# PERSPECTIVES OF MENTAL HEALTH SERVICES FOR REFUGEES IN THE U.S.: FOCUS ON RESETTLEMENT AGENCIES

by

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*This dissertation is first and foremost dedicated to all displaced persons globally, whose strength and resilience is the inspiration and foundation for this work.*

*Second, I dedicate this dissertation to my Nana, whose immigration journey from Mexico impressed upon me the challenges of navigating and adjusting to a new country.*

*Third, I dedicate this dissertation to my mother. Her belief in my ability to achieve whatever I set out to do to is in part due to her never letting me believe I was incapable of achieving my goals.*

*Finally, I dedicate this dissertation to my husband.*

*Throughout my journey as a graduate student, he has never wavered in his commitment to supporting me and supporting my education. He never failed to feed me when I was too busy working to cook, he made me cry laughing when I was crying from overwork, and he remained patient and steadfast when I ran out of patience. Throughout it all, he ensured I had a boba tea in my hand to get me through my toughest days.*

*This man deserves an honorary doctorate.*

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# ABSTRACT

As of June 2020, there were nearly 71 million displaced persons worldwide fleeing their homes due to conflict and war ("Figures at a Glance," UNHCR, 2020). One of the critical needs following displacement and subsequent resettlement is to address the immense psychological turmoil refugees may have endured. Despite the need for care, refugees often face barriers to accessing mental health care after resettlement, including inadequate translation services, poor provider cultural competence, and difficulty navigating services (Asgary & Segar, 2011). An important aspect in meeting the mental health needs of resettled refugees in the U.S. are the refugee resettlement agencies that help refugees rebuild their lives post-resettlement. Thus, this study focused on the mental health providers working with resettled refugees within refugee resettlement agencies. Through the use of mixed methods, this study collected quantitative and qualitative data across three phases to 1) obtain a greater understanding of the available mental health services within refugee resettlement agencies, 2) examine cultural competence in mental health providers working within these agencies, and 3) identify the culturally competent strategies mental health providers use to improve access to mental health services in this context. The results of this study, including an integration of the data across phases, and a discussion complete with 12 suggestions for mental health providers working with resettled refugees are presented. We hope the results and implications of this study will contribute to our understanding of, and subsequently address, the issues related to mental health service accessibility experienced by resettled refugees.

# CHAPTER 1
# INTRODUCTION

More people than any other time in history have been forced to flee their homes in order to seek safety, leading to the largest number of displaced persons ever recorded ("Resettlement," UNHCR, 2020. As of June 2020, the United Nations High Commissioner for Refugees (UNHCR) has identified more than 70 million displaced persons worldwide ("Resettlement Data," UNHCR, 2020), 30 million of which have been recognized as refugees, or individuals who have no choice but to leave their country due to conflict, civil war, oppression, and persecution. Until 2017, the U.S. had previously resettled more refugees than the number of refugees resettled by all other host countries combined, resettling more than 3 million of the 4 million resettled refugees since the start of the resettlement program in 1980 (Pew Research Center, 2019). The number of total resettled refugees living in the U.S. is still more than all other countries that partake in refugee resettlement combined, despite President Trump's suppression efforts of resettlement in the U.S. (UNHCR, 2019). Since the Trump administration began however, the number of resettled refugees has declined more than any other host country (Pew Research Center, 2018; Pew Research Center, 2019). Resettlement is the sanctioned transfer of refugees from an asylum country to another State that has agreed to admit them and ultimately grant them permanent settlement ("Refugee Resettlement Facts," UNHCR, 2018). Refugees often face multiple obstacles throughout their journey following the flight from their homeland and prior to resettlement in the U.S., as the resettlement process is a complicated and lengthy process that begins prior to the sanctioned transfer to the host country. Once displaced due to conflict, refugees may spend months to years stalled in refugee camps in countries or cities neighboring the conflict, living in tent cities with little access to clean or running water,

nutritious food, or health care, waiting for the chance to return to their homes or be resettled, (Bushak, 2016; Gary & Rubin, 2014).

Although refugees often demonstrate much resilience and strength, they have commonly endured immense trauma before, during, and after resettlement (Fondacaro & Harder, 2014), including persecution, physical and emotional trauma, and forced relocation. Refugees often experience exposure to war-related trauma, including torture, witnessing friends and family members being killed, and forced relocation. These unique experiences predispose refugees to psychological problems (Murray, Davidson, & Schweitzer, 2010), including depression, anxiety, and posttraumatic stress disorder (Lanchant, 2013). The resettlement process itself, including language barriers making it difficult to access medical and psychological services and the uncertainty of legal status and permanency in host countries, increases stress and may exacerbate psychological symptoms refugees are already experiencing as a result of potentially traumatic experiences (Kruse, et al., 2009; Momartin, Silove, Manicavasagar, & Steel, 2009). Lack of mental health treatment for psychological issues in refugees can have far-reaching consequences, impacting family and the greater community. These issues can lead to further traumatization, as untreated mental health concerns can lead to discrimination, poverty, stigmatization, and unsuccessful integration in the host country (Fondacaro et al., 2014). Thus, the availability and accessibility of mental health services for some resettled refugees may be crucial to their ability to successfully transition to their new life in the host country (Fondacaro et al., 2014). One of the main priorities during the resettlement process should be addressing and treating the immense emotional, social, and psychological turmoil refugees may have experienced pre, during, and post-resettlement. However, refugees often face barriers to accessing mental health services post-resettlement (Asgary et al., 2011).

There are multiple issues that interfere with refugees' access to mental health services post-resettlement, such as lack of resources (Colucci et el., 2015), deficiencies in provider cultural competence (Colucci et al., 2015), lack or absence of appropriate translation services (Asgary et al., 2011; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Stasio, 2012), and distrust towards mental health providers (Colucci et al., 2015; Ellis, Miller, Baldwin, & Abdi, 2011; Young, 2008). The barriers to mental health services for resettled refugees mentioned above can be synthesized as issues related to a lack of accessibility, which may be worsened by insufficient *cultural competence* within the mental health care systems that serve resettled refugees. Counseling psychology literature conceptualizes cultural competence as the ability to demonstrate an understanding of the importance and incorporation of culture, awareness to the dynamics that occur due to cultural differences and developing skills to sufficiently adapt interventions to be culturally relevant to the needs of the client (Sue, 2001).

Multiple studies and meta-analyses have demonstrated that culturally adapted therapeutic interventions provide more benefit to racial and ethnic minority clients. Specifically, culturally adapted therapies contribute to better client outcomes, including improved psychological functioning and client satisfaction with therapy (Benish, Quintana, & Wampold, 2011; Bernal Jiménez-Chafey, & Domenech Rodríguez, 2009; Griner & Smith, 2006; Rathod et al., 2018). Likewise, researchers have emphasized that a central component to universal healing practices theory is the acceptance of the explanation of distress or illness by the client (Frank & Frank, 1993; Kleinman, Eisenberg, & Good., 2006; Wampold, 2007). The *client explanatory model* (Frank & Frank, 1993) posits that when a mental health provider is able to match their understanding of distress to that of the client - and thus adapt therapeutic interventions to better fit their client's conceptualization of illness - clients will benefit more from therapeutic

intervention. Because the expression of psychological distress is an experience shaped by a particular culture's understanding of suffering (Kleinman et al., 2006), it is crucial that the therapeutic interventions used with individuals from differing cultural backgrounds honors these unique experiences of distress. Benish, Quintana, and Wampold (2011) emphasize the importance of considering culturally-specific conceptualizations of mental illness when providing therapeutic intervention, stating that distress manifests "…diversely in its expression of bodily and mental symptoms, presumed etiology, expected course, social implications, and the relative importance of these expressions of suffering (p. 281)." Given that culture informs how individuals experience distress, psychotherapeutic interventions should be adapted to fit the cultural conceptualizations and expressions of mental illness to be congruent with ones culture's explanation of illness. The American Psychological Association states that mental health providers have a duty to implement aspects of care that reflect culturally competent practices (American Psychological Association, 2017). Research has demonstrated that a lack of cultural competence has led to poorer access to care, less effective treatment, and inferior quality of care, all of which have resulted in the underutilization of mental health services, early termination of services, and greater health disparities in racial and ethnic minority groups (Pole et al., 2008; Sue, 1998; Sue, Zane, Hall, & Berger, 2009).

In response to the barriers to mental health services that are related to deficiencies in cultural competence, researchers and clinicians have emphasized "best practices, "or strategies, that should be utilized when providing mental health services for refugee populations to ensure these services are more accessible, appropriate, and effective (Asgary et al., 2011; Colucci et al., 2015; Murray et al., 2010; Rader, Lee, & Ssempijja, 2010; Sue & Sue, 1990; Weine, 2011). These suggested strategies include greater provider cultural competence, emphasizing the

counselor-client therapeutic relationship, acceptance of intervention by refugee groups, community connectedness, addressing stigmatization of mental illness, adaptability/flexibility of intervention, culturally appropriate interventions, availability of qualified translators, and evaluation and dissemination of effective interventions. Each of the strategies to counter barriers to mental health care reflects different facets of cultural competence, and through implementing these culturally competent strategies in practice, access to mental health care for refugee populations may be improved. While the literature provides some suggested strategies to improve access to mental health care for refugee populations, current studies have not identified how or if mental health providers implement these or other culturally competent strategies.

## Refugee Resettlement Agencies

A population that provides unique insight into the availability of culturally competent mental health services for resettled refugees in the U.S. are the mental health providers working within the refugee resettlement agencies that help refugees rebuild their lives post-resettlement. As of July 2019, when recruitment efforts for this study ended, there were approximately 286 refugee resettlement agencies that are scattered in both urban and rural areas throughout 190 different cities within approximately 49 states throughout the U.S. (see Appendix M). These refugee resettlement agencies are smaller representative "field offices" of nine main governing agencies (i.e., Church World Service, Episcopal Migration Ministries, Ethiopian Community Development Council, Hebrew Immigration Aid Society, Lutheran Immigration and Refugee Services, U.S. Conference of Catholic Bishops/Migration and Refugee Services, U.S. Committee for Refugees and Immigrants, and World Relief; Bridging Refugee Youth & Children's Services [BRYCS], 2018) that are responsible for overseeing the funding and allocation of resettled refugees to each of the smaller resettlement agencies. The nine governing agencies are funded by

various sources, including federal, state, local, and private resources, causing the makeup of each resettlement agency to differ based on its location and available resources (BRYCS, 2018). These agencies are crucial in assisting refugees to rebuild their lives as they are responsible for providing refugees with secure housing, cash funds, access to medical care, employment opportunities, and programs for language proficiency and cultural understanding to better assist refugee populations to adapt and integrate into the host society. According to refugee resettlement agencies' websites, some agencies also provide in-house mental health services.

Refugee resettlement agencies and the mental health providers working within them are important to examine for several reasons. First, refugee resettlement agencies are the first points of contact for refugees after they arrive in the U.S., as these agencies are responsible for ensuring refugees' various needs are met post-resettlement. Mental health providers working within resettlement agencies are conveniently housed within a system that refugees interact with consistently in order to procure social services and other basic needs. It is possible that the increased contact with resettlement agencies may also allow for increased contact with mental health providers working in this context. This increased contact may provide a potential solution to health care service accessibility issues often experienced by resettled refugees. Second, research demonstrates that community-based care - which includes refugee resettlement agencies and the mental health providers within them - rather than office-based care (e.g., receiving therapy in private practice) is more accessible and effective for refugee populations (Rader et al., 2010). Finally, since mental health providers are responsible for ensuring care and providing the most appropriate and effective psychological interventions, they may have crucial insight regarding effective strategies they utilize to improve access to care. Their insight may be particularly useful in relation to strategies highlighting cultural competence, a critical component

of mental health care that has been found to be vital in psychological outcomes following therapeutic intervention (Owen, Tao, Leach, & Rodolfa, 2011). Thus, focusing on mental health providers in the context of resettlement agencies may be beneficial to identifying culturally competent strategies to overcome the barriers related to mental health service accessibility for resettled refugees.

In addition to examining strategies to improve access to mental health services, understanding the content and extent of the mental health services provided to refugees through resettlement agencies is crucial. However, as evidenced by the above statistics, it is difficult to determine the exact percentage and the content of mental health services offered by refugee resettlement agencies due to inaccurate or missing information on refugee resettlement agency websites, as well as a lack of complete and current nationwide data. Currently, there is only one identifiable source of data regarding mental health services offered to resettled refugees in the U.S. A dissertation project conducted by Ngoubene-Atioky (2011) identified the social services offered by refugee resettlement agencies in the Northeast U.S. and the Greater area of Vancouver, Canada, including whether these agencies provided mental health services. While this data captures crucial information regarding the social services available to resettled refugees in these regions, it does not provide detailed information regarding the types of mental health services offered, regionally or nationwide. Without a better understanding of the specific mental health services offered by mental health providers within resettlement agencies, progress in improving access to culturally competent mental health care for resettled refugees may be hindered. Thus, it is imperative to understand the mental health services that are available to this population.

## Significance of the Study

This study on the mental health services and mental health providers within refugee resettlement agencies is important for several reasons. First, this study will increase our understanding of how refugees' mental health concerns are currently being addressed. In this study, I intended to obtain a better understanding of the available mental health services for resettled refugee populations living in the U.S. As there is currently limited nationwide data regarding the available mental health services for these populations in these settings, gathering detailed information about these services may increase the foundational knowledge of the current offerings provided by mental health providers working within refugee resettlement agencies in the U.S. Without this knowledge, it is difficult to estimate the impact these agencies may have on the mental health of resettled refugee populations. Consequently, this study utilized a broad assessment to better understand the mental health services that are available to refugee populations within refugee resettlement agencies.

Second, there is minimal knowledge regarding the cultural competence of mental health providers in the context of refugee resettlement agencies. Understanding the level of cultural competence of these providers may provide invaluable insight for meeting the mental health needs of resettled refugees, as greater provider cultural competence has been shown to improve the psychological functioning of individuals that engage in therapy (Owen et al., 2011). Information about level of mental health provider cultural competence may provide increased insight regarding issues related to cultural competence, and it may highlight the mechanisms that prevent or contribute to the implementation of culturally competent practices, practices that may improve mental health service accessibility and subsequent psychological functioning.

Third, researchers and clinicians currently have limited knowledge regarding the strategies to improve access to mental health care for resettled refugee populations utilized by

mental health providers working in the context of refugee resettlement agencies in the U.S. Understanding of mental health providers use of strategies, one of the three aims of this study, will assist both researchers and clinicians to identify and/or develop culturally competent strategies that may increase accessibility, effectiveness, and efficacy of care for resettled refugee populations.

## Relevance to Counseling Psychology

Counseling psychology is a specialty within psychology that emphasizes personal and interpersonal functioning, emotional and physical health, social, vocational, educational, and developmental issues across the lifespan, as well as organizational concerns (APA, 2013). According to Gelso, Nutt Williams, and Fretz' (2014), there are three central roles that counseling psychologists typically fulfill through their professional work. These roles include remedial, preventative, and educative-developmental. In the remedial role, a counseling psychologist works to assist in remedying problems as they occur. Preventative interventions may help individuals to anticipate and avoid issues that may occur at some point in the future. The final role of counseling psychologists is the educative-developmental role, which assists individuals in deriving maximum benefits throughout the lifespan by emphasizing and using an individual's strengths, qualities, and abilities. In addition to the central roles, Gelso et al., (2014) identified five unifying themes that make counseling psychology unique from other professions both within and outside the field of psychology. These themes include 1) emphasis on strengths and assets, 2) educational and vocational guidance, 3) relatively brief interventions, 4) person-environment interactions and 5) focus on intact personalities. A sixth emerging theme emphasizes the field's focus on diversity, social justice, and advocacy (Forrest & Campbell, 2012). This study was consistent with two of counseling psychology's themes including

diversity, social justice, and advocacy, and person-environment interactions. In addition, both the remedial and preventative roles were strongly emphasized in this study. Finally, this study integrated counseling psychology's emphasis on integrating theory, research, and practice (Gelso et al., 2014).

First, this study was consistent with counseling psychology's emphasis on diversity, social justice, and advocacy. The focus on improving access to mental health services for a marginalized and vulnerable population aligns with the call for counseling psychologists to go beyond their roles to ensure social justice by working as advocates against oppression through their work by confronting the forces that oppress underrepresented groups (Forrest & Campbell, 2012). The findings of this study have contributed to our understanding of refugee populations and the forces they might encounter that detract from their ability to seek the psychological help they may need. This study went a step further by examining the strategies mental health providers utilize to increase access to mental health services, which counters oppression by ensuring equal access to care and quality care (APA, 2013).

Second, this study reflected the person-environment interaction theme. This theme emphasizes viewing clients holistically through considering how differing environments (e.g., family, community, work, school) interact with the individual's personality and behavior (Gelso et al., 2014). Environments change people and people are also changed by the environments around them, and these interactions can contribute to mental health outcomes and functioning. By better understanding how individuals respond to specific environments, counseling psychologists may be better able to tailor psychological interventions so that they are more relevant and useful for a given population. An example of a person-environment interaction is how a refugee may respond to mental health services; if services are not relevant to their culture,

language, or their understanding of their psychological issues, they may not continue to seek services. However, if mental health services are receptive to refugee needs and they make changes to ensure services more accessible, refugees may experience better mental health outcomes, and thus may adapt and integrate more easily into the host country in which they resettle. This study contributed to the person-environment theme by examining the ways mental health providers responded to both the person and the environment and the interaction of each to better understand how to improve access to mental health services for refugee populations.

Third, this study contributed to the literature for counseling psychologists in relation to both preventative and remedial roles. As many refugees may have previously experienced trauma prior to, during, and after arriving in the host country, remedial and preventative interventions may provide assistance for those who developed psychological issues prior to or during their flight from their home country or are at-risk of developing psychological issues due to the stressors associated with the resettlement process. This study provided a greater understanding of the methods that mental health providers used to improve access to care, and these strategies may inform counseling psychologists in the development of both preventative and remedial interventions.

Finally, this study emphasized the importance of the scientist-practitioner model in the counseling psychology profession. The scientist-practitioner model is the most commonly used and preferred training model for the specialty, and it reflects counseling psychology's emphasis on utilizing scientific thinking when approaching therapeutic intervention (Gelso et al., 2014). The scientist-practitioner model is the integration of both science and practice throughout doctoral training so that upon completing a doctoral program, an individual may work as a scientific investigator and a clinical practitioner (Belar & Perry, 1992). The model is integrative

because science and practice continually inform each other. This study directly emphasized the importance of thinking both as a scientist and a clinician because it allowed mental health providers to use their clinical experiences and expertise to identify and/or develop strategies to improve access to care; these identified strategies can then inform scientific inquiry, which allows scientific investigators to conduct further research that can then again inform clinical practice, exemplifying evidence-based practice, a tenant strongly encouraged by the APA (2013).

# CHAPTER 2.
# LITERATURE REVIEW

In this section, I present the literature on the global refugee crisis, a brief history of refugee resettlement in the U.S., and an overview of refugee resettlement agencies including their funding sources and services offered. I then discuss the factors that contribute to the mental health outcomes observed in resettled refugees. Related to factors that contribute to mental health outcomes in resettled refugees, I identify the barriers resettled refugees face when attempting to access mental health services, with an emphasis on how these barriers relate to deficiencies in cultural competence. Following the discussion on the barriers to mental health services, I outline the suggested strategies to improve access to mental health services for resettled refugees and provide a synthesis of this literature, which will provide a framework for the current study. Finally, I review Sue and Sue's (1990) tripartite cultural competence model, my proposed theoretical framework, and conclude the section with a rationale for my study.

## Global Refugee Crisis

The number of displaced persons globally in 2020 (70.8 million) is almost double that of a decade earlier (37.5 million) ("Figures at a Glance," UNHCR, 2020). More than half of the world's refugees come from three countries: Syria, Afghanistan, and South Sudan. In addition, the genocide of Rohingya Muslims from Myanmar is one of the more recent and fastest growing crises in the world that is greatly contributing to the refugee crisis ("JRP for Rohingya," OCHA, 2018). Since the start of the civil war in Syria beginning in March of 2011, almost 7 million Syrians have fled their homeland and sought refuge in neighboring countries, as well as the U.S. An additional 6.6 million internally displaced persons, or those that have been forced to flee their

homes but are unable to leave the borders of their country, remain in Syria ("Resettlement Data," UNHCR, 2019). Since 2001, fleeing ongoing violence and war in Afghanistan, approximately 5 million registered and undocumented Afghan refugees have fled to Iran and Pakistan alone; this number does not account for the number of Afghan refugees living in other countries ("Resettlement," UNHCR, 2019). In South Sudan, the number of refugees is now over 2.2 million, with the number of South Sudanese refugees living in neighboring Uganda now almost 900,000 ("Resettlement," UNHCR, 2019). A long-lasting conflict due to discriminatory practices by Myanmar's government against Rohingya Muslims was renewed in 2017 amid charges of ethnic cleansing, leading to the mass exodus of Rohingya Muslim refugees' inhabitants from Myanmar ("JRP for Rohingya," OCHA, 2017). To date, over 1.3 million Rohingya Muslim individuals have fled the country, with over 1.1 million of these refugees having fled since August 2017 ("JRP for Rohingya," OCHA, 2017). As evidenced by the above conflicts - which only exemplify a handful of the conflicts that are contributing to the global refugee crisis - the world has never encountered a humanitarian crisis of this scale and is ill equipped to cope with the implications resulting from such conflicts in Syria, Afghanistan, South Sudan, and Myanmar. Conversely, refugees are often not prepared to manage a world of uncertainty, fear, and confusion as they navigate their upended lives to escape conflict.

## Refugee Resettlement in the United States

More than four-fifths of the global population of displaced persons and refugees are living in nations that are least able to afford to host them ("Refugee Resettlement Facts," UNHCR, 2020). Often, neighboring countries absorb refugees fleeing from nearby conflicts, which often taxes the available resources in these host countries causing host countries to be increasingly unable to adequately meet the needs of incoming refugees. To assist in shouldering

the weight of the largest refugee crisis since World War II, multiple countries further from conflict zones have pledged to resettle refugees. More than two-thirds of refugees that are resettled have been placed in the United States, which is more than all resettlement countries combined ("Refugee Resettlement Facts," UNHCR, 2020). Of those resettled in the U.S., the top ten origin countries of refugee arrivals for the year 2019 include the Democratic Republic of Congo (46.6%), Burma (17.4%), Ukraine (12.3%), Eritrea (6.3%), Afghanistan (2.2%), Syria (1.9%), Iraq (1.6%), Sudan (1.1%), Burundi (1.0%), Colombia (1.0%), and other countries ("Refugees and Asylees," Migration Policy Institute, 2019). Historically, the U.S. has led the pack in resettling refugees among highly industrialized countries ("Refugees and Asylees," Migration Policy Institute, 2017). However, this has changed dramatically since the 2016 Presidential election of Donald Trump. Prior to the Trump administration, the Obama administration agreed to significantly increase the number of refugees resettled from around the world from 70,000 to 85,000 in the 2016 fiscal year in response to the humanitarian crisis ("Disappearing Refuge," Reuters, 2018). Additionally, the former Secretary of State, John Kerry, had proposed to increase the number of global refugees allowed in the United States to 110,000 by the end of 2017 to further accommodate for the number of refugees in need of resettlement (U.S. Department of State, 2015). When President Donald Trump took office in 2017, he issued an executive order that suspended refugee resettlement entirely for 120 days. Since resuming refugee resettlement, he has essentially banned refugee resettlement from Muslim majority countries and cut the admission rate from the proposed 110,000 refugees the Obama administration hoped to be resettled to only 23,000 refugees by the end of the 2019 fiscal year (Pew Research Center, 2019). For fiscal year 2020, President Trump plans to resettle 18,000 refugees, the lowest number of refugees the U.S has admitted in the history of the resettlement

program since 1980 (“Refugees and Asylees,” Migration Policy Institute, 2019; Pew Research Center, 2019). The proposed policy changes implemented by the Trump administration have been continually challenged by the federal court and are currently blocked from being implemented (“Refugees and Asylees,” Migration Policy Institute, 2019). While the threat to refugee resettlement in the U.S. remains due to President Trump’s consistent attempts to limit refugee resettlement, refugees continue to be resettled within the U.S. While resettlement numbers in the U.S. have decreased over the past three years, refugee resettlement agencies will continue to provide much needed services for refugees post-resettlement as long as refugees can enter the U.S. In addition, since the implementation of the Refugee Resettlement Act in 1980 (BRYCS, 2018), over 3 million refugees have been resettled in the U.S. (Pew Research Center, 2019), leaving a substantial number of resettled refugees still living in the U.S. that stand to benefit from the mental health services offered by refugee resettlement agencies.

To resettle in the U.S., refugees must first register with the United Nations High Commissioner for Refugees (UNHCR), whom is responsible for thoroughly screening and documenting each individual and family member hoping to resettle. If an individual qualifies as a refugee based on UNHCR guidelines, the refugee is then referred for resettlement in the U.S. by the United Nations (UN), the U.S. Embassy, or a Non-Governmental Organization (NGO). Refugees then complete a security clearance process, which is conducted by law enforcement and intelligence agencies. These security clearances are followed by an in-person interview with a U.S. Department of Homeland Security office. If the U.S. Department of Homeland Security officer agrees that the individual meets criteria for U.S. admission, their application is conditionally approved for resettlement. The vetting process and waiting period prior to the time a refugee can enter the U.S. can take an average of 18 months to three years (“Refugee

Resettlement Facts," UNCHR, 2018). This period does not include the months or years spent waiting in a refugee camp.

Once the vetting process is completed, the Department of State - Bureau of Population, Refugees, and Migration (PRM) coordinates allocation to specific cities and refugee resettlement agencies throughout the United States. In the U.S., refugees often have little to no say about the state or city where they will be resettled ("Resettlement," UNHCR, n.d.). Upon arrival in the U.S., all refugees are required to receive a government-mandated health screening in the state they are resettled. While the health screening is compulsory, the health screening may be different across health care sites, as the Centers for Disease Control and Prevention (CDC) only provides guidelines and recommendations, rather than requirements (depending on time, training, and resources) (Centers for Disease Control and Prevention, n.d.). In addition, the majority of health screenings do not contain a mental health screening component (Murray, et al., 2010). The lack of mental health screenings may prevent many refugees from obtaining psychological treatment. Shannon et al. (2012) surveyed refugee health coordinators from 44 states in the U.S. that had an instrumental role in managing initial medical screenings, health education, outreach, and ongoing healthcare for refugees living in the U.S. ("The Role of Refugee," Office of Refugee Resettlement, 2016). Their results indicated that only half of these refugee health coordinators reported their state utilized a mental health screening for refugees. These mental health screenings are used to assess refugees for mental health issues in order to determine whether they need a referral for mental health treatment (Shannon et al., 2012). Just a third of refugee health coordinators reported that a standardized screening tool was utilized to assess psychological issues. The lack of a standardized screening tool, or any screening tool that

is culturally relevant at all, to assess the mental health of resettled refugees is just one of the many obstacles that impede refugees' access to mental health care (Polcher & Calloway, 2016).

## Refugee Resettlement Agencies in the United States

During the first few weeks of resettlement, refugee resettlement agencies provide crucial support for resettled refugees by meeting their varying psychosocial, educational, and economic needs. Specifically, refugee resettlement agencies provide refugees with secure housing, cash funds, access to medical care, employment opportunities, and programs for language proficiency and cultural understanding to better assist refugee populations to adapt and integrate into the host society, to name some of the offered services. The specific offering of services provided depends on the refugee resettlement agency and may change based on their funding and resources.

The funding of a refugee resettlement agency depends on their affiliation with one of the nine governing National Voluntary Resettlement Agencies or "VOLAGS." The 286 refugee resettlement agencies that were in operation at the time this study was conducted are actually smaller "field offices" directly connected to the larger VOLAGS. The VOLAGS control and operate the smaller field offices known as "refugee resettlement agencies" located throughout the U.S. The nine main VOLAGS include the following, with type of agency (e.g., religious, ethnic-based, secular) noted in parenthesis: Church World Service (Religious), Episcopal Migration Ministries (Religious), Ethiopian Community Development Council (Ethnic-based), Hebrew Immigration Aid Society (Religious), Lutheran Immigration and Refugee Services (Religious), U.S. Conference of Catholic Bishops/Migration and Refugee Services (Religious), U.S. Committee for Refugees and Immigrants (Secular), and World Relief (Religious) (BRYCS, 2018).

As demonstrated above, a significant portion of the VOLAGS are religiously affiliated; however, all of the VOLAGS depend largely on federal funding to continue operations. According to the Center for Immigration Studies (2012), VOLAGS receive a Reception and Placement Grant from the Bureau of Population, Refugees, and Migration for each refugee assigned to their agency. The Office of Refugee Resettlement (ORR) - which receives its funding from an appropriation provided by Congress each year - works further with VOLAGS agencies by typically providing a federal matching grant program for each dollar VOLAGS raise (e.g., $2 is awarded for every $1 raised by a VOLAGS up to $2,200 per enrollee). In addition to the ORR, a number of federal agencies also provide funding and/or determine assignment of refugee placements, such as the U.S. Committee for Refugees and Immigrants (USCRI), the United States Refugee Admissions Program (USRAP), the Hebrew Immigration Aid Society (HIAS), the Bureau of Population, Refugee Migration of State Department and Office of Refugee Resettlement, and the U.S. Department of Health and Human Services (HHS).

Upon receiving funding from the ORR or other federal programs, VOLAGS are expected to disperse these funds to their smaller refugee resettlement agencies (Office of Refugee Resettlement, 2015). After obtaining funding, the smaller refugee resettlement agencies are responsible for ensuring that all refugees allocated to their site receive access to and are enrolled in the welfare programs, which are programs that refugees are automatically qualified to receive after 30 days of arrival in the U.S., including medical support, case management, employment services, and English classes in an effort to prepare refugees for self-sufficiency (Office of Refugee Resettlement, 2015). There are additional programs that competitively awards social service discretionary funds, and each state uses different combinations of funding (e.g., state and local welfare programs) and approaches to determining which social services are offered to

resettled refugees (Office of Refugee Resettlement, 2015). Some refugee resettlement agencies offer 30-90 days of assistance to refugees, however other resettlement agencies can offer additional assistance beyond this period (up to 5 years in some instances), depending on funding and services or programs offered (Office of Refugee Resettlement, 2015).

As each refugee resettlement agency differs based of the makeup of their agency, which can be affected by the type of federal, state, and local financial support, and the resources available at each site, it can be difficult to determine exactly what services are offered at each agency. This is particularly true regarding the availability of mental health services. While it is possible federal, state, local, or private dollars or a combination of these resources may contribute to the available mental health services within these agencies, based on a web-based search, it is unclear how mental health services within refugee resettlement agencies are funded. Further, it is challenging to determine the exact mental health services that are offered within these agencies.

Prior to recruitment efforts for this study, a preliminary assessment of the available information on the websites of each of the agencies on the publicly available list of refugee resettlement agencies (Appendix L) revealed that approximately 78 agencies (26.4%) likely offered some form of mental health services, meaning that they either explicitly reported they offered services or they mentioned mental health services but the extent of these services was not clear. Of the agencies that reported they likely offered mental health services, 44 (56.4%) explicitly stated that they provided mental health services, and only 16 (20.5%) specified the types of mental health services they offered (e.g., group, individual, family). The majority of websites provided a vague description of offered "counseling" services with no supporting information to elucidate what exactly counseling services included and who provided the

counseling. In addition, the types of mental health providers available (e.g., psychologist, social worker, counselor) at each agency were also unknown. Of the agencies that stated they likely provided mental health services, only five (6.4%) resettlement agencies provided information on the types of mental health providers available at their agency on their websites. Finally, many of the approximately 191 (64.5%) religiously affiliated resettlement agencies' websites stated that they offered counseling to the general public at their sites; however, it is uncertain whether refugees were provided access to these counseling services. Thus, it is imperative that a nationwide survey was conducted in order to identify the availability of mental health services for resettled refugees within refugee resettlement agencies.

## Factors Impacting Refugees' Mental Health

Without a doubt, refugees experience a higher prevalence of mental illness than non-refugees (Porter & Haslam, 2005). The current literature on the mental health of refugees often highlights the multitude of stressors associated with displacement. For example, Miller and Rasco (2004) provide several examples of psychological concerns for refugees including social isolation, loss of familial and other social support, a decrease in social and occupational status, experiencing discrimination from members of the host society, and limited access to crucial medical, education, and economic resources. In this section, I will discuss the factors impacting the mental health of resettled refugees, including the higher rates of exposure to traumatic events refugees may experience compared to non-refugee populations, issues related to the diagnosis of psychological issues, acculturation, lack or loss of social support and xenophobia/discrimination. In addition, I will discuss the concept of resilience in refugee populations as a protective factor to mental health outcomes.

**Exposure to traumatic events.** A study conducted by Kruse et al. (2009) found that on average refugees experienced 12 potentially traumatic events (PTE), including being close to death (98.4%), brainwashing (90.6%), forced separation (87.6%), lack of shelter (87.6%), serious injury (79.7%), lack of food or water (77.7%), murder of family or friends (77.7%), and being lost or kidnapped (75.0%). In addition, 45.3% of the refugees testified to having been the victim of rape or sexual abuse. Exposure to PTE can occur before flight from the homeland, while attempting to escape conflict, and after displacement, including in the host country where one is resettled. The combination of PTE that may be experienced before, during, and after resettlement places refugees at greater risk for experiencing psychological distress than the general population (Polcher & Calloway, 2016). A large meta-analysis conducted by Steel et al. (2009) reported that the prevalence rate of posttraumatic stress disorder (PTSD) in refugees and asylum seekers was approximately 30%. Another study found that 62% of resettled Cambodian refugees still suffer from PTSD more than two decades after resettling in the United States (Marshall et al., 2005), most likely due to the persistent and chronic nature of PTSD (Kruse, et al., 2009). In comparison, only 3.5% of the average adult population in the U.S. meet criteria for PTSD, a number much lower than the prevalence rate of that experienced by refugee populations ("Statistics," National Institute of Mental Health, 2012; Polcher & Calloway, 2016).

## Diagnostic Issues

Despite the very real exposure to PTE faced by many refugees, clinicians should utilize caution when diagnosing, and thus treating refugees who report experiencing traumatic events.

A major issue with attempting to quantify refugees' distress in relation to exposure to traumatic experiences is that it may improperly pathologize the experience of refugees. One can argue that symptoms of PTSD are a normal reaction to the abnormal and traumatic experiences

refugees may have been exposed to. Quantifying refugees' distress may lead to some psychologists improperly applying Western-normed measures and diagnostic criteria to gain a diagnosis of PTSD. Historically, several challenges exist in relation to the overall assessment of refugees' distress related to exposure to trauma ("PTSD in Refugees," National Center for PTSD, n.d.). First, varied methodologies used across studies to measure distress in refugees (e.g., measuring distress in refugee camps versus distress in a clinical setting in the U.S.) are inconsistent, rendering it difficult to develop conclusions regarding actual PTSD rates across refugee populations. In addition, inadequate translation of measures into native languages and lack of cultural sensitivity regarding culturally bound symptoms of distress within measures further contributes to issues measuring refugees' responses to trauma. Wells, Wells, and Lawsin (2015) identified three fallacies that further contribute to the difficulties of applying a PTSD diagnosis to refugee populations. The first fallacy highlights the importance of recognizing that not all individuals will respond similarly to the same events given differences in culturally specific norms that inform how one will respond emotionally, cognitively, and behaviorally; what is considered normal or abnormal will change depending on a given society's norms, and how one expresses distress depends on these beliefs. These unique values and beliefs contribute to culturally specific expressions of distress and in the case of refugee groups, each culturally unique group will express their distress differently. Psychological measures that are valid in one context may not be valid in another context, and this is particularly important when considering how to measure psychological distress in resettled refugees living in the U.S. While symptoms on a measure may be meaningful for one group (e.g., it may appropriately identify symptoms of trauma), these symptoms may not translate to another group given their cultural norms related to their expressions of distress. The second fallacy identified by Wells, Wells, and Lawsin (2015) is

the assumption that if an individual has symptoms associated with PTSD, that they in fact must have PTSD. However, this is not always accurate. Research has demonstrated that some symptoms of PTSD, including re-experiencing memories of the traumatic event may be a normal response immediately following the event, and re-experiencing may be adaptive, as it allows an individual to process the event (Gorman, 2001). The third fallacy (Wells, Wells, & Lawsin, 2015) is the presumption that PTSD is a cross-cultural phenomenon. It is commonly assumed by both researchers and clinicians who use Western-normed instruments to measure symptoms of PTSD that it is self-evident that individuals from non-Western cultures must also experience symptoms of PTSD (Wells, Wells, & Lawsin, 2015). By making this assumption, those using Western-normed assessments are inferring that PTSD is a universal phenomenon, which may not be accurate.

While multiple issues related to the diagnosis and treatment of PTSD in resettled refugee populations exist, the fact remains that a large portion of refugees are exposed to multiple PTE that may impact refugees years after the initial event(s). In addition, the resettlement process may exacerbate the psychological symptoms refugees are experiencing as a result of displacement and exposure to PTE (Kruse, et al., 2009; Momartin et al., 2004). Therefore, the presence of both culturally competent providers and mental health interventions to serve resettled refugees may be central to addressing the mental health issues that this group may experience due to exposure to traumatic events.

**Acculturation**

An explanation for the higher prevalence of mental distress experienced by the refugee population could be due to high incidence of severe pre-migration traumas experienced coupled with the post-resettlement stressors related to acculturation difficulties that contribute to the

persistence of anxiety, depression, and PTSD (Lindencrona, Ekblad, & Hauff, 2008; Porter & Haslam, 2005). Acculturation is the process of modifying an individual's or group's beliefs, values, and behaviors in response to prolonged exposure to and contact with a new culture (Morris et al., 2009). As Berry states, "The process of acculturation is acknowledged to be stressful and can be associated with social and psychological problems" (1998, p. 5). Acculturation can be exceptionally challenging for resettled refugees as there are a multitude of aspects involved that one must navigate including language, culture, and socially appropriate norms and behaviors. For some, the transition period for refugees to start the acculturation process can be abrupt. At one moment, a refugee may be living in a refugee camp in a low-resource setting, and the next moment, they are landing in a foreign country and expected to navigate tasks that may seem overwhelming for someone who has endured immense stress prior to being resettled. Tasks such as grocery shopping, navigating public transit, finding employment, navigating school systems, obtaining appropriate paperwork, and finding housing can feel not only daunting, but also impossible. It is during this process of acculturation that resettled refugees are learning to navigate the intricacies of the host country; not long after arrival and during the midst of acculturation, government support terminates at eight months, leaving refugees to become financially independent. As one researcher explains, "Few studies have examined utilization of health care services after governmental assistance has ended and how this might relate to post-resettlement health conditions" (Morris et al., 2009, p.529-530). Not only is it likely the difficulties related to acculturation may negatively impact refugees' efforts to obtain appropriate health care, including mental health services, but these stressors may in fact contribute to poorer psychological functioning in refugee populations (Phillimore, 2011).

