THE ETHICS OF MENTAL HEALTHCARE FOR ASYLUM SEEKERS IN EUROPEAN RECEPTION CENTERS

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MIGRATION & CRISES

UNU-GCM

Policy Report 04/04

UNITED NATIONS UNIVERSITY

UNU-GCM

Institute on Globalization, Culture and Mobility

This is a report of the United Nations University Institute on Globalization, Culture and Mobility. It forms part of the series, *Migration and Crises*. It should be cited as:

Magalotti, Tricia. *The Ethics of Mental Healthcare for Asylum Seekers in European Reception Centers*, Policy Report No. 04/04. Barcelona: United Nations University Institute on Globalization, Culture and Mobility (UNU-GCM), 2018.

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The Ethics of Mental Healthcare for Asylum Seekers in European Reception Centers

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Summary

Asylum seekers arrive to host states with various needs and rights. Some of these are very urgent, for example the needs for food, water, and emergency care for immediately life-threatening medical problems. Others are less urgent, such as the right to education or the right to enter the workforce. In policy, it is tacitly assumed that the host state has an immediate obligation to provide for the more urgent of these needs and rights and that others may be pro-

vided for at a later time.[1] This report suggests making a clearer distinction between the two kinds of obligations, deferrable obligations and non-deferrable obligations, the latter of which are the more urgent obligations which states must satisfy immediately. It is also suggested that we develop a set of criteria to assist in determining into which category some particular obligation falls. Additionally, this report urges policymakers to consider that states may have non-deferrable obligations not only to remove legal barriers that prevent individuals from accessing things to which they have a right but also to remove further practical barriers. The first part of the report focuses on these general theoretical issues. It is important to note here is a distinction between ethical obligations (which exist independently of any laws or conventions) and political obligations (which depend on the laws and conventions that a state has passed or is party to). The general framework assumed by this report is that it is the responsibility of policymakers to be sensitive to what the ethical obligations are and to develop policies that align with these ethical obligations, thereby putting in place a system of political obligations that promote the ethical good.

One important human right that asylum seekers have is the right to healthcare. And within the domain of healthcare, the issue of mental healthcare is especially important to address in the case of asylum seekers and refugees. This is because, as explained below, these populations face distinctive challenges with respect to mental health. Accordingly, the second part of the report applies the theoretical framework developed in the first part to issues of mental healthcare for asylum seekers. This is especially important, as the EU Directive on reception conditions is unclear in its scope (more on this below). It is argued that the obligation of a host state to provide for the mental healthcare rights of asylum seekers is an obligation that is non-deferrable, one that is incurred immediately upon arrival of the asylum seeker. Furthermore, it is argued that the host state has an obligation not only to remove the legal barriers to mental healthcare but also the practical barriers that are in their power to remove. This last consideration is especially relevant, as in the EU there are several countries in which asylum seekers have legal but not practical access to healthcare. Finally, the development of a new treatment protocol in Germany designed specifically for use with asylum seekers and refugees is offered as a model for how practical barriers to mental healthcare can be removed even in a context of limited resources.

1. See, for example, the EU Directive laying down standards for the reception of applicants for international protection (2013).

I. Rights of Individuals, Obligations of States

Rights are entitlements: to have a right to something is to be entitled to it. If the employees of a company have a right to use the office coffeemaker, then they are entitled to use the coffeemaker. If female university students have a right to equal opportunities as male students, then they are entitled to such opportunities. And if all people have a right to clean water, then they are entitled to access to clean water.

Additionally, when someone has a right to something, there is always another party who has some corresponding obligation or duty. If the employees have a right to use the office coffeemaker, than the office manager has an obligation to allow them to use the coffeemaker. If female university students have a right to equal opportunities as male students, then university officials have an obligation to provide them with such opportunities. And if all people have a right to clean water, then for each person with the right to clean water there has to be some other party who has an obligation to provide them with clean water.

The last of these obligations appears more complicated than the former two. This stems from the universal scope of the right, the fact that it applies to everyone. It is an instance of what we call a "human right." Human rights are so-called due to the fact that we possess them in virtue of being human. Accordingly, human rights are rights that are possessed by all humans. There is both an ethical and a political sense of human rights. To use the term "human right" in an ethical sense is to talk about things that all humans are ethically entitled to. To use it in a political sense, then, is to talk about things that all people are politically entitled to.

