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## *PLATFORM ON MULTICULTURAL SOCIETIES AND MENTAL HEALTH*

Report on a Meeting

Bonn  
29 January 1994

1994

EUR/HFA targets 12 and 28

## TARGET 12

### REDUCING MENTAL DISORDERS AND SUICIDE

*By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.*

## TARGET 28

### PRIMARY HEALTH CARE

*By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.*

## ABSTRACT

The second meeting of the European Platform on Multicultural Societies and Mental Health heard reports from members' countries. Plans were made for the next meeting and a workshop to be held in the context of the International Conference on Migration, Aculturation and Integration in Paris in October 1994, and themes were suggested for following meetings.

## Keywords

MENTAL HEALTH  
MENTAL HEALTH SERVICES – trends  
TRANSIENTS AND MIGRANTS  
REFUGEES  
BELGIUM  
THE CZECH REPUBLIC  
DENMARK  
FRANCE  
GERMANY  
NETHERLANDS  
SWEDEN  
SWITZERLAND  
TURKEY

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## INTRODUCTION

The second meeting of the European Platform on Multicultural Societies and Mental Health, hosted in Bonn on 29 January 1994 by the Wissenschaftliches Institut des Ärzte (WIAD), was attended by 19 mental health specialists and guests from various countries in the WHO European Region (Annex 3). Mr K. Schilder was Chairperson.

The previous day a public symposium had been held in Bonn to mark the official recognition of WIAD as a WHO collaborating centre for migration and mental health. All the Platform members and representatives of local German authorities had attended the symposium, at which Mr H. Voigtländer had expressed the German Federal Ministry of Health's special interest in migration and health.

The objectives of the second meeting of the Platform were to:

- report on recent initiatives and activities in each member's country;
- discuss the reviews of committees;
- discuss implications for mental health services of recent trends in migration; and
- plan for the next meeting and further activities of the Platform.

## REPORTS

### Belgium

The political aspect of the question is concentrated on the differences between asylum-seekers, migrants and refugees. There are five main problems:

- criminality (especially among younger migrants)
- children
- elderly people
- disintegration of families
- relationships between migrants groups of different origins.

An Intercultural Health Mediation project has been developed in Brussels and the Flemish part of Belgium, aiming to improve the health of migrants (mainly Moroccan and Turkish) by developing communication with them. The basic problem is the existence of thresholds, which make health care difficult of access. About 50 migrants are undergoing a three-year training programme as intercultural mediators. They will then be employed in the area of migrants' health with the aim of making the health care services more accessible to migrants. Detailed information about the project is available on request.

### The Czech Republic

The Czech Republic can be considered a "young" country as regards the granting of asylum. In the past people fled the country for political reasons, for example in 1968. But now its geographical position almost inside the borders of Germany is used by migrants seeking to penetrate the black market in labour in rich western countries. New legislation in Germany

relating to asylum-seekers could, however, soon change the Czech Republic from a transit to a target country for migrants.

By October 1993 the camps for asylum-seekers had received 7710 people of whom 1173 had been granted asylum. They came mainly from Armenia, Bulgaria, Romania, Ukraine, Vietnam and the former Yugoslavia. There are 3800 people from the former Yugoslavia in the Czech Republic; it is estimated that another 7000 are there illegally.

The Ministry of the Interior has a special department to deal with these problems and runs various centres. The Government, in cooperation with the International Organization for Migration (IOM), the International Committee of the Red Cross (ICRC) and the United Nations High Commissioner for Refugees helps to reunite families who have been split by the imprisonment of members in concentration camps in the former Yugoslavia. Some projects in progress are a general data system, an information questionnaire and the organization of psychotherapeutic help. Children of people granted asylum and of foreigners living in the Czech Republic have the same rights and educational possibilities as Czech children for the school year 1993/1994, including at apprentice schools. The Ministry of the Interior has also developed a special programme for Romany-Sinti children.

Various nongovernmental organizations are also active in connection with migrants.

Dr Nesvadbova was carrying out a study of the health status and social problems of migrants from the Chernobyl area in Belarus and Ukraine. She also taught physicians, medical students and social workers how to help migrants.

## **Denmark**

There are three groups of foreign citizens in Denmark: immigrants, refugees and asylum-seekers. Each group has specific psychosocial problems.