**Lack or Loss of Social Support**

In refugee populations, social support is a key determinant of psychological health (Nicdao, Hong, & Takeuchi, 2008). Theories supporting the relationship between social support and psychological health hypothesize that social support can minimize or moderate stressful situations - such as acculturating to a new country or perceiving discrimination - by providing a sense of security, emotional support, and increasing positive affect, feelings of belonging, and purpose (Cohen, Underwood, & Gottlieb, 2000; Taylor, 2007). Refugees are at greater risk of experiencing deficits in social support in the country of resettlement due to likely leaving behind significant and supportive family and friends in the home country (Llacer, Zunzunegui del Amo, Mazarrasa & Bolumar, 2007; Simich, Beiser, & Mawani, 2003). A lack of social support is associated with poorer mental health (Nicdao et al., 2008). Depending on the country and culture of origin, there may be some limitations to social support imposed due to cultural norms. A lack of social support may be particularly challenging for refugee women. Cultural and/or religious expectations for women may limit the amount of involvement in environments outside of the domestic sphere, such as work or school, thus decreasing the availability of social support networks outside of the home (Mollenhorst, Volker, & Flap, 2008). Some female refugees may ultimately feel their only source of social support available, if they are married and lacking additional familial support, is their husbands. Unfortunately, researchers have found that husbands are unlikely to act as a substitute for the social support left behind in the home country (Aroian, Spitzer, & Bell, 1996). Husbands may feel unequipped to provide the social support extended family once provided, particularly if the husband is managing issues related to his own struggles related to resettlement (Aroian, Spitzer, & Bell, 1996). Other issues may contribute to lack of social support, including experiencing discrimination within the community the refugee is resettling in, which may cause refugees to avoid making social connections with members of

the host community, or a lack of community members with similar ethnic backgrounds, which is associated with positive health outcomes (Nicdao et al., 2008).

**Xenophobia and Discrimination**

Xenophobia, or the intense dislike or fear of individuals from other countries, is a form prejudice that can contribute to feelings of isolation and distress in immigrant and refugee groups (Yakushko, 2009). Xenophobia has increasingly impacted immigrants and refugees throughout the U.S., with a significant surge in xenophobic attitudes directed towards these groups following the September 11 terror attacks. Mass media and political leaders further denigrate already marginalized groups by perpetuating inaccurate representations of immigrant and refugee groups, such as portraying Muslim immigrants and refugees as inherently intolerant and violent (Giger & Davidhizar, 2002), and labeling immigrants as violent, poor, and uneducated criminals (Yakushko, 2009). Immigrants and refugees are continually blamed for many of the misfortunes in the U.S., including being wrongly associated with the cause of a declining economy, increased violence, depleted resources, and terrorism (Yakushko, 2009). Xenophobic sentiment and anti-immigrant discrimination have persisted in the U.S. during recent years, partially due to President Trump's campaign to essentially rid the U.S. of refugees and immigrants ("Key Facts About," Pew Research Center, 2017). According to the Southern Poverty Law Center (2016), during the year 2016 when Donald Trump campaigned for presidency, the numbers of hate groups in the U.S. tripled. Research examining the increase of hate groups indicated that President Trump's campaign promise for a "complete and total shutdown" that would ban Muslim immigrants and refugees from entering the country effectively sanctioned prejudicial treatment of immigrants, refugees, and Muslims living in the U.S. (Southern Poverty Law Center, 2016). According to the Southern Poverty Law Center (2016), the xenophobic campaign

and administration policies promoted by President Trump was directly correlated with a surge in hate crimes against immigrants, refugees, and Muslims.

Xenophobic attitudes often underlie anti-immigration prejudice and discriminatory behaviors (Yakushko, 2009). Researchers have hypothesized that xenophobia may act as a "discriminatory potential," (Watts, 1996, p .97), that when activated by a perceived threat to one's personal or group level may result in discriminatory action. An example of this threat can be observed in the application of specific policies and procedures that allow for the discrimination of foreign individuals, or worse, hostile and violent behaviors that directly harm those perceived as not belonging to the host country (Yakushko, 2009). Members of vulnerable groups in particular, such as refugees, are more likely to perceive discrimination as internal, consistent, and out of one's control, which may contribute to subjective feelings of exclusion and a devaluation of group membership (Schmitt & Branscombe, 2002). Exclusion and devaluation as a result of xenophobia and discrimination may be especially insidious for resettled refugees that are attempting to transition and adapt to the host country society. Research examining marginalized groups (Kobrynowicz & Branscombe, 1997; Landrine, Klonoff, Gibbs, Manning, & Lund, 1995) has shown that those who experience discriminatory behavior targeting their group are more likely than their advantaged counterparts to demonstrate greater psychological symptoms, as well as physical health issues. The association between discrimination and poorer psychological health in immigrant and refugee populations living in the U.S. is particularly worrisome, as the poorer outcomes related to discrimination may be exacerbated by the stressors (e.g., anxiety, depression, physical health issues) already associated with migration and subsequent resettlement (Abu-Ras & Abu-Bader, 2009; Dion, Dion, & Pak, 1992; Mossakowski,

2003; Jasperse, Ward, & Jose, 2012; Pieterse & Carter, 2007; Rippy & Newman, 2006; Vedder et al., 2006).

**Resilience**

Despite encountering and enduring multiple adverse experiences and oppressive systems before, during and after resettlement, many refugees have demonstrated a remarkable capacity for resilience. While there are multiple definitions of resilience, researchers generally agree that resilience refers to a personality trait of psychological adaptation that demonstrates "patterns of desirable behavior in situations where adaptive functioning or development have been significantly threatened by adverse experiences" (Masten et al. 1995, p. 283). Often, resilience is focused on the individual level; however, it is true that schools, social support, family and other collective bodies contribute to resilience for individuals and groups (Simich et al., 2011). In many refugee communities, collective support – which can be observed in how refugees might approach health care, raising children, and social relationships, for example - is more common than the type of support observed in the host countries where refugees are often resettled (Pickren, 2014). This is particularly noted for the U.S., a country that heavily emphasizes individualism. Host countries may attempt to pathologize or patronize refugees for their "different" ways of thinking about social connection and obligations, and their differences in understanding of the self and their identities (Pickren, 2014). In a study by Kohistani (2012) examining the cultural strengths of Afghan refugees resettled in Canada, participants described the observed differences in their way of thinking about family social norms and obligations compared to their Canadian counterparts:

> One important cultural value for us is respect, respecting parents. I tried to teach my kids the importance of respect in our culture because I have taken care of them today and

> tomorrow, they will need to take care of me. I want my kids to grow up to be good human beings to be respectful of the young and old and adhere to their cultural values. It is not the same in the Canadian culture, most kids say that they don't care if that person is their uncle, aunt or any other elder person, but that's not how it is in our culture. Our most prominent cultural value is to respect everyone and anyone around us. We need to respect everyone to be able to demonstrate our Afghan-ness and our Islamic beliefs." (p. 20)

These differences may create tension between refugee communities and the host country culture, as refugees may receive the message they must change to "fit in," while host countries demand refugees change to "fit in or leave" if they are resistant to doing do. However, the culturally specific practices that can be observed in resettled refugee populations living in host countries, such as utilizing and maintaining religious and spiritual values traditions and relying on family as the main support system, may also provide a source of strength that contributes to resilience. Rather than focusing solely on the problematic aspects of refugees' mental health concerns, it may benefit mental health providers to consider the cultural strengths that promote resilience in resettled refugee groups (Simich et al., 2011).

In order to avoid mirroring the common response of members of the host country demanding refugees "change, or else" directed towards resettled refugee groups, it is essential that mental health providers implement strategies that demonstrate cultural sensitivity and understanding. Research has demonstrated that integrated and culturally sensitive interventions that include the individual, family, and community have demonstrated effectiveness in increasing resilience in marginalized groups; in contrast, the absence of strong social networks, including community or familial networks, have negatively impacted psychological distress (Earnest,

Mansi, Bayati, Earnest, & Thompson, 2015; Luthar & Cicchettii, 2000; Murray et al., 2010). By providing services that are culturally competent, particularly those that uphold collectivistic values and include multi-level community-based care, mental health providers may demonstrate to refugees that their culturally grounded and unique ways of approaching life's challenges are not abnormal, but in fact a resilient response to abnormal and adverse experiences. Culturally competent care may not only benefit refugees' mental health, but it may also promote and further resilience.

## Barriers to Mental Health Services

Key topics that emerged within the literature regarding the barriers to meeting the mental health needs of resettled refugees include concerns about the challenges faced after resettlement, including lack of resources and access (Asgary et al., 2011; Colucci et el., 2015), language barriers (Asgary et al., 2011; Morris et al., 2009; Stasio, 2012), stigma and culture-specific conceptualizations of mental illness (Asgary et al., 2011; MacDonald, 2016), affordability (Morris et al., 2009), distrust of providers (Colucci et al., 2015; Ellis et al., 2011; Young, 2008), and lack of provider cultural competence (Colucci et al., 2015). Much of the research about mental health service accessibility is captured in the context of health care systems such as primary care or in hospitals, as refugees more often present to but still underutilize these forms of care prior to seeking psychological care. A possible reason for the lack of literature grounded in mental health care systems may be that refugees often first encounter primary care physicians within health care centers for the required medical screening that they must complete as a part of the resettlement process. Another reason refugees' barriers to mental health services are often represented in literature pertaining to health care systems may be due to the many difficulties refugees may encounter related to navigating mental health care systems, causing them to instead

seek care in health care systems. Finally, the differing beliefs refugees may hold towards seeking mental health care, including different conceptualizations or representations of "mental illness," or associated stigma or culturally incompetent care by mental health providers, may cause refugees to seek care through health care systems. However, while some of the following literature represents barriers to seeking care of mental health issues within health care systems (i.e., primary care, hospital clinics), these barriers are also relevant, can be applied, and are also reflected in the literature of barriers to accessing mental health services. In this section, I present the specific barriers that prevent refugees from accessing mental health services.

**Lack of Resources and Access**

One of the main issues with meeting the mental health needs of resettled refugees is the lack of available resources to meet these needs. The lack of resources for treating mental health issues may cause refugees to seek services in alternative systems of health care that are outside of mental health care service systems. For example, refugees may present to primary care and other healthcare systems for treatment of psychological issues, however providers in these systems are often untrained to meet these needs (Asgary et al., 2011), resulting in a lack of adequate resources to treat mental health issues in the systems where the care of these issues are actively sought.

In relation to lack of resources, many refugees also experience difficulties accessing mental health services due to the challenges related to navigating new and complex systems in order to receive care. Often, refugees are unaware of health care systems that are available to them, such as sliding scale services or free clinics. Furthermore, they are not familiar with laws that may protect them within these systems, such as knowing they do not have to provide personnel with documentation or information about their birth country in order to receive

treatment (Asgary et al., 2011). Another challenge to accessing services is the actual physical inability to attend places of business that provide mental health services. For example, the lack of easy access to public transport, which is frequently utilized by newly resettled refugees, is a commonly cited barrier to care (Colucci et el., 2015). Finally, there appears to be systematic challenges related to accessing mental health services; at the time of this literature review, there was no currently identifiable data officially outlining the pathways available for refugees to obtain mental health services, demonstrating the lack of guidance refugees may encounter while attempting to simply identify available mental health services.

**Language Barriers**

An important and frequently encountered barrier to accessing mental health services for refugee populations is the lack of adequate interpretation services. Refugees and asylum seekers report that they often experience difficulties engaging with providers, as they often do not speak the same language as the individuals seeking treatment (Stasio, 2012). The lack of adequate translation services has been cited as possibly the most significant barrier to refugee health care access (Morris et al., 2009). When refugees speak a language that is especially rare in the U.S., refugees have expressed that available translators that do not speak the exact same language as the refugee seeking treatment often become confused or provide inaccurate translation of what they are attempting to convey, leaving refugees feeling misunderstood or expecting to have no adequate translation services available to them (Asgary et al., 2011), further discouraging refugees from seeking treatment. Another issue related to linguistic issues is the fact that the pool of available translators in some communities may be limited, which may result in refugees being concerned that their confidentiality will be broken because interpreters may have established relationships with the family members of refugees seeking treatment. This may not only

contribute to refugees' distrust of systems that provide mental health services but may cause refugees to avoid seeking services altogether.

Providers also encounter difficulties with language and communication that make providing services increasingly difficult for refugee populations. Providers state a preference for in-person translation services as it allows for providers to have the ability to read non-verbal cues such as body language to ensure the message of treatment was understood (Colucci et al., 2015). However, when in-person translation services are not available, providers often rely on telephone translation services, which also present communication issues as it may be hard to hear the translator, it might be difficult to convey the intended message, and it is time consuming to figure out how to navigate all the dynamics related to telephone translation services (Stasio, 2015). Health care providers have suggested that not only are language barriers challenging during in-person appointments, but that refugees are likely to encounter barriers at every level of health care systems, including making appointments or filling a prescription (Morris et al., 2009). This issue carries over to in-office paperwork and understanding written materials, which provides additional challenges for resettled refugees, particularly in regard to being able to provide true informed consent (Morris et al., 2009). Finally, not all providers may have access to translation services, nor are all translation services covered by the sites that do offer translation services (Stasio, 2012), and the issue related to ensuring all refugees have translators that speak their language remains.

**Stigma and Culture-Specific Conceptualization of Mental Illness**

Refugee groups and healthcare providers acknowledge that resettled refugees are often in great need of mental health services, and further, both groups share similar concerns that stigma and shame are one of the consistent barriers to obtaining mental health services. When

interviewing healthcare providers about their perceptions as to why refugees may not obtain mental health services for psychological symptoms, researchers identified shame and stigma related to experiencing mental illness was one of the main contributing factors for refugees not obtaining mental health services (Asgary et al., 2011; MacDonald, 2016). Similar sentiments were observed in another study examining refugees' perceptions of shame and stigma related to mental illness, with one resettled refugee describing the negative impact stigma can have on refugees suffering from mental health issues, stating ''They can even just go ahead and die before they tell somebody that they have a problem that will affect their life for a long time.'' (Morris et al., 2009, p. 538). While mental illness may be a taboo topic in some refugee communities that may limit attempts at access to mental health services, providers may also contribute to perpetuating stigma by being underprepared to address refugee's mental health needs, as identified above.

Another challenge identified in meeting the mental health needs of resettled refugees relates to the differences in culture-specific conceptualizations of mental illness. In a qualitative study conducted by Asgary et al. (2011), researchers identified internal barriers to obtaining mental health services in refugees and asylum seekers that had been resettled in New York City. One of the prominent themes researchers identified among the resettled refugees and asylum seekers they interviewed were that most participants did not identify their psychological symptoms as relating to mental illness. Despite their psychological symptoms, some participants stated they did not believe they had a condition that required medication that had been prescribed for psychological symptoms and instead chose not to refill medications that had been prescribed to treat their symptoms. The rejection of medication by some refugee groups may demonstrate

the differences in cross-cultural understandings of mental illness and the appropriate treatments to address these issues.

Mental health providers often cite differing beliefs about mental illness as being a common factor that prevents resettled refugees from accessing necessary mental health services. Specifically, refugees often have differing conceptualizations of mental health, mental illness, and mental health treatments that are distinct and in contrast to the country where they have resettled (Colucci et al., 2015). Because culture directly impacts and contributes to the expression and perception of mental illness, the expression of psychological distress can vary widely. For example, non-Western refugee groups are more likely to display somatic symptoms of anxiety and depression (e.g., stomach aches, headaches) compared to their Western counterparts (Bettmann, Penney, Clarkson Freeman, & Lecy, 2015). Similarly, interventions aimed at treating psychological distress is also determined by the culture, and these treatments may conflict with common treatments used within the host countries where refugees are placed. Resettled refugees may rely on traditional healing methods to treat psychological distress including using herbs, witch doctors, shamans, and other traditional healers or methods (Bemak & Chung, 2012). It is common that refugees seek treatment from Western providers only when their symptoms are severe, which may delay necessary treatment and exacerbate symptoms. While conflicting beliefs about mental illness and the appropriate course of treatment between different cultures may prevent resettled refugees from obtaining mental health services in the host country, this disconnect may represent a greater issue related to the lack of culturally competent services that reflect culturally appropriate methods of interventions that might appeal to refugee populations in the first place.

**Affordability**

Refugees have expressed that the cost of treatment often interferes with their ability to obtain health services. Cost of insurance, gaps in insurance coverage, difficulties navigating enrollment in publicly available health insurance programs, as well as lack of insurance through one's employer contributed significantly to issues related to affordability of health care (Morris et al., 2009), which extends to difficulty in obtaining mental health services. While refugees are eligible for Medicaid due to their financial position, Medicaid is often difficult to navigate and has minimal mental health assistance, which may present further challenges in identifying both accessible and affordable services (Maitland, 2017). In addition, the costs related to insurance fees and co-payments increased the financial burden on resettled refugees (Morris et al., 2009). Some resettled refugees also cited the inability to afford to pay for medications, a major barrier to obtaining and maintaining continued access of mental health services (Asgary et al., 2011).

**Distrust of Services and Providers**

A significant barrier to accessing mental health services is the fear and distrust many resettled refugees experience. One of the common issues refugees encounter prior to and during their migration from their home country to the host country is negative experiences with authority, resulting in lack of trust in those who hold positions of power (Colucci et al., 2015). Distrust may be exceptionally profound for refugees that have experienced persecution and violence that was government-sanctioned (Ellis et al., 2011). Due to being continually marginalized within oppressive social, political, and economic arenas, refugees may apply their valid mistrust of authority towards services providers, members of a privileged group with an empowered status. The lack of trust many refugees may experience may be exacerbated by

continued experiences that reinforce distrustful attitudes post-resettlement; refugees may have attempted to seek help for their troubles, only to be rejected and sent away, perhaps due to cultural incompetence or misunderstandings, further disconnecting refugees from mental health services that may provide relief. In addition to distrust in authority, refugees may experience a sense of distrust as the world has proved itself to be an unsafe, untrustworthy place. Young (2008) states:

> Refugees…have lost everything, their homes, their relatives, their neighbors, their culture, a way of life they understand. Their sense of loss is profound. When they see that their caregiver is respectful, compassionate, and not rushed or in a hurry, then they respond…if you do not first establish the relationship, the trust, nothing will happen thereafter. (p. 144-145)

Developing trust seems to be a critical part of providing care for refugees in need of mental health services, however, it may be not carefully considered when providing these services.

The above barriers combined, including negative experiences with under-trained providers and difficulties navigating services due to both intra- and interpersonal challenges, often causes refugees to consider obtaining mental health services as a lesser priority. However, given the higher prevalence of mental health issues experienced by this population, it is crucial that providers identify and utilize strategies to increase access to mental health services.

**Lack of Provider Cultural Competence**

Resettled refugees often express a lack of provider cultural competence in relation to the health services they seek out. To possess cultural competence requires that a provider has the necessary basic knowledge about specific refugee groups including the history of the country of origin, reasons for fleeing the home country, an understanding of cultural norms and practices,

and possibly most importantly for mental health providers, a strong grasp of culturally specific explanations of and expressions of mental illness in a given refugee group (Ellis et al., 2011). If mental health providers offer explanatory models of mental illness that conflict with refugees' understanding of mental illness, rather than integrate cultural training and competence in order to allow for the adaptation of services to be more culturally relevant (Ellis et al., 2011), mental health services may be rejected or avoided altogether by refugee groups. Refugees have reported that mental health providers' lack of cultural competence, including inappropriate communication styles, such as frequent questioning, not explaining consent (e.g., the right to "opt out"), not describing the services that were being utilized, and direct probing negatively affected engagement in mental health services (Colucci et al., 2015). Lack of cultural competence can also be represented by discriminatory treatment by providers that view refugees as an "other" that is not worthy of equal treatment. A participant in a study conducted by Asgary et al (2011) described her experiences regarding discrimination saying, "They don't pay much attention to immigrants, see us fast just to finish and don't listen. They know we don't have documentation so can't complain. If American, I would surely get much better care" (p. 509).

Healthcare providers also recognize that cultural competence is an issue in some health care systems, citing that doctors, who resettled refugees often encounter for mental health issues, are not adequately trained to recognize the signs and symptoms related to torture, and further may not respond sensitively to these issues as they lack awareness with how best to treat these individuals (Asgary et al., 2011). In addition, providers may have difficulty identifying culture-bound expressions of psychological symptoms, making it difficult for providers to properly identify and treat mental health issues (Wells, Wells, & Lawsin, 2015).

## Strategies to Improve Access to Mental Health Services

In response to some of the barriers to mental health services experienced by refugees represented in the literature, researchers have developed "best practices," or strategies for improving access to mental health interventions for refugees resettling in the U.S. I identified four studies that presented literature reviews on suggested strategies to improve access and one study that identified strategies through a qualitative study conducted with mental health providers. More specifically, I will present the suggested strategies in the following section and then present a synthesis of these strategies as a framework to guide the current study.

Murray et al. (2010) identified eleven components for increasing the likelihood of successfully implementing evidence-based practice for this population. The suggestions, based on a meta-analysis of the current studies of psychological interventions for resettled refugees, include: culturally appropriate interventions; provider cultural competence; interventions that evaluate symptoms over the course of resettlement; psychosocial models that place an emphasis on individual and social/community growth and change; giving due acknowledgment to community and indigenous leaders; build community capacity; ensure cultural salience and significance; minimize power imbalance between health professionals and local leaders; evaluation and dissemination of effective interventions; eliciting refugees' personal testimonies of adversity; and using randomized controlled trials and wait-list control groups.

Rader et al. (2010) also suggest several best practices to utilize when engaging in mental health services with refugee populations based on the literature. The first suggestion, mentioned frequently throughout the literature regarding mental health services for refugee populations, is ensuring provider cultural competence. Provider cultural competence requires providers to acquire the awareness, knowledge, and skills necessary to work with populations from diverse backgrounds. The next suggestion is placing the therapeutic relationship of the provider and

client at the forefront of all therapeutic interaction. The specific emphasis is to address the isolation and social threats refugees have endured as a result of mass traumatization experienced by this population. Making available mental health services known and accessible by refugee populations is the next suggestion, with an emphasis on community-based rather than office-based, which may improve the success of these services. The fourth suggested best practice emphasize the necessity of available and qualified interpreters, as these interpreters may be crucial to engaging refugee clients in mental health services as they often act as cultural brokers who assist in the process of developing trust between client and provider. The presence and provision of mental health interventions that include holistic services is also a suggested best practice. This requires the integration of religious, spiritual, and cultural beliefs and values into mental health services in order to attend holistically to the whole person in treatment. Psychoeducation that assists in increased understanding of the development and expression of psychological symptoms is another example of holistic integration. Finally, addressing the relationship between physical health and mental health is an additional holistic approach because it again focuses on the refugee as a whole person.

Another study (Weine, 2011) describes the eight characteristics that preventative mental health interventions should utilize to address the mental health needs of resettled refugees and their families. These suggestions are based on previous developmental and intervention studies and should be considered during the implementation of any mental health intervention, irrespective of target outcomes and include feasibility, acceptability, prosaicness, culturally tailored, multilevel, time focused, effectiveness, and adaptability. Whether or not an intervention is doable - or the *feasibility* of an intervention - as well as an evaluation of an intervention must be demonstrated. The *acceptance* of the intervention depends on whether refugees and providers

believe the intervention adequately fits the needs, strengths, values, and beliefs of the targeted population. The *prosaicness* of interventions relates to the presence of language and images that are specific to and understood by the targeted population. The presence of overly clinical language only understood by psychological professionals, for example, would likely deter participation and may be a barrier to engaging in mental health services. *Culturally tailored* interventions refer to interventions that include characteristics that specifically target a groups' cultural background. Each refugee group has a unique set of cultural beliefs, values, traditions, and practices that often compete with typical Western-based psychological interventions. Therefore, it is crucial to develop or adapt interventions that fit the cultural background of the group receiving on the receiving end of a specific intervention. *Multilevel interventions* take into consideration multiple levels of risk and protective processes, including multi-level stressors (e.g., economic, familial, community, work) and multiple systems (e.g., schools, community organizations, governmental agencies) that often do not communicate with each other. Interventions that do not attempt to integrate at least some of these dimensions are likely to be lacking. *Time focused interventions* take into consideration the fact that refugees are subjected to time-dependent processes (e.g., time living in the United States, time cycle of U.S. education systems), and make an effort to be mindful in regard to timing of a specific intervention and timing of assessment. The importance of demonstrating *effectiveness* of interventions is crucial to ensuring refugees receive mental health services that make a positive impact. This dimension may be attended to by ensuring empirical evidence through the proper use of sampling, integrity of intervention, cross-cultural reliability of measures, and statistical significance of changes pre and post-intervention. Finally, *adaptability*, or whether the intervention is generalizable and flexible enough to be modified in order to be carried over to another intervention context, is

especially useful in interventions for refugees as the context of the intervention may frequently change based on population needs.

A final study by Colucci et al. (2015) identified additional strategies suggested based on the interviews with mental health providers working with resettled refugee youth and adolescents. These strategies were based on their experiences working with this population and included what they believed would facilitate access to mental health services. The first suggestion emphasized increasing the mental health literacy of refugee populations in ways that were culturally appropriate, including linking with school-based programs and other community-based advertising to increase education and facilitate engagement in mental health services. Second, mental health providers suggested improving cultural competence (e.g., increased understanding of cultural concepts of mental illness, attending to non-verbal aspects of cultural competence including body language and dressing modestly) to better understand refugees engaged in mental health services. Third, providers emphasized the need for mental health services to be more flexible regarding how and where services are delivered. Specifically, providers described the need for services to be adaptable, such as allowing walk-in appointments, and being open to providing services in more discreet places such as schools, in buildings that cannot be easily seen from the street, or providing separate, discrete entrances from services that are easily identifiable as places that provide mental health services. A fourth suggestion highlighted the importance of establishing trust with refugee clients on an individual level and as an organization. If the organization has a reputation as trustworthy, they may be regarded as more trustworthy within their communities, increasing the potential for access to mental health services. The fifth suggestion urges mental health providers to consider various issues related to linguistic challenges, including considering cultural factors (e.g., gender, age,

dialect, dynamics between various ethnic groups) that may be salient to the individual seeking mental health services, ensuring confidentiality of information shared, and employing bilingual mental health providers that can provide interpretation. Engaging both the family and community members in mental health services makes up the sixth suggestion. Ensuring the individual in treatment is asked to what extent they want family involved is crucial and finding ways to connect refugees to community resources and supports, particularly in refugees from collectivistic cultures. A seventh suggestion calls on providers to step outside of the rigid counseling roles and to advocate on behalf of refugees, such as helping refugees to obtain housing and to always ensure follow-through with stated goals.

Based on the "best practices" described in the literature (Colucci et al., 2015; Murray, et al., 2010; Rader et al., 2010; Sue et al., 1990; Weine, 2011), I synthesized the literature to develop ten distinct *strategies* comprised of the suggested best practices (Table 1). To synthesize the literature, I systemically compared the strategies discussed in each study to identify strategies that were consistently mentioned across studies and placed these frequently mentioned strategies into categories. I then examined strategies that did not appear to obviously fit within a category and placed these strategies within existing categories where appropriate. This process continued until all strategies had been considered and organized until ten distinct strategies were developed. These strategies included: 1) emphasizing community connectedness (e.g., collaborating with other organizations and developing relationships with refugee groups in the community) to improve reach of services and establish providers as trustworthy and credible 1) improving cultural competence so that providers of mental health services are better able to offer services that are culturally relevant; 2) meeting the linguistic needs of refugee populations (e.g., including translators on-staff and brochures in multiple languages); 3) addressing the stigmatization of

mental illness that may occur in refugee communities; 4) emphasizing the therapeutic relationship to increase trust between providers and refugees, as refugees often struggle with strong feelings of mistrust; 5) using culturally appropriate mental health services; 6) developing adaptable services that may be easily altered to apply to multiple refugee populations; 7) providing trainings for providers to increase cultural competence; 8) ensuring the refugee population targeted accepts the services offered as relevant and useful for meeting their psychological needs; and 9) evaluating and 10) disseminating the effectiveness of mental health services offered.

Table 1

*Mental Health Provider Strategies to Improve Access to Culturally Competent Mental Health Services for Resettled Refugees*

| Focus | Objectives | Methods | Suggested Strategies |
|---|---|---|---|
| Colucci et al. (2015) *In or out? Barriers and Facilitators to Refugee-background Young People Accessing Mental Health Services* | Mental health providers identify facilitators to engage resettled refugees in mental health services | Qualitative study | Community-based mental health literacy; provider cultural competence; adaptability of interventions; emphasis on therapeutic relationship; establishing providers as credible/trustworthy; available and qualified translators; family/community involvement in treatment; provider advocacy |
| Kaczorowski et al. (2011) *Adapting Clinical Services to Accommodate Needs of Refugee Populations* | Approaches for mental health providers to develop skills to work with refugee populations | Literature review | Multilevel/community-based partnerships; consultation with refugees/community experts/gatekeepers; obtain training in trauma; available and qualified translators |

*(Table continues)*

| | | | |
|---|---|---|---|
| Murray, Davidson, & Schweitzer (2010) *Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations.* | Identification of practice-based evidence research studies examining mental health interventions utilized with resettled refugee populations | Literature review | Provider cultural competence; evaluation of symptoms and interventions over time; emphasis on individual and social/community growth; acknowledgment to indigenous leaders; building community capacity; ensuring cultural significance; minimizing power imbalance between health professionals and local leaders; evaluation and dissemination of effective interventions; eliciting refugees' personal testimonies; randomized controlled trials and wait-list control groups. |
| Rader, Lee, & Ssempijja (2010) *Culturally Competent Mental Health Services for Refugees: The Case for a Community-Based Treatment Approach* | Suggestions of "best practices" for mental health providers working with resettled refugees to ensure adequate and ethical culturally competent mental health care | Literature review | Provider cultural competence; emphasis on therapeutic relationship; making known available mental health services; available and qualified translators; holistic mental health interventions; psychoeducation; mind-body connection |
| Weine (2011) *Developing Preventive Mental Health Interventions for Refugee Families in Resettlement* | Characteristics of preventative mental health interventions to meet the needs of resettled refugee families | Literature review | Intervention feasibility; acceptability of intervention; culturally tailored interventions; multilevel/community-based partnerships; time focused/limited interventions, intervention; culturally specific materials/prosaicness; evaluation and dissemination of effective interventions; adaptable interventions |

Each of these strategies represents an aspect of cultural competence that should be prioritized when providing mental health services to resettled refugee populations. The use of these strategies may effectively improve access to mental health services for refugee populations.

## Mental Health Provider Cultural Competence

In this section, I will discuss the importance of mental health provider cultural competence in meeting the mental health needs of refugee populations. To understand the meaning of cultural competence, it is useful to define the meaning of the construct. Competence is typically defined as an ability to adequately perform or be qualified to perform a specific task (Sue et al., 2009). With this definition in mind, mental health providers that are competent should be able to demonstrate their abilities to perform therapeutic skills with a wide range of culturally diverse clients. However, it is important to note the differences between competence and *cultural* competence and the limitations of being only competent, versus culturally competent, particularly when working with culturally diverse groups, such as refugees. While some mental health providers may be able to demonstrate high levels of empathy and therapeutic alliance to their clients, these are general competencies that are considered "good ingredients" that all mental health providers should be traditionally trained in and include in all treatments (Fuertes at el., 2006). In contrast, a counselor that is culturally competent should be trained to be increasingly culturally inclusive and informed as they work with and conceptualize refugee clients.

The abilities required to be a culturally competent mental health provider can best be captured in Sue and Sue's (1990) tripartite cultural competence model. The tripartite cultural competence model identifies the three components necessary to develop cultural competence in mental health providers. First, *cultural awareness* is the in-depth self-examination of one's personal cultural background, including identifying and challenging one's biases, assumptions, and prejudices. Second, *cultural knowledge* requires mental health providers to consistently seek and obtain education about diverse ethnic and cultural groups. Lastly, *cultural skills* include the process of learning to adapt interventions and practices to be more culturally relevant for the

specific needs of the client. This model is the most commonly utilized framework for cultural competence, and it provided the foundation for the multicultural guidelines adopted by the American Psychological Association and the organization's Division 17 multicultural counseling competencies (Sue et al., 2009). Sue et al. (2009) argue that every mental health provider should possess the culturally competent characteristics represented in the tripartite model. If every provider should possess the cultural competencies outlined in the tripartite cultural competence model, this is especially true for mental health providers working with refugee populations, a commonly marginalized population.

The need for culturally competent mental health providers developed out of concern for multiple minority groups and marginalized populations that were adversely affect by inaccessible, unavailable, and ineffective mental health services. The American Psychological Association (APA) responded to these issues by developing and publishing specific cultural guidelines that set the groundwork for psychologists to provide culturally competent mental health services, including equity and fairness in the delivery of services. These guidelines were updated by the APA in 2017 and currently state:

> Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services. (p. 4)

Failing to consider cultural competence is an ethical issue, that if not appropriately addressed may adversely harm many of the clients we serve. Hall et al. (2003) proposes that the

ethical standards mandate that all providers should be culturally competent, and that this cultural competence should be developed in collaboration with or in deference to experts within minority communities. Therefore, it is crucial that mental health providers obtain the specific cultural awareness, knowledge, and skills related to cultural competence to be able to effectively serve diverse refugee populations (Sue, 1998; Sue, 2001). This specifically relates to how providers consider implementing strategies that improve access to mental health services, one of the main purposes of this study.

## Rationale for Current Study

As evidenced above, the global refugee crisis is a humanitarian crisis unlike anything the world has seen, contributing to an increased need for adequate care to meet the mental health issues experienced by resettled refugees as more and more individuals are displaced. Refugee resettlement agencies and the mental health providers within them may provide crucial assistance in meeting the mental health needs of this particularly vulnerable group. In order to best meet the psychological needs of this group, it is important to understand the psychological issues experienced by resettled refugees, the factors that contribute to the mental health outcomes observed in this specific group, and the barriers resettled refugees encounter when attempting to access mental health services. Many of these barriers may be the result of deficiencies in cultural competence at both the individual provider and the systemic level. To address the barriers to mental health services accessibility, researchers have identified suggested strategies that mental health providers should utilize when engaging with refugee populations to improve culturally competent services, which may address service accessibility issues. I synthesized the literature on addressing barriers to mental health service accessibility to reveal eight culturally competent strategies to improve access to culturally competent mental health care. These strategies,

combined with Sue and Sue's (1990) tripartite cultural competence model focused on provider cultural awareness, knowledge, and skills, provided the theoretical framework for this study and informed both the quantitative and qualitative questions for this study.

**Research Questions**

In this study, I examined refugee resettlement agencies to assess what mental health services were available to resettled refugees. In addition, I examined cultural competence in the mental health providers working within this context. The study included three sequential phases. Phase I focused on the organizational level of refugee resettlement agencies to understand the content and extent of available mental health services. Thus, the research questions for phase one were: (1a) What are the mental health services available for resettled refugees within refugee resettlement agencies?, (1b) How well are cultural competence strategies integrated into the mental health services within refugee resettlement agencies?, and (1c) How do available mental health services differ based on demography?

Phase II focused on the mental health providers that worked directly with resettled refugees providing mental health services. This phase of the study examined providers' level of cultural competence. Therefore, my research questions for phase two were: (2a) How well prepared are mental health providers to provide culturally competent mental health services to resettled refugees? and (2b) How does level of training impact level of cultural competence?

My research question for phase III, which included the qualitative component, was (3) What strategies do mental health providers use to provide culturally competent mental health services? Finally, the mixed methods research question I answered through combining both quantitative and qualitative data sets was: (4) How do the perspectives of mental health providers

inform the data regarding the availability of culturally competent mental health services for resettled refugees?

# CHAPTER 3.
# METHOD

## Overview of the Design

This study followed an explanatory multi-phase mixed methods design in three phases. The first phase of the study utilized a web-based survey that included quantitative data regarding the available mental health services at refugee resettlement agencies. The sample targeted during this phase included individuals that held a supervisory role or other leadership role within refugee resettlement agencies. In the second phase of the study, a web-based survey was used to collect quantitative data from mental health providers working within refugee resettlement agencies, about the specific mental health services provided as well as their level of cultural competence. The sample targeted in phase two included any individual that provided direct mental health services (e.g., individual, family, or group therapy or counseling). The web-based survey was followed by a third, and final phase that included in-person interviews to capture the experiences of mental health providers and their use of strategies to provide culturally competent mental health services to resettled refugees. This qualitative phase of the study was informed by the previous, quantitative phases of the study, as each set of quantitative data highlighted significant information that was crucial to explore in the final phase of the study (Creswell & Plano Clark, 2017).

In this study, I used transformative paradigm, which is grounded in challenging inequality and oppression and seeks to promote social justice, empowerment, and political reform for marginalized groups (Creswell et al., 2017). Using the results of this study, resettled refugees may ultimately benefit from services that are culturally competent. Further, the results

of this study may augment mental health service accessibility for resettled refugees living in the U.S.

One of the goals after the data collection and integrated results included suggestions for improving cultural competence in mental health providers working with resettled refugees in the U.S. The purpose of these suggestions was to transform the results of the current study into tangible methods for to be used by mental health providers and others working with resettled refugee populations. Due to the potential benefits this study and proposed recommendations for mental health providers working with marginalized refugee populations, the transformative paradigm was an appropriate paradigm for this study.

## Rationale for Mixed Methods

An increasing amount of research examining mental health services is combining both qualitative and quantitative data within mixed methods designs, with the belief that the combination of these methods develop a broader understanding of a specific phenomenon than either method alone (Creswell & Plano Clark, 2017; Teddlie & Tashakkori, 2009). In mixed methods designs, quantitative methods may test hypotheses and increase breadth of understanding of the topic of interest, while qualitative methods allow for exploration and increased depth of understanding (Teddlie & Tashakkori, 2009). Further, the data gathered during the quantitative phases was used to identify individuals that expanded on these results through qualitative inquiry (Newman, Ridenour, Newman, & DeMarco, 2003).

