Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lectue Committee presents

THE FORTIETH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Losing and Finding a Home: Policy, Psychological, and Human Services Aspects of Migrants and Refugees

We are in an episode of major population shifts, even surpassing those in World War II. Some of the major participants are migrants in search of living resources and a better life; and refugees from war, brutality, and famine. This is one of the major, worldwide social issues. The world is struggling to: acknowledge and understand these conditions, determine values and responsibility, and develop resources and processes to respond. The 40th Annual Erich Lindemann Memorial Lecture brings together professionals who will address public policy to cope with this phenomenon, the psychology of the people finding new homes and the communities receiving them, and marshaling and providing the human services with which to respond. We will all share experience and ideas to further these efforts without expecting final solutions, which must evolve as our global society evolves toward caring for one another.

Speakers

Falah Hashem, MB, ChB, Chief of Staff, Massachusetts Office for Refugees and Immigrants

Jill Betz Bloom, PhD, Co-Director, Center for Multicultural and Global Mental Health, William James College

Rosemarie Coelho, LICSW, Jewish Family Service of MetroWest

Moderator

David G. Satin, MD, DLFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School, Chairman, Erich Lindemann Memorial Lecture Committee

Friday, June 9, 2017, 2:30 – 5:00 pm

William James College
1 Wells Avenue, Newton, MA 02459

Introduction by David G. Satin, MD

The title of today's lecture is Losing and Finding a Home: Policy, Psychological, and Human Services Aspects of Migrants and Refugees. We will have presentations by four speakrs; Dr. Falah Hasem who will speak to public policy; Dr. Jill Bloom who will speak to psychological aspects of migrants and refugees; and Rosemarie Coelho who will speak to the social service needs of migrants. After the presenters speak, we will end by having a discussion amongs the presenters along with the audience to answer any questions and discuss these topics further.

Central to Erich Lindemann's view of social and community psychiatry was the concept of life crises as they affect mental health and mental illness. He emphasized the social relationships and social conditions that support mental health and prevent mental illness, or precipitate maladaptation, and mental illness in individuals and populations. His sphere of interest graduated from individuals and families to communities and societies. He had a particular interest in identified sick patients as indicators of pathogenic agents and conditions.

Today we are inundated with such people with problems erupting from actions and conditions that are destructive, intolerable, and nonviable. As with homelessness, do we focus on help for their personal problems, or the burden they place on society, or the political implications of the stance we take with them and our competitors? Or do we see them from a public health point of view: what causes these casualties and what can- and should- we do about these causes? Today we are fortunate to hear from people who bring much experience, thought, and effort to these issues, and can shed light on our continuing struggle with them.

Falah Hashem, MB, ChB

Chief of Staff, Massachusetts Office for Refugees and Immigrants

Introduction by David G. Satin, MD

Our first speaker is Dr. Falah Hashem who is currently the Chief of Staff of the Massachusetts Office for Refugees and Immigrants (ORI) in the Executive Office of Health and Human Services. Dr. Hashem earned his medical degree from Baghdad University Medical College and worked in primary care and health care administration in Iraq. He entered the United States himself through the U.S. refugee Admissions Program. For nine years he has worked in the Massachusetts Department of Public Health with refugee and immigrant populations, including six years overseeing the state-wide Massachusetts Refugee Health Assessment Program.

Falah Hashem, MB, ChB

Good afternoon everyone, thank you for the opportunity to speak with you, it is an honor to be here.

I would like to intrigue your imagination little bit, you may close your eyes, if you want or keep them open if you worry that you may fall asleep, it is your choice…

Imagine yourself, somewhere, at this moment, living in a beautiful place enjoying spring breeze and the most beautiful scenery, just like a nature symphony, or a festival of colors that dance on a piece of canvas to mirror image what anyone would wish for his/her eyes to see. Today is somewhat different though, you are someone who decided to leave everything behind and move on. May be you just have lost something dear to your heart. Material things come and go, but you lost something that is priceless, you just have lost hope or may be your whole world turned upside down. May be you're a child that lost your whole family or a woman that lost your kids, a man that had encountered death face to face and just managed to escape.

May be you just packed your luggage and sold everything you have because you have realized that you can do much more and your homeland, at this time, cannot give you what you need, but somewhere thousands miles away you have landed a once-in-a-lifetime opportunity, they have asked you to join their team as a scientist in their world renowned institution, you can't miss that, don't you? Or may be you are someone, well-to-do, who is thinking of expanding business and wants to try the American market, or you're a student who knows for sure that your future stand a better chance with a graduate degree from one of American Universities. But, may be you're an officer working with Department of Homeland Security and you have a busy schedule today, you have to adjudicate X number of cases and you know that you can't accept them all, or

an immigration lawyer that won asylum case on behalf of your client or felt bad because the judge couldn't see what all your client went through before the he/she denies his/her case. Or maybe you're sitting in your oval office directing your staff to appeal at the Supreme Court; maybe you're saying something like: "they just don't understand, there are millions of them out there, all of them want to get-in and nobody really knows how many bad apples are there." Or may be you're holding the door at one of our points of entry and telling someone, "I know, I know, you are at risk, you lost your family, believe me I do want to help you, but that guy doesn't wanna."

Actually that morning you were sitting on your regular seat, having your coffee, reading your favorite newspaper or checking news on your cell phone and say OMG, not again! You really want to pick your fight; you may have an idea about a sound immigration system that really would work for everyone, but the moment you share your thoughts with others, things thrown off balance all of the sudden and you go back to square one.

Immigration policy's discussions did not start today by any means. Soon after independence, United States took actions to regulate immigration. At the beginning, limits were imposed and Europeans were favored. Then this was expanded in 1965 to include immigrants from other parts of the world. Nowadays regulations affected by concerns about terrorism, unauthorized immigration and refugees. The U.S. is not alone in this, many other countries have adopted immigration policies as part of their national strategies and development plans.

