European Parliament Interest Group on Mental Health, Well-being and Brain Disorders

Wednesday 4 May
Mental health and the migrants' crisis

Meeting report

Tomas Zdechovsky MEP opened the meeting, and conveyed the apologies of host MEP Nessa Childers who unfortunately could not attend. As there were many 'new' participants he briefly introduced the Interest Group and its main aims*, i.e. to advocate the development of sound EU policies which contribute to prevention of mental health problems and ensure good services, care and empowerment for those affected by mental health problems.*

He also stated that this meeting was organised as the topic was addressed in the January meeting of the Interest Group. On that occasion it was felt that there is too little awareness of and attention for the mental health risks and challenges faced by asylum seekers: being traumatized by the situation they are fleeing from, the threats and horrors faced on their journey to the destination countries and the rejection and lack of inclusion and opportunities (in many cases) when arriving in their destination countries. The Interest Group on Mental Health sees it as its role to flag this important issue and make a contribution to monitoring what is happening in this area and to make sure that the EU does what it can do – despite its limited remit in the area of health care – to raise awareness of this issue; it is important to make member states aware that this is a real and serious issue which needs to be taken into account in any effort to address the situation of asylum seekers and their integration in their host countries and communities.

The first speaker, **Isabel de la Mata (European Commission, DG Santé)** provided a brief overview of the activities of the European Commission vis-à-vis refugees. The situation is constantly monitored, and while the Commission can propose actions, it is up to the heads of state to decide what course of action will be taken. Currently, the number of migrants and refugees entering the EU is at the lowest level since beginning of the crisis; the overall number is dropping since the agreement with Turkey in March.
The current crisis can be considered an exercise of solidarity where support is being offered to those member states that need support. There are two ways in which support is being offered:

1. Through the Civil Protection Mechanism (with Greece, Croatia and Serbia requesting help). However, a lot of the requested support is not provided yet, and this is the case mainly in the health sector. Also, there is a Health Security Committee in place to share needs and help.
2. The Commission allocate funds, AMIF and ISF, on a regular basis. These funds have been increased to support countries in their needs because of refugees. A new instrument is the Emergency Aid, which until now could only be used for emergencies outside the EU. The legislation has now been modified to include emergency aid inside the EU, with the European Parliament allowing for an extraordinary budget of 700 million euro maximum. The Commission intends to work with international organisations (Red Cross and UNHCR) and NGOs in this respect as they have the infrastructure in place to be mobilized quickly.

From the point of view of supporting health needs, the EU Health Programme has allocated 7,2 million (of last year's unused funds) to various projects with different institutions to support the extraordinary

needs of member states. It has to borne in mind that the remit of the Commission is limited as health services provision is the responsibility of the Member States.

The aim of the Commission's funding support is to facilitate the integration of refugees in the 'normal' health services rather than create parallel systems. Mental health is one of the health issues considered in this respect; the Commission is aware of the risk of PTSD and other mental health risks such as depression and anxiety disorders. This year's call for proposals for the Health Programme includes a 7, 5 million allocation on the topic of health for migrants and refugees, and is mainly focused on the exchange of good practice.

The Commission also cooperates with the WHO in issuing a set of guidelines for good practice in several areas, including mental health. Training of health professionals is an important part of this work. However, it is not just the health professionals that need training; law enforcement officials need training too.

The next speaker was **Dr Angelika Kiewel (German Chamber of Psychotherapists)** who addressed the care needs of mentally ill refugees. She started her presentation with some statistics; in 2015, over 1 million refugees sought refuge in Germany. In terms of mental health problems, it was foundnd that the PTSD rate is at least 10 times higher among adult refugees.

Studies of asylum seekers who have recently arrived in Germany show that 20 to 40 % suffer from a PTSD. The PTSD rate among refugees is at least 10 times higher than among the general population. Nearly half of refugee children are under significant psychological strain, with about 20% suffering from PTSD. The PTSD rate among refugee children is 15 times higher than among children born in Germany. The PTSD rate among unaccompanied refugee minors is 20 to 30 %. However, PTSD is not the only consequential disorder of trauma: depression, anxiety disorders, somatoform disorders, dissociative disorders and substance addiction are common too. Nearly two thirds of refugees suffer from at least one mental disorder. The conditions refugees encounter in their host country also influence the severity of mental health issues. This includes obstacles and delays in processing asylum requests, fear of deportation, obstacles to health care and social services, language barriers and discrimination.

