Interventions for refugees in low- and middle-income countries

(and what can high income countries learn from them)

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Structure of presentation

1. Mental health and psychosocial support in humanitarian settings
2. Less well-known scalable psychological interventions
    1. Interpersonal Psychotherapy
    2. Community-Based Sociotherapy
    3. Integrative Adapt Therapy
3. Example from Rohingya refugee context in Bangladesh
4. Some reflections

1. MHPSS

protecting or promoting psychosocial well-being

and/or

preventing or treating mental health conditions

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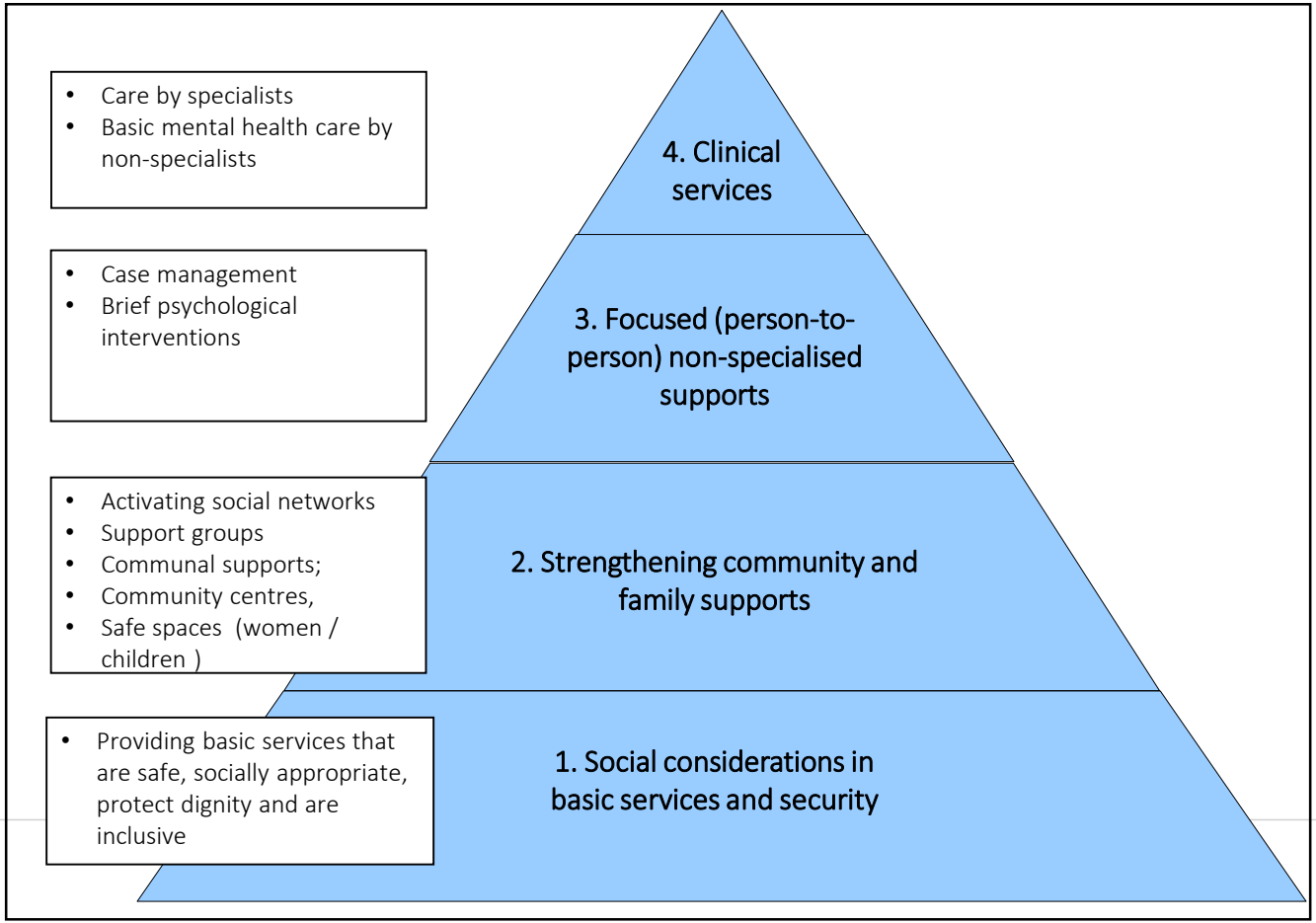
Multi-layered MHPSS services



