Improving Refugee Mental Health Care in Virginia

Final Report

April 2020

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Prepared for the Virginia Refugee Healing Project

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Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Acknowledgements

I would like to thank Eva Stitt at the VRHP for giving me the opportunity to work on this important issue that I feel so strongly about. I would like to thank my two advisors, Professor Kirsten Gelsdorf and Professor Lucy Bassett. It has been an honor to receive mentorship and guidance from two individuals I look up to dearly and whose work I admire so greatly. I would like to thank my classmates Jordan Chapman, Anna Haritos, and Paige Karp—for their thoughtful feedback throughout the process of writing this report. I would like to thank the practitioners who made themselves available for interviews that became such a valuable part of this.

Acronyms

CHW	Community health workshop
DBHDS	Virginia Department of Behavioral Health and Developmental Services
IFMC	International Family Medicine Clinic
IRC	International Rescue Committee
ONS	Office of Newcomer Services, Virginia Department of Social Services
ORR	Office of Refugee Resettlement, U.S. Department of Health and Human Services
PTSD	Post-traumatic stress disorder
RHS-15	Refugee Health Screener-15
SAMHSA	Substance Abuse and Mental Health Services Administration
SIV	Special Immigrant Visa
TICCP	Trauma-Informed Cross-Cultural Psychoeducation
TWI	The Women's Initiative
UVA	University of Virginia
VR	Virtual reality
VRHP	Virginia Refugee Healing Project
VTSS	Virginia Tiered Systems of Supports

Definitions

Below are the definitions of populations eligible to refugee resettlement services in the U.S. All definitions are retrieved from the Office of Refugee Resettlement website (Office of Refugee Resettlement, 2019a).

Refugees: A refugee is any person who is outside his or her country of nationality or habitual residence, and is unable or unwilling to return to or seek protection of that country due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion.

Asylees: Asylees are individuals who, on their own, travel to the United States and subsequently apply for/receive a grant of asylum. Asylees do not enter the United States as refugees. They may enter as students, tourists, businessmen, or even in undocumented status. Once in the U.S., or at a land border or port of entry, they apply to the Department of Homeland Security (DHS) for asylum.

Cuban and Haitian Entrants: Cubans and Haitians who have a current or expired parole, who are in pending removal proceedings, or who have a pending application for asylum are Cuban/Haitian Entrants and thus are eligible for ORR benefits and services, same as a refugee.

Special Immigrant Visas: For their service to the U.S. government in Iraq and Afghanistan, certain Iraqis and Afghans are granted Special Immigrant (SIV) status overseas by the U.S. Department of State and are admitted to the U.S. by the Department of Homeland Security. The Department of State, in conjunction with the Voluntary agencies and ORR, assist with the resettlement and integration of SIVs into the U.S. An SIV is eligible for the same ORR benefits and services and for the same time period as a refugee, from the first day the SIV arrives in the U.S.

Amerasians: Individuals fathered by a U.S. citizen and born in Vietnam after January 1, 1962, and before January 1, 1976, are known as Amerasians and may be admitted to the U.S. as immigrants. Spouses, children, and parents or guardians may accompany the Amerasian.

Victims of Trafficking: The Trafficking Victims Protection Act of 2000 (TVPA) defines 'Severe Forms of Trafficking in Persons' as:

- *Sex Trafficking:* the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act , in which a commercial sex act is induced by force, fraud, or coercion, or in which the person forced to perform such an act is under the age of 18 years; or
- *Labor Trafficking:* the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery.

Executive Summary

Refugees around the world are fleeing violence and persecution in their home countries, and come to communities throughout the U.S. in search of safety. Many of these individuals experience trauma during the process of leaving their homes, travelling toward safety, and integrating into a new community. The post-traumatic stress disorder (PTSD) rate for refugees far exceeds the national average in the U.S. **However, there remains a large treatment gap in refugee mental health around the world that has implications in the state of Virginia**. For the 17,000 refugees that have settled in Virginia since 2013, there is an need for communities throughout the commonwealth to expand mental health services for these individuals.

When refugees resettle in communities across Virginia—primarily Charlottesville, Fredericksburg, Newport News, Harrisonburg, Northern Virginia, Richmond, and Roanoke—they are typically most preoccupied with immediate economic concerns like finding housing and enrolling their children in schools. Mental health is often a last concern. That is why strategic entry points through public schools, community partners, and traditional resettlement services can be a way to connect refugees to the services they need. This paper aims to find options for reducing barriers to access for refugees seeking mental health services. The policy alternatives considered include:

1. Let present trends continue
2. Expand community-based programming
3. Invest in virtual reality therapy programs
4. Hire more mental health interpreters
5. Provide trauma-informed training for teaching by mental health professionals

The criteria for evaluating the alternatives included effectiveness in improving mental health outcomes, cultural and linguistic appropriateness, and cost. Expanding community-based programs proved to be the best option to improve mental health outcomes, as well as making services more accessible to refugees since many come from more community-oriented societies. Community-based programs have been used before in cities throughout Virginia, and there is evidence that they also help refugees form important social connections to others in their community that can have positive impacts beyond the duration of treatment. The next steps for VRHP will be to secure funding and decide which communities should first be prioritized for programs.

Introduction

Problem Statement

Refugees in the U.S. experience trauma at higher levels than the rest of the U.S. population. However, too many refugees do not receive the mental health services they need.

Globally, only 1% of refugees will ever receive mental health treatment, even though 20% of people in post-conflict settings have mental health disorders (Charlson et al., 2019). Refugees experience trauma at higher levels than the general U.S. population (Katsiaficas & Park, 2019; Refugee Health Technical Assistance Center; (National Institute of Mental Health, 2017). Refugees who settle in the U.S. experience trauma while fleeing conflict in their home country, travelling to and living in a different country, and facing new cultural adjustments in their community. However, many refugees do not receive culturally- and linguistically-appropriate mental health services. Refugees' emotional and mental well-being affects their economic prosperity, happiness, their health, and a variety of other parts of their life. When refugee mental health is given priority, the rest of society benefits from a more productive workforce, more successful students, and happier neighbors. This is an important consideration for the approximately 17,000 refugees that Virginia has admitted and resettled into communities across the Commonwealth since 2013 (John et al., 2017).

Why VRHP?

The Virginia Refugee Healing Partnership (VRHP) is a section of the Virginia Department of Behavior Health and Developmental Services (DBHDS). VRHP supports and coordinates the mental health program for refugee communities across the state and advocates for equity and language access to refugee mental health care. They coordinate among the Refugee Mental Health Council and/or Refugee Mental Health Referral System, refugee communities, and behavioral health providers.

Background

The following section of the report gives an overview of the trends in refugee resettlement in Virginia, the process by which refugee resettlement services are funded and implemented, and the data on refugee mental health. It provides the scope of the issue regarding refugee mental health and the relevant actors that can address this problem.

Demographics and Trends in Refugee Resettlement in Virginia

In FY 2018, 1,682 refugees arrived in Virginia (Office of Refugee Resettlement, 2019b).[1] That constitutes roughly 3.3% of total refugee arrivals in the U.S. during this period. The share of refugees admitted by Virginia is slightly larger than its proportion of the total U.S. population. Since FY 2013, Virginia has admitted 17,560 refugees ("Refugee Resettlement—Virginia Department of Social Services"). These figures include the populations that meet the definitions of refugees, asylees, Cuban/Haitian entrants, and Special Immigration Visa (SIV) holders.

