Dutch 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
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

2 Key predictors of ill health and political violence and the possibility of prevention

3 Epidemiology of mental health problems and filters through care

4 The plight of arriving in a safe country

5 The lack of Evidence Based Treatment (EBT)

6 Culture as confounder

Dutch care fails asylum seekers and refugees in MHPSS

7 Recommendations
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:
- 12% Americas
- 29% Africa
- 6% Europe
- 14% Asia and Pacific
- 39% Middle East and North Africa

54% of refugees worldwide came from three countries:
- Somalia: 1.1m
- Afghanistan: 2.7m
- Syria: 4.9m

Top hosting countries:
- Jordan: 664,100
- Ethiopia: 736,100
- Islamic Republic of Iran: 979,400
- Lebanon: 1.1m
- Pakistan: 1.6m
- Turkey: 2.5m

Netherlands 2016
- Asylum seekers: + 58,000
- Status holders: + 47,000
- Or + 2.5% of all displaced in Europe
Outline talk

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2. Key predictors of ill health and political violence and the possibility of prevention
3. Epidemiology of mental health problems and filters through care
4. The plight of arriving in a safe country
5. The lack of Evidence Based Treatment (EBT)
6. Culture as confounder
7. Recommendations

Dutch care fails asylum seekers and refugees in MHPSS
### 2 Common predictors of political violence & ill health and the possibility of prevention

