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Mental Health in New Zealand from a Public Health Perspective

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MANATU HAUORA

CHAPTER 11:
REFUGEES AND IMMIGRANTS

MAX ABBOTT

Migration is occurring on an historically unprecedented scale. Over 100 million people are estimated to reside outside their country of origin (Russell and Teitelbaum 1992). Approximately 20 million of these are refugees – people who have fled their homeland to seek refuge from war, political repression or persecution (Desjarlais et al 1995). It has been argued that migration is currently the worldwide 'visible face of social change' (UN Population Fund 1993), that it will be one of the major factors in global change during the next two decades and that we are in the early years of 'the age of migration' (Castles and Miller 1993).

Nearly 17 percent of New Zealand's population are foreign born (16.8 percent foreign born; 4.5 percent did not specify) (Statistics New Zealand 1997, personal communication). This is high by international standards, although comparable to Canada. For the 1991 census, 16 percent of the population were foreign born and over half of these were born in either the British Isles or Australia (Department of Statistics 1992). See Table 11.1 for more details of the source of the overseas-born population of New Zealand in 1991.

From the late 1970s, both the number and ethnic diversity of migrants and refugees entering New Zealand increased. This trend accelerated following changes to legislation in 1987 and 1991 that removed a bias in favour of British and West Europeans, which had largely dictated migrant flows for over a century (Brooking and Rabel 1995). In recent years, Northern Asia has become the major source of migrants. Since 1991, the Government's immigration target of 20 000 migrants and 800 refugees per annum has been exceeded consistently. A series of publications from the Population Studies Centre of the University of Waikato has examined these trends, particularly with relation to Asian migrants (Lidgard et al 1995; Bedford et al 1995; Ho 1996; Ho et al 1996; Bedford and Lidgard 1996).

The majority of new immigrants live in Auckland. Almost all official 'quota' refugees pass through an orientation and education programme in Mangere and most remain or resettle in Auckland (Liev 1995; Bedford et al 1995). Most asylum seekers ('spontaneous' refugees) also enter the country via Auckland. As a result, this city has become increasingly ethnically and culturally diverse relative to the rest of the country. In 1991 over a quarter of Aucklanders were 'overseas-born'. During the past decade, Auckland's Chinese, Indian and other Asian communities have seen particularly high growth from migration, while the already significant Pacific population has continued to grow through both migration and natural increase (Thomson 1993; Greif 1995). Wellington also has proportionately more immigrants than other parts of the country.

Table 11.1: **Source of overseas-born population of New Zealand, 1991, and approvals granted for residence in New Zealand of citizens of other countries 1992–1995**

Country of birth	*Percentage of NZ population in 1991 (1)*	*Percentage of all overseas people approved for residence in NZ 1992–1995 (2)*
British Isles	7.1	13.2
Other Europe	1.4	7.7
Pacific Islands	2.9	9.4
Asia	1.9	56.1
Australia	1.4	*
America	0.5	3.0
Africa	0.3	10.6
Other	1.1	–
Total	**16.6**	**100.0**

* Less than 0.5 percent

Note: The figures do not refer specifically to the country of birth, but to the country of present citizenship, from which application was made to reside in New Zealand. The figures do not refer to actual arrivals, for which there will be a time lag.

Sources: (1) Department of Statistics 1992
(2) New Zealand Immigration Service 1994

Migrants' and refugees' mental health needs are important to consider because they:

- constitute a large and growing percentage of the total New Zealand population
- come from diverse cultures and have needs that may not be adequately met by existing monocultural or bicultural health and human services
- are likely to include subgroups that are at very high risk for mental disorder.

DISLOCATION AND MENTAL HEALTH

Shifting to a new place of residence, be it temporary or permanent, involves losses, disruption to familiar life patterns and exposure to new experiences and challenges. This is all the more so if it includes crossing national boundaries or entry to a different culture. Folk wisdom and various strands of social science and psychiatric theory hold that people thus relocated or dislocated are exposed to elevated levels of stress and may, as a consequence, experience impaired mental health.

