Mental Health of Young Refugees in Resettlement Countries

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This talk

• Demographics - Numbers
• Developmental Psychopathology across the life span
  – Infancy
  – Childhood/adolescence
  – Adolescence/early adulthood
• Services & Interventions
Figure 21 | Demographic characteristics available on UNHCR's population of concern | 2006-2016

UNHCR, 2017
Map 1  Populations of concern to UNHCR by category | end-2015

Refugees, including persons in a refugee-like situation

Number of persons

- 5,000,000
- 1,000,000
- 100,000
Asylum applicants considered to be unaccompanied minors in the EU Member States*, 2008-2016

*Figures include data for Sweden, which has a separate system for未成年人 asylum seekers.
Unaccompanied asylum seeking children (<18 years) in the EU 2015

- TOTAL 88,300
- Sweden almost 35,300 = 40%
- Germany 14,400 = 16%
- Hungary 8,800 = 10%
- Austria 8,300 = 9%
- UK 3045 = 3.4%

[www.escap.eu/bestanden/Care%20(38)/Refugees/3_02052016_ap_en.pdf]
Prevalence of Psychiatric Disorder in refugees and displaced people

- Prevalence varies according to methodology eg sample size
- N< 500 ~ 37%
- N>500, better studies, ~15%
- PTSD risk increases with:
  - Torture
  - Potentially traumatic events
  - Less time since exposure

(Steel et al, 2009)
Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: a systematic review

- 6743 adult refugees from 7 countries
- Larger studies,
  - 9% (99% CI 8–10%) PTSD
  - 5% (4–6%) with major depression
- Five surveys – 260 children
  - 11% (7-17%) for PTSD
  - No relevant studies of depression identified

(Fazel et al, 2005)
Refugee Infants

• Parental PTSD associated with insecure attachment and disorganised attachment [which predicts later psychiatric symptoms, poor peer relationships and lower self esteem] (Van Ee et al 2016)

• Parental psychiatric disorder associated with range of infant/childhood psychopathology

• Family loss - affect care/routines/warmth to child
Acculturation & Family

- Adolescents – rapid integration, language acquisition and acculturation - bicultural

- Impact of family
  - Conflicts in family – generational expectations behaviour
  - Child as carer for parent [↑with missing/impaired father]

- Increased risk conduct problems – boys

(Tousignant et al, 1999)
Risk Factors: War Exposure Events Experienced
Unaccompanied asylum seeking children (UASC) & Accompanied refugees compared

Hodes et al, 2008
Impact of Events Scale - Risk of PTSD
Unaccompanied and Accompanied children

% high risk PTSD

Male

Female

Unaccompanied Accompanied

Unaccompanied

Accompanied
Daily Hassles and Depressive Symptoms amongst UASC

- Hassles (general or acculturative)
- Longitudinal study in Norway over 2.8 years
- Acculturative hassles predict depressive symptoms
- Hassles reduce over time
- Depressive symptoms didn’t reduce

(Keles et al, 2016)
Course of psychological distress (Hopkins Symptom Checklist (HSCL)) during follow-up of asylum seekers who received refusal of asylum (n=67) and asylum seekers who received residence permission or time-limited asylum (n=64).

Marianne Jakobsen et al. BMJ Open 2017;7:e015157
Course of psychological distress (Hopkins Symptom Checklist (HSCL)) during follow-up of asylum seekers placed in asylum centres for adults (n=38) and asylum seekers placed in asylum centres for youth (n=100).
Summary – PTSD & Depression

• High violence exposure, greater threat
  --> ↑ stable PTSD

• PTSD & depression, both elevated /maintained by post-migration resettlement stressors & life events [eg detention, deportation, family conflict etc ]

• High support, refugee status, time - >reduction distress especially depression PTSD – may show greater continuity
Severely Impaired Adolescents & Young People

• High level of deliberate self harm and violent self harm
• High level of psychiatric admission as lower family/social support
• High levels of stress including PTSD may trigger psychosis
Refugee migration and risk of schizophrenia and other non-affective psychoses

Cohort study of 1.3 million people in Sweden. Refugees increased risk of psychosis compared with both the Swedish-born population (adjusted hazard ratio 2.9, 95% CI 2.3 - 3.6) non-refugee migrants (1.7, 1.3 - 2.1) after adjustment for confounders.

(Hollander et al, 2016)
Tiering interventions
Community Support

Tier 4
- Highly specialised inpatient CAMH units and intensive community treatment services

Tier 3
- Specialist multidisciplinary outpatient CAMH teams

Tier 2
- A combination of some specialist CAMH services and some community-based services including primary mental health workers

Tier 1
- Universal services consisting of all primary care agencies including general medical practice, school nursing, health visiting and schools
Service Access – Sociocultural Considerations

• Access - cost, referral pathways

• Language & cultural considerations
  – Understanding of distress and disorder
  – Community/social networks
  – Including religious/non western medical approaches (healing etc)

• High mobility -> GP/primary care registration
Community Tier - School 1

- Family + child/adolescent willingness to attend/integrate
- Language support
- Support/integration groups
- Teacher support for low level distress
Community Tier – School Tier 2

- Teacher identification of more distressed and impaired
- Aided by screening instrument eg SDQ
- Referral for school based help by CAMHS professional
- Non-stigmatising, favourably regarded
- Easy review of social function & progress

(Dura-Vila et al, 2013; Fazel et al, 2016)
UASC – Help seeking

• High risk of PTSD, lower depression [eg in recent UK samples 50%]
• most not in mental health services
• consider referral on basis of: distress, impairment, willingness to attend for treatment

(Bean et al, 2006; Sanchez-Cao et al, 2013)
Clinic based services Tier 3

• More impaired - lower CGAS/GAF <60
• Psychiatrically heterogeneous
• High proportion have psychosocial disorders
  – PTSD, depression
  – Some - neurodevelopmental disorders [ADHD, etc]
• Diagnosis - consider comorbidity, stability of symptoms, family histories
Treatments

• Cognitive behavioural therapy
  – Individual or group
  – manualised
• Narrative exposure therapy
• Interpersonal psychotherapy
• Play therapy
• Parenting & Family Therapy
• Symptom/disorder based [psychological, or drug/medical]
Conclusions

• Varied difficulties across the life span
• Depending on age, exposures, family background/losses
• Over time diminution common disorders, emergence of conduct problems, serious psychopathology
• Tiered system of care needed [+ task shifting]
• More research on effective interventions needed
AMERICA AGREES WITH TRUMP’S TEMPORARY “REFUGEE BAN”

SEASONS GREETINGS FROM SWITZERLAND.

Europe

Germany hate crime: Nearly 10 attacks a day on migrants in 2016

26 February 2017

Arson attacks directed at asylum seekers are common in Germany

Nearly 10 attacks were made on migrants in Germany every day in 2016,
Stay away from negative people. They have a problem for every solution.
Thank you

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References