I agree with the following statement: "Without migration, societies worldwide would never have achieved their current level of development."

The bottom line is this, immigration policy is not an easy thing to do in any way without going through controversy, but all of us have to take a stand on that, don't we! In Massachusetts we have figured this out, we are a welcoming state. True we have our own flaws and that's why we have Maura Healy's hotline (to Report Incidents of Bias-Motivated Threats, Harassment, and Violence), but through its first days of existence, Massachusetts has welcomed many-many immigrants. In 1985 Governor Dukakis signed executive order no. 257 to declare a first refugee policy for the state. Massachusetts Office of Refugee Resettlement (MORR) was born from that order. MORR-our office name at that time- was tasked with coordinating refugee affairs in the Commonwealth. Refugee Advisory Council was also established pursuant to another executive order (EO no. 229) to advise and assist MORR. In 1992, legislatures established our current Massachusetts Office for Refugees and Immigrants (ORI) to promote the full participation of refugees and immigrants as self-sufficient individuals and families in the economic, social, and civic life of the commonwealth. Also legislatures assigned Governor Advisory Council for Refugees and Immigrants (GACRI) to advise the governor

on policy, planning, and priorities for refugees and immigrants in the commonwealth and to assist ORI efforts.

Our office serves refugees, asylees, certain Amerasians, Cuban/Haitian entrants, certified victims of human trafficking, and special immigrant visa holders from Iraq and Afghanistan. Each of those became eligible to our services based on separate legislations. We collaborate with wide network of partners including state, local governments, community based organizations, faith based organizations, mutual assistance association, and resettlement agencies, to provide wide array of services to the eligible populations. All services provided geared toward self-sufficiency and integration. Our state funds two of our programs: Citizenship for New Americans and Employment Support Services. Federal government supports most of our other programs that provide the following services: case management, employment, enterprise achievement for small businesses, social adjustment for community and youth, medical screening, health promotion, medical assistance for healthcare coverage, enhancing elder services, school impact, targeted assistance, and services to the unaccompanied minors.

We are small state agency, but we believe our impact is big! Most of our 19 (58%, 65%) employees are immigrants or former refugees and immigrants themselves. Our Executive Director Truong is also a former refugee from Vietnam. Our goal is to help our populations to reach self-sufficiency in the shortest possible way and to facilitate their pathway towards integration. We are doing our best to highlight the positive impact our populations have on various aspects of life in our Commonwealth. We are very grateful for the support we have received from Governor Baker, Lieutenant Governor Polito and Secretary of Health and Human Services Sudders; their signed welcome letter, translated into 6 languages, is handed over to our newcomers. The welcome letter is included in a Welcome Kit that also has useful resources to assist newcomers during their resettlement process.

Welcoming refugees in the U.S. reflects Americans' core values and tradition of being a safe haven for those fleeing violence and persecution. Since 1975, the U.S. has resettled more than 3 million refugees and since the enactment of the Refugee Act of 1980, annual admissions numbers have ranged from a high of 207,116 in 1980 to a low of 27,100 in 2002. In Massachusetts, we usually welcome around 2,400 individuals every year. Although refugee admission figures were inconsistent, but here in Massachusetts newly-arrived refugees and immigrants always been welcomed and their contributions are celebrated. We are proud that we have the Baker-Polito Administration's support and commitment to continue participating in refugee resettlement programs.

According to United Nations High Commissioner on Refugees (UNHCR), in 2015 "an unprecedented 65.3 million people around the world have been forced from home. Among them are nearly 21.3 million refugees, over half of whom are under the age of 18."

The ORI is always hopeful that numbers of refugee admission will increase going forward to help with this refugee crisis.

Thank you for been an excellent audience!

David Satin:

Thank you Dr. Hashem, that was a nice mixture of the heart and the regulations and I guess that's the trick of the trade to meld those two, so that one serves the other.

Jill Betz Bloom, PhD

Co-Director, Center for Multicultural and Global Mental Health, William James College

Introduction by David G. Satin, MD

Our next speaker is Dr. Jill Bloom who is an Associate Professor in the Department of Clinical Psychology at William James College, the Co-Director of the Center for Multicultural and Global Mental Health, and the Director of the Global Mental Health Program. She earned her Ph.D. at Boston College and completed the Harvard Certificate Program in Refugee Trauma: Global Mental Health, Trauma, and Recovery. Her interests cover international psychology and global mental health, the social and cultural history of psychiatric diagnosis, and gender and sexuality. She has published on topics of the cultural formulation interview, feminist mental health paradigms, sex trafficking, and the conceptualization of prejudice.

Jill Betz Bloom, PhD

Thank you. Good afternoon. I'm really delighted to be here and can't really speak more about the Lindemann lecture which I have been attending for a number of years. So first what I'm going to do by way of introduction- Rosemarie Coelho and I are going to be presenting our two presentations together. I just would like to say that Rosemarie's presentations and mine today really mirror the collaboration of Jewish Family Services and William James College on the humanitarian Syrian refugee project. Just as way of background and how we began to do this work together- last June the CFO of JFS and Nick Covino, the president of William James College, and myself, the Director of the Global Mental Health Program, began to discuss working together where WJC would provide mental health assessment and support for up to 15 Syrian families expected to arrive in late fall and winter of this current year. Over the summer and fall, we at WJC including Dr. Yousef Alajarma, Dr. Richard Mollica, Dr. Stanley Burman, and myself met in cooperation with Mark Jacobs and Rosie Coelho at JFS to develop a proposal for the types of support that we could provide.

