NEGLECTED TRAUMA

Asylum seekers in Italy:
an analysis of mental health distress
and access to healthcare

CONTENTS

ABBREVIATIONS

ASL	Azienda Sanitaria Locale - Local Health Center
ASP	Azienda Sanitaria Provinciale – Provincial Health Center
CARA	Centri Accoglienza Richiedenti Asilo – Asylum Seekers Reception Centres
CAS	Centri Accoglienza Straordinaria – Extraordinary Reception Centres
CI	Confidence Interval
CIE	Centri di Identificazione ed Espulsione – Identification and Expulsion Centres
CSM	Centro Salute Mentale – Mental Health Centre
DSM	Dipartimento Salute Mentale – Mental Health Department
DSM-5	Manuale Diagnostico e Statistico dei Disturbi Mentali - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
IQR	Inter Quartile Range
MSF	Médecins Sans Frontières/Doctors Without Borders
NIRAST	Network Italiano per i Richiedenti Asilo sopravvissuti a Tortura – Italian Network for Asylum Seekers who Survived Torture
OR	Odds Ratio
PTSD	Post Traumatic Stress Disorder
SPDC	Servizio Psichiatrico Diagnosi e Cura – Psychiatric Diagnosis and Treatment Service
SPRAR	Sistema di Protezione per Richiedenti Asilo e Rifugiati – Protection System for Asylum Seekers and Refugees
SSN	Sistema Sanitario Nazionale – National Health System
TSO	Trattamento Sanitario Obbligatorio – Compulsory Health Treatment
UNHCR	United Nations High Comissioner for Refugees, United Nations Refugee Agency

EXECUTIVE SUMMARY


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The many humanitarian crises of recent years, the persistence of conditions of war and the systematic violation of human rights in many countries have forced millions of people to flee, undertaking journeys that are often very dangerous. According to data from the UN Refugee Agency (UNHCR), there are now 65,3 million of people who left their home in the world. Recent evidence shows an increased risk of mental disorders among forced migrants and asylum seekers. In addition to the traumatic events they may have suffered before and during their journeys, some of them show signs of stress and suffering in relation to their current situation, attributable to their exile in a strange land.

MSF conducted an investigation from July 2015 to February 2016 to study the mental health needs of asylum seekers residing in extraordinary reception centres (CAS) and their access to local services. The analysis – conducted in the provinces of Milan, Rome and Trapani, which were chosen because of their large numbers of reception centres – benefited from a two-pronged approach using qualitative and quantitative methods. The use of focus groups and in-depth interviews with asylum seekers, healthcare workers and CAS operators made it possible to decipher the needs of the residents of the reception centres, the clinical paths taken where necessary and the response of local health services. The quantitative research was conducted based on the data collected by Medecins Sans Frontieres/Doctors Without Borders (MSF) from October 2014 to December 2015 during psychological support activities with asylum seekers resident in the CAS in the province of Ragusa. This provided a good starting point for identifying the extent of the problems and the potential factors influencing them.

Of the 387 patients analysed in this study, 234 (or 60.5%) showed signs of mental health problems. Eighty-four (or 42%) of the patients had complaints compatible with post-traumatic stress disorder (PTSD), 54 (27%) with anxiety and 38 (19%) with depression. The average age of the patients was 23.9 years. MSF provided care for 199 of these patients, ensuring they were followed up. Of the patients given care, 87% said they suffered from difficulties related to their current living conditions. The main difficulties of post-migration life were found to be the lack of daily activities, fear for the future, loneliness, and concern for relatives left behind in their country of origin.

A comparison between the asylum seekers with mental health disorders and those without, showed that the likelihood of having psychopathological issues was 3.7 times higher among individuals who had suffered traumatic events than those who had not suffered any.

The qualitative study provides a picture of a system that responds to this particularly distressed population as if dealing with an emergency, without adequate preparation. In many cases, there is no active screening available to assess the need for mental health support among the residents of the centres. The community health services often lack the expertise and resources needed to recognise signs of distress among this group. Cultural mediators, or other people who could help to establish contact and to reduce cultural distances, are rarely present. The length of stays at the centres is protracted and is often a source of further distress.

On the one hand, the results suggest high rates of mental illness, especially among asylum seekers exposed to traumatic events, and a negative impact caused by prolonged stays in the CAS. On the other hand, the system remains unprepared, and local services are inadequate to meet the needs of this population. It is necessary to provide an integrated response that involves the local health services, mental health departments and also the world of associations, universities and public authorities. As part of the response, dedicated multi-professional teams should be created that are able to identify specific risk factors and provide appropriate therapeutic approaches.

We know that the data presented here refers to a complex situation, and that the work done by MSF is small in comparison to the scale of the needs. However, we hope that this report can serve as an additional prompt for reflection for other organisations and institutions so that structural solutions can be developed in relation to the mental health of asylum seekers.

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INTRODUCTION

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The increase in migration towards Europe as a result of wars, political persecution, endemic poverty and the hope of a better life has called for Western countries to provide a civil and political response to a problem that has now taken on global dimensions. Indeed, although not a recent phenomenon, international migration is now centre-stage in world events. Italy, in particular, has faced this phenomenon for more than 20 years, since the early 1990s, and has received an increasing number of requests for international protection in recent years, in parallel with the increase in the number of resident foreign nationals[1]. The annual UNHCR report speaks of 65.3 million forced migrants recorded globally at the end of 2015[2], an increase of 9.7% from 2014, which is the highest increase ever recorded in a single year.

The growth in the number of new arrivals has seen a gradual saturation of places within the first reception system and those guaranteed under the SPRAR system (Servizio di Protezione per Richiedenti Asilo e per Rifugiati – or the protection service for asylum seekers and refugees). With circular of 8/1/2014[3] and with the subsequent circular of 19/03/2014[4], the Ministry of Interior requires the prefectures to source temporary additional shelters in their areas of competence, in response to the almost constant arrivals of asylum seekers, which are increasingly close together[5]. On 9 April 2014[6] the Ministry issued another circular that provided for the expansion of the "extraordinary plan".

These additional shelters are known as CAS (Extraordinary Reception Centres), and provide an emergency system for asylum seekers, regulated by temporary agreements with public facilities, private-social organisations and private entrepreneurs[7]. These facilities are of a varied nature (hotels, B&Bs, private homes, apartments rented ad hoc, holiday villages, schools, gyms, former orphanages and public buildings that have fallen into disuse). The operator, who has an agreement with the local Prefecture, is committed to providing a shelter service in return for a fee of 30/35 euro per day (or sometimes even less) for each asylum seeker. The management body ensures managerial and administrative services, general support services for individuals, cleaning and environmental hygiene services, provision of meals, provision of goods (clothes, personal hygiene products, mattresses, a daily sum of so-called pocket money equalling 2.50 euros and a telephone card containing 15 euros) and integration services (information on legislation concerning immigration, linguistic and legal support). Unlike the SPRAR system, which is part of the ordinary reception system regulated by the Ministry of the Interior, it does not provide for a connection with local authorities and the construction of projects oriented towards social and employment inclusion.

Stays in these facilities should be limited to the time strictly necessary to transfer the applicant to "first" or "second" reception centres of an ordinary nature. In fact, considering the shortage of places at a national

1. *According to the Ministry of Interior, the number of refugees who reached Italian shores in 2015 (as of 23.02.2016) was around 153,842. http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/trend-arrivi-dei-migranti-sulle-coste-italiane According to Eurostat data, the largest groups of asylum seekers who have sought protection in Italy come from Nigeria (17,780, 21%), Pakistan (10,285 12%), Gambia (8,015, 10%), Senegal (6370, 8%) and Bangladesh (6,015, 7%). Full report at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics*

2. *UNHCR, Global Trends, Forced Displacement 2015. Full report: : https://s3.amazonaws.com/unhcrsharedmedia/2016/2016-06-20-globaltrends/2016-06-14-Global-Trends-2015.pdf*

3. *Circular no. 104. Flow of foreign citizens requesting international protection. Identification of reception centres.*

4. *Circular no. 2.204. Reception centres following further landings on the Italian coast.*

5. *This plan provides for the subdivision of 2,390 shelter places between around 60 provincial capitals. In the above-mentioned circular, the Ministry also refers to another 883 places, as well as to 5,500 places already assigned in 115 temporary facilities in Sicily, Puglia and other regions.*

6. *Circular no. 14100/127. Reception centres following further landings on the Italian coast.*

7. *TThis provision is consistent with Article 18, paragraph 9 of European Directive 2013/33, which contains the standards for sheltering applicants seeking international protection and allows for the preparation of extraordinary shelter conditions provided they meet the essential requirements, as an exception, when the ordinary accommodation capacities are temporarily exhausted. See Directive: http://eur-lex.europa.eu/legal-content/IT/TXT/?uri=CELEX%3A32013L0033*

8. *For more details, see: http://www.interno.gov.it/sites/default/files/dati_per_sito_da_marzo_a_dicembre_2015.pdf*

9. *Refer to: Cantor-Graee E., Selten J.P.: Schizophrenia and Migration: A Meta-Analysis and Review, Am J Psychiatry 162:12-24, January 2005.*

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level and the slowing down of the asylum procedures, these times are becoming very long and onerous to the asylum seeker from an emotional point of view.

According to figures released by the Ministry of Interior in December 2015[8], more than 100,000 migrants are accommodated in the reception centres scattered across Italy and its islands. Of those, nearly 80,000 are distributed within CAS; some 19,000 are included in the SPRAR network; and just over 7,000 are located in government centres for the initial reception of asylum seekers. Lombardy and Sicily are the regions with the highest number of asylum seekers (with 13% and 12% respectively), followed by Lazio, Piedmont and Campania (with 8%). These figures clearly show that, at present, the majority of the demand for reception is borne by the CAS, i.e. facilities designed to be temporary and for emergency use.

