Projeto Atuação em Rede

Saúde Mental e Migração

Catarina Dahl

Rio de Janeiro, 31 de Outubro de 2019

OPAS Organização Pan-Americana da Saúde Organização Mundial da Saúde Américas

Roteiro

1. Acolhimento e Apresentação dos Participantes

2. Objetivos

3. Dinâmica em Grupo: situação-problema

4. Saúde Mental e Migração

6. Abordagem da Saúde Mental e Apoio Psicossocial

7. Trabalho em grupo: mapeamento da rede local, proposição de ações comuns e roda de discussão

7. Avaliação

Objetivos

1. Sensibilizar os participantes em relação às necessidades de saúde mental e apoio psicossocial de imigrantes e refugiados;

2. Compartilhar e construir conhecimentos sobre o tema da ***saúde mental e migração,*** com foco em aspectos conceituais, achados de pesquisa e abordagens teórico-metodológicas;

3. Promover o diálogo entre as pessoas envolvidas no acolhimento de imigrantes e refugiados na rede local e facilitar a proposição de ações conjuntas

4. Fortalecer a rede local para o cuidado e promoção de saúde mental na população de imigrantes e refugiados

Dinâmica em Grupo

Vocês são uma família que vive em um país onde há uma grave crise humanitária, caracterizada pela disputa de poder entre dois grupos políticos; violência e conflitos armados; pela desvalorização da moeda, escassez de recursos financeiros, aumento do custo de vida e, consequentemente, desemprego, pauperização da população, desabastecimento e privação de itens básicos para sobrevivência, como água e alimentação; assim como pela falta de acesso à medicação, aos serviços de saúde, educação, segurança e proteção social. Sérias violações de direitos humanos estão acontecendo no país e vocês precisam decidir se devem permanecer no país ou deixar toda uma vida que foi construída ao longo de décadas para trás - casa, familiares, trabalho e amigos – e migrar para outro país.

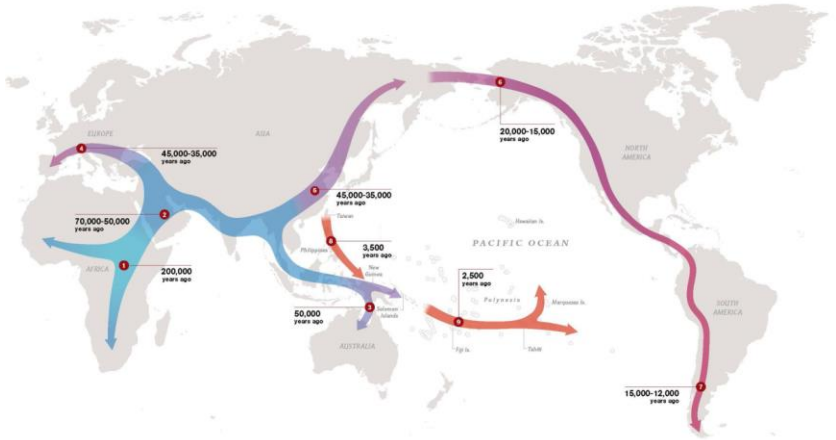
Vocês têm **10 (dez minutos)** para decidir **se devem migrar para outro país e quais pertences devem levar consigo.**

Dinâmica em Grupo

Questões para discussão:

- Como vocês se sentiram no lugar de um imigrante? Como foi o processo de tomada de decisão?
- Como o processo migratório (deslocamento forçado) pode afetar o bem-estar psicossocial e a saúde mental das pessoas envolvidas?
- Existe uma relação direta entre migração e saúde mental?

