

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

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Johnson County Public Health

Public Health
Prevent. Promote. Protect.
Linn County, Iowa

Promoting Culturally Appropriate Care for New Iowans

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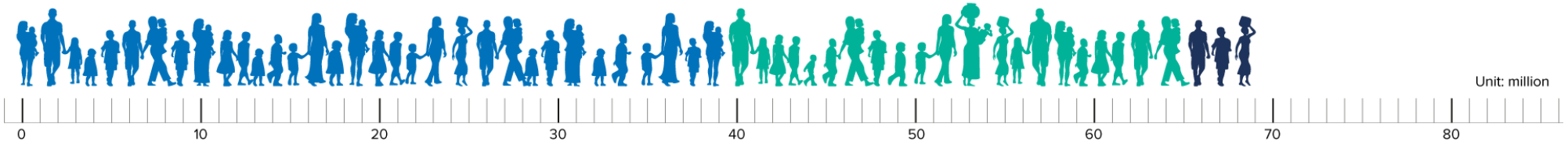
Activity 1

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

85 per cent of the world's displaced people are in developing countries

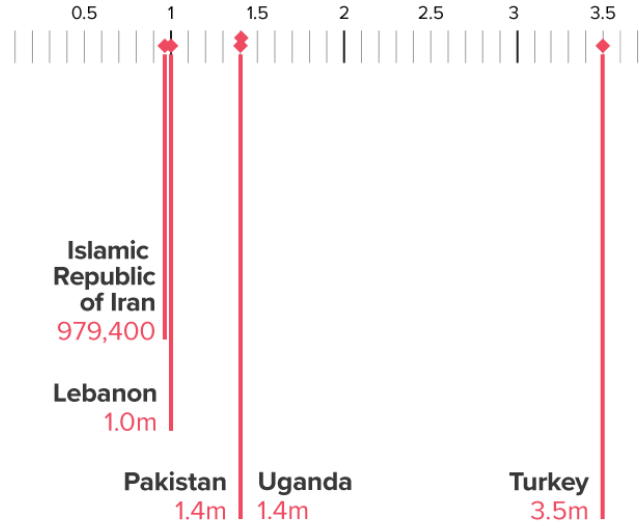
57% of refugees worldwide came from three countries

