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Assessment and Awareness of Mental Health Conditions Among Refugees in Vermont

Sandi Caus April-May 2021

CVMC-Berlin Family Medicine

Dr. Andrea Green, Dr. Jose Lopez, Katina Cummings
Problem Identification and Description of Need

- Vermont is home to refugees from all over the world including Nepal, Bhutan, Burundi, Democratic Republic of the Congo, Somalia, Iraq and many more.

- Refugees experience immense hardship in their home-country, displaced country and throughout the period of re-settlement (Immigrant, Refugee, and Migrant Health, CDC).
  - These experiences are major risk factors for development of Mental Health Problems.
  - Pre-migration experiences include direct or indirect exposure to traumatic events, torture, sexual abuse, political or civil unrest.
  - Post re-settlement experiences include stigmatized refugee identity, difficult socioeconomic status, devaluation of prior social status and professional status (EthnoMED).

- Global prevalence of mental health diagnosis among refugees remains a concern (Blackmore et al. 2020).
  - Roughly 31% diagnosed with PTSD.
  - Roughly 31% diagnosed with Depression.
  - Roughly 11% diagnosed with anxiety disorder.
  - About 1.5% diagnosed with psychosis.

- The Centers for Disease Control and Prevention (CDC) estimates the annual suicide rate among United States resettled Bhutanese refugees to be 21.5 per 100,000, compared to the annual United States rate of 12.4 per 100,000 among the rest of the population (Aoe et al. 2016).

- These are alarming findings among re-settled refugees globally, across the United States and within our Vermont community; undoubtedly in need of being addressed across all healthcare modalities.
Public Health Cost and Unique Cost Considerations in Host Community

• The literature is consistent regarding psychological distress and risk factors for development of Mental Health conditions among refugees
  • To this effect, there is increased concern regarding patient barriers to seeking appropriate mental health care among refugees (Byrow et al. 2019)
  • But, what is the major barrier? Culturally specific mental health stigma (Byrow et al. 2019)
• As an example: “The mental health system in Iraq consists primarily of psychiatric hospitals where you go if you have a chronic and severe mental illness like schizophrenia. In Iraq, having such a mental illness is still highly stigmatized as it is in many countries. Iraqi psychiatric hospitals are grim places where patients may never leave. Therefore, people have no real concept beyond the hospitals; so they would not want to have anything to do with something that could lead them to be committed to such a place.” (EthnoMED)
  • Stigmatization of Mental Health is not unique to Iraqi refugees, rather it is consistent across refugee populations
  • Overlooking the use of culturally sensitive language can lead to missed screening opportunities and poor outcomes among patients
• This is just one aspect of culturally sensitive Mental Health care among refugee populations, but undoubtedly deserving of our attention and continued education in the setting of elevated rates of mental health conditions among this population group
• Together, we can work to better identify and appropriately discuss Mental Health with our refugee populations to best provide reliable resources and mitigate poor outcomes associated with undiagnosed mental health conditions
• This starts with our own education surrounding culturally specific mental health stigma and how to best address/mitigate this barrier in care for our refugee patients
• Another aspect to best treating refugee’s is at the provider level, manifesting as a lack in referral opportunity or knowledge gap; roughly 3% of refugees are referred to mental health resources following positive screening measures (American Psychiatric Association)
Community Perspective on Issue and Support for Project

- A community refugee, who came to the United States from war-torn Bosnia with her 4 year-old son and husband in 1998, had the following to say about her mental health—

“I was in a situation where survival was the only thing I could think about, I absolutely did not have time to think about a bad situation or what could happen to me. But, when I came here [Vermont], into a better situation I was able to ask myself, ‘is it possible that I survived, is it possible all of that happened?’ While I was over there [Bosnia] I was not thinking about ‘I don’t have electricity, my child is little, I’m alone in my home; who will come into my home and will they kill me?’ … When I came here [Vermont] I felt free and this is when I really starting thinking about what happened to me, this is when my depression started.” —Sabina

- One provider from the Department of Pediatrics at the University of Vermont Medical Center provided the following perspective on the importance of cultural-sensitivity and confidentially when treating refugee patients—

