

Protecting vulnerable populations: COVID-19 pandemic, mental health, and refugees and asylees

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ABSTRACT

According to the World Health Organization, as of June 2021, there have been over 3.7 million deaths globally and nearly 600,000 Americans who lost their lives from COVID-19 (WHO Coronavirus Disease Dashboard, 2021). The health, mental health, and economic effects are apparent in every household and community. However, the most vulnerable populations tend to be more adversely affected by disasters, and the COVID-19 pandemic is no exception. This article focuses on the mental health effects of COVID-19 on the refugee, asylee, and immigrant (RAI) community, the effects of misinformation and lack of access to the healthcare system, and the results from a small qualitative program evaluation that included exploration of the effects of COVID-19 on refugees and asylees. The authors discuss specific issues reported by the RAI population, intergenerational trauma, and recommendations for health and mental health programming when working with RAI communities during disasters such as pandemics.

Key words: COVID-19, refugee, asylee, and immigrant (RAI) community, mental health

INTRODUCTION

According to the World Health Organization, as of January 2021, there have been over two million deaths globally and over 500,000 Americans who lost their lives from COVID-19.¹ The health, mental health, and economic effects are apparent in every household and

community. However, the most vulnerable populations tend to be more adversely affected by disasters, and the COVID-19 pandemic is no exception.^{2,3} Refugees, asylees, and immigrants (RAIs) have historically been an oppressed and hidden community.⁴ Often forced to leave their homeland because of conflict, economic instability, persecution, and/or danger, RAIs remain a significant vulnerable population during the COVID-19 pandemic.

This article focuses on the mental health effects of COVID-19 on the RAI community, the effects of misinformation and lack of access to the healthcare system, and the results from a small qualitative program evaluation that included exploration of the effects of COVID-19 on refugees and asylees. The authors discuss the specific issues that arise for the RAI population, intergenerational trauma, and recommendations for health and mental health consideration when working with RAI communities during disasters such as pandemics.

DEFINITIONS: REFUGEES, ASYLEES, AND IMMIGRANTS

Immigrants leave their country of origin with the hope of relocating to a new country permanently. Immigrants travel to other countries either legally (documented) or illegally (undocumented).² Immigrants who are granted legal status in the United States have more protection and access to services but still face hardships including xenophobia and economic struggles.²⁻⁴ Immigrants who do not

enter the country legally are even more vulnerable as they often live in fear of being arrested and deported in addition to economic insecurity and lack of access to healthcare.

The UNHCR defines a refugee as: “[S]omeone who has been forced to flee his or her country because of persecution, war, or violence.” Refugees often cannot return to their country of origin and enter the US legally. Unlike undocumented citizens, refugees have a clear path to citizenship. However, they remain vulnerable as immediate financial support and time-limited health insurance generally run out after 3 months (for financial aid) and 8 months (health insurance) post-arrival.³ Asylees are individuals who have fled their country of origin and “seek sanctuary in another country; they apply for asylum—the right to be recognized as a refugee and receive legal protection and material assistance. An asylum seeker must demonstrate that his or her fear of persecution in his or her home country is well-founded.”⁵

For the purpose of this article, RAIs as a specific vulnerable group adversely affected by COVID-19 will be focused on. RAIs come from around the globe and are either fleeing conflict and persecution as defined by international law (as is the case with refugees and asylees) or seeking economic security and/or fleeing violence from their country of origin (as can be the case with documented and undocumented immigrants).² RAIs remain vulnerable during disasters and historically lack access to specific resources and services including health and mental health.^{4,6} The ongoing nature of COVID-19, misinformation, and the politicized elements of the pandemic further complicate and marginalize this vulnerable population.^{4,7-10}