South Sudan
2.4m

Afghanistan
2.6m

Syria
6.3m

Top refugee-hosting 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

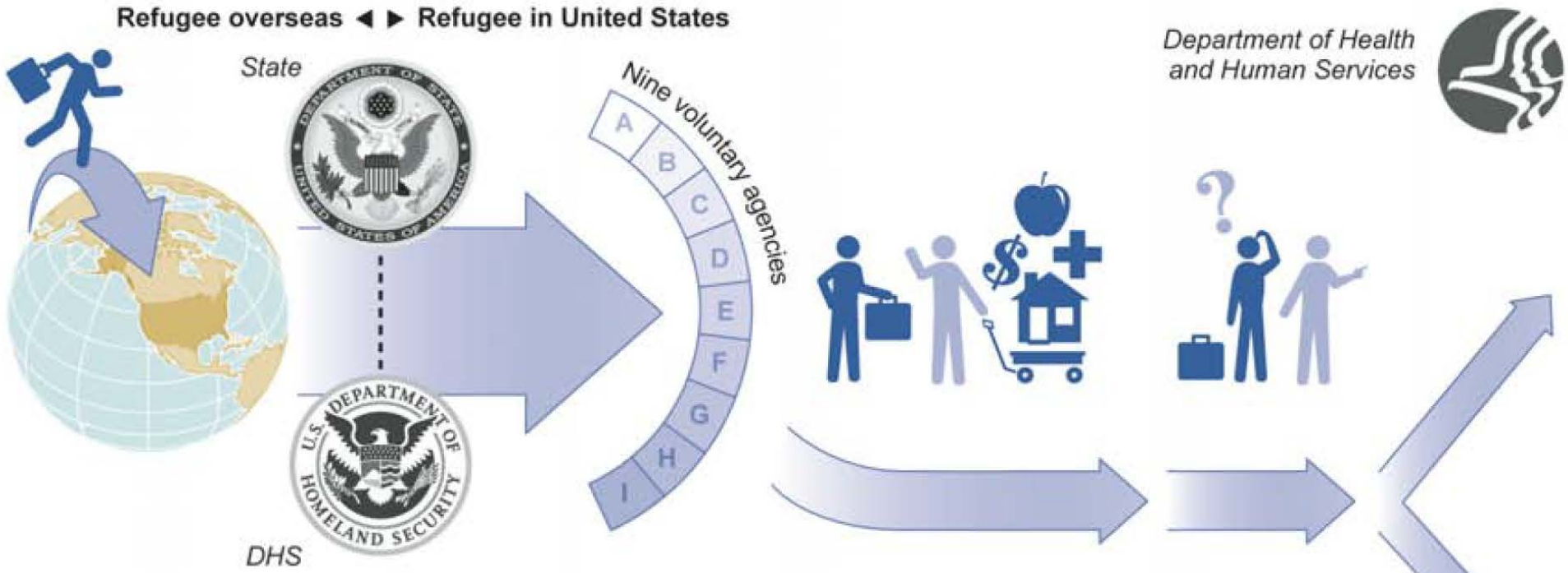
Definition of refugee and asylee

"[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

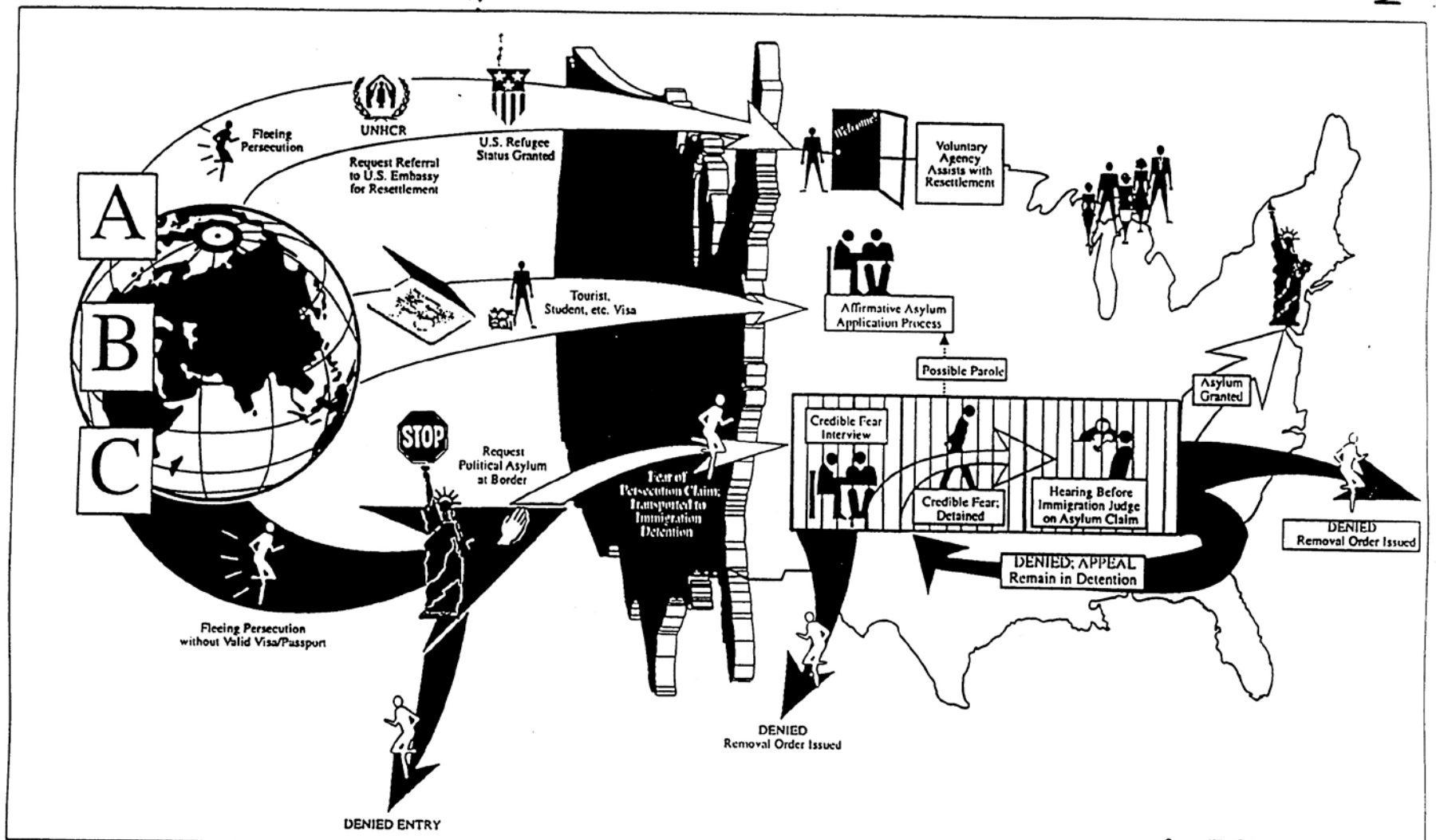
Other public assistance

- 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)

Applying for Refugee Status/ Political Asylum in the United States

Memo 1



A Refugee Resettlement

B Travel With Valid Documents

C Travel Without Valid Documents

JRS

JESUIT REFUGEE SERVICE
Catholic Community Services
976 Broad Street
Newark, NJ 07102
Phone: 973-733-3516 x207
Email: JR(ley@aol.com

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)

Community Perspectives on Mental Health Needs

Heather Meador RN, BSN

June 5th, 2019

LINN COUNTY

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**
- **Burundi**
- **Congolese**
- Iraqi
- Rwanda
- **Somalian**
- **Sudanese**
- Vietnamese
- Yemenis

Refugee Population Migration

- Last 5 years
  - **Iraqi, Syrian, Congolese, Sudanese,** Afghan, Burmese, Nepalese, Bhutanese, Burundian, Somalian
- 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

LINN COUNTY

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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**

LINN COUNTY

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

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Moderated Discussion

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/ I

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)[a].

	Number of study populations	%
Region of the world		
Africa	60	43.5
Australia	4	2.9
Central America/Caribbean	13	9.4
Middle East	3	2.2
South America	1	0.7
South Asia	12	8.7
Southeast Asia	41	29.7
United States/Europe	4	2.9
Refugee/immigrant population[b]	37	26.8
Afghans	3	7.5
Bhutanese	1	2.5
Cambodians	19	47.5
Congolese	1	2.5
Hmong	1	2.5
Karenni	1	2.5
Somali	1	2.5
Sudanese	4	10.0
Tibetan	1	2.5
Ugandan	2	5.0
Vietnamese	3	7.5
Study population		
General adult	63	45.7
Women only	29	21.0
Men only	4	2.9
Children and/or adolescents	14	10.1
Older adults	3	2.2
Health workers	7	5.1
Other/not specified	18	13.0

[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

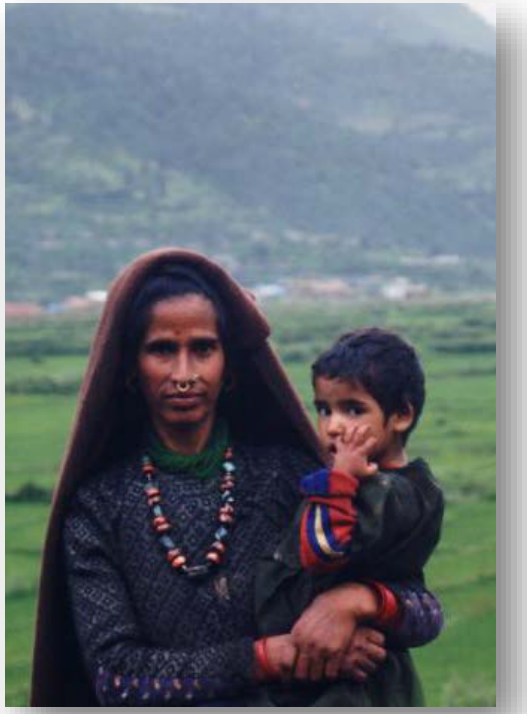
- Discussed current and prior symptoms
- Discussed how her family referred to these episodes before “bipolar”
- Discussed current and prior life stressors and trauma

- 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

Conceptual models

Interpersonal Psychological Theory of Suicide

1. Thwarted belongingness
2. Perceived burdensomeness

(Joiner, T.E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.)

Neuropsychiatric processes – impulse control

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

(Jollant et al. (2011). The suicidal mind and brain: neuropsychological and neuroimaging studies. *World Journal of Biological Psychiatry, 12(5), 319-339.)*

