Refugees from Syria, Iraq, Iran and Afghanistan already traumatised by war, violence and upheaval now seeking treatment for substance dependence

Remarks from a German Drug Treatment Clinic – and lots of questions

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On some days in our clinic, we see the conflicts in the Near and Middle East as if under a microscope: Every individual case history of new patients from Kurdistan, Syria, Iraq, Iran and Afghanistan shows biographical and political details that reflect the upheavals between Diyarbakir and Kabul.

Let me illustrate this in a case study:

Mr A. is in his mid-20s and was born and raised in Iran. His family is originally from Afghanistan, from where they had fled to the neighbouring country: father, mother, three sons and a daughter. The family lived illegally in Iran and scraped by as day labourers. When Mr A. was 17, the family was expelled by the Iranian authorities and returned to Afghanistan. There the father was killed in an act of violence. The mother then once more battled her way with the children through to Tehran. Shortly after, the eldest son disappeared without a trace. At this time Mr A., who as a child had already met opium as a medicine, began to consume theriac, as opium is called in this part of the world, and then after a while to smoke heroin. The siblings and the mother lived in extreme poverty, always in danger of being expelled again. In his early twenties he was arrested and faced the choice of avoiding the expulsion of his family by registering as a

"volunteer" for deployment in Syria. There he fought in the Iranian military units on the side of the Assad government. When the heroin he brought along was getting low, he contacted his commander, who supplied him with morphine. After a shrapnel injury he returned to Iran, continued taking heroin and also, for the first time, methadone as a substitute. He took some methadone with him when he fled to Europe, where some months after arriving in Hamburg he relapsed and came to our clinic and asked for treatment.

This history has pretty much all the elements that are associated with the topic flight from the Near and Middle East conflicts in conjunction with opioid dependence: violence, tyranny, expulsion, war wounds, a high prevalence of opium-theriac-heroin use in the country of origin, self-medication, poverty, low education, torn families, life-threatening emergency routes and uprooting. Every detail is, in itself, a risk factor for the development of a substance use disorder.

What do we need to be able to help these people? Can we manage that?

In Altona, Hamburg, where I work, for almost 25 years there has been a central substitution clinic in the town, where currently around 700 patients are treated. Since the early 1990s, we have seen patients from over 50 countries. Migrants and the special group of asylum seekers from Afghanistan, Iran and Turkey were already among the first patients: A former major from the Royal Afghan Air Force, a colonel of the Imperial Iranian Army, partisans from the mountains of Kurdistan, fugitive oppositionists before and since the Islamic Revolution in Iran – all of the political unrest in these countries led to new refugees in Hamburg, many of whom with an opioid problem turned up at our place sooner or later. In the 1990ies, the refugees came from the Balkan wars and from the conflicts in the former republics of the USSR in the Caucasus.
We have been able to admit and treat these patients, they have been able to use the health care system, many have been able to establish new roots, have reunited their families, taken up their old profession or a new one and have become members of their communities in Hamburg, of which those from Afghanistan and Iran are among the largest in Europe. But some of them have really fallen on hard times in exile, are impoverished, have developed severe psychosis or suffer from depression or perished because of uprooting, poverty, physical diseases or drugs.

What we have been experiencing since summer 2015 has another dimension: From January 2015 to August 2016, one million people applied for asylum in Germany: Two

out of three refugees in Germany are from Syria, Iraq, Iran and Afghanistan. Among them are many men who already grew up in their home countries in a pronounced opium/theriac/heroin culture.

In large parts of Afghanistan there are no alternatives to opium / theriac as a medical drug for soothing teething pain, diarrhoea, coughing and pain. In the wake of military conflicts since 1979, and particularly since 2001, the number of heroin consumers has also been rising steadily. A prevalence of more than 5 per cent is assumed.

Among Iranian patients there is usually an uncle or cousin in the family history who "brings shame on the family" because of his opium consumption, or a grandmother who drinks an evening tea with theriac at bedtime, sometimes even in the morning to ease joint pain. According to UNODC, there are over one million opioid dependents in the country (2.26% of the adult population). Methamphetamine use is also widespread and the Islamic Republic faces a drinking problem as well.

The Syrian patients bring with them harmful patterns of consumption of tramadol and captagon / fenetylline (an amphetamine derivative).

In Iraq, the use of alcohol, amphetamines, sedatives and opioids has skyrocketed since the fall of Saddam Hussein.

Reliable figures are only available from Tehran.

Millions of people worldwide are on the run nationally or have found refuge in other countries. Forced migration due to war, genocide and famine is one of the biggest humanitarian crisis of the 20th and 21st century. To my surprise, in pubmed there are just a few dozen publications on the keywords "migration" and "substance abuse". Most studies have been published on migrants from Mexico to the US, a few focus on IDP - internally displaced people in Southeast Asia, on migrant workers in China or on the refugees from Bhutan in Nepalese camps.

Even in naming this group of patients, there is confusion:

People with a migration background (MB or PMB)
Foreign-born people (FBP)
First generation migrants (FGM)
Flight and migration are risk factors for the development of substance use disorders (SUD) , often accompanied by or based on psychological disorders, such as

Depression, MDE - Major Depressive Episodes

PTSD - Trauma exposure

Suicidal Ideation

First episode psychosis (FEP)

Problematic gambling

Younger age at immigration is associated with increased risk of mood disorders, anxiety disorder or SUD, which may "lead to the adoption of local consumption patterns", as it is said in one of the rare publications.