The Refugee Crisis:
A Global Context

The current state of the global refugee crisis and projections that the crisis will worsen means that the communities throughout the U.S. should seriously consider how it provides adequate refugee mental health services. According to the UN Refugee Agency (UNHCR, 2019):

29.4 million

The number of refugee and asylum seekers around the world today.

13.6 million

The number of people forcibly displaced in 2018 alone marking a historic high.

37,000

The number of people around the world forced to leave their homes every day due to conflict or threat of violence.

17,560 refugees have been resettled in Virginia since 2013.

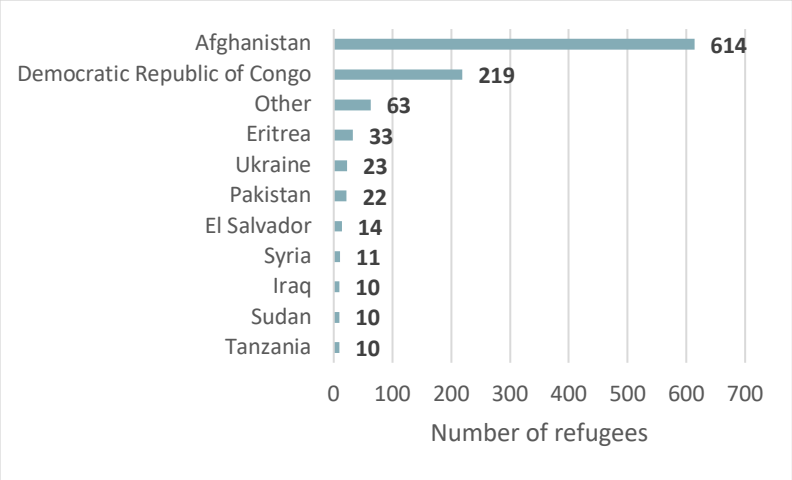
Most refugees coming to Virginia in 2019 came from Afghanistan, representing 60% of all refugees arriving in Virginia 2019 (*Refugee Resettlement - Virginia Department of Social Services*, n.d.). The

[1] This figure represents the total population served by ORR services, which includes 433 refugees (by ORR definition), 1,157 SIV holders, 30 victims of trafficking, 16 Cuban/Haitian entrants, and 33 asylees.

second most common country of origin was the Democratic Republic of the Congo (DRC), representing 21% of all refugees arriving in Virginia in 2019 (*Refugee Resettlement - Virginia Department of Social Services*, n.d.). Most of the refugees settling in Virginia are coming from conflict-afflicted countries. Afghanistan has been at war for 18 years. The Democratic Republic of the Congo (DRC) has hosted violent conflict since the spillover of the Rwandan genocide into their country in the mid-1990s.

Figure 1: Countries of origin for refugee arriving in Virginia, 2019

Source: (*Refugee Resettlement - Virginia Department of Social Services*, n.d.)



There are seven resettlement areas in Virginia: Charlottesville, Fredericksburg, Newport News, Harrisonburg, Northern Virginia, Richmond, and Roanoke. Each of these cities has its own refugee mental health referral system (Stitt, n.d.). **Figure 2** and **Figure 3** show how many refugees move to each of the resettlement areas, in terms of total number and as a percentage of all refugee arrivals in Virginia. Six non-profit refugee resettlement agencies operate in Virginia including Catholic Charities Diocese of Arlington, Church World Service, Commonwealth Catholic Charities, International Rescue Committee, International Rescue Committee-Richmond, and Lutheran Social Services of the National Capital Area. These organizations provide resettlement services and handle casework. Refugee resettlement programs across the U.S. focus primarily on employment and self-sufficiency.

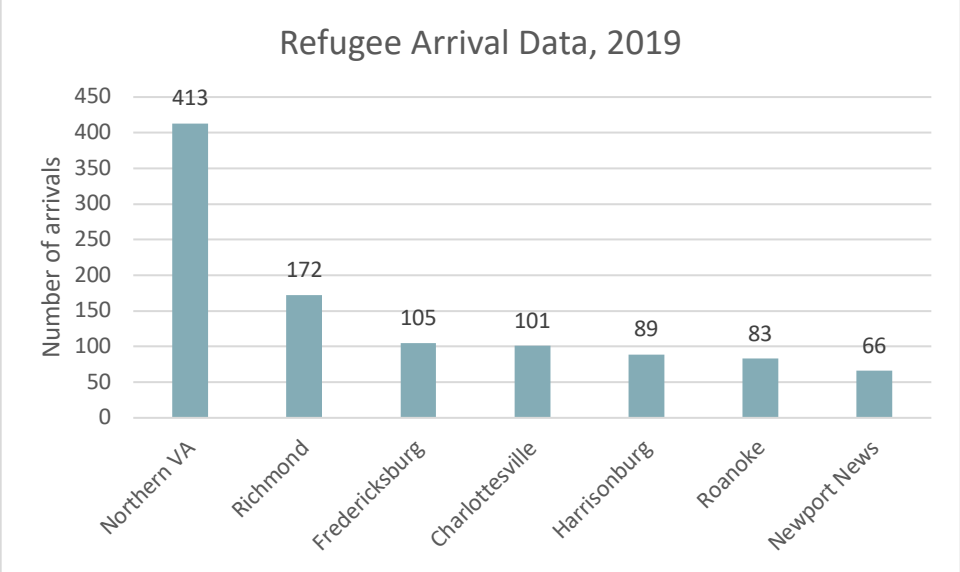
Figure 2: Refugee Arrival Data, 2019

Source: (Refugee Resettlement—Virginia Department of Social Services, n.d.)

Resettlement area	Total arrivals	Percentage of total refugee intake
Northern Virginia	413	40.1%
Richmond	172	16.7%
Fredericksburg	105	10.2%
Charlottesville	101	9.8%
Harrisonburg	89	8.6%
Roanoke	83	8.1%
Newport News	66	6.4%

Figure 3: Refugee Arrival Data, 2019

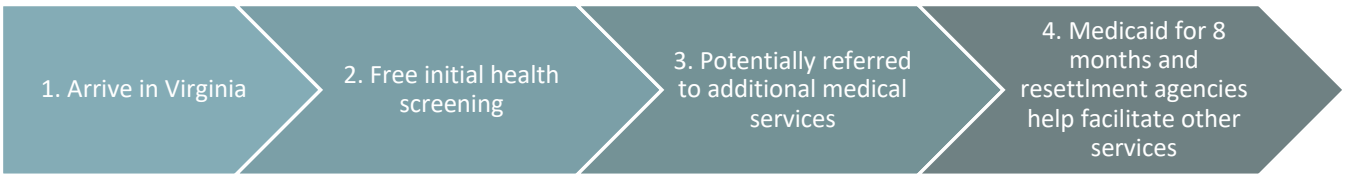
Source: (Refugee Resettlement—Virginia Department of Social Services, n.d.)



