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Migration and Mental Health of Young People

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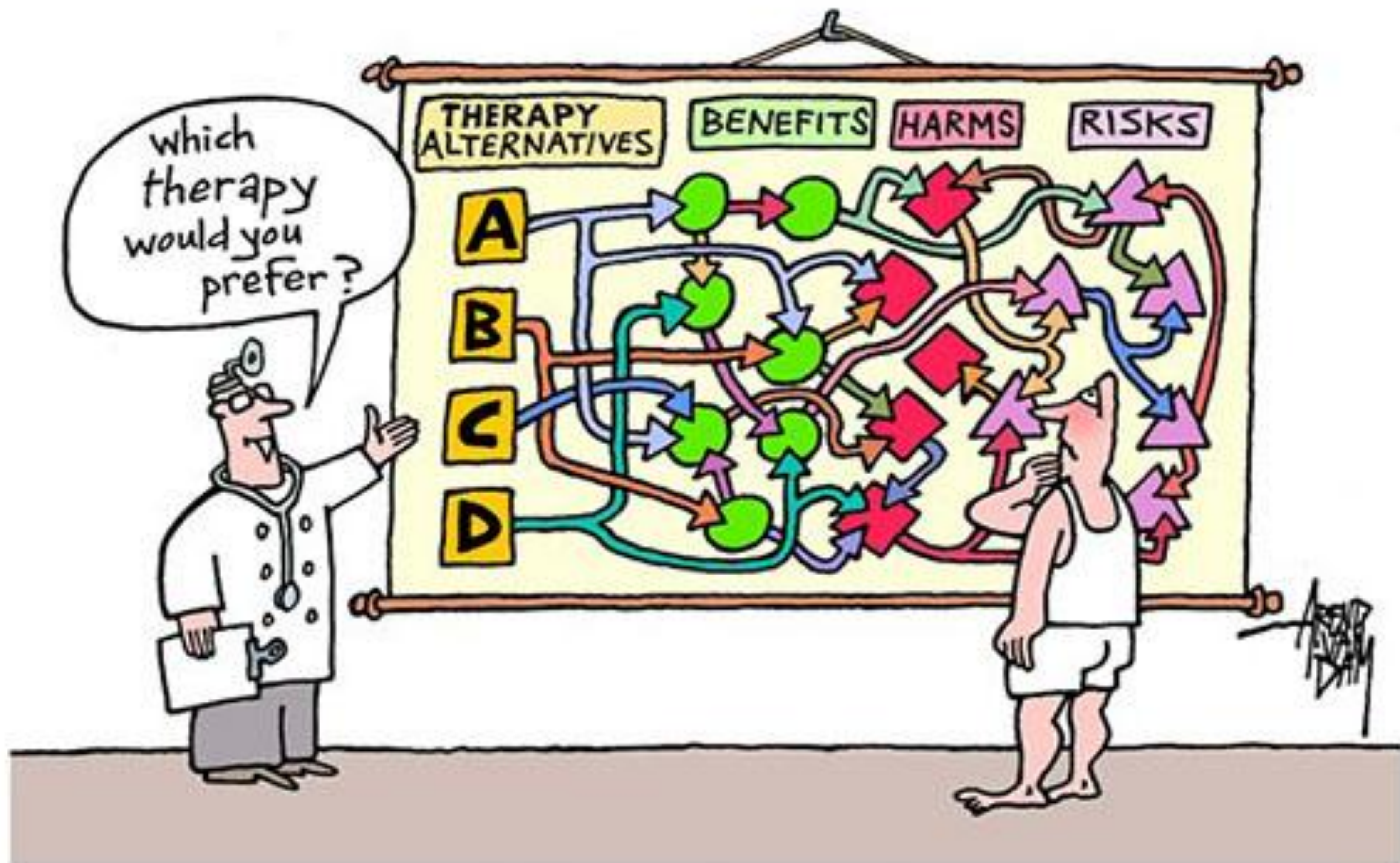
This talk will cover

- Definitions & Numbers
- Reasons for migration
- Psychopathology & Needs
- Mental health service contact & provision



informed consent

Depression- The Disorder
Symptoms

- Low mood/sadness
- Loss of enjoyment
- Loss of energy

Changes to:

Appetite / Weight-(↓ / ↑)

Sleep- (↓ / ↑)

Concentration

Thoughts:Pessimism,Guilt

Self esteem/confidence

Libido

Psychomotor agitation/retardation

Self harm / Suicide

Posttraumatic stress disorder

A Exposure to an exceptionally threatening or catastrophic stressful event, that would cause distress in almost anyone.

B. “Reliving” of experience, eg flashbacks, vivid memories, recurring dreams.

C Avoidance of circumstances associated with event.

D Hyperarousal: inability to9 recall stressor; insomnia, poor concentration, hypervigilance

Other

- Emotional Disorder

Depressive and/ or anxiety symptoms

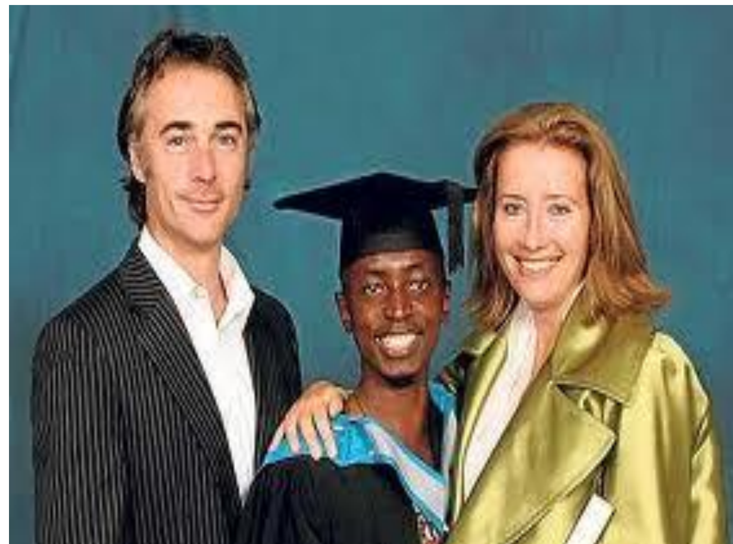
- Hyperkinetic Disorder

Persistence onset < 6 years, Inattention, overactivity, impulsivity.