“It is easy to forget that our practice of medicine is infused in culture. We study biology and talk about evidence-based medicine but it is through the lens of what we already know and is influenced by our lived experience, our education and our cultural biases. Culture is about the taboos, what is not allowed and throughout the world mental health issues are stigmatized. We tend to personalize, blame and look beyond the pathophysiology which we are still trying to understand. The space of vulnerability that lives in the emotional world, the mental health world is fragile, tender, and hidden. It takes trust to bare those hurts to the world. Confidentiality is our way of saying your hidden is safe with me. I will hold that hidden experience or shame and not share it. I will remind you that you are more than your trauma, that to be here is testimony to your resilience. I, your physician will hold that pain with you and make the burden lighter, the possibility brighter, and the hope real.”

—Andrea Green, MDCM
Intervention and Methodology

• The literature is extensive regarding the prevalence of mental health conditions among refugees from all parts of the world and there is considerable evidence that mental health stigma is a critical barrier in seeking appropriate treatment (EthnoMED, CDC)

• Given the rising data and my discussions with Dr. Andrea Green (Director of the Pediatric New American Clinic and Pediatrician at the University of Vermont Medical Center), Dr. Jose Lopez (Department of Family Medicine CVMC-Berlin) and Katina Cummings of the Northern Vermont Area Health Education Center (AHEC), I have elected to self-educate on reputable online databases/resources available for culturally effective discussion of mental health

• Furthermore, I have decided to develop a user-friendly handout to aide in discussing, screening and referring refugees to mental health resources around the State of Vermont

• Emphasis is placed on the following:
  • Introducing mental health in a culturally sensitive manner with simple language (particular emphasis on confidentiality)
  • Provider language scripts for introducing the Refugee Health Screener-15, a modality used in the Domestic Refugee Examination (emphasis on its intention for screening)
  • Helpful referral options for providers with positive-screening patients
  • And attention to the somatization of psychiatric illness among select refugee populations, an important delineation from our standard experience with mental health in the United States

• The handout will be available to providers around the State of Vermont and is intended to serve as an easily accessible tool for providers who undoubtedly may not be able to pursue further education on this topic
Results/Response Data

- My discussions with Dr. Andrea Green, Katina Cummings and self-education helped me discover several resources that are both informative and easily accessible to providers

  - **CDC Immigrant, Refugee, and Migrant Health**: this is an expansive resource with several culturally specific health profiles available, which are exceptional at outlining refugee experiences and contain information regarding refugee-specific mental health screening guidelines (https://www.cdc.gov/immigrantrefugeehealth/index.html)

  - **EthnoMed**: an expansive resource built for the purpose of "Integrating Cultural Information Into Clinical Practice"; what is most unique about this resource is the integration of introductory "scripts" containing culturally sensitive language to assist in effective mental health conversations. This resource also highlights the degree to which certain refugee groups present with somatic symptoms of mental health (https://ethnomed.org/)

  - **Medline Plus (Formerly HealthReach: Health Information In Many Languages)**: a resource which can be used by providers to provide patients with appropriately translated mental health documents— not available in all languages, but several of our major refugee populations are represented (https://medlineplus.gov/languages/languages.html)

  - **The New England Survivors of Torture and Trauma Program/ Connecting Cultures at the University of Vermont**: a unique resource for refugee mental health counseling through the Vermont Psychological Services. Providers can refer patients to this counselling resource and even more importantly, patients can be encouraged to self-refer (https://www.newenglandsurvivorsoftorture.org/)

  - **Community Health Centers of Burlington**: a well-integrated medical center consistently caring for refugee patients and with mental health services available to refugees (https://www.chcb.org/services/psychiatry/adult-psychiatry/)

- Please refer to the prepared user-friendly handout with further information to be used while working with refugee patients (view on next slide)
Results/ Response Data

Guidance for Addressing Mental Health among Refugees

(Approval for Primary Care Teams across the States of Vermont and beyond)