The Refugee Resettlement Process

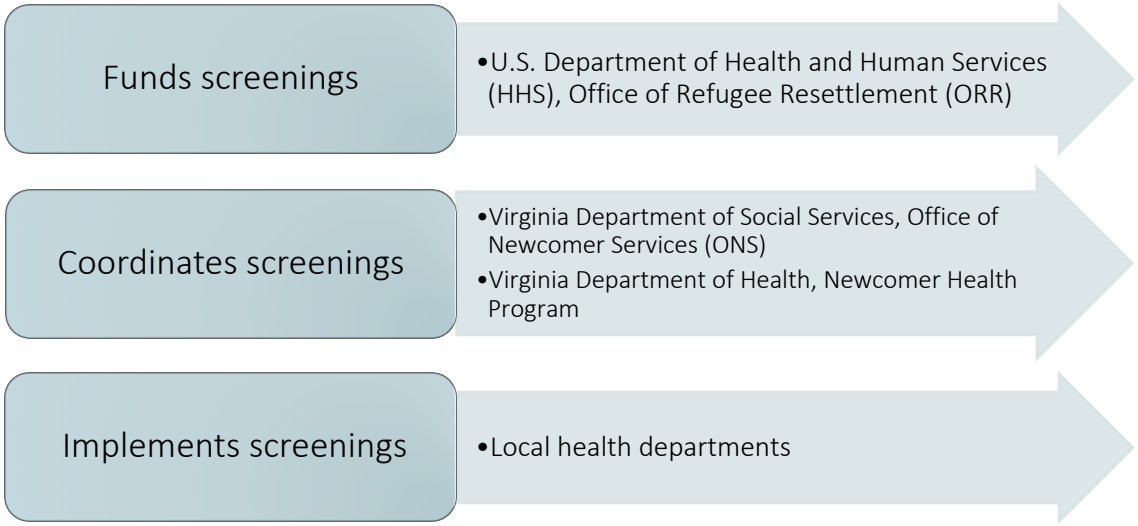
Authority over refugee resettlement in the U.S. is distributed among various federal agencies, state agencies, and local organizations. The federal government controls the number of refugees admitted to the country and grants funds to state governments who provide direct resettlement services and work with local organizations.

Figure 4: Refugee Resettlement Process



When refugees arrive in Virginia, they receive a free initial health screening at one of the local health departments throughout the state. The Virginia Department of Social Services' Office of Newcomer Services (ONS) and the Virginia Department of Health's Newcomer Health Program coordinate the screenings. The Office of Refugee Resettlement within HHS funds the screenings. The initial screening includes blood testing, tuberculosis testing, a physical, health history, vaccines, and a referral to primary care. Those eligible or a free initial health screening include refugees, asylees, Cuban and Haitian entrants, SIV holders, unaccompanied refugee minors, victims of torture, and victims of trafficking. The main objective of the initial heath screening is to treat any communicable diseases that are detected and raise public health concerns (Grumbine, n.d.).

Figure 5: Overview of the refugee initial health screening in Virginia



The Refugee Health Screener (RHS-15) is used in Virginia to detect mental health problems and refer refugees to mental health services. The screener is available in 13 languages.[2] The RHS-15 is used to refer refugees to direct services and to inform other mental health programs for refugees. The Refugee Mental Health Council (RMHC) oversees the refugee mental health referral system, which includes provides of direct mental health services to refugees in Virginia. RMHC works to coordinate the process from mental health screenings and referrals to direct services. It prioritizes culturally-appropriate mental health care to address disparities in refugee mental health care (Stitt, n.d.).

Funding for refugee resettlement services is similarly dispersed among federal, state, and local actors. The U.S. Department of State funds initial refugee resettlement, which includes the first month of rent, clothing, food, and other basic necessities for those in the United Nations Refugee Resettlement or SIV Program. The U.S. Department of Health and Human Services, Office of Refugee Resettlement gives Matching Grant funds to the non-profit resettlement agencies for additional assistance to employed refugees (John et al., 2017). In addition, the Office of Refugee Resettlement offers grants to the Virginia Department of Social Services to provide cash assistance, health services, English and employment services. Refugees in this track also qualify for Medicaid and welfare programs like Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP) (John et al., 2017).

Based off the Office of Refugee Resettlement's FY 2018 Refugee Support Services (RSS) Base Formula Allocation, the FY 2019 RSS Base Funding for Virginia was $4,437,762 (Office of Refugee Resettlement, 2019b). The Virginia Department of Social Services' Office of Newcomer Services oversees the Refugee Resettlement Program in the state (John et al., 2017).

$4,437,762 was funded to Virginia for FY 2019 from the Office of Refugee Resettlement.

Statistics on Refugees and Trauma

Refugees who settle in the U.S. experience trauma while fleeing conflict in their home country, traveling to and living in a different country, and facing new cultural adjustments in their new communities. The

[2] The RHS-15 in Virginia is available in Amharic, Arabic, Burmese, English, Farsi, French, Karen, Nepali (Bhutanese), Russian, Somali, Spanish (Cuban), Swahili, and Tigrinya.

most common mental health diagnoses refugees receive include post-traumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, and adjustment disorder (Virginia Department of Behavioral Health and Developmental Services).

In the U.S., refugees experience trauma-related mental illness at higher rates than the general population. More specifically:

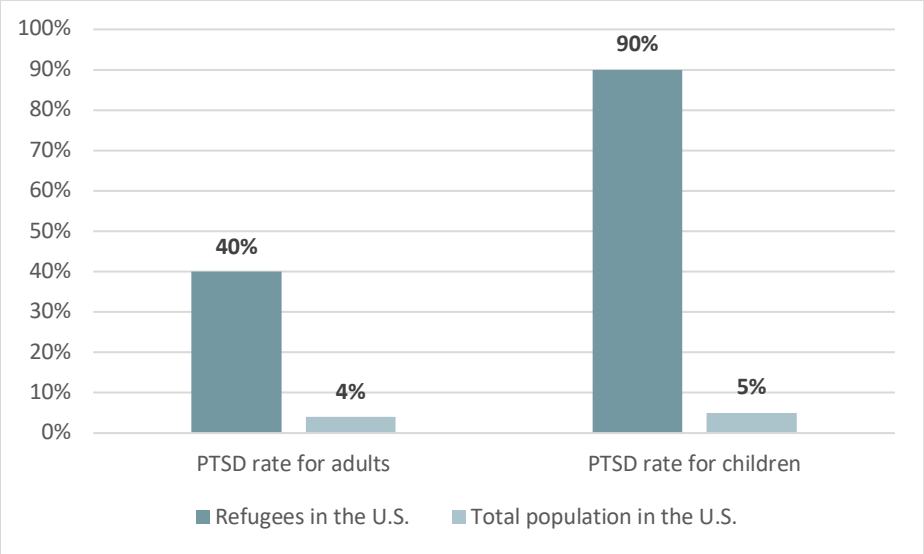
Studies find 10-40% of settled refugees suffer from PTSD and 5-15% suffer from major depression (Refugee Health Technical Assistance Center). The PTSD rate is 3.6% among the general adult population in the U.S. (National Institute of Mental Health, 2017).

Children who are refugees or whose parents are refugees experience trauma at higher levels than other children (Katsiaficas & Park, 2019). For these children, 50-90% suffer from PTSD and 6-40% from major depression (Refugee Health Technical Assistance Center).

Refugee women, who often face sexual violence and other forms of abuse, are ten times more likely than other women to develop symptoms of PTSD (Katsiaficas & Park, 2019).

Figure 6: Comparing PTSD rates for refugee adults and children in the U.S

Sources: (Refugee Health Technical Assistance Center; National Institute of Mental Health, 2017)



Mental health screening is not a wide-spread practice in refugee resettlement throughout the U.S., which is a likely reason for the large ranges of refugee PTSD rates and other mental health metrics is due to the limited data available (Pathways to Wellness, 2011).

Case Study: Refugee Mental Health Services in Charlottesville

Appendix A at the end of this report contains a case study on refugee mental health in Charlottesville, a city known for its coordination and accessibility of its services. Below is a summary of some of the key insights from the case study, conducted based off a series of stakeholders working on the provision of mental health services for refugees.