- Psychosis

Experience of delusions [fixed false beliefs] and /or hallucinations [perception without external stimulus]

Credit: The Guardian



Ethnicity

- Specific culture/language/religion and identity of one social group
- Changes over time
- May change with migration
- May be associated with specific forms of family organisation
- Association culture/ethnicity and social class/economic variables

Reasons for migration

Political

Persecution

Organised violence

-> deaths family

Destruction of community/ economy

Planning limited

Economic

Persecution variable/low

Loss of family

-> famine/disease

Usually stable family/community

Planned migration usual

Resettlement stressors

Political

Mobility in new country

Family separation usual

Poverty typical /variable/

Loose occupation

Exposure to new language/culture

Discrimination/racism

No (early) return to community

Economic

Initial mobility

Family together/may reunite

Poverty typical

Variable; gain skills

Exposure to new language/culture

Discrimination/racism

Ongoing links community

Why is the prevalence of common psychiatric disorders so similar across ethnic groups?

- Reviews equivocal :

  e.g. Stevens & Vollebergh, 2008 -> migrant children not different

- In Britain children in main minority groups may have similar or better mental health than White British children; higher rates rarer disorders [Goodman et al 2008]

Why is the prevalence of common psychiatric disorders so similar across ethnic groups?

- Resilient families migrate
- Diverse reasons for migration
- Importance of protective factors

  i. reduced intake alcohol

  ii lower rates divorce/parental separation

  iii high aspirations of immigrants eg education
- Generational effects of migrants/duration of settlement

Why do British Indian children have an apparent mental health advantage?

- To confirm the mental health advantage of British Indian children compared with white British children
- To explain this with reference to child, family, school and area characteristics

(Goodman A et al, 2010)

Methods

Sample

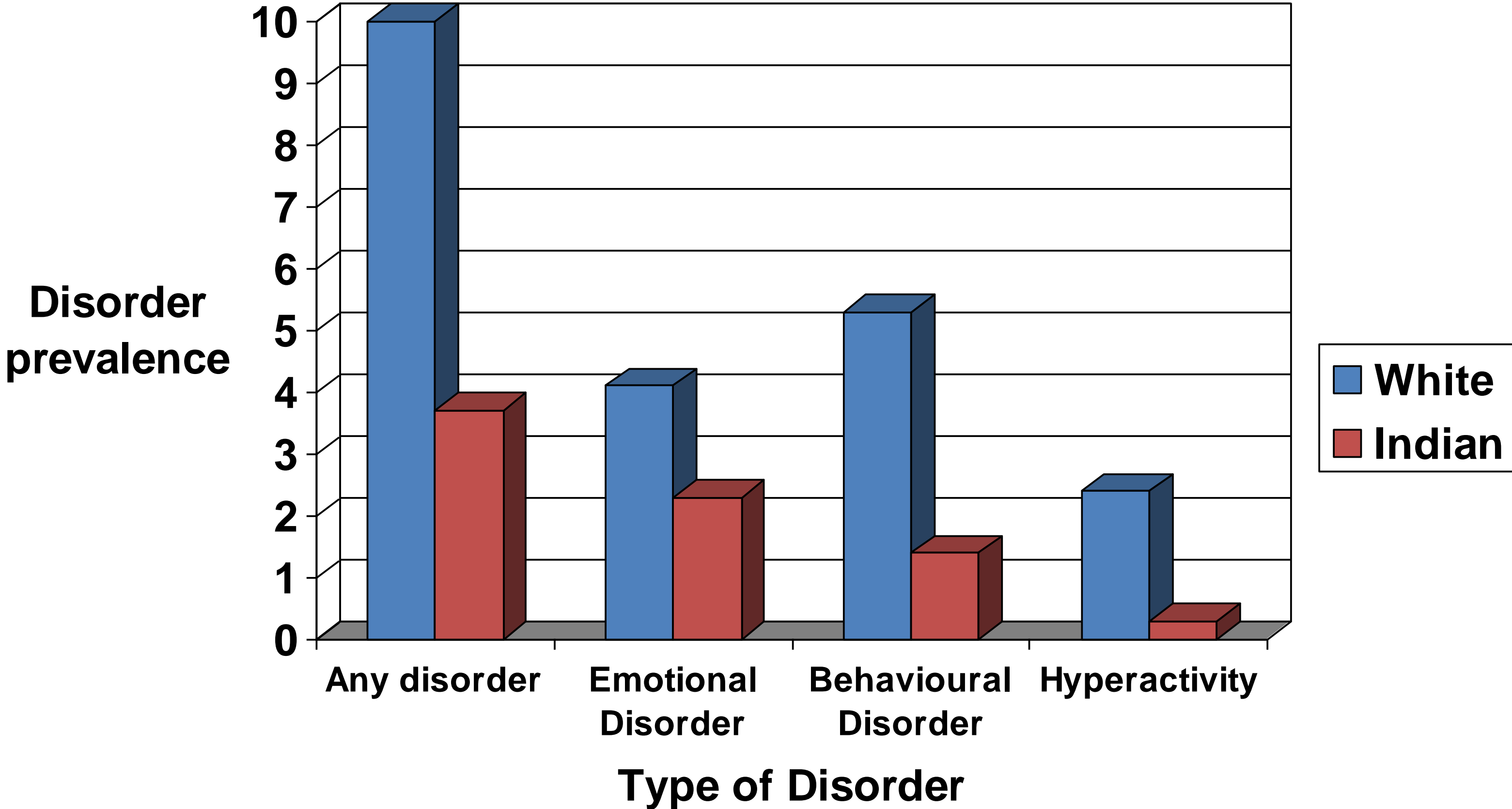
13,936 white English

361 Indian in England

Measures

Strengths & Difficulties Questionnaire (parent, teacher, child)

