumstances that add to mental health problems. Summerfield only focusses on the relationship between conflict and psychological trauma which is not always directly linked as he states. Rasmussen & Miller used his views in arguing why it is also important to look at daily stressors as adding to mental health problems. It has also been reported that refugees have a higher prevalence of mental disorders than internally displaced people (Miller & Rasmussen, 2016). Although we must be aware of a Western view influencing how mental health problems are recognized and treated, it is clear that still many people suffer from what they have experienced and that this must not be neglected. Maybe the labelling of a disorder might be too much but psychological help remains very important, maybe not in a hospital setting but in a more informal setting.

2.4 Access to mental health services

About the concept of access a lot is written. Access to health care is for example defined as entry to the health system, as the availability of financial aid and a health system or distinguished in socio-organizational and geographic access, including attributes of resources that constrain or facilitate use of health care and what the distance is to care (Aday & Andersen, 1974). In this thesis a broad definition is used, defining access as 'the ability to benefit from things' (Ribot & Peluso, 2003, p.153). This covers both entry to health services and barriers and facilitators to entry as well as the ability to benefit from the services offered after entry to a health service. Because a health service has the aim to improve health benefitting from a mental health service means improving the mental health status of an individual. Ribot and Peluso also distinguish access control and access maintenance. Access control means 'the ability to mediate others' access' and access maintenance means 'expending resources or powers to keep a particular sort of resource access open' (Ribot & Peluso, 2003, p.158). Additionally there is gaining access, which means the process in which access is established. In the case of mental health services we could say that policy makers have the ability to control access to mental health services, together with general practitioners who control access to specialized services. Workers in refugee centres maintain access for refugees, as do refugees themselves by for example establishing relationships with people that help them gain access.

Ribot and Peluso categorized mechanisms which shape access. Legal access refers to legislation about access to mental health services. This will be outlined in chapter 3. Other forms of access are structural and relational mechanisms of access, which constrain or

facilitate access to mental health services. The mechanisms that are applicable to this case are access to technology, capital, knowledge (health literacy) and access through social identity and social relations. These mechanisms will be further used in chapter 4 when mapping barriers and facilitators in access to mental health services, together with access control, maintenance and gaining access. In chapter 4 different themes will be discussed about barriers and facilitators to access to health services. These are cultural concepts of mental health, illness and treatment; service accessibility; trust; working with interpreters; engaging family and community; the style and approach of mental health providers; advocacy; and continuity of care (Colucci et al., 2015).

2.5 The role of policy in creating access to mental health services

In this research policy is understood as a set of decisions made by actors through a process of negotiation. The policy process can be viewed as a function of three factors: (1) the interaction of advocacy coalitions in a policy subsystem, with advocacy coalitions being a set of actors from public and private institutions, (2) changes external to the subsystem and (3) effects of stable system parameters, such as social structure, that constrain or contribute to policy change (Sabatier, 1991).

In this thesis, mental health policy is understood as a set of decisions which affects characteristics of the mental health system and the population at risk with the aim of changing the utilization of health services and satisfaction of patients (Aday & Andersen, 1974). Thus policy tries to affect access and availability of the mental health system. This is an example of policy trying to control access. Advocacy coalitions in the case of mental health policy can be the research institutes on EU and national level and NGOs concerned with the well-being of refugees, who advocate to maintain access for refugees to mental health services and try to control access by providing knowledge or help. Changes external to the subsystem can be the war in Syria which led to the inflow of so many refugees in European countries. Stable system parameters are the structure of mental health services, the number of hospitals and health care workers and rules concerning the availability of mental health services. It is important to look at advocacy coalitions in this thesis because they shape the way access to mental health services is controlled and maintained by these actors. Especially in the context of the current refugee crisis because already existing policy is not sufficient to this enormous influx of refugees and their mental health needs, improvisation is needed. Therefore in the next chapter different actors in Greece and the Netherlands will be discussed.

2.6 Conclusion

It is extremely difficult to draw the line between when one has a mental problem and when it is just coping with what happened. While there is a tendency to medicalize peoples' problems it also should not be neglected that war and conflict, as well as circumstances after flight are abnormal and may cause mental problems which then also should be treated. This is a difficult balance to find.

While stating that daily stressors add to the effect of traumatic experiences of war or violence the question arises whether positive daily circumstances can reduce the impact on mental health problems, such as giving more clarity about procedure, safety and education.

Although the hypothesis is yes, it is beyond the scope of this research but it would be an interesting follow up study.

Next to these daily stressors the relation between access and policy is explained. Access to mental health services is an important aim of policymakers. However, the current refugee crisis is a challenge for actors involved in providing access to mental health services because existing policy is not enough. In the next chapter we will discuss these actors as advocacy coalitions that try to provide knowledge or practical help to contribute to adjust policy.

3. How has the EU responded to the mental health needs of Middle Eastern Refugees on institutional and service level?

Now we have a clear understanding of mental health problems among refugees and the underlying causes we continue to see how the EU and European countries Greece and the Netherlands cope with mental health policy of refugees. Mental health problems limit the ability to integrate into society, which means this is a very important topic that needs sufficient policy. To analyse the response of the EU and countries a three-dimensional framework of is used which classifies mental health services into institutional, service and treatment level. The first two will be discussed in this chapter, the third in the next chapter.

3.1 Framework

In 2001, Watters developed a framework for examining mental health services and identified three levels of interaction between services and refugees' own view on their needs. This places mental health in a broader context by addressing policy as well as needs from refugees. Using this framework, different barriers will be explored as well as cultural differences and expectations.

3.1.1 Institutional level

The institutional level is the context in which decision-making takes place in the field of developing policy and financing mental health care. It is about who makes decisions, what decisions and why these decisions are made. Research points out that listening to experiences and needs of refugees are helpful when developing priorities and strategies for mental health care. That does not mean listening only to people who advocate for refugees but to refugees themselves. This is an ideal situation but in reality this happens in a different manner. Involving refugees in the policy-process is something that does not happen. Research about needs of refugees is available and can be used for policy-making. An example is a letter written by the Health Council in the Netherlands to the minister of Public Health, Well-being and Sports which informs the minister about mental health problems among refugees (Health Council, 2016). This is also an example of an actor in an advocacy coalition. In this thesis, the institutional level will be addressed as the EU-level.

3.1.2 Service level

The service level addresses the organisation of health care at the local level, including interaction between different health care services and voluntary organizations. In this level advocacy coalitions are important. This level addresses three components. Firstly mental health workers need to be trained to be able to identify the needs of refugees. Secondly advocacy services are needed which help refugees to know about what services are available and how they work. This is essential for refugees who need mental health services but it can also create demand because there is the ability to see a doctor. Thirdly specialized services need to be adapted to the needs of refugees, not only run by health workers but also by refugees themselves. However, there is evidence that it is most effective and efficient to use the same health care system for refugees as for ordinary citizens, thus focussing on providing knowledge and clarity for refugees about how the system works and what their rights are (FRA, 2015). The service level will be addressed here as country level, Greece and the Netherlands.

Additionally, the different stressor models explained in the previous chapter can be used to explain policy choices. A trauma-focused approach which is until recently the most applied approach, leads to interventions aimed at reducing war-related mental health problems while little attention is given to daily stressors. A psychosocial focus leads to interventions which do neglect the impact of the conflict refugees have gone through. Miller and Rasmussen (2010) also have suggested that one intervention is not enough, more specialized interventions are needed and more focus on daily stressors while not forgetting the impact of war on traumas and the risk for medicalization. They argue culturally adapted Western treatment strategies are needed, which include traditional, religious healers using health service strategies that are familiar to the refugees.