Creswell et al. (2017) state that the most important rationales for conducting mixed methods research includes triangulation, complementarity, development, initiation, and expansion. In the context of this study, using a mixed methods design allowed for *triangulation* of the data, as two differing forms of data – surveys and qualitative interviews - provided

corroborating evidence or shed light on a theme or perspective. I further emphasized triangulation in this study through interviewing different types of mental health providers (e.g., licensed clinical social workers, psychologists, marriage family therapists) to increase the types of data sources represented in this study. In relation to *complementarity*, this study used one research method to clarify, enhance, and illustrate the findings from the other research method. *Development* was observed using web-based surveys, which then informed the qualitative phase of the study. At the intermediate phase of the study, *initiation* occurred as any discovered paradoxes or contradictions led to reframing of the research question(s). Finally, this study utilized *expansion,* as each research method used in this study provided increased breadth and range of the topic being examined.

## Participants

A total of 35 supervisors or other leaders representing refugee resettlement agencies were included in phase I, a total of 26 mental health providers that worked within refugee resettlement agencies were included in phase II, and seven mental health providers from refugee resettlement agencies were included in phase III. In this section, I provide the demographic information of participants from each phase.

### Phase I

In the first phase of the study, individuals that had knowledge of the mental health services offered within 286 identifiable resettlement agencies in the U.S. were eligible to participate in the online survey. A total of 67 (23.4%) out of the 286 resettlement agencies responded to the survey. Of those that responded, 13 were eliminated from the study due to completing less than 80% of the survey, while 19 were not eligible to participate as they did not

provide mental health services at their agency. A total of 35 agencies were included in the data analyses for Phase I. An overview of recruitment strategies is described in Appendix A.

### *Agency Representative Demographics*

The 35 individuals representing their agencies across 26 different states indicated their role in the agency as follows: Director ($n$ = 14, 40%), Manager ($n$ = 5, 11.4%), Supervisor ($n$ = 4, 11.4%), Administrative Staff ($n$ = 4,11.4%), Program Coordinator ($n$ = 4, 11.4%), Counselor ($n$ = 1, 2.9%), Case Worker ($n$ = 1, 2.9%), Clinical Social Worker ($n$ = 1, 2.9%), and Health Navigator ($n$ = 1, 2.9%). Of these participants, 82.9% ($n$ = 29) stated they were women and 17.1% ($n$ = 6) stated they were men. The mean age of participants was 40.02 years old (SD = 11.94). Approximately 82.9% ($n$ = 29) of participants stated they were White, 8.6% ($n$ = 3) Asian or Asian American, 2.9% ($n$ = 1) of participants stated they were Middle Eastern or North African (MENA) ($n$ = 1), and 2.9% ($n$ = 1) Black or African. Four respondents (11.4%) reported they were Hispanic/Latino. Participants reported the following highest levels of education completed: master's degree (34.3%), bachelor's degree (17.1%), licensed clinical social worker (22.9%), Master of Social Work (20%), doctoral degree (2.9%), and medical degree (2.9%). Participants reported the number of years in their current position ranged from 1 to 18 years ($M$ = 5.4, $SD$ = 4.90), while the total number of years at their current resettlement agency ranged from 1 to 18 years ($M$ = 7.23, $SD$ = 5.13). Participants reported the total amount of time working with resettled refugees ranged from 1 to 21 years ($M$ = 8.89, $SD$ = 4.76).

## Phase II

Mental health providers were eligible to participate if they indicated they provided direct mental health services (e.g., therapy or counseling) within a refugee resettlement agency.

Participants from phase I were also eligible to participate in phase II if they met the criteria for phase II (i.e., provided direct mental health services to refugees within a resettlement agency). Following the initiation of the data collection procedures, 46 individuals from resettlement agencies responded to the survey. Of the 46 individuals that responded to phase II, 12 were eliminated from the study because they failed to complete a minimum of 80% of the survey. An additional eight individuals were removed from the study due to not meeting inclusion criteria, as they indicated they did not provide direct mental health services. The final sample size was 26 participants from 22 resettlement agencies from 20 states. Out of these 26 participants, 17 (65.3%) also participated in Phase 1. A chart demonstrating agency participation across phases can be found in Appendix K.

### *Participant Demographics*

Most of the sample consisted of women ($n$ = 21, 81%), followed by men ($n$ = 4, 15%), and one individual (4%) indicated they were non-binary. The average age of participants was 35.64 years old ($SD$ = 8.60). Approximately 73% ($n$ = 19) of participants stated they were White, 8% ($n$ = 2) Asian or Asian American, 8% ($n$ = 2) more than one race, 4% ($n$ = 1) Middle Eastern or North African (MENA), and 8% ($n$ = 2) provided no response. One individual (4%) indicated they were Hispanic/Latino. Two (8%) of participants indicated they identified as a refugee at some point in their life. Linguistic ability of participants demonstrated that 38% ($n$ = 10) fluently spoke one language in addition to English that they were able to use to communicate with their refugee clients, 12% ($n$ = 3) spoke a second language, while 3% ($n$ = 1) spoke a third language. The languages participants reported fluency in included: Spanish, Turkish, Arabic, Indonesian, Russian, Patois, and Turkmani. Most providers were located within resettlement agencies in

urban areas (*n* = 21, 81%), while the remaining providers were located within agencies in suburban areas (*n* = 5, 19%).

Participants reported the following highest level of education completed: high school degree or equivalent (*n* = 2, 8%), associate's degree (*n* = 2, 8%), bachelor's degree (*n* = 7, 27%), master's degree (*n* = 7, 27%), master of social work (*n* = 9, 35%), licensed clinical social worker (*n* = 7, 27%), master of marriage and family therapy (*n* = 1, 4%), doctoral degree (*n* = 2, 8%), medical degree (*n* = 1, 4%), and other (*n* = 2, 8%). It is important to note that some participants had more than one degree at a similar level of education, such as an MSW and another master's degree. The variety of mental health provider's levels of education is reflected in the broad types of mental services that are offered across resettlement agencies. For example, some participants have a high school degree or equivalent. Some of the sites surveyed for this study reported they provided psychoeducational groups, which may allow for individuals with less training in providing mental health services to participate in conveying crucial information. Other sites described employing "lay workers," that is, individuals from refugee communities that are trained to provide interventions to their peers.

Participants reported number years in current position ranging from 1 to 11 years (*M* = 3.16, *SD* = 2.10), while the total number of years at their current resettlement agency ranged from 1 to 19 years (*M* = 4.88, *SD* = 4.36). Participants reported the total amount of time working with resettled refugees ranged from 1 to 25 years (*M* = 7.24, *SD* = 5.14). In relation to multicultural counseling training and experiences, the total number of cultural competence or multicultural counseling courses ranged from 0 to 32 courses (*M* = 10.58, *SD* = 9.14). Specifically, the number of undergraduate courses on this topic ranged from 0 to 5 courses (*M* = .96, *SD* = 1.30), the number of graduate courses ranged from 0 to 5 courses (*M* = 1.58, *SD* =

1.47), the number of Continuing Medical Education (CME) courses ranged from 0 to 10 courses ($M$ = 1.75, $SD$ = 2.71), the number of workshops or trainings ranged from 0 to 12 courses ($M$ = 3.17, $SD$ = 3.40), and the number of webinars ranged from 0 to 25 courses ($M$ = 3.91, $SD$ = 5.72). Of these trainings, an average of 2.09 ($SD$ = 2.40) were provided to the participants by their employing agency (range: 0-10).

**Phase III**

Mental health providers that completed the survey portion of phase II ($n$ = 26) and consented to be contacted for the qualitative interviews were eligible to participate in phase III. Phase III recruitment resulted in seven mental health providers and seven interviews conducted and used for data analysis. All interviewees reported they were women. Five participants reported they were White (71%), one participant stated they were Asian or Asian American (14.2%), and one participated reported they were and Multiracial (14.2%). Participants reported the number of years in their current position ranged from 1 to 10 years ($M$ = 3.72, $SD$ = 3.2), while the total number of years at their current resettlement agency ranged from 1 to 15 years ($M$ = 4.71, $SD$ = 4.68). Participants reported the total amount of time working with resettled refugees ranged from 3 to 25 years ($M$ = 8.69, $SD$ = 6.89). Linguistic ability of participants indicated that 42.8% ($n$ = 3) reported they spoke one of the languages of the refugee populations they currently served, including Spanish and Patois. In relation to multicultural counseling training and experiences, the number of undergraduate courses ranged from 0 to 2 courses ($M$ = .57, $SD$ = .73), the number of graduate courses ranged from 0 to 4 courses ($M$ = 1.29 $SD$ = 1.28), the number of CME courses ranged from 0 to 10 courses ($M$ = 3.57 $SD$ = 3.25), the number of workshops or trainings ranged from 0 to 12 courses ($M$ = 5.14, $SD$ = 4.12), and the number of webinars ranged from 4 to 25 courses ($M$ = 10.57, $SD$ = 6.37). Of these trainings, an average of

4.57 (*SD* = 3.85) courses were provided to the participants by the agency (range 0 – 10). Further demographic information on each participant is outlined in Table 2.

Table 2

*Qualitative Interview Participant Demographics.*

| Pseudonym | Job Title | Gender | Country of Origin | Education | No. of multicultural competency courses | Agency Location | Types of Mental Health Services Offered |
|---|---|---|---|---|---|---|---|
| Kate | Clinical Supervisor | Woman | United States | LCSW | 31 | Urban area | Individual, family, and couples' therapy, psychoeducation, mental health screening, outreach, home-based services, psychiatric support, barrier reduction services |
| Allie | Counselor | Woman | United States | LCSW | 10 | Urban area | Individual, family, and group therapy, psychoeducation, mental health screening, outreach, home-based services |
| Eve | Marriage Family Therapist | Woman | United States | MFT, MA | 21 | Urban area | Individual, family, couples, and group therapy, psychoeducation, mental health screening, outreach, home-based services |
| Mariam | Trauma and Crisis Intervention Coordinator | Woman | United States | MSW | 15 | Urban area | Individual, family, and couples' therapy, psychoeducation, mental health screening, outreach, psychological assessment |
| Lucy | Social Worker, Therapist | Woman | United States | MSW | 12 | Urban area | Individual and group therapy, psychoeducation, mental health screening, outreach, home-based services |
| Desiree | Counselor, Director of Clinical Services | Woman | Jamaica | PhD, Educational Psychology | 26 | Urban area | Individual, family, couples and group therapy, psychoeducation, mental health screening, outreach, home-based services, psychiatry services |
| Lisa | Social Worker | Woman | Netherlands | MSW | 32 | Urban area | Individual, family, couples and group therapy, psychoeducation, mental health screening, outreach |

## Procedure

In phase I of the study, participants were identified and recruited using the publicly available list of nationally recognized refugee resettlement agencies located throughout the U.S. (see Appendix M). A total of 286 resettlement agencies were identified. The current number of resettlement agencies was determined through comparing the publicly available list of agencies (Appendix M) to information that confirmed whether an agency was active. This information was gleaned through examination of agency websites and through phone calls with agency staff during recruitment efforts. It is important to note that the exact number of operating resettlement agencies to date is difficult to determine due to the closing of multiple agencies since President Trump's decision to dramatically reduce both funding and the number of refugees to be resettled within the U.S. ("Dozens of Refugee," Reuters, 2018). The principal investigator also examined the websites and other publicly available information, including the nationwide list of resettlement agencies, to identify the director or other person in a leadership position within each refugee resettlement agency. These individuals were then contacted by email or phone and provided a description of the study and emailed a link to the online survey for phase I (Appendix E). At the completion of the survey, the directors or other leaders were asked to forward a provided link of the survey specifically for the mental health providers at their site for phase II. While the plan was for participants in phase I to forward the phase II survey to their providers, we were unable to explicitly control for phase I participants forwarding or not forwarding the link to their providers which resulted in some agencies only completing either phase I or II of the study.

In phase II, mental health providers that consented to participate were asked to complete a web-based survey to provide personal demographics and complete an assessment of their level of cultural competence (Appendix I).

After completion of the survey, all participants were asked to indicate if they were willing to participate in a one-hour in-person/by-phone qualitative interview for phase III. Those participants that were interested in participating in a qualitative interview were taken to a separate web-based survey link at the conclusion of the survey that allowed participants to provide their contact information so that the researchers were able to contact them for the qualitative interview portion of the study (phase III). Participant's contact information was not linked with their original web-based survey responses in order to protect confidentiality.

Initially, the researchers intended to utilize purposive sampling to increase the diversity of the sample of the interviewees. However, due to a small number of providers indicating interest in participating in the qualitative interviews (which may be due to the limited availability of this sometimes-overburdened population), and the coronavirus pandemic limiting the availability of potential participants to participate in the interviews, all participants that indicated interest in participating and completed interviews were included in the study. A smaller sample size is not necessarily a limitation of this study. Hill et al. (1997) recommends the use of a smaller sample size (e.g., between 8-15 participants) because additional qualitative interviews typically do not contribute a significant amount of new data.

The questions included in the interview protocol (Appendix J) were partially developed based on the cultural competence strategies we identified based on the literature (see Chapter 2, section: Strategies to Improve Access to Mental Health Services). The remaining interview questions for this study were directly informed by the quantitative data from phases I and II, which an emphasis probing for a greater understanding of the quantitative data that needed or would benefit from further examination.

One interview per mental health provider was conducted due to the time constraints often imposed on these providers. Interviews were approximately one hour or less and took by phone. With the consent of the participants, interviews were audiotaped. Confidentiality was maintained by storing all survey responses, recordings, and transcribed interviews in a secure, locked filing cabinet only accessible by the researcher. All participant information was de-identified to protect identity. An outline detailing the order of procedures can be found in Table 3 in the Data Analysis section.

## Instruments

In this section, I will review the web-based organizational assessment that were used for the resettlement agency director or other leaders in Phase I. I will then describe the demographic questionnaire and Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form that was used to assess the mental health providers in Phase II. Finally, I will present the overview of the qualitative interviews with mental health providers in Phase III.

### Phase I

The survey for this phase of the study was developed by the researcher for this study and was pilot tested by four mental health providers prior to administering it to participants. The questionnaire had two specific sections: a) demographic background of the respondent and b) organizational information about the refugee resettlement agency site (Appendix E).

#### *Demographic Questionnaire*

First, demographic data about the supervisor (or other leadership role within the agency) was collected through an online survey, including information about age, gender, race, ethnicity,

level of education achieved, type of degree, number of years of experience in current field, job title, length of time at current organization, and linguistic ability.

### *Organization Evaluation*

Then, the survey requested organizational information about the refugee resettlement agency site. The survey took an average of 12 minutes to complete and included 52 questions, including a mixture of rating scale questions and brief open-ended questions. The supervisors or other leaders were asked to provide an overview of the services provided by the refugee resettlement agency. For example, participants identified the type(s) of mental health services provided within their agencies (e.g., group therapy, individual therapy, culturally adapted, mental health screening or assessment) to provide greater understanding of the extent of mental health services that were available to resettled refugees receiving mental health services within refugee resettlement agencies (RQ1a). In addition, participants were asked to provide agency demographics, including location of agency (RQ1c), funding sources, etc. Then the director or other leader was asked to describe how their agency implemented specific cultural competence strategies in different aspects of their work (e.g., whether they provide translation services and if so, how often, or if they provided trainings emphasizing cultural competencies for their staff) (RQ1b).

Approximately 28 (77.8%) out of the 35 included agencies indicated they would be willing to pass on the second survey to mental health providers within their agency for phase II.

## Phase II

### *Demographic Questionnaire*

In the second phase of the study, demographic data was collected through an online survey from the mental health providers that directly provided mental health services to resettled refugees. Participants from phase I were eligible to participate in phase II if they also met the criteria for phase II; however, not all agencies included in the study completed both phases, with some agencies completing only phase I or phase II.

This survey took an average of 12 minutes to complete and included a total of 74 questions (Appendix I). Participants were asked to provide personal demographics including: age, gender, race, ethnicity, level of education achieved, type of degree, number years of experience in current field, job title, length of time at current organization, linguistic ability, and multicultural counseling training and experiences (e.g., number of workshops, seminars, undergraduate/graduate/CME courses taken related to cultural competency).

### *Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form*

During the online survey portion of phase II, participants also rated their level of cultural competence with the survey with the 37-item Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD) (Sheu & Lent, 2007; Appendix I). The scale uses a 5-point Likert rating scale, which assesses level of comfort with a given culturally competent skill. The scale includes three subscales, including multicultural intervention, assessment, and session management. The score is a total summed score of all subscales, with higher scores (max score: 342 points) indicating greater cultural competence. The MCSE-RD has demonstrated a high degree of internal reliability and construct validity in its ability to assess mental health providers' perceived capabilities to counsel clients from racially diverse backgrounds. In a study examining cultural competence in mental health providers, the MCSE-RD demonstrated internal

consistency of reliabilities of subscales ranging from .92-.98 and the Cronbach's alpha for the total score is .98 (Sheu & Lent, 2007). Furthermore, the MCSE-RD measure items have been found to associate with the cultural competencies suggested in the literature, including Sue and Sue's (1990) tripartite model (Sheu & Lent, 2007). This assessment was used to determine level of cultural competency preparedness to provide mental health services for resettled refugee populations (RQ2). All data collected within the online survey was collected prior to the qualitative interviews, as this data was used to inform the qualitative interview questions.

## Phase III

### *Qualitative Interviews*

The main purpose of phase III was to examine the strategies mental health providers used to offer culturally competent mental health services to resettled refugees (RQ3). The sequential-explanatory model chosen for this study required that each phase of the study inform the next, and using a qualitative phase as the final phase in this study allowed for greater breadth and depth of the subject under investigation, elucidating our understanding of the quantitative data gathered in the prior phases. To analyze the qualitative data, I used qualitative content analysis. Qualitative content analysis is one of many research methods used to analyze text data, which can be obtained from narrative responses, in-depth interviews, observations, open-ended survey questions, focus groups, and printed media (e.g., books, articles, manuals) (Kondracki & Wellman, 2002). Specifically, qualitative content analysis focuses on the characteristics of language-based communication, emphasizing the context and contextual meaning of the text (Tesch, 1990). The purpose of qualitative content analysis is to go beyond the process of merely counting words by carefully examining language with the intention of classifying text data into succinct categories to make realistic conclusions from it (Bengtsson, 2016; Hsieh & Shannon,

2005). According to Downe-Wamboldt (1992), qualitative content analysis "*provide[s] a systematic and objective means to make valid inferences from verbal, visual, or written data in order to describe and quantify specific phenomena* p. 314)." In addition to providing a structured and methodical framework for qualitative analysis, qualitative content analysis allows for exploratory analysis of the data, whereas other qualitative analysis methods may require guidance by a specific theory a priori to the data analysis. As my study is not explicitly driven by a particular theory, qualitative content analysis is an appropriate choice for the qualitative phase of this study. Further, qualitative content analysis is a well-known method for interpreting text data in health care (Robins, 2018). It has more recently been utilized in qualitive studies examining the perspectives of community stakeholders within refugee communities and resettled refugees themselves (Hahn, Steinhauser, & Goetz, 2020), as well as mental health providers experiences' of caring for refugees (Dotevall, Winberg, & Rosengren, 2018), topics which are similar to the topics examined in this study.

In addition, as with any research endeavor, it is important to also consider external resources when selecting a method for qualitative analysis - such as economics, time, and potential informants. Some research methods are cost and time-consuming and the potential informants limited, and the choice of method must be adapted to fit the available resources (Bengtsson, 2016). As a low-income doctoral student, I am inherently limited by cost and time, particularly given the current circumstances with COVID-19 pandemic. Further, the number of mental health providers working within refugee resettlement agencies was limited. These factors combined made qualitative content analysis both an effective and convenient form of analysis, as this method of analysis allowed me to complete all qualitative analysis procedures solo in a reasonable amount of time.

### *Interview Protocol*

Prior to the interview, I provided each participant with an introduction and description of the study and its purpose. In order to establish rapport with participants and increase participant comfort, the interview began with background questions. In this study, background questions related to the participant and their experiences as a mental health provider.

The qualitative interviews for this study used five pre-determined questions, including sub-questions and related probes to facilitate exploration and discussion (Appendix J), and two follow-up questions at the end of the interview to allow for participant feedback. While the interview protocol included questions developed based on the existing literature, some of the interview questions for this study were directly informed by participants' responses to the online surveys. Each interview took place by phone and lasted no more than one hour.

The interview protocol for this study was pilot tested by the primary researcher and four members of the doctoral committee prior to administering it to participants, and the questions were edited to best suit the purpose of the study and the sample population interviewed.

### *Primary Researcher*

The primary researcher developed the research questions, initial interview questions, and conducted all qualitative interviews under the supervision of the primary researcher's advisor. As the primary researcher, I am a 35-year-old woman that has completed a master's degree at an institution in the U.S., and I'm currently working toward a doctoral degree in counseling psychology. My faculty advisor is a counseling psychology faculty member at the primary researcher's institution. One committee member is a current full-time faculty in counseling psychology at the primary researcher's academic institution, another committee member is working as a post-doctoral resident at a large psychiatric clinic in the Western United States,

while the third committee member is a counseling psychology faculty member at a university in the Eastern United States.

### *Threats to Validity*

No matter the type of research design, research studies will encounter potential threats to validity. In order to address these possible threats to validity, it is crucial to consider ways to limit the ability of these issues to threaten the validity of the study. One method is to consider strategies to utilize both in advance of conducting the study and during the data analysis portion of the study that will counter or limit the impact of these threats. In this section, I will discuss three possible threats to validity, including researcher bias, threats to internal validity, and generalizability. I will then discuss the strategies I used to limit threats to validity.

One of the threats to validity for this study is that of researcher bias. Researcher bias is looking for specific and preconceived information that might confirm what a researcher wants or expects to find (Norris, 1997). A strategy to counter researcher bias is *reflexivity*. The process of reflexivity requires a researcher to examine their own biases, prejudices, and experiences that may influence the interpretation of the study results (Merriam, 1988). I am a White cis-gendered woman born in the United States. While my father's family immigrated to the United States from Mexico, I am not an immigrant myself and I do not have similar personal experiences related to immigration or resettlement to reflect on that may influence my understanding of the immigrant or refugee experience. My personal distance from the process of resettlement may in fact limit my biases about what I might expect from both mental health services and mental health providers in the context of refugee resettlement agencies, as I have only known the mental health system as an American navigating a system within the United States. However, my experiences as a doctoral student in a counseling psychology program focused on social justice, advocacy,

and cultural competence may impact my expectations for mental health providers; as cultural competence is a significant focus of my professional development, I may project the belief that other mental health providers working with a population that requires culturally competent mental health care should also be culturally competent. In addition, I am not a provider working within refugee resettlement agencies and I am minimally aware of the more common models of care (e.g., cultural competence) that may be utilized by providers within resettlement agencies due to lack of literature on this topic. While the framework of this study is based on the concept of cultural competence, it is possible that providers working with refugee populations use other competency models, or the providers represented in this study were trained in disciplines other than counseling psychology, all of which may impact providers' approaches to treating refugee clients in this setting. Throughout this study, I ensured I continually reflected on my biases, assumptions, and expectations of mental health providers working in the context of refugee resettlement agencies to ensure these potential biases did not impact my interpretation of the data.

The second threat is to internal validity. Internal validity is the level of certainty that a researcher can conclude that a relationship is causal, or that one event is the cause of a subsequent event (Creswell, 2013). To limit threats to internal validity, I used method triangulation. For method triangulation, I used multiple methods, including both qualitative interviews and surveys, to provide corroborating evidence to shed light on a particular theme or interviewee perspective (Creswell, 2013).

The final threat to validity is generalizability. For the purpose of this study, I focused specifically on internal generalizability. Generalizability is "the extent to which one can extend the account of a particular situation or population to other persons, times, or settings than those

directly in the study (Maxwell, 1992, p. 293).” In qualitative research, generalizability demonstrates not only how a process can apply across similar persons or situations, but also how the same process in a different setting can produce different results (Becker, 1970, p. 240). Internal generalizability refers to generalizing the results within a particular community or institution studied to other similar settings that were not a part of the settings or persons directly interviewed (Maxwell, 1992). One of the main issues with internal generalizability lies within the fact that the interviewer is typically in the presence of the interviewee for only a short period of time; in this period, an interviewer must draw inferences about what occurred based on this time alone. However, the interviewee’s perspective captured during the allotted interview time may leave out crucial information, leading interviewers to draw false inferences about an interviewee’s attitudes, actions, or beliefs outside of the interview (Maxwell, 1992). Therefore, it is crucial that certain aspects of the inherent social relationship that is created between the interviewee and interviewer during the interview context, including the nature of the relationship and the interviewee’s actions and beliefs, are examined to consider how these factors may impact what goes on in the interview (Briggs, 1986). As this study conducted interviews with staff members of refugee resettlement agencies in the United States, it was important that I avoided the assumption that all refugee resettlement agencies function in the same way. Further, I ensured that I maintained a collegial but professional relationship with all qualitative interviewees to avoid developing stronger interpersonal relationships that may have skewed the type of information shared during the qualitative interviews.

## Data Analysis

In this section, I will describe the data analysis of the quantitative data in phase I and II, as well as the data analysis of the qualitative interviews conducted in phase three. In this mixed

methods study, an emphasis was placed on the qualitative data over the quantitative data. First, both sets of quantitative data were analyzed independently of each other to answer the quantitative research questions. Then, the qualitative interviews were analyzed to better understand the quantitative research question. The results of each data set were then compared and grouped so that the findings of the corresponding quantitative and qualitative research questions related to each of the factors I proposed to explore (RQ4) (Creswell et al., 2017). I also present a table outlining the design procedures (see Table 3).

**Phase I**

For phase I, I analyzed the quantitative data collected from the directors and other leaders of resettled refugee agencies through computing descriptive statistics, including mean, standard deviation, and count and percentage for categorical variables to identify the available mental health services for resettled refugees within refugee resettlement agencies (RQ1a). In addition, I again used descriptive statistic to examine how well cultural competence strategies were integrated into the mental health services within refugee resettlement agencies (RQ1b). Finally, I used an independent samples t-test to examine how available mental health services differed based on demography (i.e., location of resettlement agencies [state, and urban/suburban/rural]) (RQ1c). I also used visual representations of the data (e.g., tables) to better understand the mental health services available to resettled refugees seeking mental health services within refugee resettlement agencies.

**Phase II**

For phase II of the study, I analyzed the quantitative data to understand the mental health services offered by mental health providers to resettled refugees and the current level of cultural

competence of mental health providers working within refugee resettlement agencies (RQ2a). I computed descriptive statistics (e.g., frequency counts) to analyze this data. In addition, I conducted correlational analyses to examine how level of cultural competence training experiences effected level of cultural competence (RQ2b).

**Phase III**

For phase III, to analyze the strategies mental health providers use to provide culturally competent mental health services, I conducted qualitative content analysis in four stages as described by Bengtsson (2016) following transcription of interviews:

***Stage 1, Decontextualization***

In this stage, I became familiarized with the data by reading through the transcribed text to understand the data as a whole (e.g., *decontextualization*) before then breaking the data into smaller *meaning units*, or the smallest units that provide needed insight to answer the aims of the study. Each meaning unit was then assigned a code, otherwise known as the "open coding process" (Lune & Berg, 2016), where codes help to identify concepts that allow for the data to be organized into blocks and patterns. I chose to conduct a qualitative content analysis that was a hybrid of deductive and inductive approaches (Fereday & Muir-Cochrane, 2006). The deductive approach allowed for the use of codes that were derived from the quantitative analyses and qualitative research questions and the inductive approach allowed for the qualitative content analysis to capture new information that was discovered during the analysis of the qualitative data. In qualitative content analysis, it is also crucial to choose whether the analysis will be a *manifest analysis* - describing the visible and obvious meaning of the text by describing *what* the informants actually say with their chosen words - or a *latent analysis* - interpreting the text to

find the underlying meaning, or what was *intended* to be said - prior to analyzing the text (Downe-Wambolt, 1992). Manifest approaches are often used for the purposes of developing theory or increasing understanding of under researched phenomena, while latent approaches are typically driven by underpinning theory to assign meaning to the observed phenomena (Glaser & Strauss, 1967). I chose to use manifest analysis because this study is not explicitly driven by a particular theory, there is minimal research that exists on the subject and sample included in the study, and I wanted to prioritize the words of the informants over my interpretations.

***Stage 2, Recontextualization***

In this second stage, I checked whether all aspects of the content had been examined in relation to the study aim. To do this, the original un-coded text was simultaneously read and categorized by meaning units while comparing the text to the final list of meaning units to determine whether any previously unmarked text should be included in the qualitative analysis. Any text that was not included during this process (e.g., "dross") will then be excluded from the analysis.

***Stage 3, Categorization***

In this stage, I condensed meaning units into shorter phrases, while still retaining the content of the unit. To assist in extracting the sense of the data, the coded material was divided into content areas, or broad groups that were based on different attentions of the study. For example, in our study, material was divided based on the questions used during the qualitative analysis. Then, during the categorization process, themes and categories were identified. In manifest analysis, it is common for the categories or subcategories to be the same as the codes of the meaning units, thus we used the codes of the meaning units as the categories, ensuring each

category was internally homogenous and externally heterogeneous so no data fell between categories or fit into more than one category (Bengtsson, 2016).

The creation of codes, meaning units, and categories was an iterative process that required continual reflexivity and revision of categories and themes. To increase intra-rater reliability as the solo coder in this study, I repeated the data coding at two different two periods (Time 1 and Time 2) as recommended by Mackey and Gass (2005) and checked for reliability using standard inter-rater reliability check procedures. In addition, the codebook and categories were presented to and discussed with the committee chair as part of the analytic process to increase validity.

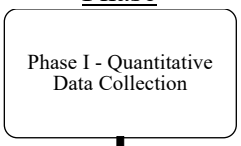
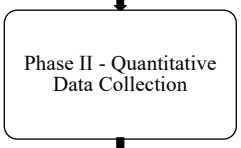
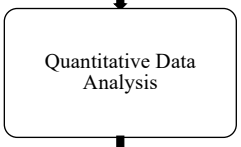
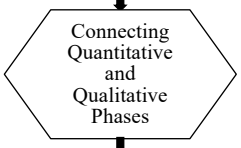
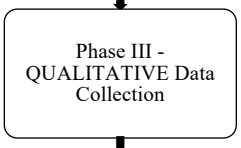
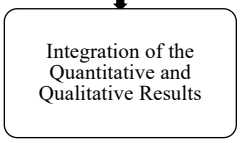
***Stage 4, Compilation***

After creating the categories, analysis of the qualitative data to examine the essence of the phenomenon began. During this phase, following Bengtsson's (2016) suggestions, data was analyzed from a neutral, objective perspective. Because the data was examined using manifest analysis, the first author gradually worked through each category, taking care to use the informants' words and frequently referring to the original text to confirm closeness to the original meanings of the text. To enhance the magnitude of each phenomena studied, categories and subcategories were quantified in combination with the qualitative approach (Berg, 2001).

To further increase the validity of the study, I presented the results to the dissertation chair who was not involved with the interviews. Finally, I examined the literature in relation to the results to determine if the results were logical and reasonable (Bengtsson, 2016).

Table 3

*Visual Model for Mixed-Methods Multi-Phase Explanatory Design Procedures*

| Phase | Procedure | Product |
|---|---|---|
|  | • Web-based survey<br>• Participants: Supervisors or other leaders within refugee resettlement agencies | • Numeric data |
|  | • Web-based survey<br>• Participants: mental health providers within refugee resettlement agencies | • Numeric data |
|  | • Descriptive statistics (e.g., frequency counts, mean, standard deviation)<br>• SPSS software | • Descriptive statistics |
|  | • Developing interview questions<br>• Purposefully selecting mental health providers to create a diverse and representative sample | • Interview protocol |
|  | • Individual 1-hour qualitative interviews conducted by phone, video-call, or in-person | • Text data |
|  | • Transcription, decontextualization, recontextualization, categorization, compilation<br>• Qualitative software (NVivo 12) | • Categories and sub-categories |
|  | • Integration and interpretation of quantitative and qualitative results | • Discussion<br>• Implications<br>• Limitations<br>• Future Research |

# CHAPTER 4
# RESULTS

In following section, I present an overview of my results in order by phase. Included in phase I results, I provide the demographic data of the participating agencies that provide mental health service to resettled refugees. I then present the results of the descriptive data analyses to answer the research questions for phase I, which include an aggregate summary of the types of mental health services available to resettled refugees, the integration of cultural competence strategies into each agency, and whether location of the resettlement agency (e.g., urban vs. suburban) impacted the number of mental health services available.

For phase II results, I discuss the data analysis I completed for phase II, including descriptive statistics and primary analyses.

Phase III results include the qualitative analysis of the qualitative interviews conducted with the mental health providers. The integration of both the quantitative and qualitative data are presented in Chapter V.

## Phase I Results

In phase one I examined descriptive data to examine the mental health services available within refugee resettlement agencies to answer the following research questions:

(RQ1a) What are the mental health services available for resettled refugees within refugee resettlement agencies?

(RQ1b) How well are cultural competence strategies integrated into the mental health services within refugee resettlement agencies?

(RQ1c) How do available mental health services differ based on demography?

### *Participating Agencies*

A total of 35 agencies were included in the data analyses for Phase 1. An overview of procedures is described in Chapter III, section Participants, while recruitment strategies are described in Appendix A.

All recruited participants' reasons for non-participation in the study were documented. Figure 1 provides an overview of all 251 agencies not included in the study. This number includes agencies that were excluded from the study based on their incomplete survey responses, as well as those that did not meet eligibility criteria (e.g., the agency did not provider mental health services). Those that completed enough of the survey to report that they offered mental health services but did not complete more than 80% of the survey were categorized as "no response (our agency has mental health services)."

### *Location of Agencies That Provide Mental Health Services*

The 35 agencies included in phase I were located within 26 states. There were 20 states with no mental health services in any of the resettlement agencies within the state (Appendix F) Regarding location, most resettlement agencies were in urban areas (82.9%, $n = 29$), while the remaining agencies were in suburban areas (17.1%, $n = 6$). A complete list of all refugee resettlement agencies in the U.S. and whether they provide mental health services for refugees is outlined in Appendix M.

### *Resettlement Agency Affiliation*

Resettlement agencies are made up of smaller affiliate offices located throughout the U.S. that are housed underneath the umbrella of a larger agency. These larger agencies are known as Voluntary Resettlement Agencies (VOLAGS). The VOLAGS include nine larger agencies: U.S.

Conference of Catholic Bishops/Migration and Refugee Services, Hebrew Immigration Aid Society, Lutheran Immigration and Refugee Services, Church World Service, U.S. Committee for Refugees and Immigrants, World Relief, International Rescue Committee, Episcopal Migration Ministries, and Ethiopian Community Development Council. Out of 35 agencies from Phase 1, their affiliation were as follows: U.S. Conference of Catholic Bishops/Migration and Refugee Services (*n* = 9, 22.9%), Hebrew Immigration Aid Society (*n* = 6, 17.1%), Lutheran Immigration and Refugee Services (*n* = 5, 14.3%), Church World Service (*n* = 4, 11.4%), U.S. Committee for Refugees and Immigrants (*n* = 4, 11.4%), World Relief (*n* = 4, 11.4%), International Rescue Committee (*n* = 1, 2.9%), Episcopal Migration Ministries (*n* = 1, 2.9%), Ethiopian Community Development Council (*n* = 1, 2.9%).

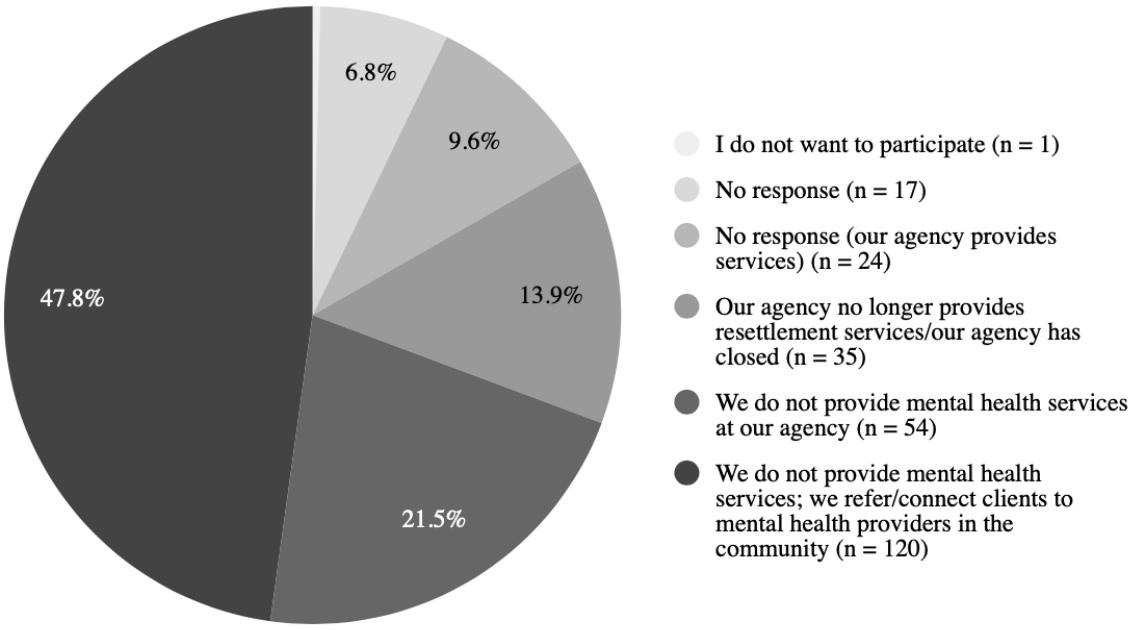



*Figure 1* Pie Chart of Reasons for Exclusion/Non-Participation in the Current Study (N = 251)

### *Funding*

Funding for the agency as a whole and funding for mental health services can have multiple resources and varies by VOLAGS affiliation, location, and other factors. Resettlement agencies as a whole indicated they were funded by the following sources: Federal government funding ($n$ = 33, 94.3%), private donations ($n$ = 30, 85.7%), grant funding ($n$ = 30, 85.7%), local government funding ($n$ = 25, 71.4%), research funding ($n$ = 2, 5.7%), insurance ($n$ = 1, 2.9%), and other funding ($n$ = 1, 2.9%). Approximately 5.7% ($n$ = 2) agencies were funded by one source, 5.7% ($n$ = 2) were funded by two sources, 22.9% ($n$ = 8) were funded by three sources, and 65.7% ($n$ = 23) were funded by more than three sources.

