



**UNC**  
SCHOOL OF SOCIAL WORK

# **UNC Global Transmigration Refugee Mental Health & Wellness Initiative**

**Pilot Year 2013-2014**

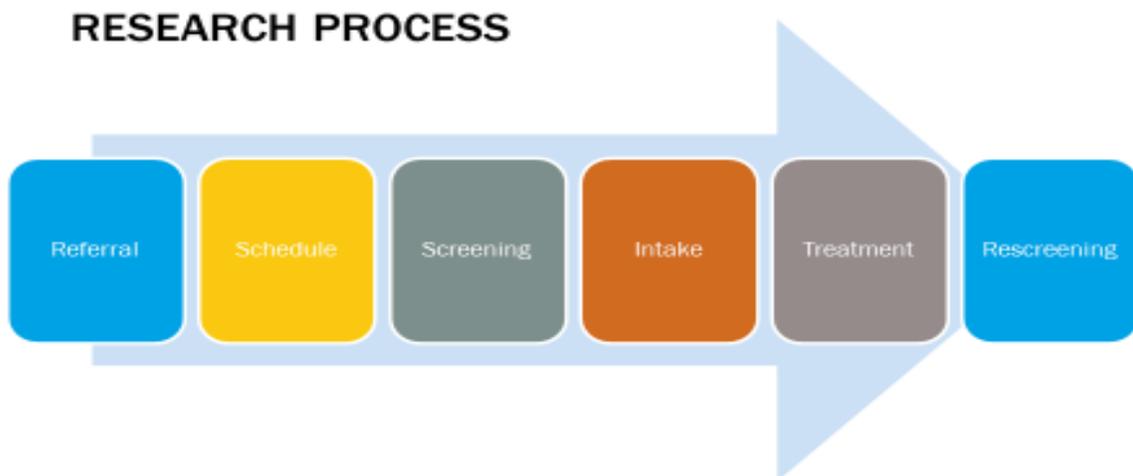


## Project Activities and Research Process

Our project consisted of:

1. Administering mental health screenings to newly arrived refugees
2. Providing individual therapy and/ or group treatment
3. Providing psychiatric case management for refugees identified as having a severe mental illness
4. Providing presentations on mental health for refugee groups and community members

Throughout these activities ran a thread of research: collecting data on the need, and finding out which mental health interventions are most appropriate and effective for refugees.



### Referrals

In 2013-2014, the RMHWI partnered with Church World Service (CWS), a national organization in Durham, NC that contracts with the NC State Refugee Office to receive and resettle refugees in Durham and Orange Counties. The project submitted all recruitment scripts, letters of informed consent, and other documents to UNC's IRB for approval before inviting refugees to participate. We received 91 referrals in all from CWS, 87.9% of whom said they wanted a mental health screening. Next the team visited interested refugees in their homes to schedule a time to come back with an interpreter.

### Screening

The RMHWI successfully scheduled and screened 71.3% of referrals who said they wanted a mental health screening. While the project aimed to screen refugees one month after their arrival, participants were screened on average about two months after arrival.

On the day of the screening, students went to the refugee's home with an interpreter



biopsychosocialspiritual assessment. Depending on the refugee's RHS-15 score and treatment needs identified in the assessment, the student advised the client on treatment options. The project offered either individual or group treatment. When offered both service options, most of our clients requested individual therapy over group. Many chose both.

### **Rescreening**

Rescreening was conducted to measure effectiveness of treatment for those who engaged in treatment, and as a way to collect some evidence on whether or not treatment seemed to make any difference for those who didn't engage in treatment. The project intended to conduct rescreenings three months after the initial screening; rescreenings were completed on average about 3.5 months after initial screening. Rescreenings used the RHS-15 for quantitative data, and included a semi-structured interview to collect qualitative data.

