Mental Health Screening and Barriers to Care of Refugees in the Triangle Area of North Carolina: a Community Survey & Program Intervention Approach

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Abstract

Numerous studies have found a high prevalence of psychopathology in refugees. This vulnerable population faces a unique trifold of stressors from the climate in their country of origin, the migration to their country of asylum and adaption to their new environment (Birma et al., 2005). Without strong coping strategies or the presence of mental health interventions, these stressful and traumatic situations often manifest into severe mental illnesses (Duckworth & Shelton, 2012). Though we have become increasingly aware of the presence of mental health illnesses in refugees, communities still face a variety of barriers in being able to offer their services to this unique population. This paper will serve to examine the history of the presence of refugee populations in North Carolina, barriers to mental health screening throughout the relocation process, as well as barriers to mental health care access in refugees and the methods in which trauma can impact an individual from a behavioral and physiological approach. The community based survey and screening in this research will assist as an analysis of trends in mental health illnesses among various cultural populations of refugees living in the triangle area of North Carolina. This analysis will guide suggestions for implementations and evaluations of programs and resources intended to aid refugee mental health concerns. The aim of this paper is to provide research that will better serve the distinctive mental health needs of refugees in the triangle and function as a model for other communities to replicate.
History of North Carolina Refugee Populations

For the majority of North Carolina’s history, the yearly net emigration was substantially higher than immigration. Looking back in the early 1800’s with hundreds of thousands of European Americans exiting to the late 1800s with the departure of over 380,000 African Americans to as recent as the 1970’s when 94,000 people emigrated. A huge change occurred between 1980-1990 when the state saw its first immigration of 374,354 people (Stuart & Baum, 2005). With this growing change of immigration arrive a number of statuses under which these individuals and families arrive; this particular paper is most concerned with the refugee status. A refugee is defined by the United Nations High Commissioner for Refugees (UNHCR) as a person who has fled their country due to persecution, violence or war. The refugee must have a rational fear associated with persecution for membership in a specific social group, nationality, political opinion, race or religion. Most refugees are afraid to return to their home country or cannot for the aforementioned reasons. Currently, the primary reasons for refugees fleeing their home country are associated with ethnic and tribal, religious and war violence (UNHRC, 2012).

Yearly, the United States has seen trends in the sub-groups of refugees arriving due to the worldwide political climate and our own nation’s involvement. Some past examples of movements include South Vietnamese fleeing after America withdrew from the Vietnam War in 1975, the arrival of Cambodians in the USA during the Khmer Rouge and Cubans seeking refugee status in the 1960’s leaving behind the socialist revolution (Stuart & Baum, 2005). These trends and the number of refugee arrivals are greatly influenced by the United States Congress and the amended Immigration and Nationality Act under Section 207 (8 U.S.C. 1157). During each fiscal year, the President releases a quota of refugees that will be authorized for admissions to the United States. At the commencement of the 2012 Fiscal Year, 76,000 Refugees were authorized for admittance with the following regional break down of the overall total: 12,000 Africa, 18,000 East Asia, 2,000 Europe and Central Asia, 5,500 Latin America/Caribbean, 35,500 Near East/South Asia, and 3,000 Unallocated Reserve (Federal Register, 2011).

For the United States 2011 Fiscal Year, North Carolina had the 9th largest grand total of refugees accepted for resettlement, up from 12th largest in 2010. Among the grand total, the largest sub-groups included Burma (916 persons), Bhutan (569), Iraq (128), Eritrea (123), and Somalia (90) (US Department of Health & Human Services, 2012). Refugees are resettled within states based on the availability of a refugee resettlement organization. In North Carolina, these organizations can be found in Charlotte, Durham, Greensboro, High Point, New Bern and Raleigh (Refugee Works, 2012). With Raleigh and Durham being only 25 miles away from one another and having many surrounding communities connecting them, the triangle area (the Piedmont area of Durham, Raleigh and Chapel Hill) is placed in a unique position to collaborate with a vast majority of refugees being resettled in North Carolina.

As increasing numbers of refugees resettle in North Carolina, we have become progressively more aware of their wide range of health needs. One area within health that has seen a lack of resources and programs is mental health of refugees particularly children, who tend to be the most vulnerable.
Barriers to Mental Health Access

Estimates up to 40% indicate the amount of refugees who may have an unmet need of mental health care services for psychiatric disorders in the United States (Ehntholt & Yule 2006). There are a number of obstacles for refugees, resettlement agencies and other community organizations that work with refugees in offering and utilizing mental health services. The most common among these obstacles include transportation, interpreter services, health knowledge and cultural competency (Chang-Muy & Congress, 2009).

