



REFUGEE SERVICES COLLABORATIVE
of Greater Cleveland

MENTAL HEALTH NEEDS AND SERVICE DELIVERY CAPACITY FOR REFUGEES LIVING IN CUYAHOGA COUNTY, OHIO

An Analysis and Recommendations

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1. Executive Summary

Introduction

Concerned about inadequately treated mental illness within refugee populations in Greater Cleveland, the Refugee Services Collaborative (RSC), with funding support from the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County, contracted with the Case Western Reserve University Center for Reducing Health Disparities to assess refugee mental health needs, and based on that assessment, to make recommendations for improving access to effective care.

Methods

The study is a descriptive assessment consisting of 1) a review of the research literature on refugee mental health; 2) a review of current perspectives on refugee mental health needs and service gaps from RSC members; 3) an analysis of available resources and services; 4) a qualitative assessment of current refugee mental health needs; and 5) development of case examples to illustrate key findings from focus groups.

Researchers utilized the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*) as the primary assessment tool. The *Standards* were developed by the U.S. Department of Health and Human Services, Office of Minority Health in 2003 (and since revised) to advance health equity and quality, and eliminate health care disparities by providing a blueprint for health care organizations to implement culturally and linguistically appropriate services. The *Standards* include one principal and 14 related goals, which health care agencies (including behavioral health organizations) should address to ensure cultural and linguistic competence. The principal standard states that health care organizations should “Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.” There are three standards addressing *organizational governance, leadership, and workforce*; four standards addressing *language and communication assistance*; and seven standards that address *engagement, continuous improvement, and accountability*.

Key Findings and Recommendations: Summary

- ***Refugees have diverse mental health needs.***

Because many refugees have experienced extreme trauma in their home countries, their mental health needs are diverse. While some refugees’ needs are obvious, with clear, diagnosable symptomatology, others are “quieter” and/or are triggered with the passage of time. Many struggle with PTSD, depression, anxiety, and adjustment disorders related to their experiences

and the loss of their homeland, social networks, and social and educational status; others cope relatively well. For those who do not, however, resources in Cleveland are insufficient.

- ***Refugees' mental health needs are often unresolved or undetected by the end of the formal resettlement period.***

The resettlement organizations are intensively involved with refugees from their point of arrival. However, because these organizations are considered to be the area experts on refugees, whenever issues with refugees arise, the resettlement organizations are asked to assist both the refugee and health/mental health organizations. Refugee organizations are limited in their ability to assist refugees and/or other organizations because the federal government restricts resettlement funding to a 90-day timeframe. Because mental health issues do not always present within that timeframe, refugees can fall through the cracks, thus threatening their ability to work, obtain proper health care, or experience general well-being.

- ***Working with refugees' mental health needs is resource-intensive.***

Key informants indicated that working with refugees is time and effort-intensive. Multiple systems need to be engaged, including locating interpreters, conducting accurate assessments, and ensuring that refugees can access necessary resources such as transportation and other supports.

- ***Providing an interpreter is essential but insufficient in meeting refugees' mental health needs.***

While mainstream providers are aware of the legal responsibility to provide interpreters to communicate with refugees in mental health contexts, the resources available for meeting those needs are largely lacking. And though language translation lines can be successfully used in health contexts, using interpreter lines in mental health contexts is problematic. Language lines are not available for every refugee language, and mental health diagnoses may be more complicated and sensitive than general health diagnoses.

Locally, refugee service provider agencies, mainstream mental health agencies, and the ADAMHS Board should consider joining together to advocate for increased federal resources to support interpreter services. In the end, enabling services such as translation/interpretation will not be feasible or sustainable without additional resources that help mental health agencies meet their legal obligation to provide such services when needed – as it stand now, the requirement is often experienced as an “unfunded mandate” by some organizations that genuinely desire to “do the right thing.”

- ***Resources are needed for 1) supporting and extending resettlement agencies' capacity to provide intensive case management services; and 2) supporting mainstream mental health agencies to learn best practices for serving refugees.***

Refugees' mental health needs are currently not being well served by available local resources. Mainstream mental health agencies do not feel adequately prepared—in terms of time, finances, or cultural competence—to address the complex service needs of refugees, and the strict guidelines to which resettlement organizations must adhere allow little leeway to vary from the constraints of the short-term resettlement time period. The adjustment period for truly resettling a refugee can be ongoing, and mental health needs can arise before refugees become acculturated and understand how to navigate local systems. The combination of resettlement agencies' limited capacity and mental health organizations' lack of preparedness creates a clear and persistent service gap that has the potential to jeopardize refugees' potential to become productive and engaged members of the community.

- ***Current refugee "experts" should be providing services.***

Because of the diversity of refugee communities, some informants felt that those who are not knowledgeable about the issues which refugees face should not be serving them at all, and that instead, support should be directed toward enhancing the capability of those who currently provide services to refugees (e.g., improving organizations like Neighborhood Family Practice's ability to provide behavioral health services).

- ***There is a need for enhanced/expanded case management services (resettlement and/or other organizations).***

Enhanced and expanded case management would allow resettlement agencies' case managers to extend their services beyond the strict and short "resettlement" time frame. Such services can follow refugees who might: a) need a longer time to resettle; b) require more technical support services for finding a job, enrolling in school, dealing with housing, etc.; c) have mental health symptoms that arise and/or worsen over time.

- ***There is a need for intensive training for providers about "cultural humility" and about best practices working with refugee populations around mental health issues.***

Training was seen as a critical need. Respondents felt that providers at mental health organizations need to know to provide culturally and linguistically appropriate services and access appropriate resources; at minimum, they need to "do no harm" as they interact with refugee populations. It was noted that training should be ongoing and at every level of the organization, from upper management to frontline service providers. Training on specific refugee issues and needs should be coupled with general training on "cultural humility," which has been defined as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the

person.” It is viewed as a different approach than “cultural competence” because it acknowledges personal limitations in cultural knowledge, and the need to partner collaboratively with clients or patients to achieve cultural understanding.

- ***There is a need for training, support, and resources for those in the refugee communities who already serve as interpreters, and for training in appropriate use of interpreters.***

Interpreters are already performing many tasks for which they are not necessarily trained or compensated; study participants felt that they deserve guidance and further training. Providers, too, need training and “guidelines” in the legal obligations for provision of interpreter services, and in the appropriate and effective use of such services.

- ***The ADAMHS Board of Cuyahoga County, as well as other funders/service contractors, raise expectations for provision of quality services to refugees.***

Several ways were recommended for the Board and others to do so. One is to insert a clause in future Requests For Proposals (RFPs) asking applicant agencies to briefly discuss steps they are taking to ensure that refugees attempting to access their agency are not experiencing barriers to care, and are receiving sensitive, informed services while in care. Another was to host a “best practices” conference for front-line providers in mental health agencies, covering refugee mental health epidemiology, needs, and effective approaches. A third was to prepare a one-page “briefing” that summarizes this report, and send it to agency directors. And a fourth was to distribute the entire report electronically to the Board’s email list. These strategies can demonstrate that there is “top-down” support for better service provision for refugees with mental health challenges.

- ***Providers and systems should recognize, and make allowances for, the importance of non-traditional approaches to care for some refugees.***

Some traditional practices designed to address symptoms related to mental illness, such as acupuncture or acupressure, may be of special importance or value to individual clients. Providers and systems should affirm the complementary role they can play, alongside “Western” medicine, in helping individuals improve their outlook and quality of life.

Full Report

The full report is 63 pages, and consists of extensive notes from interview/focus group transcripts, responses from the United Way 2-1-1 provider survey, a comprehensive literature review, and citations.

Study authors:

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2. Introduction and Methods

2.1 Introduction

Concerned about inadequately treated mental illness within refugee populations in Greater Cleveland, the Refugee Services Collaborative (RSC), with funding support from the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County, has contracted with the Case Western Reserve University Center for Reducing Health Disparities to conduct an initial assessment of refugee mental health needs, and based on that assessment, to make recommendations for improving access to effective care.

The study aimed to address four broad questions, as follows:

1. What are the mental health needs of current and future refugees settling in Cuyahoga County?
2. What resources are currently available to meet those needs?
3. What are the specific gaps between current and future needs, on the one hand, and available resources, on the other?
4. What additional resources should be developed, and/or what current resources should be modified or tailored, to fill the gaps between what is needed and what is available—and how should the establishment or modification of those needed resources be prioritized?

Four assumptions were made in forming these questions.

The first is that “currently available” must incorporate cultural and linguistic competence as a core element of “availability.” Mental health counseling that is not delivered in a manner that addresses cultural and linguistic needs cannot be said to be meaningfully available.

The second is that “cultural and linguistic competence” is itself a somewhat inexact qualification, in that such competence lies on a spectrum. Thus, it is likely that mental health services in Cuyahoga County would not be classified as either culturally competent or not culturally competent, but would rather fall somewhere on a continuum of cultural competencies.

The third is that “resources” may include services outside of mainstream mental health practices and settings. This may be especially true for refugees who may rely on

traditional treatment approaches, such as acupuncture. This question is beyond the reasonable scope of the present study, but should nevertheless be acknowledged, especially in a patient-centered analysis, as part of the array of resources which individuals may access in an attempt to improve mental health.

And fourth, some population-based mental health issues have their genesis in, or are exacerbated by, structural racism, classism, sexism, and other forms of discrimination or bias. Thus, addressing gaps in mental health services will be insufficient; the community must also address the social determinants that give rise to disparate need. This, too, is beyond the scope of the proposed study, but should also be acknowledged in the final report.

At the Case Center for Reducing Health Disparities, the study team included Earl Pike, Cyleste Collins, and Diane Gatto. The three researchers were responsible for different sections of the following report. Dr. Collins authored the qualitative material, conducting all of the interviews and focus groups necessary, and writing up her findings for inclusion here. Diane Gatto and Earl Pike designed the survey of providers, and Ms. Gatto distributed the survey and summarized results. Earl Pike conducted the literature search, integrated the separate components of the research into the current report, and served as the liaison to the Refugee Services Collaborative. The report remains the property of the Refugee Services Collaborative.

2.2 Study Methods

Overall Design/Process

The following is a largely descriptive assessment consisting of 1) a review and summary of the research literature on refugee mental health; 2) a review and summary of current data, observations, and perspectives on refugee mental health needs and service gaps from members of the RSC; 3) an analysis of available resources and services, to be conducted by United Way 2-1-1; 4) a qualitative assessment of current refugee mental health needs, achieved through interviews and focus groups; 5) development of case examples, to illustrate key findings from focus groups; 6) a gap analysis based on assessment of needs and available services; and 7) creation of a draft report for presentation to members of the RSC and research participants for feedback, refinement, and action prioritization.

Use of CLAS Standards

For the purposes of this project, we have employed the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*) as the primary theoretical and agency assessment tool.

The *National CLAS Standards* were developed by the United States Department of Health and Human Services, Office of Minority Health in 2003 (and since revised) in order to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care

For the purposes of this project, we have employed the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care...*

organizations to implement culturally and linguistically appropriate services. They are also intended to serve as a community-informed, research-grounded tool which organizations can use to more objectively benchmark progress toward cultural and linguistic competence. This is critical since measurement of cultural and linguistic competence across a range of concerns is historically highly subjective, and hence minimally useful as an assessment or planning tool.

The *Standards* include one principal and 14 subsequent goals health care providing organizations (including behavioral health organizations) should attempt to meet in order to ensure cultural and linguistic competence. The principal standard indicates that health care organizations should “Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.” There are three standards addressing questions of *organizational governance, leadership, and workforce*; four standards that address *language and communication assistance*; and seven standards that address *engagement, continuous improvement, and accountability*. A complete list of the *Standards*, as well as other documents that describe utilization and application of the *Standards* in more detail, can be found at the OMH website, here: <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>.

3. Key Findings and Recommendations: Summary

The findings are summarized across all three groups of interview informants and survey participants.

- ***Refugees have diverse mental health needs.***

Because many refugees have experienced extreme trauma in their home countries, their mental health needs are diverse. While some refugees' needs are obvious, with clear, diagnosable symptomatology, others are "quieter" and/or are triggered with the passage of time. Many struggle with PTSD, depression, anxiety, and adjustment disorders related to their experiences and the loss of their homeland, social networks, and social and educational status; others cope relatively well. For those who do not, however, resources in Cleveland are insufficient.

- ***Refugees' mental health needs are often unresolved or undetected by the end of the formal resettlement period.***

The resettlement organizations are intensively involved with refugees from their point of arrival. However, because these organizations are considered to be the area experts on refugees, whenever issues with refugees arise, the resettlement organizations are asked to step in and assist both the refugee and health/mental health organizations. Although wanting to help, the refugee organizations are limited in their ability to assist refugees and/or other organizations because the federal government restricts resettlement funding to a 90-day timeframe. Because mental health issues do not always appear/are not always obvious within that timeframe, refugees can easily fall through the cracks in the system, which threatens their ability to work, obtain proper health care, or experience general wellbeing.

- ***Working with refugees' mental health needs is resource-intensive.***

Throughout the interviews, the key informants underlined the fact that working with refugees is a time and effort-intensive journey. There are multiple systems that need to become engaged, including finding interpreters, being able to conduct an accurate assessment, and ensuring that refugees have access to the necessary resources to be successful; including transportation to appointments and to fill medication, walking them through working with the pharmacist and understanding any medication information, and any other related services and resources.

- ***Providing an interpreter is essential but insufficient in meeting refugees' mental health needs.***

While providers are aware of the necessity and legal responsibility to provide interpreters to communicate with refugees in mental health contexts, the resources available for meeting refugees' linguistic needs are largely lacking. Though language translation lines are used in the health context fairly successfully, using interpreter lines in a mental health context is more problematic. Language lines are not readily available for every refugee language, and mental health diagnoses are, in some ways, more complicated to make than general health diagnoses.

