A PTSD Decision-Making Tool for Community Support Personnel and Primary Care Physicians Tending Refugees in the GTA

TOOL KIT

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In 2015, the Liberal government announced a decision to resettle 25,000 Syrian refugees. Many of these Government-Assisted Refugees (GARs) fled extreme trauma in Syria during the ongoing conflict. Consequently, GARs are at high risk of developing a spectrum of mental health (MH) disorders. The majority of interactions refugees have during the resettlement process occur with commun ity support personnel (CSP) from a range of professional and educational backgrounds. Therefore, CSP interacting regularly with GARs could perform non-clinical risk assessments for Mental Health (MH) concerns, particularly post-traumatic stress disorders (PTSD).

Our group collaborated with the Canadian Council for Immigrant and Refugee Health (CCIRH) in Ottawa, and a MH research group at St. Michael Hospital in Toronto to develop a toolkit for frontline CSP to assess risk of GARs for PTSD, particularly after exhibiting signs of anxiety and adaptive malfunctioning. The toolkit includes a series of questions to triage GARs into different risk categories based on symptoms and adaptive functioning, and a corresponding action plan that is customizable for regional refugee resources.

The tool will be used by our collaborators for further evaluation and implementation. This toolkit will facilitate access to support and services for refugee wellbeing and adaptability in the long run.

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Please note, the project team independently managed the development and production of this Tool Kit and, thus, editorial independence is retained.

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1.0 - Introduction

The Liberal announcement to re-settle 25,000 Syrian refugees in Canada has created a unique mixture of challenges and opportunities for the Citizenship and Immigration Canada as well as its numerous partners. Waves of refugee resettlement into Canada are not new, but a wave of this scale and in such a compressed timeline is unprecedented. The Syrian refugee crisis has extended for a number of years now, and the data available from Europe has provided Canada with data about the potential needs of incoming communities. One public health concern identified in the recent European data is that the MH needs of refugee communities is a priority, especially in the area of Post-Traumatic Stress Disorder (PTSD).

The Canadian Mental Health Association (CMHA) states that: "*Frightening situations happen to everyone at some point. People can react in many different ways: they might feel nervous, have a hard time sleeping well, or go over the details of the situation in their mind. These thoughts or experiences are a normal reaction. They usually decrease over time and the people involved can go back to their daily lives. Post-traumatic stress disorder, on the other hand, lasts much longer and can seriously disrupt a person's life.*" (CMHA, 2012)

Looking at global trends of refugees who have resettled in western countries, a systematic review of mental disorders in refugees asserted that PTSD is prevalent in 1 in 10 individuals; major depression in 1 in 20; and general anxiety disorder in 1 in 25 with the consideration that there may be concurrent comorbidities with these disorders (Fazel, Wheeler, & Danesh, 2005). According to the same systematic review, refugees of the same settlement groups are ten times more likely to have PTSD when compared to populations groups of the same age in Western countries (Fazel et al., 2005). As such, these groups of studies have estimated that tens of thousands of individuals resettled in Western countries (both current and former refugees) are likely to have PTSD.

American data suggest that approximately 50,000 out of roughly 500,000 refugees living in the United States have PTSD, while some Canadian data have recorded the prevalence of PTSD in refugees at 9% (Rousseau, Pottie, Thombs, Munos, & Jurcik, 2011). Based on world mental health surveys, the WHO estimates the rates of mild or moderate mental disorders, of which PTSD is one, to be 10% prior to an emergency, and 15-20% after an emergency based on a 12-month prevalence (2015). Among Syrians, PTSD is identified as one of the emotional disorders that is most prevalent and significant (UNHCR, 2015). The UNHCR reported that among Syrian refugees referred for resettlement, 43% were submitted under the Survivor of Violence and/or Torture category (2015). Thus, despite the lack of quality data to illustrate the prevalence of Syrians who have entered Canada with a formal PTSD diagnosis, it can be expected that upon resettlement this may frequently arise.

While refugees experience distress, not all will develop poor MH (WHO, 2010). Traumatic events increase risk factors for MH outcomes in refugees; however, refugee MH has shown to be greatly impacted and/or exacerbated in the case of existing conditions by stresses experienced during the resettlement period in the the new host country. Hence, facilitating the resettlement process may have long-term impacts on refugee MH.

2.0 Literature Review

2.1 Historical Context of Refugees in Canada

The Canadian refugee program has been granting refuge to upwards of 10,000 asylum seekers annually and has expanded by 20% for three years since 2011 (CIC, 2015). Past waves of refugees include Polish, African and Middle Eastern Jews, Ukrainians, Central and Eastern Europeans, Latin Americans, Cambodians after the Vietnam war, Thai refugees, and more recently, a wave of Syrian refugees (CIC, 2015).

2.1.1 The Syrian Migrant Crisis

Syrian refugees currently, by far, constitute the largest group of refugee claimants in the European Union, exceeding countries with ongoing conflict, such as Iraq and Afghanistan. The conflict began in 2011 with the Arab spring uprising against the regime of Bashar Al-Asaad and is now reported to be the largest refugee displacement in current times (BBC, 2016). It has gradually progressed into a civil war between the proponents and opponents of the regime, and more recently started to acquire sectarian overtones (Landis, 2013). By 2015, the death toll gradually increased to 250,000, with approximately 4,000,000 people now located in internally displaced persons' camps inside or outside the Syrian borders. Nonetheless, the conflict only received major international coverage after the heightened number of Syrian citizens entering Europe, arriving primarily through Greece and Turkey.

