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How Mental Health Service Delivery Models Address The
Needs of Refugees

by

Sarah A Rogers, B.A.S

MSW Clinical Research Paper

Presented to the Faculty of the
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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation

Abstract

Refugees have higher rates of western defined mental health disorders, yet it has been documented there is underutilization of Western mental health services by refugees. A more holistic ecological approach is needed to serve refugees best over a conventional Western biomedical model. This systematic review was designed to explore the research question: How are mental health service delivery models addressing the bio-psycho-social-spiritual needs of refugees. The study was set up using peer-reviewed articles and dissertations after 2000. The databases, SocINDEX, Academic Search Premier, and ProQuest Dissertations & Theses were systematically searched using the terms; “mental health service delivery models” AND “refugees.” And terms “mental health models” AND “refugees” AND “mental health.” Out of these searches, 14 articles met inclusion criteria and were included in the review. One theme emerged on meeting the biological needs; 1. importance of blending both the western medical model and traditional healing practices as part of mental health treatment. For psychological needs three themes emerged; 1. the importance of building trust, 2. group work is being utilized across different mental health service delivery models for both adults and children, 3. non-verbal therapeutic interventions are being used across mental health service delivery models for both adults and children. One theme emerged for meeting social needs; 1. a psycho-social approach is needed. Lastly, one theme emerged for meeting spiritual needs; 1. to help address the spiritual needs of refugees it is important to collaborate with community religious leaders. Overall there is currently limited research on this topic. Of the articles, little was discussed on meeting the biological and spiritual needs as part of treatment. Moving forward, mental health service delivery models should consider meeting all domains of a refugee’s life rather than only addressing psychological distress. Understanding help-seeking behavior, traditional ways of

healing, and cultural understanding of mental health, as well as providing service to address the many unmet social needs of refugees, may lead to better mental health outcomes and service utilization. Future research should focus on the study of culturally appropriate evidence-based practices for refugee populations.

Keywords: mental health, refugees, war trauma, bio-psycho-social-spiritual, culture, service delivery

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Introduction

Since the mid-1990's there has been a steady increase of forcefully displaced persons worldwide. Just last year, in 2015, 65.3 million refugees were recorded, a 5.8 million increase from 2014 (UNHCR, n.d.). In response to the current Syria crisis, national leaders have now labeled the number of refugees a “global crisis” and this ongoing issue has finally caught the attention of western media raising the public awareness. To help deal with this matter, the United States continues to face international pressure to resettle increasingly more refugees. This federal fiscal year, September 2016 to September 2017, Congress voted to resettle 110,000 refugees to the United States, up from the 85,000 goals in 2016 and 70,000 in 2015 (Refugee Admission Statistics, n.d.). Today Minnesota continues to remain one of the top resettlement states and has historically been a welcoming state to several refugee populations. Locally, Minneapolis is home to the largest Somali population; Saint Paul is home to the largest Hmong and Karen community in the nation and Brooklyn Park, and Brooklyn Center are home to some of the largest Liberian communities in the United States (Minnesota Refugees, n.d.).

As the United States continues to welcome more refugees, it is important for social workers to understand the unique needs refugees have as they will likely interact with all social work systems including, schools, community nonprofits, government assistant programs, and the health care system. What is most important, is understanding the mental health needs of this highly traumatized population as well as the cultural sensitivity necessary to be successful in helping refugees heal and successfully integrate into our society. What refugees experience during their flight to safety, as well as the experience of resettlement, has put refugees at a greater risk for mental health distress. It has been documented refugees have higher prevalence rates of many mental health disorders compared to the general public (Savin, Seymour,

Littleford, Bettridge & Giese, 2005). Although higher prevalence rates are documented, underutilization of Western mental health treatment by refugee populations exists. Therefore, it is important for social workers to better understanding the barriers and reasons for why this underutilization exists, as well as, understand how to adequately treat. Kira and Tummala (2015) discuss it is vital for clinicians to adopt an ecological model of recovery when working with refugees to provide a holistic approach addressing the many needs refugees face after resettlement.