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

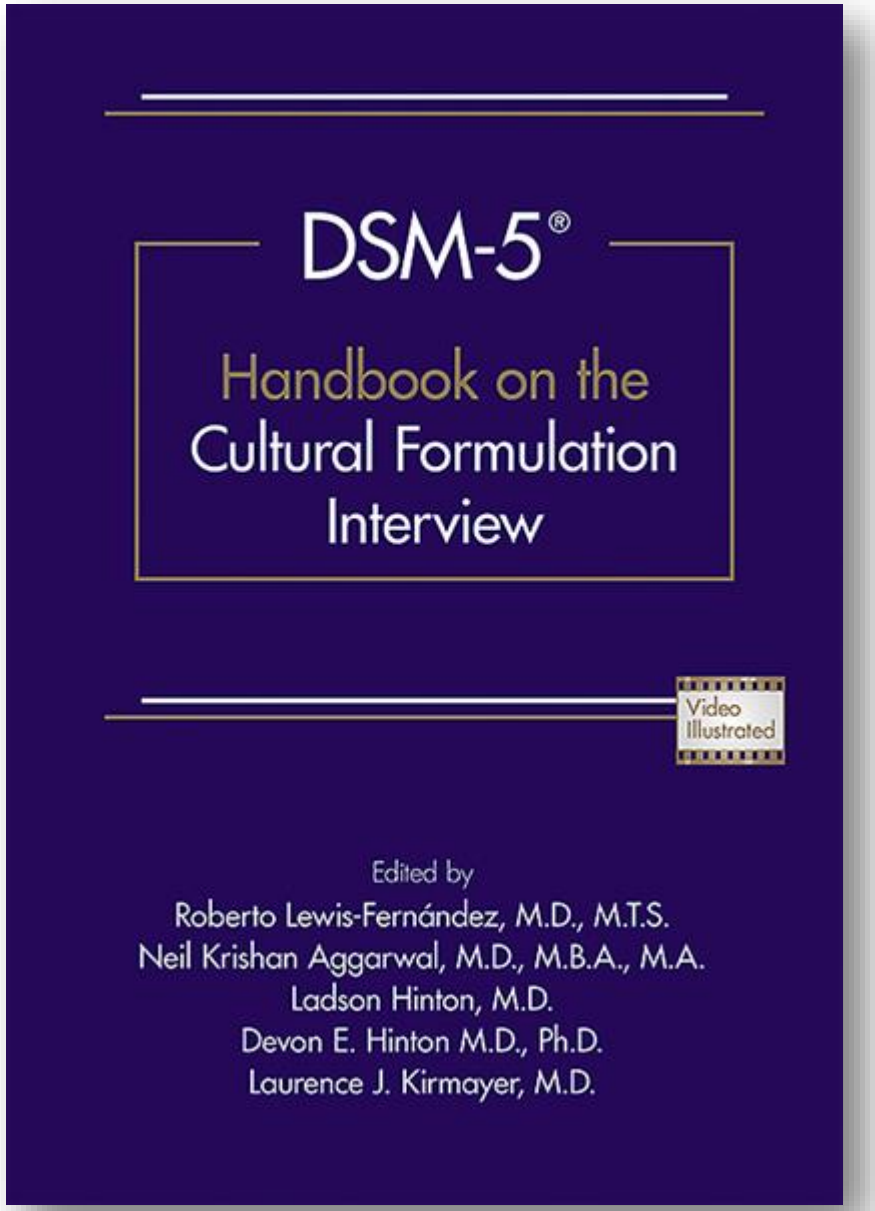
Symptoms vary by population and type of traumas

- 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

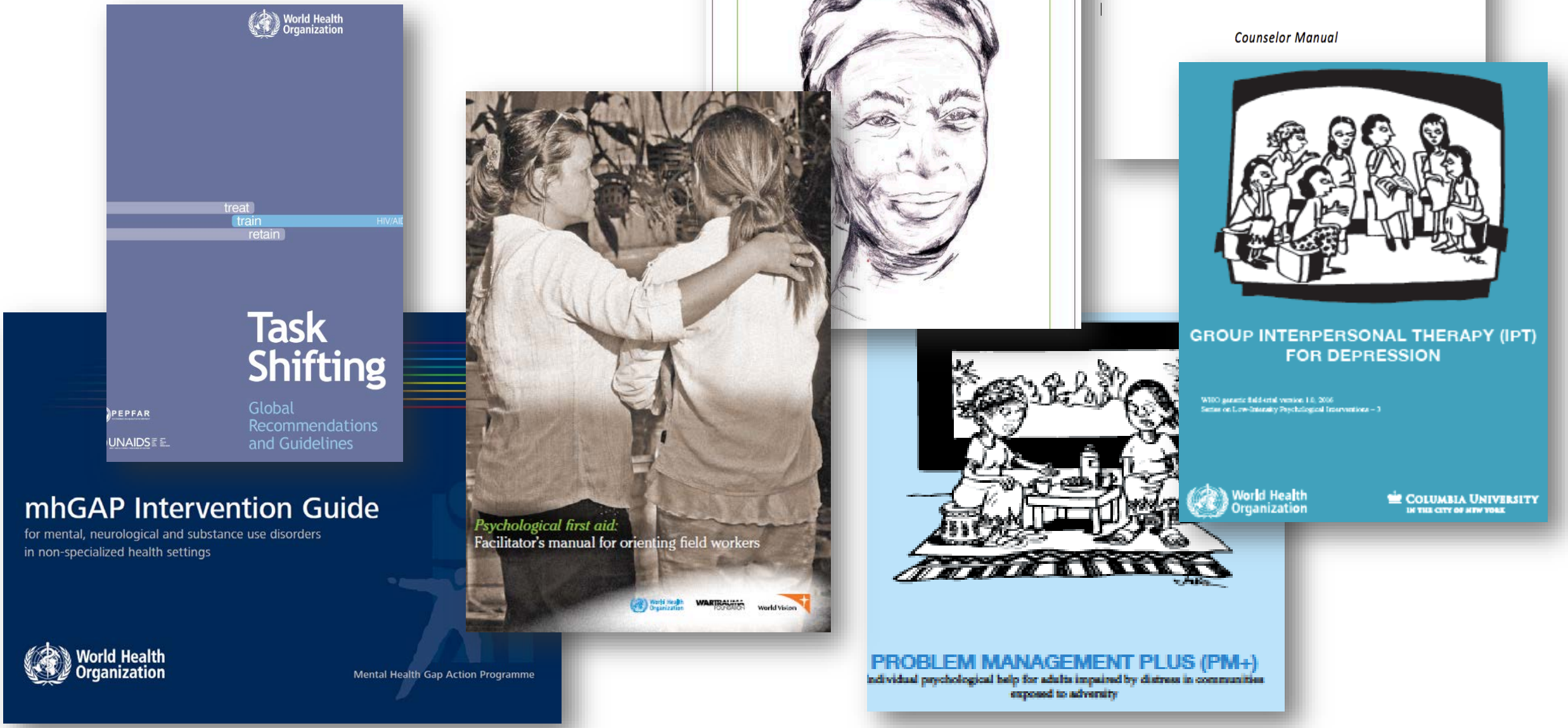
- 51 year old woman from Bhutan
- Presented to ED with headache and suicidality
- Hospitalized in psychiatric ward
- Patient had numerous somatic complaints, pain, and hypertension

- Cultural formulation:
- Structure of care:
- Impact of disruptions in care:

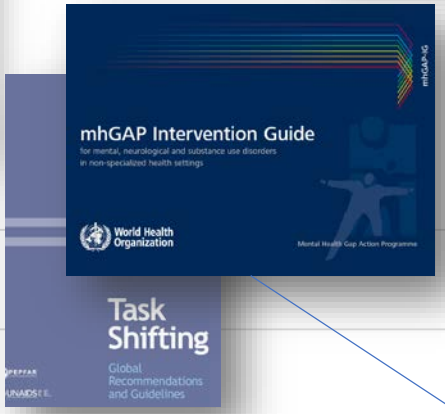
TABLE 1. Components of Nepali ethnopsychology in therapy modalities