Arriving in North Carolina, refugees can face many impediments with navigating our transportation system. For those who walk or use non-motor vehicle forms of transportation, housing complexes are often too far to access their health care needs. Public transportation can often be difficult to navigate when stops are far from housing complexes, additional language barriers persist to comprehending routes and schedules, bus routes that require multiple switches and/or lack of available buses to a health care provider (Bridging Refugee Youth, 2006). Further barriers are inherent for those who seek to pass the North Carolina Drivers License test. As previously mentioned, the highest numbers of refugees in North Carolina come from Burma and Bhutan with most speaking Burmese, Karen, Chin, Dzongkha or Nepali. The North Carolina drivers permit test accommodates a number of languages, however these are limited to: English, Spanish, Chinese, Japanese, Russian, German, Korean, Arabic and Vietnamese (NC DMV, 2009). Refugees may be able to access an interpreter during these transportation circumstances, but even then challenges continue. The interpreter challenges will be discussed in regard to mental health services.

Federal Law under Title VI of the 1964 Civil Rights Act requires hospitals to provide interpreters for patients, including mental health providers who bill Medicaid. There are however no federal standards governing mental health interpreters. Without the presence of certified interpreters, mental health professionals run the risk of miscommunication. Unqualified interpreters create further dangers for refugees and their mental health access; examples of these dangers include omitting vital information, blurring ethical lines when family members or friends stand in as an interpreter or individuals who are not highly fluent or culturally competent in the refugee’s native language or culture (Chen et al., 2007).

Adding to the possible lack of cultural proficiency of interpreters, many health care professionals have not been trained in cultural proficiency. More than just understanding the client’s language, the clinician must understand the perspective of how the client views and values their own culture and how this culture guides their behavior. Understanding the culture of a refugee can allow a clinician to examine their mental health beliefs, influences upon their health and practices and what interventions will produce successful outcomes. Cultural proficiency can further allow an understanding of what interrupts the effective utilization of health care services (Chang-Muy & Congress, 2009).

Another barrier to mental health access is the health care knowledge of refugees.
Refugees may not know their rights to health care or have knowledge of when and where to seek the available care. Much of North Carolina’s refugee health knowledge resources concentrate on hygiene and healthy home environments (Walker, 2007). Few resources or programming for mental health concerns have been provided by resettlement agencies greatly due to the way in which they receive funding. Most resettlement agencies receiving grant funding through the Office of Refugee Resettlement (ORR), which was created through the Refugee Act of 1980. The ORR awards grant funds to community resettlement agencies through the state to agencies that demonstrate their clients have reached economic self-sufficiency. With the significant emphasis on employment through this grant, few organizations have the resources or time to confront the mental health of their clients (Simmelink & Shannon, 2012).

In addition to the lack of resources and funding, resettlement organizations are on a strict timeline that they must adhere to leaving case managers and other providers with little time to spare for mental health care. In the first month of arrival, a resettlement agency must provide the following for refugees: airport pickup, housing orientation, general orientation to America, bus orientation, bank and food shopping, social security card, donations, assignment of volunteers or sponsors, English classes, Matching Grant or Refugee Assistance Program, Social Services application and if applicable WIC: Women, Infant and Children (Refugee Transitions, 2012). Each of these tasks takes a great deal of time and effort to navigate, especially when deciding which program is best for a refugee. Bear in mind that case managers have multiple individuals and families on their caseloads with most of their clients arriving with little advance notice to prepare for the resettlement process.

From one to four months, case managers then assist refugees either through the Match Grant (MG) or Refugee Assistance Program (RAP). With Match Grant, the goal is for refugees to be economically self-sufficient within six months and without support from public cash assistance. A refugee resettlement agency must provide case management, cash allowance, employment services, food subsidies, housing and transportation during this 180 day period (North Carolina Department of Health and Human Services, 2012). After this 180 day period, if a refugee has not become economically self-sufficient they may be eligible for programs, such as RAP. Refugees who have been in the US more than 30 days, but less than 5 years and are not yet economically self-sufficient may be eligible for RAP. In this program, the resettlement agency provides case management, employment services and assistance in enrolling in public cash assistance (RCA/TANF). RAP is funded through the previously mentioned Department of Health and Human Services’ Office of Refugee Resettlement (Church World Service, 2012). The push for economic self-sufficiency early on is further evident by the loan agreement with the International Organization for Migration (IOM) that requires refugees to begin paying back their plane ticket cost to the United States within five months of their arrival. Accumulating to this extensive timeline is the fact that public benefits including cash assistance, food stamps and Medicaid for refugees ends eight months after their arrival in the United States (Refugee Transitions, 2012).

Though the US Governments refugee timeline is important in assisting refugee’s
transition, it solely focuses on their immediate needs of employment and hinders resettlement agencies from assisting clients beyond this scope. With the employment and economic self-sufficiency focus, our community can forget to focus on refugees’ issues during transit and even before migration (Chang-Muy & Congress, 2009). Studies show an individual with a mental illness can be negatively impacted in their ability to engage in economic activities, literacy opportunities and may make them prone to dysfunctional families and addictive behaviors, such as substance abuse (Unite for Site, 2007). The focus of employment without regard to mental health services fails to address the connection between the two.