Saúde Mental e Migração



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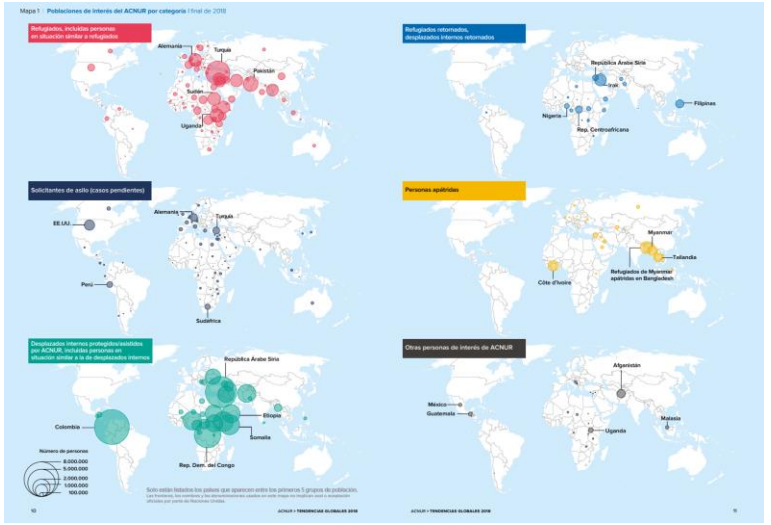
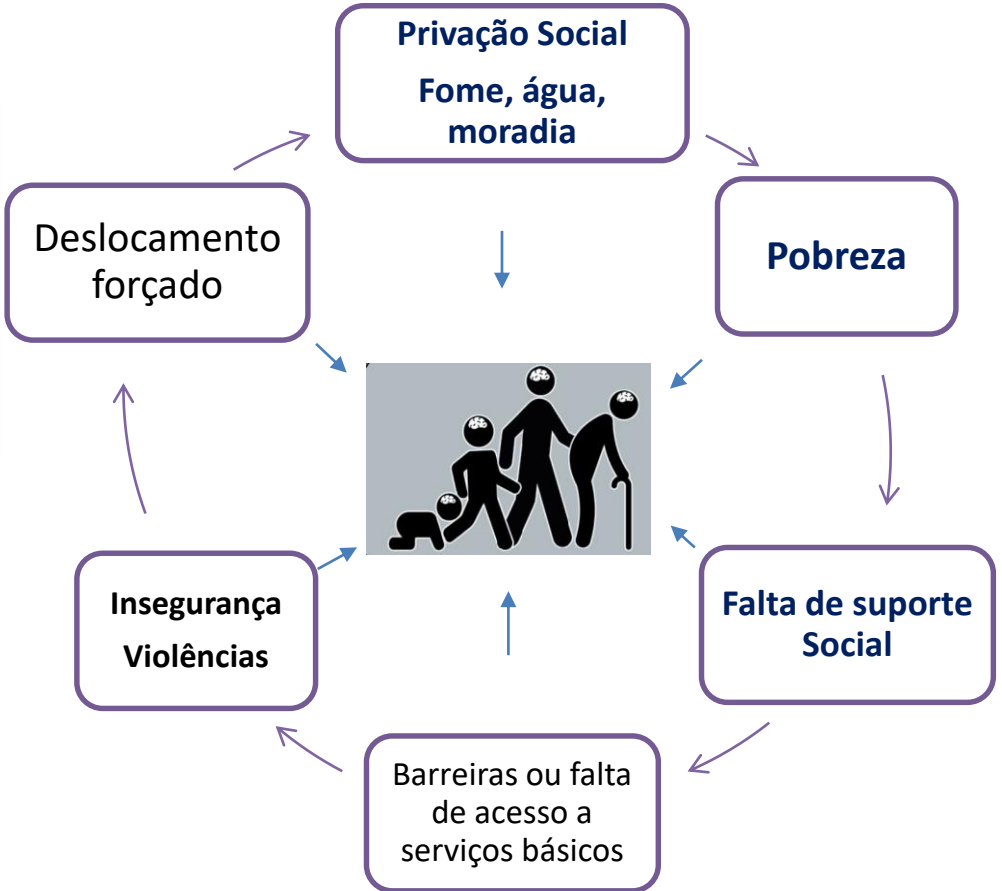


70, 8 milhões de pessoas deslocadas forçadamente (2018)

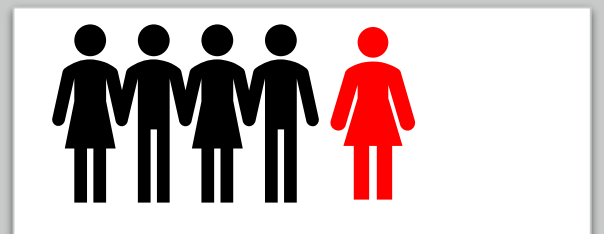
132 milhões em 42 países precisam de assistência humanitária (2019)

Saúde Mental e Migração



Saúde Mental e Migração

- Estresse, insegurança, medo,
- Ruptura de lações familiares e sociais
- Ruptura biográfica : sentimento de si mesmo e na vivência de tempo e espaço (temporalidade)
- Luto :: “Luto Cultural”
- Perda das referências culturais, simbólicas, materiais
- Desterritorialização



New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis

Fiona Charlson, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, Shekhar Saxena

Summary

Background Existing WHO estimates of the prevalence of mental disorders in emergency settings are more than a decade old and do not reflect modern methods to gather existing data and derive estimates. We sought to update WHO estimates for the prevalence of mental disorders in conflict-affected settings and calculate the burden per 1000 population.

