- implementing a campaign targeting the stigma of mental health problems and psychiatric and psychological treatment in the migrant population.

While achieving these recommendations would require substantial input from various stakeholders, reforming the current set-up of mental health services available to refugees and asylum seekers could go a long way towards this.

The setting up of a multidisciplinary treatment centre for victims of trauma operating within the national psychiatric service and specialising in the treatment of PTSD and other trauma-related disorders, as well as comorbid presentations, could represent a useful first step. This centre would provide the ideal basis for the formation of a team, equipped with the necessary expertise about cross-cultural and refugee issues, that is dedicated to the mental healthcare of refugees and asylum seekers suffering from trauma-induced disorders and that could provide consultations for other mental health services, as well as offer a liaison service in detention. By establishing a regular presence in detention centres, through screening individuals considered at risk of mental health problems and conducting initial consultations of detained asylum seekers, this team could provide the much needed link between the detained individual and national mental health services.

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THEMATIC PAPER

Refugees, the asylum system and mental healthcare in Ireland

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The number of people seeking refugee status in Ireland is increasing year on year and the burden of mental illness experienced by refugees and asylum seekers is high. The College of Psychiatrists of Ireland has recommended the establishment of a number of specialist refugee mental health teams. In this paper we discuss the Irish asylum system, the Irish evidence regarding mental illness in this population, and current health service policy regarding refugee mental health. We propose a model of specialist refugee mental healthcare delivery.

Context

Applications for asylum in Ireland are increasing. In 2015, 3271 persons applied for refugee status, more than double the figure for 2014 and triple that for 2013, according to the Office of the Refugee Applications Commissioner (ORAC, 2015).

Asylum seekers in Ireland live in a system of direct provision and dispersal while waiting for a decision on their application. They are housed, often for years, in full-board accommodation in institutional settings. Asylum seekers do not have the right to look for work, are effectively excluded

https://doi.org/10.1192/S2056474000001082 Published online by Cambridge University Press

from higher education, and receive an allowance of just €19.10 per week per adult and €9.60 per child (McMahon, 2015).

The system of direct provision has come in for much criticism, from external agencies and from within government: in 2014, Aodhán Ó Riordain TD, Minister of State at the Department of Justice and Equality, which has responsibility for direct provision, described the system as 'not humane' (McMahon, 2014).

If an application for asylum is successful, then the applicant acquires refugee status and becomes entitled to the same rights as those enjoyed by any other non-Irish migrant living in the state. However, more than 90% of applications for asylum are unsuccessful (ORAC, 2015).

Mental illness among refugees and asylum seekers

There is substantial evidence of elevated rates of mental illness among refugees and asylum seekers. Refugees are up to 15 times as likely as the general population to be diagnosed with depression or post-traumatic stress disorder (PTSD) (Bogic *et al*, 2015).

Asylum seekers are more likely to experience mental illness than refugees, because of disproportionate exposure to post-migration stressors such as insecure residency and denial of the right to look for work; accordingly, amelioration of mental illness may depend on remediation of these stressors as much as it depends on access to treatment.

Certain specific therapies appear to be beneficial for those disorders that are highly prevalent among refugees and asylum seekers. These include cognitive–behavioural therapy (CBT) and narrative exposure therapy for PTSD (Crumlish & O'Rourke, 2010).

Mental illness among refugees and asylum seekers in Ireland

Irish studies point to high levels of psychopathology in refugees and asylum seekers and, in keeping with the international literature, there is evidence that asylum seekers are more at risk than refugees.

A study set in inner-city Dublin reported a lifetime prevalence of PTSD of 6% in a native Irish group and 47% in a group of refugees and asylum seekers (Wilson *et al*, 2013). A 2009 cross-sectional study of 88 asylum seekers and refugees living in the west of Ireland found that asylum seekers were six times more likely than refugees to report symptoms of PTSD and depression or anxiety (Toar *et al*, 2009). A study in general practice showed that asylum seekers were five times more likely to be diagnosed with psychiatric illness than Irish citizens (McMahon *et al*, 2007).

The potential adverse effects on asylum seekers' mental health of the system of direct provision were noted in a report by former High Court Justice Bryan McMahon commissioned by the Department of Justice and Equality (McMahon, 2015).

Mental healthcare for refugees and asylum seekers

Irish government policy

A Vision for Change is the blueprint for Irish mental health service development for 2006–16 (Expert Group on Mental Health Policy, 2006). It makes just one reference to the mental health of refugees and asylum seekers and makes no recommendations beyond culturally sensitive care. The Health Service Executive (HSE) is responsible for all publicly funded healthcare in Ireland. Its service plan for 2015 included the following objective:

> Enhance current structures and processes to ensure a comprehensive response to the health and care needs of asylum seekers and refugees with particular reference to people living in the direct provision system. (HSE, 2014)

However, there is no specific HSE policy on the provision of mental healthcare to refugees and asylum seekers.

