

Mental Health Programs for Refugees

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In *What is the What*, Valentino Achak Deng, a Sudanese refugee, is forced out of his home at nine years old when his village, Marial Bai, is attacked by the murahaleen (Muslim army). He wanders the Sudanese forests alone until he finds a group of Lost Boys led by Dut Majok, a young teacher from Marial Bai. It takes Achak's group almost a year to walk from the South West region of Sudan all the way to Pinyudo Refugee Camp in Ethiopia. The boys survive animal attacks, murahaleen and SPLA attacks, hunger, fatigue, and recruitment into the rebel army. As they are nearing the border of Sudan and Ethiopia, Achak and his friend William K imagine a Pinyudo that has an abundance of food and the Sudanese are wealthy. When Achak reaches Pinyud, he is greatly disappointed to find a place not much different from the Sudan. The camp has no food or water, and no medical facilities; however, he makes it home for the next three years. In those three years the camp expands to thousands of refugees and the United Nations provides a monthly distribution of food. A year into living at the camp a school is built for all the children. In the third year, the Sudanese People Liberation Army (SPLA) increases its prominence in the camp by implementing mandatory military training for all boys. They also strongly recruited "healthy" boys into their diminishing army in Sudan. Achak was able to escape both of these events, because of other responsibilities, but he did watch some of his friends join the army and later die in battle. Overall, Achak was able to minimally associate with the SPLA, but one day as Achak is walking home from church he receives news that the Ethiopians were attacking the refugees, because the SPLA was stealing Ethiopian goods. The refugees swam across the Nile in the midst of crocodile attacks and Ethiopian gunshots.

After safely making it across the border, Achak follows a new group of boys that lead him to a refugee camp in Kakuma, Kenya where he will live for the next ten years before being resettled into Atlanta, Georgia in 2001. In Atlanta, he meets supportive mentors like Mary Williams, the adopted daughter of actress Jane Fonda and the Director of the Lost Boys Foundation. Mary Williams provides Achak with friendship, financial support, and connects him with other Sudanese refugees. She is a great social contact, but she is unable to help relieve him from the blinding headaches and the nightmares he suffers from the traumas he had experienced.

Valentino Achak Deng's story is only one example of the trauma and stress that refugees survive before resettlement. Susan Martin in her essay "A Policy Perspective on the Mental Health and Psychosocial Needs of Refugees" proposes Preventative Care through a program that involves non-government agencies, policy makers, mental health providers, and refugees. She does not outline the program in any more detail, but I imagine a preventative care program that is set up as a weekly meeting to discuss issues the group is dealing with. Another idea, taken from *What is the What*, is a drama troupe that acts out the issues refugees are dealing with and certain coping strategies. Getting refugees to discuss their issues is the best way to begin treating disorders before they become morbid. In addition, it will prepare them for the mental health screenings that I am advocating.

As a resettlement country, the United States needs to acknowledge these events and create mental health programs that can help treat the disorders that may arise from traumatic experiences in order to make refugees more capable in society. The goal of all federal, state, and local programs is to have self-sufficient refugees that are capable of

working, attending school, and/or caring for a family. If the refugee is suffering from headaches or nightmares, like Achak, it becomes difficult for him/her to become self-sufficient. In the U.S., few programs are addressing the issues of mental health care and the implications on refugee resettlement. Some of the problems with addressing mental health in the refugee population are caused by a lack of funding, cultural differences in treatment, and a lack of a social network of caregivers. The U.S. tries to address the problem of funding through the Medicaid insurance program for low-income families. Medicaid includes a Mental Health Care option for clients needing psychiatric help. Local agencies like the Center for Multicultural Human Services in Falls Church, Virginia address the issues of cultural sensitive treatment of mental disorders in refugees and other immigrant populations. Resettlement agencies like Refugee and Immigration Services of Richmond understand the need for network of caregivers and do try to provide available services to refugees. Although these services are available there are limits to each of them. This paper assesses the quality of these services, the people they serve, the number of clients, and the changes that need to be made.