Methods In this systematic review and meta-analysis, we updated a previous systematic review by searching MEDLINE (PubMed), PsycINFO, and Embase for studies published between Jan 1, 2000, and Aug 9, 2017, on the prevalence of depression, anxiety disorder, post-traumatic stress disorder, bipolar disorder, and schizophrenia. We also searched the grey literature, such as government reports, conference proceedings, and dissertations, to source additional data, and we searched datasets from existing literature reviews of the global prevalence of depression and anxiety and reference lists from the studies that were identified. We applied the Guidelines for Accurate and Transparent Health Estimates Reporting and used Bayesian meta-regression techniques that adjust for predictors of mental disorders to calculate new point prevalence estimates with 95% uncertainty intervals (UIs) in settings that had experienced conflict less than 10 years previously.

Findings We estimated that the prevalence of mental disorders (depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia) was 22·1% (95% UI 18·8–25·7) at any point in time in the conflict-affected populations assessed. The mean comorbidity-adjusted, age-standardised point prevalence was 13·0% (95% UI 10·3–16·2) for mild forms of depression, anxiety, and post-traumatic stress disorder and 4·0% (95% UI 2·9–5·5) for moderate forms. The mean comorbidity-adjusted, age-standardised point prevalence for severe disorders (schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) was 5·1% (95% UI 4·0–6·5). As only two studies provided epidemiological data for psychosis in conflict-affected populations, existing Global Burden of Disease Study estimates for schizophrenia and bipolar disorder were applied in these estimates for conflict-affected populations.

Interpretation The burden of mental disorders is high in conflict-affected populations. Given the large numbers of people in need and the humanitarian imperative to reduce suffering, there is an urgent need to implement scalable mental health interventions to address this burden.

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Introduction

Currently, there are major conflict-induced humanitarian crises in numerous countries, including Afghanistan, Iraq, Nigeria, Somalia, South Sudan, Syria, and Yemen. UN estimates suggest that more than 68·6 million people worldwide have been forcibly displaced by violence and conflict, the highest number of people affected since World War 2.[1] This increase in people affected by conflict coincides with a growing interest in mental health, as exemplified by the recently approved 10-year extension of the Mental Health Action Plan by 194 WHO member states.[2] Interest is especially high in the mental health of people affected by humanitarian emergencies.[3]

In 2005, WHO estimated the prevalence of mental disorders among people affected by humanitarian emergencies.[4] These estimates have been frequently repeated in policy documents,[5,6] news media,[7] and appeals and funding proposals for help for people living through the world's worst crises. WHO emphasised that these estimates represented averages across emergency settings and that observed prevalence estimates would vary by affected population and assessment method.[4] However, WHO's 2005 estimates were not based on applicable systematic reviews of evidence.

Epidemiological studies in conflict settings typically present varying results, making their interpretation difficult,[8] and their statistical heterogeneity is extremely high.[9,10] We sought to update WHO estimates of the prevalence of mental disorders in conflict-affected populations by updating systematic literature reviews for post-traumatic stress disorder and depression, searching for a wider range of disorders, and applying Bayesian meta-regression techniques while adjusting for predictors of mental disorders in conflict settings. Natural disasters

Saúde Mental e Migração

- Estimativas recentes da Organização Mundial da Saúde apontam que, em contextos de emergência, 1 em cada 5 pessoas vive com alguma forma de transtorno mental (risco aumentado)

- **22,1%, algum transtorno mental**:: Depressão, ansiedade, estresse pós-traumático, transtorno bipolar e esquizofrenia);

- **13% de formas leves** e 4% formas moderadas de depressão, ansiedade, estresse pós-traumático

- **5,1%** de transtornos mentais graves esquizofrenia, transtorno bipolar de humor, depressão grave, ansiedade grave, estresse pós-traumático)

(Charlson et al, 2019)

Saúde Mental e Migração

É inestimável o número de pessoas que se encontram em sofrimento psíquico e emocional