This chapter will only discuss people who are in the process of becoming long-term residents. It does not include returning citizens, visitors or tourists. Only passing consideration is given to sojourners such as overseas students or temporary workers, even though these groups collectively constitute a significant and increasing percentage of the country's total population and are users of health services. Pacific people's mental health issues are considered in Chapter 4 of this report.

The relationship between migration and mental disorder has long been a matter for debate and has been studied empirically since the mass migrations to North America midway through last century. While early research focused on hospitalisation for major mental disorders, more recent studies have had a broader perspective.

HOSPITAL STUDIES

Studies from various parts of the world have found proportionately higher rates of psychiatric hospitalisation among recent migrants. For example, Australian research during the 1960s and 1970s found that immigrants generally had higher hospitalisation rates for major depression than did the local-born population. In addition, non-English speaking immigrants from Eastern and Southern Europe were more likely to receive a diagnosis of schizophrenia than local-born and other immigrant groups (Jayasuriya et al 1994). Higher hospitalisation rates for schizophrenia and paranoid reactions have been documented for immigrants in a number of countries (Cochrane and Bal 1987; Leff 1988). It is often assumed that elevated hospitalisation rates reflect greater prevalence in migrant and refugee communities and reflect the stresses of migration and resettlement. However, service utilisation, at best, provides a crude proxy for psychiatric morbidity in the total population (Abbott 1994), and cannot be relied upon to make valid comparisons between the mental health status of migrant and other groups within the wider community. Further, these findings are not consistent across all countries (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees 1988a, 1988b; Leff 1988). Thus, it remains unclear whether migrants are more at risk than locals for major mental disorders, and the reasons for any association, should it exist, remain unclear.

It is not possible to determine the prevalence of mental illness in immigrant groups in New Zealand from official mental health data because they do not include a breakdown by country of birth or length of residence. Ethnicity, which is recorded, could provide an approximate measure for those ethnic groups that contain a large percentage of recent immigrants and/or refugees. However, this is only analysed at present in terms of Māori, non-Māori and Pacific people.

Wong (1992) has examined South Auckland Pacific and Chinese admissions to in-patient psychiatric units. While Pacific and Chinese communities include many local-born members, they also contain the two largest groups of recent migrants. He found that acute admission rates for Pacific and European New Zealanders were similar (1.5 per 1000), that Māori rates were almost double (2.8 per 1000) and that the Chinese rate was considerably lower (0.6 per 1000). Wong also calculated rates for community mental health service consultations. Here European New Zealander and Māori rates were similar at 6.4 and 6.1 per 1000 respectively. Pacific and Asian rates were much lower at 2.3 and 1.6 respectively (Chinese were not considered separately).

While information concerning the extent and type of utilisation of the mental health services by immigrant groups would be of some value, it is important to recognise the limitation of these data, which may provide a distorted view of the amount and degree of mental illness, and mental health, in these communities as a whole.

COMMUNITY STUDIES

Community studies conducted over the past 25 years have provided a more accurate and direct measure of the prevalence of mental disorder and a more comprehensive picture of the full range of mental health problems in the community.

Such surveys of migrant and refugee populations have found that depressive and anxiety disorders are the most common conditions (London 1986; Nguyen 1989; Jayasuriya 1994). Among refugees, especially those seeking treatment in out-patient settings or resident in refugee camps, high rates of post-traumatic stress disorder (PTSD) have been documented, frequently with coexisting affective and anxiety disorders (Boehnlein et al 1985; Gong-Guy 1987; Mollica 1989; Jayasuriya et al 1994). Relative to native-born people, higher prevalences of paranoid disorders, brief reactive psychoses, culture-bound syndromes, somatoform disorders and organic brain disorders have been found in some surveys (Garcia-Peltoniemi 1991; Silove 1995). Other research has indicated that widely used psychiatric diagnostic systems are Eurocentric and fail to capture the reality and diversity of expressions of psychological distress and disorder found in some ethnic groups (Mollica 1989; Nguyen 1989; Minas 1990).

No New Zealand studies have examined community mental health service utilisation by immigrants or refugees or determined the prevalence of the major categories of mental disorder among representative community samples of these people. However, there are some relevant community surveys of psychological distress and disorder.