The first family arrived in November and the next families in February, and the last family in March. There were 14 adults and 17 children who have come to the metro Boston area. The original estimate of 15 families was greatly affected by the current political climate. In fact, three families were able to enter after the first ban was lifted and then the second ban. More families may arrive, but as it is well known this process has been affected. So Rosie will give a much more detailed description of this extraordinary and unique program that has been developed by resettlement program by JFS. As you can see, there is the model described here- the JFS core team that deals with

the immediate resettlement of these families. Rosie will also give you information about JFS' long-term work with resettlement for refugees and immigrants. Then there are professional partners and these partners, which we are at William James College, also includes a number of cultural and religious leaders, programs, job agencies, vocational and language training, so a really extensive range of partners. What I think is particularly unique about this model is this outer ring, in the blue, this synagogue community.

What JFS has arranged with these 6 synagogues in the metro Boston area who are sponsoring families, and where this expands is that the government provides up to 90 days of services for families. This model will provide financial and a range of support for up to a year. So it is really quite an extraordinary program. As we began to work together, Rosie and I have been the point people for our mental health agencies and we have met regularly to discuss the needs of families as they settle into their new home. To date we have organized a self-care workshop for JFS case managers and volunteers. In May, the Global Mental Health students and I administered the Strengths and Difficulties Questionnaire to gather some baseline information about how children are doing. This morning, an Arabic speaking Global Mental Health student and an Arabic speaking case manager have begun to co-lead a women's group, and this was a group that was requested by the Syrian women about acculturation. And also in the summer, mothers and toddlers will begin to join play groups at the Freedman Center at William James College.

I will begin my portion of our presentation with some facts about Syria. Atrocities that have been experienced over the last 6 years of the war have been well-known, and they have raised considerable attention and horror. These horrors have incited the international and psychological communities to respond but always an important question is, "Respond how?" Like the international response, an effective psychological response is not immediately evident. What we know in global mental health is that psychology and broadly speaking psychological concepts, theories, and practices don't translate culturally. So following the facts, I will present Syrian views of psychology and social-emotional well-being, stress, and healing. And I will conclude with a discussion of culture and trauma, a very important topic, in an effort to de-link Western associations between atrocity and PTSD.

I just want to begin with a map and locating Syria geographically. You can see many of the surrounding countries where Syrians have been moved and right where the arrow is that's Jordan. And just looking more carefully at Syria, there has been a lot of news in the end of the year with the falling of Aleppo, Damascus have been central areas that have been dramatically effected. So just in terms of some facts, beginning in the 7th year of the war in Syria- it has created one of the biggest crises since World War II. 4.9 million people, 2.3 million of them are children, have fled to other countries such as Turkey,

Jordan, Lebanon, Iraq, and Egypt. At least 3 million children are estimated to be living in areas with high exposure to explosive weapons. 13.5 million people inside Syria are in need of aid, approximately 4.5 million people are trapped in areas that are besieged and hard to reach places, and over half of the population ahs been forced from their homes. At least 250,000 people have died.

Since the war began, there have been more than 4000 attacks on schools in Syria- almost 2 per day. One in three schools are now out of use and 150,000 educational personnel have fled. Prior to the outbreak of war in Syria in 2011, almost 100% of Syrian children were enrolled in school with the literacy rate at 95%. Today, the enrollment is the lowest in the world. At least 3 million Syrian children under the age of 6 know nothing but war, and millions more have grown up in the fear and shadows of conflict. This is a Save the Child study that was just published. It was conducted between December 2016 and February, and in this study 458 children, adolescents, and adults were interviewed by questionnaires and focus groups and this has been the largest and most comprehensive study conducted on child mental health and well-being inside Syria. 84% of adults and almost all children said that the bombing and shelling is the largest cause of psychological stress for children in their daily lives. 80% said that children and adolescents have become more aggressive, 50% said that domestic abuse has increased, and two thirds of children have lost a loved one. So I know these are quite dramatic and I think these are facts that we are all aware of, but I think to hear them in sequence really captures the dimensions of this crisis.

Along with the atrocities, suffering, and the risk for toxic stress, research has also found that Syria's children are incredibly resilient. Many children still dream of a better future for Syria and becoming adults who can rebuild Syria. A large number of children are showing a range of emotions and have not become desensitized to the violence around them. And they also fund that children are continuing to seek out support through their families and social networks. More specifically, the Save the Children study found that the primary cause of psychological distress in Syrian refugee children was the dire circumstances or economic conditions and poverty that their families experienced. Work with refugee families consistently shows that with basic support, most of the symptoms and signs of psychosocial stress can be alleviated. Psychosocial workers in Jordan report that over time refugee children's fears have decreased and they can convince children that they are safer. As one worker stated, "Gradually, they realize that they can fall asleep and not wake up to the sound of potential death."

This is a picture of a camp in Jordan. This is a quote, looking now at psychosocial support and the whole focus of promoting social well-being of a 15-year-old boy. "The Syrian people are in need of more than aid, we are in need of people who can feel the same as us and understand. We are so happy that you are trying to understand us and

feel what we feel." I think this is often a dilemma. People want to help, they want to give, and they want to give aid but what is, as this boy was saying, there is really a need of people to feel and understand them on their terms not on our terms. The majority of children, even some of those who have lost family or witnessed violence, may not need professional therapy and counseling but are best served by other types of psychosocial support. Strong family and social networks, a sense of normality, schools, and safe places to play with their friends are vital for helping children to cope.

Even before the war, child psychologists and mental health experts were rare in Syria and just to illustrate that, one interviewee said, "Outside counseling is not really in our culture and is rarely accepted." People get their support from their family networks. Before the war there were only 2 public psychiatric hospitals in all of Syria for a population of more than 21 million. So that really I think conveys that there is not a psychological infrastructure, that does not mean that there are not ways that psychological stress can be attended to, however, it is not from psychology or psychiatry. Social stigma is a major barrier to seeking counseling, talking openly about psychological problems, and care is taboo and leads to fear and embarrassment among people suffering with these issues. 40% of young people said they could turn to their family when they are scared or play with friends when they are feeling sad. Less than 5% said they would stay alone, that they would withdraw from social communities. Others seek out distractions to escape from the war around them- television, internet, reading, drawing, hobbies, dancing, soccer. And some of the work that Save the Children have done is providing different forms of expressive arts, theater, games, and that has been demonstrated to be very effective.

