Mental Health in Displaced Populations: a UK Perspective

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Outline

- The ‘migrant crisis’ – a UK perspective
- The range of experiences and adversities consequent on human rights abuse
- The importance of post-migration experiences including immigration detention
- Concepts of complex trauma and their implications for treatment
- The work of the Helen Bamber Foundation
- Avoiding stress and burnout
Prevalence of mental health problems in refugees

- Fazel et al 2005: Systematic review of prevalence of mental health problems in refugees resettled in western countries
  - 20 studies (6743 refugees in 7 host countries)
    - 9% diagnosed with PTSD (10x that in general population in host countries)
    - 5% diagnosed with major depression
    - Only two studies examined psychosis rates

- Bogic et al. (2012): 854 settled refugees from former Yugoslavia in Italy, Germany and UK
  - Any mental disorder: 54.9%
  - Any mood disorder: 43.4 %
  - Any anxiety disorder: 43.7 %
  - PTSD: 33.1 %

Asylum seekers and refugees are vulnerable to mental illness

**Pre-migration**
- Torture and inhuman/degrading treatment
- Human trafficking
- War violence

**Peri-migration**
- Hazardous journey
- Vulnerability to further ill-treatment/exploitation

**Post-migration**
- Prolonged immigration uncertainty
- Inability to work
- Lack of support network
- Difficulty accessing care
- Destitution
Willard et al 2013: Prevalence of torture and associated symptoms in Iraqi refugees

- 525 Iraqi refugees resettled in Utah
- 511 eligible; 497 (97%) participated
- 14-symptom checklist for key mental symptoms

Sleep disturbances: nightmares, early AM awakening, sleep better in the day then at night, flashbacks
Cognitive function: confusion, very forgetful, feeling easily overwhelmed
Arousal: easily startled, heart palpitations, racing thoughts, irritable
Chronic Pain: headaches, low back pain
Isolation: wants to be left alone
Willard et al 2013: Prevalence of torture and associated symptoms in Iraqi refugees

<table>
<thead>
<tr>
<th>Type of torture</th>
<th>For all refugees (n = 497)</th>
<th>18 and under (n = 172)</th>
<th>19 and older (n = 300)</th>
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<tbody>
<tr>
<td>None</td>
<td>217</td>
<td>79</td>
<td>126</td>
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<td></td>
<td>43.7 %</td>
<td>45.9 %</td>
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<tr>
<td>Primary</td>
<td>121</td>
<td>12</td>
<td>109</td>
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<td>24.3 %</td>
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<td>36.3 %</td>
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<tr>
<td>Secondary</td>
<td>156</td>
<td>79</td>
<td>64</td>
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<td></td>
<td>31.4 %</td>
<td>45.9 %</td>
<td>21.3 %</td>
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<tr>
<td>Missing</td>
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<td>2</td>
<td>1</td>
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<td>.6 %</td>
<td>1.2 %</td>
<td>.3 %</td>
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<table>
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<th>CI Exp (B)</th>
<th>p</th>
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<td>.056 (.27)</td>
<td>1.06</td>
<td>.62–1.83</td>
<td>.836</td>
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<td>Torture type</td>
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<tr>
<td>Primary</td>
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<td>1.00–3.78</td>
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<td>3.73</td>
<td>2.22–6.27</td>
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<td>Logistic regression predicting who will experience physical symptoms</td>
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<td>1.23</td>
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<tr>
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<td>2.08</td>
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<td>3.73</td>
<td>2.22–6.27</td>
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Porter and Haslam 2005: Pre- and post-migration predictors of refugee mental health

- 56 reports (4.4%) met inclusion criteria
- 22,221 refugees and 45,073 non-refugees
- Refugees had poorer mental health outcomes (effect size 0.41)
- Key refugee factors associated with poor MH outcome
  - Older, more educated, female, high SE status
- Key post-migration associates of poor MH outcome
  - Institutional accommodation, restricted economic opportunity, internal displacement or repatriation
Hollander A-C et al BMJ 2016; 352; i1030

