

Reducing Racial Disparities in the Treatment of Depression Webinar Series

February 3rd, 2016

**Topic: Behavioral Health Care for Refugees:
Barriers, Best Practices, and Cultural Humility**

**Presenter: Georgi Kroupin, Ph.D., LMFT, MA, LP -
HealthPartners Center for International Health**

**Antidepressant Medication Management Toolkit
Annie Halland, Quality Improvement Specialist, UCare**

This webinar is presented by a collaboration of Minnesota health plans working to improve antidepressant medication management in Minnesota. Thank you to Blue Cross Plus, HealthPartners, Hennepin Health, Metropolitan Health Plan, Medica and UCare for their commitment to this issue.



Behavioral Health Care for Refugees: Barriers, Best Practices and Cultural Humility

Georgi Kroupin, Ph. D. LMFT; MA LP
Center for International Health,
Healthpartners
St. Paul, MN

3

Behavioral Health Care for Refugees

New Americans:

Ordinary people under extraordinary stress

4

Major Themes

- Being a Refugee: Trauma and Survival
- Using Resilience/Building Agency
- Building a Partnership
- Changing Ourselves
- Applications in Clinical Practice

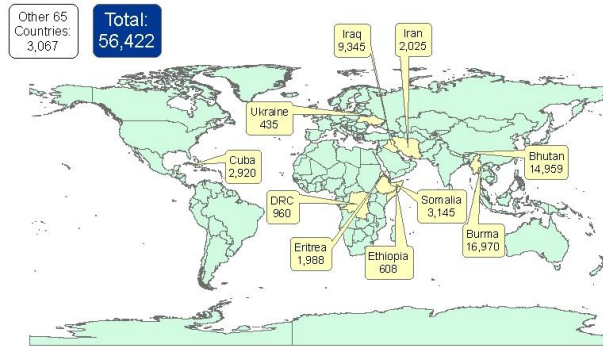
5

Major Themes

**Being a Refugee:
Trauma and Survival**

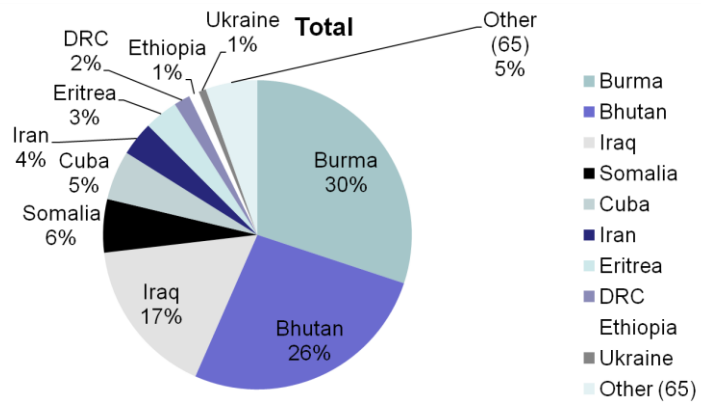
6

Top 10 Countries of US Refugee Arrivals by Nationality FY 2011



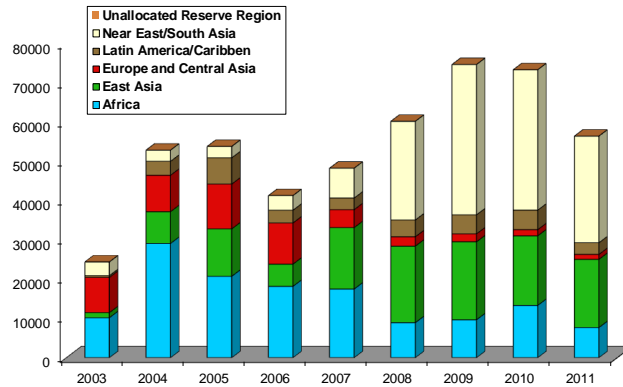
7

Top 10 Countries of US Refugee Arrivals by Nationality FY 2011



8

US Refugee Arrivals by Nationality FY 2003 – FY 2011



9

Population Statistics, 2008

(Census Bureau, Department of Human Services)