3.2 Institutional level

On European level, one of the departments of the European Commission (EC), the so called Directorate General (DG) deals with policy about refugees. The DG is the Migration & Home Affairs Department from the European Commission (EC) and responsible for preparing EU-level rules in policy about asylum, migration, border control, crime or terrorism (ECMHA, 2015a). Member states have to cooperate more and more according to this department because the refugee crisis is a cross-border issue that cannot be the responsibility of one state, especially because of the difference in entrance opportunities in countries. Not only Italy and Greece can carry the intake of so many refugees on their own. Also northern countries must take a share. The 300-employees counting DG is also responsible for funding projects in member states.

Another EU-agency is the European Asylum Support Office which provides teams that assist at arrival points in the EU, such as Greek islands. They assist in the registration of refugees arriving there (EASO, 2015). Before focussing on mental health policy, a little background will be given around the overall asylum procedure. For refugees entering Europe this is the Common European Asylum System.

3.2.1 Common European Asylum System (CEAS)

EU Member States have agreed on CEAS, which means fair and effective procedures, a joint approach for high standards of protection for refugees arriving in one of the member states. For this system international rights such as human rights are fundamental. The system aims to ensure these international rights are protected by EU states. Asylum is being recognized as an international obligation, following the 1951 Convention on protection of refugees. This convention is the basis of the system. The system has started to work since 1999 and changed to what it is now in 2013. The requirements for granting asylum are in short that international protection is needed when people flee from serious harm or persecution. Within the EU there is freedom of movement, the Schengen zone, but recently this zone has been under pressure because many borders have been shut because of the big influx of refugees. The flow is very fluctuant. In 2006 the number of asylum applicants was 200.000 but now it is up to more than a million. This has changed the policy and response of the member states. Member states are under the CEAS responsibility to welcome refugees as asylum seekers and treat them in a good way. (ECMHA, 2015b)

The CEAS has led to a more homogenous legislative framework which meets minimum standards and procedures for processing and considering asylum applications. It also has

minimum standards for treatment of asylum seekers and when granted asylum. The European Refugee Fund provides financial support to member states and projects where needed. Also there is a family reunification directive, which means there is a policy about family reunion. This addresses one of the daily stressors of refugees about separation from family and is likely to have a positive impact on socio-cultural stability and facilitates integration of the refugee (ECMHA, 2015c). In the policy plan on asylum made in 2008 are three pillars that support the development of the CEAS: more homogenisation in protection standards, effective practical cooperation, increased solidarity and responsibility among and between European countries (ECMHA, 2015b).

Besides the CEAS there are some other directives concerning fairer asylum procedures, humane reception conditions, protection after arrival and other rights but they will not be discussed here.

3.2.2 Changes in EU refugee policy as a result of the current crisis

The current refugee crisis has changed some things. The ongoing influx of refugees has put the CEAS under pressure. An example is the Dublin-agreement (ECMHA, 2016). The Dublin Agreement first stated that a refugee can be sent back to the first EU country that the refugee has reached. This creates a North-South divide in Europe because northern countries have far less refugees that reach their country first because most refugees arrive in the South, in Greece and Italy. However this agreement has recently been revised so refugees cannot be sent back to the first European country of arrival.

Another implication of the current crisis is that borders have been shut and fenced, in Macedonia, Hungary and Bulgaria for example. Now many refugees strand in Greece and cannot travel further or wait at the borders in the hope they will open. Also anti-immigrant parties have come up who are openly dismissive about refugees (OSF, 2015).

A third example that has happened as a result of the refugee crisis is that the European Agenda on Migration has been revised and published in 2015. The EU wants to undertake action to prevent further losses of life and to improve conditions for refugees. Relocation takes place of refugees which means also northern countries get refugees and the burden is not only on countries of first arrival. This decision took many debates and negotiation because not all member states were satisfied with this solution. The EU funds food programs for refugees in countries surrounding countries in conflict like Jordan, by which they hope the refugee flow towards Europe will reduce. The European Commission also has started inquiries of how member states follow the rules stated by the EU about housing, food, health care and protection. (ECMHA, 2015d)

Still, many countries have not fully implemented the CEAS standards. In every country asylum procedures are different as well as results (OSF, 2015). Therefore there is a focus in this chapter on two countries: Greece and the Netherlands.

3.2.3 Mental health

Legal status is an important factor to gain access to mental health services throughout Europe. According to WHO, each refugee must have full access to health care without discrimination of for example gender (WHO, 2016b). WHO supports policy-making on health services regardless the status of a refugee. They state it is in the interest of the host country as well to avoid spread of diseases and have healthy refugees. Good mental health can

contribute to good health in general and avoid the development of infectious diseases which may harm the host population.

The right to health and access to health care has been established in several human rights reports (Scholz, 2016). One of them is the International Covenant on Economic, Social and Cultural Rights of the United Nations (UN), which is 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (OCHCR, 1976). However many countries only provide emergency health care when there is no legal status, which contradicts with the right to the highest attainable standard of health.

A briefing from the European Parliamentary Research service (EPRS) in January paid attention at the Public Health dimension of the refugee crisis, stressing the importance of providing health care to vulnerable groups such as refugees (Scholz, 2016). The European Commission has provided emergency funding and support projects from the European Union Health Programme. One example of policy on health services is policy about health information which can facilitate access to health services. When a refugee is being transferred to another country, important health data need to be transferred before the transfer of the person, according to the Dublin reform (EC, 2016a). The purpose is the provision of medical care, where special attention is paid to vulnerable people like elderly, pregnant women, minors and people who have been subject to traumatizing violence such as rape or torture. Special needs of the person need to be transferred which may be information on mental health. This is being done in the form of a health certificate. The person must approve this information transfer.

However, concerning mental health there is not yet a policy the EU has made for Member States (Annex I). It is the responsibility of the states themselves to develop a policy. The role of the European Union in member states is important in guiding the overall asylum system but concerning health care they leave it to the member states. Officially, it is not the scope of the EU to influence national health systems via policy (Mossialos, 2010). However, it is their scope to influence flow of, goods and services and interactions with people. This suggests there is a possibility for the EU to impact mental health services. A reason why there is no policy can be that health systems vary a lot in Europe so it is difficult to provide policy for this. Besides, the implementation of the CEAS is still going on so this probably has more priority. Although they don't offer a common policy the European Union acknowledges the universal human rights such as the right to health, which is thus a form of guidance. The European Union will undertake action when these rights are violated. So the issue of mental health in refugee policy is not particularly important on EU-level. Also as we have seen all kinds of factors affect mental health, so the overall system which aims for good housing, family reunion also impact mental health.

Although EU does not have a policy other international actors have. WHO is very active in promoting health in Europe, including mental health. They have developed a project called PHAME, which stands for Public Health Aspects of Migration in Europe (Severoni, 2014). PHAME provides technical assistance to countries in order to reduce gaps in health service delivery, such as prevention, monitoring and managing diseases. It also provides policy recommendations to countries. The WHO has developed a toolkit for countries to help them dealing with mental health problems of refugees. Also other organizations have come up with other projects such as UNHCR with their programme MPHSS (Mental Health and Psychosocial Support in Emergency Settings).

