Refugees and Mental Health

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Objectives

- Background
- Risks
- Coping
- Mental Health Consequences
- Intervention
  - Cultural Framework
- Mental Health Services
Mental Health and Refugees

“War is the most serious of all threats to health.”

(World Health Organization, 1985)
Syria

- A multi-faith, multi-ethnic society with a common language (Arabic)
- 74% Sunni, 12% Shia, 10% Christian, 3% Druze
- Previously a safe haven for refugees from Iraq, Palestine and other countries
Syria

- Since 2011, \( \frac{1}{4} \) Million killed, 1 M injured
- Half the population (11 M) is displaced
- 4 Million refugees
- Half of refugees are children under 18
- Half of Syrian children unable to complete education
Mental Health Risks

- Violence
- Poor physical health
- Collapse of social supports
- Marginalization and minority status
- Socioeconomic disadvantage
- Resettlement and acculturative stress
Pre-migratory Stressors

Loss

- Livelihood & education
- Sanitation, food, housing, health care
- Family & community structures
  - e.g. Forced early marriage for protection
Pre-migratory Stressors

 Violence & Traumatic Stress

- Direct and indirect exposure
- Torture, deprivation
- Sexual violence/survival sex
- Exploitation of women and children
  - Child labour & abuse
  - Recruitment by armed groups
Migratory Stresses

- Uprooted from land and home
- Separation & disruption of networks
- Harsh transitory living conditions
- Physical and mental stress of travel
- Risk of being detained
- Uncertainty
Post-migratory Stressors

Acculturative & Resettlement Stress

- Environment and climate
- Sociocultural & Linguistic change
- Intergenerational conflict
- Loss of social status
- Economic hardship & Underemployment
- Lack of occupation & activity
- Discrimination, harassment & violence
- Exclusion & Isolation
- Disempowerment
Economic Impact

- Immigrants and refugees improve Canada’s economy (Beiser 2015)

- “Refugees from Syria bring substantial positive human and social capital that could benefit host communities”
Coping

Safety

Natural coping mechanisms for the individual, family and community

- Prayer, music, art, social gathering, talk with trusted person

Occupation / Education

Men may deal privately, women communally
Coping

Empowerment

 Refugees as active agents in their own lives

“Don’t treat refugees like refugees”
Resilience and Post-traumatic Growth

- Relevant to Syrian/Islamic context

- Some refugee/immigrant groups have better Mental Health than host population

- Associated with hope, religious belief, social support, quality of life, adaptive coping strategies.
Resilience

“This study suggests the extraordinary capacity of refugees to protect themselves against mental illness despite experiencing horrific life experiences and ongoing poverty and violence.”

Mollica 2002
Mental Health Consequences

- Normal Distress
  - The medicalization of suffering

- Mental Disorder
  - Severity
  - Persistence
  - Impairment of functioning
The Medicalization of Suffering

- Psychiatry is a product of Western ideas of psychology and medicine
- Cross cultural variations in idioms of distress
- Assumption that there is a distinct psychological fallout of war applicable to whole populations
- Disease model used to make sense of complex situations with social, cultural, and political roots
- Labeling of all distressing experiences as “trauma” & all symptoms as pathological – PTSD

Normal responses to abnormal stresses

Cultural Humility

“The challenge to Western NGO’s and other agencies dealing with refugees and other victims of violence around the world is to establish ways of supporting people through times of suffering by listening and hearing their different voices in a way that does not impose an alien order. It is a challenge which demands that we work with a spirit of humility about what we can offer, and an acceptance that there is no quick fix or magic bullet that will rid people everywhere of the suffering brought about by violence.”

Bracken et al 1997
Recovery

“Recovery is not primarily a mental process, subject to technical intervention by experts; it is embodied in the practical struggle to re-establish a life made viable by a sense of coherence.”

