Our care for refugees: A Procrustean bed?

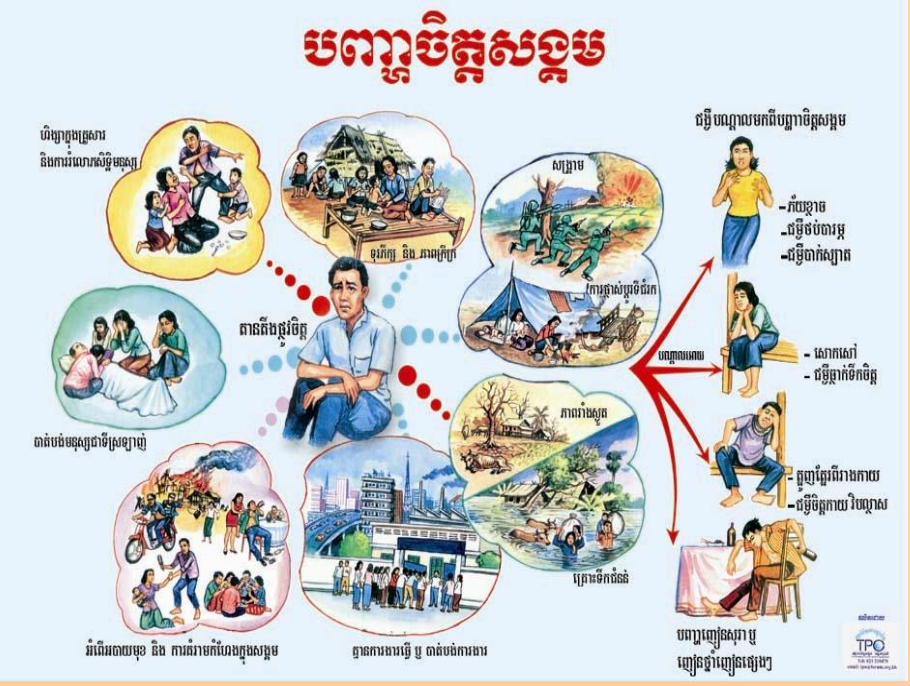
Joop de Jong

Experience combining interventions and research among adults and children in a variety of cultures

- ❑ Afghanistan
- ❑ Algeria
- ❑ Angola
- ❑ Bangladesh
- ❑ Bosnia
- ❑ Burundi
- ❑ Cambodia
- ❑ China
- ❑ Eritrea
- ❑ Ethiopia
- ❑ Gaza
- ❑ Guinea Bissau
- ❑ Haiti
- ❑ Honduras
- ❑ India
- ❑ Indonesia
- ❑ Kosova
- ❑ Mozambique
- ❑ Namibia
- ❑ Nepal
- ❑ Netherlands
- ❑ Pakistan
- ❑ Philippines
- ❑ Rwanda
- ❑ Senegal
- ❑ Sierra Leone
- ❑ Sri Lanka
- ❑ Sudan
- ❑ Surinam
- ❑ South Africa
- ❑ Swaziland
- ❑ Uganda



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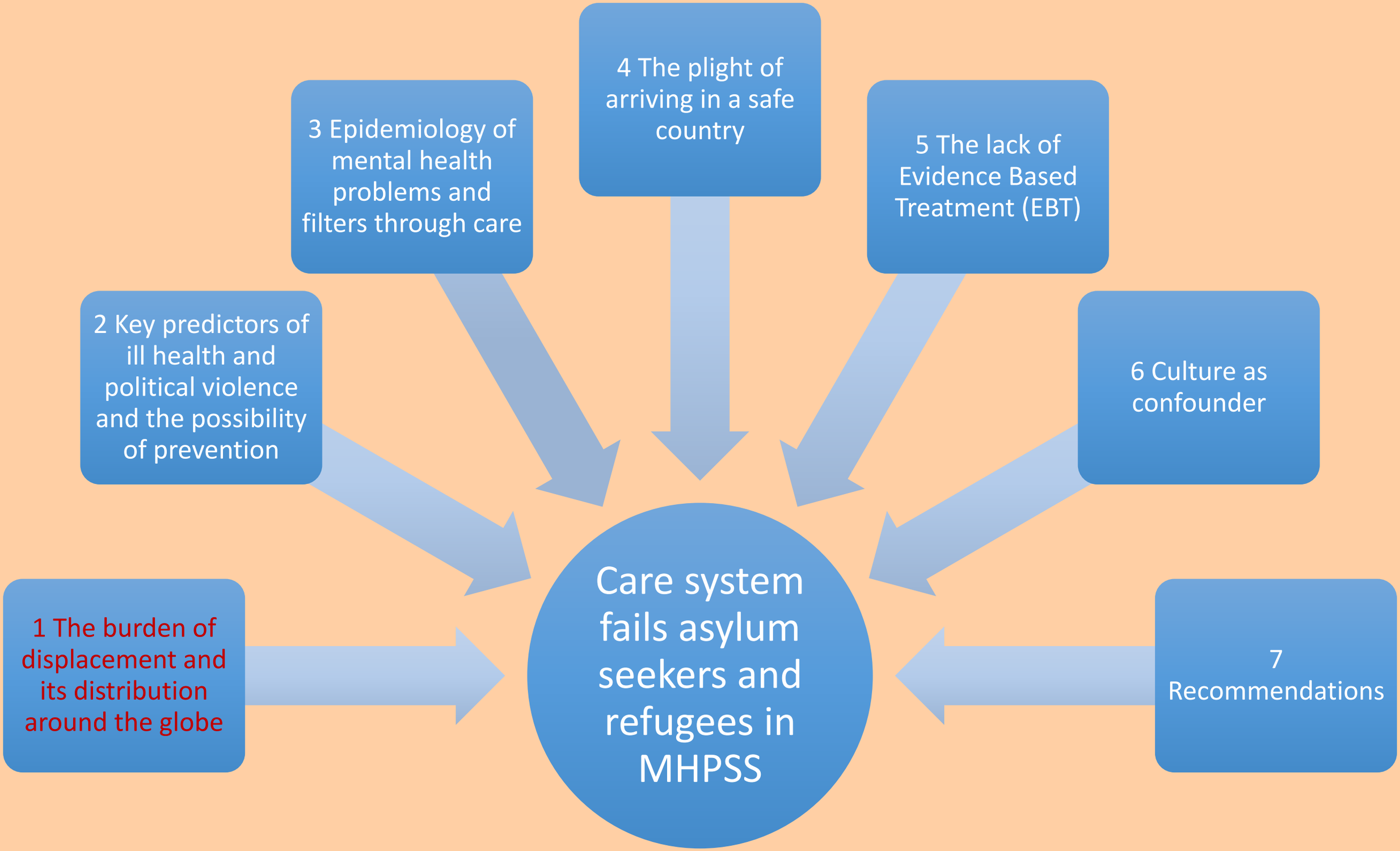
Procrustes' myth

- One size fits all
- 'All animals are equal'
- Squeezing life into preconceived ideas
- Proto-terrorist
- **Parallel myths asylum seekers & refugees:**
- Tailored care & equity

Outline talk



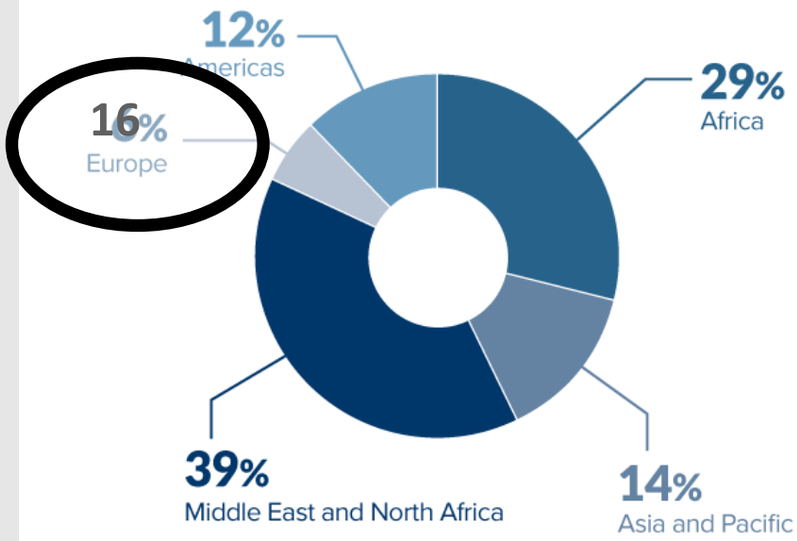
1 The burden of displacement and its distribution around the globe