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Layer 1: Social considerations in basic services and security

Layer 2: Strengthening social and community support

- ‘enabling approaches’ to facilitate creating social connectedness and mutual support.
  - Information provision / psycho-education / strengthening coping mechanisms
  - Social spaces
  - Community activities with jointly decided goals
  - Communal arts and sport
  - Support groups of people with specific vulnerabilities

Layer 3: Focussed non-specialized care

- Psychosocial case management
- Evidence-based brief psychological therapies for mild /moderate mental health conditions when delivered by non-specialists.
  - Problem Management Plus
  - Self Help Plus (SH+)
  - Interpersonal Therapy for Depression (IPT)*
  - Integrative Adapt Therapy (IAT)*
  - Community-Based Sociotherapy*

* = will be discussed later in session

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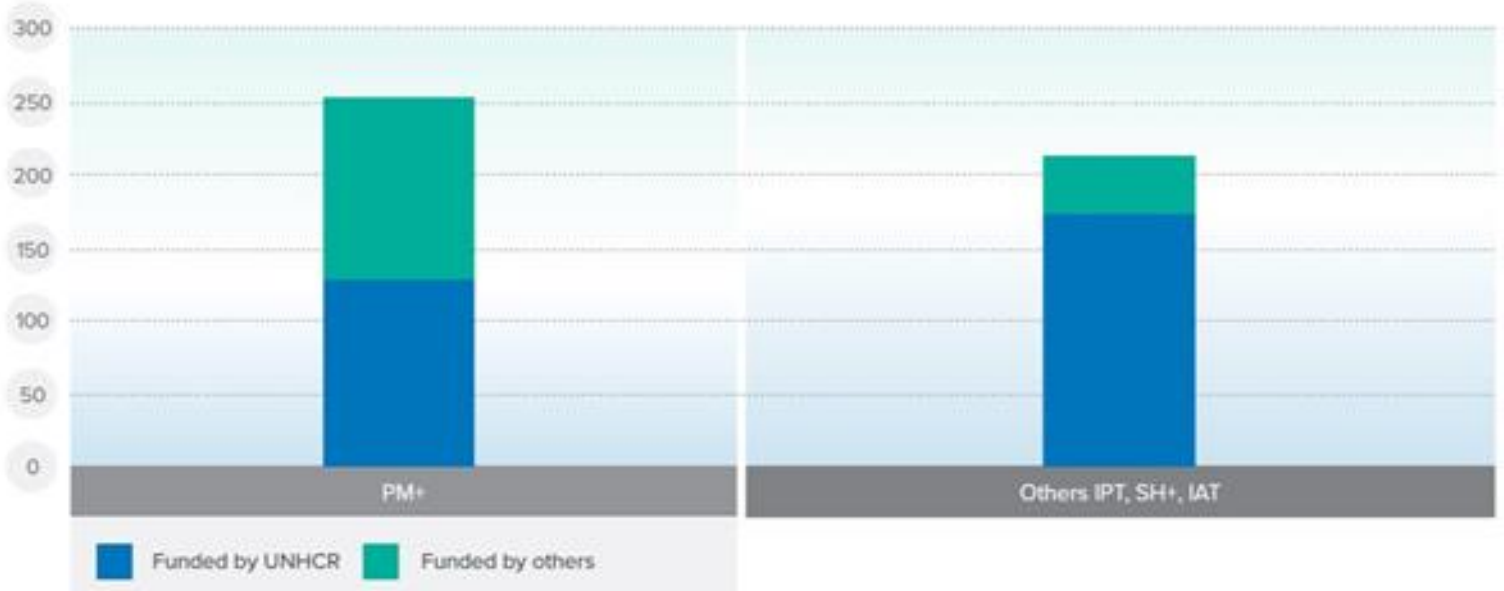
Scalable Psychological Interventions