DAWBA: structured interview with children, parents, questionnaire teacher


Disorder Prevalence in White English and Indian Children
Disorder prevalence
10
9
8
7
6
5
4
3
2
1
0
Any disorder
Emotional Disorder
Behavioural Disorder
Hyperactivity
Type of Disorder
White
Indian

Reasons

White English v Indians:

Lower child academic abilities

Less in 2-parent families

Less in owner occupied housing

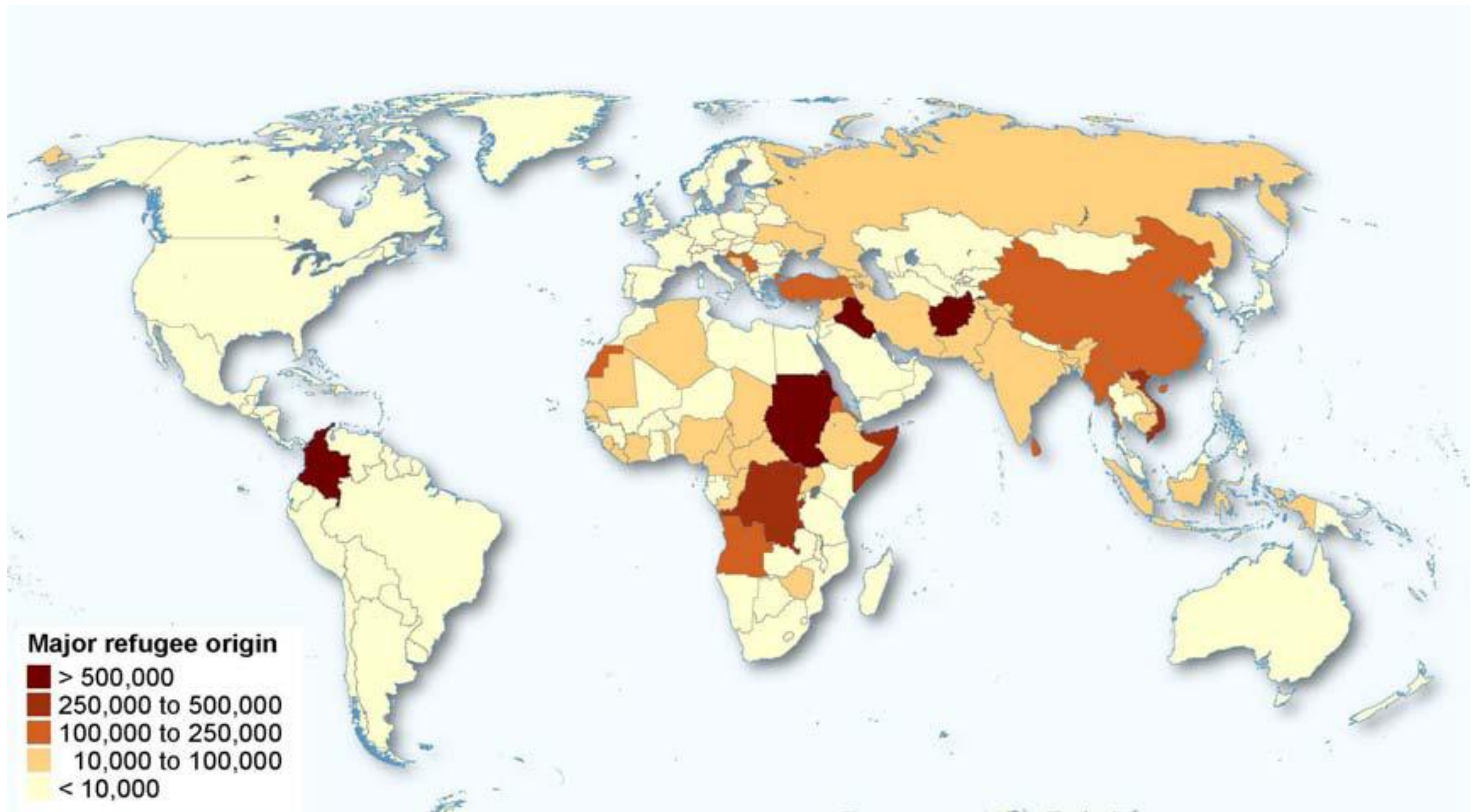
<u>No protective effect</u> three generation families

Reward -praise

UNHCR Statistics

- Forcibly uprooted people are displaced within their own country (IDP).
- 27.5 million IDPs around the world in 2010
- Refugees of concern 10.5 million in 2011
- Stateless people - >up to 12 million in 2010.

Origins of Refugees and Displaced People



Definition of Asylum-seekers

Asylum-seekers

requested international protection and whose claim for refugee status has not yet been determined.

- Refugee status & humanitarian protection

permission to enter and stay in the UK for an initial period of five years; dependants eg children included.

Other Status – Discretionary Leave to Remain

- Not recognised as a refugee or a person who qualifies for humanitarian protection, but temporary permission to stay in the UK.
- Duration – variable, unlikely to be more than three years initially.