Saúde Mental e Migração

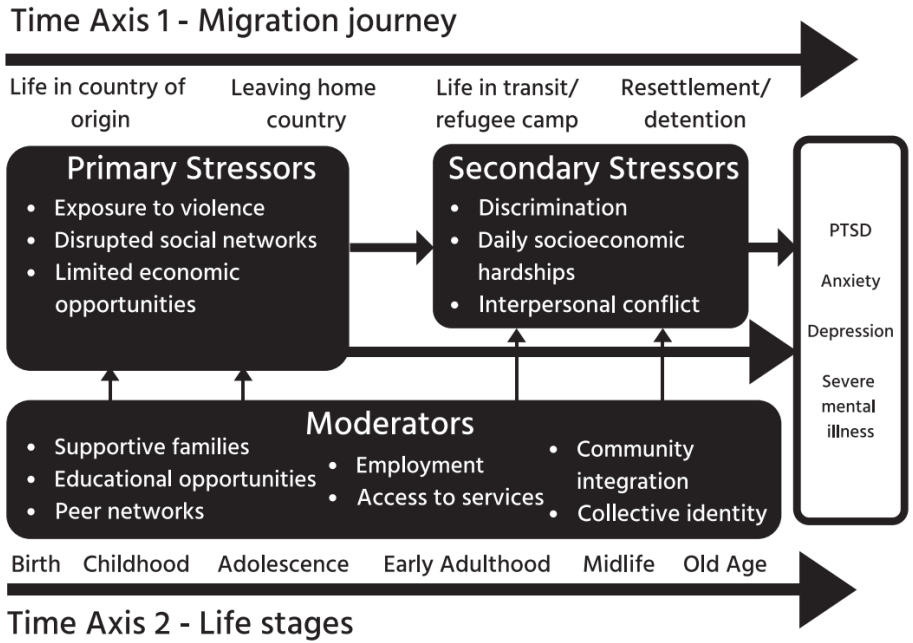


Figure 1. Risk and protective factors for migrant mental health.

Imigrantes e subgrupos de imigrantes tem maior risco de desenvolver alguma condição mental

Cécile Rousseau* and Rochelle L. Frounfelker, 2018

Saúde Mental e Migração

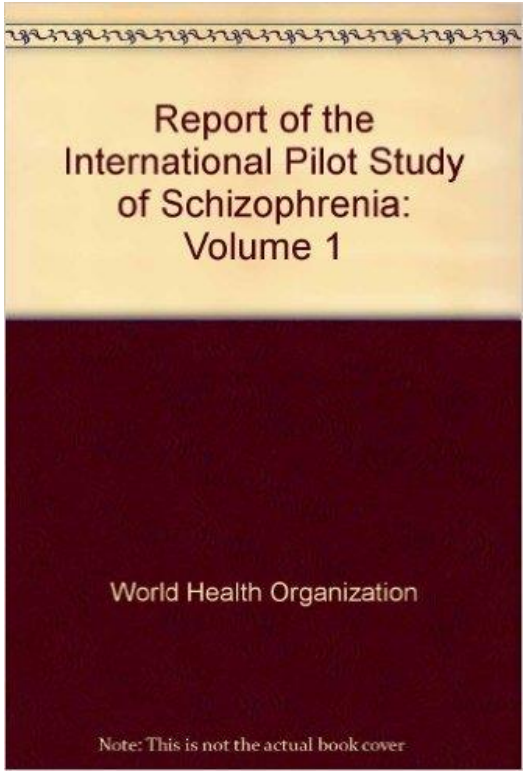
Serviços de Saúde e Saúde Mental

- Tendência a **“superestimar”** os transtornos mentais
- **Patologização e medicalização** do sofrimento (normalidade x anormalidade)
- Limites dos saber psiquiátrico ocidental e dos sistemas diagnósticos (instrumentos diagnósticos “universal”) para compreender e responder ao sofrimento psíquico e a experiência de adoecimento mental

Saúde Mental e Migração

Critérios diagnósticos estritos e universais para esquizofrenia

- a maioria dos pacientes que se apresentou nos diferentes centros teve que ser excluída, pois não preenchia os critérios
- os excluídos eram aqueles que demonstravam maior diferença cultural
- Certos sintomas diferiam em prevalência entre os centros. Ex: a maioria dos casos de catatonia estava na India e na Nigéria
- Os transtornos psiquiátricos e problemas de saúde mental diferem em culturas distintas



Saúde Mental e Migração

- Pressuposto: **a experiência de sofrimento e adoecimento mental é fortemente determinada e moldada pela cultura (crenças, símbolos e hábitos), por varáveis contextuais e sociais**

- **Baixa sensibilidade cultural** dos serviços e profissionais da saúde

Saúde Mental e Migração

Estudo de caso

Em um abrigo para imigrantes indígenas venezuelanos da etnia Warao, uma profissional relatou que, quando chovia, todas as crianças iam brincar com os “peixes” nas poças que se formavam no chão. A profissional da saúde insistiu com as crianças que ali não haviam peixes e ficou preocupada se as crianças estavam vendo coisas que não existiam, sem entender o significado da brincadeira. Após estudar a cultura a Warao, descobriu que trata-se de uma etnia que vive abaixo das montanhas, próxima a uma região com muitos rios na Venezuela.