There is a real need for treating refugees. In Germany, some 20% of people seek professional help within a year of onset of the mental health problem. By extrapolation, there are roughly 100,000 refugees requiring treatment for mental disorders in Germany. Under the Asylum Seekers Benefits Act psychotherapeutic treatment is restricted to acute mental illness and psychological pain; many case workers are not qualified enough. The assessment processes are not transparent and lack set criteria; and there are long processing periods for psychotherapy applications. Mental disorders are often wrongly assessed as non-acute; and reference to supposedly sufficient drug treatment is common. Psychotherapy is rarely granted within first 15 months of stay. Since the Federal government's so-called Asylum Package II legislation, PTSD is no longer designated as an illness that precludes deportation.

The EU Reception Conditions Directive (2013) requires the specific situation of vulnerable persons to be taken into consideration. Among those defined as vulnerable persons are those with mental disorders and those subjected to physical, psychological or sexual violence (Article 21). They are entitled to "access to [...] medical and psychological treatment or care" (Article 25). However, adequate legal provisions are still not in place. Without interpreters, psychotherapy is usually impossible. The service is rarely funded by social services, and never by the statutory health insurance authority. Psychosocial centres for refugees and victims of torture provide specialised psychosocial care such as initial consultations, stabilisation and crisis intervention, psychosocial counselling, information about all aspects of life in Germany (asylum-related and social services law), diagnostic and therapeutic services and advice on legal residency and social services issues. However,

psychosocial centres are only able to provide psychotherapeutic care to about 3,600 refugees annually. Moreover, the centres are in a precarious financial situation.

The BPtK therefore demands recognition during the initial 15-month period of mental disorders as acute illnesses requiring treatment, improved detection rate for mental disorders (through professional diagnostics), funding of language mediation services and adequate funding of psychosocial centres for refugees and victims of torture.

Dr Kiewel also informed the audience of a BPtK survey which is currently being carried out in relation to psychotherapeutic care of refugees in the EU. This is trying to assess what psychotherapeutic care do refugees receive in your country, how this care is organised, what training do caregivers receive, and whether interpreters are employed. Participants were invited to spread the word and participate in this survey which can be found at http://www.npce.eu/index.html .

The next speaker was **Erik Van der Eycken (GAMIAN-Europe**), who informed the audience of the discussions of a GAMIAN-Europe Regional Seminar held in Prague in March 2016, with participants from Greece, Malta, Romania, Czech Republic, Slovakia, Slovenia, Israel and Hungary. The aim of the seminar was to address the impact of the current migration crisis on mental health, with participants reflecting and reporting on the situation in their country, how patient advocacy groups are involved and to hear about good practices in their country. In the meeting, it became clear that the members of patient associations are very concerned and do have a lot of empathy for the refugees. For patients, this situation increases their own distress. However, as they know from experience what it feels like to be vulnerable and defenseless, they also have more empathy. Their experience of dealing with stigma makes them very sensitive for the situation of exclusion of the refugees. On the other hand, racist, xenophobic, and islamophobic sentiments are on the rise in many countries. Prejudice against ethnic and religious minorities runs deep. Two Hungarian self-help groups discussed the issue at their recent meetings and found that the response was mixed: there were some positive opinions, but on the whole the response is negative, with participants expressing fear and insecurity. How can we get over this fear? In many cases, it is not so much the problem of immigration but of politics of the right and left – and the issue is also used to gain votes. The media is playing a negative role as well. Fear should be based on reality rather than on scaremongering. But the media and politicians are shaping the reality. Dignity and equality should be the key word.

