The Mental Health Needs of People Seeking Sanctuary

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Outline

- The range of experiences and adversities consequent on human rights abuse
- The importance of post-migration experiences
- The work of the Helen Bamber Foundation
- Concepts of complex trauma and their implications for treatment in this client group
- Avoiding stress and burnout

Refugees and Asylum Seekers

- Approximately 79.5 million forcibly displaced worldwide (United Nations High Commissioner for Refugees, 2020)
  - 45.7 million internally displaced
  - 29.6 million externally displaced
  - 4.2 million seeking asylum
- Human rights violations, conflict, persecution, events causing serious public disorder
- Exposed to *complex traumas*

Asylum seekers and refugees' vulnerability 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
  - Separation from country and family
  - Immigration uncertainty
  - Deskilling
  - Destitution
  - Alcohol and/or substance misuse and dependence
  - Criminalization
  - Lack of support network
  - Rejection and disbelief
  - 'Real' continuing persecution
  - Difficulty accessing
    - Medical care
    - Legal protection

Prevalence of mental health problems in refugees

- Fazel et al 2005: Systematic review
- 20 studies (6743 refugees in 7 host countries)
  - 9% diagnosed with PTSD (x10 that in general population in host countries)
  - 5% diagnosed with major depression
  - Only two studies examined psychosis rates

- Blackmore et al 2020: Systematic review
- 26 studies (5143 refugees in 15 countries)
  - 31.5% had post-traumatic stress disorder
  - 31.5% had depressive disorders
  - 11.1% had anxiety disorders
  - 1.5% had psychoses

Bogic et al (2012). British Journal of Psychiatry, 200, 216–223.
Fazel et al. (2005). Lancet, 365, 1309-1314.

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

Katona editorial BMJ 2016; 352: i1279

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.

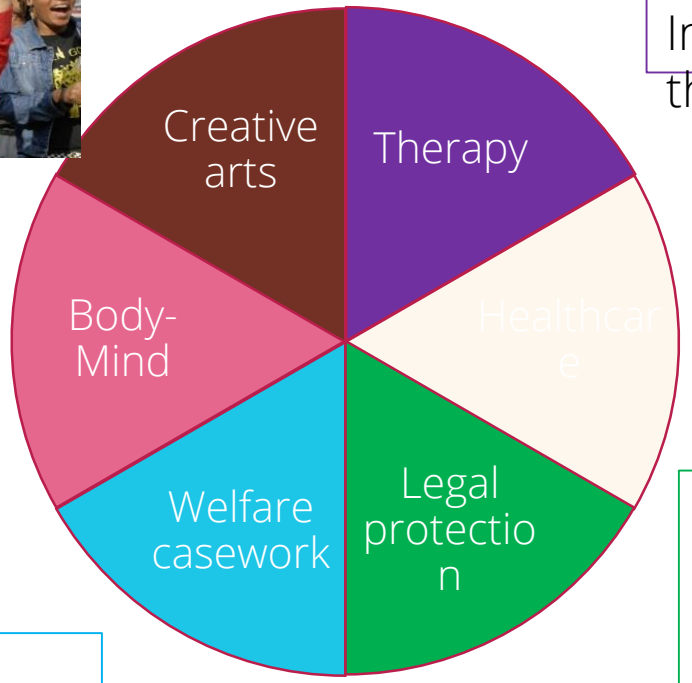
The Helen Bamber Foundation

- 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
  - Dissociation

HBF Model of Integrated Care



Individual and group therapies

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

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

- 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

What is Trauma Informed Care?

