Enhancing mental health and psychosocial support for refugee families in Iowa: What providers need to know and do

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Activity 1

Introduce yourself to your neighbor and share one thing about your work in refugee mental health care
Learning objectives

1. To **describe** the process of refugee resettlement within Iowa
2. To **identify** signs and symptoms of mental health problems among refugee populations
3. To **design** care plans involving medication, psychological therapy, and socioeconomic supports to improve mental health among refugees
4. To **collaborate** with community organizations for comprehensive approaches to identification, engagement with care, and recovery
68.5 million forcibly displaced people worldwide

Internally Displaced People
40 million

Refugees
25.4 million
19.9 million under UNHCR mandate
5.4 million Palestinian refugees registered by UNRWA

Asylum-seekers
3.1 million

Where the world’s displaced people are being hosted

57% of refugees worldwide came from three countries

Top refugee-hosting countries

Islamic Republic of Iran
979,400

Lebanon
1,000,000

Pakistan
1,400,000

Uganda
1,400,000

Turkey
3,600,000

Where the world’s displaced people are being hosted

85% of the world’s displaced people are in developing countries

10 million stateless people

102,800 Refugees resettled

44,400 people a day forced to flee their homes because of conflict and persecution
WHO estimates 10% of humanitarian crises-affected populations will have mental health problems.
Funding and conflict interests

• World Health Organization/USAID
• National Institute of Mental Health
• MQ Foundation, UK
• Bill & Melinda Gates Foundation
• UK Medical Research Council
• Consultancies: UNICEF, The Carter Center

• No affiliations with pharmaceutical companies
• All materials/tools discussed are available freely in the public domain
Introduction to refugee contexts in Iowa

Recognizing mental illness with refugees

Caring for refugees with mental illness

Community engagement and standards of practice
Definition of refugee and asylee

“[a person who] is unable or unwilling to avail himself or herself of the protection of, that country because of a persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.”

United Nations’ Universal Declaration of Human Rights (1948)
Article 14: Everyone has the right to seek and enjoy in other countries asylum from persecution
Refugee and Asylum System – Historical context

- 1800s – no limit on immigration
- 1891 – Ellis Island & Detention Center opened
- 1924 – Eastern Europeans and Asians increasingly limited
- 1948 – Universal Declaration of Human Rights
  - Article 5: No one subject to torture.
  - Article 14: Right to seek asylum.
- 1951 – United Nations High Commissioner for Refugees
- 1980 – US Refugee Act
Overseas processing
The Department of Homeland Security (DHS) approves refugees for admission to the United States. The Department of State (State) processes refugees overseas.

Voluntary agency assignment
Refugees are assigned to one of nine national-level voluntary agencies, which have multiple local affiliates.

Initial reception and placement
Representatives from voluntary agencies greet refugees upon arrival. Voluntary agencies provide housing and other basic needs for 30-90 days with funding from State.

Program placement
Voluntary agencies help refugees apply for the assistance they are likely eligible to receive.

Temporary assistance from ORR*
- Eight months of cash assistance (4 to 6 months for Matching Grant)
- Medical assistance
- Social services, such as employment assistance and citizenship services, for up to 5 years
- Administered by local voluntary agencies or by a government agency

Other public assistance
- Type and duration of assistance varies
- Administered by various government agencies
- Includes Supplemental Security Income and Temporary Assistance for Needy Families

*Fully or partially funded and administered by Department of Health and Human Services' Office of Refugee Resettlement (ORR)
Voluntary Agencies (VOLAGS)

• Church World Service (CWS)
• Ethiopian Community Development Council (ECDC)
• Episcopal Migration Ministries (EMM)
• Hebrew Immigrant Aid Society (HIAS)
• International Rescue Committee (IRC)
• US Committee for Refugees and Immigrants (USCRI)
• Lutheran Immigration and Refugee Services (LIRS)
• United States Conference of Catholic Bishops (USCCB)
• World Relief Corporation (WR)
Overview

• We interviewed nine leaders in the refugee community
  – Non-profit
  – Faith-based
  – Resettlement agencies

• We asked open-ended questions about the challenges they faced when dealing with the mental health needs of refugees in Linn and Johnson County

• We defined mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.
Refugee Populations Seeking Resources

- Bhutanese
- Burmese
- Burundian
- Congolese
- Iraqi
- Rwanda
- Somalian
- Sudanese
- Vietnamese
- Yemenis
Refugee Population Migration

