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SCHOOL OF PSYCHOLOGY

Addressing the mental health needs of forcibly displaced people

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Overview

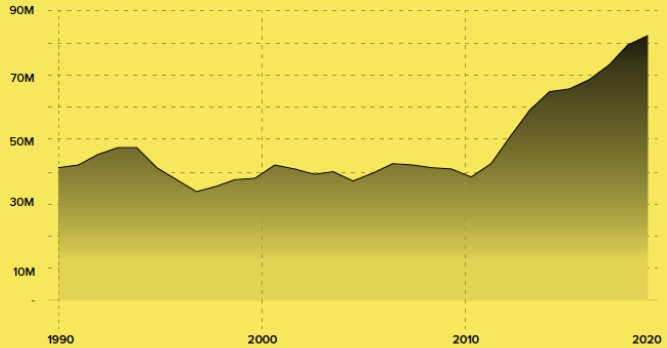
- Reflecting on where refugee numbers are highest
- Prevalence of mental health difficulties in refugee populations
- Predictors of mental health difficulties experienced by refugees and asylum seekers
- Research evaluating interventions for refugees and asylum seekers.

UNHCR Global Trends – Forced Displacement in 2020

82.4 MILLION

FORCIBLY DISPLACED WORLDWIDE

at the end of 2020 as a result of persecution, conflict, violence, human rights violations or events seriously disturbing public order.



26.4 million refugees

20.7 million refugees under UNHCR's mandate

5.7 million Palestine refugees under UNRWA's mandate

48.0 million internally displaced people[1]

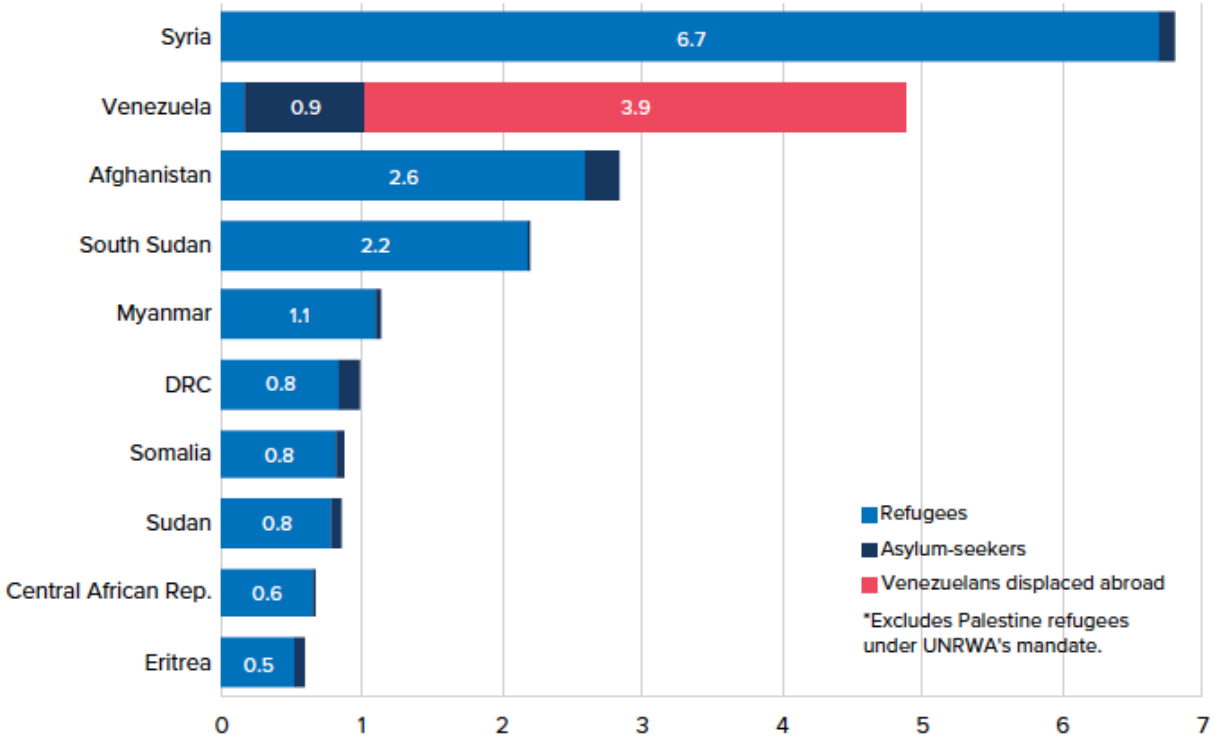
4.1 million asylum-seekers

3.9 million Venezuelans displaced abroad[2]

https://www.unhcr.org/uk/statistics/unhcrstats/60b638e37/global-trends-forced-displacement-2020.html

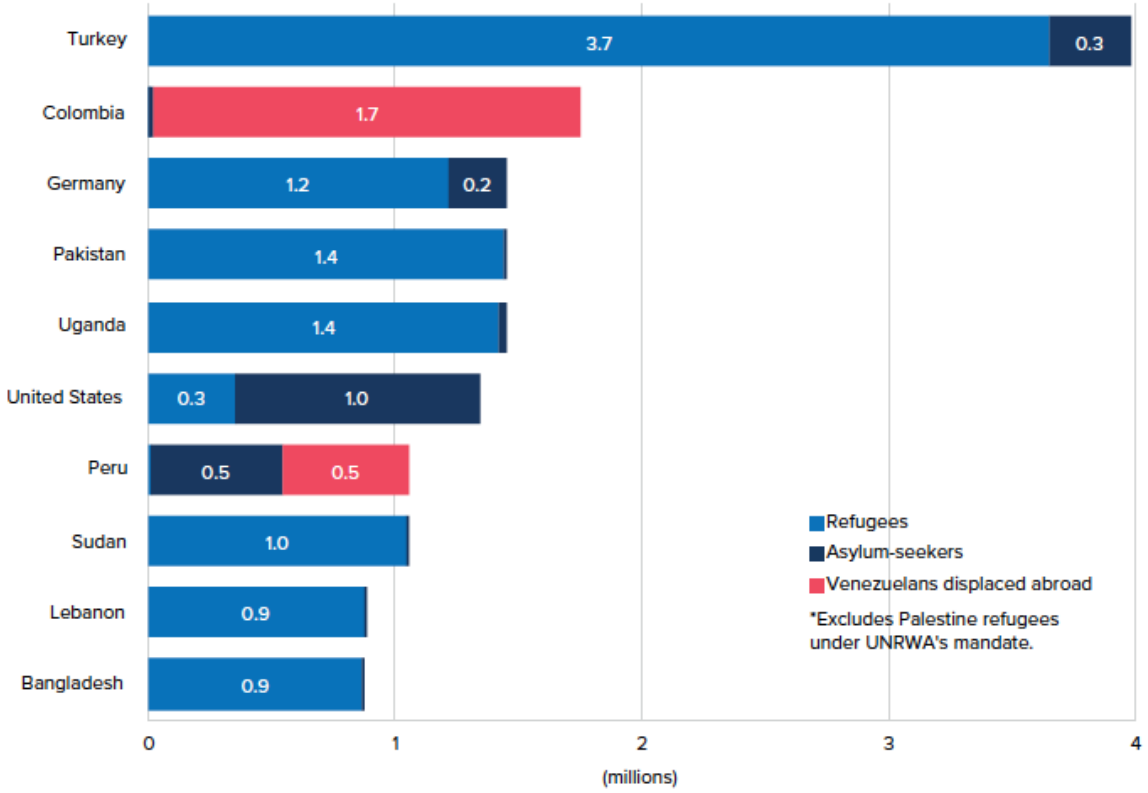
UNHCR Global Trends – Forced Displacement in 2020

