

Victimization of Bhutanese Refugees in Rochester, NY

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Abstract

In the United States, higher rates of victimization are found among the refugee population compared to non-immigrants (McDonald & Erez, 2007). The issue around victimization among refugees has increased in the past several years particularly among Bhutanese refugees residing in Rochester, NY. Higher rates of pre-resettlement trauma and suicide are seen within this refugee population. With the steady growth of refugees entering into the U.S., this is a topic of great concern. Healthcare providers were surveyed about how they screen for exposure or risk of violence within the refugee community. Adult Bhutanese refugees were surveyed about their level of safety in their community and the prevalence of victimization. Eleven adult Bhutanese refugee patients and four healthcare providers were recruited from two Community Health Centers (CHC's) in Rochester. Ninety-one percent of refugee patients agreed that violence exposure is something their healthcare provider should ask them about. Sixty-four percent have been victimized against or know someone who has been since their arrival to Rochester. Healthcare professionals in this study all agreed with the importance of screening for violence exposure and felt that refugees are inadequately prepared for the conditions they face post-resettlement. Considering the results of this study, exposure to trauma and violence should be screened for and addressed by healthcare providers among the adult Bhutanese refugee population in Rochester.

Keywords: Victimization, refugees, Bhutanese, exposure, violence, immigrants, investigation

Introduction

In 2013, approximately 263,600 refugees were allowed to enter the United States from all over the globe (The UN Refugee Agency [UNHCR], 2014). The refugee population is a significant proportion of the U.S. population and is steadily increasing annually. Quality healthcare for refugees is a major concern upon arrival to the United States. Domestic guidelines include an initial medical screening for infectious diseases (i.e., parasitic and intestinal), physical and psychological trauma, and malnutrition among refugees (Centers for Disease Control and Prevention [CDC], 2014). However, after the initial screenings and assessments are completed, refugees face significant post-migration adversity. Many post-resettlement challenges within the refugee population include the following: acculturation difficulties, lack of access to care and transportation, language barriers and different cultural beliefs regarding healthcare (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Other disadvantages many refugees suffer from after resettlement in the United States include a high susceptibility of chronic and mental illness, increased exposure to crime and high unemployment rates.

The victimization of refugees has been documented in resettlement areas of Australia, Europe and North American cities like Rochester, NY. Several cities across the United States are designated as resettlement locations for refugees and struggle to meet the needs of this growing population. Research has suggested Americans view refugees as being in a foreign land with several disadvantages and vulnerabilities (McDonald & Erez, 2007). This perception by Americans makes them easy targets for all forms of victimization including: physical assault, threats, bullying, robbery and harassment. Refugees are relocated to areas that are impoverished, crippled by violence and suffer from a whole host of socioeconomic challenges (Khort, Maharjan, Timsina, & Griffith, 2012).

The majority of healthcare services for refugees and other underserved populations are delivered in Community Health Centers (CHC). CHC's were established to provide healthcare to vulnerable populations, people ineligible for Medicaid and the uninsured. Therefore, healthcare professionals providing care in CHC's are confronted with a different set of challenges in the refugee population. Many refugee patients have a difficult time navigating an extremely complex healthcare system and miscommunication with healthcare providers due to language barriers.

Background and Significance

The increased presence of Bhutanese refugees in the U.S. is due "ethnic cleansing" by the king of Bhutan in the mid-1980's in fear that the Bhutanese would overpopulate his people and the traditional Buddhist culture would become diluted (U.S. Department of Health and Human Services [HHS], 2014). The king started the campaign of "One country, one people" which enforced one dress code, religion and language among the Bhutanese people (HHS, 2014). As a result, people either were forced out of Bhutan or fled to Nepal to seek refuge in camps.

The Bhutanese people of Nepal are the largest refugee population at approximately 2,300 currently residing in Rochester, NY (Hand, 2014). In the past several years, there have been targeted attacks against Bhutanese refugees in the Northwest part of Rochester. Bhutanese refugees have informally documented hundreds of assaults, robberies and violent bullying incidents in the past several years (Hand, 2014). In Rochester, nearly 75% of incidents go unreported either because refugees fear retaliation, the distrust in police or the feeling that their complaints would not be taken seriously (Hand, 2014). Also, research by McDonald and Erez (2007) found that refugee and immigrant populations avoid reporting crimes to the local authorities or the police.

Acts of victimization has many negative consequences on mental and physical health. Even with the growing concern about the high suicide rates among Bhutanese refugees in the U.S., it is not clear if the victimization occurring to Bhutanese refugees in Rochester is correlated to the increased prevalence. The suicide rate among Bhutanese refugees in the U.S. is 35 per 100,000, which is more than three times the national rate compared to the rest of the U.S. population (Kohrt et. al, 2012). Furthermore, the U.S. suicide rate for Bhutanese refugees is higher than the 21 in 100,000 suicides reported in refugee camps before their arrival to the United States (Kohrt et. al, 2012). A linkage between victimization in the U.S. and suicide among Bhutanese refugees has not been evidenced by research, thus requires further investigation.