**The Impact of Trauma**

Refugees are exposed to trauma in three separate ways: stressors in their country of origin, their flight to safety and during resettlement into their refuge country (Birma et al., 2005). Due to the stressors they have been exposed to, refugees are at an extremely high risk for the development of emotional and behavioral complications. The stressors many refugees have witnessed or experienced often involve torture or violence. They may have lost a family member or as a child, may be under the watch of one who is too stressed themselves to focus on the child’s emotional needs (Unite for Site, 2011). The most recurrent diagnoses of refugees with mental illnesses are post-traumatic stress disorder (PTSD), depression and anxiety with additional sleep disorders. A study demonstrated the prevalence of refugee children with anxiety disorders to be at a proportion of 49%-69% and those with PTSD at a proportion of 40% (Fazel & Stein, 2002). Another study showed that children aged 0-6 exposed to trauma were prone to showing excessive displays of anger, demanding of attention through negative behaviors, displaying regressive behaviors, startle easily, fear adults who remind them of the traumatic event, show excessive irritability and sadness, exhibit attachment disorders and act withdrawn (National Child & Traumatic Stress Network, 2010).

Children who experience trauma, especially young children (aged 0-6) are at increased risk for complications in brain development though many guardians and health professionals feel they were too young to comprehend the traumatic events (National Child & Traumatic Stress Network, 2010). The human brain rapidly develops during early from newborn to 2 years old creating increased neuron connections and growth in cell size (Blackwell, 2002). A reduced size in the human brain cortex, which has been shown in children exposed to trauma can lead to obstructions in attention span, consciousness, languages, memory, perception, and thinking. In addition, a brain cortex that does not develop to its potential size may be associated with an individual’s IQ and their capability of regulating emotions. Children in these traumatic situations are more likely to have digestive problems, headaches, wet the bed or themselves and have sleep difficulties (National Child & Traumatic Stress Network, 2010).

A high level of stress frequently produces adrenaline. This response is vital to our survival and allows the body to efficiently deal with stress, as it assembles energy stores and modifies blood flow. In the same way, our bodies also produce cortisol during stress to help us cope. However, prolonged release of adrenaline and cortisol in an individual’s body creates destructive effects. Cortisol will subdue immune responses and control gene
expression within neural circuits that are associated with emotion and memory. Having an increased activation of adrenaline and cortisol can severely harm brain development well beyond the actual exposure of stress. This suggests that children affected by trauma and left without access to health care providers will continue to experience the negative effects of stress well into the future. Additionally, researchers have seen damage to the hippocampus region of the brain in children and adults due to sustained high-level releases of cortisol; a damaged hippocampus can harm an individual’s ability to learn, retain memories and cope with stress (Harvard Center of the Developing Child, 2005). Many of the physiological brain development symptoms share the same or similar signs of the most common mental illnesses found in refugees.

Available Mental Health Screening Tool

Currently the most highly regarded mental health screening tool for refugees is the Refugee Health Screener 15 (RHS-15). The RHS-15 utilizes 121 items that have been found to be the best indicator of anxiety, depression and PTSD among refugee populations. This instrument has collaborated and gained the best practices from previous surveys allowing for an efficient and effective screening process that is both culturally sensitive and has been rigorously translated into various languages. The RHS-15 was available in five different languages in late 2011 including Arabic, Burmese, English, Karen and Nepali (Bhutanese) with future plans of expanding to Somali and Spanish. This questionnaire would appropriately serve the majority of the dominant languages found in refugee groups across North Carolina and has the ability to be used for all other languages with the aid of an interpreter. Furthermore, the RHS-15 has approval from the Institutional Review Board (IRB) allowing for appropriate use in research projects upon consent (Pathways to Wellness, 2011). Therefore, the RHS-15 is the screening tool we expect to use throughout this research survey.

Utilization, Barriers and Results of RHS-15

This section of the paper will include barriers of utilization of the RHS-15, as provided through previous programs that have used this instrument, such as Pathways to Wellness. Results of barriers found while attempting to use this screening tool in the triangle area will be included with an aim to improve the utilization of mental health screening tools for refugees. This section will also include analysis of themes from the RHS-15 tool used with refugee clients being resettled through Church World Service. After speaking with North Carolina organizations, such as the Mental Health Association of Charlotte and Orange County Health Department, this section will further discuss barriers and trends these organizations have seen while trying to assist the mental health needs of refugees. The aim of this analysis is to examine the presence and trends of mental health illnesses among refugees in the triangle area to serve as a framework for creating appropriate and culturally competent programs and resources to suit their unique needs.

Implementing Culturally Appropriate Programs and Resources

This section of the paper will provide a program of suggestion or resources that could be implemented within the community to individuals working with refugees. This
program/resource and the organization that would be best served to implement this change will be dictated by the analysis abovementioned. Suggestions of what this implementation may include are improved mental health screening tools, cultural competency training for providers, coping strategies through social support and family empowerment tools. This program or resource will revolve around the goal to aid refugees who have faced extreme stress and are prone to mental illnesses.
References


