

Mental Health Issues and Substance Abuse in the Ethiopian Community Diaspora: Economic Costs, Public Health Perspective and Policy

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Abstract

In this review paper, we estimate the percent of the US population represented by Ethiopian immigrants to be very small at about .015 percent of the total. Many Ethiopians fled their home country due to famine, violence and political repression. Many have experienced culture shock and an adjustment of their status in migrating to a new land. Thus, the likelihood of developing psychological problems has been and continues to be very high. In the literature, we found the most common mental problems encountered by Ethiopian immigrants to be somatic illnesses, depression, anxiety, post-traumatic stress disorders, and suicides. A significant number of Ethiopian immigrants also have issues of substance abuse related to alcoholism and drugs. Thus, the community faces a significant mental health burden. We relied on previous survey studies done in the United States and Canada to get an understanding of the types of mental health problems experienced by the community. There is under-utilization of mental health services by the Ethiopian community under the current provisioning of healthcare. We estimate the appropriate level of mental health expenditures for the Ethiopian immigrants to be \$20 million pro-rated based on US national per capita mental health expenditures while accounting for the extent of under-utilization of such services. The role of stigma, traditional beliefs, prejudices and superstitions regarding mental illness, access and affordability account for the under-utilization of mental health services. We offer public health perspectives, policy options and suggestions for future research direction based on our review of the literature.

Introduction

Ethiopians, like other Africans, have been part of four migration waves to the United States. They have been migrating in large numbers to the United States since the 1980s, although an elite group had migrated earlier during the 1970s. By 2009, there were 186,000 Ethiopian immigrants in the country (American Community Survey, 2009). The Ethiopian diaspora is spread over 40 countries around the world although a large bulk of them are in the United States, Israel, Canada, Sweden, Germany, UK, Italy, France, Norway and Australia. Two out of five Ethiopian immigrants are in developing countries.

In the 2010 census, there were approximately 42 million African Americans among the 306 million in the United States (Rastogi, Johnson, Hoeffel, Drewery, 2011). Thus, we estimate that the Ethiopian community constituted about 1 percent of the African population and 0.015 percent of the overall population. In 2009, there were 38.5 million immigrants in the United States. Among these were approximately 1.5 million immigrants from Africa (McCabe, 2011).

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Thus, African immigrants made up 3.9 percent of all immigrants in the country. We also estimate that the Ethiopian immigrants in 2009 were 9.9 percent of African immigrants and 0.03 percent of all immigrants.

Many of the Ethiopians fled due to famine and political repression in their home country. Ethiopian migration to the US was facilitated by changes in the US Immigration Act of 1990 (Pub.L. 101-649, 104 Stat. 4978), through being admitted as asylees and refugees, and through the diversity visa program. Approximately, half of the Ethiopian immigrants gained lawful residency in the US under the family reunification program.

There are an estimated 460,000 people of Ethiopian ancestry in the United States, which includes over 30,000 US born citizens and second generation children of Ethiopian immigrants. Ethiopians numbering 500+ can be found in more than 101 cities (Retrieved from <http://www.city-data.com/top2/h107.html> on October 28, 2013). The largest concentrations of the Ethiopian community can be found within proximate areas of three metropolitan centers of Washington DC (350,000), Los Angeles (96,000), and New York (10,000) (Terrazos, 2007).

Along with other immigrants from Nigeria, Egypt, Ghana and Kenya, Ethiopians are among the top five sources of African immigrants. They are predominantly urbanites in their home country and are very well educated. They have a college graduation rate that exceeds that of native born Americans (JBHE Foundation, 2000).

Like any immigrant group before them, the Ethiopian community has experienced problems of acculturation and assimilation in the United States (Kobel, 2011). Among the earlier admitted asylees and refugees and those that followed due to famine and repression, many have experienced culture shock and an adjustment of their status in migrating to a new land. Thus, the likelihood of developing psychological problems has been and continues to be very high. Most common mental problems encountered by Ethiopian immigrants are somatic illnesses, depression, anxiety, post traumatic stress disorders, and suicides (Gelnessa, Mohamed, Mengistu, Temesgen, and Baraki, 2003). A significant number of Ethiopian immigrants also have issues of substance abuse related to alcoholism and drugs.

