

Culturally Competent Mental Health Services for Refugees: The Case for a Community-Based Treatment Approach

Ben Rader, Psy D

Sebastian Family Psychology Practice

Leng Lee, MSW

Sebastian Family Psychology Practice

Sebastian Ssempijja, Ph D

Sebastian Family Psychology Practice



Abstract

This article addresses issues of best practice and social justice relative to refugee mental health treatment through the example of an existing mental health treatment clinic in Southeastern Wisconsin. Authors consider the state/local history (in Wisconsin), current practices, and existing funding challenges related to the provision of ethical and culturally competent mental health treatment services to refugees. Two prominent areas are explored: 1) What types of professional practice/service expenses are particular to the provision of culturally competent, ethical, and refugee mental health treatment? 2) Are funders of refugee mental health services sufficiently meeting the needs of this at-risk population?

Dedication: To Sebastian, our friend and pioneer.

Introduction

This work constitutes a critical reflection of the current provisions of mental health treatment services to refugee populations in the state of Wisconsin with implications for the provision of services to refugee populations in other regions, as well. The article offers some historical perspective regarding the development of refugee mental health treatment services in the state of Wisconsin. It also addresses considerations related to the provision of ethically-informed and culturally competent services, when serving refugee populations. Those considerations include references to professional guidelines; considerations regarding cultural competence; and research/literature pertaining to the provision of mental health treatment services to refugee populations. Finally, the operations of a successful professional practice that currently meets the multi-faceted needs of refugee populations in Wisconsin by conforming to the tenants of cultural competence is discussed.

This discussion includes the specific funding-related challenges that impede the provisions of serving refugee groups; the related discrepancies between what can be considered best practice, from a perspective of cultural competence and professional ethics; and the current status related to the funding of refugee mental health treatment services in the state of Wisconsin.

Ultimately, through focusing on the provision of culturally competent refugee mental health services at a specific practice in the state of Wisconsin, this article addresses two prominent areas of concern: 1) What types of professional practices/service expenses are particular to the

provision of culturally competent, ethical, refugee mental health treatment? 2) Are funders of refugee mental health services sufficiently meeting the needs of this at-risk population?

History of Refugee Mental Health Services in Wisconsin

Refugees, including asylees, are displaced populations resettled by the U.S. government due to war, religion, terrorism, political repression, and other violations of human rights. Initially, programs that were established to meet the needs of refugees in the United States focused on social services and did not include mental health treatments. During Clinton's administration, the federal government shifted from traditional social services for refugees to become self-sufficient by allocating a separate funding to provide mental health services to refugees throughout the country.

In 1999, the Wisconsin Department of Workforce Development, formerly known as Office of Refugee Services, competed nationally and was awarded a small fund to start providing mental health services to refugees in the state of Wisconsin. Five regional programs were established by subcontracting with county, non-profit agencies, and faith-based agencies to start delivering culturally competent mental health services to refugees in Wisconsin. Local agencies were able to hire and train bilingual/bicultural therapists and initiate specialized mental health treatment for refugees. This marked the formal beginning to mental health treatment programs in the State of Wisconsin (Wisconsin Department of Children and Families, 2009). Consequently, from the standpoint of specialized funding and prioritized attention, refugee mental health treatment intervention can be viewed as being relatively recent in its development, both in the state of Wisconsin and at a national level.

Culturally Competent Mental Health Services for Refugees

Research has suggested that refugee communities can be seen as having their own unique set of mental health risk factors. An increase in disorders stemming largely from exposure to traumatic circumstances such as war, persecution, and oppression, has been widely substantiated in the literature (Gerritsen, Bramsen, Deville, van Willgen, Hovens, and van der Ploeg, 2006; Hepinstall, Sethna, and Taylor, 2004; Fazel and Stein, 2002; Hinton, Tiet, Tran and Chesney, 1997). Refugee treatment needs related to these mental health challenges can be considerable. For the refugee, community treatment is frequently confounded by matters of ethnicity, culture, and linguistic diversity.