Also, looking now at Syrian views of psychology and the concept of self influence both how people experience and express suffering. A term that is often used in global mental health and medical anthropology is idioms of distress- not symptoms, not psychological symptoms, but what are the different idioms of people experiencing distress. So people express suffering and their distress in particular ways, how people explain illness and misfortune, and how people seek help. Just to illustrate this, looking at the ways in which culture and religious values influence idioms of distress and explanations of what causes the distress both impact the expectations and coping strategies, which then leads to the different methods of seeking help. Suffering is seen as a normal part of life that does not require intervention, except in debilitating cases. Most Syrians and Arabic idioms do not separate somatic and psychological symptoms. Physical symptoms may provide a means to assess psychosocial well-being, so to pay attention and not make a distinction between a medical condition and an emotional condition. And then looking at what we would term anxiety which is more expressed as fear, anticipated anxiety, or worries or nervousness and in the form of fear of falling or

crumbling heart. This is how it is experienced, “My heart is squeezing.” For anxiety or worry, “I’m carrying worry.” For nervousness, “I feel tense, I feel nervous.” Looking at mood disorders- sadness or adjustment difficulties, cognitive symptoms, and depression are more the expression and are expressed in the form of grieving as “black life.” Cognitive symptoms, “I cant focus or concentrate.” And for depression, brooding, darkening mood, gloomy outlook which is sort of a mixture of depressive feelings, loss of hope, or somatic symptoms. And then social difficulties are often caused by a lack of resources or financial hardship or helplessness, is the manifestation, or an inability to do or change an undesirable situation. So for the lack of resources, “the eyes see but the hand is short and cannot reach” that is the expression. Helplessness, “There is no use, I am paralyzed.” And for an inability to do anything to change an undesirable situation, “nothing is coming out of my hands” would be the way that it is described.

And then culturally sensitive interventions and challenges are language. It is very important to avoid psychological jargon. Psychological jargon is meaningful and can be very alienating. Also to be mindful of gender and help seeking behavior. Women are, for example, more likely to seek services for their children. Men’s pride and honor and changing social roles can hinder their access to care. There is also a view that men should not cry, feel fear, or feel sadness that also affects men’s access to services. The issues of power and neutrality- present services in neutral terms. Women’s programing- not a therapy group or counseling, but talking together. Provide services, not psychiatric services and mental health clinics, but provide services in health centers and religious institutions where they can become integrated into the community. And to also be mindful of the impact of stigma around mental illness. Some adaptive interventions with refugees, for example for attachment issues such as separation from others, the environment, the culture, leads to anxiety, grief, nostalgia, and depression. So the interventions have been found to be grief work, family reunification, and social community development. For security issues such as loss of control, uncertainty, and discrimination that lead to anxiety and PTSD, interventions are restoration of a sense of control, address basic needs, safe places, normalization of activities, and access to school, work, and healthcare. I think what we will begin to hear when Rosie presents the program at JFS is that all of these interventions are very much the approach.

For identity and role issues such as loss of status, occupation, misrecognition, and loss of purpose can lead to uncertain, powerlessness, role confusion, shame, and humiliation. Interventions are opportunities for meaningful actions for people, family interventions, community membership, and human rights protections. For justice issues, for example inequality and injustice, are deterring violence, discrimination which can lead to anger, hostility, lack of trust, and resentment. Appropriate interventions are efforts to receive equity, trust re-development, and reconciliation. Finally, existential

meaning for example loss of a sense of coherence, faith, and sense of a future can lead to searching for meaning, alienation, disengagement, and crisis of faith. Appropriate interventions are testimonials or telling one's story, reengagement in life projects, linking culture, community, and religious traditions, and political activism. This is the UN High Commissioner for Refugees and has really done a focus on mental health and psychosocial support. So you can see in this pyramid that really illustrates that most attention be paid to basic services in security, very much like Maslow's hierarchy. And then to strengthen family and community support, then further up with less attention is to focus psychology support and clinical services. They are really the smallest amount of attention. What mental health and psychosocial research has found is some of the problems that they have seen in refugee programs is the assumption that the majority of traumatized requires psychotherapy, or a focus on traumatic events rather than current social stressors, or resources were allocated to screening symptoms without sufficient services, or a provision of trauma counseling during emergencies or unstable situations where they should have been re-stabilizing and finding safety, or service models with an emphasis on pathology and victimhood rather than resiliency and community mobilization.

The recommendations are to avoid diagnostic labeling, work with each individual case by case, use an integrated and multidisciplinary team, support individuals to cope with symptoms, and focus on improving functionality both physically and psychologically. And a quote, "Clinical interventions need to go hand-in-hand with interventions to mitigate difficult living conditions and strengthen community-based protection mechanisms in order to help individuals regain normalcy in their daily lives. Interventions aimed at improving conditions and livelihoods may significantly contribute to mental health of refugees and internally displaced persons perhaps more than any psychological intervention.

I'm just going to finish up by talking about culture, trauma, and PTSD and also a quote from Ethan Waters. "The issue is not whether tragic events trigger debilitating psychological distress and mental illness, everyone agrees it can. The question is over the extent to which individual's cultural beliefs shape their symptoms. If culture has the impact that some researchers suggest, the PTSD diagnosis may be of little help and even do potential harm when applied wholesale in other countries." Many Americans assume that PTSD describes how all humans react to trauma. Anthropologist Al Young said, for example, "A diagnosis like PTSD can be real in a particular place and time and yet not be true for all places in time." If clinicians are unaware of local idioms of suffering, interventions are likely to be ineffective at best. Then looking at trauma- trauma is the outcome of the event. Some of the distal determinants that predispose traumatic context can place individuals at risk are individuals with a trauma history and genetics. And then

there are more proximal determinants that can precipitate traumatic triggers such as the nature of the event. And then there can be prolonged factors that amplify, augment, or extend the trauma- political trauma or a negative family reaction. And then there are protective factors that dampen or diminish the outcome such as a justice outcome or a more positive family reaction.