Pernice and Brook (1994) assessed levels of psychological disturbance among community samples of adult Khmer, Lao and Viet refugees, Pacific immigrants and British immigrants to New Zealand using translated versions of the Hopkins Symptom Checklist (Derogatis et al 1974). All had been resident for fewer than 15 years. Clinically significant levels of depression were found in 29 percent of the refugee group, 18 percent of the Pacific migrants and 8 percent of the British migrants. Similar levels of anxiety were experienced by the refugee (15 percent) and Pacific (18 percent) samples and both were considerably more anxious than the British migrants (3 percent). The depression rate for Indochinese refugees in this study is identical to the rate found by Liev (1995) among Khmer and Lao refugees during their stay in the Mangere Centre, although he found higher rates of anxiety (32 percent) using the same questionnaire. The strongest predictors of symptomatology were having experienced discrimination in New Zealand, not having close friends, being unemployed and spending most of one's time with one's own ethnic group (Pernice 1989; Pernice and Brook 1996a). It has been suggested that migrants experience a relatively symptom-free or euphoric phase after arrival in the country of settlement, followed by a crisis period. However, Pernice and Brook (1996b) failed to find support for this.

Ward and her colleagues (Armes and Ward 1989; Ward and Searle 1991; Ward and Kennedy 1992, 1993, in press) have examined interrelationships between acculturation, personality and psychological adjustment in a variety of groups of sojourners (eg, school and university students, adult workers) within New Zealand and other countries. They demonstrated that sociocultural adaptation and psychological adjustment are distinct processes that are predicted by different sets of variables. However, the relationship between sociocultural adaptation and psychological adjustment strengthens when sojourners rely more on the host culture for social interaction and support. They also found that some predictors of these two adjustment domains are consistent across cultures for sojourning or migrating groups (eg, internal locus of control, life changes, social support, cultural distance, language ability, knowledge about the host culture, quality of contact with host nationals) but others, perhaps especially personality factors such as extraversion-introversion, are specific to particular sociocultural contexts.

Cheung and Spears (1992) surveyed Chinese women living in Dunedin using Chinese and English language versions of the General Health Questionnaire (GHQ) (Goldberg and Hillier 1979). Their sample contained similar numbers of local- and overseas-born women. Overall, the GHQ-defined prevalence of psychological disorder was 21.3 percent, almost identical to that found for Dunedin women generally. Nevertheless, among the immigrants, those born in China, who had lived in New Zealand for at least 10 years, who spoke English less than once a week, and whose reason for migration was 'family reunion' or 'to follow the lead of family members', had higher mean GHQ scores, indicating more mental health problems for these immigrants.

Cheung and Spears also examined the mental health of adult Khmer refugees resident in Dunedin (Cheung 1994, 1995; Cheung and Spears 1994, 1995a, 1995b). The majority had experienced severe, multiple trauma in Cambodia, including torture. The prevalence of psychological disorder was 15.7 percent, similar to that of the general adult population of Dunedin. However, 12.1 percent of the sample were diagnosed as suffering from PTSD. Those aged 65 and above had higher prevalences of PTSD and GHQ-defined mental disorder. Despite this, only one person (0.4 percent) reported using psychiatric services during the previous year. Risk factors included being widowed, experiencing major life events during the past 12 months, and having experienced chronic post-migration stressors, a poor individual coping style and weak social supports.

Feelings of being discriminated against, inadequate language skills and conflicts with perceived moral standards in New Zealand were the most frequently mentioned post-migration cultural stressors. Other frequently mentioned classes of stressor included loneliness and boredom, financial, unemployment and family. Financial, cultural and loneliness/boredom stressors were the most closely related to increased rates of mental disorder.

Much lower rates of PTSD and GHQ-defined mental disorder were found among Khmer respondents who perceived the world as ordered and predictable and making emotional sense. These perceptions were considered by Cheung and Spears to at least in part derive from a commitment to Buddhism. Having a close confiding relationship and some other forms of perceived social support were also associated with lower GHQ scores.

Loneliness, which appeared to be one of the most significant stressors for Dunedin Khmer, was also noted by Farmer (1988) in a survey of South-East Asian refugees from throughout New Zealand. It was of most concern to elderly people and refugees who had been settled in small towns with few or no other South-East Asian residents.