The purpose of this systematic literature review is to look at how current mental health service delivery models are addressing the bio-psycho-social-spiritual needs of refugees. A systematic literature review uses a systematic method to identify, select, and analyze data from current literature on the topic. The articles identified will be reviewed, synthesized, and thematically analyzed to answer the above research question.

Literature Review

Mental Health Risk Factors

As previously stated, mental health concerns are higher among refugee populations than the general public (Savin et al., 2005). Higher mental health rates can be attributed to the trauma experienced or witnessed during forced displacement, the length of time in a refugee camp, as well as the acculturation and adjustment stress after resettlement (Agllias & Gray, 2012 Potocky-Tripodi, 2012; Savin, et. al, 2005).

Pre-resettlement risk factors. Unlike other immigrant populations, refugees are unique due to the lack of choice they have in leaving their home country. Refugees are pushed out of their country without choice due to persecution or a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group

(UHHCR, n.d.). Ethnic and religious violence is the leading causes of refugees having to flee their homeland (UNHCR, n.d.). Forced migration refugees experience creates a significant amount of loss in addition to experiencing a high level of exposure to war-related violence and ethnic persecution (Betancourt, et al. 2014). Of the largest refugee groups being resettled to the United States from Burma, Iraq, Somalia, and Bhutan, it has been documented that almost all have experienced war trauma and 30-50% of the refugees from these countries have experienced torture (Shannon, Vinson, Cook & Lennon, 2015). Sexual violence, being used as a human shield, forced landmine sweeping in a combat area, arrests, and extrajudicial killings, are just some of trauma experienced by refugee populations (Cook, Shannon, Vinson, Letts, & Dwee, 2015; Shannon, Wieling, Simmelink-McCleary & Becher, 2015).

Women are at particular risk and vulnerability due to the documented widespread of physical and sexual violence in refugee camps (Agllias & Gray, 2012). Although there are no prevalence rates the number of refugees whom experience rape, it is reported in several studies among the participants (Agllis & Gray, 2012; Shannon et al. 2014) Shannon et al. (2014) stated rape in the refugee camp was reported by both Bhutanese and Oromo participants. A Bhutanese participant discussed rape happening to girls as young as five. An Oromo participant discussed it whole villages of women would experience rape, but due to shame in their culture it is not discussed.

In addition to the trauma, lack of basic needs during the flight and while in the refugee camps are also psychological risk factors increasing the likely hood of mental health distress. Many refugees live for years in camps that are overcrowded, unsafe, restrict movement and create a dependency on others. This dependency and powerlessness had been documented to

decrease self-esteem further contributing to psychological distress (Small, Kim, Praetorius, Mitschke, 2016; Agllias & Gray, 2012).

Resettlement risk factors. Once resettled to the United States or another developed country many additional challenges arise. Alligas and Gray (2012) state the acculturation stress and unmet social needs, rather than the trauma experienced while fleeing, may be just as detrimental to refugee's mental health (Agllias & Gray, 2012). In a community-based participatory research study, Betancourt et al. (2014) conducted focus groups with both Somali youth and adults. One participant described her experience of resettling as coming to a second war. She discussed her expectation of coming here was for peace, but she described her life in the United States as falling apart.

Psychosocial needs. Language barriers, poverty, and lack of housing are additional risk factors for psychological distress experienced by refugees once resettled (Betancourt et al., 2014; Palmer, 2007). In London, researcher Palmer (2007) found refugee participants reporting their lack of stable and decent housing, poverty, and little social support being harmful to their mental health. When Palmer (2007) asked participants what would improve their wellbeing and distress, participants discussed needing practical solutions, such as help with house, income, learning English and feeling less isolated. These findings indicate unmet social needs contributing to the psychological distress refugees face after resettlement.

Change in family dynamics. Migration also puts a significant stress on family dynamics causing both intergenerational and marital conflict as roles and expectations change (Potocky-Tripodi, 2012). Often children learn English much more quickly than their parent's. Therefore, first generation refugee parents are now relying heavily on their children for interpretation and to act as cultural brokers. Parents described the change in their family dynamic as being extremely

difficult. (Betancourt et al., 2014; Potocky-Tripodi, 2012). This change in the power dynamic can lead to a lack of respect for parents. Further, first generation refugee children often find themselves caught between two worlds. In addition to learning English faster, children often learn their new culture more quickly which can cause concern among parents who want their children to continue to stay true to their cultural heritage rather than the culture of the United States.