- **Last 5 years**
  - Iraqi, Syrian, Congolese, Sudanese, Afghan, Burmese, Nepalese, Bhutanese, Burundian, Somali
- **Longer than 5 years**
  - Vietnamese, Cambodian, Laos, Sudanese, Yemenis
- **Majority of refugees are secondary**
  - Come to Iowa for good education, calm living, affordable housing
- Numbers seeking help has increased due to more established presence and refugees from target populations working/volunteering in these organizations
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Prevalent Mental Health Needs

• **PTSD from past**
  – War survivors, trauma in country of origin, child separation, rape, forced migration
  – While in camps, it's about surviving, so these issues surface once in relative safety

• **Poverty and financial insecurity**
  – Lack of job opportunities

• **Cultural adjustment to new environment**
  – Isolation
  – Generational gaps
  – Stressors of past trauma hard to process when trying to survive new environment and navigate system

• **Individual acknowledgement of mental health needs difficult to be made public**
  – “I’m not crazy”
  – The focus is not on the state and needs of their own mental health, but on survival
  – "Suck it up" mentality
  – Can lead to coping mechanisms like alcoholism

• **These factors are exacerbated by a language barrier**
Organizational Responses to Mental Health

- Connected with mental health therapist
- Referrals to case managers, service agencies, cultural organizations
- Multilingual advocates/Family Service Workers
  - Interpreting and Translating services
  - Regarded as counselors
  - Help with daily survival
- Community projects, workshops, and panels
  - Accountability and youth projects
  - ELL classes, financial literacy workshops
- Community involvement assists with stress levels
- Started groups and non-profits to hold conversations and create a safe community
  - Support groups and social networks
  - Focused on general well-being and alleviating stress; not explicitly labeled as a mental health resource
- Material and financial contributions to new families
Improvement of Mental Health Services

• Services need to go to the community, not have the community come to the services
  – Proximity
  – Develop trusting and productive relationships
• Be more transparent with available services
• Be willing to work with translators and community organizations
• Don't treat refugee patients the same as everyone else
• Increased cultural and linguistic knowledge
Barriers Faced in Meeting Mental Health Needs

• Language barrier
  – Language used by healthcare/insurance providers not transparent
  – Interpretation
    • Difficult to culturally and accurately translate mental health needs to English
    • Lack of services

• Stigma of mental health
  – “I’m not crazy”

• Accessibility
  – Proximity
    • Difficult to find multilingual mental health providers and professionals in area
    • Transportation to services
  – Accepted insurance and mental health treatment coverage

• Financial stress
  – Afraid to draw attention, don't want to use governmental support
Other Services & Support Needed

• Job training
  – Not just specific skills, also teaching things like time management
• Continue with community building & involvement
  – Community leaders and elders are a great resource, but not professionals and may not be equipped to help those with mental health needs
  – Misinformation and hierarchical relationships can and have worsened some cases, particularly among women seeking help from male leaders
• Support groups and networks
• English classes
• Transportation
Other Services & Support Needed

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• Transportation
Moderated Discussion

Rama Muzo, Chief Executive Officer, Intercultural Center of Iowa in Cedar Rapids; Intercultural Community Resources Specialist, Cedar Rapids Community School District
Experiences – stressors and resources

Country of origin → Second Country Settlement / Refugee Camp → Third Country Resettlement

- Early life stressors
- Humanitarian crisis

- Loss of personal belongings and livelihood
- Gender-based and criminal violence

- Lack of access to healthcare and employment
- Separation from family & community; inter-generational cultural differences

- Acculturation stress, racism, xenophobia
- Gender-based and criminal violence
Identifying Mental Health Problems in Refugee Populations
Symptoms related to help-seeking

- Sleep and fatigue
- Pain
- Dizzy/Loss of Consciousness
- Worry/Thinking too much
- Fear/Paranoia

Begin with a focus on the client’s concern.
Considerations for somatic complaints

Physical Co-Morbidity
- Mental health problem
- Unrelated or interacting physical health problem

Somatic idioms for communication
- Mental health problem
- Physical idioms used to express distress

Somatization, Conversion, Chronic Pain Disorders
- Mental health problem
- Solely physical presentation (denial of distress)
Symptom Presentation

• Types of Somatic presentations
  • Headaches, Pain, Dizzy/ loss of consciousness, Paresthesia

