
Psychotherapeutic Care for refugees in Europe¹

¹ This report includes results from the EU member countries Austria, Belgium, Cyprus, Germany, Greece, Hungary, Ireland, Italy, The Netherlands, Poland, Portugal, Sweden and the United Kingdom and also from Switzerland.

Foreword

Every person with a mental disorder needs support and professional help – regardless of his or her residency status. People who are forced to leave their home countries due to war and violence are especially vulnerable. Many of them experienced traumatic events prior to their arrival in a hosting country and the asylum process itself may even exacerbate the psychical health situation – in particular the fear of detention and a lack of appropriate health service and support. Many of the refugees are traumatised, psychologically burdened or ill and need help at different levels of care.

To deepen our understanding how other countries are organising the care for refugees and which challenges they face, the BPtK gathered international experiences of experts in this field – psychologists, psychotherapists, doctors and health managers – to draw a picture of the situation and to give hints to needed changes. We received feedback to our structured questionnaire from experts in Austria, Belgium, Cyprus, Germany, Greece, Hungary, Ireland, Italy, the Netherlands, Poland, Portugal, Sweden, Switzerland and the United Kingdom.

We wish that the outcomes of this survey will contribute to developing psychotherapeutic care for refugees at the national and the European level to the benefit of all concerned – and the society at large.



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1 General remarks, findings and need for action

- General remarks

In 2015 a total number of 1,255,640 asylum seekers sought shelter in the EU Member States. During the first three quarters of 2016 951,100 people applied for asylum in the EU member countries.² The provision of care to refugees³ has become a substantial challenge for the health systems in the hosting countries.

The BPtK is engaged in the topic of psychotherapeutic care for refugees. In this context we undertook a stocktaking process on the situation of care for refugees in the different European Countries to deepen our understanding of how the matter is being addressed in other countries. Based on a structured questionnaire, including open answers, we asked experts from institutions that are engaged in the psychotherapeutic care for refugees – such as reception and welcome centres - researchers at universities and representatives of professional organisations in the field of psychotherapeutic care about the treatment conditions, best practices and needed changes in the care for refugees in their country. The survey was assisted by the members of the Network for Psychotherapeutic Care in Europe (NPCE) and received support from the European Society for Traumatic Stress Studies (ESTSS). Overall we obtained feedback from 17 experts – psychotherapists, psychologists, medical doctors and health care managers – from 14 different European countries.

We can assume that a significant percentage of refugees is affected by a mental illness in need of treatment. Health care in Europe is organised at the national level. Health care provision and in particular psychotherapeutic care for refugees differs vastly between the individual European countries. The extent of care varies between wealthy and poorer states, the organisation is different between tax funded systems and those based on contributions of employers and employees. For instance in Sweden each asylum seeker is subjected to a health screening which includes a medical consultation with a doctor concerning the physical and mental health of the refugee; an interpreter will assist with this consultation, if necessary. In other countries, however, no medical service beyond emergency treatment is provided or it must be paid for by the individual. In yet other countries basic care is delivered by volunteers and private sponsors. While some countries may by law provide equal treatment to asylum seekers and citizens alike, refugees may still not

² Source: Eurostat "Asylum applicants in the EU Member States" (2016)

³ Refugees are people who are forced to leave their home country either temporarily or permanently because of political repression, war or life-threatening hardship. Legally, there is a distinction between asylum seekers on the one hand and refugees that have successfully completed their asylum recognition procedure.

be entitled to outpatient psychotherapy treatment, if health insurance does not cover psychotherapeutic treatment for their members either. Psychotherapeutic care for refugees under such conditions may even meet with reservations by the local population.

Due to the fact, that national refugee and reception systems in the EU differ to a great extent, in consequence each country participating in the survey gives voice to special concerns. On the other hand, we found examples of good practices of psychotherapeutic care in the various countries that are transferable and worth to become implemented in other countries as well.⁴

- **Findings**

- Though the prevailing conditions amongst the member states may differ in terms of performance requirements and the resources that are available to provide care for refugees, the challenges of meeting their needs do not. Following are key results and concerns and insights into need for action:
- Recent data-based studies in different countries confirm the higher prevalence rate for post traumatic stress disorder (PTSD), depression and further mental disorders amongst refugees.
- There are substantial gaps in provision of care; more coordination and cooperation amongst the responsible authorities and services is needed.
- Most of the mental health professionals are not sufficiently trained to meet the special challenges in the care for refugees.
- There is a lack of availability of specialists for mental health diagnoses (including indications for psychotherapy) and for assessing evidence and signs of torture.
- The lack of interpreters may lead to inaccurate examination results and treatment.
- Coping with trauma is often impossible if environmental conditions such as living and asylum procedures are bad. The living conditions and long procedures themselves become a source of stress and are the cause of a higher risk for mental disorders.
- Healing a posttraumatic stress disorder (PTSP) is not possible under insecure perspectives for a refugee's future life.
- Basic care only for severe somatic illnesses does not take into account consequences of non-treatment and negative long-term effects of PTSD. The longer a person in need of therapy goes without help, the greater the risk of reaching a

⁴ Examples of good practice are highlighted in the specific country reports.

crisis point, when more intensive support is needed. Access to services should therefore be timely, which includes making sure that vulnerable migrants know what support is available and where and how to access it.

- Current restrictions in several countries in legislation linked to asylum and family reunion produce crisis reactions.
- Psychotherapy may be unusual and may even be a cause of shame for the refugee. Most of the refugees first of all try to integrate and get over their past. It is to be expected that a given traumatisation and the need for psychotherapeutic treatment may evolve over time.
- There should be low barriers and different approaches to address the needs of refugees with mental health problems. Refugees themselves should be trained and employed to support the access to an appropriate treatment.
- Mutual understanding, empathy, respect and a sense of understanding in the relationship between refugees and the citizens of a country is essential. Dealing with refugees is not a one-way relationship, and therapists and society also can learn something significant from the people seeking shelter in their country.
- There are gaps in field-related research.

The responses show a need for action in different fields. There are challenges at the legislative, the organizational and the therapeutic level. To cope with these challenges is vital for the societies and the people and would be protecting and promoting human capital both of the migrants and refugees and of the native citizens.

- **Need for action**

Need for action: Legal Challenges

- Mental health of refugees has to be taken more into consideration in European and national law and policies. It is necessary to raise awareness and enhance sensibility for the psychotherapeutic needs of refugees in the political debate and to acknowledge that refugees are especially vulnerable and that the “essential treatment” they can claim focusses on physical diseases and does not take the mental health and psychological needs sufficiently into account.
- Improve the legal framework: clearly defined rights and the full implementation of Directive 2013/33/EU of the European Parliament and of the Council, which provides the required medical and other assistance for persons with mental illnesses and those who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, into the national laws is needed.

- Improve the availability of psychotherapeutic care and the accessibility to services for all people in need, national citizens and refugees alike.
- Legal rights have to be transferred into practice.
- Create the legal base within the health care system for multi-disciplinary services and ensure that people with special psychological needs do not fall through the gaps in the system of care.
- Take measures to make asylum procedures faster.
- People with mental health problems should only be subjected to detention in very exceptional circumstances.

Need for action: (Technical) requirements for successful work

- Transfer successful pilots into the regular health care system and make best practices available on a broader basis.
- Secure permanent funding. More government funding and higher special budgets at national and international level for the funding of services is needed.
- Establish networks and pool competences. Build a clear framework for the provision of services.
- Install coordination centres and working groups that coordinate care and bridge gaps between different services such as reception centres and outpatient care. Build capacity and expertise within psychiatric hospitals.
- Enhance cooperation between different bodies with responsibilities, in particular between the health care system and community services.
- A particular problem is the lack of interpreters for patient care and treatment. Funding for language mediators is essential.
- Provide money for research.

Need for action at therapeutic level

- Treating traumatised refugees is a specialised area of health care. It is necessary to find the human resources, to implement appropriate specialised training and supervision to ensure an adequately skilled staff. Everyone who becomes involved in the provision of (psycho)therapeutic care to refugees must acquire new skills and competences at a professional level.
- Implement mechanisms to adequately diagnose illnesses, including a screening process not only for communicable diseases but also for mental health issues.
- Persons suffering from trauma need to find themselves in a safe and secure living environment. This includes a halt to deportation when psychotherapy has started.
- Offer a stepped care process ranging from self-help, lay assistance, low-level psychosocial primary care to long-term psychotherapy.
- When face-to-face help is not possible, internet-based programmes may be useful.
- Reduce long waiting periods.
- Assure continuity in treatment in case an asylum seeker is transferred to another reception centre during treatment or if his/her status changes.
- Adapt psychotherapeutic concepts to the special needs of refugees.
- Develop (child-friendly and culture-sensitive) concepts especially for refugee children.
- Choose a multi-professional approach and create a team spirit and collaboration amongst all service providers.
- Interpreters need to be specially trained so that their skills include an understanding of the culture of the refugee group and not just its language.
- Psychotherapists should engage in diversity groups between citizens and refugees to enhance the coming together and reduce fear and insecurity amongst the population towards refugees. Social support and contact is needed as much as professional help.

2 Country Reports

- Austria

Prevalence: Experts in Austria assume that about half of the refugees are suffering in some way of consequences from psychological trauma and need help due to these problems.⁵

Legal framework: In Austria, refugees are assigned an insurance number and they obtain the insurance card for free health care. The psychotherapeutic care they receive is the same as for every citizen. But there are limitations so far, as the access to free psychotherapeutic treatment is restricted also for Austrian citizens.⁶ There are waiting lists for all those in need of psychotherapeutic help.

The costs are borne by health insurance funds and the European Asylum, Migration and Integration Fund (AMIF), but the latter is only accessible for greater associations. Therefore 11 organisations made a reunion to achieve money from the AMIF. There is also support of projects by the Minister for Internal Affairs and Donations.

Treatment and organisation of care: There are a number of counselling institutions like Caritas, Hemayat and the “you-are-welcome” Association that provide limited places. All psychotherapists and medical doctors with and without an education in psychotherapy are authorised to treat refugees. Language interpreters are available for the medical service and in the refugee camps.

There are special treatment centres and institutes specifically for mentally ill refugees such as the ESRA Center in Wien, Hemayat, the Welcome-Center, the Caritas Counselling Center, the outpatient department of Sigmund Freud University.

⁵ Press conference on the occasion of the Alpacher Gesundheitsgespräche, August 23, 2016.

⁶ Health insurances cover part of a therapist’s fee and are obliged to subsidise a therapeutic session with at least 21.80 EUR. In several Austrian states, fully paid-for psychotherapy is available but access is highly restricted.

Austria: Best-practice examples Hemayat and “Welcome Center”

Hemayat was developed after the Bosnian war. “Hemayat” in Arabic means protection and support. “Hemayat” is a politically independent and non-profit organisation. They provide interpreter-mediated psychotherapy, psychological consulting and medical support for survivors of war and torture. They offer psychotherapy for about 500 persons with translators.

The Welcome Center has three departments: One offers interpreter-assisted psychotherapy provided by Austrian volunteer psychotherapists and Arabic and Farsi-speaking psychotherapists that have not obtained a work permit. The second offers integration opportunity in a social group with support for everyday needs. The third facilitates integration in some intercultural projects.

Training: There is no special training required by law, but many therapists have taken it upon themselves to improve their knowledge in order to treat refugees with traumas and with other migration-related problems. Institutions like Caritas, Red Cross, the University of Medicine in Vienna and the associations for psychotherapy offer training in diagnosis and documentation (according to the Istanbul protocol) of trauma, in cultural sensitivity, in assisting with problems of migration and flight, their effects on the helpers and in psychosocial integration.

Needed changes:

- Participation of all insurance companies: Austria has a lot of insurance companies, but only one is involved in providing care for refugees.
- Creating a procedure for small teams to obtain financial support for psychotherapy and interpreters.
- Provide money for research.
- A halt of deportation once psychotherapy has started.

Further important aspects:

- There has to be a balance between the needs of refugees and the needs of citizens for psychotherapeutic help. If the provision of psychotherapeutic care that is covered by health insurance is insufficient for the citizens, it will be difficult to explain why refugees should have extensive access to psychotherapeutic care. Hence, the availability of psychotherapeutic care needs to be improved for everyone.

- Psychotherapy is very unusual and even a cause of shame for the most of the refugees. Also, they try to reintegrate and forget the past. Social support and contact are often more needed than psychotherapy.
- Many of the refugees haven't had an education in their country, by consequence not all are able to learn in an effective way. So learning to learn also could help to overcome stress in the new country where the integration is strongly connected to language skills.
- Psychotherapists should not only offer psychotherapy, but also engage in diversity groups between citizens and refugees to enhance a coming together and reduce fear on both sides.

