

**Assessment of Psychiatric and Psychological Needs Among Help-  
Seeking Migrants in Dublin: Final Report**

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Seeking Migrants in Dublin: Interim Report**

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## **Introduction**

The ethnocultural profile of Irish society has become increasingly diverse in recent years. At present migrants constitute 10.4% of the Irish population and this is expected to rise to 18% by 2030. This demographic change has created a growing need for Irish society to develop culturally sensitive health care institutions that meet the needs of migrant groups. Many in these groups have experienced specific psychosocial stressors such as economic hardship, torture and abuse of human rights, enforced migration, separation from family, and difficulties with adjustment to their new cultural and social environments. International literature shows significantly increased rates of depression, post-traumatic stress disorder, anxiety and psychosis among migrants. There is a marked dearth of research on the topic in Ireland, but preliminary work suggests that migrants entering Ireland also experience significant psychological distress and encounter substantial difficulties accessing appropriate services. The importance of further research and service provision in this field is highlighted in the National Intercultural Health Strategy (2008).

### ***Aims of the Study***

The aim of the present study was to identify the psychological and psychiatric needs of help-seeking migrants in Dublin and to compare these needs with those of native Irish help-seeking individuals. The study aimed to provide concrete guidelines to our health services in order to facilitate their adaptation to the country's increased diversity and to develop levels of cultural competence among persons providing such services. The study findings will be used both to inform the planning of a specialised cultural psychiatry clinic in the Mater Misericordiae University Hospital and to guide the training of mental

health staff within the service and beyond. The results will also provide a systematic and detailed account of mental health needs and outcomes among migrants who have accessed psychiatric services, and will determine the extent to which such a specialised service is required in this inner-city area. The present study is a necessary contribution to understanding the specific aspects and needs of migrants who are experiencing distress and mental health difficulties.

## **Methodology**

### ***Sampling and Recruitment***

#### *Definitions*

For the purposes of this study, a *migrant* is an individual who: (a) was born outside the Republic of Ireland; (b) has been living in Ireland for 7 years or less; and (c) is currently living in the catchment area covered by the psychiatric services in this study (i.e. Dublin's north inner-city). A native Irish individual is a person who was born in the Republic of Ireland and is currently living in the catchment area covered by the psychiatric services in this study (i.e. Dublin's north inner-city).

#### *Inclusion criteria*

To be eligible to participate in this study, participants had to be:

- aged between 18 and 65 years;
- capable of giving informed consent;
- in search of psychological help at (a) the Mater Sector Psychiatry Team (e.g. referred by general practitioners or self-referring to the Emergency Department);

(b) the Mater Misericordiae University Hospital Neurology-Psychiatry Clinic; (c) the North Strand Psychiatry Team, based at St Vincent's Hospital, Fairview or (d) the Cabra Sector Psychiatry Team, based at Connolly Hospital Blanchardstown.

- either a migrant or a native Irish person.

#### *Exclusion criteria*

Individuals were excluded from the study if they were:

- aged under 18 or over 65 years;
- incapable of giving informed consent;
- not in search of psychological help;
- neither a migrant nor a native Irish person.

The study recruited a consecutive sample from the psychiatric services mentioned above. 47 migrant participants and a comparison group of 100 native Irish participants were recruited for the study. Both forced (i.e. refugees and asylum seekers) and voluntary migrants were included in the migrant group.

#### *Research Tools*

At the assessment, each participant was assessed using the following instruments:

- Demographic information sheet devised by the authors. Information regarding gender, age, country of origin, native language, marital status, educational achievements, number of children, legal status and current employment was elicited

using this instrument. Participants were also asked to report their perceived proficiency in speaking, comprehending, reading and writing English.

- *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinician Version*. This psychiatric diagnostic tool has been widely validated in multiple ethnic groups (First et al., 1997; So et al., 2003; Gorman et al., 2004).
- *Multidimensional Scale of Perceived Social Support* (Zimet et al., 1988). This instrument measures the perceived social support that participants feel is available from family, friends and other significant persons in their life.
- *Kessler Psychological Distress Scale* (Kessler, 2002). This scale measures feelings of psychological distress experienced by the respondent during the past 30 days.
- *The Beck Depression Inventory* (Beck & Steer, 1993). This measure of depression has been validated for use in multiple ethnic groups.
- *The Beck Anxiety Inventory* (Beck & Steer, 1987). This anxiety measure has also been widely validated and used in multiple ethnic groups.
- *The Harvard Trauma Questionnaire* (Mollica et al., 1992). This instrument was designed for use amongst refugees and individuals from diverse cultural backgrounds. It has been validated and used in multiple ethnic groups. *The Harvard Trauma Questionnaire* has been translated into multiple languages and its psychometric properties validated in each language, in order facilitate assessment of migrant groups from myriad ethnic and cultural backgrounds (Kleijn et al., 2001). A study by Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture (2003), for example, recently used this instrument with individuals arriving in the US from a range of diverse ethnic and cultural

backgrounds, including Africa, Eastern Europe, Asia, Latin America and the Middle East.