65.3 million
forcibly displaced people worldwide

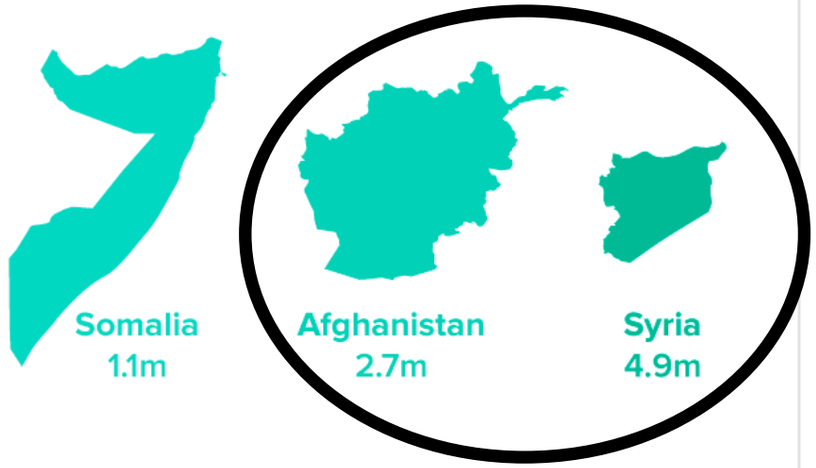
Refugees
21.3 million
16.1 million under UNHCR mandate
5.2 million Palestinian refugees registered by UNRWA

Stateless people
10 million

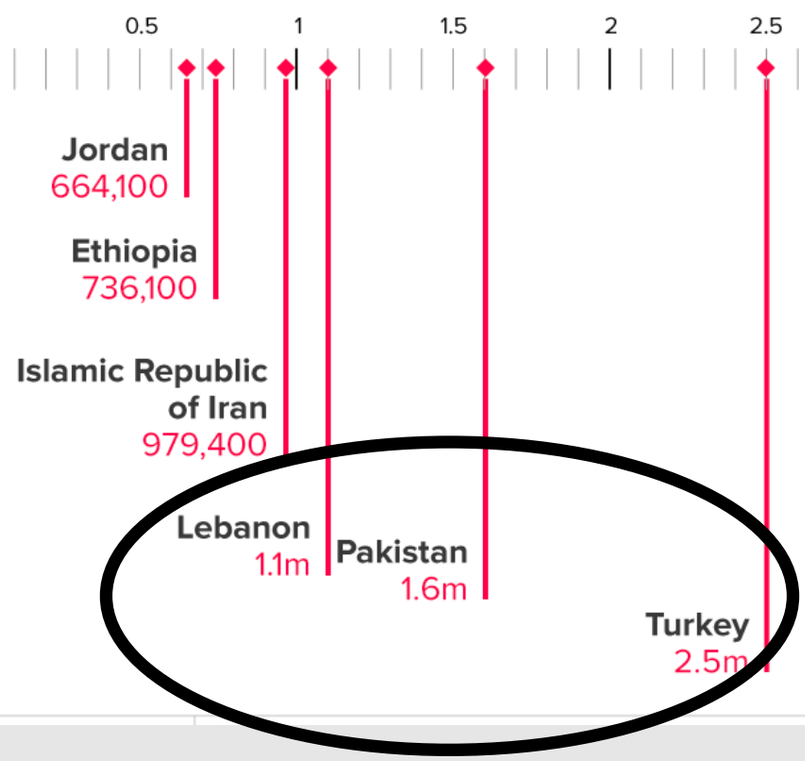
Where the world's displaced people are being hosted