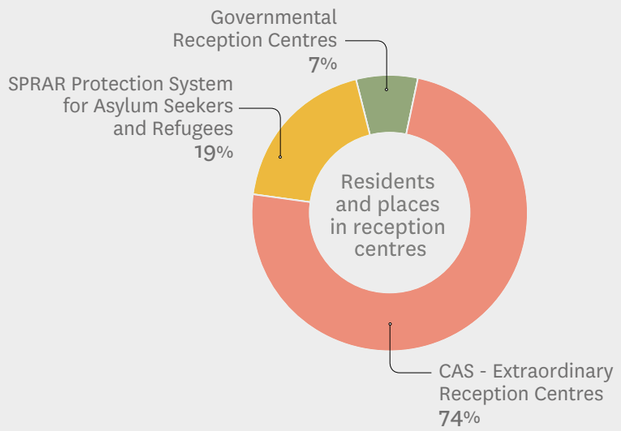
The extensive scientific literature[9] confirms that the migratory experience is closely related to mental and physical health. While migration can be a form of personal development and help to expand an individual's opportunities for choice and action, on the other hand it also exposes the migrant to numerous strains and risk factors. Factors that

Table 1.
Type of facilities and breakdown of asylum seekers, Italy, 2015

TYPE OF FACILITIES	Number of facilities	Residents/ places	%
CAS	3,090	76,683	74
SPRAR	430 Projects	19,715	19
GOVERNMENTAL RECEPTION CENTRES	13	7,400	7
TOTAL RESIDENTS		**103,798**	**100**

Data from the Ministry of the Interior, December 2015

Figure 1. Residents and places in reception centres, Italy, December 2015



can influence their physical and mental health include separation from their family and social context; the loss of support systems; the possible exposure to trauma during the journey; the existence of linguistic and cultural barriers; and the difficult socio-economic conditions in which this population often ends up. Needless to say, people who are fleeing their countries having survived armed conflicts or humanitarian emergencies are at increased risk of mental health problems[10].

Many of those arriving in Italy are refugees from conflict zones or highly repressive states. Many passed through Libya, where the situation has become increasingly chaotic since 2014, with many leaving their families and loved ones behind. They are a fragile population with special needs. In addition to the trauma experienced before and during the migratory journey, the discriminatory behaviours they experience once they arrive in their destination countries, associated with a general lack of opportunities, can lead to increased vulnerability among these people and facilitate a shift towards mental health issues of one form or another [11]. A series of scientific findings from recent years shows an increased risk and a higher incidence of mental disorders among immigrants, specifically higher rates of psychosis, depression, PTSD, mood disorders, anxiety disorders and an increased tendency to somatisation (whereby psychological distress is expressed as physical symptoms)[12]. These are attributable to individual factors, socio-environmental stress factors and exposure to trauma and adversity accumulated over time.

Many of the reception centres where the people seeking international protection are accommodated do not have a psychological support service. According to the agreement signed between the Prefectures and the centres, healthcare should be guaranteed through the facilities of the Sistema Sanitario Nazionale (SSN), or national health system, and the companies managing the centres should facilitate the connection between the residents and the local services. The contractual terms signed between each Prefecture and the provinces are highly variable, and the presence of medical centres and psychological services is not always guaranteed. The lack of a timely monitoring system and sanctions on the part of the funding institution also makes the implementation of these services discretionary. MSF conducted a study in three Italian provinces (Trapani, Rome, Milan) known to have a significant presence of asylum seekers in order to understand their access to mental health services. The goal of the study was also to observe the main mental health dynamics of the migrant population. In addition, critical issues around the extraordinary reception system were assessed and their consequences analysed on the emotional states of the migrant population.

In the first instance, this report attempts to provide an analysis of the social and personal conditions of life in the CAS and the presence of support systems for psychological distress. It goes on to evaluate the availability of local services capable of taking care of the mental health of migrants, and assesses possible support and approaches to care that could benefit this type of user. Finally, it describes the cohort of patients with mental distress followed by MSF over the course of a year in the CAS of Ragusa province. The resulting data is discussed on the basis of the information available in the literature.

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10. *Steel Z., Chey T., Silove D., Marnane C., Bryant R.A., Van Ommeren M.: Associations of torture and other potentially traumatic event with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. JAMA 2009, 302:537-549.*

11. *Aragona M., Pucci D., Mazzetti M., Maisano B., Geraci S., Traumatic events, post-migration living difficulties and post-traumatic symptoms in first generation immigrants: a primary care study, Ann. Ist. Super Sanità 2013, Vol. 49, N2:169-175.*

12. *Fazel M., Wheeler J., Danesh J.: Prevalence of serious mental health disorders in 7000 refugees resettled in Western countries: a systematic review. Lancet 2005; 365: 1309-1314.*

OBJECTIVES

Primary objective

To analyse the mental health needs of asylum seekers resident in CAS and to identify any gaps in the care of patients.

Secondary objectives

- To qualitatively describe the mental health services available to migrants both within the CAS and local authorities, as well as their accessibility.
- To describe the mental health needs and morbidity among asylum seekers residing in the CAS.
- To estimate the proportion of individuals with mental health needs residing in the CAS investigated by this study.
- To explore the barriers in accessing mental health services.

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METHODOLOGY

General purpose and qualitative research tools

An integrated qualitative and quantitative approach was adopted in order to understand the complexity of the migration process, its relationship with psychological distress, and the care provided for potential mental health needs within local services and CAS. The research qualitatively explored the mental health services available in the area. The aim of this was to understand how they are organised with regard to a migrant population with specific mental health needs, as well as to understand where responsibility lies within the CAS for identifying any care requirements and signalling the need for psychological intervention[13]. The investigative tools used were focus groups and in-depth interviews, which revealed hidden aspects of the health needs of asylum seekers and their relationship with health services.

Sixteen focus groups were held: 10 with social workers and CAS managers; five with asylum seekers residing in a number of CAS in the province of Ragusa, where MSF has worked; and one with the users of the clinic in Torre Spaccata in the Roma B ASL (Azienda Sanitaria Locale – Local Health Structure). Twenty-four standardised and semi-structured in-depth interviews were carried out with psychologists and psychiatrists of the mental health centre (CSM) and mental health department (DSM)[14]; with those responsible for mental health within the CAS; with those responsible for psychiatric diagnosis and treatment (SPDC) services in the provinces in which the survey was carried out; and with organisations and companies operating in the area. The sample used was purposive. The three Italian provinces with the highest presence of CAS and of asylum seekers were selected as study areas. The province of Ragusa was added to these three, and focus groups were conducted there with the migrant population.

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13. *The contract specifications for the management of the CAS are absolutely discretionary and may change from one province to another. By way of example, in Ragusa province, where MSF has worked for many years, the specifications initially included no kind of psychological support from the facilities.*

14. *The mental health department (DSM) is the group of facilities and services with the task of dealing with the demand linked to care, assistance and the protection of mental health within the area defined by the local health authority (ASL). The mental health centre (CSM) is the first centre of reference for citizens with mental health problems. It coordinates all the measures for the prevention, treatment and rehabilitation of citizens who have psychiatric disorders within the local context. For more information see: http://www.salute.gov.it/portale/temi/p2_6.jsp?id=168&area=salute%20mentale&menu=rete.*

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15. *Participation was ensured through a preliminary selection of the people to be interviewed and included in focus groups, who were identified on the basis of the aims of the investigation and were contacted with adequate advance notice.*

An MSF facilitator with the help of a psychologist conducted the focus groups and semi-structured interviews by introducing the purpose of the research, the use of the information and the process. The anonymity of the information collected was guaranteed. The guidelines for the topics to be addressed and explored within the focus groups and in-depth interviews were developed by compiling a literature review on the subject, which was shared with the participants.

In the first instance, the semi-structured interviews enabled us to map the psychological support services offered to migrants and the tools used to address the needs of this population. The focus groups gave voice to those managing CAS in various provinces and to the migrants, allowing us to collect relevant information and to understand the underlying issues of the investigation.

The focus groups and interviews lasted for between an hour and an hour and a half. The discussion groups with the migrant population were carried out separately from those with the social workers operating in the centres and the centre managers. They were also divided up according to the language spoken to minimise the risk of misunderstandings. The widest possible range of participants[15] was included to ensure that the voices of people of different ethnicities and geographic areas were represented. The discussions were recorded, with the participants' consent, to allow greater understanding of the different points of view, and were subsequently transcribed verbatim. Where recording was not possible, a manual transcription was carried out that was as faithful and detailed as possible. The anonymity of individuals was guaranteed and the participants' oral consent was collected.

The table below shows the distribution of the research sessions with the number of participants who attended each session.

Table 2. List of focus groups, interviews and number of participants

City	Session type	Facility	Type of qualitative research	Number of participants
Trapani and Province	1. Social Workers	CAS, Nuovi Orizzonti (Poggioreale)	Focus Group	4
	2. Social Workers	CAS, Residence Marino (Trapani)	Focus Group	4
	3. Social Workers	CAS, Hotel Villa S. Andrea (Valderice)	Focus Group	4
	4. Social Workers	CAS, Pozzitello Village (Campobello di Mazara)	Focus Group	4
	5. Social Workers	CAS, Borgo della Pace (Marsala)	Focus Group	8
	6. Social Workers	CAS, Giovanni XXIII (Marsala)	Focus Group	4
	7. Centre Director	CAS, Giovanni XXIII (Marsala)	In-depth interview	1
	8. Psychologist	CAS, Hotel Villa S. Andrea (Valderice)	In-depth interview	1
	9. DSM Manager	DSM	In-depth interview	2
	10. Prevention Service	ASP	In-depth interview	2
	11. Prefecture	Prefect	In-depth interview	2
	12. Borderline Sicilia	Worker	In-depth interview	1
	13. UNHCR	Project Coordinator for Sicily	In-depth interview	1
	14. UNHCR	Psychologist	In-depth interview	1
	15. SPDC, Service Manager	ASP	In-depth interview	1
Ragusa and Province	16. Social Workers	CAS, Cinque Vie (Modica)	Focus Group	4
	17. Social Assistant	CAS, Libeccio (Vittoria)	In-depth interview	1
	18. Social Workers	CAS, Villa Tedeschi (Modica)	Focus Group	4
	19. Migrants	CAS, Villa Tedeschi (Modica)	Focus Group	8
	20. Migrants	CAS, Chiaramonte Gulfi	Focus Group	13
	21. Migrants	CAS, Acate (Vittoria)	Focus Group	12
Roma - B ASL	22. Social Workers	CAS, Staderini	Focus Group	10
	23. Social Workers	CAS, Codirossoni	Focus Group	6
	24. SPDC, Service Manager	Ospedale Sandro Pertini	In-depth interview	1
	25. DSM Manager	ASL Roma B	In-depth interview	1
	26.Psychiatrist working with migrants	Caritas	In-depth interview	1
	27. Migration Psychiatry Clinic Coordinator	Policlinico Umberto I, Dipartimento Neurologia e Psichiatria	In-depth interview	1
	28. CSM Manager	Torre Spaccata	In-depth interview	1
	29. CSM Manager	Via degli Eucalipti	In-depth interview	3
	30. Migrants	Torre Spaccata	Focus Group	10
Milano and Province	31. Social Workers	CAS, Fondazione ARCA	Focus Group	4
	32. Social Workers	CAS, La Vincenziana (Magenta)	Focus Group	8
	33. CAS Vice-Director	CAS, Fondazione Fratelli S. Francesco d'Assisi (San Zenone al Lambro)	In-depth interview	1
	34. Psychologist	CAS, Fondazione Fratelli S. Francesco d'Assisi (San Zenone al Lambro)	In-depth interview	1
	35. Psychologist	CAS, Fondazione ARCA	In-depth interview	1
	36. Psychiatrist	Ospedale Niguarda, Etnopsichiatria	In-depth interview	1
	37. Psychiatrist	Ospedale Niguarda, Etnopsichiatria	In-depth interview	1
	38. Psychologist	CAS, Corelli	In-depth interview	1
	39. Centre Administrator	CAS, Corelli	In-depth interview	1
Totals				
4 Cities	**16 Focus groups, 24 in-depth interview**			**135 Participants**

