College of Psychiatrists of Ireland

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# The Mental Health Service Requirements in Ireland for Asylum Seekers, Refugees and Migrants from Conflict Zones.

Position Paper

EAP/01/17 approved by Council March 2017

# THE MENTAL HEALTH SERVICE REQUIREMENTS FOR ASYLUM SEEKERS, REFUGEES AND MIGRANTS FROM CONFLICT ZONES IN IRELAND

***"Refugees, asylum seekers and migrants have been identified as suffering up to ten times the rate of post traumatic disorder (PTSD) compared to the indigenous population. For many refugees, asylum seekers and migrants the term post-traumatic stress disorder is not appropriate. This is because the process of migration into an alien and frequently hostile culture can mean that the trauma is still ongoing. It has not yet reached the "post" stage ' "***

The College of Psychiatrists of Ireland, formed in 2009, is the professional and training body for psychiatrists in the Republic of Ireland. The Mission of the College is to promote excellence in the practice of Psychiatry for all in Ireland**.**

## The Situation in January 2017

Since 2009, there has been a very serious deterioration in international affairs, particularly related to mass migration into Europe. In 2015, over one million people entered the mainland of Europe, fleeing war, poverty and persecution. Due to an agreement with Turkey, the number of Syrian refugees allowed to cross the Aegean Sea was markedly reduced in 2016 due to cash payments to Turkey and promises in relation to the free movement of Turkish nationals within the EU. It has been estimated that Turkey alone hosts three million Syrian refugees. The Irish Government has promised to integrate four thousand Syrian refugees over the next four years. In 2016, Ireland granted refuge to 760 Syrian refugees[i]. Recognising that Ireland is a small country in the middle of a financial crisis, this is still a very low intake given the size of the problem. This is not the total story. An unknown number of refugees and migrants are also within Ireland, having gained access by other means. Many of these individuals have also been displaced by war, atrocities, persecution and severe poverty. All persons within the jurisdiction of the Republic of Ireland deserve the best medical and mental health care that we provide.

## Key Recommendations - Summary:

See full detail in Recommendations' section at the end of the paper.

1. Ireland should continue to honour the spirit as well as the letter of the **United Nations Convention on Refugees(1951)** and the **1967 Protocol.**
2. Replace the **Direct Provision System** with a more humane, efficient and less traumatising system expeditiously.
3. **Psychological assessment at point of arrival** should be carried out, appropriate treatment given and relevant information communicated to mental health services.
4. It is **essential that the requisite resources** are made available or developed and easily accessed for this group.
5. T**he necessary mental health skills and appropriate training along with protected time** should be provided in mental health services to care for the unique needs.

6. The asylum **process of those who arrive unofficially needs to be efficient, expeditious and fair**. The current system of review that results in protracted **legal processes needs to be reformed**.

7. S**pecialised services such as psychotherapy** that may be required for survivors of torture and other traumas should be available and accessible regardless of resettlement area.

8. The **needs of children must be included** in all plans for service delivery and they must **NEVER be required to act as interpreters**.

9. **Formal review of the use of interpreters** as well as **potential alternatives** such as training core staff in such skills.

10. **Identify** and work equitably with **potential leaders and advocates with experience** coming to and living in Ireland.