Before Resettlement

According to the 1951 United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, a refugee is an immigrant who leaves his/her own country in fear of persecution because of political beliefs, race, religion, national origin, or membership in a social group. In the United States the term refugee only applies to those who are abroad who want to enter the country because of political persecution. Asylees also fled their home country because of political persecution, but unlike refugees, they are currently living in the U.S. at the time of filing for legal status

(Jeffery, 2006). Economic refugees are migrants who leave their home countries for mainly economic reasons. These migrants are not part of the U.S. refugee program (U.S. Citizenship and Immigration Services).

The refugee process begins when a family flees its home country in hopes of reaching a refugee camp in a safer part of the country or a bordering country. At the refugee camp about 1% are given the option of being resettled into a foreign country like the United States or Great Britain. Resettlement is a last resort if the individual is unable to be safely integrated into the country of the camp and repatriation (return to home country) is seen as unsafe (Resettlement Handbook, 11). Achak was not able to gain citizenship in Kenya, because of strict immigration laws, and he was not able to return to his village in Sudan, because the Murahaleen and SPLA were still attacking it. After being given refugee status, the refugees go through an intensive interview process and health screening that can take more than 18 months before results are known. After passing the interview process, the United Nations High Commissioner of Refugees allocates the refugees to different countries based on each country's quota for refugees from a specific region. The U.S. State Department's 2008 ceiling proposal includes 16,000 Africans, 20,000 East Asians, 3,000 Europeans and Central Asians, 3,000 Latin Americans and Caribbean, 28,000 South East and South Asians, and 10,000 unallocated reserves. This totals about 80,000 refugees for 2008. In 2006, the ceiling was at 70,000 and the U.S. resettled 41,277 refugees, thus 59% of the quota was met. According to the UNHCR, the United States settles the most refugees in the industrialized world with three times Australia's numbers, which is the second largest resettlement country.

The low number of refugees resettled worldwide may be due to strict health requirements that reject those with HIV/AIDS and tuberculosis. Previous members of the military are also restricted from resettlement. This is a problem, since many refugees are from high HIV/AIDS countries and young refugees are susceptible to becoming soldiers. The U.S. waives these restrictions for special circumstances. The U.S. waived the restriction on soldiers for the child soldiers from Sudan. Most child soldiers are considered trafficking victims and they receive special rights. Since 2000, the U.S. has resettled over 3,500 Lost Boys from Kakuma, Kenya including child soldiers (Refugee International). The low number of refugees may be due to the lack of agents to administer the interviews and screening. Achak had three cancelled interview dates before he was finally interviewed, because there was only one interviewer for the camp and he had to attend to other issues. The safety of the interviewer is also important. When battles would come close to the camps or there would be hate crimes among the different groups of refugees, the interviewer had to flee the area in order to ensure his safety. All of these factors elongate the refugee process and decrease the number of refugees resettled every year.

After the State Department receives notification of the families being resettled, it allocates the families to different resettlement organizations like the U.S. Conference of Catholic Bishops (USCCB). The organizations then allocate the refugees based on their cultural background and the language skills of the employees in the organization. For example, the USCCB sends Burundi families to Refugee and Immigration Services in Richmond, VA (RIS), because there is a large African population in Richmond and the agency has Swahili speaking caseworkers. Before leaving for resettlement, the refugees

go through final health exams and clearance interviews. The interviews are similar to the first set of interviews in that they ask about previous political membership and the individual's experiences. If the interviewers find information inconsistent with the previous responses, the individual and his family can lose their spots for resettlement. This process is to insure that militant individuals and spies are not resettled. After passing the final exams and interviews, the refugees leave for their resettlement states where they start a new life.

In the United States, all refugees receive a one-time grant of \$425 per person from the State Department and a MATCH Grant of \$50 a week per adult and \$10 per child until an adult becomes employed. The Office of Refugee Resettlement gives the MATCH Grant based on funds the resettlement organization provides for its refugee programs (Office of Refugee Resettlement). Resettlement organizations like RIS use these funds and private donations to pay for housing, utilities, food, and other necessities until the family's income becomes stable. According to the RIS website, a typical family is able to find work within the first month of being resettled. From my experience with the organization, it takes about 2-3 months depending on English skills and past work experience. The families also receive Temporary Aid for Needy Families for the first year. All refugees receive Medicaid for the first six months in order to give them time to qualify for employer-based health insurance. The employment specialist at the organization helps the refugees find full-time jobs with health benefits; however, the low wages from some of these jobs are not enough to pay for living expenses and health insurance therefore, the refugees may choose not to enroll in the insurance plan. Some people will continue to be on Medicaid because of illness or low income. Medicaid

allows enrollment for up to seven years for families with income up to 133% of the Federal Poverty Line (HHS).