2.2 Mental Health and Trauma in Refugees

2.2.1 Determinants of Refugee Mental Health

Much like physical health and the social determinants associated with it, MH is determined by psychosocial, personality, and biological factors (CAMH, 2016). *Mental health* is defined by the World Health Organization as "...a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make contribution to his or her community" (WHO, 2001, p.1); whereas *Mental Illness* is defined by the Public Health Agency of Canada as a "recognized medically diagnosable illness that is characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning" (PHAC, 2015). As such, an individual may suffer from poor MH in the absence of mental illness due to external stressors, and the same can be true for individuals who experience good MH while living with a mental disorder. This distinction is important when determining the state of MH of refugees.

2.2.2 Risk Factors and Vulnerable Groups

Risk factors for MH issues among refugees can be categorized according to pre-migration, migration, and post-migration stages, although factors may overlap or be common across each stage (CAMH, 2016). Understanding responses to stress and/or trauma requires awareness of personal and sociocultural factors, as well as, the vulnerabilities of different demographic groups.

Particularly vulnerable groups include women, children, elderly, people with disabilities, and those with pre-existing or current mental illness. Specific factors that influence the severity of MH problems include nature of trauma experienced (e.g., sexual violence, torture, imprisonment, internment in refugee camps, or multiple losses), duration of trauma, and number of occurrences experienced (WHO, 2003; WHO, 2008).

Risk and protective factors during pre and post-migration stages help demonstrate the vulnerabilities of individuals and their needs to prevent or mitigate the onset of MH problems as they arrive into a new country. These are important when considering resources and types of services to provide stability and safeguard against negative outcomes. Table 1 outlines some of the aforementioned factors that influence the state of MH in individuals.

Risk factors	Protective factors
Imprisonment	Economic security
Death of a family member	Access to support services
Poverty/economic insecurity	Educational opportunities
Isolation	Supportive family
Experiences of racism	Participation in community groups

Table 1: Risk and Protective Factors for addressing mental health and supportive environments in Refugees (Source: CAMH, 2012)

Individuals identified as having a mental illness often choose to prioritize their immediate socioeconomic needs over medical or psychiatric interventions. These include securing housing, employment, or establishing their children in school systems (Watters, 2001). Thus, long term adaptive functioning is of significant consideration to address the state of an individuals' MH and the support systems they may require. Upon consultation with the Toronto Distress Centre, the staff indicated that they tended to notice more crisis calls from refugee populations in the years following the resettlement process rather than immediately upon arrival into the country (Toronto Distress Centre, personal communication, 2016).

3.0 Resources and Tools for Mental Health Support for Refugees

3.1 Existing Healthcare Resources for Refugees

It can be challenging to navigate numerous health resources providing supporting services to refugees arriving in Canada. Within Ontario, there are many programs funded by the Ministry of Health and Long-Term Care (MOHLTC), as well as, many others offered by nonprofit community-based organizations available in large urban centers. In some circumstances, due to differences in funding models, the resource network is fractured or disconnected. Therefore, an Ontario Health Insurance Plan (OHIP)-funded resource may not refer clients to a non-OHIP funded nonprofit community organization. As a result, despite numerous services available for refugees, Ontario lacks an accessible central tool to navigate these resources in major settlement areas. Currently, access to the majority of available MH services requires a primary care referral or a previous clinical diagnosis, resulting in prolonged wait times. In reality, the bulk of interactions with refugees at risk of MH challenges occurs at the community level and not at the clinician level, highlighting the requirement for creative, innovative, and accessible MH assessment tools and support options for CSP.

3.2 Initiatives in Mental Health for Refugees

3.2.1 University of Ottawa- Summer Institute for Refugee Health

Dr. Kevin Pottie is an Associate Professor in the Bruyère Research Institute at the University of Ottawa in the Departments of Family Medicine, and Epidemiology and Community Medicine. In addition, he serves as a consultant for the World Health Organization (WHO) and the European Centre for Disease Prevention (ECDP) at the European Union (EU) level. Dr. Pottie is the founder of the Canadian Collaboration for Immigrant and Refugee Health (CCIRH), which provides e-Learning modules for cultural competencies, information on Refugee Health, outreach programs, guides for clinicians, as well as a National Summer Institute in Refugee Health. The latter is a one-week leadership program for pre-clinical medical students that blends training in cultural competencies with community prevention outreach programs at a shelter for Government-Assisted Refugees (GARs) (Pottie & Hostland, 2007). The objectives of this unique program are to combine social accountability training with health advocacy and community-based education, engage in community shelters for GARs, and assist newly arrived refugees with relevant community activities (Pottie, 2007).

Until recently, the program has focused its annual training events on three areas:

- The development of a "health passport" for new refugees
- A food and nutrition module which focuses on shopping, nutrition, and assisting with food preparation in a new environment
- Working with medical interpreters

The program has been lacking a module on MH concerns in the refugee population and an effective way to engage in this conversation when doing community service work. Every year, students encounter difficult situations and crises that they struggle to handle as they lack the necessary tools to understand, identify and manage MH crises among the refugee population that they are working with.