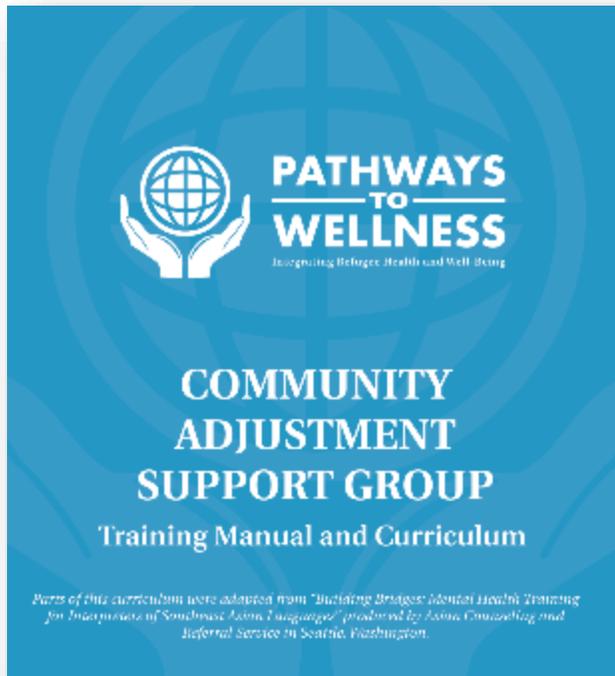
Quantitative data from the RHS-15 allows the researcher to determine if refugees' level of distress has increased or decreased since initial screening, whereas qualitative data is used to deduce refugees' beliefs regarding factors that may have contributed to the change in distress level. Qualitative prompts also elicit refugees' views on the project, specifically regarding components that refugees found helpful, or ideas they have for improvement.

### **Treatment**

The primary goal of this pilot project was to gather data on the need for services, to find out if refugees would accept services, and to assess feasibility of providing these services. However, the lack of mental health services for refugees in North Carolina raises ethical concerns around identifying a need for services when no providers are available to address that need. Therefore, the RMHWI offered treatment services primarily to address mental health concerns identified during the screening process. Because the actual treatment modality was not being studied, data collection only included screening and rescreening.

### **Individual and Family Counseling**

Treatment provided by the project included individual and family counseling, community adjustment support group, and psychiatric case management. The initial task of students was to review the research literature to identify mental health interventions that have been found to be effective with refugees. Research in this area was found to be sparse; as such, the project began by offering CBT-informed therapy, focusing on psychoeducation and supportive counseling to help refugees navigate daily stressors, identify psychosocial needs, and confront challenges using behavioral activation. Therapy was conducted through an interpreter in the client's home, with sessions averaging one hour in length, and meeting once a week until client termination. The project had established a protocol for referring refugees with severe mental illness to the UNC Department of Psychiatry, but no such cases were identified.



## Community Adjustment Support Groups

The project also conducted Community Adjustment Support groups with men from Somalia, Sudan, and another African country (due to small sample size, identifying this country would constitute deductive disclosure) using the Pathways to Wellness Community Adjustment Support Group curriculum. These groups are intended to create community and help form relationships, as well as create a therapeutic space for participants to share their experiences as refugees in a supportive environment. In particular, the curriculum normalizes refugee distress and educates participants on acculturation stress and culture shock.

Topics include:

- Introduction to Group
- Culture Shock
- The Refugee Experience
- Mental Health
- The Mind and Body Connection
- Goals and Dreams
- Creating Wellness and Creating a Community of Wellness

Participants in the groups were also interested in learning more about the healthcare system, what their Medicaid included, what happens when Medicaid runs out, how to get health insurance, and when to go to the emergency room as opposed to urgent care. The RMHWI partnered with a group of Allied Health students to do presentations on these topics, and RMHWI students took refugees on field trips to see community resources like the public library.

## Research Data

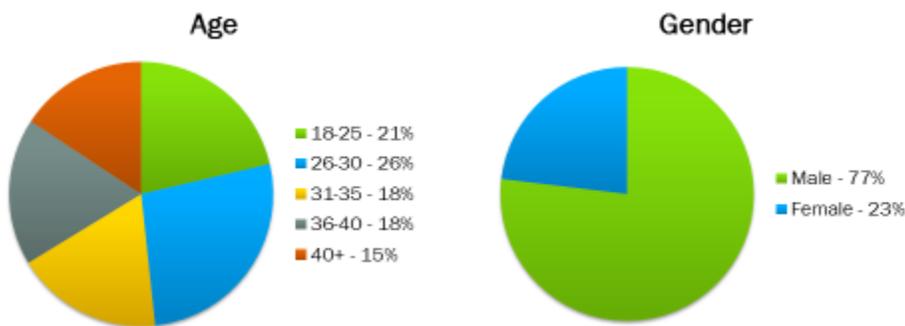
Data collected in the course of this project included:

- Demographic data
- RHS-15 Scores (pre and post)
- Qualitative follow-up data
- Process data (# of sessions, etc.)