In many cultures, the mother's role in the family is at home raising children. However, due to the high cost of living, many mothers find themselves needing to find a job, therefore, needing help with the work inside the home traditionally not done by men. It has also been found refugee women are more likely to find a job in the United States before men creating a gender role reversal (Potocky-Tripodi, 2012). This change in status can leave men feeling angry or depressed and lead to marital conflict (Potocky-Tripodi, 2012).

Resource Loss. In addition to the death of family members and friends from war, refugees have experienced a great deal of loss including loss of home, loss of possessions, loss of status, and loss of financial security. Refugees have reported these losses as one of the largest struggles after resettling (Betancourt et al., 2014). Refugees who were once professionals find their prior education and work credentials are not transferable to Western countries. Therefore, those who were once doctors and lawyers have found themselves taking minimum wage jobs to support their families (Potocky-Tripodi, 2012). Of the opposite, other refugees come from areas in the world where they lived in small villages using traditional means such as farming and hunting to meet their basic needs. Their concept of space was vast, and they could move freely and safely around before war broke out. Once resettled, many refugees find themselves in an urban setting, living in unsafe neighborhoods residing in small apartments. Children and adults feel confined

and are no longer able to live a traditional cultural lifestyle off the land. This loss of occupational meaning and status also leads to the loss of social standing. For some refugees, whom once lived an affluent life in their home country, after being resettled, they find themselves now as a low-income minority experiencing acts of discrimination (Betancourt et al., 2014).

Discrimination. Kira and Tummala- Nara (2015) state not enough clinical attention is paid to the ongoing discrimination refugees experience. Discrimination negatively impacts one's physical health and mental health. There has been a rise in xenophobia and Anti-Muslim sentiments in the United States post 9/11. Both parents and children of Islamic faith report acts of discrimination they have experienced after being resettled. Researchers Betancourt et al. (2014) found Somali youth describing being picked on at school, being called pirates and girls having their hijabs pulled off by other children. Similarly, Agllias and Gray (2012) discuss a study finding middle eastern youth experiencing a great deal of teasing, alarming 20% of the youth participants of the study had been attacked, and another 40% had witnessed an attack. These past migration acts of discrimination and perceived discrimination have been shown to hinder a refugee's ability to adjust and heal from past trauma (Ellis, Macdonald, Lincoln, & Cabral, 2008; Correa-Velez, 2015).

Additionally, refugees are being viewed as a negative social construct in the western world, they are perceived as victims, and helpless not as people bringing skills, knowledge, and ability to their new host countries. A growing trend of seeing refugees as a social problem rather than individuals who can contribute positivity to the broader community (Allan, 2015). Allan (2015) and Ellis et al., (2015) have documented both Sudanese's, and Somali refugees lack a sense of belonging to their new communities, negatively impacting their well-being.

Prevalence Rates

Due to the trauma faced overseas and the reality of resettling to a third country, many studies have documented a higher prevalence of several mental health disorders among refugees compared to the general population. Both the trauma experienced before resettlement and the stress of resettling have led to higher prevalence rates of post-traumatic stress disorder (PTSD), depression, substance abuse, somatization disorder, and traumatic brain injuries compared to the general population (Savin, et. al, 2005; Betancourt, Frounfelker, Mishra, Hussein, & Falzarano, 2015). Even longitudinal studies have found refugees struggling with high rates of mental health concerns years after being resettled (Carlsson, Olsen, Mortensen & Kastrup, 2006).

PTSD. Extreme traumatic events can lead to post-traumatic stress disorder. PTSD symptoms can manifest as nightmares causing sleep disturbance, increased arousal and avoidance of stimuli that may remind one of past trauma (Black & Andreasen, 2014). In a systematic review, meta-analysis by Steel et. al 2009), researchers found the PTSD prevalence rate for refugees between 13 to 25%, much higher than the 7% of the general population (Black & Andreasen, 2014). For refugees, the symptoms of PTSD can present themselves immediately following a traumatic event or appear years later as well as be transmitted multigenerational to children (Potocky-Tripodi, 2012).