Major criticism of PTSD is the cultural specificity of the diagnosis. An incident and even a severe stressor cannot be called a trauma until its destructive effects emerge. Different cultures interpret the symptoms differently, and are therefore not relevant to make a diagnosis. Resilience is an adaptive response to an extraordinary challenge. Resilience is the norm, and I think this is really significant. It is the norm following traumatic exposure except in conditions of ongoing threat, lack of safety, and where developmental stages are harmed. Traumatic experience does not equal pathology and disability, and the key to resilience is a socio-cultural environment, maintaining and restoring ties and returning to normal life as soon as possible.

The posttraumatic growth occurs concomitantly with attempts to adapt, and personal distress and growth often coexist. Posttraumatic growth occurs in 40-60% of cases, and increasing posttraumatic growth does not decrease PTSD. They are not necessarily connected. They coexist but they are not causative, and conversely decreasing PTSD does not increase posttraumatic growth. And this chart I think is very useful for seeing the various reactions to trauma. Resistance is that people unaffected, they resist any negative response to trauma and there is no elevation. Resilience, you see that over time there is a real spike from pre- to post- in psychological impact, and starts to go down, and then levels off. It's interesting to compare resilience and recovery. Recovery is very similar to resilience, but it goes down a little more slowly and does not level off in the same way. And then posttraumatic growth, again there is another spike. It is very elevated in the immediate period and then continues to decrease, and even in the last phase is below the level of pre-trauma. That is in contrast to PTSD where the level of disturbance continues and does not abate. Thank you.

Rosemarie Coelho, LICSW

Jewish Family Service of MetroWest

Introduction by David G. Satin, MD

Our final speaker is Rosemarie Coelho, LICSW who is the Director of Performance Management at the Jewish Family Serivce MetroWest. She earned her Masters in Social Work from Simmons College and currently is in private practice in social work. Her focus includes cross cultural treatment, and she has co-authored a number of clinical papers on Southeast Asian refugee trauma assessmetn and on post-immigration depression.

Rosemarie Coelho, LICSW

Good afternoon. I'm honored to be here to address you today. I'm going to speak about the components of a model of resettlement that Jewish Family Service of MetroWest is currently operationalizing with the assistance of multiple partners, including William James College. Dr. Hashem has already adequately addressed the content of y first slide - the definitions of refugee and asylee; so we won't need to spend time on that. I have a few slides that give numbers of refugees and asylees by country. If you look at asylees in 2015 along with the current level of refugees, you will see that the Syrians represent about 15% of refugees and asylees in this country.

This slide represents all immigrant groups to the United States. Syria does not appear on the list, indicating that they are coming with the status of "refugees" and "asylees."

In this slide we can see that the population of the U.S. who are foreign born is about 13.5%, up from about 4.7% in 1970.

This chart represents the ceiling for the number of refugees admitted to this country along with the bottom line, those admitted. And you can see that in 2017 we have a bit of a spike in the ceiling representing the numbers under President Obama's administration; the sharp downward spike reflects the reality of the current administration. In the current atmosphere of increased intolerance and decreased support for immigrants and refugees, especially those from so-called "Muslim countries," the pilot program that we will be discussing takes on a level of increased significance.

In addition to the goal of safeguarding the well-being and improving the lives of 12-14 Syrian refugee families, it is the goal of JFS and our partners to utilize the public attention associated with the pilot program to impact public awareness and sentiment positively and to decrease racial, ethnic, religious immigrant intolerance fueled by ignorance, unfounded fear, and calculated misinformation. It is hoped further that the information derived from the project, while based on a small number of families, will

help inform public policy. We undertook this project with the permission of HIAS, our resettlement agency and with the State Department. Only after assuring that all State Department requirements for resettlement would be met was permission for this pilot secured. The pilot model represents an expansion of the standard resettlement model.. And we have promised success, even though this is an experiment. We have promised that the families involved will fare better than they would have fared without the model.

The current U.S. model for refugee resettlement utilizes short-term (3-6 months) case management focused on acculturation and facilitation of access to cash and health benefits, to ESL and job placement. For families with U.S. ties, relatives frequently lend support with temporary housing, culturel brokering, jobs, etc. but for families without ties, the resettlement model is woefully inadequate. In fact, English language acquisition through standard ESL programming takes significantly longer than 3-6 months; and job acquisition without English language skill is usually minimum wage and without a career track. Wage and benefit levels are too low and affordable housing wait lists too long for families to secure adequate housing in communities other than those already over represented by low income residents. It is the premise of JFS that the current U.S. state department model for refugee resettlement ostensibly relegates families to a life of marginal stability within communities overrepresented by low income populations. Looking at this through the lens of anti-poverty programming, it falls very short.

The pilot model

The pilot model is a carefully coordinated, collaborative model that includes a resettlement agency, synagogues, Islamic centers, churches, academia, and the medical community across Massachusetts, as well as public and private donor partners. It expands upon the refugee resettlement protocols to address, aggressively, barriers to rapid acculturation and self-sufficiency, ensuring that refugee families have:

1. adequate food, clothing, and housing through rent and incidental subsidies for the first year
2. accelerated acculturation and acquisition of English language skills, combining standard classes with daily tutoring for significantly more rapid English-language acquisition
3. job training and assistance with job finding focused on existing skills and family chosen areas of employment including the possibility of small business start-up.
4. assistance with referral for needed benefits and/or to needed resources such as medical or legal.