With the recent influx of Syrian refugees and the known statistics for MH challenges identified in this population, along with data and lessons learned from the European experience, finding user-friendly MH resources and tools for community support personnel (CSP) has become an important priority area.

3.2.2 Narrative Exposure Therapy (NET) Guided Approach for Trauma

Narrative Exposure Therapy (NET) is a culturally universal intervention for the treatment of survivors of multiple and severe traumatic events. It was developed in Germany nearly 25 years ago, and has been used to treat PTSD effectively among people in refugee camps in Africa and Asia as evident in over ten years of research. It is only beginning to be recognized in North America (Robjant & Fazel 2010) and was introduced in a pilot pandomized-controlled trial in Toronto 2014 by Dr. Morton Beiser at St. Michael's as part of the Centre for Urban Health Solutions. NET focuses on organizing the traumatic events in the context of an individual's life through narratives, any re-imagining the events. It is designed to be a short-term treatment (6-8 sessions) (Shauer, Neuner, & Elbert, 2011) and involves emotional exposure to the memories of traumatic events and the reorganization of these memories into a coherent chronological narrative (Robjan & Fazel, 2010). NET is not designed to "cure" PTSD, but rather to minimize Post traumatic stress symptoms and to assist the individual with improving their day-to-day functioning (Gwozdziewycz & Mehi-Madrona, 2013).

One unique feature of NET is that it does not require a clinical degree. It can be learned in a relatively short period of time (approximately 4 days of intensive training), and the therapy can be provided to refugees without having to go through the long waiting list to see a MH specialist. Multiple studies have demonstrated the effectiveness of NET (Gwozdziewycz & Mehi-Madrona, 2013) not only for diminishing the symptoms of PTSD, but also demonstrating changes in neurobiological responses (Adenauer, Catani, Gola, Keil, & Ruff, 2011). These neurobiological changes are demonstrated over the long-term suggesting that NET therapy does in fact alter the brain's response to previous triggers on a permanent basis even after a short course of therapy (Adenauer et al., 2011). Another unique feature of NET is that it can be adapted to screening for PTSD to contain the re-exposure ensuring minimal risk. It is this guided NET approach that guides this tool kit.

4.0 Method/Approach

This tool kit originated from the need for effective means of assessing and identifying the risk of PTSD in the adult refugee population beyond the clinician context. The objective of the tool kit is to develop a non-clinical PTSD risk assessment toolkit for groups working closely with refugees.

4.1 PTSD Risk Screening Toolkit

Dr. Morton Beiser, in Toronto is a psychiatrist and an epidemiologist who has dedicated decades of research to the fields of immigration and resettlement. Dr. Anne Mantini, a Research Associate at St Michael's Hospital (Centre for Urban Health Solutions, Li Ka Shing Knowledge Institute) and Dr. Kevin Pottie worked closely with the University of Waterloo MPTT group in the design of the PTSD Risk Assessment Tool for Refugees.

This PTSD tool kit includes five components including:

- PTSD Risk Screening Tool
- Guide to PTSD Risk Screening Tool
- Action Plan and Resource Map
- PTSD Checklist - Civilian Version (PCL-C)- U.S. Department of Veteran Affairs, National Center for PTSD
- Centre for Addiction and Mental Health (CAMH) PTSD Fact Sheet

The assessment tool, guide, and action plan and resource map were designed in collaboration with key consultants. Each component is described in more depth below with the respective document in the appendices.

4.1.1 PTSD Risk Screening Tool

The PTSD Risk Assessment tool (Appendix I) is an algorithm to aid the CSP (Community Service Provider) in assessing the refugee's level of risk for PTSD. The tool is meant to guide conversations between the CSP and refugee surrounding previous experiences of traumatic events, the symptoms of stress exhibited and ability to function in daily life. It ultimately groups individuals into one of four categories of risk: low, medium, high, and very high. Each risk category has a corresponding action plan that directs the CSP to a resource map that can guide referrals.

4.1.2 Guide for Use of Screening Tool

The guide (Appendix II) is intended to provide additional information and clarification for the individual administering the assessment tool. Within the tool, key components are indicated numerically, which match a corresponding section on the guide that provides further elaboration. This is to help ensure understanding and accurate completion of the tool. The guide also highlights the importance of key competencies required of the CSP before use of the tool. These competencies are crucial to the effectiveness and sustainability of the tool.

4.1.3 Action Plan and Resource Map

The action plan portion of the toolkit (Appendix III) provides an outline of recommendations for each of the four "risk" categories: low, medium, high, and very high. The recommendations provide the end-user with the necessary steps to address these risk categories that are specific to their location and context. The action plan table further develops each risk category into three steps: "immediate actions", "considerations", and "follow-on actions". It is expected that the flow and approach to each step will be determined by the way in which the end-user community support organizations using the tool have laid out their own supervisory system and local resources.

Within the resource map resources are classified into four categories to organize where each resource may fit into the action plan. These categories are: Crisis Services, MH-specific resources, Primary Care resources, and Cultural and Resettlement-Specific resources. The intent of the resource map is to provide a customizable document that different community organizations can modify to meet their local requirements. This current version has focused on key resources in the Greater Toronto Area (GTA).

4.1.4 PTSD Checklist - Civilian Version (PCL-C)

The PTSD Checklist- Civilian Version (PCL-C) (Appendix IV) is a public, free-access document that includes a list of questions corresponding to the four PTSD-related symptom clusters included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). This checklist provides the CSP with more specific questions to ask refugees in the symptom cluster section of the assessment tool.

