SCIENTIFIC DAYS Wednesday 7 June 2023

MEDECINS SANS FRONTIERES

Exploring the minimum treatment duration for mental health interventions: a retrospective analysis from a conflict-affected region of northern Nigeria

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Introduction

Mental health and psychosocial support (MHPSS) programmes are essential for humanitarian responses in conflict settings, such as in Borno State, Nigeria. However, there is a paucity of research on how traumatic stress type and symptom severity affect clinical improvement in these settings, and there is a lack of consensus on how long these patients must engage in mental health care to see results.

Methods

The records of 11,709 patients from the MHPSS programme in the Pulka and Gwoza local government areas of Borno State, Nigeria, in 2018 and 2019 were retrospectively analysed. We gathered patient- and counselor-assessed patient information, on symptoms, type of stress, severity (clinical global impression-severity scale; CGI-S), and improvement (CGI-I and Mental Health Global State (MHGS) scales). Descriptive, univariable, and multivariable analyses stratified and adjusted by age and gender were performed to examine the associations between variables. Finally, we estimated the minimum number of consultations associated with improvement using margins of responses, obtained from logistic regression model predictions.

Ethics

This research fulfilled the exemption criteria set by the MSF Ethical Review Board (ERB) for a posteriori analysis of routinely collected clinical data, and thus did not require MSF ERB review.

Results

Clinical improvement was associated with increased frequency of consultations; odds ratio (OR) for CGI-I, 2.5; 95% confidence interval (CI), 2.04–2.74, p<0.001; OR for MHGS, 2 (95% CI,1.84–2.24), p<0.001. Patients receiving three to six counseling sessions were most likely to improve if presenting with mild or moderate, and severe symptoms. Survivors of sexual violence, torture, and other stressors linked with conflict or violence were almost 20 times more likely to develop post-traumatic stress disorder (PTSD; OR, 19.7 (95% CI, 11.8–37.8), p<0.001) and depression (OR, 19.3 (95% CI, 6.54–59.4), p<0.001). Children exposed to conflict-related violence were also nearly 40 times more likely to develop PTSD (OR, 38.2 (95% CI, 9.28–82.1), p=0.002). Most patients presented an improvement outcome at discharge, either measured by counselors (92%, CGI-I) or self-rating scores (73%, MHGS).

Conclusion

We found a minimum threshold of sessions at which patients are most likely to achieve a successful outcome (three sessions for mild or moderate symptoms; six sessions for severe symptoms). In addition, we identify specific types of stress (especially torture and sexual violence) that are particularly associated with presenting PTSD and depression. Therefore, we emphasize the importance of classifying patient stress type and severity to guarantee the minimum duration of care needed to improve.

Conflicts of interest

None declared.