Making Psychosocial Interventions Accessible to 100,000's of Refugees

Richard Bryant
University of New South Wales

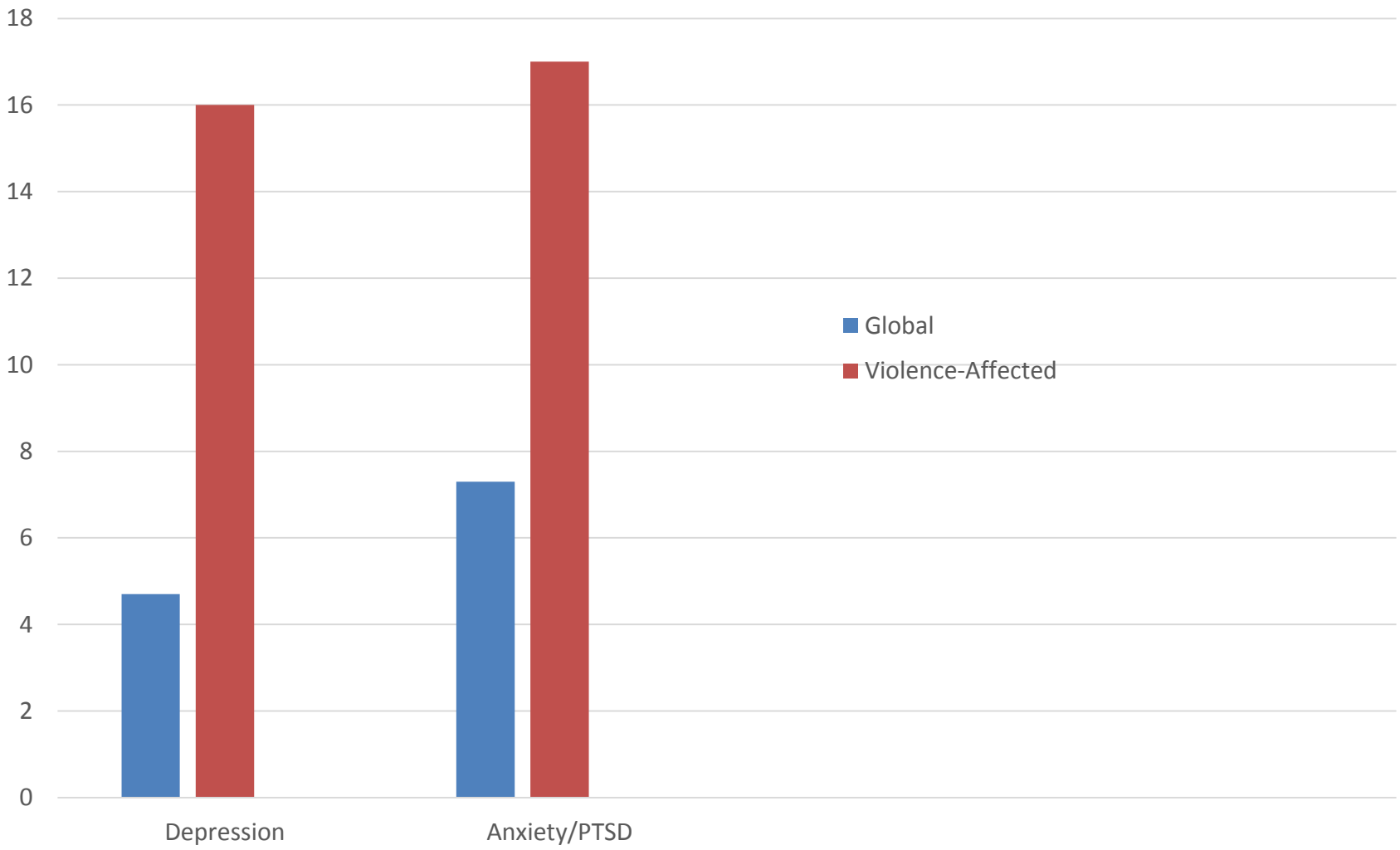

MARINA MILITARE


UNHCR
The UN Refugee Agency
UNHCR
COURTESY OF GERMAN HELICOPTER CORPS

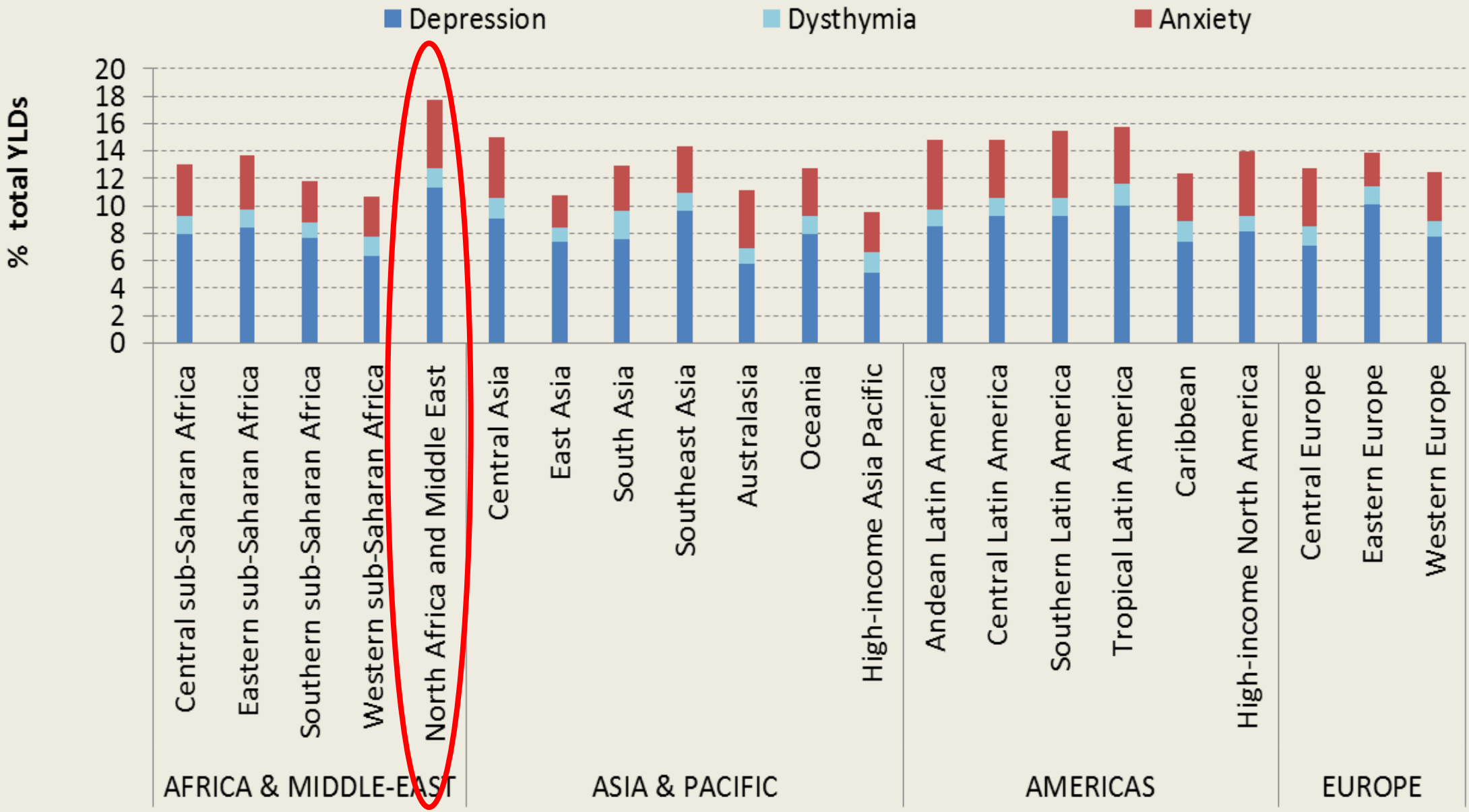
Highest number of people affected by emergencies since WW2

- Worldwide
  - 67 million people displaced, including 40.8 million internally displaced, 21.3 million refugees, and 3.2 million asylum-seekers
  - > 125 million people in need of mental health assistance

Common Mental Disorders



Society impact: Global burden of depression and anxiety (% of years lived with disability; GBD study)



What do we advise agencies with limited resources to help 1,000,000s of refugees?

