THE MENTAL HEALTH SERVICE REQUIREMENTS FOR ASYLUM SEEKERS AND REFUGEES IN IRELAND

An Overview of the Problem

Asylum seekers and refugees are one of the most marginalised groups in Ireland.There is no national strategy to meet their mental health needs. The needs of asylum seekers did not feature in A Vision for Change (2006)[1]. Asylum seekers have higher levels of psychopathology than the general population. They suffer higher rates of anxiety and depressive disorders[2] than other sections of society. They have up to ten times the level of post-traumatic stress disorder (PTSD) compared to the indigenous population[3].

Turner (2003) found that about half a sample of 842 Kosovar refugees in the UK had post-traumatic stress disorder with substantial co-morbid depression and anxiety disorder[4]. When Summerfield (2003) evaluated the same group of refugees, on their subjective complaints, only a small number of the Kosovars considered that they suffered from a mental health problem.They saw their problems as concerns related to their current plight, such as leaving their family behind and attempting to find some sort of security in the host country[5].This highlights the importance of viewing the plight of the asylum seekers from their own perspective. Summerfield questioned the applicability of PTSD questionnaires that have been developed for the English-speaking World being applied to people of different cultures. There can also be an over reliance on the diagnosis of PTSD to the detriment of other stress related factors such as having to deal with their new environment, social isolation, marginalization, loss of social support, grief and concern for those left behind in their home country. Uncertainties related to the asylum seeking process[6] is a particular stressor.

Most refugees and asylum seekers have not survived a single clear-cut traumatic event, but a collection of negative experiences of war and oppression. A torture experience will not necessarily be clearly separated from the other experiences and for some torture was

not their worst experience[7]. There has been no consistent evidence in relation to an association between age or gender and vulnerability to develop mental health problems in the asylum seeking population. Much of the evidence is contradictory and reflects the difficulty of doing research with this population[8]. There is also the possibility that those who successfully flee their country may have a greater level of resilience than those who are unable or unwilling to flee and seek sanctuary elsewhere.

There is evidence that asylum seekers and refugees are more likely to present to the medical services with psychosomatic illnesses than indigenous patients[9]. This may be partly attributable to the higher rates of physical presentations of underlying psychiatric problems found in developing countries. Due to communication difficulties and the stigma surrounding mental health problems, patients may opt to present their emotional difficulties as a physical ailment with the result that anxiety and depression can be overlooked[10]. The level of depression among asylum seekers is higher than that of PTSD, even in those who have been the subject of torture[11]. Jablensky observed in a cross cultural study that the consistent core symptoms of depression were sadness, anxiety, tension, lack of energy, loss of interest, poor concentration and feelings of inadequacy and worthlessness[12]. A study performed in Galway examining the attendance of asylum seekers at primary care noted that asylum seekers were five times more likely to attend with a psychiatric condition than their matched Irish controls. They were three times more likely to have a diagnosis of anxiety and they suffered from a higher level of "generalised body aches"[13].

Asylum seekers are exposed to pre-migration stress, the stress of the migration and post-migration stress. Pre-migration stressors include experiencing atrocities, war, persecution, natural disasters, poverty, rape, torture and imprisonment. The migration process itself can lead to the asylum seeker being vulnerable to exploitation, which can be financial, physical, sexual and emotional. Incredible hardships can be endured as the migrant attempts to reach their ultimate destination. They are separated from their family and torn from their community. Once they arrive in Ireland it is not unusual for them to have little trust in state authorities. This may be in response to their previous experiences with the abusive agencies in their state of origin, prior to their migration. This can include a suspicion of members of the health profession. The inquisitorial process of seeking asylum does not help them overcome ingrained suspiciousness. A report from Holland found that if the asylum process was extended beyond two years, there was doubling of psychiatric illnesses[14]. Insecure residency and associated fears of repatriation contribute to the persistence of psychiatric symptoms and associated disabilities among refugees.

It has to be accepted that the asylum process is required to be rigorous in order to be fair to those who have a legitimate reason to be granted asylum. As well as having to adjust to a new culture the asylum seeker may be exposed to racism and a sceptical and hostile press. Asylum seekers are placed into a position of dependency on others. What skill and qualifications they possess may atrophy, as they are unable to utilize their abilities due to their status. All this can contribute to a loss of self-worth. As their self-esteem declines they can become less assertive in seeking out their basic human rights as well as seeking out necessary mental health care.

UK/Royal College of Psychiatrists perspective

The Royal College of Psychiatrists recognised that there are three main areas of required state action in relation to Asylum Seekers and Refugees.

1. A stated and enacted public policy that minimizes the impact of social risk factors for both physical and mental illnesses.

2. Equitable access to a full range of health, social care and legal services. These are best provided together at a designated centre, both for ease of access and to ensure that the needs of the individual are delivered in a coordinated manner.