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Consequences armed conflict</th>
<th>Consequences health</th>
</tr>
</thead>
</table>
| 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)  
• Political power exercised differentially applied according to ethnic or religious identity | • Impaired access to sanitation, health, education |
| Marginalization of groups | • Poor interaction international agencies, governments and ngo’s; poor engagement in preventive, rehabilitative, and reconstructive interventions that may fuel cycles of violence | • Differential access to services and differential outcomes for minorities, urban/rural residents/IDPs |
| Lack of intersectoral collaboration | • Important determinants of conflict onset | • Lack of interconnection (sub)national policies, inability to address crucial social determinants mostly located outside the health sector |
| Health and nutritional indicators per se | • Collier 2008  
• WHO 2011 Social determinants public health  
• De Jong 2010 SSM | • 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
<table>
<thead>
<tr>
<th>Protective factors adults</th>
<th>Risk factors adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young</td>
<td>Older</td>
</tr>
<tr>
<td>More education</td>
<td>Less education, Low SES</td>
</tr>
<tr>
<td>Work, income, participation, education</td>
<td>No work</td>
</tr>
<tr>
<td>Stabillized and housing</td>
<td>Unwelcome, Social exclusion</td>
</tr>
<tr>
<td>Presence, family, partner, children</td>
<td>Number shocking life events</td>
</tr>
<tr>
<td>Social network and support</td>
<td>Length asylum procedure, lack activity</td>
</tr>
<tr>
<td>Security status</td>
<td>Limited health skills, no insight Dutch health care system</td>
</tr>
<tr>
<td>Religion</td>
<td>Physical unsafety (drowning)</td>
</tr>
<tr>
<td>Restoring resources (social capital, job at same level)</td>
<td>Low return on investment</td>
</tr>
<tr>
<td>Protective factors child development</td>
<td>Risk factors child development</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Social support and cohesion within family</td>
<td>Exposure extreme stress during and after flight</td>
</tr>
<tr>
<td>Welbeing parents</td>
<td>Unaccompanied, female</td>
</tr>
<tr>
<td>Positive experience school</td>
<td>Repeated migration guest country</td>
</tr>
<tr>
<td>Foster family same ethnic background</td>
<td>Discrimination</td>
</tr>
<tr>
<td></td>
<td>Low SES family</td>
</tr>
<tr>
<td></td>
<td>Solo parent</td>
</tr>
<tr>
<td></td>
<td>Psychiatric problems parents (mom)</td>
</tr>
<tr>
<td></td>
<td>Limited sport, movement</td>
</tr>
<tr>
<td>PRIMARY PREVENTION</td>
<td>SOCIETY-AT-LARGE or (INTER)NATIONAL</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>to eliminate a disease or disorder state before it can occur</td>
<td>Universal preventive interventions</td>
</tr>
<tr>
<td></td>
<td>Economy, governance and early warning</td>
</tr>
<tr>
<td></td>
<td>Free media and press</td>
</tr>
<tr>
<td></td>
<td>Resolve underlying root causes of violence</td>
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<tr>
<td></td>
<td>(Inter)national laws</td>
</tr>
<tr>
<td></td>
<td>Defining and condemning human rights violations</td>
</tr>
<tr>
<td></td>
<td>Research into events and their consequences</td>
</tr>
<tr>
<td></td>
<td>Setting standards for intervention and training</td>
</tr>
<tr>
<td></td>
<td>Expanding security institutions</td>
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<tr>
<td></td>
<td>Military’s role of last resort</td>
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<tr>
<td></td>
<td>Prevent the reemergence of violence</td>
</tr>
<tr>
<td></td>
<td>Transnational collaborative projects</td>
</tr>
<tr>
<td></td>
<td>Selective preventive interventions</td>
</tr>
<tr>
<td></td>
<td>Humanitarian operations</td>
</tr>
<tr>
<td></td>
<td>War tribunals and the persecution of perpetrators</td>
</tr>
<tr>
<td></td>
<td>Peace-keeping forces</td>
</tr>
<tr>
<td></td>
<td>Indicated preventive interventions</td>
</tr>
<tr>
<td></td>
<td>Human rights advocacy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECONDARY PREVENTION</th>
<th>SOCIETY-AT-LARGE or (INTER)NATIONAL</th>
<th>COMMUNITY</th>
<th>FAMILY &amp; INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>shorten the course of an illness or problem</td>
<td>Humanitarian relief operations: shelter, food, water and sanitation</td>
<td>Conflict prevention &amp; resolution</td>
<td>Recruitment of child soldiers</td>
</tr>
<tr>
<td></td>
<td>(Co-occurring) Natural disasters: quality standards</td>
<td>Crisis intervention</td>
<td>Reparation and compensation for afflicted families</td>
</tr>
<tr>
<td></td>
<td>Voluntary repatriation</td>
<td>Vocational skills training</td>
<td>Public health and disease control</td>
</tr>
<tr>
<td></td>
<td>Reparation and compensation</td>
<td></td>
<td>Mental health and psychosocial support (MHPSS)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TERTIARY PREVENTION</th>
<th>SOCIETY-AT-LARGE or (INTER)NATIONAL</th>
<th>COMMUNITY</th>
<th>FAMILY &amp; INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>reduce chronicity through the prevention of complications and through active rehabilitation</td>
<td>Peace-keeping and peace-enforcing troops. Peace agreements</td>
<td>Reconciliation and mediation skills between groups</td>
<td>Involve the family in rehabilitation and reconstruction</td>
</tr>
</tbody>
</table>

What does this implicate for us?
A public health framework to translate risk factors related to political violence and war into multi-level preventive interventions

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War
Prevention
Economy
Military
Diplomacy
Education
Traumatic stress
Interventions

A B S T R A C T

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 different 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 development pathways of generic, country-specific and culture-specific factors leading to political violence is needed.
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Dutch care fails asylum seekers and refugees in MHPSS
Outline care structure AS & R (in collective system)

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

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

AZC/GCA: PVK screens, advises or refers to GP. 1st line consultant mental health: screens, counsels and refers to GGZ (MHPSS)