The program provides intensive case management and family support. Each family is provided a team of staff and volunteers who work intensely with families beginning from the Logan airport pick-up throughout a time period of about one year, followed by a second year of tapered intensity.

This is a trauma-informed model of intervention. This slide indicates the 6 principles of trauma-informed care, emphasizing the importance of creating safety, trustworthiness, utilizing peer support, collaboration and mutuality, empowerment, and appreciation of cultural, historical, and gender issues. Our refugee clients have experienced and witnessed significant trauma: physical injuries, sexual assault, attempted abduction, displacement, deprivation, loss of friends and family, etc. We have attempted to guide our interventions according to these principles of trauma informed care. We also anticipated the potential impact that working with these severely traumatized refugees would have upon our staff and volunteers and attempted to put in place mitigating and responsive interventions.

If statistics are to be trusted, today, 29% of the immigrants ages 25 and older have Bachelors degrees compared to 31% of native born adults. That's pretty good, so a number of higher educated immigrants and refugees have come to this country. However, at the other end of the spectrum 29% of immigrants lack the high school diploma or GED compared to only 9% of U.S. born counterparts. That's important because 35% of job openings in this decade require at least a college degree. Only 36% of existing job openings don't require an education beyond high school. At the current production rate of higher education, we in this country only fall short by about 5 million workers relative to skill sets. That means that there is increased competition for fewer jobs that do not require higher education, fueling some of the anti-immigrant sentiment. The peak immigration wave was a period between 1880 and 1924 when we saw a little over half a million immigrants per year, amounting to over 25 million immigrants over a 44-year period. This period also coincided with the machine age, when many factory positions were opening up, the period of urbanization when there were lots of construction project that required man power, and a real acceleration in farm growth where we went from about 1.5 million to over 6.5 million farms. We welcomed immigrants and refugees "with open arms" during this period. As a matter of fact, it was quite common for factory owner representatives to meet ships at the points of entry and recruit the immigrants arriving from other countries to come work in the factories

Where people settle

This slide shows Prospect Heights in Millford, MA - a neighborhood of 68 housing units set up as two back to back rows of semi-detached houses along with a half a dozen

duplexes. The project was created by the Draper Corporation Textile Machine Foundry. This development was featured in one of the World's Fairs because this was the first factory housing that included indoor plumbing. My grandparents were recruited (along with some 100 other immigrants) by the representatives of Draper Corporation with the offer of an immediate job and a place to live. (These slides show Prospect Heights in 1921. That's my grandfather standing in front of #8 Prospect Heights.) Rent payment was taken out of the paycheck on a regular basis. These housing units were heated by fuel that came from a company that was owned by factory; payment also came out of the paycheck. At one point, the residents of this community decided that they needed a social center. Because the Portuguese represented the largest immigrant group living in "The Heights," they erected the Portuguese Club of Milford on the land at the south end of the row houses. Residents also created a small market that sold ethnic groceries "on time" and a school for Portuguese language literacy within the club building. Opposite, at the north end of the row houses, Eugene Guido opened a little market. Mr. Guido was second generation - his parents were born in Italy - so he became the neighborhood's culture broker. He not only sold groceries (accepting payment "on time,") but allowed his immigrant customers to leave their utilities bills with him to pay "downtown" once per week. So, as you can see, Prospect Heights became a very self-contained community. People helped raise each-other's children; they helped feed each other when they were unemployed, etc. This association of immigrant families, now three generations later, is still very tightly knit with friendships having lasted beyond the grave.

The model, however, failed to encourage (or, perhaps, even to permit) for those original immigrants, English language learning or the development of knowledge and comfort in negotiating the larger host community.

We have talked about refugees typically being settled in communities that are over represented by immigrants and by poverty. In Massachusetts, they tend to be placed in the Springfield area, in Worcester, and in Lowell. There is nothing wrong with these communities but, like for the early immigrant residents of Prospect Heights, English language acquisition and successful cultural adaptation are frequently delayed. We now know that one of the true measures of acculturation or successful cultural adaptation is development of a bi-cultural identity. We believe that putting people in integrated, middle-income communities would help to accelerate this notion of bicultural identity.

This slide shows one of the residential places that we have put our Syrians in. There are four families living in this development along with one of our case workers who we based in the same development. The 5th Framingham family lives about a mile away and we have one family settled in Needham and one in Boston.

Collaboration

JFS is an agency that has been in existence since 1979. It is a relatively small agency with about a 3 million dollar budget and has been in the business of resettlement since it began. It initially started by resettling Russian Jews and continued beyond the dissolution of the Soviet Union. The agency also has a citizenship program as well as several other community based programs working with ethnic minorities, immigrants, and refugees from a number of countries.

This pilot could not exist without the collaboration and financial support of our partners. There were a number of synagogues who spoke with us of wanting to do something to help Syrian war refugees. There was an identification with the plight of the Syrians. The synagogues are sponsoring a number of families, each contributing cost of rent for two families over the course of a year. In addition to the program director, there are four refugee resettlement case workers – three Arabic speaking. There are over 100 trained volunteers coming from synagogues, mosques, and churches. They are put through rigorous vetting and training and together they will have delivered thousands of hours by the end of this program.

I have used photographs that are public, having appeared in Jenna Russell's two installments of a series featured by the Boston Globe called Through the Closing Door. She is a partner in this project and has been with us since the beginning. We are hoping to utilize awareness of this program in the hope that it will generate some contagion of interest.

Slide: It all started at this gate. This is one of our case workers greeting our first refugee from Syria. That's Muhammad, the 5-year-old son who was up at about 2am due to several delays. There were also people from the supporting synagogue as well as other partners.

Slide: This is another welcoming photograph. Some might recognize Ed Shapiro who is a major contributing member of the program.