The research with Dunedin Khmer is impressive conceptually and technically, and provides information that is currently lacking for other migrant and refugee groups in this country. However, like other New Zealand community studies, it is cross-sectional. For this reason it is not possible to directly infer causation from the relationships identified. Prospective longitudinal and quasi or natural experimental studies are required to enable stronger causal inferences to be drawn. Such studies are rare in the international migrant and refugee literature. Pernice (1994) discusses many additional and often unique methodological difficulties that arise in cross-cultural research with migrants and refugees.

In contrast to the earlier hospital studies, approximately half of the community surveys undertaken throughout the world have failed to find higher rates of mental disorder among migrant populations than among local-born populations, and many have found the reverse. The New Zealand studies suggest similar variability. Reflecting on the international literature, Beiser (1990) comments:

> *. . . a review of these . . . studies leads to an inescapable conclusion. Migration is a condition of risk for developing mental disorder. If one migrates as a refugee, the jeopardy to emotional well-being is even greater . . . But risk is not destiny. The social and historical contingencies surrounding resettlement as well as personal strengths which individuals bring to the situation determine whether exposure to risk results in break-down or in personal fulfilment.*
>
> *(Beiser 1990: 92)*

In other words, with respect to mental health and disorder, migration is not a unitary concept. Thus there is little value in asking whether migrants or refugees *per se* have high rates of mental disorder. For the purpose of planning prevention programmes or treatment services, the more useful question is: under *what circumstances* do they have high rates?

MAJOR RISK AND PROTECTIVE FACTORS

Many risk and protective factors have been identified by reviewers of the relevant epidemiological, clinical and social science literature (eg, Nguyen 1989; Beiser 1990; Berry 1990; Brody 1990; Williams and Berry 1991; Jayasuriya et al 1994; Rogler 1994; Desjarlais et al 1995; Silove 1995). Those found in the New Zealand studies considered above are generally consistent with United States, Australian, Canadian and European research.

The following factors appear to have been most strongly and consistently linked to elevated rates of mental disorder among migrant and refugee populations:

- traumatic experiences or prolonged stress prior to migration
- separation from family and community
- isolation from people of similar ethnic/cultural background
- inability to speak the language/languages of the host country
- unemployment and underemployment
- drop in socioeconomic status
- negative public attitudes towards, and rejection of, immigrants and refugees generally and/or some groups specifically
- being a child without parents or with seriously disrupted formal education
- being adolescent or of advanced age at the time of migration
- being a woman from a culture in which sex roles and values differ from the host country.

Albee (1984) developed a model that relates the incidence of psychological disturbance to adverse life circumstances and protective factors in individuals and communities. This model (refer to the equation) provides a framework within which research findings can be organised and preventive interventions identified for the three stages of migration: pre-migration, migration and post-migration.

$$\text{Incidence of psychological disorder } (\delta) = \frac{\text{Organic factors + Stressors + Exploitation}}{\text{Coping skills + Self-esteem + Social support}}$$

