Addressing Refugee Mental Health Needs: From Concept to Implementation

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The current refugee crisis continues with outward signs indicating that political, social, and economic causes are ongoing and in some cases worsening. The most recent statistics from the United Nations High Commissioner on Refugees reveal that in 2015 alone, more than 60 million individuals were forced to flee their home countries in search of a safer place to live (Edwards, 2016). This flight often requires that individuals leave behind families, possessions, and ways of life in search of freedom in a new location where they can build a new life. All too frequently, these individuals have witnessed or experienced torture themselves or family and friends have been tortured. It has been estimated that more than half a million survivors of torture live in the U.S. through refugee resettlement initiatives (Aniyizhai, 2014). This, combined with the stressors of complete loss of stability, safety, and familiarity, may exacerbate underlying health issues, including mental health. Furthermore, once refugees arrive in the U.S., the adjustment process may be difficult. They may face xenophobia, racism, and discrimination, which also are linked to mental health sequelae (Berger & Sarnyai, 2015; Helms, Nicholas, & Green, 2012).

Assessments of health conditions of refugees consistently have recognized multiple mental health problems among newly arriving refugees. According to information provided by the Refugee Health Technical Assistance Center (Mental Health, 2011), posttraumatic stress disorder (PTSD), depression, generalized anxiety, panic disorder, adjustment disorder, and somatization are the most common mental health diagnoses associated with refugee populations, with rates of PTSD ranging between 10% to 40% in resettling refugee populations. In response to this, provision of comprehensive mental health services to these newest U.S. citizens is vital.

In 2012, the University of Louisville Global Health Center (UL-GHC) partnered with the Kentucky Office for Refugees and in 2014 began providing initial refugee health assessments to the more than 2,500 refugees resettling in Louisville each year. These health assessments include the Refugee Health Screener 15 (RHS-15), a well-used, culturally appropriate and valid mental health screening tool for refugees over the age of 14 (Hollifield et al., 2013). The tool screens for anxiety, depression, and PTSD. We found that more than 20% of the refugees scored positively on the RHS-15 and showed distress on a distress thermometer included in that tool, indicating increased risk for mental health problems. We also found that a significant proportion of those refugees expressed reluctance to follow-up on outside referrals but openness to mental health services if provided at the UL-GHC site. We noted that there was limited expertise in culturally appropriate, trauma-informed care available in the Louisville area, outside of the UL-GHC. In response to these findings, the UL-GHC concluded that mental health services represented a critical and immediate need of the refugee population. As the UL-GHC care model is based upon a patient-centered medical home approach, it was determined that mental health services could be provided on site and integrated into the total care of the refugee via a holistic, refugee-centered medical home (RCMH).

The objective of this report is to describe the concept, implementation, and initial impact of these mental health services on trainees at the UL-GHC.

Methods

Concept

The framework of the mental health service component of the RCMH approach included four interrelated elements: (a) full integration of evidence-based trauma-informed mental health care into primary care, beginning at the time of first contact with the refugee, (b) provision of individual and family counseling, (c) facilitation of support groups and referral linkages to help refugees build a sustainable social support network, and (d) coordination of a holistic care delivery process using an interprofessional approach that engages medicine, including psychiatry, psychology, nursing, law, and social work.

Implementation

First contact with the refugees was for their initial health assessment at UL-GHC, and the RHS-15 was performed there by psychologists with expertise in trauma-informed care. Using professionals with this level of expertise for their first mental health assessment enabled rapid identification of refugees demonstrating mental health issues, resulting in immediate integration into mental health services.

An additional pathway for recognition of mental health service needs involved assessments during primary care visits. This enabled identification of at-risk and in-need refugees who may have initially screened negatively on the RHS-15, refugees who were seen at another health assessment site and did not have RHS-15 results, or refugees who had migrated from another resettlement state. Referrals were also received from the resettlement agency case workers as well as other mental health providers in the Louisville community.

Building upon the holistic RCMH approach to care, clinical psychologists and psychiatrists provided individual mental health care and counseling that often
necessitated inclusion of families and counseling expanded into home visits when culturally appropriate. Successful paths toward healing were conceptualized to include not only services provided within the RCMH but also within the individual communities where the refugees lived and socialized. Support groups were facilitated and community-based trainings were provided and supported.

Considerations of sustainability required recognition of existing limitations in capacities for mental health services and the need to increase capacity through development of sustainable training programs. We therefore formed a training program that could immediately increase the capacity for mental health service provision and also could function as a culturally focused and trauma-informed training site for students. We assembled a novel team including the primary care physician, nurse practitioner, clinical psychologist, and social worker collaborating to address the body, mind, spiritual, and sociocultural needs of the refugee. Clinical psychology graduate students were included to assess and treat refugees as an external practicum placement with culturally informed supervision from knowledgeable clinical faculty.