16. *Hsieh H.F., Shannon S.E., Three Approaches to Qualitative Contents Analysis. Qualitative Health Research 2005, 15:1277-1288.*

17. *Patton M.Q., Qualitative Research and Evaluation Method, 3rd edition. Thousand Oaks, CA: Sage, 2002.*

18. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is a classification and diagnostic tool which serves as a universal authority for psychiatric diagnosis.*

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Qualitative analysis

The transcript of the interviews was analysed through a process of systematic classification and coding of the text, identifying the themes and recurring trends[16]. Once all the texts were encoded, every trend was analysed in light of the research objectives. The discrepancies were examined. In the first stage of the analysis, the codes were developed by reading the text of the first six transcripts line by line. The framework resulting from this first codification was then used to decode and encode the rest of the transcripts. The themes and new codes that subsequently emerged were incorporated into the thematic frame of reference and related to similar labels. The stage following the analysis included the conversion of codes into thematic categories[17]. The frequency at which some themes recurred was reported and summarised.

Epidemiological data collected in the MSF project

From 1 January 2014 to 31 December 2015, MSF provided psychological care in the CAS of Ragusa province, in a three-step process as follows:

- All new arrivals were systematically evaluated with the help of cultural mediators through psycho-educational group sessions.
- Individual semi-structured interviews were carried out in order to identify particular needs. Individual psychological follow-up was provided – to those identified in the group sessions, to self-reported individuals and to others screened by social workers.
- A network was set up, with the support of social workers, for referring the most vulnerable patients to a more suitable reception facility (SPRAR). With particularly vulnerable patients, MSF ensured they received follow-up by local and national health services.

A retrospective analysis was conducted of the routine data collected from 1 October 2014 to 31 December 2015. Analysis includes patient baseline as well as follow-up data. Standardised medical records were used to collect information on socio-demographic characteristics of the individuals, the length of their journey, their date of arrival in Italy and the potential trauma suffered during three distinct phases of migration: in their country of origin, during the journey, and after their arrival in Italy, with a particular focus on their living conditions after the migratory period. Information on hypothesis of diagnosis at baseline, the total number of consultations conducted and the final outcome, classified as 'improved', 'lost to follow-up', 'stable' or 'worsened' were also collected.

Diagnoses were assigned by MSF psychologists according to DSM-5[18] and were based on clinical judgment as well as on the definition of the outcome, i.e. the observation of symptoms, examination of the coping mechanisms used, their manner of relating, space-time orientation, sense of reality, capacity for emotional restraint, resilience and adaptation. No validation scale was used to decide whether to provide care for the patient, as the scales proposed were deemed to have been calibrated for Western taxonomic needs, and therefore provide a poor response to the categories of our patients.

The results here presented highlighted an interesting framework to interpret the mental health needs of this population.

Quantitative analysis

The information was collected by psychologists while visiting patients. The data was entered into an Excel spreadsheet and analysed using Stata version 13, Atlanta City, USA.

Starting from the epidemiological data collected, different variables were created to describe the profile of the migrants and the possible role of migration in the onset of psychopathological symptoms. The baseline and socio-demographic characteristics found in the group of patients showing symptoms of psychological distress and the group of those showing no psychological distress were compared using the Chi-squared test. A comparison was also made between the frequencies distributions of the categorical variables. The level of significance was set at $p < 0.05$. The qualitative variables are expressed in percentages, quantitative variables as mean or medians. A univariate analysis was conducted for each risk factor associated with symptoms or hypotheses of psychopathological diagnosis. In the multivariate model, we used logistic regression to obtain the odds ratios and confidence intervals for the relationships between risk factors and mental health status, controlling for several socio-demographic characteristics in the individuals. The results obtained were presented with a 95% confidence interval (CI) and their associated p-value.

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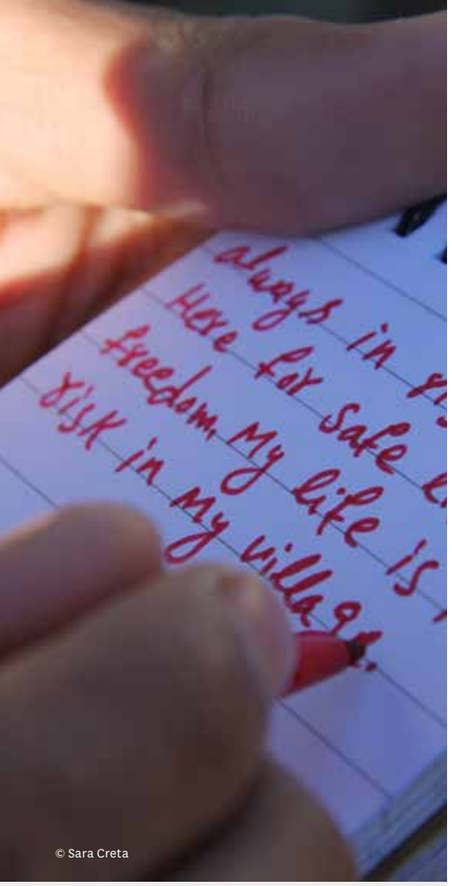

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19. *Of particular note are the CSM in Torre Spaccata with an Ethno-psychiatry clinic, which created of transcultural listening group held twice a month, and the CSM in Via degli Eucalipti, which devotes 6 hours a week to transcultural psychology.*

20. *The clinic for Post-Traumatic disorders at San Giovanni Addolorata in Rome served as the Coordination Centre for Nirast, an integrated network of medical and psychological hospital centres within the National Health Service, located in the cities of Rome, Milan, Turin, Gorizia, Caserta, Foggia, Bari, Crotone, Siracusa and Trapani. However, it closed on 1 March 2012 due to cuts to health care and the non-renewal of the Convention between the Ministry of the Interior and the National Asylum Commission. We wanted to mention it here to emphasise the experience of treatment in this area.*

RESULTS

Focus groups and in-depth interviews: mental health of asylum seekers and access to services

Our study identified a substantial gap between the CAS and the health services, and a poor – or non-existent – relationship between the ASL and the Prefectures. In many cases there was a lack of coordination and dialogue between the various centres of the reception system and the local health services. On one end of the scale are the complex and congested cases of Trapani and Ragusa, where the health services have not yet developed professional skills or operational strategies in terms of transcultural clinics. On the other end are the more structured situations in Rome and Milan, where there have been attempts to foster interaction between the public health facilities , the private-social services that treat mental illness and the reception centres. However, shortages of funds and a lack of staff with the skills to treat victims of trauma and experience of working with this population make the situation even in Rome and Milan extremely fragile. Yet, in Rome province, despite the reduced availability of dedicated human resources within the ASL[19] and a gradual downsizing of the role of public services in this field, a number of positive initiatives exist. These include the migration psychiatry clinic at the Umberto I polyclinic; the transcultural psychiatry clinic at the Sant'Andrea hospital; and the centre for psychopathology in response to trauma at the Gemelli polyclinic. In the private-social sector, too, positive initiatives include Samifo (Health Centre for Forced Migrants in ASL Roma A); Doctors Against Torture; San Gallicano; the Caritas clinic; and Nirast (Italian Network for Asylum Seekers who Survived Torture)[20]. Initiatives such as these shown that a synergy between private-social and public services is vital in creating clinical pathways for asylum seekers who are victims of trauma and violence, in order to ensure the protection, care and psychophysical rehabilitation of extremely vulnerable people, with the support of cultural mediators.

However, so far, a lack of coordination between the different parties involved led to a failure to capitalise on the current psychological support activities. At the same time, the economic difficulties facing the region of Lazio and ongoing staffing cuts in mental health services are not helping the situation.

In Milan province, by contrast, the ethno-psychiatry experience at the Niguarda and Sacco hospitals became the local point of reference for psychological support of asylum seekers. Partnerships have been established between public social and health services and the private-social bodies, significant support has been provided for institutions and reception centres. Even though the presence of private-social services in Milan province is still limited, it remains an interesting model. The ASL is constantly using cultural mediators and skilled medical professionals to identify the clinical elements of victims' psychological trauma. However, despite these efforts, the response is still insufficient for the existing needs in the area. Further, the response has been affected by communication problems following the recent establishment of the CAS managed by the Prefecture.

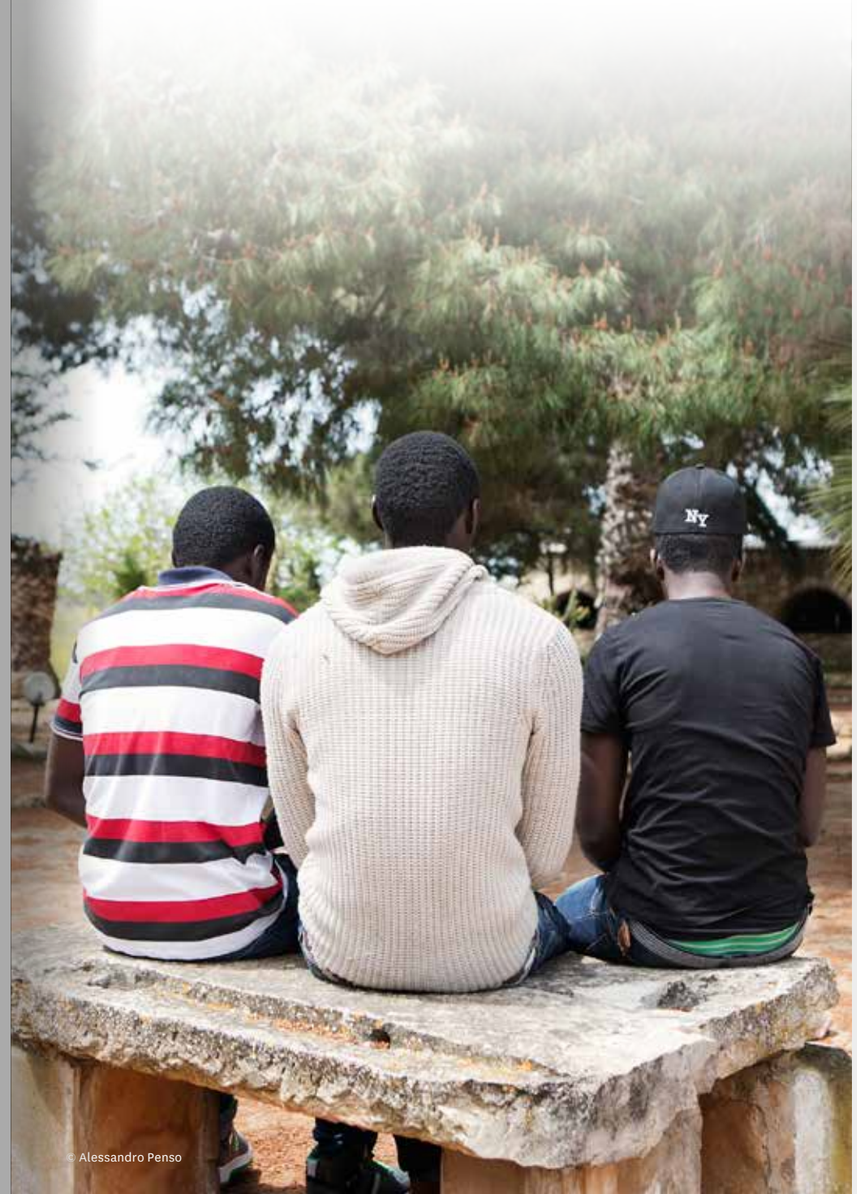
The results of our study are analysed following the two main investigative criteria:

1 **Access to local health services by asylum seekers residing in the extraordinary reception facilities put in place by the prefecture.**

2 **The most significant aspects within the reception centres relating to the living conditions of asylum seekers residing there and the identification of psychological distress.**

1.a Procedures for mental health assessment within the CAS are inadequate or completely absent.

Psychological support in the CAS is often improvised and patchy, being entrusted to young people with no previous experience working with asylum seekers. Psychologists are not always included within the CAS, which are essentially conceived as providers of services – such as meals, supervision and coordination with the police and Prefecture for issuing documents. All is left to the discretion of the centre's management, and collaboration with local health services is not guaranteed. There is a lack of shared operational protocols among the reception centres and health services in the areas studied.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We started on our own... without any specific idea of how to manage a centre for migrants. We started to manage in a community style – before that we had no notion of this kind or clear criterion about this type of centres. Now we are slowly getting organised... At first we didn't know anything about migration, we didn't know what the word migrant meant. We improvised a bit, but now we are progressively providing new skilled professionals.

The psychologist is in the process of gaining the residents' trust. For now the social worker mainly deals with them. We still have to start working on a structured and systematic work plan that will be useful for addressing any possible mental distress... but an initial analysis shows that no one has major problems in this regard.

A few months ago I started working in the centre as a psychologist. I work 12 hours a week. I've met half of the residents of the facility. I haven't seen any of them a second time and at least 30% of those I met should be followed up. I do my best, but 12 hours is not much. They are poorly prepared at the CSM, they underestimate our problems and I struggle to get an appointment. Moreover, there are no mediators available. I believe that we should invest in training professionals working in this field.

It's my first time working in the field of migration. I arrived in April. Before me, there was no psychologist in the centre. I'm trying to make myself known and to get to know the guys. I arranged individual meetings, but many of them are afraid and reluctant to speak. They are afraid their words might be used against them. I tried to explain very carefully that it was simply an exploratory interview. It's difficult to carrying out psychological screening because the guys never turn up to appointments. I'm trying to figure out how to improve this part and overcome their distrust.

Talking about the cases that come under the care of our departments, we can say that the greatest problems at the CAS arise from the shortage of workers, especially workers and psychologists trained in psychology for dealing with trauma. These centres are very large and provide minimal levels of shelter. There is a lack of listening and guidance, and an inability to intercept distress signals before they become explosive actions and require treatment as such… Who monitors these reception centres now? Who guarantees them? These centres have no trained educators.

1.b Identification of vulnerabilities and transfer of patients to ad hoc medical facilities is slow and often non-existent. There is a lack of early and timely identification.

The measures for identifying the most vulnerable subjects and those with more or less manifest mental health issues can vary, depending on the type of vulnerability[21], and can require, in addition to the disclosure and collection of stories, the observation of behaviour and verbal and non-verbal language. Time restraints, often accompanied by a lack of specific training among psychologists working in the CAS, prevents or slows prompt reporting to the relevant parties for the provision of appropriate care. With a few notable exceptions, in general there is no structured psychological pathway within the CAS, nor any clear identification of the preventive actions needed to intercept the onset of issues or provide timely care for people with serious mental health problems. Cases are only reported to the competent health authorities after incidents of aggression or when migrants have shown anger or disturbing attitudes.

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21. *For a definition of vulnerability, see http://www.unhcr.org/4317223c9.pdf section 3.4.1 identifies the following categories to be used in the procedure for determining refugee status: persons with obvious need for protection, victims of torture and people who have experienced trauma, women with special needs, unaccompanied or separated children, elderly asylum seekers, asylum seekers with disabilities, asylum seekers with medical needs.*

1.c Abuse of emergency services at hospitals and SPDC

Access to local health services currently operates on an emergency basis, which explains the growing number of emergency admittances and hospitalisations for acute psychiatric disorders among migrants in the regions studied[22]. This figure is also attributable to a different mode of accessing care for migrants, in which the SPDC becomes the shorter and easier route of entry, but only when the pathology explodes and is no longer controllable. The use of the emergency services remains the most common practice for a quick but unstructured "solution" to the problems. In terms of social and health services, there is still a lack of planning, tools and working practices adapted to individuals coming from very different areas and cultures. This is most evident in the Sicilian context.

Relations with the CAS are almost non-existent. There is no dedicated clinic. The migrants only end up in the emergency room and the SPDC emergency department if there are problems or acute cases. What is lacking is the opportunity to keep track of the patient and to follow up on their mental health in the absence of a major psychopathological crisis.

We don't have a very broad user group. Trattamento Sanitario Obbligatorio (TSO) – or compulsory health treatment – is often used improperly and to get rid of people who create problems but do not have an actual psychiatric illness. When the police have to deal with a patient with inflamed reactions, they take them to the SPDC. Psychiatric definition becomes a way of getting rid of problematic patients… most of the times the issues they have took the form and characteristics of a psychological distress related to contingent factors (residence permits that never arrive, rejected requests for asylum, life plans slipping away, the loss of reference points, the inability to restart their lives)… This behaviour is more about management than psychiatric therapy, and should be treated with a psychological rather than a psychiatric approach.

There is no systemic vision. Everything cannot just be delegated to the reception centre. If the institutions appointed to do so don't strengthen their skills and don't have the necessary human resources, then the problem will persist. We don't always have contact with the ASLs and, unless you know someone within the health districts, you can't do anything, you get stuck. The waiting lists for receiving care are unbearably long, so taking them to the emergency services becomes the simplest thing.

The CAS are a collection of dramatic situations. I'm aware that we should address their needs and respond to them. The few people who come to us do so from an acute psychological crisis. They tell of extreme situations, and the reception centres only have some of the competencies they need to address these issues.

22. *According to data provided by the SPDC in Trapani and Rome, this figure has increased in recent years. This trend is also confirmed by other studies in the literature. Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., Dazzan, P., Boydell, J.,McKenzie, K., Harrison, G., Murray, R., Jones, P., Craig, T. & Leff, J. (2005) Sample characteristics and compulsory admission: a report from the AESOP study. British Journal of Psychiatry, 186, 281-289. M. Braca, I. Tarricone, F. Chierzi, V. Storbini, T. Marcacci, D. Berardi. I disturbi mentali comuni nelle popolazioni di migranti che afferiscono ai livelli primari di cure: l'esperienza del Bologna Transcultural Psychiatric Team (BoTPT). Dipartimento di Scienze Mediche e Chirurgiche – Università di Bologna.*


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1.d Cultural mediation is often absent or else is carried out by Italian staff within the CAS and local health services.

In some of the CAS visited, the role of the cultural mediator is interpreted simply as a translator. As a result, the mediation – which should plays a key role in creating a relationship of trust with the patient, to help interpret the cultural and system of the patient's culture of origin – is often absent or is carried out by Italian staff. In addition the mediators operating within the ASL are a real exception, although a communication culturally adapted to the individuals is essential for a quality care giving.

Always having mediators available is not easy, especially for some languages such as Tigrinya or Bambara. I often get by with English and Italian – many of the guys are taking courses in Italian.

There are no cultural mediators in the CSM, and when we have to accompany one of the migrants resident here, we try to bring our mediators, but it isn't always possible. The ASL has no resources. Given all the needs in the area, it would be good to provide a team of mediators.

The ASP in Trapani has established a register of mediators, but it remains insufficient. In case of acute psychological phase of a migrant, the health system gives support to the reception centres where it is requested. There is a shortage of staff, so we only intervene rapidly on request.

I speak a bit of English, but not enough for a conversation at a level that can form a bridge and create a relationship of trust, so when I can I use interpreters or mediators, but they're not always available. We are also encouraging the guys to learn better Italian.


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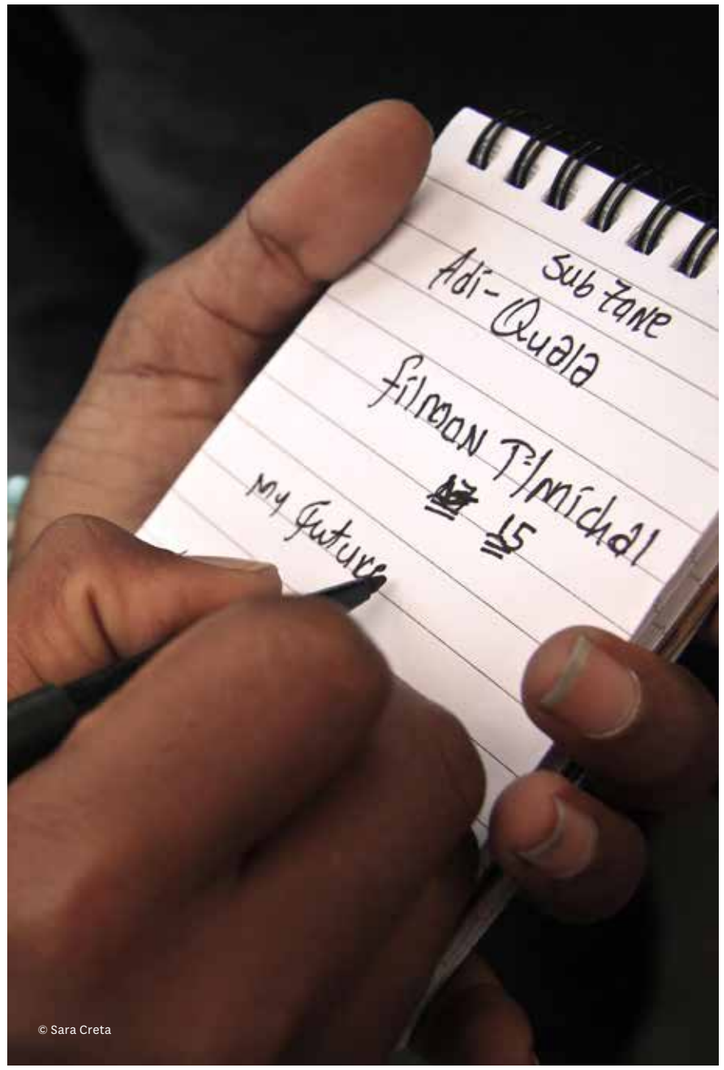
1.e There is a lack of culturally appropriate human and financial resources and mental health services to treat the asylum seekers.