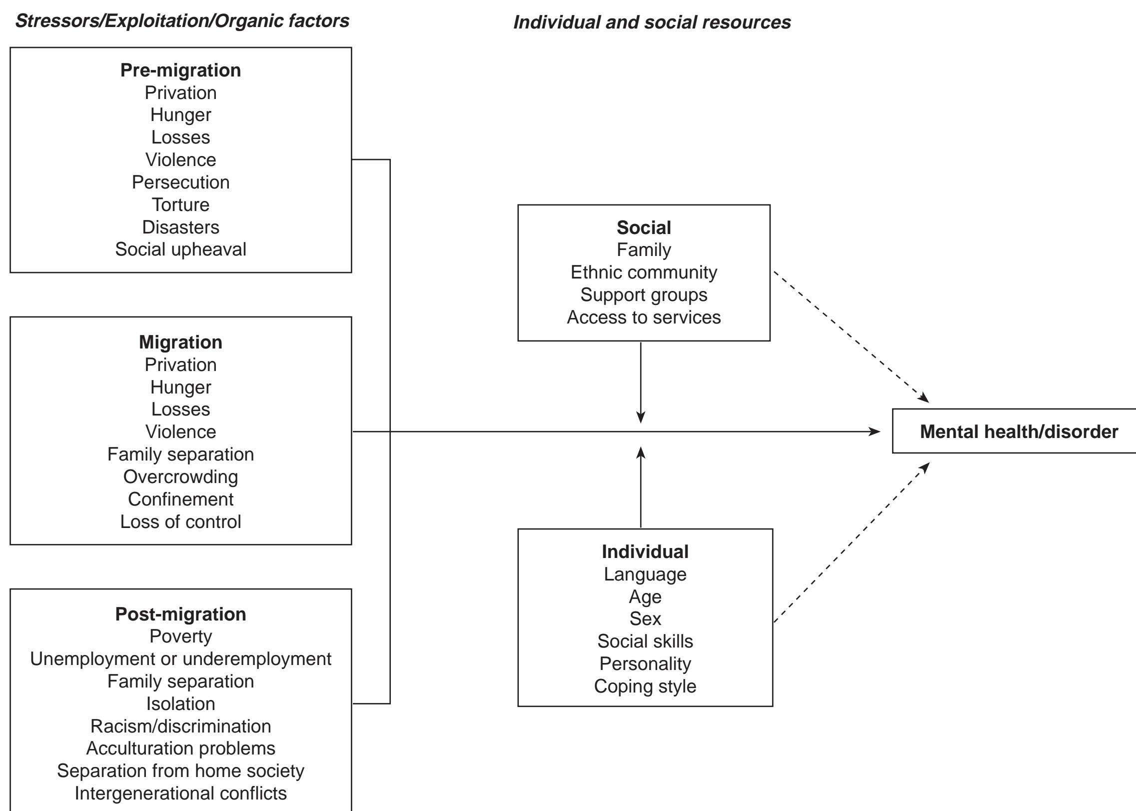
Factors above the line in Albee's model are considered to contribute to mental disorder. Those below the line play a protective or buffering role against these and may also have a direct beneficial effect on mental health. Prevention involves reducing exposure to the contributing factors and/or enhancing the buffering factors.

Organic aetiological factors include damage to the central nervous system by malnutrition, toxins, alcohol and other drugs, and trauma. Some of the particular stressors for migrants and refugees have been indicated above but they are, of course, subject to the more usual stresses of life predisposing to mental disorder as well (Abbott 1994). Exploitation refers to society-wide structural and ideological frameworks that severely disadvantage certain categories of people (eg, women, ethnic groups, the elderly) and can directly affect all of the major groups of factors in the model.

Coping skills include communication and problem-solving ability, psychological 'hardiness', self-esteem and a sense of control over one's life. Social support can come from a variety of sources.

Figure 11.1 is an expanded version of Albee's (1984) model, tailored to the groups under consideration.

Figure 11.1: **Major factors affecting immigrant and refugee mental health**



Source: Adapted from Albee 1984

PRE-MIGRATION, MIGRATION AND POST-MIGRATION

Refugees in particular may suffer mental health problems as a result of pre-migration stressors. They have frequently been exposed to severe traumatic stress including war, rape, starvation, torture and the loss of close family members through murder or forced separation. Physical injuries, including head injuries, are common. Refugees who have been exposed to multiple trauma have high rates of PTSD and major depression.

Refugees often experience a variety of severe stressors during the migration phase. Flight from their home country is usually hazardous and involves further loss of property, community and, frequently, family members. Many refugees spend months or years in refugee camps where living conditions may be poor, food and health services lacking, and meaningful employment unavailable. The process of claiming refugee status is often highly stressful. Many asylum seekers, including 'spontaneous' refugees claiming refugee status in New Zealand, remain in limbo for lengthy periods of time, facing uncertainty, interrogation by officials, the prospect of deportation and lack of access to health and social services.

Although severe and prolonged traumatic stress during the pre-migration and migration phases has been shown to have an adverse effect on mental health following resettlement, research with refugees and immigrants more generally indicates that what happens to them after entry to their host country has a more profound impact on their mental health during resettlement.

