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## **Refugees and Social Integration in Europe**

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# Refugees and Social Integration in Europe

## 1. Introduction

Refugees' social integration in the host society is high on the international agenda. Refugees' social integration is also in line with the *Sustainable Development Goal 16* which is "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all level", particularly target 16.10 which focuses on "Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements" (<https://sustainabledevelopment.un.org/sdg16>).

The goal of this paper is to examine refugees' social integration in Europe, with a focus on their psychosocial and family functioning, and modalities to support it. Refugees' integration is a complex and multidimensional construct, referring to integration into the economic, educational, health, and social contexts.

There were 22.5 million refugees worldwide in 2017, over half of them under 18 years of age (UNCHR, 2018). More than half of refugees are from three countries: Syria (5.5 million), Afghanistan (2.5 million) and South Sudan (1.4 million), and the major host countries for refugees are: Turkey (2.9 mil), Pakistan (1.4 mil), Lebanon (1 mil), Iran (979,400 people) (UNCHR, 2018).

The 1951 Geneva Convention defined as refugee someone who has a "fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or owing to such fear, is unwilling to avail himself of the protection of that country". Asylum seekers are people who "left their country of origin, have sought international protection, have applied to be recognized as a refugee and are awaiting a decision from the host government" (UNHCR, 2016, p.4).

A theoretical framework that has been used frequently when understanding immigrants' adaptation to the new society is Berry's (1997) conceptual framework of immigrants' acculturation to the host society and it includes four strategies: assimilation - when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures; separation - when individuals hold on to their original culture and wish to avoid interaction with others; marginalization - when there is little cultural maintenance or having relationships with others; and integration - when there is maintaining of one's original culture while engaging in daily interactions with other groups (Berry, 1997). Considered to be the best approach, integration is considered a two-way process and can only be successfully pursued by migrants when the host society is open and inclusive in its orientation towards cultural diversity (Berry, 1997). Inclusiveness means that refugees should be provided with equal access to housing, health care, education, training and employment.

Refugees' level of integration and adaptation depends on a number of factors, including pre-migration experiences, the departure process and the post-arrival experiences and environment. Many refugees and asylum seekers have experienced severe pre-migration trauma, including

mental and physical torture, mass violence and genocide, witnessing the killings of family members and friends, sexual abuse, kidnap of children, destruction and looting of personal property, starvation and lack of water and shelter (Craig, Jajua, & Warfa, 2009). The departure is also a complex endeavor, many times associated with life threatening risks. Although arrival in a safe place provides initial relief, frustration sometimes develops as new problems emerge, such as family separation, language barriers, legal status, unemployment, homelessness, or lack of access to education and healthcare (Craig, Jajua, & Warfa, 2009).

The circumstances and experiences of forced migration have profound effects on refugees' health and integration into the host society. Migrants who fled from armed conflicts and persecution in their countries report high rates of pre-migration trauma and high frequencies of mental health problems, particularly post traumatic stress disorders (PTSD) and depression (Stenmark et al, 2013). For example, the armed conflict in Syria since 2011 has resulted in a massive forced displacement of the Syrian population. In April 2017, there were 5 million Syrian refugees, majority to neighboring countries (UNHCR, 2017), over 50% being children, many unaccompanied (UNICEF, 2016).

Post-migration experiences are also impacting health and adaptation. Research shows that asylum seekers present higher rates of PTSD and depression than other refugees, due to post migratory stresses, delays in the application process, conflicts with immigration officials, denial of work permits, unemployment, and separation from families (Stenmark et al , 2013). Forced migrants often arrive in places where they have no contacts and or knowledge of the language which contribute further to increased isolation and limited opportunities.