Population Measure	Minneapolis-St. Paul, MN
Population	3,229,878
Foreign born population	298,970
Foreign born share of total population (2008)	9.1%
Foreign born share of total population (2000)	7.1%
7-year increase	38.2%

10



New Americans

- *Pull immigration*
- *Push immigration*
- *We mostly deal with the Push immigrants/refugees who experience stress on multiple levels*

11




Refugees

- A **refugee** is a person who due to the “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.”

United Nations High Commission for Refugees. (2012).

12



Refugees: Experience of Loss and Trauma

Multiple areas of loss that overlap:

- *Social (including legal)*
- *Cultural*
- *Mental*
- *Physical*
- *Personal loss, separation, identity crisis*


13



Refugees: Experience of Loss and Trauma

- *Trauma:*
 - *Fact of Loss (traumatic event)*
 - *Loss as a process (loss of influence)*
 - *Loss of self (I am no good)*

14



Refugees: Experience of Loss and Trauma

- *The **Fact** of Loss is **final, irreversible***
- *To establish Trust/Rapport the “**Finality**” of patient’s loss needs to be acknowledged*
- *Moving on is in learning how to live with the **Fact** of loss, not forgetting or “fixing” it*
- *People may be able to learn how to live with loss and still have hope*
- *We need to help them and learn ourselves how to tolerate ambiguity and deal with both at once*

15



What we see in our practice?

Most frequent Mental Health problems in refugee population

- *Major Depression*
- *Anxiety*
- *PTSD*

16



Major Depression: Definition

- Major Depression is a mood disorder involving
 - depressed mood
 - loss of interest in doing things
 - major sleep problems
 - possible loss of appetite and weight
 - persistent fatigue
 - feeling slowed down or agitated
- It also involves major memory and concentration problems
- Patients often report feelings of worthlessness, hopelessness and suicidal ideas
- All of the above symptoms have clinically significant negative effect on patient's work, social or personal functioning.

17



Depression: Prevalence

- Prevalence of Depression is estimated at 5%-31% which may be ascribed to a number of factors affecting refugees before migration, in the process of flight, and during and after the resettlement, as well as to differences in data collection, analysis and interpretation

(Hollifield, 2002)

18



Anxiety Disorders: Definition

- Excessive anxiety and worry occurring on more days than not for at least 6 months
- Person finds it difficult to control the worry
- 3 or more of the below
 - Restlessness
 - Fatigue
 - Difficulty concentrating
 - Irritability
 - Muscle tension
 - Sleep disturbance
- Cause clinically significant distress or impairment in functioning

19



Anxiety Disorders: Prevalence

- Meta analysis of 35 studies 1990 -2007 found **40%** prevalence of Anxiety in Refugee Population (Lindert et. al., Social Science & Medicine, July 2009)
- In the US lifetime 29%, on a given year 11-18%

20



PTSD: Definition

Post Traumatic Stress Disorder is a Mental Health Disorder that is developed as a result of an experience of an unusually traumatic event that involves both:

- **1. Actual or threatened death or serious physical injury to the person or others, and**
- **2. Experience of intense fear, horror, or helplessness.**
 - Patient repeatedly relives the event in intrusive memories, flashbacks or dreams
 - Patient also experiences marked mental distress in reaction to any reminders of those events
 - Patient also repeatedly avoids the trauma-related stimuli and has numbing of general responsiveness
 - Patient also has at least two of the following: insomnia, anger/irritability, poor concentration, increased startle response
- **The above symptoms cause clinically important distress or impair work, social or personal functioning.**

21



Definition of PTSD

- *PTSD is one of the few DSM IV diagnosis that requires presence of the psychological cause (trauma)*