UK: Numbers Obtaining Leave to Remain in 2010

- Decisions on 20,261 applications
  - 17% granted asylum
  - 8% temporary protection/leave to remain
  - 74% refusals
- UASC decisions on 2,359
  - 46% leave to remain

UK/EU Policy and Leave to Remain

- UK/EU members of UN
- Compliance with UNHCR
- Address special needs of children

- UK/EU policies to restrict entry
- Reducing the numbers categorised as children would lower:
  - the numbers with leave to remain
  - the costs associated with being LAC

Yarlswood Detention Centre

Tinsley House

Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: a systematic review

- Five surveys – 260 children
- Prevalence 11% (7-17%) for PTSD
- No relevant studies of depression identified

(Fazel et al, 2005)

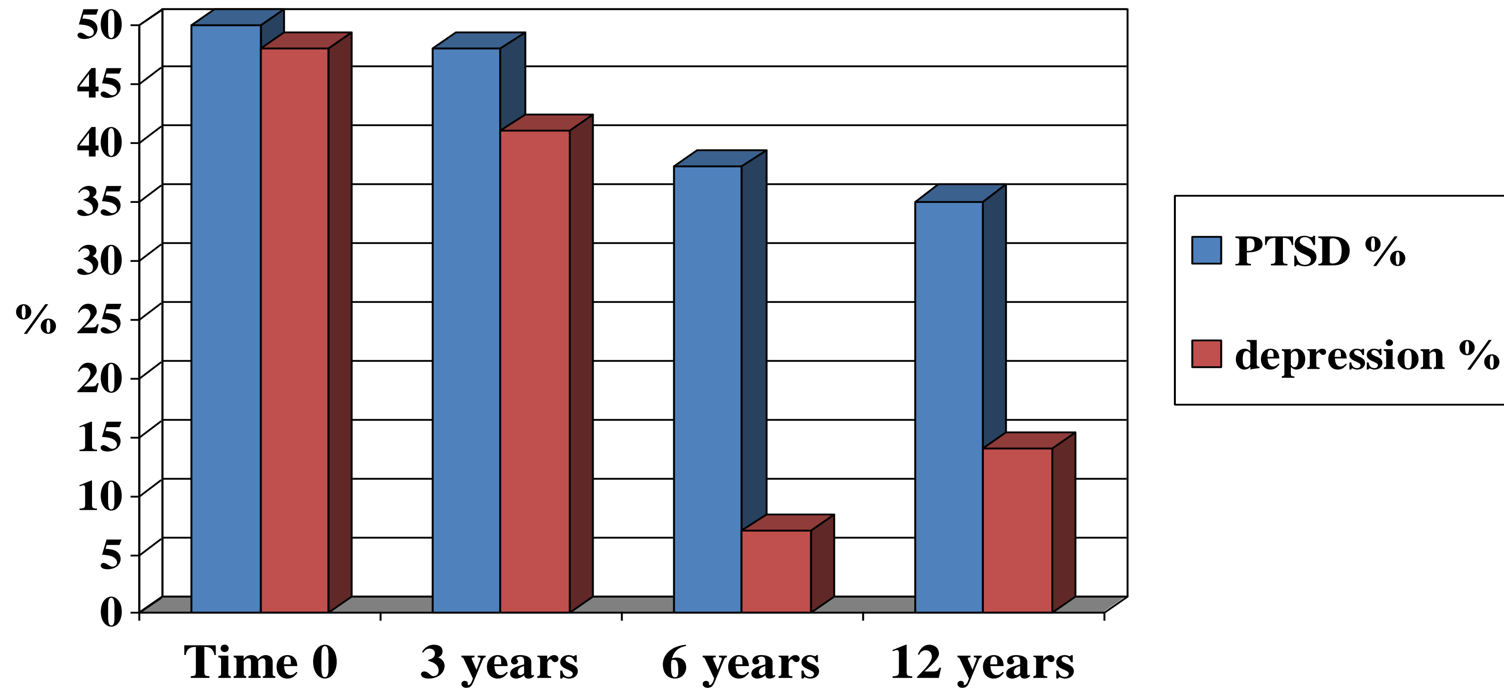
Course of Disorder & Validity of PTSD
Cambodian Refugees in USA

- 46 children aged 8-12 years

  40 exposed to Pol Pot regime, 1975-1979
- Almost all lost > one family member, 16 UAS
- Most separated and forced to live in labour camps
- Came to USA, Portland aged 15 years
- Assessment – DICA interview
- 12 year follow – up (sample loss 15/46=32%)

(Sack et al 1999)