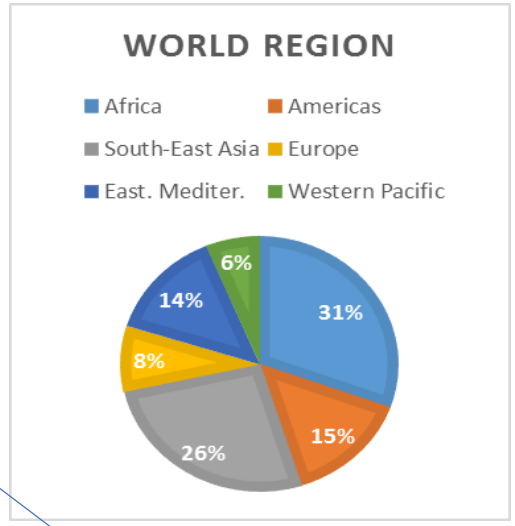
Ethno-psychology Component	Description	Cognitive Behavior Therapy (CBT)	Interpersonal Therapy (IPT)	Dialectical Behavior Therapy (DBT)
Heart-mind (*man*)	Organ of emotions, memories, and desires	'Feelings' in CBT should reference heart-mind processes	Heart-mind processes are examined in the context of social relationships; IPT grief theme relates to the heart-mind	Radical acceptance and change framed in heart-mind and brain-mind conflicts
Brain-mind (*dimaag*)	Organ of social responsibility and behavioral control	'Thoughts' and 'appraisals' in CBT should reference brain-mind processes	Behavioral control through the brain-mind is examined in the context of social relationships	Brain-mind and heart-mind conflicts are reduced; the brain-mind is responsible for regulating "opposite actions" and "response prevention"
Physical body (*jiu, saarir*)	Physical sense organ, topography of pain	Somatic complaints in CBT may be consequence of heart-mind and brain-mind processes	The connection between physical suffering and relationships is explored through the social world, heart-mind, and physical body	"Opposite actions" and "response prevention" are used to prevent self-injury to the body
Spirit (*saato*)	Vitality, energy, immunity to illness	Lost vitality in CBT can be associated with strong emotions in heart-mind (anger, fear)	Loss of vitality can be tied to difficulties in interpersonal relationships with both family and ancestral spirits	Preventing soul loss (*saato jaane*) is addressed through reducing intensity of emotions in heart-mind
Social status (*ijjat*)	Personal and family social standing and respect	Social status can be maintained through better insight into thoughts and feelings in CBT	Social status is explored by considering network of relationships; interpersonal deficits related to perceived social status can be challenged	Distress from perceived social status loss (*bejjat*) is managed through heart-mind emotional acceptance
Family and community relationships	Social support and social burden	The brain-mind processes related to relationships are explored for their effect on heart-mind processes	IPT themes of interpersonal disputes and role transitions examine social relationships	The group therapy component of DBT is used to discuss and model appropriate social relationships

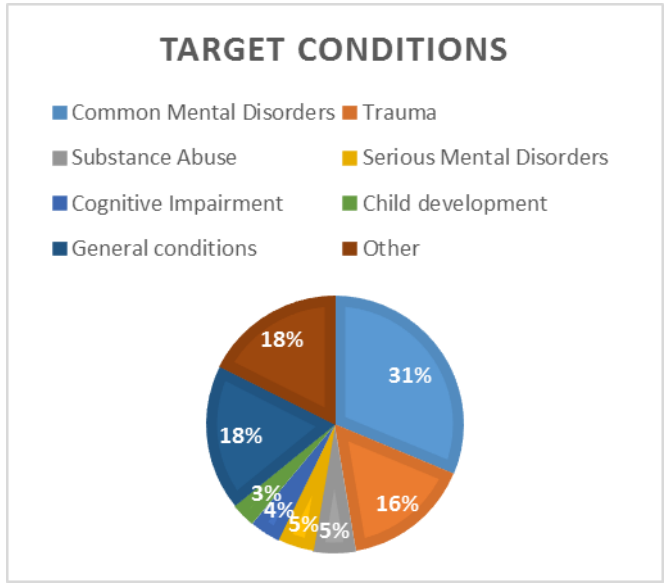
Psychosocial and Psychological Treatments



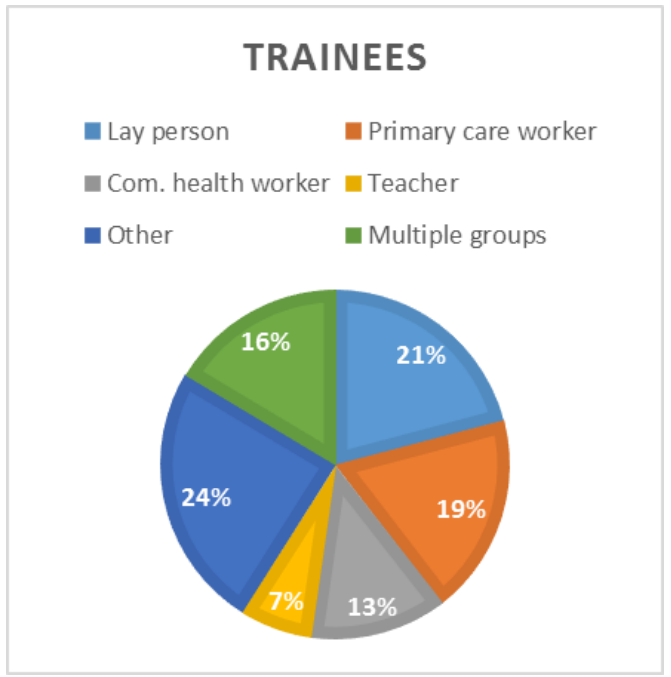
Task Sharing



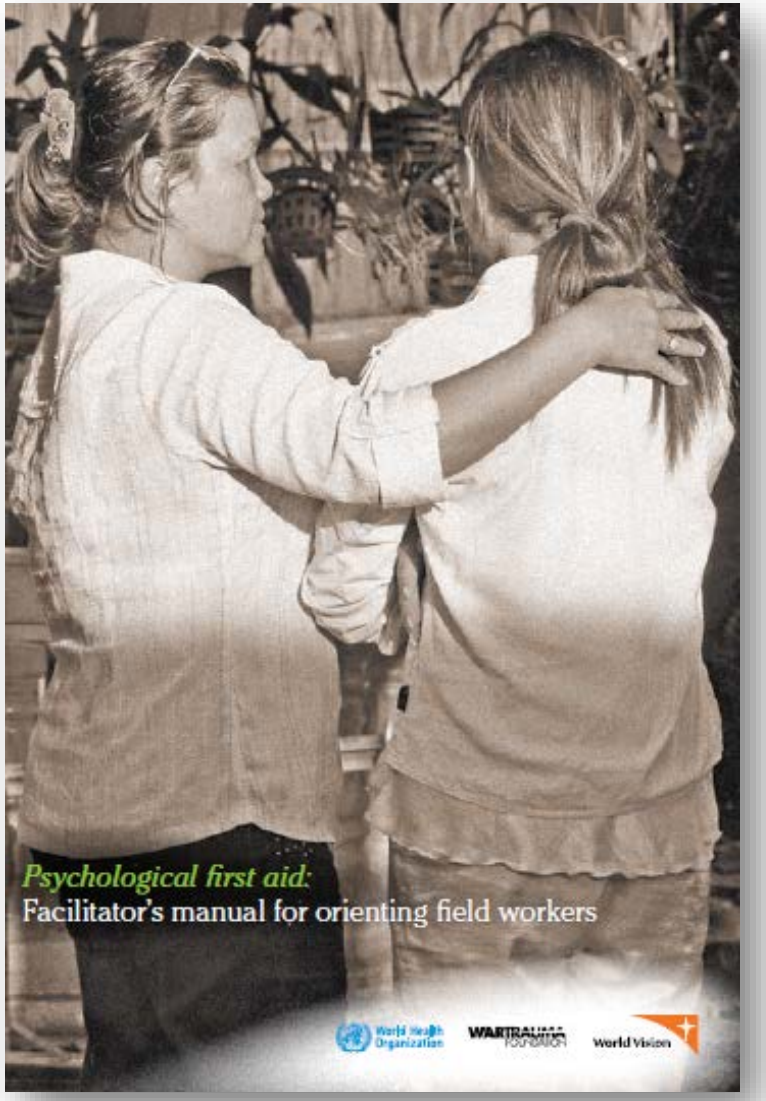




The WHO Collaborative Study on Strategies for Extending Mental Health Care, IV: A Training Approach to Enhancing the Availability of Mental Health Manpower in a Developing Country