Only recently, have we begun to consider the treatment of refugee populations as its own distinct area in the field of mental health. Most publications and texts in this area have emerged over the past two decades (Ingleby, 2005; Miller and Rasco, 2004; Je Dong, 2002; World Health Organization, 1996). Such publications have taken various sociological perspectives and have evidenced varying theoretical orientations. These treatment approaches stemming from ecological approaches to understanding the self are important, when considering issues deemed pertinent to refugee mental health treatment (Miller and Rasco, 2004; Je Dong, 2002). Such a diversity of perspectives may serve to complicate issues related to best practices, when serving refugee populations. Fortunately, professional treatment standards exist that can be of assistance in guiding treatment when serving refugee groups as members of diverse populations.

The professional standards that define the field of human services promote values of cultural sensitivity, when working with diverse populations. The code of ethics for the practice of psychology (APA, 2002), social work (NASW, 1999), and counseling (ACA, 2005), each recognize a person's culture as an important variable with regards to treatment. In addition, specific treatment guidelines have been devised to aid professionals in their efforts to best meet the needs of diverse populations.

The American Psychological Association has published guidelines for the provision of psychological services to ethnic, linguistic, and culturally diverse populations (APA, 1991). Such guidelines consist of inspirational statements that the clinician serving such populations is advised to consider. Included in this publication are guidelines regarding the provision of services in a language requested by the client (APA, 1991, Guideline 6), with considerations to particular translator services. These guidelines go beyond the principle stipulated in the APA Code of ethics which simply stipulates that psychologists "demonstrate respect for people's rights and dignity" (Principle E), and serve to actually establish standards of professional treatment when serving diverse populations. Such guidelines can also be viewed as setting the groundwork for the provision of culturally competent services for psychologists.

Cultural competence refers to a clinician's capacity to proficiently meet the clinical needs of culturally diverse populations. Sue and Sue (2003) define cultural competence with regards to the awareness, knowledge, and skills required for working with diverse populations. Sue and Sue (2003) stipulate that awareness has to do with the appreciation that the clinician asks how their own culturally-bound assumptions, values, and beliefs impact upon the treatment process. Knowledge, in turn, relates to the level of understanding acquired by the clinician regarding the client's operating world view. Finally, Sue and Sue (2003) suggest that the culturally competent clinician needs to acquire the appropriate skills for working with the given population, including culturally appropriate treatment modalities and interventions.

Beyond the ethical development of cultural competence, mental health service providers working with refugees are urged to consider issues of best practice when serving refugees. Recent research has supported the general benefits of psychotherapy, when serving refugee populations (Renner, 2007). Renner's research, which represented a population of refugee and asylum seekers with multiple mental health issues, found that 85% of the group had identified therapy as having significant benefits. Kinzie (2001) attributed treatment efficacy with refugee and immigrant populations to the important role that the human relationship plays in treatment. Since refugees are prone to isolation in response to the social threats they have endured, Kinzie (2001) has suggested that the client/therapist relationship is of central importance in addressing issues of mass traumatization identified in the population.

In order to be able to provide therapeutic services to these populations, mental health service providers need to establish means of making their services known and accessible to refugee and immigrant groups. From this standpoint, it is not surprising that organizations that have been found to successfully meet the needs of refugee populations, frequently tend to be community-based rather than office-based in their model of service provision (Cordero-Guzman, 2005). Availability of qualified interpreter services is also a clear prerequisite for serving any client in which language is a barrier. Many interpreters also serve as cultural brokers, which are crucial in engaging refugee clients and building trust with the refugee communities.

Best practice, when serving refugee populations, has also tended to emphasize the importance of providing holistic services (Sue and Sue, 2003; Pumariega, Rothe, and Pumariega, 2005). In general, holistic services can relate to any form of treatment that works to integrate aspects of the whole person into treatment, rather than localizing treatment approaches to one or two discrete aspects of the individual, such as brain chemistry or mistaken thinking. Holistic service refers to services that prioritize the incorporation of an individual's religious and/or spiritual values and culturally specific beliefs into their treatment (Sue and Sue, 2003). Also, the provision of psycho-education groups, education directed at understanding the development and expression of mental health symptoms, constitutes another example of holistic services that have been identified to be of some benefit to refugees (Goodkind, 2005).

Finally, programs that can successfully address the relationship between physical and mental health challenges that have been known to confront refugees represent another example of a holistic approach to treatment that has also been found to be of benefit to refugee services (Culhane-Pera, Her, and Her, 2007; Allden, Poole, Chantavanich, Ohmar, Aung and Mollica, 1996; Carballo, Grocutt, and Hadzihasanovic, 1996). Overall, holistic services appear to refer to many different areas, but it seems to be particularly important in serving refugees because of the global impact of the circumstances associated with being a refugee and its effect on the individual, as a whole (Gerritsen et. al, 2006; Hepinstall, et. al, 2004; Fazel and Stein, 2002; Hinton,et. al, 1997).