4.1.5 Centre for Addiction and Mental Health (CAMH) PTSD Fact Sheet

The CAMH PTSD Fact Sheet (Appendix V) provides key facts about PTSD in plain language. It is included in the toolkit to provide the CSP with a quick reference to key terms and subject matter.

5.0 Results

The tool is intended for CSP who encounter refugees irrespective of formal prior clinical training, and includes a Risk-Assessment Tool (Appendix I), as well as an explanation guide for the CSP administering the tool (Appendix II). The assessment tool triages refugees into different categories of PTSD risk, and outlines intervention steps to be taken by the CSP. The five-part toolkit includes a succinct map of general resources, along with an action plan including specific interventions for the different degrees of risk assessed by CSP (Appendix III). Two publically available documents are also appended to the toolkit: a civilian version PTSD Checklist to guide the assessment of symptom clusters (Appendix IV), and finally, a PTSD Fact Sheet publically available through CAMH (Appendix V). To accompany the resource map, an expanded guide of GTA organizations, is included with the intake eligibility criteria that qualifies refugees for service access, relevant contact information, and cost and/or coverage under OHIP or Interim Federal Health (IFH) programs (Appendix VI).

6.0 Discussion

6.1 Strength of Approach

The toolkit addresses a clear gap in the scope of public services offered to resettling refugees, which is a risk assessment of PTSD through frontline CSP. Identification of possible PTSD traditionally requires interaction with skilled clinical staff, whereas the majority of resettlement interactions with refugees occurs through community personnel, such as volunteers assisting refugees with forms, or interpreters from ethno-specific NGOs. The services of these organizations are traditionally offered through staff and volunteers, without specialized clinical training. The toolkit assists in triaging at-risk refugees into appropriate and accessible MH support services. The second advantage of the toolkit is that the action plan and resource map help consolidate resources available locally, and it can be customized for the region and organization involved. By understanding and consolidating locally available resources, it is easier to ensure that the best resource is offered at the right time to those who need them. The resource map also offers an avenue for these disconnected organizations to coordinate their support efforts to refugees and build stronger and more effective ties between groups interested in the promotion of MH wellbeing of refugees fleeing highly traumatic situations.

6.2 Limitation of Approach

The toolkit is a novel approach to the assessment of PTSD risk by a CSP. There are several challenges between the development and implementation of the approach including but not limited to: the assessment of reliability and validity of the tool, uptake by the intended population of CSP, outreach to the intended population of refugees, generalizability of the approach to different waves of refugees, and finally, the sustainability and quality assurance of the program in the long run.

7.0 Conclusion

The aim of this tool kit is to address a gap in trauma assessment for refugees and to empower frontline community support personnel to conduct PTSD risk assessments in their interactions with the refugees during the resettlement process. The goal of this tool kit is to ultimately improve the early detection of PTSD in this vulnerable population, triage them to the useful resources, and lead to improvement in refugee mental health.

8.0 Acknowledgements

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Appendix I: Post-Traumatic Stress Disorder Risk ScreeningTool for Refugees

Competencies for Administering Assessment Tool[1]

a. Cultural Competency and Sensitivity Training
   - Understanding of refugee experience (i.e. years in camp, age of resettlement, literacy in their own language)
   - Cultural backgrounds
   - Norms and traditions

b. Gender Appropriate Third Party Interpretation Services
c. Gender Equity Training
d. Anti-Oppressive Training
e. Trauma-Informed Approach
   - Understanding of unique experience

f. Active Listening Skills
g. Mental Health First Aid training (or equivalent)

Initial Assessment by PCP/CSP

Does the individual express emotional, physical concerns?

YES

NO → Resume intake and evaluation of other needs.

Critical 1st Step[2]

Has the individual been exposed to a potentially traumatic event (TE) (i.e., experienced or witnessed) or has been diagnosed with Post-Traumatic Stress Disorder (PTSD)

Assess Trauma Exposure[2]

NO → Does the Individual have a pre-existing non-PTSD mental health condition[4]

YES → Provide mental health resources[3]
Refer to Primary Care to stabalize
Ensure basic physical needs are met
Monitor individual symptoms

NO → Refer to Resettlement Services and provide Primary Care referral if required for immediate needs[3]

YES

Assess briefly on general appearance and behaviour.
Does individual demostrate one or more of the following markers?[5]

Physical Observation:
- Unexplained or vague somatic complaints (e.g. headache, muscle aches, fainting, unexplained pain)
- Scars/deformities
- Flat demeanor/inattentive
- Indicators of fear (e.g. tone of voice, body language)

Psychological Observation:
- Behaviours: risk-taking, social withdrawal, incoherent communication, anger
- Dependencies: substance abuse
- Evidence of possible Psychosis

NO → **Confirm for Risk Factors? [6]**
- Female
- Resettlement barriers
- Domestic violence
- LGBTQ

Assess environment for ongoing threats

YES

Reassure that reactions to trauma are normal and recovery is possible[7]
Remind individual that their safety and comfort will always come first

Critical 2nd Step

Has individual experienced 3 or more of the following symptoms in these symptoms clusters for more than 1 month?[8]

Intrusion	Avoidance	Negative Alterations in cognition/mood	Alterations in Arousal and Reactivity
a. Recurring nightmares, flashbacks	d. Avoid people, places, things	f. Loss of interest	h. Exaggerated startle response
b. Intrusive memories/image fragments	e. Avoid thoughts/conversation	g. Social withdrawal	i. "On guard" all the time
c. Physiological/Psychological reactions to reminders			j. Irritability or angry outbursts
			k. Difficulty sleeping, concentrating

NO → (back to Confirm for Risk Factors?)

