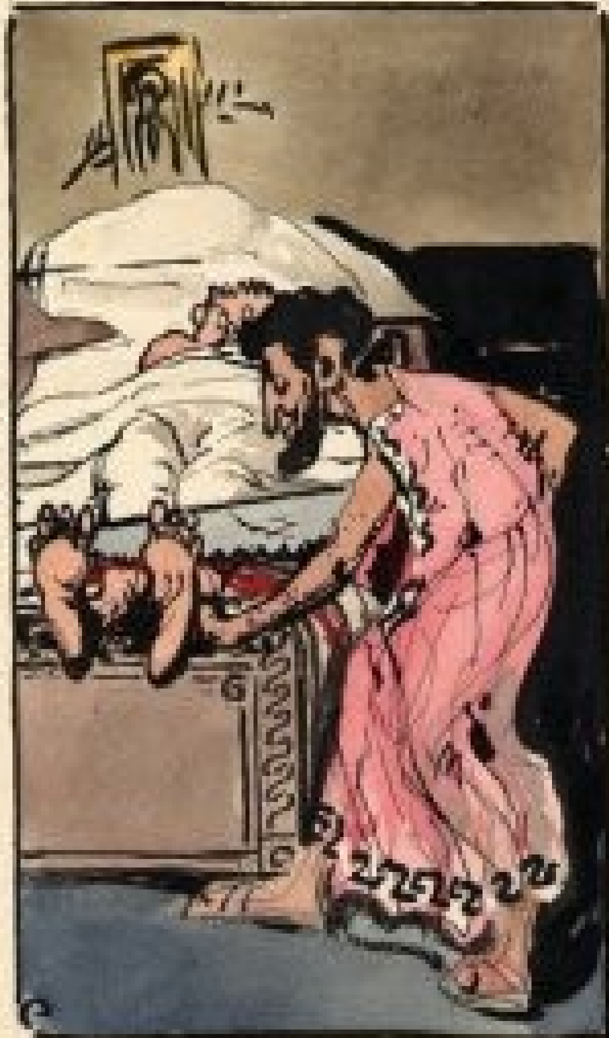
Mental Health and Psychosocial Services for Refugees (MHPSS) care for refugees: A Procrustean bed?

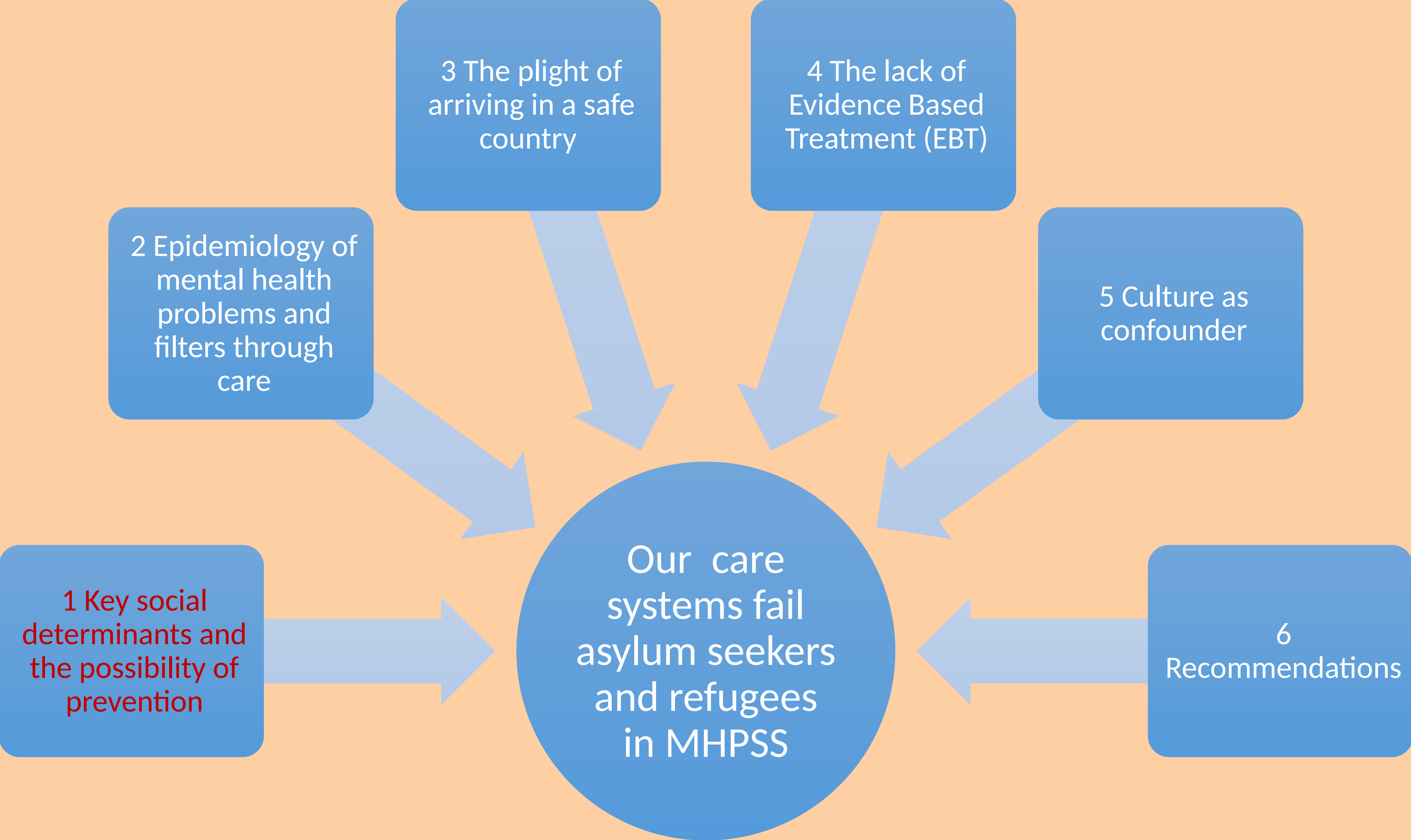
Joop de Jong

Procrustes' myth



- One size fits all
- 'All animals are equal'
- Squeezing life into preconceived ideas
- Proto-terrorist
- **Parallel myths asylum seekers & refugees:**
- Tailored care & equity

Outline talk



Because

1 Treatment figures show serious limitations

2 (Mental) health is strongly influenced by social conditions

Eg prevalence postnatal common mental disorder is 20%, determinants (low SES, unintended pregnancy, lack of partner support, IPV) increase in armed conflict
Fisher et al 2012 WHO Bulletin. Catani et al 2008 JMFT. Sriskandarajah et al 2015 BMC Psychiatry