• Idioms of distress/ Cultural concepts of distress
  • “Thinking too much” – observed in many cultures
  • Other examples: “Heart-mind problems”, “Khyal attacks”

Table 1
Number of publications by region and type of population (n = 138)

<table>
<thead>
<tr>
<th>Region of the world</th>
<th>Number of study populations</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Africa</td>
<td>60</td>
<td>43.5</td>
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<tr>
<td>Australia</td>
<td>4</td>
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<tr>
<td>Central America/Caribbean</td>
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<td>9.4</td>
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<td>Middle East</td>
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<tr>
<td>Southeast Asia</td>
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<tr>
<td>United States/Europe</td>
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<td>Refugee/immigrant population</td>
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<tr>
<td>Afghans</td>
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<td>7.5</td>
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<tr>
<td>Bhutanese</td>
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<td>2.5</td>
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<td>Cambodians</td>
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<tr>
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<td>Karenni</td>
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<tr>
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<tr>
<td>Ugandan</td>
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<td>5.0</td>
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<tr>
<td>Vietnamese</td>
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<td>7.5</td>
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<td>General adult</td>
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<td>Children and/or adolescents</td>
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<td>Older adults</td>
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<td>Health workers</td>
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<td>5.1</td>
</tr>
<tr>
<td>Other/not specified</td>
<td>18</td>
<td>13.0</td>
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</tbody>
</table>

a Percentages sum up to more than 100% because some studies included more than one study population.

b Percentages of each ethnicity represent the percent out of the total number of refugee study populations.
Case Study: Refugee from Guatemala

- 39 year old woman from Guatemala
- Hospitalized for suicidal thoughts after argument with boyfriend
- Prior diagnosis of bipolar disorder

- Discussed current and prior symptoms
- Discussed how her family referred to these episodes before “bipolar”
- Discussed current and prior life stressors and trauma

- Idiom of distress:
- Clinical diagnosis:
- Treatment plan:
Other Presentations

• Conversion disorder & pseudoseizures
• Catatonia - mostly affective disorders
• Psychosis vs. psychotic symptoms
  • Depression-related symptom
  • Culturally normal grief-related response
  • Identifying negative symptoms → lack of hygiene, disorganized speech
  • Trauma and PTSD
• Substance Abuse
Child and Adolescent Mental Health

**Children**
- Behavioral and attention problems
- Enuresis
- Developmental regression

**Adolescents**
- Anxiety and depression
- Substance use
- Conduct problems
- Suicidality

Cultural Framing
Older adults and geriatric populations

- Cultural concepts of aging and later life
- Cultural expectations of widows, widowers
- Social isolation after resettlement
- Inability to engage in religious practices
- Baseline education levels
- Physical health comorbidities
**Activity**: Identification of persons with distress

With the group at your table, discuss how refugee populations have described mental health problems – *specify the refugee population (region, gender, age).*

- e.g., common somatic complaints, idioms of distress
Interpersonal Psychological Theory of Suicide
1. Thwarted belongingness
2. Perceived burdensomeness

Neuropsychiatric processes – impulse control
1. Substance use (alcohol and drugs)
2. Trauma (PTSD)
3. Personality disorders (Borderline PD)
4. Neuropsychiatric disorders (Parkinsons)
5. Adolescence
Trauma

• Consider waiting until subsequent clinical encounters to discuss trauma – *not at the first visit*
  • Trauma history-taking can reinforce distressful or avoidant pathways
• Current stressful events are less frequently discussed clinically, but often the distress factor most concerning for patients and families
  • Domestic violence and abuse; work-place exploitation

Symptoms vary by population and type of traumas
• Content of nightmares
• Traumatic amnesia (vs. a desire to forget)
• Psychosis vs. PTSD
Cultural Formulation Interview (CFI)

1. Cultural identity of the individual
2. Cultural conceptualizations of distress
3. Psychosocial stressors and cultural features of vulnerability and resilience
4. Cultural features of the relationship between the individual and the clinician
5. Overall cultural assessment

*CFI can be done by any organizational staff and shared with clinicians, cultural brokers, etc.*
Start and Stay with the client’s concern

1. Avoid the seductive satisfaction of diagnostic terminology
2. Use findings from cultural formulation interview in selecting and framing any testing and care
3. Integrate mental health into primary care, family medicine, pediatrics, or other services
4. Manage expectations of medical testing and balance targeted testing with thorough (excessive) exploration
5. Assure regular appointments to strengthen therapeutic relationship and avoid costly emergency room visits
6. Integrate relaxation or mindfulness exercises into each visit
Case Study: Refugee from Bhutan

