Onondaga Citizens League
2012 Study Committee Notes—Meeting on June 12, 2012
Meeting held at PEC, 620 James Street, Syracuse

Attendees: Paul Ariik, Amela Gebovic, Felicia Castricone, Peter Cronkright, Ginny Felleman, Stephanie Horton, Agnes Kariuki, Karen Kitney, Patrick King, Helen Malina, Nancy McCarty, Sarah McIlvain, Brian Moore, Robin Morgan, Cynthia Morrow, Peter Sarver, Lois Schroeder, Olive Sephuma, Nancy Shepard, Marsha Tait, Amy Thorna, Lisa Warnecke and guest, Sandy Whittaker
Presenters: Cynthia Morrow, Pete Cronkright, Jeanette Angeloro, Paul Ariik and Peter Sarver
Co-chairs: Kristen Heath, Heidi Holtz
OCL: Sandra Barrett, Becky Sernett

Summary
The health committee, which included two physicians, a clinical social worker, and a refugee, discussed the challenges and rewards of caring for refugees' physical and mental health. Refugees shared their stories of struggle with illnesses and trauma and how they cope. Communication barriers figured highly in the challenges, as did finding physicians who accept public health insurance. Mental health caregivers reported being overwhelmed by the depth and breadth of the refugees' need, and emphasized that mental health underscores everything—from a refugee getting a job to maintaining her family responsibilities—and can take a long time to overcome.

The next OCL meeting will be on June 27 at 12 Noon at the United Way, 518 James St., Syracuse. A presentation will be given by the Housing subcommittee.

The schedule for future subcommittee presentations is:
June 27—Housing
July 10—Crime & Public Safety
July 25—Youth & Education (will be held at PEC, 620 James St., instead of the United Way)

Health
Peter Sarver, an OCL board member, facilitated the presentation by: Dr. Cynthia Morrow, Onondaga County's Commissioner of Health; Dr. Pete Cronkright, an internist and professor of medicine at SUNY Upstate Medical University; Jeanette Angeloro, a clinical social worker and director of St. Joseph's outpatient behavioral health services; and Paul Ariik, a refugee from Sudan.

Dr. Morrow discussed the efforts and focus of the Refugee Health Task Force of Onondaga County, which meets the first Tuesday of every month at 501 E. Fayette Street and is open to the public. Among the regular attendees are representatives from refugee assistance programs and Dr. Cronkright, who was on the subcommittee panel. The task force has a "lofty goal", she said, of developing a model program for health and mental health delivery. One of the challenges has been communication and the "paucity of information" about refugees' health. While they do receive data from Bob's School and VOLAGs, more information is needed. Another challenge is on the insurance end, as New York State automatically enrolls refugees in a public health plan and many providers don't take that insurance. This is, she said, "a case where the state is too efficient." She said the answer to easing the challenges is further teamwork and collaboration.

Dr. Cronkright said what drives him to care for refugees are their stories. He grew up on a potato farm, and he and his brothers were often out in the rows, hunting for plants among the weeds, trying to find the potato with the most eyes, or the funniest looking one, or the largest, and the excitement was a lot like looking for treasure. But then, there would be the "toppers"—potatoes that put all their growth into the plant and not the potato. It was hard and time consuming work.

He says taking care of refugees is "a lot like potato farming." At first, it's exciting with the new diseases to tend to and the tropical medicine that's atypical to central New York. "But as you work over time, you find out how difficult it is." The Jobsplus applications pile up. The walk-ins present difficulties. And he will try to explain basic concepts like prescription refills and fail. These moments feel like finding "toppers" in potato fields—all that hard work and no reward. But then he considers how refugees allow him to see the "entire spectrum of humanity", from despair to courage. "And, if I allow it, I see myself. The only difference between them and me is that I grew up on a potato patch and they grew up in a war zone." He said the biggest difference between refugees and him is "my community." "If we continue to sow and hoe and nurture our refugees so they can take root in our communities, we will have treasure."

Jeanette Angeloro said she didn't give much attention to the refugee patient population at St. Joseph's Behavioral Health outpatient clinics because their numbers were so small—a total of 15 (including 1 child). Today's meeting prompted her to look more closely at the refugees' care, and she said she has "reaped an unforseen benefit" by becoming more aware of their health issues and what the practitioners are dealing with. But it also left her overwhelmed, because the mental health needs of refugees are so "pronounced."

"These are people who have suffered greatly in many ways." The "prominent diagnosis" is PTSD; they are anxious, depressed, and have trouble sleeping. Others suffer because they were people of status in their homeland and aren't now. One patient has "psychotic symptoms". Overall, these patients are vulnerable, and mental health practitioners must ask: "What's happened in their lives that make them vulnerable? Recent or not." And it's difficult to be hopeful when there are so many challenges, but they need to find that balance of caring for the troubled patients but maintaining hope.

The refugees at St. Joseph's clinic are from Sudan, Nepal and Iraq. The gender split is about 50-50. All but one uses the adult clinic. The services include individual therapy, group therapy and medication. And because talk therapy is key to healing, language differences pose major problems. They use a phone interpreter service, and oftentimes the interpreters will hold back information or change information. Also, there is a delay in the communication, and all this presents a "huge barrier," she said. Several of the clients, though, are "amazingly fluent in English." Using parents or family members to translate is discouraged because of privacy issues, a concern that information will be changed or not communicated, and because a patient may not feel free to fully communicate his or her problems.