A substantial discrepancy was discovered between the need for mental health and the provision of health services offered, which is often due to the lack of appropriate human resources (workers experienced in the treatment of trauma psychology) and adequate financial measures to respond to the needs of migrant patients. The problem was reported by both the CSM and the CAS involved in the research. There is no network of health services catering to the real needs of this population. There are no outpatients departments with ethno-psychiatric skills which can follow up on the issues related to mental health of asylum seekers and they have no cultural mediators. In addition, there is still a substantial lack of flexibility in using Western diagnostic categories, which often do not take into account the different cultural layers of an asylum seeker which could be essential in the interpretation and definition of a psychotherapy.



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We fight against their phobias every day. They believe that whatever happens is due to spirits and rites practiced by someone in their own countries. I've explained to them that they are here in Italy and that these things do not exist here, but to no avail...

... The biggest difficulty is mistrust and getting them to keep appointments. They almost never show up. At first, we put notices in the main hall but we found them taken down. So we decided to put the notices in their rooms, but we also found those were taken down. It seems that nothing works and it's very tiring.

In general, the public health services do not have the specific knowledge to cope with treating the psychopathology of migrants. The solution would be to create small, specialised, well-trained team within the services, which could perhaps be integrated with dedicated private-social bodies. Education and commitment are the two key words. We need to create a local network of psychiatric services who are able to treat these patients and have training in psycho-traumatology.

1.f There is a lack of coordination between the Prefecture, the CAS, the Hospitals, the local Commissions[23] and the ASL.

Engagement with the ASL is critical for ensuring the equity and equality of services. Yet there is no protocol formalising an agreement between the reception centres, local health authorities, hospitals and the Prefecture that includes the different parties involved and coordinates measures with a multi-sectoral approach.

"We have repeatedly and unsuccessfully asked the prefecture for a meeting. We asked to form a working group so we could tell them about the things that do not work and create a channel for information. We wanted to establish a memorandum of understanding that would allow us to better define the needs of this population, and to implement a plan that can guide the provision and organisation of the services by our hospital. To date we have had no response.

There are no operational protocols between those responsible for the reception system and health services in the area with regard to giving care... We carry out an initial visit here, but the problem affects those who need monitoring and follow-up ... We never know whether or how they are subsequently followed up in the CAS. There is no syndromic surveillance[24].

The only thing that the prefecture does with people with problems or disturbing symptoms is take them and transfer them from one centre to another. The prefecture has a mandate to provide shelter but not to solve future health problems."

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23. *The Local Commissions analyze the applications for the recognition of refugee status in a decentralized manner.*

24. *http://www.epicentro.iss.it/focus/sorveglianza/immigrati.asp*

1.g Socio-cultural factors in the migrant population are changing.

The interviews conducted with both the private-social bodies with extensive experience of the psychiatric treatment of migrants, and with the psychiatrists working in public facilities revealed a different type of asylum seekers with a reduced capacity for resilience and no clear migration plans.

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"A few years ago the patients were strong and we had several tools to work with ... Now, and especially since 2011 and the North African crisis, the refugees and asylum seekers arriving are victims of torture and of multiple instances of violence. Our staff are often unprepared to handle these complex situations. The frustration and demotivation of the workers is high, with a significant risk of burn-out ... In addition, the economic crisis does not make it easy for arriving migrants to find a job or settle down.

It was very hard in Libya and I wanted to get out of there. I did not know I was coming to Italy when they forced me onto the boat. I didn't have a clear plan, I just wanted to get out of that country ... It wasn't easy to get here. I saw a lot of suffering and a lot of injustices but I don't want to talk about it now.

We are facing different phenomena to the kinds we dealt with in the past. Many of this new flow of migrants started out with limited personal resources. Often they do not have a migration plan or a social network. The culture shock is huge, leading to isolation and high rates of depression."

At the moment I am following the cases of three boys who expressly asked for an interview and who constantly complain about headaches, but I have no room to myself where I can devote myself to listening and talking. We talk in a room amongst the other residents... We don't even have an office in this place where you can sit and talk quietly and privately.

We are always among each other. It's like we're still in Africa. We don't have the papers and we don't talk to anyone else apart from the other residents of the centre. We don't have Italian friends, we don't talk in Italian and we have no work. Without papers we can't do anything... To go into the city you have to take a bus. It costs nine euros there and back and we have no money, so we prefer not to go out.

We have nothing to do here. I arrived seven months ago now, and every day is the same. I didn't come here to stay locked in a room. I've done nothing but sleep and eat while I've been waiting for the Commission[25] since April.

25. *The National Commission for the asylum application coordinates the Local Commissions, organizes training, updates the components of the same commissions and collects statistical data. It has decision-making powers regarding the revocation of granted refugee status.*

On the critical issues within the reception centres concerning their functioning and the living conditions of the asylum seekers residing there, four main issues were identified.

2.a The environment within the CAS is often unsuitable and overcrowded.

Many of the workers interviewed complained about the lack of adequate facilities and privacy for establishing a relationship of trust with the residents of the centre, leaving them unable to provide a level of confidentiality. Some of the facilities are not suitable for accommodating a large number of people. Sometimes they are unwelcoming and unreassuring environments, with bars on the windows and reinforced doors that certainly do not help to provide a good reception, especially for those who have experienced traumatic imprisonment during their migratory journey.


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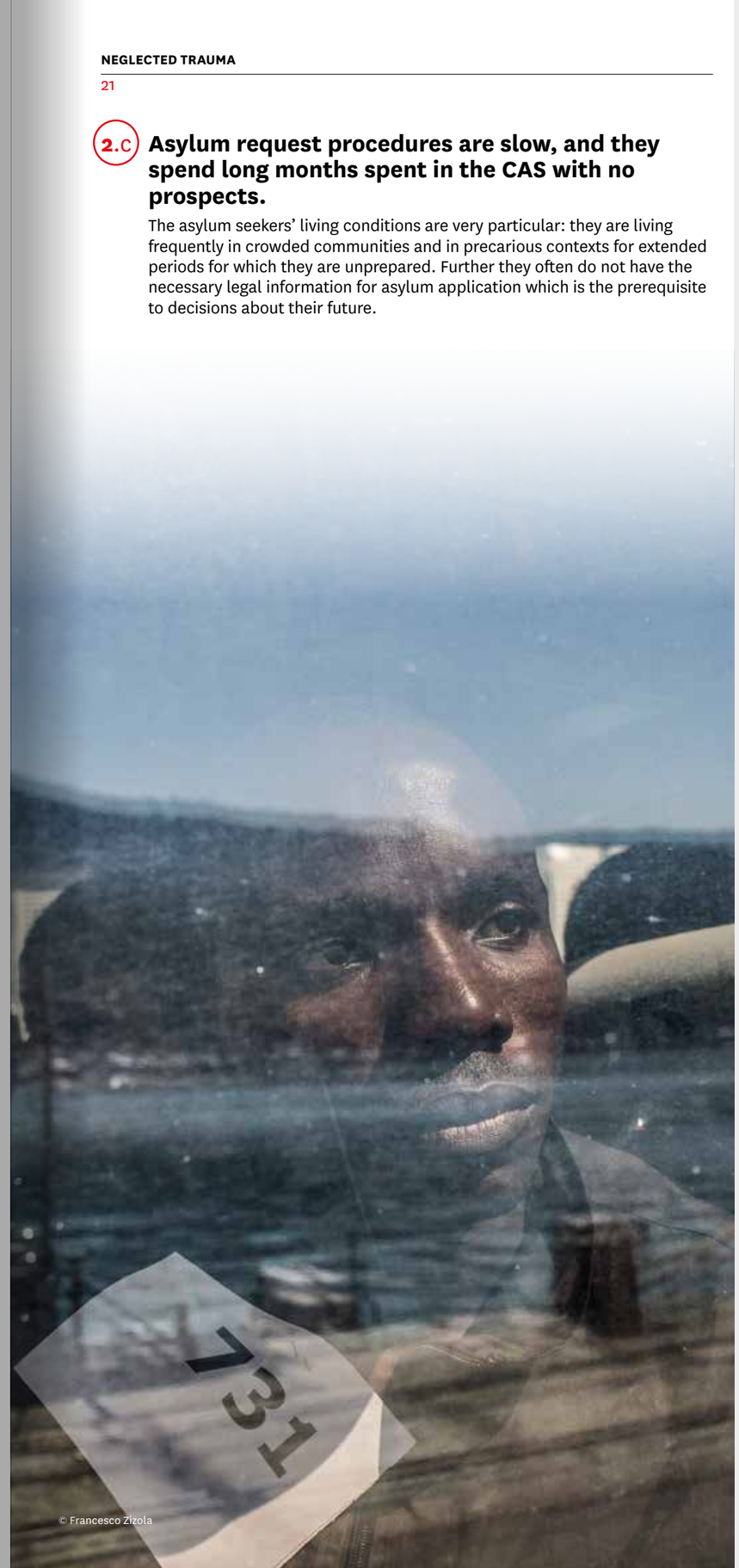
2.b Extraordinary Reception Centres are often in isolated locations, making integration impossible.

Many of the centres are located in isolated, hard-to-reach places, where residents are cut off from normal life and are unable to create connections and social networks within the area in which they are being housed. Their lives revolve around the mattresses they sleep on, the meals they consume and the television they watch. The only contact they have the outside the centre is limited to their fellow countrymen who are hosted in similar centres nearby.