22



PTSD: Rates and Risk Factors

■ The National Comorbidity Survey

- 60.7% of randomly sampled adults were exposed to DSM traumatic stressors
- Of those only 20.4% women and 8.2% men developed PTSD

23



PTSD: Prevalence/Population

■ General population

- 1.3% (Davidson et al., 1991)
- 7.8% (National Comorbidity Survey, Kessler et al., 1995)

■ Exposed to mass conflict

- 4-20% (Silove et al., 2000)
- 9-37% (Jaranson et al., 2004)
- 16-37% (deJong et al., 2001)

24

PTSD: Prevalence/Place

Rates of PTSD higher in refugee camps

■ Refugee camps

- Mollica et al.,(1993) (Cambodia) 33%
- Mollica et al., (1999) (Bosnia/Croatia) 28%
- Van Ommeren (2002) (Butan/Nepal) 43%

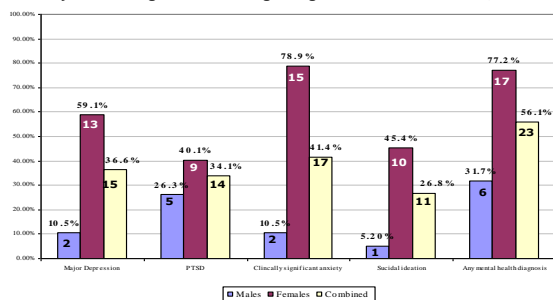
■ Post conflict/Resettled

- de Jong et al., (2001) (Ethiopia, post conflict) 16%
- Jaranson et al. (2004) (Oromo/Somali, resettled) 25% developed PTSD

25

PTSD: Prevalence/Place

Psychiatric Diagnoses in Hmong Refugees at Wat Tham Krabok, Thailand



* Quick PsychoDiagnostics www.digitaldiagnostics.com

WTK Assessment Team March, 2004

26



PTSD and Major Depression: Prevalence/Time

- Recently arrived Cambodian patients (Carlson & Rosser-Hogan, 1991)
 - PTSD 86%
 - MDD 80%
- 20 years later (Marschall et al., 2005)
 - PTSD 62%
 - MDD 51%

27



PTSD and Depression: Comorbidity

- **High comorbidity with MDD**
 - Marshall et. al., (2004): 71% of subjects who had PTSD also met criteria for MDD and 86% of those with major depression met criteria for PTSD.
- **Comorbid MDD/PTSD correlate with high suicide risk** (Oquendo et al., 2003)

28



Anxiety Disorders: Comorbidity

- MDD and Anxiety 58%
(National Comorbidity Survey, 2005)
- GAD precedes MDD 42%
- MDD preceded GAD 28%
- MADD >50%
(M. First, MD, 2007)

29



PTSD: Risk factors

(Mcnally et. al., 2003)

- Trauma exposure/severity
- Pre-existing mood disorders
- History of abuse
- Low cognitive ability
- Lack of social support
- Peritraumatic disassociation
- Catastrophic appraisal of PTSD symptoms
- Continuous Trauma

30



Major Depression: Diagnostic Tools

- PHQ9
- Hamilton Depression Scale
- Hopkins Symptom Checklist-25 (HSCL-25)
- Symptom Check List-90 (SCL-90)
- Vietnamese Depression Scale.
- Zung Depression Scale.

31



PTSD: Diagnostic Tools

- PTSD Checklist (PCL-C) (Blanchard et al., 1996)
- Clinician-Administered PTSD Scale (CAPS-I, Blake et al., 1995)
- Post Traumatic Diagnostic Scale (Foa et al., 1993)
- The Davidson Trauma Scale (Davidson et al., 1997)
- Traumatic Stress Syndrome Checklist (Basoglu et al., 2001)
- The Structured Clinical Interview for DSM IV (SCID, First et al., 1996)

32



Humanizing Mental Health Problems: **PTSD**

- *People vary in their vulnerability for PTSD*
 - *Personal/Psychological resources is a major factor*
- ***Vast majority of trauma survivors recover on their own***