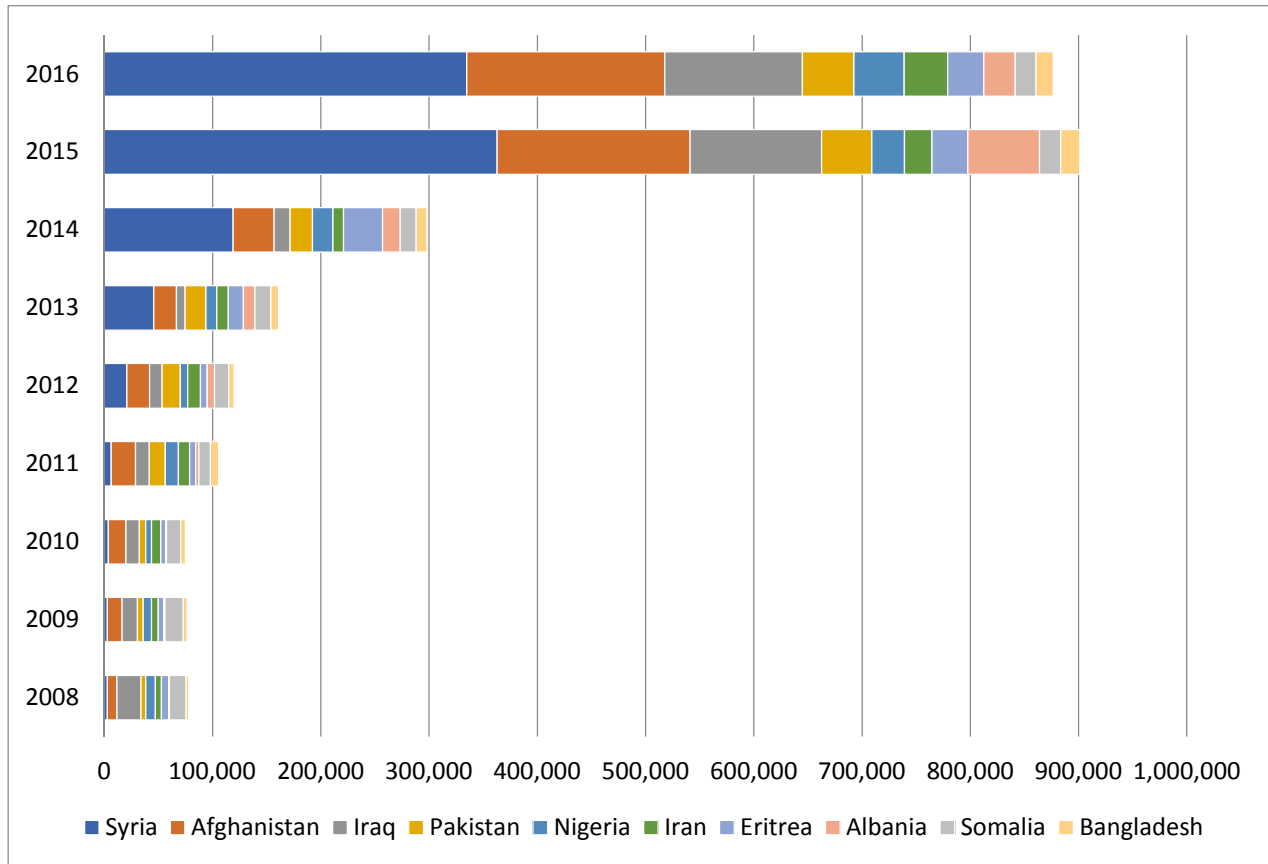
The goal of this paper is to examine refugees' social integration in Europe with a focus on psychosocial functioning and wellbeing. The following sections review the demographics of recent refugees in Europe, social policies and their integration into society.

## **2. Refugees' Demographics in Europe**

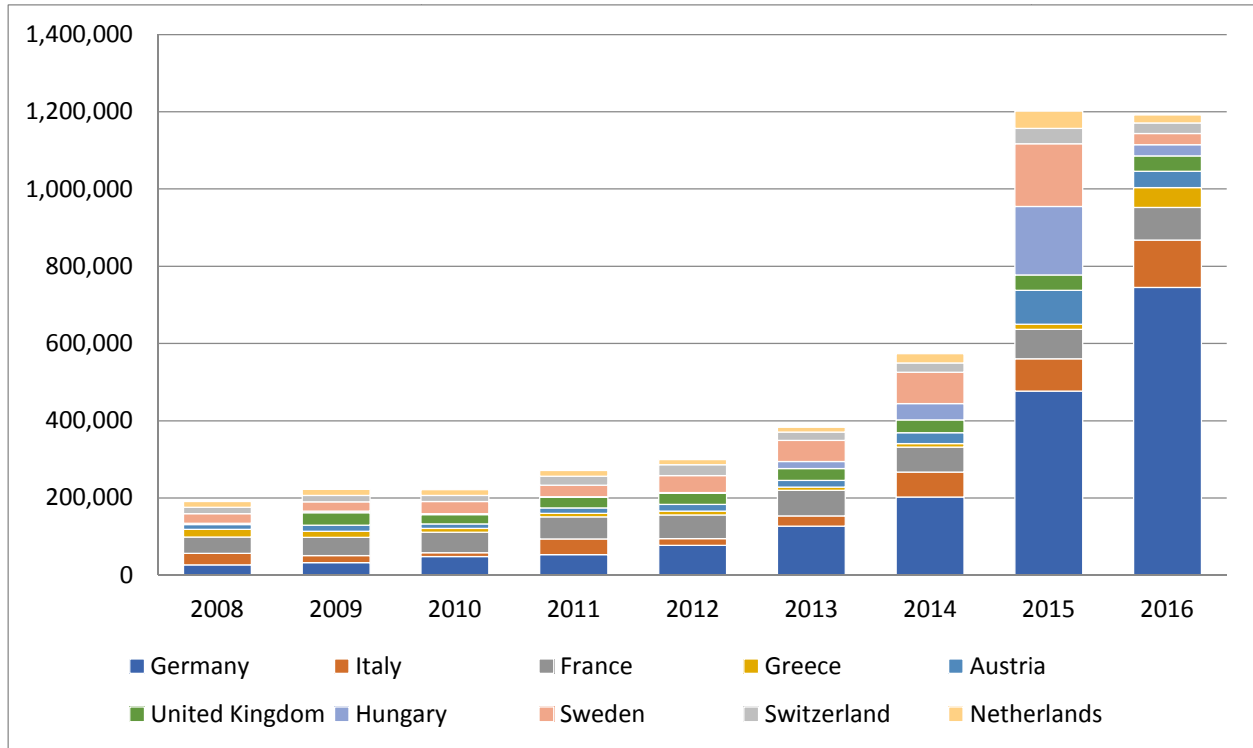
Europe has been struggling to cope with a large-scale influx of migrants and there have been divisions within the European Union (EU) over how best to support refugees (Persaud, 2017). Refugees enter Europe through Mediterranean regions, a journey that carries significant risks," in the first three quarters of 2017, at least 2,600 refugees and migrants died or went missing in the Mediterranean, 94 % of whom were trying to cross from Libya to Italy" (UNCHR, 2018, p. 92).