- ***Resources are urgently needed for 1) supporting and extending resettlement agencies' capacity to provide intensive case management services/mental health services; and 2) supporting mainstream mental health agencies to learn best practices for serving refugees.***

Refugees' mental health needs are currently not being well served by available resources in the Cleveland area. Mainstream mental health organizations do not feel adequately prepared—in terms of time, finances, or cultural competence—to deal with the complex service needs attending refugees, and the strict guidelines to which resettlement organizations must adhere allow them little leeway to vary from the constraints of the short-term resettlement time period. The adjustment period for truly resettling a refugee can be ongoing, and mental health needs can arise before refugees become fully acculturated and understand how to navigate local systems. These individuals, as well as children and other family members, are likely to fall between the cracks in care systems, with little or no safety net. The combination of resettlement agencies' limited capacity and mental health organizations' lack of preparedness creates a clear and persistent service gap that has the potential to not only threaten refugees' potential to become productive and engaged members of our community, but also their own and others' lives as well.

- ***Current refugee "experts" should be providing services.***

Because of the diversity of the refugee communities, some key informants felt that those who are not knowledgeable about the issues which refugees face should not be serving them at all, and that instead, support should be directed toward enhancing the capability of those who currently provide services to refugees (e.g., improving organizations like Neighborhood Family Practice's ability to provide behavioral health services).

- ***There is a need for enhanced/expanded case management services (resettlement and/or other organizations).***

Enhanced and expanded case management would allow resettlement agencies' case managers to extend their services beyond the strict and short "resettlement" time frame. Such services can follow refugees who might: a) need a longer time to resettle; b) require more technical support services for finding a job, enrolling in school, dealing with housing, etc.; c) have mental health symptoms that arise and/or worsen over time. In the words of one resettlement informant, "We want to bolster what we're doing. We can barely handle what we have now."

- ***There is a need for intensive training for providers about "cultural humility" and about best practices working with refugee populations around mental health issues.***

Training was seen as a critical need. Providers at mental health organizations (at all levels) need to know to provide culturally and linguistically appropriate services and access appropriate resources; at minimum, they need to "do no harm" as they interact with refugee populations. Refugees are currently seen as an invisible or rarely seen "subpopulation" but should be taken as seriously as any other group the community organizations serve. It was noted that training should be ongoing and at every level of the organization, from upper management to frontline service providers.

Training on specific refugee issues and needs should be coupled with general training on cultural humility, which has been defined as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the person." (Hook, JN, 2013: Cultural humility: measuring openness to culturally diverse clients. *Journal of Counseling Psychology*.) It is viewed as a different approach than cultural competence because it acknowledges personal limitations in cultural knowledge, and the need, therefore, to partner collaboratively with clients or patients to achieve cultural understanding.

- ***There is a need for training, support, and resources for those in the refugee communities who already serve as interpreters, and for training in appropriate use of interpreters.***

Interpreters are already performing many tasks for which they are not necessarily trained, prepared, or compensated; they deserve support, guidance, and additional training. Providers, too, need training and "guidelines" in the legal obligations for

provision of interpreter services, and in the appropriate and effective use of such services.

- ***The ADAMHS Board of Cuyahoga County, as well as other funders/service contractors, raise expectations for provision of quality services to refugees.***

There are several ways the Board and others can do so. One is to insert a clause in future Requests For Proposals (RFPs) asking applicant agencies to briefly discuss the steps they are taking to ensure that refugees attempting to access their agency are not experiencing barriers to care, and are receiving sensitive, informed services while in care. Another is to host a “best practices” conference for front-line providers in mental health agencies, covering refugee mental health epidemiology, needs, and effective approaches/interventions. A third is to prepare a one-page “briefing” that summarizes this report, and send it directly to agency directors. And a fourth is to distribute the entire report electronically to the entire Board’s email list. These and other strategies can help demonstrate that there is “top-down” support for better service provision for refugees experiencing mental health challenges.

- ***Providers and systems should recognize, and make allowances for, the importance of non-traditional approaches to care for some refugees.***

Some traditional practices designed to address symptoms related to mental illness, such as acupuncture or acupressure, may be of special importance or value to individual clients. Providers and systems should affirm the complementary role they can play, alongside “Western” medicine, in helping individuals improve their outlook and quality of life.

4. The Research Literature

4.1 Introduction

The following describes current research on refugees and mental health. Most of the references are to publications in the last ten years. A concluding section offers a brief summary of research findings, and notes the limitations in the available data. Citations can be found in Appendix D.

4.2 Refugees and Mental Health/Illness

In every study reviewed, rates of posttraumatic stress disorder (PTSD) among refugees was higher when compared to other populations; the disparities held across geographic locations of resettlement, including the United States, Austria, Israel, Norway, Sweden, Australia, and other

countries (Hocking, DC, Kennedy, GA, & Sundram, S, 2015; Hinton, DE, Field, NP, Nickerson, A, Bryant, RA, & Simon, N, 2013; Volkl-Kernstock, S et al., 2014; Palic, S, & Elklit, A, 2014; Kalt, A, Hossain, M, Kiss, L, & Zimmermn, C, 2013; Rasmussen, A, Crager, M,

In every study reviewed, rates of posttraumatic stress disorder (PTSD) among refugees was higher when compared to other populations...

Baser, RE, Chu, T, & Gany, F, 2012; Kroli, J, Yusuf, AI, & Fujiwara, K, 2011; Finklestein, M, & Solomon, Z, 2009; Silove, D, Steel, Z, Baumn, A, Chey, T, & McFarlane, A, 2007; Mollica, RF, Caridad, KR, & Massagli, MP, 2007; Ahmad, A, von Knorring, AL, & Sundelin-Whalsten, V, 2008; Elkit, A, Ostergard Kjaer, K, Lasgaard, M, & Palic, S, 2012; Neuner, F, et al., 2004; Slewa-Younan, S, Uribe Guajardo, MG, Heriseanu, A, & Hasan, T, 2014; Nickerson, A, et al., 2014; Hinton, DE, Kredlow, MA, Pich, V, Bui, E, & Hoffman, SG, 2013; Giacco, D, Matanov, A, & Priebe, S, 2013).

Researchers also noted a significant relationship between psychiatric disorders and chronic medical illnesses among refugees in various locations (Vukovic, IS, Jovanovic, N, Kolaric, S, Vidovic, V, & Mollica, RF, 2014; Junod Perron, N, & Hudelson, P, 2006; Rohlof, HG, Knipscheer, JW, & Kleber, RJ, 2014; Berthold, SM, et al., 2014).

A number of studies noted associations between refugee status and suicidal or self-injurious behavior (CDC, MMWR, 2013; Hansson, EK, Tuck, A, Lurie, S, & McKenzie, K, 2012; Patel, N & Hodes, M, 2006), and between refugee status and alcohol and other drug use and abuse (Ezard, N, 2012; Luita, NP, Jordans, M, Murphy, A, Roberts, B, & McCambridge, J, 2013).

Alexander, B, David, E, & Grills, N, 2013, found a high prevalence of anxiety disorders among refugees, as have others (Hinton, DE, Pich, V, Safren, SA, Pollack, MH, & McNally, RJ, 2006). Additional studies have highlighted the prevalence of depression among refugees (Savic, M, Chur-Hansen, A, Mahmood, MA, & Moore, V, 2013; Roth, G, & Ekblad, S, 2006; Thabet, AA, Abed, Y, & Vostanis, P, 2004; Fenta, H, Hyman, I, & Noh, S, 2004; Stapleton, H, Murphy, R, & Kildea, S, 2013). And an even larger number of studies have simultaneously examined multiple diagnoses of mental illness among refugees, finding, in nearly all cases, a disproportionate high incidence of a wide variety of illnesses (Rees, S, Silove, DM, Tay, K, & Kareth, M, 2013; Todorescu, SD, et al., 2012; Heeren, M, et al., 2012; Huemer, J, et al., 2011; Vaage, AB, et al., 2010; Ouimet, MJ, et al., 2008; Norredam, M, Garcia-Lopez, A, Keiding, N, & Krasnik, A, 2009; von Larsner, U, Elbert, T, & Nuner, F, 2008; Birman, D, & Tran, N, 2008; Bhui, K, et al., 2006; Keller, A, et al., 2006; Buhmann, CB, 2014; Palic, S, & Elklit, A, 2014; Taylor, EM, et al., 2014; Akiyama, T, et al., 2013; Marshall, G, et al., 2006).

Many studies have analyzed mental health and mental illness among refugee children and adolescents, children of refugees, and refugee parents of children or adolescents, finding high rates of psychosocial problems in all three groups (Wieggersma, PA, Stallings-Bolen, AA, & Reijneveld, SA, 2011; Aronsson, B, Wiberg, C, Sandstedt, P, & Hjern, A, 2009; Vaage, AB, Garlov, I, Hauff, E, & Thomsen, PH, 2007; Goldin, S, Hagglof, B, Levin, L, & Presson, LA, 2008; Ehntholt, KA, & Yule, W, 2006; Reijneveld, SA, de Boer, JB, Bean, T, & Korfer, DG, 2005; Rousseau, C, Drapeau, A, & Rahimi, S, 2003; Sanchez-Cao, E, Kramer, T, & Hodes, M, 2013; Guarnaccia, PJ, & Lopez, S, 1998; Bronstein, I, Montgomery, P, & Ott, E, 2013).

Other studies have addressed the special consideration of refugees who have experienced torture (Steel, Z, et al., 2009); the internalized stigma of mental illness among some refugee groups (Kira, IA, et al., 2014); memory/recall gaps among refugees diagnosed with PTSD (Graham, B, Herlihy, J, & Brewin, CR, 2014); the link between length of stay in asylum centres (Denmark) and mental illness (Hallas, P, et al., 2007); the experience of partner violence among refugee women from Somalia (Nilsson, JE, Brown, C, Russell, EB, & Khamphakdy-Brown, S, 2008); premigration exposure to political violence and its impact on subsequent mental health (Rousseau, C & Drapeau,

A, 2004); and the role of other pre-displacement factors in subsequent mental health of refugees and internally displaced individuals (Porter, M, & Haslam, N, 2005).

4.3 Access and Barriers to Care

The extant literature underscores a range of challenges and barriers experienced by refugee populations when considering, seeking, or receiving mental health services. Slewa-Younan, S, and colleagues point to low levels of health literacy among refugees as a mitigating factor in mental health care access (Slewa-Younan, S, et al., 2014). Renzaho, AM, & Polonsky, MJ, 2013, describe the role of mistrust in health encounters among Australian refugees from Africa, a finding that echoed several other studies on the importance of the health care provider relationship among refugee women attempting to cope with postpartum depression or accessing family health/reproductive health services (O'Mahony, JM, Donnelly, TT, Raffin Bouchal, S, & Este, D, 2012; Riggs, E, et al., 2012; Whelan, A, 2007). Barriers related to language, translation, and interpretation are often cited in the literature (Baker, et al., 2010; Dhooper, SS, 1998; Sypek, S, Clugston, G, & Phillips, C, 2008; Wong, EC, et al., 2006; Shawyer, F, et al., 2014).

A 2011 analysis by Ramin Asgary of the Mount Sinai School of Medicine in New York provides a useful typology of the various barriers experienced by refugees when seeking health care in general. They include 1) internal barriers, such as mental illness, mistrust, and perceived discrimination; 2) structural barriers, including affordability, limited interpretation services, poor cultural competency among care providers, and insecurity related to food, shelter, or employment; 3) barriers related to social assimilation, such as the challenge of negating complex systems of community support (Asgary, R, 2011). Numerous other studies have supported the persistence of these and similar barriers (Shannon, PJ, 2014; Wagner, J, et al., 2013; Campbell, RM, et al., 2014; Harris, J, 2003; Ginsburg, B, & Baarnheilm, S, 2008; Drummond, P, 2011; Phan, T, 2000; Schweitzer, R, Melville, F, Steel, Z, & Lacherez, P, 2006; Michelson, D & Sclare, I, 2009; Toar, M, O'Brien, KK, & Fahey, T, 2009; Durbin, A, et al., 2014).

4.4 Specific Interventions/Approaches to Mental Illness among Refugees

Though there are significant challenges related to mental health services for refugees, there is also a growing body of literature suggesting interventions or approaches that are successful in addressing those challenges. Multiple themes emerge in the literature: the importance of cultural sensitivity/competence training for practitioners; the need for linguistically appropriate services and effective interpretation; the importance of

practitioner knowledge of the refugee experience in all its dimensions; the significance of patience, trust, longevity, humility, and openness in service delivery (Williams, ME, & Thompson, SC, 2011; Mirdal, GM, Ryding, E, & Essendrop Sondej, M, 2012; McFarlane, CA, & Kaplan, I, 2012; Vostanis, P, 2014; Jensen, NK, Norredam, M, Priebe, S, & Krasnok, A, 2013; Madan, A, 2011; D'Ardenne, P, Capuzzo, N, Ruaro, L, & Priebe, S, 2005; Bean, T, Eurelings-Bontekoe, E, Mooijaart, A, & Spinhoven, P, 2006; Martin, SS, 2009; Briggs, L, 2011; Dubus, N, 2009; Cobb, TG, 2010).

Specific interventions showing some evidence of effectiveness for addressing mental illness among refugee populations include forms of narrative therapy (Gwozdziewicz, N, & Mehl-Madrona, L, 2013; Hijazi, AM, et al., 2014); loving-kindness and mindfulness (Hinton, DE, Ojserkis, RA, Jalal, B, Peou, S, & Hoffman, SG, 2013); critical ethnography (O'Mahony, JM, Donnelly, TT, Este, D, & Bouchal, SR, 2012); group therapy (Kira, IA, et al., 2012; Robertson, ME, et al., 2013; Tannenbaum, J, 1990; Weine, S, et al., 2004; Drozdek, B, 2012); cognitive behavior therapy (Vincent, F, Jenkins, H, Larkin, M, & Clohessy, S, 2013); psychotherapy (Yu-Wen, Y, 2001); Family Systems Theory (Kelley, P, & Ryan, A, 1992); Cultural Adjustment and Trauma Services (CATS) (Beehler, S, Birman, D, & Campbell, R, 2012); and various school-based programs for children and adolescents (Hughes, G, 2014; Persson, TJ, & Rousseau, C, 2009).