The most notable pronouncement of human rights is the UN's "Universal Declaration of Human Rights" (UN General Assembly 1948), wherein there are listed 30 rights that are asserted to be possessed by every human. They include the rights not to be subjected to slavery or torture; the right to freedom of movement; the right to a nationality; the rights to marry and to found a family; the rights to freedom of thought, religion, and expression; the right to take part in the government of one's country; the rights to work, to free choice of employment, and to just and favorable conditions of work; the right to a standard of living adequate for the health and well-being of oneself and one's family; and the right to education.

Human rights, like any other rights, entail corresponding obligations. If all people have a right to education, then for every person who exists in the world, there is some party who is obligated to provide them with an education. The question, then, is how to figure out who incurs the obligations that correspond to human rights.

Typically with human rights, it is taken to be the case that the party who incurs the obligations to provide for a person's human rights is the state in which that person has citizenship. (This may be contingent on the fact that our world political system is one of sovereign nation states rather than a so-called "world state.") On this way of seeing things, being a citizen of a state provides one with a claim on that state. It means that the state has the obligation to provide for one's human rights. Call this the "Simple State-based Schema."

Simple State-based Schema: Every individual has human rights, and the state in which that individual has citizenship incurs the obligation to provide for that individual's rights.

In an ideal world, every human being would be a citizen of some state or other, and every state would meet its obligations to provide for the human rights of all of its citizens, and thus every human being would have all of their human rights provided for.

(Again, we can think of these obligations in both an ethical and a legal sense. To be ethically obligated to provide for a right entails that not doing so would constitute a moral failing. To be politically obligated to provide for a right entails that not doing so would constitute a political wrong. The most obvious way in which a party would become legally obligated to provide for a group of people's rights would be to sign a legally binding agreement to do so, for example in the form a convention.)

We do not, of course, live in an ideal world, and so there are various complications for this basic rights-providing schema. The first complication is that it is unfortunately not the case that all states do an adequate job of providing for the rights of their citizens. One especially recognizable example of a state's failure to provide for its citizens is the case of refugees. According to the "1951 Convention Relating to the Status of Refugees," a refugee is "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UN General Assembly 1951). A refugee is not necessarily stateless, as they may still have citizenship in their country of origin. In the case of such refugees, the Simple State-based Schema says that it is the state in which they

have citizenship that has the obligation to provide for their rights; that state is simply failing to meet its ethical (and perhaps political, depending on which conventions it is party to) obligations to this citizen. But the Simple State-based Schema goes no further than this. It says nothing about any obligations incurred by other states. And this seems problematic.

Furthermore, the political category of refugees overlaps with that of stateless individuals. This brings us to a second complication for the Simple State-based Schema. Not all individuals are citizens of some state or other. Despite international efforts to end statelessness, according to UNHCR, there are still upwards of 10 million stateless people worldwide (UNHCR Statistics Database). And, on the Simple State-based Schema, there would be no party that incurs the obligation to provide for the human rights of stateless individuals. This is clearly problematic. Persons who are *de jure* stateless are those who, strictly speaking, have no nationality. Persons who are *de facto* stateless are "persons outside the country of their nationality who are unable or, for valid reasons, are unwilling to avail themselves of the protection of that country" (UNHCR 2010). There is substantial unclarity regarding what constitutes a "valid reason" for being unwilling to avail oneself of the protection of their country. But on one interpretation, the criteria for refugee status can serve as a sufficient condition for *de facto* statelessness. In other words, if an individual meets the criteria for refugee status, then they will also meet the criteria for *de facto* statelessness. This assumes, of course, that the individual does have official citizenship in some country. If a refugee does not have any nationality, they will qualify as *de jure* stateless. This policy report focuses on refugees who are *de facto* stateless, as the issue of *de jure* statelessness is much less hazy and, thus, in less need of clarification.

Perhaps an analogy will help to understand the problem. Consider the rights of children. We typically think that children have certain rights to be cared for and that these rights are owed to them by their parents. A parent fails to do their moral duty if they do not provide their child with food, water, clean clothes, and psychological nourishment. However, if a parent does in fact fail to do their duty in this regard, we wouldn't say that the chain of moral obligation just stops there. If a parent neglects their child, and other adults become aware of this, then those other adults have some kind of duty to ensure that the child's rights are provided for. So too, we should think, in the case of *de facto* stateless refugees. The state in which they have citizenship severely fails to meet its moral obligations. But, rather than think that the chain of moral obligation stops there, we should understand it as being passed onto other

states who can, so to speak, pick up the moral slack. Michael Dummett puts the point nicely: "To refuse to help others suffering from or threatened by injustice is to collaborate with that injustice, and so incur part of the responsibility for it" (2001, 34).