LITERATURE REVIEW: MENTAL HEALTH AND TRAUMA

Studies indicate that the RAI population has a complex relationship to specific health and mental health issues.¹¹⁻¹³ Pre-existing mental trauma and physical trauma exist at higher rates with RAIs. In addition, refugees and immigrants are at higher risk for pre-existing crises such as trafficking, interpersonal violence, poverty, fear of law enforcement, bias and hate crimes, language barriers, and cultural

differences and constraints.^{2,14-16} Many RAIs have pre-existing health issues, such as diabetes and heart conditions, that are further exacerbated once they have been resettled, relocated, or forced to move. Refugees and asylees may have high rates of exposure to war injuries, torture, rape, and disease from camp environments or because of lack of adequate healthcare. The effects of this type of vulnerability affect mental health and physical health. Once in the United States, accessing health and mental health services is challenging leaving them further vulnerable.¹⁷ From an emergency management perspective, this group is especially vulnerable during disasters such as the COVID-19 pandemic. Ensuring critical and lifesaving information reaches the RAI population in multiple languages and that services are offered in safe, culturally competent facilities is challenging.

Incorrect medical information creates a difficult situation for healthcare professionals putting the lives of RAIs and their communities at risk. When a refugee with a serious medical condition is assigned to an area that does not have adequate healthcare services, it creates layers of problems in an already taxed situation. The Harvard Humanitarian Initiative (2009) reported that not only are the contemporary groups of refugees more diverse but the medical conditions refugees are presenting are also equally diverse. The report notes that refugees coming from camp environments have high rates of infectious diseases, whereas those coming from “hot zones” (direct conflict) have physical injuries.^{12,18} In addition, the study found common themes, or “barriers” to addressing the health needs of refugees including language/interpretation access issues; difficulty navigating the local, state, and federal health systems; difficulty accessing health clinic/healthcare; and issues enrolling refugees in federal programs such as Medicare and Medicaid.

Refugees generally present with complex medical conditions, making healthcare referrals and management of the medical conditions more challenging post resettlement. In addition, because there is wider ethnic, cultural, and religious diversity within the RAI population, agencies must have broader language, cultural, and religious understanding and context. Lack of

accurate medical information has a significant impact on resettlement agencies and arriving refugees.¹⁹⁻²²

It is common for refugees to experience displacement, violence, and other psychosocial trauma specifically related to forced migration.^{13,23} There are a few specific circumstances that have led to a “cumulative trauma” experienced by the RAI population: pre-migration stressors and post-migration stressors²⁴⁻²⁹ including the experience of war, torture (physical and mental), incarceration in concentration camps or political prisons, personal loss of family or friends, fear for personal safety, and economic loss.^{2,29,30}

Refugees who experience trauma before migration are more likely to experience post-migration stress and the ongoing effects of cumulative trauma.^{31,32} For example, Iraqi refugees resettled in the Detroit area are exposed to the same stressors as native Detroit residents including lack of economic opportunity and the high levels of environmental degradation. Air pollution is toxic in some areas and poses health-related threats to refugees and residents alike.³²⁻³⁴

Post-migration stressors are associated with managing a new life in a foreign environment, culture, language, and economy while dealing with separation from family and friends, and the loss of the refugee’s social network.^{31,35-38} Refugees who experience trauma before migration are more likely to experience post-migration stress and the ongoing effects of cumulative trauma.^{32,37-40} Changes associated with resettlement can impede the refugees’ ability to make a successful transition to their new environments in ways that accommodate and mitigate their traumatic experiences.^{30,33,41}

The vulnerability assessment (Figure 1) illustrates how different levels of vulnerability affect RAIs. The most vulnerable of the RAI population are undocumented immigrants and victims of trafficking. This population often hides in the shadows for fear of either law enforcement (in the case of undocumented immigrants) or the traffickers (in the case of victims of trafficking). Undocumented immigrants and victims of trafficking do not have