Saúde Mental e Migração

Estudo de caso

Kleiman e colaboradores (1978) descreveram um caso que ilustra o significado clínico das crenças dos pacientes sobre seus corpos e a forma como elas podem afetar o comportamento e as reações clínicas. Uma mulher, branca de 60 anos foi internada no hospital com edema pulmonar secundário a doença cardiovascular aterosclerótica e insuficiência cardíaca congestiva crônica. À medida que ela começou a melhorar, seu comportamento ficou cada vez mais bizarro: ela forçava vômitos e urinava na cama frequentemente. Foi solicitada a opinião de um psiquiatra. Este, ao fazer as pergunta mais detalhadas, descobriu que, pelo menos do ponto de vista da mulher, aquele comportamento fazia sentido. Ela havia sido informada que pelos médicos que tinha “água nos pulmões” . Sendo esposa e filha de encanadores, sua concepção de estrutura corporal envolvia o tórax conectado por “canos” à boca e à uretra. Assim, a paciente estava tentando remover a “água dos pulmões” pelo vômito e pela micção frequentes. No momento em que o “verdadeiro” encanamento do corpo lhe foi explicado com auxílio de diagramas, seu comportamento bizarro teve fim.

Saúde Mental e Migração

- Perspectiva biomédica x perspectiva do paciente x perspectiva cultural

- Expressões culturais do sofrimento
- “ Ataque de nervios” :: “Problema de nervos”
- Amok (Malásia)

Saúde Mental e Migração

Essay

Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It

Arthur Kleinman*, Peter Benson

This is one of a series of articles on social medicine in the October 2006 issue

Cultural competency has become a fashionable term for clinicians and researchers. Yet no one can define this term precisely enough to operationalize it in clinical training and best practices.

It is clear that culture does matter in the clinic. Cultural factors are crucial to diagnosis, treatment, and care. They shape health-related beliefs, behaviors, and values [1,2]. But the large claims about the value of cultural competence for the art of professional care-giving around the world are simply not supported by robust evaluation research showing that systematic attention to culture really improves clinical services. This lack of evidence is a failure of outcome research to take culture seriously enough to routinely assess the cost-effectiveness of culturally informed therapeutic practices, not a lack of effort to introduce culturally informed strategies into clinical settings [3].

Problems with the Idea of Cultural Competency

One major problem with the idea of cultural competency is that it suggests culture can be reduced to a technical skill for which clinicians can be trained to develop expertise [4]. This problem stems from how culture is defined in medicine, which contrasts strikingly with its current use in anthropology—the field in which the concept of culture originated [5–9]. Culture is often made synonymous with ethnicity, nationality, and language. For example, patients of a certain ethnicity—such as, the "Mexican patient"—are assumed to have a core set of beliefs about illness owing to fixed ethnic traits. Cultural competency becomes a series of "do's and don'ts" that define how to treat a patient of a given ethnic background [10]. The idea of isolated societies with shared cultural meanings would be rejected by anthropologists, today, since it leads to dangerous stereotyping—such as, "Chinese believe this," "Japanese believe that," and so on—as if entire societies or ethnic groups could be described by these simple slogans [11–13].

Another problem is that cultural factors are not always central to a case, and might actually hinder a more practical understanding of an episode (see Box 1).

Historically in the health-care domain, culture referred almost solely to the domain of the patient and family. As seen in the case scenario in Box 1, we can also talk about the culture of the professional caregiver—including both the cultural background of the doctor, nurse, or social worker, and the culture of biomedicine itself—especially as it is expressed in institutions such as hospitals, clinics, and medical schools [14]. Indeed, the culture of biomedicine is now seen as key to the transmission of stigma, the incorporation and maintenance of racial bias in institutions, and the development of health disparities across minority groups [15–18].

Culture Is Not Static

In anthropology today, culture is not seen as homogenous or static. Anthropologists emphasize that culture

Box 1. Case Scenario: Cultural Assumptions May Hinder Practical Understanding

A medical anthropologist is asked by a pediatrician in California to consult in the care of a Mexican man who is HIV positive. The man's wife had died of AIDS one year ago. He has a four-year-old son who is HIV positive, but he has not been bringing the child in regularly for care. The explanation given by the clinicians assumed that the problem turned on a radically different cultural understanding. What the anthropologist found, though, was to the contrary. This man had a near complete understanding of HIV/AIDS and its treatment—largely through the support of a local nonprofit organization aimed at supporting Mexican-American patients with HIV. However, he was a very-low-paid bus driver, often working late-night shifts, and he had no time to take his son to the clinic to receive care for him as regularly as his doctors requested. His failure to attend was not because of cultural differences, but rather his practical, socioeconomic situation. Talking with him and taking into account his "local world" were more useful than positing radically different Mexican health beliefs.

The Essay section contains opinion pieces on topics of broad interest to a general medical audience.

Funding: Our work on cultural aspects of clinical care has been supported by the Michael Crichton Fund, Harvard Medical School, and by a National Institute of Mental Health Training Grant on "Culture and Mental Health Services" (5T32MH018006-21).

Competing Interests: The authors declare that they have no competing interests.