If this is right, then it seems as though states can incur obligations to provide for the rights of individuals who are not citizens of that state. And, in fact, the duty to provide for rights of stateless individuals and refugees is precisely what is meant to be addressed in the UN's Convention on the Reduction of Statelessness and Convention Relating to the Status of Refugees respectively. These two conventions are attempts to recognize the moral duties that states can have to non-citizens and to generate corresponding political duties.

II. Deferrable and Non-deferrable Obligations to Provide

We can distinguish between three procedural stages in the asylum seeking process. In the first stage, an individual has ground for refugee status (it is reasonable for them to fear persecution) but has not yet applied for refugee status. In the second stage, the individual applies for asylum in another state. They could do this either from the original state from which they are seeking asylum, or they may travel to a new state with the intent of seeking asylum there. At this stage, the individual is officially considered an asylum seeker. Finally, if and when the individual has their application approved in the state in which they are seeking asylum they receive official refugee status.

When considering the obligations that states owe to non-citizens, we must be careful to distinguish between these three stages. Once the individual is granted refugee status, it is clear that the state that has accepted them as a refugee is obligated to provide for all of that individual's human rights. (To return to the earlier analogy, this would be the analogue of adopting a child). The first stage, in which the individual has grounds for seeking asylum but has not yet filed any part of an application, is the most complicated. And while this

is an important question that needs to be addressed, it will not be the focus of this report. Rather, the focus here will be instead on the second stage, that of the asylum seeker, in which the individual has applied for asylum but is still awaiting a response.

To begin with, we should notice that in determining who incurs the obligation to provide for the human rights of the asylum seeker, the best candidate is the state in which the individual is seeking asylum. There are at least two reasons for why. First, this is the state that is in the best practical position to provide for the individual. And, second, in the case that the individual is granted refugee status, it will make their transition from asylum seeker to refugee an easier one. Finally, though argument for this will not be provided in this policy report, it is not implausible that in accepting an individual's application for refugee status, a state enters into some sort of contractual agreement with that individual under which the state agrees to provide for the basic needs of the applicant.

The asylum seeker stage is a notoriously murky one. Asylum seekers are often seen as facing a sort of trial in which they must prove their legitimacy. As evidenced by the EU Directive laying down standards for the reception of applications for international protection from June 2013 (EU: Council of the European Union 2013; see below for more detail), EU policy seems to tacitly endorse the view that that asylum seekers should be treated with some level of decency but that they do not yet need to be accorded the full provisions to which those with refugee status are entitled. One particularly relevant area of interest is how asylum seekers are treated in reception centers when they arrive in the state where they are seeking asylum.

The EU Directive laying down standards for the reception of applicants for international protection from June 2013 reflects the general conception of asylum seekers as occupying this transitional stage of uncertainty. It recommends treating asylum seekers in such a way as to ensure "a dignified standard of living for all applicants" and specifies different ways in which to meet that goal (EU: Council of the European Union 2013). In this way, the directive implies that host state incurs the obligation to provide for certain of the asylum seeker's rights immediately upon initiation of the application process.

However, the Directive suggests that there are other rights for which the host state is not obligated to provide, or at least not immediately obligated to do so. For example, it is allowed by the Directive that applicants can be detained under certain conditions (Article 8); that children applicants go three months without receiving schooling (Article 14); that adult applicants go nine months without access to the labor

market (Article 15); and that material reception conditions can be withdrawn under certain conditions, e.g., in situations where the applicant abandons the place of residence without permission or fails to comply with reporting duties (Article 20). Furthermore, though anyone who qualifies for refugee status has a human right to asylum, the host state is obviously not expected to immediately provide the applicant with asylum upon arrival to the host state. This is, of course, the purpose of the application process to begin with.

Accordingly, the Directive appears to implicitly endorse the ethical view that there are two different sets of human rights that asylum seekers have toward which host states have different obligations: there are the rights that host states are obligated to provide for fully and immediately and there are the rights for which the host states, while they may be obligated to provide for them in the future (perhaps conditional on success of the asylum application), they may put off for some time. Call the former kind of obligation a "non-deferrable obligation" and the latter a "deferrable obligation."

Whether or not it is true that there are only some rights for which the host state has non-deferrable obligations to provide to asylum seekers and that there are others for which their obligations are deferrable is surely an issue that warrants further careful consideration. For the purposes of this policy report, it will be assumed that there are some deferrable obligations. To be clear, making this assumption for the sake of investigation is not to endorse it. Rather, it is to show that even if there are deferrable obligations, the right to mental health care is not one of them.