3 Effective interventions are available →

IPV in S Africa, Uganda down with 50% Abramsky et al 2016 BMC Public Health

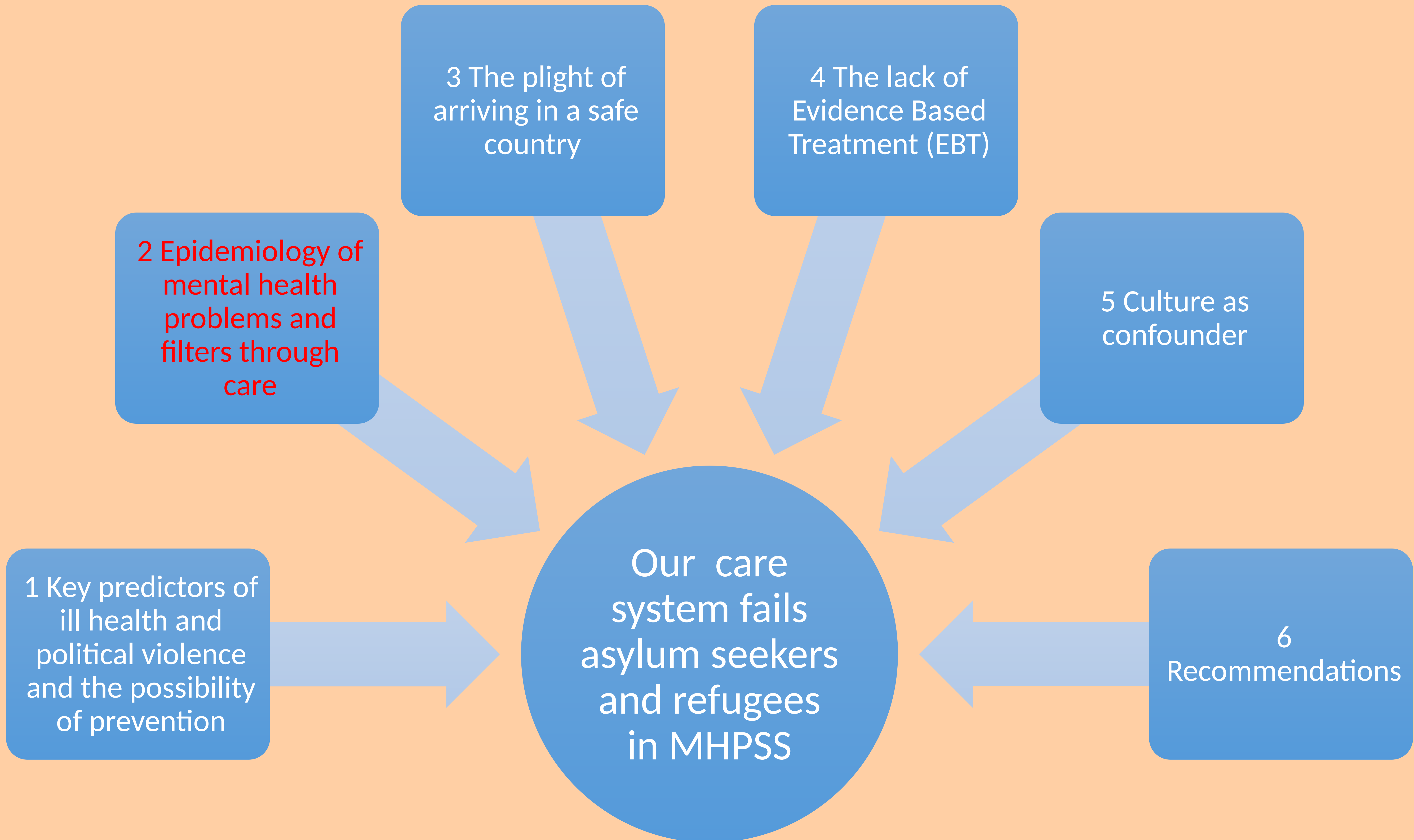
Poverty alleviation by unconditional cash transfer Kenya

Haushofer & Shapiro 2014. Lund et al 2007 Lancet

Protective and risk factors for healthy development refugee children helpful for universal prevention (blue) & selective prevention (red)

Protective factors child development	Risk factors child development
Social support and cohesion within family	Exposure extreme stress during and re-exposure after flight
	Unaccompanied, female
Decent accommodation	Repeated migration guest country
	Discrimination
Presence & wellbeing parents & parenting skills	Low SES family
	Solo parent
Positive experience school	Psychopathology parents & intergenerational transmission
	Nutritional deficiencies
Foster family & same ethnic background	Limited sport, movement

Outline talk



Prevalence rates Syrian refugees in camp and non-camp settings in Europe are similar to figures worldwide

- Depression 30% (10-50%) Steel et al 2009. Georgiadou et al 2018. Poole et al 2018
- PTSD 30% (25-35%) Steel et al 2009. Alpak et al 2015. Tinghog et al 2016
- Anxiety 13.5-92% Ben Farhat et al 2018. Georgiadou et al 2018
- <5% of those in need receive MHPSS → WHY ?

Explanation low treatment figures of refugees in HIC

- Health system factors

Arrival: screening TB, hepatitis, STD.

No good screener/ing MHPSS

Communication health professionals bad

Asylum seeker often transferred → increase of psychological problems youth

Does visit GP

Presents IOD, EMs, not depression/anxiety:

hard to recognize for GP!

GP often does not recognize MHPS:

1:6 refugees vs 1:2 indigenous patients

GP finds it hard to refer refugees to MHPSS:

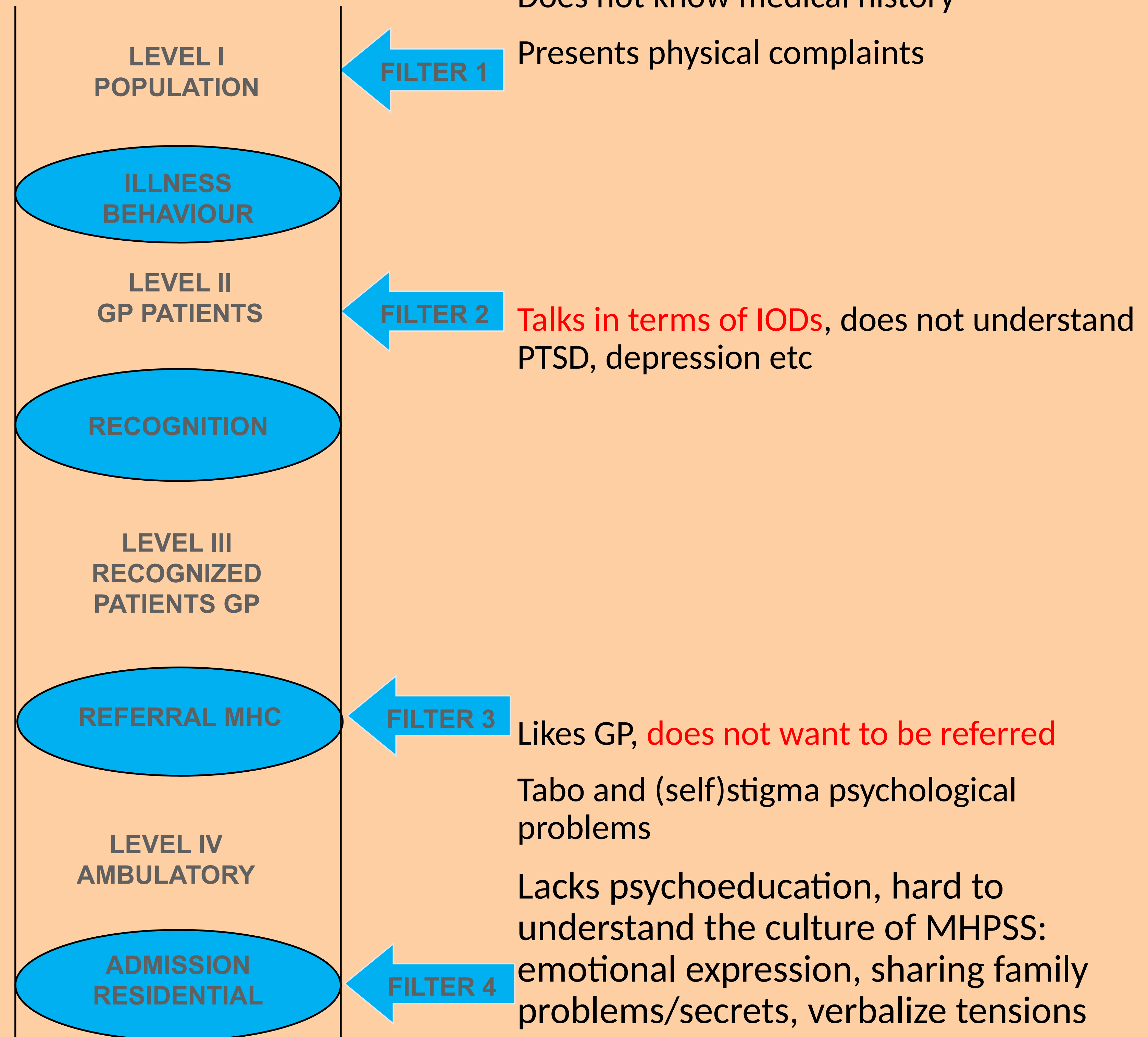
1:9 refugees vs 1:3 indigenous patients

Waiting lists → drop out

Lack of cultural competency, language barriers

Lack of interpreters

- Refugee/patient factors



Does not know medical history

Presents physical complaints

Talks in terms of IODs, does not understand PTSD, depression etc

Likes GP, does not want to be referred

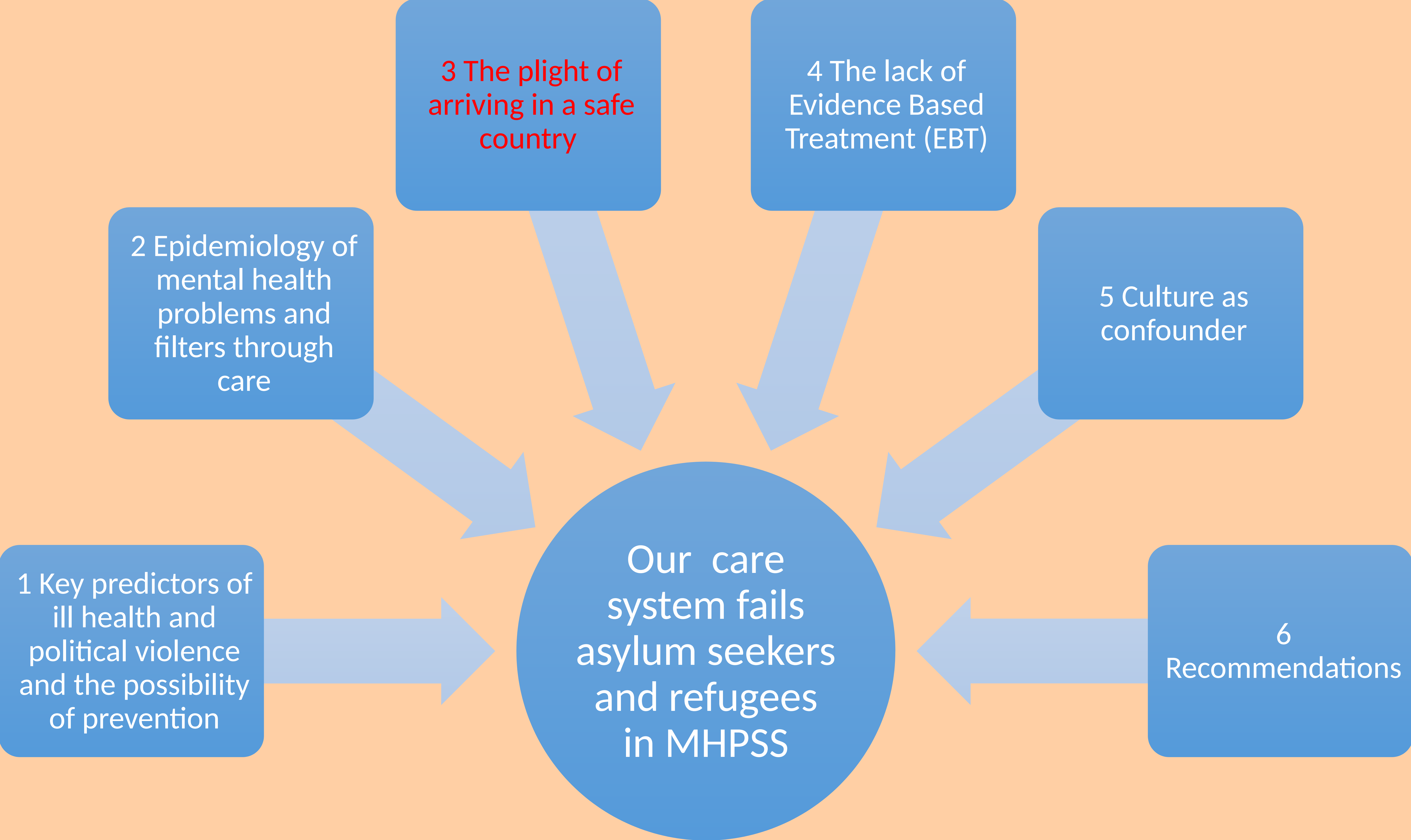
Tabo and (self)stigma psychological problems

Lacks psychoeducation, hard to understand the culture of MHPSS: emotional expression, sharing family problems/secrets, verbalize tensions

Mina Fazel talks at 12:30 about the prevalence of mental health problems in conflict zones in this venue, the Issam Fares hall

Rabih El Chammay will address the complexities of the Lebanese Mental Health System and its intersectoral approach at 12:30 in this venue, the Issam Fares hall

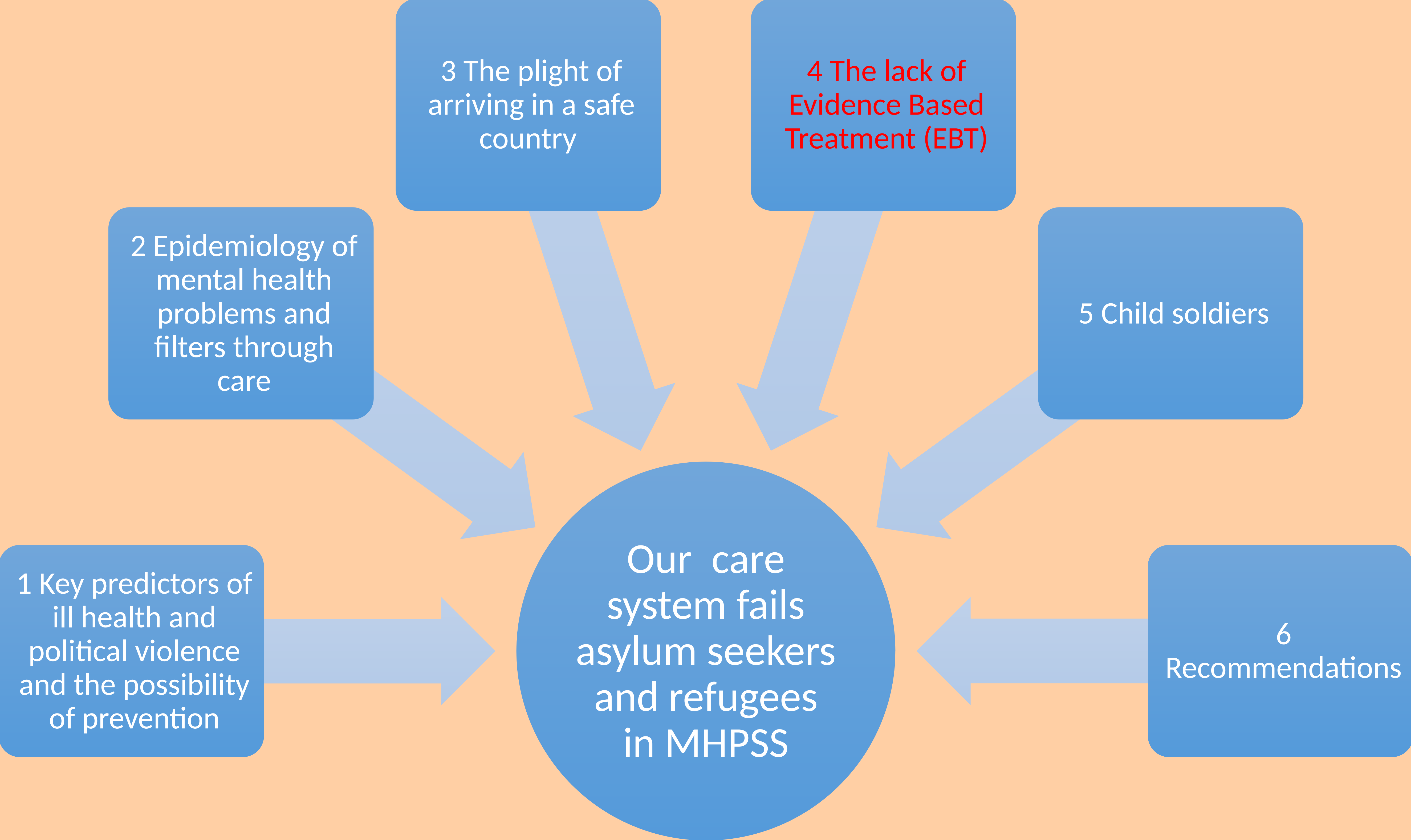
Outline talk



Plight of arriving in a new country

- Among adults: family problems, asylum procedures, lack of work show strongest relation psychopathology
  Laban CJ et al 2004 JNMD.. Laban CJ et al 2008 SPPE. Song et al 2017 JNMD
- Among refugee children: more than one dislocation/year doubles the rate of psychopathology
- Childhood adversities most important predictor PTSD, but more sensitive children show a stronger response to both negative and positive environmental experiences, more research needed cf Karam et al 2019 BJPsych
- After 15 yrs in reception country (NL), refugee children do almost as well as indigenous youth

Outline talk



World Health Organization Guidelines for Management of Acute Stress, PTSD, and Bereavement

Tol et al. 2014 PLOS Med

Mental health condition	Recommendation
Acute traumatic stress	CBT with a trauma focus (CBT-T) should be considered in adults Benzodiazepines or antidepressants should NOT be offered to adults and children
Insomnia	Relaxation techniques, NO benzodiazepines
Secondary nonorganic enuresis	No punitive responses, simple behavioral interventions
Hyperventilation	Paper bag should not be offered to children
PTSD	CBT-T, EMDR, stress management for adults & youth
	SSRIs and TCAs NOT first line treatment for adults & youth
Bereavement (without a mental disorder)	No structured psychological interventions, NO benzodiazepines

Scalable Interventions for refugees & other groups
Problem Management Plus (PM+) (adults) & EASE (youth)