- **Belgium**

Legal framework: There is no legal framework for psychotherapeutic care in Belgium so far, psychological, psychotherapeutic or psychosocial care to refugees is offered by psychologists, social workers, nurses and others. On May 10th 2015 a law passed regarding Clinical Psychology and Clinical Orthopedagogy and it is being applied since September 1st 2016. It states psychotherapy as an activity offered by medical doctors, clinical psychologists and clinical orthopedagoges. The specific realization of this law is still in process and will be enforced by several royal resolutions.

Asylum seekers in Belgium have access to psychological and psychotherapeutic care according to a specific guideline issued by the Federal Agency for the reception of asylum seekers (FEDASIL). The agency is responsible to enforce European and Belgian laws regarding refugee policies⁷. Fedasil bears the cost of psychotherapy or psychological counselling of asylum seekers in private practices for two consultations a month, or for 6 weekly consultations, after seeking medical approval in case of urgency (which can be extended with another report).

Psychotherapy or psychological counselling in public mental health services are provided by the regional Flemish government (Departement of Welfare, Public Health and Family). The frequency of those therapies is determined by the health care provider.

In case of hospital admissions or psychiatric consultations, Fedasil settles the costs through a medical warranty.

⁷ In regard to proper reception assistance, Fedasil is in the process of defining the criteria "extra vulnerable asylum seekers".

For Not Accompanied Minors Fedasil bears the global costs for housing etc. to the organisations fulfilling this needs. The cost for psychotherapy has to go from this global budget.

After receiving their asylum status, refugees are initially given a living allowance by the public social welfare centre OCMW of the city/village they live in. It depends on the OCMW whether they will reimburse psychotherapeutic care at a private practise. Most often the OCMW will not pay for psychotherapy and refer people to public services. Because these mental health services are public and the costs are low, they are affordable for most people. They are supposed to work with translators too, without any extra costs for the refugees. Hospital costs will be paid for by the OCMW. Once refugees earn their own income, the OCMW will no longer be in charge of them and any costs incurred for care. However they can and do this in exceptional cases.

Asylum seekers who have been granted the refugee status have equal access to medical care as Belgian citizens. On a national level, psychological and psychotherapeutic care is still not reimbursed in Belgium. Accessibility of public mental health care centres is limited by long waiting lists.

Asylum seekers who are not granted a refugee status or subsidiary protection will not get any financial support and are considered 'illegal' by the government. It is very hard for them to find psychotherapeutic care. A small network of volunteers provides some of them with psychological care.

Treatment and organisation of care: In Belgium the reception of asylum seekers is organized either in collective centers or in individual housing.⁸ The collective housing is organized by Fedasil, the Flemish and the Wallon Red Cross, private initiatives and some smaller partners. All collective aid falls under the coordination of Fedasil and should, according to their rules, include medical and psychological care.

The medical or psychosocial staff of a reception centre often knows about possibilities to find psychotherapists (in proximity of the centre) who have the experience and the willingness to work with refugees. Many psychotherapists, clinicians, and mental health providers are not keen to offer services to asylum seekers and refugees.

Often, even within mental health services and hospitals, the care for asylum seekers and refugees is taken on by a few team members.

⁸ Allison Male, Angie Huyskens: **Assessment Report Mental Health Services for Migrants in Belgium**,⁶ January 2016- 11 March 2016.

Individual housing is organized by OCMW/CPAS on demand from and funded by Fedasil, but the medical care of these people is not covered by Fedasil but by POD MI, a federal government fund for disadvantaged people to provide urgent medical care. In the individual housing setting there is even less knowledge available in referring the appropriate asylum seekers to psychotherapy than in the collective centers.

Training: Most often people with particular interests in refugees and this line of work specialize on their own or through their organisation. Meanwhile awareness for training was raised both in government circles as in direction boards of institutions. Training opportunities are very diversified. The experience of psychotherapy for refugees is much broader in the multicultural cities of Brussels, Antwerp and Gent. Those cities have networks for culture sensitive practice. One of the main functions of those networks is to organise intervention groups to healthcare workers.

In Flanders there are interpreter services for social service agencies. Institutions can solicit interpreters and only a small amount of the total cost will be paid by them, the rest will be for the government. Interpreters can come on site, translate by phone or even by video conferencing. For mental health services and hospitals it doesn't matter what residency status the refugee has, the availability and cost of social interpreters stays the same. When asylum seekers get counselling in a private practice, paid by Fedasil, then the interpreters are also reimbursed by Fedasil. Once they are recognised as refugee then interpreters in private counselling practises are no longer paid by Fedasil. Usually, this means interpreters are rarely solicited for private counselling as the costs become too high for refugees to pay for, only in rare occasions the OCMW steps in.

Belgium: FDGG handbook on best practices

The FDGG, Federation for Mental Health Services, bundled in a book "Goede praktijkvoorbeelden uit de hulpverlening aan vluchtelingen - Handboek" (2005). In this book some health care professionals with a long time experience in working with refugees and migrants explain their methods and guidelines. (Link to download this book: <https://www.pigmentzorg.be/toolbox/fiche/goede-praktijkvoorbeelden-uit-de-hulpverlening-aan-vluchtelingen>)

Belgium: Mindspring

Mindspring is a groupstraining and psycho-education about stress. It focus as wel on the burden of stress for asylum seekers and refugees as on there resilience. The training is given by a refugee and in the mother tongue, or a common second language, of the asylum seekers. See <http://www.mindspring.be/>

Needed changes: The following changes are highly recommended:

- **Interpreter services should be more accessible for everyone to use:** Interpreter services should be more accessible for everyone to use, also private counselling practices who offer counselling to the most vulnerable people in our society. So there needs to be more government funding for these services (Actually there is a reverse tendency, funding diminishes because politics claim that refugees should learn the language as soon as possible).
- **Offering and reimbursement of psychotherapy:** The offering and reimbursement of psychotherapy for asylum seekers and refugees should start from a general vision. At this moment the arrangement is diverse and complex. There are ad hoc solutions given. These solutions are not bad, but the complexity makes it difficult to know who can get psychotherapy by which rule, supported by which organisation.
- **Training public mental health services:** The public mental health services should receive more training in trauma, working with interpreters and cultural sensitivity in order to offer high quality mental care to asylum seekers and refugees - there is a discrepancy in the mental health care system for asylum seekers (better) and refugees, who have been granted the refugee status. It would be good to ensure a minimal continuance.
- **Continuity - refugee consulting in a private practise:** For a psychotherapist working in a private practice there is the 'insecurity of continuous care' for these clients. Asylum seekers can be transferred to another reception centre during treatment and this often means that they can't consult a psychotherapist anymore because of long travel distances. Changes in the status often means that clients have to pay for therapy (and translators) themselves and in most cases they cannot afford this. Sometimes, other agencies (like the OCMW) can pay for their counselling but this entails a period of administration, application and waiting for a decision.

As a result from this insecurity of continuity the therapist often sticks to stabilisation and does not start with trauma confrontation. Guarantees in regard to continuous care might enable trauma work in certain cases. Knowing a reasonable time frame for the client to stay in treatment wouldn't make a therapist too cautious as to the point of avoiding trauma treatment.

- Allowing psychotherapists/psychologists/and other carers to be familiar working with interpreters.
- Build capacity and expertise within psychiatric hospitals (or hospital wings) to treat refugees.
- Taking mental health of refugees more into consideration in European and Belgian laws/policies

- **Cyprus**

Prevalence: In Cyprus, there are no official data from epidemiological studies available regarding the prevalence of mental disorders amongst refugees, but expert experience show a high demand for services among this population. As part of another field observation study conducted in a refugees' camp in Cyprus researchers noted an increased self-blame of individuals being rescued as per the part of their families left behind and in an immediate danger and intense emotional states (e.g., anger) as part of developing beliefs that Cyprus has nothing to offer to them and feeling “trapped” in an island.

Legal framework: In Cyprus, the Council of Ministers defines the national strategy for preparedness for and response to emergencies. An interministerial committee is responsible for initiating the national strategy, which defines an overarching operational plan called “Zenon” or the Basic National Plan (BNP). Within the framework of “Zenon”, each Ministry, including the Ministry of Health, is responsible for drafting and implementing sectoral plans called Specific National Plans (SNPs). However, the operational complexity of a response to sudden, multiple, large arrivals of migrants by sea and/or land, coupled with the existing shortage of health workers, poses serious challenges to the capacity of the health system to respond to such events.

Treatment and organisation of care: In principle refugees are entitled to psychotherapeutic treatment, but a lot of times they may not know how to connect to receive services or the services may have a large waiting list.

The public mental health sector under the supervision of the Central Mental Health directory of the Ministry of Healthcare is responsible for providing the therapeutic care of refugees in Cyprus.

Public mental health services have a part-time psychiatrist in charge, receiving request for psychiatric care in a near the main camp in Cyprus once a week. Two Clinical Psychologists are in charge once per week, and two clinical psychiatric nurses once per week likewise. An “Info-Bus” unit (an NGO organization), is a mobile unit that acts as a service at the front line, offering services to refugees. A primary health care center near the main refugees' campus is in charged every Wednesday to provide psychosocial support to refugees upon request from social workers working at the main campus.

There is one specific budget in each Ministry, including the Ministry of Health, for emergencies which may bear the cost for the mental health care of refugees. Also, the European Coordination Section of the Ministry of Health has received funds from the European

Union for the care of asylum-seekers/refugees. The burden falls for the government to fund it via its health care plans.

Training: Caregivers are not specially trained. Cultural mediators are not systematically present in psychotherapeutic services, nor are they systematically present in migrant centres. If available, migrants with a knowledge of Greek or English provide interpretation services for other migrants and mental health providers. Also, if mental health providers request an interpreter, the migrant center, upon availability, can offer an unofficial interpreter.

Needed changes:

- A clear framework of needs and who can provide services (trained personnel) is necessary.
- Also funding of services is an issue.
- Specific recommendations include the following items:
 1. Create a team spirit and collaboration of the service providers.
 2. Good supervision for the service providers, e.g. especially in regards to act professionally and collectively and exploring emotions related to hopelessness and burn-out issues following a full day-care.
 3. A specialized training of all involved in trauma-related conditions, religious issues and cultural differences.
 4. A deeper understanding of crisis intervention in vulnerable populations.
 5. A use of manual for best practices and approaches
 6. Psychologists in the front line must be able to handle crisis at any given moment as their mood swings can “kick in’.
 7. The use of language, which is an especially important concept dealing with this population, should be further addressed in all campuses with specialized interpreters.
 8. Therapists which will be able to have the flexibility to use different approaches with this population.

- Germany

Prevalence amongst adults

Two studies among asylum seekers in Germany were conducted to determine the prevalence of PTSD (post-traumatic stress disorder) as the most frequent mental illness in the wake of traumatic experiences. According to one study⁹, which was conducted in cooperation with the Federal Office for Migration and Refugees (BAMF), 40 percent of asylum seekers were suffering from PTSD. The asylum seekers had been in Germany for one to two months on average and had been randomly chosen for the study.

In another, more recent study¹⁰, a PTSD rate of 20.5 percent was found. The participants were asylum seekers in the central initial registration facility in Bavaria that either volunteered or were chosen randomly.

In addition to that, Kröger et al¹¹ undertook a study in the summer of 2015 with 280 adult refugees in the state refugee reception centre Niedersachsen. The prevalence rate for a possible PTSD was 24 percent. The rate amongst refugees from North Africa was highest.

Other than PTSD, depression, anxiety disorder, psychosomatic conditions and addictions are frequent. Almost two thirds of all refugees (63.6 percent) suffer from a mental illness. One in five refugees (21.9 percent) is suffering from depression.¹² For roughly one quarter of the refugees a moderate depression is suspected and for 9 percent a severe depression.¹³

The asylum seekers that participated in these studies came in part from other countries of origin than the refugees currently seeking protection in Germany. More than two thirds of the persons that have applied for asylum in Germany since January 2016, come from

⁹ Gäbel, U., Ruf, M., Schauer, M., Odenwald, M. & Neuner, F. (2008). Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. *Zeitschrift für Klinische Psychologie und Psychotherapie*, 35 (1), 12-20.

¹⁰ Richter, K., Leheld, H., Niklewski, G. (2015). Warten auf Asyl: Psychiatrische Diagnosen in der zentralen Aufnahmeeinrichtung in Bayern. *Gesundheitswesen*, 77 (11), 834-838. In an older study by the same authors (Niklewski, G., Richter, K., Leheld, H. 2012) prevalence rates were as follows: 33.2% post-traumatic stress disorders; 21.9% depressive disorders.