Of 2500 applicants for asylum from 32 countries in 1993, only 150 were granted refugee status. On arrival, asylum-seekers are directed to centres which are overcrowded and have generally poor facilities. They are not allowed to work, and the non-integration policy applied at this stage does not give them the opportunity to learn Danish or use the waiting period constructively. The children are not allowed to go to Danish schools. The risk of expulsion and the forced proximity to other asylum-seekers, who are also afflicted with post-traumatic stress disorders, make their situation very taxing. Finally, a high rate of criminality and violence on the part of a small group of refugees (mainly from the Baltic countries and the Russian Federation) has had a negative effect on the attitude towards refugees of the population at large.

Once asylum-seekers are granted refugee status they are enrolled in a programme designed by the Danish Refugee Association and are given material and social support. Only 35 000 of the 180 000 foreigners living in Denmark are refugees; the rest are immigrants, mainly from the EU and Nordic countries and Turkey (the largest group from developing countries).

The mental health problems of refugee families are primarily related to the fact that at least one of the parents has often been tortured and/or suffers from the sequelae of trauma

connected to the flight from their country. Families are also subjected to the stresses of integration and the conflict of values inherent in all transcultural integration, especially when the immigrants come from underprivileged countries.

Finally, there is a group of economic migrants (guest workers) who came in the 1970s and their relatives who have joined them according to the laws of family reunion. Here, the main problems concern second generation youth. There is a higher dropout rate at school, more unemployment and, in recent years, more criminality among Turkish boys aged 12-20 years than among Danish boys of the same age.

The political situation is polarized at present, with seemingly increased negative reactions to foreigners in some sections of the population combined with expressions of solidarity and sympathy. Two positive examples of this are that a Pakistani woman politician received the highest number of votes in the last elections to the city council of Copenhagen, and that training in the problems of immigrants for professional groups such as physicians attracts attention and interest. Such education is continuing throughout the country.

### **France**

One of the goals of the Platform is to increase the accessibility and appropriateness of mental health services for migrants' groups, both as users and care providers. The number of migrants providing care in French institutions is increasing.

The same paradox can be seen in France as in other European countries, namely movements against migrants and maturity in dealing with them. The First European Congress on Migration and Health, held in Paris, had increased French awareness of the migrant population. The proceedings would be published two months later. A film about migrants and mental health problems, cosponsored by the Ministry of Social Affairs and the Red Cross Organization and based on the idea of clinical medical anthropology, was in preparation.

### **Germany**

Germany was in the grip of economic depression, with spiralling costs of unification and a worsening social situation. In this context, the elections to be held in 1994 would be particularly important.

New laws concerning asylum-seekers had been introduced in July 1993. As a result, their numbers had dropped 50% in the previous six months.

Germany would have the Presidency of the European Union from June to December 1994. The Federal Ministry of Health had already held a conference on migration and health in September 1993 and had established a plan of action with this question as a priority.

An immediate outcome of this was the planning, on behalf of the European Union, of a conference on migration and health for the autumn of 1994 in Magdeburg (Germany). The conference would focus on understanding the situations in the EU member states as regards the morbidity and provision of care for migrants, higher prevalence of infectious diseases in migrant groups, and migration and health. The goal is to draw up papers about the development of strategies and political guidelines for future work in this field.

Mrs Weilandt encouraged members of the Platform to give her addresses of people to whom the Migration and Mental Health Newsletter could be sent, and to send abstracts for inclusion in the Newsletter. She also mentioned the WIAD data bank and distributed a questionnaire calling for abstracts to be returned to WIAD with comments, proposals, etc. (Annex 1).

Dr Malhotra said that there were four types of migrant children in child care institutions: children of emigrants, refugees, asylum-seekers and guest-workers. Some epidemiological work had been done on Greek children: this showed that Greek women and children are in better mental health than indigenous people. Future research activities will probably focus on children from the former Yugoslavia.

### **The Netherlands**

Dr van Willigen reported growing negative public opinion towards foreigners. The number of asylum-seekers was increasing while the social situation was deteriorating. Stays in refugee camps were being extended even when refugee status had been granted. The migrant population had become a political issue in the elections due in spring 1994.

Health care conditions for migrants were receiving more attention; prevention and treatment programmes for refugees, for instance, had been established. There was increasing demand for training programmes and courses by hospitals, ambulatory psychosocial care providers and general practitioners.

