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Access to Mental Health Services for Refugees and Other Vulnerable Immigrants in the U.S.

Guidance for service providers based on a narrative review of the literature

Despite their mental health needs, many resettled refugees do not seek mental health care due to barriers at the individual, community, health system, and policy levels. This information guide provides evidence-based recommendations for service providers working to improve refugees' access to mental health services across these levels. This content is based on a narrative review of the literature conducted by Switchboard in 2019.

Mental Health Burden for Refugees and Vulnerable Immigrant Populations

Refugees and other immigrants who seek protection from violence and persecution often experience high levels of potentially traumatic events, such as physical, psychological, and cultural adversities, prior to arrival in the U.S. These experiences, combined with the stresses of adjustment to life in a new country, all have potential to cause emotional distress. Understanding the factors that enhance or inhibit their potential to access needed mental health care is a critical first step to serving this population.

Vulnerable immigrants arrive in the U.S. after fleeing persecution, war, armed conflict, or chronic, pervasive, interpersonal violence. Their experiences vary: Some have prolonged exposure to daily human rights violations (for example, in the Cambodian genocide and labor camps), while others have acute, intense, active exposure to war (for example, in the Syrian conflict). Some have prolonged migrations with lack of access to basic needs and constant threats to self and personhood. But those who have means may travel by plane or train. Some travel alone, others with family. Some have families or communities in the U.S. and others have no one.

Refugees and other vulnerable immigrants in the United States:

Refugees: People who have been forced to flee their countries because of persecution, war or violence; who have a well-founded fear of persecution due to race, religion, nationality, membership in a particular social group, or political opinion; and who receive permission to resettle prior to traveling to the U.S.
Asylum-seekers and Asylees: People who, on their own, travel to the U.S. and subsequently apply for or receive a grant of asylum.
Victims of Trafficking: People who are victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000.
Cuban Haitian entrants: People with parole status as Cuban/Haitian entrants as defined by Title V of the Refugee Education Assistance Act of 1980.
Amerasians: People from Vietnam admitted to the U.S. under the Foreign Operations, Export Financing and related Programs Appropriations Act 1988.
Special Immigrant Visa (SIV) holders: People who provided service to the U.S. government in Iraq and Afghanistan, admitted to the U.S. under the US Citizenship and Immigration Services special immigrant programs.

All of these populations, however, are at risk of daily life stressors in resettlement: acculturative stress, traumatic loss, cultural bereavement, and insecurity with basic needs such as food, housing, employment, and education.

Prevalence estimates of mental health disorders among vulnerable immigrants vary widely, from 20% to 80%.[1] Some estimate that about one out of three refugees experiences depression, anxiety, or post-traumatic stress disorder (PTSD). While most refugees and asylum-seekers with PTSD and depression show a reduction in these conditions over time, particularly if there are low resettlement stressors, others may experience years of PTSD. And many affected by conflict may not meet diagnostic criteria, but can experience complicated grief, complex trauma, despair, isolation, anger, and lack of trust.

Socio-ecological Approach

The various social spheres that exist around us influence our experiences in society. In research, taking these different spheres or levels into consideration is called the **socio-ecological approach.**

This information guide will discuss barriers (and strategies for responding to those barriers) within the following levels:

Individual Level

People who have experienced persecution may also have experienced physical and emotional violations and abuse that affect their mental and physical health. Individuals may fear or mistrust authorities following experiences where authorities have taken advantage of them in the past. They may perceive a poorer standard of service, or that they are not understood or respected by providers.

Research shows that the following individual-level barriers inhibit access to mental health services:

[1] Keyes, E. F. (2000). Mental health status in refugees: an integrative review of current research. *Issues in Mental Health Nursing*, *21*(4): 397–410.

Comorbid mental and physical health[2-3]

Research suggests that having both PTSD and depression at the same time puts individuals at risk of physical health problems, regardless of age.

To respond to this barrier, providers may use an **integrated care** approach**.** Because refugees may be more comfortable seeking physical care rather than mental health care, support should be given to incorporate behavioral health screening, referral, and basic treatment within the primary care setting.