Refugees in America

In the past five years, over 200,000 refugees have resettled into the United States. In 2006, the majority of refugees were from Somalia (25%), Russia (15%), and Cuba (7.6%). This made up 47% of all refugees resettled that year. More than half of all refugees live in California, Minnesota, Texas, Florida, Washington, or New York (Jeffery, 2006 p.3-4). About 51% of all refugees are male (2). The majority (59%) is single and this includes single parents. The biggest age group is children under 18, which makes up 36% of the population. College adults between 18 and 24 make up 20% of the population. The smallest age group is the 65 and over group that makes up 3% of the refugee population. The refugee population in the U.S. is a diverse group with different experiences. The Office of Refugee Resettlement must consider the diversity of its clients when creating its program.

Health Assessments

Within the first month of resettlement, all refugees must receive a thorough health examination. The Office of Refugee Resettlement (ORS) outlines this first medical screening through its Medical Screening Protocol for Newly Arriving Refugees. The screening is focused on disease control and it explicitly states, “Questions on sensitive issues such as torture, rape, or family violence should be reserved for trained experts in a setting of a trusting relationship” (2). It is understandable that the agency wants the refugee to choose when to open up, but refugees rarely tell their stories unless someone asks them. Achak had never told anyone his entire story until his sponsor Phil Mays

asked him. The resettlement coordinator at RIS told me that most refugees wait at least a year or until a problem becomes too difficult for the family to handle before they talk about their psychological illnesses. Both examples show that it is necessary to ask questions about their experiences, so that treatment, if needed, can begin early. The protocol continues to advise the screener, “Although these stressors may have a long-term negative impact in terms of building a new life in this country for some individuals, the treatment of mental health needs of refugees is not the focus of the initial screening encounter” (2). This statement shows that ORR understands some of the consequences of untreated mental disorders, but it misunderstands the short-term consequences of mental illness including difficulty in acculturation and difficulty at work. Disorders such as depression, anxiety, and posttraumatic stress disorder can affect physical health as well. Links have been made between these disorders and diabetes and high blood pressure. By ignoring these causes, doctors will only be treating the symptoms. In the protocol, there is incongruence with the previous statements and one asking doctors to refer patients to a mental health provider, if they find it necessary (4). If the doctor cannot ask questions about mental health, how can he/she refer the patient to a mental health provider? The research shows that it is best to ask questions about mental health at the doctor’s office as part of the initial screening, but ORR instructs the agencies not to.

Virginia’s Refugee Resettlement Program provides financial support and a health assessment for all refugees. During the refugees initial health examination, doctors use the *Refugee Health Assessment Form* from the Virginia Newcomer Health Program that includes ORR’s minimum procedures. The test includes Tuberculosis testing, STD testing, and a weight, vision, hearing, and dental evaluation. The only reference to mental

health comes at the end of the assessment asking if the doctor refers this patient to a mental health evaluation. No other part of the form asks any questions related to the *Diagnostic and Statistical Manual of Mental Disorders*, but the doctor can still choose to refer or not to refer the patient for a mental health assessment. These quick assessments need to be supplemented with additional care from the resettlement agencies, specifically the case managers, and other persons who spend time with the refugees.

At Refugee and Immigration Services, all refugees and their families have to participate in a 4-5 hour meeting introducing them to American life and their new financial responsibilities. The aim of the meeting is to find out as much as possible about the families past experience to see if they are capable of working and if so what type of skills they possess. During the health intake portion of the meeting, the focus is on physical ailments and no questions are asked about psychological issues the person has. During a conversation with the Job Placement Officer during my internship, I learned that very few of the refugees receive psychological care despite the immense trauma that they report experiencing during the intake. In his ten years at the organization, he remembers one Southeast Asian man who after constant phone calls to the Department of Social Services received an appointment with a Psychiatrist in Washington D.C. The Psychologist caring for his disorder, was from his country, and spoke his language. The officer agreed that that is an example of the type of care all refugees should receive.