Reports from the European Consultation on Care and Rehabilitation of Victims of Rape, Torture and other Severe Trauma of War in the Republics of ex-Yugoslavia, Utrecht, 17-19 June 1993 and from the meeting of the PHAROS Advisory Group on Health Hazards of Organized Violence in Children, London, 10-12 February 1993, would be sent to Platform members.

A special project on sexual abuse during the war in the former Yugoslavia was being prepared in collaboration with two Dutch organizations concerned with women's care.

Professor de Jong reported on a new foundation for intercultural health, which was meeting twice a year. He would keep the Platform members informed about a book he was preparing on cultural understanding, treatment and therapeutic issues and interculturalization of the health system. Financial support had recently been granted for an epidemiological study among Moroccan, Surinamese and Turkish migrants to investigate the prevalence and incidence of psychosocial and psychiatric problems in these migrant groups in comparison with the Dutch population. Professor de Jong had also developed training programmes for psychosocial intervention. The Netherlands Government was emphasizing multicultural training in health care education in order to bring about full integration.

Mr Groen had noticed that in place of separate problems among the migrants in his centre he was now seeing an overall problem of multiculturalism in big cities. The provision of care to illegal immigrants was causing new problems. His report on a project under which psychologists and psychiatrists from the former Yugoslavia stayed in the Netherlands for theoretical and practical training on treatment for trauma would be published shortly.

Mr Schilder reported that Stichting Overlegorgaan Geestelijke Gezondheidsorg (SOGG) had developed a multicultural education and training manual for psychiatric facilities and would develop cultural diversity training modules during 1994.

### Sweden

Since the elections nearly three years earlier a new political party, the New Democracy Party, had been founded with cost-cutting for migrants as one of its policies. Although opinion polls showed that this party only received 4% of the votes, it was influential because the Conservative parties had to negotiate with it in order to stay in the majority in Parliament. On the other hand, public opinion was influenced in the opposite direction by statements from the Royal Family (the Queen is of German origin).

The special quota of refugees, who were directly selected and transported to Sweden by UNHCR, had increased to 7500 in 1994. It was expected that there would be 120 000 refugees (1.5% of the population of Sweden) from the former Yugoslavia in 1995.

A new policy had been introduced aiming to reduce investments for migrants and refugees in Sweden but to give help at the places where refugees originate, or as near to them as possible. Nongovernmental organizations were also supporting a proposed change in the policy relating to the reception programme to bypass refugee camps and send asylum-seekers directly into the community, although the selection and administrative procedures for refugee status would remain the same.

An interdisciplinary network of 15-20 clinicians and researchers in medicine, psychiatry, psychology, sociology and anthropology from various parts of Sweden had met twice a term since the autumn of 1992. The network had a project under way in the field of migration and health. At each meeting one of the participants introduced his or her project and the contents were discussed from a scientific point of view. Representatives from the Ministries of Culture and of Health and Social Affairs attended. This network complemented the International Migration and Ethnic Relations network, established at Stockholm University and some other universities in Sweden, which dealt mainly with social and humanistic research in this field.

The Nordic countries were preparing a seminar on refugee families' health to be held in Sweden at the end of 1994. The publication of a book on how to handle refugees was also planned.

It was important that as well as focusing on problems, research should also look at how to sustain health (for which intervention programmes had to be found) and investigations of the health status of migrants. An important subject of study was how to succeed as an immigrant/refugee in a new country. Another topic was to ask refugees about their needs before "our" model was used: it was too easy for existential problems to become psychiatric problems. A new Unit for Immigrant Environment and Health of the National Institute for Psychosocial Factors and Health had recently been set up in Stockholm.

The Refugee Medical Centre in Linköping had been established in 1986 and was working on projects related to Bosnian refugees, such as the preparation of a manual of care for female Bosnian victims of sexual torture in war.

Finally, refugees from countries other than the former Yugoslavia should also receive attention.

### Switzerland

Although the social situation of asylum-seekers was getting worse, mental health care for them was improving. Migrants' mental health had been discussed in several conferences and workshops.

The Swiss Federal Health Office Prevention Department had started a programme on migrant health, including a national training programme for multipliers within migrant groups. Mr Fleury reported that, together with 20 other professionals, he had started a new nongovernmental organization, Appartenances, in Lausanne. This organization had a pilot project concerned with training professional and voluntary health promoters in migrant communities.