YES

Critical 3rd Step

PCP/CSP to assess level of intervention needed.

Does individual have recent/current suicidal thoughts and/or thoughts of harming self/others

YES

NO

Assess functional status:
Are symptoms interfering with your daily life?[9] (i.e. Self-care, Relationships, Work)

0 | 1 | 2 | 3+

Level of Risk for Action

Low	Medium	High	Very High
Action: Educate	**Action: Support**	**Action: Intervene**	**Action: Stabilize**
1- Provide information about PTSD	**1-** Provide PTSD or mental health agency resources	**1-** Refer to mental health agencies for psychiatric evaluation	**1-** Seek immediate attention (e.g., call 911, contact mobile crisis unit, distress and crisis line)
2- Initiate Community Care and Primary Care Referrals	**2-** Alert Health Care Providers	**2-** Recommend evidence-based treatments (e.g., NET, tf-CBT, EMDR) and/or medication	**2-** Alert Health Care Providers
3- Suggest cultural support groups or community resettlement supports	**3-** Support with skilss for stress management	**3-** Continue case management	**3-** Continue case management
	4- Repeat screen withim 3-6 months		**4-** Follow-up with intervention

Appendix II: Guide to PTSD Risk Screening Tool

Guide to Post-Traumatic Stress Disorder Risk Assessment Tool for Refugees

Examples of Required Competencies for Primary Care Provider (PCP) or Community Support Provider (CSP) [1]

- Establish safe space
- Assess need for interpreter; if needed, emphasize confidentiality, discuss goal of assessment tool
- Emphasize confidentiality
- Anti-oppressive practice: acknowledging oppression in societies, cultures, groups, and removing influences of that oppression (e.g., be sensitive that refugees may mistrust CSPs from negative past experiences with authority)

Link to Refugee and Global Health e-learning modules: http://ccirhken.ca/ccirh_main/sample-page/page2-2/

Critical 1st Step[2]

- Anyone suffering from Post-Traumatic Stress Disorder (PTSD) has either witnessed or experienced a Traumatic Event (TE)
- Assess Trauma Exposure: examples include (but are not limited to): community conflict, war conflict (e.g. military combat or peacekeeping, war crimes, torture, a civilian war zone), rape or physical assault (including childhood abuse and relationship violence), abuse

Primary Care – Community Care Referral[3]

- Refugees may have conditions/symptoms that they do not readily share
- Issues may emerge several months to years later after resettlement
- It is imperative to ensure health and support resources are made available

Pre-existing non-PTSD mental health condition[4]

- Co-morbid psychiatric disorders may occur in people with PTSD including: major depression, anxiety, substance abuse, paranoia, bipolar disorders, etc.

Physical and Mental Health Observation Markers [5]

- This section is NOT meant to be diagnostic. It is meant to guide the PCP/CSP with examples of markers to be aware of through conversation with refugees (e.g., unexplained somatic (physical) complaints, disturbing thought processes, psychosis such as hallucinations, delusion, paranoia)
- Stress-related somatic complaints are prevalent among refugees with PTSD. Stigma surrounding mental disorders can worsen somatic complaints.

Risk Factors[6]

- PCP/ CSP should be aware that these are significant risk factors for PTSD, as these are typically more vulnerable populations that are less likely to disclose concerns.

Reassure that reactions to stress/trauma are normal[7]

- Crucial to provide information about trauma and its impact on health
- PCP/CSP should emphasize that many symptoms that refugee may be experiencing can be NORMAL reactions to past stressful events minds)

Common Refugee Experiences:

- Persecution, war, trauma
- Long distance from family members
- Difficulties due to language barrier
- Difficulty adjusting to North American culture
- Difficulty understanding educational, heath care and legal systems

Common Reactions to Experiences:

- Feeling sad, crying often, changes in appetite, difficulty sleeping, losing interest in things they once enjoyed
- Worrying about jobs, health or life in new country
- Suffer from physical symptoms such as headaches, dizziness or restlessness
- Nightmares about war or trauma
- Difficulty keeping bad memories out of their minds
- Avoiding things that remind them of negative past experiences
- PCP/CSP should use this opportunity to validate these reactions, and communicate to refugee that support and resources are available (which will be determined on completion of assessment)

Symptom Clusters[8]:

Per Diagnostic and Statistics Manual (DSM-V), four symptom clusters are associated with PTSD:

- Intrusion
- Avoidance/Numbing
- Negative Alterations in Cognition/Mood
- Alterations in Arousal/Reactivity

Examples of symptoms include: recurrent disturbing dreams/flashbacks related to TE; avoidance of activities/people associated with TE; detachments/estrangement from others; trouble falling/staying asleep; feeling irritable; feeling jumpy/easily startled

Adaptive Functioning[9]:

Refers to how the PTSD symptoms (from the 4 DSM-V symptom clusters) affect daily function, including:

- self-care (e.g., bathing, grooming, cooking, caring for children)
- relationships (e.g., feeling distant/cut-off from other people)
- work (e.g., performance, attendance, job retention)

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.) Washington, DC: AuthorBeiser, M. & Mantini, A. (2016). Clinical Practice Guideline for Management of Post-Traumatic Stress in Refugee Adults. Unpublished manuscript.