Why a Mental Health Assessment?

After seeing the inadequacy of the refugee health assessment in Denver, a group of psychologists conducted a mental health screening for Denver, Colorado refugees (Savin, 1999). The aim of the study was to see if mental disorders are present in a newly

resettled refugee population. The researchers wanted to show that a comprehensive mental health assessment is necessary at the beginning of resettlement. During the customary physical health exam the researchers, case managers, primary care nurse, and physician conducted interviews on past medical history including any imprisonment, maltreatment, head injury, seizures, or learning difficulties. First, the nurse explained psychiatric disorders and their frequency in the refugee population. Then the adult refugees were given a 25-item psychiatric symptom checklist derived from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. The checklist included 14 items correlated with Depression (ex: feeling hopeless), two items related to anxiety (ex: fear of losing control), and eight items correlated with Posttraumatic Stress Disorder (ex: repetitive bad dreams). Depression is when “five or more symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure” (Mental Health Today). Posttraumatic Stress Disorder is when

the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others [and] the person's response involved intense fear, helplessness, or horror. The traumatic event is persistently reexperienced in one or more ways (Mental Health Today).

“Generalized anxiety disorder is defined by a protracted (≥ 6 months' duration) period of anxiety and worry, accompanied by multiple associated symptoms” (Surgeon General).

The checklist was translated into 12 languages and the nurse and the interpreter read the questions for those who were illiterate or spoke another language that was not available.

The study included 1,058 adults and 142 (13%) screened positive for one of the three mental disorders on the checklist. Although 142 refugees had these disorders, only 54

adult refugees chose to see the on-site mental health professional. This study is important in that it shows the prevalence of mental health disorders in refugee populations and the necessity for early detection. All of the patients seen had been in the U.S. for less than a month. Few of them had discussed their symptoms with anyone. The study also shows the difficulty in treating refugees who may not understand the necessity of treatment. There needs to be a group of professionals who can convince the clients that treatment is necessary.

Another reason for mental health assessments is the affects it has on different aspects of life. Beiser found that Southeast Asian refugees in Canada experienced psychiatric symptoms such as depression during the first 10 to 12 months of resettlement (2006). Depression, anxiety, and posttraumatic stress disorder (PTSD) can affect ability to parent, hinder acculturation, and increase frequency of absences at work and school. If a parent is suffering from any of these disorders or other psychiatric disorders, he/she may have difficulty providing the necessary care to his/her children, therefore providing poor attachment models and causing emotional and cognitive delays in children. Children who have secure attachments to their parents cry less and seek their parent's contact (Berk, 2007 p. 98). Children who feel secure are more likely to explore their environment, because they know that their parents are watching them and will protect them from harm.

The psychologists Leinonen, Solantaus, and Punamaki (2002) studied the mediators between economic hardship and parenting styles using the Conger Family Stress Model in the general population. Although this study was not focused on refugee families, the findings are still significant in understanding the effects of disorders on families. The model includes five categories: Economic Hardship, Economic Pressure,

Mental Health, Marital Interaction, and Quality of Parenting. The study found that parents suffering from anxiety had poor marital interactions, which created a bad relationship model for children. Mothers with anxiety had a noninvolved parenting style. This means that they are less likely to know where their children are and what they are doing. Mothers suffering from depression were less likely to possess an authoritative parenting style. Authoritative parents are involved, warm, and discipline their children with reason. Fathers with anxiety had more noninvolved and punitive parenting styles than fathers with no disorders. Punitive parents punish their children frequently and harshly. Parents who have good parenting styles have children who have better language abilities and fewer behavior problems. These are important factors in a child's success at school. Refugee children are already behind their peers in school because of their lack of English abilities and gaps in schooling, so it is necessary for parents to be involved and encouraging in order for these students not to give up. Providing treatment to parents suffering from mental disorders is important, because it allows them to provide these things to their children. Since children make up the largest group of refugees and they will use the most amount of public funding throughout their lifetime, it is important that they receive the best possible care. By improving the health of their parents, we are improving the future of these children.

Those suffering from mental disorders are less likely to explore their environment, which can hinder acculturation. Acculturation can also aggravate the illness, because the person must now adapt to a new environment that she knows little about. The added stress can make the person feel less capable of recovering from the illness.