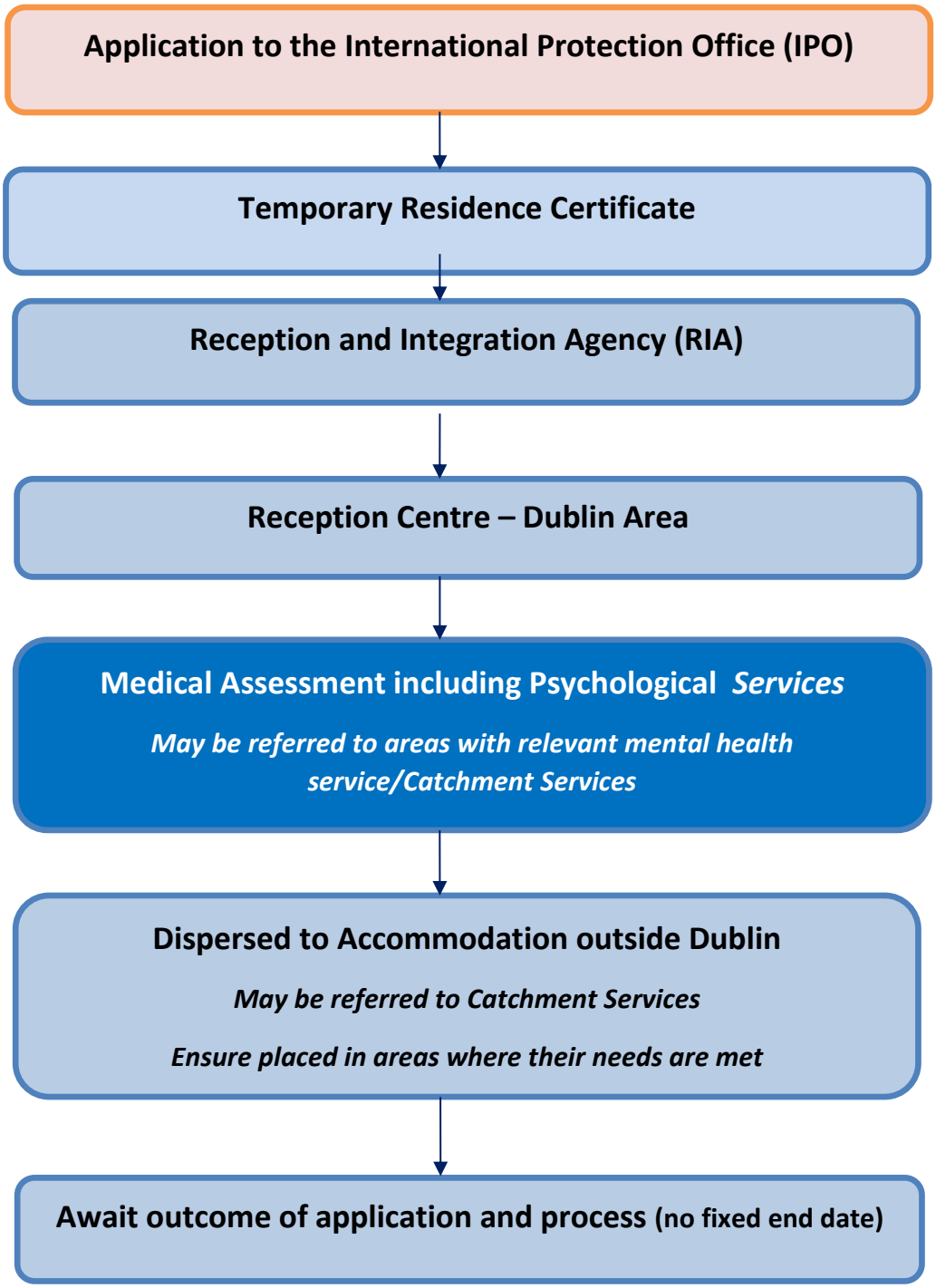
11. A **designated Consultant Psychiatrist** should be identified in each area in which a Reception Centre is located and provided with the necessary training, multidisciplinary resources and protected sessions to provide appropriate assessment and treatment to this group.

12. Set up **Consultant led Multidisciplinary Teams regionally** but at the very least, as a matter of priority, one team **nationally** to support all mental health services that provide treatment to asylum seekers, refugees and migrants

## Direct Provision

The utilization of Direct Provision which has been in place since 1999 has long outlived its purpose. It has left a significant number of people living in poor accommodation, living among strangers and allowing their abilities to self-care atrophy. They have little choice in their food intake and they are not in a position to cook for themselves. They are unable to access employment. The current desultory provision of €19.20 a week per adult and €15.60 per child is inappropriate. This programme urgently needs to be revised. Long term education, employment, and health needs of all asylum seekers, migrants, and refugees must be addressed in a timely manner. This echoes the recommendations of the Faculty of Public Health Medicine[ii].