- 51 year old woman from Bhutan
- Presented to ED with headache and suicidality
- Hospitalized in psychiatric ward
- Patient had numerous somatic complaints, pain, and hypertension

Cultural formulation:
- Structure of care:
- Impact of disruptions in care:
Psychosocial and Psychological Treatments
The WHO Collaborative Study on Strategies for Extending Mental Health Care, IV: A Training Approach to Enhancing the Availability of Mental Health Manpower in a Developing Country
Psychological First Aid

PFA is... humane, supportive and practical assistance to fellow human beings who have recently suffered exposure to serious stressors, and involves:

» Non-intrusive, practical care and support
» Assessing needs and concerns
» Helping people to address basic needs (e.g. food, water)
» Listening but not pressuring people to talk
» Comforting people and helping them to feel calm
» Helping people connect to information, services and social supports
» Protecting people from further harm.
PM+ (Individual and Group)

**PROBLEM MANAGEMENT PLUS (PM+)**
Individual psychological help for adults impaired by distress in communities exposed to adversity

WHO generic指引version 1.0, 2016
Series on Low-Intensity Psychological Interventions - 2

World Health Organization

Chart: PM+ structure

1. **Introduction to PM+**
   - Introductions and confidentiality (5 mins)
   - Review from assessment and PSYCHOLOPS (10 mins)
   - What is PM+? (20 mins)
   - Understanding Adversity (30 mins)
   - Managing Stress (20 mins)
   - Ending the session (5 mins)

2. **PM+**
   - General review and PSYCHOLOPS (5 mins)
   - Managing Problems (70 mins)
   - Managing Stress (10 mins)
   - Ending the session (5 mins)

3. **PM+**
   - General review and PSYCHOLOPS (5 mins)
   - Managing Problems (35 mins)
   - Get Going, Keep Doing (35 mins)
   - Managing Stress (10 mins)
   - Ending the session (5 mins)

4. **PM+**
   - General review and PSYCHOLOPS (5 mins)
   - Managing Problems (20 mins)
   - Get Going, Keep Doing (20 mins)
   - Strengthening Social Support (30 mins)
   - Managing Stress (10 mins)
   - Ending the session (5 mins)

5. **Ending treatment**
   - General review (20 mins)
   - Staying Well (30 mins)
   - Imagining How to Help Others (20 mins)
   - Looking to the future (15 mins)
   - Ending the programme (5 mins)
Low-intensity psychosocial/psychological services delivered by non-specialists
Psychological therapies in global mental health

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>CONTROL</th>
<th>EXPERIMENTAL</th>
<th>Weight (%)</th>
<th>Standardized mean difference (95% CI)</th>
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<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Total</td>
<td>Mean</td>
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<td>Depression</td>
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<td>Chen et al. 2000</td>
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<td>4.69</td>
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<td>Gao et al. 2010</td>
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<td>Chibanda et al. 2014</td>
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<td>21.14</td>
<td>8.19</td>
<td>163</td>
<td>11.53</td>
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<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1,900</strong></td>
<td><strong>2,206</strong></td>
<td><strong>100.0</strong></td>
<td><strong>0.46 (0.33, 0.59)</strong></td>
</tr>
</tbody>
</table>
Economic implications

- Transitioning Populations
- Low-intensity psychological interventions
- Livelihood programs, Job training, Education

The number of people with depression and anxiety is increasing.

- 416 million in 1990
- 615 million in 2013

Investing in treatment for depression and anxiety makes sense.

- US$1 of investment in treatment for depression and anxiety leads to a return of US$4 in better health and ability to work.