54% of refugees worldwide came from three countries

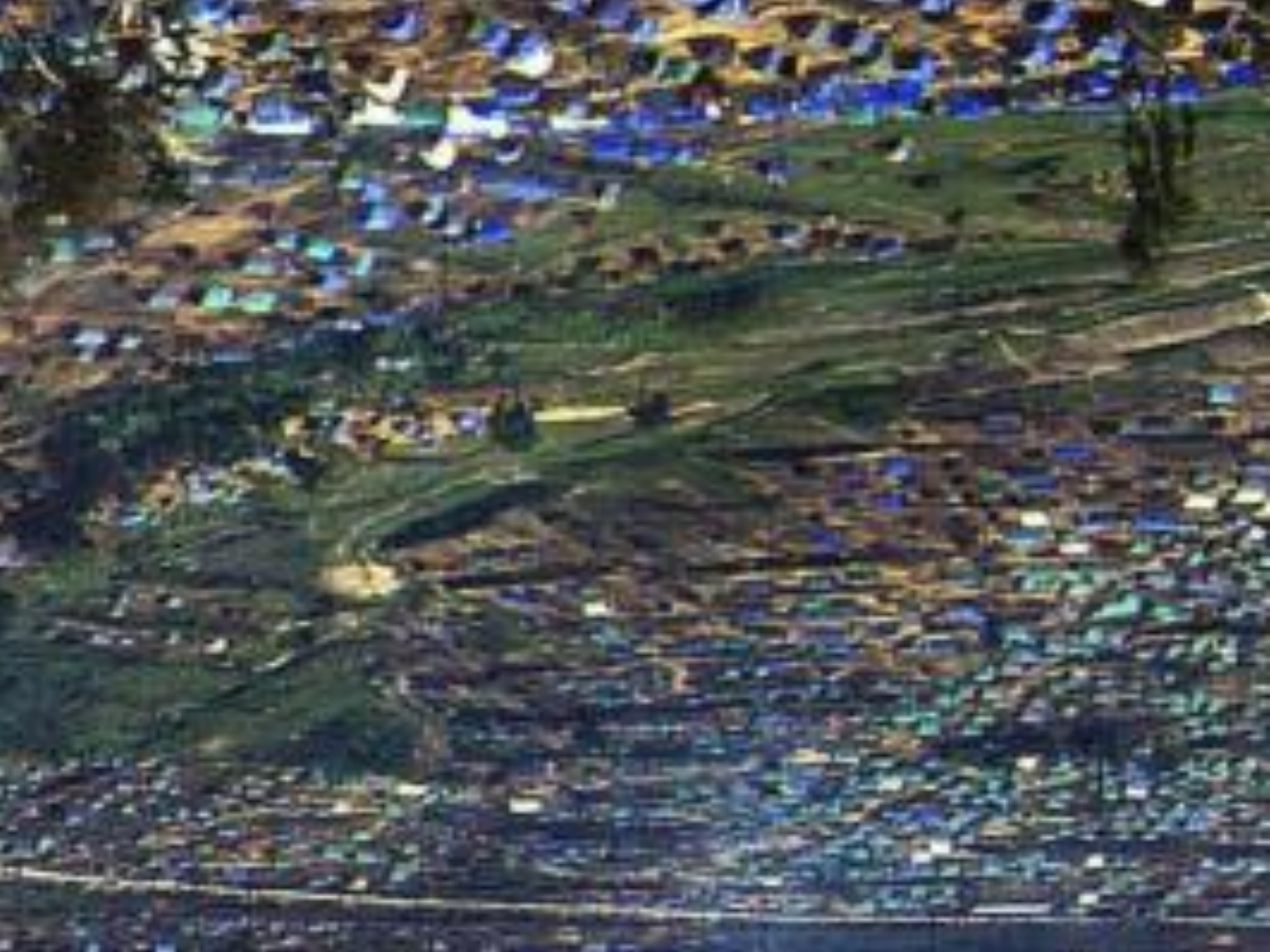


Top hosting countries

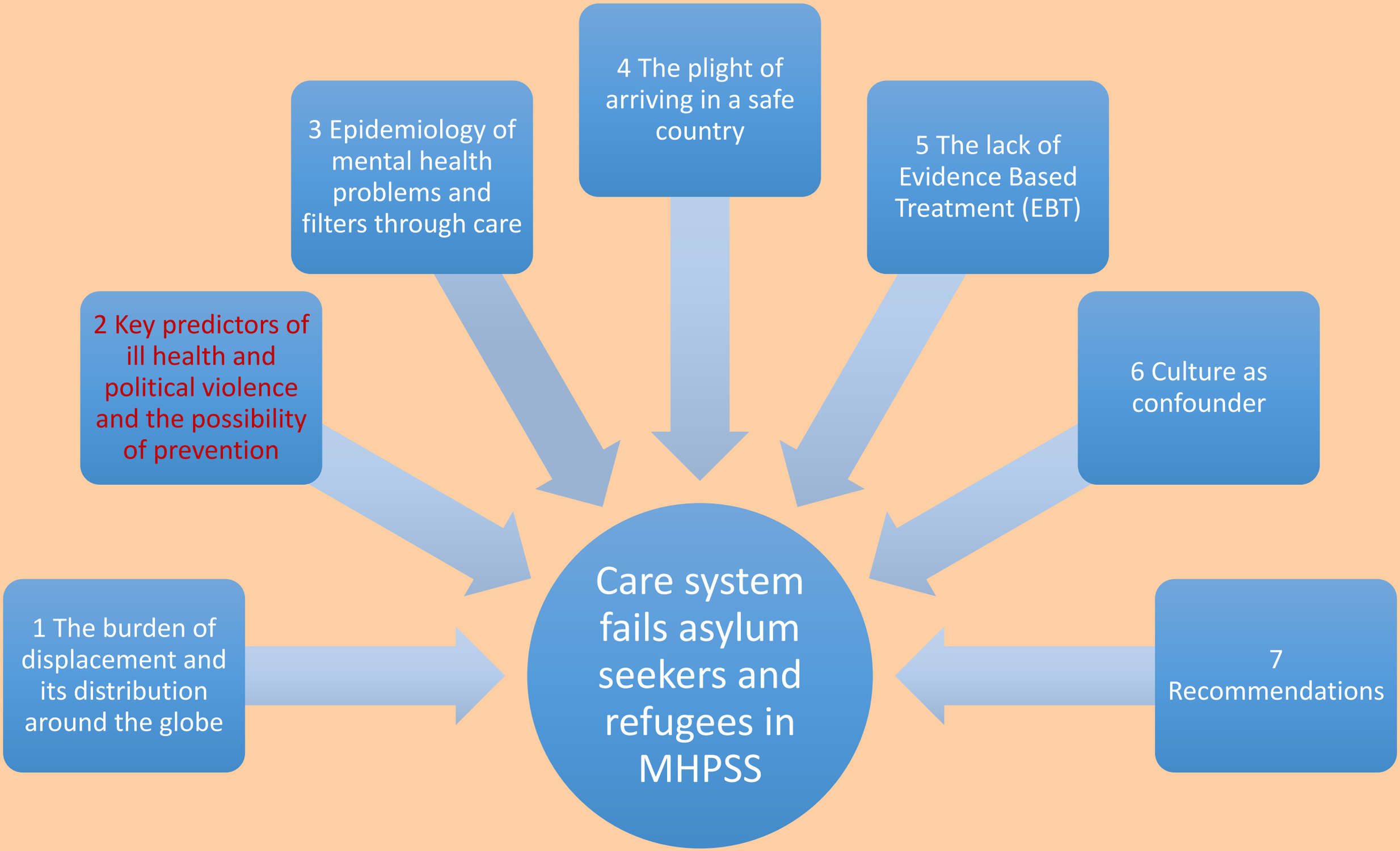


Netherlands 2016	Norway 2016	Sweden 2016
Asylum seekers : 10.000	7.500	83.000
Refugees: 100.000	59.000	230.000

UNHCR 2016



Outline talk



2 Common predictors of political violence & ill health and the possibility of prevention

Predictor	Consequences armed conflict	Consequences health
•Faulty governance/ Lack of democracy	•Human rights violation •Criminalization of the state •Faulty leadership/Corruption	• Lack of social justice • Low priority of health • Low government spending • Lack of health policy
•Inequality/inequity	•Widening socio-economic inequalities/struggle over access resources (oil, water)	• Impaired access to sanitation, health, education
•Marginalization of groups	•Political power exercised differentially applied according to ethnic or religious identity	• Differential access to services and differential outcomes for minorities, urban/rural residents/IDPs
•Lack of intersectoral collaboration	•Poor interaction international agencies, governments and ngo's; poor engagement in preventive, rehabilitative, and reconstructive interventions that may fuel cycles of violence	• Lack of interconnection (sub)national policies, inability to address crucial social determinants mostly located outside the health sector
•Health and nutritional indicators per se	•Important determinants of conflict onset	• Further deterioration of public health services and a vicious circle of reduced access to services and increased mortality and disability
• Daar ea 2007 Nature •Collins ea 2011 Nature	•Collier 2008 •WHO 2011 Social determinants public health •De Jong 2010 SSM	

Protective and risk factors for adult refugees

Protective factors adults	Risk factors adults
Young	Older
More education	Less education, Low SES
Work, income, participation, education	No work
Stabillized and housing	Unwelcome, Social exclusion
Presence family, partner, children	Number shocking life events
Social network and support	Length asylum procedure, lack activity
Security status	Limited health skills, no insight new health care system
Religion	Physical unsafety (drowning)
Restoring resources (social capital, job at same level)	Low return on investment

Protective and risk factors for a healthy development of refugee children enable us to engage in primary/universal prevention (blue) and secundary/selectieve preventiion (red)

Protective factors child development
Social support and cohesion within family
Presence & welbeing parents
Positive experience school & meaningful daily activities
Foster family same ethnic background Secure environment & privacy

Risk factors child development
Exposure extreme stress during and re-exposure after flight
Unaccompanied, female
Repeated migration guest country (attachment)
Perceived discrimination
Low SES family
Solo parent
Psychiatric problems parents (mom)
Limited sport, movement

What does this implicate for us?

	SOCIETY-AT-LARGE or (INTER)NATIONAL	COMMUNITY	FAMILY & INDIVIDUAL
PRIMARY PREVENTION to eliminate a disease or disorder state before it can occur	*Universal preventive interventions* *Economy, governance and early warning* *Free media and press* *Resolve underlying root causes of violence* *(Inter)national laws* *Defining and condemning human rights violations* *Research into events and their consequences* *Setting standards for intervention and training* *Expanding security institutions* *Military's role of last resort* *Reinforcing peace initiatives and conflict resolution* *Arms and landmine control* *Prevent the reemergence of violence* *Transnational collaborative projects* *Selective preventive interventions* *Humanitarian operations* *War tribunals and the persecution of perpetrators* *Peace-keeping forces* *Indicated preventive interventions* *Human rights advocacy*	*Universal and Selective preventive interventions* *Rural development and food production* *Community empowerment* *Decreasing dependency and learned helplessness* *Public health and education* *Peace education and conflict resolution in schools and the community* *Public (psycho-) education, community sensitization and awareness raising* *Security measures*	*Universal & Selective Interventions* *Include women and children in the distribution of economic growth* *Family reunion/family tracing* *Family/network building* *Improvement of physical aspects* *Resilience groups for children*
SECONDARY PREVENTION shorten the course of an illness or problem	*Humanitarian relief operations:* *shelter, food, water and sanitation* *(Co-occurring) Natural disasters: quality standards* *Voluntary repatriation* *Reparation and compensation*	*Conflict prevention & resolution* *Crisis intervention* *Vocational skills training*	*Recruitment of child soldiers* *Reparation and compensation for afflicted families* *Public health and disease control* *Mental health and psychosocial support (MHPSS)* *Crisis intervention*
TERTIARY PREVENTION reduce chronicity through the prevention of complications and through active rehabilitation	*Peace-keeping and peace-enforcing troops.* *Peace agreements*	*Reconciliation and mediation skills between groups*	*Involve the family in rehabilitation and reconstruction*