The period of asylum application tends to be conceived as a sort of probationary stage that precedes the concrete status of "refugee," which is obtained only after the success of the asylum application. This can make it seem as though all of a state's obligations to provide for the rights of asylum seekers are deferrable. But this is clearly wrongheaded. It must be recognized that certain, perhaps even most, of the obligations incurred by states to provide for the rights of asylum seekers are non-deferrable. For these non-deferrable obligations, when an asylum seeker is deprived of the object of these rights for any period of time, that deprivation constitutes a wrong done by the relevant state. It is a moral wrong. And if the state is party to the relevant conventions and agreements, it is a political wrong.

In so far as policymakers are concerned with developing policies that facilitate the satisfaction of the state's moral and political obligations, the distinction between deferrable and non-deferrable

rights is one that that they should be interested in. Indeed, many criticisms surrounding the treatment of refugees in reception centers, camps, detention centers, and the like can be understood as accusations of the failure of states to meet their non-deferrable obligations to provide for the human rights of asylum seekers.

What we need, then, is a principled way of distinguishing between deferrable and non-deferrable obligations. This report proposes that we start with the following criterion:

> An obligation of a state to provide an individual with the object of some right is deferrable only if either (a) it is unreasonable to expect the state (given its current resources) to provide the individual with that object, (b) it can be demonstrated that being deprived of this particular right for some determinate period of time does not cause notable harm to the individual, or (c) the individual has behaved in a way such as to warrant the revocation of the right.

Note that this criterion is a necessary, but sufficient, condition for deferability. So, it does not follow from one of (a)-(c) being met that automatically the relevant obligation is deferrable.

Condition (a) of this principle is based on the notion that ethicists call "ought implies can," the basic idea being that no one can be obligated to do something that they are not in fact capable of doing. The version of the principle that appears in (a), in terms of reasonability rather than capability, is somewhat more liberal. And this, of course, raises important questions about what it takes for an expectation to be 'reasonable' or 'unreasonable.' I intentionally leave this notion vague, as it seems that this is an important area for debate and an issue that I cannot hope to settle here. It seems unreasonable, for example, to expect a host state to grant all asylum seekers refugee status upon arrival to the host state. We generally take it that the host state is entitled to carry out some kind of application process for asylum, and such a process will require time. By contrast, I will argue that even on a fairly circumscribed notion of what is "reasonable," it is entirely reasonable to expect most European states to provide asylum seekers with comprehensive healthcare (including mental healthcare).

Condition (b) is an excusing condition meant for cases in which being deprived of the particular right in question for a specified period of time would make little difference to the individual who is being deprived. This may, for example, be the rationale behind Articles 14 and 15 of the EU Directive which allow children to lack

access to schooling for three months and adults to lack access to the labor market for nine months respectively.
Condition (c) is meant to address cases in which rights can be revoked on the basis of a right-bearer's actions, such as committing a crime. While people typically have the right to free movement, a state arguably does nothing wrong by imprisoning someone who has broken the law by committing murder. Something like this condition seems to underlie Article 20 of the EU Directive, the one that allows for the revocation of material reception conditions under circumstances in which the applicant abandons their place of residence or fails to comply with reporting duties.

III. The Current Status of Access to Healthcare in European Reception Centers

The EU Directive laying down standards for the reception of applicants for international protection (2013) can tell us what stance the EU takes regarding host states' obligations toward asylum seekers in reception centers with respect to health care. The section on health care (Article 19) is actually quite minimal. It has two paragraphs. The first reads "Member states shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious medical disorders" (106). And the second, "Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed" (ibid.). But there is little clarification about what is meant by terms such as "essential treatment of illnesses," "serious medical disorders," and "appropriate mental health care where needed".[2] Presumably, interpretation of these recommendations is left to the individual states to determine.

According to the Asylum Information Database (AIDA), all of the countries on which it provides information legally guarantee health care to asylum seekers (AIDA).[3] But out of those countries, only

2. For further discussion of the complexity underlying this issue, see Bell and Zech (2009).

3. These countries are Austria, Belgium, Bulgaria, Cyprus, Germany, Spain, France, Greece, Croatia, Hungary, Ireland, Italy, Malta, Netherlands, Poland, Sweden, United Kingdom (all EU countries), and (non-EU countries) Switzerland, Serbia, and Turkey.