## Research Design

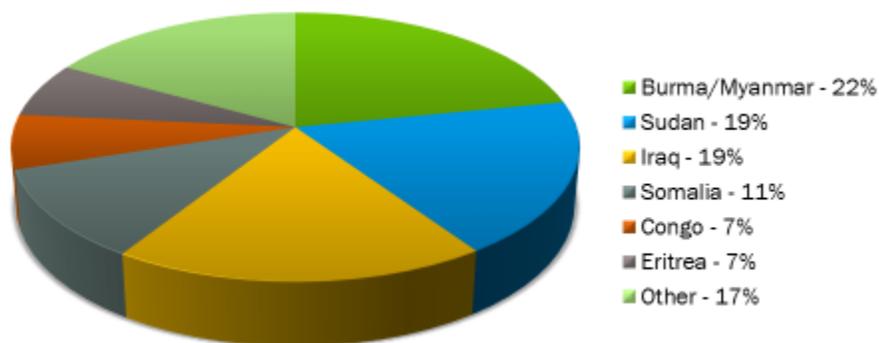
The RMHWI used a quasi-experimental design in which clients were offered individual and/or group treatment depending on their RHS-15 scores, intake assessment, and availability of groups. While a randomized control group would have provided stronger evidence of treatment effectiveness, RMHWI researchers had ethical concerns with refusing treatment to vulnerable individuals who would not be able to access treatment elsewhere. As noted earlier, the primary purpose of this project was to gather data on refugees' mental health needs, and the feasibility and acceptability of delivering mental health services to this population. As such, it is important to remember that this data is not conclusive as to the effects of treatment, or the best treatment to use with refugees.

## Preliminary Quantitative Results



**Referral demographics.** The referral group includes all of the resettled refugees referred to the RMHWI by Church World Service from summer 2013 through April 2014.

The majority of refugees in the referral group were men ages 20-40.

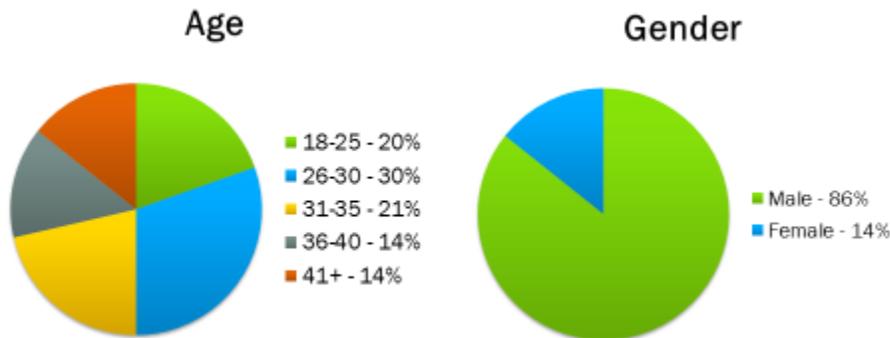


Largest referral countries included Sudan, Iraq, Burma, and Somalia. 87.9% of refugees who were offered the opportunity to participate in the project indicated that they wanted a

mental health screening. The project's research sample consists of the 71.3% of those referrals that students were able to screen.

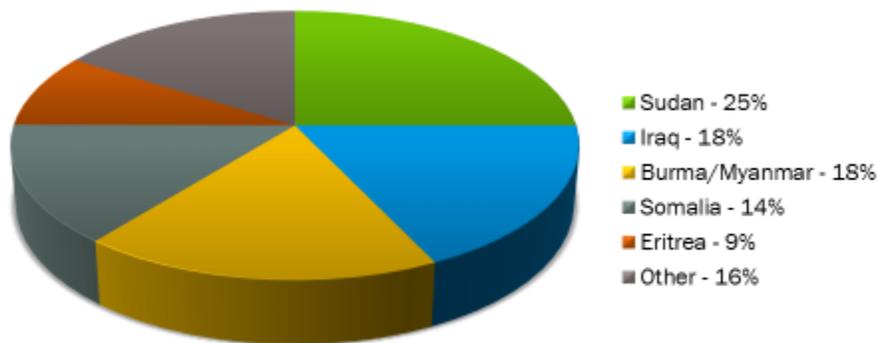
**Treatment sample demographics.** For purposes of project participation and data collection, the RMHWI served only adults ages 18 and older, but students were available to

provide supportive family counseling if the need arose. As in the referral sample, the vast majority of participants were men, ages 20-40.



Largest sending countries were Sudan, Iraq, Somalia, and

Burma.



**Process data.** The project screened 57 refugees and conducted individual or family therapy with 19 clients for a total of 63 sessions. Students facilitated 19 group treatment sessions, which were attended by 15 clients.