¹¹ Kröger, C., Frantz, I., Friel, P. & Heinrichs, N. (2016). Posttraumatische und depressive Symptomatik bei Asylsuchenden. *Psychotherapie und Psychosomatische Medizin*, 66, 377-384.

¹² Richter, K., Leheld, H., Niklewski, G. (2015). Warten auf Asyl: Psychiatrische Diagnosen in der zentralen Aufnahmeeinrichtung in Bayern. *Gesundheitswesen*, 77 (11), 834-838.

¹³ Kröger, C., Frantz, I., Friel, P. & Heinrichs, N. (2016). Posttraumatische und depressive Symptomatik bei Asylsuchenden. *Psychotherapie und Psychosomatische Medizin*, 66, 377-384.

the warfaring and crisis-ridden countries of Syria, Afghanistan and Iraq.¹⁴ It is therefore likely that these persons have mostly gone through traumatic experiences and are mentally ill. According to the S3 guideline for PTSD, 50 percent of victims of war, displacement and torture develop PTSD. Since refugees often experienced war and violence in their home countries and went through life-threatening situations during their flight, it is hardly surprising that mental illness among refugees is more frequent than among the German population. Even in the German population almost 30 percent of all adults develop a mental disorder at least once per year.¹⁵

The high mental stress on refugees was also evident in a survey conducted by the Institute for Employment Research (Institut für Arbeitsmarkt- und Berufsforschung) of the German Federal Employment Agency.¹⁶ The 2,300 refugees that were surveyed rated their state of health higher as the German comparison group did but this result was the reverse for psychological symptoms such as depressiveness. Refugees were on average more frequently depressed than German respondents (value of 1.85 respectively 1.56 on a scale of 1 to 4).

Prevalence amongst children and adolescents

Almost one in five children of asylum seekers (19 percent) suffer from PTSD.¹⁷ A study examined children and adolescents between the age of 7 and 16 years living in 13 state-funded community houses for asylum seekers in Baden-Württemberg. The children and adolescents had on average already been in Germany for 43 months.

This result corresponded to a recent study of Syrian refugee children that was conducted in an initial registration facility in Bavaria. There as well approximately one in five children (22 percent) was suffering from PTSD. Altogether more than one third of Syrian refugee children were mentally ill.¹⁸

¹⁴ http://www.bamf.de/SharedDocs/Anlagen/DE/Downloads/Infothek/Statistik/Asyl/aktuelle-zahlen-zu-asyl-november-2016.pdf?__blob=publicationFile

¹⁵ Jacobi et al. (2014). Psychische Störungen in der Allgemeinbevölkerung – Studie zur Gesundheit Erwachsener in Deutschland und ihr Zusatzmodul Psychische Gesundheit (DEGS1-MH). *Nervenarzt*, 85, 77-87.

¹⁶ IAB – Institut für Arbeitsmarkt- und Berufsforschung (2016). IAB-Kurzbericht – IAB-BAMF-SOEP-Befragung von Geflüchteten – Flucht, Ankunft in Deutschland und erste Schritte der Integration. Available at: <http://doku.iab.de/kurzber/2016/kb2416.pdf>.

¹⁷ Ruf, M., Schauer, M. & Elbert, T. (2010). Prävalenz von traumatischen Stresserfahrungen und seelischen Erkrankungen bei in Deutschland lebenden Kindern von Asylbewerbern. *Zeitschrift für Klinische Psychologie und Psychotherapie*, 39 (3), 151-160.

¹⁸ Mall, V. & Hennigsen, P. (2015). Studie in Erstaufnahmeeinrichtung: viele Kinder mit Belastungsstörungen. Available at: <http://www.mri.tum.de/node/3407>.

Prevalence rates amongst unaccompanied minors were somewhat higher. An overview of several international studies¹⁹ showed that between 19.5 and 30.4 percent of unaccompanied minors were suffering from PTSD. The overall prevalence rate for mental diseases was between 4.9 and 56 percent.

Studies regarding the number of mentally ill refugees being treated: In 2015, 14,109 refugees were treated (including the delivery of psychotherapy, (psycho)social counselling etc.) in the 33 psychosocial centres for the treatment of traumatised refugees and victims of torture in Germany.²⁰ In a study by Bozogmehr²¹ asylum seekers were questioned whether they had had contact to medical doctors or psychotherapists. 15.5 percent of the 155 interviewees responded that they had met with a psychotherapist during the past 12 months.

Legal framework: The national legal framework for refugees provides restricted benefits during the first 15 months of their sojourn in Germany as regulated in §§ 4 and 6 of AsylbLG (Asylum Seekers Benefits Act). Medical treatment is provided only in case of acute diseases or pain. Other care is only provided on a case-by-case basis if it is indispensable for health preservation. Mental illness is usually not considered an acute disease by the social authorities and treatment is hence provided only on an individual basis. In the first 15 months, traumatised refugees still have little prospect of receiving psychotherapeutic treatment due to these restrictive authorisation practices. The duration of the treatment is often twice as high as in the case of statutory health insurance patients.

There is no margin of discretion specified in § 6 AsylbLG (Asylum Seekers Benefits Act) – based on EU law as stipulated in the Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 – for particularly vulnerable groups. This Directive comprises the right for persons in need of protection to obtain the necessary medical or other help, including persons with mental disorders or special needs. This help can include psychotherapeutic treatment.

¹⁹ Witt, A., Rassenhofer, M., Fegert, J. M. & Plener, P. L. (2015). Hilfebedarf und Hilfsangebote in der Versorgung von unbegleiteten minderjährigen Flüchtlingen. *Kindheit und Entwicklung*, 24 (4), 209-224.

²⁰ Versorgungsbericht: Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland 2016, third and revised edition, Bundesweite Arbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und Folteropfer – BAfF e.V. (Ed.)

²¹ Bozogmehr, K., Schneider, C. & Joos, S. (2015). Equity in access to health care among asylum seekers in Germany: evidence from an exploratory population-based cross-sectional study. *BMC Health Services Research*, 15:502.

After the first 15 months of a refugee's sojourn in Germany the restrictions in medical care according to §§ 4 and 6 AsylbLG (Asylum Seekers Benefits Act) no longer apply and refugees are provided with a similar care as citizens that are ensured via the statutory health insurance (GKV). Psychotherapy is part of the regular services of the insurance and the insurance will be reimbursed for the costs of this treatment by the local welfare authorities.

Migrants that have been given a status as recognised refugees, asylum seekers or beneficiaries of subsidiary protection and either work or receive unemployment benefit II, are mandatorily covered by the statutory health insurance and therefore have access to psychotherapy.

As a result, the necessary medical or other assistance is provided currently only for persons who have a residence permit pursuant²² and who have special needs such as unaccompanied minors, persons who have suffered torture, rape or other serious forms of psychological, physical or sexual violence.

Treatment and organisation of care: The social services are responsible for psychotherapies for asylum seekers, while the statutory health insurance is responsible for recognised refugees and the youth welfare office in some cases for underage refugees. Previously, asylum seekers who had not yet been in Germany for 15 months, had to obtain a medical certificate from the relevant social authorities before visiting a doctor. In order to relieve the bureaucracy, the Asylum Procedure Acceleration Act provided the possibility for asylum seekers to obtain an electronic health card with restricted access to benefits. However, this card has not been introduced everywhere. Even where it has been introduced, the card is no equivalent to a genuine membership in a statutory health insurance scheme. The limited chances to obtain an adequate psychotherapeutic care therefore do not change for owners of the card. In addition to that, costs for interpreters cannot be settled via the electronic health card and must still be requested from the social services. Overall, there is no uniform access to health care for asylum seekers in the first 15 months of their stay in Germany.

All licensed psychotherapists may normally treat refugees during the first 15 months of their sojourn in Germany. After this time period and for all refugees once they are recognised, it has been stipulated that these persons can only be treated by psychotherapists that are authorised by the statutory health insurance scheme (GKV). Psychotherapeutic

²² §24 para. 1 AufenthG

treatment and psychosocial care is also offered by psychosocial centres for refugees and victims of torture. They are financed by the social welfare office and different donators like foundations. The Nationwide Association of Psychosocial Centres for Refugees and Victims of Torture (BAfF e.V.) currently connects 34 psychosocial centres for refugees and victims of torture.

Training: Treatment is delivered in Germany by psychological psychotherapists, by child and adolescent psychotherapists and by psychiatrists. Ideally, the person delivering the treatment has been trained in trauma therapy and/or in treating refugees. The various State Chambers of Psychotherapists and other institutions such as the psychosocial centres for refugees and victims of torture offer training concerning special requirements in the treatment of refugees. The training usually comprises information on trauma and PTSD, on dealing with traumatised refugees and in culture-sensitive psychotherapy. There are guidelines on training courses in culture-sensitive psychotherapy.²³

Needed changes:

- No regulations exist for the provision of interpreter assistance for psychotherapies. Whether or not a person obtains interpreter assistance depends on his or her legal status. If a refugee during the first 15 months of sojourn is granted access to psychotherapy based on an individual decision, it is also possible to obtain access to interpreting services. A different situation arises when the refugee after the first 15 months is treated in the same way as a person within the statutory health insurance scheme or if a refugee is recognised and therefore entitled to statutory health insurance services. These services do not comprise interpreter assistance. Therefore there is no financing of interpreter assistance for refugees entitled to statutory health insurance services. It is, however, necessary that interpreter assistance for refugees (and other persons with insufficient German language skills) becomes part of the service catalogue of statutory health insurance according to Volume V of the Social Insurance Code (SGB V).

23

Best practices Germany:

Subject: Short-term and low-threshold services

Psychoedukative Gruppen in Erstaufnahmeeinrichtungen

Dr. Alexandra Liedl, Refugio München

Modellprojekt „Step-by-Step“: Traumabehandlung in einer Erstaufnahmeeinrichtung in Darmstadt

Prof. Dr. Marianne Leuzinger-Bohleber, Sigmund-Freud-Institut Frankfurt

Akutprogramm zur Versorgung psychisch kranker Geflüchteter

Dr. Maria Böttche, Behandlungszentrum für Folteropfer (bzfo), Berlin

Traumafokussierte Psychotherapie / Screen-and-Treat-Ansatz / Kaskadenmodell

Prof. Dr. Frank Neuner, Universität Bielefeld

Interpersonelles integratives Modellprojekt für Flüchtlinge mit psychischen Störungen

Prof. Dr. Eva-Lotta Brakemeier, Universität Marburg

Psychische erste Hilfe für Flüchtlingskinder: Eine interaktive Bildergeschichte

Dr. Sabine Ahrens-Eipper, Halle

START – Ein Konzept zur Erststabilisierung und Arousal-Modulation für stark belastete Kinder- und Jugendliche und minderjährige Flüchtlinge

Andrea Dixius, SHG Kliniken für Kinder- und Jugendpsychiatrie, Psychotherapie u. Psychosomatik Saarbrücken, Kleinblittersdorf, Idar-Oberstein

HOPE – Projekt zur Orientierung und Psychoedukation für traumatisierte Flüchtlinge des DRK

Rabea Pallien, Psychosoziales Zentrum (PSZ) für Flüchtlinge und Migranten/-innen, Saarbrücken

Subject: Online-based services

Web- und App-basierte Angebote für psychisch belastete und kranke Geflüchtete

Prof. Dr. Christine Knaevelsrud, Freie Universität Berlin

Refugeem -Online-Selbsthilfe für belastete Geflüchtete

Prof. Dr. Yvonne Nestoriuc, Universitätsklinikum Hamburg-Eppendorf

Subject: Qualification and assignment of lay helpers

„in2balance - Laienhilfe für Geflüchtete zur psychischen Stabilisierung“

Unterstützung von traumabelasteten Flüchtlingen durch geschulte Laienhelfer

Eva van Keuk, Psychosoziales Zentrum Düsseldorf

Traumahelferausbildung

Beate Leinberger, Gewiss e.V., Sinzing

Subject: Psychotherapeutic care

Erfahrung mit der Ermächtigung zur psychotherapeutischen Versorgung von Geflüchteten in der Regelversorgung

Juliana Schäfers, Kinder- und Jugendlichenpsychotherapeutin, Soest

Erfahrung mit Ermächtigungen zur psychotherapeutischen Versorgung von Geflüchteten in den Psychosozialen Zentren für Flüchtlinge und Folteropfer

Elise Bittenbinder, Bundesweite Arbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und Folteropfer (BAfF)

Kooperation zwischen Stadt Braunschweig, Landesaufnahmestelle Standort Braunschweig und der Psychotherapieambulanz TU Braunschweig

PD Dr. Christoph Kröger, Technische Universität Braunschweig

Subject: Coordination and networking amongst services

Koordinierungsstelle für die interkulturelle Öffnung des Gesundheitssystems und Verbesserung der Behandlung von psychisch kranken Flüchtlingen in Rheinland-Pfalz

Malin Reusch, Christina Krause oder Markus Göpfert

Koordinierungsstelle für die Vermittlung von Flüchtlingen in die psychotherapeutische Regelversorgung

Karin Loos, Netzwerk für traumatisierte Flüchtlinge Niedersachsen e.V.