## Meeting Mental Health Needs during the Asylum Seeking Process




- Designated Psychological Services are listed by RIA as available but no information regarding these is available to local services.
- SPIRASI (Spiritan Asylum Services Initiative) attempts to meet the needs of those who have endured torture but given its location in Dublin the use of a dispersal programme makes access problematic.
- There is no clear pathway for sharing of information between health professionals and as GPs are often not allocated until the asylum seeker has been in a "dispersed" reception centre for some time, a mental health review may be required before any clinical details have been transferred from the initial centre.
- There is no proactive or outreach programme within the current structure.

## Why are the mental health needs of this population different?

Unless you have witnessed war, atrocities, persecution, natural disasters and grinding poverty, it is very hard to comprehend the damage that these experiences can cause to the human mind resulting in psychological illness. Concerns exist in relation to family and friends left behind in the conflict zone. Travelling companions can become lost along the way. Many are suspected to have fallen victims to human traffickers along the migratory routes. Leaving aside the physical aspects of the migratory journey, this group of vulnerable people may have been the subject of sexual abuse (both male and female), exploitation, slavery, physical abuse and witnessing the deaths and abuse of family, friends and others on these long arduous journeys. Refugee camps can be very dangerous places especially for women and children. Sexual violence can be ignored by the mental health professional and not brought up by the victim due to a culturally based sense of shame.

In Ireland, we have neglected the needs and support requirements that many of this vulnerable population require. Little financial provision has been made to provide services by professional, regulated, state registered and fully trained mental health professionals who are able to provide targeted and specific care for the severely traumatised children and adults.

It has been the expectation to date that this group be assessed and treated by the local mental health services. This is seen as making their situation equitable to that of Irish Citizens however their needs and circumstances are not the same and therefore require a more nuanced response which cannot be automatically assumed available within generic services. These services are already overwhelmed and in many situations, are having major difficulties caring for the local indigenous population. Mental health services should be provided in a culturally and linguistically sensitive manner. This needs to be addressed proactively. This requires the funding of additional mental health sessions for this population given the complexities of their needs in the catchment areas where they are present in significant numbers.

Those who have endured mass violence, gender based sexual violence, torture, and abuse by their previous state authorities or other forces require a significant time to treat and help. Issues, such as trust; language; different cultural mores; stigma; religious beliefs; fear for the future; and the use of interpreters need to be tackled.

As noted in our August 2009 position paper[iii] refugees and asylum seekers suffer higher rates of anxiety and depressive disorders than other sections of society[iv]. They also have up to ten times the level of post traumatic disorder (PTSD) compared to the indigenous population[v]. For many refugees, migrants and asylum seekers the term post-traumatic stress disorder is not appropriate. This is because the process of migration into an alien and frequently hostile culture can mean that the trauma is still ongoing. It has not yet reached the “post” stage.

### *Pre – existing Mental Health Issues and Illness*

In addition to the adverse events that induced the mass migration and the migration itself, many people may have had their own pre-existing mental health problems that will now need to be cared for by a culturally different mental health care system and without the benefit of historic clinical records in most cases. Research has demonstrated that immigrants access mental health services at a lower rate than the indigenous population, despite this population’s greater need of mental health care[vii]. A reach out programme among refugees, migrants and asylum seekers, so that those who are manifestly ill are brought into a culturally sensitive service is required. There is evidence that psychosis is more common among refugees. Trauma may also be a factor in this regard. It has been demonstrated that refugees have a 2.9 times the risk (confidence interval of 2.3 to 3.6) of developing a psychotic illness than the

indigenous people of Sweden[viii]. Similar findings were obtained in Denmark[ix]. This underlines the requirement to have suitably trained, regulated and state registered mental health expertise primarily providing the mental health care. It has also to be remembered that experience of mental health services in the country of origin – possibly negative – may have an impact on attitude and engagement with Irish services. This and other barriers to accessing care need to be considered.

