REFUGEE HEALTH TECHNICAL ASSISTANCE CENTER

# WELCOME

You are attending the webinar on

## Addressing Mental Health Needs of Refugees in Primary Care Settings

*presentation will begin shortly*

United States
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-or-
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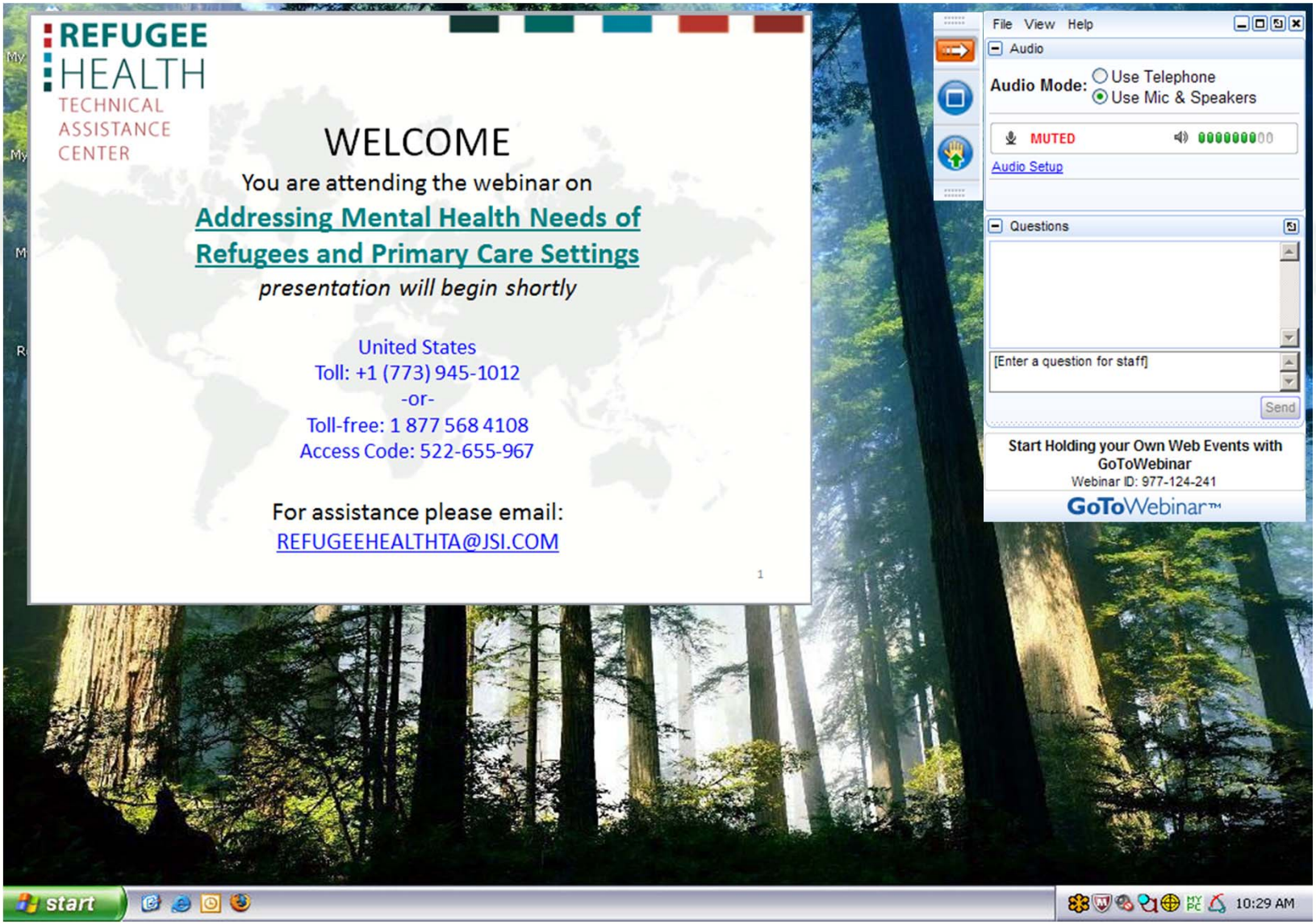
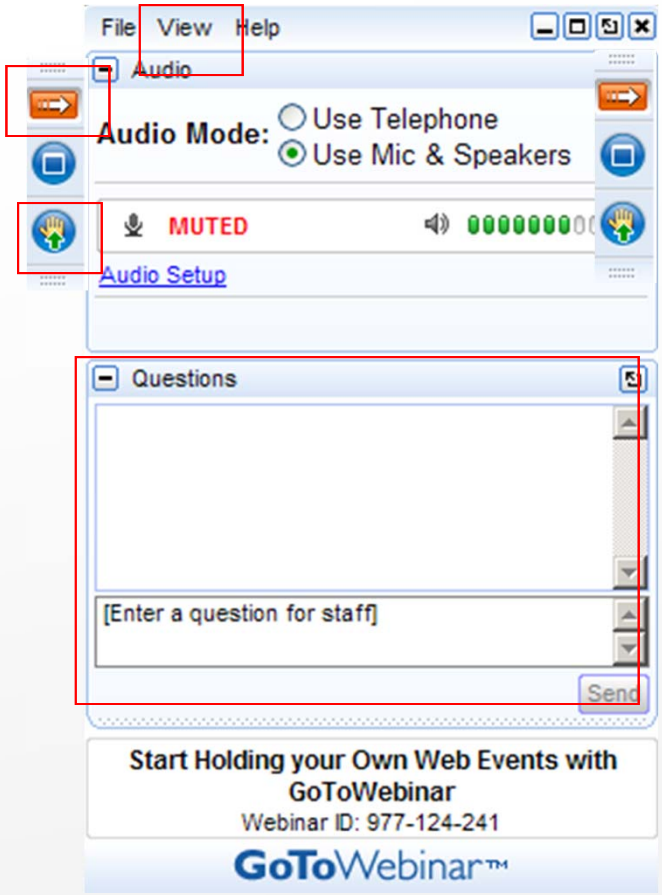
# Housekeeping