Other challenges include transportation difficulties and patients not keeping appointments. For the child patient, the mom works at night and sleeps during the day when the clinic is open. Also, there is a lack of knowledge about mental health and how to treat it. A patient stopped taking his psychotropic medicine after 30 days, because he thought he was supposed to be better, when he should have gone and got it refilled. She said it can be "difficult to help patients understand the length of time they need to get better." Many of the patients have physical manifestations of their mental illnesses and seek medical services that aren't necessary. (Dr. Cronkright said PTSD often presents many physical symptoms.)

She said St. Joseph's would like a "better connection to the refugee resettlement agencies" to educate them about St. Joe's and so St. Joe's could be better educated about refugees and their needs.

Most of their patients come from the hospital's Comprehensive Psychiatric Emergency Program (CPEP). And while the hospital has off-site clinics, refugees go to the one on James Street.

Helen Malina from InterFaith Works (IFW) introduced Agnes Kariuki, who has been working as a mental health counselor at the organization for nearly 5 years as part of a grant project to train a corps of mental health workers for the refugee population. Agnes is from Kenya, which is home to millions of refugees in camps, but she said she never had the chance to engage with a refugee until she came to the United States. "I feel very honored at this time in my life to work with this unique population." The stories that refugees share with her are humbling, and she considers it a sacred exchange. "It's almost like I've been asked to remove my shoes," she said. Agnes will be leaving the IFW to work in Canada, and the mental health trainees will take over her work.

To show how deeply Agnes' work impacted refugees and how much mental health needs to be addressed, Helen explained that IFW held a going away party for Agnes on Sunday and more than 200 people attended (many of whom were refugees), and there were three hours of speeches.

Paul Arik, a refugee from Sudan, shared personal stories of the trauma he and other refugees have endured, and said they bring this trauma with them to the camps and then to the U.S. He saw people being raped, cut up and dead bodies everywhere. He saw someone getting cut in two, and "that picture will never go away." Sometimes, he dreams of walking over dead bodies. When he came to the U.S., he was immunized against diseases, but he would also like there to be a mental health "shot" to cure these ills. "Mental health for refugees is the fundamental problem in our community." He said a "person has to be mentally stable to learn English, get a job..."

What helps are activities that help them "forget" the trauma. For many men, this is soccer. "But what about the women?" he asked. Many women stay in the home and become isolated with their trauma.

Sarah McIlvain, a member of the OCL study committee, asked if the community could "deputize" people to go into the communities and reach out to those in need (similar to firefighters and EMTs who are trained to respond to large tragedies). Helen said this is one of the goals of the IFW project that Agnes worked on--that members of the ethnic communities would take the lead on this need now that they've received some training.

Another question was raised about when mental health illnesses are and should be screened. Various attendees responded. Sometimes the illnesses are identified at the camps, and this would then be included in the refugees' medical records.

Dr. Cronkright said that "how to screen and when to screen is an issue." Canada doesn't screen because it doesn't want to open pandora's box. He looks for mental illness "red flags" and addresses those. The initial health check that's on a Wednesday night, and rushed, with children and other family members around, is not the place or time to do a mental health screening. At the Canadian Centre for Victims of Torture in Toronto, he said, the philosophy is

to deal with the most important health issues now and then move the patients forward. “Give them a purpose in life,” he said. This is where communities play a strong role.

Helen said that they also use the model developed in Toronto. “We give them permission not to relive it.”

Amela Begovic, who works for Bob’s School as a health program faciliator and is a refugee from Bosnia, said that in her experience, it’s best for refugees to move on and not dwell on past trauma. And so screening for it in the beginning is not what she would do. When she first resettled in the United States, she was depressed. She was a high school teacher back home, but worked in a factory as her first job in the United States. Eventually, she got a better job and went back to school, and now with three children and work, she doesn’t have time to relive any nightmares, and that’s a good thing. However, she recently saw part of a movie about the Bosnian War, and it quickly brought it all back. It’s tough to get over the trauma, she said, but “refugees should look to their future with a bright light.”

A refugee from Iraq, shared her story with the committee. She came to the U.S. “very sick” and so for six months while she was in the hospital, her two boys had to deal with a lot mostly on their own. She lost her husband in Iraq, and she worries for her sons even now. One of them isn’t attending school regularly. He is frustrated with being put in a younger grade in high school because of his lack of English. She tearfully asked the community for help.

Jeannette emphasized that there are numerous informal support services that can be provided, such as support groups. “You can assume that anyone can benefit from some form of informal mental health support.”

Karen Kitney, an OCL board member, said she was “struck by the isolation of women in various communities” and wanted to devise ways they could get support.

Dr. Morrow said that she has been taking notes during the meeting and will report back to the task force about how fragmented the system is and promised that they would follow up on the discussion at the June monthly meeting (which would be that afternoon).

Nancy Shepard has helped coordinate health care for refugees as a volunteer and offered this as an idea to provide support.

The next OCL study committee meeting will be on June 27, at 12 Noon at the United Way, 518 James Street. The Housing subcommittee will present its discussion.