Figure 3 | **International displacement situations by country of origin** | end-2020*



UNHCR Global Trends – Forced Displacement in 2020

Figure 4 | **International displacement situations by host country** | end-2020*



2022

- Since 24th February more than 5 million people have been forced to leave Ukraine….

Mental Health of Refugees

Mental Health of Refugees

- A meta-analysis of studies conducted in high-income countries indicated prevalence rates of mental disorders in refugees as:
  - 13% for anxiety disorder diagnoses,
  - 30% for depression diagnosis,
  - 29% for PTSD diagnoses (Henkelmann et al., 2020).
- A meta-analysis of studies conducted in low- or middle-income countries of populations internally displaced or fleeing to neighboring countries due to conflict found prevalence rates of:
  - 13% for mild forms of depression, anxiety, and PTSD
  - 4% for moderately severe forms depression, anxiety, and PTSD.
  - 5% for more severe disorders (e.g. schizophrenia, bipolar disorder, severe depression etc. (Charlson et al., 2019).

Refugees and Migrants aboard fishing boat driven by smugglers reach the coast of the Greek Island of Lesbos after crossing the Aegean sea from Turkey on October 11, 2015. Photo: Antonio Masiello

Mental Health of Refugees

- The Social adversity in the form of '**daily stressors**' (such as lack of access to basic resources, isolation, lack of safety and security, family violence) has been highlighted as an important determinant of CMD (Tol et al., 2014; Whitley, 2015).
- Refugee populations have been shown to experience elevated levels of daily stressors (Miller & Rasmussen, 2014, 2017).

Factors Impacting on Mental Health

Factors associated with mental health difficulties experienced by ASR can be classified into 3 phases of time:

- **Premigration**: Experiences include exposure to war, torture and persecution (Hollifield et al., 2002; Ryan et al., 2008)
- **Migratory journey**: Exploitation, impoverishment and lack of resources (International Migration, Health and Human Rights, 2013)
- **Post-migration**: stressors found to impact MH include perceived stigma, discrimination and the asylum process (Laban et al., 2008; Priebe et al., 2016).

Palestinian refugees queue for food parcels in Yarmouk, Syria. Photograph: Handout/Reuters


REFUGEES
WELCOME
scottish refugee council
30 years

Factors Impacting on Quality of Life

- Van der Boor et al. (2020b) conducted a systematic review of 23 studies evaluating quality of life (QoL) of asylum seekers and refugees in high-income countries.
- Bigger social networks and greater social integration were associated with higher QoL.
- Having mental disorders (i.e. PTSD or depression) was strongly associated with reduced QoL.
- More research is needed into physical and environmental predictors and correlates of QoL.

Mental Health & Wellbeing – An issue of rights

- Rather than being viewed exclusively as a *health* issue, the mental health and psychosocial wellbeing of displaced people needs to be understood as a *human-rights* issue that includes a focus on key principles such as participation in society, non-discrimination, human dignity, and empowerment (White & van der Boor, 2021).
- The *Capability Approach* (Sen, 1999, Nussbaum, 2000) is a human development approach that foregrounds individuals' freedom to engage in forms of being and doing (or *functionings*) that are valuable to them i.e. what constitutes a good life for the person.

Epidemiology and Psychiatric Sciences

cambridge.org/eps

Enhancing the capabilities of forcibly displaced people: a human development approach to conflict- and displacement-related stressors

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Special Article

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Mental health; other psychosocial techniques/treatments; psychotherapy; social environment

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Abstract

Aims. The mental health of individuals who have been forcibly displaced can be impacted both by war-related traumatic events and *displacement-related stressors*, which arise as a consequence of their migratory journey and subsequent experiences. In addition to focusing on mental disorders, there is a need to explore broader psychosocial outcomes that are important for forcibly displaced people. Our aim is to present a coherent explanatory framework to understand *how* both past traumatic events and ongoing stressors operating throughout forcibly displaced people's social environment can impact mental health and psychosocial wellbeing.

Methods. We describe the *capability approach* (CA), a human development framework that foregrounds individuals' freedom to engage in forms of being and doing that are valuable to them. We consider the opportunities that the CA provides for understanding how a myriad of factors can impact forcibly displaced people, and how different forms of support can be configured to meet the needs of particular people and communities.

Results. The CA recognises that various factors can share a common putative causal mechanism in their impact on forcibly displaced people, i.e. these factors limit a person's ability to develop capabilities and their freedom to engage in valued forms of being and doing. The rights based ethos of the CA enables multisectoral and coordinated activity, which can be directed towards addressing factors across the social environment. Importantly, the CA helps to explain why particular forms of support may be more beneficial for individuals or communities at certain times compared to others.