33



Adjustment and PTSD

- *PTSD as cultural bereavement*
(Eisenhruch, 1994)
- *PTSD and agricultural cycle*

34



Effective Treatments: EMDR

- Several studies showed elimination of PTSD in 77-90% of civilian participants after 3-7 sessions (Lee et. al., 2002)
- Other studies documented significant decrease in PTSD symptoms after 2-3 sessions (Scheck et. al. 1998)
- Treatment effects are well maintained at follow up assessments: 84% at 15 mths. f/u (Wilson et. al., 1997)

35



Major Barriers to Addressing Mental Health Problems

- *Adjustment/Priorities*
- *Providers' time*
- *Patients' beliefs*
- *Stigma*
- *Normalizing*
- *Traditional Coping Approaches*

36

Psychiatric Services: Comparative Statistics

World Atlas, WHO

	Somalia	Sudan	US
Psychiatrists per 100,000 population	.06	.09	13.7
Psychiatric Nurses per 100,000	.03	.2	6.5
No of mental health beds per 100,000 population	.4	.2	7.7

Biggest Barriers to Health

- Our fear of incompetence
 - *In addition to learning more we need to learn to embrace our incompetence*
- Patients' sense of helplessness and hopelessness (**lack of Agency**)
 - *We need to work to increase their sense of Agency*
 - *Our best tool is redefining everything a person does as Agency*

38

Major Themes

Using Resilience Building Agency

39

Agency:

- *Loss of object is often **final***
- *Sense of **influence** and sense of **good self** may be **regained***
- ***We are dealing with Survivors***
- *It is essential for fostering a sense of **Agency** in patients, for building a partnership*

40




41

Building relationship: Agency and Communion

- **“Agency”, “Communion” factors in adaptation to illness** (Bakan, 1966; Totman, 1979; McDaniel et. al., 1992)
- **Agency**
 - Agency is involvement in and commitment to one’s own care. The healthcare system and “patient” or “illness” roles” tend to reinforce passivity. Patients who take control over what’s controllable and accept what’s not tend to adapt better
 - Key to Agency is the ability to have influence over your life and have a positive sense of self
- **Communion**
 - Illness can be a very isolating experience. We need to reinforce the sense of “communion” for patients to feel that they “belong’ and have support. (Gurman, A.S. eds., 2008)

41



42

Building relationship: Agency

- **Carl Whitaker** (Napier & Whitaker, 1978)
 - Battle for Structure
 - Battle for Initiative

42



Restoring influence and positive sense of self

- Agency is **always there**, it has many forms
- Everything people do **makes sense**
- Everything we do is **fight for Being** and against Non-Being
- **We always do 100% of what we can**

43



Being vs. Non-Being

Martin Buber (1958): Life is a perpetual fight for Good against Evil

- **Good:**
 - Understanding who you are
 - Doing what's good for you
- **Evil:**
 - Not being who you are
 - Doing what's not good for you

44




45

Paul Tillich: Three Dimensions of Being

- **Physical: Threat of Death**
 - Loss of Influence
- **Spiritual: Threat of Meaninglessness**
 - Emptiness
- **Moral: Threat of Condemnation**
 - Guilt
- **All three are interrelated**

45



Paul Tillich: Three Dimensions of Being

- *Refugees and people with both physical and MH problems people **experience crisis** in all three dimensions*
 - Physical
 - Ethical
 - Spiritual
- **These dimensions are guiding their lives**
- **They (and we) may get caught in conflict within and b/w these dimensions**

46



Fight for Being

- Name a coping behavior that does:
 - *Structures time*
 - *Helps to focus,*
 - *Increase inner locus of control*
 - *Increase control over emotional states*
 - *Increase control over physiological states*
 - *Helps in social interactions*
 - *Communication*
 - *Acceptance*
 - *Increases sense of control over one's life*