Figure 1 illustrates the asylum applicants coming to Europe. The largest groups are coming from Syria, Afghanistan, Iraq and Pakistan. In 2016, the number of first time asylum applicants in the EU from Syria fell to 335,000 from 363,000 in 2015; the share of Syrians dropped from 28.9 % to 27.8 %. Afghanis accounted for 15 % and Iraqis for 11 % of the total number of applicants. In terms of countries of destinations in Europe, the largest groups go to Germany, Italy and France (see Figure 2). The refugee crisis has created a disproportionate burden on some countries and more collaboration at the EU level is needed to coordinate their integration (Persaud, 2017).

**Figure 1.** Asylum Applicants in Europe (from countries with 10 largest numbers)(Eurostat, 2016)

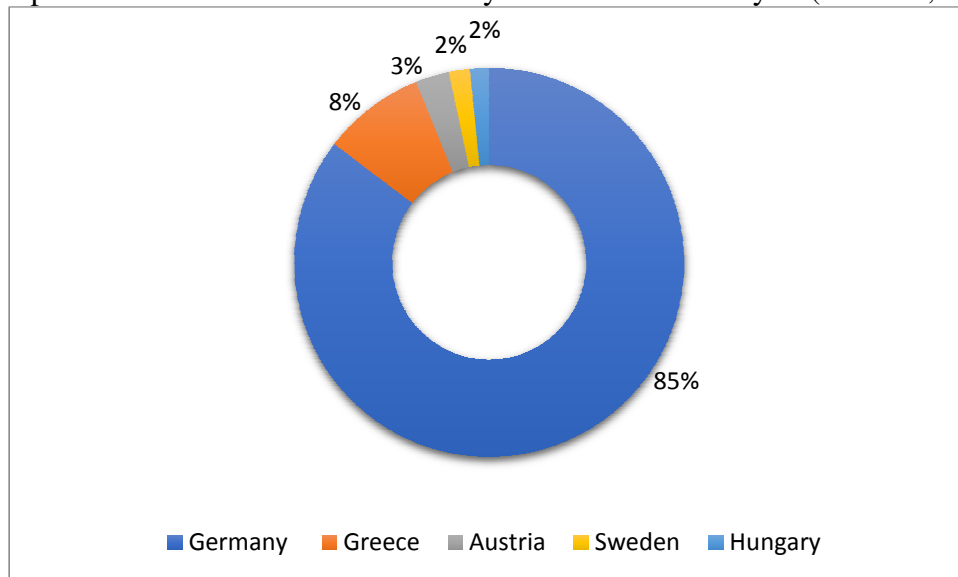


**Figure 2.** Number of Asylum Applicants by Country of Destination (Eurostat, 2016)

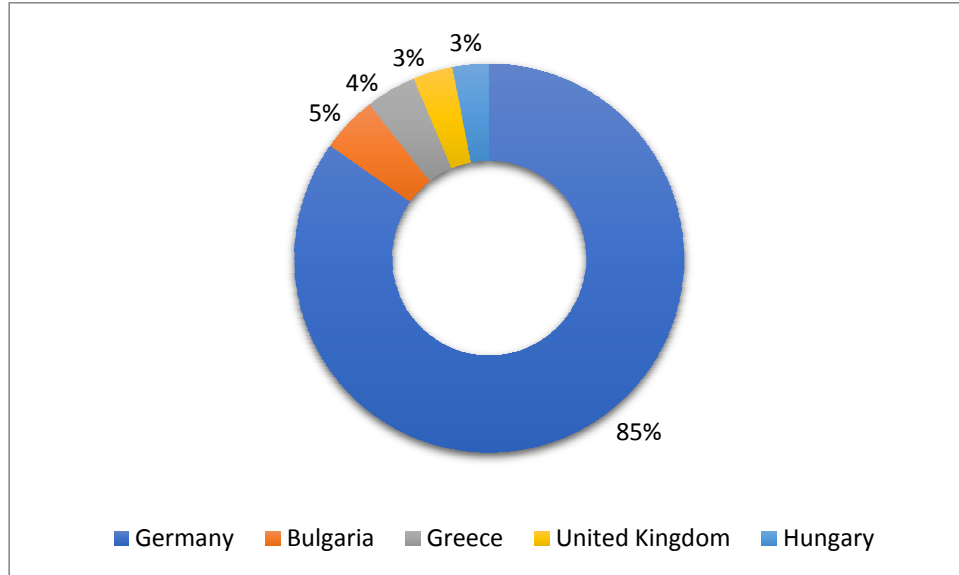


Figures 3, 4 and 5 illustrate the top five destination countries for asylum seekers from Syria, Afghanistan and Iraq, the countries of origin with the largest numbers of refugees. Data indicate that 85% of Syrian and Iraqi and 77% of Afghani asylum seekers apply in Germany, while smaller percentages apply in Greece, Hungary, Austria or Bulgaria (see Figure 3; Eurostat, 2016).