- ***Language access:*** Availability of interpreters and language translations services is another primary issue for both clinical treatment and community-based programs. There are not many interpreters available in person and there are even fewer trained on specifically mental health issues. This means that a lot gets lost in translation when trying to build trust with the patient and fully understand what they are going through.
- ***Cultural differences:*** Practitioners have found that many refugees will not seek mental health treatment on their own. Some have experienced a form of therapy before, but talk therapy the way it is done in the U.S. can be quite different for many refugees. There is a lot of confusion and even frustration about what therapy does.
- ***Collaboration among stakeholders:*** The case of Charlottesville demonstrates how various actors—on the clinical side, and the community side—work together to support local refugee communities. There is acknowledgement of the wide range of obstacles refugees face, and there is cooperation that works to address these.

Literature Review

This literature review synthesizes the external evidence on innovative attempts to improve refugee mental health that extend beyond traditional clinical-based mental health services. It evaluates existing approaches to improving refugee mental health services examining school-based and community-based programs that take more culturally- and linguistically-appropriate approaches.

School-Based Programs

One area of focus to address refugee mental health care is in public school programs. Out of the over 17,000 refugees arriving in Virginia since 2013, children under the age of 18 made up 6,134 of them, approximately 35% of total arrivals ("Refugee Resettlement—Virginia Department of Social Services"). Children who are refugees or whose parents are refugees experience trauma from their own direct experiences or indirectly from a relative (Katsiaficas & Park, 2019). The top countries of origin of children under five are Afghanistan, Iraq, the Democratic Republic of Congo, and Syria—countries home to some of the most deadly conflict in the past decade (John et al., 2017). The causes of this trauma are similar to those of adults and include fleeing violence in their home countries, making arduous journeys to safety in the U.S., leaving family behind, and witnessing the death of a family member.

Because the first five years of a child's life are especially formative for their development, mental health interventions at this age can significantly impact the rest of their lives (Katsiaficas & Park, 2019). However, one approach to addressing mental health among children refugees is through school-based programs. Virginia is already in a privileged position to adopt this approach because mental health education in ninth- and tenth-grade became mandatory in public schools throughout the state as of July 2018 (Chang & Deeds, 2018).

Best practices from pilot programs around the U.S. for mental health programs for refugee and immigrant students suggest family involvement is a critical factor in improved outcomes for children (Kugler, 2009). Engaging families helps improve students' academic outcomes. Some programs seek to engage parents at the beginning of the school year before any problems arise so that there is already an established relationship for if something does happen. Some of these programs include parent workshops at school and home visits. The use of Student Assistance Representatives (SARs), bilingual and bicultural paraprofessionals who meet with immigrant parents in support group-type meetings, makes parents feel more recognized and valued by recognizing the cultural context they are coming from.

However, there remain cultural barriers that hinder effective mental health services for refugee children through the school system. Some parents do not want to infringe on the authority of the teachers out of respect. Some parents see it as a privacy issue. Because of legal implications, some parents might not want to engage with official institutions out of fear of deportation if they are undocumented. While

school-based programs remove one obstacle to access by operating through existing institutions, there remain gaps in coverage when there is limited buy-in from parents, students, and administrators.

Community-Based Programs

Community-based programs are used for a number of health issues from diabetes to alcoholism and more. They have been used successfully in Virginia to provide an alternative to traditional clinical-based practices. Participants in these types of programs for mental health engage in a support-system model of discussing symptoms and root causes of anxiety, depression, and other disorders. Community organizations that focus on refugee resettlement services or mental health services more generally are the typical providers of these programs. They use their expertise working on these issues in the community to recruit participants and design the curriculum.

Dr. Hyojin Im[3] at Virginia Commonwealth University has worked with refugee communities throughout Virginia and is an expert on culturally-appropriate mental health services. One model she has worked on is peer-led intervention programs. In these types of programs, members of the refugee community receive mental health education training. They provide input to the curriculum to adjust to their own cultural context and language differences. Then, they take on leading the community health workshops with refugees from their country. This input makes the workshops more effective because the trained leaders from the community can provide alternative terminology and examples to make the material more relevant to participants. One of these types workshops was conducted in partnership with the International Rescue Committee in Charlottesville in 2017. Twelve refugee community leaders completed Trauma-Informed Cross Cultural Psycho-education training (TICCP), which gave them the ability to facilitate community workshops on mental health and overall wellness (*Cultivating Wellness*, 2017).

Dr. Im conducted a peer-led community health workshop (CWH) with Bhutanese refugees in Richmond. Many refugees come from more collectivist, community-oriented societies, these types of social support

[3] Dr. Hyojin Im, Virginia Commonwealth University (VCU) Associate Professor, works on culturally-appropriate mental health programs for refugees. She has worked with organizations throughout Virginia, including the International Rescue Committee, Virginia Department of Behavioral Health & Developmental Services (DBHDS), and The Women's Initiative.

workshops draw more buy-in. The study on this CWH made the following finding regarding how refugees engage with topics such as mental health:

> "Mental health therapy and related concepts, however, are not familiar to the refugee participants, especially those who are elderly or less educated. The CWH allowed the participants to open up to the tabooed topic and acknowledge mental health problems existing in the community, while encouraging and promoting the intention to seek help and help others in spite of high stigma around mental health in the Bhutanese culture" (Im & Rosenberg, 2016).

Participants of the CWH from this reported improved ability to deal with mental health concerns, as well as improved eating habits and other general health outcomes. Participants also said the workshops helped them to meet members of their communities, form stronger social ties with them, and develop their leadership and public speaking skills.

One of the difficulties of this specific study was trying to find a time and space to conduct the workshop, which signals that these types of programs are not as institutionalized and remain operating in more informal settings. The logistical difficulties of these types of workshops make this approach more suitable as a component of a more comprehensive refugee resettlement program rather than a stand-alone service. Accordingly, one of the recommendations listed in the study is to integrate this type of program was "to other programs, such as cultural orientation and resettlement services, so that it can produce synergic outcomes" (Im & Rosenberg, 2016). Lastly, peer-led interventions, like community health workshops, are typically more suitable for preventative and educational purposes rather than treatment of specific, serious mental health issues.

Limitations

The literature provides a helpful overview of culturally-relevant practices and important considerations for refugee mental health that extend beyond clinical treatment. In the refugee resettlement process, mental health services are often a last consideration of both refugees and resettlement services. This is why finding strategic entry points for solving this issue is so vital—whether it be in public schools, through community partners, or within traditional resettlement services. While the literature provides useful case studies of success, it is difficult to compare outcomes across these different approaches, as quantitative data is limited and often use different metrics of success.

Criteria

After investigating the data and literature on refugee mental health services in Virginia, three criteria were considered when thinking about what potential policy options to address the issue.

Criterion I: Effectiveness: Benefits and Quality of Evidence

Effectiveness—to what extent the policy addresses the problem—will be one of the most important criteria for evaluating policy options to improve refugee mental health in Virginia. Due to limited quantitative research on the effectiveness of the proposed mental health interventions on mental health outcomes, effectiveness will be measured in terms of the benefits a policy option provides and the strength of evidence that these options have been successful in other settings. Thus, effectiveness will be measured based on responses to the questions below.[4] Each response is given a score ("yes" is given two points, "potentially" is given one point, and "no" is given zero points). For the overall score, an option will be considered **low** on effectiveness if it receives 0-2 points, **moderate** if it receives 3-4 points, and **high** if it receives 5-6 points.

Effectiveness Logic Model
Question 1: Does this option substantially increase the availability of mental health services to refugees in Virginia?
Yes (2), Potentially (1), No (0)
Question 2: Does this option take a holistic approach to refugee mental health including other aspects of the resettlement process, such as social integration, economic opportunity, and access to other social services?
Yes (2), Potentially (1), No (0)
Question 3: Does the evidence suggest that this option has been proven to improve mental health outcomes?
Yes (2), Potentially (1), No (0)

[4] This methodology is based off that used by Aidan Brown's APP (MPP class of 2019).