Treatment

In the United States, the issue of mental health is addressed through a combination of state and local programs. The treatment centers presented are all located in Virginia, because it is the location of Refugee and Immigration Services and the location of my clients.

Medicaid

In the state of Virginia, Medicaid insures 8% of the population and employer based insurance covers over 61% of the remaining population (Kaiser State Medicaid Fact Sheet). Virginia Medicaid includes the traditional physician and dental care and it contains the optional benefit of mental health care for those under 21, above 65, and those who suffer from mental disorders (Medicaid Handbook, 13). Medicaid options, such as mental health care, allow states to have a choice on how much of their budget they want to spend on these benefits, if they choose to include them (Kaiser). Nationwide 47 states have adopted the Mental Health Care option and three states do not include it in their benefits. However, as state budgets become tighter, many states are deciding to decrease spending on optional benefits like mental health care. In 2006, Texas removed the option from its benefits, but programs like NorthSTAR provide mental health services in specific counties (Texas Department of State Health Services). NorthSTAR is a state and locally funded program for mental health and substance abuse treatment. It is important to note that even though states may not have the Mental Health option, the Early and Periodic Screening, Diagnostic, and Treatment is a federal requirement for all children. The program provides early diagnosis of cognitive delays in children. This is important when considering refugee children at risk for mental retardation or other cognitive stunting, because they were born to malnourished mothers.

In 2006, Virginia spent \$950 million in mental health services, which is about 20% of its Medicaid budget (DMAS Medical Services Expenditures). Virginia Medicaid for children and the elderly covers day treatments up to 780 time units per year for those who are found categorically or medically needy. The categorically needy are those with a family income below 185% of the Federal Poverty line. The medically needy are those with an income above the 185% eligibility line, but have high medical care expenses (HHS). States determine who is categorically or medically needy. Virginia Medicaid does not cover residential or in-home treatments for adults (Kaiser). Some disorders are treated better at a residential clinic that teaches the patient how to cope with the disorder and provides job training to those who have lost their jobs. Refugees can benefit from a residential clinic, because it provides 24-hour surveillance to ensure that the refugees are following their treatment plans. Residential treatment should be an option for patients.

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There is no co-pay for the services and Medicaid pays the state established maximum amount of \$326.50 per month. If a member is visiting a mental health clinic that is not part of a hospital, the member must pay \$1 co-pay for each visit and must receive prior approval for more than five visits (Kaiser). Personal Care Services or at home assistance services is only covered if the person is found to be unable to function normally without assistance. There is no co-pay for this service and Medicaid pays \$12.56 per hour (DMAS). Personal Care Services is not at home treatment, instead it employs a health care professional who helps the patient complete daily tasks, such as bathing and eating. Medicaid makes receiving care affordable to low-income patients. However, the caps are too low. The average cost per day for outpatient care is around \$150, which means that a patient can only seek care twice a month (Leslie & Rosenheck,

1999). At the beginning of any treatment, it is important to see the psychologist regularly, which means at least once a week. If the patient does not see the psychologist regularly treatment will be less effect. Even if more people sought psychological help, their treatments would be prematurely stopped because of Medicaid caps make it difficult for treating a disorder. The good thing is that the majority of mental health providers in Virginia, 738 out of 855, accept Medicaid. When using Medicaid to address refugee issues, it is important to note that a limited number of people over 65 are admitted into the U.S., because of their inability to work for a long period. Those who are admitted are reunifying with their families. The under 21 group will actually benefit from the Mental Health Care option. The U.S. has a high interest in unaccompanied minors, evident by the influx of Lost Boys (although many were men at resettlement) it took in at the turn of the century. These minors are seen as the most deserving of aid, because they are so vulnerable. They also have the added stress of being separated from their families, which makes it even more necessary to have mental health care for them. Children are also important because families usually resettle together. At Refugee and Immigration Services, most of the resettlement cases were of families with children. The Virginia Medicaid Mental Health Program covers a great deal, but the program needs to expand its services for the 21-65 age group.