Conclusion. The application of the CA can help to guard against the risk that the aspirations of assessment instruments and interventions aimed at supporting forcibly displaced people are narrowly focused on addressing distress and disorders, to instead adopt a more expansive focus on forcibly displaced people's potential and the possibilities that they wish to realise.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8157507/pdf/S2045796021000263a.pdf

White & van der Boor (2022): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8157507/pdf/S2045796021000263a.pdf

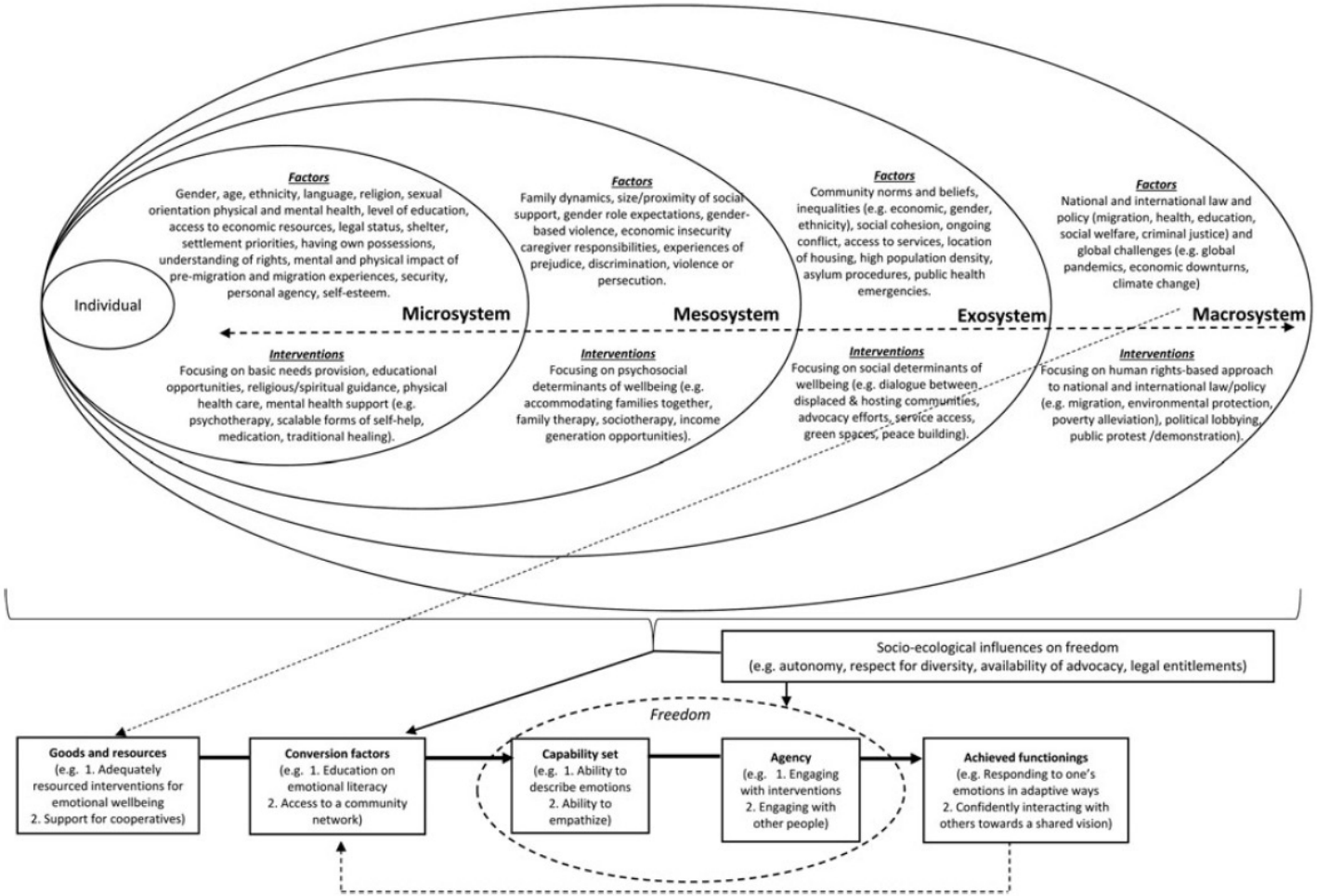


Fig. 1. A capability approach for understanding and supporting the wellbeing of forcibly displaced people.

A “Good Life”

- Focus group discussions with sixteen female refugees living in the UK (Van der Boor et al., 2020a) asking “**What does the term good life mean to you?**”.
- Three main themes were identified:

1. Legal security (i.e. feeling protected by the law),
2. Personal agency (i.e. being able to control one’s own thoughts, feelings and actions)
3. Social cohesion (i.e. feeling connected to other members of society).

This led to the development of the ‘Good Life in the Community Scale’: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-12866-x

A ‘Good Life’

We conducted interviews with 60 adult male and female Congolese refugees living in two refugee settlements in Uganda and Rwanda “**What does ‘having a good life’ mean to you?**” (Robinson et al., 2021):

- Basic needs relating to food and shelter.
- Being well dressed and being clean as important to achieve a ‘good life’.
- Women’s aspirations focused on the wellbeing of their children and material fabric of their homes.
- Men foregrounded opportunities for employment, material possessions that demonstrate their status, and opportunities for greater public participation in community life.

Interventions

Mental health interventions for asylum seekers and refugees

Turrini et al. (2019) - 26 studies included in a meta-analysis of psychological interventions have a clinically significant beneficial effect on:

- PTSD (20 studies, 1370 participants; moderate quality evidence)
- Depression (12 studies, 844 participants; moderate quality evidence)
- Anxiety outcomes (11 studies, 815 participants; moderate quality evidence).

Mental health interventions for asylum seekers and refugees

Turinni et al. (2019)

- 18 studies conducted in HIC, 8 in LMIC
- Most evidence supported interventions based on CBT with a trauma-focused component.
- There is a limited number of studies conducted to date, with a relatively low total number of participants.

Psychosocial Interventions

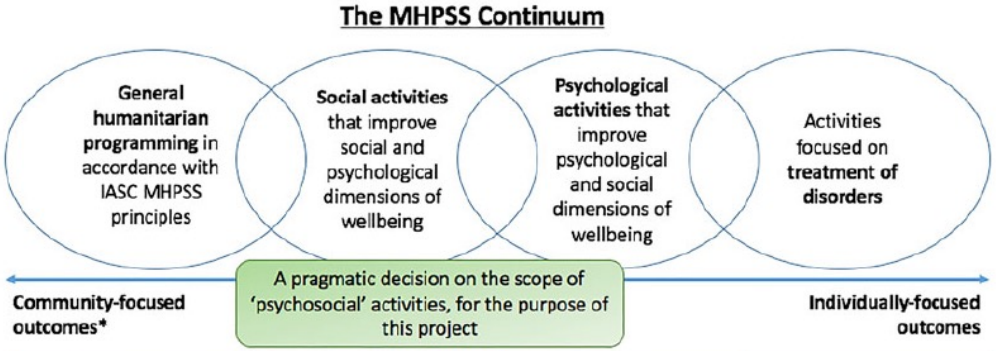
- In low- and middle-income countries, where the vast majority of refugees reside, there is a marked absence of highly skilled professionals available to deliver mental health support (Mendenhall et al., 2014)
- In such settings, group-based forms of psychosocial support that can be facilitated by community members who receive training offer great promise.
- These approaches are socially acceptable and effective in treating common mental disorders, whilst also decreasing pressure on primary health care (Tol et al., 2011; Ventevogel, 2017).