- It is **not** a therapy, specific action or an intervention
- It is an approach to engaging people with **histories of trauma**
- It recognizes trauma **symptoms**
- It acknowledges **the role** trauma has played in their lives
- It recognizes how trauma **affects** an individual
- It **shifts perspective** from “what is wrong with you”? To “what has happened to you”? This lessens blame and promotes healing.
- It **resists retraumatisation** ie; it takes steps to minimize situations that could cause distress or mirror the traumatic experience

Principles of Trauma Focused Care

- **Safety:** create a space where people feel culturally, emotionally and physically safe
- **Transparency and Trustworthiness:** provide full and accurate information about what's happening and will happen next
- **Choice:** honour the individual's dignity
- **Collaboration and Mutuality:** relationships and partnerships need shared decision making
- **Empowerment:** includes the recognition of an individual's strengths which can be validated and built on

ICD-11 Definition of Complex PTSD

- Core symptoms of PTSD
  - Re-experiencing
  - Avoidance/numbing
  - Hyper-arousal

- Disturbances in Self-Organisation (DSO)
  - Emotion regulation difficulties
  - Negative self-concept
  - Difficulties in forming/maintaining relationships

Who develops cPTSD?

cPTSD is associated with

- Multiple trauma
- Prolonged trauma
- Interpersonal trauma
- Loss of freedom/difficulty escaping
- Trauma caused by the deliberate cruelty of others
    - Childhood abuse (esp. sexual)
    - Torture
    - Trafficking
        - Sexual
        - Forced labour (inc. domestic)
- Continuing difficulties after leaving traumatic situation
    - E.g. post-migration challenges

BJPsych Open (2021)
7, e194, 1–11. doi: 10.1192/bjo.2021.1013

Review

Prevalence of complex post-traumatic stress disorder in refugees and asylum seekers: systematic review

