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Title: Pilot evaluation of a group stabilisation intervention for refugees and asylum seekers with PTSD

Short Running Title: Group stabilisation for refugees with PTSD

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Abstract

Background

PTSD is commonly experienced by asylum seekers and refugees (ASR). Evidence supports the use of CBT-based treatments, but not in group format for this population. However group-based treatments are frequently used as a first-line intervention in the UK.

Aims

This study investigated the feasibility of delivering a group-based, manualised stabilisation course specifically developed for ASR. The second aim was to evaluate the use of routine outcome measures (ROMs) to capture psychological change in this population.

Method

Eighty-two participants from 22 countries attended the eight-session Moving On After Trauma (MOAT) group-based stabilisation treatment. PHQ-9, GAD-7, IES-R and idiosyncratic outcomes were administered pre- and post- intervention.

Results

Seventy-one percent of participants (n=58) attended five or more of the treatment sessions. While completion rates of the ROMs were poor – measures were completed at pre- and post- intervention for 46% participants (n=38), a repeated-measures MANOVA indicated significant improvements in depression ($p = .001$, $\eta_p^2 = .262$), anxiety ($p = .000$, $\eta_p^2 = .390$), PTSD ($p = .001$, $\eta_p^2 = .393$) and idiosyncratic measures ($p = .000$, $\eta_p^2 = .593$) following the intervention.

Conclusions

Preliminary evidence indicates that ASR who attended a low-intensity, group-based stabilisation group for PTSD experienced lower mental health scores post-group, although the lack of a comparison group means these results should be interpreted with caution. There are significant challenges in administering ROMs to individuals who speak many different languages, in a group setting. Nonetheless groups have benefits including efficiency of treatment delivery which should also be considered.

Pilot evaluation of a group stabilisation intervention for refugees and asylum seekers with PTSD

Post-traumatic stress disorder (PTSD) is experienced by 19-53% of young refugees and asylum seekers (Kien et al., 2018) and according to different studies, between 3-88% of adults (Morina et al., 2018). The diagnostic criteria for PTSD as defined in the ICD-11 are 1) re-experiencing the traumatic event in the present, 2) avoidance of reminders of the trauma, and 3) increased sense of current danger. Complex PTSD (CPTSD) includes the PTSD criteria as well as 4) affect dysregulation, 5) negative beliefs about the self, and 6) difficulties in sustaining close relationships (World Health Organisation, 2018). Refugees and asylum seekers, while a diverse group of service users, often have histories of multiple and severe trauma including persecution, torture and sexual violence (e.g. Carswell et al., 2011; Robertson et al., 2013), which may be more likely to contribute to CPTSD. Many asylum seekers report a traumatic journey to the UK and often re-traumatising experiences navigating the asylum process. Evidence based interventions for PTSD and CPTSD, which meet the diverse needs of this population, are therefore needed.

There is debate as to how common CPTSD is in the refugee and asylum seeker population, with a review of three studies indicating that 16-67% of treatment-seeking refugees experienced CPTSD while 42-94% of the same individuals met criteria for PTSD (Ter Heide et al., 2016). National Institute for Health and Care Excellence guidance (NICE, 2018) recommends a phased approach to treatment including a stabilisation phase of treatment for individuals with CPTSD, and in treatment of PTSD in asylum seekers and refugees. This could include elements such as ensuring the safety and stability of the patient and managing barriers to treatment such as dissociation, emotional dysregulation or interpersonal difficulties. Conversely, for individuals with PTSD, accessing trauma-focused interventions such as EMDR is recommended (NICE, 2018). Existing evidence has demonstrated that CBT treatment for PTSD in refugees and asylum seekers was effective compared to waitlist and treatment as usual (Turrini et al., 2019). Moreover, stabilisation work as a standalone treatment has been found to be equally effective to EMDR treatment (Ter Heide et al., 2016). Services supporting this population must therefore consider

whether to offer stabilisation work to refugee and asylum seekers experiencing PTSD and CPTSD, with a limited body of evidence to guide clinical decision-making.