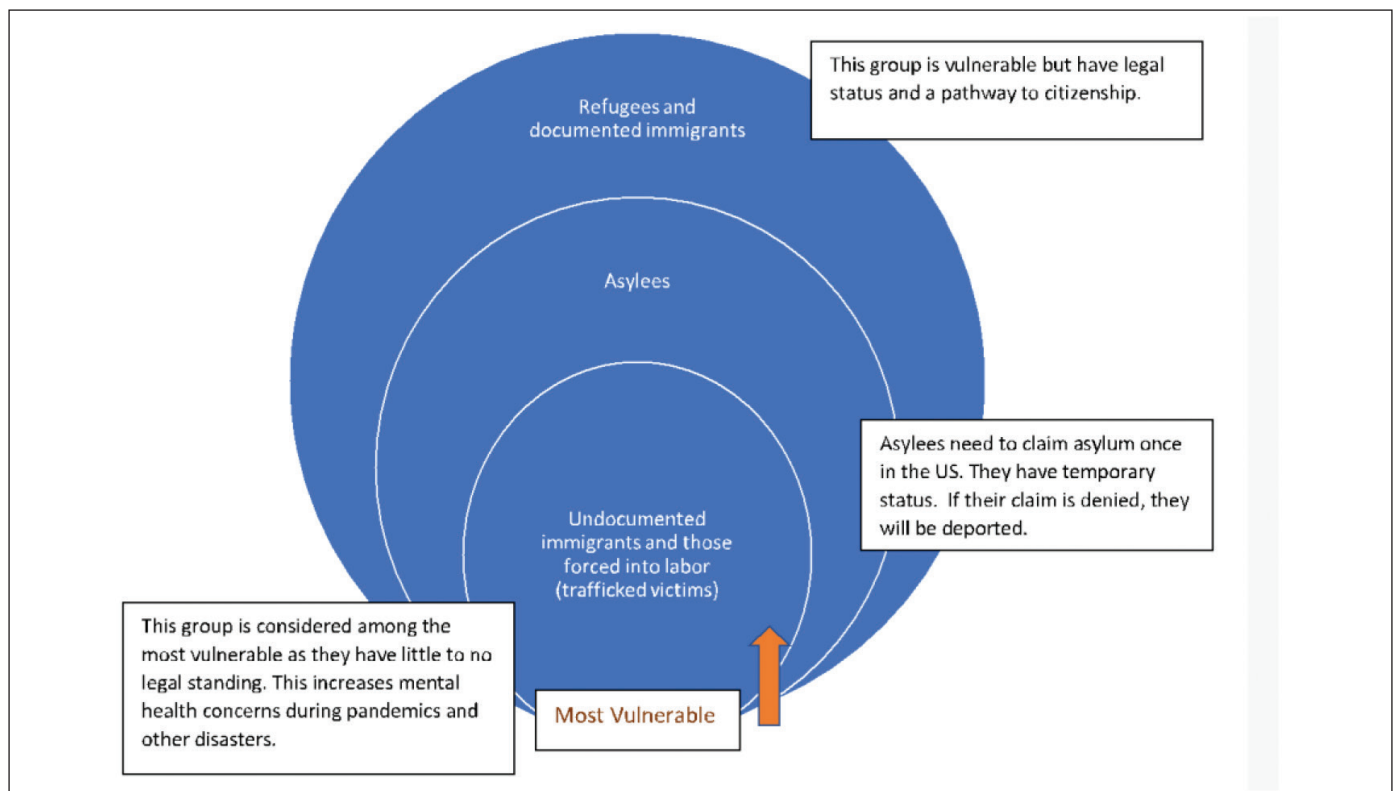


Figure 1. Disaster mental health vulnerability assessment of RAIs.

access to many social services, mental health and health care, or stable employment and housing. This a critically vulnerable group that struggles when there are no crises or disasters. When a disaster does occur, such as COVID-19, the effects are compounded. If an undocumented immigrant contracts COVID, he or she will likely not access healthcare further spreading the virus and putting the individual at risk of death or permanent health complications from the illness. Isolation and the economic instability caused by COVID-19 further affect undocumented immigrants. Isolation and economic instability and housing insecurity are linked to higher rates of depressions, anxiety, PTSD, and substance use disorders. Many are also essential workers in agriculture, healthcare, food services, and production line and do not have access to healthcare and other services and resources.⁴²