The first national HIV-AIDS prevention programme for migrant communities had been monitored. A full report was available.

A problem in migrant care throughout Switzerland was access to professional translation facilities.

The press had paid considerable attention to a link between crime and asylum-seekers and to the proportion of foreigners among prison populations.

### Turkey

Dr Erol and her colleagues had started a research programme to compare the mental health of Turkish children living in Turkey with that of Turkish children living abroad. They had adapted and standardized the *Child behaviour checklist and teacher's report form*, developed by Achenbach, for Turkish cultural conditions and had also begun to use the *Youth self-report*, also developed by Achenbach, for the adolescent population of Turkey.

In addition, Dr Erol had adapted and standardized different types of questionnaire for Turkey, e.g. the *Fear survey schedule for children*, the *Eating attitudes test*, the *Maudsley obsessive compulsive questionnaire*, the *Leyton obsessional inventory*, *Rutter's questionnaires*, the *Family of origin scale* and the *Family scale*. She also mentioned a multicentre study of the prevalence and incidence of hyperactive children in eight European countries.

With the support of the Population Council, Dr Erol and her colleagues had developed the *Ankara developmental inventory* for Turkish children, with the aim of designing a measuring device that would yield an index reflecting the development of children aged 0-6 years. Dr Erol was also working with the WHO project on the provision of primary health care for the promotion of early psychosocial development.

Dr Erol suggested that Platform members might like to use the reliable and valid assessment measures to compare the similarities and differences between and within cultural backgrounds in order to try and discern positive and protective factors as well as risk factors.

### **WHO headquarters**

A manual on mental health of refugees for nonprofessionals had been developed by WHO headquarters in collaboration with UNHCR. This was being updated and translated into several languages.

Dr Orley referred to the collection of WHO research instruments available in several languages for free use, e.g. CIDI and SCAN. He offered to prepare a short overview of WHO instruments suitable for use with refugee populations for publication in the next WIAD/WHO Newsletter.

### **WHO Regional Office for Europe**

The Regional Office expects that the health of ethnic minority groups, migrants and refugees will become an important issue and that activities will be undertaken in 1996–1997 under health for all targets 1 and 12. Target 1 addresses the problem of equity in health, stating that by the year 2000 the differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups. Target 12 addresses the need for reducing the prevalence of mental disorders in the Region.

Since August 1993, a special programme on mental health and psychosocial rehabilitation for victims of war in countries of the former Yugoslavia has been implemented through the Office of the Special Representative of the Regional Director of the WHO European Region in Countries of ex-Yugoslavia. Dr B. Jensen (Denmark) has been contracted by the Regional Office as a WHO short-term consultant to assist with the implementation of the programme.

Collaboration with the UNHCR and the PHAROS Foundation in the Netherlands has been developed through the European Consultation on the Care and Rehabilitation of Victims of Rape, Torture and Other Severe Trauma of War in the Republics of Ex-Yugoslavia, held on 17–19 June 1993 in Utrecht (Netherlands).

The first issue of the *Migration and mental health newsletter* was published in collaboration with the WHO collaborating centre for migration and mental health in Bonn (Germany) and distributed widely jointly with the *Migration and health newsletter* published by IOM. The IOM's Geneva office contributed to strengthening further the collaboration between IOM, the Regional Office and the Platform.

### **International Organization for Migration**

Dr Bollini reported that the IOM was:

- exploring the possibility of establishing a new foundation for migration and health research linked to the University of Geneva;
- looking at the transfer of Yugoslavian war victims to other countries for treatment;

- developing a screening questionnaire for asylum-seekers; and
- conducting a survey of ethnic health issues in medical and nursing schools' training programmes.

Although funds were hard to find, the IOM hoped that further developments would be possible with the support of IOM member governments.

## **REVIEWS OF COMMITTEES**

The three working committees established on the basis of a combination of achievements made towards the goals of the Platform had reported in each national review. It was therefore decided to concentrate on further developments and achievements and to encourage the committees to operate more actively.

## **IMPLICATIONS FOR MENTAL HEALTH SERVICES OF RECENT TRENDS IN MIGRATION**

It was agreed that all members of the Platform would prepare a paper on their national experiences in this area for the following meeting. Dr Geiger would collect and summarize them for the meeting. A paper had been prepared by WIAD on this issue, based on the situation in Germany (Annex 2).