### ***Fieldwork***

The postgraduate researcher approached both Irish and migrant individuals attending the psychiatric outpatient services of the Mater, Cabra and North Strand Sectors. After the establishment of the pilot Cultural Psychiatry Clinic at the Department of Adult Psychiatry in the Mater Hospital, migrants using this service were also invited to participate. Individuals willing to participate were asked to give written consent and were informed that they were free to withdraw at any stage without needing a reason. Following the completion of quantitative interviews (study 1), a sub sample of the migrants was invited to take part in an additional qualitative study phase (study 2) involving in-depth interviews. These interviews took place in both the outpatient clinics and at the Department of Adult Psychiatry of the Mater Hospital.

### ***Study 1: Quantitative Interviews***

The quantitative interviews took approximately 90 minutes to complete and were usually completed over two occasions. The SCID was administered on the first occasion and the remaining assessment tools completed at the second encounter. All of the interviews were conducted face-to-face by the psychology postgraduate researcher and all of the instruments were administered orally. On 15 occasions interviews were conducted with the aid of an interpreter where participants were not proficient in English.



### *Study 2: Qualitative Interviews*

The aim of the qualitative component of the study was to gain a much greater insight into how the migrants feel that their mental health needs would be best met and to use this information to enhance and improve services provided at the pilot cultural psychiatry clinic. A sub sample of the migrant group of service users was selected to take part in in-depth interviews. The interview was split into three sections. The first section focused on the participant's understanding of their health and illness currently, the perceived severity of their illness, their attitudes to the services they use and their responses to the different treatments. The second section focused on the differences between mental health services in the participant's country of origin and Irish mental health services, as well as the different approaches to treating a problem such as the one they are experiencing. The third section of the interview looked at the impact that the mental illness has had on the participant's life and explored the nature and extent of social support that has been available throughout the illness period. 14 males and 6 females took part in the interviews. Interviews ranged from 20 to 60 minutes each. The postgraduate researcher was careful to choose participants from a diverse range of nationalities to create a broad spectrum of diverse opinions and beliefs. The researcher also ensured that participants were selected from different legal status categories within the migrant population (i.e., asylum seekers, refugees and migrant workers) to gain an insight into the different stressors experienced by these groups. All participants gave permission for their interview to be recorded and all interviews were subsequently transcribed.

### ***Pilot Cultural Psychiatry Clinic***

#### *Description of the clinic*

A pilot Cultural Psychiatry Clinic was launched in the Department of Adult Psychiatry in the Mater Misericordiae Hospital in January 2008. The clinic took place every Thursday morning where Dr Brendan Kelly, Dr Niall Crumlish and Fiona Kelly assess new migrant patients. The overall aim of the pilot clinic was to provide a systematic and detailed picture of mental health needs of migrants and to quantify the extent to which such a specialized service is required in the Dublin inner-city area. The goal of such a service is to provide migrant patients with a more focused, individual needs assessment in a culturally friendly and welcoming environment. Interviews took place in a room provided by the Department of Adult Psychiatry that had been decorated to welcome migrants with culturally appropriate material, including a map of the world and a wide range of flags. Where patients were not proficient in the English language, the clinic recruited interpreters. This ensured that effective communication takes place. Due to the success of the pilot clinic to date, the researchers hope to establish a longer-term Cultural Psychiatry Clinic in the Department with a dedicated team of culturally competent mental health professionals.

#### *Cultural Advisory Panel*

With the helpful suggestion of the NDA, a cultural advisory panel was established in April 2008 and the first meeting took place on the 13 June 2008. The aim of the panel was to discuss the current operation of the pilot cultural clinic and to obtain feedback and advice from members on how best to provide culturally competent mental health care at

the clinic. The panel was made up of three willing migrant participants from diverse ethnic backgrounds, as well as Dr Brendan Kelly, Dr Niall Crumlish and Dr Nwachukwu, a visiting Nigerian doctor based in the Department of Psychiatry in St James' Hospital, Dublin. Topics for discussion at the first meeting included the views of the panel members on the current research being undertaken by the Cultural Psychiatry team as well as the views of panel members on the Cultural Psychiatry Clinic as a clinical entity. A point of information that arose from the discussion was the possibility that many migrants in the catchment area may not know how to access psychiatric care. Panel members discussed the possibility of advertising the Cultural Psychiatry Clinic to various community groups. Barriers to seeking mental health care among migrants were also discussed. Among these were the lack of understanding of the services available, and the possibility that people with immigration difficulties would be afraid to go to the clinic for fear of repatriation. The establishment of the panel proved to be a very worthwhile and valuable exercise for the research. Along with the information gathered from the qualitative interviews, the minutes from the first panel meeting will help to ensure that the care provided at the proposed Cultural Psychiatry Clinic at the Mater Misericordiae Hospital will meet the expectations and needs of the migrant patients.

