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Burmese Community Behavioral Health Survey
A Report of Preliminary Results

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Summary of Findings
This report provides preliminary findings from the Burmese Community Behavioral Health Survey (BCBHS). The study is being conducted in collaborative partnership with the Burmese Community Support Center and Burmese Community Services as a community-based research project. The preliminary findings reported here are based on the first 151 surveys collected between March 2015 and February 2016. Key initial findings from the study include:

- **Burmese refugees are recent arrivals to Buffalo.** Almost all (92.7%) of Burmese refugees in the study arrived in the United States within the past 10 years.

- **Burmese community consists of diverse subgroups.** The community is made up of at least eight different ethnic groups\(^1\), with a subsection with multiple ethnic backgrounds. Refugees from Burma speak various different languages based on their ethnicity. This diversity is important when understanding and working with the community.

- **Burmese have low household income.** While the majority of Burmese refugees are employed, eighty-four percent of those employed make less than $2000 per month.

- **Burmese refugees have spent multiple years in refugee camps.** Eighty-five percent of Burmese refugees have spent more than a year in a refugee camp and some for over 20 years.

- **Concerns about their behavioral health are real.** While the majority of Burmese refugees self-report as having good/excellent physical (69.2%) and mental (70.9%) health, results of behavioral health related measures highlight areas where further intervention is warranted:
  
  o Seventy-eight participants (51.7%) reported high enough trauma-related symptoms (RHS-15) that may require mental health specialist referrals.
  
  o Twenty-five participants (16.6%) reported high enough anxiety and depression symptoms (HSCL) that warrant mental health specialist referrals.
  
  o Twenty participants (13.3%) were identified as having alcohol related problems (AUDIT), who could benefit from addiction specialist referrals.
  
  o Eleven participants (7.3%) were identified as having moderate to severe problem gambling (PGSI).

- **Many in the Burmese community are not satisfied with their primary care doctors or clinic.** About one in four Burmese refugees (25.8%) are either not at all or not very satisfied with the medical care they are receiving from their primary doctor/clinic. Given high prevalence rates of trauma and other behavioral health symptoms, doctors as well as clinic staff must learn to develop trusting relationships with Burmese refugee patients.

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\(^1\) Eight major ethnic groups officially recognized by the Burmese government are Barmar, Chin, Kachin, Kayin (Karen), Kayah (Karenni), Mon, Rakhine, and Shan. Rohingya people, who are one of the most discriminated groups in Burma currently, are not recognized by the Burmese government as one of the 135 ethnic groups.
Overview
Decades of political turmoil in Burma has resulted in massive displacement of several ethnic groups from Burma. More than half a million people were reported to have lived in designated refugee camps along the western Thailand border at some point (Barron et al., 2007). Of those, approximately 121,100 refugees from Burma entered the United States between 2002 and 2013 (Office of Refugee Resettlement, 2012; Refugee Processing Center, 2014), making them the largest refugee group resettled in the United States since 2000.

The city of Buffalo is home to between 8,000 and 10,000 refugees from Burma, who significantly contributed to an increase of city population for the first time in more than three decades (Schulman, 2016, January 14). The Burmese refugee community is a critical component in revitalization for the City of Buffalo. At the same time, Burmese refugees themselves have begun to raise concerns about the overall status of their community’s well-being. In particular, there exists little to no empirical information regarding behavioral health conditions on this important and growing segment of Buffalo residents.

Behavioral health problems refer to mental and emotional concerns and/or choices and actions that affect individuals’ overall well-being (Substance Abuse and Mental Health Services Administration, 2012). Symptoms of mental illnesses, substance misuses, intimate partner violence, and gambling problems are examples of behavioral health concerns that might impact community members’ overall sense of well-being. The BCBHS study was proposed to narrow the knowledge gap in these problem areas by gathering data through survey interviews. It is the first systematic effort to collect empirical data in trying to understand behavioral health conditions among the Burmese refugee community in Buffalo, NY.