2.c Asylum request procedures are slow, and they spend long months spent in the CAS with no prospects.

The asylum seekers' living conditions are very particular: they are living frequently in crowded communities and in precarious contexts for extended periods for which they are unprepared. Further they often do not have the necessary legal information for asylum application which is the prerequisite to decisions about their future.



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Getting all the answers from the police headquarters and having their papers in order becomes their reason for existence. If they don't manage to get all the answers they want, they revolt. They get depressed. We try to do everything we can so that they understand that it's beyond our control and that the system is slow and complex... Waiting with no prospects destroys them.

The work that I want to start with them, from a psychological point of view, is hampered by the papers. As soon as I start to gain their trust, to establish contact, they ask me about their certificates and documents. Just to give you an idea of how slow the bureaucracy is: a girl discovered she was pregnant just as she arrived. Six months later she's still here and they still haven't identified the SPRAR where she will be placed.

I can't sleep. Time waits for no one, and it passes relentlessly. I have to plan a better life for my future now, before it's too late. I can't spend a lifetime sitting here, letting one day pass after another, without seeing anyone, without having papers, eating, sleeping, without any change, without any progress. These documents are our life. When we get them, everything will be over, everything will be better. Without papers, you're nobody... You're nobody in front of your friends and your family.... I've lost almost two years and still I don't have any papers... Sometimes I feel like I'm going crazy.

2.d *Trauma and the difficulties of post-migration life are expressed as physical symptoms.*

In addition to the traumatic experiences they underwent in their countries of origin or during their migration journeys, a number of difficulties concerning life in the post-migration period have been detected. In particular, many of the residents in the centres complained about a high level of intolerance and loneliness, and a lack of direction concerning their path to becoming well-adapted, socially integrated and building a new life for themselves. The difficulties of life in post-migratory situations can have a significant impact on the mental health of asylum seekers and cause secondary trauma.

"The thoughts crowd in my head. My thoughts become gloomier, especially at night when I'm lying in bed... To stop myself from thinking, I read and I try to learn Italian. On Sundays I play football and I go to church. I try to do things to stop me thinking.

At first there doesn't seem to be anything wrong but then, after a few days, they start to relax and they feel ill – headaches, stomach pain, the whole body... It's not necessarily the case that they are really sick ... It might be the body expressing the pain of the soul. They always feel ill and are only happy when they take medicine...

It wasn't easy to get here. I saw many people die. I left Senegal in 2011 and arrived in Italy at the beginning of 2015. It wasn't easy, and you can't explain everything, but a lot of us left our country and many didn't make it. The police in Libya attacked ferociously... I know that God helped me to get here, but now I hope he will help me some more. I want to get the papers, that's my primary concern. I am studying Italian and trying to get my life ready, because for the moment I'm not ready to have a real life. I want to get my papers and find a job.

I left a country with a dictatorship. I came to Italy because I knew that there was democracy, and I was disappointed. The reality that I found is very different. I thought that wherever there was a democracy, you could solve problems by talking, but I learned that that's not how it is. We are very frustrated. Some of us have been here for two years and sit in this centre without doing anything. Put yourself in my shoes: a family man, like many others in here. I left my wife and my three children in my country, and they all depend on me. You want to give them the best: a good education and a bright future...And I've been sitting here with no prospects for two years now. One day my wife called me and told me that tomorrow they wouldn't have any food to eat... What do you expect me to say or do? What can I say to my wife in these circumstances? If I'm not protected in Italy and I can't get the papers, what can I do? It makes you feel bad, useless, as a man and as a father."

Quantitative data: the mental health of asylum seekers according to MSF's experience

The data analysed and examined in this study are limited to patients seen and treated by MSF in the period from 1 October 2014 to 31 December 2015 in the CAS of the province of Ragusa. Of the 521 people included in the psycho-educational groups, 387 were given an individual interview. Of these, 153 (39.5%) did not display symptoms of psychological distress. Of the remaining 234 (60.5%) patients with identified mental health and care needs, 12 (3%) patients were referred to other facilities, 5 (1%) refused treatment and 18 (4.7%) were transferred to another centre before the MSF team could intervene. The subject of this study will be the 387 patients subject to individual assessment and the 199 patients who had a final outcome as of 31 December (Fig. 2). The majority of patients were identified by the MSF team (66%), 18% were self-referred, 15% were referred by the operating team in the CAS and the remaining 1% were referred by local health authorities.

Of the patients who underwent a first individual interview, 33 (8.5%) were women and 354 (91.5%) were men. The mean age was 23.9 (± 5.5) with a range from 3 years old to 45 years old (Fig. 3). Of the registered patients, 78 (20%) were from Nigeria, 65 (16.8%) from Gambia, 51 (13.2%) from Senegal, 47 (12.1%) from Mali and 43 (11.1%) from Bangladesh. There was a smaller percentage of asylum seekers from other countries, such as Eritrea, Afghanistan, Somalia, Egypt, Ivory Coast, Guinea Bissau, Guinea Conakry, Iraq and Ghana. Of the patients interviewed, 9.6% (37) were vulnerable. Of these vulnerable patients, 16 (4%) were unaccompanied children, 10 (2.6%) were pregnant women, 7 (1.8%) were disabled and 3 (0.7%) recorded psychiatric problems.
For 210 (54.3%) of the patients, their journey to Italy took more than 12 months. For 70 patients (18%) the journey took between 6 and 12 months. For 78 patients (20%) the journey took between 2 and 6 months. The journey lasted less than two months for just 24 patients (6.2%). Of the 234 patients who had symptoms of mental distress, 206 (88.3%) were men and 28 (11.9%) were women.

Figure 2. Pathway of the mental health cases dealt with by MSF, province of Ragusa, Sicily, 2014-2015.

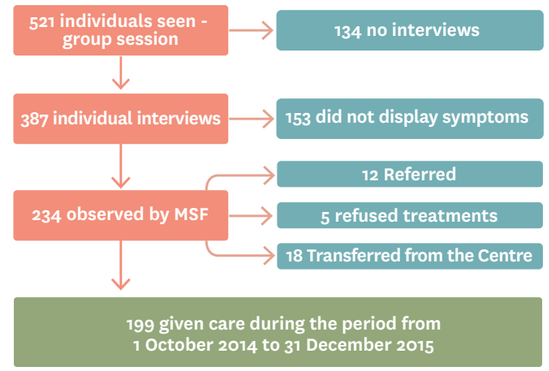
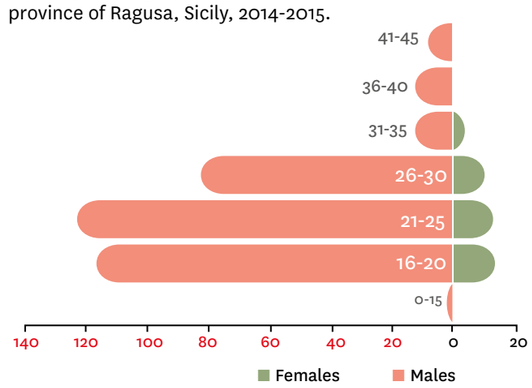


Figure 3. Demographic pyramid of the population under study, province of Ragusa, Sicily, 2014-2015.



Difficulties encountered

Among the subjects interviewed, the majority of the disorders detected were attributable to anxiety (n= 130, 33.6%), followed by post-traumatic stress disorders (n=63, 16.3%), depressive disorders (n= 46, 11.9%), personality disorders (n= 8, 1.8%) and cognitive disorders (n= 3, 0.7%). Of the 387 patients seen during this period, 189 (48.8%) were victims of traumatic events before the journey and 319 (82.4%) during the journey (Fig. 4).

The traumatic events most frequently recorded **before leaving the country** of origin (Fig. 5) were: having witnessed the abduction and incarceration of a family member (n=52, 28%); conflicts between families (n=58, 31%); and fear that their life was at risk (n=13, 7%). The commonly recorded traumatic events **from the migratory journey** were: prison and detention (n= 113, 35%); involvement in fighting (n= 38, 12%); forced labour (n=17, 5%); torture[26] (n=27, 9%); sexual violence (n=13, 4%); and constant fear that their life was at risk (n=33, 10%).

In total, 37.6% of the population analysed said they had suffered traumatic events in their country of origin and during their migratory journey. For patients affected by traumatic events before or during their migration journey (n=144), the median delay in being given care after their arrival was 80 days and the IQR [45-128].

The socio-demographic characteristics of the sample are described in table 3. An analysis of the group affected by mental symptoms and a comparison with the group of patients with no symptoms did not reveal any significant differences in terms of age, marital status or duration of the journey. However, significant differences were revealed in relation to gender, the state of vulnerability, nationality, the waiting time before being seen by a specialist, and the traumatic events that occurred before or during the migratory path. The presence of traumatic events has a significant impact on the existence of psychopathological symptoms.

26. *Note that the definition of torture used is that provided by the ICRC: https://www.icrc.org/eng/resources/documents/faq/torture-icrc-definition-faq-2011-06-24.htm.*

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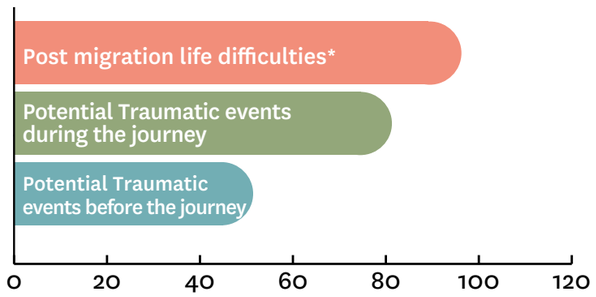
Figure 4. Frequency of traumatic events suffered by asylum seekers receiving care from MSF, province of Ragusa, Sicily October 2014-December 2015.



* The difficulties encountered in the post-migration period have only been calculated for the 199 patients treated by MSF (171/199)

Figure 5. Type of traumatic events experienced by asylum seekers, before and during the migratory journey, province of Ragusa, Sicily, October 2014-December 2015.

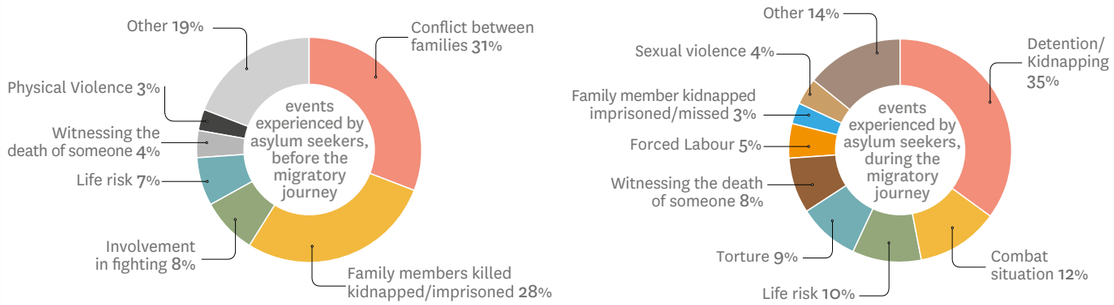


Table 3. Socio-demographic characteristics of the patients in a first individual baseline interview, province of Ragusa, Sicily, October 2014-December 2015.