3.3 Service level

In countries, the role of mental health in refugee policy is important. In the following sections there will be discussed on country level which policy is there and which actors are important and how the situation is in practice. There must be noted that policies towards refugees in countries and internationally are changing regularly, which makes it difficult to map the current situation.

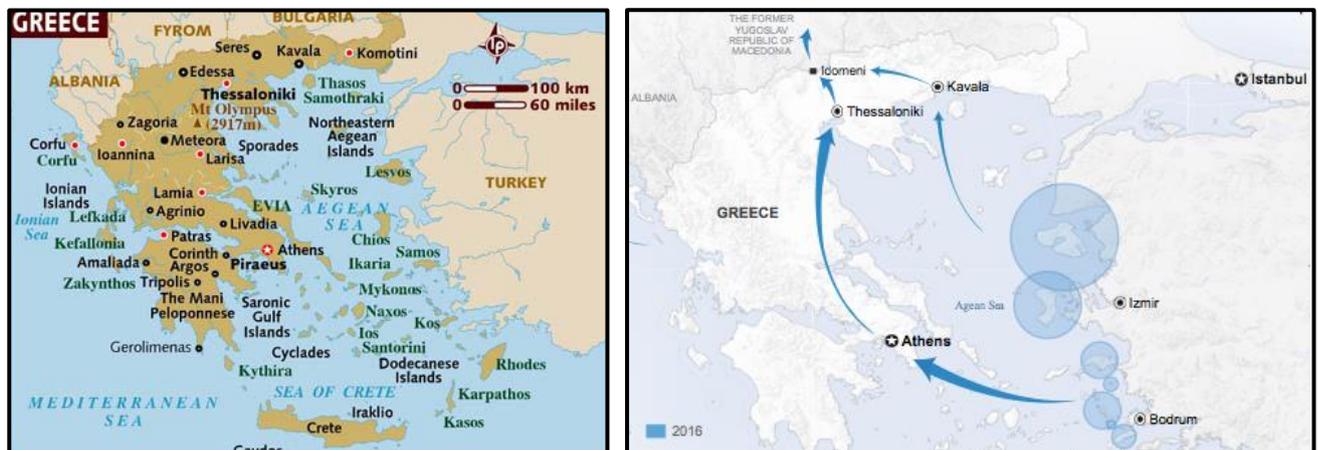


Figure 2. Situation in Greece. Left: Geography. Right: moves of refugees. (Source: IMC, 2016)

3.3.1 Greece

In Greece the situation is very difficult. Borders with Macedonia are closed which is the most used border for refugees. From there refugees want to go through the Balkan route to reach Hungary and the Schengen area, where they can travel freely between states. However, a few states have used their right to do border controls. The EU has launched in March 2016 that at the end of 2016 the Schengen area must be restored (EC, 2016b). In Macedonia, when the border is open border crossing is only allowed for Syrians and Iraqi, not Afghans (IMC, 2016). This has led to improvised refugee camps at the border being overcrowded with refugees waiting for an opportunity to cross the border.

A recent procedure Greece wants to implement has taken concerns refugee relocation, which means arrivals will be centralized in hotspots on the islands of arrival and moved more quickly to Athens where they will be matched with accepting countries (IMC, 2016). The determination of procedures for asylum seekers is unclear. There are changing policies for arrivals to the Greek shores, about who is responsible for monitoring of arrivals and who collects people from the boats. Greek authorities are responsible for the transfer of refugees from islands of arrival to the mainland (Soares & Tzafalias, 2015). Refugees stay longer in Athens because of the new procedure, where are plans to build houses for them, in cooperation between the Greek government and UNHCR. Humanitarian actions are shifting from the islands to the mainland because people will stay longer there and need aid and support services for a longer time. This means that although former mental health coordination focusses on short term it now also has to shift to a longer term view.

In Greece, mental health policy is approved nationally in 2001 with a mental health plan established in 2010 (IMC, 2016). The policy has some key points focussing on community based mental health facilities rather than hospitals. So they argue for less medicalization

where use of health services in hospitals is not encouraged but mental health problems are solved in community networks. In the case of refugees, registered asylum seekers are entitled to use the same health care services as Greek citizens (FRA, 2016). However in practice delays in registration limit access to health care. Refugees who have not applied for asylum are only entitled to emergency health care, except for children, they have the same access rights as Greek citizens.

When it comes to financing of health care, the ministry of health is the financial contributor together with some private institutions. Many costs are covered by the patient, though. Out of pocket expenditure covers 37,6% of the total health expenditure (FRA, 2016). Also access to health care services in hospitals costs money. This leads to exclusion of many refugees to mental health care services because of a lack of money.

Humanitarian and mental health aid is provided mainly by NGO's and international actors. The role of the Greek government is also important, such as the police, the coast guard, and hospitals. More actors are explained in the following section.

3.3.1.1 Actors

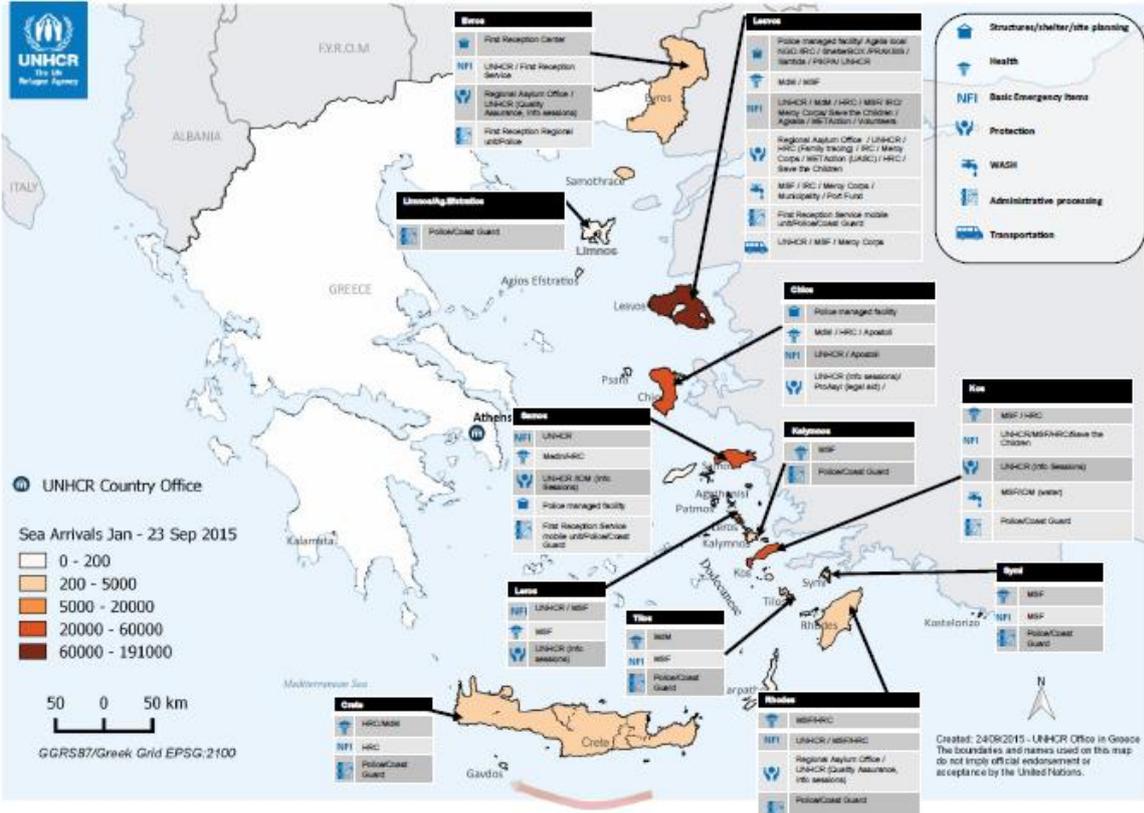


Figure 3. Who is doing what where on the Greek-Turkish borders? The situation in September 26, 2015). (Source: UNHCR, 2016c)

In the Greek government the health ministry and the public health protection agency 'Hellenic centre for disease control and prevention' are leaders in collaboration between different national and international institutions, NGO's and voluntary groups (Soares & Tzafalias, 2015). They have applied for and received emergency funding from the European Commission to make a health response plan. Almost all health care is provided by non-governmental organizations (NGO's). Two examples will be given here.