Language barriers[4-5]

The literature suggests that language barriers are especially relevant for clients who speak rare languages where interpreters may be unavailable.

The Department of Health and Human Services Culturally and Linguistically Appropriate Standards (CLAS) mandate the provision of trained, competent medical interpreters in healthcare settings, including mental health services.

In cases where trained, competent interpreters are not present due to time constraints, lack of interpreters, or poorly enforced legislation, family (including children) sometimes act as ad hoc interpreters and cultural brokers, causing ethical and privacy problems.

Studies with asylum-seekers in particular show that the inability to communicate clearly and effectively with providers led to frustration and delay in diagnosis and intervention.

To help respond to language barriers:

- **Access training** on working effectively with interpreters, such as Switchboard's e-learning modules Introduction to Working with Interpreters and Overcoming Challenges in Interpretation. These trainings are designed to be completed by refugee service providers across program areas, including mental health.
- **Share training opportunities with interpreters,** such as the Cross-Cultural Health Care Program's Bridging the Gap Medical Interpreter Training, a 40-hour in-person training available in locations across the U.S.
- **Share training opportunities with healthcare providers,** such as the free, accredited e-learning program Effective Communication for Healthcare Teams: Addressing Health Literacy, Limited English Proficiency, and Cultural Differences from the Centers for Disease Control and Prevention.

Legal status and mistrust of services[6-7]

Studies suggest that many asylees experienced extensive insecurity prior to being granted status. They may also have been subjected to torture and/or trauma, and had experiences with authorities who harmed them or failed to protect them. This may foster an ongoing fear over their legal status and mistrust of services. Among asylum-seekers, detention (often over long periods) and fears over the terms of their release represent significant sources of ongoing stress.

Individual fears or mistrust of service providers presented a significant barrier to care. Qualitative studies showed that some asylees did not believe that information related to their health would be kept confidential. Healthcare providers believed that this mistrust was not toward Western medical care in general, but rather due to a lack of a personal relationship of trust.

Fears of deportation, detention, or loss of status were linked to healthcare-related bills, with some individuals feeling that an inability to pay would render them vulnerable to arrest, detention and deportation. Some expressed concerns that hospitals might do background checks on patients and report to authorities.

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[2] Asgary R., & Segar N. (2011). Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved*, *22*(2), 506–522.
[3] Berthold S.M., Kong S., Mollica R.F., Kuoch T., Scully M., & Franke T. (2014). Comorbid mental and physical health and health access in Cambodian refugees in the US. *Journal of Community Health*, *39*(6), 1045–1052.
[4] Asgary R. & Segar N., 2011.
[5] Berthold S.M. et al., 2014.
[6] Piwowarczyk L., Bishop H., Yusuf A., Mudymba F., & Raj A. (2014). Congolese and Somali beliefs about mental health services. *Journal of Nervous and Mental Disease*, *202*(3), 209–216.
[7] Gowin M., Taylor E.L., Dunnington J., Alshuwaiyer G., & Cheney M.K. (2017). Needs of a Silent Minority: Mexican Transgender Asylum Seekers. *Health Promotion Practice*, *18*(3), 332–340.

Perceived discrimination[8]

Some refugees regarded health service providers as primarily motivated by financial gain. Some also felt that they received a poorer standard of care than did U.S. citizens. Political actions that were discriminatory or perceived to be discriminatory also presented threats to stability for refugees and other vulnerable immigrants, representing a barrier to accessing care.

Community Level

Service providers are only one of many supportive elements in a person's life. Increasing the support that refugees have by strengthening and mobilizing community supports and systems can improve wellbeing by decreasing emotional and behavioral distress, strengthening resilience to future and current adversity, and improving the care conditions that allow refugees to thrive.

Culture[9-12]

Many refugees and immigrants have different health and illness beliefs, culturally specific ways in which mental illness is explained and expressed, and cultural beliefs about the role and value of mental health services. They may be reluctant to engage in westernized forms of healing, such as psychotherapy, or beliefs about how appropriate it is to discuss personal matters with a stranger.