Persistence of Psychiatric Disorders Survivors of Pol Pot in USA

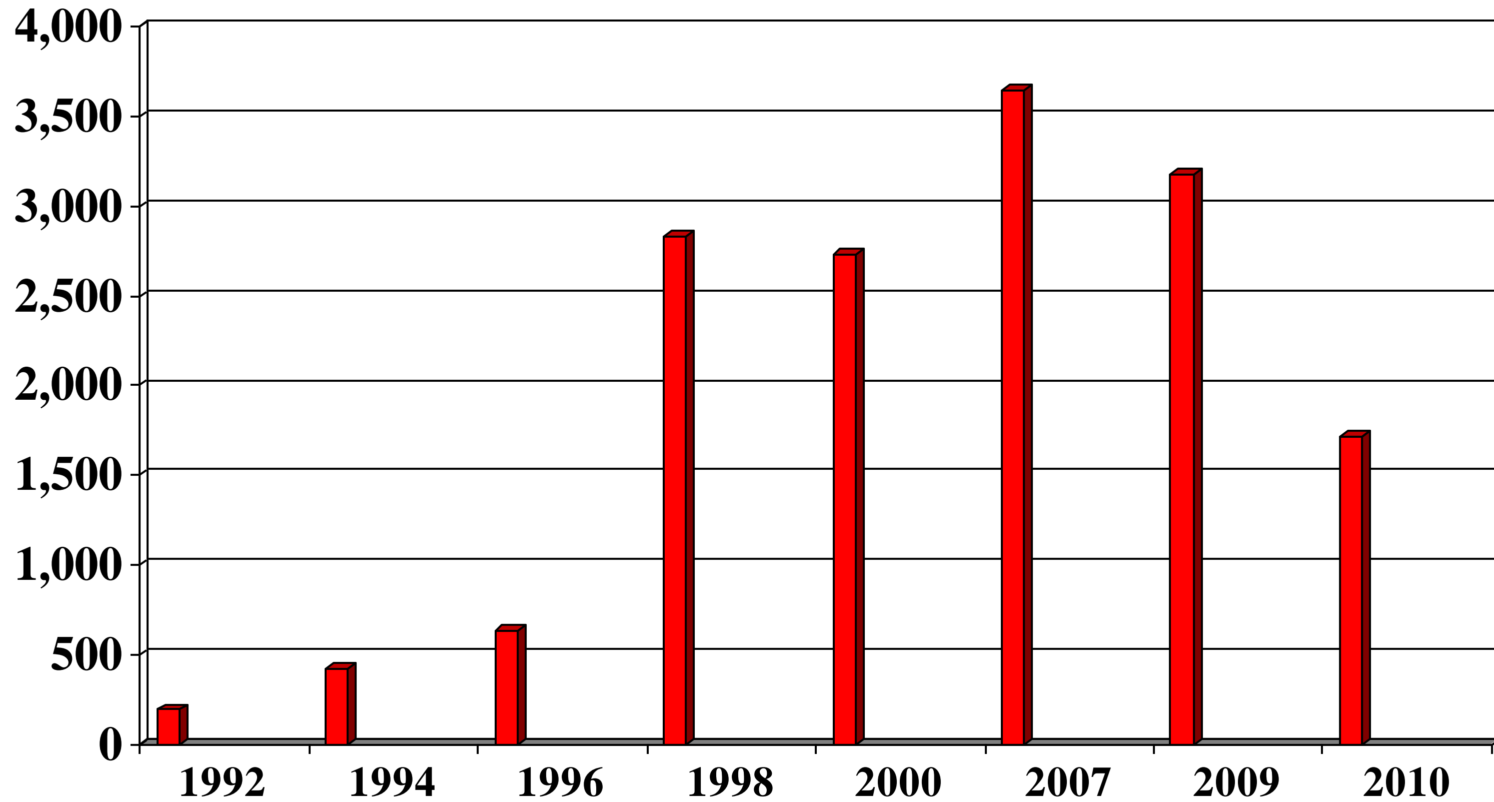


Sack et al, 1999

Background to Unaccompanied Asylum Seeking Children (UASC)

- Claim asylum - claim reassessed when 17-18 years by Home Office
- Supported or looked after by local authorities [not NASS, system for adults]
- Since 2008 policy of dispersal from London (Home Office, 2008)
- 2011, 54% in London & Kent

Numbers of Children Seeking Asylum in UK



Study of Unaccompanied Asylum Seeking Children

Sample

UAS N= 78

- supported by Westminster LA

Accompanied N = 35

- refugees School in Westminster

Both groups: median 17 yrs

(Hodes et al, 2008)

Measures

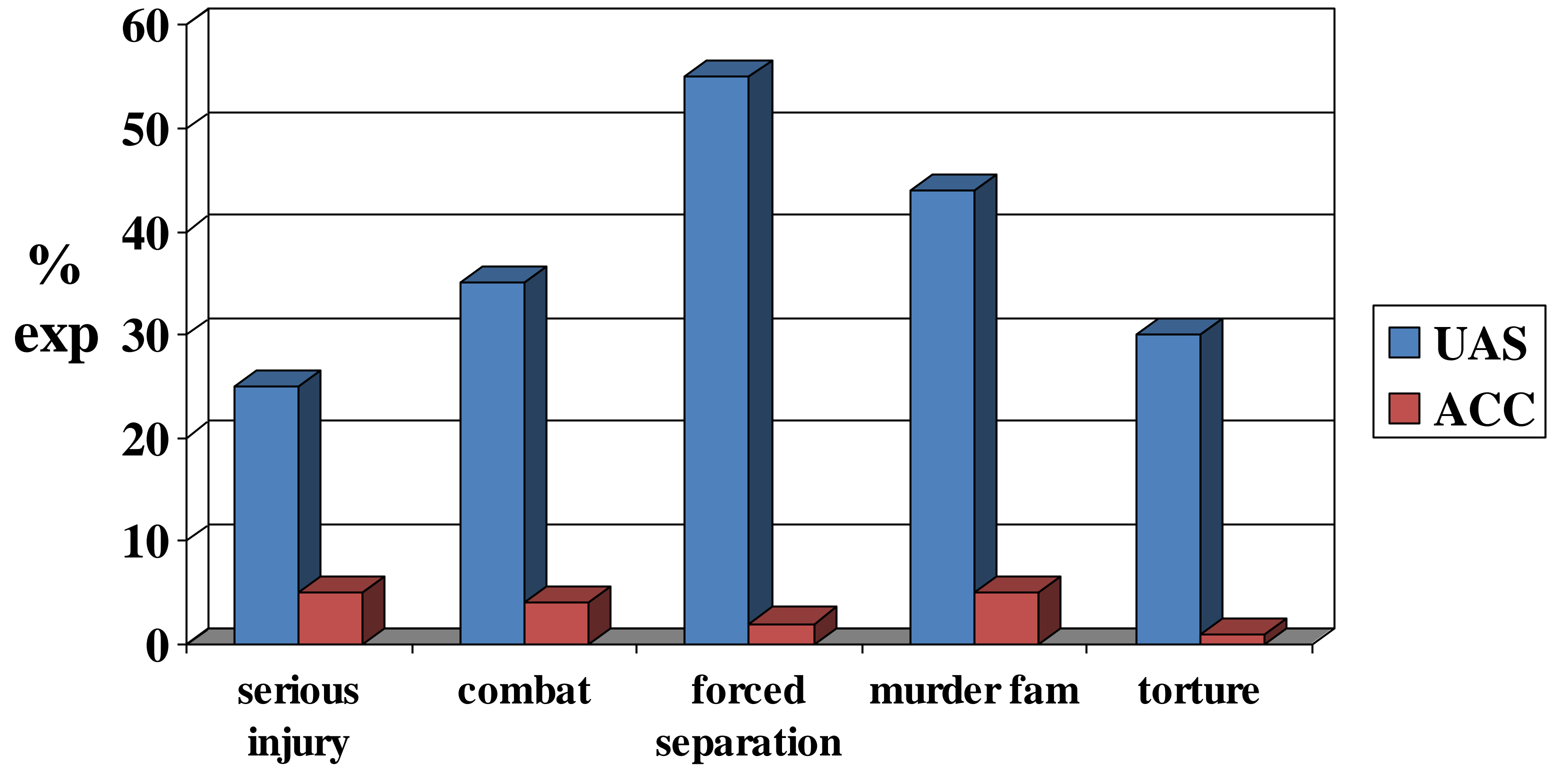
War trauma - Harvard Trauma Questionnaire (HTQ)