The first NGO and one of the main actors in providing mental health services to refugees is Médecins Sans Frontières (MSF). They are at the forefront of providing health care on Greek islands where people newly arrive, as well as on the border with Macedonia. MSF provides medical consultations as well as mental health support and psychological help (Theisen in Soares & Tzafalias, 2015). Most refugees continue their journey so help it is mostly short-term. However the recent closing of the borders make it hard to continue the journey from Greece, which means refugees are in refugee camps on the mainland for a longer time and mental health services should be adjusted to this change.

The second NGO is the Israeli NGO IsraAID which provides clinical psychological help (Rubin, 2016). They also offer logistical support when refugees leave the island. They offer group and individual therapy sessions, because they have seen that refugees often need to share their experiences with others, in order to understand what they have experienced.

Recently the International Rescue Committee (IRC) has started to focus on mental health care as well. Their goal is to help refugees on short term coping with mental health problems. Every member of IRC, whether it is a food distributor or something else is trained in psychological first aid (Rubin, 2016). Kardi, one of the IRC psychologists in Lesbos tells: 'Our role is to hear them so that they can let out their emotions, in the rhythm that they want, not to interrupt them, and to help them with dealing with the reaction rather than the trauma itself.' (Rubin, 2016).

Also the WHO is active in Greece. The WHO Regional Office for Europe provides medical supplies. Red Cross trains volunteers and professionals to be able to respond to health needs of refugees. The long term goal of the WHO is to focus on preparedness and resilience of health care systems in the future (Soares & Tzafalias, 2015). The WHO has developed the PHAME which is used in Greece. They have a team which maps the national health system by interviewing key stakeholders and have concluded countries are capable of dealing with the situation but are lacking preparation. The WHO encourages the national government to prepare for a sufficient response to health aspects of the refugee crisis. They argue for an effective and efficient plan where tasks are divided between different stakeholders. The WHO provides guidelines for mental health professionals to not diagnose because refugees don't need a clinical diagnose when they are still on the move (Bailey, 2016).

Additionally to these NGO's some Greek hospitals and mental health clinics on the islands provide free health care to the newly arrived refugees, assisted by interpreters that the UN and NGOs provide.

What is striking about the actions of the NGO's is that the trauma-approach is visible in the actions of these actors. Also the current situation adds to mental health problems. The NGOs focus on trauma and experiences before arrival in Europe and do not focus on daily stressors that are developing after migration, such as insecurity about the ability to move on to another country and the non-transparent asylum procedure.

3.3.1.2 Practice

In practice, providing mental health services to refugees is very challenging. Basic emergency care is seen as more important, because refugees arrive by boat and are at a poor state of health. The islands don't have much shelter to arrive. According to Theisen, from the WHO, they have limited access to sanitation, drinking water and food which all

affects health (Soares & Tzafalias, 2015). Most humanitarian assistance thus focuses on providing these basic needs. Only a small team focusses on psychological assistance. In Greece arrivals on the islands (Kos, Lesbos, and Samos) are within 1-7 days transferred to the mainland, to Athens. This means there are only a few days on the islands where help can be provided before the refugees move on to the mainland.

On the mainland however, there are also challenges. There are many refugee camps in which basic provisions are lacking. Until February most refugees used the Balkan route to enter Western Europe, but this route has been shut since the beginning of 2016, although still people find openings. This has led to an enormous refugee camp at the border: Idomeni, seen as one of the worst refugee camps in Europe (Worley & Dearden, 2016). Also this had its impact on mental health. Other refugees stayed in Athens in order to wait for opportunities for border openings. So on the mainland refugees stay for a longer time, which leads to the opportunity to provide longer term mental health assistance on the mainland. However, this is not yet organized. The focus of psychologists in Lesbos is to help refugees cope with their reaction to the new situation. Because often the journey is not over, they help refugees manage symptoms and short-term help, rather than providing longer term goals in healing. Arriving refugees may experience symptoms like flashbacks, insomnia or physical symptoms such as chronic pain which could ultimately lead to severe mental health problems (Rubin, 2016).

Another challenge for Greece is the continuing influx of volunteers (IMC, 2016). Many volunteers only help for a short time, like a few weeks and there is no time for education or training and teams change in composition very often. This is a challenge because training is not possible and for mental health services it is important the health workers are prepared because in Greece many traumatic stories are shared with health carers. Guilt feelings of making it to Europe while family members are left behind, negative encounters with the Islamic State are examples of what professionals hear from refugees.

Many refugees do not want mental health care but want to continue their journey (Rubin, 2016). This is conflicting with NGO's wanting to help refugees, because who decides someone needs help and what kind of help? A recent report of the International Medical Corps (IMC) sketched a situational assessment about refugee needs for psychosocial support on the Greek islands (2016). They concluded refugees face a lot of stressors, pre-migration and post-migration stressors that affect mental health. Examples are exploitation by smugglers, uncertainty about how to address basic needs without finances, separation from social networks and already existing mental health problems. Needs of refugees are both medical specialized services as well as access to information and family support. In Greece, on every island basic services and security are available although the amount of services varies. Most basic services are provided by NGO's and voluntary organizations. Community and family support are available but not for everyone. For women only on Lesbos and for children almost everywhere. Non-specialized mental health services are almost on every site provided by NGO's and specialized services only on Lesbos provided by MSF and IsraAID, but they lack trained professionals.