Exposure to emotional and physical trauma is considerably higher among the refugee population before resettlement in the United States that could possibly contribute to post-resettlement challenges. In a research study conducted by the U.S. Department of Health and Human Services, clear associations between suicide ideations, reported symptoms of mental illness and post-migration difficulties were found among adult Bhutanese refugees (≥ 18 years) living in resettlement cities throughout the U.S (CDC, 2013). Out of 423 participants, 153 (36%) experienced at least four to seven traumatic events or major stressors before arrival to the U.S. and 145 (34%) experienced eight or more (CDC, 2013). These statistics along with the heightened violence targeted against Bhutanese refugees in Rochester strongly indicate the importance of screening for trauma exposure. A part of the healthcare professional's role is the responsibility of ensuring violence exposure is addressed in the healthcare setting for refugee patients. Violence is a major crisis, safety and health issue that requires thorough assessment by healthcare providers.

The purpose of this study is to focus on the role of healthcare providers in assessing the exposure to violence and the experience of Bhutanese refugees with victimization in the resettlement city of Rochester, NY. In addition, what resources are available to refugees in preparation for the neighborhoods they are going to call their new home? Lastly, surveys completed by refugees would provide insight into their experiences with victimization (i.e., physical assaulted, threatened, bullied, robbed and harassed) since they have arrived to the U.S. Healthcare professions should screen for violence exposure considering the number of violent acts towards Bhutanese refugees in Rochester, the increased risk for suicide and the exposure to trauma before arrival to U.S. in this population.

Methodology

Participants

Two groups were targeted for surveys -adult Bhutanese patients and healthcare providers. The inclusion data for the adult Bhutanese patients (men and women) were that they had to be a refugee, over the age of 18 and seen at one of the Community Health Centers through the Office of Community Medicine in Rochester. Specifically, participants who previously established care were recruited from the Refugee Healthcare Center at Alexander Park and the Women's Clinic at Clinton Family Health Center. Only adult Bhutanese patients seen by healthcare providers at both locations were chosen to participate in the study. Pediatric Bhutanese refugee patients were excluded from the study. All potential participants were given the option to decline participation in the survey. A convenience sample of 2 men and 9 women were analyzed. Healthcare providers (i.e., physicians, physician assistant's and nurse practitioners) were surveyed at both locations about screening for victimization and violence exposure among the adult Bhutanese refugee population. The healthcare professionals surveyed in this study provide medical services

to Bhutanese refugees. A total of 4 healthcare providers completed the survey between the two research locations. Two were physician assistants, one nurse practitioner and one physician.

Materials

Patient survey. A survey was developed by the researcher based on questions about safety and violence exposure among refugees. The survey consisted of 8 questions inquiring about violence, safety and support since arriving in Rochester (see Appendix 1). The purpose of the questions was to get a true sense of violence exposure among this population directly from the refugees. Jim Sutton, Office of Community Medicine Director, and Mary Dahl Maher, PCLP Faculty Advisor, reviewed the survey questions before given to the patients.

Provider survey. The researcher developed a survey for healthcare professionals-physicians, physician assistants and nurse practitioners who provide care for adult Bhutanese refugee patients. The survey consisted of 6 questions related to screening practices for violence exposure, available resources, and feelings regarding if refugees are adequately prepared for the conditions in which they are relocated in Rochester (see Appendix 3). Jim Sutton, Office of Community Medicine Director, and Mary Dahl Maher, PCLP Faculty Advisor, reviewed the survey questions prior to data collection from providers.

Interpreters. The surveys were translated in-person or over the phone by an interpreter or an interpreter service. The interpreters used for the study were employed through the Office of Community Medicine in Rochester and interpret for both CHC's (Refugee Healthcare Center at Alexander Park and the Women's Clinic at Clinton Family Health Center). All translation for the Nepali language for Bhutanese refugees via telephone was done in-house at the Office of Community Medicine on the 2nd floor located at 222 Alexander Street in Rochester. One hundred percent of the patient surveys were completed with interpreters employed through the Office of

Community Medicine via telephone service or in-person. The healthcare providers did not utilize the interpreter services for the completion of surveys.

Procedure

The data was gathered over a 2-week time period at each Community Health Center (CHC) site. At the end of a primary care or gynecological visit, verbal permission to survey the patient was obtained. After the interaction with the provider, the interpreter phone was transferred to the primary investigator, Kawanda Swafford, in order for communication to take place between the patient and primary investigator. The translation via telephone was done with the researcher and patient wearing a headset device. The interpreter was on the other end translating between the researcher and patient. The patient responded and the answer was documented exactly how the interpreter spoke it. All in-person surveys except four were completed in a group setting at Clinton's Women's Center during bi-weekly or weekly Centering Pregnancy groups. In this case, verbal consent and participation was completed prior to the start of the group. The women were given a pen and the survey while the interpreter explained the research project. The interpreter read the paragraph on the top of the survey and received consent from everyone to participate in the study (see Appendix 1). The interpreter translated each question one by one out loud to the group. For the women who needed help selecting the answer they wanted, the interpreter went around the group to assist them with this. The surveys were collected and the participants were thanked for their time. Three of the four patient surveys not collected during the Centering Pregnancy group and were done in-person via the interpreter phone service. One patient was unable to read English but was able to understand it. Therefore, the primary investigator asked the questions in English and recorded the answers appropriately.