## **PLANNING FOR THE FOLLOWING MEETING**

On behalf of Migrations Santé, Paris, Dr Bennegadi offered to host the next meeting in Paris on 19 October 1994, immediately before the International Conference on Migration, Aculturation and Integration to be held on 20-21 October 1994.

The agenda for the meeting should include:

- reports on recent initiatives and activities in each country, to be prepared and circulated in advance (discussion would be on request);
- the implications for mental health services of recent trends in migration (Dr Geiger would present a summary of members' papers for discussion);
- scientific research, by Professor De Jong;
- a scientific report on sustaining health, to be prepared by a scientific committee (consisting of Dr Ekblad, Dr Gailly, Professor Geiger and Dr Mirdal);
- discussion of secretarial functions: Platform members asked WIAD to consider undertaking the secretarial functions of the Platform as from the meeting on 19 October in Paris; Dr Faria would request WIAD officially to this effect and keep the Federal Ministry informed;
- final outlines for the workshop on 20-21 October;

- planning for the subsequent meeting: Dr Groen invited the Platform members to meet in Rotterdam in 1995.

In close collaboration with Dr Bennegadi, who would send information about the International Conference to all the Platform members, preparations would be made for a workshop to be held by Platform members within the Conference. The Conference would concentrate on creative and positive initiatives promoting the mental health of migrant groups. The Platform members would present themselves as follows:

- (a) Introduction of the Platform and recommendations, Dr J. Sampaio Faria;
- (b) Culturally sensitive research, Professor de Jong;
- (c) Sustaining health, the Scientific Committee mentioned above.

### **THEMES FOR FORTHCOMING MEETINGS**

Themes suggested for forthcoming meetings included:

- similarities and differences between migrants and refugees;
- multiculturalization of institutions;
- effects of legal changes on the situation of migrants;
- studies on the role of interpreters (updated IOM study);
- UNHCR report on medical ethical issues in migrant health care (Dr van Willigen would report on the outcome of the advisory group);
- special types of intervention (self-help as against government action);
- the relationship between physical and mental health.

### **ACTION**

1. WHO would send a letter to all governments reporting the progress of the Platform's activities.
2. WHO would write an official request to WIAD to act as Platform secretariat and would inform the German Federal Ministry of Health.
3. Promotion material would be prepared for the October conference
4. WIAD would publish their second newsletter.
5. Stichting Overlegorgaan Geestelijke Gezondheidsorg (SOGG) would collaborate with the Regional Office on a brochure.

*Annex 1*

**DATABANK ON MIGRATION AND MENTAL HEALTH**

**CALL FOR ABSTRACTS**

The Scientific Institute of the German Medical Association (WIAD), a WHO collaborating centre for migration and mental health, is developing a computerized databank on scientific projects addressing the issue of mental health and migration and intervention programmes for promoting mental health in migrant as well as refugee groups. Information about finished, ongoing and planned research and intervention projects being developed in the European Region will be collected through this questionnaire. The databank will be updated annually.

For this purpose, we would be grateful if researchers and organizations dealing with this topic would help us by giving us information about ongoing, planned or finished projects in the field of migration and mental health.

When finished, we will send you a free copy of the documentation.

Please send the questionnaire(s) back to:

WIAD – Scientific Institute of the German Medical Association  
Godesberger Allee 54, D-53175 Bonn  
Tel. + 228 – 8104-172  
Fax + 228 – 8104-155

Please complete the questionnaire in English. If you are working on more than one project, please use one questionnaire for each project.

Title of the research project or intervention programme:

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State of the project:   planned      current      finished   

Source(s) of funding:

Project leader/responsible person:  
(name(s), disciplines)

Affiliation:

Address:  
(full address, telephone number, fax number)

Co-workers:  
(name(s), disciplines)

Description of the project:  
(objectives/methods, population, sample, data collection, results)

Publications:  
(author (name and one initial), year of publication, title, publisher, place of publication. Add editor(s) and title of journal)

*Please use another sheet if there is not enough space available.*

*Annex 2*

**IMPLICATIONS FOR MENTAL HEALTH SERVICES OF MIGRANT TRENDS IN GERMANY**

As well as the specific medical or biological factors that cause mental or psychiatric diseases, many working and living conditions among migrants and their families in the host country (in this case Germany) play a significant role both in the origin and development of these diseases and in migrants' take-up of counselling, treatment and assistance. There is no doubt that working and living environments contribute to the development of diseases, although this has been little researched or quantified and their interactions are little known. These factors also change over time and with changes in family and social structures. One such condition is the relationship between migration and mental (psychiatric) diseases.