# How to Participate Today




- Open and close your panel
- Submit text questions
- Raise your hand
- Q&A addressed at the end of today's session
- Mute your phone and computer
- Evaluation questions at end

# Webinar Overview

- Presentations by Drs. Allen Keller and Samantha Stewart (45 minutes)
- Q&A (25 minutes)
- Slides, webinar recording, Question and Answers, and additional resources will be posted to http://refugeehealthta.org after the webinar
- Email refugeehealthta@jsi.com if you have any questions after the webinar

# Who is here today?

- Health/mental health care providers, refugee health and resettlement coordinators, case managers, and many others including:
  - clinical coordinators and health services managers, family support case workers, community outreach workers, counselors and advocates, medical interpreters, employment counselors, nurses, students and researchers, volunteers and more.
- From dozens of organizations in Canada, Australia, Kenya, the Netherlands, Thailand, and 35 U.S. states

# Objectives

- Familiarize health care professionals in primary care settings with the needs of refugees presenting with mental health conditions and psychological sequel of torture or violence
- Share with health care professionals key information and best practices necessary to provide medical and psychological care to refugee and asylee patients
- Share resources that will help health care professionals comprehensively address the needs of their refugee and asylee patients

# Addressing Refugee Mental Health Needs in Primary Care Settings

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Coordinated by:

Refugee Health Technical Assistance Center

Massachusetts Department of Public Health

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# KEY POINTS

- Health professionals working with immigrants in Primary Care Settings will encounter refugees who have endured traumatic events related to their refugee experience.
- Survivors of refugee trauma may present with a variety of health concerns and needs (medical, psychological and social)
- Primary Care Providers can play an important role identifying and addressing health concerns (including mental health) of  refugee trauma survivors.

# Case Presentation

25 year old West African male  c/o chronic Stomach aches and headaches.

He describes stomach aches as  “burning” and worsen with spicy foods.  The headaches are frontal, and worsen when he is “nervous,” and improve with lying down. He denies a history of head trauma.

# Case Presentation

**Medications:**
None

**Past Medical/Surgical History:**
None

**Social History:**
Denies use of cigarettes, drugs, alcohol; was college student in his country; Arrived in the United States 2 ½ years ago. He was forced to flee his country Because of “civil war.”

**Review of Symptoms**
Denies N/V, diarrhea, blood in stool. Notes some constipation since he came to the U.S. Denies visual problems, dizziness

**Physical Examination:**
Unremarkable

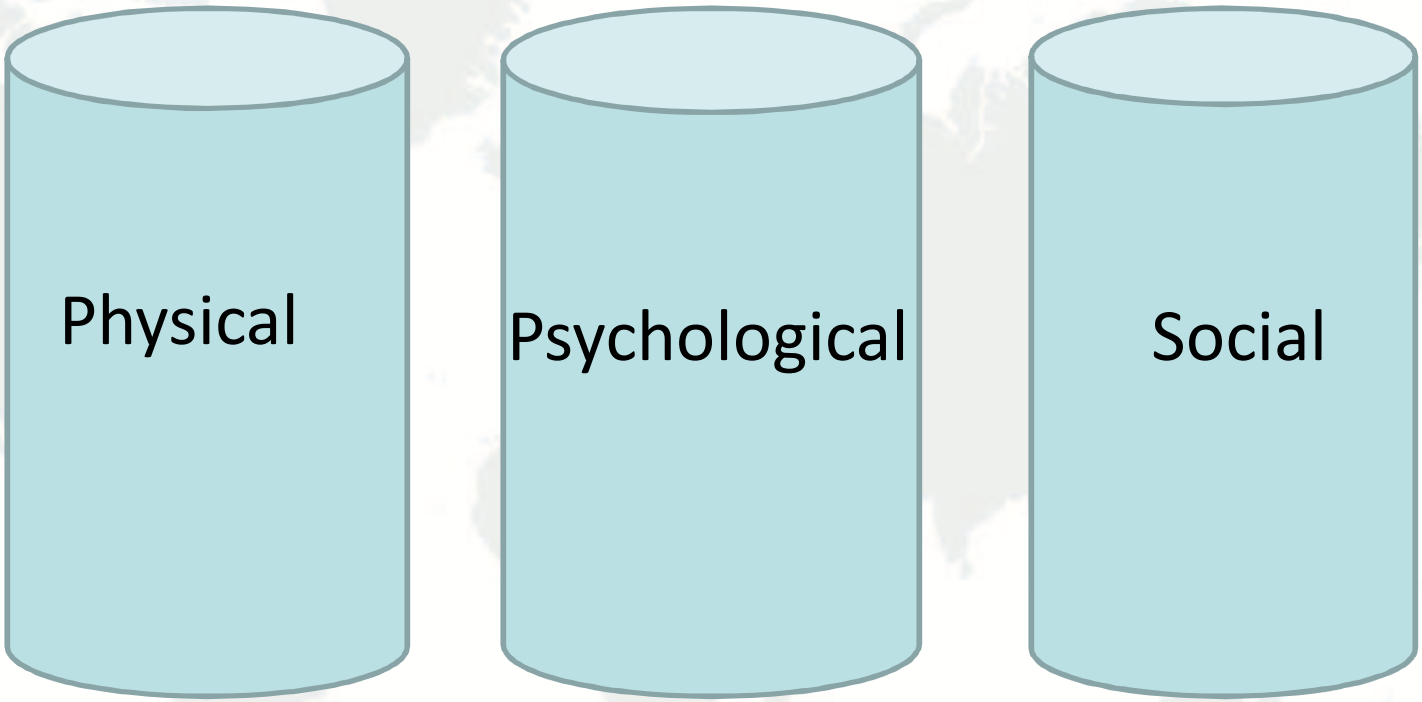
**Routine Labs:**
Unremarkable including normal CBC, Electrolytes, Liver Function tests; negative Hepatitis serologies, stool for ova and parasites, H. pylori antigen; HIV negative, PPD positive (normal chest x ray)