Criterion 2: Cultural- and Linguistic-Appropriateness

For refugees coming to Virginia with limited English proficiency, accessing traditional mental health services can be an obstacle. These individuals often rely on interpreters to liaise with them and the care provider to accurately describe their experiences and symptoms. This criterion will measure how accessible the policy option is for refugees with limited English proficiency. In addition, many refugees come from countries where they have not experienced talk therapy the way it is practiced in the U.S. and cultures where there is strong stigma surrounding mental health issues. This criterion will be measured in terms of how desirable the policy option for addressing cultural- and linguistic-appropriateness: **very undesirable, undesirable, neutral, desirable, very desirable**.

Criterion 3: Cost

Direct costs are the funds required to implement a given policy option. To assess cost, I will use cost estimates of similar programs including the cost of personnel, facilities, and training. Then, each option will be compared against each other in terms of costs, ranked on a scale of **high, medium, and low**. High will mean that a policy option ranks among the most expensive, low will mean that a policy option ranks among the least expensive, and medium will mean that a policy option ranks somewhere in the middle.

Alternatives

The following section lists five policy option for improving mental health services in Virginia. They are informed by the background and literature review sections of this paper, as well as from the insights collected from the client VRHP and the series of stakeholder interviews from practitioners in Virginia.

Option 1: Let present trends continue

Providers across Virginia are already providing mental health services for refugees through community programs, clinical services, and school interventions. There are successful practices throughout the state, and refugee mental health remains a priority of many organizations working in refugee resettlement. Current funding is insufficient, and current programming is not accessible to all of the refugees that need services. The status quo does not take full advantage of the collaboration that could

be taking place to provide more innovative, coordinated services, and additional funding could help expand practices that have proven success.

Option 2: Expand community-based programming

Community-based programs like peer-led community health workshops using Dr. Hyojin Im's model provide more culturally- and linguistically-appropriate mental health services for refugees (Im & Rosenberg, 2016). The peer-led programs already conducted in Virginia by Dr. Im in conjunction with community organizations, like the IRC and TWI in Charlottesville, can be used as models to expand upon. Community-based programs lead to more buy-in and benefit refugees in a variety of ways, with evidence of improving mental health and other general health outcomes, forming new social bonds with other refugees often from the same country, and enhancing other social outcomes like self-confidence and public speaking (Im & Rosenberg, 2016).

The Virginia Refugee Health Project (VRHP) can request additional funding for community-based programs across the state to provide holistic mental health services for the state's refugee communities. With additional funding and resources (including personnel, training, etc.) for community-based mental health programs, community organizations have the ability to provide services that assist refugees in multiple aspects of the resettlement process that can often be challenging.

Option 3: Invest in virtual reality therapy programs for resettled refugees

Virtual reality (VR) therapy programs could provide a different avenue to receive mental health services to refugees. The Veterans Administration currently supports evidence-based VR therapy programs to veterans experiencing PTSD (*SoldierStrong*, n.d.). Therapists use VR as a form of exposure therapy to recreate scenes like an Iraqi city or desert road in order to address post-traumatic stress veterans may be facing. Similar programs could be developed for refugees experiencing trauma from their home country and journey to the U.S and could replicate environments that are familiar for refugees. These types of programs are already being used by Mercy Corps in Syrian refugee camps in Jordan (*How Virtual Reality Is Helping Refugees in Jordan and Beyond - Jordan*, n.d.).

Existing programs using VR, such as those for veterans and refugees in Jordan, provide a model for how this alternative could be conducted in Virginia. VRHP can advocate for VR therapy programs to be used by mental health providers throughout the state. This alternative provides a tool for providers to

provide more tailored mental health services for refugees that include the unique experiences and challenges they face.

Option 4: Hire more mental health interpreters

Interpreters play an important role translating for adults in children in Virginia, where one in seven students speaks a foreign language at home (Internal document sent from client). In 2017, almost 500,000 individuals visited Virginia Department of Health local health districts. If one of those individuals sought mental health services, they would be required to use an interpreter to liaise between the patient and service provider (VRHP, internal document). Multiple pieces of federal legislation and state codes require the use of interpreters in these cases. Hiring more in-person interpreters throughout Virginia to work alongside mental health providers makes services more accessible to refugees who may not be able to take advantage of existing services because of language barriers (Stitt, n.d.). For refugees coming to Virginia with limited English proficiency, accessing traditional mental health services can be an obstacle. Refugees already accessing services rely on interpreters to liaise with them and the care provider to accurately describe their experiences and symptoms. Trained mental health interpreters, rather than bilingual staff or acquaintances of the patient, provides more accurate translation in a clinical setting.

VRHP can work to hire more interpreters as a way to assist with the technical needs facing mental health providers. If more refugees are able to utilize translators, this removes a barrier to receiving care and makes mental health services more accessible to more refugees.

Option 5: Provide trauma-informed training for teachers by mental health professionals

This approach targets refugee children, who are often the most susceptible to trauma from the refugee experience. Because, the first five years of a child's life are especially formative for their development, mental health interventions at this age can significantly impact the rest of their lives (Katsiaficas & Park, 2019). This option entails training for teachers by mental health professionals on developing trauma-informed care programs in schools, identifying students with trauma and referring them to additional mental health treatment, and providing additional resources for school mental health professionals. The Virginia Tiered Systems of Support (VTSS) within the Department of Education (DOE) provides technical assistance to teachers and administrators in schools across the state to implement trauma-informed

education practices (Resler, 2017). There are a variety of components that go into making trauma-informed classrooms in addition to training, including commitment from the school administration, policy changes and curriculum development to implement the lessons learned from training, and community and family involvement (Resler, 2017). Because all children are required to go to school, teachers are on the frontlines for identifying student behavior that may be indicative of trauma. By knowing what to do in these circumstances and what resources are at their disposal, teachers and school counselors have an opportunity to assist this vulnerable population. This option would also provide spill-over effects for other non-refugee students experiencing trauma.

VRHP can facilitate enhanced coordination between public schools and mental health professionals to assist refugee children in school and connect them with further resources. While this approach only focuses on children, it would still be an important step in connecting refugees to treatment and provide opportunities for this new generation to live healthy, happy, and productive lives in their new home.

Findings

The five policy alternatives were each scored against the following three criteria: effectiveness (benefits and quality of evidence), culturally- and linguistically-appropriate, and cost.

Option 1: Let present trends continue

Effectiveness: Benefits and Quality of Evidence – Low (2 points)

Does this option substantially increase the availability of mental health services to refugees in Virginia? *No (0)* – The status quo will not increase access to mental health services to refugees. It will simply allow those already able to access services to continue to do so.

Does this option take a holistic approach to refugee mental health including other aspects of the resettlement process, such as social integration, economic opportunity, and access to other social services? *Potentially (1)* – There is evidence that certain programs being used across Virginia by community providers do consider the broad range of challenges facing refugees, but there remain opportunities to further integrate mental health services (Im & Rosenberg, 2016).

Does the evidence suggest that this option has been proven to improve mental health outcomes? *Potentially (1)* – Many of the mental health services provided to refugees either use different metrics of

success making it difficult to standardize outcomes or do not collect or publish quantitative data to evaluate the effectiveness of treatments.