> "Psychiatric problems are not accepted, if you have psychiatric problems it is because you are a bad person or 'crazy.'"
>
> *- Congolese woman*[13]

In consideration of these differences, culturally aware care should incorporate cultural traditions and norms; different explanatory models for mental distress in youth and families who may relate emotional problems to non-biomedical causes, such as spirits, supranatural forces, nature, or daily life; and a flexible adaptation to different cultural explanations and perceived ways of healing.

Service providers can take the following steps to build cultural awareness into mental health services:

- **Start from within** by taking stock of your own cultural beliefs and biases and reflecting on how these impact your work. You can take assessments such as the Intercultural Sensitivity Scale or the Harvard University Implicit Bias Test.
- **Use culturally specific mental health assessment instruments** that are validated in the language and context of your population.
- **Share training opportunities with healthcare providers,** such as the free, accredited e-learning program Improving Cultural Competency for Behavioral Health Professionals from the Office of Minority Health (OMH). Visit www.ThinkCulturalHealth.hhs.gov for more resources.
- **Encourage mental healthcare providers** to shift from biomedical disease models (that focus on psychopathology) to holistic health care.
- **Incorporate idioms of distress and other local terms into care –** For example, Cambodian survivors of the genocide may complain of "thinking too much," *Pibaak Chet or Prouy Chet*. This symptom can be the focus of care, as opposed to a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis.

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[8] Dana, R. H. (2007). Refugee assessment practices and cultural competency training. In: Wilson J.P., Tang C.S. (eds) *Cross-Cultural Assessment of Psychological Trauma and PTSD*. International and Cultural Psychology Series. Springer, Boston, MA.
[9] Adams, M. C., & Kivlighan, D. M. I. (2019). When home is gone: An application of the multicultural orientation framework to enhance clinical practice with refugees of forced migration. *Professional Psychology: Research and Practice, 50*(3), 176–183.
[10] Dana, 2007.
[11] Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366.
[12] Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*(4), 496–502.
[13] Piwowarczyk, L., et al. (2014).

- **Involve cultural brokers and refugee paraprofessionals –** Refugees who are faring well, and who understand the experiences of migration and loss, acculturative stress, and discrimination that may be encountered in the U.S., can be useful in assisting newcomers.

For recommendations on building cultural awareness into referral partnerships, see Switchboard's information guide *Building a Culturally Informed Network of Mental Healthcare Providers*.

Social networks and stigma[14-16]

Stigma against mental illness and against seeking mental health support is a major barrier to accessing care. When social contacts (such as friends, family and neighbors) recognize emotional distress and intervene early on, this can mitigate mental health problems or even obviate the need for formal mental health services. Some research participants also reported that social contacts can serve as critical linkages to formal mental health services.

In recognition of the roles played by social networks and stigma when it comes to accessing mental health services, consider these strategies:

- **Implement family-based interventions** since family may be the most natural source of support and stress. Working with parents, children, and the extended family may be a more comfortable way for refugees and immigrants to manage emotional distress.
- **Implement community-based interventions** – Involving the wider community can strengthen the care and protection of refugees and immigrants by promoting inclusion and reducing the potential for stigma.
- **Identify and leverage community strengths –** For example, Bhutanese refugees have practices of care that are rooted in strong community relationships. In one study, they described how social supports actively monitor and respond to signs of distress before mental illness may become clinically apparent.[17]

Post-migration stressors[18]

Collective challenges and socio-economic pressures faced in adjusting to life in the U.S. include access to food, housing, employment, as well as acculturation stress, discrimination, and legal and/or immigration concerns.

To respond to this barrier, work to **balance support for post-migration trauma and pre-migration stressors.** There is evidence that both past traumatic exposure and daily life stressors can worsen mental health, so work to address both by meeting the client where he or she is. Often, helping with daily needs can begin to heal feelings of helplessness and despair due to past experiences.