Psychosocial Interventions

- *Psychosocial* interventions include "a range of social activities designed to foster psychological improvement, such as sharing experiences, fostering social support, awareness-raising and psychoeducation"[1].
- The *Mental Health & Psychosocial Support Network* webpage (https://mhpss.net) provides information about various forms of psychosocial support
- Guidelines have also been proposed for delivering psychosocial support in emergency situation (IASC, 2007) and with refugees specifically (UNHCR, 2013;2017)

[1] https://reliefweb.int/report/world/guidelines-mental-health-and-psychosocial-support

The MHPSS Continuum

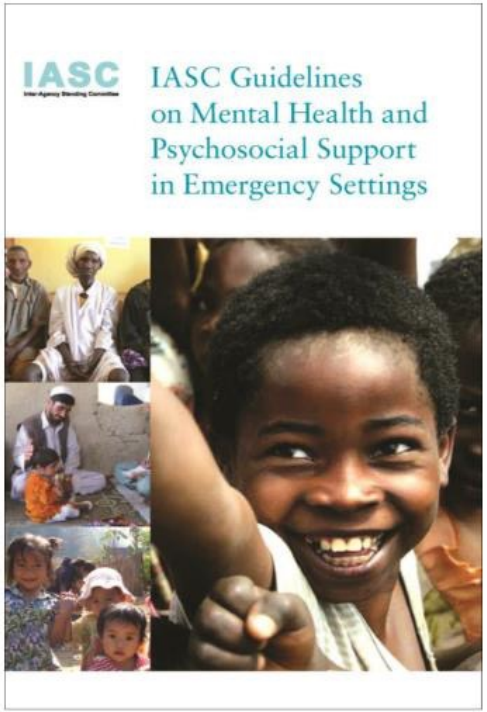


Examples			
Providing nutritional support with respect to dignity	Women's empowerment to prevent GBV and improve wellbeing	Training of individual skills to strengthen social support and coping	Psychotherapeutic treatment of posttraumatic stress disorder
Ensuring participation by affected members in humanitarian response	Community action to restore damaged social fabric	Reducing psychological distress to improve educational outcomes	Pharmacological treatment of major depressive disorder

* Terms from the IASC (forthcoming in 2017) common framework for M&E of MHPSS activities

Lee et al., 2019

IASC Guidelines

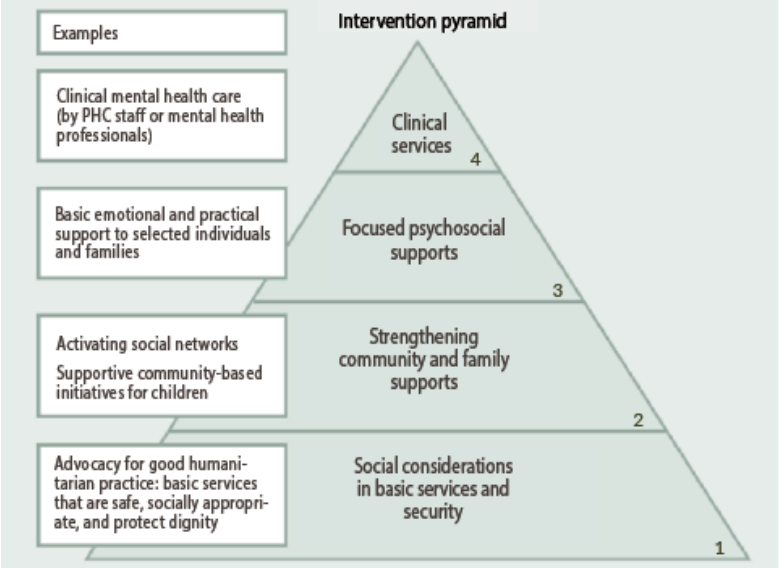


"A significant gap has been the absence of a multi-sectoral, inter-agency framework that enables coordination, identifies useful practices, flags harmful practices and clarifies how different approaches to mental health and psychosocial support complement one another."

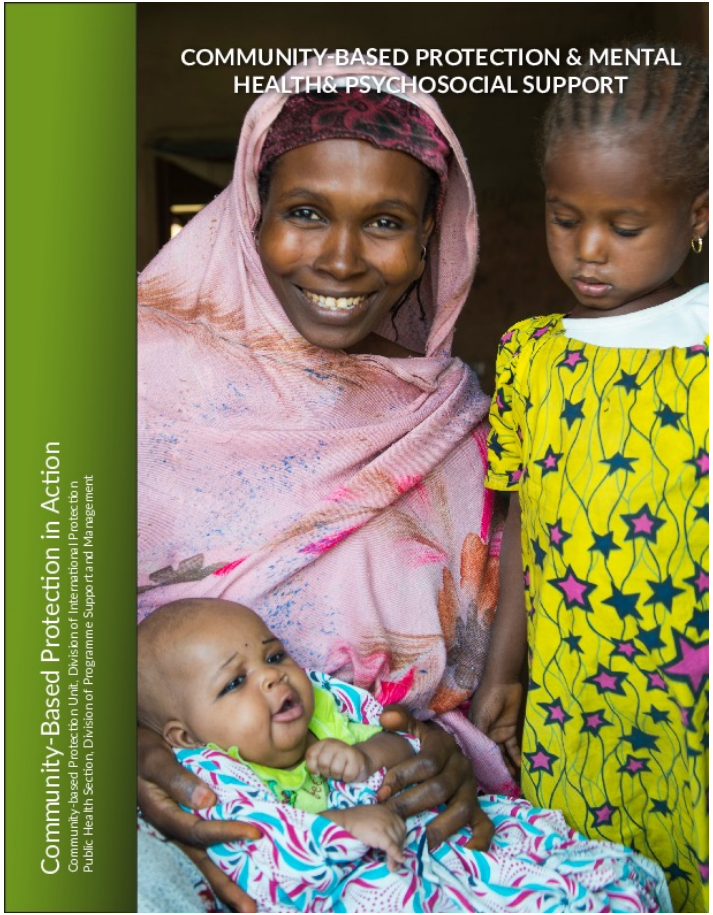
https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf - 2007