3.3.2 The Netherlands

The Netherlands is a slightly different story. First of all, the Netherlands is a country in the West where refugees don't arrive by boat. It is a country of destination, not on the travel

route. So the Netherlands hosts fewer refugees, currently 35.992 refugees are living in a refugee centre (COA, 2016b). First refugees arrive in reception centres where they are screened and urgent medical problems are dealt with. Mental problems must wait until the refugee is settled in an asylum centre. (de Ruuk, 2003)

Health policy in the Netherlands has the aim to ensure access to necessary health care. Overall the Dutch health system has become quite complicated in the sense that there is a wide range of health services and insurances. Compared to other health systems in Europe, the Dutch health system has a good quality and efficiency, monitored by the Health Inspectorate. The Dutch health system consists of four layers. Zero-line health care consists of disease prevention such as immunisation. First-line or primary health care consists of health care provided by general practitioners, dentists, and home care. The general practitioner is the gatekeeper for determining access to more specialized services. Second-line health care is acute hospital care and long-term care means psychiatric hospital care, care for mental illnesses, disabled or nursing homes. However over the last years professionals and organizations have integrated more of their services which blurred these layers. Mental health care is provided by general practitioners but also specialized nurses and social workers. Policies have tried to integrate mental health care into other forms of care with the key principles of providing flexible, integrated, patient friendly and effective care. Ambulatory care is supported rather than treatment in a hospital. Mental health institutions are changing the last years and have merged many times and are now local and regional agencies providing many different services. It is financed via the Medical Expenses Act. (de Ruuk, 2003)

Since 2000, the MOA, Community Health Services for Asylum Seekers, is responsible for preventive medical care for asylum seekers (Sobels, 2003). They have formed foundations that focus on different preventive measures, such as monitoring, screening, improving health and protecting well-being of asylum seekers in refugee centres. These foundations are intermediaries that ensure a refugee sees the right care provider. The MOA also provides policy support for the implementation of preventive health care for refugees. Curative care is being done by regular care institutions. In big centres also education is given about health topics and the health system. In the Netherlands refugees have the same rights as Dutch citizens, although their health care is a little different from normal health care, because former refugee groups found difficulties because of specific problems related to violence and culture. Refugees can get a prescription to go to the hospital or GGZ.

3.3.2.1 Actors

In refugee centers there is a team consisting of a general practitioner, assistant, nurse and a consultant of GGZ, the psychological health service organization of the Netherlands (Sweers, 2015). This team makes primary health care accessible. Also refugees can call a help line when they have a question concerning their health and well-being. Next to this there are some other actors that will be discussed here.

One important organization that not only works in the field of health care but in the overall refugee situation is the Dutch Council for Refugees (VluchtelingenWerk), an independent NGO that defends the rights of refugees and asylum seekers. They represent the interests of refugees from arrival until integration in society. Examples are a fair asylum procedure, access to housing, education and health care. They work in all accommodation centres in the

Netherlands and are funded by ministries of the government and other donors. They also provide the parliament with information about issues and policy and lobby for refugee rights. (VluchtelingenWerk, 2016)

The Central Agency for the Reception of Asylum Seekers (COA) is an important actor. They are an independent administrative agency responsible for housing and basic needs of refugees. Their responsibilities are established in the COA-act and are under the responsibility of the ministry of security and justice. (COA, 2016a)

Pharos is the Dutch Centre of Expertise on Health Disparities (Pharos, 2016). They aim to improve quality and access to care and reduce disparities between groups. One big part focusses on refugees. They do this by supporting national and local parties with providing knowledge and trainings. They have programmes in prevention, health literacy, and responsible use of medicines. Also they provide information to the suppliers of health care. The Health for Asylum Seekers and Refugees Programme provides advice for professionals and provides information for asylum seekers. They also urge for culturally sensitive care.

Menzis is since 2009 responsible for the organization of health care for asylum seekers. The right to health care for asylum seekers and the view of what is sufficient health care is established in the RZA, the Regulation for Care to Asylum seekers. (Menzis, 2016) Within Menzis there is an independent agency MCA (Menzis COA Administration) that takes care of this. Because health services for refugees is somewhat different then services for the host population MCA is entitled to contract their own services.

The GGZ is the agency that treats mental health and psychiatric health problems. GGZ provides mental health services on different levels, in primary health care and specialized services. It is divided in ambulant service and clinical service (MCA, 2016). Since 2014 General GGZ has been introduced. For both levels referral from a general practitioner is necessary. Refugees can only go to a mental health service that is contracted by MCA. MCA pays for the services, if it meets the conditions of the RZA.

3.3.2.2 Practice

Given all actors involved, the Dutch health system is highly institutionalized. It is very well organized and complex. An evaluation of mental health care for refugees from 2002 concluded that basic care is accessible via every mental health agency but on regional level there are some gaps in psychotherapy and day activities (Stants, 2002). Improving health care needs user orientation and professionalism, in which access is the most important aspect which had to be worked on. Waiting lists, lack of interpreters and education negative factors in improving health care in the Netherlands. It is a challenge to match the needs of refugees sufficiently when there are so many refugees. Stants (2002) argues user-led care is needed in order to meet the needs of refugees.

Also health literacy is something that needs improvement. Research points out that migrants receive less health education than Dutch citizens, but more often visit a doctor, more often have mental health problems and also receive more pharmacological treatment (van Wieringen et al, 1999).

Another challenge is medicalization. Medical teams in refugee centres are trained in recognizing mental health problems in an early stage (Pharos, 2016). It is acknowledged that it is positive to recognize mental health problems early because it can prevent from

developing to worse symptoms. This will contribute to independency and integration which also contributes to society. However, this is in conflict with the idea that medicalization is not the solution for mental health problems. It is a challenge for the Netherlands to not medicalize too fast, although there is not enough evidence that this is actually the case.

The Netherlands is highly institutionalized, people with serious mental health problems are often admitted to a mental health institution. However, this is not always better for the patient. Treatment in the own environment, such as community care, is sometimes more effective and facilitates integration into society. The government supports a shift towards more community care, but this is long term (Government, 2016).

Recently mental health care is being acknowledged as something that must get high priority, as can be read in a letter of the Health Council to the minister of Public Health, Well-being and Sports written this January (Health Council, 2016). The argument is that it will enhance participation for refugees with a status and is thus important for society. Mental health has this moment the most concern. The high prevalence of these mental disorders (13-25% against 2-6% for host population) is a challenge for social workers and medical workers. They also acknowledge that daily stressors such as a lack of social support, insecurity of the asylum procedure and multiple changing of asylum centres have a negative influence on mental health. However, the Health Council writes that much is still unknown about mental health disorders among refugees. Only a few disorders (PTSD, depression, anxiety) have had attention but there are also other mental illnesses. The prevalence of disorders and suicide attempts is not clear in numbers. Preventive measures to reduce mental health problems also lack expertise. They advocate for the inclusion of health in the research on refugees with status that is planned to be carried out by ministries.

3.4 Conclusion

In this chapter there is focussed on mental health policy on institutional and service level. On EU-level there is not yet a policy about mental health care for refugees. Differences between countries in health system are big and EU focusses on implementing the CEAS, the overall asylum procedure which the EU wants to make more equal between countries.

Although EU does not have a policy, other international institutions such as UNHCR and WHO do have recommendations for policy on mental health services. As have countries. Two different countries, such as Greece and the Netherlands, have completely different policies. In Greece most care is provided by non-governmental organizations and in the Netherlands it is being provided by institutions that are under responsibility of the Dutch government. These actors are advocacy coalitions who sometimes have to improvise and apply their own projects (in the case of Greece) or try to influence policy by providing knowledge or other forms of assistance (in the case of the Netherlands).

On both levels the effect of daily stressors and trauma are acknowledged as being an impact on mental health status. However, it is not clear if service strategies are in accordance with these statements. In the following chapter there will be analysed on whether refugees have access to provided mental health services.

4. Do Middle Eastern Refugees have access to mental health services?

This chapter focusses on the treatment level of the three-dimensional framework of Watters, where refugees actually get involved in the health system. In order to get health care and benefit from it the concept of access comes forward, as introduced in chapter 2. Have refugees access to health care and what are barriers that constrain access or benefitting from a health service? In this chapter will also be discussed what expectations are of refugees.