	Patients without any symptoms of mental distress (n=153)	Patients with symptoms of mental distress (n=234)	Total (n=387)	P-value
Gender				
Male	148 (41,8)	206 (58,2)	354	
Female	5 (15,2)	28 (84,8)	33	0,003
Age groups				
0-15	0	1	1	
16-30	141 (40,2)	210 (59,8)	351	0,5
31-45	12 (34,3)	23 (65,7)	35	
Marital status*				
Married	36 (36,7)	62 (63,3)	98	
Widowed	0	1	1	0,7
Single	113 (40,5)	166 (59,5)	279	
Separated	2 (33,3)	4 (66,7)	6	
Duration of journey**				
< 2 months	6 (25)	18 (75)	24	
2-6 months	35 (44,9)	43 (55,1)	78	0,5
7-12 months	28 (40)	42 (60)	70	
> 12 months	82 (39,1)	128 (60,9)	210	
Vulnerability				
No	151(43,1)	199 (56,9)	350	
Yes	2 (5,4)	35 (94,6)	37	0,000
Traumatic events***				
No	122 (51,1)	117 (48,9)	239	
Yes	31 (21,5)	113 (77,8)	144	0,000
Waiting time †				
< 2 months	41 (30,2)	95 (69,8)	136	
≥ 2 months	109 (45)	133 (54,9)	242	0,005

* 3 missing data ** 5 missing data *** 4 missing data † 9 missing data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Risk factors and difficulties of post-migration life

In the multivariate logistic regression model (Table 4), inclusive of vulnerability, sex, waiting time before accessing care and traumatic events suffered, the variables associated with a mental psychopathology, adjusted for potential confounders, were found to be vulnerability OR = 9.1 [CI: 2.1-39.9] and traumatic events OR = 3.7 [CI: 2.3-6.1]. However, the sample of variable 'vulnerability' is negligible enough (n= 37) to be deemed as imprecise with a large confidence interval.

The probability of having psychopathological disorders was 3.7 times higher among individuals who experienced traumatic events than those who did not experience any. Among the traumatic events suffered before leaving their country of origin, those who had a family member kidnapped or imprisoned were 6 times more likely to have psychological distress OR= 6.11 [CI: 2.5-14.5] than those who did not suffer any injury. Those who experienced conflicts between families were 2.2 times more likely to have psychological distress than those who did not experience any trauma OR= 2.2 [CI: 1.06-4.7]. Among the traumatic events that occurred during the migratory journey, those who were incarcerated were 5 times more likely to have mental health disorders that those who did not OR= 5.04 [CI: 2.04-12.4], and those involved in fighting were 3.2 times more likely to have mental health disorders than those who were not OR= 3.2 [CI: 1.1-9.2].

Table 4. Risk factors for mental health, Ragusa Province, Sicilia, october 2014 -december 2015

Variables	Mental Health Disorders	
	Non Adjusted OR (95% CI)	Adjusted OR (95% CI)
Sex		
Males	1	1
Females	0,2 (0,09 - 0,6)	0,4 (0,15 - 1,19)
p-value	0,001	0,08
Vulnerabilities		
No	1	1
Yes	13,2 (3,1 - 56,0)	9,1 (2,05 - 39,9)
Likelihood Ratio Test (p-value)	0,000	0,006
Waiting Time		
< 2 months	1	1
≥ 2 months	0,5 (0,33 - 0,82)	0,6 (0,38 - 1,02)
Likelihood Ratio Test (p-value)	0,08	0,06
Traumatic Events		
No	1	1
Yes	3,8 (2,3 - 6,09)	3,7 (2,3 - 6,10)
Likelihood Ratio Test (p-value)	0,000	0,000
Traumatic Events in the Countries of Origin		
No	1	1
Family member killed/kidnapped/imprisoned	5,8 (2,4 - 13,9)	6,4 (2,7 - 15,5)
Conflict between families	2,5 (1,2 - 5,2)	2,2 (1,07 - 4,8)
Life risk	4,1 (1,03 - 16,2)	4,6 (1,1 - 18,4)
Likelihood Ratio Test (p-value)	0,000	0,000
Traumatic events during the migratory journey		
No	1	
Detention	3,7 (1,6 - 8,6)	5,04 (2,04 - 12,4)
Life risk	1,6 (0,5 - 4,4)	1,7 (0,5 - 5,2)
Combat situation	2,5 (0,9 - 6,5)	3,2 (1,1 - 9,2)
Likelihood Ratio Test (p-value)	0,000	

Of the diagnoses[27] most commonly found among the patients cared for by MSF (n= 199), 42.2% (84) was for disorders related to traumatic and stressful events, especially PTSD, followed by 27% (54) for disorders due to anxiety, 19% (38) for moderate depression and 4% for personality disorders. Of the patients given care by MSF, 65% (130/199) showed a dual diagnosis of psychopathology. PTSD as a primary diagnosis (n= 84) often coexists with anxiety disorders (n = 57/84, 68%) and with moderate depression (n= 34/84, 40%).

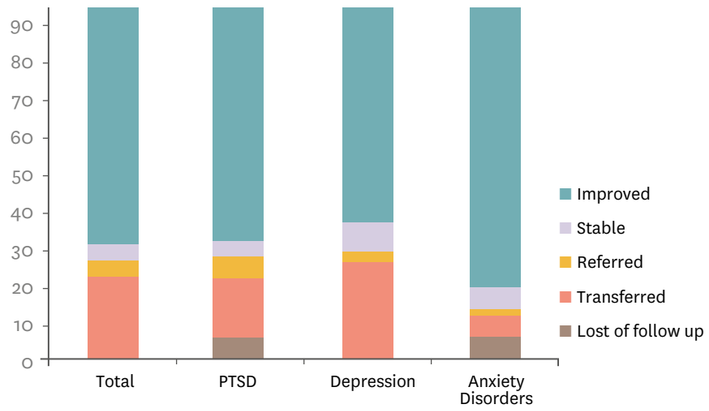
The median number of sessions in the period between 1 October 2014 and 31 December 2015 is 4 [IQR= 2-6], with a range from 1 to 20. No particularly significant association was found between the number of sessions and the final outcome of the therapy.

Among the patients cared for by MSF, 86.9% (173/199) said they had difficulties in post-migration life and this distress was significantly associated with a diagnosis of PTSD (42.2% vs 22.2%, p= 0.05), followed by a diagnosis of anxiety disorders (28.9% vs. 22.2%, p= 0.05). The most common difficulties in life during the post-migration period were found to be "the feeling of uncertainty and fear for the future" (18.8%), "concern for the family back home" (13.8%), "conflicts within the CAS" (11%), "fear of the asylum request being rejected" (8.8%), "the feeling of being neglected" (7.2%), "the inability to integrate and feel integrated"(7.7%), "prolonged waiting times for the Commission's outcomes" (5.5%), "lack of daily activities" (3.9%), "a sense of loneliness and boredom" (2.2%) and, to a lesser extent, other difficulties such a widespread sense of injustice and feeling unable to control events. In general, patients complained of a variety of difficulties in post-migration life, for an average of 6.3 (± 4.6). The traumatic events suffered during the migratory journey equally contributed to PTSD disorders (94% vs 3.5%, p= 0.02) and depression (84% vs 10.5%, p = 0.02).

The majority of patients (n= 134, 67.3%) showed an improvement at the end of the therapy, while 4.5% (n= 9) showed no improvement, 21.6% (n= 43) were transferred out of the centre before MSF could intervene, and 4.5% (n= 9) were referred.

Figure 6 illustrates the different categories of outcomes for the three major recorded psychopathologies: PTSD, depression and anxiety-related disorders. Patients with PTSD and depression showed improvement in more than 60% of cases, and 80% of individuals with anxiety disorders showed improvement. The highest proportion of patients who did not show any improvement were found to be those with depression (8%). The highest percentage of referred patients was recorded among subjects with PTSD.

Figure 6. Final outcomes for the total number of patients given care and for the three major types of psychopathology, province of Ragusa, Sicily, October 2014-December 2015.



27. *Following the indications of the DSM-5, the diagnoses were classified as follows: acute stress disorders, complex post traumatic stress disorders, psychological stress and post traumatic stress disorder related to traumatic and stressful events, moderate and severe depression in bipolar disorders, anxiety and somatoform disorders, psychotic disorders, dissociative and cognitive disorders, personality disorders (sleep disorders).*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DISCUSSION

The findings of the qualitative research, the characteristics of the patients observed in our project in Sicily, and the literature review, all combine to suggest that exposure to violence and traumas suffered by the migrant population during the migratory journey and complex situations experienced in the period following their arrival are a major source of psychological distress.

The repertoire of psychopathological phenomena appears to be broad and is expressed on different levels. Among the subjects analysed who were diagnosed with symptoms related to traumatic and stressful events and PTSD, the co-presence of other disorders such as anxiety, depression, personality and cognitive disorders was often found.

Although there is a need for further rigorous evaluation, psychological support showed a beneficial effect on the treatment of trauma, both in contexts of humanitarian crisis and among the asylum seeker and refugee population[28]. Among the asylum seekers, various interventions that included a component of psychological and therapeutic support showed promising results in terms of stress reduction and the strengthening of compensatory strategies and resilience[29]. Our data concerning the cohort of patients followed throughout 2015 seem to confirm this trend.

A high prevalence of difficulty in post-migration life was found in parallel with the traumatic experiences in the home country and especially during the migratory journey. The literature has amply demonstrated that having an accumulation of this type of experiences carries an increased risk for refugees and asylum seekers of developing PTSD in the host country and of experiencing greater difficulties with social integration[30]. According to a systematic review, PTSD was predominantly diagnosed in asylum seekers with previous traumatic history, while the stay in the reception and detention centres acted as a current trauma for other categories of mental distress[31].