- Cohort study of 1.3m people living in Sweden (9.8% non-refugee migrants; 1.8% refugees)
- Incidence of non-affective psychoses (per million)
  - 385 in Swedish-born
  - 804 in non-refugee migrants
  - 1264 in refugees
- Increased risk in refugees likely to be due to severe or repeated exposure to adversity
  - Trauma, abuse, socio-economic disadvantage, discrimination, social isolation
The Helen Bamber Foundation

- HBF supports survivors of:
  - torture (cruel, inhumane or degrading treatment)
  - human trafficking (sexual exploitation, forced labour, domestic servitude)
  - gender-based violence (FGM, forced marriage, ‘honour-based’ violence)
  - domestic violence
  - persecution based on sexual orientation
  - former child soldiers
The main commonalities we see between these groups

- Complex, repeated and prolonged trauma
- Vulnerability to further trauma
- A clinical presentation of ‘PTSD+’ including
  - Issues of trust
  - Loss of ‘agency’
  - Inability to imagine a personal future
  - Inappropriate risk-taking
  - Somatization
  - Neurological abnormalities
ISTSS Definition of Complex PTSD

- Core symptoms of PTSD
  - Re-experiencing
  - Avoidance/numbing
  - Hyper-arousal
- Disturbances in self-regulation
  - Emotion regulation difficulties
  - Disturbances in relational capacities
  - Alterations in attention and consciousness
  - Altered belief systems
  - Somatic distress

International Society for Traumatic Stress Studies 2012
Common perpetuating factors

- Separation from country and family
- Immigration uncertainty
- Deskilling
- Destitution
- Criminalization
- Lack of support network
- Rejection and disbelief
- Alcohol and/or substance misuse and dependence
- ‘Real’ continuing persecution
- Difficulty accessing
  - Medical care
  - Legal protection
  - Treatment/care
Immigration detention

- UK detains a higher proportion of asylum seekers than any other European country
- Immigration detention is associated with
  - Diminished sense of safety and freedom from harm
  - Painful reminder of past traumatic experiences
  - Aggravated fear of imminent return
  - Separation from support network
  - Disruption of treatment/care
  - High rates of PTSD, depression, anxiety and Deliberate Self-Harm
Royal College of Psychiatrists conclusions regarding immigration detention

- People with a mental disorder constitute a ‘particularly vulnerable’ group.
- Detention likely to precipitate significant deterioration in mental health.
- Detention centres are not appropriate therapeutic environments.
- Repeated examples of gross mismanagement of serious mental health problems in detention setting.
- Treatment of mental illness should take place in *least restrictive environment*.
  - Inpatient hospitalisation NOT the only alternative to detention.
  - Management of mental illness not just provision of medication and suicide prevention but provision of treatment to enable rehabilitation and recovery.
Consideration also needs to be given to the challenges that asylum seekers face during what is often a prolonged and distressing process. These factors may include institutional detention, inability to work (and resultant deskilling and loss of self esteem), destitution, and difficulty in accessing health and social care.

A robust mental health response to the refugee “crisis” must lie in a combination of clinical vigilance, recognition of vulnerability factors, and, above all, a determination to minimise the aggravating effects of post-migration experiences.
HBF Model of Integrated Care

Welfare and Casework Co-ordinator
- Prevention of homelessness and destitution
- Advocacy and legal issues

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GP Advisory clinics
- Longer appointments
- Advising GPs and other healthcare providers

Medico-legal reports
- ‘Bearing witness’ through documentation of evidence
- Impact of symptoms (e.g. credibility), risks of detention or removal
- Expert evidence for courts and tribunals

Counter-trafficking lead
Groups:
- Psychoeducation group
- Trafficked women’s group
- Women’s therapy group
- Compassionate mind group
- Community group

Individual therapy:
- Trauma-focused therapy
  - NET; tf-CBT; EMDR
- CBT
- Mindfulness-based therapy
- Longer-term psychotherapy
Treating Complex PTSD

• Identify individual’s hierarchy of needs (consider Maslow, 1943)
• ISTSS and NICE guidelines (2005)
• Phased treatment approach (Herman, 1998)
  – Phase 1
    • Stabilisation and skills strengthening
    • Ensure basic needs are met, psychoeducation, basic self-management skills
  – Phase 2
    • Trauma-focused therapy
  – Phase 3
    • Consolidation of gains
    • Engagement and integration into wider community: education, employment, social activities
Narrative Exposure Therapy (NET)