This study employs the social determinants of health (SDH) framework, which indicates that the current structural, sociocultural, and individual circumstances altogether shape and influence physical and psychosocial adjustment patterns of people in a society (Commission on Social Determinants of Health, 2008; Galea & Steenland, 2011; Solar & Irwin, 2007). This is especially true for refugees resettled in the United States, who are trying to adjust to a new cultural and built environment while not knowing the language. The SDH framework provides a useful platform in examining sociocultural dimensions, such as language and minority status, as critical factors in shaping long-term behavioral health outcomes among refugee populations in the United States (Kim & Kim, 2014). CSDH set priority for undoing social injustices that create differential physical and mental health statuses for underserved populations. This also includes responding to various behavioral health needs of refugees resettling in a geographically, culturally, and linguistically foreign environment.

Sample
Using a convenience sampling method, community interviewers have been recruiting participants at community-based agencies, religious institutions, and through various community networks. The eligibility criteria to participate in this pilot study are as follows: (a) be a refugee from Burma; (b) be at least 18 years old; and (c) be a resident of Erie County.
Preliminary sample consists of 151 community members. A little over half (57.6%) of the participants are female. Their age ranges from 19 to 75, with an average age of 39.7 (SD=10.7). The majority (66.9%) of the participants are married or in a domestic partnership. Four out of five participants (79.8%) have less than a high school education. Almost all of the participants are able to speak and understand their native language, but a smaller majority (71.4%) are able to read and write well in their native language.

**Data Collection Procedures**
Considering a high rate of illiteracy in the population, face-to-face interviews were conducted by the trained bilingual community interviewers using the survey questionnaires, which were translated in Burmese language. In addition, due to severe logistic limitations of translating the entire survey into Karen languages, interviewers who are proficient in both Karen and Burmese were recruited and trained to interview participants who communicate in Karen. Informed consent was obtained, which explained their basic rights regarding interview participation, including the right to refuse and withdraw at free will at any time during the interview.

**Results**
Burmese refugees are recent arrivals to Buffalo

<table>
<thead>
<tr>
<th>Years in the United States</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>11 years or more</td>
<td>7.3%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>35.1%</td>
</tr>
<tr>
<td>0-5 years</td>
<td>57.6%</td>
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Burmese refugee resettlement is a newly emerging development in Buffalo. 92.7 percent of Burmese refugees surveyed arrived in the United States within the past 10 years. Furthermore, over half of these refugees have been in the United States for less than 5 years. With these recent arrivals, the city of Buffalo is still adjusting to better understand their needs.
Burmese community in Buffalo consists of diverse subgroups

Burmese refugees in Buffalo are comprised of several different ethnic groups. Karen and Barmar are the two largest ethnic groups reflected in this survey, followed by Karenni, Rakhine, and Chin, which approximately mirrors the current ethnic makeup of the Burmese community in the city of Buffalo.

Similarly, the majority (52.4%) can speak Burmese, but several groups of people identified other ethnic languages as their native language. In total, the study revealed that there are at least seven different languages spoken by Burmese refugees. Providing appropriate interpretation and translation services is a crucial part of service delivery, so this linguistic diversity within the community is noteworthy when assessing an organization’s ability to effectively communicate with those they serve.
Burmese refugees have high unemployment and low household income

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>No. of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>76</td>
<td>50.7%</td>
</tr>
<tr>
<td>Student</td>
<td>8</td>
<td>5.3%</td>
</tr>
<tr>
<td>Unemployed, seeking work</td>
<td>24</td>
<td>16.0%</td>
</tr>
<tr>
<td>Unemployed, not seeking work</td>
<td>8</td>
<td>5.3%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>34</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

The unemployment rate (16.0%) of the Burmese refugees is significantly higher than in the Buffalo-Niagara Metro area as a whole, which saw an annual unemployment rate of 5.6 percent in 2015 (New York State Department of Labor, 2016). In addition, those who are able to find employment are earning less than $2000 per month as a household and the majority (56.9%) earn between $1000 and $2000 per month. Aside from language barriers, educational, vocational, or professional degrees earned in Burma are not accepted as equivalent degrees in the U.S. job market, which may contribute to underemployment and limit their earning potential. A fair number of refugees (22.7%) are also homemakers, which limits the number of workers per household and thus the total household income.
Burmese refugees have spent multiple years in refugee camps