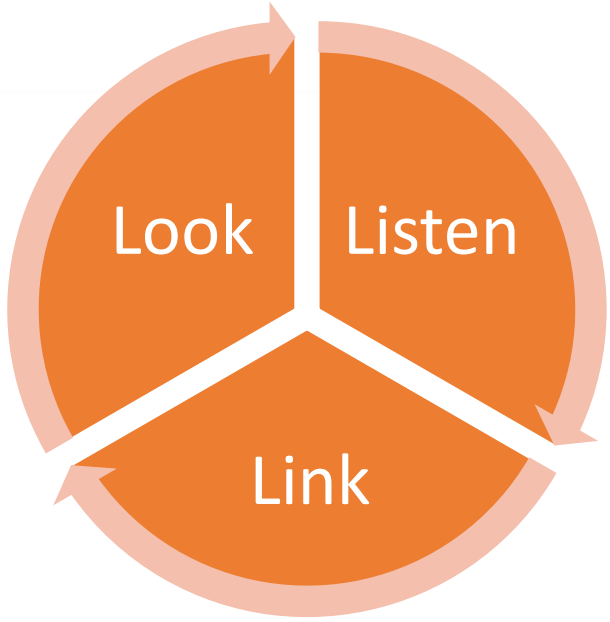


Psychological First Aid



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)

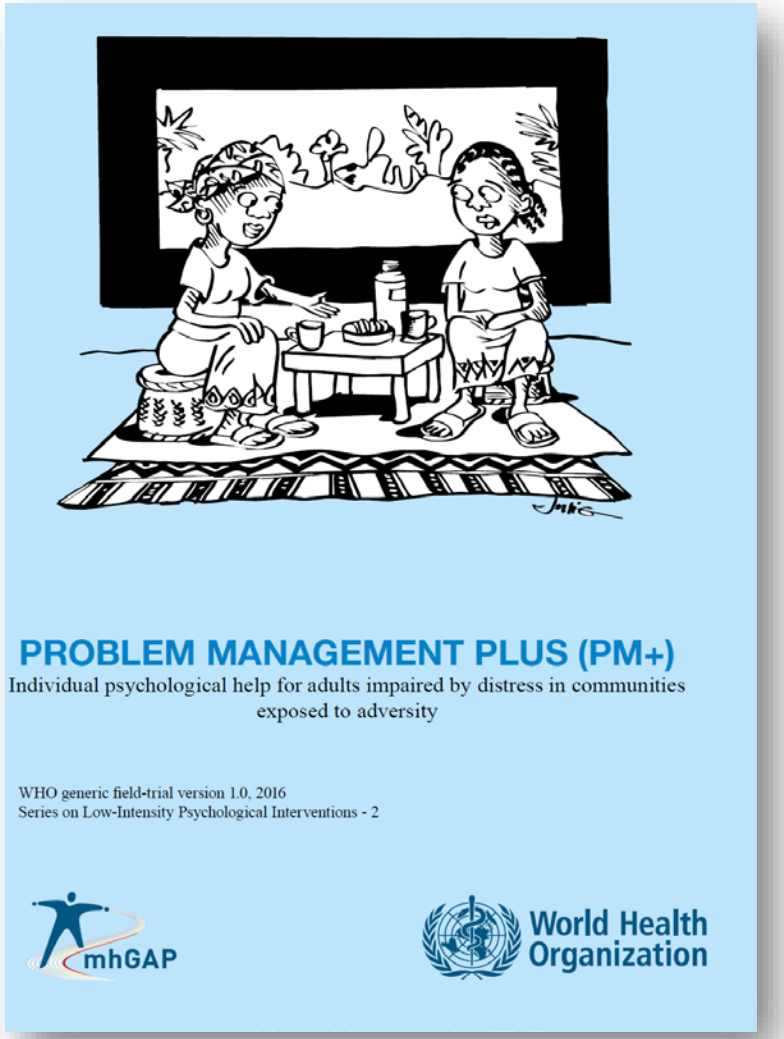


Chart: PM+ structure

1

Introduction to PM+
- Introductions and confidentiality (5 mins)
- Review from assessment and PSYCHLOPS (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 PSYCHLOPS (5 mins)
- Managing Problems (70 mins)
- Managing Stress (10 mins)
- Ending the session (5 mins)

3

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

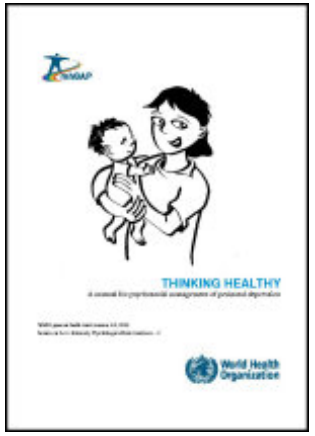
4

PM+
- General review and PSYCHLOPS (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



