

The importance of addressing mental health among refugee children

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Abstract

Mental health disorders such as depression, anxiety, and PTSD are prevalent among refugee children and can hinder their overall health as well as their chance to achieve success in the US. The proposed project will evaluate if refugee children, ages 7-13, are being screened for mental health issues at their primary care office visits at Rochester's Refugee Health Center. In addition, identifying the support services available to refugee children. Further evaluation of collaboration among the different support services available and the barriers associated with accessing care for this patient population. It concludes by offering recommendations for improved mental health outcomes for refugee children.

Keywords: refugee children, mental health, pediatric refugee, PTSD, depression, anxiety

Mental health is often overlooked but in fact correlates with physical health. Poor health outcomes and chronic diseases such as cardiovascular disease, diabetes and cancer have been associated with poor mental health (Galson, 2009). Mental illness is a global public health issue and should be addressed as such, from a multitude of angles. Mental health is essential to our welfare. It is our responsibility as (future) health care providers to provide holistic care to all of our patients by addressing all of their needs, which includes mental health. It is crucial for all patients to receive a mental health assessment of some kind at their primary care office visit, especially vulnerable patient populations who are at an increased risk; for example, refugee patients who have encountered trauma, war, and violence in their homeland. Nearly half of the world's refugees are children who are at an increased risk for abuse, neglect, violence, exploitation, trafficking, and forced military recruitment. In addition, many of them have witnessed or experienced acts of violence or family separation (UNHCR, 2013). The stressors that these children have endured in their homeland, during their resettlement, and acculturation place them at an increased risk for mental illnesses. Therefore, it is vital to bring awareness to primary care providers regarding this vulnerable patient population and highlight the importance of properly assessing, providing appropriate mental health care services and support to refugee children. Holistic and culturally appropriate medical care should be provided to all refugee children in order to help them thrive in our society.

In 1951 a refugee was defined by the refugee convention as “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such

events, is unable or, owing to such fear, is unwilling to return to it.” (UNHCR, 2014). According to the UNHCR, the United Nations refugee agency’s global trends of 2013, an estimated 51.2 million people were forcibly displaced worldwide due to persecution, conflict, generalized violence, or human rights violations; 16.7 million were refugees. More than half of all refugees, 53%, came from Afghanistan, Syrian Arab Republic, and Somalia. In 2013 50% of refugees were under the age of 18 making up the largest proportion of the refugees compared to 46% the previous year; the highest figure in a decade. One in every two refugees is a minor. The growing number is a reflection of the growing Syrian, Afghan and Somali children (UNHCR, 2013). Therefore, available mental health support services should focus predominantly on the largest proportion of incoming refugees, the refugee children.

Refugee children are faced with a multitude of adversities in their native country prior to their arrival. Some of the adversities that these refugee children are faced with in their homeland consist of: traumatic events, witnessing war atrocities, organized violence, sexual violence/abuse, victims of torture or intimidation, disruption of family ties, terror, poverty, famine, disruption of schooling, and exposures to infectious diseases. Many refugee children are exposed to multiple adversities, which is a predictor of worse mental health outcomes; in addition, there’s an increased risk associated with the severity of mental health outcomes dependent on the severity of their past traumatic event(s). A link between refugee children who have experienced war and the development of PTSD and depression exists (Pacione, Measham, & Rousseau, 2013). Studies have concluded that PTSD is prevalent, as high as 89%, among children who have experienced war. However, many refugee children do not meet diagnostic criteria for PTSD but other difficulties such as insomnia, nightmares, adjustment disorders, inattention, social withdrawal and somatization issues have been documented (Pacione, Measham, & Rousseau, 2013). It is

noteworthy to consider that refugee children may not meet diagnostic criteria due to differences in cultural understandings of distress, lack of a proper screening tool, and improper translation. Also, a higher incidence of externalizing problems among refugee boys has been reported, whereas refugee girls have been shown to be at a greater risk for internalizing their problems. (Fazel, Reed, Panter-Brick, & Stein, 2012). A child's age and developmental stage play a role in how the child experiences these adversities. Assessing for mental health issues can lead to a decrease in unnecessary office visits without value. In addition to past traumatic events refugee children are faced with additional hardships and stressors related to their resettlement and acculturation process upon their arrival to the US. These children must learn a new language, attend an American school, acculturate, adapt to possible shifts in religious identity, gender role conflicts, experience discrimination, and bullying (Pacione, Measham, & Rousseau, 2013). Early interventions, teaching protective factors, and assessments are pivotal in order to prevent and address the adverse mental health outcomes in this patient population.