PTSD - Impact of events scale (IES)

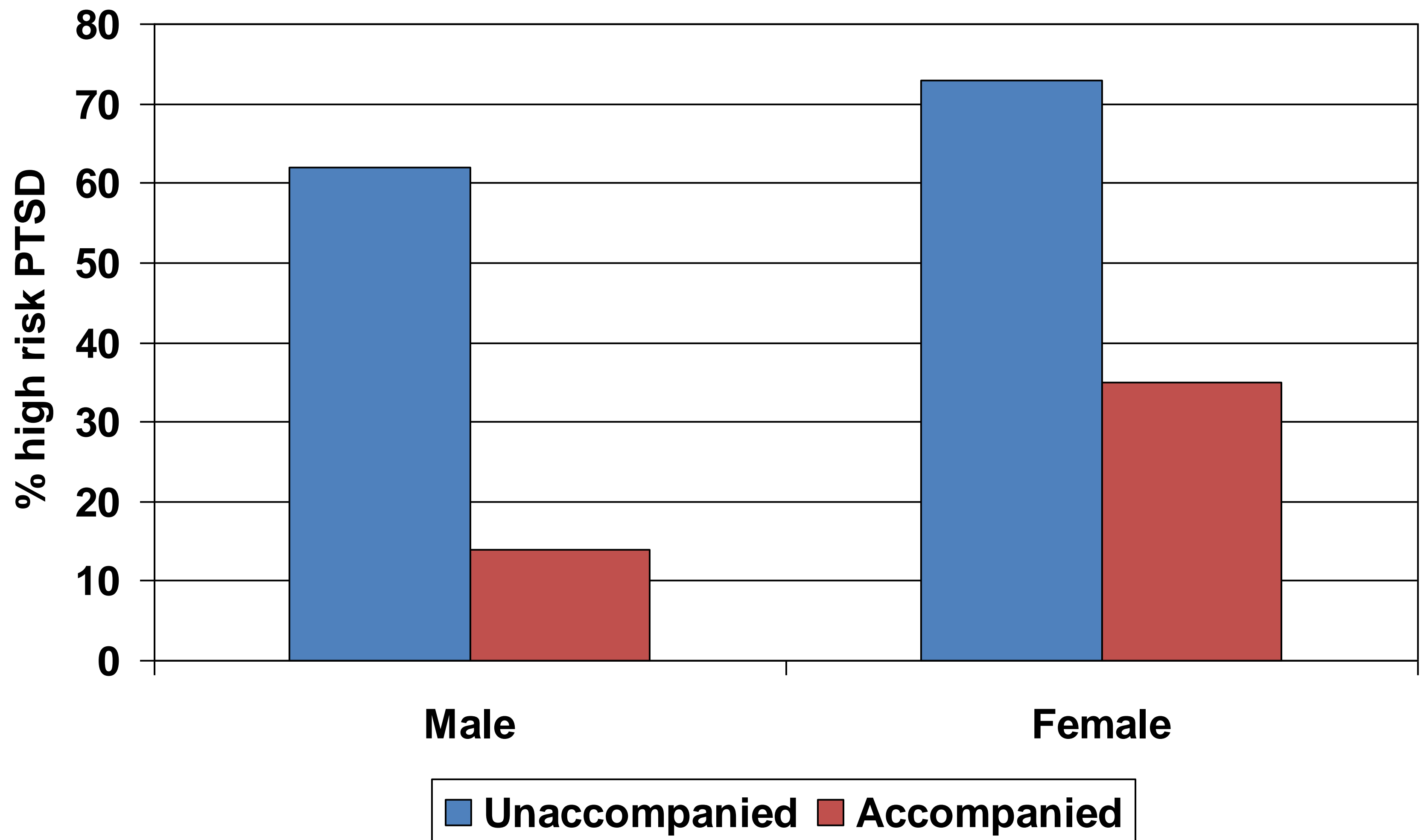
Depression-

Birlson depression self-rating scale (DSRS)

Risk Factors: War Exposure
Events experienced



Impact of Events Scale - Risk of PTSD
Unaccompanied and Accompanied children



Unmet Need in UASC

- Dutch study ~900
  - 58% UASC self-report unmet MH need
  - 72% willingness for MH contact
  - 21% Guardians report need for MHC

  (Bean et al, 2006)

- Westminster 71/78 (91%)

  12 / 71 (17%) UAS had MH contact

  Predicted by DSRS, time in UK

  (Sanchez-Cao, Kramer, Hodes, 2012)

