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The Refugee Crisis - Narrative by Rolf Carriere
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[TITLE] Brenda, Isabel and Derek gave us a graphic description **[WAR PIX]** of the often-unspeakable circumstances under which refugees and migrants lived in their countries of origin, and the horrific hardships they endured before they reached Europe's shores. **[BOAT]** They also highlighted that mental health issues are often not the first of their concerns, not a priority. At least so it seems: mental health is an *observed* need, but often not a *felt* need.

[WOMAN EMDR] Even so, there are many humanitarian professionals making heroic efforts to treat trauma, restore mental health and build capacity. We have heard of Isabel and of Derek and their teams. But there are many others, some in the audience today: Emre and his team in Turkey. Penny and her team in Greece. Mona and her team in Palestine. Nacho and his team in Latin America. Sushma in South Asia. Helga and Ute and their team in the Mekong countries. Eva and her Swiss colleagues. And many others still. We salute them all!

[DARFUR WOMAN] I want to take you briefly beyond the European refugee crisis, because while the sudden influx of traumatized refugees and migrants into Europe presents acute challenges here, it is only part of a bigger picture, and the challenge that your profession faces is much greater than Europe alone. Most traumatized people do not become refugees or migrants, but stay putt as internally displaced persons **[HUDDLING]** or just at home, whatever that looks like.

The scale of the world's trauma problem has been seriously underestimated. **[STATISTICS]** Available WHO statistics don't capture the stark reality, since most countries haven't done PTSD surveys. There is a huge, and increasing, *global* burden of trauma, especially in the developing world, as I have presented in my TEDtalk and in two recent EMDR keynotes, in Denver and Liverpool. [**CALCULATION]** My guesstimate, based on projecting the well-researched USA

prevalence rate onto the total world population, **[500M]** is that 500 million people are suffering from PTSD and other trauma-based diseases and disorders. That amounts to a worldwide trauma epidemic. **[TRAUMATIZED!]** In other words, the dominant psychological state of the world as a whole is: "traumatized". And it's likely to get worse, before it may get better.

The global response to this massive problem **[AFGHAN MAN]** up to now has been feeble-- absolutely *not* commensurate with its extent, severity and importance, either for individuals, or for society as a whole. The biggest single reason for this feeble response is *not* an absence of suitable intervention methods, or stigma, or even money, but **[CHRONIC SHORTAGE]** the chronic *shortage* and uneven distribution of mental health professionals worldwide. Therefore, increasing the pool of mental health professionals is a top priority, and **[EMDREU etc]** professional organizations like EMDREU, EMDRIA, HAPs and other regional EMDR organizations can play a vital role here, not only to help scale up EMDR *trauma* therapy, but, equally important, to scale up EMDR *psychotherapy* altogether. Increasingly, universities, too, should offer EMDR trauma and psychotherapy courses, to help fill the gaping therapy gap worldwide. EMDR would then come to contribute much more to public mental health care and capacity building.

In fact, it is my firm conviction that EMDR **[EMDR ADVANTAGE]** is uniquely placed to take the lead due to its intrinsic therapeutic superiority under field conditions. **[UNAWARE]** Unfortunately, most of the world's key players aren't even aware of EMDR, let alone its special suitability and effectiveness. **[ORGS]** Therefore, a lot of advocacy and demonstration work is needed, with ministries of health, with international and UN institutions, with donor agencies, with civil society organizations. There's an urgent need to organize that.

We can all agree that increasing the number of mental health professionals is urgent and necessary. But that *alone* will not be sufficient. **[CALCULATION]** Indeed, it will take a very long time to bring need, supply and demand into a better, healthier balance than it is now. A rough calculation shows that if we

intended to treat, over the next 25 years, only the current 'backlog' of 500 million PTSD cases worldwide; and if professional therapists would each treat 100 PTSD cases per year; then we would on average require 200,000 therapists to do that job, working in all the places of need. Multiply that number with the average salaries and maintenance costs, plus training and travel costs, and we can quickly conclude that this is not a realistic scenario… And this does not even take into account the millions of new cases added each year.

[HOW TO BRING] The only way to bring the benefits of evidence-based stress and trauma therapies to the millions who need it *now,* is to invite and organize new types of workers to come and play carefully designed roles to help tackle the problems. **[NEW CAPACITIES]** We need to build new capacities. This calls for new paraprofessional and volunteer models, such as those already practiced in other fields, for example in health, law, teaching, social service—but not yet in mental health.