Appendix III: Action Plan and Resource Map

		LOW RISK (prevention)	MEDIUM RISK	HIGH RISK	VERY HIGH RISK (emergency)
STEPS	**Immediate Actions**	• Summarize assessment status • Provide information about available MH resources • Provide information about Post Traumatic Stress Symptoms (PTSS)* • Address any immediate needs related to resettlement	• Provide PTSD information* • Provide information about MH resources • Reassurance that symptoms can be normal reactions to trauma	• Referral for MH case management/ intake for psychiatric evaluation and therapy intervention. • Provide information about PTSD* • Provide information about Distress and Crisis Lines that are available. • Discuss acute symptom management • Ensure primary care access	• Advise refugee of plan and reassure them of support available. • Consider use of Distress Line or Crisis Line for further risk assessment. • Access mobile crisis unit or other mental health resources if immediately available • Call 911 if situation is difficult to manage or obvious immediate danger.
	Considerations	• Emphasize normalization • Settlement concerns may be prioritized by individuals (i.e. housing, school enrolment for children, employment etc). • Emphasize importance of self-care (eg. proper nutrition, regular sleep, exercise, social relationships, spiritual needs)	• Emphasize normalization • Settlement concerns may be prioritized by individuals (i.e. housing, school enrolment for children, employment etc). • Emphasize importance of self-care (eg. proper nutrition, regular sleep, exercise, social • relationships, spiritual needs)	• Emphasize normalization • Cultural sensitivity regarding MH issues. • Emphasize importance of self-care (eg. proper nutrition, regular sleep, exercise, social relationships, spiritual needs)	• Cultural sensitivity regarding MH issues. • Ensure safety of refugees at all times. • Consider childcare/dependent requirements • Continuity of contact/follow up contact
	Follow on Supports	• Refer to appropriate community based services • Refer to primary care if needed	• Refer to psychiatrist support and primary health care provider to ensure acute symptom • management • Refer to appropriate community based services of interest • Ensure access to distress line inf. • Facilitate social supports	• MH resources can include Narrative Exposure Therapy (NET), Cognitive Behaviour Therapy (CBT) and cultural-specific therapy using trauma informed approaches. • Facilitate social supports	• Ensure refugee is linked with a primary care system and social supports are accessible
RESOURCES LOCATED IN THE GTA *(For further resources with details please refer to Table)*	**Crisis Services**	**Toronto Distress Centre** ⟶ 416-408-HELP (4357)	**Gerstein Crisis Line** ⟶ 416-929-5200	**Emergency** ⟶ 911	
	Mental Health Services	**Mental Health helpline** ⟶ 1-866-531-2600 **CAMH general information** ⟶ 416-535-8501, select 2 **CAMH - New Beginnings Clinic Info Line (Refugee specific service)** **LINK TO CAMH INFO ABOUT PTSD* https://	**Access Point (Central Intake system)** ⟶ 416-640-1934 **Canadian Center for Victims of Torture (CCVT)** ⟶ 416-363-1066 ⟶ 416-535-8501 ext. 31683 www.camh.ca/en/education/about/camh_publications/Documents/Flat_PDFs/Posttraumatic_stress.pdf		
	Primary Care	**Community Health Centres specifically serving Refugees:** **Access Alliance** ⟶ 416-324-8677 **Crossroads Clinic at Women's College Hospital** ⟶ 416-323-6400 **Refugee Health Line** ⟶ 1-866-286-4770 **The Canadian Centre for Refugee and Immigrant Health Care** ⟶ 647-267-2176	**Website to search for another Community Health Centre** https://www.aohc.org/find-a-centre **Website to search for a Family Health Team** http://www.health.gov.on.ca/en/pro/programs/fht/fht_progress.aspx		
	Culture-Specific Resources & Resettlement Services	**Arab Community Centre of Toronto (ACCT)** ⟶ 416-231-7746 **Christie Welcome House** ⟶ 416-588-9277	**Sojourn House** ⟶ 416-864-9136 **COSTI** ⟶ 416-658-1600		

Appendix IV: PTSD Checklist - Civilian Version (PCL-C) - U.S. Departemnt of Veteran Affairs, National Center for PTSD

PTSD Checklist – Refugee Version

Instruction to PTSD Screener: Below is a list of problems and complaints that are associated with experiencing stressful life events. Please read each one carefully to the Refugee and put an "X" in the box to indicate how much the Refugee has been bothered by that problem in the last six months.

Symptom Cluster	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quit a bit (4)	Extremely (5)
Intrusion	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
	Repeated, disturbing *dreams* of a stressful experience from the past?					
	Suddenly *acting* or *feeling* as if a stressful experience were happening again (as if you were reliving it)?					
Avoidance	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
	Trouble *remembering important parts* of a stressful experience from the past?					
	Feeling *distant* or *cut off* from other people					
	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
Negative Cognitions and Mood	Loss of *interest in things that you used to enjoy*?					
	Feeling as if your *future* will somehow be *cut short*?					
Arousal/ Reactivity	Feeling *very upset* when *something reminded you* of a stressful experience from the past?					
	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
	Trouble *falling* or *staying asleep*?					
	Feeling *irritable* or having *angry outbursts*?					
	Having *difficulty concentrating*?					
	Being *"super alert"* or watchful on guard?					
	Feeling *jumpy* or easily startled?					