- What
  - Problem-solving counselling (**problem management) plus,** behavioural strategies for stress management, behavioural activation, strengthening social supports
- Formats
  - 5 sessions individual and group face-to-face/app
- RCTs in Kenya, Pakistan, Nepal, 4 in Middle East, Europe
- Globally, 12 experimental studies in war, showing the need for multicomponent, multimodal and multisectorial interventions targeting ongoing stressors among and strengthening supportive resources in the family and community
- We need holistic, scalable, and sustainable programmes delivered by lay workers that consider and target the multiple risk factors affecting families in these settings

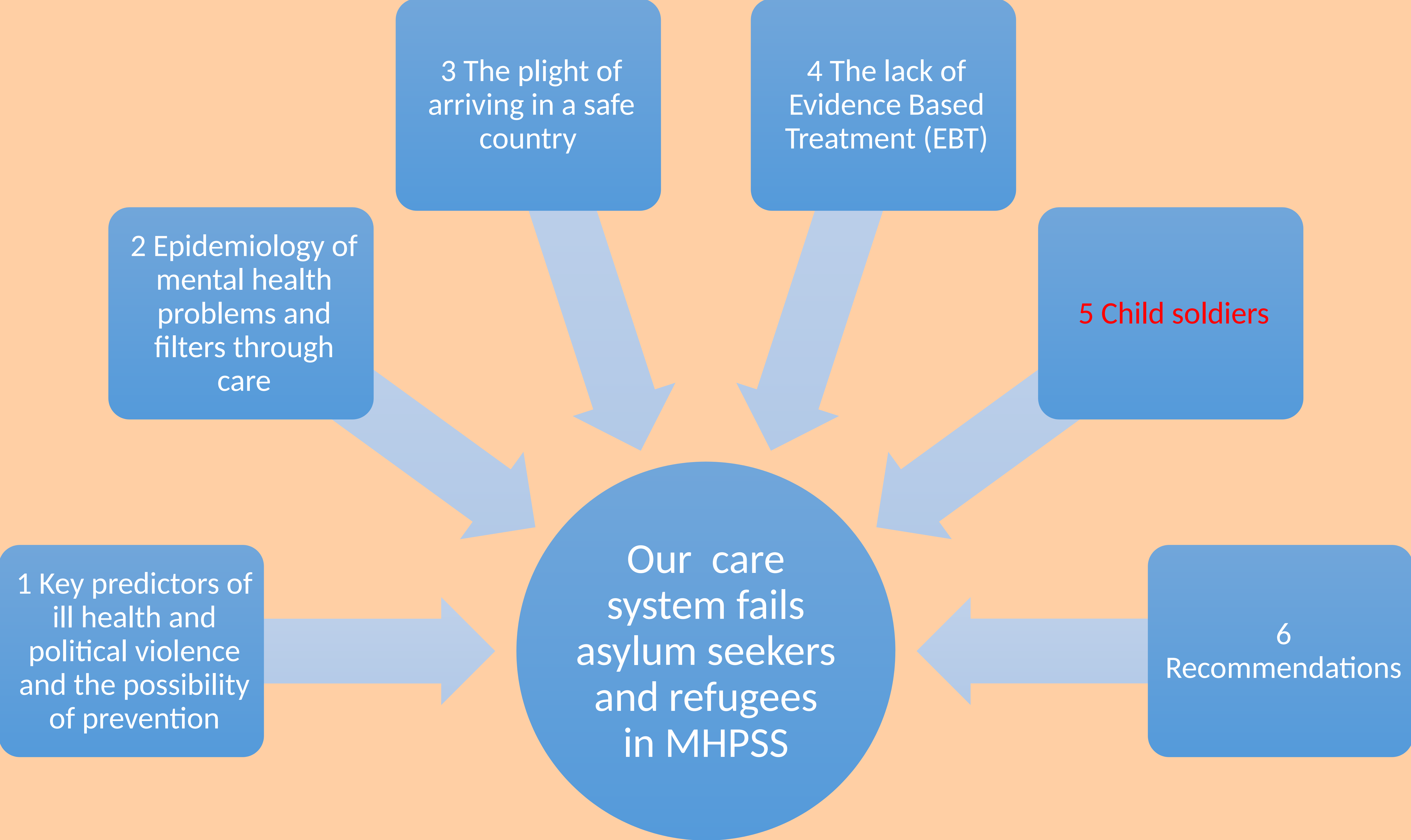
Sijbrandij et al. 2018,2019 EJTTS

Marit Sijbrandij 15:45 Westhall, auditorium A on (audio)tools in Arabic to assess distress and how to use them in MHPSS

The Multi-Family Approach (MFA

Betancourt et al. (2011), Chaudhury et al. (2016) studies in Rwanda on family-based prevention of mental health problems in children in HIV families affected, as well as on IPV.

Outline talk



Psychosocial Intervention for Ex-Combatants in Burundi: A Cluster RCT

Herman Ndayisaba

- **Methods:** A cluster RCT 384 ex-combatants with a psychosocial intervention or a waitlist control group. Baseline and post-intervention (16 months later)

- **Intervention:** Ten sessions of 10 ex-combatants per group aimed at discussing war events, narrative theatre, substance abuse, coping strategies, family problems & meetings with 3 different village groups

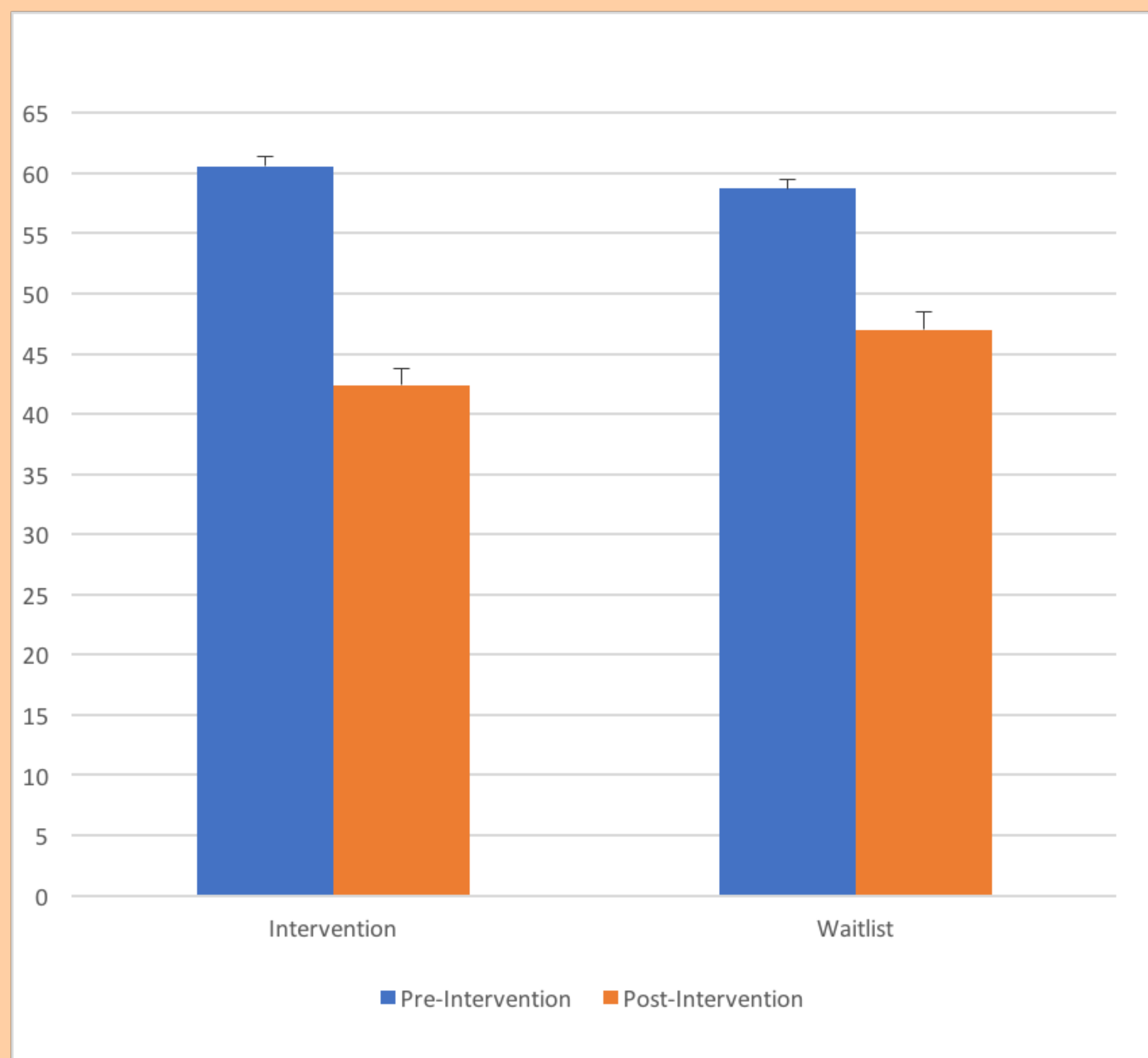
- **Measures:** PCL-C, PHQ-9, WHODAS 2.0, AUDIT, SW-4, Self-Efficacy Scale, SF-12, Everyday Discrimination Scale, Household questionnaire, CSQ-3

- Many child soldier studies, but not on ex-combatants in LMICs
- DDR programs for child soldiers typically comprise economic and education support packages Kohrt et al 2015
- Child soldiers have to be socially integrated within families and communities Jordans et al 2012. Betancourt et al 2013
- Among Colombian and Nepali child soldiers, feeling connected to the community, and hope for the future were strong predictors of functioning in school, work, and social activities among children exposed to political violence. Cortes & Buchanan, 2007

De Jong, Ndayisaba, Uppendahl, Sijbrandij in prep.