Example of a Culturally Competent Practice

Sebastian Family Psychology Practice, LLC

Since 1998, Sebastian Family Psychology Practice (Sebastian Family) has served refugee communities. As a practice, Sebastian Family prides itself on providing holistic, multilingual, culturally competent services to refugees and immigrants. Sebastian Family has served a diverse cross-section of the global community including refugee groups from Thailand, Laos, Cambodia, Burma, Iraq, Afghanistan, Eritrea, Uganda, Rwanda, Liberia, Sudan, Congo, Bosnia, Croatia, Serbia, and the former Soviet Union. Over the years, the practice has developed ties with numerous refugee/immigrant communities and has remained active in the community in addressing the needs of the ever-changing refugee community in southeastern Wisconsin.

Sebastian Family's holistic approach includes the provision of case management and support services, in addition to mental health services to individuals and families struggling to adjust to life in the United States. The practice benefits from having multilingual staff including service providers fluent in several African Languages, Arabic, Burmese Languages, French and Spanish, who are adepts at incorporating aspects of the individual's cultural experience into the treatment process. Sebastian Family also works with its own interpreters and when necessary, acquires the use of interpreter services, when available in the community.

Consistent with Kinzie's perspective (2001), the development of the client/therapist relationship constitutes a key component in the treatment of refugees. However, the success of the clinic in addressing the treatment needs of the refugee community is at least partially related to a clinical proficiency with regards to the area of cultural competence. Familiarity with diverse practices, belief systems, and world views constitutes an area of specialty for the clinic. This has allowed professionals a greater capacity to connect with diverse clientele and establish culturally appropriate treatment approaches. The inclusion of family members into therapy and the

encouragement of cultural and religious supports (shaman, priests, and other spiritual leaders) have proven to be of particular benefit for many clients, who do not conform to individualistic and self-oriented cultural norms of the west.

Although Sebastian Family operates a fully functioning mental health clinic, it also provides home-based, as well as community-based therapy and supportive services that are provided as needed. This supports the transportation needs that many refugees face, which increases the overall accessibility of services and helps to build trust. Out-patient psychiatric consultation is also provided through the use of consulting psychiatrists who see clients in the clinic at regular intervals throughout the year. On rare occasions, psychiatrists have made home visits for refugees who were homebound with severe disorders.

In general, clinicians tend to emphasize optimal social adjustment including support and assistance with the client's various vocational, occupational, educational, residential, and family stability goal areas. Cooperation with community resources and organizations is frequently necessary in addressing such goal areas as identified by the client and their family. Networking with community support agencies that serve the various refugee communities has proven to be essential in meeting the needs of the refugee population.

As an organization, Sebastian Family has developed and fostered lasting ties with community organizations that specialize in serving target refugee communities such as Pan-African Community Association (PACA), Hmong American Women Association (HAWA), Bantu American Friendship Association (BAFA), Lao Family Community inc., and local refugee resettlement and service agencies. Additionally, Sebastian Family interfaces with mainstream entities across the state in the education and advocacy regarding the needs, challenges, and risk factors particular to the state's refugee population.

Mental health consultation provided to both refugee-specific, as well as mainstream service providers working with the refugee populations, has proven to be of great benefit in helping service providers better understand the mental health treatment needs of the population. Psycho-education provided directly to the refugee community has also been helpful in identifying signs of stress and managing symptoms of trauma and anxiety.

Finally, networking with fellow service providers remains crucial in identifying the ongoing systemic obstacles facing the refugee populations and in strategically addressing these challenge areas through the appropriate avenues. It is important to note, that such activity has been deemed essential to the practice in its ambition to meet just the basic mental health needs particular to the Wisconsin refugee population.