The majority of Rochester's refugees are primarily made up of Somali, Bhutanese, Iraqi's, Karen, Burmese, Nepali, and Afghan. Catholic Family Center is the primary resettlement agency in Rochester, New York. Catholic Family Center estimates that as many as 400 refugees arrive in Rochester each year. The goal of Catholic Family Center's refugee resettlement program is to provide services and resources to new refugees and meet their basic needs. Newly arriving refugees are seen at the Monroe Department of Public Health; it is here where all refugees are triaged to determine if any have an urgent medical need, require an immediate primary care appointment, receive TB screenings and vaccinations. Occasionally some refugee patients will have had a physical done in their homeland and a copy of that written physical is provided during this office visit from the International Organization of Migration, IOM, at the

time of their initial triage. If a mental health concern was identified, that information will appear in their physical IOM report. Representatives from Pathways to Wellness Program are also present at this visit. Pathways to wellness screens refugees older than 14 years of age for mental health issues using the refugee health screener RHS-15. However, refugees under the age of 14 are not screened as a part of this project.

Approximately 2-3 weeks after their initial triage appointment at Monroe's Health Department most refugee children are seen at Rochester's Refugee Health Center for their primary care office visit. Rochester's Refugee Health Center is unique in that it focus' solely on providing primary care services to refugees. In order to evaluate if refugee children were being screened or assessed for mental health issues at the time of their primary care office visits and if support services are available to pediatric refugee patients at Rochester's Refugee Health Center data was collected. Data collection was obtained by naturalistic observation during their initial visit to the health department upon arrival, at primary care clinic appointments, and through qualitative research gathered by conducting individual interviews with multiple staff members. By attending initial triage at the Monroe Department of Public Health I was able to observe whether newly arriving refugee children were being screened or assessed for mental health issues at this time. In addition, by shadowing, speaking with and interviewing providers at Rochester's Refugee Health Center I was able to identify if these children were being screened, if so how, or assessed for mental health issues at the time of their primary care visits. By interviewing other clinicians in the community such as: a social worker who is an employee of the major refugee resettlement agency in Rochester, Catholic Family Center, a therapist and program director for children and youth at the Genesee Mental Health Center I was able to gather qualitative data

regarding some of the support services available to refugee children and gain insight regarding the collaboration between these different systems.

My findings conclude that there is inconsistency among the providers with regards to assessment and screening for mental health among refugee children. Not all refugee children under the age of 14 years are being screened for mental health issues, in fact, there is no specific screening tool being used or established set of questions to identify possible mental health issues. At the time of their primary care office visit only some of the children were asked a few questions related to mental health. For example, some of the questions that I observed being asked were: “do you ever feel sad, do you feel sad for long periods of time, what do you do when you’re sad, do you have friends?” However, if the child was being seen in clinic for a particular concern, a chief complaint, that seemed to be the sole focus of the appointment and mental health was not addressed or assessed for at this office visit. According to the pediatric social worker, if parents voice a concern regarding their child’s behavior or if the provider observes some other trigger it warrants further investigation by the provider resulting in further discussion and questions asked related to feelings, behavior and coping skills. There is currently no protocol or policy in place at the Refugee Health Center that requires a provider to assess for mental health at the time of their primary care office visit or how to go about doing so; therefore, my findings concluded that there was significant variability and inconsistency among the primary care providers in assessing for mental health if at all. However, if a mental health concern was identified the refugee children are most likely to be referred to either Genesee Mental Health Center or Catholic Family Center for therapy.