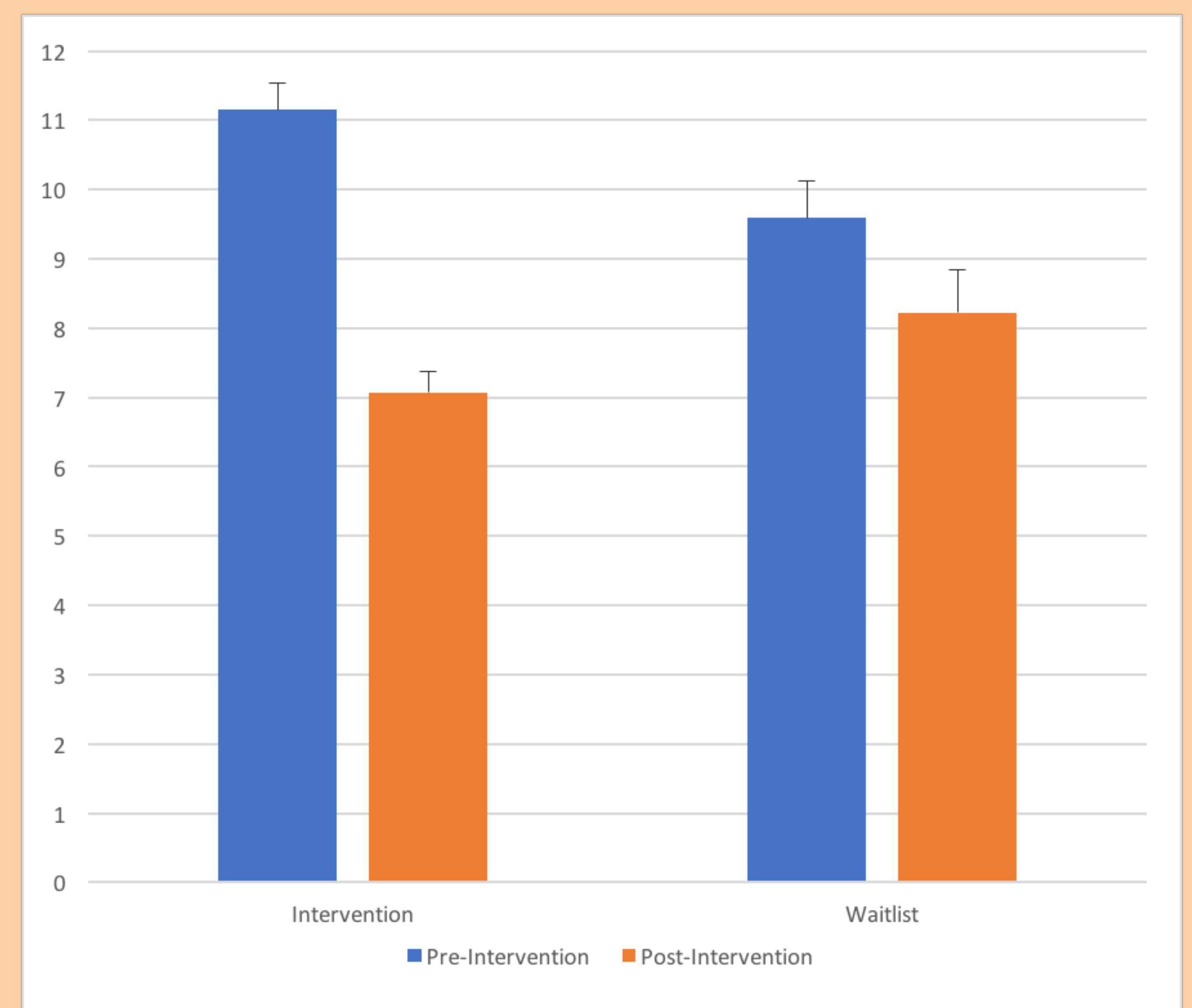
Outcomes

- PCL-C Scores



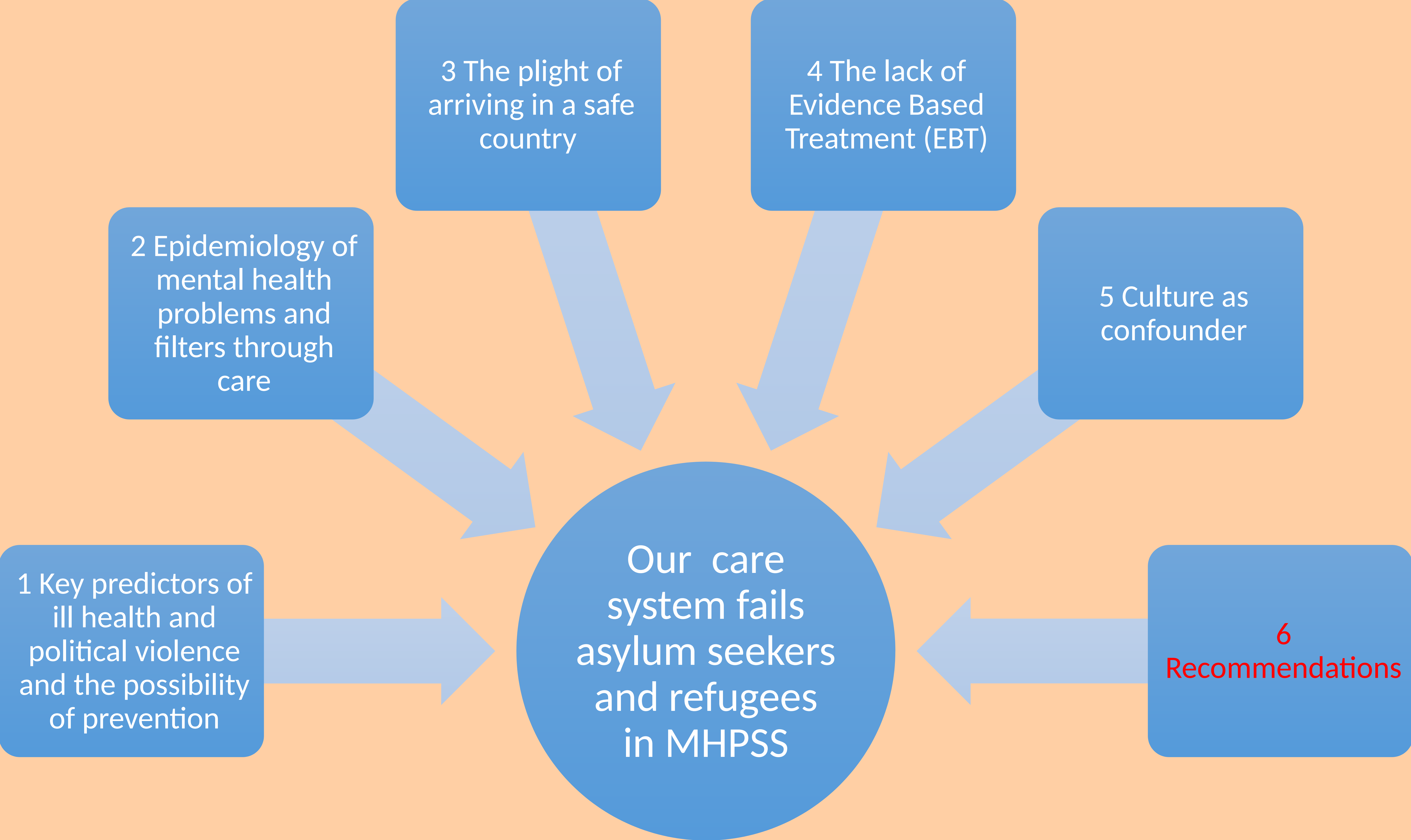
F(2,382)=23.310, p<0.001; R^2=0.108; *d*=0.236