This review paper seeks to improve knowledge regarding mental illnesses within the Ethiopian immigrant community and enumerate options for mental health care by culling information from available literature. Towards this end, data regarding the breadth and depth of the mental health burden is obtained from studies done in Ethiopia, Canada and the United States in the following two sections. We also shed light on the under-utilization of mental health services in the community due to traditional perceptions of mental illness, linguistic, cultural and economic barriers, and the role of stigma. In subsequent sections, we examine economic costs imposed by the mental health burden and provide a quantitative estimate of a pro-rated level of mental health care expenditures for Ethiopian immigrants keeping in view the level of reported under-utilization. We follow this with a public health perspective keeping in mind recent changes in healthcare law and how it affects immigrant communities. We conclude with some observations on the needed direction of future research.

Mental Health Issues of Ethiopian Immigrants

Studies conducted both in Canada (Haile, Hyman, Noh, 2007; Haile, Hyman, Noh, 2004) and the United States (Giorgis, 1996) regarding Ethiopian immigrants since the mid-1990s reveal similar types of mental problems. Some of the immigrants have experienced pre-immigration trauma such as civil war and conflict, torture, life in refugee camps and human rights violations. Other factors enhancing risks of mental illness post immigration have resulted from newly-acquired minority status, change in culture, lack of support for native norms and values, language barriers, discrimination in employment, loneliness, change in gender roles, financial hardships, educational and occupational barriers, and lack of familial and social support.

Somatic Illnesses: The Toronto study of 342 Ethiopian immigrants sought information regarding incidence of 16 most common somatic illnesses. The six most experienced were back ache, head ache, forgetfulness, abdominal pain, leg or arm pain and insomnia. Approximately, 36.8 percent reported no somatic symptoms and 5.6 percent reported symptoms which doctors could not diagnose.

Depression: In the US study involving 352 Ethiopian immigrants, a survey instrument using the Hopkins Symptom Check List (HSCL) was used. About 4.4 percent of those surveyed were categorized as being severely depressed. The most common symptoms exhibited by this group included difficulty relaxing, poor self esteem and difficulty in talking. The Toronto study found incidence of depression at 5.9 percent and lifetime prevalence of depression at 9.8 percent. The lifetime prevalence rate of depression was comparable to the general population in Ontario but about three times higher than in Ethiopia. Prevalence rate was slightly higher among males than females.

Anxiety: The US study categorized 8.6 percent of those surveyed as suffering from anxiety. The most common symptoms exhibited by this group included fidgeting, frequent swallowing, crying and a lack of a sense of humor. About 3 percent of those surveyed in the Toronto study were categorized as suffering from general anxiety disorder. There was no statistically significant difference between lifetime prevalence of general anxiety disorder between males and females.

Anxiety and Depression: The US study further categorized an additional 25.7 percent of those surveyed as experiencing both anxiety and depression. This group exhibited a variety of symptoms. These included fidgeting, startling easily, sweating a lot, irritability, impatience, difficulty concentrating, gloomy mood, slow body movements, lack of sense of humor, socially withdrawn, low energy, sadness, and cold hands. Literature suggests that genetic predisposition is a key determinant of depression etiology (Abkevich et al., 2003). However, early or current familial/social environment, in addition to adversity/stress has been known to predict depressive symptomatology (Taylor et al., 2006).

Post-Traumatic Stress Disorders: Approximately 6 percent of the respondents in the Toronto study met the criteria to be diagnosed as suffering from post traumatic disorder. The proportion was higher among males than females. People with PTSD have painful memories of torture, brutal war, escape, and concentration camp experience after they resettle in another land.

In addition to these mental health illnesses stated above, members of the Ethiopian immigrant community may exhibit other mental health conditions from their native country (WHO, 2006a; Gelmess, Mohamed, Mengistu, Temesgen, and Baraki, 2003). The following are affected by genetic disposition, brain chemistry and lack of social support.

Schizophrenia: Studies in Addis Ababa and in Butajira have shown that lifetime prevalence for schizophrenia maybe 0.5 percent of the population. Schizophrenia is a very debilitating disease (Kebede and Alem, 1999a; Kebede, Alem, Shibire, Deyassa, Bayero, Medhin, and Fekadu, 2006; Abebe, 2011). It causes impaired and disrupted thinking. People affected by it could suffer delusions and hallucinations. They may experience psychotic episodes.

