REVISTA DE PSIQUIATRÍA
INFANTO-JUVENIL
Número 3/2012
Julio - Septiembre

Artículo Original

Victor G. Carrion, M.D; Daryn Reicherter, M.D; Alexandra Aylward, B.A; Jayne Fleming, J.D; Holly Cooper, J.D; Dina Frid, M.D; Parisa Ijadi-Maghsoodi, J.D. and Suzan Song, M.D.

Construcción de un modelo de intervención médico-legal efectivo tras el terremoto en Haití

Building an Effective Medico-Legal Intervention Model in post-Earthquake Haiti

ABSTRACT

The earthquake that struck Haiti on January 12, 2010 left the country and its people devastated, with overwhelming losses, death, homelessness and increased violence and safety concerns. This study proposes an effective intervention model for facilitating humanitarian parole for survivors of the earthquake. A medico-legal team of psychiatrists and human rights and immigration evaluated traumatized individuals and families in Port-au-Prince in March 2010. With support from local NGOs, the legal team screened and prioritized the most severe cases, and the medical team assessed individuals with acute medical and psychiatric concerns. 124 cases were screened for humanitarian parole. Psychological, psychiatric and medical assessments were completed in 48 families (68 individuals) to identify orphans and vulnerable children, survivors of past violence who faced a risk of re-traumatization, and those at high-risk of psychological trauma. All cases needed shelter, clean water and food. Mental health impairment beyond loss and grief were identified in 89.7% of cases. Our findings suggest that a multi-disciplinary, community-based model is effective in identifying individuals and families that meet the conceptual criteria for Humanitarian Parole. The model is also effective in identifying the psychosocial and medical needs of survivors and assisting them in receiving essential health services.

RESUMEN

El terremoto que azotó Haití el 12 de Enero de 2010 dejó devastados al país y a su gente, con abrumadoras preocupaciones en torno a la pérdida, la muerte, el aumento de la violencia y la seguridad. Este estudio propone un modelo de intervención efectivo para proporcionar refugio humanitario en EE.UU. a los supervivientes del terremoto. Un equipo médico-legal de psiquiatras, personal de inmigración, y de derechos humanos, evaluó a los individuos traumatizados y a sus familias en Puerto Príncipe en Marzo de 2010. con el apoyo de ONGs locales, el equipo legal valoró y priorizó los casos más graves, y el equipo médico evaluó a los individuos con problemas médicos y psiquiátricos. Se seleccionaron 124 casos para proporcionarles refugio humanitario en EE.UU. Se completaron las valoraciones psicológica, psiquiátrica y médica en 48 familias (68 individuos), con el fin de identificar niños huérfanos y vulnerables, supervivientes de violencia pasada con riesgo de nueva traumatización, y persona de alto riesgo de trauma psi-

cológico. Todos los casos necesitaban albergue, agua limpia y comida. Se identificó desajuste mental más allá del propio de la pérdida y el duelo en un 89,7% de los casos. Nuestros hallazgos sugieren que un modelo multidisciplinar, basado en la comunidad, es efectivo para identidicar las necesidades psicológicas y médicas de los supervivientes y asistirles para recibir sevicios sanitarios esenciales.

Nota: *se ha traducido como "refugio humanitario en EE.UU." el término "humanitarian parole", utilizado por el Servicio de Inmigración de Estados Unidos para referirse al permiso temporal para entrar en EE.UU. dado a una persona por razones humanitarias, y que de otro modo no se le daría.*

INTRODUCTION

On January 12, 2010, a catastrophic earthquake of 7.0 Mw magnitude had an epicenter about 16 miles west of Port-au-Prince, Haiti's capital1. Within two weeks, at least 52 aftershocks measuring 4.5 or greater were recorded[2]. An estimated 3 million people were affected, with more than 200,000 deaths estimated, 300,000 injured, and 1,000,000 becoming homeless[3]. This was the biggest disaster in Haiti in more than 200 years4. In a matter of seconds many Haitians lost the protection and safety that they had found in their homes: safety that was valued by a country that had experienced multiple periods of socio-political turmoil marked by violence, terrorism, and gender-based violence[5].