Agencies indicated that funding for mental health services within their agencies can have multiple resources including grant funding (85.7%), federal government funding (57.1%), private donations (40%), local government funding (31.4%), insurance (17.1%), and other funding (2.9%). Approximately 22.9% agencies were funded by one source, 25.7% were funded by two sources, and 51.4% were funded by three or more sources.

## Phase I Data Analysis

To answer RQ1a, I analyzed the quantitative data collected by computing descriptive statistics, including mean, standard deviation, count and percentage, and correlational analyses.

### *Available Mental Health Services*

The number of mental health providers per resettlement agency ranged from 1 to 22, with an average of approximately 5 providers per agency ($SD$ = 4.63). The availability of specific types of mental health services offered to resettled refugees within resettlement agencies is represented in Table 4.

Table 4

*Aggregate Number of Agencies That Offer Specific Type of Mental Health Service (Numbers & Percentages)*

| Type of therapeutic intervention | N* | % |
|---|---|---|
| Individual Therapy | 29 | 82.90% |
| Group Therapy/Support Groups | 25 | 71.40% |
| Mental Health Screenings | 25 | 71.40% |
| Psychoeducational Workshops | 22 | 62.90% |
| Family Therapy | 20 | 57.10% |
| Women's Groups | 20 | 57.10% |
| Home-Based Services | 18 | 51.40% |
| Couples Therapy | 15 | 42.90% |
| Outreach | 15 | 42.90% |
| Other | 6 | 17.10% |
| Psychological Evaluation | 5 | 14.30% |

*N represents the total number of agencies that integrated each mental health service

Almost all agencies (97%, $n = 34$) indicated they also had a referral network of mental health providers outside of the resettlement agency that they connected their clients to when necessary. The average number of currently available mental health services (e.g., individual therapy, group therapy) per participating agency was 5.71 ($SD = 2.38$).

### *Integration of Cultural Competence Strategies*

To answer RQ1b, I examined the extent to which resettlement agencies integrated specific cultural competence strategies into their agency as a whole and within available mental health services. These strategies (described in-depth in Chapter II, section: Strategies to Improve Access to Mental Health Services) included: 1) improving cultural competence so that providers of mental health services are better able to offer services that are culturally relevant; 2) meeting the linguistic needs of refugee populations; 3) addressing the stigmatization of mental illness that may occur in refugee communities; 4) emphasizing the therapeutic relationship to increase trust between providers and refugees; 5) using culturally appropriate mental health services; 6) developing adaptable services that may be easily altered to apply to multiple refugee populations; 7) providing trainings for providers to increase cultural competence; 8) ensuring the refugee population targeted accepts the services offered as relevant and useful for meeting their psychological needs; and 9) evaluating and 10) disseminating the effectiveness of mental health services offered. The average number of cultural competence strategies integrated within the 35 resettlement agencies included in the study was 7.51 ($SD$ = 1.76). The specific mental health services offered and integrated cultural competence strategies by each agency included in the study can be found in Appendix G. An overview of the integration of cultural competence strategies and the availability of each of the strategies in all agencies included in the study is represented in Table 5.

The agencies that stated they emphasized community connectedness used a variety of sub-strategies to connect with refugee groups in the community, including outreach (91.4%), partnering with schools (85.7%), working/partnering with healthcare providers and systems (80%), working/partnering with religious leaders and communities (74.3%), providing presentations for the community (62.9%), providing workshops (54.3%), participating in

advocacy (54.3%), and other (11.4%) (e.g., partnering with other agencies, connecting refugees to similar refugee communities). Agencies endorsed using an average of 5.14 (*SD* = 1.72) of the eight sub-strategies.

Table 5

*Aggregate Number of Resettlement Agencies That Integrated Each Cultural Competence Strategy (Numbers & Percentages)*

| Cultural Competence Strategy | N* | % |
|---|---|---|
| Emphasizes Community Connectedness | 35 | 100% |
| Meets Linguistic Needs of Refugees | 34 | 97.1% |
| Addresses Stigmatization of Mental Illness in Refugee Communities | 32 | 91.4% |
| Providers Emphasize Therapeutic Relationship with Refugee Clients | 31 | 88.6% |
| Use of Culturally Appropriate Services | 30 | 85.7% |
| Use of Flexible/Adaptable Services | 29 | 82.8% |
| Provides Trainings to Increase Cultural Competence of Providers | 29 | 82.8% |
| Refugees Accepting of Mental Health Services Offered | 25 | 71.4% |
| Evaluates Effectiveness of Services | 13 | 37.1% |
| Disseminates Results of Evaluations | 5 | 14.3% |

*N represents the total number of agencies that integrated the culturally competent strategy

Those resettlement agencies that indicated they provided interpretation services (e.g., an individual to translate verbally) for mental health services stated translators were available:

*Always* (68.6%), *Often* (17.1%), *Sometimes* (11.4%), and *Never* (2.9%). In addition, agencies described how they incorporated interpretation services into mental health services, with 91.4% of agencies providing in-person translators, 71.4% using interpreters by phone, and 5.7% offering video-based translation services (e.g., Skype, Zoom, etc.).

The sub-strategies used by agencies that reported they worked to address the potential stigmatization of mental illness in refugee groups included: working/partnering with healthcare providers and systems (85.7%), outreach (65.7%), providing presentations for the community (62.9%), partnering with schools (60%), providing workshops (60%), working/partnering with religious leaders and communities (51.4%), participating in advocacy (42.9%), and other (17%) (e.g., discussing mental illness one-on-one or during the new arrival/cultural orientation). The mean number of the eight listed sub-strategies used by agencies was 4.46 ($SD$ = 2.10).

In relation to providing trainings to increase the cultural competence of mental health providers, resettlement agencies provided an average of 3.17 ($SD$ = 2.12) trainings to providers within their agencies. Specifically, agencies provided trainings on cultural competence/multicultural counseling (68.6%), refugee mental health (62.9%), domestic violence/interpersonal violence (48.6%), trainings on distinct ethnic/religious/refugee groups (48.6%), education about psychological disorders (42.9%), women's mental health (25.7%), and other (20%). Agencies most often offered trainings yearly (48.6%), followed by monthly trainings (17.1%), then bi-monthly trainings (14.3%).

Finally, approximately 37.1% of agencies surveyed stated they evaluated the effectiveness of the mental health services they offered using patient-completed assessments and formal research methods, while approximately 14.3% reported their agency disseminated (e.g., published) the results of their agency's evaluations of their offered mental health services.

### *Demography and Number of Mental Health Services*

To answer RQ1c, I conducted an independent sample t-test to examine how the availability of mental health services differed based on demography (i.e., suburban versus urban). The six resettlement agencies in suburban areas ($M = 7.50$, $SD = 2.59$) compared to the 29 agencies located in urban areas ($M = 5.35$, $SD = 2.21$) demonstrated significant differences in numbers of mental health services per agency, $t(33) = 4.48$, $p = 0.042$, with suburban groups offering higher numbers of types of mental health services than their urban counterparts for resettled refugees.

## Phase II Results

Phase II focused specifically on the experiences of mental health providers and those who participated in Phase I were also eligible to participate if they indicated they provided direct mental health services (i.e., therapy or counseling) to refugees within a refugee resettlement agency.

### *Phase II Data Analysis*

For phase two of the study, I provided descriptive and correlation analysis related to the cultural competence of mental health providers working within refugee resettlement agencies to answer the following research questions:

(RQ2a) How well prepared are mental health providers (MHPs) to provide culturally competent mental health services to resettled refugees?

(RQ2b) How does training impact level of cultural competence?

### *Preparedness of MHPs*

I computed descriptive statistics (e.g., frequency counts) to analyze the quantitative data to determine how well-prepared mental health providers were to provide culturally competent services based on the cultural competence strategies (RQ2a). The following culturally competent strategies were examined in relation to mental health providers and their preparedness to provide culturally competent mental health services: 1) meeting the linguistic needs of refugees and, 2) providing trainings for providers to increase cultural competence.

All the providers ($n$ = 26) reported they provided interpretation services to translate verbally for mental health services and that their clients had access to an interpreter that spoke their language *Often* (34.6%) and *Always* (65.4%). Providers reported they incorporated interpretation services into counseling/therapy sessions most often using an in-person interpreter (96.2%), followed by phone interpretation (65.4%), and interpretation provided through video technology (e.g., Skype, Zoom, etc.) (3.8%). The linguistic ability of participants demonstrated that 38.5% ($n$ = 10) of providers fluently spoke one language in addition to English that they were able to use to communicate with their refugee clients, 11.5% ($n$ = 4) spoke a second language, while 4% ($n$ = 1) spoke a third language. The languages participants reported fluency in included: Spanish, Turkish, Arabic, Indonesian, Russian, Patois, and Turkmani.

Approximately 65% of providers reported their agencies offered trainings and workshops specifically for the providers at the agency. Of the providers that reported trainings were offered, approximately 24% reported receiving bi-monthly trainings, 38% received monthly trainings, and 38% received yearly trainings. The following types of trainings offered by resettlement agencies were endorsed by providers: refugee mental health (57.7%), cultural competence/multicultural competence (53.8%), trainings of distinct ethnic/religious/refugee groups (46.2%), education about psychological disorders (42.3%), domestic

violence/interpersonal violence (42.3%), women's mental health (19.2%), and Other (11.5%) (i.e., annual refugee mental health conference, assessment for immigration cases, any requested trainings).

### *Impact of Training on Level of Cultural Competence*

To answer RQ2b, I first assessed providers' cultural competency using the Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD). The MCSE-RD is comprised of three subscales, including Multicultural Intervention (MI), Multicultural Assessment (MA), and Multicultural Session Management (MSM). Responses for each question were rated on a scale from 0 = *Not at all Confident*, to 10 = *Extremely Confident,* with higher summed scores indicating greater cultural competence. After computing the total scores for the MCSE-RD, I examined the data for univariate and multivariate outliers by examining skewness, kurtosis, and multicollinearity, and found no outliers. The overall mean score on the MSCE-RD scale was 6.75 (*SD* = .80). I also calculated the mean scores for each subscale. The mean score for providers on MI was 7.11 (*SD* = .31), the mean score for MA was 6.7 (*SD* = .94), and the mean score for MSM was 5.15 (*SD* = .39)

I then conducted correlational analyses to determine relationships between variables including number of cultural competence trainings, level of cultural competence (e.g., MCSE-RD Cultural Competence Score), years of experience working with refugees, number of years at current resettlement agency, and level of education (Table 6). Level of cultural competence was moderately positively correlated with number of cultural competence trainings and level of education. The number of cultural competence trainings was moderately positively correlated with education and years of experience working with refugees.

Table 6

*Summary of Correlations, Means, and Standard Deviations for Cultural Competence and Personal Demographics for Mental Health Providers*

| Variable | NCC | CCS | EXP | AGN | EDU |
|---|---|---|---|---|---|
| Number of Cultural Competence Trainings[a] | - | | | | |
| MCSE-RD Cultural Competence Score[b] | .40* | - | | | |
| Years of Experience Working with Refugees[c] | .49* | .33 | - | | |
| Number of Years at Current Agency[d] | .05 | .12 | .54** | - | |
| Education[e] | .47* | .36 | .47* | .31 | - |
| *M* | 10.35 | 245.51 | 7.27 | 5.00 | 6.27 |
| *SD* | 9.10 | 52.17 | 5.04 | 4.32 | 1.56 |

*Note*. *$p < .05$, **$p < .01$, ***$p < .001$

[a]Number of Cultural Competence Trainings (NCC)

[b]MCSE-RD Cultural Competence Score (CCS)

[c]Years of Experience Working with Refugees (EXP)

[d]Number of Years at Current Agency (AGN)

[e]Education (EDU)

**Phase III Results**

Phase III focused on the qualitative experiences of mental health providers and the mental health services they provide to resettled refugees with their resettlement agencies. My research question for phase three is:

(RQ3) What strategies do mental health providers use to provide culturally competent mental health services?

To answer RQ3, I conducted qualitative interviews with mental health providers, focusing on how they integrated specific cultural competencies within mental health services.

Providers were asked to describe their understanding of the meaning of cultural competence, as well as discuss how they gained and utilized cultural competencies when working with refugee clients. Providers were also asked to give additional details regarding the different mental health services they provided and explain their use of cultural competence strategies in their work to clarify and increase our understanding of the function of the cultural competence strategies used by mental health providers working with resettled refugees.

### *Phase III Data Analysis*

I analyzed the qualitative data using qualitative content analysis (see section: **Data Analysis, Phase III**). I then coded all qualitative data into eight main categories with sub-categories (Table 7).

The categorized data provided a greater understanding of the cultural competence strategies providers used, as well as richer data regarding the available mental health services including benefits of and barriers to implementing each. Further, the qualitative interviews brought forth several unique themes about different facets of providers' experiences working with resettled refugees that was not previously explored in prior phases of the study.

Table 7

*Overview of Qualitative Categories and Sub-Categories*

| Categories & Sub-Categories | Description of Each Category | Number of Providers Endorsing Category | Number of Instances per Category |
|---|---|---|---|
| **Category 1. Description of Mental Health Services for Resettled Refugees** | The available mental health services for refugees in resettlement agencies | 7 | 42 |
| **1.2 Adaptation of Treatment Modality** | Providers modification of treatment modality to meet refugees' needs | | |
| **Category 2. Learning and Integrating Culturally Appropriate Interventions** | Providers' learning and integration of culturally appropriate interventions | 7 | 66 |
| 2.1. A New Definition For "Cultural Competence | Cultural competence definition | 7 | 4 |
| 2.1.1. Provider Willingness to Learn | Willingness of providers to learn about cultural competence | 3 | 5 |
| 2.1.2. Gaining Cultural Knowledge | Methods to gain cultural knowledge | 6 | 10 |
| 2.1.3. Implementing Cultural Skills | Providers' implementation of culturally relevant skills and practices | 7 | 9 |
| 2.2. Methods to Increase Cultural Competence | Methods to gain cultural competencies | 6 | 10 |
| Learning from Refugees | Learning from refugees as a method to learn about culture | 6 | 11 |
| 2.3. Barriers to Obtaining Cultural Competence | Barriers to gaining cultural competency | 4 | 10 |
| **Category 3. Developing Community Relationships** | Developing community relationships | 7 | 88 |
| 3.1 Developing Relationships with Other Agencies and Providers | Types of agency and community-based partnerships | 7 | 34 |
| 3.2. Providing Services for Other Organizations | Services resettlement agencies provide to outside organizations | 5 | 10 |

*(Table continues)*

| | | | |
|---|---|---|---|
| 3.3. Methods to Develop Community Relationships | Methods to develop relationships in the community | 3 | 6 |
| 3.4. Developing Refugee Relationships | Methods for developing relationships with refugee communities | 4 | 8 |
| **Category 4. Stigma** | Addressing stigma with refugee communities | 7 | 12 |
| **Category 5. Evaluation and Research** | Evaluation of provider interventions with refugees | 7 | 38 |
| 5.1. Evaluation of interventions | Assessing the effective of interventions | 6 | 13 |
| 5.2. Engaging in Research Activities | Providers involvement in research activities | 7 | 9 |
| 5.3. Barriers to Engaging in Research. | Barriers to conducting research or publishing data | 7 | 16 |
| **Category 6. Connecting Refugees to Mental Health Services.** | Connecting refugees to mental health services within and outside agency | 7 | 20 |
| 6.1. Acting as an Advocate for Refugees. | Using advocacy to connect refugees to services | 3 | 5 |
| **Category 7. Barriers to Using MH Services** | Barriers refugees encounter when accessing services | 2 | 4 |
| **Category 8. Administration Changes to Refugee Resettlement *Services*** | Overall impact of administration changes on refugee services | 7 | 37 |
| 8.1. Loss of Funding | Financial changes due to administration changes | 4 | 4 |
| 8.2. Change in Numbers Served | Impact of administration changes on arrival numbers | 5 | 8 |
| 8.3. Impact of Sociopolitical Climate | Impact of sociopolitical changes on refugees and providers | 5 | 8 |

In the following sections, each category is described, and related quotes from participating providers from the Phase III qualitative interviews are used to elucidate the category.

***Category 1. Description of Mental Health Services for Resettled Refugees.*** For the code "description of mental health services for resettled refugees," an overview of the available mental health services for resettled refugees is described and an integration of some of the perceived benefits of interventions is included. In addition, provider's use of specific theoretical orientations is reviewed.

The availability of mental health services for resettled refugees within resettlement agencies demonstrated significant overlap in therapeutic services (e.g., individual, couples, family, and group therapies), and less overlap in services focused on psychiatric support and assessment A therapeutic intervention three providers highlighted as crucial to the care they provided was couples therapy. Mariam initially described working with couples as a way to address increasing concerns related to domestic violence in refugee communities. However, the focus of couple's interventions shifted to include psychoeducation regarding healthy relationships:

> "…what we began noticing as well, were…kind of red flags that we recognize we're not fully domestic violence…this particular client came in and once she had completed the questionnaire we were a bit concerned maybe there might be domestic violence…And it turned out with some further assessing…there was no…domestic violence. We brought the husband in and turned out that both of them had been in an arranged marriage. Neither one of them wanted to get married, and neither one of them really knew how to establish intimacy…We really walk them through how to have a healthy conversation, how to not isolate themselves from each other. We've started teaching these things…about what healthy relationships look like…And the same with child discipline cause a lot of folks were getting in trouble with CPS for using physical discipline and not

knowing that it's against the law. The number of faces that were just like, 'Oh, so I can't like, do discipline in this way. That's not a big deal. Just give me another option.'…That once we realized that that prevention piece is there, that psychoeducation was there, those numbers definitely reduced."

Within the group model, all providers included in the qualitative interviews provided "new arrival" groups and/or psychoeducation groups. Eve offered an overview of their typical new arrival groups and how they helped resettled refugees:

> "Once a quarter people come together in a group…the ones we've had previously are much smaller and it gives them the opportunity to be more comfortable and have conversations…about cultural adjustment and the culture shock. We talk about, you know, the differences that they see and what they think they're going to have the most trouble with here in America and what they think, what their dreams and aspirations are, and what their goals are."

Lisa explained her beliefs regarding the benefits of group interventions for resettled refugees, describing how community healing can occur within the group model:

> "In all the research that I've seen around immigrant and mental health services, there's a focus on community healing. And so I don't believe that you can do this work without a community focus. And I don't believe that you can do this work without bringing people together and sharing and I really believe that there's so much that can be accomplished in a group setting."

All providers in the qualitive phase reported conducting mental health screenings. However, only one provider in phase III reported her agency offered in-depth psychological assessment. Eve was the sole provider that reported that her agency offered "limited" testing for

children, including assessments for Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorders. Largely, providers reported using brief mental health screening measures assessing current psychological symptoms (e.g., Refugee Health Screen, RHS-15) that providers typically used to connect refugees to appropriate services. Eve elaborated about how the screening measures she used with her clients provided multiple benefits, including encouraging some refugees to speak more openly about their psychological health:

> "…RHS-15 assessment, the Refugee Health Screener…it kind of starts a conversation about mental health because it asks questions about your physical pain as well as your emotional pain and it asks a few questions about trauma. And most clients are willing to do that because they have a physical pain or a somatic symptom of their trauma or other mental health…And so they'll come in and do the assessment and it opens that door for them to be a little bit more willing to talk about their emotional and mental health."

Mental health screenings have also been used to help identify issues related to domestic violence and abuse. Mariam outlined her screening process for assessing for risk and abuse:

> "…we created a questionnaire in intake that assesses for red flags in a culturally responsive way…not just asking about the potentiality of spousal abuse, but of other family member abuse. Since we know, statistically, depending on the country of origin, but in the region we're looking at, roughly 40% of domestic violence actually occurs by another household number, not the spouse."

Largely, providers did not identify mental health interventions that were unique to what the other providers shared. However, one provider did endorse using a unique method of intervention not discussed by other providers, nor mentioned in prior phases. Kate stated her agency provided peer counseling by laypersons, "We provide what we're calling community

listener training…people that are basically bilingual who ended up being cultural brokers for their community. We teach them how to be good listeners and how to deal with difficult issues like suicide and domestic violence."

***1.2. Adaptation of Treatment Modality***. Providers often modified their treatment modalities to better suit the mental health needs of their refugee clients, as well as adapted their interventions to be more culturally relevant. These modalities included Acceptance and Commitment Therapy (ACT), trauma-focused therapies, Cognitive Behavioral Therapy (CBT), and mindfulness. The treatment modality mentioned most frequently in the interviews (by four providers) was narrative therapy based on refugees being more accepting of this particular intervention. Eve described the treatment modality she typically uses, with her therapeutic experiences informing her choice of treatment:

> "I've really learned that with this population narrative therapy really works well…cause a lot of these cultures are very story-based. Like how they look at life or how they explain things, their analogies, how they teach their children. All those these things are very story based and very folklore based. I kind of try and bring that narrative context in here cause it's easy for them to be able to understand and to like externalize things. So if they're, especially when they're traumatized, it gives them the ability to like, kind of play that out in a story that they can understand."

Six providers indicated they adapted their therapeutic modality to provide more culturally relevant care. Mariam emphasized that she modified her treatment modality to be more culturally relevant to increase engagement in mental health services:

> "CBT [Cognitive Behavioral Therapy] is a great intervention technique for a certain population, not one of the best ones for the clients that we serve, right? So, it's more

> narrative exposure therapy or ACT or, um, you know, deep breathing meditation things - we're watching our words with those as well. We don't talk about meditation as meditation cause that has a negative connotation culturally with our clients. So, we talk about practicing breathing or on deep concentration and really just watching the wording we're using and the practices that we're doing to make sure that they're culturally/religious responsive."

Providers gave a thorough overview of the types of mental health services available to refugees, describing both the benefits and issues with certain forms of intervention. Individual, group, family, and couples' therapy were frequently offered, while formal psychological assessment was offered minimally across sites. Providers did not endorse any particular treatment modality as a "gold standard," however more than half of providers perceived narrative therapies as particularly effective when working with refugee populations.

**Category 2. Learning and Integrating Culturally Appropriate Interventions.** The category "learning and integrating culturally appropriate interventions" is comprised of a number of facets related to cultural competency, including provider's descriptions of the concept of "cultural competency," the barriers to increasing cultural competency, provider's rejection of the phrase "cultural competency," instead favoring the concept of "cultural humility, provider's methods for gaining cultural competence (e.g., culturally relevant knowledge and skills), and barriers to gaining cultural competence. All providers in Phase III discussed learning about and using culturally appropriate methods of intervention.

***2.1. A New Definition For "Cultural Competence."*** Cultural competency is often described as a key component in ensuring individuals receive services that are culturally relevant and appropriate. However, six of the seven providers interviewed for this study rejected the

commonly used phrase “cultural competence” when discussing how they learn and integrate strategies to improve the cultural relevance of the mental health services they provide Mariam expressed her feelings about the concept of “cultural competence” when asked to describe her definition of the phrase: “…we don't use ‘cultural competence,’ and the reasoning for this is that we're of the understanding…that no one can ever be fully competent in a culture. Cultures are ever changing.” Instead, providers frequently used phrases like “cultural humility” and “cultural responsiveness” when describing the methods they used to improve their understanding of culture and providing care that aligned with the cultural background of the refugees they worked with. Lucy provided an alternative to “cultural competence”:

> “I would probably call it more like cultural humility. Going in knowing that I'm not an expert in this person's culture and viewing them as the expert and being willing to learn from them. Then learning from them what's important to them and their culture, and kind of adjust the way that I provide services based on what seems to work best in their culture.”

All providers contributed to describing the multiple facets of being a culturally “humble” clinician, including provider willingness to learn about refugee cultures, gaining knowledge to better understand refugee cultures, integrating culturally relevant skills and practices into therapeutic interventions, and learning about culture directly from refugee clients.

***2.1.1. Provider Willingness to Learn.*** In relation to willingness to learn about refugee cultures, Lisa emphasized both the importance of a mindset of curiosity and a willingness to go beyond one’s training experiences to learn about refugee cultures:

> “I’ve been asked, ‘How do you recommend training for new people who are coming into this?’ I'm not able, as one person, to push that on people who don't want that themselves.

So that means curiosity. I must have curiosity. I must have people who are willing to spend time exposed to cultures outside their own, in their private personal life. I feel that meeting somebody in your office shouldn't be the first time that you've interacted with that group of people."

The responses from three providers emphasized the importance of individual characteristics (e.g., curiosity) in wanting to learn more about refugee communities.

***2.1.2. Gaining Cultural Knowledge.*** In addition to willingness to learn about refugee cultures, almost all providers discussed the value of gaining knowledge about refugee cultures to better inform the services they provided to their clients. This was true particularly in relation to understanding the sociopolitical context and its impact on refugees. Lisa shared how learning about the global context impacts her understanding of refugee's experiences: "What are the immigration implications of the client situation? …what is the global context of this person's situation and how does that impact their wellness and their mental health right now?" Kate added a similar sentiment, "I think before a doctor or anybody provides services…in the health and mental health arena, they really have to understand a basic background of what has happened to the client from a global perspective." Mariam expressed how increasing one's understanding of refugee's experiences can also be enhanced by belonging to a similar culture: "I think it helps that I'm from a very similar culture. I am from one of the Desi cultures, right? That Southeast Asian culture. I also married into one of the neighboring cultures as well. I think that helps on a personal level."

***2.1.3. Implementing Cultural Skills.*** All providers also identified a number of culturally relevant skills and practices that they integrate into their therapeutic interventions with refugee clients. In relation to provider adeptness at implementing culturally relevant skills, providers in

Phase II reported a mean Multicultural Intervention score of 7.11 out of 10 (*SD* = .31) on the MCSE-RD. The cultural skills provider's highlighted were varied across providers and demonstrated the multiple areas one can exercise cultural competencies. Kate provided an example of how to ask about culturally relevant or culture-bound issues during the first meeting: "Even things like cupping, or sweat lodges, or herbal teas, or things that they might be using. Just at least ask if those things are part of the client's healing." Lisa shared that she has adapted client evaluations of services to meet the needs of illiterate or non-English speaking clients: "…modify the language that they use to be simple and powerful and not at a child level." Desiree emphasized the importance of providing services in the language of refugee clients, stating "we work with another …(redacted) Language Network so we can offer all psychological services in 70 different languages." She also discussed another culturally relevant skill, which included incorporating religion or religious practices into therapy: "If I have a client that is Christian and wants to pray, I'll pray with them." Allie regularly encouraged feedback from her clients if the therapist has made a cultural faux pas: "I usually inform clients, like if I say something offensive or if I'm asking questions that you don't feel like are appropriate, please let me know"." While six providers reported they offered formal family therapy, Lucy described including family in therapy sessions informally when appropriate: "it's very common for other family members to be prevalent in my therapy sessions." Additional skills providers shared using included somatic-based therapy interventions and increasing group-based interventions to increase refugee's connection to those from similar cultures.

***2.2. Methods to Increase Cultural Competence.*** There were a variety of methods providers utilized to improve their understanding of and working with different refugee cultures. These methods included attending workshops, trainings, school-based courses, webinars, and

conferences, reading books, watching movies, reading the news, providing trainings about different cultures to agency staff, inviting leaders from refugee communities to present on culture to staff, attending community celebrations, and developing relationships with other agencies that serve refugees. Six providers described learning about culture and culturally appropriate forms of intervention from their refugee clients:

> "…I just ask questions like if I'm confused or I have a question about something… 'Hey, I don't have the cultural awareness or understanding here, can you show me, or can you teach me? And am I thinking this right? Am I hearing this right? What does that mean?'…We do…have quite a few interpreters and community members that very frequently come in and actually do trainings for us and kind of talk about their culture and talk about the differences and kind of teach us about like the history of their country and how things might've been then and what they look like now."

While there are a number of methods to gain cultural knowledge and skills, there are also multiple barriers providers face in their attempts to obtain training in evidence-based culturally informed interventions to use with resettled refugee clients living in the U.S. Lucy shared her experience:

> "I'm trying to grow as a therapist and learning skills can be very hard because…there's not really people that have experience in this work to go learn from and then, you go to professional development and things and most of the times in those trainings, it's not people that have worked with refugee populations…So, a lot of times it seems like the skills that we learn or the techniques we have, we're always having to try to figure out like, okay, how does this work for the people I'm working with?…is this actually like evidence-based for the group population I'm working with?…The literature...I found on

> refugees is when they're in the refugee camp setting and not like providing mental health services after having resettled in another country or in the U.S… I've tried to like, find ways to connect with other people and the biggest thing I've found is yeah, like it seems like the way I'm feeling is how people are feeling in other places. Like, no one's really sure like what's out there or what's being done and what resources people are using."

Providers demonstrated they work diligently to obtain training in cultural competencies to better work with refugee populations. Overall, providers did not foster the concept of "cultural competence," looking to alternative models such as cultural responsiveness and cultural humility, emphasizing the knowledge and expertise over the clinicians to guide clinical decision making. The methods providers used to gain skills and knowledge were similar among providers, however, providers did note barriers to increasing their knowledge in how to better provide more relevant and evidence-based interventions for refugee populations, including a lack of literature highlighting best practices for working with resettled refugees living in the U.S.

***Category 3. Developing Community Relationships.*** The importance of developing community relationships was consistently present throughout each interview. The areas providers focused their energy in when developing community relationships included developing relationships with other agencies that worked with refugee populations. In addition, providers discussed the services they provide for other agencies and providers, (e.g., trainings, workshops), as well as the methods they use to develop these relationships. Finally, providers highlighted their methods for developing trusting relationships with refugee communities.

***3.1 Developing Relationships with Other Agencies and Providers.*** All providers reported developing relationships with a large catchment of community services, agencies, and providers, including medical providers, law enforcement, schools, Child Protective Services (CPS),

domestic violence prevention services, religious leaders, schools, suicide prevention services, and more for the purposes of improving knowledge about refugee mental health across organizations and improving interconnectedness amongst refugee-serving organizations. In Phase III, providers reported they developed relationships with the following: partnering with healthcare providers and systems (100%, N = 7), religious leaders and communities (71.4%, N = 5), and schools (28.6%, *N* = 2).

Eve described a mutually beneficial partnership their agency developed with a local domestic violence shelter:

> "We just created a really, really great partnership with…a center and they specifically work with survivors of domestic violence…And so they have a very, very robust program, but they are very limited in their resources for refugee and immigrant populations. So, we have partnered with them on providing services to the clients that are more culturally appropriate and being able to kind of connect with the larger community within refugee and immigrants to decrease domestic violence within those communities because it's so high and kind of building trust and building those relationships."

Five providers reported community partnership involving working with local religious leaders, collaborating with religious leaders to identify the needs of their followers. Lucy explained her process for fostering these relationships: "we try to develop relationships with them and ask what they see that their community is needing."

Providers also reported collaborating with local medical providers to enhance continuity of care, with Allie stating:

> "I work a lot with primary care providers…a lot of them have behavioral health embedded inside, so we talk about ways to do more holistic care or collaborate on

referrals…if they have a concern that pops up after a medical visit…or sometimes if I have a concern that someone denied services, they can be aware that…something may pop up in the future."

Lisa described taking initiative to improve suicide prevention efforts in her state through connecting a large network of community providers:

"…one of my staff came to me and said, 'I'm really worried about suicide in our communities,' and I know, I feel this myself…and I don't know how I would connect them to resources if they would need them…To me, it seems like we could make some goals around this and we could bring together a number of community members who want to be a part of the solution…we could fairly easily have more marketing so people know where their suicide response resources are…and we could improve interpretation on the crisis line.' And then through conversations and bringing other community members into the conversation…we started talking about training and…we quickly had filled our twentyish spots…I looked around the room when we were training …and we had community members who were direct service workers and like almost every person was from a different organization, almost every person spoke a different language than the other people in the room. So, we had probably like 25 languages represented in the room and we had the person training was the director of the 24-hour crisis line. So, she was getting trained from the community members about what their perspective was and how this is different in their communities, so it was bi-directional learning."

Kate discussed the cruciality of creating relationships with other agencies to help meet the needs of the clients:

> "I'm thinking of Maslow's hierarchy of need…we really cannot do therapy when somebody is wondering how they're going to pay their rent or where they're going to get their next meal. And so we use our partnering agencies to help resolve some of those super basic needs that the refugee might have, which causes a barrier to mental health enrollments."

With the development of community partnerships, not only are refugee's overall needs better met, the ease with connecting refugees to other necessary services is improved. Mariam elaborated, saying:

> "We get a lot of referrals from one community health center…they'll have a client come in who is an immigrant or refugee and speak some English, but you know, would prefer Farsi. And so they ring us up and they're like, 'Hey, I have this client who speaks Farsi. Can we do a warm hand off?' And we'll do a call with all three of us with the client, with our interpreter, and then it's just a much smoother transition."

Providers cited multiple reasons for developing these relationships including enhancing continuity of care, working in coalitions to discuss intervention and prevention efforts, improving the ability to meet the needs of refugee clients, and improving the ease of access to care.

***3.2. Providing Services for Other Organizations.*** Five providers reported that in addition to developing and fostering community partnerships, they also provided trainings and other forms of education to outside agencies to enhance outside services for refugees. Mariam shared her efforts to increase cultural knowledge for CPS providers through a training they offered:

> "…making sure that CPS does their work as well to understand things. You know, part of our training talks about the fact that a lot of clients in this demographic, the mom and

dads will not sleep in the same room, or same bed, and that this is normative, right. This is not an indicator of marital distress, which has been categorized by a lot of CPS workers."

Five providers also stated they offered both trainings (71.4%, N = 5) and presentations (71.4%, N = 5) to community partners on a wide variety of topics including domestic violence, abuse, human trafficking, suicide prevention, trauma, and cultural competencies. Desiree shared her agency's offerings:

"And one of the cultural competency presentations is one that we do for other agencies…they got to go through that and increase their own, you know, awareness of what they think that the definition of culture means, and you know, compare their own belief system to other cultures, belief systems, and it's a whole hour-long lecture."

***3.3. Methods to Develop Community Relationships.*** There were a number of methods providers utilized to develop partnerships with other agencies and providers. Two providers reported developing a coalition or consortium to connect with other refugee resettlement agencies or refugee providers. Desiree described the coalition here agency is apart of:

"We're part of a refugee coalition. There are five different agencies in the area that we do refugee resettlement, and we all work together. And even though our services, uh, sometimes overlap, there are certain services like the psychiatric and the counseling that other agencies don't offer, or they don't have the language capability…we make sure that, you know, all the refugees are provided services. We have pretty regular consortium meetings, and when there are changes to the rules or the laws."

Four providers described marketing their services to other agencies, letting them know about the services they offer through the use of flyers, brochures, searching online for agencies

that may benefit from a reciprocal relationship, and cold calling other agencies to indicate an interest in developing a relationship, and providing presentations to other programs. Mariam shared how she develops relationships with other community partners:

> "For the school districts, we've done presentations there, we have some relationships already with…libraries, and community centers. For the refugee agencies, there's the refugee quarterly forum that we tend to present at…For CPS and law enforcement, we've already had some relationships with them…from our history of clients having involvement there…we have done trainings, we've done presentations, we kind of work hand in hand to help each other to understand what the other one does and why we have to work together.

***3.4. Developing Refugee Relationships.*** When developing relationships with refugee groups, four providers highlighted the variety of methods to engage with and develop trusting relationships with refugee communities.. Eve described how she engaged with refugee communities outside of the office:

> "We celebrate on World Refugee Day and we have big events like that where we have communities come together. But then more specifically within our clients, we just kind of go out into the community and kind of make our face known. Like we just go and try and build the relationships within the clients that we have. And through those clients, they kind of welcome us into their home and welcome us into their community."

One provider emphasized hiring therapists that speak the same language as the clients they serve to enhance connections with their refugee clients, while another provider reported partnering with other community agencies for the purpose of fostering greater community connectedness between overlapping clients. Two providers shared that the "new arrival" and

psychoeducation groups that also discuss available mental health services in the agency provided refugees with both information and a familiar face that can foster the development of a relationship that may lead to refugees accessing mental health services later. Eve described this concept: "Hey, if I do have issues…I can come back to this person because she taught me about it…and she understands maybe cause we had this group and this conversation." Lucy also reported that the development of new relationships with refugees are created through the relationships they've already established with refugee communities: "…a lot of our referrals actually come from like, other people within the community letting us know that someone, you know, is struggling or something."

In the code "developing community relationships," providers focused on how they developed and improved their relationships with a number of community members and stakeholders, including other health and mental health providers, community agencies, law enforcement agencies and social services, and refugee communities. Community relationships appeared to be a vital aspect in ensuring refugees are connected to both resettlement agency services, as well as a host of other services that are crucial in meeting the needs of refugees.

**Category 4. Addressing Stigma with Refugee Groups.** All providers reported they addressed stigma surrounding mental health issues and mental health treatment with refugee groups in a variety of ways. Some of these methods providers highlighted included using psychoeducation and support groups as forums to destigmatize mental health for refugee groups. Other methods included normalizing responses to traumatic experiences and providing hope that mental health issues are treatable. Eve described reducing stigma through training and working with community and religious leaders:

> "We kind of connect with those community leaders because they truly are able to get the clients like more comfortable with coming to our office to receive the services…because those are the people that the clients go to first because they are the community elders…They're the ones that are supposed to help, they're your religious, um, your religious leaders."

A common technique four providers employed when discussing potentially stigmatizing topics was to carefully choose words to describe mental health issues and treatment. Kate stated, "we move really far away from that (using language to describe mental health issues)," while Mariam described seeing similar distancing from potentially stigmatized language when assessing clients: "So our questions don't just ask right out about ACEs (Adverse Childhood Experiences) or anything like that. They ask kind of in a roundabout way." Kate discussed using more indirect language as a method to gently encourage refugees to enter treatment through developing rapport, so refugees might more readily engage in treatment once trust is established:

> "Well, we are really acutely aware of the stigma…When they ask us what we do, we say, 'we work with things like sadness or fear or worry, are you having sadness, fear or worry?' And they you know, of course they say yes. And we'll say, 'we'll come on in, we'll talk about the sadness and help you learn how to relax so you're not so sad…And once we get in the office and things get rocking and rolling, we've got enough rapport and trust with them, and so then they do fine."