## **Literature Review**

### **Introduction: migration, mental health and Ireland's changing society**

The ethnocultural profile of Irish society has become increasingly diverse in recent years and Ireland is fast becoming transformed into a multicultural society. Prior to the 1990s Ireland was one of the most mono-cultural societies in the Western world, with a long

tradition of emigration. However, the economic boom of the 1990s saw a dramatic rise in inward migration. According to the Central Statistics Office, approximately 419,000 foreign nationals were residing in Ireland in 2006. The population of Ireland increased by 8.1% between 2002 and 2006, and migration was the dominant factor in this increase. Currently, migrants constitute 10.4% of the population (CSO, 2006).

In 1992 Ireland received 39 applications from persons seeking refugee status. A decade later this figure had risen to 11,634 applications (Office of the Refugee Applications Commissioner, 2003). The number of asylum applications reached their peak in 2002 and since then have decreased yearly. According to the latest statistics from the Reception and Integration Agency, 6,759 asylum seekers are currently in accommodation centres across Ireland. Out of the current 62 centres nationwide, 18 of the centres are situated in Dublin with 13 based in the inner-city area. According to Ryan (2006), there is an uneven distribution of asylum-seeker housing across the four local authority areas.

However, when all immigration figures are considered, asylum seekers only make up a small minority of people who migrate into Ireland every year. With the marked growth of in-migration to Ireland in recent years, Ireland faces the challenge of providing services to an increasingly diverse population. To meet the needs of this diverse population, Irish society must develop culturally sensitive institutions and services. A key step in developing culturally competent services is the assessment of the needs of service users from our growing migrant communities. One area in which major changes are required is the health sector. The health sector has to adapt to the unprecedented levels of cultural

diversity among its service users and the new challenges they pose to the effective planning and delivery of services. Recognition and acknowledgement of the ethnic diversity of people with disabilities is one of the major challenges facing health services in Ireland. Minority ethnic groups encounter cultural, linguistic and institutional barriers in accessing health services, and in the quality and continuity of care. Maximising the potential contribution of migrants to a country requires that their health is optimal and that their access to health services is facilitated (Rafnsson & Bhopal, 2008). However, in their *Regional Health Strategy for Ethnic Minorities*, the Eastern Regional Health Authority (2004) concluded that, “ethnic minorities tend to be a socially excluded, vulnerable group whose health needs should receive special attention” (p. 12).

### **Policy and legislation in Ireland**

The need for greater knowledge of the mental health needs of migrants has been highlighted repeatedly in the psychiatric literature (Clare, 2002; Gavin et al., 2001; Feeney et al., 2002; Kelly 2004). National policy and legislation has also recognised the importance in meeting migrants’ mental health needs. For example, the National Disability Act 2005, a key element of the National Disability Strategy, aims to improve access to mainstream public bodies for people with disabilities as well as supporting the provision of disability-specific services. Migrants with mental health needs fall under this legislation as the strategy reinforces the Government’s commitment to social inclusion for people with disabilities. The National Disability Strategy builds on existing policy and legislation, including the Employment Equality Act 1998, the Equal Status Act 2000 and the Equality Act 2004. The Equality Acts prohibit discrimination on nine grounds,

including race and disability. The most recent statement of national mental health policy, *A Vision For Change* (Expert Group on Mental Health Policy, 2006), notes that the needs of specific groups such as refugees, asylum seekers and “other immigrant populations will be addressed by the provision of comprehensive mental health services that are based on care planning taking *all* the needs of the individual into account” (p. 48).

The Health Service Executive’s *National Intercultural Health Strategy*, launched in February 2008, stresses that, “a key element of the strategy is comprehensive assessment of need for ethnic minorities” (p. 18). A comprehensive and systematic assessment of migrants’ mental health is urgently needed for adequate psychiatric and psychological care among this target group: “Data is key to identification of priority needs and concomitant planning of services to address needs of persons from ethnic minority communities” (Eastern Regional Health Authority, 2004, p. 33). Similarly, the *Cultural Diversity in the Irish Health Care Sector* report (2002) stresses the importance of establishing what the health needs of diverse groups in Ireland are. The needs of asylum seekers in Dublin have also been highlighted by the Inspector of Mental Health Services (Inspector of Mental Health Services, 2005).

### **The international context**

Empirical studies on migration and mental health in Europe are still rare (Lindert et al., 2008). Despite the dearth of research in the area, it is generally acknowledged that migrants experience a greater level of psychological distress than native populations (Wittig et al., 2008). Most research in the area has taken place during the last three

decades (Haasen et al., 1997; Cabral Iversen & Morken, 2003) and reveals strong evidence of increased rates of post-traumatic stress disorder (Fazel et al., 2005), depression (Wittig et al., 2008) and schizophrenia (Cantor-Graae et al., 2005) amongst migrant individuals.