Recommendations from the College of Psychiatrists of Ireland and international bodies

In 2009, the College of Psychiatrists of Ireland published recommendations in this area (Nwachukwu *et al*, 2009). The College noted the lack of a national strategy for refugee mental health and the key recommendation was the establishment of regional consultant-led multidisciplinary teams specialising in mental health services for refugees and asylum seekers.

The World Psychiatric Association (WPA) published recommendations regarding the mental health needs of migrants, refugees and asylum seekers (WPA, 2015). These were broadly on training and service provision rather than on specialised clinical services. They advocated training in cultural psychiatry and psychotherapy at undergraduate and postgraduate level. One recommendation was for service providers to train all staff in cultural competency. The WPA suggested that each clinical service, such as a hospital or clinic, should have a lead clinician responsible for cultural competency training and delivery.

The UK mental health charity Mind made recommendations on mental healthcare services for refugees and asylum seekers in *A Civilised Society* (Mind, 2009). Like the WPA, it urged wider awareness within statutory services of the needs of asylum seekers and refugees. Like the College of Psychiatrists of Ireland, Mind advocated the establishment of specialist mental health services.

Current practice in Ireland

The mental healthcare of refugees and asylum seekers is the remit of generic catchment-based general adult psychiatry community mental health teams (CMHTs). There are no specialised teams as recommended by the College. There is no additional resourcing or specific training for CMHTs with direct provision centres in their catchment areas, although a CMHT with such a centre in its catchment could be expected to

https://doi.org/10.1192/S2056474000001082 Published online by Cambridge University Press

have a greater demand for its services. When consultant psychiatrists in Ireland were asked, the majority of respondents reported that they felt underresourced to deal with the specific needs of asylum seekers, and that asylum seekers were 'a particularly difficult group to treat' (Nwachukwu *et al*, 2009).

Spirasi in north Dublin is an independent organisation established in 1999 to address the needs of individuals within the asylum process. It is not affiliated with any particular mental health team or other service within the HSE. Spirasi accepts referrals nationally and focuses its services primarily on survivors of torture, for whom it offers multidisciplinary assessments, medico-legal reports and psychotherapy.

Conclusion: how should Ireland proceed?

As the HSE recognises the health of refugees and asylum seekers as a priority (HSE, 2014), as refugee numbers increase (ORAC, 2015) and as *A Vision for Change* expires in 2016, it is timely that a national strategy be put in place. A reasonable place to start is with the College's recommendations (Nwachukwu *et al*, 2009), informed by the recommendations of the WPA (2015) and Mind (2009).

A national programme of mental healthcare for refugees and asylum seekers could begin with the establishment of regional specialised teams. Each team should be led by a consultant psychiatrist trained in refugee mental health or transcultural mental healthcare. Each team must have ready access to interpreters and should include at least a trainee psychiatrist, a social worker, an occupational therapist, and a clinical psychologist with training in relevant treatment modalities such as trauma-focused CBT and narrative exposure therapy (Crumlish & O'Rourke, 2010).

The question of which region each team should cover, not addressed by the College, may have an intuitive solution. The HSE's National Service Plan organises hospital services into hospital groups, six of which are adult hospital groups (HSE, 2014). Three hospital groups serve greater Dublin, one serves the greater Cork region, one Limerick, and one Galway. Each hospital group comprises a minimum of six hospitals across a minimum of four counties. One specialist refugee mental health team could serve each hospital group. (Child and adolescent refugee mental healthcare does not map on to this model as there is just one national children's hospital group and we do not venture a model of child and adolescent care in this paper.)

Regional specialised teams could adopt a three-pronged approach: specialised clinical care, training, and advocacy.

Given the wide geographical area each specialist team would serve, we would not envisage the specialist team taking over the care of each patient referred. The role of the CMHT would remain central. Rather, we propose that the clinical service be a tertiary service, accepting referrals from CMHTs, providing a comprehensive assessment and where appropriate a package of multidisciplinary treatment, and referring back to the CMHT with advice for further management.

Each specialist team should train local professionals, and one member of each team could take on the role of lead clinician for cultural competency in mental health within each hospital group, in keeping with the recommendations of the WPA (2015).

Finally, bearing in mind that the mental health of asylum seekers is strongly influenced by post-migration stressors, that direct provision negatively affects mental health (McMahon, 2015) and that decisions about how the state treats asylum seekers are political decisions (McMahon, 2014), specialist refugee mental health teams will be well positioned to advocate for what the Minister of State for Justice and Equality would term the 'humane' treatment of people in Ireland's asylum system.

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https://doi.org/10.1192/S2056474000001082 Published online by Cambridge University Press