A provider described their reasoning as to why they use and don't use certain wording when engaging refugees in mental health services:

> "So with working with the community, with clients, you know, watching the wording we use…Try not to focus on diagnoses…And when someone doesn't actually have a

diagnosis we don't arbitrarily assign them one…I think the fact also that we don't just sit and talk about feelings. That's helped a lot of folks to not feel stigmatized…talking about feeling leads to clients thinking that there's something emotionally wrong with them…or that they're crazy…And so we tend to start with those clients that are concerned with stigma by working with holistic life changes first, and giving them time to kind of get comfortable, adjust their life, get everything else stabilized…Then we start slowly edging into some of the more emotional or trauma base."

Addressing stigma related to mental health issues and treatment is an important piece in treating mental health, as evidenced by the level of care and intention providers used when working with refugees reluctant to engage in services due to concerns related to stigma. From developing relationships with religious communities to changing how providers speak about mental illness with refugees altogether, providers worked diligently to establish trust and safety and normalized refugee's responses to stress and traumatic experiences. These methods for reducing stigma proved to be effective, as refugees appeared more willing to engage in services upon providers implementing them.

***Category 5. Evaluation and Research.*** In this category, five providers indicated they evaluated the effectiveness of their services in some form, while no providers reported they disseminated formal research regarding the mental health interventions they offered at their site.. These evaluation methods providers used are discussed, and barriers that inhibit engaging in research activities are also described.

***5.1. Evaluation of interventions.*** Five providers indicated their agencies tracked the effectiveness of their interventions over time to assess how well their clients responded to treatment. Allie outlined their method of evaluating clients as follows:

> "I asked if they'd benefited from services…I'll ask if they've benefited from our meetings together or the things that we talked about. If they say, yes, I'll ask how so?…we also review the goals that we had originally set when we started meeting, and I asked if they felt that those goals had been completed. I ask if they think they will use the things we talked about…And then if you need additional help, would you look for another counselor or would you contact me?"

The methods of evaluation providers described using for their evaluations included PTSD scales, Refugee Health Screener (RHS-15), General Anxiety Disorder Assessment (GAD-7), Hopkins Symptom Checklist-25 (HSCL), Session Rating Scale (SRS), Outcome Rating Scale (ORS), and qualitative questions assessing client progress and clinician effectiveness, which varied by agency.

Providers in this study largely indicated they evaluated their services mainly for insurance reasons and/or for the purposes of meeting grant or other funding requirements. Desiree explained, "…per the agency, because we all have different grants and different grant reporting requirements, we do internal evaluations on our clients as needed for whichever grant we happen to be adjudicating." With an emphasis on assessing client outcomes for the purposes of meeting funding requirements, some providers mentioned that they did not feel their evaluations were sufficient. Lucy shared: "I don't think there's a great system of looking at what is actually being done. Like the numbers that are looked at in like grants and reports and things I don't think necessarily show if the client is actually, um, having a ton of improvement." Allie added, "We are, um, maybe behind in evaluative options or research. I think a lot of small, nonprofits probably fall in that field."

***5.2. Engaging in Research Activities.*** When asked if providers engaged in or published research related to outcome data, all providers largely denied engaging in formal research endeavors, emphasizing their need to provide funding agencies with data and providing mainly demographic information. Mariam provided an overview of the data her agency collects from their refugee clients:

> "We don't publish any papers directly. Again, the only thing that we tend to publish at our agency, and that's usually our growth numbers per year…how many cases of domestic violence, sexual assault, child discipline/child abuse cases, emotional abuse, et cetera…We also parcel it out in terms of demographics and total numbers served, and then also in the types of services that were offered. So, referrals versus resources versus crisis intervention, safety planning, et cetera."

However, four providers did report wanting to conduct research, citing working with nearby universities, graduate students, interns, and medical facilities as potential sources for collaboration for research. Allie reported how her current coursework has inspired her interest in conducting research:

> "I'm actually doing right now a global mental health class and they have very much encouraged working more with universities on trying to show outcomes and evaluative steps for programs. So, I intend this year to start conversations with maybe a couple of partners to see in the future, if there could be work that could be done on this."

***5.3. Barriers to Engaging in Research***. The main barriers to engaging in research for many providers was lack of time, funding, uncertainty about how to conduct research, and concerns related to community backlash. Eve discussed her concerns related to being overburdened with client concerns as contributing to a lack of time to conduct research, saying,

“I think the only thing that really gets in the way of it is that I'm the only person on staff who knows how to do that stuff…I'm the only therapist on staff period…I stay pretty busy, so it's hard to kind of get that information together when I'm focused on clients.” Desiree offered her view about how lack of funding opportunities inhibits research: “It's so much easier to get funding through a university than it is, you know, straight to a nonprofit. They're like, who are you and what do you do with publishing? When there's university behind it, then it's like, ‘Oh, okay, got it.’” Lucy described her uncertainty about how to go about the research process: “We don't really know…is this being done other places? How are they doing it? We're kind of like siloed off in our little area…we don't know what to do with that or how to go about it or how to connect with other people doing the work.” Finally, concerns about negative community perceptions or backlash was a concern that has prevented Mariam and her agency from publishing research:

> “Everything is very politicized in the refugee resettlement world…So, we tend not to publish things that can have a skewed result or perception. And I think that's the biggest barrier that we see within the agency…we just have to be very careful with how we handle things. Um, because we've been under attack in the past already…for decisions that were made that had political ramifications in the local community.”

While all providers in this study provided some form of evaluation for their interventions, no providers indicated they engaged in formal research or disseminated that research. Multiple issues interfered with research efforts, most often a lack of time, funding, and knowledge on how to conduct research, and even fear of backlash regarding research results. Providers suggested strategies to increase research efforts, including partnering with local universities and other expert to assist in overcoming barriers to in research engagement.

***Category 6. Connecting Refugees to Mental Health Services.*** All providers discussed the ways in which they connected their clients to both mental health services and other psychosocial services within and outside of their agencies. One method identified by two providers was identifying the need for services through an initial screening at intake. Sometimes these intakes take place in a separate department within the agency, or they occur within another agency or program entirely, and sometimes they take place within the mental health faction of the resettlement agency. Kate described the process of being connected with a resettled refugee for mental health services upon receiving a referral from their refugee health clinic: "Our refugee health clinic gives us the client and then sends them to us when they score high and we…bounce our intake call off of, you know, 'I see here from the refugee health clinic that you feel you're crying a lot. So, come on in. We'll help you with that'."

Three providers stated it was common for resettled refugees to be connected to mental health services through other departments in their agency, where observant staff members identified a need for services and referred them to mental health providers within the agency:

> "Their teacher or career navigator, sometimes [they're] talking with people and all of a sudden they [refugees] start crying about some recent stress that happened in their life and then they can talk about mental health and guide them over to an appointment with a therapist. Their English teacher can notice that something is going on in their attendance and recommend that they need to talk with somebody about wellness or some specific event in their life."

It appeared common that the relationship resettled refugees developed through their participation in other services provided by the agency assisted in increasing refugee's level of trust and willingness to obtain mental health services within the agency. Mariam discussed the

process of accepting referrals for the mental health services they provided stating, “Our work has been really easy because we have so many other programs already that work with the refugee populations that they feel safe when it's just a new staff but the same organization.” Mariam, like all providers in this study, emphasized the importance of developing relationships with communities familiar to refugees, such as places of worship, immigration lawyers, school staff, and other community groups to assist in connecting refugees to mental health services:

> “…we have another staff [member] who works in mosques, who does announcements. And it's easy for him to just be like, ‘Hey, by the way, if there's anyone you need to talk to, here's this referral sheet here. If anyone wants to sign up,’ you know, I think that makes our job much easier, cause that trust is already there.”

In addition, Lisa recommended including the person who referred the individual for services is included in the refugee’s treatment moving forward “…making sure that when we have referrals that I find a way to include the person who referred them. And that could be ongoing communication with their doctor or their caseworker or their community organization that identified the need.”

***6.1. Acting as an Advocate for Refugees.*** In addition to connecting refugees to mental health services within the agency, three providers reported they often accompanied refugees to other health services outside of the agency, such as medical visits and psychiatry appointments, to ensure continuity of care. In phase I, agencies reported they participated in similar advocacy efforts 54.3% (N = 19) of the time. Lucy described her role in this process: “A lot of times I am going to those appointments with them to help provide information to the psychiatrists and kind of be like a bridge between them.” Kate detailed the work they do with their clients to help their clients navigate new and/or challenging systems:

> "A lot of times the refugees aren't really sure why they're going to the doctor to talk. And so, we go with them into the doctor appointment…and then the doctor will prescribe whatever necessary medicine. We help the client go to the pharmacy, pick up the medicine, and then every week they come into our office and we help fill their pill trays and help see if they have any side effects and that sort of thing…So we just kind of prompt them for all the things that are really important for them to talk about and help them learn how to manage the emotions that might come up with an intake."

Further, three providers stated they acted as advocates for their clients when connecting refugees to services outside of the agency:

> "So that's the other difference of refugee immigrant mental health. It's a blend of therapy and case work because you're trying to navigate and help people advocate for themselves and you know, work with these resources and help them reduce some of the behaviors and limitations that they have just because of the needs of living in poverty and navigating the new legal system and sometimes language barriers."

Refugees were connected to mental health services in resettlement agencies in a variety of ways, including most often through initial assessment by the agency. Other referral methods included community agencies and partners connecting refugees to resettlement agencies for mental health services, as well as staff in other resettlement agency departments noticing issues with refugees and connecting them to care. The latter method was particularly effective, as refugees had already established a sense of safety and connection to the agency through their other support services, which allowed for a smoother warm hand-off for services. In addition, it appeared common that providers acted in multiple roles, including advocacy, to ensure and enhance care.

***Category 7. Barriers to Accessing Mental Health Services.*** In discussing methods to connect refugees to mental health services, providers also identified a number of barriers to accessing mental health services including lack of transportation, lack of childcare, logistic concerns, perceptions that other refugee providers were not able to accurately address refugee's concerns, and limitations of some forms of therapeutic intervention. Lucy described two barriers to care, including lack of transportation or childcare issues: "…most of the people I provide therapy to, um, transportation or childcare is an issue." Lisa cited issues with logistic barriers, including lack of space, time, organization, and understanding by providers in the community:

> "We currently have people in the community who are experts and willing to do presentations and [they] just don't have a big location, don't have the frequency, and don't have the, like, vision or strategy that these are impacting people's mental health and wellness and that there's this ongoing [issue] with access to the community."

The same provider continued describing an additional barrier, specifically that both individual and group models may not sufficiently meet the increasing need of those seeking mental health services:

> "…I think about group services and…other clinicians that I've talked to, [they say] you can bring people out of your individual practice into inviting them into a group…but [group] really limits the topics that you can talk about, and when I think about the level of need within our community and how people aren't finding access to the support that they need around mental health and recovery…we have to have a model that can meet more people than the number of clinicians that we have. I don't see how we can limit it to the number of people who are already in services."

This particular code highlighted some of the difficulties providers experience when providing services to their refugee clients. This data demonstrates some of the potential factors that make it hard not only for refugee clients to obtain services, but it may also help to explain the reasons providers may struggle to meet the needs of their refugee clients.

***Category 8. Administration Changes to Refugee Resettlement Services.*** According to all providers, the changes the Trump administration made to refugee resettlement in the U.S. impacted all providers and agencies in some way, including loss of agency funding and staff, changes in numbers of refugees served, and observed changes in how the sociopolitical climate has affected refugee clients and the surrounding community.

***8.1. Loss of Funding.*** Four providers voiced concerns related to the loss of funds for their agencies. Mariam described a trickle-down effect with a loss of staff related to funding cuts within their agency: "With funding cuts, we've also lost a lot of case workers within the agency…That means less refugees. That means less federal funds for us, which means less people that [we] can assist in serving." Five providers shared similar experiences of serving fewer new arrivals due to administration changes, with Desiree sharing, "…as an agency we used to resettle, oh my gosh, 60 families a month, and now it's down to like two…it's slashed." However, the decrease in new arrivals has not necessarily translated to serving fewer clients. Two providers have seen the scope of their work expand to serving other populations, such as asylum seekers, immigrants, and human trafficking survivors. In addition, three providers reported focusing on providing mental health services to previously resettled refugee clients that may not have utilized services in the past. Kate explained:

> "…we used to focus a lot of time and energy on new arrivals. And now that we don't have them anymore, we are focused on established refugees and immigrants. People that

might have been here 10 years, five years, but we've kind of missed them in providing them care. So, we focus more on who's already in the community rather than who's just arriving."

***8.2. Change in Numbers Served.*** Two providers have also seen a recent rebound in new arrivals, with greater numbers of new arrivals than anticipated. As a result, providers have experienced difficulties with meeting the needs of those arrivals due to staffing shortages as a result of funding cuts following the changes to refugee resettlement enacted by the Trump administration. Allie described how this has looked in her agency:

"Because we have reduced staff, we've actually continued to get clients, a higher level than we anticipated. So, the smaller number of staff is now meeting the demand as if when we were kind of fully operational…we had kind of thought maybe we would get 50 people for the entire fiscal year. Right? And we got 50 people in the first two months."

***8.3. Impact of Sociopolitical Climate.*** In addition to difficulties in meeting the needs of refugee clients due to budget and staffing cuts, five providers observed how refugee communities are increasingly negatively impacted by the shifting sociopolitical climate that has occurred in tandem with the progressively restrictive changes to refugee resettlement. Lisa shared her observations about how her client mental health has suffered as a result:

"My clients are really struggling…it's been hard to find hope…and then that can impact everything else about their life…when people aren't treated well by their neighbors and other people, but they're not able to move their house or their location…and just have to put up with it, it can really affect their mental health. And they don't have the support of anybody to advocate for them or any to anybody to really believe or change their situation or change the way that that person is treating them."

Six providers noticed the shifts in the sociopolitical climate have resulted in an observed increase in the use of mental health services by refugees that are seeking a safe and familiar space to process heightened anxiety, fear, and uncertainty. Eve stated, “The work that I do continues to grow, and partially because of the political situation because there are so many people in fear…They don't have anywhere else to go. They're afraid to go anywhere and the relationships that we've built have actually created a better opportunity for them to get services with us.”

In response to the increasingly xenophobic policies, three providers have also observed an increase in community members volunteering with their agencies, including Mariam:

> “…while it's hit us hard in the actual numbers, those decreases have actually driven up community support for our agencies…because people are recognizing that these immigration laws are unfair…or they're becoming more passionate about the issues…we've gotten a lot more volunteers. We've got a lot more interns, we've gotten a lot more spotlight put on agencies like ours.”

Kate also described some of the positives to patient care that have occurred as a result of changes to resettlement:

> “We used to be very much ‘keep your head above water’ because we had so many referrals coming in. But now we're able to do a higher quality of care, more of a WrapAround care and spend more time with the client…now we can offer psychiatric advocacy…or helping them find a medical doctor and just doing a little bit more medical case management and mental health behavioral case management.”

Providers emphasized their concerns about the impact of policy changes and increasing xenophobia and discrimination and the impact these issues have had on their refugee clients.

Most worrisome to providers was the decrease in funding, loss of staff, and decrease in resettlement numbers. However, providers highlighted the positives from these changes, including improved quality of mental health services as providers have more energy to devote to refugee clients with lower arrival numbers and increases in community engagement and volunteerism.

# CHAPTER 5
# DISCUSSION

In this study, I sought to identify the services that mental health providers that work with refugees within the context of resettlement agencies offered to illuminate *what* services are available for refugees within the U.S. Further, I examined *how* mental health providers integrated aspects of cultural competencies throughout their interventions to highlight the successes and areas of growth in their efforts to better provide culturally responsive care for resettled refugee populations. In this section, I provide an integration of the data across phases, to answer my fourth research question: How do the perspectives of mental health providers inform the data regarding the availability of culturally competent mental health services for resettled refugees? In addition, we provide suggestions based on the results of this study to assist mental health providers in providing mental health care that is increasingly responsive to refugees' needs and cultural preferences.

The benefits of therapeutic intervention for most individuals globally is clear: therapy provides a myriad of benefits including reducing psychological distress, providing a safe place to process difficult content, and develop coping skills to better manage life's challenges. The benefits of and access to psychological intervention for refugees and resettled refugees is equally, if not more essential, as refugees experience rates of psychological turmoil at rates far greater than non-refugees. The number of stressors resettled refugees experience are beyond what many of us can comprehend experiencing in one lifetime: Prior to and during a refugee's journey to a hopefully safer place, refugees are forced to flee their homelands to escape civil war, genocide, and violent conflict, potentially experiencing or witnessing torture, sexual violence, and/or the death of family members and friends. Upon resettlement after this forced journey,

refugees may encounter severe social isolation, loss of social and occupational status, lack of access to necessary health and mental health care, and discrimination by members of the host country. These stressors demonstrate the clear need for psychological assistance; however, research has demonstrated that refugees face multiple barriers to obtaining mental health services, with a lack of culturally relevant care being a significant barrier (Colucci et al., 2015).

Across all phases of this study, the data demonstrated that individual, group, couples, and family therapy, and psychoeducation were frequently offered and were "gold standards" among the resettlement agencies that offered mental health services that participated in the study. Most resettlement agencies and their providers offered these mental health services both within and outside the office (e.g., home-based services, other community spaces). The benefits of therapeutic intervention for resettled refugees described by providers in this study were innumerable. For example, couples therapy not only addressed issues related to domestic violence in refugee families, providers also used couples' therapy as a method to provide psychoeducation about the negative impact of corporal punishment on children (Ferguson, 2013; Mulvaney & Mebert, 2007) and demonstrate to parents alternative forms of parenting and discipline. In turn, this method of therapeutic intervention helped to reduce the number of CPS cases reported in refugee households. Group therapy was also highlighted as a particularly helpful method of intervention. The types of groups offered ranged from "new arrivals" groups that provided psychoeducation to prepare refugees to navigate multiple systems and manage assimilation challenges, to women's and other support groups. These groups were particularly useful for resettled refugees as they provided opportunities to normalize experiences, instilled hope that mental health issues were treatable, and provided a shared space for community connection and healing. Groups also helped to address the potential stigmatization related to

mental illness in refugee communities, as these groups often functioned as forums wherein thoughtful conversations about mental health issues and psychoeducation by providers assisted refugees in being more willing to accept additional mental health treatment, such as individual therapy. When difficult content such as traumatic experiences and other difficult experiences not appropriate for a group setting appeared, individual therapy provided an alternative or complementary venue to discuss these concerns. Based on our results, we suggest resettlement agencies continue to offer a variety of mental health service options, including offering a combination of individual, couples and/or family, group therapy, and psychoeducation. Each intervention can provide unique experiences that may enhance connection and healing, provide refugees with a variety of skills they can utilize to better cope with previous traumatic experiences and other psychological distress, and learn much needed information that may assist refugees in successfully adjusting to the host culture.

Resettlement agencies and providers reported offering other mental health services, including mental health screenings and psychological assessments. Most agencies and providers in this study reported they conducted brief mental health screenings (e.g., Refugee Health Screener RHS-15, Hopkins Symptom Checklist-25), with providers expressing that these brief screenings were crucial to connecting their clients to mental health services. However, across phases, formal psychological assessment was lacking. The reasons for the lack of formal psychological assessment were not clearly identified in this study. It is possible there was not a need, there were minimal qualified providers, or limited time to conduct assessments. It is also possible the lack of assessment reflects provider's knowledge that many assessments are often culturally biased. In our interviews with providers, it was clear providers were highly aware of the importance of providing culturally appropriate care in all aspects of therapeutic intervention

and prevention. Thus, a lack of formal psychological assessment in resettlement agencies may be a reflection of providers' knowledge of the problems inherent in psychological assessment, rather than an issue with the provision of services to refugees: many psychological assessments are culturally biased and may not accurately reflect refugees' abilities and struggles (Kim & Zabelina, 2015; Leung & Barnett, 2008). This finding can serve as a reminder that providers should be knowledgeable in identifying cultural idioms of distress and that they are cautious in using assessments that are not normed with refugee populations.

While theoretical orientations were discussed only briefly throughout the interviews, and not at all in the surveys, providers most frequently emphasized the effectiveness of narrative therapies for their refugee clients. A metanalysis examining the effects of Narrative Exposure Therapy (NET) groups demonstrated that NET was effective in reducing symptoms of PTSD in refugee populations (Gwozdziewycz & Mehl-Madrona, 2013). Compared to the traditional form of trauma exposure therapy, NET is distinct in that it works with clients to construct a narrative of their entire life, with an emphasis on detailing traumatic experiences throughout. By elaborating on the narratives surrounding trauma, the client becomes habituated to the emotional responses elicited by their memories until their anxiety is reduced (Gwozdziewycz & Mehl-Madrona, 2013). In addition, NET works to help clients recapture a sense of self-respect and recognize their human rights (Lely et al., 2019). These aspects of NET may be the precise reason this therapeutic intervention has demonstrated effectiveness with refugee communities. Refugees' human rights and self-respect are often stripped away through no fault of their own and acknowledging these aspects in therapy may remind patients of their value and right to dignity. In addition, the foundation of NET is essentially storytelling, which providers in this study described as a component refugees valued in the therapeutic context as it reflected facets of

their cultural backgrounds. The process of storytelling may be more culturally relevant than other APA suggested interventions for treating PTSD such as Cognitive Processing Therapy or Trauma Focused Cognitive Behavioral Therapy (NET was also included as a suggested intervention by the APA) (APA, 2020).

An interesting finding that may address the need for more providers versed in working with refugee populations - a need mentioned by the providers in this study - was demonstrated by the impact of a peer-to-peer version of NET. Gwozdziewycz & Mehl-Madrona (2013) found that refugees that received NET by refugee "laypersons," or those with minimal to no background in medicine or psychology, trained to deliver NET to their peers demonstrated the greatest effect size in symptom reduction. There are a number of additional studies demonstrating the effectiveness of layperson counseling with traumatized populations in low-resource settings outside of the U.S. (Lewandowski et al., 2016; Patel et el., 2010; Patel et al., 2011) and there is literature suggesting methods for how to adapt these interventions for use within in the U.S. (Winiarski, Rufa, & Karnik, 2019). Within the U.S., there is extensive literature on the effectiveness of peer support persons, commonly referred to as "community health workers," "lay health advisors," "*promotores*," "patient navigators," and "health coaches" (Gibbons & Tyus, 2001). Our study highlighted how few agencies offer mental health services to resettled refugees in the U.S., and further, how few providers there are within each agency that are able to provide those services. The interviews with our providers also brought to light numerous barriers to accessing mental health services, including lack of transportation to the agency to receive care, lack of childcare, lack of appropriate spaces for group-based services, and concerns about the lack of providers to adequately meet the needs of refugee clients. While therapy groups are one method to efficiently increase the number of refugee clients served at a time, there remain

barriers to group services. Due to these barriers, resettlement agencies and refugees alike may benefit from training refugee laypersons to conduct counseling with their refugee peers to overcome some of these obstacles. Further, training refugee laypersons may meet the need for additional mental health service providers. By including refugees in the care process, refugees on the receiving end of peer support may be more willing to engage in services due to an enhanced sense of support through shared understanding of culture, community, and circumstances with their refugee peer (Solomon, 2004). In addition, the inclusion of culturally similar refugee providers of care may allow for more culturally appropriate services (Andrews, Felton, Wewers, & Heath, 2004), as the providers with similar ethnic identities to their refugee peers will be more familiar with the cultural mores and traditions that may be crucial to include in treatment. Shared cultural background may even open the door for access to alternative spaces for counseling closer to the homes of refugee communities being served by resettlement agencies. These shifts in how care is provided may address the need for increased confidential spaces within the community, decrease transportation burdens as services may be closer to home, and even reduce childcare issues if refugee clients are less impacted by time and cost if transportation issues are lessened. Given the evidence for NET as an effective method of intervention, and the commonly used format of group therapy in refugee resettlement agencies, a suggested starting point for agencies and providers interested in layperson counseling may be implementing and assessing the effectiveness of using both trained counselors and laypersons to conduct NET in resettlement agencies, given that there is minimal research examining this particular intervention within the context of refugee resettlement in the U.S. If providers and/or researchers consider utilizing the layperson approach, they should pay careful attention to training and supervising refugee layperson counselors, ensure refugees layperson counselors are not simultaneously traumatized

while doing this work, and employ methods to avoid exploitation or coercion to work as a layperson counselor.

Another method for increasing the cultural relevance of mental health services offered is through modifying interventions using practice-based evidence (PBE) to inform and guide treatment. Research demonstrates that some evidence-based practices (EBP) have inadequate or no inclusion at all of important cultural factors in studies examining their effectiveness, and many studies on EBPs do not examine the impact of cultural variables on outcomes (Isaacs, Huang, Hernandez, & Echo-Hawk, 2005). This is especially true for refugee populations. The providers in this study noticed similar shortcomings in the research on therapeutic interventions for refugees that they have encountered and wondered: how can we provide care that is culturally relevant *and* evidence-based? One method to increase both culturally relevant and evidence-based treatment for refugee populations is to integrate practices that best suit the needs of the population on the receiving end of services. This process describes the core concept of PBE. The following definition defines the many benefits of PBE, particularly for populations underrepresented in psychology:

> The field of Practice Based Evidence (PBE) can be defined as a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally specific framework. Practitioners of practice-based evidence models draw upon cultural knowledge and traditions for treatment and are respectfully responsive to the local

definitions of wellness and dysfunction…" (Miranda, Bernal, Lau, & LaFromboise, 2005)

Based on our data, it appeared common that providers working with resettled refugees selected their interventions based on whether therapies were accepted or rejected by refugee clients, and if certain therapeutic interventions appeared more or less effective based on provider's observations. For example, most providers noticed refugees responded positively to narrative-based therapies, Acceptance and Commitment Therapy, and Mindfulness. In contrast, refugees did not as readily embrace behavioral-based interventions such as CBT. Within the more commonly accepted and utilized treatment modalities, providers also reported implementing different aspects of refugee cultures into therapy (e.g., praying, engaging in culturally relevant rituals or traditions), and modifying their interventions to better meet the needs of refugee clients. One example that appeared repeatedly in the data was choosing language carefully when discussing certain skills or interventions to match both refugee's understanding of illness and distress and to ensure that the practices used were culturally responsive. It is crucial to document and analyze the effectiveness of these changes to EBPs, as well as the novel methods providers have developed to enhance the cultural relevance of therapeutic interventions and better engage refugees in mental health services. Developing formal methods for evaluating PBE would benefit both providers in search of evidence-based practices for their refugee clients, and more importantly, benefit the refugees in need of effective mental health services that embrace their cultural background.

While agencies and providers largely denied engaging in formal research endeavors to evaluate the effectiveness of the mental health interventions utilized, providers and agencies frequently reported collecting data regarding the effectiveness of their services with their refugee

clients. Generally, this data did not make its way outside of the agency due to the purposes of the data collection, as it was collected for insurance carriers, or to meet grant or other funding requirements. While some providers reported concerns that this evaluative data did not sufficiently or accurately capture all facets of their client's experiences, there appeared to be standardized systems in many agencies for evaluating their therapeutic efforts. Through their evaluations, providers have collected invaluable data that may help to develop an evidence-base of PBE interventions for resettled refugees. Given the lack of time and infrastructure to engage in formal research activities (e.g., research training, staff, funding), it may be inappropriate and unreasonable to expect resettlement agencies and their providers to independently initiate research endeavors to evaluate the PBE data. Looking at our data cumulatively, it appears most providers and agencies were stretched thin and activities outside of providers day-to-day tasks; engaging in and disseminating research were not prioritized due to more pressing client-related matters. Our providers proposed potential solutions to this issue, including developing relationships with local colleges, universities, other experts or organizations, or hiring interns or graduate students that might have an interest in collaborating on research endeavors. While developing the relationships with these programs may in itself be a time barrier, during both my formal and informal conversations throughout this study, I learned of a number of qualified individuals and organizations that are greatly interested in working with resettlement agencies for research purposes. How resettlement agencies decide with whom and how they will develop research partnerships is up to them, but the opportunities for research collaborations are plentiful. Developing research partnerships between agencies and qualified researchers will not only help to reduce some of the burden on resettlement agencies to conduct and disseminate research, these relationships will assist individual agencies in better understanding the impact of their essential

services in the refugee populations they work with. Future research on the process of developing these research partnerships may help to identify methods to streamline the process of creating these research collaborations.

In addition to engaging research experts outside of the resettlement agency to increase research efforts, agencies should also consider how to involve refugee clients in the research process. Collaborative approaches such as community-based participatory research (CBPR) may deconstruct the inherent power differentials between providers and refugee clients and bridge the gap between academia and those receiving services informed by academia (Betancourt et al., 2015). This approach ensures community members participate in all stages of the research process and privileges community member's knowledge. Most importantly, study results are disseminated directly into the community, making sure those in need of knowledge and assistance are the first to receive it. A CBPR approach may greatly benefit resettled refugees, given the need for more effective culturally relevant evidence-based practices for resettled refugees in the U.S.

The relationships resettlement agencies and their providers built both within and outside of the agency were fundamental to improving access to necessary and culturally relevant services for resettled refugees. These partnerships were developed with places of worship and/or religious leaders, school staff, medical providers, law enforcement, Child Protective Services (CPS), and domestic violence and suicide prevention services, among many other refugee-serving organizations. In this study, agencies and providers demonstrated the community relationships they established contributed to an invaluable network of providers that worked together to ensure continuity of care through warm hand-offs, smoothed transitions between providers, and connected refugees to necessary services they might not otherwise know existed or know how to

navigate. Partnering with other organizations also demonstrated a number of reciprocal benefits. According to our providers, working with the local police and CPS assisted in reducing the number of CPS reports and domestic violence calls. Providers taught refugees new skills to decrease negative disciplinary behaviors, while trainings offered by resettlement agencies to enforcement agencies assisted these agencies in responding in more culturally sensitive ways. Providers noted other mutual benefits in their community partnerships. Where one agency is lacking in providing culturally competent therapy for refugee clients, resettlement providers can step in to supplement this care. This allows for refugees to obtain necessary services from one agency (e.g., shelter from domestic violence), while ensuring they're also receiving psychological care in a culturally sensitive manner from resettlement mental health providers. There were several methods agencies and providers used to develop community relationships. Providers often cited a more traditional method for creating connections: cold calling. Providers would call individuals or organizations identified through an internet search to share the details of their mental health services and ask how they might be of service to the organization. Other methods included flyers, brochures, reaching out to religious communities to identify areas of need, and providing trainings and presentations to other programs. Once community relationships are established, each party can refine the benefits they offer one another and the processes for referrals to each other can be enhanced, improving the ease of access to services for refugee clients, addressing the prevalent accessibility issues refugees often encounter when seeking care.

While developing relationships with refugee-serving organizations is crucial to improving access to care, the relationship most important to consider is the relationships agencies and providers develop with their refugee clients and communities. Across our study,

our agencies and providers highlighted the importance of establishing trust with refugee communities and their suggestions to increase trust were simple: show up to outreach events, make your presence and support for the refugee community known through developing relationships with stakeholders in refugee communities, and share information about services carefully and thoughtfully, knowing refugees may not readily accept the services offered. Refugees are not wrong to distrust strangers or authority; for many refugees, the world has demonstrated itself to be an unsafe, untrustworthy place. Thus, providers must demonstrate understanding and commitment to establishing trust when attempting to engage refugees in services, as forming trusting relationships may be a central factor in providing mental health services to refugee clients (Young, 2008). To help form the foundation of trusting relationships between providers and refugees, providers in this study suggested increasing visibility of the agency and their services through consistently participating in cultural events put on by refugee communities. The importance of developing community relationships with other organizations is again underscored here, as our providers reported their services were deemed more trustworthy when refugees were referred for services by another organization they had already established a trusting relationship with. Further research on developing relationships with other refugee serving organizations and community stakeholders within refugee communities may be beneficial to enhancing trust in refugee communities.

Providers should also consider how they can increase trust with refugees in the therapy room. Across all phases, providers and agencies stressed the importance of hiring therapists that spoke the same language as their refugee clients. In our study, while most agencies and providers reported they had frequent access to and regularly integrated interpreters into their sessions with refugee clients, only a small number of participants reported they were able to fluently

communicate in the same languages as their refugee clients. Research demonstrates that language and processes of communication are essential facets of culture and are culture-bound (Isaacs, Huang, Hernandez, & Echo-Hawk, 2005). In addition, refugee clients that can receive therapy in their native language are more likely to increase their level of disclosure within the therapy room (Isaacs, Huang, Hernandez, & Echo-Hawk, 2005). These statements infer that access to services in one's native language is a necessary component of culturally responsive interventions. While interpreters are a meeting a critical need in resettlement agencies, agencies should also consider how they can recruit more providers that speak the languages of the refugee communities they serve. Some refugees may have personal connections to interpreters, either personally or through friends and family, particularly where interpretation services are limited. Concerns related to lack of confidentiality or fear of being stigmatized due to familiarity with interpreters may discourage refugees from seeking services altogether. Thus, agencies should prioritize hiring additional providers that speak the same language as their refugee clients to addresses the concerns that may arise when using a small pool of interpreters that may belong to the same communities as those being served.

In addition, because refugees are often ethnically and racially different than the majority of providers in the U.S., providers working with refugee populations should consider how racial differences between provider and client impacts trust, particularly for racial minority refugee clients. While data on the race of refugees living in the U.S. was unavailable at the time this study took place, almost half of the refugees resettled in the U.S. in 2019 were from Africa, specifically the Democratic Republic of Congo. Inc contrast, as of 2016, approximately 88% of providers in the health service psychology workforce were white (APA, 2016). Similarly, in our study approximately 83% of agency representatives in phase I and almost 75% of providers in

phase II were white. Despite the obvious racial imbalance between providers and clients, none of the providers in this study discussed race in the qualitative interviews. Prior research has demonstrated that providers' racial prejudices, minimization of client concerns, lack of cultural competence (e.g., poor cultural awareness, knowledge, and skill), and unwillingness to acknowledge racial/cultural differences contributed to a poorer therapeutic alliance, lower ratings of providers' competence, and lower rates of satisfaction of therapy services (Chang & Berk, 2009). Based on the results of a qualitative study examining the factors that racial and ethnic minority clients perceive contribute to successful cross-racial therapy relationships, Chang and Berk (2009) offer multiple suggestions for how providers can improve cross-racial therapy relationships. The "critical ingredients of care" for successful cross-racial therapy include providers demonstrating genuine care, concern, respect, and acceptance, emphasizing the therapeutic relationship as the central component in therapy, validating and responding to clients' expressed needs, provider self-disclosure, communication about and attending to ruptures, provider adoption of a directive and active role in therapy, demonstrating culture-specific knowledge, eliciting feedback about the therapeutic relationship, and acknowledging the impact of race and culture on development and identity. The latter suggestion, acknowledging how race impacts our clients, highlights the need for frequent self-reflection and self-awareness, examining how the provider's race, specifically white providers, may contribute to further marginalization of clients in therapeutic spaces. Baima and Sude (2020) explored what diversity experts believed white therapists needed to understand about whiteness. Based on expert feedback, Baima and Sude (2020) suggest the following:

> "…white therapists need to explore their oppressive tendencies, hold nonjudgmental attitudes toward clients of color, and engage clients in conversations about race while

> acknowledging their own social locations. Participants indicated that while a cognitive understanding of whiteness is important, deep personal transformation is essential for building trustworthy relationships with people of color, and an ongoing commitment to continue to learn and grow is foundational to responsible use of privilege and power. (p. 66)

Given the overwhelming number of white therapists in the workforce, we urge providers to engage in continually reflexive processes about how their whiteness impacts the therapeutic relationship with their refugee clients.

One of the most salient issues discussed by almost all agencies and providers throughout all phases of the study was working to reduce the potential stigmatization of mental illness in refugee communities. This was particularly important during providers' first meetings when discussing mental health concerns. During intakes, providers intentionally chose more neutral or relatable words to describe mental health concerns, such as 'feeling sad,' 'worried,' or 'afraid,' rather than 'depressed,' 'anxious,' or 'traumatized,' to avoid the stigma that is often associated with more clinical language. Using more indirect language to describe distress, combined with normalizing the distress many refugees experience, helped to gently encourage refugees to enter treatment. Once in treatment, many providers described the value of not focusing solely on psychological distress; instead, providers often focused on working to meet refugees' needs holistically first. Providers helped refugees to adjust to cultural differences, eat nutritiously, develop good sleep hygiene, and attend their medical appointments. When these basic needs were met, refugees appeared to better respond to discussing difficult emotional content. Additional suggestions to reduce the potential stigmatization of mental health in refugee communities included psychoeducation, community outreach, and training other refugee-serving

providers. Again, future research addressing stigma in refugee communities may further illuminate methods to reduce it.

Given the researchers in this study were Counseling Psychologists and a Counseling Psychologist-in-training, and it is unsurprising that themes relevant to the Counseling Psychology division influenced the framework for this study, specifically the division's call for increased advocacy efforts and elevation of research and practice that promote social justice for oppressed and marginalized groups (Forrest & Campbell, 2012). These themes were reflected through the actions of the providers in this study, who shared their role as advocates both in and outside of the therapy room. Providers described accompanying refugees to psychiatry and medical appointments (among other services) outside of the agency to help refugees better navigate unfamiliar systems, as well as advocate for refugees' needs within these systems. The advocacy efforts for refugee clients appeared to increase access to vital services that complemented mental health services. The importance of advocacy efforts by providers cannot be emphasized enough; poor access to services and resources is a significant area of concern for many resettled refugees and overcoming obstacles to care is crucial in meeting refugees' mental health needs (Asgary et al., 2011). The American Counseling Association (ACA) provides guidance for advocacy through the ACA Advocacy Competencies, framing advocacy as an ethical facet of service delivery (Lewis, Arnold, House, & Toporek, 2002). These guidelines state that providers should advocate with or on the behalf of oppressed individuals on three levels: 1) encouraging the client to use their strengths to advocate for themselves, or acting on behalf of the client to help them gain access to resources, 2) collaborating with organizations at the system level to challenge unfair and unjust policies, and 3) educating the public about social justice issues, or advocating for change at the macro level (Lewis, Arnold, House, & Toporek,

2002). In our study, both agencies and providers demonstrated the countless ways they used their skills to advocate for their clients and their needs on all three levels. By joining refugees for care in alternate care systems, providers are directly helping refugees to gain access to resources, while also collaborating with organizations to overcome barriers that often impede care through educating and helping to guide organizations in providing more culturally responsive care. In engaging with refugees outside of the therapy room, providers are also demonstrating their level of care and commitment to meeting refugees' needs, which may enrich the level of trust between the provider and client, while also modeling how refugees may better advocate for themselves. We encourage all providers working with refugee clients, regardless of training background or affiliation, to incorporate advocacy and social justice into their work. These efforts help to ensure access to care and challenge systems of care that have historically oppressed marginalized individuals, promoting equitable care for those that need it the most.

