

Refugees from Somalia, Iran and Afghanistan in the Netherlands: health over time after resettlement

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Little is known about how resettlement impacts health of refugees in Europe, and more specifically, which factors contribute to physical and mental health improvements of refugees after resettling in a West European country. Most research until now focussed on the period between arrival in a resettlement country for refugees, and the moment at which asylum seekers are granted a residence status. Very little is known about how physical health outcomes and mental health problems develop after getting a residence permit, after leaving the reception centres that offered temporary shelter for refugees.

In the Netherlands, the practical situation for refugees changes dramatically at the moment of getting a residence status. Before having a residence status, refugees reside in reception centres across the country (more than 40 reception centres in July 2014), awaiting a decision on their asylum application. Some of those centres are located in large cities, others in a rural environment. All have access to public transport, and schools and food stores are within reach. The reception centres mostly provide accommodation with shared facilities. Depending on the reception centre, a living-room or kitchen is shared by 5-8 persons. Also, paid work is only allowed for a few weeks per year, and often limited by practical circumstances. Therefore, daily life is mostly happening within the boundaries of the reception centre, and social contacts are mainly taking place with other refugees within the centre. This period in the reception centre is also known to be a period of uncertainty about the future situation, which can cause a lot of stress and anxiety (1).

After getting a residence status, refugees receive the same entitlement to work and housing as any other Dutch citizen, and they leave the centre to resettle in municipalities across the country. During the asylum procedure, access to health care is facilitated by a specialized contact point for all asylum seekers. After leaving the centre, refugees face the exact same organisation of health care as other Dutch citizens, characterised by a strong primary health care and a central position held by general practitioner (GP).

In which way do those important changes affect the mental and general health of refugees after resettlement in Dutch municipalities? On the one hand, the uncertainty of the procedure is over, practical circumstances are meant to be improving and people are in theory able to take fully part into society. On the other hand, finding one's way through health care and other public services is not facilitated anymore, GP's do not specifically have the expertise in dealing with refugees' migration history and its impact on (mental) health. Finally, resettlement into another culture also can bring a lot of stress (2). The lack of evidence on the course of health and health care utilisation after resettlement needs therefore to be filled, in order for public health services and primary health care to adequately address the potential issues of this specific group.

With this purpose, we started a two-wave cohort study among longstanding and recent refugees in the Netherlands in 2003. This study was questionnaire-based, and also collected GP medical records for one sub-study. In total, 172 refugees took part in both waves.

Refugees were coming from Somalia, Iran and Afghanistan, three of the main countries of origin in the Netherlands at the start of the study.

We examined separately:

- The role of change in residence status on mental and general health improvements;
- The course of post-traumatic stress disorder (PTSD) in time, in relation to health care utilisation;
- The quality of primary care for resettled refugees with chronic conditions (diabetes, hypertension and common mental disorders (CMD)).

Residence status and mental health

When looking at health changes over time, we saw that refugees who recently got a residence status experienced larger decreases in post-traumatic stress disorder (PTSD) symptoms and anxiety/depression symptoms, and larger improvements in self-rated general health over time as compared to longstanding permit holders. Health improvements were not directly influenced by the fact of getting a residence permit, but rather by the subsequent improvement of the experienced living conditions, in particular employment and the presence of family/social support. The changes in social context are therefore the mechanism underlying health improvements accompanying a residence permit (3).

The course of PTSD and health care utilisation

Despite these health improvements through time among refugees, evidence shows that the prevalence of PTSD remains high, even several years after resettlement. Our findings show that the PTSD prevalence remained considerably high among resettled refugees at a seven-year interval (around 15%, compared to 7% among the general population, (4)). This seemingly unchanged rate has two main explanations. The first one concerns the onset and persistence of PTSD symptoms. Only half of the respondents having PTSD during the second measurement already had PTSD during the first measurement. The other half concerned new cases, for which PTSD developed later on, between both measurements. The second explanation concerns the low use of mental health care during the first wave. We saw that during the first wave, only 21% of respondents symptomatic of PTSD were reporting contacts with a mental health care provider at the same time point. This last explanation is all the more important given the results of the analyses on the effectiveness of previous mental health care use: respondents with PTSD who made use of mental health care during the first wave were more likely to see an improvement in PTSD symptoms during the second wave compared to those who did not, regardless of differences in other pre- and post-migration factors. Having previously used mental health care in the Netherlands proved therefore to be beneficial for PTSD recovery (5).