Conclusions - PTSD

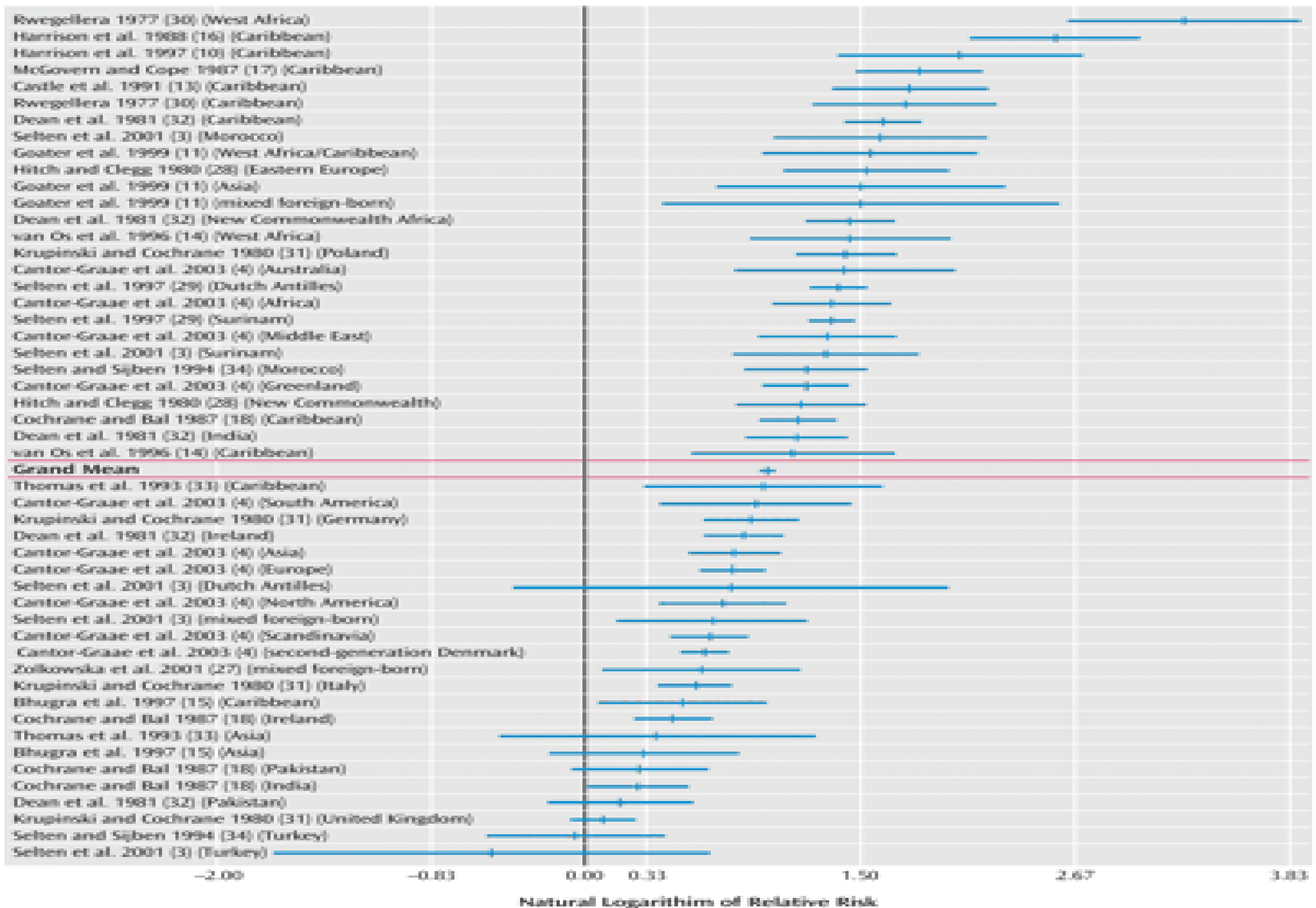
- High violence exposure, greater threat

  -> greater chance and stability PTSD
- Evidence for cross-cultural validity of disorders
- Varied course of PTSD and depression argues for validity
- May be high level unmet need in some groups eg recently arrived asylum seekers, UASC

Psychosis

- Decades of research
- Individual variation in risk – substantial genetic and biological contribution in cause
- Ethnic – cultural variation now established
- Differences between ethnic groups non-genetic
- Not caused by misdiagnosis

Natural Logarithm of Relative Risk (and 95% Confidence Intervals) for Migrant Groups Included in Population-Based Incidence Studies of Risk for Schizophrenia Associated with Migration