While the basis of our study was founded on the model of cultural competence, a particularly noteworthy finding in our study was the emphasis providers placed on moving away from the concept of cultural competence altogether. Instead, providers proposed a model that stressed the importance of *cultural humility.* The concept of cultural humility is unique to cultural competence in that it focuses on lifelong self-reflection and self-critique of the provider's cultural background and cultural lens (Hook et al., 2013). Cultural humility also focuses on what it *not* known and encourages providers to seek out information directly from their clients to interpret and develop hypotheses rather than make conclusions prematurely based on prior knowledge about a culture that may be irrelevant (Hook et al., 2013). In contrast, cultural competence focuses on what *is* known through gaining knowledge about individuals from different cultural backgrounds, which may promote the belief that providers can become

"competent" in the cultural identities of others. Providers in this study and researchers critical of the model of cultural competence are concerned that focusing on gaining "competence" in other cultures promotes stereotyping and limits the provider's ability to engage with clients flexibly in treatment (Yeager & Bauer-Wu, 2013). Approaching clients with cultural humility demonstrates providers' awareness that they will forever be limited in their understanding of other's cultural backgrounds. Acceptance of these limitations encourages providers to thoughtfully and humbly attend to the client as the expert on their cultural background and life experiences.

In alignment with the cultural humility model, providers described most frequently learning about cultures directly from their clients, rather than relying on information gleaned from coursework or readings. Instead, providers encouraged refugees to share the salient aspects of the cultural background in session, which providers used to individualize treatment for each client. While tailoring treatments based on information gathered in session rather than applying interventions generally is commended, there is the concern that providers may unintentionally rely on clients to "teach" providers about their culture. Providers should carefully consider the inherent power differentials that exist between provider and client, and employ a balanced, collaborative approach. While refugees should be encouraged to share and integrate their cultural identities into the therapeutic space, providers should take additional measures to learn about the sociopolitical histories of the different refugee communities they work with, particularly the conditions that contributed to the flight from the home country This allows providers to integrate what is known about the cultural and historical contexts of refugees' experiences with the information shared by the unique individual sitting in front of them. Research has demonstrated that cultural humility is correlated with better therapy outcomes, most likely due to the providers humble disposition enhancing the therapeutic alliance with culturally different clients (Hook et

al., 2013). While cultural humility is not an entirely new concept, its origination in healthcare has likely contributed to its slower transition into the mental health domain. However, based on the provider's responses in this study, and emerging literature in the field of psychology, it may benefit all mental health providers - and present both a challenge and opportunity for transformation for researchers and psychology training programs - to consider how to integrate aspects of both cultural competence and cultural humility models to better serve all clients, particularly the most marginalized and underserved.

While most providers expressed a preference for using the cultural humility model, providers encountered several barriers that impeded their efforts to learn more culturally appropriate ways of engaging their refugee clients in mental health services. Providers described a lack of research on effective therapeutic interventions for resettled refugees living in the U.S., and a lack of experts that have direct experience working with resettled refugee populations in the U.S. Providers also reported a broad concern that resettlement agencies throughout the U.S. are generally disconnected from one another other. Providers shared that these issues have created confusion about the appropriateness of their chosen interventions, and to question if there are interventions being used in other agencies that are demonstrating effectiveness with refugee clients that they are unaware of. These concerns imply that providers would benefit from better connections with their peers, and in creating these connections, refugee clients would also benefit. To address similar concerns, one provider shared how she and other providers in her agency are connected to an organized network of refugee-serving providers in their state. The network of providers meets regularly and discusses advances in their field and information relevant to care, including recent policy changes, community events, and areas of concern. In my research, I too discovered similar networks and coalitions - such as the fast-growing Refugee

Mental Health Resource Network, an APA interdivisional project - where multiple agencies and organizations connect with each other through organized meetings or listservs. These networks may directly address the barriers providers shared by creating community for providers and agencies alike and develop a space for sharing knowledge, research, and practice-based evidence. In addition, these networks and coalitions can assist in sharing the burden of carrying out time-consuming tasks, such as planning community outreach events or research endeavors. With a network of providers and/or agencies, each contributing their area of expertise, they can better assist in contributing to the knowledge base for providers, which can certainly improve care for resettled refugees living in the U.S.

We would be remiss if we did not discuss the impact of the current administration's impact on refugee communities, including how newly enforced or modified policies have dramatically impacted refugee's feelings of safety and belonging in the U.S. and drastically impacted the operations of resettlement agencies. Unsurprisingly, the providers in our study reported that their refugee clients have suffered significant psychological distress and have become increasingly isolated in response to growing xenophobia and discriminatory behaviors directed toward refugee communities in the current sociopolitical climate. The consequences of the current administration's policy changes have resulted in decreased funding and a diminished capacity to provide mental health services as agencies have lost crucial staff members, and some agencies serving resettled refugees have been forced to shut their doors entirely. Throughout my phone calls with providers and other staff members when recruiting for this study, the strong sentiment among those working with refugee communities was that very little, if any, positive change has come from the policy changes impacting refugee resettlement. In the face of these negative outcomes, providers revealed unexpected benefits. Some providers reported that they

have more time and energy to better serve their remaining refugee clients as they are not overburdened by referrals, which allows for a higher quality of care. Providers have also noticed a shift in community ally-ship for resettled refugees and resettlement agencies alike. This burgeoning ally-ship has resulted in increased volunteering and other tangible support for resettlement agencies. While the current sociopolitical environment may feel disheartening and at times hopeless, it will benefit refugee resettlement agencies to continue to promote their services, to encourage community allies to provide much needed support for their refugee neighbors, and to remind resettled refugees of the safe haven resettlement agencies can provide.

## Suggestions for Mental Health Providers Working with Resettled Refugees

The following suggestions were developed based on the integration of data across all phases of this study. These suggestions are described more thoroughly throughout the discussion section, however for ease of reference, these suggestions are succinctly outlined below. Providers and agencies may consider how they can implement each of these suggestions to improve access to culturally responsive mental health services for the resettled refugees they serve.

### Suggestion 1

Offer a combination of mental health services including individual, couples, family, and group therapy and psychoeducation to meet the needs of refugees using multiple approaches. For example, group interventions may provide a shared space to normalize experiences and promote collective healing, while individual, family, or couple's therapy may provide a more private space to process difficult emotional experiences that may not always be appropriate for groups.

Providing a variety of complementary mental health services improves access to care and alternative approaches if one intervention is not effective or appropriate based on client concerns.

**Suggestion 2**

Be knowledgeable in identifying cultural idioms of distress in refugee populations across all areas of therapeutic intervention, including assessments which are often not normed with refugee populations. This will help providers to better understand, connect with, and treat refugees in a culturally appropriate manner.

**Suggestion 3**

In our study, Narrative Therapy was perceived as an effective intervention. Prior research has also demonstrated that narrative therapies are an effective approach for refugees, and possibly most effective when conducted by refugee "layperson" counselors. Agencies may consider the possibility of training interested refugees in working as "layperson" counselors that can provide supervised counseling to their refugee peers. This may assist understaffed agencies, provide refugees with counseling from individuals with shared identities, and contribute to the evidence base.

**Suggestion 4**

Integrate culturally relevant practices into evidence-based treatments to better meet the needs of refugees based on information and feedback provided by refugee clients. Consider how accepting or rejecting refugees are of specific treatments and use this data to inform practice-based evidence, drawing upon cultural knowledge, traditions, and values to provide care that is culturally responsive and useful to the targeted population. Further, develop formal methods to

evaluate the effectiveness of practice-based evidence to contribute to the evidence-base for therapeutic interventions that are effective for treating refugee mental health.

**Suggestion 5**

Develop relationships with local colleges and universities, experts on refugee populations, and other capable researchers to expand the efforts of assessing the effectiveness of resettlement agencies' therapeutic interventions. These partnerships may ease the burden on resettlement agencies in carrying out formal research, and most importantly, benefit the refugees on the receiving end of services as more culturally responsive methods of intervention are identified. In addition, consider using community-based participatory research methods to engage both researchers and community members in research efforts. This collaborative approach may deconstruct the power differentials that are inherent between academia/providers and those of the receiving end of care and contribute to a shared understanding of culturally relevant care.

**Suggestion 6**

Work towards developing and fostering community relationships, as doing so will provide invaluable benefits to refugee communities. Relationships to consider developing with community organizations include but are not limited to places of worship and/or religious leaders, school staff, medical providers, law enforcement, Child Protective Services (CPS), domestic violence and suicide prevention services, and other refugee resettlement agencies. While developing community relationships may mutually benefit each organization, these partnerships may also raise awareness about the existence of other organizations for refugee communities. Refugees interacting with one organization may become aware of another

organization due to the first organizations relationship with the second; if a refugee trusts the first organization, they may be more likely to trust the referral to the other agency. Further, refugees will benefit from increased ease of access to other services as the web of interconnected organizations expands, which may address the accessibility issues refugees often encounter.

**Sugge**stion 7

Consider how to continually establish trusting relationships with refugee communities. Hiring therapists that speak the same language and/or are from similar refugee communities may enhance trust with refugee clients and benefit the therapeutic process. Another option is to hire multiple interpreters that speak the languages used by the refugee communities served by the agency. However, agencies should carefully consider how they will protect the confidentiality of their clients due to possible personal connections between providers and refugee clients, an issue that becomes more problematic when small pools of interpreters are used. Additional methods to enhance trust with refugee communities include participating in outreach events and developing relationships with stakeholders in these communities. Finally, providers should engage in lifelong reflexive processes to examine how their biases, assumptions, and prejudices impact the establishment of a trusting relationship with refugee clients. This is particularly salient for white providers working with refugees of color. The examination of whiteness and the impact of oppressive whiteness must be examined to ensure equitable care is provided to clients of color that have been historically underserved in predominantly white therapeutic spaces.

**Sugges**tion 8

Identify methods for reducing the potential stigmatization of mental health issues in refugee communities. Possible methods to reduce stigma include using non-stigmatizing and

more neutral language to describe mental health concerns (e.g., use 'feeling sad,' 'worried,' or 'afraid,' rather than 'depressed,' 'anxious,' or 'traumatized') to avoid the stigma that is often associated with more clinical language. Additional suggestions to reduce the stigma of mental illness in refugee communities that refugee resettlement agencies can partake in include providing psychoeducation, community outreach, and culturally informed trainings to other refugee-serving providers.

**Suggestion 9**

Encourage providers or other resettlement agency staff to accompany refugee clients to various appointments and services outside of the therapy room (e.g., medical visits, psychiatry appointments) in order to advocate on behalf of and with refugee clients. These efforts may help refugees to utilize their strengths to advocate for themselves, while also demonstrating how to obtain resources and to navigate unfamiliar systems.

**Suggestion 10**

Identify and learn how to integrate additional models of culturally relevant care, including *cultural humility* and *cultural responsiveness*. One of the most popular models of care for refugees in the literature is based around the concept of *cultural competence*; however, as our participants emphasized, providers cannot become "competent" in in understanding refugees' cultures, as there is always be more to learn. Learning to work with refugee clients is an ongoing process that should be frequently informed by the feedback given by refugee clients. If something in treatment is not culturally relevant, replace it with what your clients identify as valuable. In addition, reflect on personal biases, assumptions, blind spots, and make efforts to

learn what is not understood. It is only through engaging in these reflexive processes that we can assure our care is culturally responsive, and subsequently beneficial to refugee clients.

**Sug**gestion **11**

Providers and agencies alike may benefit from developing and/or engaging in coalitions as members of a collective group comprised of other refugee-serving providers. In these spaces, providers and agencies may become increasingly informed about knowledge, research, community events, policies, and other information that may improve agency processes and benefit refugee clients. A fast-growing example is the Refugee Mental Health Resource Network, an APA interdivisional project that provides trainings and webinars on working with refugees, as well as connection to providers that are knowledgeable about working with this population.

**Suggestion 12**

Be vigilant of the impact of the sociopolitical environment on refugee communities. While most resettlement agencies have firsthand experience with the impact of the current administrations changes on refugee resettlement policies, it will benefit providers and other agency staff to be knowledgeable about how these changes directly affect their refugee clients and negatively contribute to refugees' mental health. Consider also increasing promotion of the mental health services offered by the agency for refugees and highlight opportunities for community engagement. Ally-ship for refugee communities is increasing, and both resettlement agencies and resettled refugees could benefit from additional support.

## Limitations of the Study

There were several limitations to this study that should be considered. First, the population in this study may not be representative of the larger population of mental health providers working with resettled refugees both within the U.S. and globally. The context of working as a mental health provider within a resettlement agency in the U.S. may be unique for an indefinable number of reasons compared to other contexts, which may make it difficult to apply what is learned in this study to other settings. For example, the systemic issues unique to the context of resettlement agencies may limit the findings of this study. As demonstrated in our study, resettlement agencies are often at the mercy of other organizations and institutions that determine where in the U.S. refugees will be placed, how many resettled refugees a particular resettlement agency will be responsible for, how much money is allocated to a specific agency for refugee resettlement and their various services, and for how long services were available to resettled refugees, including mental health services. It was unclear based on the available literature and the data gathered in this study for how long mental health services were available to resettled refugees. Based on the minimal informal information gathered during the course of this study, it appeared the range of time mental health services were available to refugees varied widely and sometimes lasted well beyond the 30 to 90-day period of financial and other social service assistance. As this information was not assessed during the study, we are unable to make inferences about how funding or the length of mental health treatment may have impacted the responses of those in our study, which further limits our findings.

In addition, the constant seesawing of workload demand and factors out of the control of providers may impact how providers operate in the resettlement context at a given time. As evidenced by the largely fluctuating numbers of refugees resettled in the U.S. each year, the workload of mental health providers may also vary drastically, from overburdened to trickling.

Because this context may change without notice, as evidenced by the drastic cuts and closures of multiple resettlement agencies in the past year, the information and perspectives gathered within this study may not provide an accurate representation of resettlement agencies over time, but only a glimpse of agencies and how they are currently functioning.

Finally, this study intentionally focused on the mental health providers that work with resettled refugees, not refugees directly. It cannot be ignored that the perspective of refugees is missing from this study. While mental health providers are responsible for ensuring adequate and informed care, the perspective of the individual on the receiving end of therapeutic intervention is of equal, if not greater, importance to that of the provider.

# APPENDIX A: OVERVIEW OF RECRUITMENT STRATEGIES

Recruitment for this study required creativity, a strict system of organization, and persistence. First, to identify that currently active resettlement agencies I used a list of publicly available refugee resettlement agencies. While going through this list, I found information was often outdated and contacts listed were no longer with the agency. To determine if an agency was still active, I enlisted the help of Google, carefully scoured agency websites, and utilized cold calling to inquire about an agency's status. I carefully documented all contacts and attempts to reach an agency once I was confident I had the correct contact information to ensure I was reaching out to potential participants equally and could identify when enough attempts had been made to cease recruitment efforts. Identifying the most appropriate participants for inclusion in each phase of the study required persistence as I was often passed along by multiple agency staff until I was connected to the most appropriate individual for participation in the study. I was sometimes connected to up to four different individuals until I reached the right one.

During recruitment efforts, I sent up to three recruitment and follow-up emails to the email addresses listed on the publicly available PDF of refugee resettlement agencies in the U.S. I used an email tracking system that allowed me to track email addresses that were no longer valid, as well as emails that went unopened. When I found invalid or unopened email addresses, I referenced the resettlement agency's website to locate a current email address, which I then used for further recruitment efforts. Due to the limited number of responses through email recruitment attempts, I chose to primarily utilize phone-based recruitment. Specifically, I attempted to call each of the 302 refugee resettlement agencies by phone up to three times in order to recruit participants from each agency, leaving messages requesting a call back if the call went unanswered. If after three attempts I was still unable to reach an individual at an agency, this agency was recorded as "non-responsive."

In addition, upon receiving a suggestion from a resettlement agency staff member who served in a dual role as the State Refugee Coordinator, I also contacted the State Refugee Coordinators and State Refugee Health Coordinators from each state. The resettlement agency staff member/State Refugee Coordinator shared that State Refugee Coordinators and State Refugee Health Coordinators would likely have the most up-to-date information for each resettlement agency in their state, including the status of mental health programs for resettled refugees within the state. Recruitment efforts through contacting State Coordinators improved recruitment efforts, as many of these individuals served as both State Coordinators and as staff members within a resettlement agency, allowing them to complete the surveys. In addition, individuals in these roles utilized "word of mouth" recruitment, including emailing agencies on my behalf or directly connecting me with the most appropriate individuals within agencies to complete the surveys, which proved to be one of the most effective methods of recruitment for the study.

For future researchers engaging in recruitment efforts with mental health providers, it may benefit potential participants to clarify what is meant by the phrase "mental health services." While my study recruitment materials attempted to list examples of mental health services (e.g., individual therapy, couples therapy, group therapy), it appears there was still confusion about what qualified as a "mental health service." It is possible some agencies that indicated they did not provide mental health services in fact did provide mental health services as defined by this study. Being explicit in defining the term "mental health service" or doing away with the phrase entirely and simply listing the services that qualify may improve recruitment efforts.

# APPENDIX B: RESEARCH PARTICIPANT ONLINE CONSENT FORM

## DIRECTOR/LEADER VERSION

Perspectives of Mental Health Services for Refugees in The U.S.: Focus on Resettlement Agencies

Ayşe Çiftçi, Ph.D.
Lindsay Mayott, M.A.
Purdue University
College of Education

**Please Print this Information Sheet for Your Records**

**Key Information**

Please take time to review this information carefully. This is a research study. Your participation in this study is voluntary which means that you may choose not to participate at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask questions to the researchers about the study whenever you would like. If you decide to take part in the study, you will be asked to sign this form, be sure you understand what you will do and any possible risks or benefits.

The purpose of this study is to understand more about the content and extent of available mental health services for resettled refugees within refugee resettlement agencies and to gain a better understanding of mental health providers experiences in this context. Participation in the online survey is expected to take approximately 10-12 minutes. Forwarding the link to the mental health providers in your agency is expected to take approximately 1-3 minutes. The risks of participating are minimal and no greater than those encountered in everyday activities. There are no direct benefits to you from participating in this study. However, the findings from this survey may increase our understanding of mental health services for resettled refugee populations. In addition, the researchers intend to publish the results of this study as a report that will be available to all refugee resettlement agencies at no cost. These results may benefit both

resettlement agencies and the refugee populations that access mental health services at these sites.

**What is the purpose of this study?**

You have been invited to participate in a research study examining the available mental health services provided by refugee resettlement agencies and the mental health providers within these agencies. The purpose of this study is to understand more about the content and extent of available mental health services and to gain a better understanding of your experiences in this context. This information will help to increase our understanding of how refugees' mental health concerns are currently being addressed, which in turn may contribute to improving mental health service accessibility often experienced by resettled refugees. We would like to enroll up to 400 people in this study.

**What will I do if I choose to be in this study?**

By taking part in this study, you will be asked to complete a short online survey regarding your background and the mental health services your agency provides to resettled refugees. You will then be asked to forward a separate survey link to the mental health providers in your agency.

**What are the possible risks or discomforts?**

The risks of participating are minimal and no greater than those encountered in everyday activities. There is a potential risk you might feel uncomfortable or upset while answering the questions. You may refuse to complete the questionnaire or refuse to answer the questions, and/or discontinue your participation at any time. A breach of confidentiality is a risk associated with research. However, safeguards have been put in place to minimize this risk.

**Will I receive payment or other incentive?**

Your participation in this study is completely voluntary.

**Will information about me and my participation be kept confidential?**

The privacy and confidentiality of your responses will be protected through multiple methods.

We will collect your survey responses anonymously. You are not asked to provide your name or any identifying material other than general demographic information. Your survey answers will not be able to be traced directly to you or your email address. All completed forms will be kept in a secure computer database. Only the co-investigators of this study will be able to access the data. The data from this study will be analyzed collectively, including all responses to this survey. The data will be kept for a minimum of three years. Any reports, publications, or related documents will be reported on an aggregate (not individual) level. The project's research records may be reviewed by the Institutional Review Board at Purdue University to ensure that your data is being properly protected. Research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

**What are my rights if I take part in this study?**

Participation in this study is voluntary. You do not have to participate in this research project. If you agree to participate, you can withdraw your participation at any time without penalty. This research project has been approved by Purdue University Institutional Review Board

**Who can I contact if I have questions about the study?**

If you have any questions about this research project, you can contact Ayşe Çiftçi, Ph.D., the first point of contact, at ayse@purdue.edu or (765) 494-9746. You may also contact Lindsay Mayott, M.A. at lmayott@purdue.edu.

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email: irb@purdue.edu or write to:
Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.,
West Lafayette, IN 47907-2114

To report anonymously to Purdue's Hotline see www.purdue.edu/hotline

**Documentation of Informed Consent**

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been

answered. I am prepared to participate in the research study described above. I will print out a copy of this form for my records.

# APPENDIX C: DIRECTOR/LEADER RECRUITMENT E-MAIL

SUBJECT: Research Study Examining Mental Health Services for Resettled Refugees

Dear _____,

You are invited to participate in a study examining the available mental health services provided by refugee resettlement agencies and the mental health providers within these agencies. Your responses to this survey will not only assist the lead investigator in completing her dissertation project, they will also help to contribute to the development of an aggregate report discussing the mental health services available to resettled refugees in refugee resettlement agencies nationwide in the U.S. Your participation in this study is greatly appreciated and may help to address mental health service accessibility issues experienced by refugees resettling in the U.S.

In order to participate, **you must be the director or in another similar leadership role in a refugee resettlement agency within the United States**. If you would like to participate, please click on the link below and you will be directed to the online survey. The survey should take you approximately 10-12 minutes to complete. Your responses will be kept confidential and will only be viewed by the investigators of the study.

At the end of the study, you will be provided with a unique link for a different survey created for the mental health providers working within your agency. We would greatly appreciate if you would please consider forwarding this link and the provided blurb about the study in an email to your providers.

Thank you in advance for your time and participation. If you have any questions about this study, feel free to contact me at lmayott@purdue.edu.

**If you agree to participate in the study, simply click on this link or copy-and-paste it into your web browser.**

>>[Link to Qualtrics Survey for Directors/Leaders]

This study has been approved by Purdue University Institutional Review Board (IRB Research Project Number: 1805020582).

Sincerely,

Lindsay Mayott, M.A.

Doctoral Candidate
Counseling Psychology
Department of Educational Studies

Purdue University

lmayott@purdue.edu

Ayşe Çiftçi, Ph.D

Associate Professor, Counseling Psychology
Department of Educational Studies
Purdue University

ayse@purdue.edu

# APPENDIX D: DIRECTOR/LEADER REMINDER E-MAIL

SUBJECT: Reminder to Participate in a Research Study on Refugee Resettlement Agencies

Dear _____,

This is a friendly reminder about participating in a research study examining the available mental health services provided by refugee resettlement agencies and the mental health providers within these agencies. If you have already completed the survey and submitted it, we are very appreciative. If not, please do complete the survey by going to the link below.

In order to participate, **you must be the director or in another leadership role in a refugee resettlement agency within the United States**. If you would like to participate, please click on the link below and you will be directed to the online survey. The survey should take you approximately 15-20 minutes to complete. Your responses will be kept confidential and will only be viewed by the investigators of the study.

At the end of the study, you will be provided with a unique link created for the mental health providers working within your agency. Please consider forwarding this link and the provided blurb about the study in an email to your providers.

Thank you in advance for your time and participation. If you have any questions about this study, feel free to contact me at lmayott@purdue.edu.

If you agree to participate in the study, simply click on this link or copy-and-paste it into your web browser.

[Web Survey Link]

This study has been approved by Purdue University Institutional Review Board (IRB Research Project Number: 1805020582).

Sincerely,

Lindsay Mayott, M.A.
Doctoral Student, Counseling Psychology
Department of Educational Studies
Purdue University
lmayott@purdue.edu

Ayşe Çiftçi, Ph.D
Associate Professor, Counseling Psychology
Department of Educational Studies
Purdue University
ayse@purdue.edu

# APPENDIX E: DIRECTOR/LEADER ONLINE SURVEY QUESTIONS

**Instructions:** *We are interested in learning more about the mental health services available for resettled refugees at your resettlement agency. Please answer the following questions to the best of your ability.*

| Item | Question | Response |
|---|---|---|
| 1. | Are you a director or in another leadership role at a refugee resettlement agency in the United States? | 1 = Yes<br>2 = No (end) |
| 2. | Does your resettlement agency offer mental health services (e.g., therapeutic intervention/prevention including but not limited to individual, group, family, or couples' therapy, psychological assessment, etc.) | 1 = Yes<br>2 = No (end) |
| 3. | Do you have a referral network of mental health providers outside of the agency that you refer your clients to if necessary? | 1 = Yes<br>2 = No |
| 4. | What is your job title at your resettlement agency (e.g., director, supervisor, etc.)? | Open-ended: |
| 5. | How long have you held your current position at your resettlement agency? | Years (drop down number) |
| 6. | What it the total amount of time you have worked at your current resettlement agency? | Years (drop down number) |
| 7. | What is the total amount of time you have worked with refugee populations (e.g., the amount of time you have worked in any setting or position with refugees combined) | Years (drop down number) |
| 8. | What is your age? | Drop down (number) |
| 9. | What is your race? Please check all that apply | 1 = White<br>2 = Black or African American<br>3 = Middle Eastern or North African<br>4 = Asian or Asian American<br>5 = Native Hawaiian or Pacific Islander<br>6 = Native American/Indigenous<br>7 = Other, please specify |
| 10. | Are you Hispanic? | 1 = Yes<br>2 = No |

| | | |
|---|---|---|
| 11. | What is your country of origin? | Drop down (list of countries) |
| 12. | At any time in your life, have you identified as a refugee? | 1 = Yes<br>2 = No |
| 13. | What is your gender identity? | 1 = Man<br>2 = Woman<br>3 = Transgender Man<br>4 = Transgender Woman<br>5 = Non-binary<br>6 = Please specify |
| 14. | What is the highest level of education you have completed? | 1 = Bachelor's degree BA or BS) (drop down: type of degree)<br>2 = Associate's degree (AA or AS) (drop down: type of degree)<br>2 = Master's degree (MA or MS) (drop down: type of degree)<br>3 = Master of Social Work (MSW)<br>4 = Licensed Clinical Social Worker (LCSW)<br>5= Master's degree in Marriage and Family Therapy (MFT)<br>6 = Doctoral degree (drop down: type of degree)<br>7 = Psychiatrist<br>8 = Medical Degree<br>9 = Nurse Practitioner<br>10 = Please specify |
| 15. | Where is your agency located? | City:<br>State (drop down): |
| 16. | My agency is located in a _____ | 1 = Rural area<br>2 = Suburban area<br>3 = Urban area |
| 17. | Which National Voluntary Resettlement Agencies, or "VOLAGS" is your organization affiliated with? | 1 = Church World Service<br>2 = Episcopal Migration Ministries<br>3 = Ethiopian Community Development Council<br>4 = Hebrew Immigration Aid Society<br>5 = International Rescue Committee<br>6 = Lutheran Immigration and Refugee Services<br>7 = U.S. Conference of Catholic Bishops/Migration and Refugee Services<br>8 = U.S. Committee for Refugees and Immigrants<br>9 = World Relief |

| | | |
|---|---|---|
| 18. | How is your agency funded? Please select all that apply | 1 = Federal government funding<br>2 = Private donations<br>3 = Grant funding<br>4 = Research funding<br>5 = Local government funding<br>6 = Other (open-ended) |
| 19. | Approximately how many mental health providers (e.g., any individual that provides direct therapeutic intervention to resettled refugees including but not limited to individual, group, family, couples, psychological assessment, etc.) are employed in your agency? | Drop down (number): |
| 20. | Do you personally provide direct mental health services (e.g., including but not limited to individual, group, family, couples, or other therapeutic intervention, psychological assessment, outreach, workshops, etc.) to the refugees served at your agency? | 1 = Yes<br>2 = No |
| 21. | What types of mental health services does your agency provide? Please select all that apply | 1 = Individual therapy<br>2 = Family therapy<br>3 = Couples therapy<br>4 = Group therapy/Support Group<br>5 = Psychoeducational workshops<br>6 = Mental health screenings<br>7 = Outreach<br>8 = Home-based mental health services<br>9 = Psychological testing/evaluation (e.g., psychodiagnostic, neurological, etc.)<br>10 = Women's groups<br>11 = Other (open-ended): |
| 22. | How are the mental health services at your agency funded? Please select all that apply | 1 = Local government funding<br>2 = Federal government funding<br>3 = Private donations<br>4 = Grant funding<br>5 = Research funding<br>6 = Other (open-ended) |
| 23. | Does your agency offer interpretation services (e.g., an individual to translate verbally) for mental health services? | 1 = Yes<br>2 = No |
| 24. | Does your agency work to address stigma related to mental illness within the refugee populations you work with? | 1 = Yes<br>2 = No |

| | | |
|---|---|---|
| 25. | How do you address stigma related to mental illness with the refugee populations you work with? | 1 = Outreach<br>2 = Workshops<br>3 = Advocacy<br>4 = Presentations<br>5 = Working with/partnering with religious leaders/communities<br>6 = Working with/partnering with schools<br>7 = Working with/partnering with healthcare providers/systems<br>8 = Other, please specify |
| 26. | What methods has your agency used to develop relationships with refugee groups within the community? | 1 = Outreach<br>2 = Workshops<br>3 = Advocacy<br>4 = Presentations<br>5 = Working with/partnering with religious leaders/communities<br>6 = Working with/partnering with schools<br>7 = Working with/partnering with healthcare providers/systems<br>8 = Other, please specify |
| 27. | Does your agency provide trainings and/or workshops for your mental health providers? | 1 = Yes (if yes, show next two questions)<br>2 = No |
| 28. | What types of trainings does your agency provide to the mental health providers within your agency? Please select all that apply | 1 = Education about psychological disorders<br>2 = Domestic violence<br>3 = Cultural competence<br>4 = Refugee mental health<br>5 = Trainings on distinct ethnic/religious/refugee groups<br>6 = Women's mental health<br>7 = Other category (open-ended) |
| 29. | Approximately how often are trainings offered? (e.g., daily, weekly, bi-weekly, monthly, yearly) | 1 = Daily<br>2 = Weekly<br>3 = Bi-weekly<br>4 = Monthly<br>5 = Yearly |
| 30. | Does your agency evaluate the effectiveness of the mental health services you offer using scientific inquiry? | 1 = Yes<br>2 = No |
| 31. | Does your agency disseminate (e.g., publish) the results of your evaluations of your offered mental health services? | 1 = Yes<br>2 = No |

| | | |
|---|---|---|
| 32. | ___ Number of multicultural counseling/cultural competence courses attended during undergraduate (include ones currently attending)<br>____Number of multicultural counseling/cultural competence courses attended during graduate school (include ones currently attending)<br>____Number of multicultural counseling/cultural competence CME courses attended (include ones currently attending)<br>____Number of multicultural counseling/cultural competence webinars attended (include ones currently attending)<br>____Number of multicultural counseling/cultural competence trainings or workshops attended (include ones currently attending)<br><br>Of the above, how many of these courses/trainings were offered by your resettlement agency? | Drop down (number) |

**Instructions:** *Please state how much you agree or disagree with the following statements.*

| | | |
|---|---|---|
| 33. | Instructions: Please state how much you agree or disagree with the following statements: The mental health providers at our agency are culturally competent in providing mental health services to refugee populations. | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know<br>4 = Agree<br>5 = Strongly Agree |
| 34. | The mental health providers at our agency work hard to establish a therapeutic alliance with the refugee clients they provide mental health services for. | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know<br>4 = Agree<br>5 = Strongly Agree |
| 35. | Refugee populations that utilize the mental health services at our agency are accepting of the psychological interventions that are offered. | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know<br>4 = Agree<br>5 = Strongly Agree |
| 36. | Our agency offers culturally appropriate mental health services targeting refugee populations. | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know |

| | | |
|---|---|---|
| | | 4 = Agree<br>5 = Strongly Agree |
| 37. | The mental health services at our agency are flexible/adaptable so that they can be used with multiple refugee groups | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know<br>4 = Agree<br>5 = Strongly Agree |
| 38. | I have an investment in our mental health services being culturally competent | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know<br>4 = Agree<br>5 = Strongly Agree |
| 39. | Do you have any comments or feedback for the researchers of this study? | Open ended: |
| 40. | For the second phase of this study, we are asking directors or other leaders to pass on a different survey that is specifically for the mental health providers in their agency (e.g., any individual that directly provides mental health intervention [individual/group/family therapy] to resettled refugees). Please copy and paste the following blurb and link into an email for your mental health providers. Directors or other leaders that also provide direct mental health services as described above are welcome to also take this survey. Simply follow the link to participate. Your assistance with each phase of this study is crucial to its success. Thank you in advance for all of your help. | Text for providers to include is shown below |

TEXT TO FORWARD SURVEY TO MENTAL HEALTH PROVIDERS

***Text:*** *For the second phase of this study, we are asking directors or other leaders to pass on a different survey that is specifically for the mental health providers in their agency (e.g., any individual that directly provides mental health intervention [individual/group/family therapy] to resettled refugees). Please copy and paste the following blurb and link into an email for your mental health providers. Directors or other leaders that also provide direct mental health services as described above are welcome to also take this survey. Simply follow the link to participate. Your assistance with each phase of this study is crucial to its success. Thank you in advance for all of your help.*

*Please feel free to forward the following message:*

"SUBJECT: Research Study Examining Mental Health Services for Resettled Refugees

Hello,

I am forwarding the following information regarding a research study examining the mental health services provided by refugee resettlement agencies in the U.S. and the mental health providers within these agencies. Your responses to this survey will not only assist the lead investigator in completing her dissertation project, they will also help to contribute to the development of an aggregate report discussing the mental health services available to resettled refugees in refugee resettlement agencies nationwide in the U.S. Your participation in this study is greatly appreciated and may help to address mental health service accessibility issues experienced by refugees resettling in the U.S.

In order to participate, **you must be a mental health provider that offers mental health services to resettled refugees within a refugee resettlement agency in the United States**. To participate, please click on the link below and you will be directed to the online survey. The survey should take you approximately 10-12 minutes to complete. Your responses will be kept confidential and will only be viewed by the investigators of the study.

Thank you in advance for your time and participation. If you have any questions about this study, feel free to contact Lindsay Mayott at lmayott@purdue.edu.

**If you agree to participate in the study, simply click on this link or copy-and-paste it into your web browser.**

>>[Link to Qualtrics Survey for Mental Health Providers]

This study has been approved by Purdue University Institutional Review Board (IRB Research Project Number: 1805020582).

Sincerely,

Lindsay Mayott, M.A.

Doctoral Candidate
Counseling Psychology
Department of Educational Studies

Purdue University

lmayott@purdue.edu

Ayşe Çiftçi, Ph.D

Associate Professor, Counseling
Department of Educational Studies
Purdue University

ayse@purdue.edu

# APPENDIX F: LIST OF MENTAL HEALTH SERVICE AVAILABILITY BY STATE BASED ON AVAILABLE DATA

| States Without Available Mental Health Services in Resettlement Agencies | States with One Resettlement Agency per State | States with No Resettlement Agencies |
|---|---|---|
| Alabama | Alabama | Wyoming |
| Alaska | Alaska | |
| Arkansas | Arkansas | |
| Georgia | Delaware | |
| Hawaii | Hawaii | |
| Idaho | Maine | |
| Louisiana | Montana | |
| Maine | New Mexico | |
| Maryland | Oklahoma | |
| Montana | West Virginia | |
| New Hampshire | | |
| New Jersey | | |
| New Mexico | | |
| Oklahoma | | |
| South Carolina | | |
| Tennessee | | |
| Vermont | | |
| West Virginia | | |
| Wisconsin | | |

# APPENDIX G: AVAILABLE MENTAL HEALTH SERVICES AND CULTURALLY COMPETENT STRATEGIES FOR AGENCIES INCLUDED IN PHASE I

| State | Location | Number of Providers | Available Mental Health Services | Incorporated Cultural Competence Strategies |
|---|---|---|---|---|
| Arizona | Urban area | 1 | Individual therapy, Family therapy, Group therapy/Support group, Psychoeducational workshops, Home-based mental health services | Meets linguistic needs, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Refugees are accepting of mental health services |
| California | Urban area | 2 | Individual therapy, Family therapy, Couples therapy, Psychoeducational workshops, Mental health screenings, Outreach, Psychological testing/evaluation | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services |
| Connecticut | Urban area | 1 | Individual therapy, Home-based mental health services | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Delaware | Urban area | 3 | Individual therapy | Meets linguistic needs, Addresses stigmatization of mental illness, Uses culturally appropriate services, Provides trainings to increase cultural competence of providers |
| Florida | Urban area | - | Group therapy/Support group, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers |
| Illinois | Suburban area | 2 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Home-based mental health services, Psychological testing/evaluation | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services |

| | | | | |
|---|---|---|---|---|
| Illinois | Urban area | 5 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services, Disseminates results of evaluations |
| Indiana | Urban area | 1 | Individual therapy, Group therapy/Support group, Psychoeducational workshops, Outreach, Women's groups, Screening | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Kansas | Urban area | 1 | Individual therapy, Group therapy/Support group, Mental health screenings | Meets linguistic needs, Addresses stigmatization of mental illness, Provides trainings to increase cultural competence of providers |
| Kentucky | Urban area | 1 | Individual therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers |
| Kentucky | Suburban area | - | Group therapy/Support group | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Massachusetts | Suburban area | 8 | Individual therapy, Family therapy, Mental health screenings, Outreach, Home-based mental health services, Women’s groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Michigan | Urban area | 7 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Mental health screenings, Women’s groups | Meets linguistic needs, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Refugees are accepting of mental health services |

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| Michigan | Suburban area | 11 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Missouri | Suburban area | 6 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Refugees are accepting of mental health services |
| Missouri | Urban area | - | Individual therapy, Mental health screenings, Women's groups, Assessments to exempt qualifying persons from the written test component of the citizenship test | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Refugees are accepting of mental health services, Evaluates effectiveness of services |
| Missouri | Urban area | 5 | Individual therapy, Family therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services, Disseminates results of evaluations |
| Nebraska | Urban area | 10 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services, Disseminates results of evaluations |
| Nevada | Urban area | - | Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are |

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| | | | | accepting of mental health services, Evaluates effectiveness of services |
| New York | Urban area | 10 | Individual therapy, Family therapy, Home-based mental health services, Psychological testing/evaluation (e.g., psychodiagnostics, neurological, etc.) | Meets linguistic needs, Addresses stigmatization of mental illness, Provides trainings to increase cultural competence of providers |
| North Carolina | Urban area | 1 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| North Dakota | Urban area | 22 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Mental health screenings, Outreach, Home-based mental health services | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Ohio | Urban area | 7 | Individual therapy, Family therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach, Home-based mental health services, Psychological testing/evaluation (e.g., psychodiagnostics, neurological, etc.),Women's groups, | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Ohio | Urban area | 5 | Individual therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Evaluates effectiveness of services |
| Ohio | Urban area | 4 | Psychoeducational workshops, Outreach, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural |

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| | | | | competence of providers, Evaluates effectiveness of services, Disseminates results of evaluations |
| Oregon | Urban area | 12 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach, Home-based mental health services, Peer-based services | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Refugees are accepting of mental health services |
| Oregon | Urban area | 4 | Individual therapy, Family therapy, Couples therapy, Women's groups | Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services |
| Pennsylvania | Urban area | 3 | Individual therapy, Couples therapy, Psychoeducational workshops | Meets linguistic needs, Addresses stigmatization of mental illness, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Rhode Island | Urban area | 2 | Family therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Home-based mental health services, Women's groups | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| South Dakota | Urban area | 4 | Individual therapy, Family therapy, Couples therapy, Mental health screenings, Outreach, Home-based mental health services, Psychological testing/evaluation (e.g., psychodiagnostics, neurological, etc.) | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers |
| Texas | Urban area | 5 | Individual therapy, Family therapy, Couples therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Outreach, Women's groups, School-based | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services |
| Utah | Urban area | 1 | Group therapy/Support group, Psychoeducational workshops, Mental health | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic |

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| | | | screenings, Outreach, Home-based mental health services, Women's groups | relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Evaluates effectiveness of services |
| Washington | Suburban area | 11 | Individual therapy, Group therapy/Support group, Psychoeducational workshops, Mental health screenings, Medication Management | Meets linguistic needs, Addresses stigmatization of mental illness, Providers emphasize therapeutic relationship, Uses culturally appropriate services, Uses flexible/adaptable services, Provides trainings to increase cultural competence of providers, Refugees are accepting of mental health services, Evaluates effectiveness of services |

# APPENDIX H: RESEARCH PARTICIPANT ONLINE CONSENT FORM

## MENTAL HEALTH PROVIDER VERSION

Perspectives of Mental Health Services for Refugees in The U.S.: Focus on Resettlement Agencies

Ayşe Çiftçi, Ph.D.
Lindsay Mayott, M.A.
College of Education
Purdue University

**Please Print this Information Sheet for Your Records**

**Key Information**

Please take time to review this information carefully. This is a research study. Your participation in this study is voluntary which means that you may choose not to participate at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask questions to the researchers about the study whenever you would like. If you decide to take part in the study, you will be asked to sign this form, be sure you understand what you will do and any possible risks or benefits.