Vermittlung psychisch kranker Geflüchteter in ambulante psychotherapeutische Behandlung

Judith Schild, Arbeitskreis Asyl des PsychotherapeutInnen-Netzwerk Münster und Münsterland e.V. und Refugio Münster

Subject: Deployment and qualification of interpreter assistance

Fortbildung und Finanzierung von Sprachmittlern in der Psychotherapie

Cornelia Reher, Seelische Gesundheit, Migration und Flucht e.V. (SEGEMI), Hamburg; Monika Eingrieber, Bundesverband der Dolmetscher und Übersetzer e.V. (BDÜ)

ZwischenSprachen - Qualitätsstandards zur Qualifizierung von Sprachmittlern in der (psycho-) sozialen Arbeit mit Geflüchteten

Dr. Mike Mösko, Universitätsklinikum Hamburg-Eppendorf; Varinia Morales, bikup e.V.

- Greece

Legal framework: According to a recent legislation concerning refugees in Greece, victims of torture should have a specific treatment in specialised units, etc. In reality, there is a unique project all over Greece addressed to victims of torture and providing rehabilitation services. This project is implemented jointly by the Greek Council for Refugees, Day Centre Babel and Medicines sans Frontiers – Belgium. Babel also follows people subjected to other types of violence. Medicines sans Frontiers France are implementing a project to deliver specialised services to GBV victims.

Treatment and organisation of care: Refugees, either recognised or asylum seekers, have the right to access public health and mental health services. There is no specific provision concerning the delivery of psychotherapeutic treatment to anyone, the same is for these people. These days a discussion and a negotiation with the National Provider of Health Services have started, concerning the delivery of psychological/psychotherapeutic care in the frame of Special Education. The provider suggests the price of 2.26 €/hour for psychological care and psychotherapy in this frame.

There is no specific way to organise refugee psychotherapeutic care. There is only one specialised mental health unit that delivers specialised mental health care to this population (Babel Day Centre). This unit is collaborating, for psychotherapeutic issues, with the Centre for Trauma, Asylum and Refugees (University of Essex and Tavistock Clinic) which offers training and supervision.

Language interpretation service is not regulated and it is not financed. To give an example: although Babel Day Centre is officially entitled to offer mental health care to migrants and refugees, although interpreters constitute a recognised professional role and such figures are included in the payroll, their services are not paid.

Training: The majority of those who treat is not specially trained, only in some contexts they are.

Needed changes:

- Recognise that refugees are human beings and as such may need psychotherapeutic care
- Be aware of the need for whoever desires to get involved in the provision of (psycho)therapeutic care to refugees must acquire new skills and competences at professional level
- Be aware of the fact that for the previous two points to become operational money should be allocated.

- Implement the above.

Further important aspects:

- Fortunately, in Greece refugees have the right to basic health services. Unfortunately in Greece psychotherapeutic care is even not provided to the citizens of the country (unless they go to private practitioners). Thus it is very difficult to think to provide such service to foreigners, refugees or anything else they are.
- Health services and health professionals need to acquire skills and competences in order to meet refugees' needs.
- Refugees are not a burden, also society can profit from their experiences and way of living and thinking.

- Hungary

Prevalence: In Hungary, mentally ill refugees are mostly only treated by the Cordelia Foundation, in 2016 Cordelia treated 1767 patients, mostly asylum-seekers, and some beneficiaries of international protection.

Legal framework: According to EU and domestic law, vulnerable asylum-seekers should get adequate health and mental health care if needed. In the governmental decree on the implementation of the Law on Asylum (301/2007 XI.9.) it is prescribed that in case it is needed, asylum-seekers should receive free medical specialist care or in-hospital care. There is no specific provision regarding psychotherapeutic care. Asylum-seekers are only provided specialist and in-hospital care in case of emergency, whereas ordinary citizens with a social security status can receive some basic form of free psychotherapeutic care. NGOs which provide complex psychotherapeutic care operate mostly from foreign resources, such as funds from the UN or the EU, the state does not fund it. There has been a large-scale overhaul of the Hungarian asylum-system. Experts deplore the almost explicitly stated governmental objectives of keeping asylum-seekers outside the country and of urging asylum-seekers in Hungary to move on from the country by the introduction of fast-track procedures that lack fundamental legal safeguards; the restriction of access to international protection; the abolishment of basically all integration support for beneficiaries of international protection; and the closing of the biggest and best-equipped asylum reception centres.

Treatment and organisation of care: Regular psychiatric and psychologic assessment, treatment and therapy is only provided by the Cordelia Foundation.

The state health care system only provides basic medical care by General practitioners on a regular basis to asylum-seekers. Asylum-seekers and refugees are only given special psychiatric treatment if they are in so severe mental condition (being psychotic, hallucinating or suicidal) that they need to be taken to hospital. As hardly any hospital can afford to employ interpreters, in most cases they cannot treat the asylum-seekers/refugees and discharge them from hospital after a mere 1-day care.

Cordelia Foundation has official permission from the Hungarian Office of Immigration and Nationality and from the National Public Health and Medical Officer Service to regularly visit the asylum reception and detention centers to provide psychiatric and psycho-social care there. Menedék Association also carries out a smaller scale psycho-social treatment of asylum-seekers and refugees, but at fewer locations than Cordelia.

The public health system only provides emergency care, but it is not specialised for refugees, and it is often provided without using interpreters. There are no specific psycho-therapeutic centres for asylum-seekers and refugees within the regular Hungarian health system.

Training: The public mental health doctors do not have a special training. The psychiatrist, psychologists, non-verbal therapists and interpreters of the Cordelia Foundation are specially trained to work with asylum-seekers and refugees. The staff also takes part at monthly supervision events.

Hungary: Best practice example Cordelia foundation

The Cordelia foundation has been providing complex psychiatric and psycho-social treatment for asylum-seekers and refugees since 1996. Cordelia provides individual, family and group, verbal and non-verbal therapies including art and music therapy. It also writes special medico-legal reports, which are quite effective in facilitating mentally unstable or traumatised asylum-seekers' transfer from detention to open reception centres. Cordelia writes these medico-legal reports using the Istanbul Protocol as a basis, which is the most accepted international tool to identify and document instances of torture. Cordelia Foundation works with a team of highly trained interpreters who speak Arabic, Armenian, Dari, Farsi, Pashtu, Urdu, Oromo, Amharic, Somali and French.

Cordelia Foundation has official permission from the Hungarian Office of Immigration and Nationality and from the National Public Health and Medical Officer Service to regularly visit the asylum reception and detention centers to provide psychiatric and psycho-social care there. Menedék Association also carries out a smaller scale psycho-social treatment of asylum-seekers and refugees, but at fewer locations than Cordelia. NGOs – such as Cordelia– who provide complex psychotherapeutic care to them operate mostly from foreign resources, such as funds from the UN or the EU. The Hungarian state does not fund Cordelia's work.

Needed changes

- Most importantly the state should introduce a nationwide mechanism to adequately diagnose and provide treatment to asylum-seekers and refugees who suffered torture or other trauma or who suffer from other psychological disorders. This mechanism should employ the services of independent expert organizations with experience in the field. There should be regular psycho-social care provided by state resources at all open asylum-seeker centers and asylum detention centers.

- Ireland

Legal framework: The cabinet has agreed to a network of emergency reception and orientation centres, the Irish Refugee Protection Programme.²⁴

Recently Ireland agreed, under an EU initiative, to resettle 300 more refugees from a list drawn up by the UNHCR. Together with the impending arrival of 114 Syrian refugees and 310 others earmarked to arrive under the UNHCR programme by 2016, it represents a reversal of the last government's five-year moratorium on accepting refugees, after the economic crisis.²⁵

Treatment and organisation of care: In Ireland²⁶, specific reception centres are required to provide also assessment of medical needs. In the past, experts criticized the system in place: "A lack of funding and organization over the years within the healthcare system has led to a situation where the service is not as responsive to the needs of patients as it ought to be. This can be particularly the case when dealing with the special needs of refugees...The system currently in place for assisting refugees in Ireland actually damages rather than improves the physical and mental health of people in his community."²⁷

²⁴ <http://www.irishtimes.com/news/politics/ireland-to-take-4-000-refugees-in-new-programme-1.2346948>

²⁵ <http://www.irishtimes.com/news/social-affairs/what-awaits-refugees-in-ireland-1.2222337>

²⁶ In Northern Ireland asylum seekers are entitled to free health care under the National Health System (NHS). The system is administered in six UK regions, Northern Ireland and Scotland being a single region in this system. <http://www.migrationni.org/DataEditorUploads/RAISE%20Refugees%20and%20Asylum%20Seekers%20in%20NI.pdf>, page 10.

²⁷ <http://www.irishhealth.com/article.html?id=2384>

Ireland: Best practice example University of Sanctuary, Limerick

Ireland has about 4.6 million inhabitants, but only a few refugees are looking for shelter on the island. In a commitment the Government has agreed to host Syrian refugees, only a smaller number of them have arrived so far. The University of Limerick is working on a new concept of having the university recognised as a University of Sanctuary, which means a university with a special welcome culture for refugees. A pilot of the scheme will be running in the winter semester 2017/18. The University of Limerick will provide a specific counseling for students who are refugees and training of the staff to learn more about teaching students who have experienced/are experiencing trauma.

To provide language assistance, there is a translation service available to public health nurses, doctors and casualty departments, but the staff is not always aware of the service. At the reception centers, a multi-disciplinary team of psychologists is available to assess any psychiatric or mental health difficulties. In some places, funding of the European Refugee Fund is available to pay for an interpreter and an intercultural worker.

Needed changes:

- A key concern is the lack of availability of specialists to assess evidence, such as signs of torture.²⁸

Italy

Prevalence: Refugees cumulate numerous vulnerability factors and have a higher prevalence of mental disorders than the general population. Migration may further destabilise the balance between risk and protective factors. Stressful pre-migration experiences, especially witnessing violence, are known to be important risk factors for refugee children. The number of traumatic experiences and refugee camp residence have been shown to be associated with the development of posttraumatic stress disorder (PTSD) and other mental health problems, such as anxiety disorders mental health. One of the few longitudinal studies in this field has identified a number of predictors for long-term mental health problems in young refugees. Thus, the number of stressful events after arrival, experiences of discrimination and lack of stability and integration into the host society were predictive of psychological problems eight to nine years after arrival. Perceived discrimination by the community or the society has been associated with more severe PTSD symp-

²⁸ <http://www.migrationni.org/DataEditorUploads/RAISE%20Refugees%20and%20Asylum%20See-kers%20in%20NI.pdf>, S.16.

toms. Lack of family and community support also predicts higher risk of psychological distress and is a well-known problem in unaccompanied refugee minors. Administrative processes are another source of post-migration stress. A long asylum procedure has been correlated with anxiety, depressive and somatoform disorders in adult asylum seekers. Asylum seeking children and adolescents, having experienced protracted stays in asylum centres and multiple relocations within the system, have been shown to have an increased risk of mental difficulties.²⁹

Legal framework: Psychotherapeutic care for refugees is regulated by the Italian Public health System. The state and the region bear the cost and some time the municipality give additional funds. Some private charities also contribute voluntarily. The Person Centered Approach Institute (IACP) for instance offers free of charge psychotherapy in some Italian locations and gives to some qualified refugees that want to help their fellows, free 4 years long psychotherapy training in IACP Messina (Sicily), IACP Rome, IACP Florence and IACP Milan. Language interpretation service is regulated and paid by the Italian health system and paid by the local health agencies or by the ONG and its part of their budget. Treatment and Organisation of care: Psychotherapists and Psychiatrists of the Public Health Agencies and the ONG that have special agreements with the Italian health System are authorised to treat refugees.

Training: Psychotherapists and Psychiatrists are partly specially trained by Local health Agencies. The content of the training are continuing education courses authorized by the Italian Health Ministry and by the psychotherapy schools. Some schools include in their training programs intercultural communication and some principles of Etnopsychiatry.

Italy: Best practice example Lampedusa:

In Lampedusa a Sicilian Island where many refugees land and where the Psychiatrist Enza Malatino M.D. one of IACP trainers and a Person Centered Therapists that is operating in the local Local health Agency (ASP) uses person Centered Encounter groups. Enza Malatino has noticed and shared in many lectures internationally that the women that come voluntary to her person Centered encounter groups, and share their terrible stories of violence and sexual abuse, requests from 70% to 80% less medication and have dramatically less psychotic episodes.