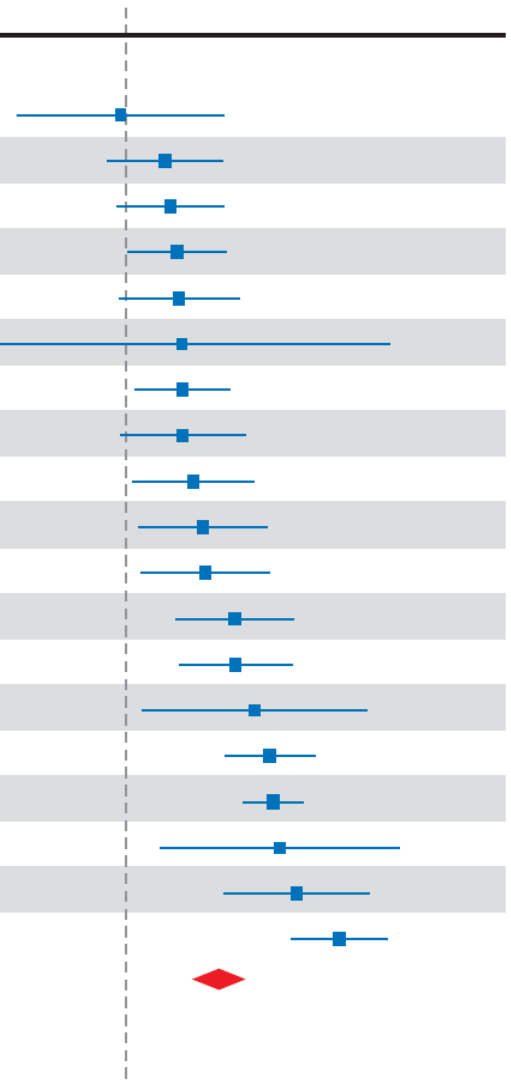
Step 3: Practicing healthy actions

Psychological therapies in global mental health

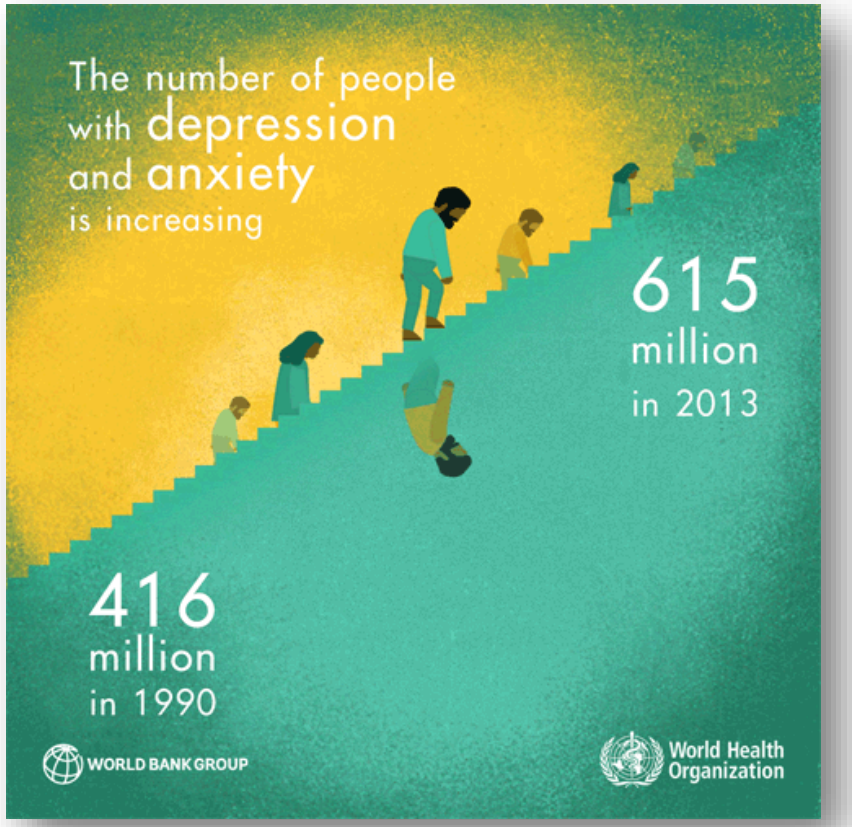
b

Study or subgroup	CONTROL Mean	SD	Total	EXPERIMENTAL Mean	SD	Total	Weight (%)	Standarized mean difference (95% CI)
Depression								
Chen et al. 2000	15.73	6.19	30	15.9	6.83	30	3.6	–0.03 (–0.53, 0.48)
Tiwari et al. 2010	18.25	11.4	100	16.1	10.69	100	5.8	0.19 (–0.08, 0.47)
Rojas et al. 2007	12.5	7.42	116	10.9	7.08	114	6.0	0.22 (–0.04, 0.48)
Fritsch et al. 2007	14.8	8.18	131	12.8	7.62	143	6.3	0.25 (0.01, 0.49)
Weiss et al. 2015(i)	0.7	0.8	64	0.48	0.85	154	5.7	0.26 (–0.03, 0.55)
Hirani et al. 2010a	27.63	9.1	8	24.71	10.9	7	1.3	0.28 (–0.75, 1.30)
Singla et al. 2015	18.61	10.44	131	15.36	12.51	160	6.3	0.28 (0.05, 0.51)
Bolton et al. 2014a(i)	1.15	0.73	66	0.88	1.07	114	5.5	0.28 (–0.02, 0.58)
Gao et al. 2015	8.96	4.55	90	7.61	3.43	90	5.6	0.33 (0.04, 0.63)
Bolton et al. 2014a(ii)	1.16	0.73	66	0.89	0.7	101	5.4	0.38 (0.06, 0.69)
Ho et al. 2009	7.11	4.69	80	5.33	4.37	83	5.5	0.39 (0.08, 0.70)
Gao et al. 2010	8.87	4.37	98	6.59	4.1	96	5.7	0.54 (0.25, 0.82)
Araya et al. 2003	17.5	15.93	107	8.61	16.91	104	5.9	0.54 (0.26, 0.81)
Milani et al. 2015	10.33	3.93	27	7.95	3.45	27	3.3	0.63 (0.09, 1.18)
Bolton et al. 2014b	0.74	0.72	165	0.31	0.48	182	6.5	0.71 (0.49, 0.93)
Rahman et al. 2008	10.7	8.1	386	5.4	6.5	412	7.2	0.72 (0.58, 0.87)
Chibanda et al. 2014	10.7	2.7	22	8.22	3.6	27	3.0	0.76 (0.17, 1.34)
Weiss et al. 2015(ii)	1.01	0.92	50	0.42	0.56	99	5.0	0.84 (0.48, 1.19)
Bolton et al. 2003	21.14	8.19	163	11.53	10	163	6.3	1.05 (0.82, 1.28)
Subtotal (95% CI)			**1,900**			**2,206**	**100.0**	**0.46 (0.33, 0.59)**

Heterogeneity: $T^2 = 0.06$; $X^2 = 66.92$, $df = 18$ ($p < 0.00001$); $I^2 = 73\%$
Test for overall effect: $Z = 7.02$ ($p < 0.00001$)