Migration takes many forms. Forced migrants are distinguished from voluntary ones by the greater level of ‘push’ versus ‘pull’ factors that determine their decision to migrate. A voluntary migrant is someone who chooses to migrate for economic or educational reasons, while a forced migrant flees his or her country due to political or safety reasons. However, although migrants originate from different cultural, educational and social backgrounds and do so for different reasons, they all share the challenge of adapting to a new socio-cultural environment. Migrants encounter a range of psychosocial and acculturative demands that are not generally experienced by the native population in Western countries. These include family separation, discrimination, social isolation and cultural and linguistic barriers to social participation (National Intercultural Health Strategy, 2008). Discrimination may in fact be part of the explanation for an increased incidence of psychotic disorders among ethnic minorities in Western Europe (Veling et al., 2007).

Lack of employment has also been noted to be a psychosocial stressor for migrants. In their *Realising Integration* study, the Migrants Rights Centre Ireland, noted that many migrants work at levels that do not reflect their level of education and training, and that this can lead to low self-esteem.

Levels of quality of life have also been found to be lower in migrants compared with native populations (Ekblad et al., 1999). To date, there has been little analysis of the experiences of either forced or voluntary migrants living with a disability in Ireland (Pierce, 2003). The importance of recognizing diversity among persons with disabilities is increasingly emphasised at the national, European and international levels.

### **The specific mental health needs of asylum seekers and refugees**

Asylum seekers and refugees face additional challenges as compared to voluntary migrants in relation to their mental health and are at high risk for developing mental health problems (Ekblad et al., 1999; Gilgen et al., 2005). Legal status insecurity and the constant fear of repatriation places additional psychological demands on asylum seekers (Ryan et al., 2008). In a national study of 162 refugees and asylum seekers, Ryan et al. (2008) found that 46% of the sample reported severe levels of distress. Begley et al. (1999) found similarly high levels of distress in their study of 43 asylum seekers in Dublin and Ennis, with 42% experiencing severe symptoms of depression and 54% experiencing severe anxiety. Laban et al. (2005) reported that the length of the asylum procedure was an important risk factor for psychiatric disorder among Iraqi asylum seekers in the Netherlands. Under the current 'Direct Provision' system in Ireland, persons awaiting decisions on their asylum claim are required to live in centres designated by the Government for up to five years. During this time, asylum seekers are not entitled to paid work and are required to live on €19.10 per week (adults) or €9.60 (children) in addition to the accommodation and food supplied at their centre. Remaining



in direct provision for this length of time is an additional stressor for asylum seekers, as it removes a person's sense of independence (Hyland, 2001).

Refugees and asylum seekers have different motivations for leaving their home country than persons who migrate for social, educational, economic or other reasons. Many asylum seekers and refugees have been forced to leave their country of origin to escape imprisonment, persecution, torture and even death (Jones & Gill, 1998).

Female refugees and asylum seekers are especially at risk for poor mental health, with many women experiencing anxiety, guilt, loss and bereavement (Kennedy & Lawless, 2003). It is widely accepted that women are at a greater risk of experiencing physical abuse and sexual violence (Nolen-Hoeksema & Rusting, 1999). Sexual violence includes such acts as forced nudity, rape, sexual slavery, forced pregnancy, forced abortion and forced sterilisation. Such violence also brings the risk of the victim contracting sexually transmitted diseases and other health problems. Gender-related trauma may also stem from culturally sanctioned practices such as female genital mutilation (FGM). FORWARD, an organisation that works against FGM, estimates that there are 86,000 first generation forced migrants in the UK who underwent this practice before migration (see Powell, Leye, Jayakody, Mwangi-Powell & Morison, 2004).

### **Migrants' access to mental health services in Europe and Ireland**

Stigma has long been cited in the literature as a barrier to accessing mental health services. In both the 2001 and the 2006 National Disability Authority Public Attitude to

Disability in Ireland surveys, public attitudes towards mental health problems were found to be more negative than attitudes to other disabilities. However, in some cultures, much greater stigma is attached to mental health problems. For example, in China, mental illness is seen as a result of the sins of ancestors, leading to the stigmatisation of people with mental health problems (Rosen, Greenberg, Schmeidler & Shefler, 2008). In Japanese culture, psychological distress is linked to psychological weakness, which can lead to social discrimination in relation to marriage, education and business (Hong Ng, 1996). Among the Vietnamese mental illness is viewed as “madness” and is considered untreatable (Lien, 1993). Youssef and Deane (2006) noted that stigma and shame in accessing mental health services proved to be a barrier for Arabic-speaking communities in Australia. Therefore, the cultural beliefs of many migrants in Ireland may prevent them from accessing mental health services due to the stigmatisation attached to their problems.