# HEALTH

**“A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”**

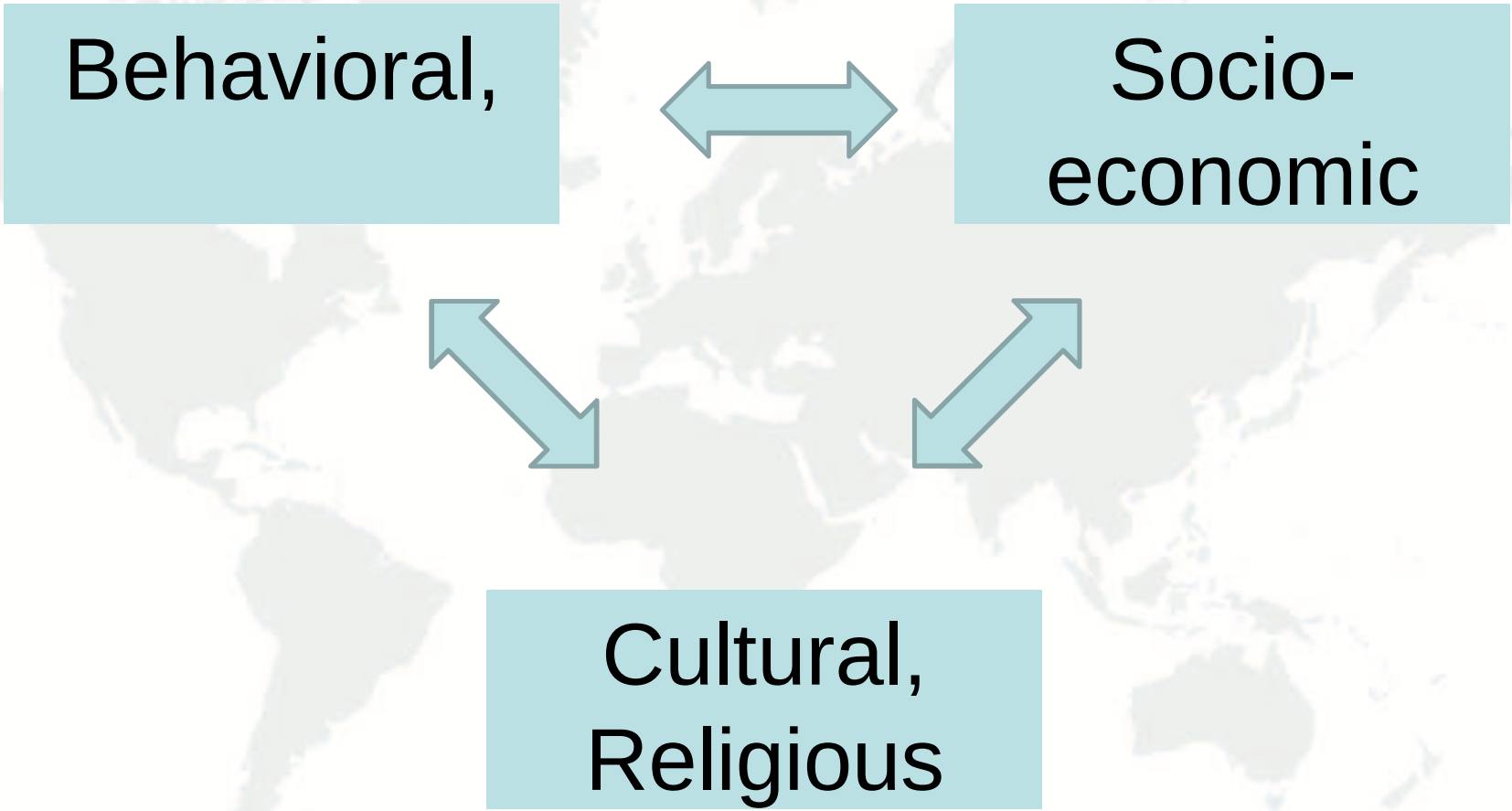
World Health Organization Constitution

# Health



# HEALTH

# Social Dimensions of Health



# Case Presentation (continued)

**Trauma History:**

- Forced to flee when rebels attacked village because of ethnicity
- House set on fire
- Kicked in the back by a rebel soldier who yelled “Don’t come back!”
- Witnessed neighbors chased and attacked with machetes
- Separated from family while running to hide in forest
- Has not seen nor heard from family since and fears them dead.
- Walked for several days with little to eat before arriving in a “camp” on the border of a neighboring country.
- With a friend’s assistance, secured a student visa to the U.S.
- Applied for and after nearly 2 years was granted asylum.