On January 18, 2010, Secretary Janet Napolitano announced that the Department of Homeland Security (DHS) would extend humanitarian parole to Haitian orphans who were already in the process of being adopted by United States citizens prior to the earthquake and others who could demonstrate compelling circumstances justifying their evacuation to the United States[6]. Pursuant to 8 U.S.C.S. § 1182(d)(5), the Secretary of Homeland Security has the authority to allow noncitizens into the United States on a temporary and case-by-case basis for "urgent humanitarian reasons or significant public benefit7." Such parole does not constitute permanent admission to the United States and when the purposes of the parole have been served, the noncitizen must return to his or her country of origin[7,8]. An individual can be paroled into the United States only if "compelling reasons in the public interest with respect to that particular alien require that the alien be paroled into the U.S. rather than be admitted as a refugee[7]".

Humanitarian parole may arise in cases involving the need for family reunification or when a noncitizen with a serious medical condition needs to enter the United States for treatment[8]. To request humanitarian parole, the prospective parolee must complete an application form (Form I-131), specify the length of time parole is sought, and if the parole is for medical reasons, provide evidence in support of the medical condition[8]. The request must also contain supporting information from a fiscal sponsor in the United States[8]. In reviewing medical requests, factors taken into consideration include the nature and severity of the medical condition, whether the requested treatment is available in the home or neighboring country, the medical verification of the need of the prospective parolee, and proof that a hospital in the United States has agreed to providing the care for free[9]. From the policy's initiation on January 18, 2010 until its close on April 14, 2010, the U.S. Citizenship and Immigration Services (USCIS) authorized parole for more than 1,000 orphans under the special program[10].

In addition to being used in individual cases, the United States has invoked humanitarian parole throughout its history to assist populations fleeing persecution and tragedy[11]. In 1956, President Eisenhower invoked the provision to temporarily admit 15,000 Hungarians escaping from communism[11,12]. Since then, the United States has granted humanitarian parole for Cubans seeking refuge, Indochinese fleeing after the Vietnam War, and numerous others from China, Iraq, El Salvador, India, Iran and Lebanon13. Despite Haiti's history of internal turmoil and violence, in the last decade, Haiti has had the lowest rate of approval of the 11 foreign nations with the most humanitarian parole applications, an 8% approval rate; 92% denial rate[9].

In order to put the humanitarian parole benefit into effect, a group of three immigration and human rights lawyers created a medical-legal team to travel to Haiti and initiate the petition process for individuals and families who could benefit from humanitarian parole status. The group also included four psychiatrists, one Haitian medical student who served as an interpreter, and a journalist from the San Francisco Bay Area. Relationships were established with community-based organizations that identified vulnerable individuals and families. In this article, we describe our intervention, its implementation, and our

findings. We also offer suggestions on how to improve the model and discuss the need for replication.

METHODS

Participants

We identified 124 families through the community-based organizations, Avocats Internationaux (BAI), KOFAVIV and FAVILEK (grassroots women's organizations in Haiti), based on the following criteria: a) identified as more vulnerable than the general population; b) had acute needs beyond those experienced by the general population; and c) lived in extreme poverty. Examples include orphans and vulnerable children, victims of violence, homeless individuals and families, individuals with acute medical needs that cannot be treated in Haiti, elders without caretakers, widows with small children, pregnant women, disabled individuals, young girls vulnerable to or survivors of sexual violence, and survivors of prior trauma.

We subsequently medically evaluated 48 families (68 individuals) to identify orphans and vulnerable children, survivors of past violence who faced a risk of re-traumatization, and those at high-risk of psychological trauma.

Components of Model

Human rights lawyers and medical doctors with expertise in psychiatry were selected as team members based on their extensive experience working with trauma survivors, displaced persons, refugees and other highly vulnerable groups. All team leaders had worked with survivors of torture, persecution, trauma and displacement for over a decade. The medical team leaders had worked in post-disaster and post-conflict situations and the legal team members all had expertise in international human rights law. The US based medico-legal team worked in conjunction with a Haitian based human rights organization and Haitian based staff who served as interpreters. The health care providers' roles were to assess the medical/psychiatric issues of clients, determine the level of severity of medical and psychiatric pathology, and recommend appropriate interventions. Often these treatment recommendations were not available in Haiti, but were essential, and would become part of the argument for Humanitarian Parole. The acuity of the psychiatric and medical conditions and lack of resources to address treatment would add to the legal argument for parole.