²⁹ Pfarrwaller, E. & Suris, J.C. (2012). Determinants of health in recently arrived young migrants and refugees: a review of the literature. Italian Journal of Public Health (IJPH). Volume 9, Number 3).

Needed changes:

- A change of culture is needed to improve the relationship between therapist and client. Instead of being trapped in rigid stereotypes, more empathy and respect is needed and the understanding, that is not a one way relationship. The therapist can not only help refugees but grow with them, he also can learn something significant in this relationship and will become a better professional.
- Refugees themselves should be trained and employed to help their own people and teach the therapist how to help them better.
- A lot of research is needed and retooling of how to train mental health personnel.

- **The Netherlands**

Prevalence amongst adults

A lot of studies have been undertaken in The Netherlands on the mental health situation of refugees.³⁰

Based on the evidence from higher-quality studies (i.e., those with probability sampling, sample size 500, and diagnostic interview used as measure) is concluded that 13-25 percent of the refugees and asylum seekers suffer from either PTSD and/or depression. There seems to be high co-occurrence of PTSD and depression. The lower-quality studies indicate higher prevalence rates. There is some evidence to suggest that the prevalence rate of either PTSD and/or depression tend to decrease over time. However, the prevalence rate among refugees and asylum seekers remains higher relative to the general population and some regular migrants in the host countries, even 6-22 years since displacement.³¹

³⁰ Haker F, Muijsenbergh M van den, Torensma M. et al. Kennissynthese gezondheid van nieuwkomende vluchtelingen en indicaties voor zorg, preventie en ondersteuning. Utrecht: Pharos; 2016. Results:

<http://www.pharos.nl/documents/doc/kennissynthese%20gezondheid%20van%20nieuwkomende%20vluchtelingen%20en%20indicaties%20voor%20zorg%20preventie%20en%20ondersteuning.pdf>

Goosen (dissertation): Epidemiological studies on the health of asylum seekers and refugees in the Netherlands (2014).

Dourleijn, E., Muller, P., Dagevos, J., Vogels, R., van Doorn, M., & Permentier, M. (2011). Vluchtelingengroepen in Nederland. Pdf: http://www.vijfeeuwenmigratie.nl/sites/default/files/bronnen/http_www.scp.nl_8080_gvisapi_dsplug.pdf

* Engelhard (red.): Met kennis van feiten. Vluchtelingen, nieuwkomers en gezondheid in cijfers (2007). Results: http://www.pharos.nl/documents/doc/webshop/met_kennis_van_feiten.pdf

³¹ Adulkram, U. & Stronks, K. (2016). Preserving and improving the mental health of refugees and asylum seekers. A literature review for the Health Council of the Netherlands. Amsterdam: AMC.

With this conclusion it cannot be suggested that the remaining 75-87 percent of the refugees and asylum seekers do not suffer from mental health problems at all. As the meta-analyses and reviews relied upon in this report define mental health according to the presence or absence of mental disorders, there could only be drawn a conclusion regarding the prevalence of PTSD or depression. However, mental health is more than the presence or absence of a mental disorder. This implies that although the majority of the refugees and asylum seekers will not suffer from either PTSD or depression they might experience psychosocial problems (e.g. distress).

There is important variation in the prevalence of mental health problems within the refugee and asylum seeking populations. Evidence indicates a large variation in the prevalence of PTSD or depression within the larger refugee and asylum seeking population, with some specific groups having higher rates. This variation is likely to be observed for other (less severe) mental health problems as well. Women and older refugees (also relevant to children) have a higher risk of mental health problems. Several studies indicate that the more traumatic events the refugees experienced before resettlement, the more likely they are of having mental disorders. This also applies to those who have experienced torture or sexual violence – constituting around 20-30 percent of the refugees –, suggesting that the severity of trauma plays a role as well.

Prevalence amongst children

The self-reported psychological distress of refugee minors in the Netherlands was found to be severe (50 percent) and of a chronic nature (stable for one year) which was confirmed by reports from the guardians (33 percent) and teachers (36 percent). The numbers of self-reported experienced adverse life events were strongly related to the severity of psychological distress. Baseline psychopathology was the largest predictor of psychological distress at follow-up reported by all informants accounting for 22–51 percent of the variance.³²

Unaccompanied refugee minors (URMs) consistently reported significantly higher scores for internalizing problems, traumatic stress reactions, and stressful life events than immigrants/refugees or Dutch adolescents. URMs reported to have experienced twice as many stressful life events than immigrants/refugees and natives. URMs appear to be at significantly higher risk for the development.

³² Bean TM, Eurelings-Bontekoe E, Spinhoven P. Course and predictors of mental health of unaccompanied refugee minors in the Netherlands: one year follow-up. *Soc Sci Med* 2007; 64: 1204–15.

Unaccompanied adolescent asylum seekers in a restricted reception setting reported more emotional problems on the Hopkins Symptom Checklist than their counterparts in the more autonomy group. A restrictive reception may therefore affect the mental health of minor asylum seekers.³³

Concerning **access to mental health care** there are **findings** that for refugees and asylum seekers with PTSD or depression effective cognitive-based therapies (e.g., CBT and NET) are available, but that they experience barriers in accessing mental health services. This is a relevant issue for the Netherlands, as a recent Dutch study showed that only 20 percent of the refugees with PTSD use mental health services.³⁴ This figure increased to 54 percent over the 7-year follow-up period, but still remains relatively low. Another study³⁵ found that only 9 percent of the asylum seekers with mental disorder visited a mental health worker. Similar findings were observed in other Dutch studies. The recent covenant between mental healthcare providers and health insurer might possibly improve this situation. It was agreed to take necessary measures to improve the quality of mental health services (including prevention) along the whole chain for asylum seekers. However, this covenant applies to those in asylum procedure only, while no specific plans have been made for refugees resettled in the municipalities. It is quite likely that resettled refugees with PTSD or depression will experience significant barriers in accessing proper and quality mental health services, as local healthcare providers might lack the necessary skills for providing cultural-competent mental health services. Hence, policies should be developed to improve the access of mental health services in the municipalities where refugees will resettle and use healthcare.

³³ Reijneveld SA, de Boer JB, Bean T, Korfer DG. Unaccompanied adolescents seeking asylum: poorer mental health under a restrictive reception. *J Nerv Ment Dis* 2005 Nov; 193: 759–61.

³⁴ Adulkram, U. & Stronks, K. (2016). Preserving and improving the mental health of refugees and asylum seekers. A literature review for the Health Council of the Netherlands. Amsterdam: AMC. P. 41-42. You can read the whole study here: https://www.gezondheidsraad.nl/sites/default/files/201601briefadvies_geestelijke_gezondheid_van_vluchtelingen.pdf. This study refers to other interesting studies done in the Netherlands: Gernaat H, Malwand A, Laban C, Komproe I, de Jong J. Many psychiatric disorders among Afghan refugees in Drenthe, the Netherlands, with a residence status, in particular

³⁵ Laban CJ, Gernaat HB, Komproe IH, De Jong JT. Prevalence and predictors of health service use among Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology* 2007;42:837-44.

Legal framework: The Netherlands have special health care arrangements for refugees who seek asylum in the Netherlands. This arrangement applies to them during the time that their application is being processed.³⁶

The Dutch government is responsible for acknowledged asylum-seekers who are received by the Central Agency for the Reception of Asylum Seekers. Asylum seekers who have received a residence permit are located in a designated municipality. They get a house, money for furniture and an integration process and they get access to the normal Dutch health care arrangements. Coverage is provided for medical care, which is equivalent to the basic package for Dutch insured clients.³⁷

Treatment and organisation of care: Psychotherapeutic care for refugees goes mainstream, just the same as for Dutch people, via the general practitioner (GP). Asylum-seekers' centres have a GP surgery with a consultant in mental health care. These consultants offer accessible mental health care according to the stepped care model. They are nurses who have been trained in social-psychiatric nursing. The GP can refer the refugees to someone who is authorised to psychotherapeutically treat refugees. There are various authorised professionals (psychologist, POH GGZ, psychiatrist etc.). There are national institutions specialized in the treatment of asylum seekers and refugees. Youth mental health care institutions are also contracted.

For asylum seekers interpreting services are paid by the government. The reimbursement of interpreter services for asylum seekers is the responsibility of the COA. When they receive a residence permit (becoming a refugee) healthcare institutions can not charge for interpreting services anymore - so then these institutions have to bear the costs.

A Dutch research showed that there is a need for the use of professional interpreters.³⁸

Training depends on the organisation and the professional. Professionals working on asylum seeker centres are generally trained in treating refugees with intercultural sensitivity.

³⁶ De Regeling Zorg Asielzoekers (RZA) <http://www.rzasielzoekers.nl/home/zorg-voor-asielzoekers.html> and information provided by ESIP experts, including Zorginstituut Nederland. According to this information, there is also a health care arrangement for persons who stay in the Netherlands illegally. Under this arrangement care-providers can obtain compensation for loss of income for the provision of medically necessary care. The doctor will have to decide if treatment is possible despite the unfavourable environmental factors.

³⁷ Source: Zorginstituut Nederland

³⁸ <https://www.nivel.nl/nl/nieuws/zorgverleners-meer-professionele-tolken-nodig-voor-goede-zorg>

Also there are specialized mental health care professionals whom are specialized in working with cultural awareness and intercultural communication.

Some people are trained by their specialisation during their studies, some professionals are trained during extra training given by e.g. Pharos-Academy, Arq Academy, and other experts. The content of this training is mostly focussed on intercultural communication and cultural differences in perceiving mental health issues.

Treatment concepts: experiences in the Netherlands

The dissertation of **Jackie June ter Heide**: An eye for complexity - EMDR versus stabilisation in traumatised refugees³⁹ show, that refugees may be safely treated with a short course of EMDR (9 sessions), but efficacy may be limited. Treatment response may be hampered by depressive symptoms. The construct of complex PTSD may only limitedly apply to traumatised refugees. Current research supports a recommendation of trauma-focused rather than phase-based treatment in refugees who seek treatment for PTSD, including asylum seekers.

The thesis of **Boris Dorzdek**⁴⁰ presents a model for understanding psychological consequences of exposure to war, torture and political violence in asylum seekers and refugees. This contextual, developmental, and culture-sensitive model is based on theoretical and empirical findings and implies framing and interpreting of life events in “the ecological environment” and throughout the life-span of a survivor. The model investigates into both sources of damage and resilience in traumatized individuals in order to frame posttraumatic impacts in a comprehensive way.

³⁹ Jackie June ter Heide: An eye for complexity - EMDR versus stabilisation in traumatised refugees.
<https://www.arq.org/nl/projecten/eye-movement-desensitisation-and-reprocessing-emdr-versus-stabilisatie-de-ambulante>

⁴⁰ Boris Dorzdek: If You Want to Go Fast Go Alone, If You Want to Go Far Go Together. On Context-Sensitive Group Treatment of Asylum Seekers and Refugees Traumatized by War and Terror

The Netherlands: best practice „specialized treatment centres“

The Netherlands has treatment centres specialized in treating refugees or working with people from different cultural backgrounds. Below a list of some specialized institutes:

Foundation Centrum '45 is the Dutch national centre for treatment of and research into the consequences of organised violence.

website: <http://www.centrum45.nl/index.php?uid=125>

Equator Foundation is an outpatient clinic for traumatized refugees and victims of human trafficking and sexual assault. Since September 2014 a special treatment program started for refugees who are living illegally in the Netherlands.

website: <http://www.equatorfoundation.nl/>

De Evenaar (ggz Drenthe) is a specialized centre for transcultural psychiatry. It offers several day care treatment programmes en polyclinic care to people with a different cultural background (such as labour migrants, refugees with or without a residence permit) of all ages.

website: <https://www.ggzdrenthe.nl/centrum/de-evenaar/>

Psychotrauma Centrum Zuid Nederland, Reinier van Arkel groep

website: https://www.reiniervanarkel.nl/ptczn?original_request=ptczn

Phoenix (part of Pro Persona)

website: <https://www.propersona.nl/phoenix/>

Based on this model, a group treatment approach aiming at helping asylum seekers and refugees with impacts of psychological trauma and resettlement stress has been designed and applied throughout 12 years. This group treatment is phase-based and trauma-focused, it combines group psychotherapy with non-verbal therapies (psychomotor therapy, art therapy, and music therapy). It is executed within a day treatment setting, and lasts for one year. The approach does not exclusively focus on treatment of posttraumatic stress disorder (PTSD) and other co-morbid axis I and II disorders, but includes interventions targeting damaged core-beliefs, guilt, shame, grief, marital and systemic problems, legal issues due to procedure of seeking asylum, and other resettlement stressors. The outcome studies presented in this thesis suggest that this group treatment approach improves mental health of asylum seekers and refugees with PTSD, both on the short and on longer terms. The PTSD, anxiety, and depression symptoms are reduced upon completion of the treatment. The trend of reduction of the examined psychopathology continues up to five years after the treatment. Over an even longer period of time, up to seven years, the treatment gains are maintained but reduced in strength. Both asylum seekers and refugees can benefit from the applied group treatment, irrespective of the absence

of stable living arrangements. However, positive changes in the resettlement context lead to more favorable treatment outcomes. Asylum seekers who are granted a permanent refugee status during the treatment show larger symptom reductions upon termination of the treatment than the patients whose legal status did not change in the course of the treatment.