47



Fight for Being

- ***Coping with threat to Being results in different strategies***
- *Just like everything is behavior, everything is communication, **everything is coping***
- ***Problem behaviors are coping strategies that create more problems in the same or other dimensions***
- *Some of them may manifest as **Mental Illness, Resistance or Bad Habits***

48



Mental Health Problems as Coping: ***Major Depression***

- *I've tried everything I could and failed*
- *I can't get hurt any more*
- *I give up*

49



Mental Health Problems as Coping: ***Major Depression***

- *Depression is not sadness but **reduced vitality***
- *Purpose is to reduce your life space to a point where you feel **reasonably safe and have influence***
- ***Helplessness: I don't have to keep trying (failing)***
- ***Hopelessness: I don't have to try in the future***
- *Feeling of **guilt** is an attempt to increase the sense of **control***

50



Coping

- **Problems are real and patients' reactions are purposeful**
 - *Depression in some elderly Russian speaking patients*
 - *Anxiety in Somali patients*


51



Paul Tillich: Three Dimensions of Being

- **Crisis in Physical Dimension (Death)**
 - *Fear of dependence on medications*
 - *Dealing with side-effects*
 - *Problems with abstinence from substance abuse*
 - *Problems with PT, exercise, meditation in chronic pain*
 - *Refusing more experience of lack of Control (Hospital)*
 - **Most patients deal with most of their MH problems on their own!**

52




53

Paul Tillich: Three Dimensions of Being

- **Crisis in Spiritual Dimension (Emptiness)**
 - *Life has no value, not worth living*
 - *No control over one's life*
 - *No future*
 - *Isolation from the community*
 - *Dissolution of the family*
 - **Loss of skill, loss of profession, loss of status**

53




54

Paul Tillich: Three Dimensions of Being

- **Crisis in Moral Dimension (Guilt)**
 - *I have no right to take care of myself*
 - *Because I did not protect my loved ones*
 - *I lost everything I worked for, my whole life was for wasted*
 - *I failed myself*

54




55

Paul Tillich: Three Dimensions of Being

- **Physical, Spiritual and Moral may be in Conflict**
 - **Physical affects Physical**
 - *I will rather risk dying than loose control of my life*

55




56

Paul Tillich: Three Dimensions of Being

- **Physical, Spiritual and Moral may be in Conflict**
 - **Physical affects Spiritual**
 - *Treatment controls patient's life and he feels a non-person*
 - *Medications have side effects and patient can not function*
 - *Giving up bad habits takes away the only happiness*

56




57

Paul Tillich: Three Dimensions of Being

- **Physical, Spiritual and Moral may be in Conflict**
 - **Spiritual affects Physical**
 - *Patients refusing to live*
 - *Active or passive suicide*
 - *Giving up Hope*
 - *Patients refusing to compromise their self-image*
 - *Refusing to go on an insulin shot*
 - *Refusing to take psychotropic medications (stigma)*
 - *Patients refusing to suffer humiliation:*
 - *I am not treated with respect*
 - *I feel too dependent*
 - *I can't take more experience of incompetence*

57



58

Paul Tillich: Three Dimensions of Being

- **Physical, Spiritual and Moral may be in Conflict**
 - **Moral is more important than Physical and Spiritual**
 - *I have no right to feel good until I take care of my kids*
 - *I have no right to move on because I did not save my brother*
 - *I have no right to take care of myself because I failed in life*

58

Paul Tillich: Three Dimensions of Being

- *If we focus on one dimension (Physical) we may see patient behavior in **negative** terms*
- *Although it may be acknowledged that patient behavior is justified it may still be seen as irrational, **not purposeful***
- *It then is perceived as a manifestation of patient's **weakness***
- *We end up **fighting against patients' agency***

Paul Tillich: Three Dimensions of Being

- *When we consider all three dimensions we see that patient behavior is **always purposeful***
- *It can **always** be defined in positive terms*
- *It can be viewed as a manifestation of patient's **strength** in his coping attempts*
- *We have a chance to align ourselves with patients' struggles and use their agency/energy that is always there*



Increasing Patient Agency

- *Reframing*
 - “What helped you to survive?”
 - “What do you do now when you feel bad?”