Catholic Family Center, CFC, resettlement agency assists refugee families with a variety of support services to ease their resettlement process, and is the only center that provides specific

resettlement support services to refugees in Rochester, New York. Some of the support services available are: refugee interpreter services, match grant program, employment, loan services, enrichment activities, special programs, community resource services, in home services, home energy assistance program. In addition, a case manager is provided to refugee families during their first 90 days of resettlement. Case management services include crisis intervention and counseling. According to a social worker at this center, mental health is of great concern among this patient population. Volunteers and interpreters at CFC are often former refugees who reflect the same backgrounds as some of the refugee patients they are serving, they have lived in the US for a few years and speak English well; they help to facilitate appointments, drive the patients to their appointments, serve as great resources by assisting with cultural barriers and often times identify health concerns, including mental health issues. CFC refers their pediatric patients to either their mental health department or to Genesee Mental Health for therapy if a mental health concern is identified. Additionally, CFC mental health therapists offer both scheduled appointments and drop in hours.

Genesee Mental Health children and youth center's therapists are open to seeing refugee children in their practice. This center receives most of their referrals from Rochester's Refugee Health Center and some from CFC. However, Rochester's Refugee Health Center and Genesee Mental Health center do not share the same electronic medical record system, making it difficult to follow up and provide multidisciplinary and collaborative quality patient care. Genesee Mental Health Clinic does not have a social worker or case manager; therefore, the therapist on occasion will fax the referring provider the report and plan. Otherwise, if the referring primary care provider would like to follow up with the child's therapy visit they personally call over to request the office visit notes and recommendations. The disconnect between these two different

health systems proves to be an unfortunate break in the system and demonstrates the need for increased collaboration and improvement in order to provide quality patient care to these children.

We must also consider some of the identified challenges associated with providing quality mental health care services to this patient population from all aspects. Challenges to providing appropriate mental health care to this patient population exists among providers, and on a systems level. Also, barriers to receiving mental health care exist among patients, family and also on a systems level. For example: limited resources, limited funding, language barriers, the use of live interpreters vs. phone interpreters, cultural barriers, limited appointment time to address all of the patients needs, stigmatization related to mental health, transportation issues, mental health is not a priority for refugees who are trying to meet their basic needs, lack of cultural awareness, training and refugee history. Furthermore, if refugee children are not being screened for mental health the opportunity to provide early intervention, protective factors and support is missed. Accurate data concerning the mental health status of refugee children can only be captured if these patients are being screened or assessed. Without appropriate mental health assessments opportunities to provide support, protective factors, and interventions are missed. By properly assessing we can gather data to increase awareness, highlight importance, request funding and therefore have a way to measure improvements

Identifying and addressing current gaps in the system can help diminish barriers to accessing care. For example, addressing the mental health needs of all refugee children therefore enhancing the overall health outcomes of half of the refugee patient population. Early interventions can help to prevent behavioral issues, crisis, delinquent behavior, decrease drop out rates, substance abuse issues, ease emotional distress and provide support during their

acculturation process. Mental health assessments as well as services should be integrated into all primary care office visits, especially when caring for vulnerable patient populations. The goal is for primary care providers to assess for any mental health concerns, not diagnose, at the time of a patient's office visit in order to provide appropriate referrals and follow up to allow for early interventions. Primary care providers can begin making strides by implementing a set policy/protocol on how to assess/screen refugee children under the age of 14 that works for their practice and the patients best. This can be accomplished by simply establishing a set of questions to ask all refugee children, or by simply asking why they left their country in order to open up a dialogue and understand their exposure to past stressors. Development of modules, a web based training system, and continuing education units support further education and training regarding refugee children that can be beneficial for all clinicians who provide care to these children. A group of trained specialists who provide mental health services specifically to refugee children and work directly with primary care providers can be beneficial and even motivate providers to assess for mental health knowing that they have easy access to refer patients, support resources and trained professionals/specialists. In addition, providers should establish cross-disciplinary coalitions in order to provide quality patient care to refugee children across the board by collaborating with families, schools, clinicians, and resettlement agencies.

Rochester's refugee health center has the ability to be a prospective leader in providing holistic care to refugees. It is vital for Rochester's Refugee Health Center to serve as an exemplary refugee health center in order to positively impact future refugee health centers by providing holistic, culturally sensitive care to all of their patients, by addressing all of their health care needs, including mental health. By setting high standards of care Rochester's Refugee Health center can serve as a model for other refugee health centers across the nation.

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