Asylees come to the US and apply for asylum when they arrive. The asylum process can take months to years. Many asylees are detained in harsh conditions often isolated from others and unable to access health and mental healthcare. The pandemic has made this situation more untenable setting up asylees for PTSD and compounded trauma once released from detention. In addition, they are subjected to the same economic and housing insecurity as immigrants and refugees. Job and housing insecurity complicates mental health problems and mental illness. Internal resiliency and coping mechanism maybe pushed resulting in maladaptive coping. Although refugees and documented immigrants may have legal standing in the US, they remain a vulnerable population in consideration of specific mental health needs prior to, during, and after a disaster. In terms of COVID-19, misinformation, loss of employment, illness from the virus, medical vulnerabilities not related to COVID-19, and pre-existing mental health conditions can be exacerbated by the pandemic.

The COVID-19 pandemic has had a hold on the US and global economy and forced the world into levels of isolation and conflict over how to manage and remedy the crisis. In addition, language barriers add to poor and incorrect medical information, where

to go for testing and treatment, and access to mental health services. Mental health professionals may not know about or integrate the specific needs of RAIs in general, and specifically during a pandemic. This severely limits the RAIs ability to find mental health relief, care, support, and build on healthy adaptive coping mechanisms.⁴³

Intergenerational trauma, chronic stress, and the effects of the pandemic are compounding trauma among vulnerable populations generally, but specifically RAIs.⁴³ Intergenerational trauma is defined as trauma that is “handed” down from generation to generation.⁴⁴⁻⁴⁷ Specifically, intergenerational trauma (also referred to as multigenerational and trans-trauma) can be understood as “the dominant culture perpetrates mass trauma on a population in the form of colonialism, slavery, war, or genocide. In the second phase, the affected population shows physical and psychological symptoms in response to the trauma. In the final phase, the initial population passes these responses to trauma to subsequent generations, who in turn display similar symptoms”.⁴⁶

PROGRAM EVALUATION STUDY: COMMUNITY HEALTH PEER PROGRAM EVALUATION

In 2018, a state-run refugee office received funding to implement a Community Health Promoter (CHP) program to outreach to the refugee, asylee, and immigrant community. The CHP program focused on increasing health and mental health literacy among newly arriving refugees as well as increasing refugee utilization of needed medical and mental health services through the delivery of in-home health literacy education by trained peers. A small, qualitative program evaluation was conducted to examine the CHP’s role in improving well-being, attitudes, and behaviors among refugees serving as CHPs within the state, while also learning from the CHPs about the impact of the program on the clients they served. The evaluation attempted to identify if there were changes in well-being of refugees and asylees from the perspective of the CHPs, former refugee members who implemented the curriculum and worked with newly arrived refugees.

METHODOLOGY: PROGRAM EVALUATION, QUALITATIVE RESEARCH, AND MEASUREMENT TOOLS

Program-driven theory evaluation and program evaluation offer various research measurement tools designed for implementation by human service organizations, among others.^{16,48-50} In many ways, program evaluation employs the same principles and tools from qualitative and quantitative research, but with practical ways to employ them in the workplace.^{48,49} The authors used both closed-ended and open-ended questions in the survey. Interviews were conducted via videoconference call to ensure the health and safety of participants and researchers during the COVID-19 pandemic.

The researchers conducted qualitative interviews with seven of the 15 former CHP workers. The interviews included semi-structured questions and were confidential with no identifying information asked or recorded. This was to establish that the workers were providing an unbiased reflection as they were not employed in the CHP program at the time of the interview. The questionnaire included questions related to their experience serving as CHP workers, and their sense of well-being, inclusion, and resilience through engaging in a community-based health education initiative with the objective of improving health outcomes.