Belgium, Spain, Greece, Ireland, Italy, and Serbia provide full health care to asylum seekers "in practice" (ibid.). Furthermore, it appears as though even in most of these countries, it is debatable whether full health care is in practice available to asylum seekers due to various barriers that they face in accessing health services (see individual AIDA country pages on health care; also FRA 2016).

Additionally, in a thematic focus report on health care, the EU Agency for Fundamental Rights (FRA) indicates that the healthcare available at reception centers to newly arrived asylum seekers is relatively minimal. First, the FRA found that all of the countries that they investigated all conducted initial health screenings for newly arrived asylum seekers (though not for all newly arrived migrants).[4] But in some countries, these screenings were solely for the purpose of screening applicants for communicable diseases. To the extent that screenings are aimed at the detection of communicable disease, it seems that states are concerned not with the health of the asylum seekers for their own sake but rather for the sake of protecting the general population of that country. While the aim of protecting public health interests is also important, it seems that full respect for the personhood of the applicants themselves would require concern for their health for its own sake. One way in which this might be implemented is to conduct more comprehensive screenings and to subsequently provide applicants with the relevant follow-up care. Some effort is mentioned (in Sweden) of attempts to identify individuals who may be suffering from post-traumatic stress disorder.

Aside from initial screenings, the FRA report found that some states (Slovenia and Croatia are mentioned specifically) provide only emergency care to asylum seekers. It was found that in other states, as mentioned above, that although asylum seekers are legally entitled to health care, they are prevented for various reasons for actually accessing it. Regarding mental healthcare, the FRA identifies "psychological issues" as one of the main health issues affecting newly arrived migrants. And yet, little is mentioned about anything that is done to address this issue.

More research needs to be done on the availability of healthcare to asylum seekers, and particularly in reception centers. Part of the issue is that, as mentioned in the FRA report, few states keep records about the healthcare provided to newly arrived migrants and asylum seekers and, of those who do, the records are fairly minimal. Nonetheless, the literature on the availability of healthcare to migrants paints a coherent. if somewhat sparse, picture: while healthcare is largely

4. These countries are Austria, Bulgaria, Germany, Greece, Slovenia, Italy, Sweden, Croatia, and Hungary.

available to asylum seekers (and sometimes other migrants) throughout Europe in a legal sense, it is largely unavailable in a practical sense. There are several layers of confusion regarding states' obligations to provide healthcare and whether they are being fulfilled. The first layer of unclarity is in the EU directive itself: as stated above, we need to hear more about what constitutes "essential treatment of illnesses," "serious medical disorders," and "appropriate mental health care where needed."

The next layer is that, regardless of what is actually recommended by the EU, these recommendations may or may not align properly with states' actual ethical obligations. The idea here is that it could be the case that states are ethically obligated to have more legally available healthcare services than is stipulated in the directive.

A final layer of complication is that, as we have seen, there is a difference between the level of healthcare that is legally available to asylum seekers and what is practically available. If healthcare is legally available to an individual, then there are no legal barriers preventing them from accessing healthcare. If it is practically available, then there are no excessive practical barriers preventing them from accessing healthcare. One might think that so long as the state makes healthcare legally available, they fulfill whatever obligations they have to provide healthcare. Alternatively, if they have the obligation to provide for the healthcare of the asylum seekers that they are hosting, then they have the obligation to remove practical as well as legal barriers.

We have three basic questions then. First, how are we to interpret the EU directive with respect to recommendations on the obligation to provide healthcare to asylum seekers? Second, is the obligation to provide asylum seekers with healthcare a deferrable or non-deferrable obligation from an ethical point of view? And, third, if it is a non-deferrable obligation, does it include the obligation to remove practical barriers to healthcare or only legal barriers?

This report focuses specifically on the issue of mental healthcare for asylum seekers. This is for two reasons. First, narrowing the field of focus to a more constrained topic will allow for a more substantive discussion. And second, the issue of mental healthcare for asylum seekers is especially important for reasons that will become apparent. I have little to say with respect to the first question. I only mention it to highlight an important difficulty that we must keep in mind. In response to the second question, I will answer that the ethical obligation to provide mental healthcare is non-deferrable. And in response to the third question, I will argue that if mental healthcare is a non-deferrable obligation, then it includes the obligation to remove practical barriers to healthcare in addition to legal barriers.

IV. Evaluating the Obligation to Provide Healthcare

This section addresses two of the aforementioned questions: first, whether states have an obligation to remove practical barriers to the object of a right given that the right is non-deferrable; and second, whether the obligation to provide for the right to healthcare for asylum seekers is deferrable.