Prejudice and discrimination are important post-migration stressors. This has emerged from a number of the New Zealand studies and appears to apply most to the 'visible minorities' such as Asians and Pacific people (Pernice and Brook 1994; Greif 1995). Nonetheless, unemployment, separation from family members and isolation are among the most powerful post-migration stressors. Isolation is influenced by fluency in the local language and the presence of a community of the same ethnicity. Low income, non-recognition of qualifications and poor quality housing have also been identified as important. Exposure to these and other post-migration risk factors vary from one migrant or refugee group to another.

SOCIAL AND INDIVIDUAL RESOURCES

A supportive spouse and family have been shown to contribute directly to wellbeing and to buffer stressors. However, most refugees and significant numbers of migrants have broken families. Local ethnic communities can in part compensate for dislocated family and social networks and also offer additional support to new arrivals generally. This is one reason why most immigrants and refugees choose to live in Auckland (*Vista New Horizons for Immigration News* 1993). The much higher rates of clinical depression among Indochinese refugees than among Chinese refugees in Canada has been attributed to the presence of existing ethnic communities for the Chinese but not the Indochinese and the level of support therefore available to new migrants (Berry and Blondel 1982; Beiser 1990). New Zealand is similar to Canada in also having an established Chinese, but not Indochinese, community.

While these links with existing migrant and refugee communities can promote wellbeing and reduce the risk of psychopathology, Krupinski (1981) argued that this may be counter-productive in the longer term and particularly detrimental to children and adolescents. While different rates of acculturation among family members over time can result in family conflict, it is still unclear whether those second-generation migrants who maintain stronger links with their ethnic group in a new culture are at greater risk of mental illness (Jayasuriya et al 1994). This hypothesis is also based on the assumption that

maintaining one's own culture and integration with the host society are mutually exclusive. They are not. Many migrants and refugees value and pursue both and there is evidence that both home cultural maintenance and host cultural acquisition are associated with lower levels of psychological disorder (Williams and Berry 1991; Cheung 1995; Liev 1995).

While immigrant community groups and networks play an important role in new settler adjustment and wellbeing, there appears to be some concern on the part of government and sections of the wider community regarding the geographical distribution of recent immigrants (Maxwell 1994). It is possible that the large increase in the number of visible ethnic minority members in particular locations has exacerbated existing racist attitudes and discrimination on the part of the 'host' population. However, it is not possible from existing research to specify an optimal ratio in terms of maximising benefits for recent immigrants and minimising adverse reactions from longer-term residents (Moritsugu and Sue 1983). Many factors other than actual or perceived migrant neighbourhood density are associated with ethnic intolerance and hostility.

Inadequate service provision and poor access to health, language education, employment and social services, particularly for refugees, has long been of concern in New Zealand (Abbott 1989; New Zealand Immigration Service 1994).

Language proficiency is critically important in securing employment and enabling new settlers to become active participants in the host society. It has been consistently linked to mental health status. There are some indications that elderly people, women and unaccompanied children are more at risk of developing mental disorders, although this has yet to be investigated in New Zealand.

A recent Australian community study of immigrant and refugee adolescents found no differences between native-born Australians, Australian-born adolescent children of immigrants and immigrant and Vietnamese refugee adolescents on a variety of psychopathology indices, although refugee adolescents had poorer self-concepts than the other groups (Klimidis et al 1994).

EVIDENCE AND PROSPECTS FOR PREVENTION

It is important that prevention programmes are developed for refugees and immigrants as these populations contain significant numbers of people with elevated rates of distress and mental disorder following arrival. Local research suggests these levels persist for many years and that mental health service utilisation is much lower than that of other New Zealanders. Significant spillover effects into subsequent generations are also possible although this requires further investigation.

Prospects for primary prevention are good. A number of high-risk subgroups and major factors associated with mental disorder within these groups have been identified. Many of the provoking and most of the moderating factors are to a degree modifiable or potentially modifiable. This provides a solid base from which prevention interventions can be developed along the pre-migration–migration–post-migration chain at international, national and local levels. Williams and Berry (1991) give examples of interventions likely to have a preventive impact at each of these levels. The post-migration resettlement phase is the point at which prevention is most readily initiated. Most of the factors discussed above and summarised in Figure 11.1 under the headings post-migration, social and individual resources are potential focal points for general or specifically targeted interventions.