Modified from PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

Appendix V: Centre for Addiction and Mental Health (CAMH) PTSD Fact Sheet

camh Centre for Addiction and Mental Health

Did you come from a country affected by war, political conflict or disaster?

Do you have
sleep problems
nightmares
unwanted memories
forgetfulness
relationship problems?

Do you feel
worried
restless
guilty
sad
tired
less pleasure
angry
fearful?

IF YOU SAID YES TO MOST OF THE QUESTIONS ON THE FRONT OF THIS BROCHURE, YOU MAY HAVE PTSD (POSTTRAUMATIC STRESS DISORDER).

WHAT IS PTSD?

PTSD is a natural emotional reaction to terrible experiences that involve actual or threatened serious harm to oneself or others. These types of experiences are called "traumatic." Examples of traumatic events are bombings, rape, torture, death or disappearance of family members or friends, being forced to leave your home or seeing another person harmed or killed. Other examples of traumatic events are hurricanes, floods or earthquakes. Experiencing any of these events can cause PTSD.

Before coming to Canada, some people—particularly those who have come as refugees—may have lived through events like these.

Everyone faces difficult situations. Often we think about them long after the event. But for some people, the thoughts or memories of these horrible events seriously affect their lives, long after any real danger has passed. This is PTSD.

PTSD can affect anybody, including children. PTSD usually appears within three months of the event. But sometimes symptoms may not appear for years.

SYMPTOMS OF PTSD

Reliving the horrible experience over and over

- having nightmares that keep coming back
- having unwanted, disturbing memories of the event
- acting or feeling as if the event is happening again
- feeling upset when you are reminded of the event

Avoiding reminders of the event

- avoiding activities, places or people that remind you of the traumatic experience
- avoiding friends and family

Losing emotions

- losing interest in activities you used to enjoy
- experiencing difficulty having loving feelings
- losing ability to feel pleasure

Always feeling that something bad is about to happen

- constantly worrying
- having a hard time concentrating
- getting angry easily
- having trouble falling or staying asleep
- fearing that someone will harm you
- having sudden attacks of dizziness, fast heartbeat or shortness of breath
- having fears of dying

DO PEOPLE OF DIFFERENT CULTURES AND AGES HAVE THE SAME PTSD SYMPTOMS?

The symptoms of PTSD are the same in all cultures. But how these symptoms are described and expressed can change from culture to culture. Children and adults may not show the same signs of PTSD. Children respond differently to traumatic events, depending on their understanding and age.

WHY DO BAD MEMORIES KEEP COMING BACK?

Due to the extreme stress connected with a traumatic event and the memories of the event, the mind tries to defend itself by pushing thoughts and feelings deep inside. While bad memories may go away for a time, the mind still needs to deal with the feelings. If they are not dealt with, the feelings come back as other physical and emotional problems.

WHY DO I ALWAYS FEEL THAT SOMETHING BAD IS GOING TO HAPPEN?

People who have been through life-threatening events may stay on high alert. These people feel tense much of the time. They react as though there is danger, even when there is no danger. Their bodies react this way to make sure that they won't miss any sign that such an event may occur again. People with PTSD are not able to control feelings of wanting to run away, wanting to defend themselves or wanting to be prepared for something terrible or painful.

Could my health problems be related to PTSD?

Other problems often come with PTSD. Many people get depressed. Some people may get dizzy, have chest pain or stomach problems or get sick often. Other people with PTSD use alcohol or other drugs to help them deal with symptoms. This can develop into a serious problem.

Dealing with new stresses may be harder for a person who has experienced a traumatic event. New situations can bring back old memories or feelings. For example, a short power outage might bring back terrible memories and feelings for a person who has lived through power blackouts during war.

Often people seek help from their doctor for illnesses or emotional problems without realizing that the problems may be linked to PTSD. Yet getting help for PTSD often improves the other problems.

Could PTSD be affecting my relationships?

Symptoms of PTSD can make it hard to get along with people. This can lead to problems with family, friends and co-workers. When a person constantly worries or feels guilty, has poor sleep patterns, uses alcohol or other drugs, or has no feelings, these issues can strain relationships. It's hard to be with a person who seems to get angry for no reason or who often gets into bad moods. It's also hard to be with a person who will not go out or take part in social events.

The good news is that there are effective treatments!

What help is available?

People can recover from PTSD. Some recover in six months, while others take much longer. Everyone's experience is different. The same event may be more traumatic for some people than for others.

Counselling or therapy

Trauma counselling or therapy can be done one-on-one or in a group, and can be very helpful for people with PTSD. Family counselling and individual treatment can help with relationship troubles.

Medication

Psychiatrists and family doctors can prescribe medication for depression, nervousness and sleep problems (common in people with PTSD). Medication works best when a person is also in counselling.

Where can I find help?

If you have signs or symptoms that might be PTSD, there are people who can help you find the support you need.

Contact:

- your settlement agency
- a family service agency
- a community mental health agency
- a counsellor or therapist
- your family doctor
- a community health centre
- a religious leader
- your workplace employee assistance program (EAP).