Culturally- and Linguistically-Appropriate – Neutral

With continued issues related to barriers to access and language and cultural differences noted by stakeholders throughout the state, more can be done to make mental health services more culturally- and linguistically-appropriate. Practitioners continue to cite this as one of the main issues in reaching refugee populations (J. Ajex, personal communication, February 20, 2020)(Dr. C. Allen, personal communication, February 24, 2020) (M. Dickey, personal communication, January 20, 2020). Many refugees remain skeptical of current mental health services being offered or are not able to participate in them due to limited English proficiency.

Cost – Low

Not making additional changes means the status quo is relatively inexpensive compared to other policy options.

Option 2: Expand community-based programming

Effectiveness (Benefits and Quality of Evidence) – High (5 points)

Does this option substantially increase the availability of mental health services to refugees in Virginia? *Yes (2)* – This option would make community-based programming available to more of Virginia's refugee population. It both increases the number of programs offered reaching more refugees and uses a method that has been proven to gather more buy-in.

Does this option take a holistic approach to refugee mental health including other aspects of the resettlement process, such as social integration, economic opportunity, and access to other social services? *Yes (2)* – A community-based program used previously in Virginia report that participants experienced improved mental health outcomes as well as other social benefits (Im & Rosenberg, 2016). Refugees develop a sense of community with others and build a support model with other participants for leading a healthy lifestyle and assisting each other in any way they can (e.g. emotional, financial, etc.).

Does the evidence suggest that this option has been proven to improve mental health outcomes? *Potentially (1)* – The evidence from former community-based programs indicate that many participants

did receive improved mental health outcomes. In one of these programs, refugees' emotional wellness improved and participants developed better coping techniques (Im & Rosenberg, 2016). However, the literature suggests that these types of programs are often best for educational and preventative purposes, rather than treating acute mental health issues (Im & Rosenberg, 2016). In addition, these types of programs are not always conducive to tracking individuals' mental health outcomes over time (Im & Rosenberg, 2016).

Culturally- and Linguistically-Appropriate – Very Desirable

Community-based mental health programs allow refugees from the same country and similar backgrounds to participate together, and using peer leaders promotes more linguistic appropriateness with labelling mental health symptoms and conditions. In many refugees' native language, there are no direct translations for words like "depression" and "anxiety." The peer-led model is more effective at using vocabulary that better resonates with refugees and allows them to more easily identify symptoms and stressors that contribute to their mental wellbeing (Im et al., 2017). Participants in community programs, like community health workshops (CWH) respond positively to the social support model these programs are based off because the connections they make with other participants have spillover effects on their individual wellbeing (Im & Rosenberg, 2016).

Cost – Moderate

Due to limited data about the costs of mental health programming throughout Virginia, I used cost estimates from similar community-based mental health programming for Native Americans. The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services provided a grant of approximately $500,000 to the Yukon Kuskokwim Health Corporation's Native Connection Program that aims to serve 10,000 individuals through. Similar to community-based programs for refugees, this grant recipient focuses on incorporating the guidance of tribal elders and acknowledges various cultural considerations for a population also historically subjected to trauma. Relative to other policy options, this one is moderate in costs because it is not as expensive as investing in new technology or hiring additional personnel; however, there remain costs for training personnel and facilitating the workshops, and securing a location to hold the workshops potentially.

Option 3: Invest in virtual reality (VR) therapy programs for resettled refugees

Effectiveness (Benefits and Quality of Evidence) – Moderate (3 points)

Does this option substantially increase the availability of mental health services to refugees in Virginia? *No (0)* – This option does directly expand services, but rather, it offers a different approach to mental health treatment that might be more accessible and/or effective for refugees.

Does this option take a holistic approach to refugee mental health including other aspects of the resettlement process, such as social integration, economic opportunity, and access to other social services? *Potentially (1)* – This option is limited to clinical treatment. It is not integrated with other resettlement services. However, it could be more flexible and be used as a community tool to foster support among refugee population.

Does the evidence suggest that this option has been proven to improve mental health outcomes? *Yes (2)* -- Clinicians using VR for treating trauma, depression, and anxiety have cited positive outcomes for this approach—symptoms diminish and enhanced coping mechanisms are developed (Valmaggia, 2017); (*KVC Institute Showcases Virtual Reality to Treat Trauma, Depression and Anxiety*, 2017).

Culturally- and Linguistically-Appropriate – Desirable

Best practices from practitioners working with refugees suggest that having patients engage with the places they are from can help them address trauma related to their journeys as refugees. VR can allow a deeper, more visual connection with these elements of their past. Practitioners have stated that it is best practice when working with refugees to ask the patient about where they are from in descriptive detail allowing them to work through the patient's journey to the U.S. (Dr. C. Allen, personal communication, February 24, 2020). This demonstrates how inclusion of more visual storytelling methods inherent in VR technology can assist refugees' wellness and the unique cultural issues they may face.

Cost – High

The costs associated with this option include the technology to facilitate the VR technology as well as training for practitioners to learn how to incorporate this tool into therapy services. As a comparison, a the U.K. National Institute of Health Research spent $4.4 million on a large-scale virtual reality therapy program for individuals with serious mental health conditions (Fearn, 2019). A similar initiative would likely be smaller than that, but even at half the cost, this still remains one of the most costly options.

Option 4: Hire more mental health interpreters

Effectiveness (Benefits and Quality of Evidence) – Moderate (3 points)

Does this option substantially increase the availability of mental health services to refugees in Virginia? *Potentially (1)* – While this option does not directly increase the availability of services, it may incentivize more refugees to take advantage of existing services if they know that they will have access to an interpreter that can accurately translate their experiences.

Does this option take a holistic approach to refugee mental health including other aspects of the resettlement process, such as social integration, economic opportunity, and access to other social services? *No (0)* – This option focuses primarily on clinical services, not incorporating services into the broader aspects of the resettlement process, therefore it scores low on this criterion.

Does the evidence suggest that this option has been proven to improve mental health outcomes? *Yes (2)* –Practitioners state that having a mental health interpreter can vastly improve the accuracy of mental health treatment (J. Ajex, personal communication, February 20, 2020) (Dr. C. Allen, personal communication, February 24, 2020).

Culturally- and Linguistically-Appropriate – Desirable

A critical part of this healing through psychotherapy services is through interpreters who are not only able to translate the patient's words to the doctor but can convey meaning and the cultural-context of the patient's experiences (Médecins Sans Frontières (MSF) International, 2019). Practitioners state that in-person translators can play a critical role in addressing linguistic nuances, cultural differences, and emotions so that therapists can be more effective and accurate (J. Ajex, personal communication, February 20, 2020). While this option assists refugees for whom language might be a barrier to accessing mental health treatment, one practitioner stated that they feel more comfortable using someone they know as a translator, i.e. not a trained mental health interpreter, for confidentiality purposes (Dr. C. Allen, personal communication, February 24, 2020). It is given a score of desirable because it provides language services and removes language differences as a barrier. However, this approach potentially lacks the sensitivity that must be given to refugees seeking treatment for what they view to be very private matters.

Cost – Moderate

The relative costs of this option is high because it includes the full salaries and potential additional trainings of hiring more mental health interpreters. To use a cost comparison, a foreign language interpreter at the UVA Medical Center earns approximately between $16 and $25 per hour (UVA HR, n.d.). Hiring an additional full-time mental health interpreter for each resettlement area in Virginia would then cost between $224,000 and $350,000.