The following factors are important in the relevance of working and living conditions to the origin, development and treatment of mental diseases:

- linguistic communication
- working conditions in the host country
- living conditions
- the change of roles and structures in the family
- the increasing collapse of family ties
- the failure or exhaustion of family resources
- the lack of adequate counselling and assisting professions and institutions
- the legal situation and social protection
- the changing social atmosphere in Germany.

Since medical professions and institutions in Germany have concerned themselves with the health and care of migrants, the significance of the psychosocial or psychosomatic dimensions in dealing with problems and diseases due to migration has become clear. For example, shortly after migrating, migrants are subject to reactive depressive disorders which are followed by psychosomatic symptoms, syndromes or diseases in subsequent years. Recently, it has also become clear that changes in the family system within or between generations and in the protective functions of different cultural and social orientations contribute to the origin and the development of mental diseases.

Few non-German patients are evident in statistics for the incidence and prevalence of psychiatric diseases. This indicates a reluctance on the part of these patients to use psychiatric care institutions: they and their relatives fear neurological practices, especially psychiatric clinics, and transfer to them their experiences – and probably also prejudices – with other authorities. This nonutilization is misunderstood as better family coping and social support and means that preventive attempts cannot be effective.

Among migrants, 50% of the admission diagnoses to psychiatric clinics are for neurosis or psychopathic diseases and 30% for schizophrenia or endogenous psychosis. However, many

admission diagnoses based on psychotic or aggressive behaviour were revised to neurosis diseases by the clinics. There have not been many surveys of psychiatric care of migrants in Germany, but based on results dating back 5–10 years it is clear that

- in 20–30% of the cases, there has been no communication with the patient or with relatives, an interpreter or a linguistically proficient physician, and in 10–15% of cases the diagnosis was based exclusively on the clinical aspect;
- in 25–50% of cases, admission to the clinic was against the will of the patient, and the dismissal led in almost 25% of cases to the repatriation of the patient to his country of origin by authorities or family;
- in almost 45% of the cases the psychotic patients were repatriated; this figure reveals the weaknesses of psychiatric care, specifically the lack of integrated health services close to the place of residence as well as special and main focus-oriented treatment.

The importance of social, psychological, family and cultural conditions in the development of diseases and in the take-up of counselling and treatment on the one hand, and the evident inadequacy of the care institutions on the other are revealed by the lack of experienced, linguistically and culturally competent sociopsychiatric institutions in Germany devoting themselves to the problems of psychiatric ill migrants and their families and staffed by specialists competent in different languages and cultures.

The obvious conclusion is the need for broad, in-depth interdisciplinary and intercultural studies of the situation. Such studies should take into account cultural-anthropological and ethnolinguistic factors and be validated through national comparisons, enabling explicit conclusions to be drawn on the prevalence of mental disorders within the process of migration and the extent to which a causal relationship exists between an (assumed) elevated health risk (e.g. aggravations in the course of an illness) and the problems of assimilation.

The establishment of linguistically and culturally competent psychosomatic counselling and therapeutic services and facilities should be one objective in improving the current health care situation. Specifically, these should include special psychotherapeutic provisions for adolescents involved in family crises, cultural conflicts, crisis intervention and suicide prevention. Services and facilities dealing with crises and psychic disorders should be established on a national basis and be publicized. Regional follow-up care should be ensured within the local community, e.g. through social counsellors. Consideration should also be given to increasing the number of foreign specialists as well as practitioners and other medical personnel at existing facilities and orienting existing institutions towards specific therapeutic needs (e.g. those of alien addicts) and the rehabilitation of aliens suffering from psychosomatic disorders. In view of the particular problems pertaining to health legislation, it is urgent to improve the situation of alien patients by securing their legal and social rights so that their treatment conforms as far as possible to the legal and social benefit norms applying to German patients, to allow for situations where insurmountable problems arise, and to ensure that counselling as well as culturally and linguistically competent expertise is available in conflicts with social legislation.

*Annex 3*

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