61



Increasing Agency: *Increased Control*

- *Trauma is a loss of control over one's life*
- *Working on patient's ability to manage their **Physical Being** (increase Control):*
 - *Safety*
 - *Discuss limits*

62




63

Increasing Agency: *Physical Being*

- Working on patient's ability to manage their **Physical Being** (increase Control):
 - Use their resources
 - Manage Physical/Emotional States
 - Mindfulness/Bodywork
 - Structuring your life
 - Increasing competence
 - Encourage decision making and accept their choices

63




64

Increasing Agency: *Spiritual Being*

- Working on Patient's ability to improve their **Spiritual Being** (Meaning)
 - Person is always doing his/her best
 - Acknowledge their fights/effort
 - Acknowledge their responsibility

64




65

Increasing Agency: *Moral Dimension*

- Working on patient's ability to manage their **Moral Being** (Value)
 - Show Respect
 - Be on time, apologize when late
 - Shake hands, look in the eyes, etc. when appropriate
 - Ask them who they were in their "previous life"
 - Education
 - Skills
 - Languages

65




66

Increasing Agency/Vitality: *Finding Hope and Happiness*

- What gives you hope?
- Increasing **Positive Experiences**
- People can't live without moments of **happiness**
- What do you do that makes you **feel good**?
- What stops you from having **more** of that?

66



67

From Non-Being to Being

- ***I want to die***
 - *No on all three aspects*
 - *No treatment, Smoking*
- ***I don't want to hurt (don't care live or die)***
 - *Remedial treatment, Smoking, Refuse Therapy*
- ***I don't want to die***
 - *Physical*
 - *Preventive treatment, no smoking*
- ***I want to live***
 - *Physical, Spiritual, Moral*
 - *Active involvement in own care, Improving health*

67



Major Themes

Building Partnership

68



Patient/Provider Relationship

- *Meta analysis of effectiveness of different approaches in Psychotherapy showed that 85% of success in therapy is attributed to non-specific factors*
- *Facilitating Patient-Provider relationship*
 - *Caring*
 - *Understanding*
 - *Trust*
 - *Safety*
 - *Accessibility*
 - **Building Partnership**

69



Building Partnership

- Martin Buber (1958) "I and Thou"**
- *"I – It" versus "I – Thou"*
 - *To facilitate patient's responsibility we need to treat them as "Thou"*
 - *To do that we need to be mindful of **Power/Control Dynamics***

70



71

Building Partnership

- *Power and Control Dynamics*
(Maddock, 1989; 1995)
- *Definitions of Power and Control*
 - *Power is the ability to influence*
 - *Control is the absence/negation of influence*

71




72

Building Partnership

- *Bases of Power* (French and Raven, 1959; 1965)
 - *Coercive*
 - *Expert*
 - *Referent*
 - *Informational*
 - *Reward*
 - *Legitimate*

72



73

Building Partnership

- *We are perceived as having more Power*
- *Refugees have little Power and often resort to Control*
- *Control responses to Power are passive*
 - *Flight*
 - *Be "Dead"*
 - *Be "Crazy"*
- *Power response to Power are active*
 - *Fight/Negotiate/Change the Rules*

73



Major Themes

Changing Ourselves

74



Changing Ourselves

- *Possible consequence of your reframing their behavior as power is **your loss of Power***
- *Accepting our own **vulnerability, limits in influencing others, helplessness***

75

What Works for US?