Bipolar Disorder: Studies among the Borana semi-nomadic community in Southern Ethiopia and an isolated island community on the Zeway island have shown bipolar disorder affects between 0.1-1.8 percent of the population (Bayero, Alem, Kebede, Shibire, Desta & Deyessa, 2004; Fekadu, Shibire, Alem, Kebede, Kebeab, Negash & Owen, 1980). Manic depression is the psychiatric diagnosis for this mood disorder. Individuals may behave erratically or impulsively. Individuals may have distorted beliefs about the world, regarded as psychosis. They experience elevated mood states.

Panic Attack Disorder: People afflicted by this mental health illness experience fear, heart palpitation, terror, and a sense of impending doom. There can be recurrent and unpredictable attacks accompanied by sweating, tremors, and dryness of mouth, chest discomfort and abdominal distress. The panic disorder illness affects about 0.8 percent of Ethiopians (Du, 2009a; Du, 2009b; Kebede, and Alem, 1999b; Kebede and Alem, 1999c)

Substance Abuse: In the US study of Ethiopians (Giorgis, 1996) 9.8 percent had used drugs. The prevalence rate for substance abuse in Ethiopia for cannabis was 1.5 percent and the abuse of khat varied widely from 0.3 - 64.7 percent (Fekadu, Alem and Hanlon, 2007; Baingana, Alem, and Jenkins, 2006).

Alcohol Abuse: In the study of Ethiopian immigrants in the US (Giorgis, 1996), the depressed reported being drunk three times per month, those who suffered from anxiety reported being drunk 7.5 times per month and those who were both depressed and suffered from anxiety reported being drunk 9.12 times per month. Family members thought that 40 percent of those that suffered both from depression and anxiety had a drinking problem. Alcohol abuse seemed fairly common among Ethiopian men. In Ethiopia, as a contrast, the prevalence of hazardous drinking was 3.0% (Fekadu, Alem, and Hanlon, 2007; Baingana, Alem, and Jenkins, 2006).

Traditional Perceptions of Mental Ill Health in Ethiopia

Although there are statistically significant differences between the more educated and less educated Ethiopians' perceptions of mental ill health, a study done in Agaro town (Deribew and Tamirat, 2005) shows that the general perceived causes of mental health problems include poverty, God's will, evil spirit, drug/substance abuse, stress, physical illness and other in decreasing order of importance. Although more than 70 percent would seek modern medicine for cure, a substantial number would seek help from family, holy water, traditional healer, prayer houses, witchcraft and others. Some in the Ethiopian immigrant community could be influenced by these traditional perceptions in their native land (Gizachew, 2012).

Immigrants and Mental Health Services Use

There have been various studies, both in the US and Canada, examining why immigrants in general under-utilize mental health services relative to the larger population (Haile, Hyman and Noh, 2007). These suggest that immigrants hold views different from the general population about the appropriate cause and treatment of mental health illnesses. Other reasons for under-utilization of mental health services include language barriers, knowledge gap, economic status, racial discrimination in the health care system and personal preferences with respect to alternative remedies and modes of treatment. There could be other cultural barriers as explained above in the case of Ethiopians. One of the most prominent barriers may be the role of stigma in seeking and utilizing mental health care services (Kibour, 2010).

Role of Stigma

Social stigma due to mental illness can make an individual experience shame, blame and/or isolation, feel like a black sheep in the family, be socially excluded (which could extend to the family) and stereotyped and also be subject to social and economic discrimination (Byrne, 2000).

A study done in Ethiopia among patients with Schizophrenia showed that rural residence, single marital status and prominent psychotic symptoms were associated independently with a high stigma score for internalized stigma (Assefa, Shibre, Asher and Fekadu, 2012). According to the authors, personal experience of stigma could be considered in three ways: i) perceived stigma - what the individual thinks about society's beliefs with respect to the stigmatized group; ii) experienced stigma - the discrimination an individual actually experiences; and iii) self-stigma - the internalization of the public stigma. Stigma could impact adherence to medical treatment through psychological mechanisms such as loss of self-esteem and self-efficacy, demoralization, hopelessness and depression.

High levels of stigma are also associated with a history of suicide attempts. Thus, tackling stigma is a top and important public mental health priority in general and in the immigrant community (Ethiopian News Agency, 2008).