In the last years, UNHCR encourages the use of brief evidence-based psychological treatments, including those that can be delivered by trained non-specialists. In 2022, 488 people in refugee settings were thus trained, mostly (52%) in Problem Management Plus (PM+), and the others on Self-Help Plus (SH+), Interpersonal Therapy for Depression (IPT) or Integrative Adapt Therapy (IAT) (figure 4).

Figure 4:
People Trained in Scalable Psychological Interventions in Refugee Settings (2022)



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Layer 4: Clinical services

- Training of health workers in basic mental health care (mhGAP)
- Cultural mediators
- Training clinical staff in cultural competence
- Practical arrangements to facilitate access

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2. Less well-known scalable psychological interventions

Community-Based Sociotherapy

Interpersonal Psychotherapy for depression

Integrative Adapt Therapy

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2A. Community-based sociotherapy

- Developed since 2005 in Rwanda and introduced in Uganda in 2021
- Aim: To improve psychosocial well-being and strengthen interpersonal reconciliation and social cohesion at grass-roots level
- Using groups as therapeutic medium in establishment of trust, creation of an open environment for discussion formation of peer-support structures
- 15 weekly group sessions of 3 hours
- Phases related to: safety, trust, care, respect, engagement in rulemaking and processing emotional memories
- Process is described but not content (no teaching of pre-defined strategies)

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Community-Based Sociotherapy for refugees in Uganda

		Southwest	West Nile
Basic (2022)	Trainees	28 (18M, 10F)	28 (17M, 11F)
	Participants	178 (50M,128F)	180 (52M, 128F)
Intermediate (2022)	Trainees	28 (18M, 10F)	26 (16M, 10F)
	Participants	350	180
Advanced (2023)	Trainees	26 (18M, 8F, 2 dropped)	22 (4 dropped out)
	Participants	647 (171M, 476F)	691

Testimony of a refugee participant in Community-based Sociotherapy in Uganda

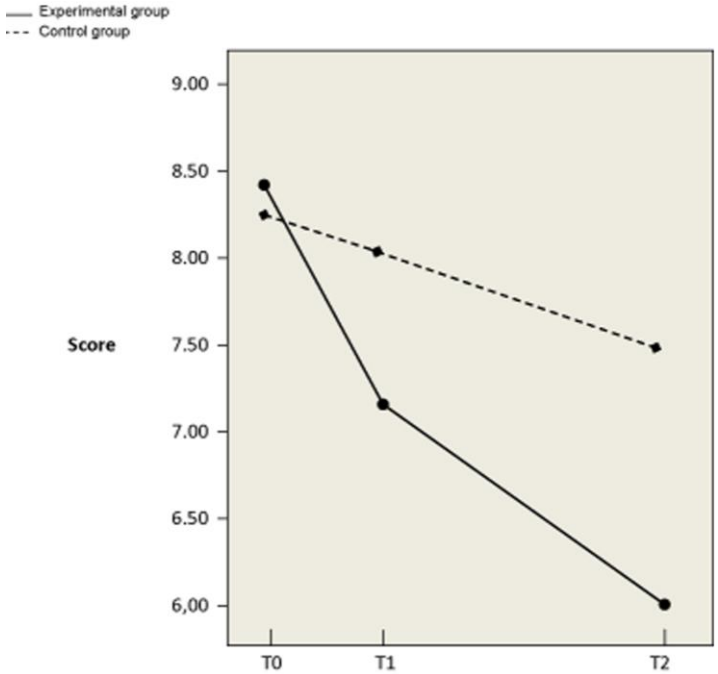
- "*In our group we have participants from the same tribe (Dinka) but from different areas and they never even wished to greet each other. Now they are visiting each other and interact very well*". (Female facilitator, Rhino Camp)

