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Submission of Spirasi

to the

Advisory Group

13th August 2020

Company no. 476831 | Charity no. CHY 16923

Board of Directors: David Regan (Chair) | Rev. Brendan Carr C.S.Sp | Connie O'Halloran (Secretary) | Luke Fitzgerald (Treasurer) | Siobhán Conlon | Rev. Paddy Moran C.S.Sp | Grace Mulvey | Immaculate Akello | Sr Eileen Browne DOC | Denis Murphy | Dr. John Tobin

Spriasi is supported by HSE, CDETB, AMIF through the Dep. of Justice and Equality, UN Fund for Victims of Torture, Tusla, Christian Brothers, Daughters of Charity, and World Mercy Fund

Spirasi, the Centre for the Care of Survivors of Torture in Ireland, provides two key services for torture victims, the vast majority of whom are refugees or asylum seekers.

1.

Firstly, Spirasi provides ongoing holistic rehabilitation comprising of appropriate medical, psychological, psychosocial and educational interventions. Torture victims are dramatically overrepresented among refugees (Baker & Basoglu, 1992). According to research, 30-60% of refugees residing in Europe (Sansani, 2004), and 50% of migrants in Ireland (Wilson, Hennessy, Dooley, Kelly, & Ryan, 2013), have suffered torture or serious violence. Spirasi understands torture according to the definition of the United Nation's Convention Against Torture and Cruel, Inhuman, or Degrading Treatment or Punishment (UNCAT) [1] and uses this definition when deciding the scope of its remit.

Many Spirasi clients have also undergone what we refer to as the *Triple Trauma Paradigm*: the trauma that happened in the country of origin i.e. torture; the trauma of their transit to Ireland i.e. perilous journeys and refugee camp experiences; and the trauma that happens in the host country i.e. the long and arduous asylum process, direct provision system, cultural shock and racism. Modvig and Jaranson (2004) recorded rates of 43% for current Post-traumatic Stress Disorder (PTSD) and rates of 74% for lifetime experience of PTSD in refugee victims of torture. However, a diagnosis of PTSD for victims of torture is too inadequate a description of the complexity and magnitude of the effects of torture (de C Williams and van der Merwe, 2013).

> *'No diagnostic terminology encapsulates the deep distrust of others which many torture survivors have developed, nor the destruction of all that gave their lives meaning'* (de C Williams & van der Merwe, 2013, p. 103).

For this reason, many working with victims of torture assess for and treat Complex PTSD, as this appears to be a more accurate diagnosis to describe trauma experienced by victims of torture.

[1] *torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions* (UNCAT, 1984).

Recent data analysis carried out in Spirasi found that 71% of clients attending Spirasi fell into the diagnostic category for a trauma disorder (32% for PTSD / 39% for Complex PTSD). For comparison, in a general population prevalence rates average on 1.5% for PTSD and 0.5% for Complex PTSD. Our findings are not surprising given that the experience of torture is deemed to be the most extreme form of psychological abuse. Symptoms related to Complex PTSD are thought to arise from severe, prolonged and repeated interpersonal trauma (Briere & Spinazzola, 2009; Herman, 1992a, 1992b; B. A. van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) where there is a perception by the victim of being unable to escape, due to physical, psychological or social constraints (Cloitre et al., 2011). The triple trauma paradigm of the refugee experience very much fits into this category.

Spirasi assesses for both PTSD and Complex PTSD (as well as depression, anxiety and psychological well-being) at the initial assessment stage and tailors the subsequent interventions to specifically work with the symptoms experienced by our clients. This requires skilled staff and a holistic approach to treatment. It often requires long-term support where safety and trust are built carefully and slowly, always ensuring the sessions are client-led, empowering and well-boundaried.

The need is compelling and, while Spirasi is supported by the HSE to provide a response, the funding is inadequate and waiting lists are increasing to a distressing level for clients with its knock-on effects on staff morale. Spirasi, therefore, calls for adequate resources to be made available to provide the service required.

Furthermore, the sooner victims of torture are identified the sooner rehabilitation can begin. This early identification of torture victims has long been advocated by Spirasi and, while acknowledging the Advisory Group's call for the immediate implementation of the vulnerability assessment – now a statutory requirement, we wish to add our voice for this implementation without further delay.

Finally, it is also clear from research that positive therapeutic impact is significantly lessened as long as trauma victims remain in what is for them an 'unsafe' situation – namely Direct Provision. This in turn contributes to longer waiting lists as people move through the therapeutic process at a much slower pace. The sooner trauma victims move to a stable situation the sooner the trauma can be processed.

2.

Secondly, Spirasi provides Medico Legal Reports (MLRs) for the international protection process. Reports are produced in accordance with the *Istanbul Protocol* [2] to a high standard by specifically trained physicians. Compiling a report is complex and time-consuming, involving a lengthy detailed interview with the person alleging torture and follow-up medical and legal reviews before the final report is submitted to the requesting solicitor. MLRs can and often do make a significant contribution in the determination of whether or not a person has been tortured and to the degree that may be the case.

With current resources Spirasi could produce approximately 120 MLRs per year. However, with the lockdown and current Covid 19 restrictions, that number will be significantly reduced in 2020 to approximately 60 in total. As the numbers seeking asylum in Ireland in 2020 has reduced so too have the requests for MLRs.[3]. This will allow Spirasi reduce its considerable waiting list for an MLR – now standing at 13 months – which had built up over the last number of years. Spirasi has recently commenced again the production of MLRs

Spirasi does not wish to contribute to delays in the protection process. Spirasi also acknowledges the risk in deterioration of the health of applicants and the potential negative impact on the rehabilitation of people waiting extensive time for reports. While Spirasi acknowledges the efforts have been made to fund its work in this regard – particularly the funding through the AMIF (Asylum Migration and Integration Fund) – there is need to place the production of MLRs on a priority footing in the overall international protection process so that the production of MLRs are adequately funded and produced in a timely fashion and as required, matching the ebb and flow of international applications into the country.

[2] https://www.ohchr.org/documents/publications/training8rev1en.pdf

[3] By May 31st 2019 the numbers seeking International Protection in Ireland were 1852. In May 31st 2020 that number had reduced to 775. (IPO statistics)