4.1 Treatment level

This chapter focusses on the treatment level of the three-dimensional framework of Watters (2001). This level is the level where face-to-face interaction between refugees and mental health workers takes place. In this the role of the general practitioner is crucial because they open the gate to specialized services and determine what the refugee needs. The concept 'Explanatory Model' (EM), defined by Kleinman, is useful in understanding this level. An EM is a process in which illness is patterned, interpreted and treated (Helman, 2007, p.128). It means how one defines and explains a disease or symptom and how one thinks dealing with. Both patients and practitioners have their own EM which determines the choices for the follow-up treatment. Interaction of a refugee and a doctor is a transaction of the two EMs. What often happens is that a patient defines their symptoms to a doctor in a different way than to family, in order to get what he or she wants. The doctor puts their understanding of the problem in a certain medical model of a disease so it can be treated. So an interaction between doctor and patient, in this case a refugee, is a redefining of the EM into a biomedical category (Watters, 2001). What is particularly striking in the case of refugees is that they tend to present their complaints in the form of social (I can't make my own choices), economical (I don't have a job) or political circumstances rather than perceiving themselves as being sick. This is their EM, which can be understood from the fact that mental health and social environment is overlapping. With this theory can be concluded that in order to help a refugee it is more necessary to help the refugee in the broader context than providing only medical care. However, there must be noted that not also specialized services are still needed because it is partly somatization but partly still mental.

On treatment level, access is very important. With no access a refugee with mental health problem cannot benefit from available treatments.

4.2 What barriers constrain access to interaction with a mental health worker?

Although multiple research documents identified there is a high prevalence of mental health problems among refugees, there is low use of mental health services. Colucci et al. (2015) have investigated what reasons are behind this low use of health services. They have concluded with eight key themes that emerge when identifying these barriers. Additionally they have turned these themes into opportunities which they name facilitators, which address how medical workers and other people from the host country should deal with refugees and their mental health problems. These themes will be discussed here and combined with the different mechanisms of access as described by Ribot and Peluso.

4.2.1 Cultural concepts of mental health, illness and treatment

As mentioned in the second chapter, Middle Eastern refugees come from a culture where illness is defined differently as in the West and explained with a different EM. This also implicates the view how illness should be treated. Barriers are cultural misunderstanding or underestimating the impact of resettlement. Facilitators are recognizing the EM of the patient, respecting cultural values and increasing health literacy, which is understanding how the health system works and how to get access to it. Health literacy is also a form of access through knowledge from Ribot & Peluso.

In the Netherlands it is very hard to get a prescription for medication, compared to Middle Eastern countries (Gagnon, 2002). To give an example, in Syria it is possible to buy antibiotics without any prescription (Al-Faham et al., 2011). Also it is a difficult choice for mental health workers to choose the right treatment and understand what someone actually needs. Sometimes the only thing a refugee needs is to talk with somebody about it and complaints will be over. In other cases specialized treatment is needed. It is a challenge for mental health workers who often did not have enough training to deal with these cultural challenges. Training of professionals in knowledge and skills to help refugees is at this moment lacking, but there is a demand from the side of professionals to receive more training (Pharos, 2016).

One thing that can be provided relatively easy is health information. Health information about how to get access to health services and how health services work in the Netherlands will increase access through knowledge. Refugees do not know the gatekeeper role of a general practitioner and the necessity of a referral note from the doctor to specialized care. This is also the case in Greece, where NGO's can provide information about access to mental health services.

4.2.2 Accessibility

Accessibility has to do with where to go when help is needed. Services should be easy to find and access by public transportation is crucial. It also matters if services are located discrete and out of sight. In some cultures it is seen as inappropriate or abnormal to see a doctor for mental problems, which should be respected by health providers. Barriers are that there are no after-hour services, age restrictions, no activity-based programs and differences in time concepts. Opportunities are to improve accessibility by public transport, flexible appointment systems, and key workers. Ribot and Peluso's access through transportation is applicable here.

In the Netherlands, once a week a doctor comes to the asylum seekers centres and there is a service line you can call. In Greece, in the camps there are NGOs which provide mental health services. Services are thus easy to find. However, specialized treatment is more difficult to access. Refugees need to know about this. Another thing is Dutch planning. This planning is very strict which sometimes collides with how refugees deal with time. In the Netherlands, transportation costs are paid by the MCA when the provided mental health service falls under the RZA. In Greece, mental health services are in the camps or just outside so transportation is not needed. When needed, NGOs provide this transportation, such as MSF (Soares & Tzafalias, 2015). In Greece specialized treatment is in theory accessible but in practice not often used because people want to continue their journey or may not know or understand these services.

4.2.3 Trust and confidentiality

One of the most important themes throughout providing health care is to develop a relationship of trust (Thiede, 2005). Access through social relations, a form of access of Ribot and Peluso, must improve the effectivity of mental health services. Many refugees have had negative experiences with authority, therefore trust and confidentiality takes time to develop. This means transparency and patience towards the patient from the viewpoint of the mental health worker. Not only must the individual get care, but also the family and community. Thus social relations include the individual as well as his network.

In the case of refugees it often happens refugees do not show all their feelings and complaints (Pharos, 2016). The reason for this is that they are afraid of not being granted asylum when they have a serious illness because this is seen as a burden on society. Trust is very important in this case.

4.2.4 Working with interpreters

Working with interpreters is on the one hand very positive because language barriers are devolved and there is better understanding from both sides. However patients might be concerned about confidentiality when someone is present. On top of that interpreters can interpret wrongly or he is not trusted by the patient. Gender, age, dialect and other ethno-cultural factors are important in the work of an interpreter. To reduce the risk patients can be asked to have a say in which interpreter is present and interpreters need to have a qualification. This is a problem because of the enormous flow of refugees there is a high need of interpreters in the Netherlands and Greece so quality may therefore be lacking.

In the Netherlands the language barrier between a refugee and a doctor is seen as the main barrier in benefitting from health services. Working with interpreters is often not done because it is very expensive. In the past doctors used a so-called 'interpreter telephone', but this has been dispensed because it was 'not necessary' (Pharos, 2016). However, this leads to a communication problem between the general practitioner and the refugee, which leads to longer consults because of language barriers, understanding of the complaints and explaining health services. In May, the government has provided temporarily funding for the use of interpreters at a consult (Van der Velden, 2016). However, this is only temporarily and doctors advocate for a permanent policy.

Besides the use of interpreters education is important in the language. Access to education is also a form of access by Ribot and Peluso. Learning the language facilitates the benefit of health services, no interpreter is needed and it has many other benefits such as easier integration.

4.2.5 Engaging family and community

For Middle Eastern people family is very important (Carteret, 2011). So when one family member gets involved in mental health services also the family is involved in consultations. A barrier for access to mental health services can be underestimating the role of the family and provision of only individual care. Likewise, it can happen that the family does not acknowledge the problem or have a negative attitude towards mental health services. Opportunities can be to involve the community and family. Access through social relations, just as with trust and confidentiality, are thus very important in improving how the individual benefits from mental health services.

Recommendations for the Netherlands and Greece are for health workers to speak with the family spokesman, usually the oldest and most educated (Carteret, 2011). Sexual segregation is also important to respect. Engaging family into health services is not reported as an important barrier. However, in practice it is likely difficult to find a balance between engaging the family into health services which are mainly individual, and to help the patient in a way that aligns with the national health system.