Healthcare providers who participated in the study were given surveys at the Refugee Healthcare Center at Alexander Park and Women's Clinic at Clinton Family Health Center. Healthcare providers were asked if they would like to participate in a survey regarding screening practices for victimization among adult Bhutanese refugee patients. Of all four of the healthcare providers asked to participate in the survey, none declined. The healthcare providers completed the survey individually and returned it to the primary investigator.

Results

Patient Survey

The gender ratio of the completed surveys was 18% male and 82% female (Appendix 2: Figure 1). The average length of time the participants lived in Rochester was 24 months (Appendix 2: Table 1). Nine (82%) of participants felt safe where they lived compared to two (18%) feeling unsafe in their neighborhood (Appendix 2: Figure 2). Yet, 64% have been a victim of a crime themselves or knew someone who has been victimized against (Appendix 2: Figure 2). Of the seven who answered yes to the previous question, 6 reported it was someone they knew and in 1 case the actual participant was the victim. When asked what was done when an incident like this occurred in the past, five (71%) of the participants reported nothing was done (Appendix 2: Figure 3). One participant selected other in which the landlord was notified. Ten (91%) feel like they have support and 4 described the police as the source of support (Appendix 2: Figure 4). Ten (91%) of refugee patients agreed that violence exposure is something their healthcare provider should ask them about. (Appendix 2: Figure 4).

Healthcare Provider Survey

Of the 4 surveys collected from healthcare providers, 3 described their adult Bhutanese patient population was 50% or more (Appendix 3: Figure 1). For 50% of the providers, it was

common practice to screen for victimization (Appendix 3: Figure 2). Among the providers who screen for victimization, they do provide patients with resources. All healthcare providers surveyed believe it is important to screen for violence exposure within this population. Also, they felt refugees are ill prepared for the conditions they will face in Rochester (Appendix 3: Figure 3).

Discussion

The results from patient surveys indicate that violence is something they would like their healthcare provider to talk to them about. This clearly means there is a concern within this population to talk about violence they have experienced pre or post resettlement. For example, while administering the surveys to women during the Centering Pregnancy group, they were quite interested in the topic of violence. With the question, do you think violence exposure is something your healthcare provider should ask you about, many of the women wanted clarification if the researcher meant violence “in the home” or “outside of the home”. Once the researcher explained it consisted of both, a couple of the women disclosed domestic violence is an area they would like their healthcare provider to talk to them about. It is not clear if Bhutanese refugee women in Rochester are suffering from domestic violence at higher rates than the rest of the population but based on this discussion while completing surveys this was a topic of concern for the women. However, the Department of Health and Human Services did report in the Bhutanese Refugee Health Profile that domestic violence is probably the most prevalent form of gender-based violence experienced by Bhutanese refugee women (HHS, 2014). The one thing that is clear from this study is that Bhutanese women would find it helpful for healthcare providers to dialogue with them about violence and would most likely benefit these types of conversations.

In this study, the experience of victimization was not uncommon among adult Bhutanese refugees. An overwhelming percentage of patients experienced violence for themselves or know someone who has since arriving in Rochester. This is suggestive that the Bhutanese refugees are being targeted and suffer from higher rates of victimization. As discussed in the background section, previous research and articles from the local newspaper in Rochester report refugees are less likely to contact authorities when they are victims of crime. The data from this study reveals similar behavior with the majority of the people who reported experiencing some form of victimization did nothing about it. Yet, out of the five who did nothing about the violence, three expressed that they felt like they had the support of the police. This may seem counter-intuitive to many. However, a good explanation for this is that there have been many articles recently written about the victimization of Bhutanese refugees in Rochester coupled with community outreach by the police and the word has spread that contacting the police should be the first step. Therefore, maybe the incidents reported in this study were committed before it was a hot news topic by the local newspaper. The male participant who actually experienced the violence firsthand reported nothing was done because he had “no cell phone”. He stated, “Nobody came to help, [so] no good support system in this manner”. Interestingly, the only participant who experienced violence firsthand was the only one who felt like there was no support. He seemed very passionate in his responses to the survey questions. He reported that healthcare providers could “Give good suggestions and tell us what to do, that would be great”. With the unique set of challenges refugees face after resettling in the U.S., victimization is an added burden that requires attention from healthcare professionals.

Unanimously, healthcare providers feel it is important to assess for violence exposure. Likewise, they feel refugees are not adequately prepared for the conditions in which they are

placed in Rochester. One healthcare provider added, “PTSD (Post-traumatic stress disorder) [is] also in place in many people [and they] do not recognize increased symptoms as “abnormals”. Refugees generally come from areas of conflict and have experienced some form of trauma already. She went on to say that their, “Very passive people and have become desensitized to violence through their current living situation as [a] refugee in Nepal. Maybe preparing refugees for the circumstances in which they will face in the U.S. is not seen as important as removing them from refugee camps. However, with research telling us that there is an increased number of suicides and mental illness specifically among Bhutanese refugees, assessment of violence is crucial. Half of the healthcare providers actually perform screening for violence exposure and provide resources. The resources for refugees include the Catholic Family Center, Mental Health and the police. There is room for improvement in that violence is a topic each healthcare provider should ask all their patients about but for the refugee population this is even more so the case. From the perspective of the healthcare provider, time may be a barrier to assessing for violence. However, a simple question like, do you feel safe where you live or have you experienced any trauma can open up the dialogue. Especially, when the healthcare providers patient population consist of more than 50% Bhutanese refugees. In this study, healthcare professionals do recognize the value in screening for violence exposure within this population.