Option 5: Provide trauma-informed training for teachers by mental health professionals

Effectiveness (Benefits and Quality of Evidence) – Moderate (3 points)

Does this option substantially increase the availability of mental health services to refugees in Virginia? *Potentially (1)* – This option could allow teachers who work with refugee students to identify symptoms that could lead to a referral to direct services, or students could overall benefit from a classroom environment that better allows for their wellbeing and success. As a result of their training during the 2017-18 school year with 506 participating schools, VTSS reported an 71% increase in students serviced by mental health professionals (Virginia Tiered Systems of Supports (VTSS), 2019). However, this policy option only addresses children, who are often most vulnerable to trauma related to the refugee experience.

Does this option take a holistic approach to refugee mental health including other aspects of the resettlement process, such as social integration, economic opportunity, and access to other social services? *Potentially (1)* – Because this option focuses on children in schools, there is an added benefit that interventions could also help improve a student's academic performance and social integration.

Does the evidence suggest that this option has been proven to improve mental health outcomes? *Potentially (1)* – While there is evidence that these kinds of trainings have been achieved success in schools across Virginia, the impact is limited because teachers can only measure outcomes in terms of referrals to direct providers and improved behavior measured in terms of disciplinary measures. VTSS's training in the 2017-18 school year led to an average decrease of 37% in office discipline referral rates (Virginia Tiered Systems of Supports (VTSS), 2019). However, as mentioned, trauma-informed training for teachers is recommended as an approach to addressing children's mental health issues, but success is limited because while teachers can create welcoming environments for students experiencing trauma, they can only refer children with more acute issues to direct services.

Culturally- and Linguistically-Appropriate – Low

This policy option does not take additional precautions to address cultural and linguistic differences of refugee students. In addition, a stakeholder interview with a practitioner working to address trauma in the classroom cites difficulties working with refugee parents who share different conceptions around issues related to mental health (K. Roorbach, personal communication, November 19, 2019).

Cost – High

The associated cost of this policy option includes the training for teachers as well as any associated costs with implementing the techniques provided to teachers. It is moderate relative to other policy options because while it does require additional training, there is an existing system of provide this kind of training throughout Virginia through VTSS that VRHP can work with so that there is already the curriculum and personnel to administer the training. The FY 2018 budget for VTSS of $5.54 million provides a cost estimate of this policy option (Virginia Governor's Children's Cabinet, 2017). Therefore, if VTSS could scale up their operations by approximately 25%, it would require an additional $1.3 million in funding (Virginia Governor's Children's Cabinet, 2017).

Outcomes Matrix

	Effectiveness	Culturally- and Linguistically-Appropriate	Cost
Option 1: *Status quo*	Low	Neutral	Low
Option 2: *Community-based programs*	**High**	**Very Desirable**	**Moderate**
Option 3: *Virtual reality therapy programs*	Moderate	Desirable	High
Option 4: *More mental health interpreters*	Moderate	Desirable	Moderate
Option 5: *Trauma-informed training for teachers*	Moderate	Low	High

Recommendation

Based off an analysis of the policy options with the selected criteria, it is recommended that the Virginia Refugee Healing Project (VRHP) expand community-based programming, specifically through programs like peer-led interventions. By using grants and redirecting existing funds, VRHP can implement more of these types of programs throughout the state. Community-based programs provide an alternative that is more accessible to refugees, many of whom come from cultures where social support models are preferred over clinical talk therapy. With the additional benefits provided by community programs, such as their ability to enhance social integration and broader health outcomes, this option has the potential for the greatest positive impact for Virginia's refugee community.

It is also important to note that community-based programs are not intended to treat acute mental illness. They can instead be important avenues to eventually accessing clinical treatment. Their primary purpose is to strengthen social support systems within refugee communities and to educate individuals on symptoms and root causes of mental health issues.

Additional Recommendations

In addition to implementing more community-based programs, I recommend collecting additional data on refugee mental health care in Virginia and proposing that mental health services for refugees receives its own line-item in the state budget .

Additional data on refugee mental health in Virginia could serve as an important step toward improving services and programs throughout the Commonwealth. Data that would be helpful include the prevalence of mental health disorders among Virginia's refugee population with demographic breakdowns. This could help inform future policies because programs could be more targeted to the most vulnerable communities who could benefit the most from additional programming. Improvements in refugee's access to mental health treatment would take the most time with this approach because data collection would be used to inform the next step in how to improve services and there would not be immediate results. One way to collect better data on refugee mental health is through screeners. VRHP can work with the Refugee Mental Health Council (RMHC), which uses the RHS-15 as a referral tool, on how to utilize the screeners to collect additional data.

Because refugee mental health funding falls under the category of refugee health in the budget, it is difficult to track funding year-by-year and to perform analysis on the effectiveness of current funding levels. With more specific data on refugee mental health funding, actors like VRHP can better advocate for additional funding if there appears to be gaps in services for refugees across the state. Knowing what programs can be most effective and cost-efficient for refugee mental health has the potential to improve services in the future.

Implementation

Next Steps

The next steps for VRHP will be to determine whether to redirect existing funding for additional community-based programs, to request additional funding, and/or to direct community organizations to apply for grants. My recommendation is that the resettlement areas in the state with the highest population of refugees should be prioritized, like Northern Virginia and Richmond are prioritized. The decision should be made in consultation with community organizations who have the best localized knowledge of their area's needs.

With the current outbreak of COVID-19, the implementation of these programs will be delayed in compliance with Governor Ralph Northam's Stay at Home Order announced on March 30, 2020 (Northam, 2020). In the interim, VRHP and community organizations can start the process of securing funds and identifying communities for the programs to be enacted in FY 2021. Throughout the duration of the Stay at Home Order, VRHP and community partners should collaborate to ensure refugee communities have access to mental health services, whether through telehealth or otherwise. See Appendix B for a compiled list of online resources for refugee mental health during the COVID-19 crisis.

Further Considerations

Community-based programs should be coupled with efforts to raise awareness among the refugee community about the services available to them. Outreach can be most effective when conducted by the community organizations responsible for refugee resettlement overall (e.g. the International Rescue Committee in Charlottesville). When refugees first arrive to the community and interact with resettlement organizations for other purposes, that is a good opportunity to recruit participants to the programs. Print materials at community organizations' offices and word-of-mouth recruiting by community organizations have proved to be effective strategies used in similar programs (Peers for Progress, 2015).

Community organizations facilitating the mental health programs should also consider other potential obstacles to participation in the programs, such as transportation to the workshops, timing conflicts with work, and child care responsibilities. This is where community organizations that provide a range of

services can assist in order to maximize participation. Another way to address these obstacles is to hold fewer, longer workshops to minimize the number of times participants have to figure out transportation, coordinate child care, and make other plans in order to attend. Organizations can also provide re-imbursements to patients for potential transportation and child care costs. This approach has been used in other peer support programs (Peers for Progress, 2015).

Appendix A: Case Study of Refugee Mental Health Services in Charlottesville

In communities across Virginia, the provision of refugee mental health services is dispersed among a variety of actors. To provide a more in-depth look at what the refugee mental health care system looks like in these communities, I conducted stakeholder interviews with providers in Charlottesville working with refugees. As a student living in the city, this provided an opportunity to gain a first-hand perspective in a city well-regarded in refugee mental health provision.

The information in this case study is based off stakeholder interviews with:

- Mirna Dickey (Family Support Coordinator, IRC)
- Dr. Joanna Ajex (Therapist, TWI)
- Dr. Claudia Allen (Clinical Psychologist, IFMC)
- Professor Heather Zelle (Associate Director of Mental Health Policy Research at UVA)
- Brooke Ray (UVA Global Policy Center)
- Dr. Kristen Roorbach (UVA Batten School of Leadership and Public Policy, works with addressing trauma in Charlottesville public schools)

Who provides refugee mental health services?