Umanga de Silva, Naomi Glover and Cornelius Katona

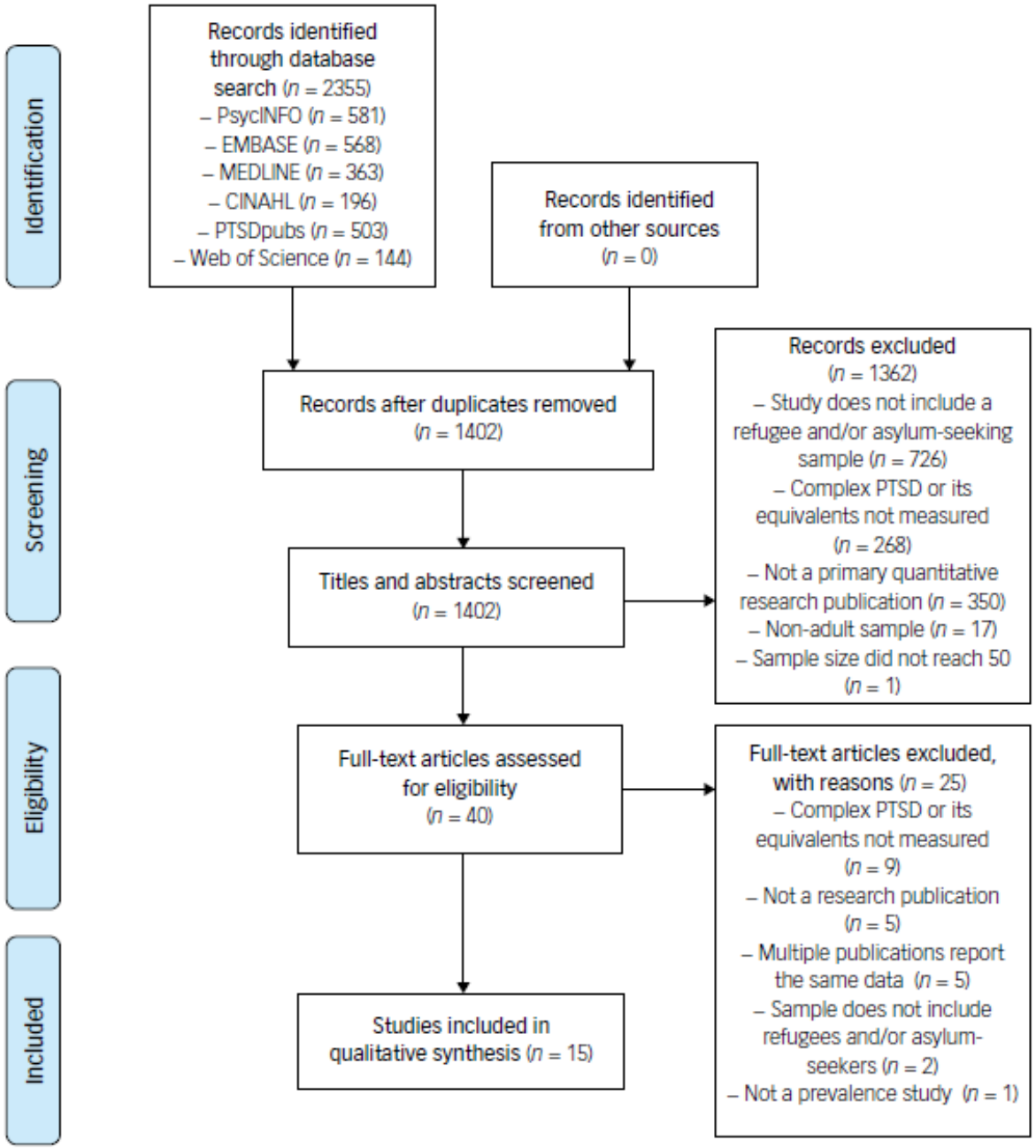
Screening

First stage

- Titles and abstracts of all results screened against eligibility criteria (first author)
- Exclusion of studies meeting exclusion criteria

Second stage

- Potentially relevant studies screened in full (first, second, and third authors)



