Mental health »in transit«: social and political contexts of refugees' mental health care

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The presentation

- will deal mostly with theoretical considerations of:
  - the articulation of the so called “social model” in relation to mental health practice with refugees.
  - how the social and political context of welfare and health services influence access and quality of service delivery for refugees,
  - and what are the application of these concepts for education and training of staff working in social and health care.

1. Social model in the context of refugees‘ mental health

- The usual “*social approaches to mental health*” have argued for
  - the inclusion of a wider range of social, political and economic factors beyond the individual when responding to one's distress, which are all central to understanding and responding to refugees' mental distress.
- Social model as developed by service users:
  - highlighting the issues of social oppression and discrimination in relation to distress and
  - challenging conventional individualistic models of ‘mental illness’,
  - emphasizing principles, such as valuing self-support, commitment to anti-oppressive practice, prioritising advocacy and self-advocacy, and others. (Beresford, 2005)

2. Personal experience perspective: from suffering to resistance

- It seems that the empirical research on refugees' mental health supports the ideas of this approach in more than one aspect, the strongest being *the resistance to the prevalent view on refugees as victims and traumatized people.*
  - This view is based on the premise that ethnic cleansing, war, economic devastation, loss of relatives etc. all constitute mental health emergencies and therefore result in 'post-traumatic stress.
- This is not to deny refugees' suffering.

Trauma as a major discourse to explain refugees' suffering

- But trauma as a major discourse could
  - lead to the exclusive use of individualistic treatment based on the Western biomedical model,
  - to the neglect of refugees' own resilience, indigenous and innovative ways to cope (Goździak 2004),
  - their resistance and networks of solidarity (Zorn 2014).
- As, Goździak pointed out that frequent medicalization of refugees' suffering may diminish the capacity of human beings to deal with anxiety, suffering or death.
- Beside negative and traumatic experiences, before or after the flight, they may also experience
  - solidarity, capability to survive, friendship: their narratives are full of hope, humour and innovative ways to cope.

Mental health care or social care services

- Mental health care or social care services should consider and learn from their comprehensive experiences.
- In reality, in order to access refugee services and programs, the negative aspects of the refugee experience are often emphasized: refugees are characterized mainly as traumatized people and helpless victims with their lives full of pain and despair.
  - there can be a pressure for refugees to emphasize suffering or over reporting psychiatric symptoms in their encounters with service providers in order to be considered legitimate (to achieve so called biolegitimacy).

Victim talk

- However, as they are »victims« we deny them power, aspirations, skills and hope.
- We deny them the sense of ownership and entitlement as to what helps them.
- As Goździak said, "*there is a focus on research on pathology, but lack of studies of those who are functioning well*"
  - we miss to learn about coping strategies from them.

3. Social and political contexts of refugees' mental health care

- If in the past there was an research focus on the impact of experiences in refugees' countries of origin to their mental health,

more recent research has shifted focus

- to the impact of experiences in the flight and post-flight context, *in particular, the correlations between specific policies of deterrence and the mental health of asylum seekers and refugees* (Watters 2004).
- Two consistent risk factors predicting higher rates of mental disorders have emerged from the cumulative body of research: past traumatic experience and the post-migration socioeconomic situation (Bogic 2015).

4. Social and political contexts of mental health service delivery

- Mental health services for refugees and asylum-seekers are not delivered in neutral, social context free environment.
- Research that is confined to a clinical profiling of asylum seekers and refugees within post-migration contexts may lose sight of a broader picture.
- Watters (2007) sees a fundamental inter-relationship between the delivery of mental health services to migrant groups and the broader socioeconomic and political contexts in which they are placed.

- For example, *inter-relationship between immigration controls and welfare provision* appeared to be very meaningful in terms of getting service.
  - For example, access to mental health services may be crucially determined by factors such as age, as children and adults have different levels of entitlement, or mode of entry.
- The access to the services is also influenced by *the policies of processing refugees at borders*, the tightening of asylum legislation, the return of refugees.
  - Faster procedures also mean faster "processing" of people, in cases of acute mental distress may also mean denial of aid.
  - Emphasis on security aspect rather than social or humanistic aspect.
- *Culture of mistrust* within all of the governmental bodies responsible for addressing asylum seekers needs: uncritically accepted and generalized representation of asylum seekers, specific atmosphere towards refugees, which influences access and quality of service delivery

Culture of mistrust (May 2018)

Moral economy of care

- Provision of services to refugees and asylum seekers is governed by what may be referred to as a *moral economy of care* (Watters, 2001) that
  - distinguishes legitimate refugees who are *deserving of protection and care*, and illegitimate refugees who are *not deserving of it.*
  - 'genuine' refugees and those who are considered not genuine (illegals, illegal immigrants, undocumented migrants, irregular migrants, economic migrants)
- *Biolegitimacy:* gaining legitimacy through gaining leave to stay in a country for humanitarian reasons, typically as a result of physical or mental illness.

How did the prevailing culture of mistrust and deterrence policy manifest in Slovenia?

- out of more than 300.000 refugees that transited the state from September to December 2015 only around 100 persons lodged an asylum application.
- the Slovenian authorities are striving for refugees to transit through Slovenia as soon as possible.
  - Change of asylum legislation (speeding up the procedure)
- razor-wire fence along the Slovenian border:
  - a message to both locals and the refugees; many locals presume that militarisation of the border (special police forces, soldiers, razor wire) is a response to a real threat.
- Slovenia complied under the refugees relocation scheme to receive only 567 refugees!

Insanity of conditions in reception centres at the borders: refugees' mental health

- In the reception centre where I worked medical care was seen as necessary only in very urgent cases.
- In transit, mental health care is often disregarded as a 'luxury'.
- In practice, the moral economy of mental health care shapes socio-legal spaces where entitlement to assessment and care is either limited or non-existent. It places those who should be protected outside the parameters of care.
- Case of a man in acute psychosis crisis

Struggling to perform professional work at receptionist centre

- Security was a word of magic and the alfa and the omega of the principle of everything that was going on.
- The care-providing was organised in terms of conveyor belt which processed people: feeding-registration-rest-toilets-back on the bus, it all followed the planned trajectory among the fences which separated the volunteers from refugees.
- This basic setting also provided the scenery for the »principles of working with people« which were diametrically opposite to usual professional standards.

Keeping distance as a “principle of working with people”

Mingling…

Making contact…

Implications for education and training in social and health care

- Social science perspectives are not well integrated with medical science and treatment, which is contradictory with social reality.
- Experiences of social work students working with refugees:
  - *to deconstruct the image of the refugee*
  - *Advocacy*
  - *Building supporting community with migrants*

Thank you for your attention!

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