4.5 Systemic/Structural Approaches

Other researchers have highlighted the importance and effectiveness of systemic or structural approaches to the challenges of mental illness within refugee populations. Stenmark, H, and colleagues suggested that, using the appropriate methodologies, refugees can be successfully treated within the general psychiatric health care system (Stenmark, H, Catani, C, Neuner, F, Elbert, T, & Holen, A, 2013). Baarnhielm, S, and colleagues in Sweden, Germany, and Norway have suggested that focusing on the cultural diversity of mental health services can lead to better care and outcomes for refugees (Baarnhielm, S, Javo, C, & Mosko, MO, 2013). Numerous authors have suggested that refugee mental health needs are best addressed by multi-level, integrated systems that incorporate a range of community services, as well as medical and behavioral health services (Ellis, BH, et al., 2013; Margalit, R, et al., 2014; Nazzal, KH, Forghany, M, Geevarughese, MC, Mahmoodi, V, & Wong, J, 2014).

4.6 Conceptual/Theoretical Issues

A variety of conceptual/theoretical issues have been raised with respect to mental illness and refugees, and are worth noting. Fox, H, has theorized about the role of

religious faith among genocide survivors, noting that some draw upon religion as they negotiate postgenocide identity and belief (Fox, N, 2012). Drozdek, B, has suggested that the use of contextual and developmental models may assist in assessment and management of posttrauma symptoms among refugees (Drozdek, B, 2015). Other authors have underlined the role that resilience plays in mental health among refugees (Gagnon, AJ, & Stewart, DE, 2014; Orton, L, Griffiths, J, Gren, M, & Waterman, H, 2012; Arnetz, J, Rofa, Y, Arnetz, B, Ventimiglia, M, & Jamil, H, 2013). Still others have focused on the role of self-efficacy in resettlement (Sulaiman-Hill, CM, & Thompson, SC, 2013); the need for culturally sensitive diagnostic instruments (Eytan, A, et al., 2007; Montgomery, E, & Foldspang, A, 2006); the need for qualitative approaches when researching refugee mental health needs (Halabi, JO, 2005); the role of gender in diagnosing and providing care (Noble, J, & Ahearn, F, 2001; Chantler, K, 2012); and culturally diverse conceptions of mental illness and culturally diverse treatments (Martin, SS, 2009; Longacre, M, Silver-Highfield, E, Lama, P, & Grodin, M, 2012; Highfield, ES, Lama, P, Grodin, MA, Kaptchuk, TJ, & Crosby, SS, 2012).

4.7 Themes in the Literature

Despite significant gaps in the available research (discussed below), there are some clear findings and discernable themes:

First, there is strong evidence of heightened risk of mental illness among refugee populations. These findings hold true 1) for a range of mental illnesses, including PTSD, depression disorders, and anxiety disorders; 2) across differences in country or region of origin, including Africa, Asia, and South America; 3) across geographic resettlement locations, including Europe, the United States, and Australia; and 4) across other differences, including age and gender.

Second, there is compelling evidence that there is a wide variety of factors influencing an individual refugee's experience of being diagnosed with mental illness, living with mental illness, attempting to access services, and/or being treated for mental illness. These include mental health and general health literacy, gender, age, educational background, employment status, and language. Other factors include length of time in indeterminate status before resettlement, whether the individual has been subjected to torture, and substance abuse history.

Third, there are clear indications, provided by both the research and through refugee narratives, that barriers to care inhibit, in many cases, effective refugee treatment for mental illness. Barriers cited in the literature include language (both written and

verbal), lack of understanding of refugee process and experiences, and low levels of cultural competence.

Fourth, the research points to a number of individual interventions that show evidence of effectiveness in treating, at least some of the time, mental illness among refugees. Those interventions include group therapy and conversation, narrative-based strategies, individual counseling, psychiatric care, family systems approaches, and school-based interventions.

Fifth, more recent research points to the utility of multi-level, systems-based approaches, integrating individual treatment, community interventions, and supports for basic needs such as employment and housing.

And sixth, the research raises some conceptual questions about transpositions of meanings across cultural groups—for example, the meaning of “mental illness” in various cultural communities, or beliefs in the efficacy of culturally-embedded interventions such as acupuncture.

4.8 Limitations

At the same time, there are profound gaps in the available literature on refugees and mental illness. Those gaps include the following:

First, while numerous studies confirm elevated rates of mental illness among refugee groups, comparative data, within that broader conclusion, are generally lacking. Although the literature is replete with evidence of PTSD, conclusions about relative rates of other forms of mental illness among refugees cannot be reasonably made. Similarly, comparative data about forms of mental illness and patterns of refugee experience and/or country/region of origin are non-existent. There is thus no reasonable typology that can summarize rates of mental illnesses and lived refugee histories—a typology that would be useful for treatment/intervention planning, and that would contribute to a more nuanced understanding of the overall issue.

Second, while a range of interventions and approaches has been attempted and assessed, comparative data, about the relative utility of different interventions for varying populations under different conditions, is not available.

Third, while the value of structural interventions has been demonstrated in a number of settings, there is no deep understanding of the relative effectiveness of a variety of

common structural interventions. This can lead practitioners to assume, for example, that bilingual staff, availability of interpreters, staff training in the refugee experience, and staff training in cultural competence or humility are of equal importance, when in fact they may not be.

And fourth, a number of the existing studies have significant methodological limitations, including small sample sizes, definitional problems (such as “depression” and “PTSD,” or even “refugee”), and reliability/validity concerns.

5. Qualitative Research and Findings

Overview

This section communicates findings from in-depth interviews conducted in January and February of 2015. The interviews with service providers and refugees explored refugees' experiences, services, and needs with regard to mental health in the Cleveland area.

The purpose of the interviews was to learn from key informants about the needs of and services for local refugees. Three groups of key informants were interviewed representing: 1) organizations whose main job is refugee resettlement; 2) organizations that provide health, mental health, or other assistance services; and 3) refugees themselves.

Methods

Key Informant Recruitment & Sample

Key informants were identified in collaboration with the Refugee Services Collaborative (RSC). A member of the Collaborative provided a list of informants to the team, and the team worked to schedule willing participants. To capture the perspectives of key groups knowledgeable in some way about the delivery of mental health services locally, interviews were conducted with: 1) refugee-specific service providers; 2) local service providers; and 3) refugees.

The Refugee Services Collaborative provided the interviewer with a list of persons involved locally with both refugee services (primarily directors of the three local resettlement agencies and the state refugee health coordinator) and local providers. The interviewer then contacted those persons on the list to invite them to be interviewed. While the resettlement agencies responded promptly to the invitation, as did two other service providers, others required multiple contacts. The team also employed snowball sampling, asking interviewees to recommend other key informants who would be knowledgeable about refugee mental health services locally.

Refugee Resettlement Organizations. Four key organizations were referred that were considered knowledgeable about refugees specifically. These organizations included resettlement agencies and the state refugee coordinator. The team was able to interview representatives from three of the four groups referred, as well as two additional providers from one local health organization that works closely with refugees

and provides training for others working with refugees. Two in-person interviews were conducted. One interview included four employees from one resettlement organization and one from another, and the second interview was with two providers from the same organization. An additional informant who lives out of town was interviewed by phone.

Community Service Providers. The Collaborative provided the interviewer with a list of community service providers that have served refugees locally. The team was able to interview seven representatives from four of the six organizations referred (one by phone), and with another service provider by phone who was recommended by a previous interviewee. Although the interviewer attempted to schedule a group interview with these providers together, attempts to gather these busy professionals in one place on the same date proved futile. Instead, the interviewer either visited the professionals at their workplaces or interviewed them by phone when possible. It is worth noting that multiple attempts were made to engage and follow-up with the organizations that did not respond to requests for interviews.

Refugee Advisory Council. A group interview was conducted with the Refugee Advisory Council to explore refugees' experiences with mental health providers and services. The refugee group was identified by the RSC and referred to the interviewer. Additionally, the interview questions were changed to reflect sensitivity to mental health terminology, and addressed "feelings" and refugee coping skills.

Interview Questions. Questions were developed that explored perspectives on mental health services available for refugees, the gaps the informant saw in those services, and explored their ideas on how the gaps could be filled (see Appendices A & B for the interview guide). To increase the trustworthiness of the interviews, the interviewer performed member checks with each interviewee, sharing findings from previous interviews and allowing the interviewee to talk about their experiences.

Transcription and Analysis. Immediately after completing the interviews, the interviewer wrote up their notes. A professional transcriptionist transcribed the interviews and the interviewer analyzed the transcripts thematically, question-by-question, to write the report.

Findings

5.1 Resettlement Organizations

5.1a Mental Health Issues

All informants talked about refugees' traumatic experiences, but depression, anxiety, post-traumatic stress disorder (PTSD), stress isolation, and adjustment disorders figured prominently in resettlement organizations' mentions of the typical refugee mental health issues. Informants from the resettlement agencies had the greatest breadth of experience with refugee issues, and talked about the importance of recognizing the diversity of refugees' backgrounds. Informants distinguished between the experiences of refugees who had lived in refugee camps for many years and those who had been exposed to and experienced extreme traumas, including rape, torture, and other atrocities. Said one resettlement organization informant:

The refugees come from so many different countries and different backgrounds in terms of schooling, how long they were in refugee camps, how well they speak English, what their understanding of mental health care is, what their understanding of Western Medicine is. So with each individual we are working with, we're trying to figure out sort of where they're coming from and how we can best plug them in, but where they're at is very, very different among cultures, even among, you know, same cultures, but different levels of education or whether they were urban refugees or they were in refugee camps.

Resettlement organization informants also cautioned about the potential for stereotyping or making assumptions about refugees' needs: "[It's a] slippery slope if we start walking down . . . It's almost like you're labeling. You know 'You had the trauma. You should have these symptoms. We expect you to have these symptoms. Why aren't you having these symptoms?'"

Some refugees' issues are natural outcomes of relocating, while others suffer from more serious mental health needs. Those with severe mental health issues tend to be more obvious, and sometimes their refugee documents note these issues. For example, although the resettlement organizations might be made aware of refugees' diagnoses of schizophrenia and bipolar disorder, they often lack knowledge about refugees' more general mental health needs:

I've seen all the overseas documents from Day 1, and they're minimal when you get into Behavioral Health. I mean you'll get psych consults overseas for like someone like severely depressed or schizophrenics or bad alcoholics, but you don't see the Psych consult as much overseas . . . Then you have folks that are in the middle, folks that are quietly depressed, folks that have underlying mental

health issues that we don't catch right away, that takes time to get to know them and then we start hearing odd behavior.

- **Timing: When Mental Health Needs Arise**

Although resettlement organizations are the most knowledgeable and most resourceful agencies for refugees, our informants said time is a critical barrier to supporting refugees' mental health needs. Resettlement organizations' work is time-sensitive, and requires that they act quickly to settle refugees, meeting their basic needs immediately:

Our services are very intense in the beginning, and then the idea is to taper off as quickly as possible, you know, so we can prepare for the next refugees coming in, and that's what the funding dictates and . . . that's how we staff ourselves. We've built a lot of resources around the needs over the years.

Although all refugees are screened for physical and behavioral health issues upon arrival in Cleveland (usually within the first month or so), this screening can only point to some initial red flags. Thus, the timing can be problematic. Informants described a "honeymoon period" after refugees arrive, in which they feel great and often positive. At about four-six months post-arrival, however, mental health issues can arise, and this can be a time when refugees are less connected to services. One informant reported that although agency X screens all refugees, the behavioral health part of the screening tool is somewhat limited.

It's just to see if there's anxiety or tension, but most of the stuff that we, if we don't have indication that there's a preexisting issue, we don't really start to realize that this person's having a hard time adjusting here until four or five months after. They're already out of the agency. They might be working or on their second job. They're a little bit less bit less linked in, and they're not as involved with the agency.

Informants went on to talk about their limitations in helping to serve refugees who have been in Cleveland for longer periods of time:

Our main focus really right now is the recent arrivals. There are so many other people that have been here two, three, four, five years that we can't really do that outreach to connect them with services. One, we just don't have the time to do that. Two, like we've been discussing, there's not a lot of partners and community resources then to refer them to for counseling or therapy, etc. So

really we could expand services and we want to expand services, but we are limited.

Several informants talked about the lack of services on the East side as compared with the West. While one of the resettlement organizations (on the West side) was larger, there is a smaller one on the East side that has many fewer resources and mental health needs can “go untouched, unnoticed” unless the refugee brings the issues up. Informants discussed the consequences of refugees’ needs going unmet, including the potential for attempting or committing suicide. Informants also shared their experiences with some refugees’ being unable to maintain employment, and job loss leading to loss of housing, and thus, to homelessness.

5.1b Current Mental Health Services and Gaps

Resettlement organization informants felt that current Cleveland support systems are inadequate for meeting refugees’ needs. Some informants, describing the limitations of current systems, said that, at times, they felt that the homeless system was better equipped than resettlement organizations to link refugees to services and, therefore, might be the best option in some circumstances, especially when resettlement agencies don’t have resources to serve as advocates.

While resettlement organization informants mentioned having good experiences with some local mental health organizations (including Recovery Resources, Neighborhood Family Practice, The Centers, the Cleveland Hearing and Speech Center, the Cleveland Sight Center, and Frontline Services), for the most part, they felt that mainstream providers are hesitant to work with refugees. Fear, liability, and discomfort were all issues informants mentioned, and some providers have rejected refugee mental health referrals, claiming they don’t have the service capacity. As one informant noted, however, this is discriminatory and illegal. Several informants described the challenges they face when doors are “closed” to refugees, often because of language barriers and cultural competence issues:

Cleveland has an abundance of resources. We have a plethora of hospitals, of mental health agencies. We have everything, you know, but the reality is that a lot of times refugees have difficulty navigating those systems, accessing, just getting through the front door, even though they’re there.

Providers that we work with are hesitant to work with refugees because they’re worried about the liability. They’re afraid because of the language, because of the culture. . . . without having a Case Manager there with them to really make

sure that what they say for their treatment plan, that it's not gonna be followed up on correctly, if they're afraid to treat them to some degree, because there are issues with the fear of misdiagnosing folks, you know, having things incorrectly interpreted to them..

Providers, resettlement informants said, tend not to be knowledgeable about refugees: "Most of the time they can't distinguish like a refugee and an immigrant:"

I've had providers say 'We don't have the capacity,' and then I've had other providers who just say 'I don't even know where Bhutan is. Like can you tell me a little bit about Bhutan? Like what is this guy's story?' And that is so refreshing, because you can say 'Well let me tell you. They didn't sneak in the country. They're here legally. He's got Medicaid. He's got a Social Security Number. This is his background,'—and it's just that shift of mindset, not like, 'We can't do it. It's not our problem,' but, 'Let's figure out how we can drum up the resources to meet his needs.'