Clinical providers

The International Family Medicine Clinic (IFMC) is housed within the Department of Family Medicine at UVA. It provides general medicine and mental health services. The IFMC has an agreement with the health department and the IRC to see patients that they refer (for general medicine, acute issues, mental health, etc.). The IFMC has two clinical psychologists and one psychiatrist that sees referred patients. The mental health services provided vary—sometimes patients are seen once or a few times to assist with adjusting to a new community and others seek long-term treatment for trauma related to the refugee experience or pre-existing issues.

Community providers

The prinicple refugee resettlement agency in Charlottesville is the International Rescue Committee (IRC). Other organizations in Charlottesville serve the refugee community, as well. These actors are important, especially because the IRC primarily works with refugees for the first three months of their resettlement. These organizations can provide care beyond this three-month period and help connect refugees to more long-term services. Some of them include:

- International Neighbors offers resettlement services after the three-month period of IRC support.
- The Women's Initiative (TWI) provides mental health services to women in the Charlottesville community, especially for immigrants and refugees. TWI hosts free walk-in appointments five days per week, which is the main point-of-access for working with refugee women in the Charlottesville community.

Alternative providers

Mental health can be addressed through existing public services refugees have access to, such as the public education system. For refugee children attending Charlottesville City Public Schools, this is an opportunity to support students who have experienced trauma in the classroom and help connect them to further treatment if necessary.

There is no trauma policy in the public education system . Screening for trauma has the potential to re-trauamatize children, so it is sometimes difficult for teachers to identify students who might need to seek mental health treatment (K. Roorbach, personal communication, November 19, 2019). Dr. Roorbach stated that educators do not need to know about what trauma their students have experienced. Rather, teachers should know how to foster an environment in the classroom that makes students with trauma feel supported.

Why is there a treatment gap for refugee mental health services?

One interviewee said that mental health services for refugees is on the fringes of resettlement services, but actors in Charlottesville are still making great strides. The availability of services is just one factor of the problem. More imporantly, stakeholders are focusing on ways to removing barriers to access.

Costs and funding

Costs are typically not a principle barrier to accessing mental health services for refugees (M. Dickey, personal communication, January 20, 2020). Refugees have Medicaid for the first eight months upon being resettled in the U.S. There are ways that organizations are trying to fill the gap for refugees after those eight months if they do not qualify for Medicaid. For instance, mental health services at TWI are free and no insurance is necessary to receiving care. Even for longer-term options co-pays can be negotiated to as low as $5 per session so that cost is not a barrier to accessing treatment (J. Ajex, personal communication, February 20, 2020).

Cultural differences

Practitioners have found that many refugees will not seek mental health treatment on their own. Some have experienced a form of therapy before, but talk therapy the way it is done in the U.S. can be quite different for many refugees. There is a lot of confusion and even frustration about what therapy does.

Therefore, some of the goals of organizations like the IRC and TWI focus on trying to inform the refugee community about the types of services provided and how mental health services could benefit them. Dr. Joanna Ajex at TWI started hosting office hours at the IRC office with patients the IRC scheduled. She started seeing 3-4 clients per week with these office hours with the ultimate goal of introducing the concept of counseling—what it could provide them and how it could validate the "rollercoaster of emotions" they feel during the resettlement process. When the stress experienced during the resettlement process proves to not be temporary, then that becomes a problem where clients are then referred to seek longer-term therapy through TWI. It is important to define roles as therapists and what they are able to provide because refugees encounter so many different kinds of providers during the resettlement process (J. Ajex, personal communication, February 20, 2020).

Language issues and access to translators

Availability of interpreters and language translations services is another primary issue for both clinical treatment and community-based programs. The IFMC has access to translators (both in-person and over the phone) 24 hours/day. Some physicians find that patients typically prefer phone translators for confidentiality purposes (Dr. C. Allen, personal communication, February 24, 2020). Typically, the translators that patients use over the phone are people they know and have asked to translate.

There are not many interpreters available in person and there are even fewer trained on specifically mental health issues (Dr. C. Allen, personal communication, February 24, 2020). This means that a lot gets lost in translation when trying to build trust with the patient and fully understand what they are going through. Some challenges Dr. Allen mentioned regarding serving the refugee community is the language barrier, particularly as it related to translating words like 'depressed' that have very culturally-bound definitions.

Adults typically have a more difficult time adjusting than children because kids are immediately enrolled in school and start learning English. Dr. Allen thinks it would be beneficial to have more opportunities for socialization with people who speak the same language.

Transportation

Transportation is another significant challenge Dr. Ajex and Dr. Allen mentioned. Many refugees who are not familiar with the area, do not have a car, or have other constraints have a difficult time making appointments. The IRC and International Neighbors provide transportation for refugees to their medical appointments, but they have limited capacity.

What are the main lessons learned from Charlottesville?

Refugee mental health in Charlottesville serves as one of the best case studies. It demonstrates how various actors—on the clinical side, and the community side—work together to support local refugee communities. There is acknowledgement of the wide range of obstacles refugees face, and there is cooperation that works to address these. Practitioners still identified ways to continue to increase the quantity and quality of services.

1. Community-based solutions work in important ways to form social support systems among refugees and provide culturally-appropriate care.

From 2017 to 2019, TWI along with the IRC hosted Trauma-Informed Cross-Cultural Psychoeducation (TICCP) programs with the immigrant and refugee community in Charlottesville. The TICCP program ended in 2019 due to lack of funding, formerly funded by a NoVo Foundation Grant (J. Ajex, personal communication, February 20, 2020). Dr. Ajex said that it is one of her goals for this year to do an iteration of this program. In addition, TWI has conducted mother and parenting groups, swimming groups, and other groups similar to these. They foster community building as well as a safe space to grieve losses and talk about stresses they face in their life.

2. Coordination among clinical providers, community organizations, public schools, and other relevant actors help establish a clear referral system for individuals who need treatment and give refugees a variety of pathways to access services.

Mental health for refugees works well in Charlottesville because of communication, Dr. Allen says. Quarterly meetings are held for coordinating care, information sharing, trust building among relevant partners.

The power of storytelling:

One best practice Dr. Allen discussed is asking refugees to point on a map where they are from and ask them to talk about what it's like there, what their journey was like, where other family members are. It brings the story to life and shows interest on their part, since there is sometimes a notion among the refugee community that people do not care about where they came from or about their journey.

3. Refugee mental health services are most effective when integrated into other aspects of the refugee resettlement process and when economic concerns are acknowledged.

Another best practice is respecting refugees' hierarchy of needs—recognizing the fundamental issues that are more at the forefront of many refugees' minds, typically related to economic self-sufficiency (Dr. C. Allen, personal communication, February 24, 2020).

Appendix B: Resources for Refugee Mental Health during the COVID-19 Crisis

Below is a consolidated list of resources for refugee mental health during the COVID-19 crisis.

The Center for Survivors of Torture compiled a list of mental health resources for refugee written in multiple languages.
Link: https://www.cvt.org/COVID-19-resources

The Hebrew Immigrant Aid Society (HIAS) reported on how services to refugees have changed in light of COVID-19, including how HIAS staff is conducting mental health services over the phone or on Zoom.
Link: https://www.hias.org/covid-19-response

The Society of Refugee Healthcare Providers compiled general health resources for refugees, as well as COVID-19 information sheets in multiple languages.
Link: http://refugeesociety.org/covid-19-resources

The World Health Organization (WHO) published guidance for mental health providers, administrators, and caretakers.
Link: https://news.un.org/en/story/2020/03/1059542

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