## The Barriers to Care for an Asylum Seeker

- Assignment to a GP
- Transport to GP
- Attitudes towards Mental Illness (Patient)
- Attitudes towards Asylum Seekers (Doctor)
- Understanding what the referral means
- Understanding the appointment letter
- Transport to the mental health service appointment
- Childminding
- Chaperones/cultural issues
- Availability of past records
- Language
- Integration with other services
- Psychotherapies not available in relevant language

## Children

***In 2015, 51% of refugees worldwide were children*.**

The mental health care of children is unique. They are the frequently forgotten element of the migrant crisis. Failure to deal with their needs can result in the storing up of social difficulties and mental pain that could have serious problems for the individual as well as society in the future. In 2015, 51% of refugees worldwide were children. Irish mental health services have reports of families sending their oldest son with relatives or friends who are migrating to ensure that the family line survives. Children are often separated from the families with whom they are travelling by well-meaning but misguided authorities. Sometimes these children are then exposed to severe risk when they are on their own. The World Psychiatric Association has emphasised the special mental Health needs of the children.[vi] As recommended by the European Society of Child and Adolescent Psychiatry (ESCAP) "organizations (including governmental) should release professionals to work with these populations"[vii]. ESCAP recognised that the financial resources of European countries are strained. It recommends that there should be a sharing between countries of state of the art knowledge which mainly focuses on the acute needs of refugees as well as the risk and protective factors in relation to child and adolescent mental health. The Direct Provision System does not provide the optimal safety environment for children.

## Recommendations:

1. Ireland should continue to honour the spirit as well as the letter of the **United Nations Convention on Refugees (1951) and the 1967 Protocol.**

2. The **Direct Provision System be replaced** by a more humane, efficient and less traumatising system. This should be implemented expeditiously.

3. **Psychological assessment at point of arrival** should be carried out, appropriate treatment given and relevant information communicated to mental health services subsequently involved in a timely manner.

4. The dispersal of refugees and asylum seekers around the country has several benefits as well as disadvantages. It is essential that the **requisite mental health resources** are made available or developed and easily accessible.

5. Those who provide mental health services for asylum seekers, refugees and migrants should have the **necessary mental health skills and appropriate training along with protected time** in order to care for their unique needs. It is not acceptable to consider this groups' situation as "equitable" simply because they can potentially access the same services. They need assistance in ensuring appropriate access and face numerous barriers (see Table 2) to obtaining appropriate care. In addition the generic services themselves cannot simply absorb this group without additional supports. There are no reports of mental health services in sectors where Reception Centres are located being allocated additional resources to assist them.

6. As insecure or unsuitable residency and associated fears of refoulment can contribute and aggravate any mental illness among this vulnerable group, the asylum **process of those who arrive unofficially needs to be efficient, expeditious and fair**. The current system of review that results in protracted legal processes needs to be reformed.

7. We endorse the recommendations of the Faculty of Public Health Medicine that **specialised services such as psychotherapy that may be required for survivors of torture and other traumas** should be available and accessible for those who need them, wherever they are resettled.

8. The **needs of children** involved in this process must be included in all plans for service delivery and they must **never be required to act as interpreters**.

9. We encourage a **formal review of the use of interpreters** throughout mental health services with particular attention to the governance currently in place as well as **potential alternatives** such as training core staff in such skills.

10. **Identify and work equitably with potential leaders and advocates** with experience coming to and living in Ireland.