Despite a long term commitment to inclusivity in mental health services, people from BAME communities with mental health problems, including refugees and asylum seekers are still less likely to access therapy; less likely to have good outcomes and more likely to report negative experiences in therapy, compared to white majority service users (Mercer et al. 2018, Crawford et al., 2016). People from BAME communities are less likely to use IAPT services; less likely to complete treatment, less likely to reliably improve and less likely to achieve a full recovery (Beck et al, 2019). Cultural barriers included concerns that services will not understand culturally-specific problems or caution about being stigmatised within the local community by engaging with mental health services, as well as lack of access to interpreters (Beck et al., 2019). Asylum seekers and refugees also report high levels of social isolation (Schweitzer et al., 2006); poverty (Laban et al., 2005); concurrent physical pain and high levels of anxiety (Robertson et al., 2013) often linked to processing their asylum applications (Morgan, Melluish & Welham 2017, Laban et al., 2004, Laban et al., 2005). Areas of unmet need are substantial and the current Covid-19 pandemic has further exacerbated existing disparity in access to services (Public Health England, 2020). In the absence of specific mental health commissioning guidance there is a risk that refugees and asylum seekers presenting with PTSD or CPTSD fall in the gap between IAPT and secondary mental health services. Refugees and asylum seekers often have needs which cannot be met by IAPT services while their mental health needs do not meet the required thresholds for secondary mental health services.

One potential solution to the multiple barriers to good mental health support for refugees and asylum seekers presenting with PTSD and CPTSD is to include stabilisation treatment for all individuals before moving onto individual trauma-focused work, irrespective of diagnosis of CPTSD or PTSD. This has the benefits of the standard elements of stabilisation work, building trust and engagement while providing support around practical needs via liaison with local community organisations. It further allows for socialisation to using UK mental health services and to a CBT approach to mental health, and increases familiarity and confidence with working through interpreters. It should be noted that other authors have argued

for offering individual trauma work as a first-line intervention for this population (Ter Heide, Mooren & Kleber., 2016), so careful and thorough evaluation of different treatment models is needed. This study evaluates one model of PTSD treatment, delivering stabilisation work via IAPT as a specialist group provision for refugees and asylums seekers, before encouraging individual, formulation-driven PTSD treatments.

Group interventions are commonly offered as a first-line intervention within IAPT services in order to increase access to mental health services, and individual therapy is offered to those who require further treatment. A recent systematic review and meta-analysis of studies of psychological interventions for post-traumatic stress disorder with refugees and asylum seekers (Thompson, Vidgen & Roberts, 2018) found only one group-based intervention which met the inclusion criteria. While this study (Otto et al., 2003) reported a large positive effect size for combined treatment (trauma-focused CBT group intervention and Sertraline) it was based on a small sample size (n=10). The meta-analysis points to a dearth of evidence supporting the use of group trauma treatment for refugees and asylum seekers.

The use of routine outcome measures is fundamental to the ongoing evaluation of the effectiveness of all IAPT services. While standardised measures (e.g. Patient Health Questionnaires or PHQ-9 and Generalised Anxiety Disorder assessment or GAD-7) have been translated and tested for reliability and validity within various cultures (PHQ-9: Löwe et al., 2004; Reich et al., 2018; GAD-7: Konikan et al., 2013; García-Campayo et al., 2010), this has not been done for all the Black, Asian and Minority Ethnic communities who use IAPT services. Even if translations exist, service users do not always have literacy in their first language in order to access translations and require an interpreter (Deisenhammer et al., 2012). While there are often benefits to working with interpreters in terms of cultural co-working the interpreting process often adds time to treatment sessions.

This study therefore aimed to evaluate the feasibility of a bespoke, group-based, manualised stabilisation course, delivered within an IAPT service, as a specialist provision for refugees and asylum seekers with PTSD. Delivering a group-based intervention offers a potential efficiency in terms of clinical time and use of interpreters, valuable in the context of the strain on mental health services, and

fundamentally accessible to refugees and asylum seekers. The clinical team were also keen to explore steps taken in delivering a more culturally responsive intervention, for example in exploring different cultural understandings of PTSD symptoms, facilitating trusting relationships with professionals and facilitating social interventions (Grey & Young, 2008), all of which were core components of the course.

This study investigated:

- 1 – Does a group-based stabilisation intervention for refugees and asylum seekers with PTSD reduce anxiety, depression and PTSD symptoms?
- 2 - Is it feasible to administer routine outcome measures in a group-based intervention for refugees and asylum seekers with PTSD?