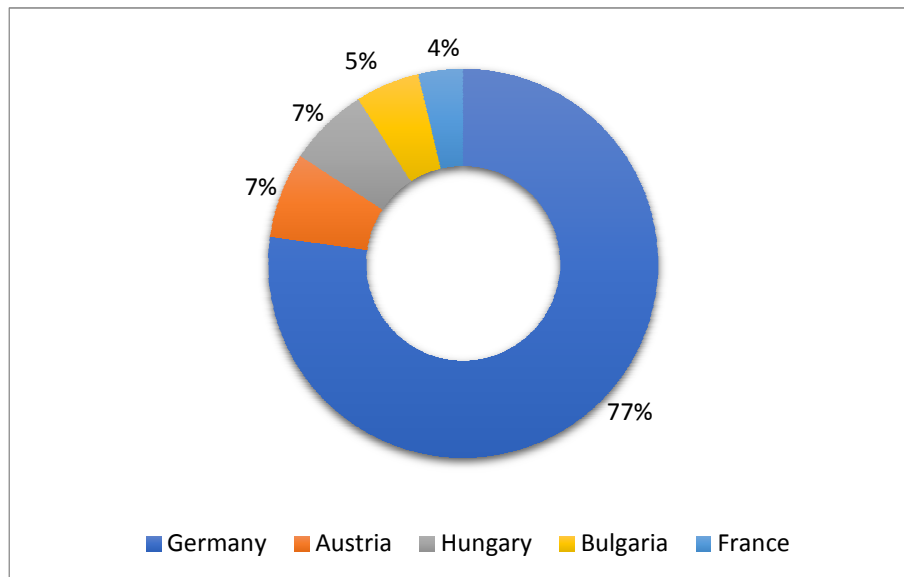
**Figure 3.** Top 5 Countries of Destination for Asylum Seekers from Syria (Eurostat, 2016)



**Figure 4.** Top 5 Countries of Destination for Asylum Seekers from Iraq (Eurostat, 2016)



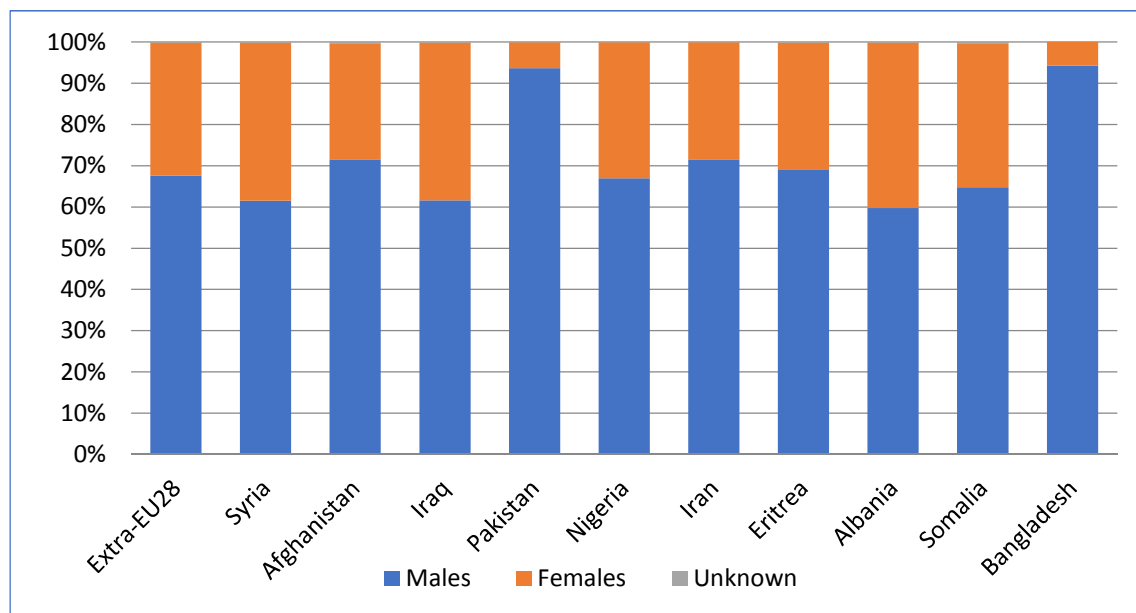
**Figure 5.** Top 5 Countries of Destination for Asylum Seekers from Afghanistan (Eurostat, 2016)



## Gender Issues

The data indicate that more men than women have been seeking asylum. Figure 6 indicates that across the ten largest countries of origin source of migrants, more than 60% are men, and for Pakistan and Bangladesh, men asylum seekers represent more than 90% (Eurostat, 2016).