Migrants face many cultural, linguistic and educational barriers in accessing mental health care services in Europe. The lower rate of utilisation of mental health care services is likely to be reflective of such barriers, including linguistic barriers (Lindert et al., 2008). Communication difficulties along with a lack of information and the fear of being misunderstood all contribute to the difficulty in accessing appropriate services. In the European literature rates of admissions have been reported to be higher among migrants than native populations. In a systematic review of ethnic variations in pathways to and use of specialist mental health services in the United Kingdom, Bhui et al. (2003) report that most studies comparing Black and White patients found higher rates of in-patient

admissions among Black patients. In assessing the risk of acute admissions among immigrants to a psychiatric hospital in Norway, Cabral Inversen and Morken (2003) found that the risk was higher for asylum seekers compared with Norwegians (odds ratio: 8.84). Surinamese, Antillean, Turkish and Moroccan women made considerably less use of mental healthcare services than native Dutch-born women (Ten Have & Bijl, 1999).

In Ireland there is a marked paucity of research on migrants' access to mental health services. However, among the small body of literature, there are two studies worth noting. A chart-review study ( $N = 31$ ) at St James's Hospital, Dublin, suggested that the mental health needs of migrants are likely to be high and probably comparable to the increased mental health needs demonstrated in migrant populations in other countries (Kennedy et al., 2002). Communication difficulties between the asylum seekers and the mental health professionals were noted, as well as a high drop-out rate from the outpatient service. The authors concluded that this group may be in need of specialised services to meet their needs. Foley-Nolan and coworkers (2002) studied the needs of immigrants in Cork and Kerry ( $N = 210$ ) and found that 70% of the respondents had generally poor psychological health. Of these, only 4% had seen a counsellor and 2% had seen a psychiatrist. This study did not, however, report which psychological disorders were most prevalent and did not include a native Irish comparison group.

## **Findings**

The mean age of participants ( $n=147$ ) was 41.32 years (standard deviation 12.73, range 18-65); the mean age of migrants (33.37 years, standard deviation 10.11,  $n=47$ ) was

significantly lower than that of Irish individuals (45.17 years, standard deviation 12.10,  $n=100$ ) ( $t=6.21$ ,  $P<0.001$ ). Fifty-three per cent of participants were male; the proportion of male participants did not differ significantly between migrant and Irish groups (52.1% and 53.5%, respectively; Pearson Chi-Square 0.027,  $p=1.00$ ). The median number of children of participants ( $n=147$ ) was 0 (range 0-8); median number of children did not differ significantly between migrant and Irish groups (mean rank for migrant group 68.22, mean rank for Irish group 76.80, Mann-Whitney U 2098.50,  $p=0.204$ ). The mean number of years participants ( $n=147$ ) had spent in education was 12.54 (standard deviation 3.74, range 0-24); this did not differ significantly between migrant (mean 12.68 years, standard deviation 4.07) and Irish (mean 12.46, standard deviation 3.60) groups ( $t=-0.297$ ,  $p=0.767$ ). 20.4% of participants were married or cohabiting; 63.9% were never married or cohabiting; 13.6% were separated or divorced; and 2.0% were widowed; migrant individuals were more likely than Irish individuals to be married or cohabiting (33.3% and 14.1%, respectively; overall Pearson Chi-Square 8.482,  $p=0.037$ ).

Of the 15 migrants who were married or cohabiting, 11 (73.3%) had their partner present in Ireland. Of the 20 migrants who had children, 11 had all of their children with them in Ireland; 5 had left one child, one had left two children and one had left three children behind in their home country. Twenty-three migrants (47.9%) had attained residency status in Ireland; 9 (18.8%) were seeking asylum; and 9 (18.8%) were refugees. Thirty (62.5%) migrants had work permits; of these, 18 (60.0%) were unemployed and 3 (10.0%) were in full-time education. Migrants were significantly more likely than Irish individuals to report personal experiences of torture (28.3% and 3.0% respectively; Pearson Chi-Square 20.360,  $p<0.001$ ), murder of family and friends (41.3% and 8.1%

respectively; Pearson Chi-Square 22.877,  $p < 0.001$ ), and imprisonment (32.6% and 11.1% respectively; Pearson Chi-Square 10.179,  $p = 0.006$ ).