Resettlement organizations' noted that on one hand, they are the ideal group to help refugees navigate the mental health system and they are "home base" for refugees. On the other hand, refugees need extensive support, advocacy and what multiple informants described as "handholding,"—efforts not supported by resettlement agencies' funding streams over the long term. Often, resettlement organization informants noted that mental health providers are unaware of the limitations of the resettlement organizations and have high expectations of them.

Some informants talked about how health providers are able to serve refugees effectively, but pointed out the additional challenges with regard to behavioral health:

It's the behavioral mental health, where there is a disconnect in terms of really accepting that you have to meet this client where they're at. There seems to be less willingness to kind of go the extra mile when it comes to behavioral health and mental health.

Thus, informants said, refugee cases that have a mental health component can be challenging. For example, refugees will often miss appointments and/or "shut down" when their provider is trying to communicate with them. Extra training is essential to reach clients effectively. One informant talked about how busy mental health agencies function, in trying to close cases and limit caseloads:

The easy ones to close are the folks that don't show up for appointments, that don't call back, that don't seem engaged. Well, refugees aren't gonna be engaged a lot of times. It takes extra effort . . . and sometimes it's the symptom of the disease. Like the guy that we have now who was struggling with his mental health problems, this is what he does: he shuts down. He doesn't want to see anyone. He's so depressed that he doesn't keep appointments. He doesn't open his door. He turns off his cell phone. So there's a lot of extra steps you have to take to engage him.

5.1c Critical Needs

Resettlement organization informants identified a number of critical needs, including intensive case management; taking coordinated, team approaches to identification and treatment; ensuring that there are linguistically and culturally appropriate services available, delivered by open-minded flexible, resourceful providers; and educating community members about mental health to try to decrease the stigma surrounding mental health.

- ***Case Management and Coordinated/Team Approaches***

Informants reported that refugees have difficulty navigating care and treatment systems, in addition to the normal or expected cultural adjustment refugees undergo—managing differences in food, clothing, language, and so on. Further, although some local resources are readily available, they tend to be siloed and focused on specific needs; thus, refugees return to the resettlement agencies because they are most comfortable and familiar with them:

If it's the first time the provider deals with the refugee, they kind of treat them as a mainstream person and it never works. When you serve refugees, everything needs customization, and that's why you know it never works to just refer a refugee to a community provider. We need to be involved, you know, on every level of it all the time, but we are very, very small, very short-staffed, and just we don't have that capacity.

Case management support, especially through multi-disciplinary teams, was also identified as an important component of refugee support. Case management is crucial for ensuring that people attend appointments, fill prescriptions, and follow up on treatment recommendations. Transportation, one informant said, “is always an issue.” “Getting them there,” the informant said, was an important element of refugees being

able to follow through. Thus, enhanced case management must include a transportation component.

Informants also noted that one of the most important needs is having some kind of safety net that would include case management for refugees who run into mental health problems past their resettlement period:

So this is my dream, to have someone in the office. Like if I look at the situation, we do need someone in the office to kind of address those issues, to explain to people about the resources that are available, to hook them up with those resources, but then when we refer them out, to kind of expect those places to be equipped with things that will enable them to serve refugees, linguistically, culturally, like in every way possible, because refugees can't function on their own. They don't know where to go. So to teach them, to kind of show them what to do to coordinate their care.

- ***Linguistically Appropriate Services/Interpreters***

“If they [mental health providers] are aware,” one informant said, “they think that all they have to do is provide any interpreter to help with the language barrier.” Differing interpretations of Title VI leads to some confusion. “Good providers,” one informant said, “make the extra effort to meet cultural, and not just linguistic needs.”

Another consideration was important as well, however: Title VI requires providers to provide interpreters for their patients, but Medicaid does not reimburse them for the cost of the interpreter. While some organizations absorb the cost, others might be harder pressed to do so. Thus, reimbursement issues serve as a barrier.

Another significant issue is that interpreters are commonly not trained to offer specific services in mental health, raising issues of confidentiality and professionalism. Some informants thought that mental health providers should make greater use of the language lines that health providers use, since these lines provide “impartiality” and might protect confidentiality (because the interpreter is not from the local community):

Mental health providers, they don't understand the need to use interpreters. If you have a patient who doesn't speak the language, then you kind of have to involve an interpreter, and nobody understands that.

- ***Culturally Appropriate Services***

“Culturally appropriate” services were cited as a critical need. Whereas traditional mental health services have relied on a medical model and traditional in-person individual counseling, for refugee populations, such services and models are not necessarily best practices. Providing a “linguistically appropriate” service, such as an interpreter, during counseling sessions, is far from adequate in addressing refugees in a culturally appropriate way. For example, one participant elaborated on unintended barriers such practices create from the refugee perspective: using an interpreter (someone the refugee does not know, and in some cases, someone they do know, which can be even worse) to discuss with a mental health provider (whom the refugee probably also does not know); or the provision of a service (i.e., counseling) that can be foreign and, in many cases, culturally stigmatized, involving personal thoughts, feelings, and mental health issues. Such a situation can be not only uncomfortable, but ultimately untenable for refugees.

Instead, informants said “alternative” services might be a better way to meet refugee mental health needs. Such alternative services included wellness initiatives or alternatives to traditional in-person, individual therapy that include community components, such as group outings, working with music, yoga, mentorship programs, and others. One informant said: “that the provision of mental health services should include a focus on overall emotional wellness, along with connection to community.” Such awareness is an important and needed shift in perspective.

- ***Provider and Community Education***

Resettlement agencies talked about the necessity of having flexibility in refugee work. They said that refugees’ situations and new populations coming to Cleveland can change quickly, and their organizations have to be patient, consistent, open-minded, and ready to learn about new populations with short notice:

As soon as we gear up and we staff things and we’re ready for Nepali refugees, everything changes . . . now we’re getting folks from Zimbabwe, so we constantly have to be changing and prepared and shifting how we’re gonna handle refugees, the linguistics, our staffing needs, and but that’s the reality of refugee resettlement.

Resettlement organization informants pointed out the need to train and educate community providers as well as the community as a whole about refugees and the issues they face that might be unique from what they have seen before:

There needs to be outreach, education and training for mental health providers to figure out how you work with an interpreter and ‘How do you do therapy with a phone line?’ you know, and then just education around the specific needs that a lot of these populations bring—some pretty hideous scenarios of torture and imprisonment and rape.

Other informants also talked about limitations to training community providers:

And it’s tough because even like with hospitals, [resettlement organization staff] could’ve done an in-service with them just a month ago, but when a crisis happens and there’s actually a refugee client there, they tend to totally forget what they’ve been told and then turn back to ‘It’s your responsibility as a resettlement agency.’ So all the outreach in the world can sometimes not help when an actual crisis happens.

Resettlement organization staff talked about how little they had known about refugees before they came to work at their organizations. They noted that they didn’t know Cleveland had refugees, and that the community as a whole was similarly not knowledgeable. One provider said: “The community is really clueless.”

5.1d Model Programs and Resources

Informants pointed to models they had seen in their own and other communities of effective refugee community mental health. Overall, they felt that important steps included systematizing care by pulling resources together, creating networks, unifying screening procedures, taking innovative and nontraditional approaches to refugee mental health, and using resettlement organizations as a key resource.

- ***Behavioral Health Screening***

Neighborhood Family Practice, a local health provider who sees all refugees for their initial health screening, was held up as an example of such a network, in that it conducts mental health screenings as part of its health screenings for refugees and also provides health and mental health services under one roof. The Refugee Health Screening tool, which has been in use for the last two years, helps to identify people who might be in need of mental health services. This year, the State of Ohio has instituted adopting the tool statewide. Having a basic screening tool would allow providers to pick up on “red flags” and follow-up with providers and clients for treatment.

- ***Provider Networks***

Creating provider networks is seen as crucial for bridging the mental health services gap. One informant pointed to efforts in Franklin County as an example of how one county is working hard to create a “community of providers” that focus on how best to assist refugees. This community works to develop a list of “effective referrals” for refugees.

Informants identified community psychiatric support teams as one kind of ideal case management. One key informant reported that the model is being used in the Russian community on Cleveland’s East side, where community support workers and social workers who work in psychiatric offices speak their clients’ language:

I have a kind of great model in mind that’s been in place for Russian-speaking clients with mental health illness. So there are like psychiatric offices that have Community Support Workers on staff, right, and they kind of become Case Managers and they’re in charge of their needs. They work in conjunction with psychiatrists. There are counselors there, like clinical social workers, but also those community support workers who are case managing. They’re even providing interpretation.

Asked about how the best possible mental health services could be delivered to refugees, informants from the resettlement organizations elaborated on their desire to expand capacity:

We want to bolster what we’re doing to be able to help. We can barely handle what we have over here on this side; you know our main focus right now is the recent arrivals. There are so many other people that have been here two, three, four, five years that we can’t really do that outreach to connect them with services. One, we just don’t have the time to do that. Two, like we’ve been discussing, there’s not a lot of partners and community resources to refer them to for counseling or therapy, etc. So really we could expand services and we want to expand services, but we are limited.

- ***Innovative/Nontraditional Approaches to Mental Health***

One informant, from the state level, talked about the Cleveland Catholic Charities’ program “Pathways to Wellness” as one model of a useful alternative approach. The model, in which refugees work through a curriculum of wellness activities, places participants in groups of similar populations. Using a mentorship model, they “train the trainer” to implement the program. Other services include music and/or art-based programs.

- **Resettlement Organizations as Recognized Resources**

Resettlement organization informants noted that the community organizations that have been most successful at working with refugees have reached out to resettlement organizations for help, asked a lot of questions, been open to learning, and treated the resettlement staff as partners rather than as antagonists. Resettlement organization informants urged service providers to consider refugee cases the way they would any other “mainstream American in this situation who doesn’t have family and doesn’t have support. Do the same thing, but . . . have the resources, because this person doesn’t know the language.” One informant urged service providers to remember what their jobs are and what they seek to do in the community:

You have to fall on the mission of your agency. ‘What is your mission? Why are you in existence? Why are you taking up that real estate?’ We don’t reject cases because there are strings attached.

Resettlement organization key informants noted that their role is not always understood and providers frequently do not recognize either their expertise or the extent to which they could be helpful. Said one resettlement organization provider:

You know we are pretty seasoned. We’ve done this for a while. We might be able to provide some insight or direction, and a lot of times folks won’t even reach out, you know, and when they reach out, it’s like ‘Hey, find them another house and make sure they take their meds.’

5.1e Case Example

One particularly complicated case that involved depression, domestic violence, two suicide attempts and subsequent hospitalizations was mentioned by several informants. It demonstrates how quickly a challenging situation can ‘spiral out of control,’ even when being addressed by highly effective service providers.

Probably about four months after arrival in Cleveland, we started seeing someone showing symptoms of major depression and suicidal ideation. I called [agency] and we made an appointment. We took him to the appointment there. Then the therapist called me back, and said that he was seen, that they didn’t think that he needed meds, and that they would work on a follow-up lab. So I think he was only seen once. He never came back, and it ended nasty: he came

to the office and in front of the Employment Specialists' room, took two bottles of pills. We called 9-1-1, and he was taken to the hospital.

The client lived, but because he was hospitalized and didn't go to work, he lost his job (his fourth since arriving in Cleveland). He was living alone, and could not pay his bills.

So now the hospital will be calling us telling us 'what are you guys thinking? Why doesn't he have a job? He doesn't have money to pay his rent,' because all of this adds to his depression, you know.

The informants explained in more detail the background of the case—that it included domestic violence (“he beat his wife”), which resulted in a protection order; as a result, the man was homeless. The hospital questioned the resettlement agency about where they would house him after his hospital release (“You brought him here”), noting that he could not get an apartment because he was unemployed. The hospital staff argued that the resettlement agency should try to get the man back home in spite of the protection order. The informant explained:

So the hospital tried to fight us on the status of the Protection Order. Well it takes about a month to get an official Order, so what are you gonna do? You're gonna try to slip him back home and discharge him back home before the Protection Order? Then they tried to debate us on the abuse and what happened and what the mother was saying. The only thing I can take is what the client says and what the client's kids say that they witnessed. So they fought us on that, and I say, 'Listen. Why don't you just discharge him to 2100 [Lakeside, the men's homeless shelter]? We'll pick it up after the fact.' They said, 'Well we can't do that. Find him another place.' We said, 'No. He's not working.'

Eventually, the informant explained, the resettlement organization arranged housing:

I begged one of the shelters, and I promised and I pretty much had to cut my wrist and sign myself in blood—promised that this guy isn't gonna just live there forever. 'Give us a week, and we'll figure out what to do with him.' So I convinced them, and the hospital reluctantly, you know at discharge actually, we agreed, that we would go there to pick him up. Then they were upset that we didn't come with an interpreter at discharge.

The informant pointed out that the hospital had expected the resettlement agency to take care of everything, and the agency did, although it was far outside of its scope of work (“We figured out some things, piecemeal”). Together, the ADAMHS Board and the

resettlement agency created a plan for the refugee to work with a local mental health agency, but that plan, too, got off to a tenuous start. When the resettlement agency staff transported him for his initial assessment, they said, “Well he doesn’t speak English. We don’t have the language capabilities. We’re gonna send him to this Hispanic service provider because they’re better at handling language.” So our Caseworker and I said “What? This guy speaks Nepali.” After an agency director was notified of the language issues with the assessment, the case was treated differently:

They quickly changed course and said, ‘Bring him back tomorrow. We’ll do an Assessment.’ They did a good job. Once we got through the door, I shared with them a lot of resources, assured them that we’ll help in this process. So the guy’s in treatment. He’s in Anger Management classes. After about two months, three months, he kind of came back here and said ‘I’m gonna kill myself,’ and pulled a rope out.

Again, the informant said, the client was hospitalized, at a different hospital from his first hospitalization, but within the same hospital system, and this experience turned out better, in part because of the hospital taking a more collaborative approach to the case:

When we were on the way to the hospital, I notified [hospital staff], just out of courtesy, ‘Hey, this guy is coming back,’ and [hospital staff] said to me, ‘Well we will only accept him under a couple of conditions: if you make sure that he’s gonna have a place to go to when he comes out, and if he takes his medicine.’ That we would visit him every day. Recovery Resources really stepped up and they worked with our social worker to develop a plan. You have the same guy that kind of came in two different tracks and two different results, one that got very contentious and blew out of proportion, ‘You handle this. You brought him here,’ to a different [same guy, same needs], to a totally different approach.