# Case Presentation (continued)

**Additional Social History**

Lives in apartment with 10 other Africans and unsure he will be allowed to continue staying there; Works p/t as street vendor or “night shift dishwasher in diner; Was studying to be an accountant; French speaking with limited English; Single, no children, 6 younger siblings; practicing Muslim

**Psyche ROS**

- Sleep disturbances (difficulty falling asleep), frequently awakened by nightmares (2-3 times/week);
- Recurrent memories of trauma, particularly when not working; Easily startled; Tries (unsuccessfully) not to think about what happened;

- Profound feelings of sadness, and hopelessness; denies suicidal thoughts; normal appetite, stable weight

# Traumatic Events Commonly Experienced by Refugees

- Forced Migration (uprooting from home)
- Torture and sexual violence
- Imprisonment/harsh detention
- Poor conditions of refugee camps
- Witnessing killings and destruction , material losses,
- Uncertainty over the future
- Disruption of community and social support networks

# Prevalence of Torture

- Documented to occur in more than 90 countries, worldwide (Source: Human Rights Watch, Amnesty Intl. U.S. State Dept.)
- 5-35% of refugees and asylum seekers are torture victims (Source: numerous sources in the medical literature)
- More than 400,000 torture victims, who fled their native countries, are believed to reside in the USA (Source: Office of Refugee Resettlement)

# Prevalence of Torture in the Primary Care Setting

- 7-11% of immigrant patients in the primary care setting have endured torture

  (Source: Eisenman, Keller Kim, 2000; Eisenman, Gelberg, Liu & Shapiro, 2003; Crosby et al. 2006;)
- Many more have likely experienced / witnessed traumatic human rights abuses
- Few if any individuals reported their history of torture / trauma to their physician nor were asked about it

# Health Consequences of Refugee Trauma

- **Physical**
  - Infectious diseases, musculoskeletal pain/injuries, scars, broken bones, gastro-intestinal disorders, headaches, neurological damage (including from head trauma), infectious diseases (e.g. STD's, chronic pain)
- **Psychological**
  - Symptoms/diagnoses of Depression, Anxiety, Post-traumatic Stress Disorder, Cognitive deficits
- **Social**
  - Withdrawal, isolation, mistrust, substance abuse

**The physical, psychological and social Dimensions of health, and the health consequences of trauma are all interrelated.**

# Refugee Trauma: Context and Setting

- Traumatic events typically have physical and psychological and social components
- Any one traumatic event rarely occurs in isolation but in the context of multiple traumas
- Potential harm caused by multiple traumas is greater than the additive effect of isolated traumas
- Traumatic events  commonly involve loss of autonomy/control
- Such loss of control, or loss of autonomy, results in extreme helplessness and distress

# Refugee Mental Health

- Higher rates of stress/ exposure to trauma than general population
- Higher rates rates of mental health sequelae
  - WHO estimates >50% of refugees have significant mental health symptoms
- Similar to general population, resettled refugees are more likely to present to PCP's than specialized mental health providers
- Unlikely to spontaneously offer trauma histories or mental health symptoms
- Mental health often more stigmatized in countries of origin than in U.S.