Recommendations

The leading recommendation to healthcare professionals would be to simply ask patients about violence. It can be about their feeling of safety where they live or any previous experiences with trauma pre-resettlement or after coming to the U.S. A question as simple as, tell me your story of how you got to the U.S. can spark a conversation and give a healthcare provider great insight into one’s experience with violence. Once rapport has been established, these kinds of questions

can easily open up a discussion about violence and have patients tell their stories. This is an effort to provide refugee patients with the best possible healthcare and resources.

It is crucial for healthcare providers to be aware of the available resources within the healthcare system and in the community. For example, the Catholic Family Center in Rochester has many resources for mental health that include: an Adult Mental Health Clinic, Children's Mental Health Clinic and a counseling program. These resources could be very helpful especially in a situation where trauma have been experienced. Peer counselors are available through Rochester General Group to provide support to newly arrived refugees. These counselors are usually trained in suicide prevention and in the facilitation of support groups for refugees. Maybe more importantly the peer counselors are usually refugees themselves with similar reasons why they chose to resettle and backgrounds. Support groups can help with preparing refugees for the challenges they will face and connecting people with a common experience. Advising refugees to call 911, pairing them up with a buddy to walk around the city and avoid threatening areas could help reduce victimization. Tips on how to handle violence in the community and to lessen their chances of being victims of crimes can definitely help people be as safe as possible and to know what to do if an incident occurs.

Conclusion

Many Bhutanese refugees resettle in the U.S. due to challenging circumstances and have experienced some form of trauma in their homeland. In the past several years, Bhutanese refugees in Rochester have been victims of violence within the community in which they have been placed. With the pre and post-migration difficulties refugees face, it is crucial that healthcare providers take the time to assess for violence exposure, mental health illness and

trauma. Not only is this a comprehensive approach to holistic health, Bhutanese refugees want healthcare providers to discuss violence exposure with them. Also, healthcare providers feel it is extremely important to screen for victimization within this patient population. Therefore, the proper screening should be done. Although a severe limitation of this study was the small sample size, the conversation about violence was very important for both healthcare providers and adult Bhutanese refugee patients surveyed.

Appendix 1: Patient Survey**Survey**

I would like to ask you some questions about your experience as a refugee since arriving in Rochester, NY. This information would be used to help provide better healthcare services to refugee, specifically Bhutanese patients. THANK YOU!

1. Gender M F

2. How long have you been in Rochester, NY? _____

3. Do you feel safe where you live?

Yes

No

4. Have you or anyone you know been victimized against (i.e. physically assaulted, threaten, bullied, robbed or harassed) in Rochester, NY?

Yes

No

If yes, was it you or someone you know? _____

5. If it was you, how many times has something like this happened? _____

6. What was done in the past if an incident like this occurred to you or someone else you know?

Called 911

Nothing

Other _____

7. Do you feel like you have support?

Yes

No

If yes, please describe what that support consists of:

8. Do you think violence exposure is something your healthcare provider should ask you about?

Yes

No

Appendix 2: Patient Survey Results

Figure 1

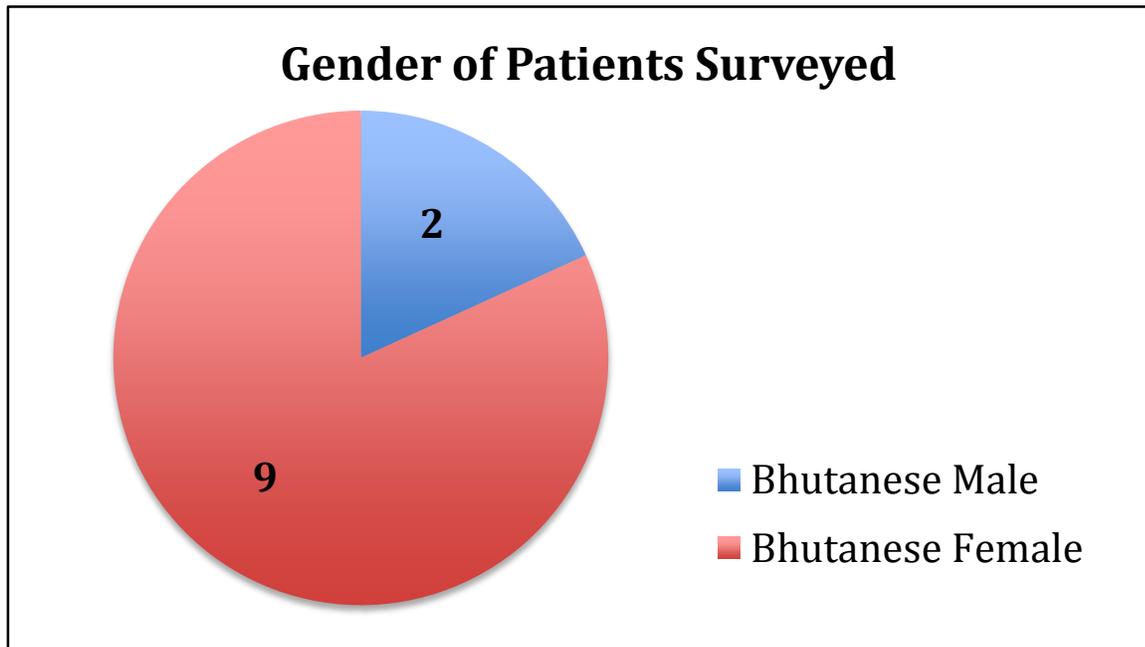


Table 1

Number of adult Bhutanese refugee patients	Number of months lived in Rochester
1	5
2	60
3	24
4	12
5	24
6	9
7	24
8	18
9	3
10	60
11	24
	23.90909091