Some progress has been made in measuring mental illness stigma (Link, Yang, Phelan and Collins, 2004). The conceptualization of stigma processes has led to a consideration of the components of stigma such as labeling, stereotyping, cognitive separating, emotional reaction, status loss and discrimination. There are now a variety of quantitative and qualitative measures that can be used to study mental illness stigma. However, the lacunae in the literature on measuring mental illness stigma pertain to structural discrimination, assessment of the emotional response of patients, assessment of children's knowledge, attitudes and experiences of stigma, and the use of experimental and cross cultural approaches, which are all relevant to the Ethiopian community as well.

Utilization of Mental Health Services by the Ethiopian Community

The study of mental health services utilization by Ethiopians (342 surveyed) in Toronto revealed that it did not differ greatly from the general population of Ontario which was about 6 percent. However, this represented only 12.5 percent of those needing mental health care services. They sought it mainly from family health care physicians. Another 18.8 percent sought assistance from traditional healers. Therefore, about 41 percent of the Ethiopian population who needed mental health care services did not seek care. Cultural and linguistic barriers, knowledge gap, unfamiliarity with the healthcare system and stigma could be reasons for non-utilization of services (Haile, Hyman and Noh 2007).

Estimated Costs of Mental Health Services of the Ethiopian Community

In the US, mental health expenditures accounted for \$113 billion in 2005 (Kliff, 2012). Given that the population of the country was 296 million, the per capita mental health care expenditure was thus about \$392. In 2009, 15.7 million Americans received mental health care services representing 7.1 percent of the population (NSDUH, 2011). A quarter of them listed themselves as main payer of services. They paid out-of-pocket costs between \$100 and \$5000. Financial costs and attitudinal barriers are still obstacles in seeking mental health services in the population at large.

As mentioned earlier in the paper, the Ethiopian community makes up only 0.015 percent of the population. Assuming that the community uses mental health care services at about the same rate as the general population, we then estimate the pro-rated mental health care expenditures for the entire Ethiopian community in the United States to be \$2.38 million in 2005 dollars. For reasons suggested by both the US and Canadian studies on Ethiopian immigrants, there may be substantial under-utilization of mental health care services in the United States. Assuming the extent of under-utilization of mental health services at the same level as revealed in the Toronto study, we then estimate that the Ethiopian community may need \$16.7 million additional spending on mental health services in 2005\$ or about \$20 million in 2013 dollars. Historically high rates of depression, anxiety disorders and growing substance abuse within the community are reasons for expanded mental health care services to the community. Cultural taboos, financial costs, attitudes and stigma may all be factors in the non-utilization pattern of mental health care services by Ethiopians in the US.

Some Economic Impacts of Mental Health

Mental health status can have economic impacts (WHO, 2006b). It can result in loss of productivity at work which weighs the same as absenteeism. This is because even if the individual is present at work, the individual is unable to work at full capacity. Furthermore, mental illness stigma/discrimination is known to impact negatively on employment, income, public views about resource allocation and healthcare costs.

After the Mental Health Parity and Addiction Equity Act (MHPAEA) passed in 2008, it has been the federal government's attempt to provide consistent benefits between mental health and general health treatment (Weymouth, 2013; Nagar, 2012; Pumariega, 2011).

The rate of growth in mental health costs has been declining in the United States due to substitution of psychopharmacology for psychotherapy (Nagar, 2012). Despite that, mental health costs have been high, partly due to negative externalities and partly due to comorbidities. Various social costs arise due to disability and unemployment, homelessness and crime.

Mental health costs are also linked to the heavy social and economic costs of suicide in addition to other medical costs and productivity loss due to depression. Mental illnesses prevent affected people from properly evaluating utility of products in the market. Psychological stress leads to reduced self efficacy, fatigue and poor decision making. Thus, it is in the interest of the Ethiopian community to lead a healthy life physically and mentally, and seek timely intervention for mental ill health and work actively to diminish the taboos and stigma associated with it.

Facing a distressing triangle of escalating costs, diminishing support system and limited access to care besides numerous aforementioned barriers to seeking help, there is an immediate need for affordable mental health services to be made accessible to these immigrants. Empirical work has shown that mental health care has relatively high price elasticity (Nagar, 2012). It is also important to provide an environment that encourages the use of services that are available by increasing knowledge regarding how to access, mitigating the stigma associated with its use and offering unparalleled resources in an easy to access, understand and use manner (Program for improving mental health care: Evidence on scaling-up mental health services for development. Retrieved from <http://www.prime.uct.ac.za>).