Procedure

A three-stage process was developed that included screening for individuals who may fulfill criteria for potential humanitarian parole and for those requiring medical and/or psychiatric assessments as part of their parole application. In stage 1, the local NGO partners identified their "worst cases." American attorneys then screened these cases for agreement of validity and to determine if they had a strong legal case. Stage 2 included the medical and psychiatric evaluations of cases that the attorneys had determined to be the most extreme and the most likely to suffer acute medical and psychiatric pathology. In stage 3, the attorneys prioritized cases based on severity of risk and began preparing applications for Humanitarian Parole based on all the evidence collected.

RESULTS

Demographics

Of the 68 individuals interviewed, 48 (70.6%) were female and 20 (29.4%) were male. The interviewees ages ranged from 5 to 65 (M = 33.0, SD = 21.4). Of the 26.5% of the individuals under age 18, four had no adult caretakers. Additionally, there were four young adults (ages 18-24 years), taking care of young children.

Table 1. Psychosocial Needs of the families interviewed (N = 48).

Psychosocial Needs	Nº of Participants	Percent
Homeless	48	100
In need of a tent	36	57.9
Asking for safe shelter	47	97.1
In need of food	48	100

Medical, Psychosocial, and Psychiatric Needs

These forty-eight families (68 individuals) underwent medical evaluations. We assessed the psychosocial needs of each family unit (Table 1), psychiatric diagnoses (Table 2) and medical problems that required immediate emergency attention (Table 3) for each individual.

Table 2. Psychiatric Diagnoses (N = 68).

Psychiatric Diagnosis	Nº of Participants	Percent
PTSD	59	86.8
Traumas		
At least one prior trauma	19	27.9
Politically motivated GBV	8	11.8
Rape prior to the earthquake	13	19.1
Rape after the earthquake	8	11.8
Death and Loss	66	97.1
Depression MDD Depression NOS	37 30 7	54.4 44.1 10.3

PTSD = Posttraumatic stress disorder
MDD = Major depressive disorder
NOS = not otherwise specified
GBV = gender-based violence

All of the clients suffered multiple losses from the earthquake and were subsequently compromised psychosocially. Homelessness, hunger, and lack of security from violence and/or sexual violence were of paramount concern for most clients. Eight female clients had been raped after the earthquake and many were threatened with rape in the post-earthquake environment. All participants were homeless and in need of food and the vast majority (97.1%) were asking for safe shelter.

In regards to psychiatric diagnoses, nearly all met criteria for PTSD (86.8%) and almost half (44.1%) met criteria for depression. More than a quarter had experienced a severe trauma prior to the earthquake, and 97.1% had faced death and loss since the earthquake. Pain was the most common medical problem, affecting 39.7% of the sample. In addition, infections resulting from rape affected 62.5% of the victims and 37.5% were pregnant as a result of the rape.

The model enabled the teams to identify clients with a high need for emergent medical care and assist them in receiving essential medical services. Medical concerns ranged from traumatic injury incurred directly from the earthquake, to illness from exposure in the post-earthquake environment, to injury from assault and/or sexual violence after the earthquake. Medical needs varied widely, but were often urgent and previously inadequately addressed or unaddressed. Our team was able to identify two medical clinics run by Doctors without Borders where our subjects could receive immediate medical services.

Of the 48 families assessed by a medical doctor, 34 met the conceptual framework for Humanitarian Parole. All had compelling, urgent psychosocial needs. Most had severe medical and mental health impairment requiring urgent intervention.

DISCUSSION

Our findings suggest that a multi-disciplinary, community-based model is effective in identifying individuals and families that could benefit from humanitarian

Table 3. Medical Problems Requiring Emergent Attention (N = 68).