- PHQ-9 Scores



F(2,382)=13.641, *p*<0.001; R^2=0.066; *d*=0.143

Outline talk



6 Recommendations: multilevel-multisectoral

- Get multisectoral. Active involvement ministries of health, education, labour, international collaboration instead of dependence on justice

- Early on participation, activation, integration, language acquisition (Dutch municipalities +)

- Professional interpreters initial phase

- More prevention and monitoring physical and mental problems

Best predictors well-being

- NEEDED
- Social support
- Proximity kin
- Lead normal life with perspectives on:
  - Jobs
  - Education

- REALIZED?
- AS dragged around the country, unable to build social network
- Family reunion allowed
- Not allowed even though employers ask for refugees
- Few opportunities for study & advanced education, despite shown needs

Vluchten
doe je niet
voor de lol !
Ik wil
gewoon
Toekoms

Summary

- The world can gain a lot with universal prevention regarding political violence and ill health
- Size of displaced people's burden is limited in the Netherlands
- GPs recognize psychological problems among asylum seekers and refugees 3 x less (1 in 6) and refer them 3 x less than the indigenous
- Long asylum procedures increase psychopathology with 50%
- We deny economic, social and cultural rights
- We have to do with a lack of culturally adapted and EBT
- Culture is a complicating factor for (mental) health professionals

Summary II

7 As

- Accessibility ±
- Availability ±
- Acceptability -
- Affordability +
- Adequacy in service design, implementation and evaluation -
- Awareness -
- Adaptability -

- Like Procrustes we seem to have two beds and standards
- We achieved a lot, but we can do much much better

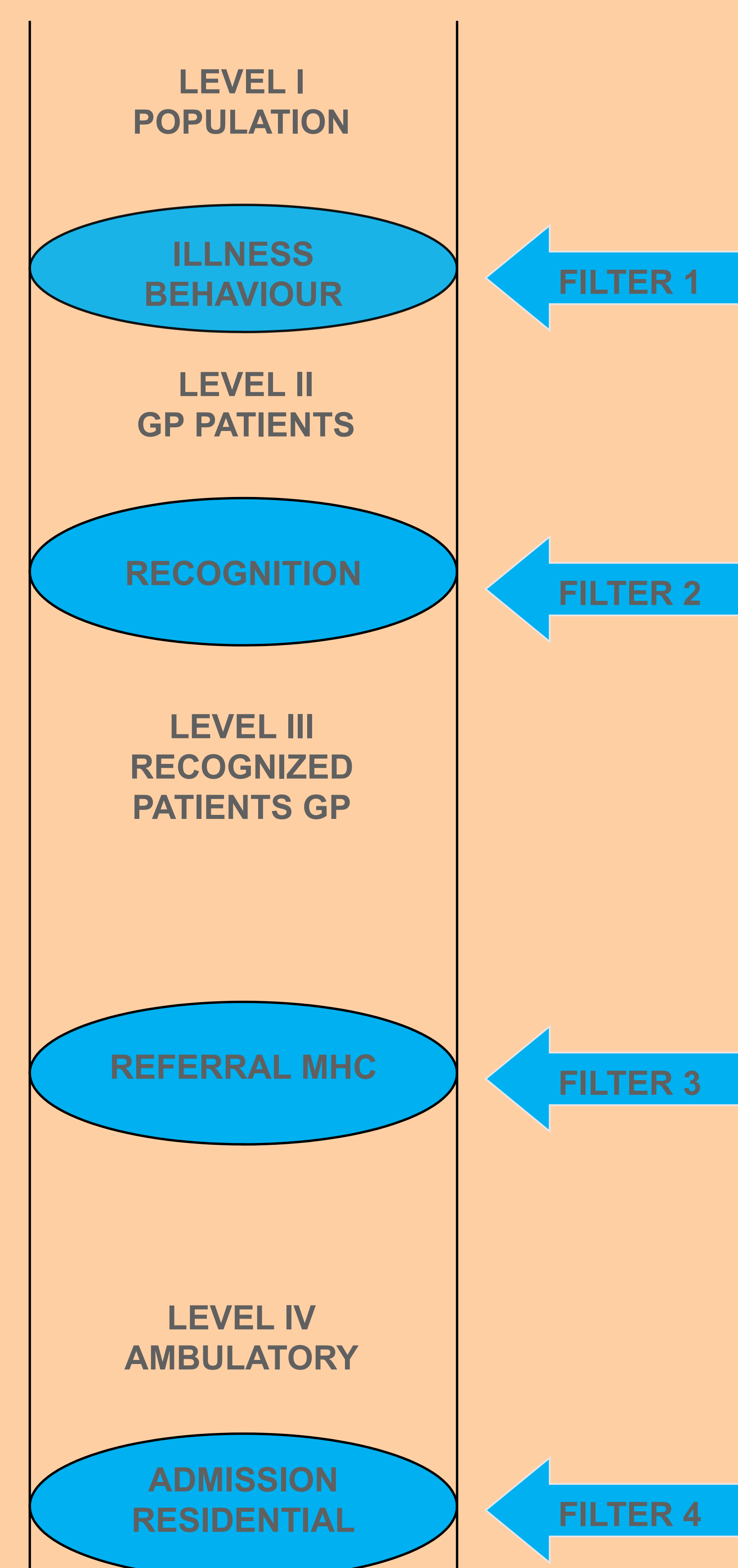
- Thank you for your attention

- If you want to receive a paper: jtvmdejong@gmail.com

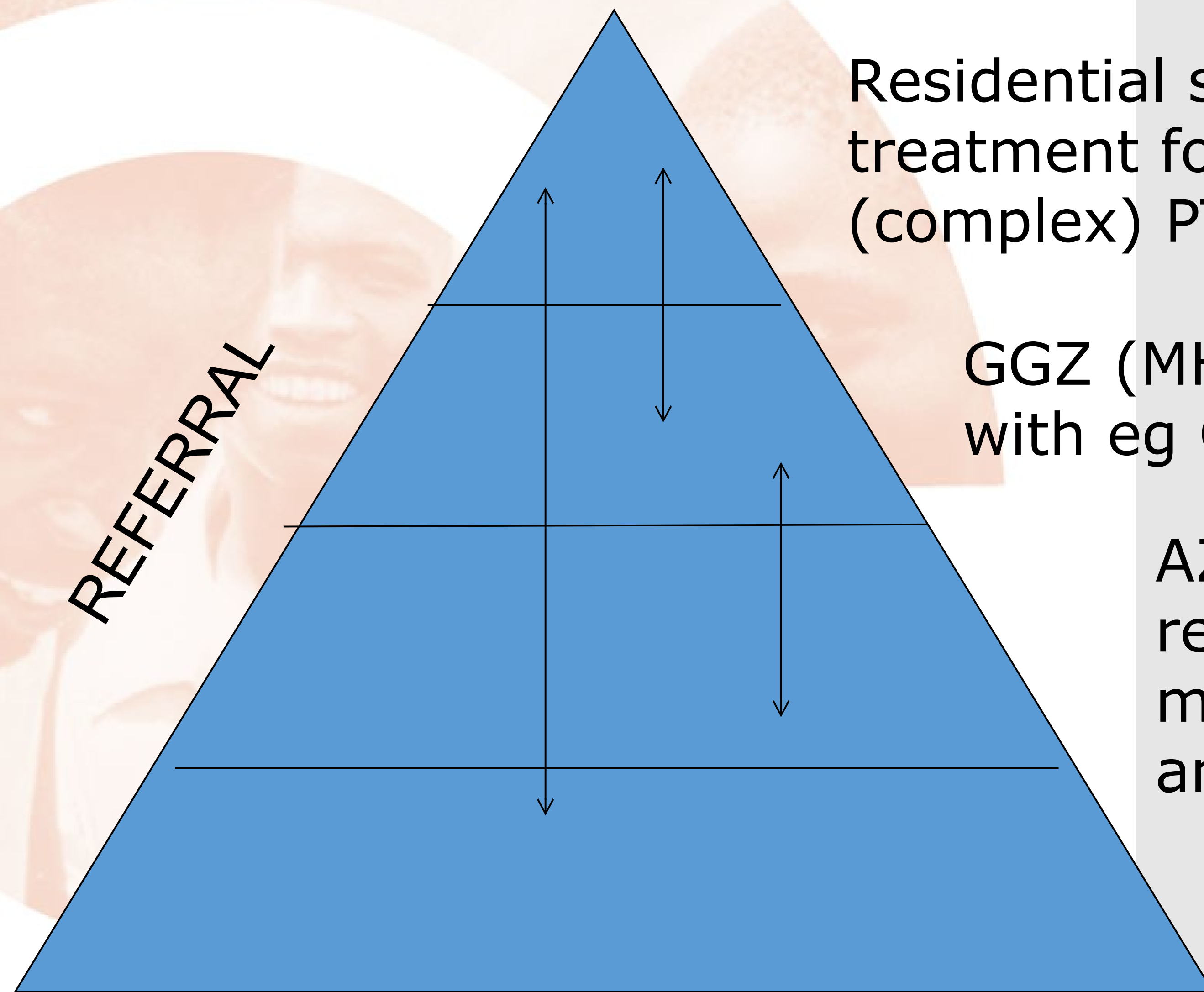
1 Common predictors of political violence & ill health and the possibility of prevention