GGD/PH: Screening asylum seekers including youth for CD
<table>
<thead>
<tr>
<th>Depression</th>
<th>PTSD</th>
<th>Depression</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>33</td>
<td>130-250</td>
<td>130-360</td>
</tr>
<tr>
<td>Filter 1 functions</td>
<td>Filter 1 functions</td>
<td>Filter 1 functions</td>
<td>Filter 1 functions</td>
</tr>
<tr>
<td>500</td>
<td>500</td>
<td>600-700</td>
<td>600-700</td>
</tr>
<tr>
<td>Filter 2 DS 0.50</td>
<td>Filter 2 DS 0.50</td>
<td>Filter 2 DS 0.16</td>
<td>Filter 2 DS 0.16</td>
</tr>
<tr>
<td>30</td>
<td>16</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Filter 3 (35%)</td>
<td>Filter 3 (35%)</td>
<td>Filter 3 (11%)</td>
<td>Filter 3 (11%)</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>5-12</td>
<td>5-12</td>
</tr>
</tbody>
</table>
Epidemiology of help seeking in sum

- 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
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Plight of arriving in a new country

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

* Strongest relation psychopathology
### Results

<table>
<thead>
<tr>
<th>Measure</th>
<th>Gr 1</th>
<th>Gr 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more psychiatric disorder (%)</td>
<td>42.0</td>
<td>66.2 *</td>
</tr>
<tr>
<td>Overall Quality of life (mean)</td>
<td>2.88</td>
<td>2.23 *</td>
</tr>
<tr>
<td>Perceived QoL general health (mean)</td>
<td>3.06</td>
<td>2.74 *</td>
</tr>
<tr>
<td>Physical and Role Disability (mean)</td>
<td>17.31</td>
<td>19.25 *</td>
</tr>
<tr>
<td>Days of disability (mean)</td>
<td>5.37</td>
<td>7.68 *</td>
</tr>
<tr>
<td>Physical diseases (mean)</td>
<td>0.85</td>
<td>0.84</td>
</tr>
<tr>
<td>Physical complaints (mean)</td>
<td>0.83</td>
<td>1.62 *</td>
</tr>
</tbody>
</table>


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Dutch care fails asylum seekers and refugees
## World Health Organization Guidelines for Management of Acute Stress, PTSD, and Bereavement

Tol et al. 2014 PLOS Med

<table>
<thead>
<tr>
<th>Mental health condition</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute traumatic stress</td>
<td>CBT with a trauma focus (CBT-T) should be considered in adults. Benzodiazepines or antidepressants should not be offered to adults and children</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Relaxation techniques, no benzodiazepines</td>
</tr>
<tr>
<td>Secondary nonorganic enuresis</td>
<td>No punitive responses, simple behavioral interventions</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>Paper bag should not be offered to children</td>
</tr>
<tr>
<td>PTSD</td>
<td>CBT-T, EMDR, stress management for adults &amp; youth</td>
</tr>
<tr>
<td></td>
<td>SSRIs and TCAs not first line treatment for adults &amp; youth</td>
</tr>
<tr>
<td>Bereavement (without a mental disorder)</td>
<td>No structured psychological interventions, no benzodiazepines</td>
</tr>
</tbody>
</table>
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
• CBT and NET good candidates, but need cultural adaptation and intercultural competence
• Lack of family interventions
• Interventions should address a range of outcomes, incl functioning
• PM+ future candidate: 5-sessions, reduces symptoms of depression, anxiety, PTSD, and related conditions, trained non-specialized workers or lay people, individual and group formats (children and adults)
• PM+ uses EBT of (a) problem solving, (b) stress management, (c) behavioural activation, and (d) accessing social support
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 & culture
• Limited knowledge MH & stigma within refugee populations
• Limited capacity MH professionals to deliver specialized services when indicated
Dutch care performs worst among asylum seekers and refugees

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Culture and PTSD debate. Three major issues

- Ecological utility
- Validity/historicity
- Politisation/medicalisation
Ecological utility: PTSD not the most significant expression

488 societies: 74% spirit possession

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
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Dutch care fails asylum seekers and refugees in MHPSS
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 (Dutch municipalities+)

• 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
Vluchten doe je niet voor de lol!

Ik wil gewoon Toekomst.
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 the Netherlands
• GPs recognize psychological problems among asylum seekers and refugees 3 x less (1 in 6) and refer them 3 x less than the indigenous
• 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 As

- 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