Testomony of a CBS facilitator

- *“In our community there was a father who had a young child, he did not care for his child and people in his neighbourhood were taking the child in and feeding it. The father was drunk most of the time and did not take care of himself and his child. I kept inviting the father to the sociotherapy group and finally convinced him to join at the third session. Since that session he gained interest and stayed until the 15th week. He started to take care of himself and his child. He became a true inspiration of the community; his neighbours were very surprised at his complete change*”. (Female facilitator, Rhino Camp)

Research on community-based sociotherapy

- Rwanda quasi experimental survey with matched control): improvement mental health symptoms (sustained 8 months follow up)
- Costar (2020-22); Congolese refugees in Rwanda and Uganda: no outcomes yet
- RCT in Rwanda (Rwandan national) results being analysed



- Scholte et al (2011). The Effect on Mental Health of a Large Scale Psychosocial Intervention for Survivors of Mass Violence: A Quasi-Experimental Study in Rwanda. PLoS ONE 6(8):e21819.doi:10.1371/journal.pone.0021819
- Kagabo et al (2023) . Community based sociotherapy for depressive symptomatology of Congolese refugees in Rwanda and Uganda (CoSTAR): a protocol for a cluster randomised controlled trial, European Journal of Psychotraumatology, 14:1, DOI: 10.1080/20008066.2022.2151281
- Jansen et al (2022). Evaluating the impact of Community-Based Sociotherapy on social dignity in post-genocide Rwanda: study protocol for a cluster randomized controlled trial. Trials 23, 1035

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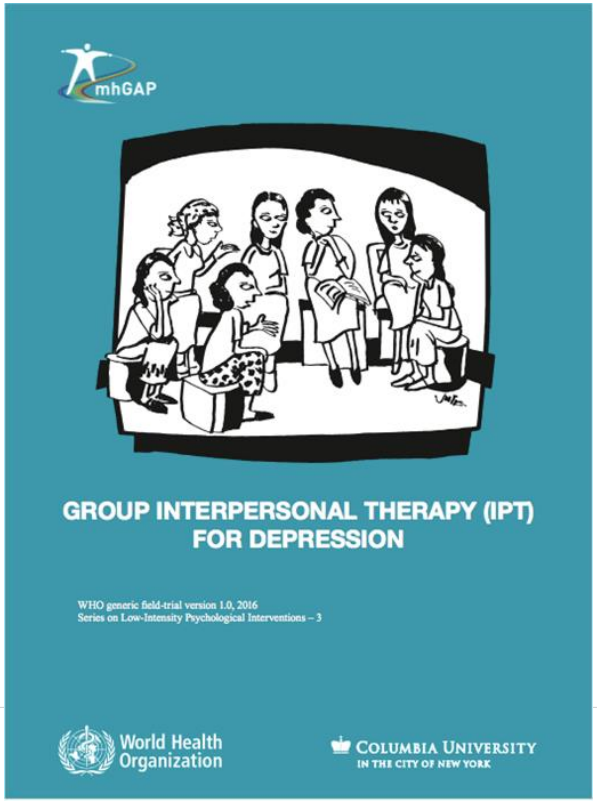
2B: Interpersonal Therapy for Depression

(data provided by Lena Verdeli, Teachers College, Columbia University)



- Assumes that **depression is triggered by interpersonal difficulties**:
  - **Grief**
    - Death of a person significant to the patient
  - **Interpersonal Disputes**
    - Disagreements (overt and covert)
  - **Role Transitions**
    - Life changes—negative and positive
  - **Interpersonal Deficits**
    - Loneliness, social isolation

Duration
- **"Standard"** (12 or 16 sessions)
- Brief (8 sessions)
- Very brief--IPC (~3 sessions)
- Treat-to-target