4.2.6 Mental health providers' style and approach

The research of Colucci et al. (2015) concluded that the style and approach of mental health providers is the most important theme with regard to refugees. This involves communication, reliability, involvement of young people in decision-making, nonverbal communication and boundary-setting. Positive characteristics of a mental health practitioner were having empathy, being respectful, understanding and informal. This also has to do with building a relationship based on trust. Barriers are providers who are overloaded and changing staff in organizations. Facilitators are qualities such as empathy but also clothing style, matched providers with respect to gender, age, a holistic approach and being clear about expectations.

One barrier in Greece is the constant changing of volunteers in voluntary organizations. This impedes the ability to build a relationship of trust. Communication is also a barrier when doctors inform refugees about their ability to access health services. Refugees report that they need a health worker who tries to understand what they have experienced and daily stressors they still experience (Pharos, 2016). So this must be something health workers need to be aware of.

4.2.7 Advocacy – assisting young people with their priority areas

A focus on disease, emphasize on its symptoms and treatment is not what suits refugee patients. A holistic approach which describes the person as a whole and integrates treatment with other activities was found as suiting better. General practitioners identified that refugees often put higher priority on economic security, housing stability, family separation and isolation. These priorities must be recognized by doctors and addressed when aiming to build a relationship based on trust, thus a form of advocacy.

In practice, this is difficult. Health professional cannot help refugees with things like economic security or housing. This could be a task for people working in organizations that address multiple needs, such as COA-workers in Dutch refugee centres and NGO's that address primary needs in Greece. They can build a relationship of trust and be a relation through which refugees can gain access to mental health services.

4.2.8 Continuity of care

Often it happens that refugees are referred from one service to another, which causes fragmentation of service provision. Communication towards the patient is important, also when a refugee is going from one country to another. Coordination and cooperation between services is very crucial in reducing fragmentation. In the Netherlands, the general practitioner is the main gatekeeper for other medical services including mental health services. They are responsible for continuity of care by referring refugees to the right service and coordinate between different services.

As described by Colucci only the medical service has responsibility to take care of refugees. However, responsibility must also come from the patients. It is unrealistic to expect that the health system becomes fully adapted to refugees. Furthermore, it is found to be inefficient to build a whole new health system. It reduces costs when refugees are integrated into the health system of the host country (Scholz, 2016). In Greece, health care for refugees is not integrated in the Greek health system but provided by NGO's. But the reason is that refugees stay there for a shorter period. In the Netherlands, refugees are integrated in the Dutch health system, although attention is given to cultural sensitivity in treating refugees.

Another aspect that challenges mental health is the time delay between becoming aware of a mental health problem and the start of the problems because refugees arrive unexpectedly. This challenges health providers to adequately treat them when having lack of resources (Thomas & Thomas, 2004). Still, awareness of these eight themes is very crucial. Now mental health care workers struggle with dealing with all the refugees and some guidelines can be very useful in this situation.

When applying the concepts of controlling access and maintaining access to this case, we can conclude the important role of the general practitioner in the Netherlands in controlling access. This health worker is the gatekeeper to all other services because refugees always first see a general practitioner. However, dealing with mental health problems of refugees in a culturally appropriate manner takes a lot of preparation, training and improvisation. The question arises whether all this pressure must be put on the general practitioner, given he already has a very demanding job. To understand more about the needs of refugees and constraining barriers, expectations of refugees will shortly be outlined in the following section.

4.3 Expectations of refugees

The view of refugees on what they need to promote their health consists of several things which do not only concern health but also an improvement of their social and economic position. Examples are: (de Ruuk, 2003)

- A short and transparent asylum procedure
- Access to employment
- More privacy and safety in centres
- Socio-cultural activities and gatherings
- Access to learning the language and culture
- Society must have a better image towards asylum seekers and refugees

Also children reported homesickness, tiredness, worrying. Their self-perceived health was a 4,3 on the Cantrell scale, while Dutch children score an 8. This can be explained by several reasons: they don't have residence permit, reception centres are boring, they miss family, do not have enough activities and don't have their own house. Some refugees relate their health status to the new climate, but most relate it to experiences in home country and to their situation now which has no future vision. (de Ruuk, 2003)

This implicates that from a mental health perspective, mental health needs need to be addressed in a holistic way where several more parts, daily stressors, of the situation of the refugee are being addressed. From an organizational perspective, this could be different because it is extremely difficult to implement a holistic approach, because all parts are now separated and being organized by different people and institutions.

4.4 Traditional healing

Another reason why the use of mental health services is low is that families still rely on traditional knowledge and healing. There is not yet research about the role of traditional healing practices of mental health problems among refugees, but a research in the New York identified that especially for mental health problems Islamic people go to the imam to seek help (Abu Ras, 2008). This is likely to be the case for refugees in Europe, too.

4.5 Conclusion

Refugees face a few barriers that limit their access to mental health services. It is the role of policy makers and health care workers to reduce these barriers, although refugees also need to adapt to the current situation. The general practitioner is the gatekeeper that controls access to mental health services. Cultural sensitivity is crucial in providing effective health services. Both countries face challenges in the light of the current refugee crisis, which will be the topic of the next chapter.

5. What are remaining gaps, challenges and choices for the EU?

Now we have analysed how access is constituted on different levels it is clear that mental health of refugees is a complex topic which requires understanding, trust and appropriate services for the sake of the refugee as well as the host population. There are still some remaining gaps and challenges for policy makers which will be addressed in this chapter.

First of all, mental health is recently been seen as of big importance, and also gained attention when providing basic needs as food and primary health care. UNHCR says mental health disorders hinder integration in host population which creates problems for European countries (Bailey, 2016). The European Psychiatric Association said that psychiatric health needs to be provided to asylum seekers so mental health problems are avoided. The UNHCR advocates for psychological first aid, which must encourage people in interaction with refugees to interact in a way that is culturally sensitive. Thus from a mental health perspective mental health services should be incorporated in providing primary health care, especially in Greece. It is very simple to embed the importance of mental health in providing basic needs, because basic needs are the first big step towards a better mental health status. If no basic needs are provided this will lead to daily stressors which do harm to mental health status. Thus, basic needs are crucial before engaging people in mental health therapy (Bailey, 2016). This has to do with a relationship of trust which facilitates access to health services. Also barriers need to be reduced by governments, health workers, NGO's and other involved actors such as providing qualified interpreters and cultural sensitive health care. In practice, refugee camps in Greece are very chaotic. This makes the work of mental health workers more difficult. Additionally a balance between medical treatment and humanitarian support must be found, because basic support and clarity about the asylum procedure also have a positive impact on mental health.

In general, the impact of daily stressors is widely acknowledged by different actors. From a mental health perspective it is necessary for policy makers to integrate mental health policy with other policies, about education for example. Also transparency is something that impacts mental health. Therefore a holistic approach on mental health is needed, but this might be difficult in practice because of separate policies between health policy and other refugee policy.

On EU-level, policy is needed about mental health care. Although officially national health care systems do not need EU-legislation elements in financing and provision are under EU-legislation. Since the EU does have a common asylum policy with the aim of equalizing asylum systems, it is in line with this argumentation that equalizing health systems will be desirable as well, to ensure there is sufficient provision of medical workers, medicines and therapies. This might be something the EU must make a choice of, currently in the light of the situation in many refugee camps in Greece and Italy. Policy may be a step ahead but guidelines are also a good option. Countries can use this when dealing with the new refugee situation.