KEY QUESTIONS

- What should agencies try to achieve in meeting the needs of 100,000s of people affected by trauma?
  - Helping everybody severely distressed?
  - Helping everybody at risk of a mental disorder?
  - Helping everybody with a mental disorder?
  - Helping everybody with a severe mental disorder?
  - Helping people with priority disorders only (psychosis, suicidal, etc)
  - Helping everybody who seeks help?

DECISION POINTS

- Do we resource a few clinics/centres very well?
- Do we help just people in a few communities very well?
- Do we spend a lot of resources on helping a few 100 people with maximum clinical effectiveness
- How does one set priorities?

Treating PTSD

- Overwhelming evidence indicates trauma-focused psychotherapy is the treatment of choice for PTSD
- Meta-analyses indicates this effectively reduces post-trauma depression
- Meta-analyses indicate that these also effective in LMICs after trauma

Limitations of Traditional Approach

- Disorder-specific
- Lengthy duration (10+ sessions)
- Rely on complex and intensive strategies
- Typically provided by qualified practitioners
- Requires considerable (and costly) training
- These factors preclude implementation in LMICs because of inadequate infrastructure and limited budgets

Mental Health Treatment in LMICs

- The limitations of evidence-based treatments result in most people in LMICs not receiving help
- Estimated that 93% of those in LMICs who need treatment do not receive it (Chisholm et al., 2016)
- Estimated that 90% of those in China and India who need treatment do not receive it (Patel et al., 2016)

Current Priority for Scalable Interventions

- Feasibile, affordable and cost-effective interventions that can be implemented on a large scale, especially in settings in which health systems are stretched and have inadequate resources

Towards scalable psychological interventions

Conventional psychological interventions

- By specialists
- One treatment manual per problem
- Often many sessions
- Often require diagnostic assessment

More scalable psychological interventions

- Innovative delivery : reduced reliance on specialists (rather: lay people, IT, self-help guides etc.)
- One treatment for multiple problems (where possible)
- May not require diagnostic assessment
- Fewer sessions
- **Focus on skills for self-management**

Low Intensity Interventions Must:

- Be scalable:
  - Be easily trained to local para-professionals
  - Understandable to local health providers
- Be cost-effective & feasible:
  - Be affordable to LMIC governments
  - Be amenable to local capacity development
  - Be reasonably short to enhance engagement, attendance and completion
- AND EFFECTIVELY REDUCE DISTRESS

Can Lay Helpers Be Effective?

- Major shift in recent years is training lay people to deliver psychological interventions
- Meta-analysis of 27 studies using lay people to treat anxiety/depression found effect size of 0.49 (Singla et al., 2017)
- Suggests ‘task-shifting’ can play an important role in alleviating common mental disorders

Current Goal of WHO

- Publish a range of different scalable psychological interventions with focus on increasing access to effective care as part of mhGAP program
- All tested through partnerships (minimally in 2 countries)
- WHO Press as publisher to put manuals and resources online as a public good (serving free dissemination and quality control of any translation)

Five phase model for new intervention testing (for each intervention at 2 sites)

Phase 1
- Adaptation of intervention for local sociocultural context (**qualitative** research) and, sometimes, an uncontrolled pilot run

Phase 2
- Small, feasibility randomized controlled trial (**RCT**) to explore (a) feasibility, safety and delivery of intervention in a RCT and (b) feasibility of high quality evaluation (n = 40 – 120)

Phase 3
- Process evaluation (**qualitative** research) of administering and trailing the intervention to finalize intervention and prepare for Phase 4 (n = 25)

Phase 4
- Large, definitive, state-of-art **RTC** (n = 350-550)

Phase 5
- Process evaluation (**qualitative** research) of administering the intervention to prepare for scaling up (n = 25)

Problem Management Plus

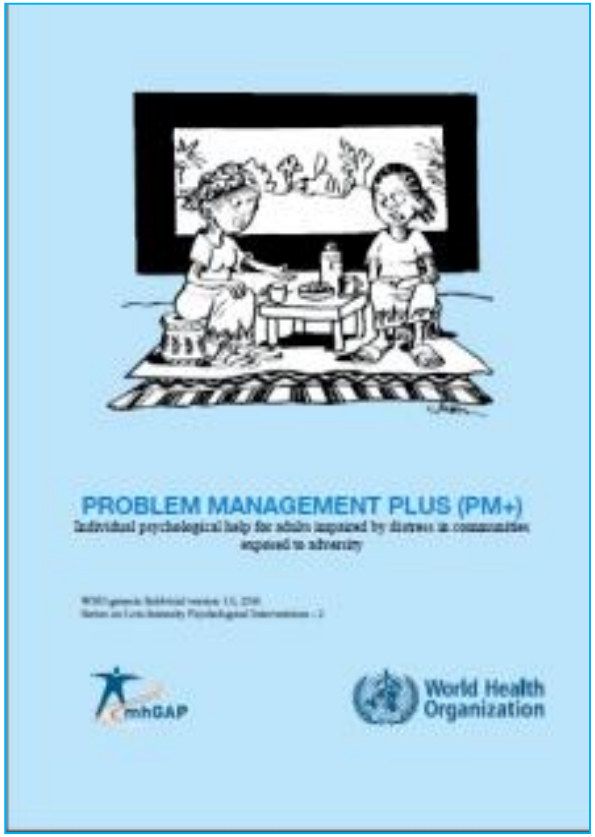
- UNSW collaborated with World Health Organization to develop PM+
- Aimed to be driven by current evidence for best interventions to impact common mental disorders
- Yet be simple enough to be delivered by local lay providers

What Does Evidence Suggest?

- Anxiety management
- Problem solving
- Behavioural activation
- Accessing social supports

Problem Management Plus (PM+)

- For whom
  - Adults, **transdiagnostic (stress, depression, anxiety)**
  - Inclusion criterion : must have high distress and impaired functioning
- What
  - Problem-solving counselling (**problem management) plus** behavioural strategies stress management, behavioural activation, strengthening social supports
- Formats
  - 5 sessions individual face-to-face (**released already)**
  - 5 sessions group face-to-face
  - 7 sessions group for young adolescents
- Large RCTs
  - Kenya
  - Pakistan (x 3)
  - Nepal
  - plus more planned



PM+

- Psychoeducation (Session 1)
- Managing stress (slow breathing) (S 1)
- Managing problems (S2)
- Keep Going, Keep Doing (S2)
- Promote Social Support (S3)
- Relapse Prevention (S5)

Research

JAMA | Original Investigation

Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan

A Randomized Clinical Trial

Atif Rahman, PhD; Syed Usman Hamdani, MBBS; Naila Riaz Awan, PhD; Richard A. Bryant, PhD; Katie S. Dawson, PhD; Muhammad Firaz Khan, MRCPsych; Mian Mukhtar-ul-Haq Azeemi, MBBS; Parveen Akhtar, MPhil; Huma Nazir, BS (Hons); Anna Chiumento, MSc; Marit Sijbrandij, PhD; Duolao Wang, PhD; Saeed Farooq, PhD; Mark van Ommeren, PhD

Supplemental content

IMPORTANCE The mental health consequences of conflict and violence are wide-ranging and pervasive. Scalable interventions to address a range of mental health problems are needed.