Migrants were significantly more likely than Irish individuals to fulfil diagnostic criteria for post-traumatic stress disorder (27.1% and 6.1% respectively; Pearson Chi-Square 12.694,  $p < 0.001$ ) and less likely to fulfil diagnostic criteria for alcohol dependence syndrome (8.3% and 32.3% respectively; Pearson Chi-Square 10.061,  $p = 0.002$ ). There was no difference between migrant and Irish groups in rates of schizophrenia (12.5% and 23.2% respectively; Pearson Chi-Square 2.351,  $p = 0.182$ ) and bipolar affective disorder (6.3% and 15.2% respectively; Pearson Chi-Square 2.384,  $p = 0.180$ ). There was no significant difference between migrant and Irish groups in mean scores for depression (mean BDI score 14.50, standard deviation 12.50, and mean 16.25, standard deviation 11.50, respectively;  $t = 0.842$ ,  $p = 0.269$ ) or mean scores for anxiety (mean BAI score 18.36, standard deviation 12.97, and mean 21.02, standard deviation 14.97;  $t = 1.045$ ,  $p = 0.298$ ).

A wide variety of nationalities are represented in the migrant group (see Table 1).

**Table 1.** Country of origin of migrant sample

Country of Origin	No. Recruited
1. Kazakhstan	1
2. China	3
3. Poland	3
4. Nigeria	5
5. Lithuania	2
6. England	1
7. Moldova	1
8. Russia	1
9. Vietnam	1

10. Palestine	2
11. Somalia	1
12. Algeria	2
13. South Africa	1
14. Zimbabwe	1
15. Cameroon	1
16. Uzbekistan	1
17. Armenia	1
18. Iraq	2
19. Romania	6
20. Iran	2
21. Latvia	1
22. Germany	1
23. Afghanistan	1
24. Mongolia	1
25. Azerbaijan	1
26. Canada	1
27. Mauritius	1
28. Sudan	1
29. Spain	1
Total number of migrants	47

The migrant group (n=47) included individuals of 29 different nationalities (Table 1) and 24 different mother-tongues (Table 2).

**Table 2.** Mother-tongue of migrant sample

Mother-Tongue	Number of Participants
English	4
Chinese	2
Polish	4
Moldovian	1
Kurdish	1
Russian	4
Vietnamese	1
Arabic	5
Somali	1
Zulu	1
French	1
Uzbek	1
Armenian	1
Algeria	1

Romanian	6
Farsi	1
Benin	1
Mandarin Chinese	2
Igbo	4
Howramy	1
Mongolian	1
Creole	1
Lithuanian	1
Spanish	1
Total	47

## Discussion

### Study 1

#### *General characteristics*

The migrant individuals in our sample (n=47) tended to be younger than Irish individuals and were more likely to be married, but did not differ in terms of educational level or number of children. A significant proportion of migrants who had children had left at least one child behind in another country (45%). The migrant group included individuals from 29 different countries of origin; the highest number to come from any single country was six (from Romania). The migrant group included individuals with 24 different mother-tongues; again, the highest number with any single mother-tongue was six (Romanian).

#### *Psychiatric diagnoses*

Migrants were significantly more likely than Irish individuals to fulfill diagnostic criteria for post-traumatic stress disorder (PTSD) (27.1% and 6.1% respectively). This is consistent with previous findings of increased rates of PTSD in migrant populations. One

recent systematic review looked at the prevalence of serious mental disorder in seven western countries and found that refugees resettled in the west are approximately 10 times more likely to have PTSD than their age-matched counterparts in those countries (Fazel et al., 2005). Urlic (1999) reported high levels of PTSD in Bosnian war refugees compared with the non-refugee group. In Oslo, PTSD affects 47% of all refugees (Lavik et al., 1996). An Australian study reported that 37% of its asylum seeker participants met full criteria for PTSD (Silove et al., 1997). Epidemiological studies have identified PTSD and depression as the two most prevalent disorders in refugee populations (Steel et al., 2002). These disorders often appear co-morbidly.

There was no significant difference between migrant and Irish groups in mean scores for depression (mean BDI scores 14.50 and 16.25, respectively) or anxiety (mean BAI scores 18.36 and 21.02, respectively). It is notable, however, that mean depression scores in both groups were within the category of mild to moderate depression (BDI 10-18) and mean anxiety scores in both groups were within the category of mild to moderate anxiety (BAI 16-25). Existing literature reports significant rates of depression and anxiety amongst migrants: Wittig et al. (2008), for example, assessed the mental health of migrants from Poland and Vietnam living in Germany and reported higher levels of anxiety and depression for forced migrants from Poland compared with the native German population. More mental health and addiction problems were found among the Polish migrants than the Vietnamese migrants. Psychiatric problems, mainly anxiety and depression, accounted for 14% of all problems reported in a study of Bosnian refugees in Ireland (Murphy, 1994). It has been well documented that depression and minor



psychiatric disorders that are common in western countries are more likely to present with somatic symptoms among Asian immigrants (e.g. Wittig et al., 2008). For example, Abbott et al. (1999) found that Chinese immigrants in New Zealand presented frequently with somatic symptoms, which were later attributed to depression.