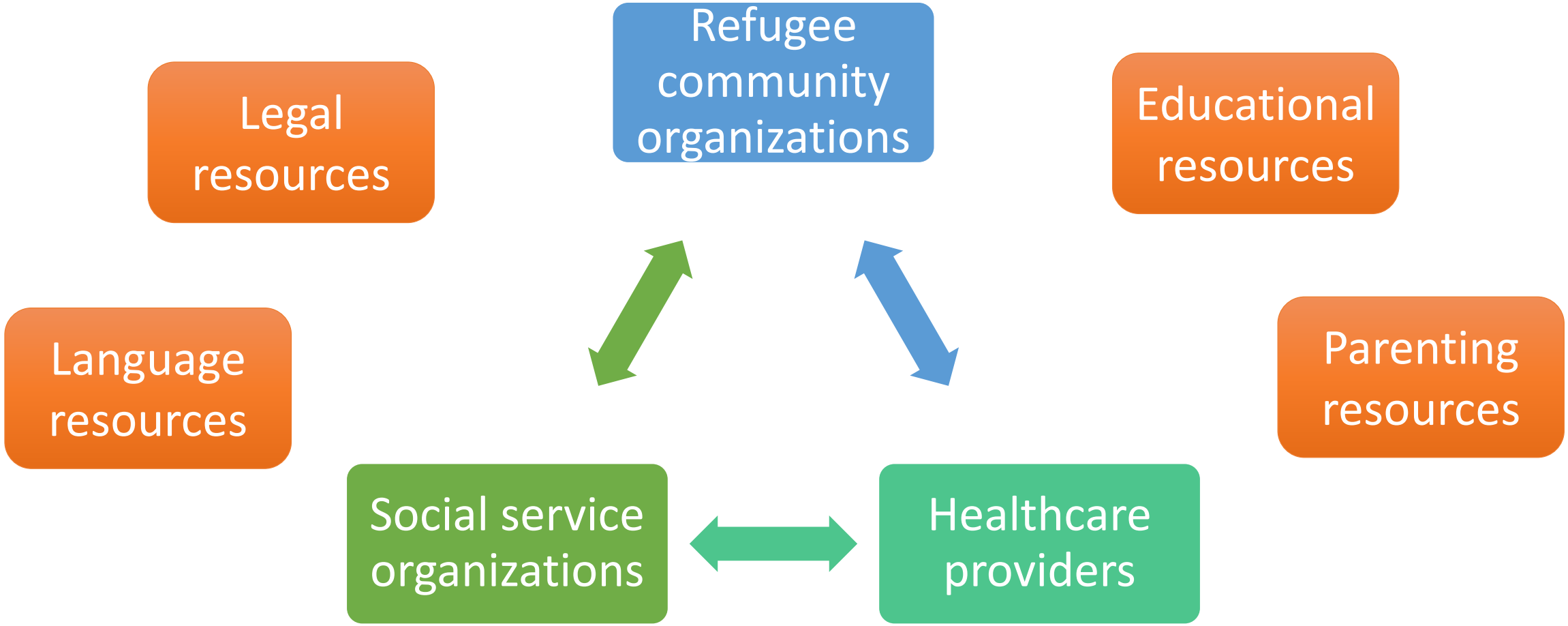


Economic implications



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

Linkages and collaboration among services



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:*

The Iowa Experiment

TABLE 1. Contrast of Traditional "Broadcasting" Versus Iowan "Cluster" Resettlement

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

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

REFUGEE HEALTH SCREENER (RHS-15)

Instructions: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

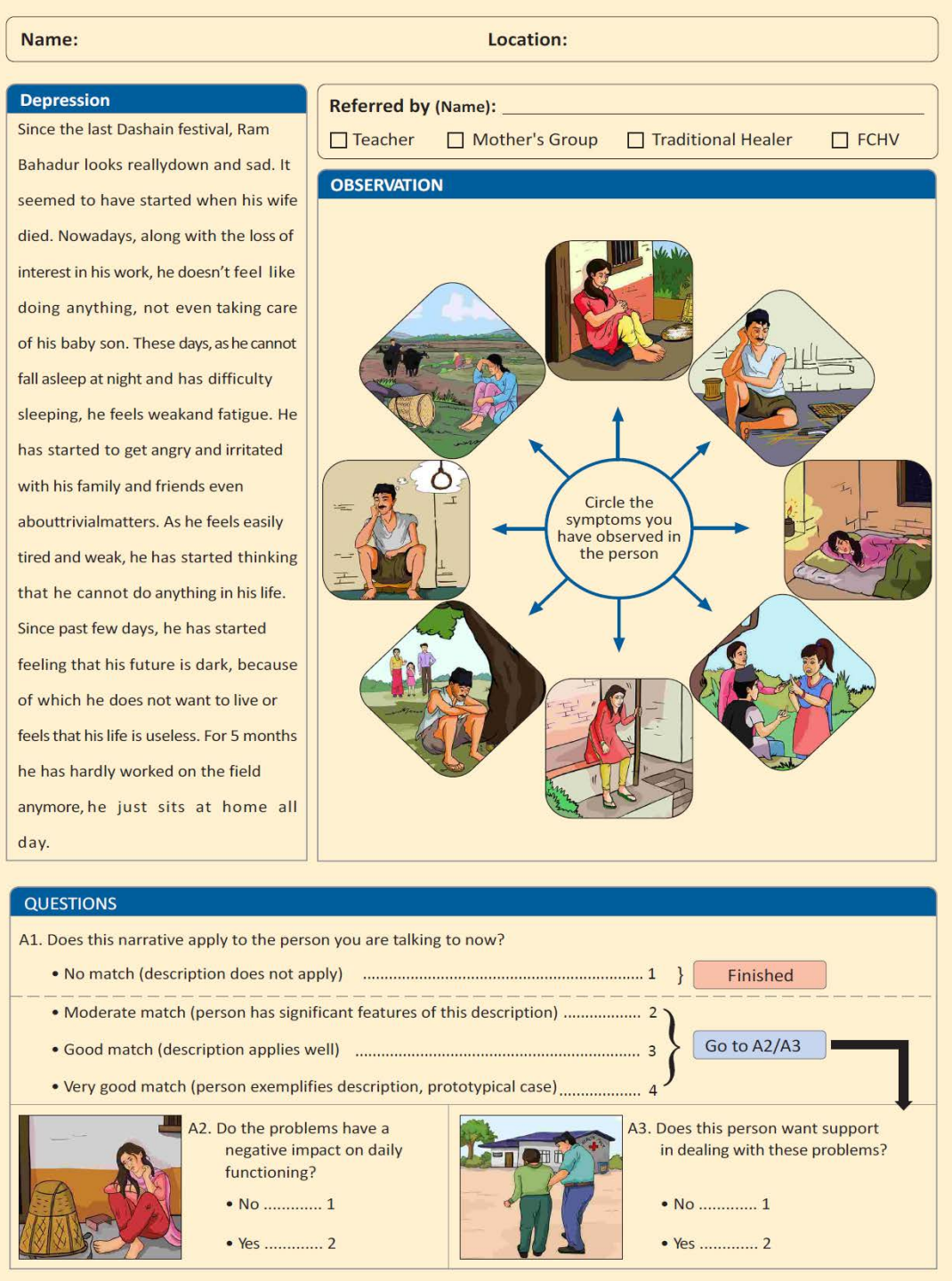
SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODER-ATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

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



Name: Location:

Depression

Since the last Dashain festival, Ram Bahadur looks reallydown and sad. It seemed to have started when his wife died. Nowadays, along with the loss of interest in his work, he doesn't feel like doing anything, not even taking care of his baby son. These days, as he cannot fall asleep at night and has difficulty sleeping, he feels weakand fatigue. He has started to get angry and irritated with his family and friends even abouttrivialmatters. As he feels easily tired and weak, he has started thinking that he cannot do anything in his life. Since past few days, he has started feeling that his future is dark, because of which he does not want to live or feels that his life is useless. For 5 months he has hardly worked on the field anymore, he just sits at home all day.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION

Circle the symptoms you have observed in the person

QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) ..... 1 } Finished
- Moderate match (person has significant features of this description) 2
- Good match (description applies well) ..... 3 } Go to A2/A3
- Very good match (person exemplifies description, prototypical case) 4

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

Collaboration with Law Enforcement and Juvenile Justice Personnel

TABLE 2—Proposed 5-Day Liberian Mental Health Crisis Intervention Team (CIT) Curriculum for Correctional and Patrol Officers: Liberia, 2013