The purpose of this study is to understand more about the content and extent of available mental health services for resettled refugees within refugee resettlement agencies and to gain a better understanding of mental health providers experiences in this context. Participation in the online survey is expected to take approximately 15 minutes. Participation in the qualitative interview, if you are selected to participate, is expected to take approximately 60 minutes. The risks of participating are minimal and no greater than those encountered in everyday activities. There are no direct benefits to you from participating in this study. However, the findings from this survey may increase our understanding of mental health services for resettled refugee populations. In addition, the researchers intend to publish the results of this study as a report that will be

available to all refugee resettlement agencies at no cost. These results may benefit both resettlement agencies and the refugee populations that access mental health services at these sites.

**What is the purpose of this study?**

You have been invited to participate in a research study examining the available mental health services provided by refugee resettlement agencies and the mental health providers within these agencies. The purpose of this study is to understand more about the content and extent of available mental health services and to gain a better understanding of your experiences in this context. This information will help to increase our understanding of how refugees' mental health concerns are currently being addressed, which in turn may contribute to improving mental health service accessibility often experienced by resettled refugees. We would like to enroll up to 400 people in this study.

**What will I do if I choose to be in this study?**

By taking part in this study, you will be asked to complete a short survey regarding your background, the mental health services you provide to resettled refugees, and your counseling experiences. Upon completion of the survey, you will be asked if you are interested in participating in a qualitative interview by phone/Skype/in-person at a later date at your convenience. The qualitative portion of the study is optional, and you will not be excluded from the survey portion of the study if you do not want to participate in the qualitative interview. Not all individuals that indicate that they are interested will be selected for participation in the qualitative interviews.

**What are the possible risks or discomforts?**

The risks of participating are minimal and no greater than those encountered in everyday activities. There is a potential risk you might feel uncomfortable or upset while answering the questions. You may refuse to complete the questionnaire or refuse to answer the questions, and/or discontinue your participation at any time. A breach of confidentiality is a risk associated with research. However, safeguards have been put in place to minimize this risk.

**Will I receive payment or other incentive?**

Your participation in this study is completely voluntary.

**Will information about me and my participation be kept confidential?**

The privacy and confidentiality of your responses will be protected through multiple methods. We will collect your survey responses anonymously, unless you indicate at the end of the survey that you would like to participate in a qualitative interview to expand upon your survey answers. If you indicate an interest in participating in a qualitative interview, your name and contact information will be collected, and this information will be connected to your survey responses for the purposes of participant selection for the interviews. If you do not indicate an interest in participating in the qualitative interviews, your responses will remain anonymous. All completed forms will be kept in a secure computer database. Only the co-investigators of this study will be able to access the data. The data from this study will be analyzed collectively, including all responses to this survey. The data will be kept for a minimum of three years. Any reports, publications, or related documents will be reported on an aggregate (not individual) level. The project's research records may be reviewed by the Institutional Review Board at Purdue University to ensure that your data is being properly protected. Research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

**What are my rights if I take part in this study?**

Participation in this study is voluntary. You do not have to participate in this research project. If you agree to participate, you can withdraw your participation at any time without penalty. This research project has been approved by Purdue University Institutional Review Board.

**Who can I contact if I have questions about the study?**

If you have any questions about this research project, you can contact Ayşe Çiftçi, Ph.D., the first point of contact, at ayse@purdue.edu or (765) 494-9746. You may also contact Lindsay Mayott, M.A. at lmayott@purdue.edu.

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at

(765) 494-5942, email: irb@purdue.edu or write to:
Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.,
West Lafayette, IN 47907-2114

To report anonymously to Purdue's Hotline see www.purdue.edu/hotline

**Documentation of Informed Consent**

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above. I will print out a copy of this form for my records.

# APPENDIX I: MENTAL HEALTH PROVIDER ONLINE SURVEY QUESTIONS

**Instructions:** *We are interested in learning more about the mental health services available for resettled refugees at your resettlement agency. Please answer the following questions to the best of your ability.*

| Question # | Question | Response |
|---|---|---|
| 1. | Are you a mental health provider (e.g., any individual that directly provides mental health intervention [individual/group/family therapy] to resettled refugees) at a refugee resettlement agency in the United States? | 1 = Yes<br>2 = No (end) |
| 2. | What is your age? | Drop down: |
| 3. | What is your race? Please check all that apply | 1 = White<br>2 = Black or African American<br>3 = Middle Eastern or North African<br>4 = Asian or Asian American<br>5 = Native Hawaiian or Pacific Islander<br>6 = Native American/Indigenous<br>7 = Other, please specify<br>8 = More than one race |
| 4. | Are you Hispanic? | 1= Yes<br>2 = No |
| 5. | What is your country of origin? | Drop-down menu |
| 6. | At any time in your life, have you identified as a refugee? | 1 = Yes<br>2 = No |
| 7. | What is your gender identity? | 1 = Man<br>2 = Woman<br>3 = Transgender Man<br>4 = Transgender Woman<br>5 = Non-binary<br>6 = Please specify |
| 8. | What is the highest level of education you have completed? If you earned a degree, please enter the specific degree you received in the text box next to your response. | 1 = Bachelor's degree BA or BS) (drop down: type of degree)<br>2 = Associate's degree (AA or AS) (drop down: type of degree) |

| | | |
|---|---|---|
| | | 2 = Master's degree (MA or MS) (drop down: type of degree)<br>3 = Master of Social Work (MSW)<br>4 = Licensed Clinical Social Worker (LCSW)<br>5= Master's degree in Marriage and Family Therapy (MFT)<br>6 = Doctoral degree (drop down: type of degree)<br>7 = Psychiatrist<br>8 = Medical Degree<br>9 = Nurse Practitioner<br>10 = Other, please specify |
| 9. | Where is your agency located? | City:<br>State: |
| 10. | My agency is located in a _____ | 1 = Rural area<br>2 = Suburban area<br>3 = Urban area |
| 11. | How long have you held your current position at your resettlement agency? | Years: |
| 12. | What it the total amount of time you have worked at your current resettlement agency? | Years: |
| 13. | What is the total amount of time you have worked with refugee populations (e.g., the amount of time you have worked in any setting or position with refugees combined) | Years: |
| 14. | Approximately how many mental health providers are employed in your agency? | Drop down number: |
| 15. | What is your job title at your resettlement agency? | Open-ended: |
| 16. | What types of mental health services does your agency provide? Please select all that apply | 1 = Individual therapy<br>2 = Family therapy<br>3 = Couples therapy<br>4 = Group therapy/Support Group<br>5 = Psychoeducational workshops<br>6 = Mental health screenings<br>7 = Outreach<br>8 = Home-based mental health services<br>9 = Psychological testing/evaluation (e.g., |

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| | | psychodiagnostic, neurological, etc.)<br>10 = Women's groups<br>11 = Other (open-ended): |
| 17. | Which languages (other than English) are you fluent in that you can also use to communicate with your refugee clients? | Open-ended: |
| 18. | Does your agency offer interpretation services (e.g., an individual to translate verbally) for mental health services? | 1 = Yes (if yes, drop down to the following two questions below)<br>2 = No |
| 19. | How often do clients have access to an interpreter that speaks their language to translate for mental health services? | 1 = None of the time<br>2 = Sometimes<br>3 = Often<br>4 = Always |
| 20. | When using interpreters for mental health services, how are they incorporated into services? | 1 = In-person<br>2 = By phone<br>3 = Through video technology (e.g., Skype, Zoom) |
| 21. | I am committed to becoming competent in multicultural counseling. | 1 = Strongly Disagree<br>2 = Disagree<br>3 = I don't know<br>4 = Agree<br>5 = Strongly Agree |
| 22. | Approximately how often are trainings offered? (e.g., daily, weekly, bi-weekly, monthly, yearly) | 1 = Daily<br>2 = Weekly<br>3 = Bi-weekly<br>4 = Monthly<br>5 = Yearly |
| 23. | When was the most recent staff training? | 1 = Within the last week<br>2 = Within the last month<br>3 = Within the past 3 months<br>4 = Within the past 6 months<br>5 = Within the past 9 months<br>6 = Within the past year |
| 24. | ___ Number of multicultural counseling/cultural competence courses attended during undergraduate (include ones currently attending)<br>____Number of multicultural counseling/cultural competence courses attended during graduate (include ones currently attending)<br>____Number of multicultural counseling/cultural competence CME courses attended (include ones currently attending) | Drop down number |

| | | |
|---|---|---|
| | ____Number of multicultural counseling/cultural competence webinars attended (include ones currently attending)<br>____Number of multicultural counseling/cultural competence trainings or workshops attended (include ones currently attending)<br>Of the above, how many of these courses/trainings were offered by your resettlement agency? | |

**Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD) (Sheu & Lent, 2007):** *The following questionnaire consists of items asking about your perceived ability to perform different counselor behaviors in individual counseling with clients who are racially different from you. Using the 0–9 scale, please indicate how much confidence you have in your ability to do each of these activities at the present time, rather than how you might perform in the future. Please choose the number that best reflects your response to each item.*

| Item | Question | Subscales |
|---|---|---|
| 1. | Remain flexible and accepting in resolving cross-cultural strains or impasses | Multicultural Intervention (MI) |
| 2. | Manage your own racially or culturally based countertransference toward the client (e.g., Over-identification with the client because of his or her race/ethnicity) | MI |
| 3. | Help the client to clarify how cultural factors (e.g., racism, acculturation, racial/ethnic identity) may relate to her or his maladaptive beliefs and conflicted feelings | MI |
| 4. | Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse | MI |
| 5. | Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses | MI |
| 6. | Assess the salience and meaningfulness of culture/race/ethnicity in the client's life | MI |
| 7. | Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation) | MI |
| 8. | Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns | MI |

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|---|---|---|
| 9. | Take into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client's presenting problems | MI |
| 10. | Manage your own anxiety due to cross-cultural impasses that arise in the session | MI |
| 11. | Respond in a therapeutic way when the client challenges your multicultural counseling competency | MI |
| 12. | Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs) | MI |
| 13. | Help the client to set counseling goals that take into account expectations from her or his family | MI |
| 14. | Openly discuss cultural differences and similarities between the client and yourself | MI |
| 15. | Address issues of cultural mistrust in ways that can improve the therapeutic relationship | MI |
| 16. | Help the client to develop culturally appropriate ways to deal with systems (e.g., school, community) that affect him or her | MI |
| 17. | Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background | MI |
| 18. | Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race into therapy when the client is not ready to discuss) | MI |
| 19. | Help the client to utilize family/community resources to reach her or his goals | MI |
| 20. | Deal with power-related disparities (i.e., counselor power versus client powerlessness) with a client who has experienced racism or discrimination | MI |
| 21. | Take into account cultural explanations of the client's presenting issues in case conceptualization | MI |
| 22. | Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues | MI |
| 23. | Take into account the impact that family may have on the client in case conceptualization | MI |
| 24. | Deliver treatment to a client who prefers a different counseling style (i.e., directive versus nondirective) | MI |
| 25. | Treat culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness) | Multicultural Assessment (MA) |
| 26. | Assess culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness) | MA |
| 27. | Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways sensitive to cultural differences | MA |
| 28. | Select culturally appropriate assessment tools according to the client's cultural background | MA |
| 29. | Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way | MA |

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| 30. | Conduct a mental status examination in a culturally sensitive way | MA |
| 31. | Encourage the client to take an active role in counseling | Multicultural Session Management (MSM) |
| 32. | Evaluate counseling progress in an ongoing fashion | MSM |
| 33. | Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief) | MSM |
| 34. | Keep sessions on track and focused with a client who is not familiar with the counseling process | MSM |
| 35. | Assess the client's readiness for termination | MSM |
| 36. | Help the client to articulate what she or he has learned from counseling during the termination process | MSM |
| 37. | Identify and integrate the client's culturally specific way of saying good-bye in the termination process | MSM |
| 38. | Thank you for taking the time to complete this survey. Do you have any comments or feedback for researchers? | Open ended: |
| 39. | Would you be willing to participate in a qualitative interview to expand on your answers to this survey? Interviews will last approximately 1-hour and take place by phone (or in-person if possible).<br><br>If yes, please enter your name and contact information (Name, email address and phone number) | Yes or No<br><br>Name and contact info |

If participants respond that they would like to participate, they will be prompted to enter their email address and/or phone number so that the researcher can contact them in the future for a qualitative interview. Indicating an interest in participating will connect identifying information with participant responses. If participants do not indicate an interest in participating, no identifying information will be collected.

# APPENDIX J: QUALITATIVE INTERVIEW PROTOCOL FOR PHASE III

1. Tell me about your **role** at the resettlement agency. What do you do regarding providing mental health services to resettled refugees?
2. How does your agency work to **develop relationships** with refugee groups?
    - ***Sub-questions/Prompts:***
        - In what ways do you or your agency **partner with other programs or agencies** to target mental health issues in the refugee populations you work with?
        - How do you address the **potential stigmatization of mental illness** with your refugee clients?
3. How does your agency **evaluate the effectiveness** of the mental health services you offer to your refugee clients?
    - ***Sub-questions/Prompts:***
        - If evaluations occur at the site, ask: Does your agency **disseminate** (e.g., publish) the results of your evaluations of your offered mental health services?
        - What are the **barriers** to disseminating the results of your evaluations?
4. How do you **define** cultural competence in the context of working with refugee clients?
    - ***Sub-questions/Prompts***
        - How do you **obtain** cultural competence to work with this population?
        - How do you **integrate** cultural competence into your therapeutic interventions with refugee clients?

5. How have the **recent administration changes** related to refugees impacted the work that you do?
6. Are there any additional issues you want to discuss that I did not ask, or we have not talked about?
7. Was there anything in the way I asked these questions that impacted your responses?

# APPENDIX K: AGENCY PARTICIPATION ACROSS PHASES I, II, AND III

| Resettlement Agency | State | Phase I | Phase II | Phase III |
|---|---|---|---|---|
| 1 | CA | Yes | Yes | Yes |
| 2 | FL | Yes | Yes | Yes |
| 3 | IN | Yes | Yes | Yes |
| 4 | IA | No | Yes | Yes |
| 5 | MO | Yes | Yes | Yes |
| 6 | NC | Yes | Yes | Yes |
| 7 | TX | Yes | Yes | Yes |
| 8 | AZ | Yes | Yes | No |
| 9 | CT | Yes | Yes | No |
| 10 | DE | Yes | No | No |
| 11 | IL | Yes | Yes | No |
| 12 | IL | Yes | Yes | No |
| 13 | KS | Yes | Yes | No |
| 14 | KY | Yes | Yes | No |
| 15 | KY | Yes | No | No |
| 16 | MA | Yes | No | No |
| 17 | MI | Yes | Yes | No |
| 18 | MI | Yes | No | No |
| 19 | MN | No | Yes | No |

| | | | | |
|---|---|---|---|---|
| 20 | MO | Yes | No | No |
| 21 | MO | Yes | No | No |
| 22 | NE | Yes | Yes | No |
| 23 | NE | No | Yes | No |
| 24 | NV | Yes | No | No |
| 25 | NY | No | Yes | No |
| 26 | NY | Yes | No | No |
| 27 | NC | Yes | No | No |
| 28 | ND | Yes | No | No |
| 29 | OH | Yes | No | No |
| 30 | OH | Yes | No | No |
| 31 | OH | Yes | No | No |
| 32 | OH | Yes | No | No |
| 33 | OR | Yes | No | No |
| 34 | OR | Yes | No | No |
| 35 | PA | Yes | Yes | No |
| 36 | RI | Yes | Yes | No |
| 37 | SD | Yes | No | No |
| 38 | UT | Yes | No | No |
| 39 | WA | Yes | Yes | No |

## APPENDIX L: LIST OF REFUGEE RESETTLEMENT AGENCIES IN THE U.S. AS OF JUNE 2019

| Resettlement Agency | State | City | Offers Mental Health Services? |
|---|---|---|---|
| **Alabama** | | | |
| Catholic Social Services | AL | Mobile | No |
| **Arkansas** | | | |
| Canopy Northwest Arkansas | AR | Fayetteville | No |
| Catholic Charities Immigration Services | AR | Springdale | Unknown |
| **Arizona** | | | |
| Arizona Immigrant and Refugee Services | AZ | Phoenix | Yes |
| International Rescue Committee | AZ | Phoenix | Yes |
| Arizona Refugee Resettlement Program | AZ | Phoenix | No |
| Lutheran Social Services of the Southwest Phoenix | AZ | Phoenix | No |
| International Rescue Committee | AZ | Tucson | Yes |
| Catholic Migration & Refugee Services | AZ | Tucson | No |
| Lutheran Social Services of the Southwest | AZ | Tucson | No |
| **California** | | | |
| World Relief Southern California | CA | Garden Grove | No |

| | | | |
|---|---|---|---|
| Catholic Charities | CA | Glendale | No longer provides resettlement services/Closed |
| International Institute of Los Angeles | CA | Glendale | No |
| International Rescue Committee | CA | Glendale | No |
| African Community Resource Center | CA | Los Angeles | No longer provides resettlement services/Closed |
| Interfaith Refugee and Immigration Service | CA | Los Angeles | No |
| Jewish Family Service of Silicon Valley | CA | Los Gatos | No |
| International Rescue Committee | CA | Oakland | Unknown |
| Catholic Charities East Bay | CA | Oakland | No longer provides resettlement services/Closed |
| Lao Family Community Development | CA | Oakland | No |
| Sacramento Food Bank and Family Services | CA | Sacramento | No |
| Lao Family Community Development | CA | Sacramento | No |
| World Relief | CA | Sacramento | No |
| International Rescue Committee | CA | Sacramento | No |
| Opening Doors, Inc. | CA | Sacramento | Yes |
| Catholic Charities | CA | San Bernardino | No |

| | | | |
|---|---|---|---|
| Catholic Charities | CA | San Diego | Unknown |
| International Rescue Committee | CA | San Diego | Unknown |
| Jewish Family Service of San Diego | CA | San Diego | Unknown |
| Alliance for African Assistance | CA | San Diego | Yes |
| Catholic Charities | CA | San Jose | Yes |
| International Rescue Committee | CA | San Jose | No |
| Lao Community Development | CA | San Pablo | No |
| International Rescue Committee | CA | Turlock | No |
| **Colorado** | | | |
| Lutheran Family Services of Colorado | CO | Colorado Springs | No |
| International Rescue Committee | CO | Denver | No |
| Ecumenical Refugee and Immigration Services, Inc | CO | Denver | Unknown |
| African Community Center | CO | Denver | No |
| Lutheran Family Services of Colorado | CO | Denver | Yes |
| Lutheran Family Services of Colorado | CO | Greeley | No |
| Lutheran Family Services | CO | Rocky Mountains | No |
| **Connecticut** | | | |
| Connecticut Institute for Refugees and Immigrants | CT | Bridgepoint | No |
| Catholic Charities | CT | Hartford | No |

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|---|---|---|---|
| Integrated Refugee and Immigrant Services | CT | New Haven | Yes |
| **Delaware** | | | |
| Jewish Family Service Refugee Integration Support Effort | DE | Wilmington | Yes |
| **Florida** | | | |
| Coptic Orthodox Charities | FL | Clearwater | No longer provides resettlement services/Closed |
| Gulf Coast Jewish Family and Community Services | FL | Clearwater | No |
| Church World Service | FL | Doral | No |
| St Augustine/Jacksonville Catholic Charities | FL | Jacksonville | Unknown |
| Lutheran Social Services of N.E. Florida | FL | Jacksonville | No |
| World Relief | FL | Jacksonville | Yes |
| Catholic Charities | FL | Miami | Unknown |
| International Rescue Committee | FL | Miami | No longer provides resettlement services/Closed |
| Lutheran Services Florida | FL | Miami | No |
| IRSA Youth Co Op Inc | FL | Miami | No |
| World Relief | FL | Miami | No |
| Episcopal Migration Ministries | FL | Miami Springs | No longer provides resettlement services/Closed |

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|---|---|---|---|
| Catholic Charities | FL | Naples | No longer provides resettlement services/Closed |
| Catholic Charities | FL | North Port | Unknown |
| Catholic Charities of Central Florida | FL | Orlando | Unknown |
| Lutheran Services Florida | FL | Orlando | Unknown |
| Church World Service | FL | Palm Beach | No |
| Catholic Charities of Northeast Florida | FL | Pensacola | No |
| Catholic Charities | FL | Riviera Beach | No |
| International Rescue Committee | FL | Tallahassee | No longer provides resettlement services/Closed |
| Catholic Charities | FL | Tampa | No longer provides resettlement services/Closed |
| Coptic Orthodox Charities | FL | Tampa | No longer provides resettlement services/Closed |
| Lutheran Services Florida | FL | Tampa | No |
| **Georgia** | | | |
| International Rescue Committee | GA | Atlanta | Yes |
| Catholic Charities | GA | Atlanta | No |
| Inspiritus | GA | Atlanta | No |
| New American Pathways | GA | Atlanta | No |
| World Relief | GA | Atlanta | No |
| Inspiritus | GA | Savannah | No |
| **Hawaii** | | | |

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|---|---|---|---|
| Pacific Gateway Center | HI | Honolulu | No longer provides resettlement services/Closed |
| **Iowa** | | | |
| Catherine McAuley Center | IA | Cedar Rapids | No |
| Catholic Charities | IA | Des Moines | No |
| US Committee for Refugees and Immigrants | IA | Des Moines | No |
| US Committee for Refugees and Immigrants | IA | Des Moines | No |
| Lutheran Services Iowa | IA | Des Moines | Yes |
| **Idaho** | | | |
| Jannus, Inc. | ID | Boise | Unknown |
| International Rescue Committee | ID | Boise | No |
| The Agency for New Americans | ID | Boise | No |
| College of Southern Idaho Refugee Programs | ID | Twin Falls | No |
| **Illinois** | | | |
| World Relief | IL | Aurora | Yes |
| World Relief | IL | Carol Stream | Yes |
| Jewish Child and Family Services of Chicago | IL | Chicago | No longer provides resettlement services/Closed |
| Catholic Charities | IL | Chicago | No |
| Ethiopian Community Association of Chicago | IL | Chicago | No |
| Heartland Alliance for Human Needs and Human Rights | IL | Chicago | No |

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|---|---|---|---|
| World Relief | IL | Chicago | No |
| RefugeeOne | IL | Chicago | Yes |
| World Relief | IL | Moline | No |
| Catholic Charities | IL | Rockford | No |
| **Indiana** | | | |
| Catholic Charities | IN | East Chicago | No longer provides resettlement services/Closed |
| Catholic Charities | IN | Fort Wayne/South Bend | No |
| Exodus Refugee Immigration | IN | Indianapolis | Yes |
| American Red Cross St. Joseph County Chapter | IN | South Bend | No longer provides resettlement services/Closed |
| **Kansas** | | | |
| International Rescue Committee | KS | Garden City | Unknown |
| Catholic Charities of Northeast Kansas | KS | Kansas City | Yes |
| International Rescue Committee | KS | Wichita | Unknown |
| Episcopal Wichita Area Refugee Ministry | KS | Wichita | No |
| **Kentucky** | | | |
| International Center of Kentucky | KY | Bowling Green | No |
| Church World Service | KY | Louisville | Yes |
| Kentucky Refugee Ministries, Inc. | KY | Louisville | Yes |

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|---|---|---|---|
| Western Kentucky Refugee Mutual Assistance | KY | Owensboro | Yes |
| **Louisiana** | | | |
| Catholic Charities | LA | Baton Rogue | No |
| Catholic Charities | LA | Metairie | No |
| **Massachusetts** | | | |
| Catholic Charities | MA | Boston | No |
| International Institute of New England | MA | Boston | No |
| Refugee & Immigrant Assistance Center | MA | Jamaica Plain | Yes |
| International Institute of Lowell | MA | Lowell | No |
| Catholic Charities | MA | Northampton | No |
| Jewish Family Service of Western Massachusetts | MA | Pittsfield | Yes |
| World Relief | MA | Salem | No |
| Jewish Family Service of Western Massachusetts | MA | Springfield | Yes |
| Catholic Charities Agency | MA | Springfield | No |
| Ascentria Care Alliance, INC. | MA | West Springfield | Unknown |
| Ascentria | MA | Worcester | Unknown |
| Catholic Charities | MA | Worcester | No |
| Refugee and Immigrant Assistance Center | MA | Worcester | No |
| **Maine** | | | |
| Catholic Charities | ME | Portland | No |
| **Michigan** | | | |
| Jewish Family Services of Washtenaw County | MI | Ann Arbor | Yes |

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|---|---|---|---|
| Samaritas | MI | Battle Creek | No |
| Catholic Charities of South East Michigan | MI | Clinton Township | No |
| USCRI Dearborn | MI | Dearborn | No |
| Samaritas | MI | Grand Rapids | No |
| Samaritas | MI | Lansing | Unknown |
| St Vincent Catholic Charities | MI | Lansing | No |
| Michigan Catholic Conference | MI | Lansing | Yes |
| Lutheran Social Services of Michigan | MI | Troy | No |
| **Minnesota** | | | |
| Lutheran Social Services of Minnesota | MN | Minneapolis | No |
| Minnesota Council of Churches/Refugee Services | MN | Minneapolis | No |
| Arrive Ministries | MN | Richfield | No |
| Catholic Charities | MN | Rochester | No |
| Catholic Charities Migration & Refugee Services | MN | Saint Paul | No |
| Lutheran Social Services of Minnesota | MN | Saint Paul | Yes |
| Lutheran Social Services of Minnesota | MN | St. Cloud | No |
| **Missouri** | | | |
| Refugee & Immigration Services | MO | Columbia | Yes |
| Della Lamb Community Services | MO | Kansas City | No |

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|---|---|---|---|
| Refugee & Immigration Services | MO | Kansas City | Yes |
| International Institute of Southwest Missouri | MO | Springfield | No |
| Refugee & Immigration Services | MO | St. Louis | Yes |
| **Mississippi** | | | |
| Catholic Charities | MS | Jackson | Yes |
| **Montana** | | | |
| International Rescue Committee | MT | Missoula | No |
| **North Carolina** | | | |
| Carolina Refugee Resettlement Agency | NC | Charlotte | No |
| Catholic Charities | NC | Charlotte | No |
| International Rescue Committee | NC | Charlottesville | No |
| Church World Service | NC | Durham | No |
| World Relief | NC | Durham | No |
| Church World Service | NC | Greensboro | No |
| North Carolina African Services Coalition | NC | Greensboro | No |
| World Relief | NC | High Point | Yes |
| Diocese Of East Carolina Interfaith Refugee Ministry | NC | New Bern | No |
| UC Committee for Refugees and Immigrants | NC | Raleigh | No |
| Lutheran Family Services In The Carolinas | NC | Raleigh | No |

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|---|---|---|---|
| Diocese of East Carolina Interfaith Refugee Ministry | NC | Wilmington | No |
| **North Dakota** | | | |
| Lutheran Social Services Of North Dakota | ND | Bismarck | Yes |
| Lutheran Social Services Of North Dakota | ND | Fargo | Yes |
| Lutheran Social Services Of North Dakota | ND | Grand Forks | Yes |
| **Nebraska** | | | |
| Catholic Social Services | NE | Lincoln | No |
| Lutheran Family Services of Nebraska, Inc. | NE | Lincoln | Yes |
| Lutheran Family Services of Nebraska, Inc. | NE | Omaha | Yes |
| Refugee Empowerment Center | NE | Omaha | Yes |
| **New Hampshire** | | | |
| Ascentria Care Alliance | NH | Concord | No |
| International Institute Of New Hampshire | NH | Manchester | No |
| **New Jersey** | | | |
| Refugee Microenterprise Development, Diocese of Camden | NJ | Camden | No |
| Jewish Vocational Services of Metrowest | NJ | East Orange | No longer provides resettlement services/Closed |
| International Rescue Committee | NJ | Elizabeth | No |

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|---|---|---|---|
| Reformed Church Highland Park | NJ | Highland Park | No |
| Church World Service | NJ | Jersey City | No |
| Catholic Charities | NJ | Newark | No longer provides resettlement services/Closed |
| **New Mexico** | | | |
| Lutheran Family Services Rocky Mountains | NM | Albuquerque | No |
| **Nevada** | | | |
| African Community Center In Las Vegas | NV | Las Vegas | No |
| Immigration & Migration Services | NV | Las Vegas | Yes |
| Northern Nevada International Center | NV | Reno | No |
| **New York** | | | |
| USCRI Albany Field Office | NY | Albany | No |
| Catholic Charities | NY | Amityville | Unknown |
| American Civic Association Inc | NY | Binghamton | No |
| Catholic Charities | NY | Brooklyn | No longer provides resettlement services/Closed |
| International Institute Of Buffalo, Inc. | NY | Buffalo | No |
| Journey's End Refugee Services | NY | Buffalo | No |
| Refugee Assistance Program Catholic Charities | NY | Buffalo | No |

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|---|---|---|---|
| Jewish Family Service of Buffalo and Erie County | NY | Buffalo | Yes |
| Catholic Charities of Tompkins/Tioga | NY | Ithaca | No longer provides resettlement services/Closed |
| Catholic Charities Community Services | NY | New York | Yes |
| FEGS Health & Human Services | NY | New York | No longer provides resettlement services/Closed |
| HIAS New York | NY | New York | No |
| International Rescue Committee | NY | New York | No |
| HRH Care Community Health | NY | Poughkeepsie | No longer provides resettlement services/Closed |
| Catholic Family Center/Refugee Resettlement Program | NY | Rochester | No |
| Interfaith Works of Central New York | NY | Syracuse | No |
| Northside CYO/Catholic Charities | NY | Syracuse | No |
| Mohawk Valley Resource Center for Refugees | NY | Utica | No |
| HIAS New York | NY | Westchester County | No |
| Catholic Charities | NY | Yonkers | No longer provides resettlement services/Closed |
| **Ohio** | | | |

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|---|---|---|---|
| World Relief | OH | Akron | No longer provides resettlement services/Closed |
| International Institute of Akron, Inc | OH | Akron | No |
| Catholic Charities | OH | Cincinnati | No |
| The International Services Center | OH | Cleveland | No |
| Us Together | OH | Cleveland | Yes |
| Migration and Refugee Services | OH | Cleveland | Yes |
| World Relief | OH | Columbus | No longer provides resettlement services/Closed |
| Us Together | OH | Columbus | No |
| Catholic Social Services | OH | Dayton | No |
| Us Together | OH | Toledo | No |
| **Oklahoma** | | | |
| Catholic Charities | OK | Oklahoma City | No |
| Catholic Charities | OK | Tulsa | No longer provides resettlement services/Closed |
| SOAR/Ecumenical Ministries of Oregon | OR | Portland | Yes |
| Lutheran Community Services Northwest | OR | Portland | Yes |
| Refugee Resettlement | OR | Portland | Yes |
| **Pennsylvania** | | | |
| Bethany Christian Services of Greater Delaware Valley | PA | Allentown | No |

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|---|---|---|---|
| Catholic Social Services | PA | Chester | No longer provides resettlement services/Closed |
| Catholic Charities | PA | Erie | No |
| International Institute of Erie | PA | Erie | No |
| Catholic Charities | PA | Harrisburg | No |
| Church World Service | PA | Lancaster | No |
| Bethany Christian Services of the Greater Delaware Valley | PA | Lancaster | No |
| Bethany Christian Services of the Greater Delaware Valley | PA | Philadelphia | Yes |
| Nationalities Service Center of Philadelphia | PA | Philadelphia | Yes |
| HIAS and Council Migration Service | PA | Philadelphia | No |
| Acculturation for Justice, Access, and Peace Outreach | PA | Pittsburg | No |
| Jewish Family and Community Services | PA | Pittsburg | Yes |
| Catholic Charities | PA | Pittsburgh | No longer provides resettlement services/Closed |
| Northern Area Multi Service Center | PA | Pittsburgh | No longer provides resettlement services/Closed |
| Catholic Charities | PA | Scranton | No longer provides resettlement services/Closed |
| **Rhode Island** | | | |

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|---|---|---|---|
| Immigration and Refugee Services | RI | Providence | No |
| Dorcas International Institute of Rhode Island | RI | Providence | Yes |
| **South Carolina** | | | |
| Lutheran Services Carolinas | SC | Charleston | No |
| Lutheran Family Services in the Carolinas | SC | Columbia | No |
| World Relief Upstate | SC | Greeneville | No |
| World Relief | SC | Spartanburg | No |
| **South Dakota** | | | |
| Lutheran Social Services Center for New Americans | SD | Sioux Falls | Yes |
| **Tennessee** | | | |
| Bridge Refugee Services | TN | Chattanooga | No |
| Bridge Refugee Services | TN | Knoxville | No |
| Catholic Charities of Tennessee, Inc. | TN | Nashville | No |
| Nashville International Center for Empowerment | TN | Nashville | No |
| **Texas** | | | |
| International Rescue Committee | TX | Abilene | No |
| Refugee Services of Texas | TX | Amarillo | Yes |
| Catholic Charities of Texas Panhandle | TX | Amarillo | No |
| Refugee Services of Texas | TX | Austin | Yes |
| Refugee Services of Texas | TX | Dallas | Yes |
| Catholic Charities | TX | Dallas | No |

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|---|---|---|---|
| International Rescue Committee | TX | Dallas | No |
| Migrant and Refugee Services | TX | El Paso | No longer provides resettlement services/Closed |
| Catholic Charities | TX | Fort Worth | No longer provides resettlement services/Closed |
| Refugee Services of Texas | TX | Fort Worth | No |
| World Relief | TX | Fort Worth | No |
| Catholic Charities | TX | Houston | No |
| Interfaith Ministries for Greater Houston | TX | Houston | No |
| YMCA International Services | TX | Houston | No |
| Refugee Services of Texas, Inc | TX | Houston | No |
| The Alliance | TX | Houston | Yes |
| Catholic Charities | TX | San Antonio | No |
| Refugee and Immigrant Center for Education and Legal Services | TX | San Antonio | No |
| **Utah** | | | |
| Catholic Community Services | UT | Salt Lake City | No |
| International Rescue Committee | UT | Salt Lake City | Yes |
| **Virginia** | | | |
| Catholic Charities | VA | Arlington | No |
| Ethiopian Community Development Council | VA | Arlington | No |

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|---|---|---|---|
| Lutheran Social Services of The National Capital Area | VA | Falls Church | No |
| Catholic Charities | VA | Fredericksburg | No |
| Church World Service | VA | Harrisonburg | No |
| Commonwealth Catholic Charities | VA | Richmond | Yes |
| Church World Service | VA | Richmond | No longer provides resettlement services/Closed |
| International Rescue Committee | VA | Richmond | No |
| Commonwealth Catholic Charities | VA | Roanoke | Yes |
| **Vermont** | | | |
| USCRI | VT | Colchester | No |
| USCRI | VT | Rutland | No |
| **Washington** | | | |
| World Relief | WA | Kent | No |
| Lutheran Community Services Northwest | WA | Kent | Yes |
| Jewish Family Service of Greater Seattle | WA | Kent | No |
| World Relief Tri Cities | WA | Richland | No |
| International Rescue Committee | WA | SeaTac | No |
| Lutheran Community Services Northwest | WA | SeaTac | Yes |
| Refugee Resettlement Office | WA | Seattle | No |
| World Relief | WA | Spokane | No |