Predictor	Consequences armed conflict	Consequences health
•Faulty governance/ Lack of democracy	•Human rights violation •Criminalization of the state •Faulty leadership/Corruption	• Lack of social justice • Low priority of health • Low government spending • Lack of health policy
•Inequality/inequity	•Widening socio-economic inequalities/struggle over access resources (oil, water)	• Impaired access to sanitation, health, education
•Marginalization of groups	•Political power exercised differentially applied according to ethnic or religious identity	• Differential access to services and differential outcomes for minorities, urban/rural residents/IDPs
•Lack of intersectoral collaboration	•Poor interaction international agencies, governments and ngo's; poor engagement in preventive, rehabilitative, and reconstructive interventions that may fuel cycles of violence	• Lack of interconnection (sub)national policies, inability to address crucial social determinants mostly located outside the health sector
•Health and nutritional indicators per se	•Important determinants of conflict onset	• Further deterioration of public health services and a vicious circle of reduced access to services and increased mortality and disability
• Daar ea 2007 Nature •Collins ea 2011 Nature	•Collier 2008 •WHO 2011 Social determinants public health •De Jong 2010 SSM	

1 yr Prevalence indigenous Dutch per 1000 inhabitants		1 yr Prevalence asylum seekers (AS)/refugees (R)/1000	
Depression	PTSD	Depression	PTSD
60	33	130-250	130-360
Filter 1 functions	Filter 1 functions	Filter 1 functions	Filter 1 functions
500	500	600-700	600-700
Filter 2 DS 0.50	Filter 2 DS 0.50	Filter 2 DS 0.16	Filter 2 DS 0.16
30	16	60	60
Filter 3 (35%)	Filter 3 (35%)	Filter 3 (11%)	Filter 3 (11%)
10	10	5-12	5-12



Outline care structure AS & R (in collective system)



Residential setting GGZ: specialized treatment for torture survivors with eg (complex) PTSD, psychosis

GGZ (MHPSS): treatment CMD & PTSD with eg CBT, EMDR, NET, drugs

AZC/GCA: PVK screens, advises or refers to GP. 1st line consultant mental health: screens, counsels and refers to GGZ (MHPSS)

GGD/PH: Screening asylum seekers including youth for CD

Epidemiology of help seeking in sum

- Prevalence among AS & R : Depression 2-4 higher, PTSD 4-10 times than indigenous Dutch
- More AS & R find their way to GP than indigenous Dutch
- GP recognizes 1 in 2 indigenous with psychological problems and 1 in 6 AS/R
- Indigenous Dutch reach GGZ/MHPSS 3 times more often than AS & R

What does this implicate for us?

	SOCIETY-AT-LARGE or (INTER)NATIONAL	COMMUNITY	FAMILY & INDIVIDUAL
PRIMARY PREVENTION to eliminate a disease or disorder state before it can occur	*Universal preventive interventions* *Economy, governance and early warning* *Free media and press* *Resolve underlying root causes of violence* *(Inter)national laws* *Defining and condemning human rights violations* *Research into events and their consequences* *Setting standards for intervention and training* *Expanding security institutions* *Military's role of last resort* *Reinforcing peace initiatives and conflict resolution* *Arms and landmine control* *Prevent the reemergence of violence* *Transnational collaborative projects* *Selective preventive interventions* *Humanitarian operations* *War tribunals and the persecution of perpetrators* *Peace-keeping forces* *Indicated preventive interventions* *Human rights advocacy*	*Universal and Selective preventive interventions* *Rural development and food production* *Community empowerment* *Decreasing dependency and learned helplessness* *Public health and education* *Peace education and conflict resolution in schools and the community* *Public (psycho-) education, community sensitization and awareness raising* *Security measures*	*Universal & Selective Interventions* *Include women and children in the distribution of economic growth* *Family reunion/family tracing* *Family/network building* *Improvement of physical aspects* *Resilience groups for children*
SECONDARY PREVENTION shorten the course of an illness or problem	*Humanitarian relief operations:* *shelter, food, water and sanitation* *(Co-occurring) Natural disasters: quality standards* *Voluntary repatriation* *Reparation and compensation*	*Conflict prevention & resolution* *Crisis intervention* *Vocational skills training*	*Recruitment of child soldiers* *Reparation and compensation for afflicted families* *Public health and disease control* *Mental health and psychosocial support (MHPSS)* *Crisis intervention*
TERTIARY PREVENTION reduce chronicity through the prevention of complications and through active rehabilitation	*Peace-keeping and peace-enforcing troops.* *Peace agreements*	*Reconciliation and mediation skills between groups*	*Involve the family in rehabilitation and reconstruction*

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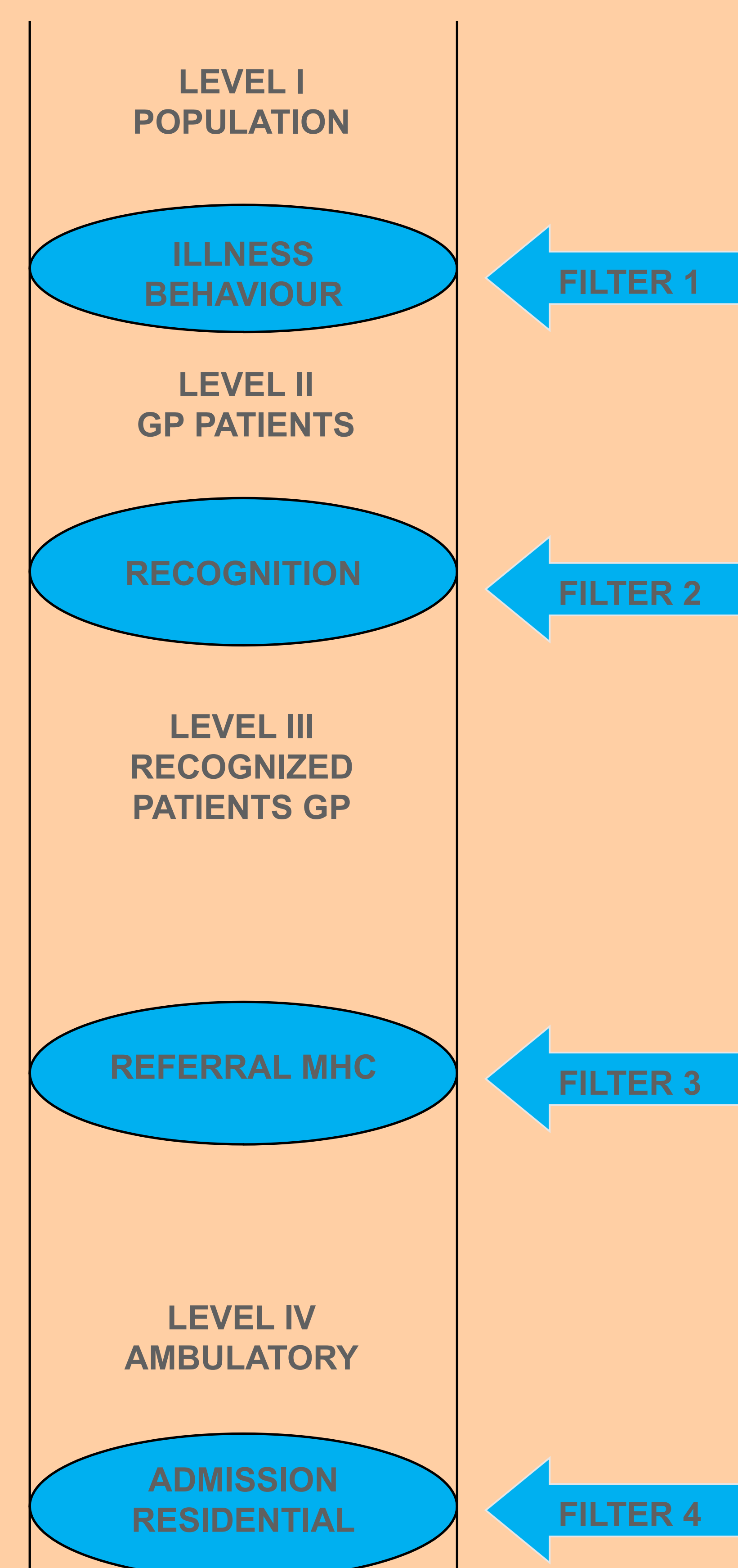