RESULTS ON EFFECTS OF COVID-19, HEALTHCARE, AND SPECIFIC NEEDS OF RAIS

Although the results are not generalizable given the scope of the study, they do provide a foundation for further study and development of health and mental health outreach programs for RAIs. For the purposes of this article, the results analyzed focused specifically on COVID-19, but are contextualized within the broader study as well as the research in this area. Given the consistent comments about how challenging the US healthcare system is, CHPs generally felt that this program helped them better understand and navigate the system as well as help their clients to navigate the system. One participant termed the US system as “challenging and cumbersome”, while another simply stated it was “horrible.” According to the study, it seems the CHP role in assisting newly arrived refugees and asylees was invaluable in helping refugees navigate

the complex healthcare system. The results of the study pertaining to COVID-19 are reported below.

Part I of the questionnaire

The first part of the questionnaire included closed-ended questions with probing focus on participant’s interest in being a CHP in the future, if the program had a negative or positive impact on their lives, and if participants felt they had an impact on the community as a CHP. Questions included “Since becoming a CHP, I feel that I have improved my ability to identify signs of common refugee health and mental health issues” and “Educating my community members through the CHP program helps me feel a sense of satisfaction.”

Part I questionnaire findings included participants reporting that being a CHP enabled them to access more specialist medical services. Additionally, each of the participants felt that they could access mental health support services more as well as they had a better understanding of common challenges refugees/asylees had with the healthcare system. Furthermore, participants felt a sense of satisfaction from educating their community member. Finally, each of the participants felt that the work they did was important to them, meaningful to the community, made a difference to their own personal families, and they felt valued as a CHP worker.

One participant, when asked if the CHP program increased self-confidence reported that because of COVID, they did not feel an increase in self-confidence. The respondent felt their confidence was decreased, not because of the actual CHP program, but because of lack of accurate and consistent information about COVID. The CHP stated, “Nobody knew any information on the virus. I had to search for answers, and I lost a lot of my confidence because of the COVID information not being good.” This seemed to be a commentary on the amount of inaccurate COVID-19 information and misinformation there was on the internet and through some media outlets. The respondent felt misinformation made their job harder despite having access to accurate COVID material received from the CHP training program. The CHPs had to dispel inaccurate or incorrect information

refugees were exposed to that created a sense of frustration.

Part II of the questionnaire: open-ended questions

The second part of the questionnaire utilized open-ended questions focusing on the experiences of the CHPs and any recommended changes they would make to the program in the future. The open-ended nature of the part II questionnaire illustrated a robust and in-depth narrative to the experiences and demonstrated a sense of pride in being a CHP during COVID-19. COVID-specific questions included: “From your perspective, in what ways did the coronavirus affect refugees and asylees?” and “In what ways did the coronavirus affect you?”

The second part of the questionnaire findings include rich discussions that illustrated the participants’ deep satisfaction in being able to relate to the hardships the more recently arrived refugees faced. The CHPs profoundly understand the journey to the US including the cumbersome and hard-to-access healthcare system that refugees face. As one respondent stated, “I’ve had challenges regarding getting a job. Being a community health promoter, I can share what I went through . . . I know people could learn from some of the mistakes that I made. Because I didn’t have information, you know, even when regarding healthcare, I couldn’t access healthcare.”

Given the consistent comments about how challenging the US healthcare system is, CHPs generally felt that this program helped them better understand and navigate the system as well as help their clients to navigate the system. One participant termed the US system as “challenging and cumbersome,” while another simply stated it was “horrible.” According to the CHP, it seems the CHP role in assisting newly arrived refugees and asylees was invaluable in helping refugees navigate the complex healthcare system. This finding is important as it relates to COVID. All participants indicated that COVID effected refugees and asylees regarding across the healthcare, getting accurate information, job loss, and childcare issues. Since RAIs tend to come over without financial means, job loss and no healthcare has significant impacts on mental health.^{4,51}

MOVING FORWARD: PROTECTING THE MOST VULNERABLE DURING EMERGENCIES

Based on the research findings and evidence-based and best practices working with the RAI population, the authors have specific recommendations for disaster mental health professionals and emergency management professionals. The practice recommendations integrate lessons learned from the small, program evaluation qualitative study the authors conducted.