Although Medicaid is available, Refugee and Immigration Services rarely uses Medicaid to fund treatment. One of the reasons may be a lack of knowledge about the Mental Health Care option and the application process. Another reason is the lack of psychologists in Richmond who can address refugee issues. It is also difficult for refugees to miss work in order to apply for Medicaid. Medicaid is notorious for asking

clients to visit the office several times in order to receive benefits. Local programs may be a better option for refugees.

Community Services Board

Virginia's alternative to Medicaid, is the local Community Services Board, although it works with Medicaid recipients. Those who are in need of mental health services are required to contact their local Board for a screening before being placed at a public-funded mental health and substance abuse service in the area. The Boards work with the Department of Mental Health, Mental Retardation, and Substance Abuse Services, although it is not part of the organization. There are 40 local CSBs in Virginia and they have connections with private and public hospitals and clinics (Community Services, 2). The majority of services for adults 21-65 are outpatient services, unless the person suffers from substance abuse. In 2006, the CSBs received \$227 million from the Department, \$160 million from state matched federal Medicaid Reimbursement, \$196 million from local governments, which puts Virginia at 39th in Community Mental Health spending per capita. Arkansas spends the most at \$249.48 per person in 2004 (NASMHPD Research Institute, Inc). The large budget allows the Board to provide more help to those suffering from mental disorders. The CSBs provide emergency care and case management and when funds permit, it provides inpatient and outpatient services, day support, employment, residential, and prevention and early intervention. The Richmond area has one of the largest budgets (\$33 million) while the Rockbridge area has one of the smallest (\$6 million) (6). In 2006, the CSBs provided mental health care to 195,794 clients (22). It served 75,573 clients between the ages of 21 and 65, who would not qualify for Medicaid. It served 43,503 minority patients (26). This minority group

includes refugees. The national Refugee and Mental Health program helps fund Boards that are addressing the issues of resettlement through assessing, treating, and consulting of refugees. The program started in 1980 to help the Cuban and Haitian immigrants in South Florida. In 1995, the program was transferred to the Special Programs Development Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA), which allows it to assist agencies under the Office of Refugee Resettlement. The Community Services Board works along with SAMHSA to provide quality services to all of its clients. The Board does not provide any specific programs for refugees, but refugees can use its regular clinical services.

Center for Multicultural Human Services

The most comprehensive program available in Virginia is at the Center for Multicultural Human Services in Falls Church, which has a specific program for those who have experienced torture and trauma. It serves more than 200 trauma victims a year. It provides services in over 30 languages from professionals who are also refugees or immigrants. The center acknowledges the cultural differences in therapy and it incorporates different methods to help diverse groups. An example is a therapeutic program that addresses fears through art for clients who prefer art as a way of expression. The center provides psychologists, psychiatrists, interpreters, and social workers to all clients that need them (CMHS). It is funded through federal and state grants and clients are charged for services based on income level. The organization can help clients find housing in the area for clients who need it. This is one of the few programs that provide therapy and in-depth cultural orientations to reduce acculturation stress. The program attempts to provide a safe place for refugees to communicate the problems they are

having without the fear of being misunderstood or harassed. Although it provides such a comprehensive program, RIS has found that few refugees are willing to relocate to receive the services. The clients would have to leave their communities and families and this may not be a good option for parents. In order for the center to be effective in helping refugees there needs to be more than one clinic in the state. It is important that state funding helps provide more centers that are comprehensive for refugees. Refugees in other states would also benefit from similar programs.

YWCA

Female refugees who were sexual assaulted can be referred to the Young Women's Christian Association (YWCA), which provides individual and group counseling to all immigrant and non-immigrant women. The non-profit organization helps empower thousands of women all over the world. YWCA is also one of the few organizations that is present in the refugee camp helping women who are suffering from assault and sexually transmitted diseases. The organization understands the refugees' experiences and can therefore provide better counseling services than the Community Services Board. In Richmond, VA, the organization allows interpreters for refugee counseling. An important feature of the Richmond YWCA is that the organization does not have a psychologist, but it provides a Licensed Social Worker. Therefore, clients will need to be referred to other mental health professionals if counseling is not effective enough. Recently, RIS received a young Burundi woman who was born and raised in a Tanzanian camp. The agency had placed her with another Burundi family. A few days into their living arrangement, the family noticed that the girl was acting strange. She eventually told someone that she feared living in a house with a man, because she was

sexually assaulted at the camp. RIS immediately removed her from this house and placed her in another home with two Liberian sisters. She is also receiving counseling from the local YWCA. The issue could not have been addressed without communication among the family, RIS, and YWCA. The program mainly addresses sexually assault issues, therefore it is not an effective tool for a diverse group of refugees. However, the program shows that non-profits can be effective in treating refugee mental programs. Since the YWCA is best as a preventive measure for serious mental disorders, it is important for the resettlement agency to have a close connection to these types of non-profits.