Now the guy is actually shaving, coming to class daily. He’s pretty much appropriate, and doing pretty well. I think that the expectations originally were, ‘You brought him here. You fix it. You do everything,’ and we’re trying to say, ‘Well his needs and his illnesses and his addiction was getting in the way of all that. Now you need to be comfortable to help with trying to figure out what the follow-up plan is.’

5.2 Other Community Service Providers

5.2a Mental Health Issues

Service providers listed a number of mental health issues that they saw in their work with refugees, including PTSD; grief and anxiety related to family members who have died or were left behind in their home country; finding a job and job problems (stuck in entry level jobs, inability to create wealth, having to “settle” for less prestigious jobs); isolation, depression, anxiety, and uncertainty about decisions made, being part of a small community, being one of only a few of their group; learning English; and lack of education. One provider informant talked about the stress of moving and how simply being in the U.S. could contribute to refugees’ mental health issues. This provider talked about timing issues, and cases that fall through the cracks of a system set up to ensure short-term management but not long-term well-being.

One provider spoke of the difficulty of finding out about refugees’ mental health issues, in part because refugees have been so careful to make sure that everything is “lined up” for them to come to the U.S., and mental health issues can be easier to hide. Not knowing about or addressing mental health needs can have severe consequences. One provider shared a story in which a refugee’s mental health needs interfered with his/her job in a factory; the noise triggered his/her PTSD symptoms, which ultimately led to his/her losing the job. Another provider spoke of trying to learn about potential issues refugees face before they arrive:

We try to keep our providers up-to-date on different customs and cultures, you know, ‘Heads up. We’re going to be getting a lot of Congolese refugees. They have had recent trauma.’ It’s a lot different than the Bhutanese refugees living in camps for 20 years.

5.2b Current Mental Health Services and Gaps

Informants noted a number of issues with currently available mental health services. Important gaps included language, cultural and communication barriers between providers and the lack of dedicated funding for interpreters at mainstream mental health organizations, as well as the resettlement organizations’ limitations in being able to help. Providers said that resource limitations are a major barrier to providing high quality mental health services to refugees. One provider said, “Behavioral health in general is underfunded and under-provided.”

- **Communication Barriers**

Being able to identify refugees' mental needs was identified as an obstacle to providing appropriate services. Often, providers said, it is difficult to understand what the refugees are dealing with because they do not communicate—whether because of language barriers and/or because the providers lack the skills for asking culturally appropriate/sensitive questions. One provider distinguished between work with primary care and physical health, and behavioral health limitations, noting that many of the tools available—for example, the interpreter phone and clinical tests—provide methods for uncovering refugees' health issues, but with psychological symptoms, the provider must rely on whatever information the patient is willing/able to reveal. Providers said that it was often the “quieter” clients whose needs are most easily missed: “It’s the middle group where the ones that are more private or the ones where the health literacy isn’t there. They don’t understand that it is a problem they can talk about.”

One provider talked about the frustration in dealing with these “quiet” clients. While he/she was very interested in working with the refugee population, he/she characterized his/her experiences with refugees as beset by “more difficulties” than successes. This provider spoke openly of feeling “inadequate” and pointed out that mental/behavioral health tools rely heavily on communication—as much art as science—and the language and cultural barriers providers face with refugees are “so dense, so deep” that it makes it very difficult to know how to help.

Tools such as the interpreter phone were described as helpful for physical symptoms but are more problematic for behavioral health: the back-and-forth is difficult, it’s hard for the provider to know whether their messages are being correctly interpreted, and the nonverbal behaviors and other subtleties that are so critical for work in mental health are lost when using a phone:

There is no health care management, like day-to-day management, literacy for the refugee community, so they are in the hands of their interpreter, who turns into their health care planner or manager, and that’s just wrong. And so advocates are a gap, somebody that they can go to and say, ‘I don’t know where to go and my stomach keeps on hurting, despite me changing food,’ or despite this and that. ‘I don’t know what to do.’

Providers said that time limitations, caseload, funder and organization expectations about productivity, and lack of reimbursement for certain services (including interpretation), were gaps. Providers generally noted that the services available for children tended to be better than those for adults. One provider said: “It’s these adults that it seems just fall off the radar.”

Resettlement agencies, one provider said, want to help, but “have their hands tied,” in offering time-limited services. Providers mentioned several community organizations with which they had good experiences. Like the resettlement organization informants, providers noted that there are fewer services on the East side, and transportation barriers for getting East side refugees to the services on the West side.

5.2c Critical Needs

- ***Case Management***

As in the resettlement organization interviews, providers noted that intensive case management services were a critical need. One informant said that while case management is not a need unique to refugees, he/she noted that it was especially needed and important because refugees need help in so many areas of their new lives: getting and keeping a job, attending to their physical health, ensuring that they are attending doctors’ appointments, dealing with their children, etc. “Getting into the system in the first place” before issues arise and having refugees connected to a case manager who could direct them where to go was considered a best practice.

One provider said that early connection and case management can help ensure that refugees are connected so they get “true” acculturation services (“What can we expect from people who are coming out of the desert in Iraq or coming out of small towns in the mountains of Nepal who didn’t have any sort of attachment to civilization and they come here to a concrete jungle?”) Such services would include helping them to learn the unwritten “scripts” of how to access public transportation, how to go grocery shopping, or use a credit card (and becoming financially literate). One provider said that there needs to be a “genuine reaching out to issues” that refugees face. One provider felt that resettlement agencies’ roles should be opened up to allow them to be fully dedicated to acculturation, to helping the refugees properly settle, helping them integrate into American culture without losing their cultural distinctiveness. One provider said, “We want to integrate them into society without taking away their unique features, and that’s the only way that they will be participating citizens.” Helping refugee parents deal with their young children who are growing up and straddling two cultures, is also important. Parents, one provider said, often have issues with seeing their children rejecting their religions, cultures and customs.

- **Provider Training**

Several informants noted that there were certain people in their organizations (usually just one or two) who were considered refugee “experts” (though most organizations had none). However, the organizational capacity to deal with refugees on the whole was generally lacking at most organizations, and when the refugee “experts” moved on in their careers, the organization was left with little capacity and knowledge. Said one provider: “Maybe you have to have a constant teacher, a culturally confident person who could guide you.”

Several providers said that one of the most important issues is that organizations as a whole need to be trained on how to work with refugees all the way from upper management to frontline workers. Trainings on working with refugees are essential, providers said, because “you’re supposed to know about the community you’re serving” in order to provide the best possible services, and currently many providers are not comfortable working with refugees. This training, they said, needs to be an organizational priority:

Yeah, the entire organization needs to be involved in training. At the end of the day, the comfort level needs to go all across the board.

One provider suggested that training retreats could help. He/she was eager to learn more about how experts have grappled with the challenges working with refugees and behavioral health, and how he/she can work to better communicate with refugees so he/she could feel “less ignorant,” particularly with “questionable” cases.

Like the resettlement organization informants, the community providers distinguished between different categories of mental health issues and how they are dealt with differently. For example, it is more obvious what to do in cases in which clients show more pronounced symptomatology, such as is the case with schizophrenia or other severe mental illnesses, and/or require partial hospitalization. “Very high-need, high-risk people, we have stuff for them. They’re helped immediately.” Providers said that it’s more difficult for clients that have less pronounced symptoms or those that develop over time. One provider characterized this group of refugees as often “quiet,” “polite,” and/or “nice,” and perhaps eager to please. The “vastly different” customs and ways of communicating, one provider said, made him/her feel “lost” and as though they are not serving refugees as best as they can. One provider informant talked about the need to educate providers about how refugee mental health will be different from dealing with other kinds of mental health cases. In particular, they talked about how mental health

symptoms often show up as physical symptoms for some, and they want to know more about the connection between the physical and psychological in refugee populations:

It's gonna be a physical complaint—they're not immediately going to admit that it's something else, and so a lot of provider education needs to be cultural, like 'Okay, sometimes people from this area may say this. This is what they mean. This needs to be more in-depth.' It's education on the patient and the provider side. The providers need to know the cultural differences as much as the patients do.

While at least one provider said that his/her agency allowed him/her “more time” with the refugees to help him/her work through the cases, more time was not what he/she needed. He/she said that working with refugees can feel like walking around with one's eyes shut, “in the dark,” and that he/she needed concrete tools to inform his/her work (e.g., how to approach a line of questioning that communicates mental health concepts most effectively).

- ***Screening and Coordinated/Team Approaches***

Many informants talked about how coordinating services would be ideal, and several pointed to the NFP screening and protocol of coordinating the physical and mental health components in one organization. If any behavioral health “red flags” are identified, a “soft handoff” between the primary care provider and behavioral health provider can occur. A team approach to advocacy, one provider said, must start at “the beginning,” with needs assessments and services tailored to those needs. For this to be successful, communication is critical at every step so that refugees understand what is happening, transportation is available as needed, and there is adequate assurance of follow-through. Ensuring that different organizations communicate appropriately about their cases would also be important. Said one provider: “My understanding is that many already come with mental illnesses of different kinds and so maybe the problem for providers like us, which are not resettlement agencies, is not having that information passed down to us appropriately.”

The Centers was also considered a model of coordinated services. The El Barrio program was noted in particular about its efforts to link health, mental health, jobs, and childcare in one agency. But regardless of approach, ensuring that those in need have “someone to go to” is critical. One provider said:

I would love to see a streamlined process where everyone would understand their role and accept it and be a part of it. We could be more efficient, but when agencies that are very tight on funds and those funds are highly linked to federal timelines, you're under the pressure to do too much in too little time.

Another provider said he/she would like to see resettlement organizations:

Partner with workforce agencies to help them find a job so that all the federal monies that they have can be dedicated to teaching them how to live here and to pay for their living here until they can find a job. That is very difficult, but it's ideal. Right now under the current legislation, that can't happen, so that's a problem. So workforce development agencies would help them find jobs, and obviously social service agencies will provide services, specialized services to them as well in healthcare.

- ***Linguistically Appropriate Services/Interpreters***

Providers noted that more funding for interpreters is a critical need, and although Medicaid Title VI requires that social service organizations provide interpreters, Ohio does not reimburse providers for those services, leaving the burden to the organizations. Because Medicaid covers refugees, they can go to any community health provider that accepts Medicaid, but getting in the community health providers' doors, however, can be challenging, given language and cultural barriers. Informants with more refugee experience said that although "everybody's entitled to an interpreter," refugees need much more than an interpreter—they need someone who can help them navigate the American health care system, and serve as their advocate. One provider noted how crucial meeting it is to meet refugees' linguistic needs:

Because no matter how comfortable we can get with somebody, you're always going to be more comfortable with somebody who speaks your first language. It doesn't matter how good at English you're gonna get. It's probably easier to explain your problems in your original language.

Providers were aware that they are expected to provide interpreters, but also noted that interpreters were not always available or easy to get for every language. One provider said that they have had a difficult enough time getting Spanish-speaking interpreters, and that it can be much more difficult for other languages. Providers noted that family members, including children, are often used as interpreters, though this is highly problematic when it comes to mental health or other sensitive and/or potentially stigmatizing information. Another provider talked about his/her

organization's approach, trying to use a live interpreter when possible, but that it can be difficult when the refugee and interpreter are from the same (small) community and there are concerns about privacy and confidentiality (even with interpreter phone lines):

If it's somebody that's from a country where we really don't have that many refugees here from there, a lot of them aren't very open about even speaking on the phone, 'cause they're afraid they're gonna know them. 'There's not that many. It's easy to identify me.'

Other providers mentioned difficulties with interpreters giving correct interpretation, in part because their own English isn't very good, and/or they themselves are not well educated or don't understand mental health issues. One provider talked about the difficulties that he/she had experienced with an interpreter who had not translated correctly, and because of this, the client did not fully understand the situation: "We realized that there wasn't a full comprehension of some of the notions that we were trying to get across afterward, then that kind of raised a red flag for us. So there aren't even appropriate interpretation services."

Some mentioned that in-person linguistic issues weren't the only ones; English-only paperwork that refugees receive in the mail is also problematic. Often, one provider said, the paperwork has deadlines, and not responding to the paperwork can lead to loss of services. An additional issue is that refugees are sometimes illiterate in their own language.

- **Culturally Appropriate Services**

Several providers pointed out the importance of mental health providers being aware of and sensitive to the specific details of the cases that come before them, as well as the cultural worldview of their refugee clients. In particular, they said, in some cases, the gender of the provider needs to be considered in the context of both the cultural background of the refugee and the details of the case (e.g., domestic or sexual violence cases). Services thus need to be tailored for the individual, without stereotyping.

Other providers noted the importance of other cultural factors in working with refugee clients. Food was mentioned many times as an important aspect of culture. One provider noted that programming for refugees must take into account culturally appropriate food when food is part of the program. One provider talked about refugee parents rejecting and not trusting child care providers for their children, at least in part because of cultural issues and food; children are thus not adequately welcomed in programs that could potentially prepare them for school.

- **Educating Refugees about Mental Health**

Some informants talked about the importance of educating refugees themselves about mental health issues, and how to recognize mental health conditions in one another, as well as the resources that exist and how to access them. One provider talked about the number of Bhutanese suicides and how important it is to help remove or lessen the stigma around mental health within the communities, to open lines of communication and get people to talk about their issues. Another provider said it “ . . . comes down to educating the patients, using their own people, internal people, that are respected, the community leaders.”

It shouldn't put you outside the community,' but to them they don't want other community members knowing it [mental illness]. It's an uncomfortable thing. They try to keep it to themselves and not share, where a lot of their other problems, they react with the community. We need them to know is that 'It's okay to go to them when you're feeling anxious, when you're feeling depressed.' You need to use the same channels.

5.2d Model Programs and Resources

Some providers noted that there are particular models that they know about that could inform Cleveland's efforts to improve services to refugees—for example, the Centers for Victims and Torture in Massachusetts, the Visiting Nurse Association model of conducting home visits, and recruiting trained specialists from the communities from which refugees come.