11. A **designated Consultant Psychiatrist** should be identified in each area in which a Reception Centre is located and provided with the necessary training, multidisciplinary resources and protected sessions to provide appropriate assessment and treatment to this group.

12. **Consultant led Multidisciplinary Teams** should be set up regionally but at the very least, as a matter of priority, a team set up nationally to provide advice to all mental health services that provide treatment to asylum seekers and migrants as well as directly managing complex cases. This team would also develop appropriate services, in particular the psychotherapies required, and be responsible for the collection of relevant data collection including in relation to the use of translators**.**

**See Appendix 1 for suggested key role and responsibilities of a National Lead and of a Regional Lead Consultant Psychiatrists on the Refugee Team.**

## Conclusion

Ireland can no longer ignore or downplay the significance of the mental health needs of refugees, migrants and asylum seekers. It can no longer be assumed that their needs can be adequately addressed by generic mental health services without additional expertise, training or funding. This needs to be addressed in a coordinated, culturally sensitive and appropriately resourced manner. It is essential that the interventions required are provided by properly qualified, state registered, regulated and trained mental health professionals. Our primary objective is not just to address the psychological aftermath of initial traumatic experiences and subsequent forced flight, but to ensure that our response and offer of asylum does not worsen or add to that distress.

This paper was prepared by a working group comprised of Dr John Tobin, Dr Rachael Cullivan, Dr Helen Keeley and Dr Niall Crumlish and is an update of a previous position paper published by the College in August 2009**.**

## Glossary

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# Appendix 1

## *Example 1: Post and Role suggested outline*

## *National Lead - Consultant Psychiatrist in Refugee Mental Health–*

This is a post for a consultant psychiatrist with a special interest in mental health care of refugees and asylum seekers, and refugees from conflict zones ("refugees", for brevity, from this point).

This is the position of National Lead in Refugee Mental Health in keeping with the recommendations of College of Psychiatrists of Ireland Position Paper EAP/01/17 "The Mental Health Service Requirements in Ireland for Asylum Seekers, Refugees and Migrants from Conflict Zones".

It is anticipated that the position of National Lead will be undertaken on a full-time basis by a consultant general adult psychiatrist. It is anticipated that the role will include the duties of a Regional Lead (see '***Consultant psychiatrist on the Refugee Team – Regional Lead***'). The post is to be divided half time between "Regional Lead" and "National Lead" duties.

Given the sessional nature of the specialised service, any patient attending the Refugee Team for an episode of care must be referred by a CMHT and will by necessity remain under the care of a CMHT during the episode of care by the Refugee Team. Close liaison by the Refugee Team with CMHTs in the region for which the Refugee Team has responsibility will be central to the operation of the team.

***Key roles and responsibilities as National Lead:***

1. Develop national best practice methodology for assessment and treatment of refugees by a specialised Refugee Mental Health service.
2. Develop national guidelines for assessment and treatment of refugees by CMHTs.
3. Define the core clinical outcomes in refugee mental health.
4. Improve clinical outcomes for refugees with mental health difficulties.
5. Aim to ensure timely access to specialised care for referrers and patients.
6. Identify resource requirements for regional Refugee Teams and/or local CMHTs.
7. Define staff competencies and develop training programmes for specialised skills for those working with refugees, e.g. psychotherapies, pharmacotherapies, cultural competence, effective use of translators.
8. Develop and maintain a central database of referrals, service need, service provision, diagnosis, and outcomes for people availing of the Refugee Mental Health service
9. Collaborate with relevant Government departments and agencies, e.g. RIA, HSE, Department of Justice, Department of Health.
10. Collaborate with psychiatric and allied mental health colleagues in Ireland.
11. Collaborate with GPs and other medical and healthcare colleagues.
12. Liaise with international colleagues in refugee mental health.
13. Develop and maintain links with refugee advocates and advocacy organisations.