Summerfield 2004
**Epidemiology of Mental Disorder: World Health Organization Projections**

<table>
<thead>
<tr>
<th>12 month Prevalence</th>
<th>Pre-Emergency</th>
<th>Post Emergency</th>
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<tbody>
<tr>
<td>Severe</td>
<td>2-3%</td>
<td>3-4%</td>
</tr>
<tr>
<td>Mild-Moderate</td>
<td>10%</td>
<td>15-20%</td>
</tr>
<tr>
<td>Normal Distress</td>
<td>“a large percentage”</td>
<td>“a large percentage”</td>
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Mental Health Consequences

- **Emotional** – sad, grief, fear, frustration, anxiety, anger, despair

- **Cognitive** – worry, boredom, intrusive memories, flashbacks, nightmares

- **Somatic** – insomnia, pain, fatigue, medically unexplained symptoms

- **Behavioural** – withdrawal, avoidance, aggression, substance use, hyperactivity, tantrums, interpersonal difficulties, trauma-themed play, regression
Mental Disorders

- Exacerbation of pre-existing conditions
- Disorders triggered by violence and displacement
- Disorders triggered by the post-emergency context
  - Post-migratory stressors more predictive of mental health than pre-migratory stressors
Mental Disorders

Most common
- Depression
- Anxiety
- Post-traumatic Stress Disorder
- Somatic syndromes
- Substance Use?
  - Alcohol, Captagon (Fenethylline = D-Amph+Theophylline)
- Psychoses? – migration-triggered

Mostly mild to moderate

Cumulative & recurrent trauma = greater risk
Children

- Half of all refugees are under 18
- Separation & disrupted attachment
- Loss of education (major determinant of health)
- Broad range of mental health outcomes
  - Internalizing: sad, anxious, sleep/nightmares, withdrawal, somatization
  - Externalizing: aggression, tantrums, oppositionality, conduct, impulsivity, hyperactivity
Intergenerational Issues

“Intergenerational transmission of trauma may affect multiple generations”

Intergenerational conflict and lack of communication increases risks of major mental health issues by 30x

Healthy Immigrant Effect
Ecological Framework

- **Microsystem**
  - Attachments & supports

- **Mesosystem**
  - school

- **Macrosystem**
  - Political, regional, cultural
Gender - Men

Men - “depressed and ashamed of their inability to continue their education”

- Forced to work in underpaid jobs
- Distress as weakness – cannot acknowledge
- Increased domestic violence
Gender - Women

- Confined to home for safety
- Role shift to provider
  - Greater responsibility and lack of security
- SGBV-sexual and gender based violence
- Sexual and physical violence
- Presumed sexual abuse of detained women – stigmatized and ostracized
Assessment

- Screening not recommended
  - Primum non nocere
  - Eliciting trauma may activate it

- Listen for issues
  - Highly symptomatic - emotional, cognitive, behavioural, somatic
  - Medically unexplained symptoms
  - Not functioning as expected

- Open-ended exploration

- Delayed onset traumatic response
Culturally Responsive Mental Health Care

Cultural Formulation

- Cultural Identity

- Cultural Conceptualization of Distress
  - Cultural Idioms of distress

- Cultural Factors of Vulnerability and Resilience

- Cultural Factors and Therapeutic Rapport
Cultural Framework

Social Suffering
- normal part of life not needing medical intervention accept in severely debilitating forms

Sociocentric and Cosmocentric
- Each individual connected to the other and to the universe (monorealism)

Submission-acceptance of suffering
- Patience in the face of helplessness

Catastrophe as an opportunity for growth

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Holism vs. Dualism

“Most Arabic and Syrian idioms of distress do not separate somatic experience and psychological symptoms, because body and soul are interlinked in explanatory models of illness”
Intervention

- Supportive public policy

- Clinical intervention
  - Barriers: mobility, absenteeism, lack of trust in system, stigma

- Social intervention
  - Refugees are less likely to use Mental Health services than host population
Research Evidence for Intervention