**Monthly Household Income**

- None: 8.6%
- <$500: 5.0%
- <$1000: 13.0%
- <$1500: 28.8%
- <$2000: 28.1%
- <$2500: 7.9%
- <$3000: 5.8%
- <$3500: 1.4%
- $3500+: 1.4%

**Length of Camp Stay**

- 20 years or more: 8.5%
- 10-20 years: 29.9%
- 5-10 years: 21.5%
- 1-5 years: 25.2%
- Less than a year: 15.0%
A large portion of the refugees in the study (85%) spent over a year in a refugee camp. The mean length of stay in a refugee camp was 9 years and 2 months. While living in camps, refugees are limited in their ability to move freely outside of the camps and resources can sometimes be scarce inside the camps (Capps et al., 2015). Protracted stay, along with safety and security problems, in the camps can add additional stress to refugees who have escaped violence and persecution in their country of origin. In addition, lack of food and sanitation in the camps contribute to developing various medical problems and exacerbating pre-existing medical conditions. Finally, uncertainty surrounding their fate while surviving in the camps can further worsen their already tenuous emotional and psychological status.
Concerns about Burmese behavioral health is real

<table>
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<tr>
<th>Behavioral Health Measures</th>
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<tr>
<td><strong>Trauma Symptoms</strong>²</td>
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<tr>
<td>No. of participants</td>
</tr>
<tr>
<td>Percentage</td>
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</tbody>
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While the majority of Burmese refugees self-report as having good/excellent physical (69.2%) and mental (70.9%) health, results of behavioral health related measures highlight areas where further intervention is warranted. A significant portion of the Burmese refugees in the study reported high symptoms of trauma-related symptoms (RHS-15), anxiety and depression (HSCL), and alcohol related problems (AUDIT). More than 7 percent of the participants were also identified as having moderate to severe problem gambling (PGSI). As a newly arrived group, early behavioral health intervention is key to ensuring the continuing well-being of the community.

Many Burmese refugees are not satisfied with their primary care doctors or clinic

<table>
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<tr>
<th>Primary Care Physician Satisfaction</th>
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<tbody>
<tr>
<td><strong>Not At All Satisfied</strong></td>
</tr>
<tr>
<td>No. of participants</td>
</tr>
<tr>
<td>Percentage</td>
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</table>

Over a quarter of all participants indicated that they are not satisfied with their primary care physician. Past literature suggests that Asian Americans in general have relatively lower satisfaction with the primary care (Murray-Garcia, Selby, Schmittiel, Grumbach, & Quesenberry, 2000; Ngo-Metzger, Legedza, & Phillips, 2004). What we do not yet know clearly is the rate of physician satisfaction among refugees generally, and with Burmese refugees in particular. This level of dissatisfaction with their physicians may contribute to refugees’ decisions not to seek services from their primary care physician. Nearly 17 percent of those in the study did not visit their primary care physician in the past year, in spite of having high rates of medical insurance.

² Refugee Health Screener – 15 (Hollifield et al., 2013)
³ Hopkins Symptom Checklist (Hesbacher, Rickels, Morris, Newman, & Rosenfeld, 1980)
⁴ Alcohol Use Disorder Identification Test (Saunders, Aasland, Babor, De La Fuente, & Grant, 1993)
⁵ Problem Gambling Severity Index (Ferris & Wynne, 2001)
Conclusion
This report highlights some of the important preliminary findings from the ongoing BCBHS study. These initial findings begin to confirm many of the real concerns aired by the Burmese community, such as trauma, language barriers, and alcohol problems, which have initiated this study in the first place. On the other hand, the findings so far failed to confirm community members’ other concerns, such as domestic violence incidences. By Spring 2017, a final report is anticipated with comprehensive results of the BCBHS study, which will be finishing its data collection phase in December 2016.

Acknowledgement
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References