**Figure 6.** Asylum Applicants by Gender and Countries of Origin (Eurostat, 2016)



Studies on gender differences in post-traumatic stress in asylum seekers and refugees indicated that women reported significantly more somatic symptoms, emotional outbursts, and loss of sexual interest than men who reported more detachment (Renner & Salem, 2009). For women, typical coping strategies were concentrating on their children and various indoor activities, while men preferred looking for work and socializing. Thus social psychiatric interventions should take gender-specific symptoms and coping strategies into account.

European policies do not provide special provisions to facilitate the settlement of refugee women and instead place barriers to their social and economic participation (e.g., unfavorable family reunion policies). The legal basis for asylum, the requirements and the procedures all reduce the protection which is likely to be conferred to asylum-seeking women (Bloch, Galvin, & Harrell-Bond, 2000).

### Age Considerations

An unaccompanied minor is a person younger than 18 years old who arrives on the territory of an EU Member State not accompanied by an adult or who is left unaccompanied after having entered a Member State. In 2016 there were 633,000 applications in the EU from unaccompanied minors; 15.9 % of all minors were unaccompanied. Among minors who applied for asylum, the share that was unaccompanied was less than half in most EU Member States in 2016, the exceptions being in Italy and Slovenia (Eurostat, 2017).

More than 4 in 5 (83 %) of the first time asylum seekers in the EU in 2016 were younger than 35 years old; those who were 18–34 years accounted for about half (51 %) and one third (32 %) were minors younger than 18 years (Eurostat, 2017). Figure 7 indicates that around 40% of asylum applicants who came from Syria, Afghanistan and Iraq are younger than 18 years of age.

In 2014, 26 % of all asylum applicants in EU were minors (19 % younger than 14; 7 % between 14 and 18 years of age) (Hebebrand, et al., 2016) Among the youngest age group (0–13 years), males accounted for 53 % of the total number of applicants. The majority (86 %) of migrant/refugee children travelled with their parents (males - 50 % for the accompanied vs 85 % for the unaccompanied).

The needs of young refugees arriving in Europe focus, similarly with the adults', on their pre-migration, flight and host country experience. The pre-migration experiences of young refugees depend on their country of origin; exposures to poverty, or war and conflict, but also on their education, social status, familial, religious, and sociocultural values (Hebebrand, et al., 2016). The flight experience of the individual refugee can be traumatic and associated with separation experiences, sexual abuse, or trafficking (e.g., forced labor). The arrival in the hosting country entails risks due to unsafe living conditions, non-access to schooling, years of insecurity with uncertain status, multiple moves, parental illness and unemployment, or social exclusion.

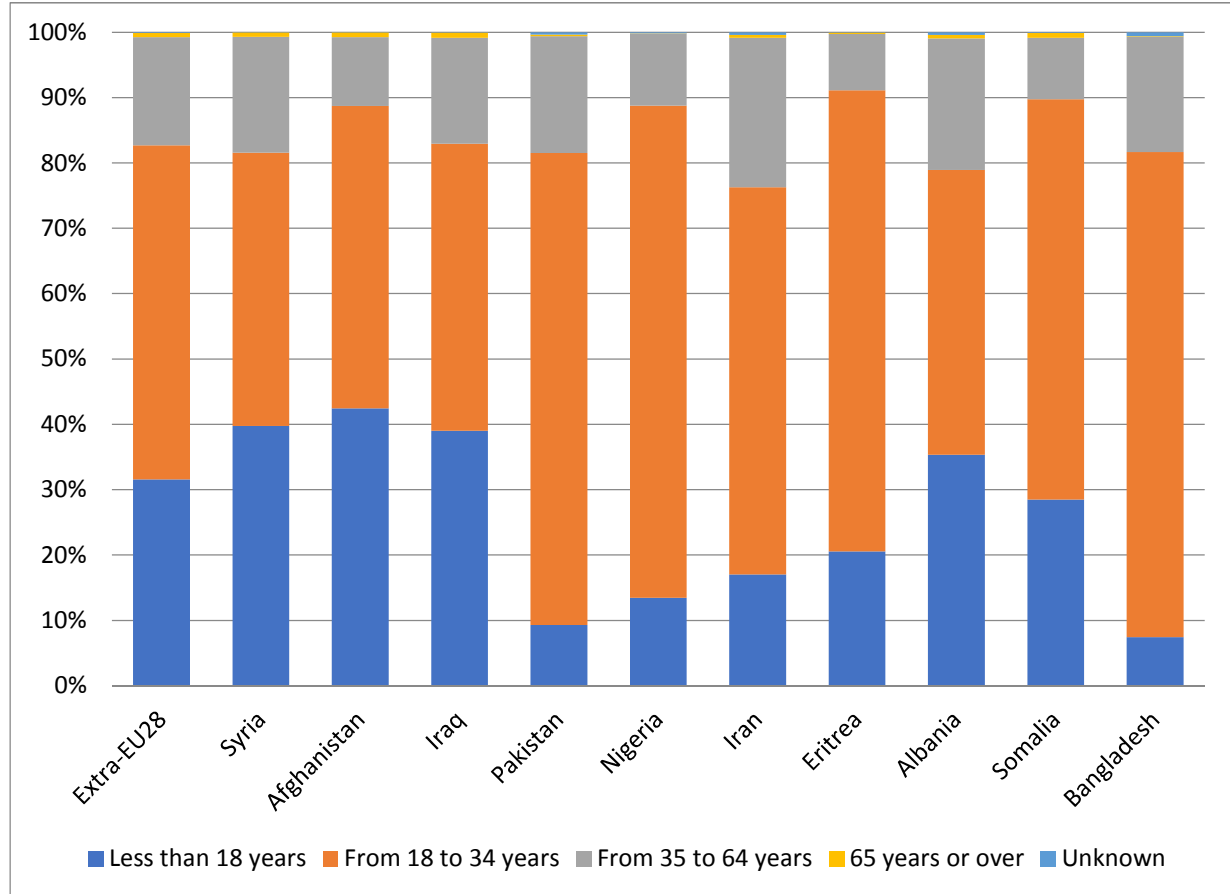
Children of refugees may have been separated from their parents, witnessed members of their family being tortured or experienced violence or torture themselves. These abusive events might be internalized and impact on subsequent development and thus a holistic focus is required on rehabilitation, social integration, care, asylum, education, support, health and therapeutic needs (Melzak, 2009). They may be living with just one parent, in fragmented families or with unfamiliar caregivers. Some might have arrived alone and most experience multiple losses, anxiety, depression and conduct disorder. In children and adolescents, who comprise as much as half the world's refugees, high rates of PTSD, depression and behavioral problems are commonly reported even up to two years following re-settlement (Craig, Jajua, & Warfa, 2009). Waiting for asylum could be both productive and debilitating, confirming that asylum-seeking young people are in limbo, unable to influence the resolution of their claims (Kohli & Kaukko, 2017).