Funding of Cultural Competence

The provision of culturally competent, holistic, mental health services has proven to bring with it a host of challenges that can make operating a practice dedicated to meeting the needs of refugee communities an on-going struggle. Central to these challenges have been unique challenges in the funding of treatment and compensation for operating expenses that are particular to and necessary for the work with refugee populations. For instance, for a limited period of time, resettlement organizations are able to help provide funding for mental health treatment for the refugee, as the refugee attempts to get settled in the United States (U.S. Department of Health

and Human Services, 2010). However, when refugees are unable to access their own medical coverage following this transitional period of time, they frequently find themselves unable to pay for the mental health services they need. Given the severity of the challenges facing many refugees, it may become unadvisable and an ethical liability to discontinue services, due to an inability to pay. Consequently, it is not uncommon for clinicians to feel the need to provide pro-bono services for an indefinite period of time to maintain trust with the client and his/her community, while other means to pay for services are being explored.

In other circumstances, funders may limit the payment of services to those that occur in the office, which means that when the client's social disposition and/or issues related to best practice necessitate the use of home visits, clinicians will not be reimbursed for services. Even when home services are funded, it is rare for service providers to be compensated for mileage placed on personal vehicles or reimbursement for travel time.

The need for interpreter services present additional challenges for those serving a refugee population. In the past, it was not uncommon for a client's family member to serve the role of interpreter. Having a family member serve this role can be seen as an infringement on client privacy and treatment efficacy, given the dual role and the family member's inexperience in providing medical interpretations. None-the less, family members are utilized as interpreters, due to a lack of formal interpreter services available within the community. Over the years and through the emergence of state support and training programs, formal interpreter services have become available for members of the state's larger refugee communities that include the Hmong community and Spanish-speaking clients. Currently, interpreter services are covered by HMOs when the interpreter has acquired the necessary certification. However, given the dearth of certified interpreters for many of the more recent refugee communities that have arrived in Wisconsin, acquiring certified interpreter services for Burmese, Iraqi, and Afghan refugees, is not always possible. Interpreter services can usually be acquired from the community, but such services can become an operating expense of the clinic, when the interpreter's services are not covered by the funding entity.

The central role that community networking plays in sustaining a practice committed to meeting the needs of refugee communities constitutes a time expense that is rarely, if ever, compensated. With the exception of the provision of formal consultation services, a practice's involved commitment in addressing the broader mental-health needs of the refugee community is performed with singular attention to the greater needs of the community. Finally, state-grants have been of great assistance in helping compensate for such extraneous expenses, when serving this population. Unfortunately, state-grants are largely contingent on economic conditions and have diminished, due to the national recession. Consequently, 2009 brought with it a loss of grant funding that had previously helped the clinic meet the needs of the refugee community.

Conclusion

The provision of mental health treatment services to refugee populations both in Wisconsin and across the United States constitutes a relatively recent priority in terms of public health, beginning with the provision of government resources first allocated in the 1990s. Since this period, service providers in the state of Wisconsin have made strides in meeting the needs of this at-risk population across the state. Issues related to professional ethics and cultural competence have necessitated that the provision of these services include additional services and expenses

not typically associated with mental health treatment when serving domestic populations as well as have contributed to an increase in the provision of pro-bono services at varying points in time.

From this view, funding challenges provide considerable deterrents to any mental health practice otherwise interested in addressing the considerable mental health need areas facing refugee communities. Specifically, existing funding realities limit service providers in the provision of ethically-informed, best practices, and are financial liabilities, which threaten the viability and sustainability of professional practices and programs designed to meet the needs of this population. These include the payment of interpreter services when no licensed provider is available, lack of sufficient compensation to offer community-based services when deemed clinically indicated, as well as the on-going networking demands necessitated of work with populations, which by nature are outside the mainstream population. Practices that choose to prioritize by addressing the mental health needs of refugees and displaced populations do so at their own professional expense. This becomes an obstacle to best practice in mental health treatment and also a social justice concern.

Given these circumstances, it is recommended that continuing dialogue be established between existing service providers and current state, federal, and private funders, in better meeting the treatment needs of the refugee community. Given our review of the matter here, it would appear that a community-based and integrated approach to treatment, rather than an office-based individualistic approach, is most suitable for working with refugees.