A. On the Obligation to Remove Practical Barriers

If someone has a human right, then they have a claim on someone to provide them the object of that right. We have established that once an asylum seeker applies for asylum in a particular state, that state then becomes the party who owes the asylum seeker their human rights. In the case of deferrable obligations, this obligation to provide for a right can be postponed for some period of time, and with non-deferrable obligations the obligation is immediately in force. Given this framework, whether the barriers that stand in the way of the individual's obtaining the thing to which they have a right is legal or practical is inconsequential. If it is the state's obligation to provide the individual with a certain right, then the state has an obligation to remove all substantial barriers, regardless of whether they are legal or practical. Thus, the fact that a barrier is a practical one is not a reason for thinking that it is not the duty of the state to eradicate it.

However, there is one instance in which there may be a notable difference between practical barriers and legal barriers. This would be in cases in which it would be reasonable, given its current resources, to expect the state to remove all legal barriers but unreasonable to expect it to remove certain practical barriers. In other words, it might be the case that the removal of practical barriers will meet condition (a). If this were true, then it may constitute grounds for classifying the obligation to remove practical barriers to the object of the right as deferrable even if the obligation to remove legal barriers to the object of the right is non-deferrable. Below, I concentrate on practical barriers and make a case for the stronger claim that the obligation to remove practical barriers to mental healthcare is also non-deferrable.

B. On the Non-deferrability of the Obligation to Provide Healthcare

Previously, I suggested that in order for an obligation to provide for the human right of an asylum seeker to be deferrable by the host country, it must be the case that at least one of the following three conditions is met: (a) it is unreasonable to expect the state to provide the individual with that object, (b) it can be demonstrated that being deprived of this particular right for some determinate period of time does not cause notable harm to the individual, or (c) the individual has behaved in a way such as to warrant the revocation of the right. I will now argue that none of these three conditions is met in the current case. I will start with conditions (b) and (c), because they are more straightforward. I will then turn to a discussion of condition (a).

Condition (b) states that it can be demonstrated that being deprived of this particular right for some determinate period of time does not cause notable harm to the individual. The case that we are considering is the right to mental healthcare for asylum seekers. There is a growing consensus in the psychology literature that refugees and asylum seekers are at greater risk for various psychological problems including sleep disturbances, depression, anxiety, psychosomatic disorders, and post-traumatic stress disorder (PTSD), especially in unaccompanied minors.[5] In addition to being at risk of psychological distress due to traumatic or otherwise stressful experiences prior to migration to the host state, there is further evidence that the process of seeking asylum itself can be a detrimental impact on mental health, again with the effect exacerbated in unaccompanied minor populations. Being at greater risk of psychological issues obviously puts asylum seekers in greater need of psychological treatment. Furthermore, there is evidence that some psychological disorders such as PTSD, when untreated, can persist and continue to negatively affect the individual's quality of life decades into the future. In addition to the negative impact that suffering with such untreated conditions could have on their long-term health, the very fact that individuals should simply have to suffer through PTSD, anxiety, depression, sleep disturbance, or psychosomatic disorders even in the short term is constitutes a human rights violation. Deprivation of psychological treatment for these individuals does cause them notable harm, and thus condition (b) is not met.

Condition (c) seems obviously unmet in the case of asylum seekers. States have no evidence that asylum seekers have done something to warrant denying them a human right and, thus, cannot be excused from providing it on this basis.

5. See, for example, Bell & Zech (2009), Jakobsen et al. (2017), Schock et al. (2015).

It may be argued that since asylum seekers have not yet had their applications accepted by the state and thereby granted refugee status, that states are warranted in deferring the full right to healthcare on the basis of potentially fraudulent claims. Since the state has no way of knowing whether the asylum seeker 'deserves' to have their rights provided for, the objection would go, the state is not yet obligated to provide for those rights.

There are two responses to this worry. The first is that there is an important sense in which the public overestimates the rate of asylum fraud. Even supposing that everyone who is denied asylum in Europe is rightly denied (which is contentious at best), that is the state that denied them did nothing wrong in so denying them, it does not follow that these applications were "fraudulent." Rather, many such applicants could have very well taken themselves to have a legitimate claim to asylum. And since the term "fraudulent" implies dishonesty on the part of the asylum seeker, the term would clearly not be applicable in these cases. Furthermore, once we grant that such people are doing nothing wrong or dishonest in seeking asylum, it becomes much less plausible that they ought to be denied mental healthcare at least during the time of their application.[6]

The second response is that even if the number of fraudulent claims were relatively high, this would not warrant depriving legitimate asylum seekers of their rights. And, given the state's knowledge at the time of application, they are not in a position to identify which claims are the legitimate ones and which aren't. They are not, then, entitled to refuse to provide for the rights of asylum seekers on the basis of potential fraudulence.