IASC Pyramid

FIGURE 1. THE IASC PYRAMID (ADAPTED WITH PERMISSION)



https://app.mhpss.net/?get=309/unicef-cb-mhpss-guidelines1.pdf - 2018

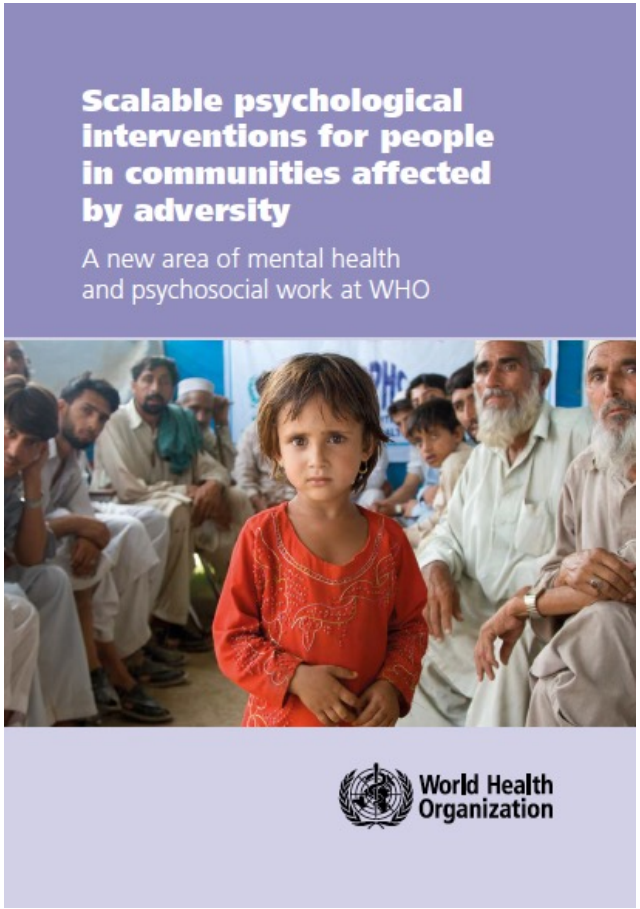


https://resourcecentre.savethechildren.net/node/11929/pdf/unhcr_cbcp_and_mhpss.pdf - 2018

Coordinating Support

Although support such as psychological interventions can bring about positive change for a significant proportion of people, it may be that these interventions need to be delivered in coordination with other forms of support including (but not restricted to):

- Positive social interactions
- Poverty alleviation programmes (e.g. microcredit schemes),
- Educational opportunities,
- Access to transportation
- Affordance of legal protections (e.g. leave to remain in the host country) etc.



(WHO, 2017): https://apps.who.int/iris/bitstream/handle/10665/254581/WHO-MSD-MER-17.1-eng.pdf;jsessionid=10EE8987576E8FD31BD221EFB196D12E?sequence=1

WHO Low-intensity Interventions

- Problem Management +: http://apps.who.int/iris/bitstream/10665/206417/1/WHO_MSD_MER_16.2_eng.pdf
- Thinking Healthy: http://www.who.int/mental_health/maternal-child/thinking_healthy/en/
- Self-Help +: http://onlinelibrary.wiley.com/doi/10.1002/wps.20355/abstract

Research Example 1 – Completed

Female South Sudanese Refugees in Northern Uganda

The Rhino Settlement, Uganda

102,000 refugees from South Sudan
(UNHCR, August 2017)
Language = Juba Arabic

The SH+ Package – based on ACT

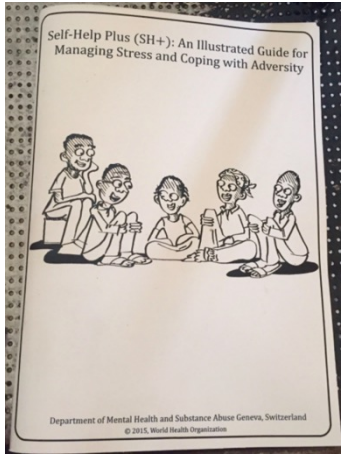
Session	Material Covered
1	**Grounding:** Introduces concepts of stress, how emotions can be similar to being overwhelmed by a storm (emotional storms), and how “grounding” can help. Grounding refers to attending to the breadth of current moment experiences.
2	**Unhooking:** Explains how a person can “unhook” from stress thoughts or emotions. Unhooking is a technique for identifying difficult thoughts and emotions and using grounding to focus on what is around you, so you may be less caught up in struggling with thoughts or emotions.
3	**Doing what matters:** Explains how identifying personal values (e.g. being kind, being a good parent) and behaving in a way that is in line with these values may reduce stress, compared to behaving in a way that is not in line with them. It explores how to engage in actions consistent with values.
4	**Being kind:** This session explains how being kind to oneself and others can help reduce stress. It also introduces the concept of problem solving using personal values.
5	**Making room:** This session reviews all the skills and techniques, finishes problem solving and provides another technique that builds on the concept of

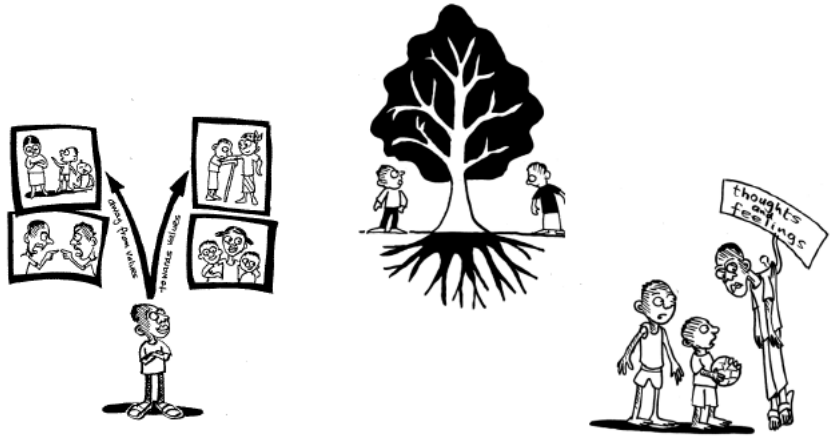
The SH+ Package

SH+ has the following parts:

- **A manual**: provides guidance on the overall intervention. The main resource used by facilitators running a course
- **Audio course:** Contains the audio for the 5 sessions to be used by facilitators when running the course.
- **Illustrated book:** Designed to remind participants of key learning points. Each participant will receive a copy of the book.
- **Pictures and supporting materials:** Used during the course to illustrate important points.

SH+ Package





The SH+ package and audio files are available to download for free:
https://www.who.int/publications/i/item/9789240035119

The SH+ Package

- SH+ groups should be 30 people or less. In many settings it will be preferable for the groups to be single gender.
- Each session lasts between 2 to 2.5 hours and supported by trained facilitators.
- The facilitators manage the course, play the audio, read discussion questions and demonstrate exercises. The package is simple to run after training and practice in how to run a pre-recorded course.