**RHS-15 pre-test scores.** 58.9% of the refugees screened were above the threshold of 12 points. Mean score was 15.28. Including Distress Thermometer scores, 69.6% of refugees screened positive. The RMHWI reports a higher percentage of positive screens compared to other researchers who have used the RHS-15. One factor that could explain this difference is the practice of screening refugees in their homes rather than in an agency. The home environment may allow researchers to develop a more trusting relationship with project participants, and affords time to go through each question together with refugees. However, we are not sure what effect these variables have on the screening scores. RHS-15 pre-test scores indicate some differences based on gender, age group, or country of origin. Women scored an average of 12.25 points higher than men. Cuban individuals scored at the top of the range with an average score of 24, and Eritrean individuals scored at the bottom of the range with an average score of 3.8. There appears to be no association between scores and

time since arrival in the US.

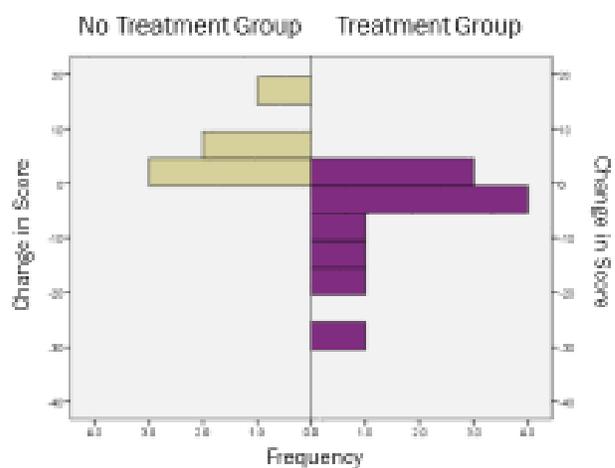
**RHS-15 post-test scores.** Students were only able to administer the post-test to 26 individuals, revealing an attrition rate of 54.4%. Reasons for attrition included refugees moving out of state, declining to participate in the post-test, and taking jobs that limited their availability for follow-up. The mean score on post-tests was 17.62, with a standard deviation of 9.87. 57.7% of the refugees who completed the post-test scored above the threshold of 12, compared to 58.9% on the initial screening. Including Distress Thermometer scores, 73.1% screened positive compared to 69.6% initially. There were no significant differences based on gender at post-test. The only significant difference based on country of origin was a significant difference between Somali participants and those from the aforementioned country in Africa. Participants from that country scored an average of 27.67 at post-test, while Somali participants scored an average of 8 at post-test, a difference of 19.67 points. While there was also a significant difference based on age, participants over 40 years old scored significantly higher at post-test than other participants. The over 40 average was 31.67, while the under 40 average was 12.39. In terms of the change between pre- and post-test scores, there were no significant differences in amount of change based on country of origin.

**Treatment group improvement.** While there are no significant differences between treatment and nontreatment groups based on gender or age, age was a significant predictor of an individual's improvement on the RHS-15 in the treatment sample. On average, post-test scores increased by 14 points among participants over 40, while those under 40 decreased by 5.22 points (a difference of 19.22 points). Another significant predictor of an individual's improvement on the RHS-15 was whether or not they participated in treatment.

Those who engaged in treatment saw a significantly greater change in scores than the nontreatment group (mean difference -13.8 points). This effect remains significant even after controlling for other factors including pretest scores, age, and gender. The only significant difference regarding treatment choices between different countries of origin was that individuals from Sudan were significantly more likely to engage in treatment than individuals from Burma/Myanmar (86.7% vs 10%). Since this was not a randomized control trial, there is not a conclusive causal relationship between treatment and improved outcomes; those who engaged in treatment may also have had other qualities that contributed to their improvement.

### Qualitative Data

The post-test screening included questions to elicit refugees' theories to explain increases or decreases in RHS-15 scores, as well as refugees' thoughts about mental health



screening and treatment. While some themes emerged from these interviews, qualitative data has not yet been coded or analyzed. Qualitative prompts were:

**For refugees who did not participate in treatment:**

- 1) (If follow-up RHS-15 score was higher than at initial administration) ***What do you think is making you feel worse now than we last asked you these questions? What would help you feel better?***
- 2) (If follow-up RHS-15 score was lower than at initial administration) ***What has helped you feel better since we last asked you these questions? What else do you think would be helpful?***
- 3) (If subject refused services) ***What services would you be interested in if they were available?***
- 4) (For all subjects): ***What has it been like to answer these questions? Do you think it is helpful/appropriate for us to ask refugees these questions? What would be more helpful? What do you think would be the best time and place to ask refugees these questions?***