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- Competência cultural: antropologia, etnografia, etnopsiquiatria, psiquiatria cultural
- Modelos explicativos (origem da enfermidade)
- Formas de manifestação e de atribuir sentido/significado ao sofrimento
- Estratégias de lida e busca de ajuda

Saúde Mental e Migração

- Desafios:
  - Acessibilidade: imigrantes comumente subutilizam os serviços de saúde

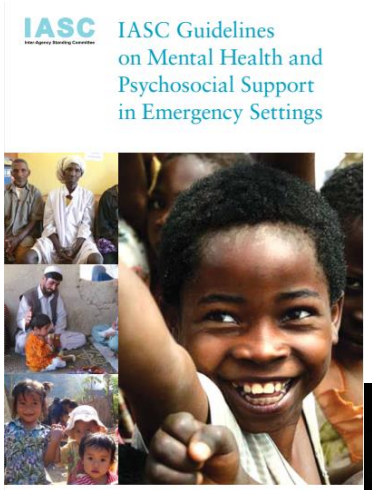
    - Barreiras culturais → sensibilidade cultural

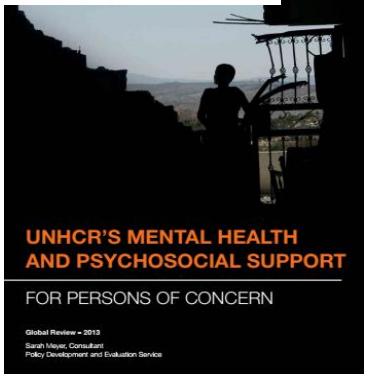
    - Barreiras linguísticas de comunicação → intérprete

    - Barreiras atitudinais: estigma e discriminação (profissional, auto-estigma)

    - Determinantes sociais e culturais

Abordagem da Saúde Mental e Apoio Psicossocial






Global Mental Health 3

Mental health and psychosocial support in humanitarian settings: linking practice and research

Wietse A Tol, Corrado Barbui, Ananda Galappatti, Derrick Silove, Theresa S Betancourt, Renato Souza, Anne Golaz, Mark van Ommeren

This review links practice, funding, and evidence for interventions for mental health and psychosocial wellbeing in humanitarian settings. We studied practice by reviewing reports of mental health and psychosocial support activities (2007–10); funding by analysis of the financial tracking service and the creditor reporting system (2007–09); and interventions by systematic review and meta-analysis. In 160 reports, the five most commonly reported activities were basic counselling for individuals (39%); facilitation of community support of vulnerable individuals (23%); provision of child-friendly spaces (21%); support of community-initiated social support (21%); and basic counselling for groups and families (20%). Most interventions took place and were funded outside national mental health and protection systems. 32 controlled studies of interventions were identified, 13 of which were randomised controlled trials (RCTs) that met the criteria for meta-analysis. Two studies showed promising effects for strengthening community and family supports. Psychosocial wellbeing was not included as an outcome in the meta-analysis, because its definition varied across studies. In adults with symptoms of post-traumatic stress disorder (PTSD), meta-analysis of seven RCTs showed beneficial effects for several interventions (psychotherapy and psychosocial supports) compared with usual care or waiting list (standardised mean difference [SMD] −0·38, 95% CI −0·55 to −0·20). In children, meta-analysis of four RCTs failed to show an effect for symptoms of PTSD (−0·36, −0·83 to 0·10), but showed a beneficial effect of interventions (group psychotherapy, school-based support, and other psychosocial support) for internalising symptoms (six RCTs; SMD −0·24, −0·40 to −0·09). Overall, research and evidence focuses on interventions that are infrequently implemented, whereas the most commonly used interventions have had little rigorous scrutiny.

The prevalence of mental health and psychosocial problems in humanitarian settings is high. These settings consist of a broad range of emergency situations, including armed conflicts, as well as natural and industrial disasters. Most frequently, mental health researchers in humanitarian settings have focused on identifying rates of post-traumatic stress disorder (PTSD)

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See Comment Lancet 2011; 378: 1441
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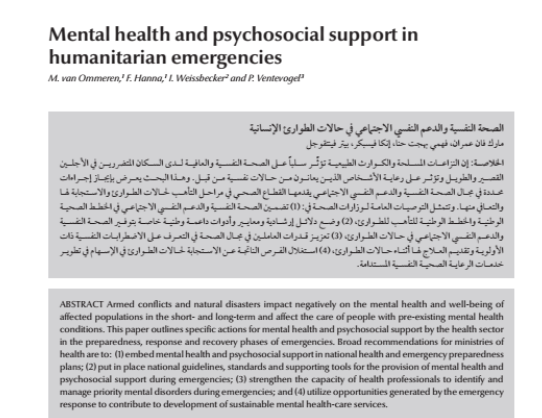
This is the third in a Series of six papers about global mental health
Global Health Initiative, Macmillan Center, Yale University, New Haven, CT, USA (W A Tol PhD); HealthNet TPO, Amsterdam, Netherlands (W A Tol); Section of Psychiatry and Clinical Psychology, University of Verona, Verona, Italy (C Barbui MD); University of Colombo, Colombo, Sri Lanka (A Galappatti MSc); School of Psychiatry, University of New South Wales,