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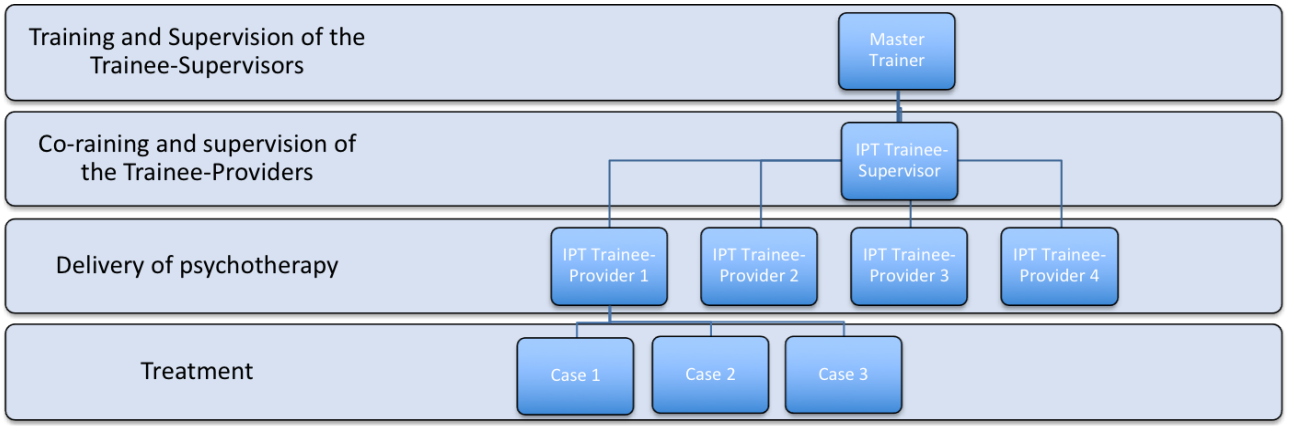
Overview of IPT Training Process Apprenticeship Model

3-level process:

- Providers
- Supervisors
- Trainers



Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J., Neugebauer, R., Weissman, M. (2003). Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. World Psychiatry 2003; 2(2):114-120.

Murray, L. K., Dorsey, S., Bolton, P., Jordans, M. J., Rahman, A., Bass, J., & Verdeli, H. (2011). Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers. International journal of mental health systems, 5(1), 30.

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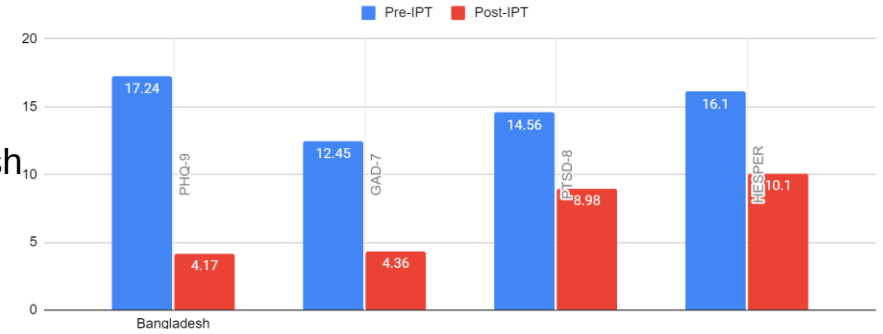
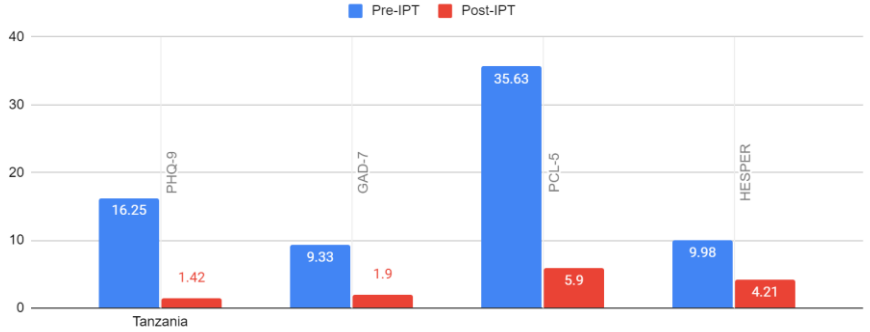
Effectiveness of IPT with refugees in Bangladesh, Tanzania, & Peru