OBJECTIVE To test the effectiveness of a multicomponent behavioral intervention delivered by lay health workers to adults with psychological distress in primary care settings.

DESIGN, SETTING, AND PARTICIPANTS A randomized clinical trial was conducted from November 1, 2014, through January 28, 2016, in 3 primary care centers in Peshawar, Pakistan, that included 346 adult primary care attendees with high levels of both psychological distress and functional impairment according to the 12-item General Health Questionnaire and the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).

INTERVENTIONS Lay health workers administered 5 weekly 90-minute individual sessions that included empirically supported strategies of problem solving, behavioral activation, strengthening social support, and stress management. The control was enhanced usual care.

MAIN OUTCOMES AND MEASURES Primary outcomes, anxiety and depression symptoms, were independently measured at 3 months with the Hospital Anxiety and Depression Scale (HADS). Secondary outcomes were posttraumatic stress symptoms (Posttraumatic Stress Disorder Checklist for *DSM-5*), functional impairment (WHODAS 2.0), progress on problems for which the person sought help (Psychological Outcome Profiles), and symptoms of depressive disorder (9-item Patient Health Questionnaire).

RESULTS Among 346 patients (mean [SD] age, 33.0 [11.8] years; 78.9% women), 172 were randomly assigned to the intervention and 174 to enhanced usual care, among them, 146 and 160 completed the study, respectively. At baseline, the intervention and control groups had similar mean (SD) HADS scores on symptoms of anxiety (14.16 [3.17] vs 13.64 [3.20]; adjusted mean difference [AMD], 0.52; 95% CI, −0.22 to 1.27) and depression (12.67 [3.27] vs 12.49 [3.34]; AMD, 0.17; 95% CI, −0.54 to 0.89). After 3 months of treatment, the intervention group had significantly lower mean (SD) HADS scores than the control group for anxiety (7.25 [3.63] vs 10.03 [3.87]; AMD, −2.77; 95% CI, −3.56 to −1.98) and depression (6.30 [3.40] vs 9.27 [3.56]; AMD, −2.98; 95% CI, −3.74 to −2.22). At 3 months, there were also significant differences in scores of posttraumatic stress (AMD, −5.86; 95% CI, −8.53 to −3.19), functional impairment (AMD, −4.17; 95% CI, −5.84 to −2.51), problems for which the person sought help (AMD, −1.58; 95% CI, −2.40 to −0.77), and symptoms of depressive disorder (AMD, −3.41; 95% CI, −4.49 to −2.34).

CONCLUSIONS AND RELEVANCE Among adults impaired by psychological distress in a conflict-affected area, lay health worker administration of a brief multicomponent intervention based on established behavioral strategies, compared with enhanced usual care, resulted in clinically significant reductions in anxiety and depressive symptoms at 3 months.

TRIAL REGISTRATION anzctr.org.au Identifier: ACTRN12614001235695

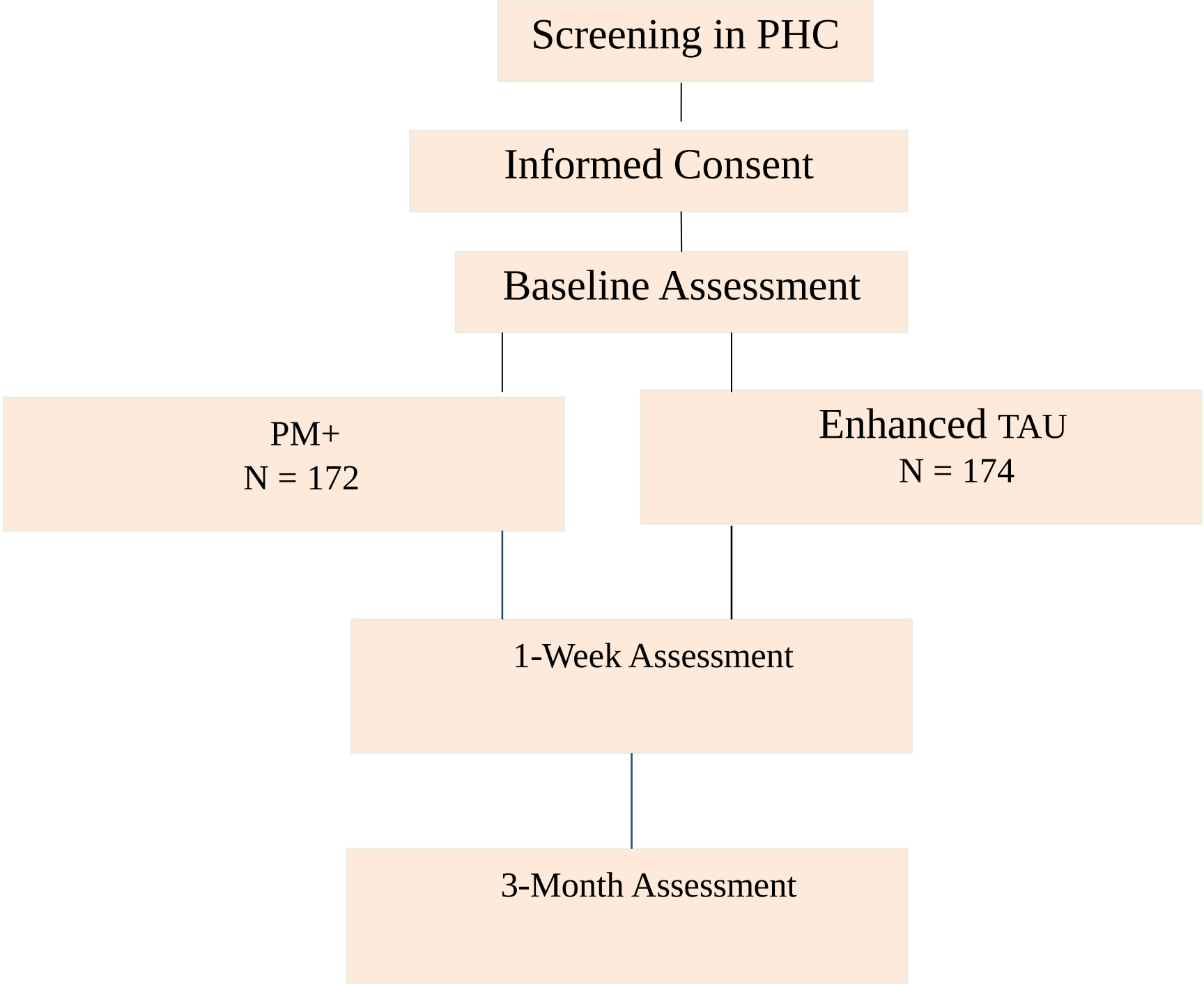
JAMA. doi:10.1001/jama.2016.17165
Published online November 12, 2016.

Author Affiliations: University of Liverpool, Liverpool, England (Rahman, Chiumento); Human Development Research Foundation, Islamabad, Pakistan (Hamdani, Akhtar, Nazir); Lady Reading Hospital, Peshawar, Pakistan (Awan, Khan, Azeemi, Farooq); University of New South Wales, Sydney, Australia (Bryant, Dawson); VU University Amsterdam, Amsterdam, the Netherlands (Sijbrandij); Liverpool School of Tropical Medicine, Liverpool, England (Wang); Research Institute for Primary Care & Health Sciences, Keele University, Staffordshire, England (Farooq); World Health Organization, Geneva, Switzerland (van Ommeren).