Condition (a) is the most complicated of the three conditions, at least in the particular case of mental healthcare. It is beyond the scope of this report to address all concerns relevant to determining whether it is reasonable to ask of host states that they make an effort to remove both legal and practical barriers to asylum seekers' access to mental healthcare. This report makes a case that such a request is indeed reasonable.

The first thing to note in support of this case is that there is considerable consensus on the identification of the practical barriers that prevent asylum seekers from accessing healthcare (and mental healthcare in particular). That is, we agree on what the barriers are. This means that the targets are clear.

The first practical barrier is the language barrier between asylum seekers and healthcare professionals in the host country.[7] The issue with language is both that there are not sufficiently many translators

6. See Wild (2015) for someone who argues for universal access to healthcare for all migrants.

7. See Bell & Zech (2009), Cheng (2015), FRA (2016), Chauvin et al. (2015).

available to help the asylum-seeking individuals communicate with the medical staff and that even when translators are available, they do not always do an adequate job of interpreting in such a way that the asylum-seeking individual feels heard and understood by the medical professional. This latter problem might be, for example, the result of certain cultural differences. The second barrier is lack of information about the healthcare system.[8] Unfortunately, it is too often the case that asylum seekers are not aware either that certain services are available to them or how to access those services even when they know that they are in principle available. Thus, there is a need for more effective communication about how to utilize the particular healthcare system in the host state. And, of course, this information must be made available in the language of the asylum seeker. The third barrier consists of obstacles from cultural disparities.[9] One problem in this area is that individuals report feeling as though their medical professionals were stereotyping them or treating them in a racist way. Some individuals also reported that they did not understand the medical treatments that they were being prescribed, which gave rise to discomfort. They also report lack of trust in healthcare professionals, which could be attributable to either feeling stereotyped or lack of familiarity with how healthcare works in the host country. The final set of barriers are administrative barriers and limited access to services.[10] This includes problems such as lack of transportation to services, excessive waiting times, and administrative problems such as inability to secure appointment times.

These barriers are concrete problems with tractable solutions. As such, it seems that there should not be an in principle reason that it should be unreasonable to ask host states to take steps toward eliminating these barriers. In the following section, I discuss one set of programs that made a concerted effort to do so. The thought is that this program will serve both as evidence both that such barriers can be successfully mitigated without excessive use of resources as well as an illustration of how they might be so mitigated.

8. See Cheng (2015) and Chauvin et al. (2015).

9. See Bell & Zech (2009) and Cheng (2015).

10. See Cheng (2015), FRA (2016), and Chauvin et al. (2015).

V. The Stepped Psychological Care Model in Germany

The aim of this section is to provide a case study of one way in which psychologists are working to meet the increased demand on the resources of the healthcare system and effectively treat asylum seekers and refugees. There have recently been various programs in Germany based on the principles of "stepped treatment," peer counseling, and internet-based counseling.[11]

"Stepped treatments" are a special class of psychological treatment protocol that are designed to aid in the management of limited resources, particularly in cases in which there is a shortage of trained professional psychologists.[12] The basic structure of the protocol is that there are various levels of the intensity of care that a patient can receive ranging from self-help approaches to group therapy to one-on-one therapy. The patient starts out on the lowest "step," the least intensive type of therapy and progresses to the next step only if the first is unsuccessful. They are then evaluated after spending some specified amount of time on each subsequent step. This allows mental healthcare providers to concentrate resources at the higher steps, with the more intensive treatment reserved for patients who did not have success with the less intensive treatments.

Schneider et al. (2017) have adapted this model particularly to work with asylum-seeker and refugee populations in Germany. On this model, there are four levels. At the first level, there is no actual treatment and patients are simply monitored. At the second level, there is peer counseling and internet-based interventions. At the third level, there are group therapies led by psychologists. And at the fourth level there is native language or interpreter-assisted one-on-one therapy with a psychologist.