**Increasing Agency/Building
Partnership in Clinical Practice**

76



Increasing Agency/Building Partnership in Clinical Practice

■ Sharing Responsibility, increasing Agency/Control:

- *My job is to ask questions, your job is to protect yourself*
- *Stop me if you don't want to do talk about that*
 - You need to follow through and actually give them control over the situation
 - do it consistently so that they feel in control and safe

77



Increasing Agency/Building Partnership in Clinical Practice

■ Embrace limits of your competence, make patient an Expert:

- *Use your ignorance to your advantage: ask “stupid questions”*
 - It makes both you and your patient more **Free** to explore and challenge stereotypes

78



Increasing Agency/Building Partnership in Clinical Practice

■ Positive reframing: You are a Survivor!

- *What helped you to survive all the hardship you've been through?*
- *How did you do that?*
 - The fact that they sit in front of you is a living proof of their resilience

79



Increasing Agency/Building Partnership in Clinical Practice

■ Positive reframing: You are doing the right thing!

- *Shifting from “no, but” to “yes, and”. Everything makes sense.*
 - Defines their behavior as purposeful, as doing something right and to some extent being in control

80



Increasing Agency/Building Partnership in Clinical Practice

- **Shared Definition of the Problem**
 - *Use lay language, avoid jargon*
 - *Use symptoms, not diagnostic labels*
 - Normalize whenever possible

81



Increasing Agency/Building Partnership in Clinical Practice

- **Ownership of the Problem – Foundation of Agency**
 - *Do you think you worry/think/feel sad too much?*
 - If they say “no, not too much” you need to take their word for it, let them decide and not push your agenda

82



Increasing Agency/Building Partnership in Clinical Practice

■ Using Patients' Competence/Agency

– *When this happens to you, what do you do (to calm yourself down)?*

- People ALWAYS do something
- You need to explore it in detail and validate their coping

83



Increasing Agency/Building Partnership in Clinical Practice

■ Building Partnership

– *Do you want me to offer you something else you can do?*

- Try to utilize what they do and build on it
- If they refuse you have to accept it

84



Increasing Agency/Building Partnership in Clinical Practice

■ Creating Commitment

– *Will you do that (will you commit to that)?*

- Be prepared for them to say “no”
- Accept that, whatever they do makes some sense
- Explore and validate the reason for their refusal
- Continue with “yes, and” to find more effective ways of dealing with the problem

85



Useful information on refugee Mental Health

CDC refugee screening guidelines (includes mental health screening recommendations):

<http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html>

Canadian evidence-based clinical guidelines for refugee and immigrant health:

http://www.cmaj.ca/cgi/collection/canadian_guidelines_for_immigrant_health

Minnesota Dept of Health refugee health website – a wealth of local information:

<http://www.health.state.mn.us/divs/idepc/refugee/>

The Body Keeps the Score. Van Der Kolk, 2015
Immigrant Medicine, Editors: Walker, PF and Barnett, ED
Elsevier, 2007

86

Improving Antidepressant Medication Management Provider Toolkit

Antidepressant Medication Management



Provider Toolkit

Tools to increase antidepressant medication adherence and reduce racial and ethnic disparities in depression management.



MEDICA.
INSURANCE PLAN



HealthPartners

MHP
METROPOLITAN
HEALTH PLAN

Hennepin
Health
PEOPLE. CARE. RESPECT.

[Antidepressant Provider Toolkit](#)

87

AMM Provider Toolkit Content Examples

- Best Practices for Depression Care
- Cultural Awareness & Treating Depression
- Shared Decision Making for Depression Treatment
- Mental Health Resources
- ***New for 2016***: Resources for Seniors

[Antidepressant Provider Toolkit](#)

88

Thank you for joining our webinar today!

- Complete the evaluation/survey following today's webinar to receive your participation certificate.
- Please forward the survey to all those in your organization who attended, as needed.
- Stay tuned for more webinars in this series. Tentative schedule for 2016:
 - May: Depression Care for Seniors
 - July: Behavioral Health Care for East Africans/Somalis
 - Nov: Depression Care in Rural Minnesota