Methods

Study design

This study investigated the feasibility of a group-based trauma stabilisation intervention delivered within an NHS IAPT mental health service, for refugees and asylum seekers in the UK. We aimed to investigate how reliably outcome measures could be completed when non-English speakers, from many different countries participated in a group intervention. Routine IAPT outcome and additional idiosyncratic measures were used to assess mental health outcomes pre- and post-treatment.

Procedure

This study reports on a routine service evaluation and so the procedures outlined are standard for all referrals. Following initial assessment by IAPT clinicians, patients were screened for suitability for treatment based on factors including: consent to group treatment; risk behaviours and availability to attend sessions. In order to increase informed consent, the treatment pathway was outlined during this assessment and patients were shown a short film, translated into the most commonly used languages among patients of the service which explained what

the course and subsequent 1:1 therapy would look like. Participants were informed that they would not be able to talk about their traumatic experience in this initial group setting, but rather would have the opportunity to better understand the impact of trauma and learn skills to cope.

PTSD can lead to an impairment in cognitive function, for example in concentration, memory and recall (e.g. Herlihy, 2007) and for this reason sessions had frequent breaks; included tasks which offered but did require interaction (e.g. discussing how nightmares are understood in different cultures) and sessions included frequent summary and repetition. As most participants did not have literacy in English or in their first language, the course material included pictures and simple diagrams which helped reinforce material. Participants were invited to move around or use a break-out room with the assistant psychologist if required due to physical pain or emotional distress.

Each group had 8-10 participants and a maximum of four interpreters. With few exceptions interpreters were the same across the courses and had experience of delivering this material and preparation in how to work within this group setting. Preparation for interpreters included guidance on a suitable interpreting process i.e. the facilitator talking in manageable chunks followed by interpretation, rather than simultaneous interpreting which can be distracting for others. Interpreters were asked to interpret every contribution made and to avoid any private conversation with participants. Session content was discussed with interpreters at the start of each session and feedback sought throughout the course in debrief sessions around how participants were engaging in the group and with the material and any observations they had.

The courses were delivered by a clinical psychologist and co-facilitated by an assistant psychologist. It was important that the facilitators had specialist clinical skills and experience in order to work with several interpreters in a group; signpost to partner agencies for support and have confidence in assessing and managing often high levels of distress, dissociation and risk. While this may appear resource heavy in comparison to groups within IAPT often facilitated by low intensity therapists, there is a need for clinical skill and expertise in facilitating a group of this kind. This

requirement was also an efficiency in offering group treatment rather than 1:1 sessions.

On completion of the course, patients were offered 1:1 trauma work and approximately two thirds of participants opted to be put forward for this trauma-facing therapy (such as TF-CBT, EMDR or NET). From our observations those who continued with treatment were able to engage in 1:1 therapy with greater understanding of the rationale for therapy and for processing work; familiarity with stabilisation skills and were more comfortable using interpreters and trusting therapists. Participants also gained a clearer sense of where to find help with some of their other difficulties e.g. around immigration or physical health problems. This ensured that those people who put themselves forward for 1:1 therapy were making an informed decision and were well prepared to start trauma-facing work.

Data reported are taken from groups delivered between April 2017 and January 2020. Ethical approval was not required as data collected was part of a research project but constituted routine outcome measurement which fed into a service evaluation.

Participants

The service works solely with refugees and asylum seekers, many of whom are victims of trafficking, therefore all participants were either a refugee or asylum seeker referred to IAPT for psychological support for PTSD. A refugee is defined as someone who is 'unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' (UNHCR, 1951). A refugee has been given the right to remain in the UK and has recourse to all public services. An asylum seeker is defined as someone whose application for refugee status has not yet been decided (UNHCR, 2021) Asylum seekers should have equal access to all health services and some provision for accommodation and financial support from the Home Office. A formal psychiatric diagnosis of PTSD or CPTSD was beyond the remit of the clinical service where the research took place, however all participants completed questionnaire measures of PTSD indicating high levels of trauma symptoms in the participants.