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A public health framework to translate risk factors related to political violence and war into multi-level preventive interventions

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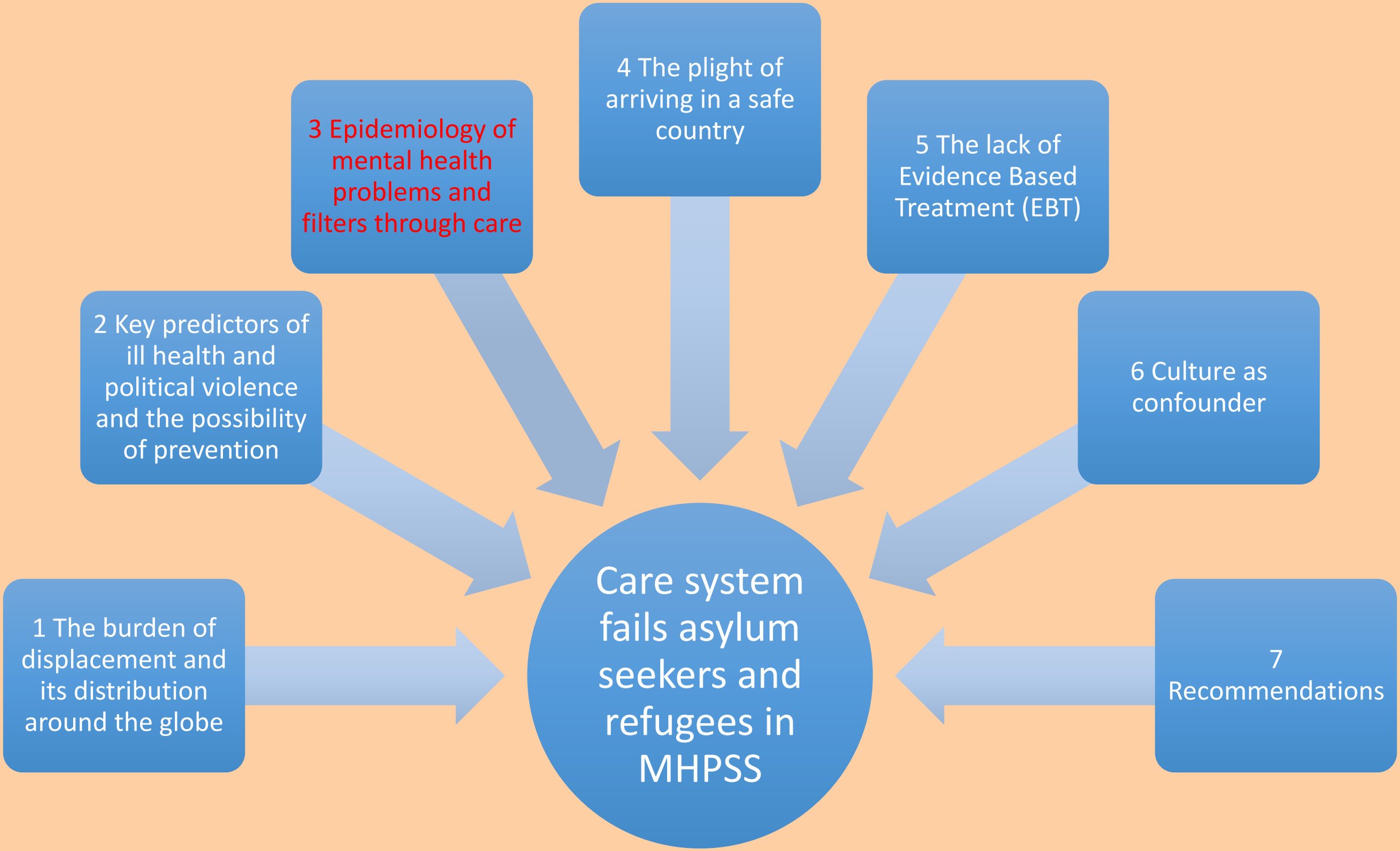
ABSTRACT

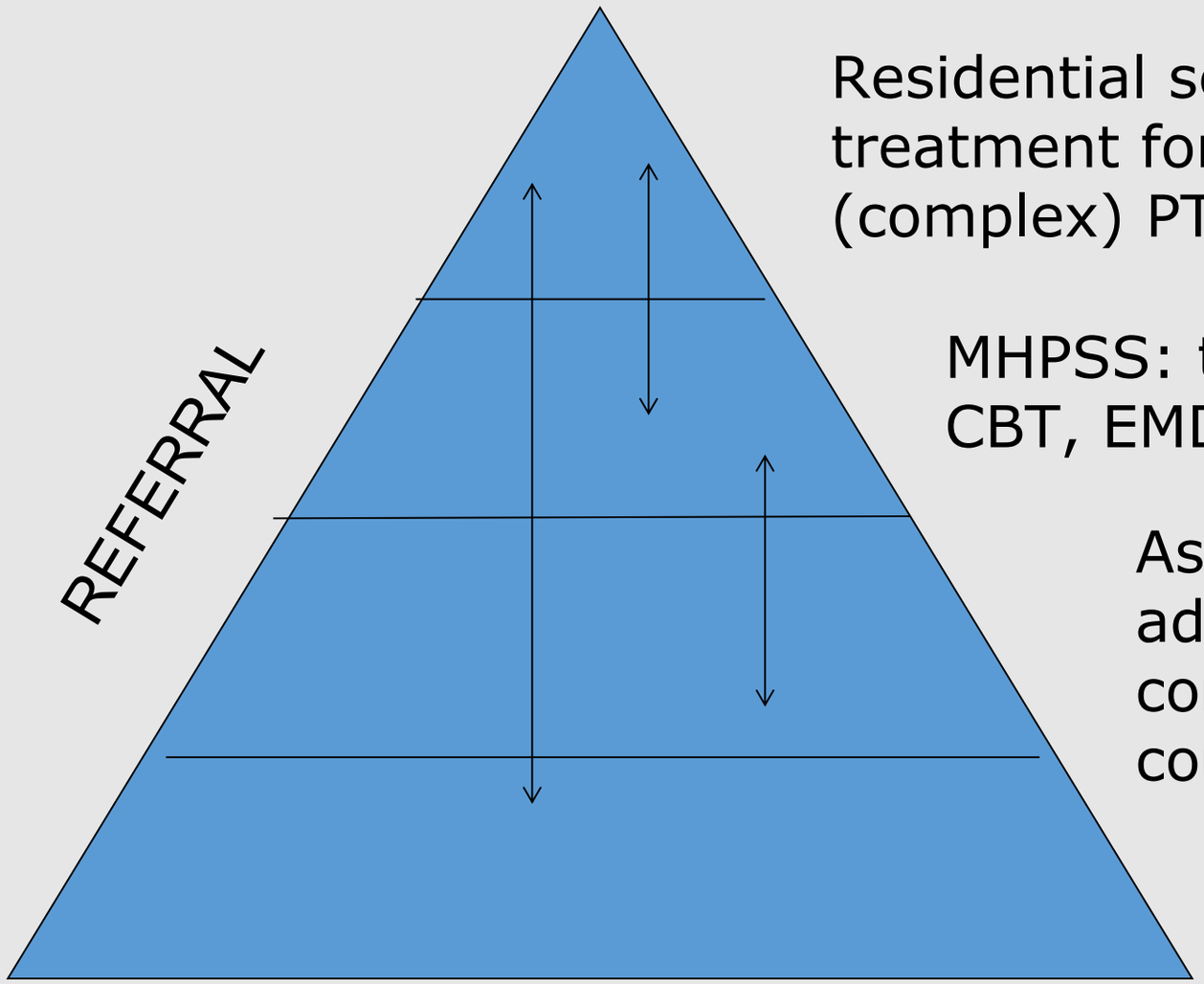
Political violence, armed conflicts and human rights violations are produced by a variety of political economic and socio-cultural factors. Conflicts can be analyzed with an interdisciplinary approach to obtain a global understanding of the relative contribution of risk and protective factors. A public health framework was designed to address these risk factors and protective factors. The framework resulted in a matrix that combined primary, secondary and tertiary interventions with their implementation on the levels of the society-at-large, the community, and the family and individual. Subsequently, the risk and protective factors were translated into multi-sectoral, multi-modal and multi-level preventive interventions involving the economy, governance, diplomacy, the military, human rights, agriculture, health and education. Then the interventions were slotted in their appropriate place in the matrix.