- **Specialized Programs**

The Center for Victims of Torture in the Twin Cities was mentioned as one model program. This Center offers mental health services, and specifically trains service providers about how to deal with the serious and specific sorts of trauma that refugees can experience, focusing also on wellness and preventative healthcare. The Center follows up to ensure that its clients attend appointments.

Another provider talked about services available such as those offered by the Visiting Nurse Association as one effective way of reaching refugees, in which an RN visits the home, and works through interpreters to follow up and address barriers to medication compliance. Frontline Services' Spanish speaking case manager approach was also mentioned as a model.

- ***Recruiting Providers from Refugee Communities***

Some providers talked about the fact that refugees often will seek non-mainstream treatment for their issues—physical and mental health. Elders, traditional healers, churches, pastors, and deacons were all mentioned as resources that refugees seek out. Figuring out ways to include these groups in collaborative approaches to address refugee mental health might be one approach to improving services.

One informant spoke of innovative efforts the Cleveland Clinic has made to bring in Arab physicians, and how access for Arabic-speaking refugees has opened up as a result. “We have Arabic-speaking doctors from the Middle East. It’s a different situation, but the Bhutanese and the Nepalese, which is one of the fastest-growing communities, do not have that.” While the informant noted that small organizations would be unlikely to be able to have the resources to bring mental health providers from different countries to address refugee needs, the Clinic has the resources to assess its client populations and expand its efforts and improve refugee services:

We need to show those numbers to the Cleveland Clinics of the world. They have been intentional of going around the world and hiring people and bringing them here. Go out and hire somebody for the Bhutanese and the Nepalese and bring them here. They have the funds to do that. They’re the only organization that can do that.

- ***Innovative/Nontraditional Approaches to Mental Health***

The Cleveland Clinic’s Lyndhurst Campus, which has “alternative” medical services, was cited as a potential model. While mainstream western medicine may view such approaches as “alternative,” and not covered by insurance, for many refugees, such approaches may be more culturally “mainstream.” One provider said, “How can the system be approached to say ‘These people, this is their healthcare. This is the way they understand health. How can you cover it for this margin of the community?’”

- ***Best Practices: Experienced Refugee Providers***

Asked how providers who are considered “experts” in the field handle client interactions, informants said that “establishing comfort” was critical, and that “cultural learning” was essential (e.g., spending some time to quickly learn about the populations that will be arriving).

Characteristics of the “best” providers included “Just the willingness to learn about the culture and to understand.” Informants also talked about the importance of approaching refugees with respect, listening carefully and being compassionate and caring. Reaching out through agencies that refugees already trust was seen as very important, especially when seeing a client initially:

We are their first experience of health care, so it's very important for us to show them that anything . . . like they need to be comfortable with anything they want to bring up, that they're respected, that they're culture is respected. We obviously don't know everything about their culture and we can ask, and that makes them comfortable. Like they know that we're not Bhutanese, or we're not Arabic. So we'll be wrong a lot, and but we try to get to a comfort level with them that we can laugh about being wrong.

5.3 Refugees

The Refugee Advisory Council provided an important perspective, different from those of the community providers and those working in the resettlement organizations.

5.3a Mental Health Issues

The refugee group started by emphasizing the sense of relief, safety, and freedom from persecution they felt by being in the U.S., and that they recognized that many opportunities are open to them here. One said, “She appreciated how people here have a giving and helping spirit, and said many Americans have helped her family without expectation of something in return.”

- **Anxiety, Depression, Isolation**

Asked about refugees’ critical mental health needs, the refugee group emphasized that finding a job and getting a job were their biggest challenges—a challenge linked to anxiety and depression. They said that the difficulties they faced in finding jobs that matched the job skills they had in their home countries were their biggest obstacles to good mental health. Feeling isolated after leaving family, friends, their careers, and losing the educational attainment and social status they had gained, also created barriers, contributing to feeling “a little depressed.” They also noted that there is substantial social stigma related to mental health issues, and contrasted that with the “American attitude” that mental health is not as stigmatized.

One refugee said that most of what she and others experience is a “general anxiety,” but not serious, clinically significant anxiety. The refugee group talked little about the traumas they experienced in their home countries, but more about feelings of isolation and the need to feel supported and understood:

My big problem when I came here . . . like, I lost my job. I lost my friend. I lost everything in Sudan. I have education, but here I feel a little depressed.

Another informant said, “Yeah, everybody has the depression from my community,” and elaborated on both the good and bad elements of coming to a new country, adding that sad feelings are normal but that having a job would be a likely remedy for most people:

. . . sometimes we miss our place where we came from. But as time goes by we feel better. Like the kids start going to school a couple years, and then you get a job, a steady job, steady income flow. They kind of get used to this new environment, adjust to the new things. But for a certain group, certain families that don’t have steady incomes . . . The most important thing for my community is a steady job. For one family, if one member got a steady job, they don’t feel like going back home at all. They don’t feel homesick . . .

Refugee informants also talked about more severe cases, when mental health needs went unmet. In one case, a man eventually committed suicide, and the community had little warning:

There was a case in Canada. He works, stays with his parents, but I mean to his friends, he is normal. He acts normal, but one evening, he came back from work and he was cleaning his house and then in the house there was nobody, so he planned to kill himself. So when people came home and saw he killed himself, all of a sudden people got shocked because nobody expected he’s gonna do that. So nobody really knows what are the issues that caused him to do that. We need awareness, and need someone like community people to refer to each other, because the suicide, you cannot see. You can prevent it.

- **Loss of Identity**

Being unable to eat food with which they are familiar, to speak their own language, to achieve recognition of their educational attainment and social status and behave in ways consistent with their customs—these were all mentioned as issues related to loss of identity. One refugee joked that there is a saying that for refugees, U.S.A., means “U

Start Again.” The refugees said they have to work to find, or rebuild their identities here:

So that means whatever you had in your country, it's you start again. . . . a lot of our people, they have like doctorate degrees. They finished all their courses, and when they come here and they have nothing to start.

Other refugees felt that starting again was positive: “...in refugee camp I had no identity, no destiny, nowhere to go and I don't know who I am.” But some refugees talked about losing their culture and national identity as well:

And my daughter asked me this question: 'So and you guys are running here, coming here. So who's going to stay where you came from?' I didn't think about it when she asked because I'm trying to train her how in the Congo we cook, we clean, we do stuff, and she asked me, 'So many of you, you are here. Who's staying back there doing all these things?' and my tears just came down 'cause you know I felt I just will have to have the Congo, this thing she asked me was a good question and I was like, 'I don't know.'

The refugee group noted the social stigma associated with having illness for many of their community members:

If you have mental illness or something, the stigma stops you from seeking the treatment, you know, but here I see that people go to the doctor easy, if you have depression or something. It is not gonna cause you a problem, like in my country—in my country, all the people will not go to psychologist, the people go to a traditional healer.

One refugee who was working on gaining American citizenship spoke to the importance of community members helping one another:

I want to help people, and our people need a lot of help. It's not because they don't know anything. But because of the different culture—even my parents, they can't speak English, so they don't know where to go, how to find stuff, and I am their right hand. So a lot of our people, they need our help.

- **Stress**

Stress was also as a major issue for the refugee groups. This was related to job status, loss of identity, isolation, and anxiety and depression. Having no one who understands you, who speaks your language or understands your cultural background was described as intensely stressful. One refugee spoke of being able to provide comfort for someone from his/her home country when he was hospitalized. Stress associated with work and having time to rest was also mentioned by one informant: “Back home, we don’t have a shift, those kind of working shifts, so you have more leeway back home, like more leisure time. Here, no.”

- **Health Maintenance/Improvement**

Some refugees talked about coming to the U.S. and becoming less healthy than before they came—that their food choices were less nutritious and they exercised less. In refugee camps, at least, they said, there were soccer and volleyball games and other activities:

In Nepal, we barely eat very nutritious food. You know we are under poverty in refugee camps. Here, as soon as we came here, we’re eating all kinds of nutritious food day-by- day, but also a lot of sodas, and we’re getting fat. You know, we were undernourished before. Now we got too many nutrients and we are in health problems now. So maybe now we can have gym class somewhere for free, we don’t have to join, maybe we can walk. We’re gonna have Medicaid for a certain period of time and after that, it’s gonna cost a lot of money. So maybe we can maintain our health, educate our community.

- **Coping Strategies and Service Utilization**

Asked what needs to happen to support refugee mental health, members of the refugee group emphasized that the best thing that can be done is to get refugees established in school, and/or in a steady job. Without these supports, they doubted there could be much done to help their mental health. While at least one person said he/she realized that the hospital was a place they would go if they had severe problems, another said most members of the community would not

...members of the refugee group emphasized that the best thing that can be done is to get refugees established in school, and/or in a steady job.

go to the hospital. They find it helpful to talk with members in their communities when they are missing home. Several were grateful for having come to the U.S. with their families, and therefore having built-in social supports, but they still felt like having mental health issues would subject them to stigma and they would not want to be seen going to the hospital for these issues. Asked where they would go if they had mental health issues the refugee group said overwhelmingly that they would consult their own family. One informant said her family was her key source of support: “I thank God every day during my prayers that I came here with my parents and my two siblings. So if I have any problem, I have someone so close to me to speak with him and to find solutions and to find support and solutions, even if I have financial problems. So it’s a good idea to come here with a family, not on your own.”

Given that earlier informants talked about the inappropriateness of one-on-one therapy, the refugees were asked about how they felt about the approach. The informants indicated that they would prefer to talk with someone individually, because they wouldn’t want others to know their personal problems. Said one informant: “I think I should be one-on-one. You need privacy. Everybody needs privacy, so I strongly recommend one-on-one.” Another echoed the sentiment: “Back home we don’t have group therapy. We have only if you have a problem, you talk to your parents and only them.” Another informant said many people would only go to traditional healers with their issues. Other informants recognized that group therapy was a common Western approach, and although it didn’t initially appeal to them, they could get used to the idea:

Most of us tend to be more private with our issues, but if you share with others, some people don’t like it, but if you come into the country where you have social therapy, then people get used to it. I was born there. If I stay here longer, I will get used to the social therapy, so yeah, eventually it would be, yeah, they would do it.

At least two others in the group, however, said they would prefer group therapy to individual because it would help them to know they weren’t alone: “You need to be exposed to other people so you can see like you’re not alone in that situation.” They also noted that they would be open to group therapy, but it depended on the issue they were having:

The group therapy, to know others’ experience, that might help you to see yourself, like ‘I have a small problem,’ or you know if you’re sharing your experience, it helps. For me, I like groups. I like confidentiality, one-to-one with my doctor for the private things, like the small detail I can’t tell in front of the

people, but if I get depression or if I get like some problem, I'm gonna share my experience with other people so they can learn from my experience, how I solved my problem and sought help.

- ***Linguistically and Culturally Appropriate Services***

The refugee group expressed concern about translation and culturally appropriate services. One talked about problems with getting the wrong translation in medical settings, sharing a story she had heard in which a woman was erroneously told she had cancer, causing tremendous stress. Throughout the interview, the refugees noted how strongly they felt about working with people they trust, who understand them (i.e., members of their own communities). “It’s the intimacy,” one said, that makes the biggest difference. At the end of the interview, one member talked about her father, who is a community leader, and how much he works for the community—long hours serving as a driver, translator and advocate for others.

- ***Recommendations***

Refugees said that it would be helpful to have someone who could help them walk through the systems and understand about paying rent and utilities. Caseworkers, they said, are too busy and do not go to houses to check in on people, so some people tend to fall through the “cracks” in the system. With regard to the important role caseworkers could play:

I think our community also prefers one-on-one just to advise them personally, and I think we need to have more volunteers just to talk to people, since this is a different culture. People are worried about their rent and their utilities, and that's making more depression. The caseworker we have, probably one for East side, one for West side, they're just very busy making the appointments, taking people to the hospital or something like that, and there's no one available right now. As a volunteer, we can actually stop by house-by-house and talk to people, and ask, 'How are you doing? Any problem you have?' You know there's no people who actually go to the house. So I think if the organizations can hire somebody full-time so they don't have to worry about their rent and all that, so they can actually go, stop by and advise them.

The caseworkers, ideally, the refugee informants said, would come from their own communities because they would know the linguistic expressions, cultural subtleties and nonverbal behavior better than anyone else, and would be more likely to find the “right” way to deal with the issues:

They have a problem, they probably say 'I have no problem,' and she can know whether that's true. She just can catch the word and she can make the decision by the word, but all the facial actions, are they saying right or wrong, or you know they have the problem or not. Actually, it'll be more effective if we have the people from their own community just to help in the depression.

Although one informant suggested that a mentor or volunteer system would be best, others countered that volunteers were not enough, pointing out that there are volunteers now who tend to be overused. One person noted that the current community volunteers are vulnerable to burnout and taking on the problems of everyone in the community and are neither trained nor prepared to deal with mental health issues.

5.3b Case Example #1

One refugee talked about his own hospitalization experience, and although it was not explicitly for mental health needs, his cultural needs figured prominently in his experience. After coming to the U.S., he was hospitalized for two months with tuberculosis, but there was no one to visit him, and the hospital was serving him unfamiliar American food. The refugee described the stress of having no one to visit him, to speak his language, eating strange food, and the relief he felt when the nursing staff brought a doctor from his culture to see him:

I came here in 2005. I was sick, like literally sick. I had TB, tuberculosis, so I was admitted [to the hospital]. I remember a guy, he used to work at Catholic Charities, and he came maybe once a week, 'cause I stayed in [the hospital] for two months. I was very sick, I swear to God. I was like flipping out. The simple fact . . . I know it sounds crazy to you guys: So every day we eat chicken, and back home we have, it's literally just leaves, plants, and we used to cook that daily, and I missed that for a period of two months. I flipped that day. I said, 'No. I'm gonna go back home.' They brought doctor. You know him? So he translated to them and he—it was a cultural thing, you know what I mean. Then actually they brought [cultural] food that day, and all the nurses, they came and they clapped. After that I started eating normally. It was just so crazy. It's somehow stress, especially when you cannot find someone from your, not just family, but somebody who just speaks your language who can sit with you for ten, 15 minutes. I'm sorry, that makes a big difference, you know. Now I work [at the hospital], and one of the doctors, he's from Sudan, 'cause he's been here for 20 or 30 years, he's a doctor [at the hospital], but he got sick and then of

course you know nobody came around and they were searching around, you know. I knocked on the door. I swear to God, I came and I started talking to him. This doctor, he had heart surgery, but he almost got up and hugged me, and just like it's just so crazy. So it's helpful when you come and find somebody from the same country or culture that will relieve the level of stress you have.