# Evaluating and Caring for Survivors of Refugee Trauma

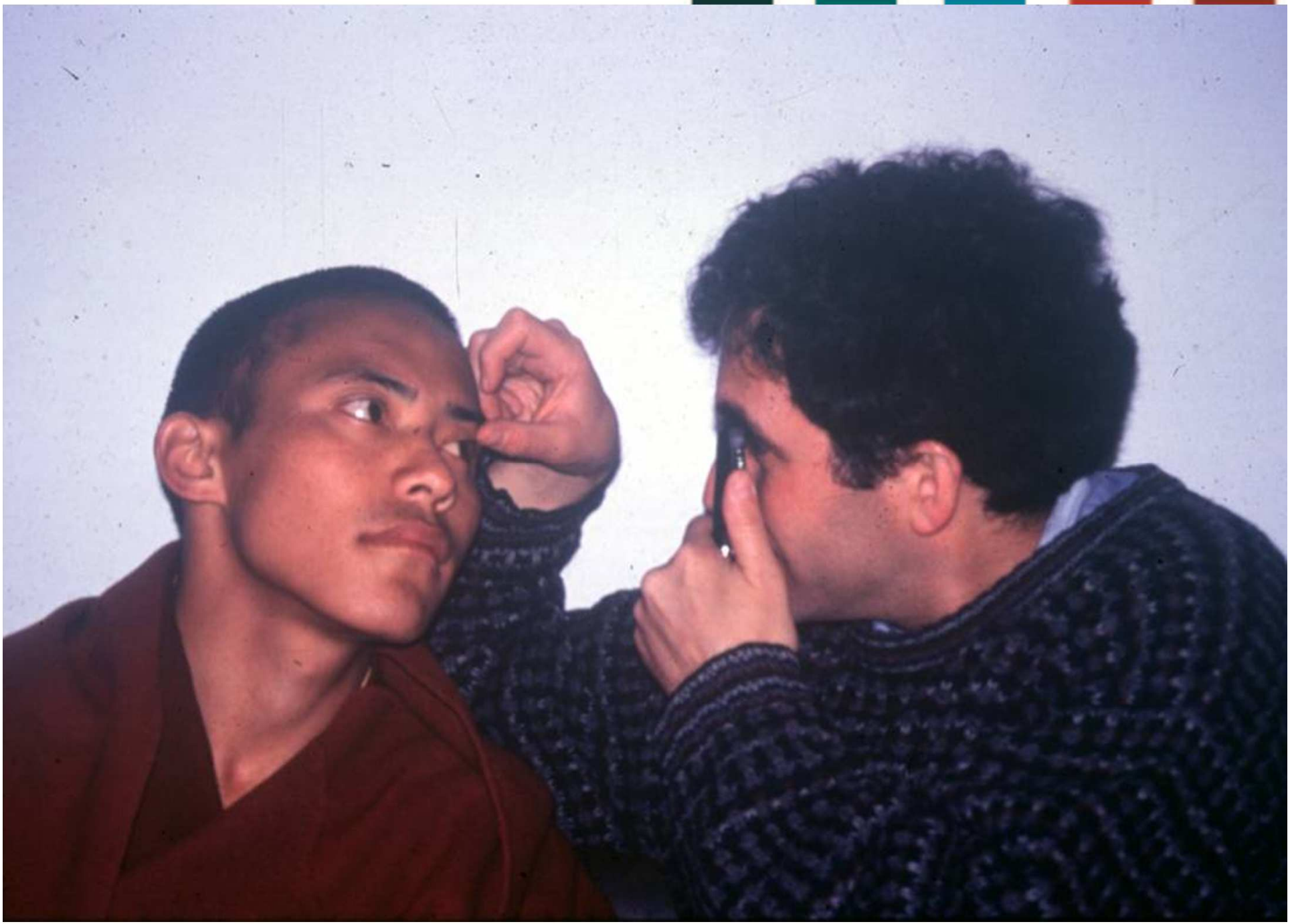
- Recounting traumatic events is extremely stressful and potentially re-traumatizing for the victim
  - utilize “active listening”
  - Acknowledge difficulties of talking about traumas
- Listening to accounts of torture / trauma is stressful for the interviewer as well (vicarious traumatization)
- Establishing a rapport and eliciting a thorough and complete history takes time
- Variability with degree of physical/psychological signs, symptoms, or consequences a trauma survivor manifests
- There is variability in the manner in which trauma victims conduct themselves in interviews and in recounting the events of their abuse
- Anticipate and Address potential barriers
  - E.g. Interpreter needs, gender issues, time limitations

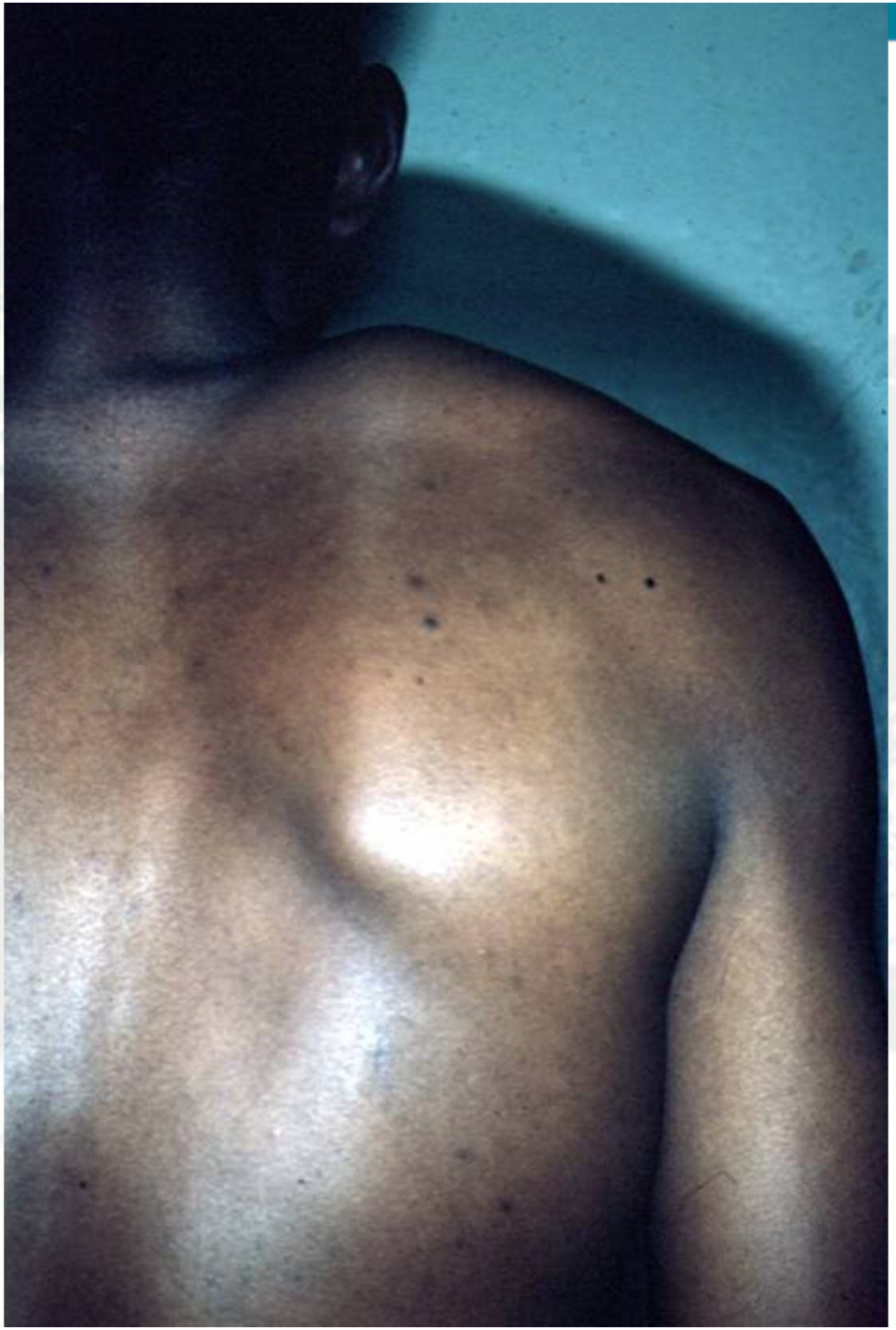
# Physical Examination of Trauma Survivors