We also found significant rates of depression and anxiety amongst migrants, but these were not higher than the rates amongst Irish individuals in our study. Our study, however, only included Irish persons who were attending psychiatric services, who would, therefore, be expected to have high rates of depression and anxiety. In addition, the Irish individuals in our study had higher rates of alcohol dependence syndrome compared to the migrant group, and this may have contributed further to the relatively high rates of depression and anxiety in our Irish comparator group.

We found no difference in rates of schizophrenia in the migrant group compared to the native Irish group. This is inconsistent with existing literature documenting an increased risk of schizophrenia amongst migrants in Western Europe (Cantor-Graae et al., 2005). For example, Cochrane et al. (1977) reported an increased incidence of psychotic disorder in migrants from the Caribbean to the United Kingdom. This finding has been reported in many subsequent studies in the United Kingdom (Bhugra et al., 1997; Carpenter & Brockington, 1980; Dean et al., 1981; Harrison et al., 1997). In the Netherlands schizophrenia is four times more common among migrants compared with the native population (Selten et al., 1997). Cooper (2005) noted that this elevated risk is also present among African immigrants and to a lesser extent among Asian immigrants

residing in the United Kingdom. The increase in the rate of psychosis among migrants – especially from Surinam, Morocco, Netherlands Antilles and the Caribbean but not other immigrant groups (Turkish, western and eastern European countries) – is a consistent finding in the international literature (Lindert et al., 2008).

Our study was not designed as an epidemiologically complete incidence study of schizophrenia; we focussed on individuals who were referred to, or presented at, psychiatric services. As a result, we are not in a position to collect or report data on the population-based incidence of disorders such as schizophrenia; we can conclude, however, that if the increased incidence of schizophrenia amongst migrants holds true in Ireland, then these individuals are failing to present to services and are not receiving the treatment and support they require. A community-based incidence study is required to clarify this matter.

#### *Experiences of torture and human rights abuses*

Migrants were significantly more likely than Irish individuals to report personal experiences of torture (28.3% and 3.0% respectively), murder of family and friends (41.3% and 8.1% respectively), and imprisonment (32.6% and 11.1% respectively).

These figures are broadly consistent with existing literature demonstrating that between 5% and 35% of those seeking asylum in western countries will have experienced torture in their country of origin (Loutan et al., 1999). In addition, asylum seekers reporting torture were identified as a highly traumatised group, with a high prevalence of psychiatric and psychological problems (Loutan et al., 1999).

## **Study 2**

Help-seeking behaviour of migrants in comparison with native populations may differ due to different explanatory models of illness and health beliefs (Kleinman, 1980). Explanatory models of illness refer to the way that people, especially from different cultural backgrounds, have different ways of conceiving and understanding illness, its consequences and how best to treat it. An individual's explanatory model of their illness will influence their treatment satisfaction and compliance. Study 2 focused on participants' understanding of their health and illness, attitudes to the services they use, the treatment provided and the impact of the mental illness on their lives. The migrant interviews were carried out with both voluntary and forced migrants accessing the mental health services included in the project. The research team carried out qualitative analysis of the interview transcriptions and many common themes emerged from the interviews.

### ***Cause of mental difficulty***

Interviews revealed that the majority of the forced migrants believed that their illness was primarily caused by the traumatic events they experienced in their home countries. Such events included forced evacuation due to dangerous situations, kidnapping of family members, murder of family members and friends, war and torture. For example, one participant who was forced to flee from terrorists in his home country explained,

*“I feel [felt] very bad when I came to Ireland. Because you know what happened in my country? I had three petrol stations and then I lost everything. I take all my money and my family and I left my country. It's like, you remember what happened and why did it happen? And you lost, like, in one month, you lost everything”.*

Another participant spoke about the effect that the war in his home country of Algeria had on him,

*“War is not easy, it’s not easy. I don’t know if anyone can see what I saw in my life. You live all your life with it, you know?”*

Others pointed to the stress of the migration itself and having to adapt to a new culture with different values and norms,

*“Irish people is [are] different. It’s not like in my country. This is different. It’s like people is [are] thinking differently”.*

*“I think one of the reasons why they [the mental health problems] started is just moving from one country to another. It’s a very big change. There were no other people from Afghanistan and I was a bit poor with English at that time. So I was kind of isolated, you know? Not being able to express yourself, low self-worth, that kind of thing”.*

The feeling of insecurity surrounding refugee status was a particularly stressful problem for many of the asylum seekers interviewed. For example,

*“I think I feel [felt] much, much better after I got refugee status in Ireland. Then I feel [felt] safe and very comfortable and I start[ed] my life much better after that”.*

### ***Western Terminology and Treatment Satisfaction***

An interesting finding that arose from the interviews was the lack of knowledge that many of the migrants had about Western psychiatric diagnoses. Many, in fact disagreed with the diagnosis given to them. For example,

*“I do not feel about depression. I do not feel I was depressed. I was not feeling well because I was worrying about my family”.*