While the above example refers less to severe mental health issues than cultural adjustment issues (that could evolve into more serious issues if not handled well), the case example below describes a case that involved obvious mental health issues, the signs of which were not understood as red flags by the client's friends and family members.

5.3c Case Example #2

One refugee informant spoke of a man he/she knew who had been depressed for two-three months, was "afraid in his heart" and had bad dreams. His family said he was "useless" and people talked about him badly. While people were aware of his difficulties and behavior, he did not get treatment, and eventually attempted suicide:

My experience is pretty different. In our country or in our culture, when people have depression, I can say more than 90% never go to the hospital, and so in a family when somebody got depression and the rest of the family, they don't take them to the hospital either for the treatment. The first thing is, it's not a disease. Like they can have medication sometimes, and sometimes the rest of the family members think you know 'He's useless, and he can't do anything. That's why he's in depression.' So I think we need to create an awareness program for our community, saying that depression needs to be seen by a doctor, and there's a way to get out from the depression. I have one example. That is one guy who tried to do suicide on the East side, and he got in depression for at least two or three months and nobody paid attention, and neither did we pay attention. He said 'I have no energy, or I always get effort in my heart and when I see people I get afraid. I think they try to kill me. I always got the bad dreams,' and so the family thinks 'He's useless.' He's the only one son in the family. His parents are older and can't work. They're getting ISI [meaning SSI], and so we think he is useless too. So he keeps hearing these bad things, you know bad motives, bad dreams, and so like some people, they start talking bad about him. Most of the time, he used to cry. So I started thinking he probably has a real problem in his heart. I started spending time with him, and he used to come in our church and after service I used to help him. I used to speak positive to him, 'You know you have no problem. You are good. Everybody's talking good things about you.

Don't get frustrated and don't think you are alone. We are with you,' and he got a little better, but in about after a week, again he had the same problem. So I decided that he has a problem, he probably needs to be seen by a doctor. I brought him here two or three times and he's been followed with the doctor. So one day he had the medication. I think that medication made some side effect and he tried to kill himself in my house. So luckily he's been taken care of by the doctor, he's okay now. He's no more feeling depression anymore, but he's still denied to work. He's like 30 years old, and he's very healthy and he's able to work. He's strong too, but he still don't want to work, so don't know why, but he has no more depression. His family's economic condition is very, very poor, so that's the problem.

The informant emphasized that it is important that people from the community are used to identify issues such as those presented in the case example. "The people from their community, they know their expression. It is hard to say, but if I see somebody from my culture and at one glance I can see how they are, even if they can't say anything, because I know my culture."

In general you need somebody that watches, just kind of watching. You can tell if somebody has some serious mental status, even though if he tried to hide it, if you're close to that person, you'll be able to tell somebody else, and that person, if he had an open mind and you can talk to him, 'Go to the doctor.'

5.4 Interviews/Focus Groups: Summary Findings

Findings identified several gaps with regard to refugees' mental health needs, service gaps, and potential solutions.

- **Critical Needs**

Key informants identified a variety of refugee mental health needs.

1. **Traumatic experiences.** Informants were clear that refugees have often experienced traumatic experiences, including torture and rape, and have often witnessed the casualties of war. Exposure to such experiences has a different impact on each person but common consequences, providers indicated, include symptoms of PTSD, depression, and anxiety, as well as adjustment disorders.

2. ***Mental health needs that are not “obvious” and/or develop over time.***

Informants made distinctions between individuals who arrive with “obvious” symptoms (e.g., symptoms associated with schizophrenia), and/or arrive with known diagnoses, and those refugees whose symptoms are less obvious and/or manifest over time. Although refugees are served intensively during the first few months they arrive, sometimes mental health issues arise after their resettlement period ends.

- ***Service Gaps***

Interview and focus group participants indicated a number of critical service gaps, including those indicated below.

1. ***Lack of linguistic competence.*** Service providers were aware of the need for translators, but often noted that translators used for other purposes (i.e., community members, client family members or friends, and/or language lines for health providers) are often not suitable or appropriate for mental health services. Mental health diagnosis and treatment, one provider noted, is at least partly based upon the relationship between the provider and client, a process that can be disrupted by an interpreter, including the provider’s own uncertainty about whether the translation is correct.
2. ***Lack of cultural competence.*** Even if an appropriate interpreter is available for refugees in need of mental health services, it is not necessarily true that the provider knows how to communicate effectively with a client/patient in line with his/her cultural beliefs and traditions. Refugees have different degrees of familiarity with Western culture in general and Western medicine in particular, and mental health conditions might be interpreted in a number of different ways. Providers who have little understanding of the backgrounds and worldviews of their clients have little chance of successfully “reaching” them.
3. ***Unrealistic expectations of resettlement organizations.*** Resettlement agencies are the first and primary point of contact for refugees. As such, other service providers often see them as the refugee “experts” and expect them to conduct ongoing case management. Thus, when refugees have needs outside the timeline of their resettlement period, other organizations often expect resettlement agencies to step in, and/or guide them in helping the refugees—often tasks for which the resettlement organizations are either unprepared and/or unfunded. Thus, refugees whose needs arise later will sometimes fall through the “cracks” of the system. At least one informant also noted the lack of

services for secondary refugees, whose arrival in Cleveland often falls outside the official resettlement period.

4. ***East vs. West side service availability.*** Despite increasing populations of refugees on the East side of Cleveland, informants noted that there is a dearth of services on the East side and that services (and refugee knowledge) tend to be concentrated on the West side.
5. ***Stigma.*** The stigma associated with having mental health issues adds another critical layer to mental health needs: some refugees view mental health issues as something to be ashamed of, abnormal, and/or a stain on one's character. This stigma prevents some from seeking treatment.

6. Provider Surveys

6.1 Methods

Including the perspective of mental health and other service providers in Cuyahoga County was critical to the current study. Their experiences, capacities, and challenges in relation to provision of mental health services to refugees helped form a fuller picture of community needs.

- **CLAS Standards**

To harvest those perspectives, the study employed a modified version of the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*) as an assessment tool.

The *National CLAS Standards* were developed by the United States Department of Health and Human Services, Office of Minority Health in 2003 (and since revised) in order to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. They are also intended to serve as a community-informed, research-grounded tool which organizations can use to more objectively benchmark progress toward cultural and linguistic competence. This is critical since measurement of cultural and linguistic competence across a range of concerns is historically highly subjective, and hence minimally useful as an assessment or planning tool.

The *Standards* include one principal and 14 subsequent goals health care providing organizations (including behavioral health organizations) should attempt to meet in order to ensure cultural and linguistic competence. The principal standard indicates that health care organizations should “Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.” There are three standards addressing questions of *organizational governance, leadership, and workforce*; four standards that address *language and communication assistance*; and seven standards that address *engagement, continuous improvement, and accountability*. A complete list of the *Standards*, as well as other documents that describe utilization and application of the standards in more detail, can be found at the OMH website, here: <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>.

This study's use of the *CLAS Standards* modifies those standards minimally, eliminating several that are not relevant in the present context.

- ***Survey Format and Distribution***

Researchers used the *CLAS Standards* to develop a 20-question survey intended to measure organizations' responsiveness to the *CLAS Standards*. In all but a few of the questions, respondents were asked to rank their organization in a four-point Likert scale, in terms of the degree to which the respondent believes the organization has met each individual CLAS standard. Question #3, for example, reads as follows:

To what degree do staff at all levels receive ongoing education/training on culturally and linguistically appropriate service delivery?			
Not At All/Rarely	Somewhat	Often/Regularly	Consistently/Always

And question #4 reads as follows:

To what degree does your organization offer no cost language assistance services to clients with limited English proficiency?			
Not At All/Rarely	Somewhat	Often/Regularly	Consistently/Always

The questionnaire was sent via Survey Monkey to 715 Cuyahoga County survey providers in the United Way 2-1-1 database. A first round of survey dissemination yielded a 3% response rate. Surveys were sent out again, targeting especially, key mental health providers. The final response rate was 5%, which met the goal established by the study researchers at the outset.

Results were tabulated by United Way's 2-1-1 Director, Diane Gatto. Specific responses to each question are attached as Appendix C.

6.2 Provider Survey Summary Findings

- Overall, respondents demonstrated a commitment to delivering culturally appropriate services as evidenced by their efforts to recruit diverse staff/management and train staff on cultural competence. Respondent comments indicated an appreciation of the inquiry and an eagerness to learn how to better serve clients utilizing the CLAS tool.
- Most respondents do not employ speakers (native or non-native) of the languages listed and instead rely on interpreter services. Respondents also indicated limited availability of signage and written materials in other languages, including grievance policies specific to resolving cross-cultural issues.
- While data collection about race and ethnicity was quite universal, data collection regarding country of origin, written language and refugee status was atypical.
- More than half of all respondents indicated a lack of tools (needs assessments, demographic profiles) to assist them in serving their community.
- Nearly all respondents indicated a lack of training in refugee trauma.
- Respondents indicated an ability to serve refugees in various areas of behavioral health, but specific programming targeted to refugees is lacking.
- None of the agencies listed in the United Way 2-1-1 database were identified as targeting behavioral health services to the refugee population. Only two survey respondents indicated targeting the refugee population in the area of behavioral health. There are more than 100 behavioral health providers listed in the 2-1-1 databases as serving Cuyahoga County in some capacity.

APPENDIX

A: Interview Questions: Service Providers

- **Introduction**

1. I'd like to first get a sense of your knowledge about refugees in the community here in Cleveland? What do you know about them?
2. What do you believe are the (most important/critical) mental health needs of current refugees settling in Cuyahoga County?
 - a. This is a follow-up to the previous question: Do you believe the mental health needs of future refugees settling in Cuyahoga County will be the same or different as those of current refugees?
3. From what you know, what factors contribute to refugees' needs for mental health services?
4. What resources are currently available to meet those needs?
 - a. Probe: mainstream resources/services?
 - b. Alternative/outside of mainstream mental health resources/services?
5. What do you see as the gaps between the needs and available resources?
6. Do you think that the mental health resources currently available address the specific cultural and linguistic needs of Cleveland's refugee populations? Why/why not?
7. What things do you think help and/or prevent refugees from obtaining the services that would best help them?
8. Next I'd like to hear about some of your experiences. Please talk about experiences you know of when refugees with mental health needs:
 - a. Did not access services? Why do you think they did not access the services?
 - b. Tried to access services and were unsuccessful. What factors led to this lack of success?
 - c. Accessed mental health services, but the experience was negative. (Probe, if needed: Did the provider(s) lack cultural or linguistic competence?) What happened?
 - d. Accessed mental health services and their needs were successfully addressed. What factors that contributed to that success?
9. What do you think needs to be done to successfully address the mental health needs of Cleveland's refugee populations? (Probe, if needed: What additional resources should be developed? What current resources should be modified or tailored to fill the gaps between what is needed and what is available?)
 - a. What is the first priority?

10. What do you think providers understand their responsibility is to be in providing culturally and linguistically appropriate mental health services under title VI services?
11. What other questions should we be asking to fully capture the picture of refugee services locally?

B: Focus Group Questions: Consumers/Refugees

Introduction: I am working with the Refugee Services Collaborative to help them learn more about refugees' experiences in moving to and settling in Cleveland. One thing that we are interested in learning is about the things that are helpful and the things that are not helpful for refugees. Sometimes, refugees have experienced some difficult things in their lives, and also when anyone moves to a new place, it can be hard getting used to the new place. Some people feel angry, sad, confused, worried, and/or are afraid. Sometimes people have trouble sleeping and/or eating or have other experiences. I would like to hear about what people do when they have these kinds of experiences once they get to Cleveland.

1. My first question then, is, what kinds of feelings, from what you know are most common? What do you think troubles people the most/what is most difficult?
2. How do refugees take care of these feelings? What do they do? Do they go anywhere to ask for help? Where do they go? There are some people in the U.S. whose jobs are to help people with these kinds of things, usually by talking about them. Do you think this is something refugees would like to do/feel comfortable with?
3. What kind of person do you think you/people would trust to help them with these kinds of feelings?
4. Do you think that people in Cleveland are respectful of refugees' language(s) and/or culture?
5. Have you heard of a time when a refugee has tried to find help for these kinds of feelings, but hasn't been able to for some reason?
6. Have you heard of a time when people have gotten good help that helped them feel better?
7. How do you think people in Cleveland can best help refugees adjust when they come here? What should be done?

C: Provider Surveys



Q1: Effective and Respectful Care. To what degree does your organization ensure that clients receive effective and respectful care in a manner compatible with their cultural beliefs and preferred language?

Answered: 34 Skipped: 0

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	2.94% 1	14.71% 5	38.24% 13	44.12% 15	34	3.24

Q2: Diverse Staff/Leadership. To what degree has your organization implemented strategies to recruit, retain and promote diverse staff and leadership, representative of community demographics?

Answered: 34 Skipped: 0

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	2.94% 1	14.71% 5	52.94% 18	29.41% 10	34	3.09

4

Q3: Ongoing Training. To what degree do staff at all levels receive ongoing education/training in culturally and linguistically appropriate service delivery?

Answered: 34 Skipped: 0

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	11.76% 4	35.29% 12	32.35% 11	20.59% 7	34	2.62

5

Q4: Language Assistance Services. To what degree does your organization offer no cost language assistance services to clients with limited English proficiency?

Answered: 34 Skipped: 0

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	26.59% 7	29.61% 10	17.65% 6	22.35% 11	34	2.62

4

Q5: Notification of Language Assistance Availability. To what degree does your organization provide clients, in their preferred language, both verbal and written notices informing them of their right to receive language assistance services?