This is good for people, and good for economies.
Linkages and collaboration among services

- Legal resources
- Language resources
- Social service organizations
- Healthcare providers
- Refugee community organizations
- Educational resources
- Parenting resources
Case Study: Refugee from Afghanistan

• 33yo refugee woman from Afghanistan
• Husband collaborated with US military in Afghanistan and family was forced to flee to Pakistan
• In the US, the patient presented to the emergency department because of dizziness; patient presented with 5 children in 100-degree weather
• Patient lost consciousness in ED, and children were taken by Department of Family and Child Services
• When patient regained consciousness and children were gone, she reported being suicidal and was hospitalized in the psychiatric ward
• Additional history of refugee experience and resettlement obtained:
  • Experience with of children in DFACS:
  • Legal and clinical experience of patient:
### TABLE 1. Contrast of Traditional “Broadcasting” Versus Iowan “Cluster” Resettlement

<table>
<thead>
<tr>
<th>Description of Characteristics</th>
<th>Traditional Broadcasting Resettlement</th>
<th>Iowan Cluster Resettlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical origins</td>
<td>Post-World War II relocation of Europeans displaced by war</td>
<td>Post-Vietnam era relocation of a tribal people from northern Laos</td>
</tr>
<tr>
<td>Planning approach</td>
<td>Top-down, with federal authorities randomly deciding on relocation site</td>
<td>Top-down and bottom-up, with involvement on federal, state, and refugee levels</td>
</tr>
<tr>
<td>Chronology of adjustment</td>
<td>Begins when the refugees arrive in the community (Westermeyer, 1984a)</td>
<td>Begins before the refugees arrive in the community</td>
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<td>planning</td>
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<td>Characteristics of receiving</td>
<td>Unimportant in relocation decisions</td>
<td>All important in relocation decisions</td>
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<tr>
<td>Characteristics of refugees</td>
<td>Unimportant in relocation decisions</td>
<td>All important in relocation decisions</td>
</tr>
<tr>
<td>(skills, interests, family</td>
<td></td>
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<tr>
<td>organization)</td>
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<tr>
<td>Secondary migration and</td>
<td>Fosters secondary migrations and ghettos</td>
<td>Impedes secondary migration and ghettos</td>
</tr>
<tr>
<td>ghetto formation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acculturation</td>
<td>Impedes acculturation by distancing migrant from indigenous Americans (Westermeyer and Her, 1996)</td>
<td>Fosters acculturation by linking the migrant to the American sponsor and employer</td>
</tr>
<tr>
<td>Social consequences</td>
<td>Favors gangs, substance abuse, crime, welfare dependence, unemployment</td>
<td>Reduces untoward social consequences, such as gangs</td>
</tr>
<tr>
<td>Effects on refugee populations</td>
<td>Increased incarceration, violence, and mental-emotional-behavioral disorders (Westermeyer, 1985;</td>
<td>Reduced incarceration, violence, and mental-emotional-behavioral disorders</td>
</tr>
<tr>
<td></td>
<td>Westermeyer, 1993)</td>
<td></td>
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<tr>
<td>Effects on receiving</td>
<td>Increases cost of social services, welfare, criminal justice, and mental health services (Westermeyer</td>
<td>Reduces cost of social services, welfare, criminal justice, and mental health services</td>
</tr>
<tr>
<td>communities</td>
<td>et al., 1990)</td>
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</tr>
</tbody>
</table>
Identification in communities

- Screening base approaches
  - Use of translated and validated questionnaires
  - Use of adult and child versions
  - Assure availability of successful referrals

- Tools
  - RHS-15, PHQ-9, GHQ-12, CES-D, PHQ-A, DSRS, RCADS, CPSS
Community Informant Detection Tool (CIDT)

- Narrative and pictorial approach to recognizing persons in need of care
- Involves discussing care seeking with person to be referred
- Training = 2 days
- Uses in U.S. – Bhutanese in Philadelphia, Korean Adolescents in Maryland
Collaboration with Law Enforcement and Juvenile Justice Personnel