To date, while some changes to New Zealand immigration and refugee policy have been informed by research, at least in part (eg, family reunification policies and the abandonment of refugee 'pepper potting' throughout the country), and various actions have been taken by statutory, voluntary and ethnic community organisations with the intent of reducing adjustment and mental health problems (eg, cultural maintenance within refugee communities (Liev 1995)), few of these types of activity have been evaluated here or abroad. A recent review of the international literature located only two relevant published studies (see Mrazek and Haggerty 1994). These studies show that specific interventions aimed at strengthening individual and social resources in high-risk groups can prevent the onset of future clinical depression and depressive symptoms. Further research is needed in this country to more clearly delineate which subgroups within refugee and immigrant populations are most at risk, and to develop and evaluate prevention programmes for these particular groups.

The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988a, 1988b), guided by an extensive literature review and nationwide consultation, made a number of recommendations with respect to prevention. These included:

- pre-migration orientation
- broadening the definition of family for purposes of admission in order to increase available support systems
- increasing funding for ethnocultural settlement support agencies (particularly those serving the elderly, youth and women)
- developing school curricula to promote multicultural understanding and tolerance
- public education to increase knowledge of, and acceptance of, the benefits of pluralism to society and of the contribution of newcomers to the cultural and economic life of the country
- increasing public awareness of the possible difficulties faced by newcomers and the effects of prejudice on both victim and perpetrator
- improving access to language courses and to trades and professions for those educated outside Canada.

Similar recommendations emerged from 1986 to 1988 New Zealand-wide consultations with refugee communities and the 1988 National Seminar on Refugee Mental Health (Abbott 1989). The Canadian and local recommendations retain their relevance. If implemented with vigour, along with community development activities within new settler communities and more specifically targeted interventions for the most at-risk subgroups, there is good reason to anticipate that considerable psychopathology and associated distress would be prevented. Political will is the major missing ingredient. A commitment to further research and evaluation and a mechanism to disseminate knowledge relevant to prevention should help to sharpen the focus and improve the efficacy of undertakings in this area.

A TENTATIVE PREVENTION AGENDA

It is difficult to be precise about the priority and weighting of particular recommendations to improve the mental health of refugees in the absence of any evaluation of the benefit or otherwise of current immigration or refugee policies, resettlement procedures and refugee mental health services. The diversity of groups involved and relative lack of local research also precludes reliable estimates of attributable risk to be made in relation to the various factors known to be associated with mental disorder in migrant and refugee populations. While a thorough review, perhaps associated with a consensus conference or national task force, would be an important step towards the introduction of a comprehensive prevention programme, some gaps are apparent and tentative measures can be specified. These include:

- nationwide collection of mental health service utilisation data by ethnicity, country of birth and length of residence
- the inclusion of mental health screening within routine refugee health assessments conducted upon arrival and the provision of treatment in a culturally acceptable context to recent and longer-settled refugees. The effectiveness of the recently established Refugees as Survivors Centre in Auckland (Mental Health Foundation 1995) should be evaluated in this regard and consideration given to establishing similar services in other parts of the country with significant refugee populations.
- providing language education to all new settlers not proficient in English and financial assistance for refugees and other migrants who cannot afford to attend classes
- greater recognition of overseas professional and educational qualifications and the provision of ‘top up’ courses to assist refugees and migrants to practise their profession or trade in New Zealand
- consultation with refugee and recent migrant groups with regard to the ways in which health, education and social service providers can better assist them to strengthen their communities and families, to mitigate the loss of past social and cultural supports, to foster acculturation and adaptation, to reduce alienation from mainstream services and to develop targeted prevention programmes for high-risk groups including the elderly, unemployed and socially isolated
- the establishment of ongoing media, school and community programmes aimed at reducing prejudice and ethnocentrism, especially with regard to visible minorities and refugees.

To implement such a programme it will be necessary to recognise that this is a priority area. It will also be necessary for designated individuals to be given responsibility for refugee and/or immigrant policy, service access and provision at national and local levels. In addition, greatly improved co-ordination and co-operation between the various services as well as with voluntary organisations and new settler communities will be required.

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