In terms of good practice, one of the ongoing projects in Malta relates to the provision of mental health first aid: it is now possible to train and get a license as a mental health first aider. This focuses on a number of mental health conditions, and migrants themselves are being trained as well. The programme needs to be adapted to national culture but has great potential for wide dissemination. Refugees have to be accommodated. To include psychological support is not easy but recognizing the first symptoms of mental health conditions is already a useful start.

The full report of the Regional seminar is available on the GAMIAN-Europe website at http://www.gamian.eu/conventions/1458/

Tomas Zdechovsky MEP warmly thanked GAMIAN-Europe for the organisation of this seminar, which he attended. He underlined the importance of the view of patients on this issue and noted that he was the only policymaker attending the event – this indicates that there is a clear need to raise awareness of this topic at policy level – hence a Written Declaration (see appendix for final version). He again thanked GAMIAN-Europe for their support on the preparation of the Written Declaration which will be co-signed by himself and 10 other MEPs. The Declaration will be tabled as soon as possible and will need to be signed by 376 MEPs in order to be adopted. This means that organisations present will need to help and ask their member to approach the MEPs from their countries to sign. Tomas Zdechovsky MEP reminded the audience that the Written Declaration does not intend to be exhaustive – as it can only be a very short text it will not be possible to incorporate all issues that are relevant in relation to mental health and refugees. However, he invited the audience to come forward with comments in order to ensure that even this short text is as strong as possible.

Participants made the following comments:

- The Written Declaration should not only focus on PTSD, but also include other disorders such as anxiety disorders and depression.
- What happens to refugees before they arrive if not under our control. However, we do have control over what happens to refugees when they arrive in our countries; we have to be

  aware of the mental health consequences of difficult and slow asylum procedures. Systems can be improved to cut long waiting times and speed up asylum decisions.
- Physical health needs (e.g.; vaccinations) are usually addressed upon arrival – there is attention for those needs. However, mental health is not looked at. What is required is somebody who cares about mental health as well and not let physical health take precedence.
- The EU Reception Conditions Directive is currently not being implemented – this could be referred to in the Written Declaration.
- The refugee crisis truly confronts us with the current lack of knowledge and training, both amongst health professionals as well as the general public. Clearly, the earlier help in on offer, the better. Better training in psychiatric knowledge is required for nurses and all doctors. Despite this, the duration of psychiatric training is decreasing while these skills are becoming more important. The Commission should be asked Written Questions about this. Targeted training courses for all those that are dealing with refugees are crucial.
- The fact that the Commission is combining efforts with the WHO was welcomed; at Brussels level the WHO-Europe office should be involved to prevent duplication of efforts.
- The Commission is also promoting massive online education together with the WHO. The electronic possibilities of supporting migrants and refugees should be further explored.
- The Written Declaration was welcomed by all, in particular its psychosocial approach. The human rights angle could be emphasized.
- Various organisations are active on this topic, such as MHE (position paper), EPA (position paper on training of health care professionals), the European Health Parliament (position paper) and EFPA (establishing a working group). Participants were called upon to join their efforts and map which other initiatives are ongoing as well. Cooperation is crucial.
- Not only should the mental health risk of current refugees be addressed: account should also be taken of the 10% of refugees who were already affected by mental health conditions before they fled. Their current treatment is interrupted because of their flight from their home country.
- Special attention was asked for unaccompanied minors as they are particularly vulnerable in this respect. In general, children and adolescent have special care needs that need to be taken into account.
- Now is the time to show empathy; however, discrimination is rampant. Communication is key to raising awareness and creating empathy as society is becoming more and more divided. In the countries that do not provide care, how can strategies be proposed to ensure screening upon arrival in order to recognize mental health problems? The EU cannot oblige countries to take action, and many countries do not have the resources to provide the required services. However, in some countries, mental health officials are ready to take more action.

In conclusion, Tomas Zdechovsky MEP thanked participants and reminded them that the Written Declaration cannot take all relevant issues into account, as there are legal limits to the amount of words. However, he informed the audience about this plans to organise a hearing on this topic in the autumn, in the presence of the relevant Commissioners. This will be the next step to put this topic on the EU agenda.

Christine Marking, May 2016