Major Depression. Often major depression is comorbid with PTSD for refugees. It is also the number one mental health diagnosis refugees seek treatment for (Potocky-Tripodi, 2012). There are varying statistics on depression prevalence rates for refugees. Steel et al. (2009) indicated major depression among refugees could be as high as 30%. Both torture and prolonged exposure of trauma were found to be factors strongly associated with both PTSD and

depression (Fazel, Wheeler & Danesh, 2005). Rather than psychological or emotional symptoms, depression among refugees often manifests as somatic complaints (Potocky-Tripodi, 2012).

Little research has been conducted looking at suicidal ideation rates among refugees. Two studies document Karen and Afghani women residing in refugee camps are at high risk for suicidal ideation (Agllias & Gray, 2012; Falb, McCormick, Hemenway, Anfinson & Silverman 2013). Agllias and Gray (2012) discuss a study conducted in 2003 surveying 297 Afghan mothers. They found 36% suffered from a mental health disorder with an alarming 91% of them having suicidal thoughts. Financial concerns and the stress of their children's future were documented as the largest worries refugee parents face in camp (Agllias & Gray, 2012). Falb et al. (2013) found 50% of women who experienced victimization during conflict and intimate partner violence reported suicidal ideation. However, research documenting suicidal ideation for refugees after resettlement is sparse. Researchers Kanya and White (2011) argue that suicide is not a monolithic concept. They discuss Islam as a protective factor for Muslim refugees. Somali Muslim participants of the study discussed taking one's life is against their religion (Kanya & White, 2011).

Somatization. Many cultures do not distinguish the difference between mind and body, as well as cultural norms that discourage the expression of feelings, are two factors related to why refugees discuss somatic complaints over emotions and feelings when psychological distress is present (Potocky-Tripodi, 2012). Because of this, many refugees seek medical care over mental health treatment. In a study measuring the prevalence of somatization in Asian refugees in a primary care clinic, it was found 42.7 % of the refugees were seeking medical services for a somatization disorder (Lin, Carter & Kleinmens 1985). Arthritis, gastrointestinal problems, headaches, allergies, respiratory disorders, and sexual dysfunction are common

somatic symptoms refugees experience (Potocky-Tripodi, 2012). This high rate of somatization found in primary care settings poses a challenge; most physicians' emphasize the biomedical model. Therefore psychosocial problems often go untreated (Lin, Carter & Kleinmens, 1985).

Substance Abuse. Substance abuse is a growing concern among refugee populations (Weaver & Roberts, 2010). However, current empirical data on substance abuse in refugee population is limited. Prevalence rates vary considerably depending on the refugee population (Potocky-Tripodi, 2012). Like the mainstream population, substances are used as a coping mechanism to provide relief from symptoms of mental health distress. Since exposure to trauma and acculturation stress after resettlement leads to increased rates of PTSD and depression, it is believed refugees are likely to have higher rates of substance abuse (D'avano, Frye, & Froma, 1994). A study by D'avano, Frye, and Froma (1994) looked at substance use among Cambodian women in the United States. Of the 120 participants, 45% discussed using alcohol to deal with nervousness, stress, headaches, insomnia, and pain. Further, 15% of respondents indicated that they knew of family members who used street drugs. Additionally, Potocky-Tripodi (2012) reported refugee youth are at higher risk for substance abuse and subsequent generations show an increased use of substances compared to first generations refugees. In Canada, a rise in both drugs and alcohol use and abuse has been seen among Muslim youth (Jozaghi, Asadullah, Dahya, 2016).

Underutilization

Underutilization of Western mental health services by refugees has been widely documented (Palmer, 2007 & Bettmann et al., 2015). Some of the primary reasons for this underutilization are due to the stigma of mental health, cultural understanding of mental health, and access barriers (Shannon, Weiling, Simmelink-McCleary, & Becher, 2015).