The study of **Arnoud Arntz et al**⁴¹ tested the effectiveness of Imagery Rescripting (ImRs) for complicated war-related PTSD in refugees. Ten adult patients in long-term supportive care with a primary diagnosis of war-related PTSD and Posttraumatic Symptom Scale (PSS) score > 20 participated. A concurrent multiple baseline design was used with baseline varying from 6 to 10 weeks, with weekly supportive sessions. After baseline, a 5-week exploration phase followed with weekly sessions during which traumas were explored, without trauma-focused treatment. Then 10 weekly ImRs sessions were given followed by 5-week follow-up without treatment. Participants were randomly assigned to baseline length, and filled out the PSS and the BDI on a weekly basis. Data were analyzed with mixed regression. Results revealed significant linear trends during ImRs (reductions of PSS and BDI scores), but not during the other conditions. The scores during follow-up were stable and significantly lower compared to baseline, with very high effect sizes (Cohen's $d = 2.87$ (PSS) and 1.29 (BDI)). One patient did clearly not respond positively, and revealed that his actual problem was his sexual identity that he couldn't accept. There were no dropouts. In conclusion, results indicate that ImRs is a highly acceptable and effective treatment for this difficult group of patients.⁴²

According to **Adulkram and Stronks**, cognitive-based therapies are efficacious for refugees and asylum seekers with PTSD or depression. Experimental evidence suggests that as treatment for refugees and asylum seekers with PTSD or depression, cognitive-based therapies (e.g. CBT and NET) are efficacious. Specifically, evidence indicates that CBT is efficacious for depression and PTSD, preserving and improving the mental health of refugees and asylum seekers whereas NET works for PTSD only. It should be noted that cognitive-based therapies are most widely studied. In addition, observational evidence suggests that multimodal interventions are effective for refugees with PTSD, while the effects

⁴¹ Imagery Rescripting as treatment for complicated PTSD in refugees:

A multiple baseline case series study. By Arnoud Arntz, Dana Sofi a and Gerard van Breukelen.

<https://www.ncbi.nlm.nih.gov.proxy.library.uu.nl/pubmed/?term=Imagery+Rescripting+as+treatment+for+complicated+PTSD+in+refugees%3A+A+multiple+baseline+case+series+study>

⁴² Imagery Rescripting as treatment for complicated PTSD in refugees: A multiple baseline case series

study. By Arnoud Arntz, Dana Sofi a and Gerard van Breukelen. <https://www.ncbi.nlm.nih.gov.proxy.library.uu.nl/pubmed/?term=Imagery+Rescripting+as+treatment+for+complicated+PTSD+in+refugees%3A+A+multiple+baseline+case+series+study>

are mixed for depression. For the other treatment modalities (e.g., EMDR, pharmacology), the evidence base is weak.

Despite this, as mentioned above, the available evidence suggests that refugees and asylum seekers experience barriers in accessing mental health services. These barriers are due internal factors (e.g. low priority on mental health, stigma) but also because of external factors such as lack of information on services, distrust, and lack of cultural-sensitive and -competent services. Consequently, mental health services are underutilized, leading to unmet needs among some refugees and asylum seekers who are in need of help. So even though evidence-based treatment modalities exist, access to mental health services remains problematic and hence requires attention.⁴³

There also preventive interventions available in the Netherlands, for example:

- Multi Family Therapy. MFT is a system-oriented intervention that aims to facilitate adequate functioning in couples, parent-child dyads or families.⁴⁴
- Mind Spring. Mind-Spring, in cooperation with refugees and Medical Care, developed a program on mental-health and psycho education. The program is developed to support asylum seekers and refugees and is given in own language and taken original culture into account. Specially educated asylum seekers and refugees run the program together with the GGZ, mental health institutes. Mind-Spring trains (ex) asylum seekers and refugees as a peer educator/trainer, who works together with a mental health professional. The aim of the program is to learn how to cope with the actual situation and loss of identity. Attention is also paid to coping with psychosocial problems that are a direct or indirect result of events that happened in the past in their country of origin, during flight and afterwards. Stress, grief, feelings of guilt, isolation from culture, trauma, alcohol and/or drug abuse and the daily problems of life in an asylum seeker centre often trouble refugees. These subjects are addressed in the groups by communicating information on psychological and psychosocial processes that are common among refugees via group discussions with fellow refugees. Relaxation exercises and cognitive techniques aimed at coping with the problems mentioned and exercises directed at rediscovering their own possibilities, strengths and self-empowerment

⁴³ Adulkram, U. & Stronks, K. (2016). Preserving and improving the mental health of refugees and asylum seekers. A literature review for the Health Council of the Netherlands. Amsterdam: AMC. P 36-37.

⁴⁴ For example: <http://estss2015.eu/wp-content/uploads/2015/04/Trudy-Mooren.pdf> or <https://mijn.bsl.nl/multifamily-therapy-met-vluchtelingengezinnen-van-oorlog-naar-ve/605430>

are also addressed. Also a train the trainers program is developed to start parenting support groups for asylum seekers in AZC's and for refugees who seek support to bring up their children in the new situation.

The program Mind-Spring is offered to asylum seekers living in AZC's at the moment in 30 locations in the Netherlands. The program is successfully offered to refugees (people with a license to stay in Holland) outside centre. To be able to offer the program there is a cooperation with many GGZ institutes in the Netherlands, the Medical Care (GCA), the COA (Central Organ opvang Asielzoekers), VluchtelingenWerk, Arq, Pharos and GGZ Netherlands. Arq Psychotrauma Expert Group is coordinator of Mind Spring Junior, for children 8-12 years and their parents.

Needed changes:

Some recommendations:

- Also after obtaining a residence permit GP's (for example) need the financial ability to work with interpreters.
- The deployment of "cultural mediators" to recognize discrepancies between cultures and promote mutual understanding between cultures and to prevent miscommunication.
- Exploiting expertise by encouraging contact with 'former' asylum seekers/ refugees.
- Reduction of daily stressors (post-immigration stressors). For example: to let refugees move to different locations during their asylum procedure less often.
- Investing in preventive programs with a view to activating asylum seekers and psycho-education.
- Train also volunteers or other people who work with refugees/asylum seekers in observing and identifying psychological problems, supported by a clear overview of the social map of the region, care options around and a guide with do's & don'ts.
- Investigating in access to care for this group. Low-threshold treatment settings/programs. Reduce fear and stigmatization. For example by working out-reaching, more continuity in care, E-health, shorter waiting lists, more cultural sensitive programs.
- Promoting cultural sensitivity - creating awareness of the own culture. Awareness of taboos and the presence of other disease explanatory models. Improving basic attitudes as listening, empathetic, curious and open/respectful towards different complaints perception and presentations. Be familiar with cultural interview.
- Paying extra attention to children and unaccompanied minors.

- **Poland**

Legal framework: In Poland, refugees are entitled to psychotherapeutic treatment. Asylum seekers have psychotherapeutic care provided by specialists working with refugees. People suffering from a mental illness or acute psychiatric disorders may require external services, such as an in-hospital treatment. People who already obtained temporary or permanent residency in Poland have psychotherapeutic care provided as any other Polish citizen.⁴⁵

Treatment and organisation of care: Though care does not differ in principle, there are often extra difficulties/demands that need to be dealt with, like language problems, cultural differences, traumatic experiences etc. Psychotherapists are authorized to treat refugees. Some of them are specialists who come from the same countries as refugees - there have been substantial increase of refugees from Ukraine with severe PTSD syndromes in Poland in the last few years.

There are no special clinical centres for mentally ill refugees in Poland. There is a need to expand care; the country's only reception centre for refugees accommodates 200 people. Refugees obtain psychological/psychotherapeutic help either in state clinical centres and/or within the scope of clinicians working for specific charities/foundations that work with refugees. NGOs and charities in Poland provide a range of psychological/psychotherapeutic assistance – i.e. culturally sensitive service - ensuring long-term therapeutic support.

The cost is mostly covered by state centres but also by specific charities/foundations that work with refugees (these agencies often receive financial support for their services from the state).

Because the vast majority of refugees does not speak any Polish - or occasionally have very limited Polish-, interpretation is an essential part of work with this group of clients. Interpreters are based in all hostels for refugees. Many of the specialists working with refugees, including psychotherapists, speak different languages.

Training: Additional training/ areas of expertise is important in working with this group of clients. Special training in work with torture survivors, PTSD or mental illness is organised

⁴⁵ The psychotherapeutic treatment in hospitals and practices in Poland is free in principle. Due to underfunding of the system extra payments are requested.

by experts in this specific fields. For instance, therapeutic work with refugees suffering from PTSD is often based on Edna Foa approach.

Needed changes:

- Ensuring that the asylum procedures are done faster and that people with special psychological needs do not fall through the gaps in the system of care.
- Building awareness of often harsh reality of day to day living in a foreign country.
- More coordination of different services and more cooperation between different centres providing care for refugees.

- **Portugal**

Legal framework, treatment and organisation of care: In Portugal, refugees are entitled to psychotherapeutic treatment in the same conditions as the national citizens.⁴⁶ A directive from the DGS (Manual-Apoio-Psicossocial-a-Migrantes) is covering the availability of the National Health Service access to all the refugees. The public health care services, following the DGS directive, promote equal access for the refugees and national citizens. There could be required payment of moderation taxes for those who have good financial conditions.

The refugees could choose a health professional with same sex of them.

There are few mediators and interpreters, some of them from non-profit organisations.

Training: The DGS manual for the Psycho-social support for Migrants⁴⁷, recommend the use of cultural mediators, for what it will be needed provided specialized training.

Portugal: best practice PARnetwork

Within PAR, the Portuguese refugee council collaborates with professional and scientific organizations and local authorities. This network provides a platform for refugees and is active in Portugal and Greece. It offers emergency assistance in refugee camps, takes a multidisciplinary approach and works with the support of non-governmental organizations and official bodies at the local, national and international level. Since September 2015 about 1,200 refugees have arrived, approximately 1,800 refugees are expected before the programme is completed.

⁴⁶ Portugal has no national regulation about the psychotherapeutic treatment for its national citizens.

⁴⁷ *<http://www.youblisher.com/p/1332226-Manual-Apoio-Psicossocial-a-Migrantes/>

Needed changes:

- In order to improve the psychotherapeutic care of refugees in our country, the first step is to improve the availability of the psychotherapeutic treatment generally inside the National Health System.
- The collection of online information could be useful in order to set an observatory network with others professionals and citizens organizations. Promoting emergency psychological aid and psychotherapeutic care to refugees and migrants by such a platform could become an important step further.

- **Sweden**

Prevalence: Data published in 2015 estimated that poor mental health in refugees in Sweden was 20-30 percent.⁴⁸ In a survey made by the Swedish Red Cross in 2016⁴⁹ on mental ill health among asylum seekers and so called “newly arrived refugees”⁵⁰ depression and anxiety was found in 36,1 percent, PTSD in 30,1 percent and poor mental well being in 38,3 percent. In some groups - for instance asylum seekers from Syria, Eritrea and Somalia - rates were higher⁵¹. The study concluded: “The results indicate that mental ill health is common among newly resettled refugees from Syria and asylum seekers from Syria, Eritrea and Somalia in Sweden in 2016”. A register-based study⁵² has found a higher risk for a diagnosis of non-affective psychosis in refugees compared to non-refugees and Swedish-born citizens.

Regarding the number of mentally ill refugees being treated, available statistics show that asylums seekers and newly arrived consumed 2,1 percent and 2,7 percent - inpatient and outpatient care respectively - of the total psychiatric care in Sweden 2009-2014. Due to the nature of the Swedish registration of health care, this is probably an overestimation. Also, not everyone who is considered newly arrived or doesn't have a social security number is necessarily a refugee. No statistics available show the use of psychotherapy or other such interventions.