Variable	Nº of Participants	Percent
Rape after the earthquake		
[of those who were raped]: Pregnancy resulted	3	37.5
[of those who were raped]: Developed infections	5	62.5
[among the 48 women]: Excessive menstrual bleeding	4	8.3
[among the 48 women]: Urinary Tract Infections	3	6.3
Fractures	7	10.3
Pain	27	39.7
Dermatological	4	5.9
Cardiovascular	4	5.9
Peripheral Vascular Disease	6	8.8

parole. The model is also effective in identifying the psychosocial and medical needs of survivors after a disaster, such as the January 12 earthquake. The importance of our collaborative efforts with local, Haitian groups was critical as these efforts led to identification of individuals and families at high-risk. In addition, collaboration with local entities increased participants' sense of trust in a team that was inquiring about extremely personal information, such as their trauma histories. Prior research has demonstrated that involving culture-congruent staff in intervention teams provides subjects with more confidence in the process and higher feelings of safety when revealing personal information[14-16]. Furthermore, these collaborations allowed our team the opportunity to work with victims who had limited or no access to other earthquake relief services and would, therefore, receive more benefit from intervention and application for humanitarian parole.

Our findings demonstrate the severe impact of the earthquake in the families and individuals evaluated. These survivors were a severely traumatized group, and the traumatic experience from the earthquake caused or exacerbated severe psychiatric symptoms in most clients. The majority of adult clients assessed met full DSM-IV criteria for PTSD. Many adult clients also met DSM IV criteria for Major Depressive Disorder. All of the clients evaluated had serious psychiatric symptoms, regardless of whether they met full DSM IV criteria for a formal diagnosis. The psychiatric symptoms had severe impact on the functionality of clients generally, resulting in very poor adaptability and poor coping. Thirteen of the adult female clients were survivors of rape prior to the earthquake and eight were survivors of rape that occurred after the earthquake. Moreover, two women had experienced rapes both prior to and after the earthquake. All of the rape survivors met full DSM-IV criteria for PTSD. A major subset of the clients who were rape survivors were targeted politically and raped as a method of political terror. Their rape trauma was compounded by additional major violence against their families and continuing persecution after the initial violence. The traumatic experience from the earthquake and subsequent loss and stress from the conditions afterward were complicating factors on pre-existing PTSD in many cases. According to the Institute of Medicine[17], the compounding of traumatic experience combined with the unsafe living condition predicts for exaggerated symptoms and poorer functioning.

Limitations

The client data from this project was collected on a specific sub-population, and thus is likely not representative of the greater population of earthquake survivors because of the selection criteria that were imposed for screening and because of the partner organizations that were chosen to identify candidates. Clients were chosen by grass-roots Haitian non-governmental organizations (NGO's) with specific areas of concentration (for instance KOFAVIV is a partnering NGO with special interest in gender-based violence). The partner organizations were instructed to identify the individuals with the most severe need for inclusion. Additionally, the use of clinical evaluations for diagnoses rather than the use of structured instruments may have influenced the diagnoses. Due to the setting, the urgency of the work, and the need to maintain a flow of evaluations on a limited amount of time, the evaluators concentrated on the assessment of trauma and mood. Future research may prefer to use structured clinical evaluations, but given the circumstances, a semi-structured culturally adapted interview would be the most appropriate for the proposed model. At present there is no protocol accepted by the court as the standard for evaluations of this nature.

Future Improvements on the Model

This pilot projected relied heavily on the expertise of psychiatrists because of the focus on the mental health outcomes of traumatic experience in children and adults. However, we identify a need to strengthen the team by including other health care professionals for assessment and potential triage to provide urgent or emergency services. In particular, gynecology and a developmental pediatrics would be important disciplines to have represented for the needs of the clients seen in this sample. Another major area for improvement may be in improving resource linkage for clients that need immediate service and cannot wait for the humanitarian parole process. As these resources are exceedingly limited in poor countries, methods for expedient identification of resources, referral and transport need to be developed prior to a disaster.