- Growing literature
- Few controlled studies
- Focus on measuring trauma to the exclusion of understanding other risk factors
- Social and community based interventions may be the most helpful
- Establishing/Rebuilding Mental Health Services and incorporating into overall public health plan

Clinical Interventions

Therapy

- Play therapy
- Creative arts therapies
  Rousseau et al
- Talk therapy
  Beiser

Community based psychosocial support

- Social networks & spaces for women
Clinical Interventions

Psychotropic Medication

- Cochrane Collaboration - no evidence
- Use for properly diagnosed mental illness
- *Medicate mental illness, not suffering*
**Social Interventions**

**Family unity**

- Keeping community and family networks intact

**Supporting Occupation**

- those not working 44% more likely to be depressed
  - Mollica (2002)
Social Interventions

Religious practices
- those not engaged in religious Buddhist practice 3x more likely to suffer PTSD
  - Mollica (2002)

Supporting caregivers
- Empowerment vs. Dependency
  - Mollica (2002)
  - Less depression in Za’atari Camp in Jordan than in refugees outside the camp
**Social Intervention**

**Education**

- Associated with lower risk of PTSD and depression
- Language proficiency associated with better MH outcomes
- Source of pride and sense of purpose
- The education of women is the single most important determinant of health worldwide
Social Intervention

“Improvement of living conditions of refugees and IDPs may contribute significantly to improving mental health, in many cases more so than any psychological or psychiatric intervention”
Mental Health Services - Ottawa

Initial Medical Assessment
(Ottawa Newcomer Health Centre)

Acute mental health issues requiring hospitalization:
- Transfer to hospital
  - ED Civic, General, QCH, Montfort, CHEO

Acute mental health issues: Contact psychiatrists associated with clinics for urgent treatment

Non-acute mental health issues:
To be followed by:
- Primary health care provider
- Psychiatrist (see list)
- Refer to appropriate service (see list)

No mental health issues initially identified at assessment:
Establish primary care health care provider

Identification of mental health issues/needs by physician, Imam, family, patient:
- Referral to appropriate service (see attached list)
- Use Primary Care PTSD Screening tool as required (see attached)

Each ED and inpatient units to have list of providers to refer if admission not required or upon discharge for ongoing tf/u care respectively
(Arabic and non-Arabic speaking)

Dr. Azaad Kassam
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Psychiatric Services

- Coordination & Collaboration – uOttawa with R613
- eConsult - https://www.lhinworks.on.ca/eforms/econsult2

- Psychiatry Clinics
  - CHEO
  - Bruyere
  - Ottawa Newcomer Health Centre
  - Hopital Montfort
  - TOH/Office

- Evolving list of services and efforts at coordination
Therapy Services

- Best delivered in primary language

- Range from general counseling to trauma-specific psychotherapy

Community-based agencies

- Ottawa Newcomer Clinic (ONHC)/Catholic Centre for Immigration (CCI)
- Immigrant Women’s Service Organization (IWSO),
- Ottawa Community Immigrant Services Organization (OCISO)
- Jewish Family Services (JFS) and Catholic Centre for Immigration.
- Children

- Referral pathway – work in progress
Online Resources

- www.ementalhealth.ca
- www.kidsnewtocalifornia.ca
- www.multiculturalmentalhealth.ca
- www.refugee613.ca
Resilience

“Refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity.”

Barrios 1999
Paradoxes of the Refugee’s Predicament

- trying to regain agency and control is essential but may be misperceived by others as aggression, entitlement or lack of credibility because what legitimates the claim for refuge is vulnerability and powerlessness
- the opportunity for resettlement in a safe place is life-saving but also life-changing and is associated with both opportunities and loss, which leads to grief and mourning
- this complicates the assumption that refugees should be grateful for the safe-haven they are offered
- the destruction of one’s country of origin may make the possibility of return unimaginable
- being future-oriented is important for well-being, but identities rooted in personal history and traditions of family, community, culture and religion are important sources of identity, strength and resilience