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28. *See: Tol W.A., Barbui C., Galappatti A., Silove D., Betancourt T.S., Souza R., Golaz A., Van Ommeren M.: Mental Health and psychosocial support in humanitarian settings: linking practice and research. Lancet 2011, 378: 1581-1591. Van Ommeren M., Saxena S., Saraceno B.: Mental and social health during and after acute emergences: emerging consensus? Bull. World Health Organ. 2005, 83 : 71-76.*

29. *Moro M.R.: Psychiatric interventions in crisis situations. The Signal 1994, 2 :1-4.*

30. *See: Silove D., Sinnerbrink. I., Field A., Manicsvasagar V., Steel Z., Anxiety, depression and PSTD in asylum seekers: association with pre-migration trauma and post-migration stressors. British Journal of Psychiatry, 170: 351-357. Aragona M., Pucci D., Mazzetti M., Maisano B., Geraci S.: Traumatic events, post-migration living difficulties and post-traumatic symptoms in first generation immigrants: a primary care study, Ann Ist. Super. Sanità 2013, Vol. 49 N2:169-175.*

31. *Robjant K., Hassan R., Katoma C.: Mental health implications of detaining asylum seekers: systematic review, The British Journal of Psychiatry (2009) 194:306-32.*

As we noted in discussions with migrants and CAS workers, it can be a stressful experience to live in reception centres that are designed as emergency measures and are often limited to ensuring basic services, with no clear plan for inclusion in host society, and where asylum seekers spend the entire duration of their stay until they receive hearing with the local commission, and with no clear future prospects. In addition, living in this kind of limbo, without any useful employment, could exacerbate old traumas and increase the risk factors of secondary trauma. The long wait for the preliminary examination of the application for international protection through the C3 form can take several weeks from their arrival at the facilities, and in some cases even months (as is the case in Trapani). This already represents a cause for destabilisation for the applicant, which is worsened by additional waiting for the call to attend the hearing at the local commission.

The testimonies of the CAS workers and especially the residents themselves have confirmed these criticisms by highlighting the extent to which the draining wait for a summons and a response from the commission is a key factor of instability for asylum seekers. It also has an effect on workers, making management of the CAS tiring and distressing. Asylum seekers residing in these extraordinary facilities often lose their concept of time and live in limbo. Their days are always the same, and are only marked by the alternation of the meals as they await the commission's decision to interrupt their alienating rhythm. This waiting phase, which can last from a few months to over a year depending on the case, only serves to increase the fragility of the asylum seeker's condition, as someone who has just completed a journey under extreme conditions, fled a dictatorship or a desperate situation and has often left a family behind. If the state of uncertainty and the transient situation experienced by asylum seekers lasts for months, it can lead individuals to a state of psychological instability in addition to the trauma suffered during the migratory journey. Their thoughts are caught up in their most pressing concerns: getting hold of the right the documents and the wellbeing of family members who remain in the country of origin.

Many of the CAS are located in remote areas, far from towns and cities, meaning integration with the native population is impossible. As such, social relationships are limited to residents of the centre or similar facilities, causing a strong feeling of marginalisation and a lack of access to services. The forced inactivity to which people may be subjected for several months at a time brings feelings of apathy and depression, as well as a sense of worthlessness, dependency and frustration.

The characteristics of the facilities themselves often represent a risk factor for the onset or aggravation of psychological suffering. Many structures are improvised in Centres (in some locations, for example in Sicily, the centres are converted Public Welfare and Benevolent Institutions (IPAB), and assistance is offered to the elderly and migrants in the same building), and staff confuse the complexity of the asylum seekers hosted with other individuals with different needs. When a person who has survived violence or has been the victim of inhumane and degrading treatment is forced to live in overcrowded or unsuitable conditions, they are even more at risk of developing psychological symptoms related to their previously experienced trauma, or of developing symptoms connected to the dynamics of social exclusion, isolation and prolonged cohabitation for a significant period of time.

The staff working in the CAS are not always adequately prepared to meet the demands and needs of this population, a significant portion of whom may have complex personal stories from having been a victim of trafficking, or having suffered or witnessed terrible violence. Throughout the centres visited, especially those in the south (the provinces of Trapani and Ragusa), links with the local area are completely absent, and the support and care activities are delegated to private-social bodies, where they exist. Moreover, the reception conditions in these facilities often make it difficult to

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promptly identify the migrants who are in a state of psychological distress and in need of urgent care. The situation is different in Rome and Milan, but the commitment of addressing the mental needs of asylum seekers is still too unstructured. The training of workers in dealing with asylum seekers who are suffering from mental illness is still not widespread enough and the available human resources are not sufficient.

In fact, the system developed in 2014 and coordinated locally by the prefecture has now given rise to a parallel mechanism that places people seeking asylum and international protection in a wide variety of facilities. These centres have much lower reception standards compared to those ensured by the SPRAR system, and are not required to provide individual integration plans. A report by the Ministry of the Interior[32] confirms a picture of an asylum seekers reception system build on heterogeneous structures and a complex management including a wide range of stakeholders[33]. It paints a picture of a system whereby measures are primarily aimed at finding quick fixes and spaces in which to place asylum seekers during the long wait for the commission's responses to applications for international protection.

Study limitations

A number of limitations must be taken into account with respect to the results of the study presented. The data shown in the quantitative analysis are based on routine data collected in the project run by MSF in the province of Ragusa. As such they suffer from the lack of an initial epidemiological design based on a clear investigative hypothesis and on a direct comparison with a control sample. Despite the efforts and measures taken to standardise the evaluations and the definition of the cases, the turnover of psychologists may have potentially caused inconsistencies in the assignment of diagnosis and outcomes. Given the type of data collected, it was not possible to assess the evolution of the therapeutic outcome attributed. These results should to be understood as a proposal for a hypothesis, and need to be confirmed by a properly designed longitudinal study. The selection of CAS in the provinces of Milan and Rome for conducting the interviews and focus groups was made based on the indications of the prefecture that authorised the visits. This may have caused a selection bias by including the more virtuous CAS while preventing the participation of the more problematic ones. However, in many cases the open atmosphere of discussion allowed for a transparent debate and the expression of criticism, including severe criticism, of both the system and the Prefecture.

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32. *http://www.interno.gov.it/it/notizie/sistema-accoglienza-oggi-rapporto-qualificato-e-aggiornato-aspetti-procedure-e-problemi*

33. *See: Doctors Without Borders, Out of sight. Asylum Seekers and refugees in Italy: informal settlements and social marginalization, 2016. Ministry of Interior, Report on International Protection in Italy, 2015. http://www.interno.gov.it/sites/default/files/t31ede-rapp_prot_int_2015_-_rapporto.pdf*

CONCLUSIONS AND RECOMMENDATIONS

The above results highlight the need to reform the approach to the issue of mental health treatment in the context of migration in Italy. The widespread absence of professionals with *expertise* in the context of migration is undermined by the frequent lack of cultural mediation figures, even in the public referral facilities, with harmful consequences for the early and essential identification of cases of mental distress among the hosted migrant population.

Multidisciplinary and multicultural teams should be present in order to take all the dimensions involved into consideration. At present, the existing facilities are inadequate, and in the majority of cases they are managed by non-profit organisations. The role of the national health service is limited, and the local health authorities are not prepared to respond to requirements of the reception centres under their regional responsibility.

The emergence of disorders connected to trauma related to the context of origin and migration thus requires a structured and comprehensive approach. This should be the result of synergistic coordination between the different parties involved in responding to the issue of migration, which requires more than merely temporary or emergency solutions. It has been shown that, in order to effectively treat asylum seekers who have often been victims of traumatic events, it is necessary to put in place an integrated reception system involving both public institutions and private-social services, and to work on supporting individuals to be resilient as soon as they arrive[34].

In light of the above, MSF deems it appropriate to put forward recommendations aimed at defining concrete solutions to the issues identified in this study, with the hope that the institutions and competent authorities will find food for thought that may be useful for making the necessary changes at the legislative level.

In particular, MSF recommends that:

1. The competent Prefectures should formulate strict selection criteria for the recruitment of cooperatives and institutions managing the centres, as well as the staff employed by them, to ensure the presence of skilled professionals with experience in the area of migration.
2. Public facilities, with particular reference to the Mental Health Department and Mental Health Centre, should hire staff trained in the context of transcultural psychology and/or ethno-psychiatry. In addition, creating departments specialising in cross-cultural psychology and ethno-psychiatry at the facilities would also be beneficial.
3. The Ministry of Health, at the national level, and the ASL, at the local level, should designate a advisor in the area of migration. This person should be responsible for coordinating the response of local health services, at different levels, as well as the mental health departments, reception centres, associations, social services and universities. This would ensure that patients with complex needs are systematically provided with care. The public health services should provide medical centres integrated with the private-social organisations for the assistance and psychological rehabilitation of the asylum seekers.
4. In order to reduce the risk factors of psychological stress and the re-traumatisation of asylum seekers associated with the conditions of the reception centres, the Prefectures and local health authorities should ensure systematic joint monitoring of the facilities and detailed monitoring of the quality of the services provided.
5. The Ministry of Health and local health authorities should develop appropriate guidelines addressing mental health of asylum seekers that capitalize on the existing experience and best practices within the Italian territory. These guidelines shall respond in particular to a migrant context currently undergoing significant transformation which requires new tools to understand its full complexity including the mental health aspect.


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34. *Geraci S., Aragona M., Mazzetti M.: Quando le ferite sono invisibili. Vittime di tortura e di violenze: strategia di cura. Rome, October 2014.*

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The decision to launch a MSF Mission in Italy, as for other European countries, has been reached by the end of 90s. At this time, Medecins Sans Frontieres realized that the same people we assisted at thousands of miles away in other continents were the same we met here, in Italy and Europe, very often in extremely precarious and vulnerable conditions.
Today MSF continues its work with the migrant population through several projects: in Gorizia, at the northeastern border with Slovenia, where we provide medical care, shelter and first assistance for the hundreds of asylum seekers who remained excluded from the institutional reception system (in partnership with the local health authorities and the Red Cross); in Rome, where in April 2016 we opened a rehabilitation center for torture and ill-treatment survivors (in partnership with the NGOs Doctors Against Torture and ASGI- Association for Juridical Studies on Migration). In Rome we are also carrying out an echocardiographic screening activity aimed at identifying positive cases of rheumatic heart disease within migrant population living in informal sites. In Trapani MSF teams of psychologists and cultural mediators provide psychological support to asylum seekers hosted in extraordinary reception centers (CAS) of the province.
Further, since the end of April Mission Italy is coordinating the search and rescue activities of the Bourbon Argos vessel, one of the three MSF ships prepositioned in international waters north of Libya for actively searching for boats in distress. On shore, MSF mobile teams are working in Sicily and in Southern regions' ports, at critical landings related to shipwrecks and incidents at sea, to support psychologically and give first assistance to people who survived such traumatic events.

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