Call to Action

The post-earthquake, humanitarian situation has be-

come worse since the initial visit by the medico-legal team in March 2010. Aid has not been distributed appropriately to those in greatest need. Furthermore, the lack of basic needs, including food, shelter, and security from violence, which have been persistent issues since the January 2010 disaster, compound medical and psychiatric problems[18]. These factors combine to create a continued and escalating call for humanitarian action. Clearly the magnitude of the situation is greater than what can be addressed through this mechanism alone, as Humanitarian Parole is only one potential option and will likely be reserved for those in greatest need. Nevertheless, this multi-disciplinary team approach is an effective method for identifying candidates that meet the conceptual criteria for Humanitarian Parole.

REFERENCES

1. "As it happened: Haiti Earthquake 13 Jan," BBC News, January 13, 2010.
2. Magnitude 7.0 - HAITI Region. US Geological Survey. January 12, 2010. (Accessed March 2, 2010, at http://earthquake.usgs.gov/earthquakes/eqinthenews/2010/us2010rja6/.)
3. M. Wooldridge, "Haiti Will Not Die, President Rene Preval Insists," BBC News. February 12, 2010.
4. S. Romero and M. Lacey, "Fierce Quake Devastates Haitian Capital," New York Times, January 12, 2010.
5. World Bank. Social Resilience and State Fragility in Haiti: A Country Social Analysis. Caribbean Country Management Unit, ESSD Sector Management Unit Report No. 36069-HT. Washington, D.C., 2006.
6. Secretary Napolitano announces Humanitarian Parole policy for certain Haitian orphans fact sheet. U.S. Citizenship and Immigration Services. January 18, 2010. (Accessed April 5, 2010, at http://www.dhs.gov/ynews/releases/pr_1263861907258.shtm.)
7. Homeland Security Act of 2002, Pub. L. No. 107-296, 116 Stat. 2135. INA § 212(d)(5), 8 U.S.C. § 1182(d)(5). (2002).
8. Checklist for Humanitarian Parole Requests, reprinted in 69 No. 34 Interpreter Releases 1099, 1111 (Sept. 4, 1992).
9. Government Accountability Office, GAO-08-282, Immigration Benefits: Internal Controls for Adjudicating Humanitarian Parole Cases Are Generally Effective, but Some Can Be Strengthened (Feb. 2008), available at www.gao.gov.
10. Special Humanitarian Parole Program for Haitian Orphans Draws to a Close at Request of Haitian Government. U.S. Citizenship and Immigration Services, 2010, available at <http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=dc4535f9b29d7210VgnVCM100000082ca60aRCRD&vgnextchannel=68439c7755cb9010VgnVCM10000045f3d6a1RCRD>.
11. A.B. Cox and C.M. Rodriguez, "The President and Immigration Law," Yale Law Journal, 119 (2009): 458.
12. Message from the President of the United States to the House of Representatives, 85th Cong., 103 Cong. Rec. 1355 (1957).
13. S. Song, "Haiti: Addressing Atrocities Following the Quake," Huffington Post, March 31, 2010.
14. D. Griner and T.B. Smith, "Culturally Adapted Mental Health Intervention: A Meta-Analytic Review," Psychotherapy: Theory/Research/Practice/Training, 43, no. 4 (2006): 531–548.
15. S. Sue, N. Zane, G.C.N. Hall, and L.K. Berger, "The Case for Cultural Competency in Psychotherapeutic Interventions," Annual Review of Psychology, 60 (2009): 10.1–10.24.
16. H. Ton, "Cultural and Ethnic Considerations in Disaster Psychiatry," American Psychiatric Association Committee on Psychiatric Dimensions of Disaster: Disaster Psychiatry Handbook, 2004:28-33, available at <http://www.psych.org/disaster-psych/pdfs/apadisasterhandbk.pdf>.
17. Institute of Medicine. Neurological, psychiatric, and developmental disorders: meeting the challenges in the developing world. Washington: National Academy Press, 2001.
18. Institute for Justice & Democracy in Haiti (IJDH) "We've been forgotten": Conditions in Haiti's displacement camps eight months after the earthquake (September 15, 2010), available at <www.ijdh.org/archives/14633>.