SH+ in Northern Uganda

- Moderate psychological distress using the Kessler 6 (K6) (primary outcome, cut-off ≥5)[6].
- Secondary outcomes:
  - Disability (WHO Disability Assessment Schedule 2.0);
  - Self-defined psychosocial concerns (PSYCLOPS)
  - Depression symptoms (PHQ-9);
  - Post-traumatic stress disorder (PTSD) symptoms (PTSD Checklist Civilian)
  - Hazardous alcohol use (two survey questions)
  - Feelings of anger (shortened explosive anger index);
  - inter-ethnic relations (three survey questions);
  - subjective wellbeing (WHO Wellbeing Index, WHO-5);
  - psychological flexibility (Acceptance and Action Questionnaire).

THE LANCET
Global Health

Articles

Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial

Wietse A Tol, Marx R Leku, Daniel P Lakin, Kenneth Carswell, Jura Augustinavicius, Alex Adaku, Teresa M Au, Felicity L Brown, Richard A Bryant, Claudia Garcia-Moreno, Rashelle J Musci, Peter Ventevogel, Ross G White, Mark van Ommeren

Summary

Background Innovative solutions are required to provide mental health support at scale in low-resource humanitarian contexts. We aimed to assess the effectiveness of a facilitator-guided, group-based, self-help intervention (Self-Help Plus) to reduce psychological distress in female refugees.

Methods We did a cluster randomised trial in rural refugee settlements in northern Uganda. Participants were female South Sudanese refugees with at least moderate levels of psychological distress (cutoff ≥5 on the Kessler 6). The intervention comprised access to usual care and five 2-h audio-recorded stress-management workshops (20–30 refugees) led by briefly trained lay facilitators, accompanied by an illustrated self-help book. Villages were randomly assigned to either intervention (Self-Help Plus or enhanced usual care) on a 1:1 basis. Within 14 villages, randomly selected households were approached. Screening of women in households continued until 20–30 eligible participants were identified per site. The primary outcome was individual psychological distress, assessed using the Kessler 6 symptom checklist 1 week before, 1 week after, and 3 months after intervention, in the intention-to-treat population. All outcomes were measured at the individual (rather than cluster) level. Secondary outcomes included personally identified problems, post-traumatic stress, depression symptoms, feelings of anger, social interactions with other ethnic groups, functional impairment, and subjective wellbeing. Assessors were masked to allocation. This trial was prospectively registered at ISRCTN, number 50148022.

Lancet Glob Health 2020; 8: e254–63

See Comment page e165

Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (W A Tol PhD, D P Lakin PhD, J Augustinavicius PhD, R J Musci PhD); Peter C Alderman Program for Global Mental Health, HealthRight International, New York, NY, USA (W A Tol), and Arua, Uganda (M R Leku MA, A Adaku MB ChB); Department of Mental Health and Substance Abuse (K Carswell DClinPsy, T M Au PhD, M van Ommeren PhD), and

https://www.thelancet.com/action/showPdf?pii=S2214-109X%2819%2930504-2

THE LANCET
Global Health

SH+ in Northern Uganda

- Trial completed Dec 2017 (n=679). At 3-month follow-up: 8% attrition rate
- 83% average session attendance
- There were larger mean post-intervention differences for the SH+ condition on all outcome measures.

	Effect size Posttreatment	p	Effect size follow-up	p
Psychological distress (K6)	-.72	<.0001	-.26	.04
Self-defined concerns (PSYCHLOPS)	-.58	<.0001	-.25	.06
PTSD symptoms	-.68	<.0001	-.30	.02
Depression symptoms	-.75	.0003	-.31	.03
Explosive anger	OR=.50	.002	OR=.63	.04
Interethnic relationships	-.06	.37	-.07	.30
Psychological flexibility	.42	.02	.09	.66
Disability (functional impairment) (WHODAS 2.0)	-.77	<.0001	-.30	.05
Subjective wellbeing	.51	.0006	.36	.0028

RESEARCH REPORT

Effectiveness of a WHO self-help psychological intervention for preventing mental disorders among Syrian refugees in Turkey: a randomized controlled trial

Ceren Acarturk[1], Ersin Uygun[2], Zeynep Ilkkursun[1], Kenneth Carswell[3], Federico Tedeschi[4], Mine Batu[2], Sevde Eskici[1], Gulsah Kurt[1], Minna Anttila[5], Teresa Au[3], Josef Baumgartner[6], Rachel Churchill[7], Pim Cuijpers[8], Thomas Becker[9], Markus Koesters[9], Tella Lantta[5], Michela Nosè[4], Giovanni Ostuzzi[4], Mariana Popa[10], Marianna Purgato[4,11], Marit Sijbrandij[8], Giulia Turrini[4], Maritta Välimäki[5], Lauren Walker[7], Johannes Wancata[6], Elisa Zanini[4], Ross G. White[10], Mark van Ommeren[3], Corrado Barbui[4,11]

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Refugees are at high risk of developing mental disorders. There is no evidence from randomized controlled trials (RCTs) that psychological interventions can prevent the onset of mental disorders in this group. We assessed the effectiveness of a self-help psychological intervention developed by the World Health Organization, called Self-Help Plus, in preventing the development of mental disorders among Syrian refugees experiencing psychological distress in Turkey. A two-arm, assessor-masked RCT was conducted in two Turkish areas. Eligible participants were adult Syrian refugees experiencing psychological distress (General Health Questionnaire ≥3), but without a diagnosis of mental disorder. They were randomly assigned either to the Self-Help Plus arm (consisting of Self-Help Plus combined with Enhanced Care as Usual, ECAU) or to ECAU only in a 1:1 ratio. Self-Help Plus was delivered in a group format by two facilitators over five sessions. The primary outcome measure was the presence of any mental disorder assessed by the Mini International Neuropsychiatric Interview at six-month follow-up. Secondary outcome measures were the presence of mental disorders at post-intervention, and psychological distress, symptoms of post-traumatic stress disorder and depression, personally identified psychological outcomes, functional impairment, subjective well-being, and quality of life at post-intervention and six-month follow-up. Between October 1, 2018 and November 30, 2019, 1,186 refugees were assessed for inclusion. Five hundred forty-four people were ineligible, and 642 participants were enrolled and randomly assigned to either Self-Help Plus (N=322) or ECAU (N=320). Self-Help Plus participants were significantly less likely to have any mental disorders at six-month follow-up compared to the ECAU group (21.69% vs. 40.73%; Cramer's V=0.205, p<0.001, risk ratio: 0.533, 95% CI: 0.408-0.696). Analysis of secondary outcomes suggested that Self-Help Plus was not effective immediately post-intervention, but was associated with beneficial effects at six-month follow-up in terms of symptoms of depression, personally identified psychological outcomes, and quality of life. This is the first prevention RCT ever conducted among refugees experiencing psychological distress but without a mental disorder. Self-Help Plus was found to be an effective strategy for preventing the onset of mental disorders. Based on these findings, this low-intensity self-help psychological intervention could be scaled up as a public health strategy to prevent mental disorders in refugee populations exposed to ongoing adversities.