Health Systems and Policy Level[19]

Refugees and vulnerable immigrant groups may feel they have few options for accessing mental health services due to lack of consistent programs to address their specific needs, long wait lists, and difficulty in coordinating complex health care systems. Moreover, there are needs for culturally aware services and for training that emphasizes provider biases and explanatory models for distress. Lack of clarity over service costs as well as the complicated application process for Medicaid continue to be barriers to treatment.

In addition, mental health screening is inconsistently conducted for newly resettled refugees in the US, and screening practices differ significantly by state.

[14] Ballard-Kang, J. L., Lawson, T. R., & Evans, J. (2018). Reaching out for help: An analysis of the differences between refugees who accept and those who decline community mental health services. *Journal of Immigrant and Minority Health, 20*(2), 345–350.
[15] Chase L., & Sapkota R.P. (2017). "In our community, a friend is a psychologist": An ethnographic study of informal care in two Bhutanese refugee communities. *Transcultural Psychiatry, 54*(3), 400–422.
[16] Asgary R. & Segar N., 2011.
[17] Ballard-Kang, J. L. et al., 2018.
[18] Miller, K. & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology Psychiatric Science*, *26*(2): 129-138.
[19] Asgary R. & Segar N., 2011.

Few culturally appropriate screening and assessment tools have been validated for use in multicultural populations. And among clients who do screen positive, many do not follow up with a primary care provider or request mental health treatment.

While health systems and policy-level barriers cannot be addressed by service providers alone, consider taking the following steps in consideration of these barriers:

- **Provide intensive case management and care coordination –** Directly scheduling appointments, arranging transportation, and facilitating the first referral has been shown to help some refugees overcome barriers.[20-22]
- **Systematically screen for mental health conditions, and provide follow-up support to those who screen positive –** Keep in mind that a positive screen and subsequent referral are important, but may not be sufficient to ensure access to mental health services.
- **Work to foster strong communication and trust**, both between patients and providers and between different providers, to improve case coordination and overcome logistical barriers to care.

Conclusion

While there is a large mental health treatment gap for refugees and vulnerable immigrants in the U.S. due to various socio-ecological barriers, research suggests promising strategies that providers and organizations can implement to enable those who need care to receive it.

Among the individual-, community-, health system-, and policy-level strategies discussed above, we can highlight the importance of culturally competent services to help ease the discomfort many may feel with formal care, along with services that incorporate family and community relationships, in recognition of the significance of family and community values for many of our clients.

Resources

Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families: These UNICEF operational guidelines provide a good overview of how to build community-based mental health and psychosocial programs.

Effective Communication for Healthcare Teams: Addressing Health Literacy, Limited English Proficiency, and Cultural Differences. This free CDC online series aims to help healthcare professionals assess their patients' health literacy and language needs. Attendees may receive continuing education credits.

Child/Adolescent and Family Refugee Mental Health: A Global Perspective: This forthcoming text by editors Suzan Song, MD, MPH, PhD and Peter Ventevogel, MD, PhD is a collaboration between academia, clinicians, and humanitarian practitioners on mental health assessment for refugees (Springer Nature publishers, forthcoming, Spring, 2020).

To learn more about Switchboard, visit **www.SwitchboardTA.org.**

The IRC received $1,194,063 through competitive funding through the U.S. Department of Health and Human Services, Administration for Children and Families, Grant # 90RB0052. The project is financed with 100% of Federal funds and 0% by non-governmental sources. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services, Administration for Children and Families.

[20] Adams, M. C., & Kivlighan, D. M. I., 2019.
[21] Salt, R. J.; Costantino, M. E.; Dotson E.L.; & Paper, B. M. (2017). "You Are Not Alone" Strategies for Addressing Mental Health and Health Promotion with a Refugee Women's Sewing Group. *Issues in Mental Health Nursing, 38*(4), 337–343.
[22] Moreno A.; Piwowarczyk L.; LaMorte W.W.; Grodin M.A. (2006). Characteristics and utilization of primary care services in a torture rehabilitation center. *Journal of Immigrant and Minority Health, 8*(2): 163-71.