The complex issue of immigrant mental health requires a multidisciplinary and multi-level approach to resolve. Tailored interventions are required to mitigate barriers and enable individuals to seek care as needed.

Public Health Perspective

From a public health perspective, all community stakeholders need to get educated and involved in providing care. Providing access to a psychologist or a psychiatrist at a hospital or a healthcare provider organization would prove to be useful to only a minority of the Ethiopian population. There are multiple ways that this access can be increased for Ethiopian immigrants and their children. The solutions range from providing school-based programs for children to organizing community outreach activities such as wellness clinics to incorporating the religious influencers in talking openly about mental healthcare needs.

For children, school-based mental health services can offer an easy to access solution. Schools should make it a priority to train teachers and mentors to recognize signs of mental health needs among children coming from diverse cultures. They should be provided clear information on how to guide the parents of these children to access needed care and counseling. Organizations such as the Robert Wood Johnson Foundation have launched multiple programs under initiatives such as 'Caring Across Communities' (CAC) Initiative (Kugler, 2009) that promote innovative partnerships between schools, mental health service providers, immigrant and refugee community organizations. Other programs such as 'Prevention and Early Intervention (PEI)' provide a range of services to immigrant children from one-on-one treatment to cultural wellness activities and community events to reduce the barriers that prevent immigrants from seeking care. Unaddressed mental needs of school children can translate into worsening of performance in school, low self-esteem, social awkwardness, behavioral and growth problems and in worst cases result in violent behaviors, putting the children themselves and others at risk. Initiatives such as CAC and PEI work towards supporting the mental health needs of youth in school-based programs to ensure a healthier future.

Another effective community outreach alternative would be to collaborate with religious leaders from the church or other places of worship, influential businessmen, clan leaders and mental health providers. An example of such an outreach is the 'Hmong American Association of Colorado' serving the metropolitan Denver area (Colorado Trust, 2013). The association coordinates with all the aforementioned stakeholders to promote greater trust and awareness between healthcare providers (including mental health service providers) and Hmong community. Funding a similar program could tremendously benefit the Ethiopian community.

Majority of Ethiopian immigrants are church going and are similar to other immigrant communities that attend various places of worship. As they attach a stigma to mental health needs and turn to folk cure/treatment and have an inherent distrust of western medicine to cure what they consider 'madness' or 'evil possession' or abnormality of some sort, working with key influencers can tremendously help reduce these barriers to seek mental health care services. Pastors, influential elders of the family, clan, or support groups, and other influential Ethiopians such as businessmen can help increase awareness regarding the mental health conditions themselves. They can also provide guidance to the availability of services that help treat those conditions. Involving the influential stakeholders can help make the outreach, family advocacy, education and support services more effective and welcomed with greater trust by the community.

Policy Issues

Many solutions can be enhanced at the policy level to increase access to mental health services and reduce barriers to care. Instating a policy that requires the presence of linguists and interpreters at mental health clinics and during community outreach activities can considerably help address the language, cultural and social barrier to seeking and receiving care.

Expanding on the SCHIP and Medicaid programs in states can also help address some of the access issues in mental health services for Ethiopians and their children. Providing additional funding for building community health centers and increasing funding for existing centers that have culturally competent staff can also prove to be very useful. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricts access to government sponsored or subsidized health insurance (Derose, Escarce and Lurie, 2007). Revamping this law to allow access to all health care services rather than only emergency services would enable Ethiopian immigrants to access mental health services.

With the passage of healthcare reform-Patient Protection and Affordable Care Act (PPACA) of 2010, it is encouraging to note that immigrants would have greater access to primary care. However, it remains to be seen whether the policy changes being brought through individual mandate, employer mandate, expansion of publicly funded insurance or a combination of any of these help increase utilization of mental health services by the immigrants, especially the Ethiopian community.

Lacunae and Need for Further Research

We did not uncover the hidden costs of the mental health burden within the Ethiopian community in the United States which can be significant for any immigrant group. As the World Health Organization (WHO, 2006b) suggests, there is a need to research and correctly estimate the significance of the mental disorder burden, to design interventions that are cost-effective (for example, psychopharmacology and psychotherapy treatments and educational initiatives), to decide the appropriate cost level for such effective care and work on the most cost-effective strategies not only for the general population but also for immigrants such as the Ethiopian immigrants and others.

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