The interventions can be applied in an integrative form by international agencies, governments and non-governmental organizations, and molded to meet the requirements of the historic, political-economic and socio-cultural context. The framework maps the complementary fit among the different actors while engaging themselves in preventive, rehabilitative and reconstructive interventions. The framework shows how the economic, diplomatic, political, criminal justice, human rights, military, health and rural development sectors can collaborate to promote peace or prevent the aggravation or continuation of violence. A deeper understanding of the association between risk and protective factors and the developmental pathways of generic, country-specific and culture-specific factors leading to political violence is needed.

Outline talk



Outline care structure



Residential setting MHPSS: specialized treatment for torture survivors with eg (complex) PTSD, psychosis

MHPSS: treatment CMD & PTSD with eg CBT, EMDR, NET, drugs

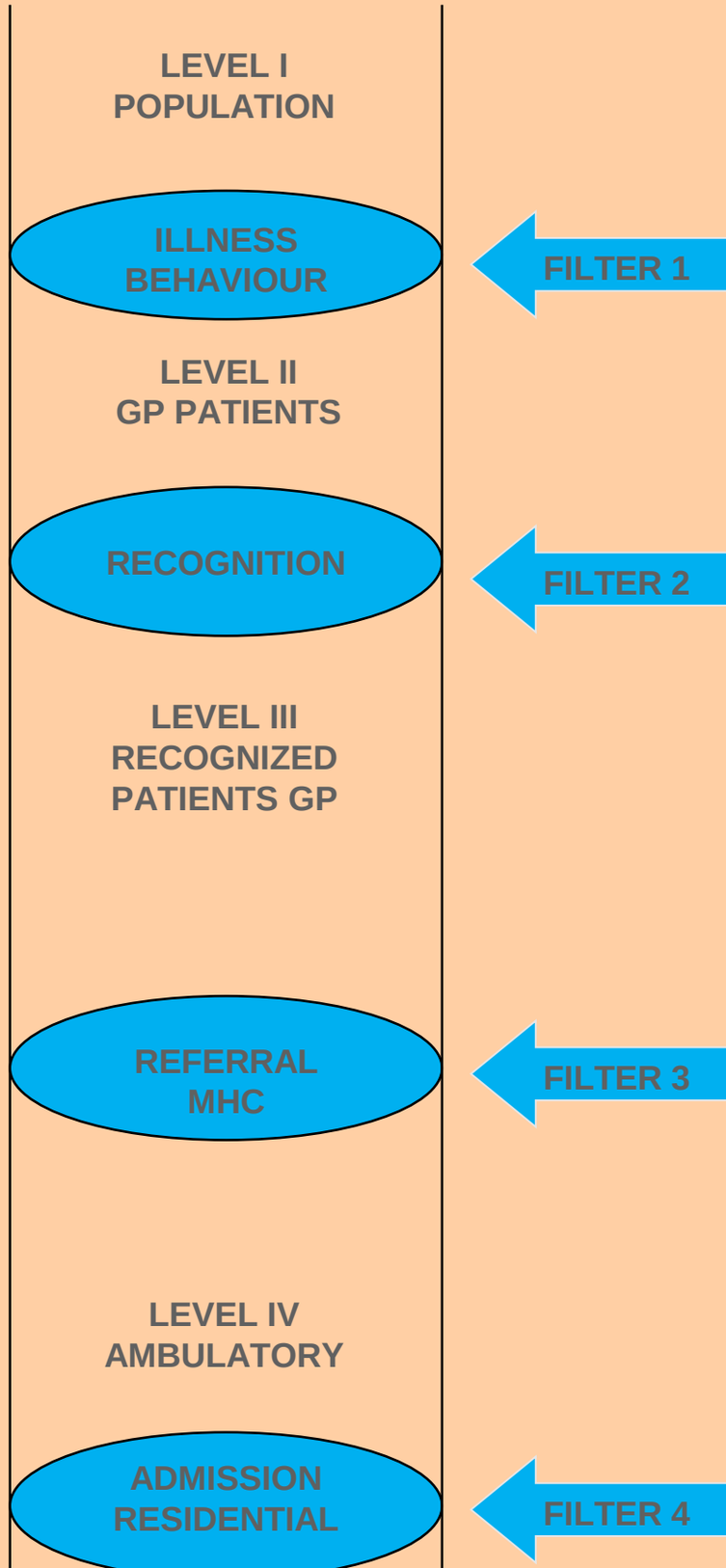
Asyl Seekers Center: screening, advises or refers to GP/1st line consultant mental health: screens, counsels and refers to MHPSS

Screening asylum seekers including youth for distress, CMD

Some data on Syrian refugees

- Prevalence rates PTSD 30% in Turkey (Alpak et al 2015) and Sweden (Tinghog et al 2016)
- 30-40% for major depression in Jordan (Gammouh et al 2015), Lebanon (Naja et al 2016), Sweden (Tinghog et al 2016)
- Nearly half Syrian refugee children in Turkey report clinically significant levels of anxiety and withdrawal (Cartwright et al 2015)
- In Switzerland, lack of social integration highly correlated with decreased QOL, functional impairment & severity of depression, anxiety, PTSD symptoms, while symptoms of PTSD and depression predicted difficulties in integration (Schick et al 2016)
- Jordan, Turkey free access MHPSS, yet hampered by many factors (Hassan et al 2015)
- Within Europe financial obstacles (eg fees) may impede access for all refugees (Mladovsky et al 2012)
- Mostly offered in Europe: CBT, NET, EMDR for PTSD. No evidence family interventions, for reviews see (Slobodin & de Jong 2015)
- Meta-analysis on fourteen RCTs among refugees and asylum seekers resettled in HIC: NET and CBT effective for PTSD and depression, with the strongest evidence base for NET (Nose et al 2017)