**For refugees who participated in treatment:**

- 1) (If follow-up RHS-15 score was higher than at initial administration) ***What do you think is making you feel worse now than we last asked these questions? What would help you feel better?***
- 2) (If follow-up RHS-15 score was lower than at initial administration) ***What has helped you feel better since we last asked these questions? What else do you think would be helpful?***
- 3) ***What has been most helpful about the treatment you've received? What additional services would you be interested in if they were available?***
- 4) ***When this project is over, would you like to continue receiving treatment?*** (If YES, explore with subject options for treatment and follow-up with referral for services)
- 5) (For all subjects): ***What has it been like to answer these questions? Do you think it is helpful/appropriate for us to ask refugees these questions? What would be more helpful? What do you think would be the best time and place to ask refugees these questions?***

## Discussion

If the primary purpose of this pilot project was to determine the need for mental health services among refugees in this area, then data so far would suggest that a need exists, and there appear to be no easy ways for refugees who do not speak English to access services in our current system of care. If the secondary purpose was to test the feasibility and acceptability of providing mental health services using this model, then the RMHWI has demonstrated that services can be delivered to this population using this model, and that refugees are willing to accept them and find them valuable.

Unfortunately, referring refugees out for care at the end of the project proved challenging; while we attempted to coordinate care with Alliance Behavioral Healthcare, the managed care organization that serves Durham County, we were not able to find providers who were knowledgeable about the unique mental health concerns and diverse cultures of refugees. More concerning, interpretation is not a Medicaid reimbursable service in NC, and paying for interpreters makes mental health services prohibitively expensive for refugees and providers

## **New Directions**

The RMHWI has identified a need for services in the refugee population of NC, and has uncovered a gap in services to meet this need. These revelations have gained the attention of community members, mental health practitioners, refugee resettlement agencies, and other refugee service providers across NC and the nation. Additional data and larger sample sizes are needed for NC refugees, as well as testing of specific treatment modalities for effectiveness with these populations. NC's State Refugee Office – an office within the NC Department of Health and Human Services – is particularly interested in partnering with the RMHWI to help continue its research and expand the delivery of mental health services.

**Agency-based services.** While the model of home-based services was essential to carrying out the pilot project, it may not be the most efficient means of service delivery due to the time and travel involved. Having screenings and services located in a resettlement agency could potentially allow the project to reach more refugees and more accurately assess their interest in engaging in treatment. For the second year of the project, USCRI has agreed to host the RMHWI in its Raleigh, NC Field Office. In conjunction with the NC State Refugee Coordinator, the RMHWI has applied for federal Office of Refugee Resettlement (ORR) funds to support this partnership. Funding will allow the RMHWI would continue as a field unit for UNC School of Social Work MSW students in the 2014-2015 year, with students being housed at USCRI's offices in Raleigh and providing services in Wake, Durham and Orange Counties.

**Interpreter training.** This project has also identified a need for professional interpreters trained in working specifically in mental health settings with people who may have survived torture, war trauma, or sexual violence. The Voice of Love (VOL) is a nonprofit organization based in Ellicott City, MD that has developed a curriculum to train interpreters in these areas, and to prepare mental health providers to work with interpreters more effectively. In its recent grant applications, the RMHWI has included requests for funding to hire VOL to train interpreters who will work on the project in the future.

**Survivors of torture.** Many refugees have suffered from torture before coming to the U.S. The ORR awards funding to torture survivor treatment centers across the U.S., and the RMHWI has been approached by the NC Office of Refugee Resettlement to apply for funds that would establish a center at the UNC-Chapel Hill campus. Such a center would significantly expand the mental health services available to refugees in NC, would create opportunities to

train providers who could deliver integrated healthcare services to torture survivors, and would raise awareness of this population across the state. The request for proposals is expected to come out in 2015.

### **Next Steps**

Given the mental health needs of NC's refugee communities and the tremendous potential to build on the RMHWI's service model, it is essential that the project continue. However, the uncertainty surrounding federal funding for refugee services has prompted the RMHWI to seek more sustainable methods for providing refugees with mental health services. Future iterations of this project will focus on training mental health providers to serve refugees, integrating mental health services with primary care services for refugees, and building capacity with refugee communities to develop mutual support and advocacy networks.

For more information, contact:

Josh Hinson, MSW, LCSW, LCAS  
Clinical Instructor, School of Social Work  
Program Director, Graduate Certificate in Global Transmigration  
University of North Carolina at Chapel Hill  
Tate-Turner-Kuralt Building  
325 Pittsboro St. CB #3550  
Chapel Hill, NC 27599-3550  
919-962-6434  
[Qhinson@email.unc.edu](mailto:Qhinson@email.unc.edu)  
[http://sww.unc.edu/programs/Global\\_Transmigration\\_Certificate](http://sww.unc.edu/programs/Global_Transmigration_Certificate)  
<http://www.facebook.com/UncGlobalTransmigrationCertificateProgram>