- For multiple/repeated/prolonged traumatic events e.g. sexual abuse, domestic violence, torture, war, sexual exploitation
- Devised to be administered in refugee camps; time-limited treatment that could be delivered with limited resources
- Draws on components of other evidence based therapeutic approaches e.g. prolonged exposure/ TfCT as well as narrative “testimony” approaches
- Evidence in many different client groups e.g. refugee camps, resettled refugees, CSA, BPD, children and adults
- Aim is to embed traumatic experiences within autobiographical context of the person’s life

Overview
- Pre-treatment – psychoeducation, grounding etc
- Session 1- Lifeline
- Session 2: narrative of stones and flowers in chronological order (starting with birth).
- Session 3 onwards: Re-read narrative from past session, correct/add in additional details. Continue narrative, focusing on the stones that are traumatic.
- Final session: Focus on future hopes and goals; re-read entire narrative and sign it.

Schauer, Neuner, & Elbert (2005): Narrative Exposure Therapy: A Short-Term Treatment for Traumatic Stress Disorders
Lifeline

• Rope is used as the symbol for the person’s life.

• The end is kept coiled to represent the future.

• Flowers are used as symbols for positive events or relationships (resources).

• Stones are used as symbols for negative events (traumas, losses).

• Lifeline as the “map” for therapy
Narrating a stone

• Sensory: What could they smell/see/hear/feel?
• Cognitive: What did they think?
• Emotional: What did they feel?
• Physiological: What physical sensations did they feel? “Where in your body did you feel that emotion?”

• Elicit this information from the past and also the present moment (e.g. can they hear/smell/see the same things now?). This helps to put the memory into context, and also avoid dissociation
The HBF Medical Advisory Clinic

- Volunteer GPs and other doctors
- Addressing range of medical problems suffered by victims of extreme human cruelty and their difficulties in accessing care
- Clinical issues addressed include:
  - Injuries from being beaten, stabbed, burnt, restrained, raped, including fractures, sprains, dental and facial injuries
  - Sequelae of head injuries – headaches, traumatic brain injury, post-traumatic epilepsy
  - Pregnancy
  - Sexually transmitted infections and other gynaecological complications
  - Physical consequences of captivity and poor hygiene
  - Exploitative work-related injuries
  - Mental health concerns
  - Unexplained medical symptoms (e.g. abdominal pain, headaches, total body pain)
  - Chronic medical conditions from neglect
Recognising stress and burnout

• What does burnout look/feel like?
  – Exhaustion
  – Cynicism (towards clients and colleagues)
  – A sense of professional inefficiency

• What fosters it?
  – Culture of overwork/competitiveness/need to be ‘best’
  – Poor leadership
  – Individuals’ perfectionism
  – Excessive exposure to trauma

• What is vicarious trauma?
  – Cumulative effect of contact with trauma survivors
  – Sense of commitment/responsibility without ability to fulfil it
    • Feeling burdened, overwhelmed and hopeless

• Why does all this matter to organizations?
  – Suboptimal client safety/care
  – Reduced staff retention
  – Reduced ‘productivity’
Addressing stress and burnout

- **At organizational level**
  - Mentoring and peer support
  - Availability of supervision (and promoting a culture that encourages it)
  - Encouraging staff development and training
  - Flexible working arrangements
  - Discretionary ‘mental health days’ +/- time off in lieu
  - Avoiding ‘culture of overwork’

- **At individual level (unlikely to be effective without organizational support)**
  - Using peer support and supervision (rather than seeing it as a sign of failure)
  - Mindfulness
  - Stress reduction
  - Exercise
Conclusions

- The post-migration process has considerable potential to worsen mental health.
- Early identification of those most at risk and an asylum process sensitive to mental health needs and vulnerabilities could mitigate this risk considerably.
- Complex PTSD
  - should be suspected/assessed in victims of human rights abuses
  - requires comprehensive evaluation of needs and individualised treatment
- Narrative Exposure Therapy (NET) shows particular promise but requires more extensive evaluation.
- LOOK AFTER YOURSELVES – AND EACH OTHER!