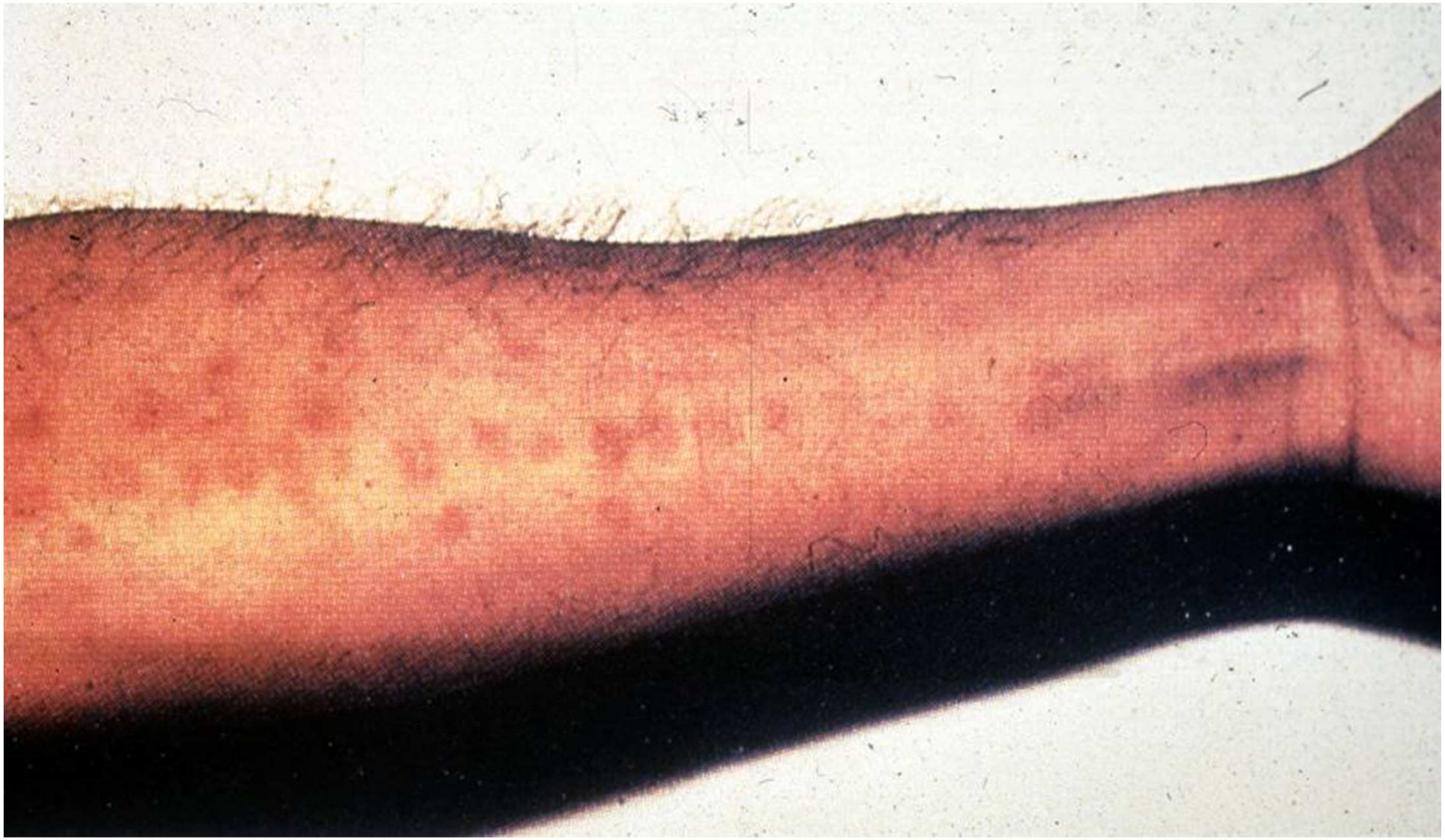
- Thorough physical examinations are important for addressing health needs and for documentation

- Sensitivity
  - start with less intrusive elements of physical examination
  - avoid prolonged nakedness
  - explain each step as you go

- Physical findings may or may not be present
  - A “normal” physical examination does not negate allegations of torture/trauma
  - Many forms of torture / trauma leave no marks
  - Substantial gap of time between trauma and evaluation