Corresponding Author: Atif Rahman, PhD, Institute of Psychology, Health, and Society, University of Liverpool, 1-5 Dover St, Block B, Waterhouse Bldg, Liverpool L69 3BX, England (atif.rahman@liverpool.ac.uk).

Peshawar

- Near the border with Afghanistan - capital of KP
- Study in PHC in peri-urban area
- 60% of study participants have experienced conflict
- 20% of study participants have natural disaster

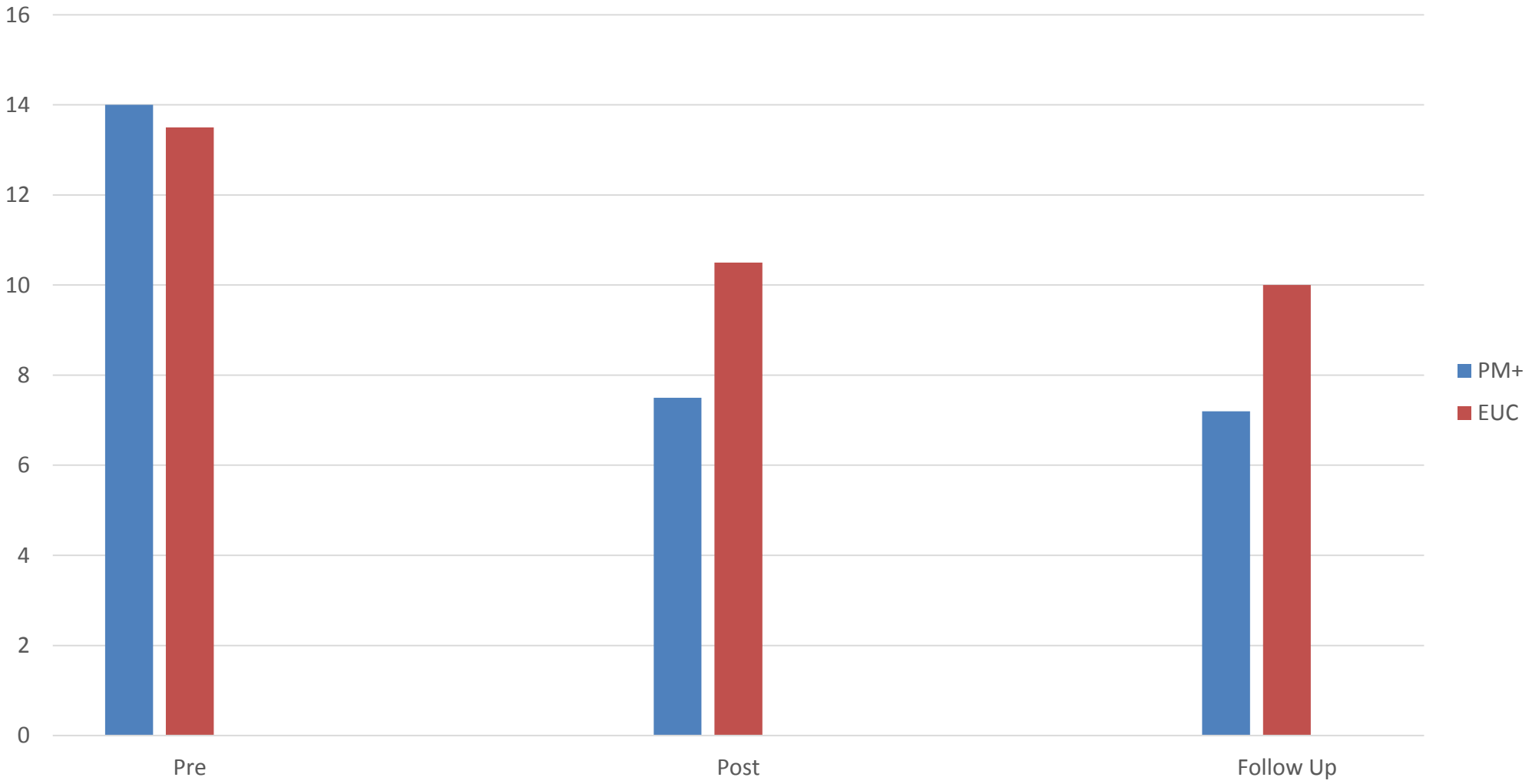

Screening in PHC
Informed Consent
Baseline Assessment
PM+
N = 172
Enhanced TAU
N = 174
1-Week Assessment
3-Month Assessment

Results from mixed model analysis of primary outcomes

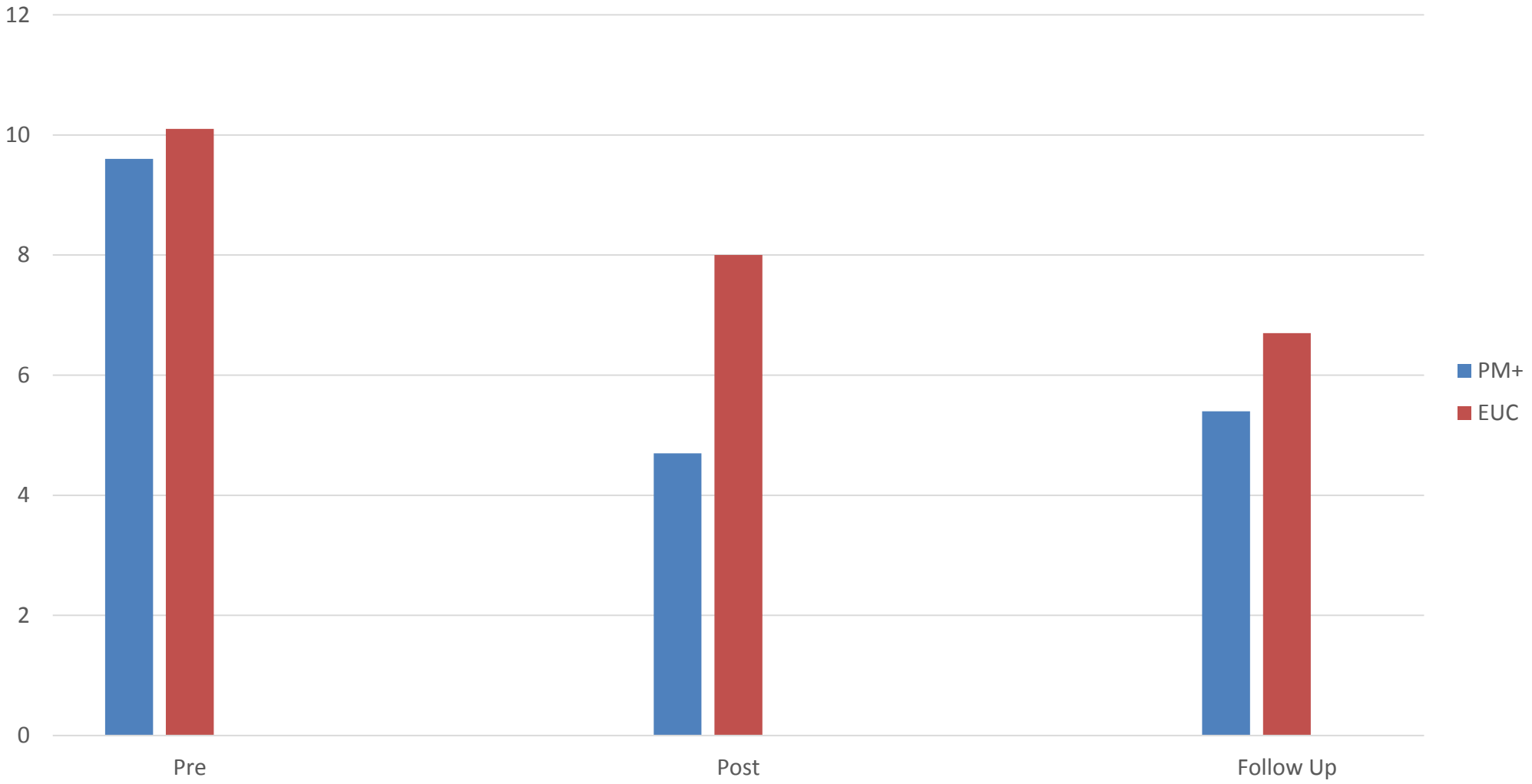
		Intervention		EUC		Mixed model analysis		
Outcomes	Visit	n	Mean (SD)	n	Mean (SD)	Difference in LS mean (95%CI)	P-value	Effect size**
HADS Anxiety	Pre-Intervention	172	14.16(3.17)	174	13.64(3.20)			
	Post-Intervention	112	7.56(3.41)	97	10.26(3.92)	-2.77(-3.72,-1.82)	<.0001	0.76
	Follow-Up	146	7.25(3.63)	160	10.03(3.87)	-2.77(-3.56,-1.98)	<.0001	0.74
HADS Depression	Pre-Intervention	172	12.67(3.27)	174	12.49(3.34)			
	Post-Intervention	111	6.49(3.25)	97	9.45(3.38)	-3.02(-3.93,-2.10)	<.0001	0.91
	Follow-Up	146	6.30(3.40)	160	9.27(3.56)	-2.98(-3.74,-2.22)	<.0001	0.85