Quality of primary care for resettled refugees

To assess the quality of primary healthcare for resettled refugees with chronic mental and physical health problems, we examined: a) general practitioners' (GP) recognition of common mental disorders (CMD; depression and anxiety, and PTSD symptoms); b) patients' awareness of diabetes type II (DMII) and hypertension (HT); and c) GPs' adherence to guidelines for CMD, DMII and HT. About 50% of the refugees with CMD had been diagnosed by their GP. About 80% of refugees with hypertension and/or diabetes were aware

of their condition. Finally, we saw that GP's guideline adherence for refugees diagnosed with hypertension, diabetes and/or CMD was about 66%. Compared to the general population, those figures do not point at a specific problem in quality of GP care for refugees with chronic conditions. However, given the high burden of CMD among this specific population, we think that GP's detection of CMD could be improved (6).

Ethnic and cultural differences?

The above mentioned results were analysed (when possible) separately for each country of origin. Generally speaking, we found no difference between refugees from Somalia, Afghanistan and Iran on these three specific topics. This might be explained by the fact that, even if the prevalence of some problems (PTSD, chronic conditions, general health, etc.) differ per country of origin, mechanisms explaining health outcomes development over time after resettlement are common to all those who resettle in the same conditions.

Lessons learnt: improve practical circumstances, stimulate access to mental health care and inform GPs.

Three important lessons are standing out at the end of this research project. First, the practical circumstances in which asylum seekers are set should be improved as soon as possible in the asylum procedure. The living conditions, and especially the access to paid work and the presence of social support are two key-points which can lead to better mental health outcomes on the long run. Likewise, a better access and active detection of symptoms of PTSD during the asylum procedure and the stay within the boundaries of the reception centre would most probably result in a better, timely treatment of PTSD for this group at high risk. Finally, GPs dealing with refugees should be informed about the high prevalence of CMD among this group. Also, the patient-provider communication on this sensitive topic should be facilitated by using professional interpreters in the general practice, though telephone or in face-to-face.

Note that the views expressed in this article are those of the author and do not necessarily represent the views of PHASA.

References:

1. Laban CJ, Gernaat HB, Komproe IH, Schreuders BA, De Jong JT. Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *J Nerv Ment Dis.* 2004;192(12):843-51.
2. Williams CL, Berry JW. Primary prevention of acculturative stress among refugees. Application of psychological theory and practice. *Am Psychol.* 1991;46(6):632-41.
3. Lamkaddem M, Essink-Bot ML, Devillé W, Gerritsen AA, Stronks K. Health changes of refugees from Afghanistan, Iran and Somalia: the role of residence status and experienced living difficulties in the resettlement process. Submitted at the EJPH.
4. de Vries GJ, Olf M. The lifetime prevalence of traumatic events and posttraumatic stress disorder in the Netherlands. *J Trauma Stress.* 2009;22(4):259-67.
5. Lamkaddem M, Stronks K, Devillé WD, Olf M, Gerritsen AA, Essink-Bot ML. Course of post-traumatic stress disorder and health care utilisation among resettled refugees in the Netherlands. *BMC Psychiatry.* 2014;14:90.
6. Van Melle M, Lamkaddem M, Stuijver MM, Gerritsen AA, Devillé W, Essink-Bot ML. Quality of primary care for resettled refugees in the Netherlands with chronic mental and physical health problems: a cross-sectional analysis of healthcare medical records and interview data. Submitted at BMC Family Practice.