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
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<tbody>
<tr>
<td>8:00 am</td>
<td>Breakfast and introductions</td>
<td>Breakfast and prior day reviews</td>
<td>Breakfast and prior day reviews</td>
<td>Breakfast and prior day reviews</td>
<td>Breakfast and prior day reviews</td>
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<tr>
<td>8:30 am</td>
<td>Pre-Test</td>
<td>CIT principles</td>
<td>Substance abuse disorders</td>
<td>Liberia mental health policy</td>
<td>Review: de-escalation techniques</td>
</tr>
<tr>
<td>9:30 am</td>
<td>Definitions of mental health</td>
<td>Communication skills and verbal</td>
<td>Psychotic disorders</td>
<td>Liberia legal issues and</td>
<td>Review: de-escalation techniques</td>
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<tr>
<td></td>
<td>and mental illness</td>
<td>de-escalation</td>
<td></td>
<td>mental health legislation</td>
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</tr>
<tr>
<td>11:00 am</td>
<td>Signs and symptoms of mental ill</td>
<td>Communication skills and verbal</td>
<td><strong>Trauma-related disorders</strong></td>
<td>Liberia legal issues and</td>
<td>Review: suicide prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>de-escalation</td>
<td></td>
<td>mental health legislation</td>
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<tr>
<td>1:00 pm</td>
<td>Lunch</td>
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<tr>
<td>2:00 pm</td>
<td>Mental illness myths and facts</td>
<td>Suicide prevention</td>
<td>Mental health facility site</td>
<td>Mental health in correctional</td>
<td>Review: CIT principles</td>
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<tr>
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<td></td>
<td></td>
<td>visit</td>
<td>facilities and communities</td>
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<tr>
<td>3:00 pm</td>
<td>Engagement with consumers</td>
<td>Mental health referral processes</td>
<td>Mental health facility site</td>
<td>Working with families and</td>
<td>Post-test</td>
</tr>
<tr>
<td></td>
<td>and families</td>
<td></td>
<td>visit</td>
<td>communities</td>
<td></td>
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<tr>
<td>4:30 pm</td>
<td>Daily review and lessons</td>
<td>Daily review and lessons</td>
<td>Daily review and lessons</td>
<td>Daily review and lessons</td>
<td>Graduation</td>
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<td>learned</td>
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<td>learned</td>
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</table>
Activity: Next steps in collaborations

• As a group, discuss what additional activities could be integrated into communities and/or social service organizations. For example,
  • identification and referral (screening, CIDT, other approaches)
  • low-intensity psychosocial and psychological services (Psychological First Aid (PFA)/Mental Health First Aid, Problem Management Plus PM+)
  • linkages with clinical services (community navigators), law enforcement/juvenile justice, etc.

• What are key facilitators and barriers to implement such activities?
• What additional information would you need to design your program?
Culturally and Linguistically Appropriate Services (CLAS) Standards

Quality care responsive to culture and language

Governance, leadership and workforce

Engagement, continuous improvement, and accountability

Communication and language assistance

Language assistance, advertise language assistance, competence of interpreters, print materials

Goals and accountability, ongoing assessment, record REAL demographics, community assessments, partner with community, conflict resolution, communicate CLAS implementation to public

https://www.thinkculturalhealth.hhs.gov/clas
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

1.2a Identify and designate a CLAS champion or champions, who are supported by the organization’s leadership, and whose specific responsibilities include (at a minimum) continuous learning about, promoting, and identifying and sharing educational resources about CLAS and the National CLAS Standards throughout the organization.

1.2b Create and implement a formal CLAS implementation plan that is (at a minimum) endorsed and supported by the organization’s leadership, that describes how each Standard is understood, how each Standard will be implemented and assessed, and who in the organization is responsible for overseeing implementation.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

1.3a Target recruitment efforts to the populations served to increase the recruitment of culturally and linguistically diverse individuals, through actions such as: posting job descriptions in multiple languages in local community media, holding job fairs in the community(ies) served, and/or working with leaders of local community institutions to create mentorship and training programs targeting populations served.

1.3b Create internal organizational mentorship programs, specifically targeting culturally and linguistically diverse individuals, that provide information about and support for additional training opportunities, and that links individuals in junior positions with individuals in senior positions to receive career guidance and advice.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate practices and policies on an ongoing basis.

1.4a Deliver or make freely available continuous CLAS-related training and technical assistance to leadership and all staff.

1.4b Create and disseminate new resources about CLAS within the organization using widely accessible platforms (e.g., employee- dedicated webpages, employee Intranet, employee break room).

1.4c Incorporate assessment of CLAS competencies (e.g., bilingual communication, cross-cultural communication, cultural and linguistic knowledge) on an ongoing basis into staff performance ratings.

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

2.5a Complete an organizational assessment specific to language assistance services to describe existing language assistance services and to determine how they can be more effective and efficient.

2.5b Standardize procedures for staff members and train staff in those procedures. It may be appropriate to provide staff with a script to ensure that they inform individuals of the availability of language assistance and to inquire whether they will need to utilize any of the available services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

2.6 Provide individuals with notification that describes what communication and language assistance is available, in what languages the assistance is available, and to whom they are available. Notification should clearly state that communication and language assistance is provided by the organization free of charge to individuals.