**Effect size is calculated by the difference in LS mean by standard deviation

HADS-Anxiety



HADS-Depression



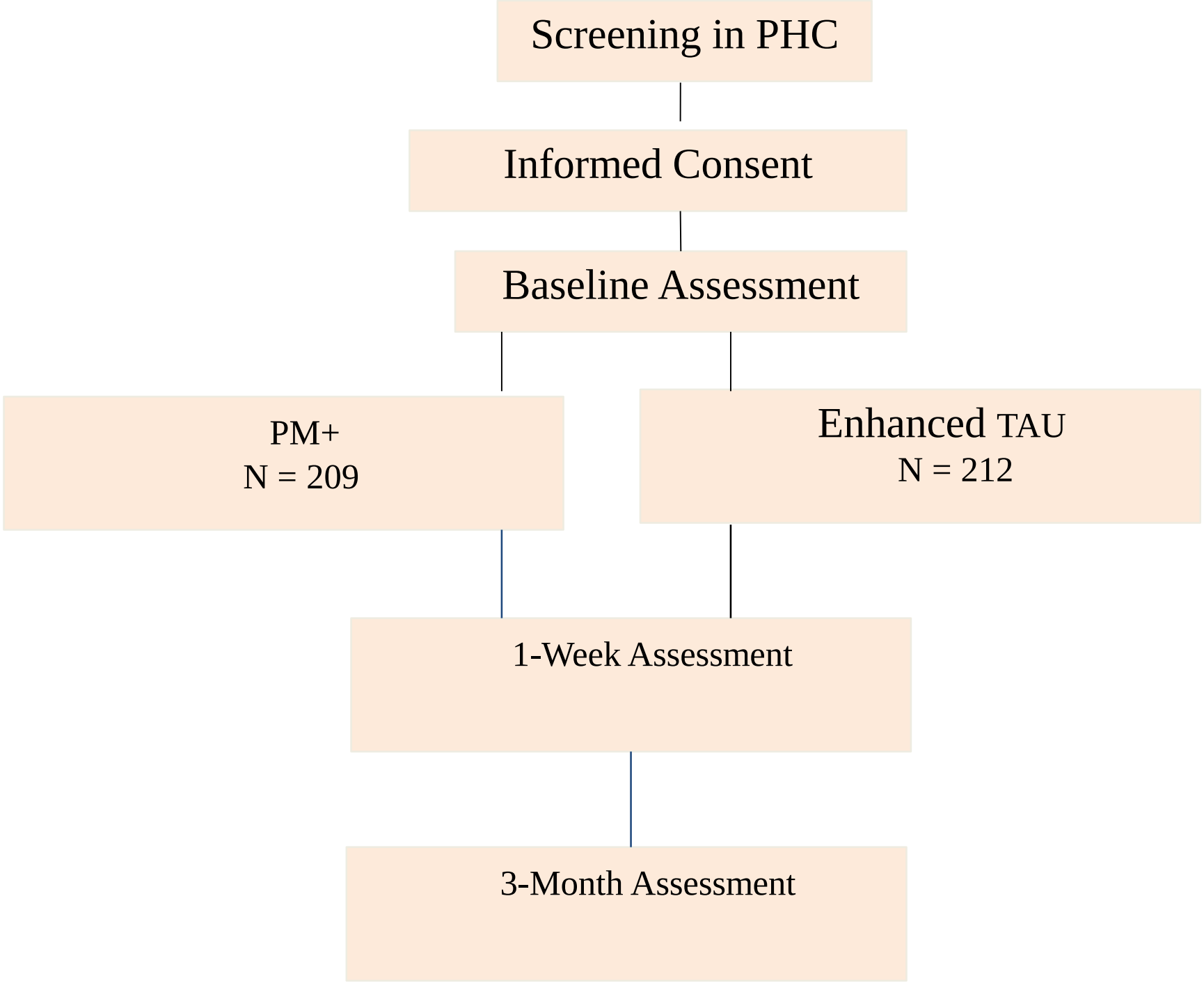
PLOS MEDICINE

RESEARCH ARTICLE

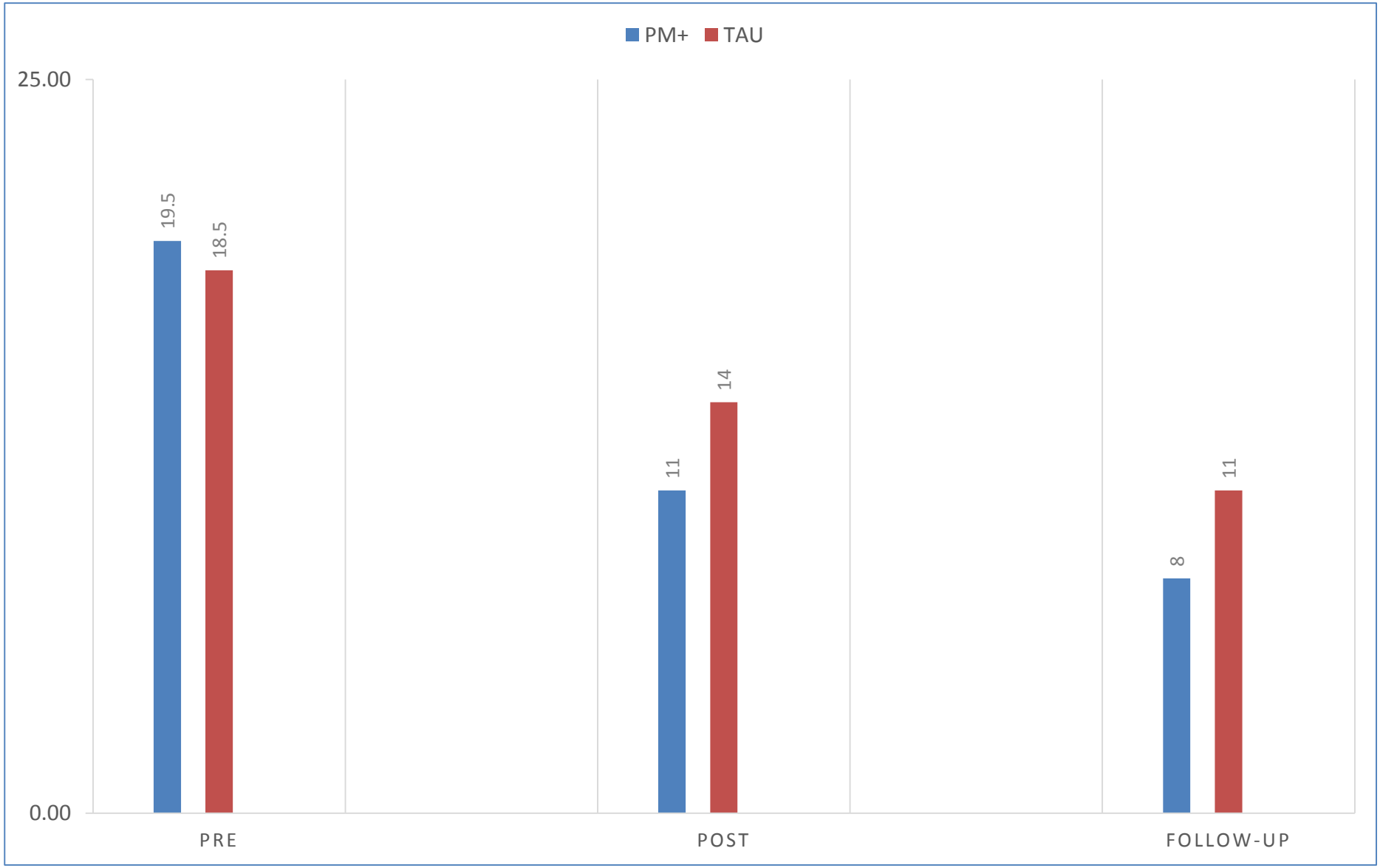
Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial

Richard A. Bryant[1,2]*, Alison Schafer[3], Katie S. Dawson[1,2], Dorothy Anjuri[4], Caroline Mulili[4], Lincoln Ndogoni[5], Phiona Koyiet[4], Marit Sijbrandij[6], Jeannette Ulate[7], Melissa Harper Shehadeh[8], Dusan Hadzi-Pavlovic[1], Mark van Ommeren[8]

1 School of Psychology, University of New South Wales, Sydney, New South Wales, Australia, **2** Westmead


Screening in PHC
Informed Consent
Baseline Assessment
PM+
N = 209
Enhanced TAU
N = 212
1-Week Assessment
3-Month Assessment

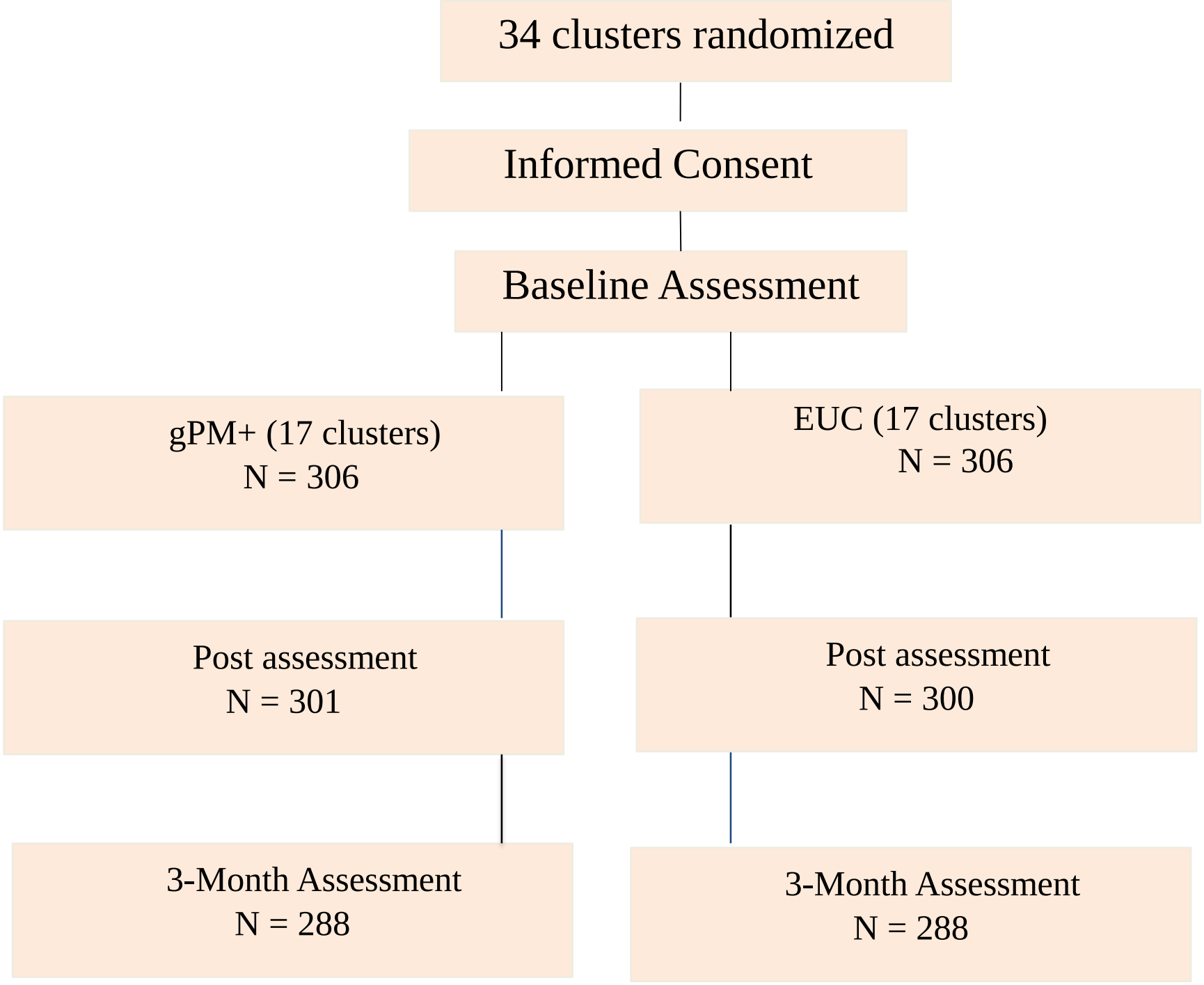
General Health Questionnaire