(Routine outcome data, courtesy Lena Verdeli)

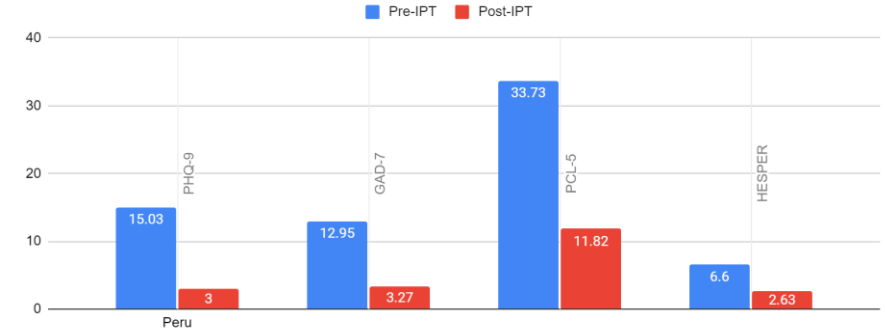
Bangladesh



Tanzania



Peru



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Interpersonal Counselling (IPC-3)

- Taps on potential of peer counsellors who are refugees or migrants themselves and have access and credibility
- It aims to provide structure and language to support, clarify current problems, and mobilize the person's social networks and problem-solving : ***"what is happening in your life right now that is contributing to your distress?"***
- Its interpersonal areas of focus (grief, disagreements, life changes, loneliness) are relevant to the lives of the displaced persons
- It is a "filter" that differentiates those who just need clarification and support from those who need more treatment (and referral)

3C: Integrative Adapt Therapy

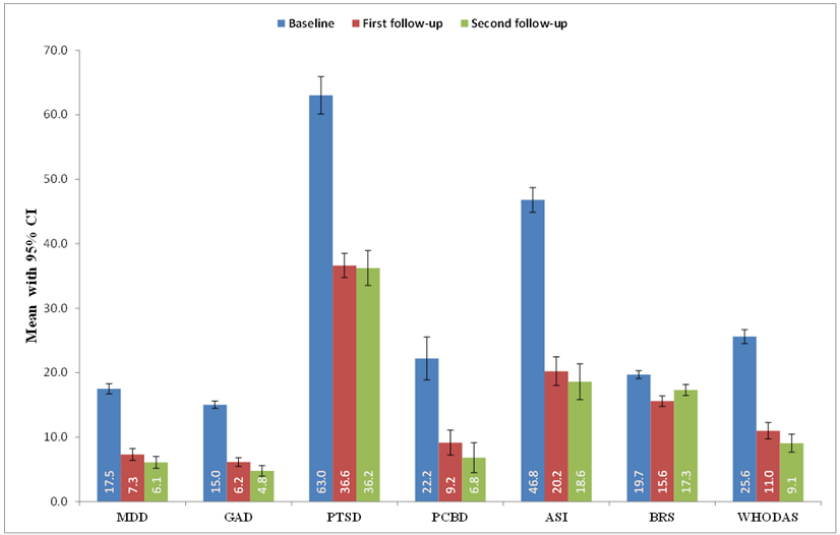
- Six sessions (group or individual) with techniques rooted in CBT and packaged in a way that makes sense to refugees (Tay et al., 2020a)
- Based on the ADAPT model (Adaptation and Development after Persecution and Trauma, Silove, 2013)
  - safety/security
  - interpersonal bonds and networks;
  - justice;
  - identities and roles;
  - existential meaning
- Good effects among Myanmar refugees in Malaysia, slightly better than PM+ (Tay et al 2020b)

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings. Intervention, 11(3), 237-248.
Tay, et al. (2020a). Theoretical background, first stage development and adaptation of a novel Integrative Adapt Therapy (IAT) for refugees. Epidemiology and Psychiatric Sciences, 29.
Tay, A. K. et al (2020b). An Integrative Adapt Therapy for common mental health symptoms and adaptive stress amongst Rohingya, Chin, and Kachin refugees living in Malaysia: A randomized controlled trial. PLoS Medicine, 17(3), e1003073.