Figure 2

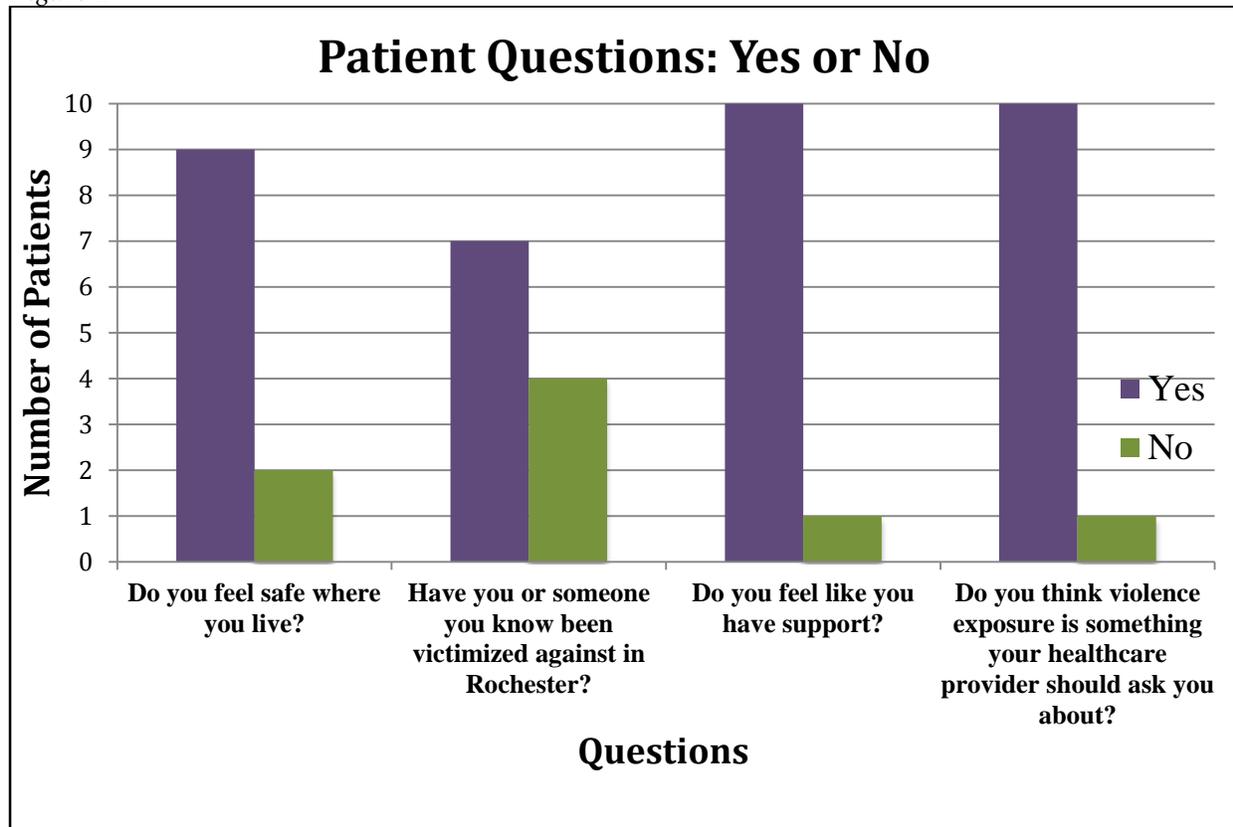


Figure 3



Figure 4

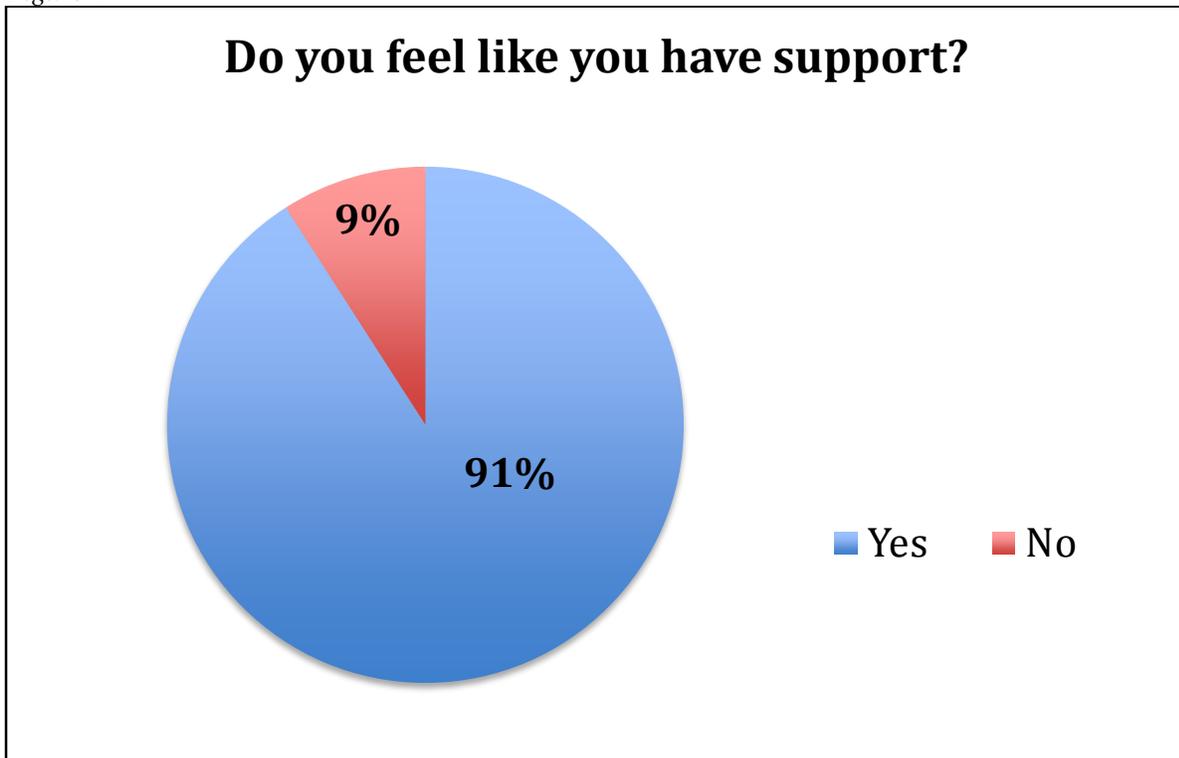
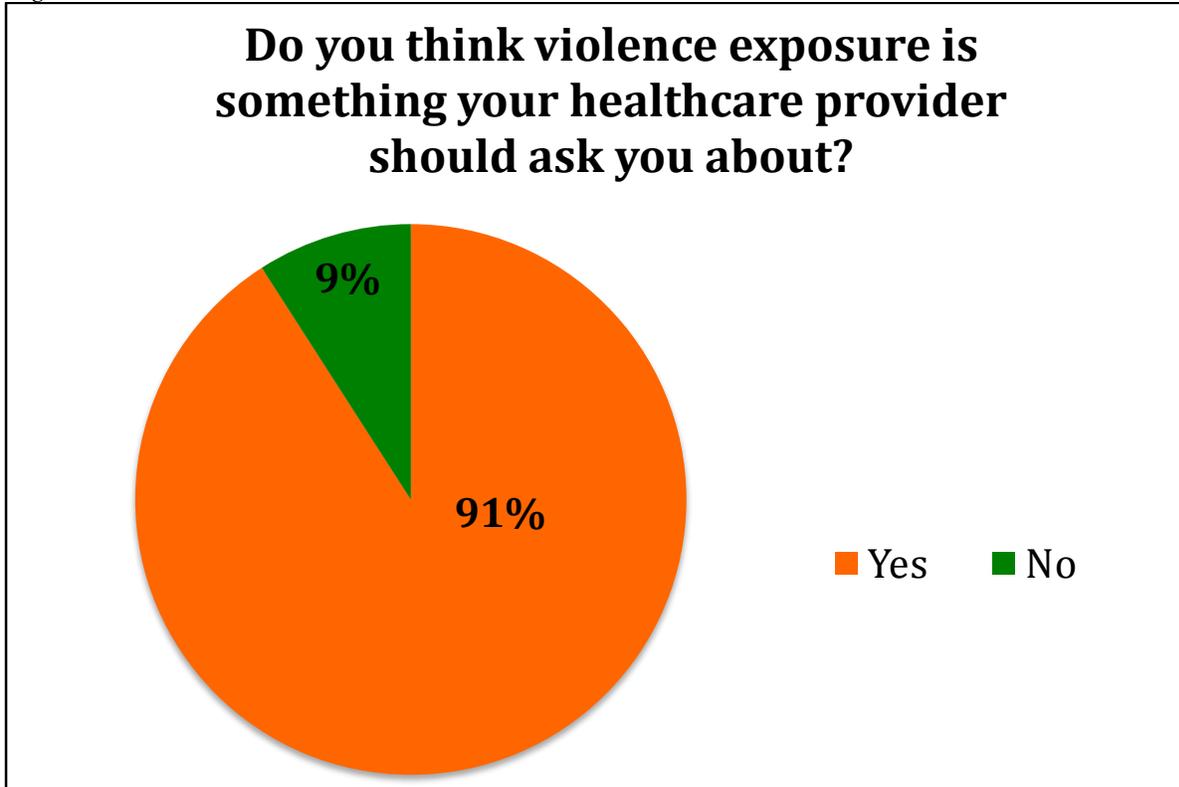