Answered: 34 Skipped: 0

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	26.47% 9	26.47% 9	29.41% 10	17.65% 6	34	2.38

6

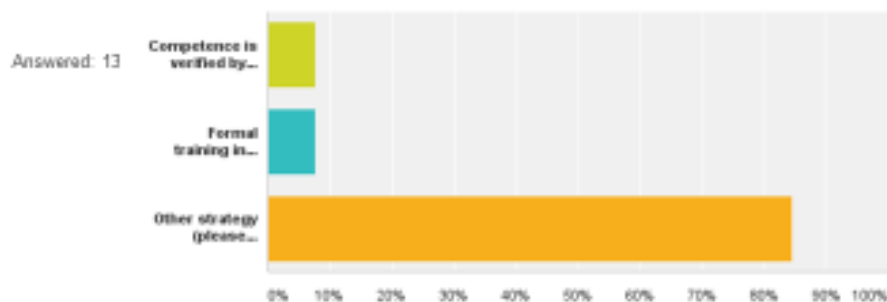
Q6: Assuring Interpreter Competence. To what degree does your organization assure the competence of language assistance provided to limited English proficient clients by interpreters and bilingual staff? (Note: Family and friends should not be used to provide interpretation service, except on request by the patient/consumer.)

Answered: 19 Skipped: 15

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	26.32% 5	26.32% 5	31.58% 6	15.79% 3	19	2.37

4

Q7: Assuring Interpreter Competence. Please check how competence is assessed.



Answer Choices	Responses
Competence is verified by formal testing prior to employment	7.69% 1
Formal training in medical interpreting is provided and/or required for staff	7.69% 1
Other strategy (please specify)	84.62% 11
Total	13

4

Q8: Translated Materials/Signage. To what degree does your organization make available easily understood client-related materials and post signage in the languages of the commonly encountered groups in your service area?

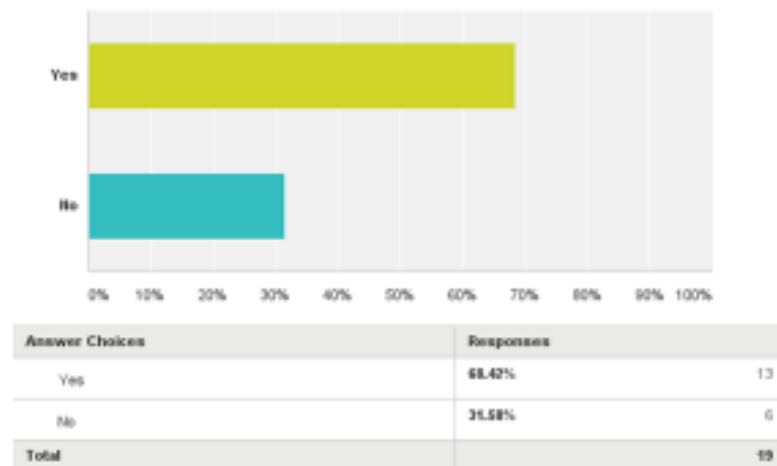
Answered: 18 Skipped: 16

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	16.67% 3	44.44% 8	27.78% 5	11.11% 2	18	2.33

4

Q9: Strategic Plan for Competent Services. Has your organization developed and implemented a strategic plan outlining goals, plans and accountability mechanisms to provide culturally and linguistically appropriate services?

Answered: 19 Skipped: 15



4

Q10: Self-Assessment. To what degree does your organization conduct ongoing organizational self-assessments of CLAS-related activities, such as performance improvement programs and client satisfaction assessments?

Answered: 18 Skipped: 16

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	33.33% 6	33.33% 6	66.66% 2	22.22% 4	18	2.22

4

Q11: Data Collection. To what degree does your organization collect and update data on clients' race, ethnicity, country of origin, refugee status and spoken/written language in client records?

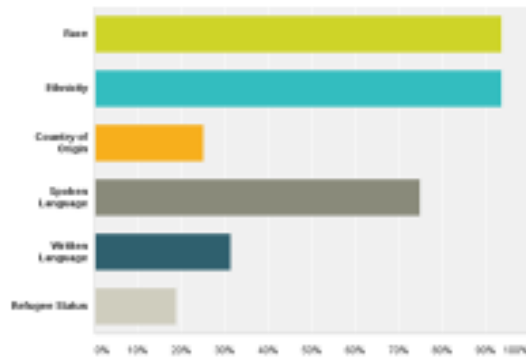
Answered: 19 Skipped: 16

	Not at all/Rarely	Somewhat	Often/Regularly	Consistently/Always	Total	Weighted Average
(no label)	21.65% 4	8.66% 0	31.58% 6	42.33% 9	19	3.05

4

Q12: Data Collection. If previously responded Often/Regularly or Consistently/Always, please check all data elements collected.

Answered: 16 Skipped: 18

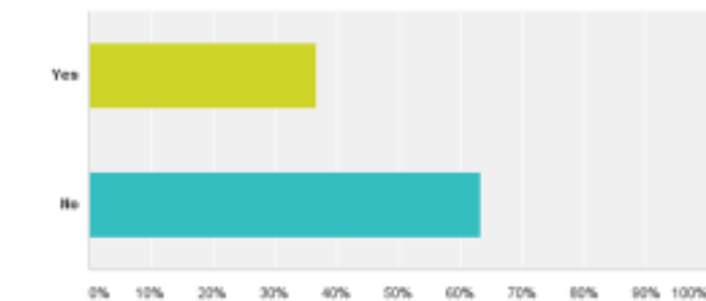


Answer Choices	Responses
Race	93.75% 15
Ethnicity	93.75% 15
Country of Origin	25.00% 4
Spoken Language	75.00% 12
Written Language	31.25% 5
Refugee Status	18.75% 3
Total Respondents: 16	

4

Q13: Community Profile. Does your organization maintain a current demographic/cultural profile of the community, as well as a community needs assessment, in order to plan and implement culturally and linguistically appropriate services?

Answered: 19 Skipped: 15

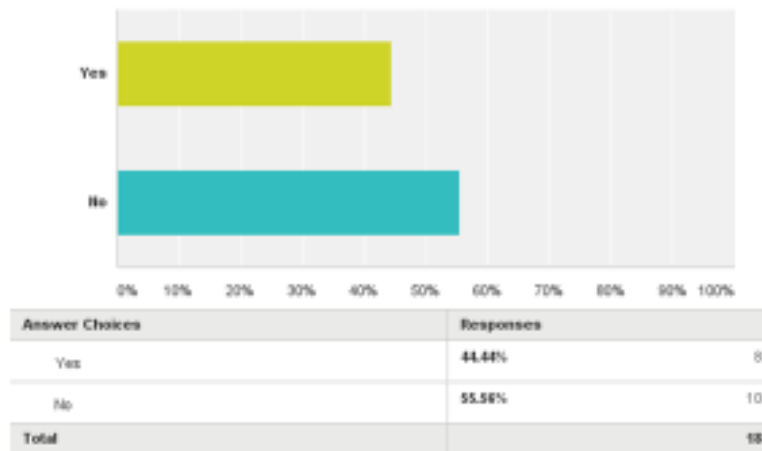


Answer Choices	Responses
Yes	36.84% 7
No	63.16% 12
Total	19

4

Q14: Conflict/Grievance. Does your organization have a written conflict and grievance resolution process that is culturally and linguistically sensitive and capable of resolving cross-cultural conflicts involving clients?

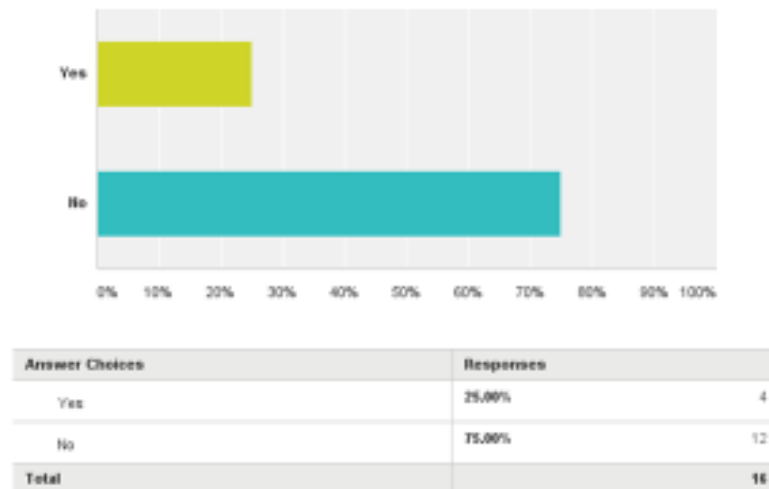
Answered: 18 Skipped: 16



4

Q15: Communicating Progress. Does your organization make available to the public information about its progress in implementing CLAS standards?

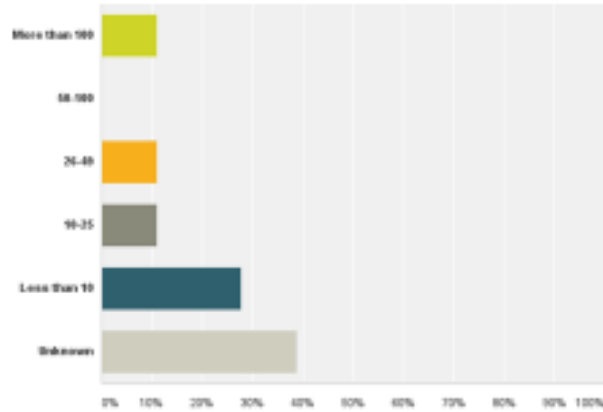
Answered: 16



4

Q16: Number Receiving Services. Approximately how many refugees received behavioral health services from your organization in 2014?

Answered: 18 Skipped: 16



Answer Choices	Responses
More than 100	11.11% 2
50-100	0.00% 0
25-49	11.11% 2
10-25	11.11% 2
Less than 10	33.33% 5
Unknown	33.33% 7
Total	18

4

Q17: Bilingual Employees. How many employees (FTEs) are speakers of the following languages?

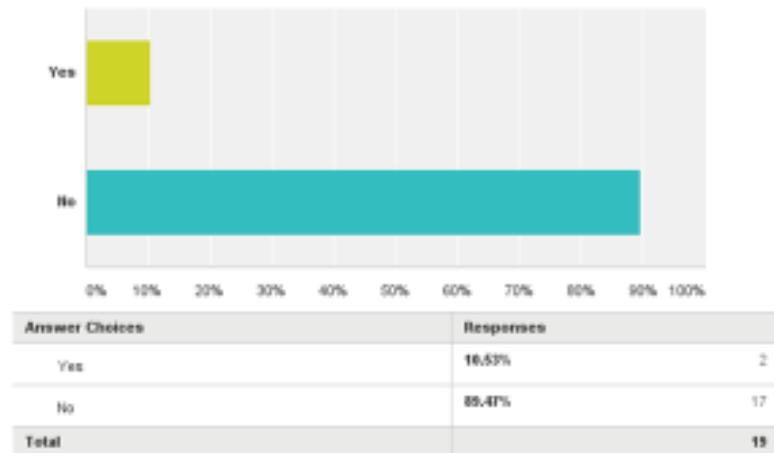
Answered: 8 Skipped: 26

Method	10+	5-10	3-5	1-2	0	Total
Arabic	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Hebrew	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Urdu	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Korean	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Spanish	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
German	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Armenian	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Burmese	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Tigrinya	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 7	7
Non-Method	10+	5-10	3-5	1-2	0	Total
Arabic	0.00% 0	0.00% 0	0.00% 0	10.00% 1	90.00% 5	6
Hebrew	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
Urdu	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
Korean	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
Spanish	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
German	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
Armenian	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
Burmese	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5
Tigrinya	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 5	5

4

Q18: Trained Staff. Have any of your current employees received formal training in refugee trauma?

Answered: 19 Skipped: 15



Q19: Services Provided. Please indicate which of the following services your organization provides, if any, that can accommodate refugees (provide basic, non-specialized care, not specific to refugee status) and which services are specifically designed for refugees? Service categories are based on Chapters 5122-29 of the Ohio Administrative Code.

Answered: 10 Skipped: 24

	Can Accommodate	Targets	Total Respondents
Community psychiatric supportive treatment (CPST)	66.67% 4	33.33% 2	6
Behavioral health counseling and therapy service	100.00% 10	10.00% 1	10
Mental health assessment service	100.00% 3	66.67% 2	3
Pharmacologic management service	100.00% 3	0.00% 0	3
Partial hospitalization service	0.00% 0	0.00% 0	0
Forensic evaluation service	0.00% 0	0.00% 0	0
Crisis intervention/mental health service	100.00% 4	0.00% 0	4
Behavioral health hotline service	100.00% 1	0.00% 0	1
Inpatient psychiatric service	0.00% 0	0.00% 0	0
Adjunctive therapy service	100.00% 1	0.00% 0	1
Assertive community treatment (ACT) service	0.00% 0	0.00% 0	0
Intensive home-based treatment (IHT) service	100.00% 3	0.00% 0	3

Q20: Is there anything else you would like us to know about your agency's work with refugees – your experiences, concerns, limitations, qualifications and/or your needs? Answered: 8 Skipped: 26

- We have one Therapist in our agency that works very closely with our migration and refugee department and the needs of the refugees.
- Most other language work for behavioral health is done in Spanish or Eastern European language. Other languages have to use contracted interpreters. One staff uses American Sign Language (for English).
- The Greater Cleveland Food Bank works with over 750 partner agencies in our 6-county service territory. We provide our pantry network with annual and as needed trainings in regards to civil rights and LEP support. Pantry programs receiving TEFAP product available through the Federal Government are required to document civil rights training for all their program volunteers. In addition to mandatory Civil Rights training, LEP services are also required. The Ohio Association of Food Banks has contracted with the Affordable Language Line service to provide translation services to food bank member pantries throughout Ohio in over 150 languages 24/7.
- We would welcome any information about how to better accessible to refugees, and how to reach different populations.
- As a federally-designated and mission-directed health care provider for individuals who are homeless or living in and around public housing, Care Alliance works with for very few refugees. We are well-equipped and culturally competent to care for our target population. Patients with needs beyond our expertise are connected to our fellow primary and behavioral health care providers.
- This survey has certainly enlightened me as to what we need to be doing in this important area!
- We provide recreation and homework help to children in the Collinwood/Nottingham neighborhood. All our current youth are US citizens born in the US whose first language is English. We have no employees; we are an entirely volunteer run organization.

4

D: Literature Review Citations

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