***Key roles and responsibilities as Regional Lead:***

1. Improve access for refugees to appropriate health services, mindful of the barriers to access, which may be cultural, linguistical, logistical, social, or financial.

2. Assessment of refugees and asylum seekers referred by community mental health teams.
3. Recruitment of multidisciplinary colleagues to form a team: necessary members of the team alongside a consultant psychiatrist are (a) a clinical psychologist to provide trauma-focused CBT and other applicable interventions, (b) a social worker, and (c) administrative staff.
4. Outreach to local migrant centres to identify cases likely to benefit from early or preventative intervention
5. Establishment of a local treatment program with an emphasis on the psychological sequelae of torture and displacement, including post-traumatic stress disorder.
6. Training in and use of standardised clinical measures in line with best international practice as agreed with the national lead in Refugee Care.
7. Data collection and audit on service demand, engagement and outcomes.
8. Liaison with local community mental health teams to provide support and guidance on culturally competent care as well as prompt feedback on assessments and future planning.
9. Delivery of training and education to:
    a. Adult CMHTs and approved centres
    b. CAMHS CMHTs and approved centres
    c. GPs and primary care teams
    d. Medical, nursing, and other healthcare students
    e. Advocates among the refugee and asylum-seeker populations and local organisations representing the interests of refugees and asylum-seekers
    f. Staff in RIA migrant centres
    g. Staff in schools and other educational facilities
    h. Other stakeholders
10. Liaison with local translating services to establish local best practice procedures.
11. Provision of medicolegal reports to the Dept of Justice and the Courts.
12. Provision of reports and local data to the national lead of refugee mental health care.

## *Example 2: Post and Role suggested outline*

## *Consultant Psychiatrist on the Refugee Team – Regional Lead:*

This is a post for a consultant psychiatrist with a special interest in mental health care of refugees and asylum seekers, and refugees from conflict zones (“refugees”, for brevity, from this point).

It is anticipated that the position of Consultant Psychiatrist on the Refugee Team will be undertaken on a part-time/sessional basis by a consultant general adult psychiatrist.

Given the sessional nature of the specialised service, any patient attending the Refugee Team for an episode of care must be referred by a CMHT and will by necessity remain under the care of a CMHT during the episode of care by the Refugee Team. Close liaison by the Refugee Team with CMHTs in the region for which the Refugee Team has responsibility will be central to the operation of the team.

**Key roles and responsibilities:**

1. Improve access for refugees to appropriate health services, mindful of the barriers to access, which may be cultural, linguistically, logistical, social, or financial.
2. Assessment of refugees and asylum seekers referred by community mental health teams.
3. Recruitment of multidisciplinary colleagues to form a team: necessary members of the team alongside a consultant psychiatrist are (a) a clinical psychologist to provide trauma-focused CBT and other applicable interventions, (b) a social worker, and (c) administrative staff.
4. Outreach to local migrant centres to identify cases likely to benefit from early or preventative intervention
5. Establishment of a local treatment program with an emphasis on the psychological sequelae of torture and displacement, including post-traumatic stress disorder.
6. Training in and use of standardised clinical measures in line with best international practice as agreed with the national lead in Refugee Care.
7. Data collection and audit on service demand, engagement and outcomes.
8. Liaison with local community mental health teams to provide support and guidance on culturally competent care as well as prompt feedback on assessments and future planning.
9. Delivery of training and education to:
    a. Adult CMHTs and approved centres
    b. CAMHS CMHTs and approved centres
    c. GPs and primary care teams
    d. Medical, nursing, and other healthcare students
    e. Advocates among the refugee and asylum-seeker populations and local organisations representing the interests of refugees and asylum-seekers
    f. Staff in RIA migrant centres
    g. Staff in schools and other educational facilities
    h. Other stakeholders
10. Liaison with local translating services to establish local best practice procedures.
11. Provision of medicolegal reports to the Department of Justice and the Courts.
12. Provision of reports and local data to the national lead of refugee mental health care.