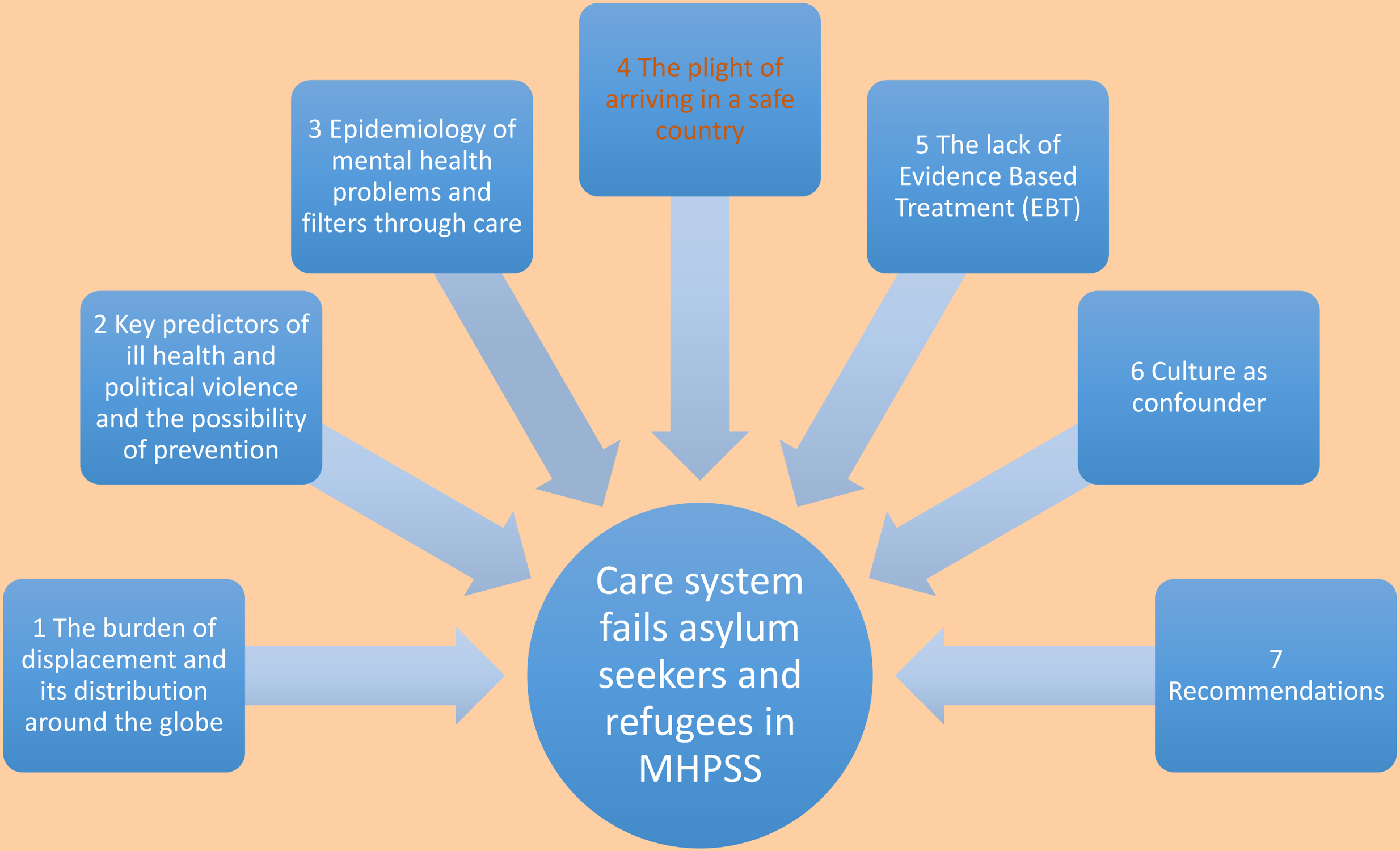
1 yr Prevalence indigenous Dutch per 1000 inhabitants		1 yr Prevalence asylum seekers (AS)/refugees (R)/1000	
Depression	PTSD	Depression	PTSD
60	33	130-250	130-360
Filter 1 functions	Filter 1 functions	Filter 1 functions	Filter 1 functions
500	500	600-700	600-700
Filter 2 DS 0.50	Filter 2 DS 0.50	Filter 2 DS 0.16	Filter 2 DS 0.16
30	16	60	60
Filter 3 (35%)	Filter 3 (35%)	Filter 3 (11%)	Filter 3 (11%)
10	10	5-12	5-12



Epidemiology of help seeking in sum (Netherlands)

- Prevalence among AS & R : Depression 2-4 higher, PTSD 4-10 times than indigenous Dutch
- More AS & R find their way to GP than indigenous Dutch
- GP recognizes 1 in 2 indigenous with psychological problems and 1 in 6 AS/R
- Indigenous Dutch reach GGZ/MHPSS 3 times more often than AS & R

Outline talk



Plight of arriving in a new country

- Family problems *
- Asylum procedures *
- Work *
- Discrimination
- Low SES
- Religion

* Strongest relation psychopathology

Dutch Study Iraqi Asylum Seekers: Gr 2 > 2 yrs in the Netherlands

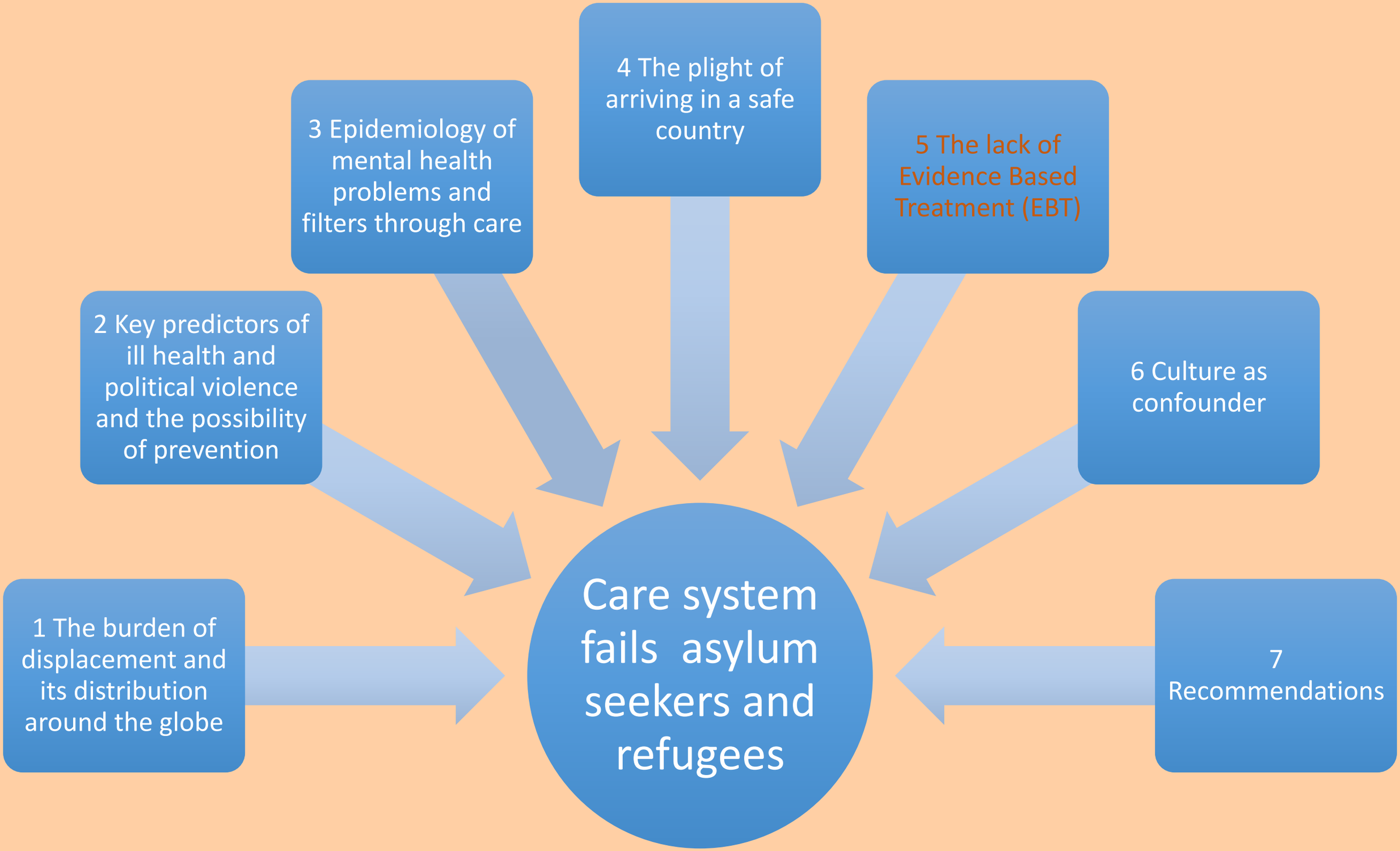
Results

	Gr 1	Gr 2
One or more psychiatric disorder (%)	42.0	66.2 *
Overall Quality of life (mean)	2.88	2.23 *
Perceived Qol general health (mean)	3.06	2.74 *
Physical and Role Disability (mean)	17.31	19.25 *
Days of disability (mean)	5.37	7.68 *
Physical diseases (mean)	0.85	0.84
Physical complaints (mean) [5]	0.83	1.62 *

Laban CJ, Gernaat HBPE, Komproe IH, Schreuders GA, De Jong JTVM (2004) Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. J Nerv Ment Dis, 192:843-852

Laban CJ, Komproe IH Gernaat HBPE, De Jong JTVM (2008) Impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. Soc Psych Psych Epidemiol.43: 507-515.