Physical suffering among refugees associated with substance use disorders manifests as:

TBC (pre-migration and reactivating factors, MDR-TB)

Hepatitis B

HIV and Hepatitis C

Battlefield injuries and torture sequelae

Miserable dental status

Skin problems by poor hygiene on the run or - a special case - leishmaniasis (Aleppo boil)

Malnutrition

How do we cope with these challenges?

The city of Hamburg responded quickly in 2015, setting up a model system for those admitted here. This includes, among other things, the setting up of consultation hours in the reception centres. Drug cabinets have been set up according to the recommendations of MSF - Médecins Sans Frontières. A uniform screening takes place, special offers are reserved for children and women. Refugees obtain an insurance card in a short time giving access to the outpatient and inpatient health care system. And what's more: a monthly pass for public transport.

The public health service is responsible for this programme, and a large number of volunteers from various health professions are also involved, aid agencies have set up reception centres, the chambers of physicians and dentists offer courses and indicate specialised doctor's offices, the tropical medicine department of the University Hospital has expanded their outpatient-clinic, and much more.

The ASKLEPIOS clinic for Substance Use disorders, my employer, is doubly challenged: Patients made themselves known since summer 2015 in the inpatient department for detoxification from various substances, mostly opioids. Initially, however, an outpatient treatment was almost impossible, substitution treatment by no means. That led to a revolving-door-effect. This has changed: In the clinic there are now once weekly patient

appointments with interpreters for Farsi and Dari, two to four beds are constantly reserved for patients from Iran and Afghanistan. In the central psychiatric emergency department, a laptop is on 24 hours a day for use as a translation help via Skype.

Since last summer in the Altona ost-clinic, we admitted about a dozen new patients from this group for opioid substitution treatment.

Other institutions have also been adjusting to the new situation: In the central consumption room of the city there is a doctor colleague from Afghanistan working on an hourly basis.

The substance abuse prevention system of the city of Hamburg, in which more than a quarter of the population has an immigrant background, has for several years been training "key persons" who, operating in their native language, explain in the various ethnic communities about dependence risks, SUD and access to the help system.

The police carefully notes that a new consumer and small peddlers group is forming with Iranian-Afghan background. In the clinic, we admit patients from these two countries who are already heavily in debt by drug-related crime and vulnerable to being pressed into further illegal activities. It is feared that within this group drug criminal structures will be formed; sooner or later there will be direct trade routes from the "Golden Crescent", the main poppy-growing area: This is equally a law of opioid addiction as the drug economy. The police and the healthcare sector face a difficult task that requires close cooperation.

Hamburg is a rich metropolitan area with international links and with a variety of immigrant cultures. Undoubtedly, the city that is both municipality and federal state offers better conditions in substance use disorders than most of the over 400 counties in Germany.

In other parts of Germany are already problems with the insurance status of refugees in the first months: Only a few federal states have unbureaucratically taken these patients into the public health insurance system; often the new arrivals receive the so-called emergency certificates for a long time that give treatment entitlement for acute illnesses and only in exceptional cases entitlement for chronic ones. It is clear that untreated chronic diseases soon cause acute complications, but the cash-strapped local authorities are afraid they cannot afford this financial challenge. This is unfair, and by the way also a naïve assumption.

What is generally true for medical care also applies to the field of SUDs: acute intoxication or states of withdrawal can be treated. The follow up treatment often fails for logistical reasons, since neither adequate outpatient treatment, let alone translation aids are available. The treatment of opioid dependence is anyway limited in some regions of Germany – how patients from these countries are to gain access to it, I do not know.

We must assume that the issue of migration and SUDs will still greatly occupy us in the coming years. As well as the causes brought along for developing a Substance Use Disorder, further immigration stressors come into play, such as cultural stress and discrimination.

Large groups of immigrants are a challenge for any society: politically, economically, and culturally. In addiction medicine I see a number of questions and tasks that that are presumably not only a challenge in Germany:

- Can we manage to gain transcultural competence in treating refugees? Should there be standard intercultural teams for addiction medicine?

- When is it the right time to take a detailed medical history of traumatic experiences? How can we bring trauma therapy and addiction medicine together?

- How can alcohol prevention be operated under Muslim immigrants in a country with a pronounced alcohol culture?

- How can we reach the female refugees from these countries with a substance problem?

- In the context of migration, should integration be defined as the 5th pillar of drug policy?

- How can we contribute to the integration of refugees / immigrants? What can research contribute?

- Are the supranational organisations putting the topic on their agenda?

- Is global addiction medicine ready to take a stand on the topic? Should we develop recommendations, guidelines and best practice models for treating refugees in addiction medicine?

- Are right wing populist circles gaining such a strong political influence that social policy, integration and harm reduction will be bled dry by it?

Can we manage to achieve this?

Thank you very much for your attention.

This was first presented at the 12th Global Addiction Conference in Venice October 3rd 2016.

We would welcome your thoughts, comments or answers to any of the questions above that Hans-Guenter presents above.