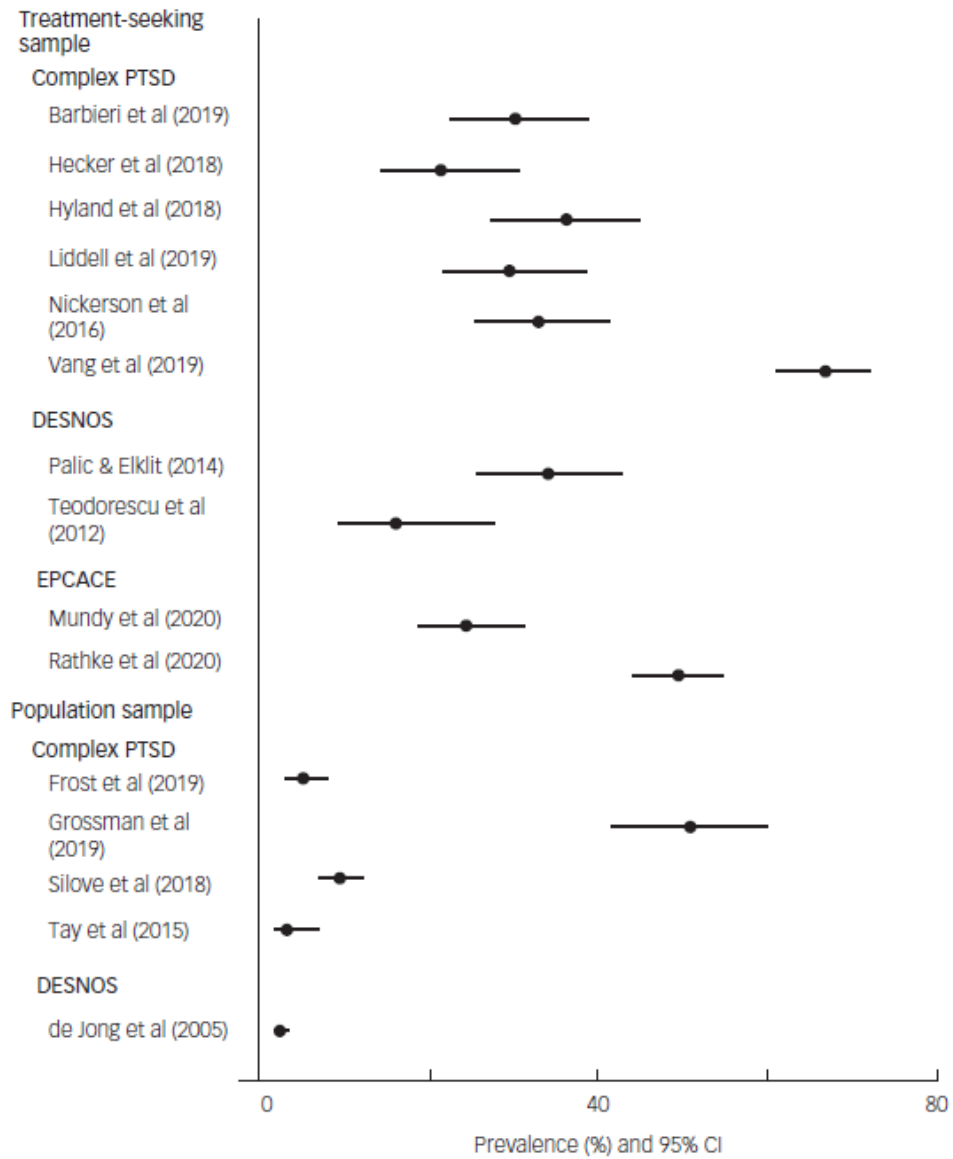


Fig. 3 Prevalence of complex post-traumatic stress disorder (PTSD), enduring personality change after catastrophic events (EPCACE) and disorder of extreme stress not otherwise specified (DESNOS) in treatment-seeking and population samples.

BJPsych Open (2021)
7, e181, 1–4. doi: 10.1192/bjo.2021.1007

Short Report

Complex post-traumatic stress disorder in asylum seekers and victims of trafficking: treatment considerations

Sally Jowett, Angeliki Argyriou, Odile Scherrer, Thanos Karatzias and Cornelius Katona

Results

- N=101
- Mean age 34.6
- 48.5% female
- Most common trauma was sexual abuse/rape (55%)

- 66% met ICD-11 criteria for cPTSD
- 14.3% met ICD-11 criteria for PTSD

Those with cPTSD showed
- Higher CORE risk scores
- More difficulties with integration
- Higher rates of housing problems

The potential role of Narrative Exposure Therapy (NET)

- NET is a trauma-focused intervention designed for use in conflict zones and effective for alleviating PTSD symptoms in asylum seeking and refugee populations (Robjant, Roberts, & Katona, 2017; Lely et al., 2019b)
- Recent meta-analysis demonstrated that NET has a strong evidence base, with 28 randomised control trials having been performed across 30 countries, with a range of vulnerable populations who were exposed to multiple traumas in varied cultural contexts (Siehl et al., 2020).
  - NET significantly more effective at reducing PTSD symptoms than both an active comparator (with small-to-medium effect size) and a nonactive comparator (with medium-to-large effect size).
  - NET is effective for PTSD symptoms over the longer-term, with larger improvements being maintained at six months follow-up than at three months.
  - NET was also shown to reduce co-morbid depression significantly.
- NET has been trialled successfully in pilot studies in groups with comorbid psychosis, personality disorder, dissociation, and chronic pain, indicating its potential to alleviate distress from comorbid difficulties in populations with multiple and complex needs.
- NET has never been formally evaluated as a treatment for CPTSD.

BJPsych Open (2021)
7, e196, 1–9. doi: 10.1192/bjo.2021.1029

Narrative exposure therapy for survivors of human trafficking: feasibility randomised controlled trial

Francesca Brady, Amy Chisholm, Eileen Walsh, Livia Ottisova, Leonardo Bevilacqua, Claire Mason, Martha von Werthern, Teresa Cannon, Christina Curry, Kemi Komolafe, Rachel Elizabeth Robert, Katy Robjant and Cornelius Katona

Narrative Exposure Therapy for survivors of human trafficking: Feasibility randomised controlled trial. Brady F et al BJPsychOpen 2021