None presented with clear criteria required for support from secondary mental health services, however due to PTSD presentation and vulnerabilities linked to seeking asylum participants were referred to this specialist trauma service, which works in partnership with the local IAPT provider.

All patients who agreed to take part in the Moving On After Trauma (MOAT) course were included (N=82). Seventy-one percent of these (n=58) attended at least five out of the eight course sessions, but all participants who had completed pre- and post- outcome measures were entered into the analysis.

The average age of participants was 30 years (Range=16-65, SD=11), and 66% (n= 54) were male. Participants came from 22 different countries: see table one for a summary of participant nationalities. Participants spoke 14 different languages including English, Pashto, Arabic, Kurdish and Albanian. Sixty-one percent of participants (n=50) accessed treatment via an interpreter.

Table 1. Participants' country of origin

	N	Percent
Afghanistan	17	22%
Albania	8	10 %
Bangladesh	3	4%
Egypt	3	4%
Iran	6	8%
Iraq	8	10%
Libya	3	4%
Somalia	6	8%
Sri Lanka	2	3%
Sudan	3	4%
Syria	5	6%
Turkey	2	3%
Uganda	2	3%
Unknown	5	n/a
Other ¹	9	9%

Measures

All standardised assessments were administered at baseline, either at assessment in the 3 weeks before the course began, or immediately before the first session. Measures were administered again in the final session. Outcome measures were administered via interpreters where translated versions of the questionnaires were not available or if the patient did not have literacy in their first language. Interpreters were supported in the use of these measures by a qualified clinical psychologist. Although session-by-session measuring is preferable in most settings, this was not possible as measures took considerably longer to complete when translation was required.

PHQ-9 – The Patient Health Questionnaire (PHQ-9) is a nine-item questionnaire for depression recommended by the DSM-5 (APA, 2013) and NICE guideline (QS8) (NICE, 2011), with possible responses ranging from “0” (not at all) to “3” (nearly every day). For example, ‘little interest or pleasure in doing things’ and ‘feeling down, depressed or hopeless’. Total scores range from 0 – 27, with 10 the clinical threshold in IAPT services. Cut-off points for mild, moderate, moderately severe and severe depression symptoms are 5, 10, 15 and 20 respectively.

GAD-7 - The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item questionnaire measuring generalised anxiety recommended by the DSM-5 (APA, 2013) and NICE guideline (CG113) (NICE, 2011) with possible responses ranging from “0” (not at all) to “3” (nearly every day). For example, ‘feeling nervous, anxious, or on edge’ and ‘not being able to stop or control worrying’. Total scores range from 0 – 21, with 8 the clinical threshold in IAPT services. Cut-off points for mild, moderate and severe anxiety symptoms are 5, 10 and 15 respectively.

Impact of Events Scale – The Revised Impact of Events Scale (IES-R) has been commonly used to assess for PTSD, validated in different communities and translated in various languages among refugee populations (Davey et al., 2015; Matheson et al., 2008; Morina et al., 2013; Sohn et al., 2019). The 22-item scale has subscales for avoidance, intrusion and hyper-arousal. Possible responses range from “0” (not at all) to “4” (extremely). For example, ‘any reminder brought back feelings about it’ and ‘pictures about it popped into my mind’. Total scores range from 0-88 with 33 representing the cut-off for probable PTSD.

Idiographic Scales – Capturing change in a patient group whose complex life circumstances often remain constant throughout treatment, presents a challenge. Positive psychological change, for example around building supportive relationships can be obscured by responses which assume respondents have language, or opportunity and access to a social network. Similarly, questions around anxiety, arguably underestimate the profound lack of safety concomitant with the ongoing fear of forced return to a home country - a process which many patients leaves them in fear for their life. With this in mind, clinicians within this service piloted a qualitative snapshot of psychological functioning in key areas. In developing the MOAT course, clinicians had delivered similar stabilisation groups and sought feedback as to the benefits of this treatment approach. Thematic analysis of responses to a focus group discussion with a group who had completed the course suggested three areas of impact. From this analysis a three-part idiographic measure was developed which was administered three times pre-treatment and then completed weekly. Each area was scaled from 0-10 using the statements provided as a guide to the lowest and highest score. Participant were offered a prompt for each statement if required, for clarity (examples below). The ‘connection’ item was focused on close relationships, whereas the ‘integration’ item referred to cultural and societal integration.