EMHJ • Vol. 21 No. 7 • 2015 Eastern Mediterranean Health Journal La Revue de Santé de la Méditerranée orientale

Mental health and psychosocial support in humanitarian emergencies

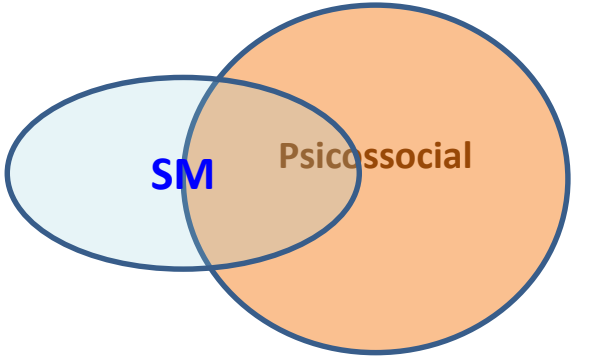
M. van Ommeren,[1] F. Hanna,[1] I. Weissbecker[2] and P. Ventevogel[3]

الصحة النفسية والدعم النفسي الاجتماعي في حالات الطوارئ الإنسانية

مارك فان عمران، فهمي بحث حنا، إلكا فيسكر، بيتر فينتفوجل

الخلاصة: إن التراعات المسلحة والكوارث الطبيعية تؤثر سلباً على الصحة النفسية والعافية لدى السكان المتضررين في الأجلين القصير والطويل وتؤثر على رعاية الأشخاص الذين يعانون من حالات نفسية من قبل. وهذا البحث يعرض بإيجاز إجراءات محددة في مجال الصحة النفسية والدعم النفسي الاجتماعي يقدمها القطاع الصحي في مراحل التأهب لحالات الطوارئ والاستجابة لها والتعافي منها. وتشمل التوصيات العامة لوزارات الصحة في: (1) تضمين الصحة النفسية والدعم النفسي الاجتماعي في الخطط الصحية الوطنية والخطط الرئيسية للتأهب للطوارئ، (2) وضع دلائل إرشادية ومعايير وأدوات داعمة وفنية خاصة بتوفير الصحة النفسية والدعم النفسي الاجتماعي في حالات الطوارئ، (3) تعزيز قدرات العاملين في مجال الصحة في التعرف على الاضطرابات النفسية ذات الأولوية وتقديم العلاج لها أثناء حالات الطوارئ، (4) استغلال الفرص الناتجة عن الاستجابة لحالات الطوارئ في الإسهام في تطوير خدمات الرعاية الصحية النفسية المستدامة.