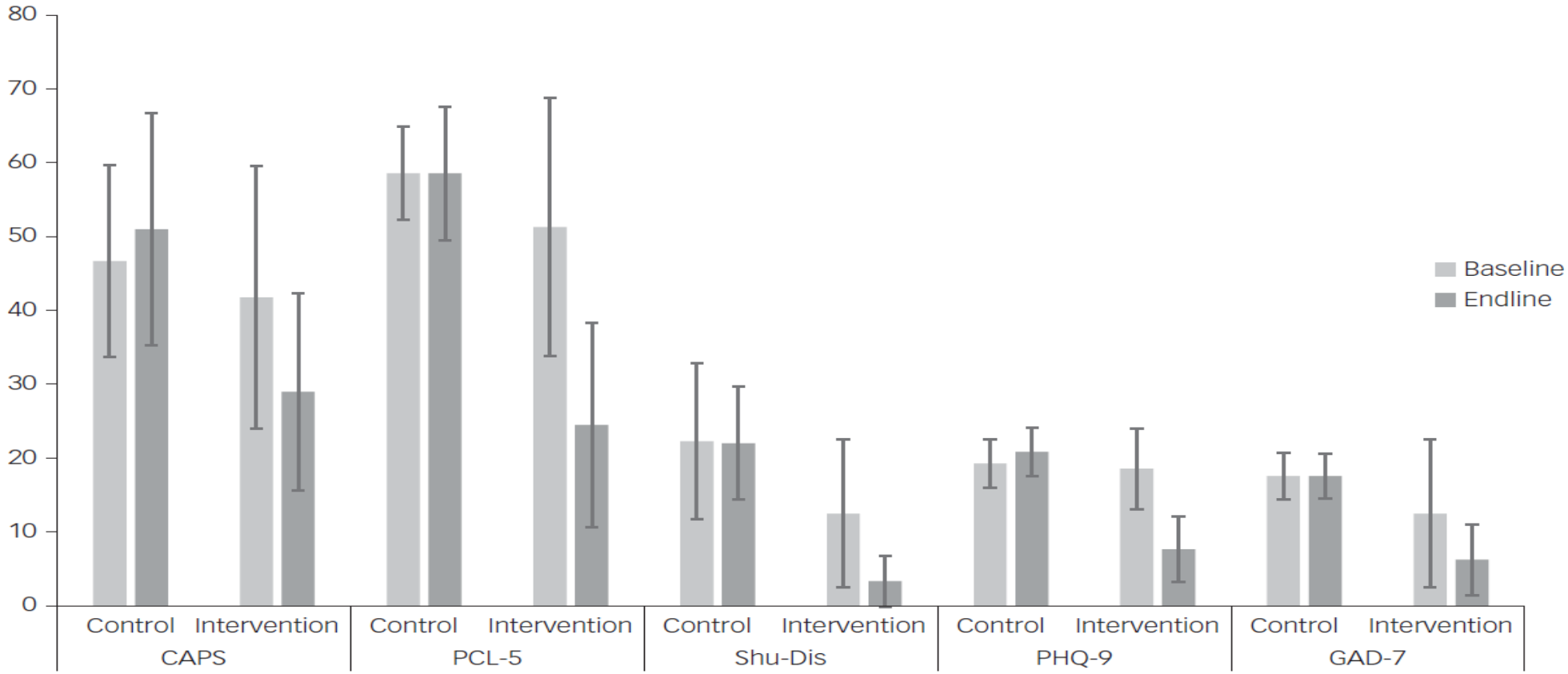


Fig. 4 Scores for NET and wait-list groups at baseline and endline.

Results and Conclusions

- NET was well tolerated by participants.
- There was a significant reduction in PTSD, depression, and anxiety symptoms at post-treatment in the NET group, but no significant change in the wait-list group.
- The results build on the existing literature and indicate that NET is a promising and acceptable treatment for trafficking survivors.
- Psychological therapy in an RCT design can be safely delivered to this vulnerable group, although modifications are required to ensure that their holistic needs are also properly addressed.
- The study was not designed to identify changes in cPTSD domains but did show significant benefit in dissociation (ShuDis) and in depressive and anxiety symptoms as well as PTSD symptoms

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
- LOOK AFTER YOURSELVES – AND EACH OTHER!