# Ancillary Tests

- Be mindful of cultural issues and potential for re-traumatization
- Provide appropriate explanation/preparation
  - Blood drawing
    - Blood is a “sacred” element in many cultures
    - blood drawing may have been a form of abuse
  - Electrocardiograms
    - May be stressful for individuals subjected to electric shock torture
  - CT Scans/MRI’s
    - May cause anxiety from sensation of enclosed space
    - start with less intrusive elements of physical examination

# Common Psychological Symptoms, Diagnoses Among Trauma Survivors

- Depressive symptoms
  - Sadness, hopelessness, shame, difficulty concentrating, sleep difficulties
- Anxiety symptoms
  - Nervousness, Intrusive memories, nightmares, sleep difficulties, startle response, irritability,
- Memory and concentration impairments
- Somatic symptoms
- Diagnoses of Depression, Posttraumatic Stress Disorder

➔ Presence of multiple symptoms and co-morbidity of Depression/PTSD is common

# Posttraumatic Stress Disorder (PTSD)

- *Re-experiencing*: intrusive thoughts and images, flashbacks, nightmares
- *Hyperarousal*: poor sleep, irritability, startle response, poor concentration
- *Avoidance*: numbing, emotional constriction, avoiding reminders of the trauma

# Depression

- Low mood
- Sleep, appetite disturbance
- Low energy
- Feelings of self-blame, guilt, worthlessness
- Poor concentration
- Suicidal feelings

(All of these symptoms can seriously impair day-to-day coping and planning for one's future)

# “Mental Health” Concerns May Present as

- Stress
- Difficulty Functioning
- Common mental health disorders (eg. depression/anxiety)
- Substance abuse
- Traditional explanations
- Excessive visits or reluctance to seek care
- Pain or vague physical complaints

# Mental Stress Can Manifest As Physical symptoms

- Fatigue
- Headaches
- Tense muscles
- Palpitations
- Shortness of breath
- Nausea/abdominal pain
- Poor appetite
- Vague pains in limbs
- Menstrual irregularity

# As Behavioral Symptoms

- low energy, less activity
- overactivity, restlessness
- difficulty concentrating
- substance abuse
- sleep problems (excess or insomnia)

# As Relationship Problems

- lack of emotion
- arguments, disagreements
- overdependence on others/difficulty making decisions

# As Mental Problems

- anxiety and irritability
- sadness, crying, feeling helpless
- mood swings
- poor concentration
- ruminating

# Facilitating Conversations About Mental Health

- Provide safe, private environment
- Be aware of possible traumatic immigration history (torture/trauma)
- Ask about migration history and trauma history
- If torture/trauma history elicited consider:
  - sensitivities in physical exam
  - more thorough review of social situation
  - more thorough review of mental health symptoms

"Assumptions, however, to the fact that entire refugee populations become mentally disturbed and are in need of psychiatric care  need to be avoided. Psychiatric morbidity and psychosocial dysfunctioning depends on the nature and time span of the conflict, on the level and the rapidity with which resilience will emerge, based on socio-cultural factors, and other environmental parameters. The rapidity of mental health support is critical."

World Health Organization. "Mental health of refugees, internally displaced persons and other populations affected by conflict" http://www.who.int/hac/techguidance/pht/mental_health_refugees/en/

# Challenges Accessing Mental Health Services

- Shortage of mental health services worldwide
- Shifting burden of mental health care to primary care services
  - When planned and intentional this  can be effective
  - When ignored, there is increased likelihood of mental health issues falling through the cracks

# Addressing Challenges to Accessing Mental Health Services

- Given high rates of trauma and stress, primary care services with refugee clients should anticipate mental health referrals
- Care is integrated so PCP’s can be in collaborative consultation with mental health providers
- PCP’s should always consider mental health part of total health

# Addressing Challenges to Accessing Mental Health Services

- Mental Health referrals are more likely to happen when appointment is on same day
- Referrals are more likely to take place when services are co-located
- Referrals are more effective when there is direct verbal communication between providers

# Common Mental Health Resources

- Depression care nurse
- Emergency room
- Identified mental health clinic
- Psychiatric consultants
- Support groups

# Primary Care Providers Can:

- Prescribe standard dose antidepressant and anti-anxiety medication
  - safe in context of adequate follow up
  - provider comfort varies
- Coach on self care, sleep hygiene, adequate exercise, social support
- Develop rapport allowing patients to share stress/mental health concerns
- Review stress and common mental disorder symptoms as part of ROS

# Recommend Mental Health Referral When:

- Suicidal ideation or behavior
- Psychotic symptoms
- Cases that make provider anxious
- Failure to respond to treatment

**Referral does not mean PCP no longer Follows mental health!**

# Refugee Mental Health Considerations

- Unfamiliar with mental health terms
- Increased stigma re mental health care
- Consider provider gender when discussing sexual trauma, sexuality
- Interpreter issues
- Majority of cultures distinguish stress-based symptoms from physically-based symptoms
- Elicit patient’s understanding of symptoms
- Discuss in shared language

# Psychoeducation for Providers

- Discussing mental health issues does not worsen mental health
- Not discussing mental health issues does not make them go away
- Developing a way to speak about symptoms possibly related to stress (somatic, functional) that sets realistic expectations for patient is most effective
  - i.e. not endless tests/medication trials

# Psychoeducation for Patients

- Treatments are available and effective for mental health symptoms and problems
- Use of antidepressants is common in the United States.
- Health care is private and confidential
- Your PCP is interested in your opinion
- Patient is own best advocate