[PYRAMID] Beginning at the bottom of the referral pyramid, with Psychological First Aid, rolled out by WHO and endorsed by hundreds of NGOs, we can now help bring about a quantum jump in the number of volunteers. **[BOOKLET]** Psychological First Aid is not psychotherapy or counseling. Instead, it's a series of practical measures that emphasize safety, support, comfort, care and hope. **[WIDELY SUPPORTED]** PFA deserves to be widely supported, and as professional organizations we can lend a hand.

[PYRAMID] Working from the top down, we must find ways to extend a **[SPECIAL DR PACKAGE]** special learning package on trauma to medical doctors, especially those working in the developing world. That would seem like a strategic partnership.

[PYRAMID] Beneath that, we should help create a new cadre of well-trained and well-supervised paraprofessional personnel to undertake well-defined, simplified tasks within a clearly defined system. **[DIFFERENT NAMES]** They may be called by different names, associate trauma worker, intermediary mental

health assistant, paraprofessional trauma responder, therapist associate, assistant counselors… the nomenclature will vary from country to country depending on their educational levels and what tasks will be shifted down to them. **[TASK SHIFTING]** The technical term for this is task shifting.

Task shifting has been done in public health for almost four decades. I myself got professionally involved in UNICEF **[WERNER]** in the late 1970s, working with the David Werner model, Where There's No Doctor. Initial professional reluctance, and understandRolf Carriere Page 4 21-06-16able scepsis, to leave certain tasks to what, at that time, were considered to be non-professionals, were soon found to be unwarranted, and, consequently, great strides were made in mortality and morbidity reduction. Well-trained and well-supervised volunteers and paraprofessionals, doing simplified tasks, were, and remain, central to the success of the Child Survival Revolution. **[ETHICALLY]** And in the process we found ways to transcend the eternal medical ethical dilemma of committing an error of *omission* versus an error of *commission*.

A similar discussion now needs to take place within the mental health community. **[PATEL]** We now have Vikram Patel's model, Where There's No Psychiatrist, and his organizing acronym **[SUNDAR]** SUNDAR. Considerably more research, design and training work will be required before such primary and secondary mental health care interventions are truly ready for scaling up. Indeed, scientific validation of effectiveness and safety should have the final word!

Fortunately, some promising work is already underway, both with approaches based on EMDR and with TF-CBT. **[SHORTCUTS]** This shows that shortcuts *are* possible by bringing new types of workers into the mental health system. There's an urgent need to accelerate these pilot projects, field trials and evaluative research, including RCTs. **[TREATMENT DEFERRED**] Because treatment deferred is treatment denied, which is a human rights violation.

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As a development professional, I firmly believe that EMDR and EMDR-based interventions are the **[EMDR BEST HOPE]** best hope the world has right now to come to grips with the huge global burden of trauma in a reasonable period of time, whether we are talking about Europe and America, or countries like Syria, Iraq, Afghanistan or any other low-income country.

[COMMITMENT] In her opening address on Friday, Isabel mentioned EMDR's commitment to humanitarian principles. Some of us have made a concrete proposal that would further strengthen and concretize that commitment. Tentatively it's called **[GISTT]**, Global Initiative for Stress and Trauma Therapy. It is a plan to create a professional capacity in Geneva (the humanitarian capital of the world and the second UN headquarters) **[GISTT2]** to facilitate ongoing global-level interaction and dialogue between the community of trauma therapists and the international humanitarian community there. This could initially be cosponsored by EMDRIA and EMDREU.

This initiative would organize advocacy presentations and trainings with many of the 300 international humanitarian NGOs and with several UN agencies there. **[CONFRONTING TRAUMA]** This recently completed manual, a collaboration between UNITAR, EMDREU, NGO Forum for Health and Worcester University, will be converted into a professionally facilitated e-learning course together with face-to-face delivery options. These courses would initially be aimed at high-risk personnel within organizations: especially humanitarian aid workers and peace operations personnel. The focus would be on psycho-education, self-care and peer-to-peer work. This curriculum, with Derek Farrell as its principal author, would also be available to university students and physicians worldwide.

[GISTT3] We expect that this initiative will lead to requests for trauma therapists, trainers and facilitators, and for services contracts. So it cannot succeed without participation of EMDR members.

This initiative would also engage in grant writing to raise funds from sources that have not yet been systematically explored for specific trauma projects,

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making full use of, and collaborating with, the Trauma Aid/HAP capabilities already developed— not in competition with them.

Further down the line, this initiative would explore the feasibility to organize a working conference that would critically review the available research on the cost-effectiveness and safety of various paraprofessional models.

I hope that when we meet next year in Barcelona, we will be able to report back on our first achievements.

[FACE OF TRAUMA] In conclusion, colleagues, I believe we have the potential to change the face of trauma.

And let me add this
[IF NOT]
If not us, who?
If not now, when?

Thank you.