Outline talk



WHO Guidelines for Management of Acute Stress, PTSD, and Bereavement

Tol et al. 2014 PLOS Med

Mental health condition	**Recommendation**
Acute traumatic stress	CBT with a trauma focus (CBT-T) should be considered in adults Benzodiazepines or antidepressants should not be offered to adults and children
Insomnia	Relaxation techniques, no benzodiazepines
Secondary nonorganic enuresis	No punitive responses, simple behavioral interventions
Hyperventilation	Paper bag should not be offered to children
PTSD	CBT-T, EMDR, stress management for adults & youth
	SSRIs and TCAs not first line treatment for adults & youth
Bereavement (without a mental disorder)	No structured psychological interventions, no benzodiazepines

Barriers to the delivery and uptake of mental health interventions for refugee population

What is problematic with the existing evidence?

- Most evidence exists for PTSD by specialized professionals
- But often CMD, problems with daily tasks for survival & recovery
- For scalability, interventions should be of **short duration, simple**, to be carried out **in PC** or in **the community**
- Brief interventions may prevent more serious disorders
- Lack of family interventions
- CBT and NET adequate
- Interventions should address **a range of outcomes**, incl functioning

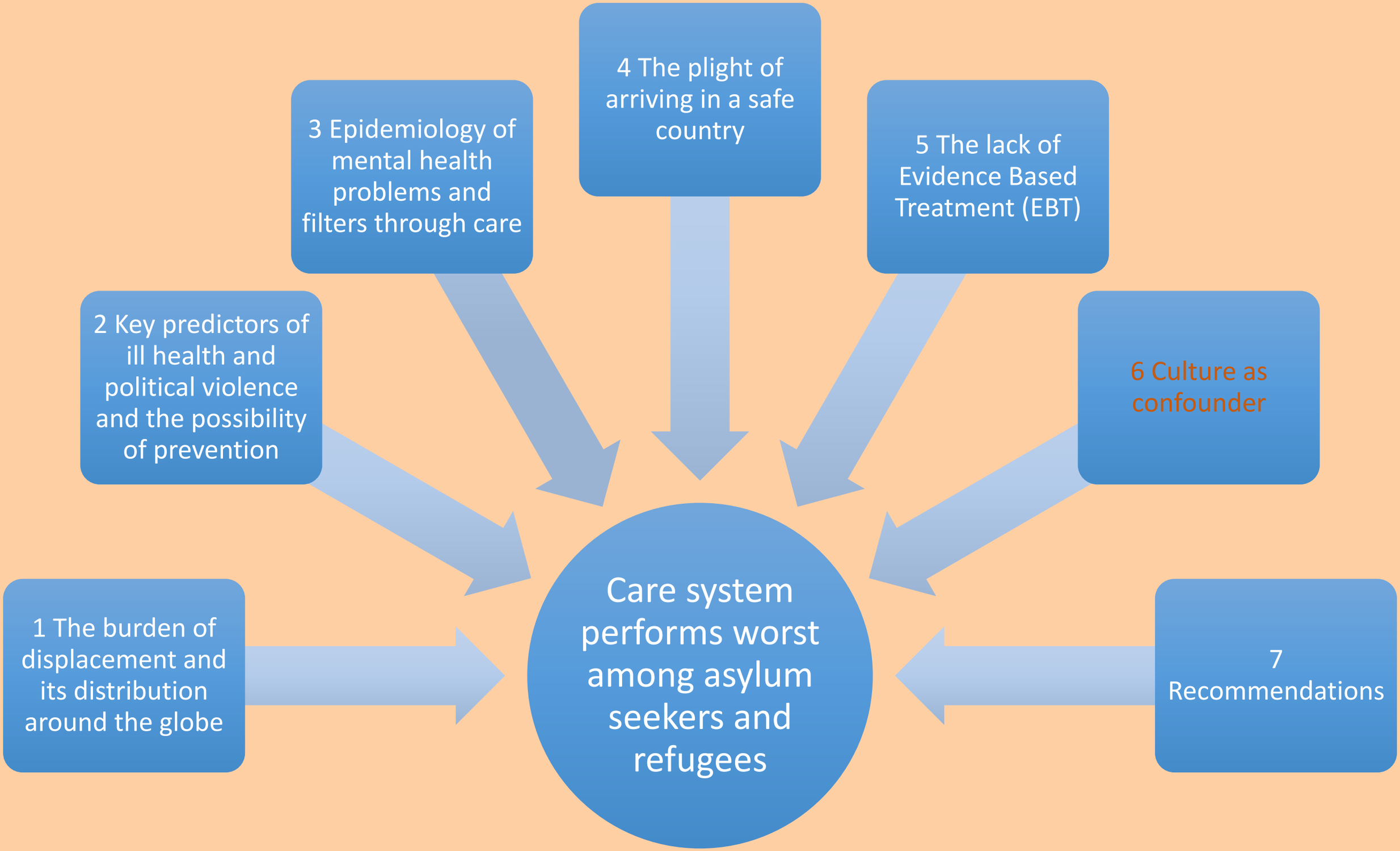
Barriers to the delivery and uptake of mental health interventions for refugee population (continuation)

- The length of treatments difficult for AS & R
- Lack of adaptation to language and intercultural competence
- Limited knowledge MH & stigma within refugee populations
- Limited capacity MH professionals to deliver specialized services when indicated

Problem Management Plus (PM+)

- For whom
  - Adults, **transdiagnostic (stress, depression, anxiety)**
  - Inclusion criterion : must have high distress and impaired functioning
- What
  - Problem-solving counselling (**problem management) plus** behavioural strategies stress management, behavioural activation, strengthening social supports
- Formats
  - 5 sessions individual face-to-face (**released already)**
  - 5 sessions group face-to-face
- Large RCTs in Kenya, Pakistan & Nepal, plus 4 more planned

Outline talk



Culture and PTSD debate. Three major issues

- Ecological utility
- Validity/historicity
- [Politisation/medicalisation]

de Jong & Hinton 2017. Traumascape. In: Bhugra & Bhui (eds.) *Textbook of Cultural Psychiatry*.