Key words: Refugees, prevention, common mental disorders, Self-Help Plus, psychological intervention, public health strategy, randomized controlled trial

(World Psychiatry 2022;21:88–95)

https://onlinelibrary.wiley.com/doi/epdf/10.1002/wps.20939

Psychotherapy and Psychosomatics

Standard Research Article

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Effectiveness of Self-Help Plus in Preventing Mental Disorders in Refugees and Asylum Seekers in Western Europe: A Multinational Randomized Controlled Trial

Marianna Purgato[a, b] Kenneth Carswell[c] Federico Tedeschi[a] Ceren Acarturk[d] Minna Anttila[e] Teresa Au[c] Malek Bajbouj[f] Josef Baumgartner[g] Massimo Biondi[h] Rachel Churchill[i] Pim Cuijpers[j, m] Markus Koesters[k] Chiara Gastaldon[a, b] Zeynep Ilkkursun[d] Tella Lantta[e] Michela Nosè[a, b] Giovanni Ostuzzi[a, b] Davide Papola[a, b] Mariana Popa[l] Valentina Roselli[h] Marit Sijbrandij[j, m] Lorenzo Tarsitani[h] Giulia Turrini[a, b] Maritta Välimäki[e] Lauren Walker[n] Johannes Wancata[g] Elisa Zanini[a] Ross White[l] Mark van Ommeren[c] Corrado Barbui[a, b]

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https://www.karger.com/Article/Pdf/517504

RE-DEFINE: SH+ Preventive Approach

- *Refugee Emergency: DEFining and Implementing Novel Evidence-based psychosocial intervention* (RE-DEFINE): http://re-defineproject.eu/
- Two RCTs conducted in assessed the effectiveness of the ACT-based SH+ intervention for preventing mental disorders among refugees:
  1) Five EU countries (n = 459)
  2) Turkey (n = 642)
- Adult refugees experiencing psychological distress, but no mental disorder, were randomized into Enhanced Treatment as Usual (ETAU) or SH+.
- The primary outcome measure was the Mini International Neuropsychiatric Interview (MINI).

RE-DEFINE: SH+ Preventive Approach

- In Turkey RCT, **SH+ participants had half the risk of having developed any mental disorder at 6-month follow-up** compared to ETAU (Cramer's V 0.205, p<0.001, R Risk Ratio 0.533, 95%; CI 0.408 to .696), with no differences at post-intervention.
- In EU trial, **SH+ participants had half the risk of mental disorders at post-intervention** (Cramer's V 0.13, p= 0.01, Risk Ratio 0.50, 95%; CI 0.29 to 0.87), with no differences at 6-months follow-up (Cramer's V 0.007, p= 0.90, RR 0.96, 95%; CI 0.52 to 1.78).
- Findings suggests that SH+ is effective for preventing mental disorders among refugees.

Research Example 2 – Ongoing
Congolese Refugees in Uganda and Rwanda

COmmunity-based **S**ocio-**T**herapy – **A**dapted for Refugees (COSTAR)

Project Oversight Group Meeting

@CostarProject

The Project

- *Full Title:* Treating depressive symptomatology in Congolese Refugees in Uganda and Rwanda: Adapting and Evaluating Community-based Sociotherapy

- *Funder:* ESRC/AHRC GCRF ‘New social & cultural insights into mental, neurological and substance use disorders in developing countries’

- *Total FEC Grant Award:* £1,152,626.04 (subject to confirmation)

The Context

Democratic Republic of the Congo (DRC) has been subject to three major conflicts in the last 20 years:

- *First Congo War* from 1996-1997
- *Second Congo War* from 1998-2003
- *Kivu Conflicts in Eastern DRC* from 2004-present

The Context

- In early 2020, Uganda (422,989) and Rwanda (76,266) were the 1st and 4th largest recipient of refugees from the DRC respectively (UNHCR, 2020a).
- A survey of people living in Eastern DRC, where the majority of refugees originate, found that 40.5% met criteria for major depressive disorder and 25.9% reported suicidal ideation over a 1-year recall period (Johnson et al., 2010)
- It has been estimated that 54% of female refugees from the DRC living in Uganda are experiencing depression (Morof et al., 2014).

The Intervention

- Community-based Sociotherapy (CBS) is delivered in 15 weekly group sessions of 3 hours duration. Group members are facilitated to focus on phases of safety, trust, care, respect, new life orientations and memory (Richters et al., 2010).

- *Heal me, I heal you*.

- Kinyarwanda: **Mvura-Nkuvure**

- Kiswahili: **Ni Ponye, Ni Ku Ponye**

The Intervention

- Community-based Sociotherapy consists of 6 phases:
  - *Safety*
  - *Trust*
  - *Care*
  - *Respect*
  - *New Life directions*
  - *Memory*
- CBS guided by the following principles:
  - Interest, Equality, Democracy, Responsibility, Participation, Learning by Doing and Here-and-Now

The Trial

- Cluster RCT comparing aCBS with enhanced care as usual (ECU)
- This will involve the running of 16 CBS groups in Rwanda and 16 CBS groups in Uganda. The groups in each country will be delivered in 2 blocks of 8 groups
- Training and supervision for 16 facilitators in Rwanda and Uganda will be provided by CBS Rwanda. The fidelity of aCBS delivery will be monitored in a subset (10%) of randomly selected sessions using an existing checklist.
- ECU will involve NGO staff and healthcare workers receiving training on *IASC Guidelines on Mental health and Psychosocial support in emergency settings*, and the reviewing/updating of mental health referral pathways, and participants attending weekly updates on news in the refugee settlement & UN Sustainable Development Goals

The Partners

COMMUNITY BASED
SOCIOTHERAPY

Visit to Gihembe Refugee Camp – September 2018

Visit to Gihembe Refugee Camp

Visit to Gihembe Refugee Camp

Visit to Kyangwali, Uganda – May 2019

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Conflict and Health

RESEARCH Open Access

Exploring the mental health and psychosocial problems of Congolese refugees living in refugee settings in Rwanda and Uganda: a rapid qualitative study

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Abstract

Background: Refugees fleeing conflict often experience poor mental health due to experiences in their country of origin, during displacement, and in new host environments. Conditions in refugee camps and settlements, and the wider socio-political and economic context of refugees' lives, create structural conditions that compound the effects of previous adversity. Mental health and psychosocial support services must address the daily stressors and adversities refugees face by being grounded in the lived reality of refugee's lives and addressing issues relevant to them.