Despite their experiences, most refugee children have many strengths and few need specific psychiatric treatment (Craig, Jajua, & Warfa, 2009). Because refugee families underutilize formal mental health services, schools can have a key role to play in identifying problems and facilitating access to appropriate care (Craig, Jajua, & Warfa, 2009).

With respect to children, particularly important is their right to education and how accessible and welcoming the education system is in different countries. For example, in Sweden undocumented refugee children might be excluded from the right to remain there, while holding formal rights to education and health, undocumented refugee children having an important role in hiding their own and the family's whereabouts and migration status, and having to decide whom to reveal their undocumented refugee status to (Smith, 2018).



**Figure 7.** Asylum Applicants by Age and Countries of Origin (Eurostat, 2016)



### 3. Policies Regulating the Refugees' Experience

Policies turn some refugees into undocumented migrants and shield EU Member States from their international legal obligations. The EU Member States have established asylum procedures across the EU so that all those applying for asylum in EU Member States are guaranteed certain basic conditions of reception and access to the asylum procedures, protections, and rights to reduce the incentives for those seeking asylum to move from state to state (Schuster, 2011). Thus the state that allows someone to enter or remain in their territory is responsible for examining that person's application for asylum and no other state need examine that claim, placing a burden on countries of first arrival. Since the recognition rates are much higher in other countries, many who would be recognized as refugees might turn into 'illegal migrants' in the country of first arrival, a status that follows them afterwards. Although making a claim does not lead to recognition in that country, nor does it lead to rejection; thus the applicants are left without a decision, but not allowed to try anywhere else within EU. This issue is very important because legal status has significant implications for refugees' social and economic integration (Schuster, 2011).

An important outcome of the global crisis for refugees has been the abandonment of forced migrants to live in makeshift camps inside the EU. Davies, Isakjee, and Dhesi's (2017) paper reviewed the ways states prevented refugees from integrating, leading to thousands to live in hazardous spaces such as the informal camp in Calais France which hosted 10,000 refugees in 2016 underlining the deliberate political indifference towards refugees. Examination of newspapers covering the refugee crisis indicated that more than 50% of the stories on the refugees were about political and administrative issues, politicians and governmental officials being the dominating sources, rather than the refugees themselves (Silva, Brurås, & Bañares, 2018).

#### *Refugees' Family Reunification*

Costello, Groenendijk and Storgaard (2017) reviewed the multiple factors impacting refugees' family reunification in Europe including the legislation, specifically the Charter of Fundamental Rights of the European Union (EUCFR) - Article 7 which guarantees everyone's right to respect for his or her family life and the 2003 Family Reunification Directive (FRD) which establishes common rules for exercising the right to family reunification in EU Member States (excluding the United Kingdom, Ireland and Denmark). Based on this analysis, the Council of Europe Commissioner for Human Rights made several recommendations, including: "Ensure that family reunification procedures for all refugees (broadly understood) are flexible, prompt and effective", "Strengthen the position of children in the family reunification process" and "Reduce practical barriers to family reunification" (p.8). It is imperative to underline the importance of quick family reunification in supporting refugees integration in the host country.