⁴⁸ National Board of Health and Welfare, 2015).

⁴⁹ Petter Tinghög, Charlotta Arwidson, Erika Sigvardsdotter, Andreas Malm, Fredrik Saboonchi (2016): “Newly resettled refugees and asylum seekers in Sweden – a study of mental ill health, trauma and living conditions”.

⁵⁰ In Sweden, the term newly arrived is used for persons with residential permit the first two years, during the so called “establishment period”.

⁵¹ Tinghög et al (2016)

⁵² Hollander (2016)

Research shows that refugees have less access to specialized psychiatric care and that they receive less psychotherapeutic interventions.⁵³

Legal framework: Within the health care budget for 2017 an extra 3 million Euro of the Swedish Association of Local Authorities and Regions-SEK is devoted to “positive health development for asylum seekers and refugees” on a national and regional level during 2017.

There have been changes in Swedish law, with a temporary law that has made temporary residence permits the norm instead of permanent residence that previously was the norm. There were also some changes in the law concerning the reception of asylum seekers (LMA) but no changes in laws concerning health care.

Refugees (or anyone) with a permanent or temporary residence permit (and a complete social security number/ in the Swedish national registry) has the same rights to health care as citizens of Sweden. With the new temporary law there is still some uncertainties regarding persons with temporary permits – in any case they have the same rights as asylum seekers.

Asylum seekers and undocumented migrants fall under the general law on healthcare etc. for asylum seekers and others. Psychotherapeutic care is not mentioned, only the provision of healthcare that “cannot be postponed” (vård som inte kan anstå). It is up to each region and even individual health care staff to assess what that entails since it is not regulated by law. Besides the “health care that cannot be postponed” asylum seekers have a right to emergency care, dental care, maternal care (incl. contraception advice and health care connected to abortion).

People without necessary permits (undocumented migrants) have the same rights to subsidized health care as asylum seekers since 2013. In addition the region is given the ability to provide health care up to the same level as for residents for asylum seekers and undocumented migrants. Children regardless of legal status have the same rights to health care as children who are citizens.

Treatment and organisation of care: In Sweden, regional health authorities are responsible for providing healthcare, but private actors exist and are entitled to work, including NGOs and humanitarian actors. Any healthcare provider should follow relevant national

⁵³ Transkulturellt centrum (2015)

health legislation and regulations. Some regions offer psychotherapy and to a larger extent – psychosocial support to asylum seekers. However access to psychotherapeutic treatment can vary depending on legal status and where in the country you live. Technically lots of regions lack psychologists and others that have knowledge in the treatment of trauma. According to the Swedish Red Cross experience, it is difficult for asylum seekers and undocumented migrants to receive long term psychotherapeutic treatment within the regular healthcare system. The Swedish RC treatment centres provide treatment irrespective of legal status.

Most of the care for refugees is provided within the regular psychiatry and primary care. Some regions have specialized teams on the local and regional level. The Swedish Red Cross is the key service provider for refugees, asylum seekers and other migrants who suffer from trauma linked to torture, armed conflict and dangerous migration. They run six treatment centres across the country. Apart from that, some eight other similar centres exist, run by private actors and regional authorities. Some regions have specific clinics for children with a refugee background.

Training: Anyone who is authorised to work with psychotherapy (licensed psychologists and psychotherapists) is authorized to treat refugees. Also other healthcare staff is authorized if they have done extra schooling which may have last just a couple of days. There is a lack of specialists in trauma treatment and no formal training regarding treatment of refugees is at hand. Information on trauma affected refugees is not systematically integrated in relevant university curricula for healthcare personnel. There are projects nationally and regionally to raise competence and disseminate knowledge in this area, mainly with a focus on the effects of trauma and PTSD and migration related stress, and to a lesser extent with a focus on therapeutic treatment. There is no national best-practice concerning therapeutic work with refugees. On regional level there are guidelines for treatment of PTSD and trauma, and in some regions for refugee health care. On national level there are guidelines for the treatment of specific diagnoses (depression, anxiety etc, from the National board of Health and Welfare). In the guidelines, there is a focus on psychosocial support and stabilization, especially for asylum seekers.

In practice, many registered psychologists and psychotherapists do attend trainings and gain experience in this field. The Swedish Red Cross provides trainings to various staff on trauma, torture etc. based on their needs and requests.

Language interpretation services in Sweden:

In Sweden, it is a legal right to have an interpreter when needed to access health care or in contact with other official agencies. The service is financed within the regional welfare budget or state budget.

Swedish government is “welcoming a harmonization” of migration law within the EU:

In Sweden, as in many other countries, the Directive 2013/33 /EU of the European Parliament and of the Council of 26 June 2013 that provides persons with mental illnesses and those who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence with the required medical and other assistance, has not yet been implemented in national law. The government has ordered an official report on how to implement it to be finished during 2017. However other EU directives (2013/32 on the asylum procedure for example), has rendered few changes in Swedish national law. The Swedish government is “welcoming a harmonization” of migration law within the EU.

Needed changes:

- In general a better and more humane reception system that facilitates integration and makes stepped health care available to those who need it.
- Changes in the judgement of the Migration office which show a lacking knowledge on the consequences of trauma and the serious affects of the impossibility to be able to plan ones future and of problems with family reunification.
- Improve the number of staff, especially in the rural part of the country. More resources for psychiatry are needed in many places also for the countries citizens.
- Enhance group treatments to make more help available for people in urgent need of psychotherapeutic support.
- Further education nationwide, with a focus also on specialized psychotherapy. Instead of a lot of different projects on regional or even national levels, it would be necessary to make this knowledge integrated in courses in undergraduate studies and in the basic training to become a psychologist, psychotherapist and social workers etc.
- Better information and access to health care regardless of legal status.
- Better conditions for interpreters in health care to make this an attractive career choice.

- **Switzerland**

Prevalence: Four out of ten participants met diagnostic criteria for at least one DSM-IV disorder. Major depression (31.4%) and PTSD (23.3%) were diagnosed most frequently. The number of experienced traumatic event types was highly correlated with psychiatric morbidity.⁵⁴

Feedback from the authorities show that the rate of refugees and asylum seekers with traumatisation or mental illness cannot be quantified. However, half of the cantons in Switzerland responded that they regard it as high. At the same time, the ratio of refugees that receive treatment and mental health care varies considerably from one canton to the other. From the perspective of several cantonal authorities more efforts have to be made to provide (early) diagnosis of traumatisation or mental illness.⁵⁵

According to estimates provided by ten cantons approximately 100–200 places with specialist treatment, offering psychosocial therapy and care for refugees with traumatisation or mental illness, are missing. Based on these figures, one can assume that in the entire country places for approximately 200–500 patients are lacking.⁵⁶

Legal framework: Switzerland has a compulsory health insurance scheme for all persons with a legal status, including asylum seekers. This basic insurance, covering the exact same services for all members, also includes all types of psychiatric or psychotherapeutic treatment that are indicated by a physician. It includes psychotherapy (up to 40 sessions per year are unproblematic) as well as inpatient treatment and medication etc. Therefore, on the legal level, persons with all types of residence papers have access to the same kind of basic insurance. However, inequalities exist in everyday practice, for instance because costs for interpreters are not covered by the health insurance which makes access to psychotherapy impossible for anyone not speaking the local language.

Payment of interpreters is not regulated and unresolved and a major obstacle to establishing care provision. Depending on the case, the institution and on the city, this payment is taken on by the municipality, by private organisations, charities or it can be accommodated in the overall budget of a clinic.

⁵⁴ Heeren et al. (2012). Mental health of asylum seekers: a cross-sectional study of psychiatric disorders. *BMC Psychiatry*, 12, 114.

⁵⁵ <http://www.sem.admin.ch/dam/data/sem/integration/berichte/analyse-psysoz-angebote-d.pdf>

⁵⁶ Ibid.

Treatment and organisation of care: Even though they are in principle entitled to psychotherapeutic treatment, many asylum seekers are insured via a gatekeeper model so that the physician decides whether to refer them on to a psychiatrist or psychotherapist. The compulsory health insurance scheme ceases in case of asylum denial and a revocation of the residence permit; health matters then are at the discretion of the social authorities in charge.

No special approval is necessary for the treatment of refugees. Clinical psychiatric general care as well as psychotherapeutic treatment by office-based psychiatrists can be delivered independent of the residency status of the patient; the psychologists are assigned by the responsible authorities (except with self-pay patients, practically never the case with refugees).

A study conducted by the State Secretariat for Migration (Staatssekretariat für Migration – SEM)⁵⁷ prior to the present substantial influx of refugees concluded that the basic care providing treatment for refugees is not of sufficient quality and that up to 500 specialist treatment places are missing in Switzerland.

Training: Most refugees are typically treated within the ordinary structure, as specialised care provision is rare and psychotherapists usually do not have sufficient language skills to enable communication. This ordinary treatment structure does usually not comprise therapists with a special training. In the entire country of Switzerland, only a few specialised treatment facilities exist: five outpatient practices for victims of torture and war as well as several refugee counselling centres. Their staff members typically have received training in trauma therapy and in dealing with transcultural issues.

Switzerland: best practice afk

An outstanding best-practice case is the outpatient centre for victims of torture and war (Ambulatorium für Folter und Kriegsoffer – afk) in Zürich. Multi-modal services offer various types of treatment on the one hand (psychiatric care, psychotherapy including trauma-confrontational methods, body-oriented therapy, social work) and integration measures on the other hand (German classes, labour integration measures, social integration). In addition to that there is an in-house professional interpreting service and the afk cooperates closely within a network of other involved agencies (legal counselling, the municipality, primary care providers et al).

⁵⁷ <http://www.sem.admin.ch/dam/data/sem/integration/berichte/analyse-psysoz-angebote-d.pdf>

Needed changes: Many refugees do not have access to psychiatric or psychotherapeutic treatment – no matter what their residency status is – because they do not speak the language, lack information or because of cultural prejudices or fear of stigmatisation associated with mental problems.

- **United Kingdom**

Prevalence: In the UK, mental health policy recognizes that refugees and asylum-seekers are a particularly vulnerable and at-risk group. It is widely acknowledged that the prevalence of mental health problems among refugees and asylum seekers is greater than among the general population.⁵⁸ Refugees and asylum-seekers experience a higher incidence of mental distress than the wider population.⁵⁹ The most common diagnoses are trauma-related psychological distress, depression and anxiety.⁶⁰

Studies in immigration detention centres specifically show: High proportions of immigration detainees experience depression, post traumatic stress disorder and anxiety, as well as intense fear, sleep disturbance, profound hopelessness, self-harm and suicidal thoughts. In a study monitoring immigration detainees over a nine month period 85 per cent reported chronic depressive symptoms, 65 per cent reported suicidal ideation, 39 per cent experienced paranoid delusions, 21 per cent showed signs of psychosis and 57 per cent required psychotropic medication.⁶¹

In more general health settings available to refugees living in the community, stigma around mental health can prevent people speaking out and is particularly acute in some migrant communities. Services are not always culturally appropriate and there may also be language barriers to overcome. Vulnerable migrants, including refugees and asylum seekers, are at higher risk of homelessness and poverty, which can also impact severely on mental health.⁶²

⁵⁸ Examples of this acknowledgement can be found in [the National Service Framework for Mental Health](#) (1999, Department of Health, p.17) and [Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett](#) (2005, Department of Health, p.51).

⁵⁹ The Future Vision Coalition, Opportunities for a new mental health strategy, 2009.

⁶⁰ Crowley, 2003: An Exploration of Mental Health Needs of Asylum-seekers in Newcastle, The Tyne, Wear and Northumberland Asylum-seeker Health Group.

⁶¹ [Mental health implications of detaining asylum seekers: systematic review](#), British Journal of Psychiatry 2009, Katy Robjant, Rita Hassan and Cornelius Katona, p.307.

⁶² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf

Legal framework: The UK has retained a special status in relation to EU's Asylum and Immigration Programme. This means that the UK is not automatically bound by EU legislation falling within these areas, unless it exercises its right to opt-in to the measure. The UK has not opted into Directive 2013/33/EU so it is not bound by it. It will therefore continue to be bound by the original Reception Conditions Directive (Directive 2003/9/EC).

Regulation 15 of The National Health Service (Charges to Overseas Visitors) provides an exemption for refugees and asylum seekers so that no charge may be made or recovered in respect of any relevant services – including psychotherapy - provided to them.