In Greece, the challenge for the government is the coordination of other institutions and organizations responsible for the health of refugees. Because mental health care services on national level are not sufficient or accessible for refugees NGO's have filled this gap by implementing their own mental health strategies. Greece has the responsibility to coordinate these services and provide health care in all camps and on all islands in order to provide

effective assistance. Especially when refugees will stay for a longer time in Greece because of insecurities about the asylum procedure. However, in practice this is a huge challenge, because the refugee crisis brings more problems than health care, such as huge amounts of asylum applications, lack of food supplies and drownings. Next to this, the Greek economic crisis also still has consequences in the whole country.

In Greece NGO's all have their own strategies, such as PHAME and MPHSS. However, it would be a challenge for these actors to start cooperating more and develop one approach to deal with the inflow of refugees and the big camps where mental health services are needed, especially now that refugees stay longer in these camps than before. Also the many temporarily volunteers make cooperation and an equal approach difficult to manage.

In the Netherlands health services are organized but there is a lack of training of health professionals concerning cultural sensitive care. Therefore misunderstandings can occur where a refugee wants specialized care but the doctor doesn't acknowledge this need, for example. Cultural sensitive care makes health therapies effective and accessible. On the other hand, health services for refugees need to be integrated into the normal health system to make it efficient. It is a challenge for the service level, for countries, to incorporate cultural sensitivity in health policy. It is a challenge for health workers, such as psychiatrics and psychologists, to deal with the cultural differences. There is a call from health professionals for more training in how to deal with differences and in understanding the background of refugees (Berkum et al, 2016). Also refugees want to be involved in mental health services, which help to shape care towards what is needed. A lack of interpreter services contributes to the problem of cultural insensitivity. These are barriers that lead to refugees not benefitting from health care and is a challenge for policy makers to make decisions about training for health professionals.

In the Netherlands health literacy is another challenge. Advocacy coalitions such as Pharos and GGZ advocate for more health education so refugees benefit from access through education. The Dutch health system is difficult to understand for a foreigner, where the general practitioner is a very important actor. Health literacy facilitates access to mental health services and should therefore be of concern of policy makers.

Overall more research is needed on the role of traditional healing and effectiveness of interventions. As mentioned in chapter 4 not much is known about traditional healers in European countries and the role of this group for refugees. The hypothesis is that traditional healing can be a very important part of mental health services, because this is often associated and explained using religion, as well as the treatment. Traditional healers have better accessibility for refugees because it is close to what they are used to and traditional healers can play a big role in facilitating access to other forms of mental health care. In this, cooperation between traditional healers and the normal system is very crucial.

The effectiveness, efficacy and applicability of different interventions or therapies to improve the mental health status of refugees, in short, what works for refugees when it comes to improving mental health needs research. The literature has many guidelines and frameworks for working with refugees but there is not much empirical evidence that confirm these theories (Slobodin, 2015). If we do not know which forms of services are effective no effective policy can be made. Effective services are positive for access to health services because refugees have more benefits from effective services.

5.1 Conclusion

Although mental health services have gained more attention the last months and years there are still some remaining gaps and challenges on institutional, service and treatment level. In this chapter we have discussed some of these challenges.

5 Conclusion

Mental health is very crucial, on both short and long term. On the long term it facilitates integration in the new society, which will in turn reduce mental health problems. Prevention is very important because severe mental illnesses are more difficult to treat, put a burden on the health system and is economically inefficient. This thesis focussed on the role of policy in providing access to mental health services for Middle Eastern refugees in the EU, in the light of the current refugee crisis. Access is defined in this research as the ability to benefit from mental health services. For analysing these three levels are identified: institutional, service and treatment level.

First of all, mental health problems by refugees result from daily stressors during pre-migration, migration and post-migration. The most diagnosed disorders are PTSD, anxiety and depression although there is a risk of medicalization which leads to provision of health services that do not fit with the needs of refugees.

On the institutional level access is defined in legal rights, such as the right to health and the right for a fair asylum procedure. Although there is no policy concerning mental health services in the EU, WHO- Europe has developed some guidelines and shared research which address the mental health needs and concerns of refugees.

On the service level we zoomed in on two completely different countries, Greece and the Netherlands. What becomes clear is that policy is not a one-way directive but is constituted in a process of negotiation. In the current refugee crisis we could say much policy is improvised. The current refugee crisis happened before policy could be adapted to the huge influx of refugees. Experiences from the civil war in Syria and other traumatic experiences, losses of the social network, beloved ones and a terrible and long journey together with bad circumstances in camps and insecurity about the asylum procedure have resulted in mental health problems. In Greece coordination by the government is lacking and NGO's like MSF and IsraAID have arrived at the islands and in refugee camps to provide mental health services and psychological assistance, all using their own strategies and policies.

In the Netherlands, access to mental health services is taken care of by the government, coordinated by Menzis. GGZ, the national institute for mental health care provides health care for refugees. Research centres, such as Pharos, provide knowledge to policy makers. However, also the GGZ and Menzis have to improvise coordination of health care with many new refugee centres being opened and full.

On treatment level access is controlled by general practitioners, volunteers and teams in asylum centres. Cultural sensitive treatment is important on this level. It is up to health workers to be aware of the background of refugees and how to interact with refugees that creates a mutual understanding. Because of a lack of training this cultural sensitive treatment also needs to be improvised.

There are however many barriers refugees face which constrains them from benefitting from mental health services. Language barriers, cultural inappropriate care and no coordination between different services are examples of this. Recommendations for policy makers are to find more evidence on certain aspects of health care, such as the role of traditional healers and the efficacy of different forms of treatment. Also the role of daily stressors in practice can be implemented in policy.

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Annex I – E-mail

Topic: Mental health policy refugees

Dear sir/madam,

My name is Eline, an International Development student from Wageningen university, the Netherlands. Currently I am writing my thesis in order to graduate. My topic is mental health care refugees and the role of the European Union in this with regard to policy. It is a literature study. Searching on this website I couldn't find a clear overview on what policy the EU has concerning mental health of refugees. Also I am curious to know how important (mental) health policy is in the refugee policy and if the policy has changed recently because of the current refugee crisis in Europe. I am wondering if you could send me some information or documents that help me with my research. That will be really appreciated!

Thanks in advance and I am looking forward to hearing from you,

Kind regards, Eline Verhoeven

Dear Eline Verhoeven,

Thank you for your message.

The EU does not yet have a common policy towards the health problems of migrants, it is under the competence of Member States. Regional and local authorities across Europe have varying competences in the field of health policy.

You can read about the issue from the following links:

http://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-cost-healthcare_en.pdf

[http://www.europarl.europa.eu/RegData/etudes/BRIE/2016/573908/EPRS_BRI\(2016\)573908_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/BRIE/2016/573908/EPRS_BRI(2016)573908_EN.pdf)

http://www.epgencms.europarl.europa.eu/cmsdata/upload/3a3f00c0-9a75-4c84-94ad-06e4bd2ce412/WHO-HEN-Report-A5-2-Refugees_FINAL_EN.pdf

http://picum.org/picum.org/uploads/publication/PolicyBrief_Local%20and%20Regional%20Authorities_AccessHealthCare_UndocumentedMigrants_Oct.2014.pdf

We hope you find this information useful. Please contact us again if you have any other questions.

With kind regards,

EUROPE DIRECT Contact Centre

<http://europa.eu> - your shortcut to the EU!

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