3. Public bodies should deliver this care to the standard required by both national and international law[15].

Findings from an investigation into primary care in England found that "front-line staff do not think they have the right clinical skills needed to provide good quality care to refugees and asylum seekers"[16]. They expressed the view that clinicians need more training on the process of being granted asylum, the impact of forced migration, the human rights of refugees and asylum seekers and other relevant medico-legal issues. The anxiety that ensues from uncertainty in relation to their status within the country can be very significant. This can be compounded by a fear of deportation back to their country of origin and the dangers that they have fled from. In 2004, the non-government agency, Medecin du Monde which normally works in areas of conflict and severe deprivation; opened a special primary care centre for refugees and asylum seekers in the area of Tower Hamlets, in East London[17].

The current situation in Ireland

In 2002, the Irish Psychiatric Association recognised that the treatment of asylum seekers is a highly specialised area. It required a set of particular skills that were not normally found in a conventional mental health setting. This was particularly noted for asylum seekers who had experienced torture. They recommended that services be improved so that adequate and appropriate mental health interventions could be delivered to this vulnerable group stating: "Health services and mental health services should be systematically informed and trained for the reality that culturally sensitive mental health care is now a requirement of modern Ireland. The extra needs of non-national communities should be known widely and properly provisioned for"[18].

The current policy of dispersing asylum seekers around Ireland to avoid the development of ghettoes and to hasten their integration into the wider community can inadvertently lead to social isolation of the asylum seeker. This can aggravate any underlying mental health difficulties that may be present. Asylum seekers get little choice as to where they are domiciled. This can have a dislocating effect on them and it can be disruptive to the developments of social networks. They can be forced to live in accommodation with asylum seekers of other nationalities with whom they have little in common. This geographical spread has the effect that it impedes the development of expertise in relation to the treatment of asylum seekers within certain mental health centres. The constant movement of asylum seekers around the country can result in multiple assessments by different mental health teams, making it difficult to provide continuous consistent care.

The Irish Times, of 5th May 2008, reported that there were 6,844 asylum seekers living in 62 accommodation centres around the country in April 2008.Their asylum seeking status precludes them from obtaining employment. They were provided with accommodation, food and € 19.10 a week. As they await the results of the protracted process of being granted asylum, they are caught in a situation of dependency and idleness that can have a destructive impact on their self-esteem. This can lead to substance abuse due to boredom and aggravate any underlying mental health difficulties. The current arrangements for asylum seekers in Ireland leave them in a situation of controlled poverty. For the year 2003 and 2004, 2,798 people were held in prison in Ireland for immigration related reasons. In 2004, two thirds of those detained were held in prison for periods longer than 51 days[19].

What is being done in Ireland to address the needs of asylum seekers? SPIRASI, a non-profit agency, which is accredited by the International Rehabilitation Centre for Torture Victims, is attempting to fill the void in service provision for asylum seekers. In 2007, SPIRASI treated 892 victims of torture from 66 different countries. Its services are provided free of charge. Due to current financing difficulties, they now only take referrals from North East Dublin. SPIRASI in their communications with the College of Psychiatry of Ireland has emphasised the need for a professional network of interpreters and the requirement to train staff in how to work with interpreters. They have noted a tendency among the medical profession to inappropriately diagnose asylum seekers as mentally ill due to lack of cultural awareness.

Questionnaire Results

A questionnaire was prepared by the Irish College of Psychiatrists in 2008. It was filled out by 57 consultant psychiatrists who were selected from the 236 consultant psychiatrists who were members of the College and provided their e-mail addresses to the College. The vast majority of respondents recognised that asylum seekers were a particularly difficult group to treat and the majority felt they were under resourced to cater for their specific needs. There is recognition that due to the complexity of these cases, they required a higher level of mental health assessment and care than other members of the community. The complexity related to language barriers, difficulties with obtaining suitable translators, a lower level of trust on behalf of the asylum seekers in dealing with those in authority who were also aiding the asylum seekers, time constraints and cultural barriers in relation to talking about issues such as being the victim of torture, intimidation, physical abuse, sexual abuse and emotional abuse.

Half the respondents felt that asylum seekers were over-represented at the community mental health clinics in relation to their overall number within their catchment area. The continual movement of asylum seekers from one catchment area to another made it difficult to provide a consistent mental health intervention. There was a willingness to prepare the necessary medico-legal reports required for the asylum process and to provide the best quality service that they could deliver. There was a consistent opinion that there was a failure of the administrative element within the Health Service Executive to recognise that asylum seekers had special mental health needs and to provide the extra resources required. They considered that their clinics were already overburdened and under-resourced in relation to caring for the current indigenous population. There was a sense that they did not have the adequate resources to liaise with the outside agencies that are responsible for the asylum seekers. There was an acceptance that the psychiatric

reports that they were already providing require a high input of time and effort. The need to collect collateral information and adequate and appropriate translation services placed a high demand on clinical time. There was consensus that special skills were required and that transcultural psychiatry needs to be developed further.

Recommendations

1. Consultant led multidisciplinary teams with a special interest in the mental health of asylum seekers and refugees should be established in areas where the need warrants. The dispersal of asylum seekers within Ireland should take account of available access to these specialised teams where they are established.

2. Training in the transcultural aspects of psychiatry should be emphasised and the issue of establishing a special interest section in transcultural psychiatry should be considered.

3. Training courses on the preparation of psychiatric reports on asylum seekers should be provided by the College or other appropriate organisations.

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