## **4. Refugees' Social Integration**

Refugees' integration is a complex and multidimensional construct, referring to integration into the economic, health, educational and social contexts. Multiple factors contribute to how smooth refugees' integration occurs, including their experiences, their physical and mental health, or social support. There is in general a lack of understanding of the diversity and the range of experiences refugees bring with them. Protective factors that can support their social integration include key resilience characteristics such as personal agency, beliefs that life has meaning, goal direction, sense of purpose, and motivation (Kuschminder, 2017; Rivera, Lynch, Li & Obamehinti, 2016). Refugees' integration is a two way process depending on how resourceful is the individual and how open the society (Strang, & Ager, 2010).

*Immigrant integration* refers to the incorporation of new elements (immigrants) into an existing social system. Integration is a multi-dimensional concept, including *structural integration* - socio-economic aspects of integration referring to education, employment and *social and cultural aspects* referring to cultural adjustment, shared norms and social contacts of immigrants with natives (Vermeulen & Penninx, 2000). Structural and cultural dimensions of integration are strongly related, migrants with good social positions (high education, stable job) having more informal contact with the society (Dagevos, 2001; Odé, 2002). Refugees become involved in a range of economic, social and cultural transnational activities (e.g., sending remittances) (Al-Ali, Black, & Koser, 2001; Snel, Engbersen, & Leerkes, 2006).

Studies on obstacles to refugee integration in the European Union indicated that some of the major impediments to integration they experienced were the racism and ignorance experienced at both the personal and institutional levels (Mestheneos, & Ioannidi, 2002; Zetter, Griffiths, and Sigona, 2005). Personalities of refugees appeared to be another critical factor in the ability to be accepted in the new host society.

Working with refugees needs a multi-professional approach and an accurate assessment of physical, emotional, social, and legal aspects (Turner, & Herlihy, 2009). Healthcare professionals must familiarize themselves with the cultural background and gain an understanding of their refugee communities (Kramer, et al 2017). The task of the mental health professional and the assistance offered needs to focus on helping the patients achieve their goals, as part of a wider multi-sector collaboration with social workers, refugee organizations, housing and employment agencies (Craig, Jajua, & Warfa, 2009).

### **Economic Integration**

Employment is the most important factor in securing the integration of migrants into society as it enables interactions, increases opportunities for learning local language and it provides the opportunity to build a future and to regain confidence (Phillimore, & Goodson, 2006). Refugees who are working adjust more easily to the host society than those who are unemployed (Bloch, 1999, 2000; Shields and Wheatley-Price, 2003). Inability to locate work and underemployment are the most significant barriers to successful integration of refugees into society (Bloch, 2004; Feeney, 2000). Refugees struggle to locate employment commensurate with their skills and as a result the process of integration is often associated with downward professional mobility.

The different integration programs that countries have set up for immigrant economic integration have a big impact on their outcomes. Scandinavian countries such as Sweden and Norway have developed extensive state sponsored integration programs and housing and employment assistance are the two major pillars in their refugee integration policies (although inequalities between refugees and the rest of the population still exist) (Valenta, & Bunar, 2010). Dispersal policy in UK for example, is sending asylum seekers to excluded urban areas where there is an excess of available housing and thus while asylum seekers and refugees have both skills and qualifications, they are experiencing high levels of unemployment and those who are employed are working in low-skilled jobs with earnings below the average (Phillimore, & Goodson, 2006). Facilitating the social inclusion and integration of refugees requires also a shift away from the present focus on formal, individualized education provision to a greater recognition of informal and social learning opportunities (Morrice, 2007).

### **Health Care System**

Countries have different top-down or bottom up approaches to health and social care systems. For example, the Dutch mental health services for refugees are more stratified and hierarchically organized than the British ones which are less systematic and with large differences in the range and quality of the services but include many refugee community organizations (Watters &

Ingleby, 2004). It seems that an effective approach might be a top down planning of services to ensure, an appropriate distribution of resources, combined with community based initiatives.

Mental health varies between migrant groups and access to psychosocial care facilities is influenced by the legal frame of the host country; mental health and consumption of care facilities is shaped by migrants' previous patterns of help-seeking and by the legal frame of the host country (Lindert, et al., 2008). In many European countries migrants fall outside the existing health and social services, particularly asylum seekers and undocumented immigrants.

### ***Mental health***

Refugees present high prevalence rates of trauma-related mental disorders. Despite their psychological impairment, they are expected to meet high functional requirements in terms of social integration and financial independence (Baker, 1999; Schick et al. 2016). The most common disorders among refugees are posttraumatic stress disorder and major depression, trauma and loss. Psychiatric surveys of refugees indicated that 9% of adults were diagnosed with PTSD, 4% with generalized anxiety disorder and 5% with major depression, and 11% of children with PTSD (Craig, Jajua, & Warfa, 2009). There is a correlation between difficulties in acculturation and mental distress and thus prevention of future mental health problems among migrants have to focus on easing the process of integration into the host society (Haasen, Demiralay, & Reimer, 2008).