One participant diagnosed with Post Traumatic Stress Disorder described having heard the term but claimed,

*“I don’t know if this one [PTSD] is a sickness? To put it like a term of sickness. Like diabetic[diabetes]?”*

Overall, participants reported being very happy with the care they received from the services and pointed to improvements that they felt with the medication prescribed,

*“Well whenever I came here I received new hope because doctors in Lithuania were saying that I will never get off medication. So, I was kind of upset because I didn’t want to be on medication my whole life. And here, the doctors think differently. Suddenly, you know, they are trying to reduce the medication. And if that doesn’t work the first time I come back on the same dose and then I try after a few months again. So it’s good”.*

*“Well, since I took it [the medication], it was just like one big leap forward! My situation just went one step up and just stayed like that for a long time”.*

One of the participant’s wives who was present during the interview revealed,

*“You have a very good system. I see around him you and social worker and doctors and nurses. First time I see lots of people around him. It’s very good. I’m very happy. In Lithuania, just a doctor and a hospital and a closed door and I never spoke about [the] problem”.*

However, many believed that talking about problems was the best way to treat mental illness. For example,

*“I think the best treatment is when they [people with mental health difficulties] have to open up to people. Like talk to you, share something. Somebody you can talk [to], somebody you can share [with]. You know, you’re not feeling lonely”.*

Many participants talked about the lack of social support around them to help cope with their mental health difficulties. For example,

*“In Algeria, you could be much better because there is your family. Okay, with medication, with doctors, but the caring of your family may help you a lot”.*

### ***Alternative Treatment***

An interesting finding of the study was that many of the migrants had sought alternative treatment, therapy or care from outside the psychiatric services. This included visiting herbalists, traditional Chinese doctors and Sheik healers. For example, a South African participant revealed,

*“I went to what you’d call a herbalist, not a witch doctor. I mean, before the doctors, before the white men stepped on African soil, we had our herbalists. Digging roots and healing people from the juices in the herbs”.*

An Iranian man interviewed gave a preference for seeing a Sheik healer over a psychiatrist and revealed that many of the Iranian community in Ireland are seeking outside help for health-related problems,

*“One of these Sheik is in London. If you have some problem, if you call him, and you speak with him, he would solve your problem. If you had a serious problem he would tell you to go to the doctor, go to the hospital. If you have not serious problem, he would give you some prescription, which is some other spice...Herbs.*

### ***Stigma***

A common finding from the interviews was the stigma that the migrants felt from the Irish public surrounding having a mental health difficulty. For example, a Nigerian lady who suffered a psychotic episode talked about reactions many members of the public gave her,

*“They shout. They look at you or something like that. But when you are having a psychotic episode and the face, your face is very, like, sick. You show sick on the face”.*

Another participant, suffering from PTSD, felt that people were ignorant to those with a mental illness,

*“The people, they can’t understand. I don’t think so, because they will say, “Oh this one is mad. This one is crazy”. If you give him a chance to explain himself, you give him rights in some way.”*

### ***Impact of Mental Illness on Quality of Life***

Finally, many participants spoke about the negative impact that mental illness had on their lives and how their lives had changed since their problems started,

*“My life has finished. I feel my life is going to be finished. I passed 40 years so it’s useless. My life is useless”.*

*“Well firstly, I don’t feel like I’m living. I don’t feel like I’m living, you know? You feel yourself like you are in jail but you are not in jail. But you just feel it.”*

*“I will never be cured of that. I’m living day to day. You know, since I come [came] here, it’s like something inside is broken, broken in me. Like, I’m a different person now”.*

## **Recommendations**

1. The pilot study of the Transcultural Psychiatry Clinic was very successful and highlighted the clear differences that exist in the experiences of many migrants versus Irish individuals in terms of levels of trauma experienced. Therefore, the researchers would strongly recommend the establishment of a permanent Transcultural Psychiatry Clinic at the Mater Misericordiae University Hospital.
2. The study also pointed to the many different nationalities and mother tongues presenting to Irish psychiatric services. A National Interpreting Service for mental health services is urgently required to prevent barriers in communication and to improve understanding between clinician and patient.
3. The researchers strongly recommend that a cultural competence module be included in the teaching curriculum of all health care faculties in Irish Universities. This will ensure that students entering the health services are adequately trained to care for people from the many diverse cultural backgrounds presenting to Irish health care services.
4. Mental health practitioners should aim to gain a greater understanding of migrants' explanatory models of mental illness and health beliefs surrounding alternative therapies. This will improve the practitioner-patient relationship and may also strengthen treatment compliance and potentially reduce drop-out rates among migrants.
5. The researchers hope that the findings will assist with the planning and delivery of appropriate mental health services for migrants nationally.



6. The researchers recommend that similar studies be carried out in other counties in Ireland to tackle the issue of the lack of systematic and comprehensive data on migrants accessing mental health services in the country.

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