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|---|---|---|---|
| Jewish Family Services of Seattle | WA | Tacoma | No |
| **Wisconsin** | | | |
| Resettlement and Immigrations Services | WI | Green Bay | No |
| Jewish Family Social Services | WI | Madison | No |
| Catholic Charities | WI | Milwaukee | No longer provides resettlement services/Closed |
| Pan African Community Association | WI | Milwaukee | No longer provides resettlement services/Closed |
| International Institute of Wisconsin | WI | Milwaukee | No |
| Lutheran Social Services of Wisconsin and Upper Michigan, Milwaukee and Madison | WI | Milwaukee | No |
| World Relief Fox Valley | WI | Oshkosh | Unknown |
| Catholic Charities | WI | Sheboygan | No longer provides resettlement services/Closed |
| **West Virginia** | | | |
| Catholic Charities | WV | Charleston | No |

# APPENDIX M: PUBLIC LIST OF REFUGEE RESETTLEMENT AGENCIES

**Department of State**
**Bureau of Population, Refugees, and Migration**
**Office of Admissions - Refugee Processing Center**
**Affiliate Directory**

| | | |
|---|---|---|
| | ***Alaska*** | |
| **USCCB** | | |
| **AK-USCCB-01: CATHOLIC SOCIAL SERVICES** | | |
| Address: | 3710 E. 20TH AVE.<br>ANCHORAGE, AK 99508 | |
| Phone: | 907-222-7376 | Fax: 907-276-5539 |
| | ***Alabama*** | |
| **USCCB** | | |
| **AL-USCCB-03: Catholic Social Services** | | |
| Address: | 406 Government St.<br>Mobile, AL 36602 | |
| Phone: | 251-432-2727 | Fax: 251-432-2927 |
| | ***Arkansas*** | |
| **USCCB** | | |
| **AR-USCCB-03: Catholic Charities Immigration Services** | | |
| Address: | 2022 W Sunset Ave.<br>Springdale, AR 72762 | |
| Phone: | 479-927-1996 x304 | Fax: 479-927-2979 |
| | ***Arizona*** | |
| **IRC** | | |
| **AZ-IRC-01: International Rescue Committee** | | |
| Address: | 4425 West Olive Avenue, Suite 400<br>Glendale, AZ 85302-3847 | |
| Phone: | 602-433-2440 | Fax: 602-433-2881 |
| **CWS** | | |
| **AZ-CWS-01: Lutheran Social Services of the Southwest** | | |
| Address: | 3443 N. Cental Ave., North Rotunda<br>Phoenix, AZ 85012 | |
| Phone: | 602-248-4400 | Fax: 602-248-4968 |
| **ECDC** | | |
| **AZ-ECDC-01: Arizona Immigrant and Refugee Services** | | |
| Address: | 10240 North 31st Avenue, Suite 112<br>Phoenix, AZ 85051 | |
| Phone: | 602-944-1821 | Fax: 602-944-1860 |
| **LIRS** | | |
| **AZ-LIRS-01: Refugee Focus** | | |
| Address: | 3443 N.Central Ave, North Rotunda<br>Phoenix, AZ 85012 | |
| Phone: | 602-248-4400 | Fax: 602-248-4968 |

| | | |
|---|---|---|
| | *Arizona* | |
| **USCCB** | | |
| **AZ-USCCB-01: CATHOLIC CHARITIES COMMUNITY SERVICES** | | |
| Address: | 1825 W Northern Avenue<br>Phoenix, AZ 85021-5298 | |
| Phone: | 602-997-6105 x51028 | Fax: 602-870-2891 |
| **USCCB** | | |
| **AZ-USCCB-03: Catholic Charities Community Services** | | |
| Address: | 615 West Pierson Street<br>Phoenix, AZ 85013 | |
| Phone: | 602-530-5519 | Fax: 602-944-1829 |
| **DFMS** | | |
| **AZ-DFMS-01: Refugee Focus** | | |
| Address: | 120 N. Stone Ave.,Suite#220R<br>Tucson, AZ 85701 | |
| Phone: | 520-721-4444 | Fax: 520-721-4479 |
| **IRC** | | |
| **AZ-IRC-02: International Rescue Committee** | | |
| Address: | 3100 N. Campbell Avenue, Suite 101<br>Tucson, AZ 85719 | |
| Phone: | 520-319-2128 | Fax: 520-319-2160 |
| **LIRS** | | |
| **AZ-LIRS-02: Refugee Focus** | | |
| Address: | 120 N. Stone Ave. Suite# 220R<br>Tucson, AZ 85701 | |
| Phone: | 520-721-4444 EXT 13 | Fax: 520-721-4479 |
| **USCCB** | | |
| **AZ-USCCB-02: Catholic Migration & Refugee Services** | | |
| Address: | 140 W. Speedway Blvd #130<br>Tucson, AZ 85705 | |
| Phone: | 520-623-0344 x1012 | Fax: 520-770-8556 |
| | *California* | |
| **ECDC** | | |
| **CA-ECDC-04: East African Community Of Orange County** | | |
| Address: | 2323 W. Lincoln Ave., Suite 205<br>Anaheim, CA 92801 | |
| Phone: | 714-254-8880 | Fax: 714-991-5258 |
| **LIRS** | | |
| **CA-LIRS-06: Crittenton Services For Children & Families** | | |
| Address: | 801 E. Chapman Ave. # 230<br>Fullerton, CA 92831-3839 | |
| Phone: | 714-680-8221 | Fax: 714-680-8222 |
| **WR** | | |
| **CA-WR-01: World Relief Garden Grove** | | |
| Address: | 13121 Brookhurst Street, #G<br>Garden Grove, CA 92843 | |
| Phone: | 714-210-4730 | Fax: 714-210-4733 |

**USCRI**
**CA-USCRI-02: International Institute Of Los Angeles**
Address: 3800 La Crescenta Ave., Suite #204
Glendale, CA 91214
Phone: (818) 244-2550 Fax: (818) 244-2580

**CWS**
**CA-CWS-07: Interfaith Refugee & Immigration Service**
Address: 3621 Brunswick Ave
Los Angeles, CA 90039
Phone: 323-661-8588 Fax: 323-667-2271

**DFMS**
**CA-DFMS-02: Interfaith Refugee And Immigration Minitsry Of The Episcopal Diocese Of Los Angeles**
Address: 3621 Brunswick Ave
Los Angeles, CA 90039
Phone: 323-667-0489 Fax: 323-667-2271

**ECDC**
**CA-ECDC-01: African Community Resource Center**
Address: 3540 Wilshire Blvd., Suite 321
Los Angeles, CA 90010
Phone: 213-637-1450 Fax: 213-637-1455

**HIAS**
**CA-HIAS-02: JFS Immigration And Resettlement Program**
Address: 4311 Wilshire Blvd., Suite 211
Los Angeles, CA 90010
Phone: 323-935-5303 Fax: 323-935-5161

**LIRS**
**CA-LIRS-01: Interfaith Refugee And Immigration Service**
Address: 3621 Brunswick Ave
Los Angeles, CA 90039
Phone: 323-661-8588 Fax: 323-667-2271

**HIAS**
**CA-HIAS-08: Jewish Family Service Of Silicon Valley**
Address: 14855 Oka Road Suite 202
Los Gatos, CA 95032
Phone: 408-556-0600 Fax: 408-551-0091

**WR**
**CA-WR-09: World Relief Modesto**
Address: 1401 F Street
Modesto, CA 95354
Phone: 209-491-2712 Fax: 209-575-1132

**IRC**
**CA-IRC-03: International Rescue Committee**
Address: 405 14th Street, Suite 1415
Oakland, CA 94612
Phone: 510-452-8222 Fax: 510-452-8228

**USCCB**
**CA-USCCB-10: Catholic Charities**
Address: 433 Jefferson Street
Oakland, CA 94607-3539
Phone: 510-768-3106 Fax: 510-451-6998

*California*

**CWS**
**CA-CWS-06: Opening Doors, Inc.**
Address: 1111 Howe Avenue, Suite 125
Sacramento, CA 95825
Phone: 916-492-2591 Fax: 916-492-2628

**IRC**
**CA-IRC-08: International Rescue Committee**
Address: 2020 Hurley Way #395
Sacramento, CA 95825
Phone: 916-482-0120 Fax: 916-482-8806

**USCCB**
**CA-USCCB-09: Sacramento Food Bank & Family Services**
Address: 2469 Rio Linda Blvd.
Sacramento, CA 95815
Phone: 916-649-6745 Fax: 916-648-8739

**WR**
**CA-WR-07: World Relief Sacramento**
Address: 3750 Auburn Blvd, Suite B
Sacramento, CA 95821
Phone: 916-978-2650 Fax: 916-978-2658

**USCCB**
**CA-USCCB-03: Catholic Charities**
Address: 1450 North D Street
San Bernardino, CA 92405-4739
Phone: 909-388-1243 x217 Fax: 909-384-1130

**ECDC**
**CA-ECDC-02: Alliance For African Assistance**
Address: 5952 El Cajon Blvd
San Diego, CA 92115
Phone: 619-286-9052 Fax: 619-286-9053

**HIAS**
**CA-HIAS-05: Jewish Family Service Of San Diego**
Address: 8804 Balboa Ave.
San Diego, CA 92123-1506
Phone: 858-637-3030 Fax: 858-637-3239

**IRC**
**CA-IRC-02: International Rescue Committee San Diego**
Address: 5348 University Ave, Suite 205
San Diego, CA 92105
Phone: 619-641-7510 Fax: 619-641-7520

**USCCB**
**CA-USCCB-01: Catholic Charities**
Address: 4575-A Mission Gorge Place, Suite A
San Diego, CA 92120
Phone: 619-287-9454 x185 Fax: 619-287-6328

**HIAS**
**CA-HIAS-09: Jewish Family & Children's Services Of San Franciso**
Address: 2534 Judah St.
San Francisco, CA 94122
Phone: 415-449-1286 Fax: 415-449-2901

*California*

**USCCB**
**CA-USCCB-11: Catholic Charities Cyo**
Address: 990 Eddy Street
San Francisco, CA 94109
Phone: 415-972-1311 Fax: 415-972-1360

**IRC**
**CA-IRC-05: International Rescue Committee San Jose**
Address: 1210 South Bascom Avenue, #227
San Jose, CA 95128
Phone: 408-453-3536 Fax: 408-277-0697

**USCCB**
**CA-USCCB-16: Catholic Charities**
Address: 2625 Zanker Road,2nd Floor
San Jose, CA 95134-2130
Phone: (408) 325-5195 Fax: 408-944-0347

**IRC**
**CA-IRC-11: International Rescue Committee**
Address: 2130 Geer Road Suite C
Turlock, CA 95382
Phone: 209-667-2378 Fax: 209-667-9713

**HIAS**
**CA-HIAS-16: Jewish Family & Children's Services Of East Bay**
Address: 1855 Olympic Blvd.
Suite 200
Walnut Creek, CA 94596
Phone: 905-927-2000 Fax: 510-704-7494

*Colorado*

**LIRS**
**CO-LIRS-02: Lutheran Family Services Of Colorado**
Address: 132 E Las Animas
Colorado Springs, CO 80903
Phone: 719-314-0223 Fax: 719-227-7592

**CWS**
**CO-CWS-01: Ecumenical Refugee and Immigration Services, Inc.**
Address: 1600 Downing Street, Suite 400
Denver, CO 80218
Phone: 303-860-0128 Fax: 303-860-1015

**DFMS**
**CO-DFMS-01: Ecumenical Refugee and Immigration Services, Inc.**
Address: 1600 Downing Street, Suite 400
Denver, CO 80218
Phone: 303-860-0128 Fax: 303-860-1015

**ECDC**
**CO-ECDC-01: ECDC African Community Center**
Address: 5250 Leetsdale Drive, Suite 200
Denver, CO 80246
Phone: 303-399-4500 Fax: 303-399-4502

*Colorado*

**LIRS**
**CO-LIRS-01: Lutheran Family Services Of Colorado**
Address: 1600 Downing Street, Ste 600
Denver, CO 80218
Phone: 303-980-5400 ext 182 Fax: 303-980-8588

**LIRS**
**CO-LIRS-05: Lutheran Family Services Of Colorado**
Address: 800 8th Avenue , Suite 225
Greeley, CO 80631
Phone: 970-336-. 2201 Fax: 970-353-5284

*Connecticut*

**USCRI**
**CT-USCRI-02: International Institute Of Connecticut**
Address: 670 Clinton Avenue
Bridgeport, CT 06605
Phone: 203-336-0141 Fax: 203-339-4400

**USCCB**
**CT-USCCB-01: Catholic Charities**
Address: 125 Market Street
Hartford, CT 06103-1308
Phone: 860-548-0059 ext. 18 Fax: 860-549-8697

**CWS**
**CT-CWS-01: Integrated Refugee And Immigrant Services (IRIS)**
Address: 235 Nicoll St, 2nd Floor
New Haven, CT 06511
Phone: 203-562-2095 Fax: 203-562-1798

**DFMS**
**CT-DFMS-01: Integrated Refugee And Immigrant Services (IRIS)**
Address: 235 Nicoll Street, 2nd Fl
New Haven, CT 06511
Phone: 203-562-2095 Fax: 203-562-1798

*Delaware*

**USCCB**
**DE-USCCB-01: Catholic Charities**
Address: 2601 West 4th Street, P.O. Box 2610
Wilmington, DE 19805
Phone: 302-655-9624 ext 141 Fax: 302-655-9753

*Florida*

**ECDC**
**FL-ECDC-01: Coptic Orthodox Charities**
Address: 2312 Gulf-To-Bay Blvd
Clearwater, FL 33765
Phone: 727-785-3551 Fax: 727-787-8442

**HIAS**
**FL-HIAS-11: Gulf Coast Jewish Family And Community Services**
Address: 14041 Icot Boulevard
Clearwater, FL 33760
Phone: 727.450.7274 Fax: 727-450-7285

**CWS**
**FL-CWS-03: Church World Service/Palm Beach (Sub-Office)**
Address: 220 S. Congress Park Drive, Suite 300
Delray Beach, FL 33445
Phone: 561-266-0624 Fax: 561-266-0629

**CWS**
**FL-CWS-01: CWS/IRP-Miami**
Address: 1924 Nw 84th Ave Building 10, Beacon Centre
Doral, FL 33126
Phone: 305-774-6770 Fax: 305-774-6586

**DFMS**
**FL-DFMS-03: Lutheran Social Services Of N.E. Florida**
Address: 4615 Philips Highway
Jacksonville, FL 32207
Phone: 904-730-8225 Fax: 904-448-6044

**LIRS**
**FL-LIRS-02: Lutheran Social Services Of Ne Florida**
Address: 4615 Philips Hwy
Jacksonville, FL 32207
Phone: 904-448-5995 Fax: 904-448-6044

**USCCB**
**FL-USCCB-02: St Augustine/Jacksonville Catholic Charities**
Address: 134 East Church Street, Suite 2
Jacksonville, FL 32202-3130
Phone: 904-354-4846 Fax: 904-354-4718

**WR**
**FL-WR-03: World Relief Jacksonville**
Address: 5107 W. University Blvd. Suite 200
Jacksonville, FL 32216
Phone: 904-448-0733 Fax: 904-448-0736

**IRC**
**FL-IRC-01: International Rescue Committee**
Address: 730 Nw 107th Avenue, Suite 100
Miami, FL 33172
Phone: 305-640-9881 Fax: 305-640-9978

**LIRS**
**FL-LIRS-05: Lutheran Services Florida**
Address: Festival Shopping Center, 8532 Sw 8th Street, Suite #270
Miami, FL 33144
Phone: 305-567-2511x 102 Fax: 305-567-2944

**USCCB**
**FL-USCCB-07: Refugee Resettlement Program**
Address: 7707 NW 2nd Avenue
Miami, FL 33150
Phone: 305-883-4555 Fax: 305-883-4498

**USCRI**
**FL-USCRI-01: IRSA/Youth Co-Op Inc.**
Address: 3525nw 7th Street
Miami, FL 33125
Phone: 305-643-6730 Fax: 305-643-1146

*Florida*

**WR**
**FL-WR-01: World Relief Miami**
Address: 2150 Sw 8th Street, 2nd Floor
Miami, FL 33135-2800
Phone: 305-541-8320 Fax: 305-541-9841

**DFMS**
**FL-DFMS-02: Episcopal Migration Ministries**
Address: 700 S. Royal Poinciana Boulevard
Miami Springs, FL 33135
Phone: 305-541-8327 Fax: 866-546-4518

**USCCB**
**FL-USCCB-09: Catholic Charities**
Address: 2210 Santa Barbara
Naples, FL 34116
Phone: (239) 352-0449 Fax: 239-445-7235

**USCCB**
**FL-USCCB-05: Catholic Charities**
Address: 5900 Pan American Blvd., Suite 202
North Port, FL 34287
Phone: 941-564-8738 Fax: 941-876-3159

**LIRS**
**FL-LIRS-03: Lutheran Services Florida**
Address: 427 N Magnolia Ave (2nd Floor)
Orlando, FL 32801
Phone: 407-869-0988 Fax: 407.822.8910

**USCCB**
**FL-USCCB-06: CATHOLIC IMMIG./REFUGEE SERVICES**
Address: 1819 N SEMORAN BOULEVARD
ORLANDO, FL 32807-3544
Phone: 407-658-1818 X.2061 Fax: 407-673-1380

**USCRI**
**FL-USCRI-03: Youth Co-Op, Inc., Palm Springs**
Address: 2112 Congress Avenue
Palm Springs, FL 33406
Phone: 561-964-1693 Fax: 561-964-5413

**USCCB**
**FL-USCCB-01: Catholic Charities**
Address: 1 North C Street
Pensacola, FL 32502
Phone: 850-436-6420 Fax: 850-435-3562

**HIAS**
**FL-HIAS-12: Gulf Coast Jewish Family And Community Services - Broward County office**
Address: 100 South Pine Island Road
Suite 230
Plantation, FL 33324
Phone: 954-598-4920 Fax:

**USCCB**
**FL-USCCB-04: Catholic Charities**
Address: 100 W 20th Street
Riviera Beach, FL 33404
Phone: 561-345-2000 Fax: 561-863-1680

# APPENDIX N: INTEGRATION OF DATA ACROSS PHASES I, II, AND III

Comparison of Available Mental Health Services Across Phases (RQ1a)

| Mental Health Service Offered | Phase I – Agency Quantitative Survey | Phase II – Provider Quantitative Survey | Phase III – Provider Qualitative Interviews |
|---|---|---|---|
| Individual Therapy | 82.9% (N = 29) | - | • 100% (N = 7)<br>• "We built up this program that would incorporate individual counseling for adults initially, we've now also expanded it to kids, marriage, couples counseling and family counseling, but originally it was individually, and we would do weekly counseling sessions." |
| Group Therapy | 71.4% (N = 25) | - | • 71.4% (N = 5)<br>• "In all the research that I've seen around immigrant and mental health services, there's a focus on community healing…And I don't believe that you can do this work without bringing people together and sharing and I really believe that there's so much that can be accomplished in a group setting." |
| Mental Health Screenings | 71.4% (N = 25) | - | • 100% (N = 7)<br>• "…RHS-15 assessment, the Refugee Health Screener…it kind of starts a conversation about mental health because it asks questions about your physical pain as well as your emotional pain and it asks a few questions about trauma. And most clients are willing to do that because they have a physical pain or a somatic symptom of their trauma or other mental health." |
| Psychoeducation: | 62.9% (N = 22) | - | • 100% (N = 7)<br>• "What I've seen work the most is starting with like…a psychoeducation-based session, essentially. I work with |

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| | | | trauma survivors. A lot of them don't know…what trauma really is and how it's impacting them…I start with education because a lot of these people don't have that education…They're still kind of getting used to mental health." |
| Family Therapy | 57.1% (N = 20) | - | • 71.4% (N = 5)<br>• "A lot of folks were getting in trouble with CPS for using physical discipline and not knowing that it's against the law. The number of faces that were just like, 'Oh, so I can't like, do discipline in this way. That's not a big deal. Just give me another option.'…once we realized that prevention piece is there, that psychoeducation was there, those numbers definitely reduced." |
| Women's Groups | 57.1% (N = 20) | - | • 29% (N =2)<br>• "We have a group that is Arabic speaking women, a group of Congolese women, and then we have a group that's teenage girls that have been resettled." |
| Home-Based Services | 51.4% (N = 18) | - | • 71.4% (N = 5)<br>• "I provide intensive therapy, individual therapy, usually in their home or wherever, in the community that they feel comfortable meeting…Most of the people I provide therapy to, um, transportation or childcare is an issue and so going to their homes is typically the best way to be able to serve them." |
| Couples Therapy | 42.9% (N = 15) | - | • 57.1% (N = 4)<br>• "We brought the husband in and turned out that both of them had been in an arranged marriage. Neither one of them wanted to get married, and neither one of them really knew how to establish intimacy…We really walk them through how to have a healthy conversation, how to not isolate themselves from each other. We've |

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| | | | started teaching these things." |
| Outreach | 42.9% (N = 15) | - | • 100% (N = 7)<br>• "We celebrate on World Refugee Day and we have big events like that where we have communities come together. But then more specifically within our clients, we just kind of go out into the community and kind of make our face known. Like we just go and try and build the relationships within the clients that we have. And through those clients, they kind of welcome us into their home and welcome us into their community." |
| Psychological Evaluation | 14.3% (N = 5) | - | • 14.2% (N = 1)<br>• "We offer some limited testing for the children…[and] limited testing for ADHD and a screen for autism." |

| **Mental Health Service Offered** | **Phase I – Agency Quantitative Survey** | **Phase II – Provider Quantitative Survey** | **Phase III – Provider Qualitative Interviews** |
|---|---|---|---|
| Individual Therapy | 82.9% (N = 29) | - | • 100% (N = 7)<br>• "We built up this program that would incorporate individual counseling for adults initially, we've now also expanded it to kids, marriage, couples counseling and family counseling, but originally it was individually, and we would do weekly counseling sessions." |
| Group Therapy | 71.4% (N = 25) | - | • 71.4% (N = 5)<br>• "In all the research that I've seen around immigrant and mental health services, there's a focus on community healing…And I don't believe that you can do this work without bringing people together and sharing and I really believe that there's so much that can be accomplished in a group setting." |

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| Mental Health Screenings | 71.4% (N = 25) | - | • 100% (N = 7)<br>• "…RHS-15 assessment, the Refugee Health Screener…it kind of starts a conversation about mental health because it asks questions about your physical pain as well as your emotional pain and it asks a few questions about trauma. And most clients are willing to do that because they have a physical pain or a somatic symptom of their trauma or other mental health." |
| Psychoeducation: | 62.9% (N = 22) | - | • 100% (N = 7)<br>• "What I've seen work the most is starting with like…a psychoeducation-based session, essentially. I work with trauma survivors. A lot of them don't know…what trauma really is and how it's impacting them…I start with education because a lot of these people don't have that education…They're still kind of getting used to mental health." |
| Family Therapy | 57.1% (N = 20) | - | • 71.4% (N = 5)<br>• "A lot of folks were getting in trouble with CPS for using physical discipline and not knowing that it's against the law. The number of faces that were just like, 'Oh, so I can't like, do discipline in this way. That's not a big deal. Just give me another option.'…once we realized that prevention piece is there, that psychoeducation was there, those numbers definitely reduced." |
| Women's Groups | 57.1% (N = 20) | - | • 29% (N =2)<br>• "We have a group that is Arabic speaking women, a group of Congolese women, and then we have a group that's teenage girls that have been resettled." |

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| Home-Based Services | 51.4% (N = 18) | - | • 71.4% (N = 5)<br>• "I provide intensive therapy, individual therapy, usually in their home or wherever, in the community that they feel comfortable meeting…Most of the people I provide therapy to, um, transportation or childcare is an issue and so going to their homes is typically the best way to be able to serve them." |
| Couples Therapy | 42.9% (N = 15) | - | • 57.1% (N = 4)<br>• "We brought the husband in and turned out that both of them had been in an arranged marriage. Neither one of them wanted to get married, and neither one of them really knew how to establish intimacy…We really walk them through how to have a healthy conversation, how to not isolate themselves from each other. We've started teaching these things." |
| Outreach | 42.9% (N = 15) | - | • 100% (N = 7)<br>• "We celebrate on World Refugee Day and we have big events like that where we have communities come together. But then more specifically within our clients, we just kind of go out into the community and kind of make our face known. Like we just go and try and build the relationships within the clients that we have. And through those clients, they kind of welcome us into their home and welcome us into their community." |
| Psychological Evaluation | 14.3% (N = 5) | - | • 14.2% (N = 1)<br>• "We offer some limited testing for the children…[and] limited testing for ADHD and a screen for autism." |

Comparison of Cultural Competence Strategies Across Phases (RQ1b)

| **Phase I – Agency Quantitative Survey** | **Phase II – Provider Quantitative Survey** | **Phase III – Provider Qualitative Interviews** |
|---|---|---|
| Emphasizes Community Connectedness: 100% (N = 35) | - | • 100% (N = 7)<br>"I'm thinking of Maslow's hierarchy of need…we really cannot do therapy when somebody is wondering how they're going to pay their rent or where they're going to get their next meal. And so we use our partnering agencies to help resolve some of those super basic needs that the refugee might have, which causes a barrier to mental health enrollments." |
| Meets Linguistic Needs of Refugees: 97.1% (N = 34) | • Providers provided access to an interpreter that spoke their refugee clients' language: *Often:* 34.6% (N = 9) and *Always:* 65.4% (N = 17)<br>• In-person interpreter: 96.2% (N = 25), phone interpretation: 65.4% (N = 17), video interpretation (e.g., Skype, Zoom): 3.8% (N = 1)<br>• Number of providers that fluently spoke one language in addition to English that they were able to use to communicate with their refugee clients: One language: 38.5% (N = 10), two languages: 11.5% (N = 4), three languages: 4% (*n* = 1) | • 100% (N = 7)<br>• "We work with another …(redacted) Language Network so we can offer all psychological services in 70 different languages." |
| Addresses Stigmatization of | - | • 100% (N = 7)<br>• "Watching the wording we use…Try |

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| Mental Illness in Refugee Communities: 91.4% (N = 32) | | not to focus on diagnoses…we don't arbitrarily assign them one…I think the fact also that we don't just sit and talk about feelings. That's helped a lot of folks to not feel stigmatized…talking about feeling leads to clients thinking that there's something emotionally wrong with them…or that they're crazy…And so we tend to start with those clients that are concerned with stigma by working with holistic life changes first, and giving them time to kind of get comfortable, adjust their life, get everything else stabilized…Then we start slowly edging into some of the more emotional or trauma base." |
| Providers Emphasize Therapeutic Relationship with Refugee Clients: 88.6% (N = 30) | - | • 100% (N = 7)<br>• I think [building rapport in] our work has been really easy because we have so many other [agency] programs already that work within the refugee populations that they feel safe when it's just a new staff but the same organization… we do a presentation [in other agency programs] on mental health and open it up if anyone wants to sign up or learn more…I think that makes our job much easier, cause that trust is already there…Our refugee resettlement agency case workers, they're working one on one with these folks for the first 90 days. They build a good rapport, so when they notice something's up and they say, 'Hey, you want to take this intake and talk to my friends over here?' They're like, 'sure.' I think that…really has helped us to build that rapport." |
| Use of Culturally Appropriate Services: 85.7% (N = 29) | • Provider's MCSE-RD Multicultural Intervention score: 7.11 (*SD* = .31)<br>• Provider's MCSE-RD Multicultural Assessment | • 100% (N = 7)<br>• "CBT [Cognitive Behavioral Therapy] is a great intervention technique for a certain population, not one of the best ones for the clients that we serve, |

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| | score: 6.7 (*SD* = .94)<br>• Provider's MCSE-RD Multicultural Session Management score: 5.15 (*SD* = .39) | right? So, it's more narrative exposure therapy or ACT or, um, you know, deep breathing meditation things… watching the wording we're using and the practices that we're doing to make sure that they're culturally/religious responsive."<br>• "…we created a questionnaire in intake that assesses for red flags in a culturally responsive way" |
| Use of Flexible/Adaptable Services: 82.8% (N = 29) | - | • 85.7% (N = 6)<br>• "I would probably call it more like cultural humility. Going in knowing that I'm not an expert in this person's culture and viewing them as the expert and being willing to learn from them. Then learning from them what's important to them and their culture, and kind of adjust the way that I provide services based on what seems to work best in their culture." |
| Provides Trainings to Increase Cultural Competence (CC) of Providers: 82.8% (N = 29) | • Percentage of agencies that offer trainings for providers: 65% (N =17)<br>• Providers reported agencies offered trainings in: Cultural Competence/Multicultural Counseling (53.8%, N = 14), Refugee Mental Health (57.7%, N = 15), Domestic Violence (42.3%, N = 11), Trainings on Distinct Ethnic/Religious/Refugee Groups (46.2%, N = 12), Education About Psychological Disorders (42.3%, N = 11), Women's Mental Health (19.2%, N = 5), Other (11.5%, N = 3) | • 85.7% (N = 6)<br>• "We have our comprehensive trauma training, so that's a 10-hour training that we provide, it's a requirement for all of our staff or interns that do direct client service work. So we also opened that up, so we've done that training as well for some of the school districts and some of the other agencies. We also do an interpreter sensitivity [training]. That one is also mandatory for all of our interpreters. And then for all of our interpreters on site, that one goes over understanding confidentiality as interpreters, self-care, self-advocacy, boundary setting, um, transference, countertransference, etcetera...We also have a religion and culture training that we do that focuses on Muslim immigrants, and South Asian immigrants as well. The CPS one, we did an amended version of that was specific to children." |

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| Refugees Accepting of Mental Health Services Offered: 71.4% (N = 25) | - | • "I've really learned that with this population narrative therapy really works well…cause a lot of these cultures are very story-based. Like how they look at life or how they explain things, their analogies, how they teach their children. All those these things are very story based and very folklore based. I kind of try and bring that narrative context in here cause it's easy for them to be able to understand and to like externalize things. So if they're, especially when they're traumatized, it gives them the ability to like, kind of play that out in a story that they can understand." |
| Evaluates Effectiveness of Services: 37.1% (N = 13) | - | • 71.4% (N = 5)<br>• "I asked if they'd benefited from services…I'll ask if they've benefited from our meetings together or the things that we talked about. If they say, yes, I'll ask how so?…we also review the goals that we had originally set when we started meeting, and I asked if they felt that those goals had been completed. I ask if they think they will use the things we talked about…And then if you need additional help, would you look for another counselor or would you contact me?" |
| Disseminates Results of Evaluations: 14.3% (N = 5) | - | • 0% (N = 0)<br>• "We don't publish any papers directly."<br>• "I think the only thing that really gets in the way of [research] is that I'm the only person on staff who knows how to do that stuff…I'm the only therapist on staff period…I stay pretty busy, so it's hard to kind of get that information together when I'm focused on clients." |

Comparison of Community Connectedness Strategies Represented Across Phases (RQ1b)

| **Phase I – Agency Quantitative Survey** | **Phase II – Provider Quantitative Survey** | **Phase III – Provider Qualitative Interviews** |
|---|---|---|
| Conducts Outreach: 91.4% (*N* = 32) | - | • 100% (*N* = 7)<br>• "We celebrate on World Refugee Day and we have big events like that where we have communities come together. But then more specifically within our clients, we just kind of go out into the community and kind of make our face known. Like we just go and try and build the relationships within the clients that we have. And through those clients, they kind of welcome us into their home and welcome us into their community." |
| Partnering with Schools: 85.7% (*N* = 29) | - | • 28.6% (*N* = 2)<br>• "For the school districts, we've done presentations there, we have some relationships already with…libraries, and community centers." |
| Partnering with Healthcare Providers and Systems: 80% (*N* = 28) | - | • 100%, (N = 7)<br>• "I work a lot with primary care providers…a lot of them have behavioral health embedded inside, so we talk about ways to do more holistic care or collaborate on referrals…if they have a concern that pops up after a medical visit…or sometimes if I have a concern that someone denied services, they can be aware that…something may pop up in the future." |
| Partnering with Religious Leaders and Communities: 74.3% (*N* = 26) | - | • 71.4% (N = 5)<br>• "We kind of connect with those community leaders because they truly are able to get the clients like more comfortable with coming to our office to receive the services…because those are the people that the clients go to first because they are the community elders…They're the ones that are supposed to help, they're your religious, um, your religious leaders." |

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| Providing Presentations for The Community: 62.9% (*N* = 22) | - | • 71.4% (N = 5)<br>"And one of the cultural competency presentations is one that we do for other agencies…they got to go through that and increase their own, you know, awareness of what they think that the definition of culture means, and you know, compare their own belief system to other cultures, belief systems, and it's a whole hour long lecture." |
| Providing Trainings/Workshops for The Community: 54.3% (N = 19) | - | • 71.4% (N = 5)<br>• "We are going to connect with the community leaders of the refugee and immigrant communities, so the religious leaders and Shamans and people who are very high up in their community and we are going to do, we're going to do a domestic violence training with those leaders because those are the people that the clients go to first because they are the community elders, they're the ones with the answers. They're the ones that are supposed to help…and so we're going to be training them on how to appropriately identify domestic violence and how to get them to the right resources." |
| Participating in Advocacy: 54.3% (N = 19) | - | • 42.9% (N = 3)<br>• "So that's the other difference of refugee immigrant mental health. It's a blend of therapy and case work because you're trying to navigate and help people advocate for themselves and you know, work with these resources and help them reduce some of the behaviors and limitations that they have just because of the needs of living in poverty and navigating the new legal system and sometimes language barriers." |
| Other (e.g., partnering with other agencies, connecting refugees to similar refugee communities): 11.4% (N = 4) | - | • "We just created a really, really great partnership with…a center [for] survivors of domestic violence…And so they have a very, very robust program, but they are very limited in their resources for refugee and immigrant populations. So, we [provide] services to the clients that are more culturally appropriate…to decrease domestic |

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| | | violence…and kind of building trust and building those relationships.” |

Comparison of Mental Health Providers' Level of Preparedness to Provide Culturally Competent Mental Health Services Across Phases (RQ2a & RQ2b)

| Theme | Phase I – Agency Quantitative Survey | Phase II – Provider Quantitative Survey | Phase III – Provider Qualitative Interviews |
|---|---|---|---|
| **Perceived Level of Cultural Competence (CC)** | • Percentage of agencies that believe providers use culturally appropriate services: 85.7% (*N* = 29) | • Provider's MCSE-RD Multicultural Intervention score: 7.11 (*SD* = .31)<br>• Provider's MCSE-RD Multicultural Assessment score: 6.7 (*SD* = .94)<br>• Provider's MCSE-RD Multicultural Session Management score: 5.15 (*SD* = .39) Cultural Knowledge<br>• **(RQ2b)** Number of CC trainings was significantly correlated with greater cultural competence (MCSE-RD score): *p* = .40* | • Implementation of cultural competence (knowledge): "I think before a doctor or anybody provides services…in the health and mental health arena, they really have to understand a basic background of what has happened to the client from a global perspective."<br>• Implementation of cultural competence (skills): "Even things like cupping, or sweat lodges, or herbal teas, or things that they might be using. Just at least ask if those things are part of the client's healing." |
| **Number of CC Trainings** | • Agencies reported they provided an average of 3.17 (*SD* = 2.12) CC trainings to MH providers | • Providers reported agencies offered them 2.09 CC trainings (*SD* = 2.40)<br>• Average number of cultural competence CC courses/trainings | - |

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| | | complete: (*M* = 10.58, *SD* = 9.14) | |
| **Provider Training Opportunities** | • Agency provides trainings to increase cultural competence of its providers: 82.8% (*N* = 29)<br>• Agencies offered the following trainings for their mental health providers (MHPs): Cultural Competence/Multicultural Counseling (68.6%, N = 24), Refugee Mental Health (62.9%, N = 22), Domestic Violence (48.6%, N = 17), Trainings on Distinct Ethnic/Religious/ Refugee Groups (48.6%, N = 17), Education About Psychological Disorders (42.9%, N = 15), Women's Mental Health (25.7%, N = 9), Other (20%, N = 7) | • Agency offers trainings for providers: 65% (*N* =17)<br>• Providers reported agencies offered trainings in: Cultural Competence/Multicultural Counseling (53.8%, N = 14), Refugee Mental Health (57.7%, N = 15), Domestic Violence (42.3%, N = 11), Trainings on Distinct Ethnic/Religious/ Refugee Groups (46.2%, N = 12), Education About Psychological Disorders (42.3%, N = 11), Women's Mental Health (19.2%, N = 5), Other (11.5%, N = 3) | • "I definitely attend as many workshops and like training as I can, especially when it comes to like culture or specific populations that you're working with, like…refugees and immigrants coming from the Middle East or refugees, immigrants coming from Central America…And I also look for materials like books, because people have written books about this stuff too."<br>• "You go to professional development and things and most of the times in those trainings, it's not people that have worked with refugee populations…So, a lot of times it seems like the skills that we learn or the techniques we have, we're always having to try to figure out like, okay, how does this work for the people I'm working with?…is this actually like evidence-based for the group population I'm working with?" |
| **Linguistic Needs of Refugees** | • Meets linguistic needs of refugees: 97.1% (N = 34)<br>• Interpretation methods - In-person: 91.4% (*N* | • Refugee access to interpretation in their language: *Often:* 34.6% (N = 9) and *Always:* 65.4% (*N* = 17)<br>• In-person | • Number of providers that fluently spoke one language in addition to English that they were able to use to communicate with their refugee clients: One |

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|---|---|---|---|
| | = 32), Phone: 71.4% (N = 25), Video (e.g., Skype, Zoom, etc.): 5.7% (*N* = 2)<br>• Availability of translators: *Always* (68.6%, *N* = 24), *Often* (17.1%, *N* = 6), *Sometimes* (11.4%, *N* = 4), and *Never* (2.9%, *N* = 1) | interpreter: 96.2% (*N* = 25), phone interpretation: 65.4% (*N* = 17), video interpretation (e.g., Skype) 3.8% (*N* = 1)<br>• Number of providers that fluently spoke one language in addition to English that they were able to use to communicate with their refugee clients: One language: 38.5% (*N* = 10), two languages: 11.5% (*N* = 4), three languages: 4% (*N* = 1) | language: 42.8% (*N* = 3)<br>• "we work with another …(redacted) Language Network so we can offer all psychological services in 70 different languages." |

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