Figure 5



Appendix 3: Healthcare Provider Survey**Survey**

I am conducting a study as part of my Primary Care Leadership Program (PCLP) commitment. Please assist me by completing this brief survey about your assessment of violence exposure within the Bhutanese refugee population you care for. If you write down your email address at the end of the survey, I will send you an executive summary of my results. THANK YOU!!

1. What percentage of your patients are Bhutanese refugees?

- >90%
- > 50%
- <50%
- <25 %
- <10%

2. Is it common practice to screen for victimization (i.e. physically assaulted, threaten, bullied, robbed or harassed) among your Bhutanese patients?

- Yes
- No

3. Do you provide them with any resources?

- Yes
- No

If so, what are they?

4. Do you feel it is important to assess for violence exposure within this population?

- Yes
- No

5. Do you think refugees are adequately prepared for the conditions in which they are placed in Rochester, NY (For example: strategies to decrease their chances of being victimized)?

- Yes
- No

6. Other Comments:

Email: _____

Appendix 3: Provider Survey Results

Figure 1

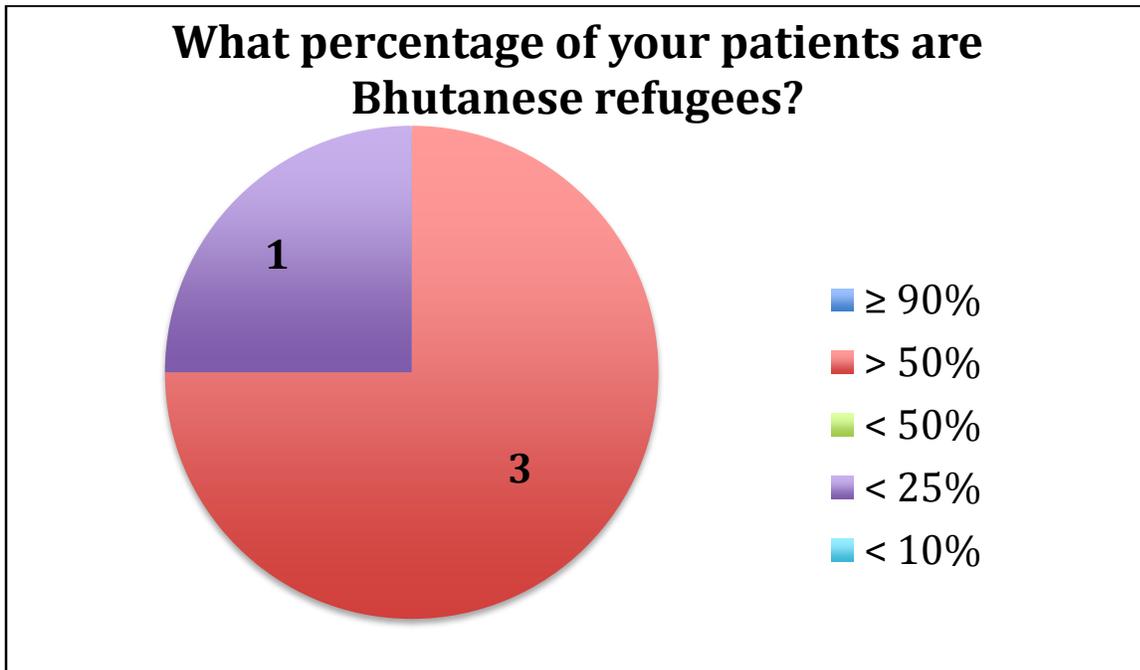


Figure 2

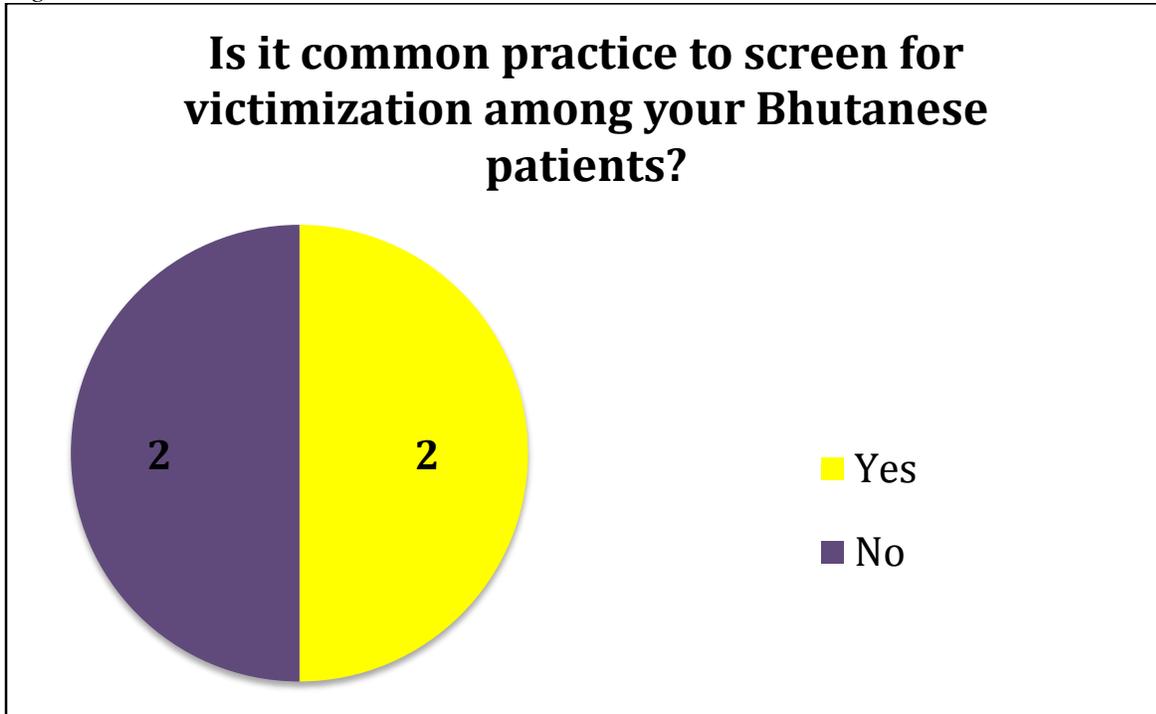
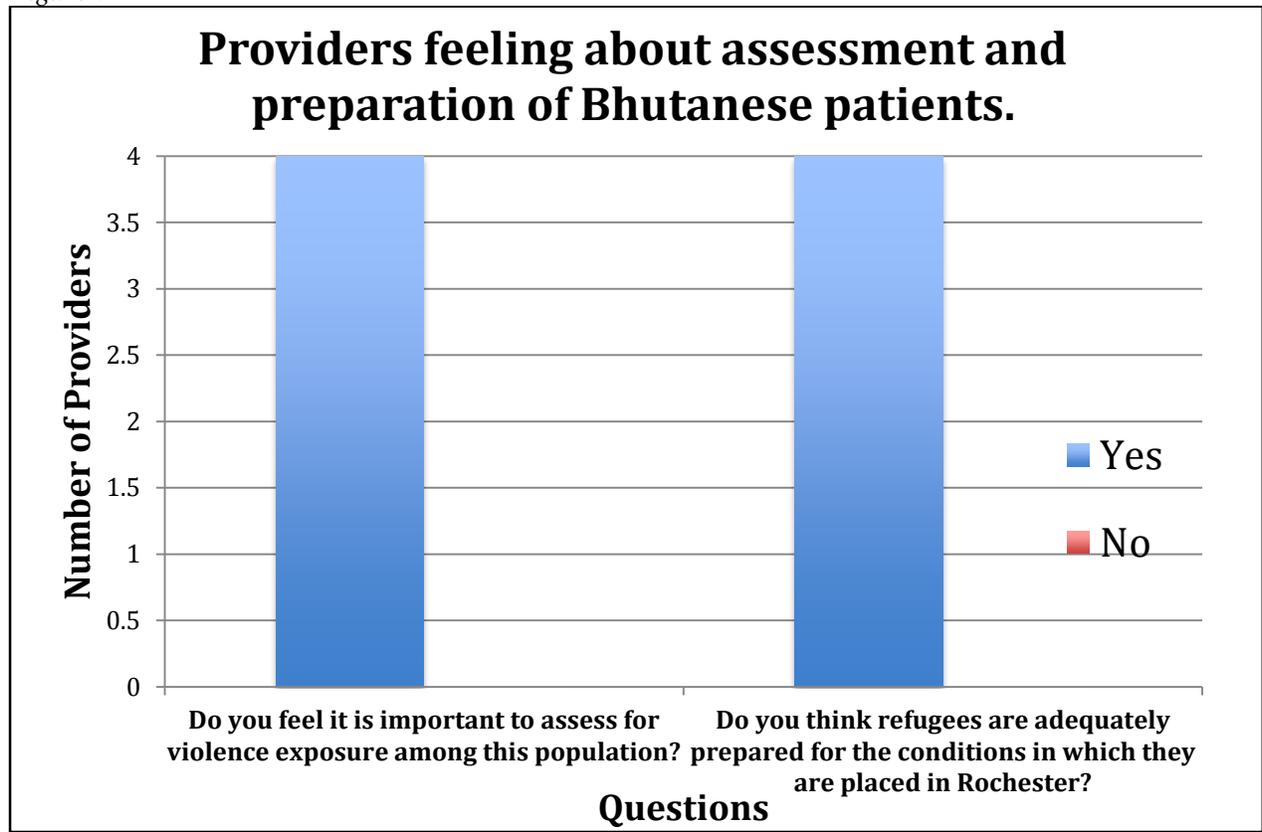


Figure 3



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