Ecological utility: PTSD not the most significant expression

Fall out
Terrorism

Satanic cults

Cola

Cyberchondria

Low back pain

Tics

Tajin
kyofushu

Shootings/amok

Veterans syndromes

Merd le-esab

Tashvish

Yao yan (salt hysteria)

L'riah

Chinta
Rog

Jok
jok

Leukorrhoea

Body heat

Kyang Yang

Dhat

Koro

Khyal Bakshbat

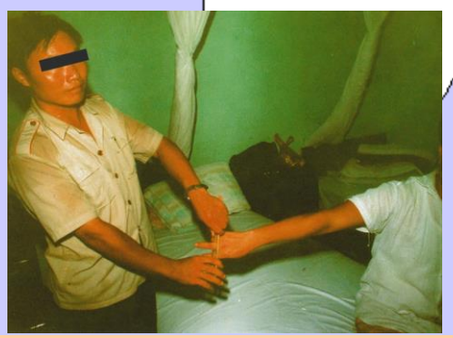
Susto
Ataques de nervios

Chen

488 societies:
74% spirit
possession

Gamba

Thousand of annual
episodes of mass
sociogenic illness or
'epidemics'
throughout the world



Validity/historicity

- PTSD found around the globe
- Despite diagnostic validity trauma reactions not identical
- Culture influences
  - Local phenomenologies of post-trauma experiences
  - Local illness vocabularies, IODs
  - Mental and bodily experience (local ethnopsychology and ethnophysiology)
  - Attention to particular symptoms (eg somatic due to arousal, catastrophic cognitions)
  - Healing and ritual practices aimed at reducing symptoms
- Historicity: symptoms PTS change, a historical era expresses itself in an idiosyncratic way in the presentation of individual suffering

Cultural Competence, Cultural sensitivity – or Culturally and Linguistically Appropriate Services (CLAS)

- Def: ‘providing optimal care due to mutual adaptation of beneficiaries, treaters, managers and policy makers from different (sub)cultures’.
- Eighty percent of providers in the Netherlands think that cultural competence should primarily focus on the primary process and on intercultural communication
- Implicates quality management: on content (do we do the right things), professional quality (do we do them right) and management quality (do we enable do do the things in the right way) (MIS adapted?)

Cultural Competence, Cultural sensitivity

What is most important in the therapist-patient relationship?

1 Learn to handle discrimination and racism
We all discriminate→(group)countertransference→dare to make mistakes
Prevent passive tolerance→appeal patiënts→(pseudo)respect for C
Development of expertise: attention to own socialisation (skin color, culture, etnicity and identity

2. Matching? 50% immigrants: professionalism, empathy and shared world view more important than ethnic matching (Knipscheer 2004)

- Differentiate between ethnic matching (origin), cultural matching (norms, ideas) and identity matching (on 'identity'). Viz the latter: look for common denominator in therapeutic relation (ethnic identity, also religion, gender, age, parenting)
- Caveat: consensus treatment plan probably more important than matching

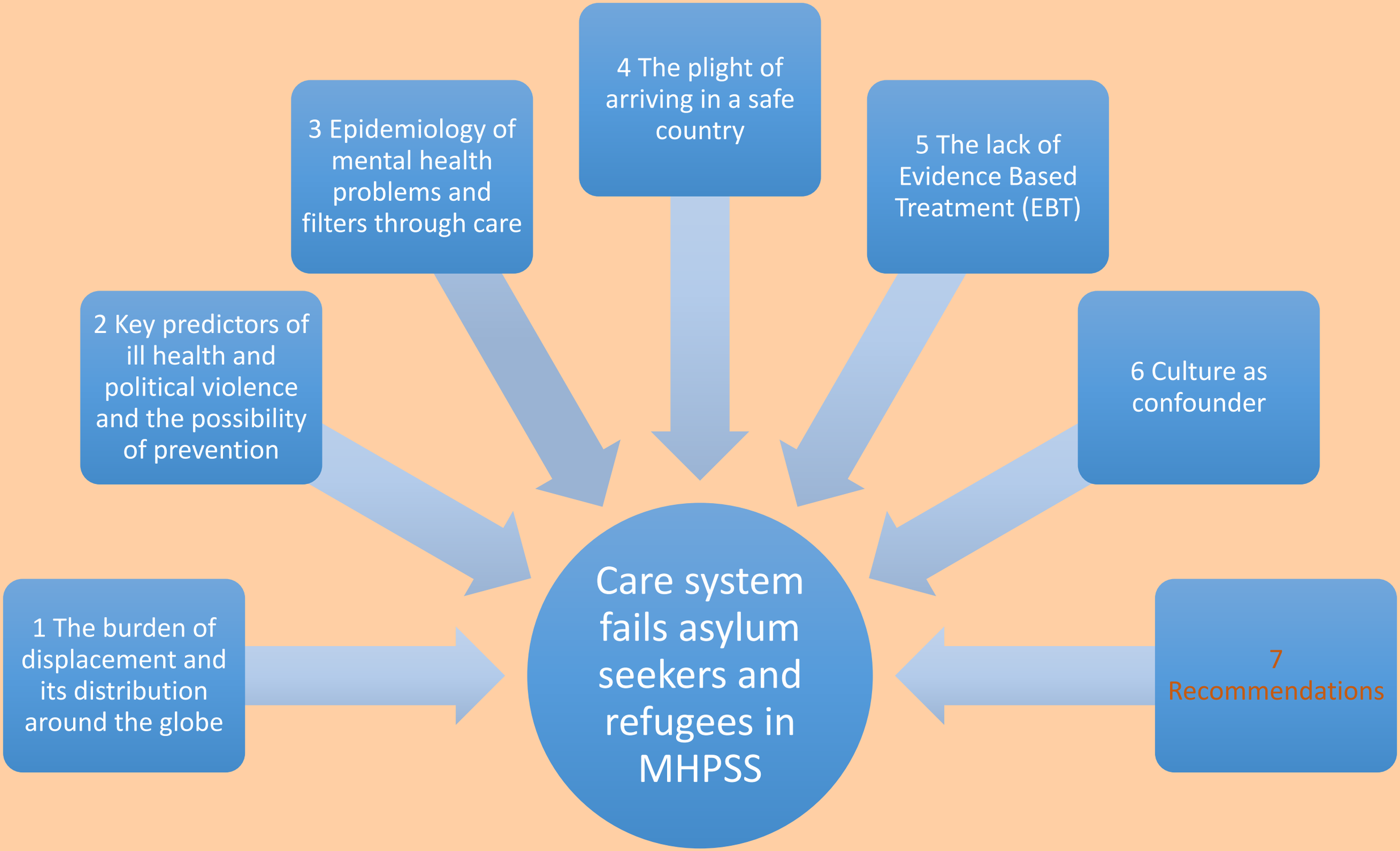
3 Intercultural perspective on treatment → next slide

Cultural formulation of diagnosis: components

- Cultural identity
- Cultural explanation illness. EMs: Cause, Time onset, Pathophysiology, Course (seriousness, duration), Treatment Preference
- Cultural factors in relation to psychosocial environment and level of functioning
- Cultural elements in the relation between patient and helper
- Cultural evaluation diagnosis and treatment

DSM-5

Outline talk



7 Recommendations: multilevel-multisectoral

- Get multisectoral. Active involvement ministries of health, education, labour, international collaboration instead of dependence on justice
- Early on participation, activation, integration, language acquisition
- Professional interpreters initial phase
- More prevention and monitoring physical and mental problems

Best predictors well-being

- NEEDED
- Social support
- Proximity kin
- Lead normal life with perspectives on:
  - Jobs
  - Education

- REALIZED?
- AS dragged around the country, unable to build social network
- Family reunion allowed
- Not allowed even though employers ask for refugees
- Few opportunities for study & advanced education, despite shown needs

Summary

- The world can gain a lot with universal prevention regarding political violence and ill health
- Size of displaced people's burden is limited in Europe
- GPs recognize psychological problems among asylum seekers and refugees 3 x less (1 in 6) and refer them 3 x less than the indigenous (in Netherlands)
- Long asylum procedures increase psychopathology with 50%
- We deny economic, social and cultural rights
- We have to do with a lack of culturally adapted and EBT
- Culture is a complicating factor for (mental) health professionals

Summary II

7 A's

- Accessibility ±
- Availability ±
- Acceptability -
- Affordability ±
- Adequacy in service design, implementation and evaluation -
- Awareness -
- Adaptability -

- Like Procrustes we seem to have two beds and standards
- We achieved a lot, but we can do much much better

- Thank you for your attention

- If you want to receive a paper: jtvmdejong@gmail.com