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

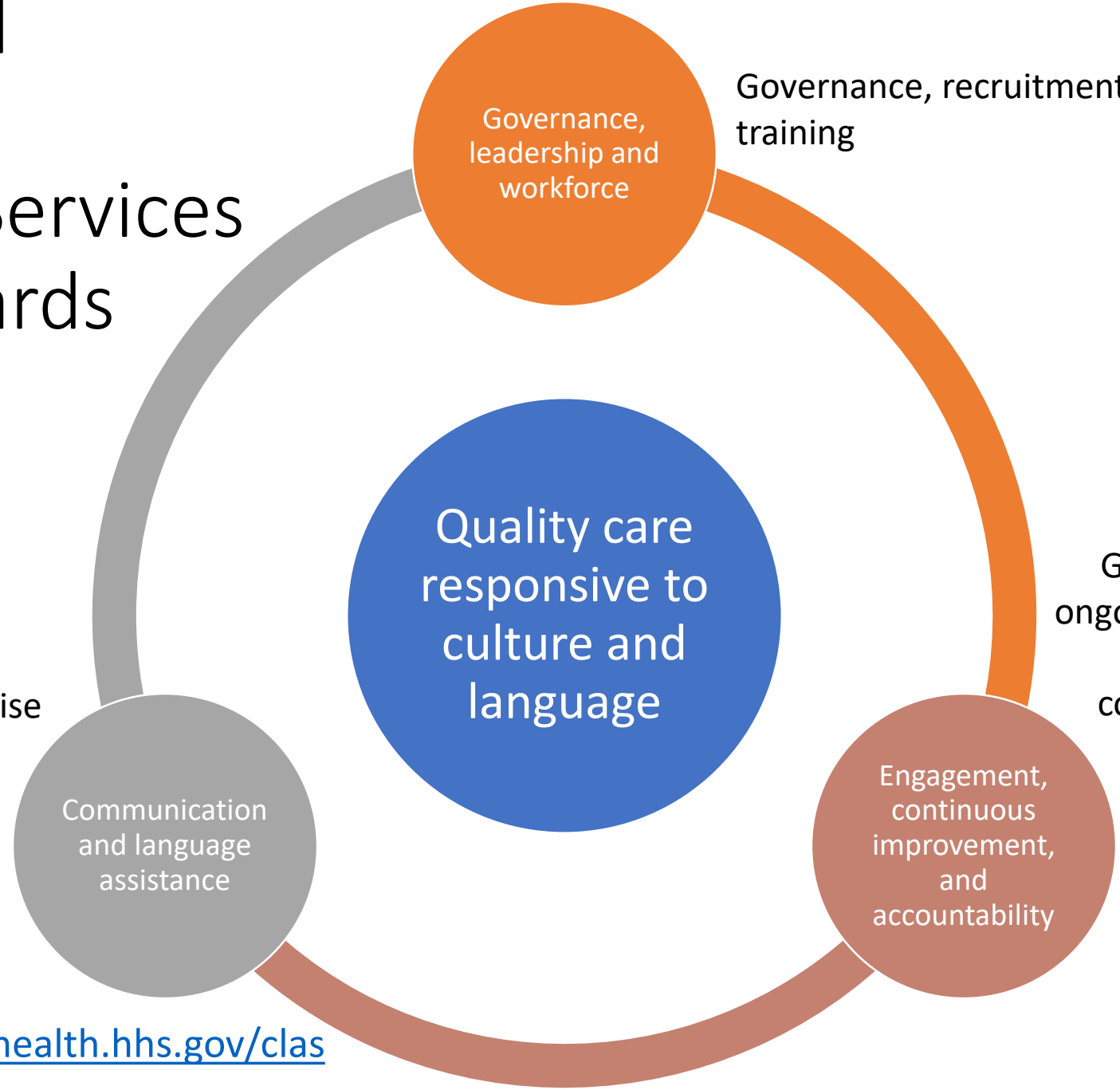



Activity: Next steps in collaborations

- 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



https://www.thinkculturalhealth.hhs.gov/clas

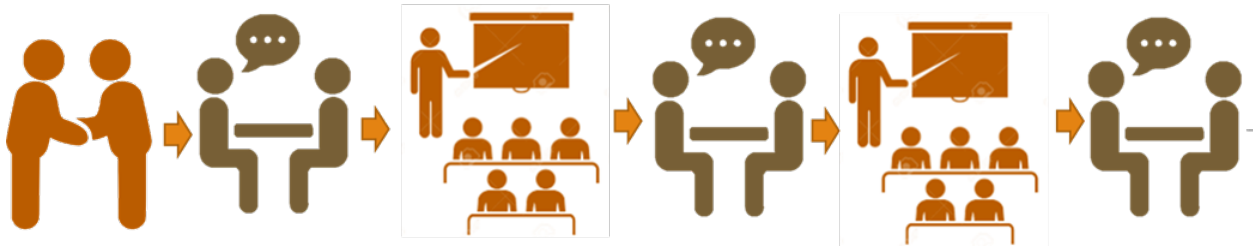
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	1.2a	Identify and designate a CLAS champion or champions, who are supported by the organization's leadership, and whose specific responsibilities include (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 policies and practices 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	Formalize 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.	3.9	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.

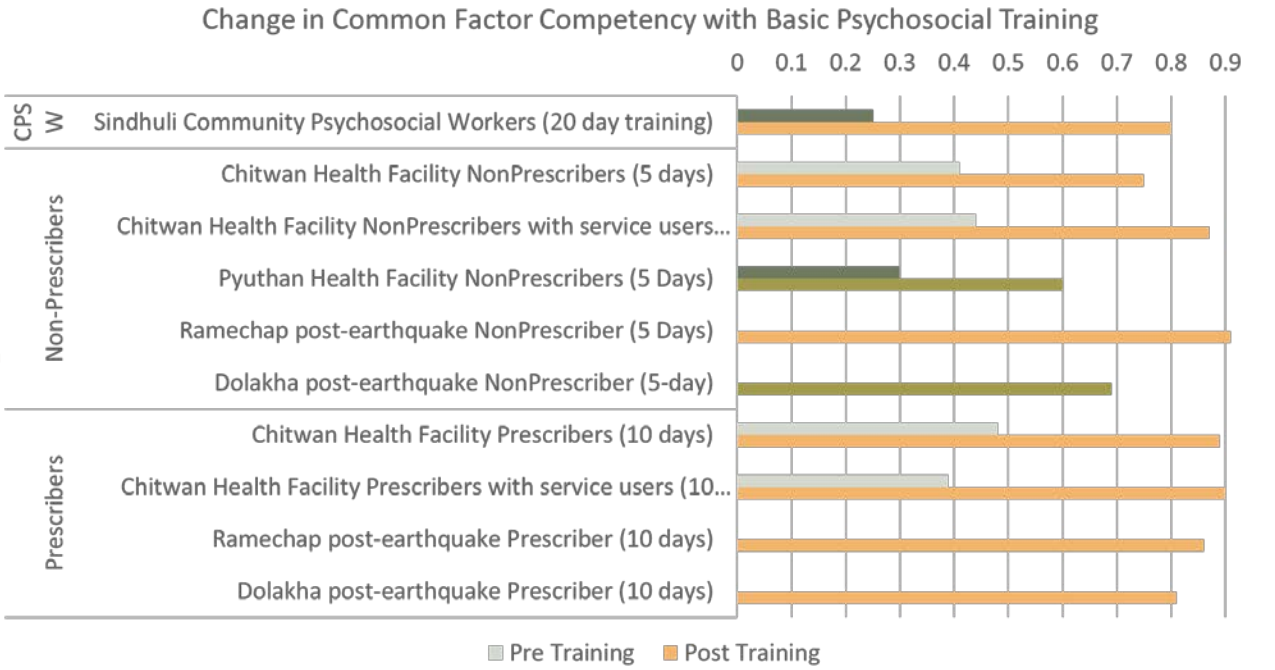
Personal and Institutional Responsibilities

- 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

ENACT Application





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 (ETHNOPSYCHOLOGICAL) 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

EQUIP:
Ensuring Quality in Psychological Support

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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