Six clinical psychology students participated, as well as one visiting MSW therapist completing her clinical hours. The therapist trainees were a diverse group, consisting of three African Americans, two Hispanic Americans, one Syrian American, and one non-Hispanic White student. Two students were sexual minorities. Three students were fluent in Spanish and one was fluent in Arabic. The curricula for student therapists included training in CBT interventions, including behavioral activation for Hispanics (Kanter et al., 2015), functional analytic psychotherapy to improve the therapeutic alliance when working cross-culturally (Miller, Williams, Wetterneck, Kanter, & Tsai, 2015), and prolonged exposure for PTSD (Foa, Rothbaum, & Hembree, 2007; Williams et al., 2014). Supervision often included guidance on how to tailor empirically supported treatments developed for Americans to meet the needs culturally diverse patients (Hays, 2009). Students also received training in issues impacting the mental health of marginalized groups and working with interpreters (Faroqq & Fear, 2003; Laban, 2015). In addition to the RHS-15, students administered clinical interviews, which included the DSM-5 Cultural Formulation Interview (CFI; American Psychiatric Association, 2013), Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5; Brown & Barlow, 2014), and Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013). Bilingual students translated and back translated measures that were not available in Spanish, such as the ADIS-5 and many self-report measures. Several psychologists in the community with expertise in trauma were willing to serve as individual supervisors for the students, donating their time to further the mission of the clinic.

**Results**

From November 2015 through June 2016, 540 refugees aged 14 and older were seen for their initial refugee health assessment at the UL-GHC. Of those, 525 completed the RHS-15. From those that completed the RHS-15, 65 (12.4%) screened positively, prompting an initial triage for mental health service needs. Of those 65, 40 were entered into a formal and comprehensive mental health service process. Among these 40 refugee patients, the most common mental health diagnoses were depressive disorders (40%), trauma and stressor-related disorders (35%), and anxiety disorders (11%). Schizophrenia and other psychotic disorders were also seen (5%). These refugees were resettled from Syria, Sudan, Iraq, Cuban, Bhutan, Afghanistan, and Democratic Republic of Congo. The care provided was individualized for the refugee and included a variety of family and social/community contacts.

It quickly became apparent that ideal outreach care needed to include an individual who could relate directly to the refugee in terms of cultural knowledge, understanding of resettlement issues, and the potential trauma involved. To that end, to promote and support care linkages and provide a solid foundation for interprofessional practice and education, a new group of health care workers, termed the global health navigator, were hired. Position requirements included experience as a refugee, fluency in native languages and English, and experience in health care and community outreach. These navigators assisted with multiple aspects of care, including interpreting, advocacy, teaching, and connecting with local groups and agencies as key elements in the mental health service process.

As the mental health program is in its early stages, it continues to be refined and outcome data are still being collected. However, nine medical and clinical psychology student trainees involved in the project were asked to describe their experiences and provide feedback on this new service. Their comments were overwhelmingly positive and included statements such as, “It has been an overall positive and great training experience,” “A strength was the cooperation and collaboration between all involved,” “I was able to see firsthand how consistent interpreting services enhanced the client–doctor relationships,” and “It became a well-oiled machine.” Suggestions for improvement included: “Have bilingual clinical psychologists in addition to the navigators,” “Improve abilities in how to better work with interpreters,” and “Address how to deal with cancelled appointments and when refugees do not show up for appointments.”

**Conclusions**

Our experience is that employing a RCMH, interprofessional approach to embed mental health services into primary care for refugees at the UL-GHC has been a tremendous success. We were able to identify the mental health needs of our refugee patients, including the severity of need and the urgency of intervention, and provide culturally informed interventions. Although we have not yet analyzed outcomes, the program appears vital for the provision of safe and quality care for a vulnerable population and is well received by refugees and staff. Sustainability was considered foundational in our conceptual model, including financial and service resources. Financial metrics were developed that included expenses for staff and the related payments from health insurers. As most refugees are covered by Medicaid during their initial resettlement period, the financial evaluation focused on Medicaid reimbursement. This was the most critical hurdle in sustainability as reimbursement rates simply do not cover costs of care. Additional difficult coverage issues included delayed benefits, interruption in coverage, and lack of understanding of the health care system by the refugees themselves.

In terms of sustainability of service resources, the program must include training, recruitment, and retention of the full scope of experts in mental health and health care providers. Continuous opportunities for learning must be available with oversight for students provided by professionals with relevant expertise. Providing holistic care requires a full spectrum of participants. These participants include a team of trauma-informed and culturally aware
health care providers (e.g., primary care physicians, nurse practitioners, psychiatrists, and clinical psychologists), members of related disciplines (e.g., social services, health navigators, and case managers), and individuals who can facilitate effective communication with the patient in the context of their own communities and environments.

The mental health needs are not going away, and the difficulties facing refugees in this country may be expected to worsen in the current political climate. In this difficult context, our efforts are guided by an ethical responsibility to care for new and vulnerable members of our communities and an awareness that failing to provide needed care harms not only the individual but the community as well. Although much more work is needed, our experience is that an approach that uses existing strengths, identifies new partnerships, and provides care as good stewards of available resources can become the basis of a sustainable program that addresses a significant public health need in our communities.

References


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Addressing Barriers to Care Among Hispanic Youth: Telehealth Delivery of Trauma-Focused Cognitive Behavioral Therapy

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Prevalence and Impact of Traumatic Exposure Among Hispanic Youth

Exposure to potentially traumatic events (e.g., physical abuse, sexual abuse, witnessing domestic or community violence, violent or unexpected death of a loved one) is a significant public health concern with approximately half of all youth reporting experiencing at least one type of potentially traumatic event before the age of 18 (Finkelhor, Turner, Shattuck, & Hamby, 2013; Kilpatrick et al., 2003). Nationally representative surveys indicate that racial and ethnic minority youth, in particular Hispanics and African Ameri-