ADDITIONAL RESOURCES

- Search for "PTSD" on CAMH's website at **www.camh.ca** for more information on PTSD and trauma.
- Search for "multi-lingual brochures" on the Canadian Mental Health Association website at **www.cmha.ca** for online mental health brochures in many languages.
- Call the Canadian Centre for Victims of Torture at **416 363-1066**. Or visit their website at **www.ccvt.org** for services and referrals available to refugees and immigrants.

For more information on addiction and mental health issues, or to download a copy of this brochure, please visit our website: www.camh.ca

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camh Refugee Mental Health Project

To learn more about
Addressing trauma: the effective use of narrative exposure therapy (NET) for refugee clients

https://www.porticonetwork.ca/web/rmhp/participate/webinar-series/2016-2017/mantini

Appendix VI: Table of Resources for the Greater Toronto Area

Organization/Agency	Contact	Eligibility	Programs/ Services available	Partnerships with organizations	Intake/ Referral Process	Cost if any	Interpret. if available	Wait time
CRISIS SERVICES								
Toronto Distress Center	416-408-HELP (4357)	24/7 call center self-referral	Suicide hotline - crisis line with a physician on subway. Ontario-wide crisis chat/text service 2pm-2am, call-out program for seniors referral or self-referred.	CAMH, EMS, TTC, PARO	Self-referral, self-call	No cost	yes	
Gerstein Crisis Line http://gersteincentre.org/our-crisis-services/telephone-crisis-intervention/	416-929-5200	Crisis Workers are available 24/7. Our goal is to help callers who are experiencing a mental health crisis to work out some effective ways of addressing their immediate problems, and connect them to services that can offer ongoing support.	Crisis management by phone with access to mobile assessment team (if in catchment area). Crisis center- 3 day stay only. Transitional housing for up to 10 days.	CAMH, distress line.	Self-referral preferred, but family, friends and services providers including hospitals, may also refer people to our services by calling our Administration and Referral Line at 416-929-0149		yes	Sometimes phone line busy.
MENTAL HEALTH-SPECIFIC RESOURCES								
Mental Health helpline	1-866-531-2600	Self-call 24/7	Resource direction/ service management	Limited engagement with community resources. Primarily focussed on OHIP supported resources.	Not	nil	yes	Not relevant
CAMH	416-535-8501, select 2		New Beginnings Clinic for refugees- started Mar 2016. Provides Case consultation for FPwith access to SW, & psychiatrists for advice about a pt. Provides access to psychiatrist consultation and brief interventions for refugees. CAMH has some inpatient beds available.		MH- ER dept (24/7) or FP referral For addictions- self-referral	OHIP	yes	Triage 3-6 wks; 2-3 months for assess-ment

Organization/Agency	Contact	Eligibility	Programs/ Services available	Partnerships with organizations	Intake/ Referral Process	Cost if any	Interpret. if available	Wait time
MENTAL HEALTH-SPECIFIC RESOURCES (Cont'd)								
Across Boundaries (HB) LM	416-787-3007 1-888-640-1934	416-787-3007 1-888-640-1934			Self-referral, Family members, Health professionals, Social service agencies, Diversion programs, Religious institutions and community organizations			
Access Point	416-640-1934	Intake line only -screening navigator conducts assessment, can be done overthe phone INTAKE LINE ONLY -THEY DO SCREENING FOR WHAT THE PERSON IS IN NEED OF -MAINLY SUITED FOR CASE MANAGEMENT & HOUSING 16 years of age or older Have mental health problems that are seriously affecting your life Live within the City of Toronto	Case management, housing supports, counselling, mental health services	SERVICE NAVIGATOR DOES ASSESSMENT -OVER THE PHONE	Family doctor refers, may be out pt program, clinic			Bottleneck b/c central intake but once in the system can access services depending on needs and urgency
Canadian Center for victims of torture http://ccvt.org/	(416) 363-1066	All welcome for immediate needs assessment. Then individual has to fit mandate of centre: Victims of war, crimes against humanity and torture.	- immediate assessment on site - 9 psychiatrist - staff already versed in multiple languages (do not usually need 3rd party interpretation) - Group and individual therapy/ peer support options available - Youth mentorships - Matching 1 on 1 community engagement with survivors of torture - Volunteer and student placements with MSW programs	Organization has been in existence for 38 years, multiple collaborations: with legal clinics, CIC, police, hospitals social planning organizations and community health centres	Self-referral, immediate needs assessment, then book follow-up appointments where needed	Free. Organization funded through fundraising and different level of government	Yes, staff already versed in many languages + access to third party interpretation if needed	Immediate assess-ment

The recommendations and resources found within this PTSD Decision-Making Tool Kit are intended to inform and instruct care providers and other stakeholders who deliver services to refugee adults who are demonstrating signs of distress. This decision-making tool is not intended for use with patients or clients under the age of 18 years, and it is not intended for use by people who have experienced a traumatic event for any self-diagnosis or treatment. Patients or community members who are refugees may wish to bring their healthcare and community service providers' attention to this tool kit.

The recommendations provided in these guidelines are informed by up-to-date, best available evidence at the time of publication, and relevant evidence published after this decision-making tool kit could influence the recommendations or conclusions made within. Primary Care Physicians and Community Service Providers should also consider their own clinical judgement, patient preferences and contextual factors, such as resource availability in clinical decision-making processes.

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