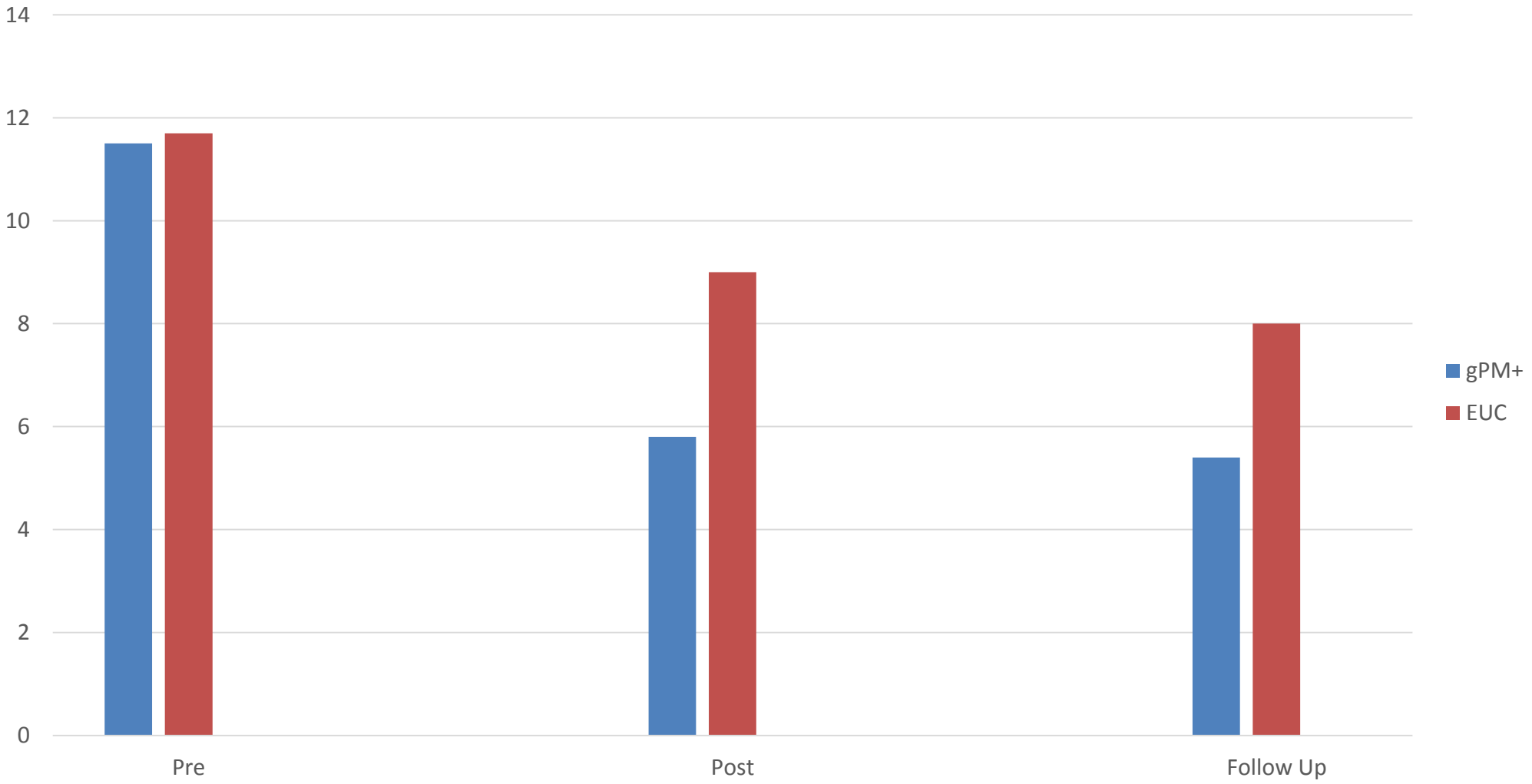
Group PM+

- Scalable interventions need to be delivered in groups
- Also suits many collectivist cultures
- We adapted PM+ to be conducted in groups
- Initial trial conducted in Swat valley in Pakistan

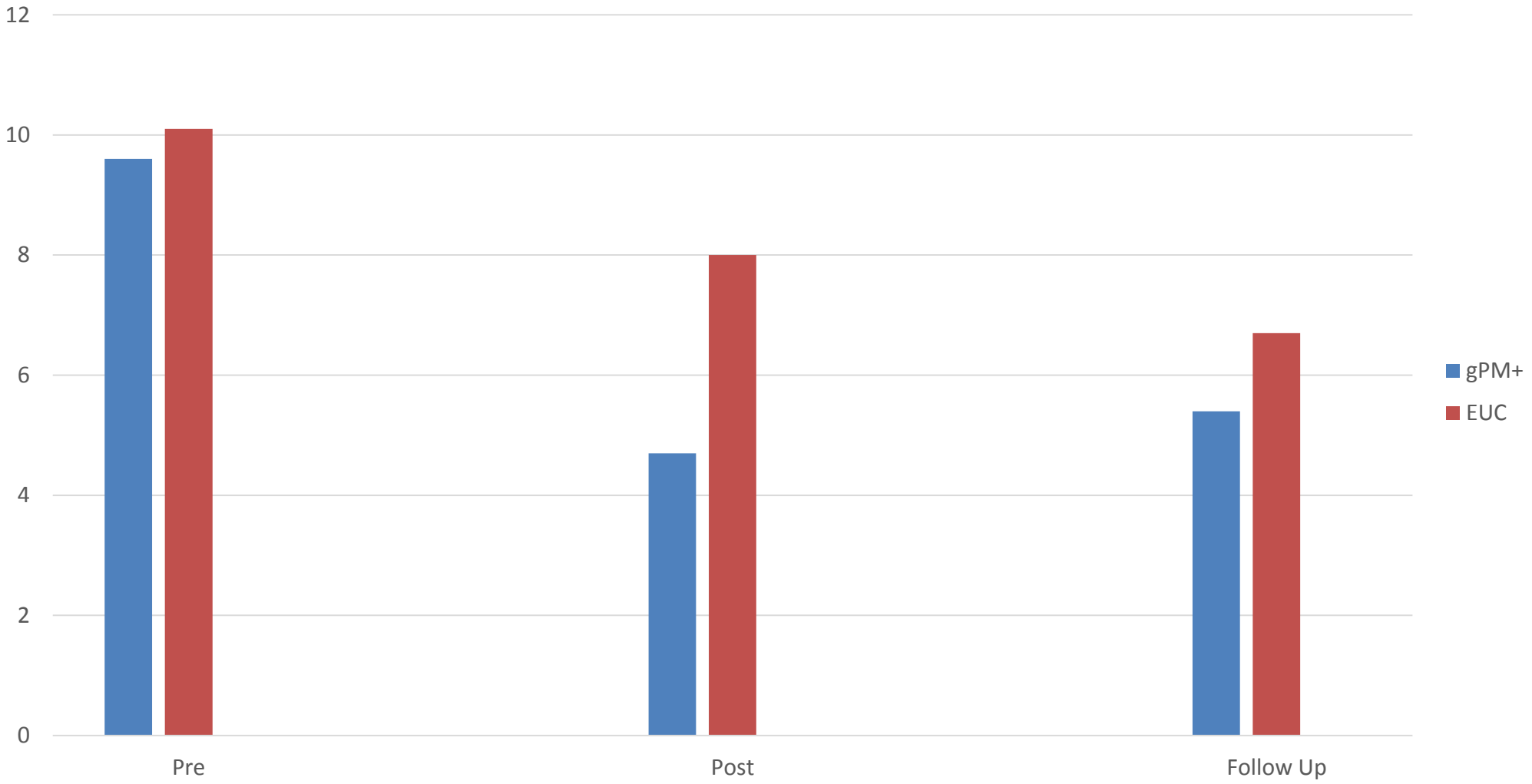
Rahman et al., in press, *Lancet*


34 clusters randomized
Informed Consent
Baseline Assessment
gPM+ (17 clusters)
N = 306
EUC (17 clusters)
N = 306
Post assessment
N = 301
Post assessment
N = 300
3-Month Assessment
N = 288
3-Month Assessment
N = 288