Assessment Tool

The Harvard Program in Refugee Trauma is a clinical program researching the effects of trauma on refugees in refugee camps, post-war countries, and resettlement countries. The program provides the *Measuring Trauma, Measuring Torture* manual on working with trauma victims for agencies working with East Asian and Southern European refugees. The manual is one of the few available for training agencies on how to detect and support refugees suffering from trauma. The only problem with the manual is that it only addresses a small population of refugees and most of the case studies are based on victims of WWII. Refugee and Immigration Services does periodically receive Vietnamese and Cambodian refugees, but their caseload includes a variation of people. Last summer the focus was on Burundi refugees living in Tanzanian camps, but this February and March the majority were Iraqis. Therefore, they need a more comprehensive program to deal with the changing population. Nonetheless, the Harvard program is a good start to addressing mental health in tortured victims. The clinical program begins with an interview process at the doctor's office using the Harvard

Trauma Questionnaire or the refugee version of the Hopkins Symptom Checklist-25. The Harvard Trauma Questionnaire is a trauma survey for a specific population, for example, there is a version for Croatian soldiers who survived the war in the Balkans and a Bosnian version for civilians who survived the same war. The first part of the questionnaire asks about the events the person has experienced with a three-point scale (Experienced, Witnessed, Heard About It, or No). The second part asks the person to describe his/her most traumatic experience. Part 3 asks about head injuries and the fourth part uses a likert scale (Not at all to Extremely) to describe traumatic symptoms the person may have. The HSC-25 has 10 items correlated with anxiety and 15 items for depression. The average of the two scores is highly correlated with severe emotional distress. After assessing the patient, the program tries to create a treatment plan that uses both Western and cultural specific plans. The Harvard Program also addresses the problem of prescription usage in refugees. Psychiatrist must adjust the dosage for different population or side effects may occur and cause the patient to lose trust in the field of psychiatry. Mental health workers must address the fear of addiction, stop taking the medicine when symptoms stop, or share the medication with non-patients (Harvard Program in Refugee Trauma).

Challenges to Treatment

At Refugee and Immigration Services, a referral to a mental health professional depends on the client's willingness to disclose information about his or her mental well-being. In a conversation with the Resettlement Officer, I learned that the average refugee does not willingly disclose information about mental disturbances, such as depression and nightmares. Some ethnic groups find disturbances to be socially unacceptable and prefer

to deal with the issues at home. There is a cultural gap between the types of treatment for mental disorders. Many of the refugees do not understand and therefore do not trust the Western “talk therapy” method. Jane continued to tell me that some individuals would prefer to hold séances or exorcisms in order to relieve the person from this disorder. A study of Black immigrants found that mental health treatment-seeking behavior was low in first generation Americans, but it was higher in the population born in the U.S. (Jackson et al., 2007). Clinical research done with the Haitian population suggests that psychologists incorporate the culture’s traditional form of therapy into treatment of special groups. The study found that Haitian women suffering from depression believed the cause of their disorder was due to a disconnection with the gods. They would then perform voodoo rights in order to cure themselves of the disease. The study found that the Western treatment is more successful when voodoo elements were incorporated (Nicolas et al., 2007).

Other Resources

With knowledge about treatment-seeking behavior in immigrant groups, organizations like Refugee and Immigration Services need to be proactive in teaching their refugees about the Western Style therapy and the symptoms it addresses. RIS needs to make the refugee feel more comfortable talking about their mental health, by explicitly asking questions about it. In my conversations with the Resettlement Officer, she told me that their main priority is getting the refugees economically stable, because of the way the social system is set up. She acknowledges that a system that focuses on economic well-being rather than both economic and personal well-being can exacerbate any problems the person may have. Although caseworkers are not able to focus their energy on mental

well-being, other organizations work with RIS, such as the churches that try to recruit the new refugees into their congregations. These churches provide a social network of people from a similar background as the refugees; religion can also be therapeutic in that it provides an outlet for emotions.