- 1) Connection: ‘I feel unconnected and alone’ (e.g. prompt: ‘I don’t feel connected to other people in a meaningful way e.g. friends, family or professionals’) to ‘I feel connected to other people in a meaningful way’
- 2) Integration: ‘I feel socially isolated’ to I feel socially integrated’ (e.g. prompt ‘I feel I belong to /am supported by friends, groups or community’)
- 3) Understanding symptoms: ‘I don’t understand my symptoms/I feel I am going mad’ to ‘I understand my symptoms to be part of PTSD’

Intervention

The MOAT intervention was an eight-week, CBT-based stabilisation course for patients presenting with PTSD. The course was divided up into six topics and facilitators found that at least one session at the start was required for orientation

e.g. finding the building, housekeeping, understanding the wider treatment pathway and building trust in the interpreting process.

Weekly sessions lasted two hours and topics were facilitated by a clinical psychologist using interpreters throughout. Structured within a psychoeducation framework, manualised sessions covered topics such as 'Understanding the Brain's Response to Trauma', 'Feeling Too Much or Too Little' and 'Improving Sleep'. Metaphors and visual aides were used to reinforce concepts and chosen for their accessibility across different cultural frameworks and diverse levels of education. Each session included a hands-on skills-based relaxation or grounding technique, which emphasized the use of strategies which can be used in day to day life. Topics were explored by the facilitators using diagrams, material props and resources, and reinforced in group discussion. Participants were given a copy of the manual in English (not translated due to resource limitations) and encouraged to refer to diagrams and illustrations. Participants were also given simple grounding materials to take home and an important component of each course was developing ways to remember skills to practice e.g. using visual aids or smart phone audio recordings.

Analysis

The data analysis was completed in SPSS. Analysis aimed to look at the completion rates of outcome measures as a percentage of the number of participants who started treatment. A repeated measures MANOVA compared participants' scores before and after participating in a MOAT course on the PHQ-9, GAD-7, IES and idiographic scales. For all outcome measures, the data collected at a participant's first attended session were used as the pre-Group score and the data collected at the last attended session were used as the post-Group score. All participants for whom pre- and post-group scores were available were included, with post-scores defined as the final measure taken from any participant who attended at least five sessions. Five sessions was considered to be the minimum number of sessions a participant would need to attend to receive the essential components of the intervention.

Results

The average number of sessions attended was 5.21 (SD=1.20) for all the MOAT participants (N=82). Seventy-one percent of participants (n=58) attended five

or more MOAT sessions. PHQ-9 and GAD-7 and data were collected for 46% participants (n=38), IES pre- and post- scores were available for 27% of participants (n=22), and idiographic data were collected for 51% of participants (n=42).

There was a significant improvement with large effect sizes in PHQ-9 (depression) and GAD-7 (anxiety) among participants following MOAT group attendance. There were significant improvements with large effect sizes on all three items of the idiographic scales: Connection, Integration and PTSD understanding (see table 2).

Table 2. Means, Standard Deviations and Repeated Measures MANOVA for dependent variables

Measure	N	Pre-Group		Post-Group		<i>F</i>	(η_p^2)
		Mean	SD	Mean	SD		
PHQ-9	38	20.08	4.901	17.08	5.221	13.12***	.26
GAD-7	38	17.32	3.222	14.68	4.094	23.70***	.39
IES	22	66.59	12.901	58.64	9.074	13.60***	.39
Idiographic Scales							
1. Connection	42	2.67	1.692	4.36	1.936	30.57***	.43
2. Integration	42	2.81	1.864	4.57	1.810	25.26***	.38
3. PTSD understanding	42	3.17	2.129	6.38	2.594	45.96***	.53

*** $p < .001$

Discussion

In this study we investigated outcomes of a low-intensity, group-based stabilisation course for refugees and asylum seekers with a PTSD presentation. Participants reported significantly lower rates of depression, anxiety and PTSD after the intervention, although the lack of comparison group and non-randomised design means that we must interpret these findings with caution. This does indicate that group-based stabilisation work warrants further investigation as a treatment for PTSD and CPTSD in refugees and asylum seekers.