Methods: We undertook a rapid qualitative study between March and May 2019 to understand the local prioritisation of problems facing Congolese refugees living in two refugee settings in Uganda and Rwanda. Thirty free list interviews were conducted in each setting, followed by 11 key informant interviews in Uganda and 12 in Rwanda.

Results: Results from all interviews were thematically analysed following a deductive process by the in-country research teams. Free list interview findings highlight priority problems of basic needs such as food, shelter, and healthcare access; alongside contextual social problems including discrimination/inequity and a lack of gender equality. Priority problems relating to mental and psychosocial health explored in key informant interviews include discrimination and inequity; alcohol and substance abuse; and violence and gender-based violence.

(Continued on next page)

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The 'good life', personal appearance, and mental health of Congolese refugees in Rwanda and Uganda

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ABSTRACT

Rationale: Research into mental health and wellbeing recognises the role of positive mental health to enable people to lead healthy and emotionally fulfilling lives. Mental health difficulties continue to be associated with high levels of disability worldwide, and refugees fleeing conflict are known to suffer from poor mental health for years after their forced migration.

Method: Informed by Sen's Capability Approach and as part of a wider research project, we used semi-structured interviews to engage with 60 men and women in two refugee communities in Uganda and Rwanda to explore their aspirations and what a 'good life' meant to them.

Findings: While aspects of what constituted a good life were gendered, both men and women struggled to achieve their aspirations within their communities. Following the basic needs of food and shelter, the complex needs of being dressed well and being clean were consistently associated with be able to achieve a 'good life' by women and men across age groups. Looking good and being clean were highly valued and associated with gaining the respect of others, achieving good relationships with neighbours, and avoiding conflict. Participants identified personal appearance and related social status as critical precursors to their successful engagement with other gendered dimensions of social and economic life in their communities, such as finding employment and being well regarded in their religious communities.

Conclusions: Our findings suggest that without the means to present a good appearance, people living in refugee communities may experience feelings of shame and isolation and are unable to gain self-respect and the respect of others needed to achieve the positive mental and physical health they associate with leading 'a good life'.

https://www.sciencedirect.com/science/article/pii/S0277953621009734

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Conflict and Health

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Translating, contextually adapting, and pilot testing of psychosocial and mental health assessment instruments for Congolese refugees in Rwanda and Uganda

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Abstract

Background: Forcibly displaced people are at elevated risk of experiencing circumstances that can adversely impact on mental health. Culturally and contextually relevant tools to assess their mental health and psychosocial needs are essential to inform the development of appropriate interventions and investigate the effectiveness of such interventions.

Methods: We conducted two related studies: (1) to translate and contextually adapt the Patient Health Questionnaire (PHQ-9), a measure of depressive symptomatology, along with assessment instruments measuring levels of daily stress (Checklist for Daily & Environmental Stressors; CDES), social capital (Shortened and Adapted Social Capital Assessment Tool; SASCAT) and perceived social support (Multidimensional Scale of Perceived Social Support; MSPSS) for use with Congolese refugees; (2) to conduct pilot testing of the assessment instruments (including cognitive interviewing about participants' views of completing them) and a validation of the adapted PHQ-9 using a 'known group' approach by recruiting Congolese refugees from refugee settings in Rwanda (n = 100) and Uganda (n = 100).

Results: Study 1 resulted in the translation and adaptation of the assessment instruments. No substantive adaptations were made to the SASCAT or MSPSS, while notable linguistic and contextual adaptations were made in both sites to the CDES and the PHQ-9. The cognitive interviewing conducted in Study 2 indicated that the adapted assessment instruments were generally well received by members of the refugee communities. Participants recruited on the basis that local informants adjudged them to have high levels of depressive symptoms had significantly higher PHQ-9 scores (M = 11.02; SD = 5.84) compared to those in the group adjudged to have low levels of depressive symptoms (M = 5.66; SD = 5.04). In both sites, the adapted versions of the PHQ-9 demonstrated concurrent validity via significant positive correlations with levels of daily stressors. Each of the four adapted assessment instruments demonstrated at least adequate levels of internal consistency in both sites.

Conclusions: The adapted versions of the PHQ-9, CDES, SASCAT and MSPSS are appropriate for use amongst Congolese refugees in Rwanda and Uganda. We recommend further application of the approaches used in the current studies for contextually adapting other assessment instruments in humanitarian settings.

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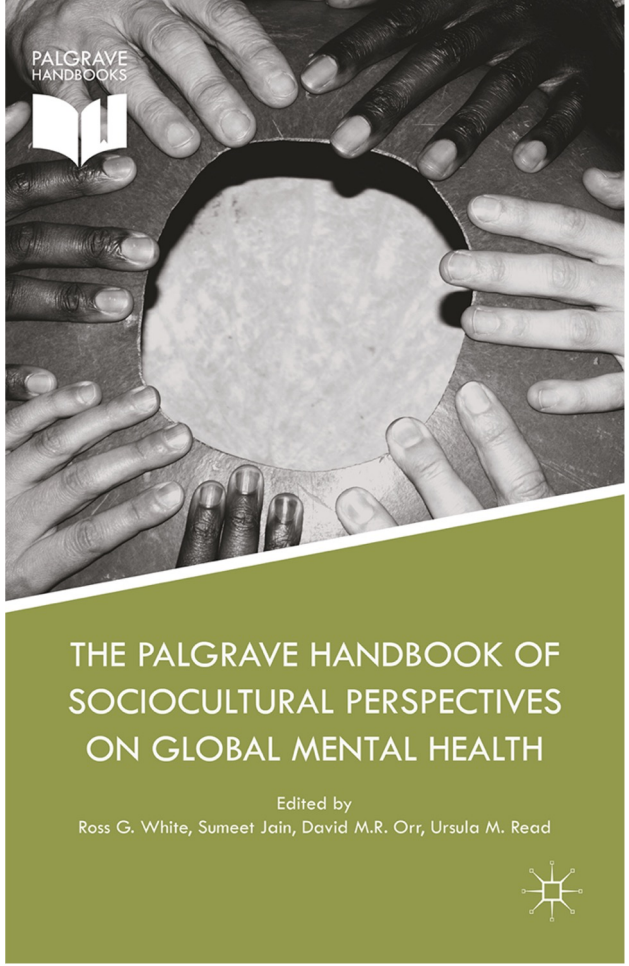

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