Step two is the most distinctive to the system and it is also the level at which, ideally, the majority of treatment will take place. This is because the hope is that at each step, some of the patients will be successfully treated and will not have to advance to the following step. There are two important characteristics of step two: peer counseling and internet-based therapies. The peer counseling helps to address language and cultural barriers. The peers speak the language of the patient and also share a familiar cultural background. It is also likely that this will help to facilitate trust between the patient and the peer counselor, thus allowing for more effective treatment. Incorporating peer counseling into the structure of psychological treatment has

11. See Abbott (2016), Curry (2017), Schneider et al. (2017).

12. See Bower & Gilbody (2005) and Schneider et al. (2017).

the further benefit that it allows the opportunity for established refugees to serve as peer counselors, thus providing additional jobs for refugees and, more than that, jobs that are likely to afford a sense of meaning and satisfaction. This is important, as these types of opportunities are crucial for successful integration into the host nation.

The second characteristic of treatment at step two is the internet-based therapies. These are also meant to help with language and cultural barriers. For individuals who have access to smartphones, internet-based therapies can provide assistance with self-help for stress management and even PTSD.[13] These internet resources are additionally able to provide information to patients about the healthcare system in Germany, thereby helping to address another of the identified barriers to mental healthcare access described above.

The stepped care model in Germany, which incorporates peer counseling and internet-based treatments, demonstrates how even with limited resources, progress can be made with respect to the mental healthcare available to asylum seekers. This provides evidence that it is not unreasonable to expect European governments to take steps toward breaking down the practical barriers that stand in the way to asylum seekers' ability to access mental healthcare.

13. For evidence about the effectiveness of internet-based therapies and smartphone apps in the treatment of PTSD see Kuester et al. (2016) and Miner et al. (2016).

Conclusions and Recommendations

There are two sets of conclusions that we can draw from this investigation. The first concerns the specific case of mental healthcare for asylum seekers. The second concerns the more general issue of obligations to provide for the human rights of asylum seekers. Let us start with the specific case of mental healthcare.

A. Recommendations for Mental Healthcare

- According to the arguments made in this report, the obligation to provide mental healthcare to asylum seekers should not be categorized as a non-deferrable (rather than deferrable) obligation. Here are some recommendations suggesting ways in which this imperative can be best recognized by policymakers.

- Policymakers at the large-scale level should make attempts to fully appreciate the non-deferrability of the obligation to provide for mental healthcare of asylum seekers. They must recognize that this includes not just the obligation to remove legal barriers but also an obligation to make attempts to remove practical barriers. Goals should then be set accordingly and appropriate recommendations should be made to national governments.

- Efforts should be made at the national and regional levels (but also, ideally, internationally) to clarify the vagueness in the EU Directive on reception conditions. This should be done with an eye toward identifying which medical services the state has a non-deferrable obligation to provide.

- At the national and regional levels, there should be a commitment to meeting the non-deferrable obligation to provide for the mental healthcare needs of asylum seekers. There should be investigation into potential ways of removing practical barriers to mental healthcare including language, culture, access to information about the healthcare system, and administrative barriers that may be specific to that area.

B. More General Recommendations

The failure to explicitly distinguish between deferrable and non-deferrable obligations, and to employ a strict set of criteria in deciding whether an obligation is deferrable, has the detrimental effect that

governments and policymakers fail to fully appreciate the urgency with which they should be addressing their non-deferrable obligations. In decisions regarding the rights of asylum seekers, policymakers should be cognizant of this distinction, taking special care to implement policies that facilitate the satisfaction of all on their non-deferrable obligations. More specifically:

- Policymakers should bear in mind that one of the primary aims of policymaking should always be to formulate policies in such a ways as to generate political obligations that track already existing ethical obligations. This requires a sustained inquiry about what the ethical duties are. Only once the ethical duties are clearly identified can the corresponding political duties be properly developed.

- At the broadest levels of policymaking (e.g., the UN and the EU) there should be more emphasis on determining whether an obligation is deferrable. This report has provided a model of the sorts of considerations that seem relevant to making such determinations. Further discussion is needed, however, to develop clear guidelines. For example, it would be helpful to have a more determinate idea of what it takes for a given expectation to be reasonable or unreasonable for a state given its resources. Additionally, it would be good to have an international system in place to provide assistance to states with relatively fewer resources that would help them in removing practical barriers to human rights for asylum seekers in those states.

- It should be made clear that there is sometimes a non-deferrable obligation to remove not only legal barriers to the objects of certain rights but also practical barriers. Large-scale policy makers should be careful to make clear which practical barriers fall into this category.

- At the national and regional levels, there should be a focus on implementing policies that facilitate the achievements of the expectations set out at the more large-scale level. This includes investigating the particular barriers to providing for the rights of asylum seekers in that particular context as well as texting new ways of circumventing those barriers. This could include the funding of research projects (such as the stepped care project) that could provide innovative methods for breaking down those barriers in the long term.

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ISSN 2521-1102

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