Approach:
1. Recognize that discussing such a stigmatized topic with refugees may cause a patient to withdraw or disengage in the clinical encounter:
   a. One profound example of mental health stigma is among Iraqi refugees who often associate mental illness (primarily depression and anxiety) which may be seen as a "crazy".
   b. If you are unable to avoid using "mental health" in your clinical encounter, explain your intention and emphasize that this does not label a patient as "crazy" or may be common in their culture.
   c. Furthermore, carefully emphasize the conceptual framework of confidentiality in our healthcare models, lack of confidentiality in several refugee cultures contributes to mental health stigma.
2. Consider asking about mental health with your refugee patients in plain language as this will improve support:
   a. An example, avoid regular use of the following terms: depression, Post-traumatic stress disorder (PTSD), psychosis, anxiety.
   b. Try to make use of plain language scripts; as an example, when discussing PTSD, you could say "you are having bad nightmares and think about what happened to you frequently?".
   c. Avoid be tires of culturally specific beliefs surrounding preventative medicine and the reluctance of some refugee patients to endorse concerns outside of the acute setting (small samples, as an example).

Identification/Screening:
1. Several refugee populations somatize symptoms of mental health illnesses, often reporting headaches, body aches, abdominal pain, and weight loss.
2. The Centers for Disease Control and Prevention (CDC) recommends use of the Refugee Health Screener-15 (RHS-15) as a screening tool for patients >18 years of age.
   a. The RHS-15 provides reliable screening for PTSD, depression and anxiety as a single tool.

b. When introducing the RHS-15 to a refugee patient it must be emphasized that the tool serves a screening purpose and is not diagnostic: below is an example of an introductory script to be used:

"Some refugees have had body symptoms because of the difficult things they have been through, and because it is very stressful to move to a new country. The symptoms are not being lingus. Help people who are having a hard time and who might need extra support." -Interruption

Resources and References:
1. Brief self-education:
   a. EthnoMed.org: expansive online resource for brief, informative educational materials aimed at appropriately integrating culture into healthcare and mental health.
   b. Centers for Disease Control and Prevention (CDC) Immigrant, Refugee, and Migrant Health: expansive resource including mental health screening strategies (RHS-15 and others) as well as Refugee Health Profiles.
   c. MedlinePlus.gov: resource which contains several translated documents, many of Vermont’s large refugee populations are represented.
2. Referrals:
   a. Community Health Centers of Burlington- Riverside (607 Riverside Avenue Burlington, VT 05401, T: 802-664-6309)
   b. New England Survivors of Torture and Trauma- Connecting Cultures at the University of Vermont (2 Colchester Avenue Burlington, VT 05405 T: 802-654-2661)
   c. Howard Centre (230 Flynn Ave Suite 33 Burlington, VT 05401 T: 802-488-6800)

Information was gathered largely through the Centers for Disease Control and Prevention, EthnoMed, AEC Health Education Center (AHEC) in refugees and discussions with local providers within the University of Vermont Health Network."

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Evaluation of Effectiveness and Limitations

• Through my work with Dr. Andrea Green and Katina Cummings I hope this short discussion, self-education and the prepared handout are useful tools to improve awareness of culture-specific mental health stigma among our expanding refugee population in Vermont.

• As we strengthen our awareness of mental health stigma among our patients in the setting of alarming mental health trends, we will undoubtedly better serve their mental health needs.

• Time constraints were a limiting factor for this project, but even so it is important to highlight the importance of this topic and to continue devising strategies to best care for refugee patients. This project is one aspect of a multi-factorial approach to caring for refugee patients within our community.

• It may seem that this topic does not directly affect many of Vermont’s primary care clinics, as many refugees are clustered in the Chittenden county area, but even so the user-friendly handout outlines several skills that can be used across all patient demographics to encourage mental health discussion.
Recommendations For Future Interventions/Projects

- Continue to develop best-practices and self-educate by means of several easily accessible online databases to better address and screen for mental health among refugees.

- Further develop effective introductory “scripts” for discussing mental health with refugees, specifically with those who come from cultures which have strong stigma associated with mental health diagnoses.

- Make use of several Vermont-specific refugee mental health resources including the Community Health Centers of Burlington, Connecting Cultures at the University of Vermont and the Howard Center.

- The effectiveness of the newly developed handout and provider knowledge of refugee-specific mental health resources within our state can be addressed in the future by surveying Vermont’s primary care clinic sites; this is certainly a topic that deserves to be re-visited periodically for the purpose of developing innovative and effective care strategies/skills among healthcare professionals working with refugee patients.
References