Psychotherapeutic care isn't legally regulated in the UK. There are no national standards, no code of conduct and no obligation to join a professional register. The Department of Health published a consultation in 2007 with the intention of introducing statutory regulation for psychotherapists.⁶³ However, in 2011 they confirmed that they would not introduce mandatory registration.⁶⁴

Treatment and organisation of care: Access to NHS services is based on clinical need, so services should be available to everyone equally.⁶⁵ Refugees and asylum seekers, along with their dependents, are fully entitled to receive health care through NHS primary care, secondary care, accident and emergency care and NHS Walk-in Centres⁶⁶. This includes the right to register with a GP. Most asylum seekers will also be exempt from prescription charges and related benefits.

Asylum applicants, who have not been successful in their application, retain entitlement to some free health care, for example emergencies or treatment that is immediately necessary. In these cases the hospital must treat the patient first and charge later for services.⁶⁷

⁶³ <https://www.gov.uk/government/publications/trust-assurance-and-safety-the-regulation-of-health-professionals-in-the-21st-century>

⁶⁴ <http://www.hpc-uk.org/assets/documents/10003436Item29-anyotherbusiness.pdf>

⁶⁵ Some overseas visitors may have to pay for some services.

⁶⁶ The tax funded NHS in the United Kingdom provides health coverage to „ordinary residents“, a definition enclosing free access to secondary care for people with an explicit permission from the immigration authorities to remain in the UK. This may be a temporary protection, an asylum or a protection for humanitarian reasons. Free primary care is delivered also to a temporary resident or a person without resident in any place. Regardless of the patient's status there is a free service for victims of torture. Undocumented migrants have an only limited free access in emergency departments and communicable diseases and have to pay for hospital and secondary care.

⁶⁷ Mind's report Improving Mental Health Support for refugee communities:

https://www.mind.org.uk/media/192447/Refugee_Report_1.pdf

In the UK there isn't a specific part of the health system set up to specifically treat refugees and provide psychological therapies. Refugees are expected to register to their local General Practitioner (GP) and access mainstream health services.

In reality, refugees do not tend to register to GPs and Community nurses are the most likely NHS staff to be involved in supporting the groups who have difficulty accessing mainstream health services. These include people who are homeless, vulnerable migrants (such as asylum seekers and refugees), sex workers, gypsies, Roma and travelers.

Most frontline community nurses will see people who fall into one or more of these groups. Some nurses work exclusively with vulnerable individuals and families, often employed by charitable organizations in outreach work, taking the (often specialist) healthcare to the people.

Studies in the UK show adverse effects of care in detention centers

Detention can have an independent adverse effect on mental health exacerbated by:

- the inadequacy of mental health assessment and care in immigration detention;
- limitations of the reception and screening process;
- the lack of mental health awareness amongst staff;
- failures of the Rule 35 reporting system;
- the likelihood that detainees will have suffered pre-migration trauma;
- the long-term or indefinite nature of immigration detention;
- the lack of structure and routine in immigration detention;
- the isolation from the outside world experienced by many detainees; and
- the detention of individuals who have been in prison for criminal offences with individuals who do not have a criminal record.

(Mental health implications of detaining asylum seekers: systematic review", British Journal of Psychiatry 2009, Katy Robjant, Rita Hassan and Cornelius Katona, p.307.) and https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf

The NHS does not offer a structured, coordinated, nationwide approach to offering psychological support to refugees. There are a number of centres on the territory that treat refugees with mental health problems but these are largely run by charities and third sector organisations including the Refugee Council, Refugee Action, Mind, and the British Red Cross.

Best-practice examples available in the UK have shown that the crucial aspects ensuring the success of interventions are community engagement and co-design of services to make sure the treatment is culturally competent, relevant to the individual and person-centred.⁶⁸

Training: Specialist training is not offered consistently to members of staff working with or treating refugees. When training is actually provided it most frequently happens through third sector organisations such as the Refugee Council or Refugee Action who offer training to health & social care staff working with refugees.

Experts agree that increased coordination among health practitioners and training for frontline staff is necessary⁶⁹ and that treating refugees needs to be seen as a specialism⁷⁰.

As far as psychological treatment is concerned, the closest thing to a coordinated approach to ensuring its relevance to refugees is the Asylum Seekers and Refugees Mental Health Network established by the UK Royal College of Psychiatrists.⁷¹

Professionals working in psychotherapeutic care are voluntarily regulated. There are a number of professional registers that professionals can join but there is no statutory obligation to do so. Organisations include United Kingdom Council for Psychotherapy (UKCP), British Association for Counselling and Psychotherapy (BACP) and The British Psychoanalytic Council.

The Professional Standards Authority for Health and Social Care (PSA) launched an Accredited Voluntary Register scheme. They develop standards for accredited registers to meet and encourage to develop good practice. They use them when they review the performance of regulators and accredit registers.

⁶⁸ The Social Care Institute for Excellence has captured some useful information:

<http://www.scie.org.uk/publications/atagance/atagance26.asp> Mind has also produced a number of publications capturing best practice examples. They can be accessed on this webpage:

<http://www.mind.org.uk/about-us/our-policy-work/equality-human-rights/supporting-vulnerable-migrants/>

⁶⁹ „It could speed up the evolution of effective mental and physical health services, helping to tackle stigma around mental health and wellbeing as well as enabling greater levels of integration of refugees into their new communities". (Milly Macdonald, Policy Officer at the Mental Health Foundation).

⁷⁰ „Their needs are incredibly different [to a typical member of the general public] and complex, and nurses must understand that" (Dr Jane Gray, a former practice nurse and director of Leicester's ASSIST practice, which specialises in the treatment of refugees and asylum seekers).

⁷¹ <http://www.rcpsych.ac.uk/workinpsychiatry/faculties/generaladultpsychiatry/aboutthefaculty/networks/asylumseekersandrefugees.aspx>

At present, anyone can advertise as a psychotherapist or counsellor because there is no statutory protection of these particular titles. Training standards are inconsistent. Complaints procedures and codes of practice vary from association to association and so the outcomes for people raising a concern may differ according to which body receives the complaint.

When practitioners are disbarred by their professional association they are legally entitled to continue working. Where sanctions are imposed, there is no legal obligation to implement them.

Needed changes:

- Mind firmly supports the need for statutory regulation of psychotherapists and counsellors. Statutory regulation will provide better protection for service users, some of whom will be accessing therapy when extremely vulnerable. It will also help to maintain a consistent high standard of practice amongst these professions.
- Mind has long been concerned about the mental health of vulnerable migrants including refugees and asylum seekers. People with mental health problems should only be subjected to immigration detention in very exceptional circumstances. When someone arrives in the country and is first assessed, a clinical judgment should be made to determine whether someone is experiencing mental health problems and, if so, whether they can be satisfactorily managed in detention. Detainees experiencing mental health problems that are caused or exacerbated by detention to the point that they become serious should be released into the community, except in very exceptional circumstances. It is never appropriate for a person likely to suffer from acute or crisis mental health breakdown to be detained in immigration detention“.
- There needs to be adequate healthcare provision in immigration removal centres which mirrors that which is available in the community and is capable of meeting individuals’ needs and promoting recovery, including a range of treatments that are not limited to, and may not include, medication. This should include talking therapies such as counseling and cognitive behavioral therapy, access to therapeutic groups and activities, drop-in sessions, specialist services and alternative therapies, all delivered by competent practitioners and consistent with NICE guidance.⁷²

⁷² Mind recently produced a set of recommendations for commissioners: <http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/02/Vulnerable-Migrants-guidance-for-commissioners-August-2014-FINAL.pdf>

- Services need to recognize the adversity that vulnerable migrants have faced and may continue to face once they arrive in the UK. Services need to be culturally appropriate for different communities and should put measures in place to overcome language barriers. Staff should be trained in diversity and cultural sensitivity and have the resources they need – such as interpreters, information in different languages and access to expertise about working with migrant communities – so that they can best support people.
- The sooner people get help, the better. The longer anyone goes without help, the greater their risk of reaching crisis point, where they will need more intensive support. Access to services should therefore be timely, which includes making sure that vulnerable migrants know what support is available and where and how to access it.

3 List of experts

We are very grateful to all the experts who have taken part in the survey. We particular thank:

Austria: Dr. Sonja Kinigadner, Head of the “Welcome” counselling and traumatherapy center off “you-are-welcome” Association

Belgium: Sarah Strauven - clinical psychologist, psychotraumatologist and narrative therapist in a reception centre for asylum seekers and in private practice.

Johan Op De Beeck - clinical psychologist, systemtherapist, specialised in psychotrauma - private practise (and through previous work familiar with the mental health services in Flanders).

Cyprus: Maria Karekla, Ph.D., Assistant Professor at University of Cyprus and Dr. Vasilis S. Vasiliou, Clinical Psychologist, Instructor at the Department of Psychology, University of Cyprus, president at the local Greece Cyprus chapter of the Association of Contextual and Behavioral Science (ACBS).

Germany: Dr. Theresa Unger, Bundespsychotherapeutenkammer. Working group „Trauma and Migration“ of the German society for Psychotraumatologie (DeGPT)

Greece: Nikolaos Gkionakis, psychologist, Scientific Associate, Babel Day Centre, Mental health unit for migrants and refugees, Athens.

Hungary: Dorottya Átal, project manager at the “Cordelia Foundation”

Ireland: Declan Aherne, Clinical Psychologist and Head of Counselling at the University of Limerick

Italy: Dr. Alberto Zucconi, President of the Person Centered Approach Institute (IACP), founder and General Secretary of the Coordinamento Nazionale Scuole di Psicoterapia (CNSP)

The Netherland: Marieke Sleijpen, psychologist and researcher, Foundation Centrum '45 and Larissa van Beek, coordinator Arq Expertise centre Psychosocial support Asylum Seekers and Refugees.

Poland: Iga Jaraczewska - clinical psychologist, cognitive psychotherapist, supervisor of the Polish Association of Cognitive-Behavioural Therapy.

Portugal: Jorge Gravanita, President of Portuguese Association of Clinical Psychologists (SPPC).

Sweden: Aline Braun, lic psychologist/psychotherapist, Unit for transcultural psychiatry, Uppsala and Mikaela Lindström lic psychologist, Crisis- and Traumacenter, Stockholm. Swedish Red Cross.

Switzerland: Prof. Andreas Maercker and Dr. Tobias Hecker, University of Zurich, Dept. of Psychology, Lehrstuhl Psychopathologie & Klinische Intervention and Spezialambulatorium Traumafolgen.

United Kingdom: Alessandro Storer, Equality Improvement Manager - Mind

Further experts involved:

Marina Schmidt, European Social Insurance Platform (ESIP). ESTSS task force on refugees and forced-migrants.

4 Appendix: Questionnaire

Survey of NPCE members regarding the psychotherapeutic care of refugees in the EU

General items

1. Author (name and function)

Please enter your text here

2. Country (short information on population and expenditure on health/ mental health care)

Please enter your text here

Prevalence of mental disorders among refugees

3. Have any data-based studies been undertaken in your country regarding the prevalence of mental disorders among refugees? If so, what were the findings?

Please enter your text here

4. Have any studies been undertaken in your country regarding the number of mentally ill refugees being treated? If so, what were the findings?

Please enter your text here

Treatment of mentally ill refugees

5. Are refugees in your country entitled to psychotherapeutic treatment?

Please enter your text here

6. Who is authorised in your country to psychotherapeutically treat refugees?

Please enter your text here

7. Are those who psychotherapeutically treat refugees specially trained to treat refugees?

Please enter your text here

- a. If so, by whom, and what is the content of this training?

Please enter your text here

8. How is psychotherapeutic care for refugees organised in your country? Are there any treatment centres or institutes in your country specifically for mentally ill refugees?

Please enter your text here

9. Are there best-practice examples in your country regarding the treatment of mentally ill refugees? If so, can you describe them?

Please enter your text here

10. Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 provides that persons with mental illnesses and those who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence be provided with the required medical and other assistance. How has this Directive been implemented into the national law of your country?

Please enter your text here

Legal framework

11. How is psychotherapeutic care for refugees legally regulated in your country?

Please enter your text here

12. Does the provision of psychotherapeutic care to refugees differ according to residence status?

Please enter your text here

13. Does the psychotherapeutic care received by refugees differ from that received by citizens of your country?

Please enter your text here

14. Who bears the cost of providing psychotherapeutic care to refugees?

Please enter your text here

15. Have there been changes to the law in your country as a result of the “refugee crisis” that have altered the provision of care to mentally ill refugees? If so, what changes have been made?

Please enter your text here

Language interpretation services

16. Please explain whether the use of language interpreters in the provision of psychotherapeutic care to refugees is regulated and financed in your country, and if so, how.

Please enter your text here

Needed changes

17. In order to improve the psychotherapeutic care of refugees in your country, what changes do you believe are necessary?

Please enter your text here

18. Do you wish to add any further remarks about any important aspects that this survey has not addressed?

Please enter your text here