Slide: For each arriving family, our team volunteers helped to furnish the apartment and make it a home. They brought flowers and arranged the kitchen and did all kinds of things so that the family would feel safe and welcome. Slide: This is one of the families greeting the volunteer. We tell families that they can control when and how often volunteers visit. The response is always a version of "In Syria we always had people living with us. We miss them. The volunteers make us feel whole They are our family and friends in the US. Send us as many volunteers as possible and as frequently as possible."

Slide: This is the night that this family with three children arrived at their new home at 3 a.m.. Despite exhaustion, the boys were very interested in looking at their bedroom – a welcome departure from the unheated and unfurnished apartment they lived in before coming to the United States.

Slide: This is Dr. Halaly, one of our caseworkers and an Egyptian immigrant. This is actually not as happy a scene as it appears to be. We were expecting a family with a young mom win her 7th month of pregnancy when the travel ban stopped her from getting on the plane. This photo was taken when we learned that the family would not be arriving as scheduled. We were devastated because we thought we had lost her. Through the intercession of Ed Shapiro, we found them in Jordan and were able to provide resources so that the delivery went smoothly and the children had basic needs met. Slide: She did arrive when the baby was 1-month-old and they are all here now.

Slide: This is a family sitting at their table having their first meal in the USA.. The family has been here 3 months, now.

Slide: Asam is teaching her refugee volunteer team how to cook a traditional Syrian soup. She, like all, want to give back as much as possible.

Medical needs

We are dealing with people who have had no medical care for years, mostly because it did not exist where they were but also because of poverty. Their nutrition has been pretty poor, and some have suffered war injuries. We had one of the fathers who was significantly injured in an explosion when he attempted to save a child who had been shot. He underwent emergency surgery that was probably one step up from street side surgery, recorded by a UN team documenting the impossible conditions under which medical staff struggled to save lives. He has this recorded on his phone and he watches periodically as a reminder of the strength of human will to survive. One week after he arrived we had an emergency that we thought was related to the shrapnel that remains in his body. One of our partners was the head of surgery at a local hospital and left his breakfast table to oversee the extensive diagnostics he was afforded. He was diagnosed with Lyme disease – an unusual condition in a desert climate but apparently caught in a pre-departure camp.

Poor dentition is a common condition. Most of our adult Syrian refugees have not been to a dentist in a decade and many of the children have never seen a dentist. We had another medical emergency where one recent arrival developed a high fever and other symptoms related to a severe abcess. An emergency extraction was performed but extensive dental work is required for most of these adults and children.

All our refugees have been enrolled in Mass Health, as dictated by the State Department. They all received medical assessment and assignment to primary care doctors and pediatric physicians. They also have been assigned needed specialists such as psychiatrists, endocrinologists, dentists etc. Some of our medical partners have donated thousands of dollars of needed care, otherwise not covered by Mass. Health. We

are providing ongoing transportation to and interpretation during medical appointments and provide any cash assistance that they might need for co=pays, medication, etc.

English Language Acquisition

The literature tells us that for kids it takes 4-7 years before they are on par with their American born equals. For adults, it is usually 5-7 years. This relates to those fully literate in their native language. It takes somewhere between 500 and 1000 hours of formal ESL training to be able to satisfy basic English language needs. So, at an acquisition rate of 500-1000 hours, assuming that someone takes a 2 hour per week ESL class, it would take 5-10 years before someone would acquire English. For the most part, our refugees are not highly educated and some are functionally illiterate. Many of them are young and had secondary education interrupted by the war, suggesting that language acquisition would take even longer.

Several studies have found that people who spoke a language other than English at home were less likely to be employed and less likely to find work when unemployed. When employed full time, they earn a lower median wage than those who speak English. Those with the lowest English speaking ability have the lowest employment rate, the lowest rate of full time employment, and lowest median earnings. On average, English speaking workers earn $5-6000 more than those who spoke another language at home. So there is a direct relationship between the level of English language acquisition and earnings. This project has people enrolled in twice weekly formal ESL from 1.5-2 hours per week. They also receive daily ESL tutoring from our ESL specialist. We also have a number of ESL volunteers who are working with the families; and we are providing targeted ESL that has to do with the families areas of expressed interest and their professional choice. So for the tailors we have people teaching them language associated with material and threads and sewing, etc.

Slide: First day of school, meeting the school principal.

Slide:These are two gentleman in the ESL class.

Income disparity

Social policy experts as well as economic policy experts have regularly said that it takes a generation to escape poverty. It takes about 20 years. “Refugee income rises over time almost reaching parity with United States born.” This is a quote from the migration policy institute. Refugees generally arrive with very few resources, many penniless. Over time, however, they advance until they reach self-sufficiency, which is a goal that resettlement programs have. The median household income for recent refugees, defined as those arriving with the last 5 years is 42% of the median for the US born population.

This slide shows the median income or US born workers as just shy of $50,000, meaning that average refugee who has been living in the US for 5 years or less is making $20,600. By the time they have been here 10-20 years, they are making 87% of the median wage.

To mitigate this disparity, the pilot works aggressively with job preparation & job finding agencies such as Jewish vocational services and with employment training resources. The program also has a dedicated jobs coordinator. We are working with our program refugees to choose the kinds of jobs they would like to have and looking to provide the skill sets and identify the English language level that would be necessary for acquiring those positions. We would like people to be getting to work as soon as possible; however, our experience with other refugees that we have received is that they take a minimum wage job that they don't like, stop taking ESL and remain "stuck." We are trying to help our refugees find positions that will maximize their skill sets and interest levels and that will provide a good living wage. Our partners also have helped identify potential employers and positions. Joseph Aboud and Rebok have offered positions to a highly skilled master tailor and an accomplished shoe maker. Both of these positions are well above minimum wage positions. All but one man is currently employed and several of our women are preparing to work. We are hoping that our families will find fulfilling work where they will generate enough income to be able to maintain residence in middle income communities, if they choose to do so. We have facilitated connections among the refugee families as well as with the host community. The families share experiences and camaraderie.