Differences in resident status are associated with mental health outcomes. Thus asylum seekers (54%) and refugees (41.4%) fulfilled criteria of PTSD most frequently while anxiety and depression were reported by asylum seekers (84.6% and 63.1%, respectively) and illegal migrants (both 47.6%) (Heerena, et al.2014). Prevalence rates of depression and anxiety among migrants vary and may be linked to financial strain in the country of immigration. An evaluation of the associations between the Gross National Product (GNP) of the immigration country as a moderating factor for depression, anxiety and PTSD indicated that the rates for depression were 20% among labor migrants vs. 44% among refugees and for anxiety 21% among migrants vs. 40% among refugees and higher GNP in the country of immigration was related to lower depression and/or anxiety in migrants but not in refugees (Lindert,et al., 2009).

Schick et al. (2016) examined the relationship of mental health problems, post-migration living difficulties, and social integration in Switzerland and found that despite an average time of residence of over 10 years, participants showed poor integration and a high number of difficulties. Integration difficulties were associated with psychological symptoms, but not with education or visa status. Thus, psychological impairment in treatment-seeking traumatized refugees is associated with poor integration.

### ***Strategies and interventions for working with refugees with mental health struggles***

Intervention models for refugees with mental health problems include developing safety, trust, and stabilization, providing specific therapies and support with integration in a new society (Chang-Muy, & Congress, 2015; Herman. 1997; Valtonen, 2008). Support with integration may be long term and draw on support from other agencies. It is recommended that mental health and

social care of refugees include an integrated approach, cultural sensitivity, political awareness and accessibility (Watters, & Ingleby, 2004). Culturally sensitive mental health needs assessments need to be conducted early during the asylum process (e.g., include interpreters and translated materials) and asylum seekers and refugees should be consulted about the services they would find helpful. There is an increased prevalence of stress-related common mental disorders in these populations due to the journeys individuals take and thus the mental health practitioner must be informed of the cultural issues and the stigma associated with trauma and mental illness (Craig, Jajua, & Warfa, 2009).

There is a need to examine the effectiveness of different therapeutic techniques and treatments for refugees, to help guide the practitioners (Palic, & Elklit, 2011). For example, Narrative Exposure Therapy (NET) is effective in treating refugees and asylum seekers' PTSD after war experiences and torture, the patients being assisted to construct a chronological narrative of their life stories through active listening and empathic understanding (Stenmark, et al., 2013). Trauma-focused and cognitive-behavioral therapy (CBT) approaches also showed efficacy in treating PTSD in refugees (Nickerson et. al. 2011; Palic, & Elklit, 2011).

### ***Scaling –up mental health interventions for refugees***

Major conflicts challenge health systems' capacity to adequately respond to the needs of vulnerable individuals and communities affected by these events (WHO, 2012). Thus scalable psychological interventions have been developed in different countries (Sijbrandij, et. al. 2017). In 2008, the World Health Organization (WHO) launched the mental health Gap Action Programme (mhGAP) to provide effective mental health treatments through primary and community care (WHO, 2010). A specific recommendation of WHO was to implement *task-shifting*, meaning that a task that is originally performed by a specialist is transferred to a less specialized worker with fewer qualifications.

As part of its mhGAP programme, WHO developed scalable psychological interventions for use in settings affected by adversity, such as *Problem Management Plus* (PM+), which is available as an individual and group versions and was evaluated in several countries (e.g., Pakistan (Rahman et al., 2016); Kenya (Bryant et al., 2017) (Dawson et al., 2015). These interventions are short, delivered over five weekly sessions, address several mental health symptoms, and are delivered by nonprofessional helpers or by peer-refugees after training, to teach clients different strategies to manage stress, solve problems, use positive behaviors and strengthen social support. Another scaling-up mental health and psychosocial intervention with refugee populations is *e-mental health apps interventions* through smart phones which could reach clients that would not have access to mental health treatment (Ruzek, Kuhn, Jaworski, Owen, & Ramsey, 2016).

## **5. Conclusions and Recommendations**

Refugees integration remains high on the current international political agenda. United Nations General Assembly adopted the New York Declaration for Refugees and Migrants (2016), which reaffirms the importance of the international refugee regime and represents a commitment by Member States to strengthen and enhance mechanisms to protect people on the move. Two global compacts are expected in 2018: a global compact on refugees and a global compact for

safe, orderly and regular migration to support this process. Supporting refugees' integration in society also supports the achievement of SDG 16 focused on promoting peaceful and inclusive societies.

Recommendations for refugees' integration include

- Streamlining of the asylum process to reduce the waiting period and facilitate refugees' economic and social integration in the host society
- Assuring refugees access to health services and promoting their use (including mental health services)
- Assuring refugee children and adults access to the education systems
- Facilitating refugees' access to adequate employment commensurate to their qualifications
- Developing multidisciplinary professional teams to work with refugees (lawyers, social workers, family counselors) and provide systematic and coordinated services to facilitate refugee integration
- Promoting cultural sensitivity when interacting with the different cultural groups (e.g., using translators)
- Developing policies to facilitate families to immigrate together or/and to speed up the family reunification process

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