1. Reflect on potential self-bias and past/historical context of RAIs. Providing disaster mental health counseling services, practitioners should explore personal capacity and willingness to dive deep into a client’s historical context, acknowledge and validate past traumas and racism, and validate the current realities and experiences of RAIs. Allowing space to explore, understand, respond with respect and compassion, deep listening, and building a path with clients can assist with healing and creating successful pathways.
2. Work with local and community-based organizations that work with the RAI community. This is a critical area regarding disaster mental health as community-based organizations have existing infrastructure, cultural and language capacity, and trust within the community. Community-based organizations are in a better position to provide health and mental health services and peer-driven psychoeducational programs such as the CHP. In addition, peers and community-based organizations can help break down barriers and stigmas associated with disaster mental health/mental health issues and services.
3. Educate and connect before the pandemic occurs during planning and mitigation activities. In the CHP program evaluation, all research participants indicated that continuation of community-health

programs makes a significant difference in reaching out to the RAI community. Based on the interviews, the program was valuable, successful, impactful, and necessary. Emergency managers and partners in disaster human services and mental health can prepare communication materials and establish Memorandum of Understanding (MOU) with appropriate agencies to ensure that information is provided in the appropriate language and given cultural considerations.

4. Continue to include training on health emergencies and pandemics. Given COVID and the “broken” US healthcare system, a CHP-type program is critical. As the pandemic unfortunately highlighted, the US healthcare system is inadequate and often there is misinformation disseminated by social media and other media outlets. Pandemics and other health emergencies will likely occur in the future. Having a team of trained CHPs who are trusted within the refugee community can not only prevent misinformation but help keep refugees safe, healthy, and indeed alive. In addition to the effects of the pandemic on the health and wellness of refugees, it has had a dire effect on the economy. RAIs have lost their jobs in addition to having to navigate a complex healthcare system. As one participant stated, “I think health-care and job security are very bad. This is a short-term and long-term problem.” The participant went on to say, “COVID has shown us how important public health is.”

5. Utilize peer models. All participants not only felt empowered by participating as a CHP but the peer exchange and intrinsic ability of CHPs to relate to clients is perhaps the most powerful and critical aspect of the program. Connecting to other RAIs enabled the CHPs to share their experiences for

the benefit of the clients. All participants felt positive about sharing their experience and one CHP even stated that it expanded compassion and empathy. One participant said, “It makes me feel useful to my community.... I feel like I’m making a mark and I’m improving my local community.... I feel [like I am helping] people to avoid some of the mistakes that I that I made. Some of the challenges that I went through.” This is a strength that should be utilized and incorporated into any disaster response.

6. Emergency managers have been aware for decades that vulnerable communities and population groups are adversely affected by disasters and harder hit than the general population. This means that more targeting planning, response, and recovery systems should take priority and be in place. Disaster mental health should be fully integrated into planning, response, and recovery efforts. Specific attention should be paid to vulnerable populations including RAIs and other special needs populations. In addition, disaster mental health training and response teams should be nationalized and well coordinated. A state-by-state response is disjointed, uncoordinated, and creates unacceptable levels of unequal resource sharing. States with more robust health and mental health services may fair better than states without access to health and mental health care.

CONCLUSION

The disjointed nature of the COVID response thus far has resulted in over 500,000 deaths, millions of people left with long-term health complications, job loss, and mental health and trauma; we have yet to fully understand as we are still in the throes of the pandemic. For populations, like RAIs, who were vulnerable economically and in terms of health and mental health prior to the pandemic, the layering effects of the pandemic can trigger past trauma and

anxiety about current and future survival and integration. It is not only critical to recognize the needs of specific vulnerable populations but also to recognize the economic, intergenerational trauma, and health and mental health need of disaster victims. This means, in part, being open to understanding their experiences with racism, violence, oppression, and not feeling/being safe as well as their dreams for a better life here in America; something we all want. It is critical to creating pathways to systemic change and to return to an emergency management system that works. This includes an integrated Incident Command Structure and a robust health, mental health, and human service disaster response system. This is mental health wellness in the truest sense; this is our charge as emergency managers and disaster mental health professionals.

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