They help each other out, babysitting and cooking for one another, attending events together, etc.

Promoting and measuring economic self-sustainability

The model provides extensive financial literacy training. Each family created a budget to better understand true costs of living and implications for purchases such as autos. For example, many had no idea that a free car meant anything but. They didn't know about registration fees, insurance, taxes, etc. We have also opened up checking accounts (as interest bearing accounts are prohibited by Muslim law) and have deposited $1000 in each account. We review and help them maintain budgets on a regular basis.

JFS treats this pilot as an anti-poverty program. Slide: This slide indicates one of the measurement tools we use to track economic status across a continuum from emergency to vulnerability to stability to self-sustainability. It is a home-grown instrument that looks at a number of variables including level of income, monthly income over expenses, household savings, debt to equity ratio, housing stability, etc. We hope to demonstrate

over time that this intense model helps families truly stabilize and even to become economically self-sufficient..

We know that this is a better model for families. Is it a sustainable model? This is a very expensive model. However, if refugees can be helped to earn a higher medium income instead of the 42% of US born workers, they will have less reliance on public benefit programs and pay higher taxes. We are attempting to better understand what the costs are in relation to the longitudinal cost savings, again working with our resettlement agencies, the State Department, and ORI in order to determine if any of these interventions if not the entire model will be sustaining in the future.

Discussion

David Satin:

(missing audio)…and what your suggestions are. My one thought after all of this is about immigration and refugee status- what should we do about this? Since all of this is going on and all of these ideas are here, what do we want to do other than keep trying? I want to open it up to the audience. If someone has something to say, please raise your hand.

Rosemaire Coelho:

One of their spokesperson said that we are in the business of resettling refugees because they are Jewish, and now we are in the business of resettling refugees because we are Jewish.

Audience Member:

That's beautiful.

Rosemarie Coelho:

I must acknowledge that there is a Jewish tradition of welcoming the strangers, and right now the Syrians are the strangers.

Audience Member:

It was a great presentation and one of the reasons that I chose to come…I'd like if you could possibly assist us with the following; what happens when a refugee unfortunately enters into the state system such as child welfare, mental health in particular, which is more my interest. And what could we do in the state system to expedite a return back to the community in a way that is mindful and respectful in a way that the person does not get labeled and then get entrenched in the state system that does not produce better results?

Falah Hashem:

(inaudible) case managers at resettlement agencies help refugee-clients to access services and benefits they are eligible for, for example, cash assistance (for those who are 18 years of age and older without dependent children) to pay for their rent, and for food stamps. This is separate from the health services provided to refugees. Refugee-clients receive health assessment services through a network of community health centers in Massachusetts. Access to these health care services established within the initial 30 days of arrival. Health assessment clinicians and behavioral health specialists are well-trained to interact with the culturally and linguistically diverse refugee and immigrant-

populations. Refugee health assessment clinicians follow CDC's guidance to make a follow up plan for clients' health conditions identified overseas, diagnose and manage any health conditions identified during the visit, and make referrals to specialty clinics including behavioral health by the end of second visit.

The only behavioral health services provided through refugee health assessment is the RHS-15 screener that is used to test those who are 14 years of age and older for the following conditions: Depression, Anxiety, and PTSD. Upon diagnosis and depending on urgency, refugee health assessment clinician may decide to manage the health condition during the visit, refer to behavioral health department, or wait until patient connected to primary care. What makes community health centers special is their approach to become a medical home where refugee-clients served on the spot for all of their need. If they need non-medical assistance, social workers at the health center can help them with their needs through referring them to the mainstream services. (inaudible) Does this answer your question?

Audience member:

It does.

Falah Hashem:

For our office, ORI does not provide direct services, but rather direct services provided through a network of service providers, like Jewish Family Services, and they in turn provide these kinds of direct support to refugee and immigrant-clients. So remember, when you believe that your patient need assistance, the best thing to do is to contact his/her case manager at the resettlement agency. Refugee and immigrant-clients do know who their case manager is at the resettlement agency and/or at the health assessment site (inaudible).

Rosemarie Coelho:

And Dr. Hashem, are they able to receive a list of agencies that may represent their particular area?

Falah Hashem:

Definitely, we can provide this list. You may also want to visit our website at www.mass.gov/ORI to check our Community Partners Directory, now we have 2016 edition posted. Feel free to contact any of the agencies listed if you need assistance for your patient; and if you encounter any challenges in contacting them, please feel free to contact our office and we would be happy to help.

David Satin:

It's all clear to you?

Audience:
(laughter).

Audience Member:
I just wanted to say thank you to all who are here. This was very informational, riveting, and inspiring. All three of you, thank you very much. I don't know if it's possible to get copies of your presentations? There was just so much material there and I would love to have it.

Unknown Speaker:
If you want to give me your email addresses we can send it.

David Satin:
If there are no other comments, then I too want to thank you for really vivid focused, inspiring information about what is going on and understanding and responding to this population. Two questions remain that we will not finish here because its too much. 1) what are we going to do with this insight and these skills? How can they be applied to this population and to internal migrant populations? The other issue that we have studiously avoided is where do they come from? What is the issue about admitting migrants and refugees to the United States so that they are people that we can help? How much is that our national occupation to deal with this and welcome it. 2) even more basic, what happened to their homes? How come they are refugees and migrants? How come a third of half of a population of some countries are expelled from their own countries and become in need of a home. That is a larger problem than what we do about the causalities that end up here. I want to thank you all for coming and listening, and I want to start you thinking about the 41st annual Erich Lindemann lecture. And Insha'Allah we are all here next spring an are able to talk about another important issue in community psychiatry and mental health.