References

- Allden, K., Poole, C., Chantavanich, S., Ohmar, K., Aung, N. N., & Mollica, R. F., (1996). Burmese political dissidents in Thailand: Trauma and survival among young adults in exile. *American Journal of Public Health*, 86 (11), 1561-1569.
- American Counseling Association (2005). *American Counseling Association Code of Ethics*. Retrieved April 14, 2010 from <http://www.counseling.org>.
- American Psychological Association (1991). *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*, Retrieved April 15 2010, from <http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx>.
- American Psychological Association (2002). *Ethical Principles of Psychologists and Code of Conduct*. Retrieved April 15, 2010 from <http://www.apa.org/ethics/code2002html>.
- Cordero-Guzman (2005). Community-based organizations and migration in New York City, *The Journal of Ethnic and Migration Studies*, 31(5), 889-909.
- Carballo, M., Grocutt, M., & Hadzihasanovic, A. (1996). Women and migration: A public health issue. *World Health Statistics Quarterly*, 49 (2), 158-164.
- Culhane-Pera, K.A., Her, C., & Her, B. (2007) We are out of balance here: A Hmong cultural model of diabetes. *Journal of Immigrant and Minority Health/Center for Minority Public Health*, 9 (3) pp. 179-190.
- Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood*, 87 (5), 366-370.

- Gerritsesn, A.M, Bramsen, I., Devvillé, van Willigen, L.H.M., Hovens, J.E., & van der Ploeg, H.M. (2006). Physical and mental health of Afghan, Iranian, and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 41 (1), 18-26.
- Goodkind, J.R. (2005). Effectiveness of a community-based program for Hmong refugees. *American Journal of Community Psychology*, 36 (3-4), 387-408.
- Hepinstall, E. Sthna, V., & Taylor, E. (2004). PTSD and Depression in refugee children. *European Child & Adolescent Psychiatry*, 13 (6), 373-380.
- Hinton, W., Tiety, Q, Tran, C., & Chesney, M. (1997). Predictors of depression among refugees from Vietnam: A longitudinal study for new arrivals. *The Journal of Nervous and Mental Disease*, 187 (1), 39-45.
- Ingleby, D. [Ed] (2005). *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons*. NY: Springer.
- Je Dong, J. [Ed] (2002). *Trauma, War, and Violence: Public Mental Health in a Socio-Cultural Context*. NY: Plenum
- Kinzie, J.D. (2001). Psychotherapy for massively traumatized refugees, *American Journal of Psychotherapy*, 55 (4), 475-491.
- Miller, K.E., & Rasco, L.M. [Eds]. (2004). *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*. Mahwah NJ: Erlbaum.
- National Association of Social Workers (1999). NASW Code of Ethics. Retrieved April 15, 2010 from [www.http://socialworkers.org/pubs/code/default.asp](http://www.socialworkers.org/pubs/code/default.asp).
- Pumariega, Rothe, & Pamariega (2005). Mental health of immigrants and refugees. *Community Mental Health Journal*, 41 (5), 581- 597.
- Renner, W. (2007). The effectiveness of psychotherapy with refugees and asylum seekers: Preliminary results from an Austrian study. *Journal of Immigrant and Minority Health/Center for Minority Public Health*, 11 (1), 41-45.
- Sue, D.W. & Sue, D. (2003). *Counseling the Culturally Diverse: Theory and Practice*, 4th (Ed), New York: John Wiley & Sons.
- U.S. Department of Health and Human Services (2010). Office of Refugee Services; Preventive Health. Retrieved April 26, 2010 from http://www.acf.hhs.gov/programs/orr/programs/ref_prev_health.htm.
- Wisconsin Department of Children and Families, 2009. *Refugee Mental Health Program, 2009*. Retrieved from http://dcf.wisconsin.gov/refugee/programs/health_programs.htm on January 15, 2010.
- World Health Organization [Ed]. (1996). *Mental Health of Refugees*. World Health Organization.

Dr. Ben Rader is a graduate of the Adler School of Professional Psychology in Chicago, IL and Capital University in Columbus Ohio. He currently works in the Milwaukee community as a therapist, psychological consultant, and community educator through Sebastian Family Psychological Services.

Leng Lee LCSW is a multi-talented licensed clinical social worker and a graduate from the University of Wisconsin, Madison. At the Sebastian Family Psychology Practice, Lee specializes in serving the Hmong community, as well as various other immigrants groups who struggle with mental challenges.

Dr. Sebastian Ssempijja is a child and family psychologist with over 25 years of extensive experience in serving diverse client groups in the Milwaukee, WI area that includes refugees, asylees, and immigrants from Africa, South East Asia, the Middle East, former Russian Soviet Union, as well as children, youths, and families distressed by poverty, inner city and suburban pressures.

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