7. Ensure the [mental health] competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

2.7a Require that all individuals serving as interpreters complete certification or other formal assessments of linguistic and health care terminology skills to demonstrate competency.

2.7b Provide financial and/or human resource (e.g., time off) incentives to staff who complete interpreter training and meet assessment criteria, to build organizational capacity to provide competent language assistance.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

2.8 Formulate processes for translating materials into languages other than English and for evaluating the quality of these translations. This may include testing materials with target audiences.

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.

2.9 Incorporate CLAS into mission, vision, and/or strategic plans by determining how organization acknowledges and addresses concepts such as diversity, equity, inclusion, and practices such as asking individuals about preferences for care/services.

10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

3.10a Tailor existing evaluation efforts to include measures of CLAS implementation (e.g., patient/client satisfaction measures can include questions about CLAS; outcome data can be stratified by REAL data to determine demographic differences).

3.10b Complete a CLAS-related organizational assessment of the cultural and linguistic needs of populations served and of organizational resources to address these needs.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

3.11a Collect race, ethnicity, and language (REAL) data (at a minimum) from all individuals receiving services, either by tailoring existing data collection approaches or creating a new data collection process.

3.11b Use REAL data to identify needs, describe current care and service provision trends, and improve care and service provision.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

3.12 Collaborate with stakeholders and community members in community health needs assessment data collection, analysis, and reporting efforts to increase data reliability and validity.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

3.13 Include community members in the process of planning programs and developing policies to ensure cultural and linguistic appropriateness by convening town hall meetings, conducting focus groups, and/or creating community advisory groups.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

3.14 Consider using staff as cultural brokers to help improve feedback mechanisms, conflict resolution process, and communication with culturally and linguistically diverse individuals.

15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

3.15 Partner with community organizations to lead discussions about the services provided and progress made and to create advisory boards on issues affecting diverse populations and how best to serve and reach them.
Personal and Institutional Responsibilities

• Staff recruitment
• Staff training, capacity building, and promotion
• Awareness of CLAS standards and educating others
• Availability and advertising of language services
• Linguistic competence [in mental health terminology and concepts]
• Cultural translation and adaptation of materials
• Monitoring of outcomes by REAL categories*
• Partnering with community in design, implementation, and evaluation of programs

*Consider post-encounter surveys on language, ethnicity, age, gender, and sexual orientation preferences for service providers
ITEM 11. EXPLORATION OF PATIENT’S & SOCIAL SUPPORT NETWORK’S EXPLANATION FOR PROBLEM (CAUSAL & EXPLANATORY MODELS)

○ 1 NEEDS IMPROVEMENT = clinician does not ask the patient about his/her own view of the cause or is judgmental/critical about patient’s explanation (e.g. “Witchcraft doesn’t cause these problems, that is an ignorant/backwards idea!)

○ 2 DONE PARTIALLY = clinician asks patient about his/her own view of cause but does not explore if this the same as the family’s view

○ 3 DONE WELL = clinician asks the patient about cause and asks if family/support network have similar or different explanations

ITEM 16. PSYCHOEDUCATION INCORPORATING LOCAL (ETHNOSCIENCE) CONCEPTS & TERMS

○ 1 NEEDS IMPROVEMENT = clinician uses technical jargon to explain mental health or uses stigmatizing terms or does not explain how treatment works

○ 2 DONE PARTIALLY = clinician uses a limited amount of technical jargon and no stigmatizing terms, but clinician does not incorporate patient’s explanatory model or other local psychological concepts into psychoeducation

○ 3 DONE WELL = clinician conducts psychoeducation using local psychological concepts including patient’s explanatory model (see Item 7), local terminology, and idioms of distress to explain mental health and treatment in non-stigmatizing language, and checks to see if patient understands
Welcome to the prototype EQUIP platform

This is a testing area for us to quickly review content and functionality that we think might be useful to the wider group.

**Implementation Guidance**
This guide offers practical guidance on how to choose, prepare, implement, monitor, and evaluate effective interventions...
Learn More →

**Training Content Library**
A library resource to support trainers developing and tailoring core competency training for non-specialised professionals...
Learn More →
Summary: Three Pillars of Successful Mental Health Care with Refugee Populations

1. Partnerships
2. Comprehensive integration with other services
3. Cultural humility

Resources: CLAS, ENACT, WeACT, EQUIP, CIDT, CFI, CLI, PFA, PM+, SH+, THP, EASE, DBT