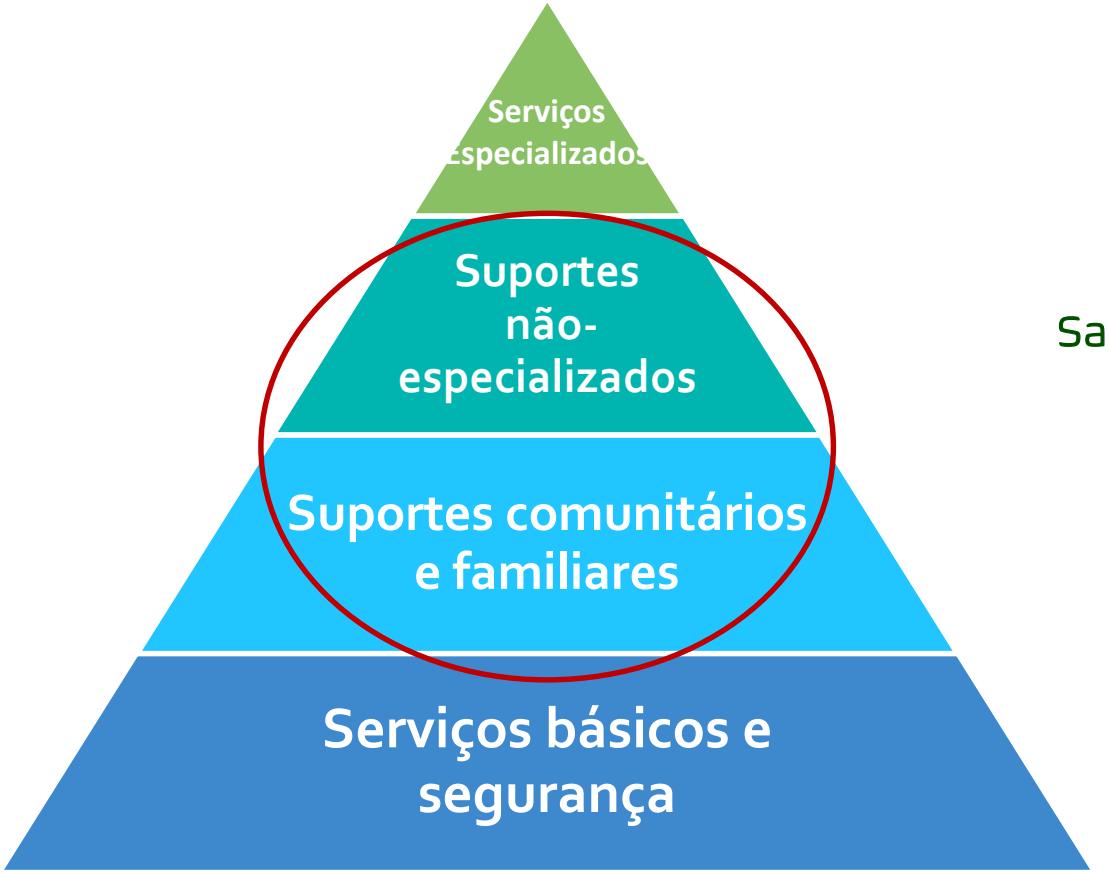
ABSTRACT Armed conflicts and natural disasters impact negatively on the mental health and well-being of affected populations in the short- and long-term and affect the care of people with pre-existing mental health conditions. This paper outlines specific actions for mental health and psychosocial support by the health sector in the preparedness, response and recovery phases of emergencies. Broad recommendations for ministries of health are to: (1) embed mental health and psychosocial support in national health and emergency preparedness plans; (2) put in place national guidelines, standards and supporting tools for the provision of mental health and psychosocial support during emergencies; (3) strengthen the capacity of health professionals to identify and manage priority mental disorders during emergencies; and (4) utilize opportunities generated by the emergency response to contribute to development of sustainable mental health-care services.



- **<u>Abordagem prática</u> que visa:**
  - **<u>Proteger e promover</u> o** bem-estar psicossocial e/ou
  - **<u>Prevenir e tratar</u>** os transtornos mentais
- **<u>Campo</u>** de práticas e de conhecimento
- Lacuna de estudos/conhecimento na América do Sul

Abordagem da Saúde Mental e Apoio Psicossocial

Abordagem da Saúde Mental e Apoio Psicossocial



Pirâmide de intervenção para Saúde Mental e Apoio Psicossocial em emergências (IASC, 2007)

Abordagem da Saúde Mental e Apoio Psicossocial

Abordagem da Saúde Mental e Apoio Psicossocial

Acessibilidade

- Conhecimento sobre os serviços
- Barreiras culturais
- Restrições legais

Adaptação cultural

- Expressões culturais do sofrimento
- Sistemas formais e informais de cuidado culturalmente sensíveis

Meio social

- Fortalecimento laços familiares e sociais
- Moradia
- Emprego e renda
- Integração sociocomunitária

Trabalho em grupo

- Diagnóstico local e proposição de ações comuns
- Compartilhamento

Potencialidades	**Desafios**
Quais as principais potências em relação ao tema?	Quais os principais desafios em relação ao tema?

Trabalho em grupo

O que podemos fazer juntos?

Que ações precisam ser feitas e poderiam ser realizadas pelos participantes/ instituições que estão no seu grupo?

Não ex: Capacitação para migrantes

Ex: Reunião com Departamento de Línguas da Universidade Federal para criação de um curso de língua portuguesa para migrantes.

Trabalho em grupo

Ilustração de template a ser preenchido pelos grupos, no momento de Trabalho em Grupo

Como?
O que precisa ser feito para que as ações sejam realizadas?

Não ex: Articulação da rede local

Ex:

- Levantamento de organizações que já oferecem curso de português para migrantes.
- Contato com representante do Departamento de Línguas da Federal
- Levantamento de coletivos de migrantes que podem atuar na divulgação do curso.

Trabalho em grupo

Ilustração de template a ser preenchido pelos grupos, no momento de Trabalho em Grupo

Quem?

Para realizar essas ações, quem (participante e instituição) assumiria a responsabilidade por cada uma delas?

Não ex: Universidades e sociedade civil.

Ex:

- Departamento de Línguas da Universidade Federal (contato será feito por fulano)
- Coletivo de Migrantes Haitianos (contato será feito por cicrano)
- etc…

Avaliação da Atividade

Discussão