Specific physical morbidity and issues (im)migrants

- genetics/farmacokinetics
- depending on origin -> infections (tb, hepatitis B/C, STD)
- skin -> vit D shortage -> skin disease different
- cultural influence -> infibulation, circumcision
- sexual abuse, limited knowledge contraception ->
- not always easy for health personnel to discuss even though refugees want it
- inactive life conditions: overweight, DM, CV, arthrosis

Study Iraqi Asylum Seekers: Gr 2 > 2 yrs in the Netherlands and similar findings in California

Results

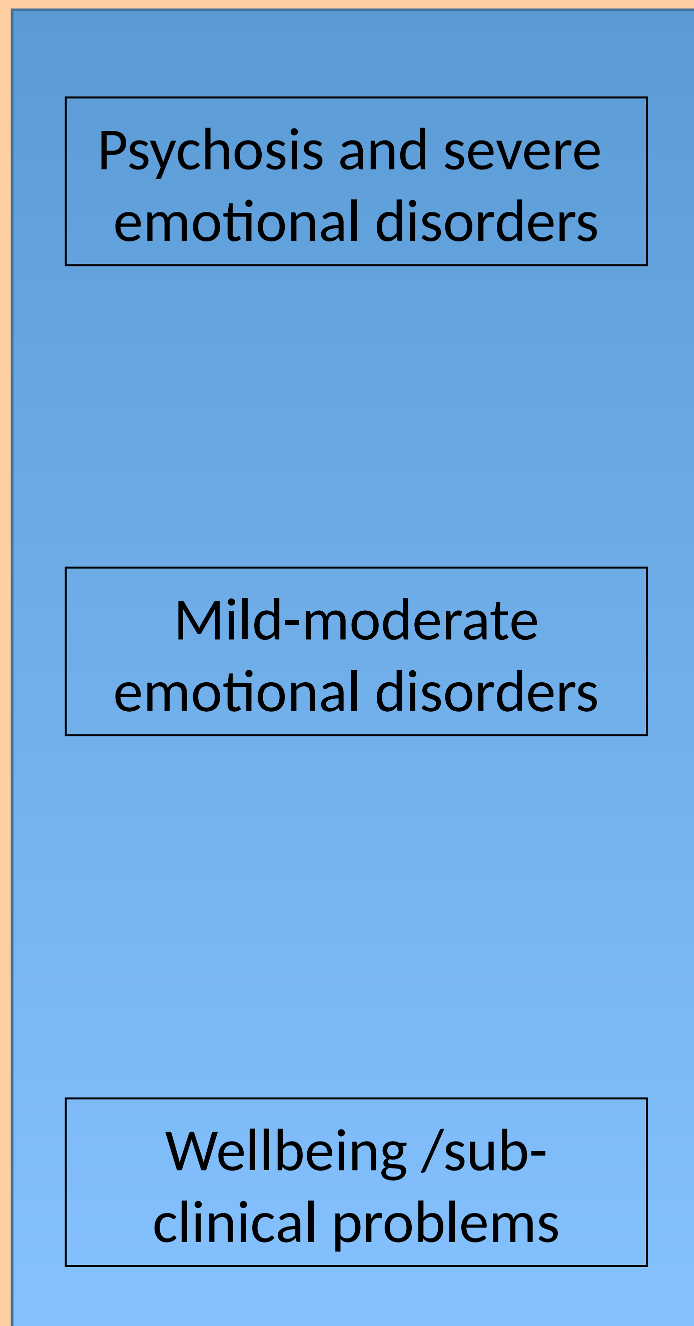
	Gr 1	Gr 2
One or more psychiatric disorder	**42.0%**	**66.2 %**
Overall Quality of life (mean)	2.88	2.23
Perceived Qol general health (mean)	3.06	2.74
Physical and Role Disability (mean)	17.31	19.25
Days of disability (mean)	5.37	7.68
Physical diseases (mean)	0.85	0.84
Physical complaints (mean) [5]	0.83	1.62

Laban CJ et al 2004 JNMD. Song et al 2017 JNMD. Laban CJ et al 2008 SPPE

Barriers to the mental health interventions for refugee populations

What is problematic with the existing evidence?

- Most evidence exists for PTSD by specialized professionals
- Often CMD, problems with daily tasks survival & recovery
- For scalability, interventions should be **short, simple**, to be carried out **in PC** or in **the community**
- Lack of family interventions
- The length of treatments difficult for AS & R
- Lack of adaptation to language & culture
- Limited knowledge MH & stigma among refugees
- Limited availability & capacity MH professionals to deliver specialized services when indicated

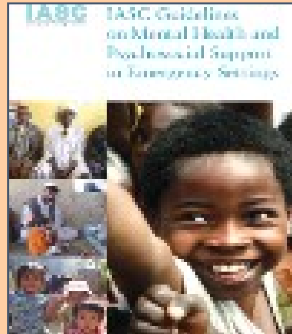


6.2 & 6.3 IASC guidelines

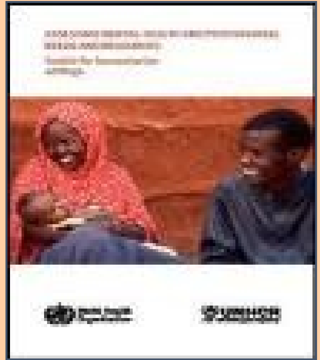
mhGAP-HIG

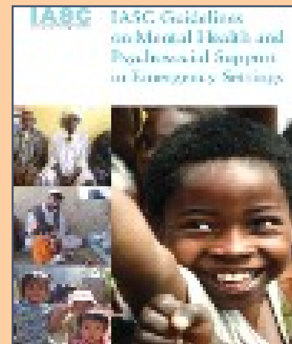
Psychological interventions

IASC guidelines



Cross-cutting tools





WHO van Ommeren ISTSS 2016

Social determinants parents can be addressed or promoted with preventive policy (in red)

Protective factors adults
Young
Education
Work, income, participation
Stabillized and housing
Presence family, partner, children
Social support, access legal, health and social services
Security status
Religious activities
Restoring resources (social capital, job at same level)

Risk factors adults
Older
Less education, Low SES
No work
Social exclusion, Discrimination
Number shocking life events
Length asylum procedure, lack activity, postmigration difficulties
Limited health skills, no insight psychosocial issues or health system
Physical unsafety
Low return on investment

Culture and PTSD debate: Three major issues

- Ecological utility
- Validity/historicity
- Politisation/medicalisation

De Jong & Hinton 2018 An Ecological–Cultural–Historical Model for Extreme Stress. In: D. Bhugra & K. Bhui (eds.) *Textbook of Cultural Psychiatry*. Cambridge 2nd ed.

Ecological utility: PTSD not the most significant expression

Validity/historicity

- PTSD found around the globe
- Despite diagnostic validity trauma reactions not identical
- Culture influences
  - Local phenomenologies of post-trauma experiences
  - Local illness vocabularies, IODs
  - Mental and bodily experience (local ethnopsychology and ethnophysiology)
  - Attention to particular symptoms (eg somatic due to arousal, catastrophic cognitions)
  - Healing and ritual practices aimed at reducing symptoms
- Historicity: symptoms PTS change, a historical era expresses itself in an idiosyncratic way in the presentation of individual suffering

Ensure that all your staff gets training in

- **Cultural Competency, Cultural sensitivity** – or
- **Culturally and Linguistically Appropriate Services (CLAS)**
- **Cultural Interview with the components:**
- Cultural identity
- Cultural explanations incl EMs
- Cultural factors in relation to one's psychosocial context and level of functioning
- Cultural elements in the patient-helper relation
- Cultural evaluation of diagnosis and treatment