Outcomes of Integrative Adapt Therapy among Rohingya refugees in Bangladesh

- Pragmatic naturalistic evaluation of seven-session group intervention
- 144 adult Rohingya refugees
- Inclusion criteria
  - PHQ ≥10,
  - PTSD-8 ≥3
  - WHODAS-brief ≥17
- Outcomes IAT-G at posttreatment and 3-month follow-up (compared to baseline scores)
  - significantly lower mean scores on
    - Depression (PHQ-9)
    - Anxiety (GAD-7
    - PSTD (PTSD-8
    - Adaptive stress,
    - Functional impairment)

Mean score with 95% CI for outcome measures of IAT at Baseline (T1), Posttreatment (T2) and 3-month Follow-up (T3)



Tay et al. (2021). A Naturalistic Evaluation of Group Integrative Adapt Therapy (IAT-G) with Rohingya Refugees During the Emergency Phase of a Mass Humanitarian Crisis in Cox's Bazar. E-Clinical Med 38:100999

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What do these interventions add?

- Community-based Sociotherapy: do not forget the power of community and social connectedness
- Interpersonal Therapy: deep clinical work for people who need it, including people who have suicidal ideations
- Integrative Adapt Therapy: Contextualize the intervention to the lived reality of refugees

3. Examples from UNHCR's work in Bangladesh

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Rohingya refugees in Bangladesh

- Ethno-linguistic, religious minority in Myanmar
- History of persecution and marginalization
- Social violence
- Consecutive waves of refugees to/from Bangladesh Major displacement to Bangladesh in 2017
- 1 million Rohingya in camps

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Video from Arafat Uddin, Rohingya refugee and community psychosocial volunteer in Bangladesh

The story of a Rohingya refugee: becoming a community psychosocial volunteer

Arafat Uddin[1] & Hasna Sumi[2]

[1]Medical Assistant, Community Psychosocial Volunteer, Gonoshashthaya Kendra, Cox's Bazar, Bangladesh,
[2]M.S., Public Health and Nutrition Unit, UNHCR Cox's Bazar, Bangladesh

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Mental health and psychosocial support in Rohingya refugee camps

- Community-based psychosocial activities:
  - psychosocial volunteers and other refugee volunteers
- Provide evidence-based psychotherapy: IAT, IPT, PM+,
  - national psychologists and Rohingya paracounsellors
- Providing clinical mental health services integrated within primary health care (mhGAP)
  - medical doctors trained and supervised by psychiatrist.

Summary statistics of MHPSS work in Rohingya refugee camps in Bangladesh

Psychiatric consultations in UNHCR- supported primary health care facilities

- 2,865 in 2018
- 5,115 in 2019
- 7,734 in 2020
- 7,803 in 2021
- 5.500 in 2022
- 8,872 in 2023)

Individual psychological interventions by psychologists and para-counsellors

- 10,095 in 2021
- 15,526 in 2022
- 38,724 in 2023

Attendees in community based psychosocial group activities

- 238,074 in 2020
- 362,919 in 2021
- 494,260 in 2022
- 286,535 in 2023

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4. Reflections

In summary: what have we learned?

1. Task-sharing in psychotherapy is feasible and effective
   → modest effect sizes. Statistical significance ≠ clinical relevance
2. Scalable psychological interventions must be embedded in systems of care
   → some form of stepped care (but how?.Do not forget the social and the clinical). And ensure people get the right care from the start
3. Psychosocial workers should have a toolbox of interventions
   → But which ones?
4. Strengthening family and community support is key
   → facilitating agency, social networks, community support (social work methodology)

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