HADS-Anxiety



HADS-Depression



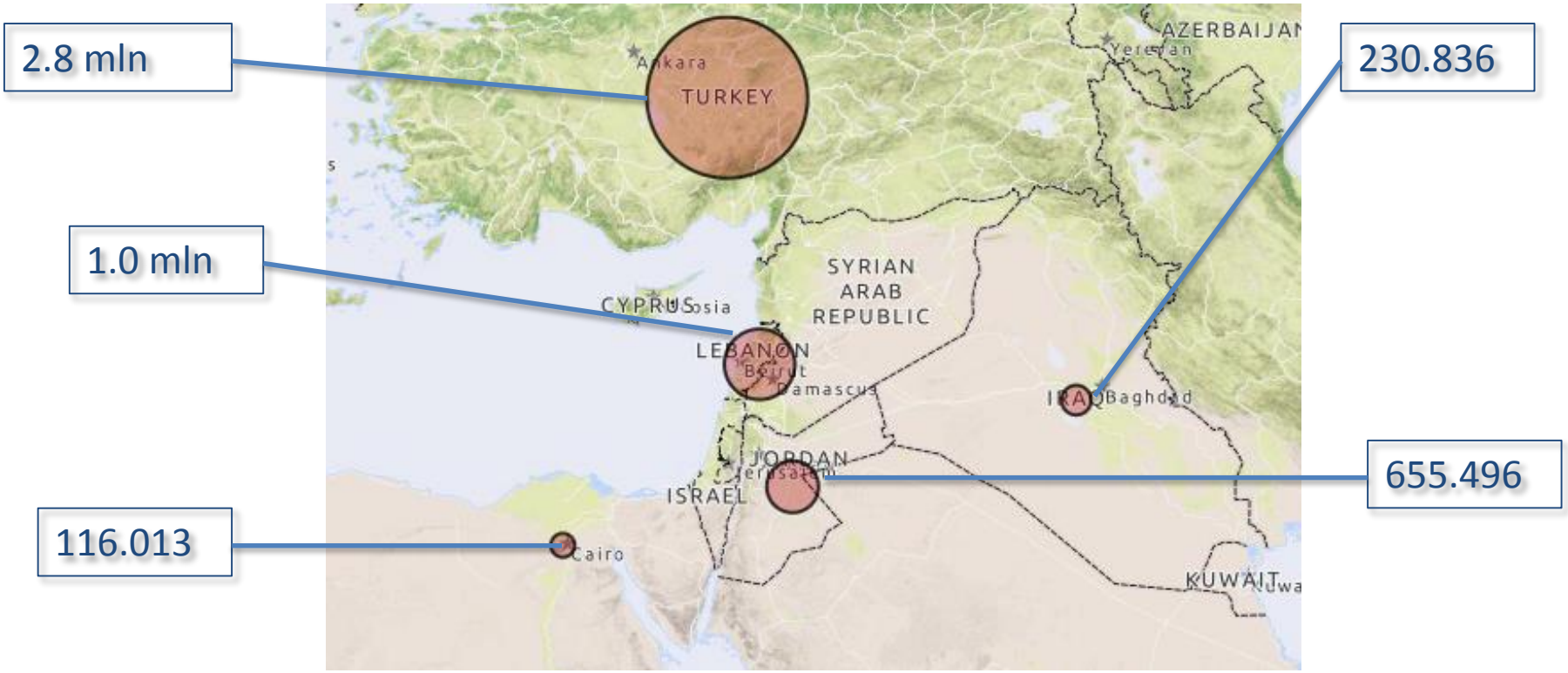
What About Refugees?

- It is one thing to demonstrate an intervention works
- BUT can it can rolled out in a local health system?
- This was always the goal of WHO's agenda

Unprecedented increase in refugees

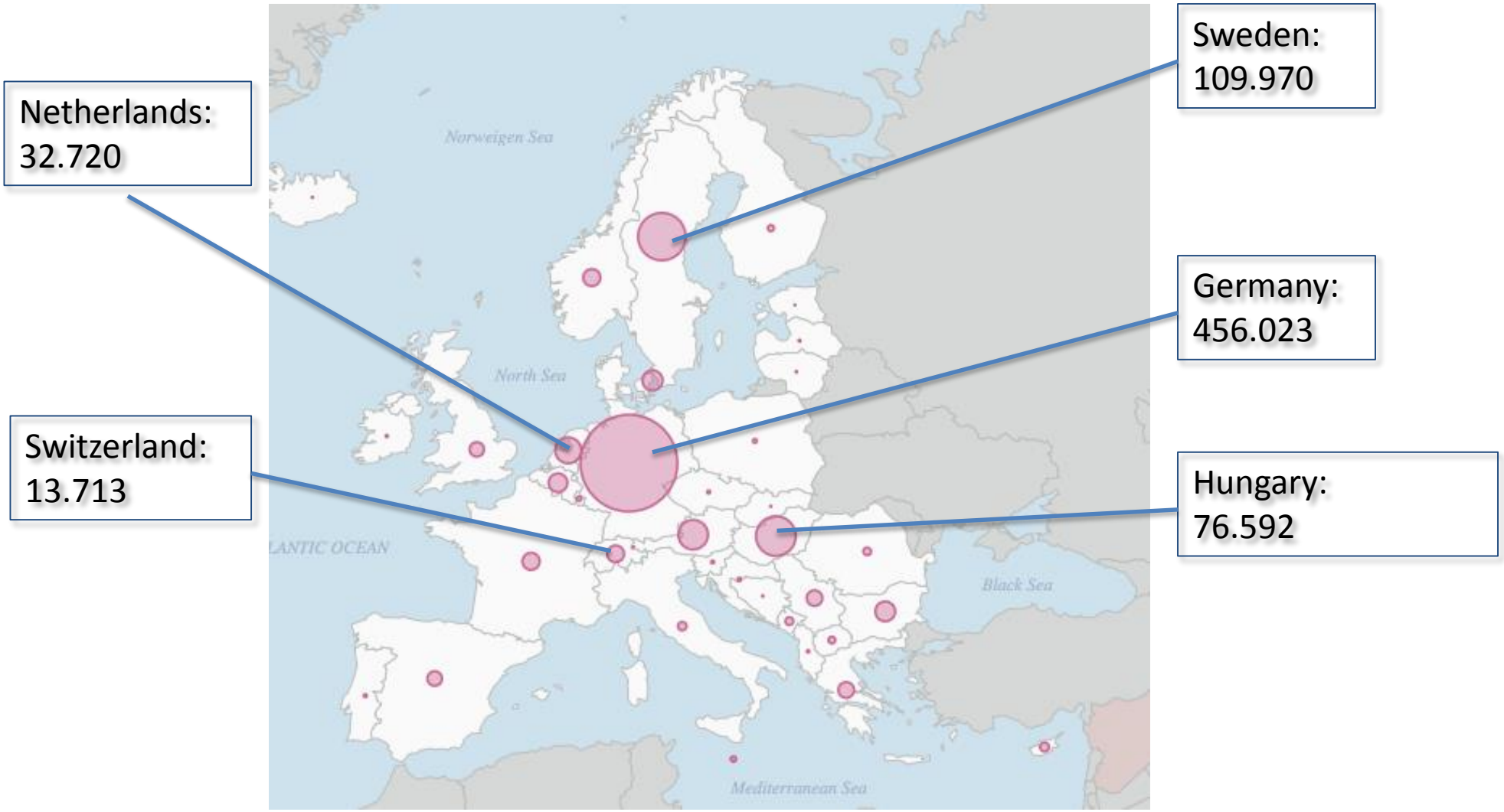
Over 4.8 million Syrian refugees registered by UNHCR

50% children, often unaccompanied



Source: http://data.unhcr.org/syrianrefugees/regional.php; Jan 22, 2017

Asylum applications by Syrians in Europe (April 2011-Oct. 2016)



Source: http://data.unhcr.org/syrianrefugees/asylum.php; Jan 22, 2017

Studies

- Individual PM+ for adult Syrians (Netherlands, Switzerland)
- Group PM+ for adult Syrians (Jordan, Turkey)
- Early Adolescents Skills for Emotions (EASE) (Lebanon, Jordan)
- E-PM+ (app-based version) (Germany, Egypt, Sweden)

Subsequent Steps

- Once trials are complete, implementation phase will complete
- Ramp up training of lay workers across agencies throughout countries and evaluate outcomes
- Aim to lead to increase in evidence-based interventions for refugees in country