Conclusion

All of the government and agency websites I have found stated the same mission: to make refugees financially stable as soon as possible. It is as if they are forgetting that people need more than a job to live. I understand that the American public fears new immigrants living on their tax dollars, but these refugees have suffered for years and sometimes decades of war and poverty. They did not expect to leave their homes to be sent to a country that does not share their culture. The nation needs to understand that these people are victims and need more than money to help them rebuild their lives. The Office of Refugee Resettlement needs to acknowledge the effects of such experiences on mental health and then have a proactive plan to treat these disorders.

I know we as Americans fear spending more money on social programs, but we need to look at the benefits. Those who are treated for a disorder are more productive at work, have better parenting skills, and are more active in the community than those who are left to suffer on their own. All these things translate to the individuals making more money on their own without social services. If we continue to ignore the problem, the physical effects of these disorders will cause the government to spend more money on Medicaid. Those suffering from mental disorders are more likely to be homeless than the normal population. Therefore ignoring the problem will increase the number of homeless people and increase the burden on the few shelters available. Refugees who are having

difficulties at work are less likely to advance and increase their wages, therefore agencies like RIS will have to spend more money on the families in order to provide supplementary income.

The Medicaid programs in all states need a more comprehensive mental health program for all clients, if not only for refugees. In the United States 22% of the population suffers from a mental disorder (Mental Health Today). With such a large portion of the population suffering from a disorder it is important to provide treatment. It is strange that there is a limited number of services for adults 21-65. These are the people who are working and raising families. They need the most services to keep functioning. If federal funding cannot be allocated to increase mental health insurance and then states have a responsibility to their residents to ensure that there is funding for similar programs. According to the organization Mental Health America, the U.S. is losing \$31 billion because of a loss of productivity for untreated depression patients. That is only one of the major disorders. It is in America's benefit to increase these programs and provide routine mental health assessments as part of a physical exam.

The best program in Virginia is the Center for Multicultural Human Services in Falls Church, which idealizes the type of treatment all refugees should be receiving. If Achak was able to find a center with Sudanese or at least African mental health workers who were willing to work with him on dealing with the memories, then he would have less debilitating headaches and nightmares. He would have a higher rate of adjustment. By offering such a program at the beginning of resettlement, it would increase refugees' disclosure of information about their mental health, so that treatment and preventative measures can be put in effect.

Although my focus is mainly on adult refugees, I do think it is necessary to provide a comprehensive program for addressing mental health problems in children as well. By addressing the issues at a young age, children will have a greater opportunity of being adjusted adults. The Center for Multicultural Human Services provides an educational tool called “Children of War” for educators and caregivers of refugee children that explains the type of experiences their children may have or are currently going through. While interning at Refugee and Immigration Services I worked with several refugee children. One girl was raped at age 12 and became pregnant. Her family did not know she was pregnant until she was going through the health examinations for resettlement. Her family and RIS provide her lots of support in raising her son. She has many dreams and one is to become a nurse, but the teachers at her high school are not supportive. Her English for Speakers of Other Languages teacher does not teach the class and the students use the time to socialize instead of learn. She has problems at school, because of her poor education background. She wants to catch up to the other students, but the classes she is in are not conducive to that. Many of her classmates have behavioral problems, which makes it difficult for the teacher to teach. Schools need to address the issues of having refugee students and the mixing of refugees and low-achieving students. Other problems that I noticed in my other clients are that some were having difficulties at school, because they were not receiving the help they needed. Tools like “Children at War” can help teach educators about the connection between trauma and psychological problems and school. There also needs to be tools teaching educators about the special educational needs of refugees.

In conclusion, the psychological disorders can only be addressed through a network of federal, state, and local programs focused on refugee well-being. The changes will not be easy or inexpensive, but we are responsible for this group. The United States should consider all of the programs currently available domestically and abroad in order to create a strong resettlement program that addresses mental health. By caring for refugees the U.S. will have a higher return on its investment and U.S. citizens will be more willing to care for these migrants.

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