# Psychopharmacology

- it is appropriate for primary care doctors with knowledge of basic psychopharmacology to prescribe initial trial of antidepressant
- SSRI’s are safe, evidence-based treatments for depression, anxiety, ptsd and pain syndromes
- although different ssri’s have earned different indications it is likely that they are all equally effective

# Psychopharmacology (continued)

- Different side effect profiles may be used to determine best fit for individual patients
  - eg prozac more activating
  - paxil more sedating
  - celexa/lexapro fewer sexual side effects
  - zoloft for constipation
  - remeron for low appetite, poor sleep
  - wellbutrin for low energy
- Psychopharmacology includes some trial and error “like soup”

# How Medication is Discussed Influences Medication's Effectiveness

- Empower pt to observe medication effects
  - "take at night if it makes you tired"
  - small side effects are "body getting used to"
  - "not a miracle"
  - "feel something or we will increase"
- Results will be gradual and subtle
- Not addictive
  - "you can always decide to stop"
- Continue medication after improvement
  - " 6 months of feeling good to prevent relapse"

# Additional Mental Health Treatment Options

- Individual therapy
- Group therapy
- Behaviors that improve mood/mindfulness
  - socializing
  - exercising
  - writing in journal
  - problem solving
  - education/learning language


World
ANTARCTICA
Postgraduate Center for Mental Health
Thank You

# Optimizing Mental Health in  Primary Care

- Elicit mental health complaints
- Initiate management of non-complex mental health disorders
- Provide psycho-education
- Be aware of community/refugee resources
- Make appropriate referrals

# Provision of Multidisciplinary and Interdisciplinary Care

Identify colleagues from different disciplines in your practice/institution, referral network

–Medical/subspecialty

–Mental Health

–Social

–Legal

–Community organizations

• Establish and maintain effective communication

• Learn about the communities you are serving (cultural competency

# Mental Health Screening Instruments for Refugee Populations

- Hopkins Symptoms Checklist
- Harvard Trauma Questionnaire
- Patient Health Questionnaire (PHQ-9)
- Beck Depression and Anxiety Inventory
- Refugee Health Screen (RHS-1)

Self-administered _____

DATE: _____/_____/_____ Not self-administered _____

**Instructions:** Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

| SYMPTOMS | NOT AT ALL | A LITTLE BIT | MODERATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 1. Muscle, bone, joint pains | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling down, sad, or blue most of the time | 0 | 1 | 2 | 3 | 4 |
| 3. Too much thinking or too many thoughts | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling helpless | 0 | 1 | 2 | 3 | 4 |
| 5. Suddenly scared for no reason | 0 | 1 | 2 | 3 | 4 |
| 6. Faintness, dizziness, or weakness | 0 | 1 | 2 | 3 | 4 |
| 7. Nervousness or shakiness inside | 0 | 1 | 2 | 3 | 4 |
| 8. Feeling Restless, can't sit still | 0 | 1 | 2 | 3 | 4 |
| 9. Crying easily | 0 | 1 | 2 | 3 | 4 |

*The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:*

| | | | | | |
|---|---|---|---|---|---|
| 10. Had the experience of reliving the trauma; acting or feeling as if it were happening again? | 0 | 1 | 2 | 3 | 4 |
| 11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma? | 0 | 1 | 2 | 3 | 4 |



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| | | | | | |
|---|---|---|---|---|---|
| **12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?** | 0 | 1 | 2 | 3 | 4 |
| **13. Been jumpier, more easily startled (for example, when someone walks up behind you)?** | 0 | 1 | 2 | 3 | 4 |

14. Generally over your life, do you feel that you are:

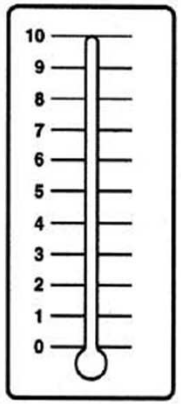
| | |
|---|---|
| Able to handle (cope with) anything that comes your way | 1 |
| Able to handle (cope with) most things that come your way | 2 |
| Able to handle (cope with) some things, but not able to cope with other things | 3 |
| Unable to cope with most things | 4 |
| Unable to cope with anything | 5 |

**ADD TOTAL SCORE OF ITEMS 1-14: _____**

15.

## Distress Thermometer

**FIRST:** Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.




**Extreme distress**

"I feel as bad as I ever have"

**No distress**

"Things are good"

**SCORING**

**Screening is POSITIVE if:**

1. **Total score of items 1 to 14 is ≥ 12 AND/OR**
2. **Distress Thermometer is ≥ 5**

**CIRCLE ONE:** **SCREEN NEGATIVE** **SCREEN POSITIVE REFER FOR SERVICES**

# Resources

**The following sites provide referral resources as well as educational materials about caring for refugees**

- **Refugee Health Technical Assistance Center** http://www.refugeehealthta.org/
- **Refugee Health Information Network** http://rhin.org/
- **Bellevue/NYU Program for Survivors of Torture** www.survivorsoftorture.org
- **Office of Global Health Affairs, U.S. Dept. of Health and Human Services**
- http://globalhealth.gov
- **National Consortium of Torture Treatment Programs** (USA)
  - Includes more than 25 programs throughout the United States providing services to torture victims. http://ncttp.org
- **Florida Center for Survivors of Torture, National Partnership for Community Training** http://www.gcjfs.org/fcst/npct.htm