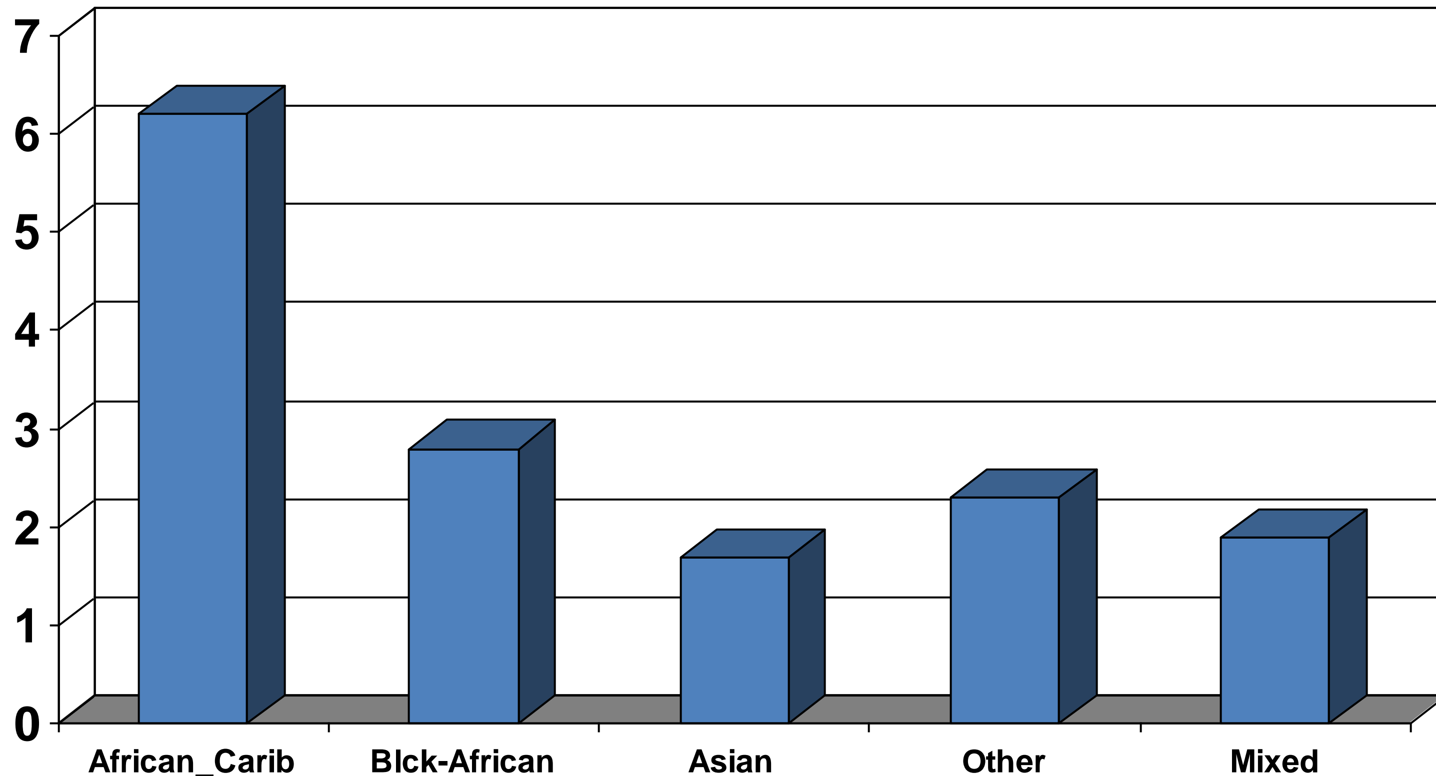


Migration and Risk of Schizophrenia

Migrant group	Relative risk	95% CI
1st gen	2.7	2.3-3.2
2nd gen	4.5	1.5-13.1
‘black’	4.8	3.7-6.2
‘white’	2.3	1.7-3.1

Cantor-Graae & Selten, 2005

Age –Specific Incidence Rate Ratios in ethnic minority groups 16-19 years in UK



(AESOP Study; Fearon et al, 2006)

Reasons for Variation in Psychosis

- Migration effects – adversities/persecution
- Socio-economic adversity (poverty, unemployment)
- Lone parent households
- Social isolation
- Low same ethnic group contact
- ?Early child abuse/neglect
- ?Bullying

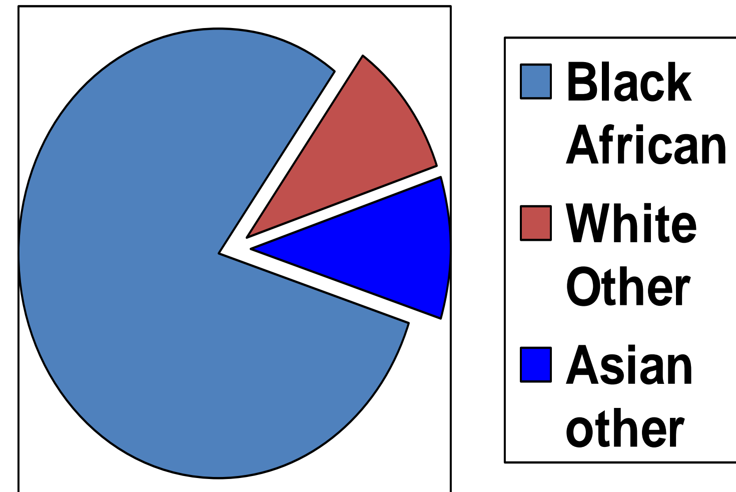
Adolescents Psychiatrically Admitted

Survey of London Adolescents 2001

- 15 in total sample (N=113)
- 10 of 15 have been diagnosed with psychotic disorder
- 8 of the 10 are Black African adolescents
- none of the Black African refugees had schizophrenia

(Tolmac & Hodes, 2004)

Ethnicity refugees



Adolescent Psychosis Study

- Black/Minority group: may be more coercive admissions [ie involuntary]
- Less family /social support - Black/refugee group
- Uncertainty about risk of admission in relation to prevalence

(Tolmac & Hodes, 2004; Hodes & Tolmac, 2005)

Severely Impaired Adolescents & Young People

- High levels of stress including PTSD may trigger psychosis
- High level of psychiatric admission as lower family/social support
- High level of deliberate self harm and violent self harm

Service Access – Sociocultural Considerations

- Access - cost, referral pathways, language
- GP registration
- High mobility

Management Issues 1
Working with the Unknown

- Language /cultural difficulties
- Fear disclosure – asylum seeking
- Avoidance traumatic events –fear disclosure
- Trust in therapist (language, culture, interpreter, confidentiality)

Management Issues 2
Psychiatric Heterogeneity

- Assessing cognitive function/language delay
- Change of symptoms and social function over time (cf inattention, disruptive)
- Distinction aetiology/disorder

Management Issues 3
Working with Parent(s)

- Cultural variation in views problem/disorder
- Under/over estimate children's distress/impairment
- Parental distress /psychiatric disorder eg PTSD
- Parental wish to protect child(ren) from further distress/recounting
- Stigma- may be less with school based services

Management Issues 4
Past or Future Orientation

- Western psychology (psychoanalysis & CBT) past (trauma) focus
- Survival may require present/future orientation
- Mechanisms: psychological (avoidance of PTSD); cultural; pragmatic (can’t change past/problem solving)

Conclusions

- Continuing influx Asylum seekers, UASC, other migrants;
- Difficulties: local planning + resource constraints
- Support : SW, integration, living arrangement
- range psychopathology + varied treatment needs: community + clinic (range services)
- Help seeking, type of problem related to duration settlement.

- Policy/law:
- Unresolved tensions UASC immigrants/children

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