Completion rates of outcome measures reinforced challenges noted by IAPT services in meeting data reporting targets. Administering standardised IAPT measures posed various issues in terms of accessibility. Patients without literacy in English or in their first language relied on translation by interpreters. Even using experienced interpreters there will be variation in language and in the administration of measures. Translations have been approved for some outcome measures but not in all community languages and these translations have good validity and reliability only for particular BAME communities. Patients accessing translations require literacy in their own language which many refugees and asylum seekers do not have. Questionnaires vary in length but even relatively short questionnaires (e.g. GAD-7), together with the additional time required for translation can represent strain on already compromised cognitive function, attention and concentration. While PTSD scales have been developed specifically for measuring the impact of torture, trauma and PTSD (e.g. Harvard Trauma Questionnaire; Mollica et al., 1992), the treatment pathway described sat within an IAPT service which prescribed the use of particular standardised assessments, namely the IES-R. The use of further assessment measures for PTSD was not possible due to the time taken and associated increased cognitive load. The use of a shorter measure of change, translated into the patient's own language, and ideally including an option to access in audio form, would have clear benefits.

Although patients agreed to try to attend all sessions, they sometimes had to prioritize other appointments at the same time e.g. with solicitor or doctor. Patients also reported simply being too tired at times to complete questionnaires. Cognitive impairment e.g. concentration difficulties and severe fatigue linked to sleep disturbance are both consistent with PTSD (Herlihy & Turner, 2007). High levels of physical illness were reported which can be understood in the context of e.g. compromised immune systems (Neigh & Ali, 2016); a history of concurrent physical trauma and higher incidence of somatic symptoms in this group e.g. headaches (Neigh & Ali, 2016).

Frequent snapshot data collection during the group session accommodated missed sessions more easily, was less time consuming to administer than standardised measures and allowed questions to be more closely linked to patients' common experiences.

In the absence of a control group, the observations and reflections from this service evaluation are speculative. Outcome data nevertheless demonstrated a significant reduction in symptoms of anxiety, depression and PTSD. The changes in average score represented a shift from 'severe' to 'moderately severe' depression, and from 'severe' to 'moderate' anxiety. PTSD scores remained well above the cut-off for probable PTSD, indicating the importance of providing a PTSD focused intervention following the group. It may well be that offering a PTSD intervention first is most effective, as argued by ter Heide and colleagues (2016). Another possibility is that a minority of participants met the criteria for CPTSD, and so the stabilisation group was effective for just this minority of participants. Future research should therefore carefully establish the rate of CPTSD versus PTSD in participants and investigate the utility of a pre-trauma treatment phase on stabilisation in this group.

In comparison to 1:1 interventions, there were efficiencies in offering group based stabilisation interventions in terms of reduced clinical time and in the use of interpreters often with more than one patient. Qualitative feedback from participants indicated that they found the practical support offered during the stabilisation group useful, for instance when clinicians liaised with community-based services to challenge internal dispersal by the Home Office while in treatment. Feedback also mentioned the positive effects of building relationships with other members of the group. If offering a trauma-focused treatment as a first-line intervention, clinicians should consider how to offer such practical support alongside therapy.

The principles underlying the delivery of these groups reflect key messages in the IAPT BAME Positive Practice Guide (Beck et al., 2019). This Guidance highlights the need to provide specialist training for staff working with refugees and asylum seekers for example in how distress is manifested following trauma or the role of dissociation, sees benefits in multi-agency working and fundamentally reinforces the need for culturally responsive or culturally adapted therapy.

Delivering stabilisation groups of this kind requires skilled facilitation, hence groups were led by an experienced clinical psychologist supported by an assistant psychologist. In addition to clinical specialism, an understanding of the field and strong links to local community services and resources is recommended, and again reiterated in good practice guidance (Beck et al., 2019).

From this evaluation, key recommendations would include:

- clarity on commissioning responsibility for such specialist interventions which could inform the allocation of appropriate resources
- the need to promote accessible services for asylum seekers and refugees which incorporate measures to address structural barriers (e.g. by providing well-trained and supported interpreters, flexible DNA policy) and cultural barriers (working with community organisations; recruiting community based mental health workers)
- formal translation of key routine outcomes measures including audio-translation for those who cannot access outcome measures in written form.

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