Cultural factors of shame and stigma are often the most cited reason in research as to why there is an underutilization of Western mental health services by refugees (Shannon et al., 2015; Behnia, 2004). In an exploratory study by Behnia (2004), who interviewed refugee survivors of war and torture from five different ethnic backgrounds, found the participants described any mental health diagnosis is considered being crazy. Therefore, the western concept that mental health lies on a continuum is not a shared concept among many refugee populations, rather one is either sane or crazy, so any mental health diagnosis is considered being labeled at crazy (Behnia, 2004; Palmer, 2007). Palmer (2007) found within the Somali culture if one is labeled crazy, it leads to social isolation by being ostracized by the community. Therefore, Somalis are reluctant to seek services for fear of being an outcaste. Similarly, researchers Shannon et. al. (2015) found although Bhutanese refugees may at times indicate that a mental health concern with a community member is caused due to a biological reason, community members still stay away due to the belief they are violent and intend to harm others. Therefore, again, members of the community perceive they will be ostracized from their community if given a mental health label. Shannon et. al. (2015) found similar themes of stories from Oromo and Karen refugees as well. Participants also discussed talking about one's mental health is taboo and it is not appropriate to discuss (Shannon et. al. 2015).

Cultural understanding of mental health. The Western biomedical model used to treat mental health fails to address how refugees perceive the cause of their mental illness and lack to address the cultural context of the patient. (Gashaw-Grant, 2004) As previously discussed, many cultures do not distinguish the difference between mind and body (Potocky-Tripodi, 2012). For many, especially refugees of Muslim faith, the cause of mental health distress is spiritually

based; it is believed that God/Allah as the cause of mental illness (Clarkson Freeman, Penney & Bettmann, 2013).

In many cultures religion plays a large role in developing an understanding of mental health. (Johnsdotter et al., 2010; Bettmann, et. al, 2015; Freeman et al. 2013). Muslim refugees credit God as the causer and curer of all illness (Freeman et al, 2013). For traditional Somali's who believe in Islamic cosmetology the possession of Jinn, evil spirits, can be the cause of mental health psychosis. It is believed that if one hears voices, Jinn has entered the body. Therefore, it is with no surprise religious healing is sought rather than Western mental health services contributing to the underutilization of services (Johnsdotter et al., 2010).

Barriers to Mental Health Treatment. Research has also found refugees often cite talk therapy is not useful, or they are unable to discuss their past trauma (Bettmann et al. 2015; Shannon et al., 2015). In a participatory-action research study by Shannon et al. (2015), researchers conducted 13 focus groups totaling 111 participants from the Bhutanese, Somali, Karen, and Oromo community. Participants discussed due to consequences for speaking out in the past which led to torture, arrest, or imprisonment, many find it difficult or do not to discuss their past. Participants described disclosing info in the past lead to torture and many discussed bringing up their painful past is not something they find helpful. Bettmann et al. (2015) and Palmer (2007) also found refugees don't believe talk therapy is a helpful treatment for mental illness and is a waste of time. Rather Palmer (2007) found, refugees prefer practical solutions such as help with housing or employment.

Other barriers that lead to underutilization include systemic and access barriers. Access barriers which include, lack of transportation, providers unwilling to serve refugees, providers lack of cultural competency to work with refugees, and language barriers/translation problems

are all barriers leading to failed mental health follow-up (Kaczorowki et al., 2001; Shannon et al., 2016). Kaczorowski et al. (2011) discuss it is often the therapist who must take on more responsibility to overcome these barriers on behalf of the client which may lead to increase burnout of the therapist. Further, refugees lack knowledge of health care resources and have little knowledge on how to navigate the United States health care system, therefore this lack of knowledge prevents refugees from seeking services (Potocky-Tripodi, 2002).

Treatment

Although research has documented prevalence rates of mental disorders are higher among refugees and due to a variety of conditions and barriers underutilization of Western mental health services is known, there is less research on evidence-based interventions and successful service delivery models. Knowing both the traditional ways refugees treat mental illness as well as western mental health interventions or services delivery models being used or researched to be evidence based, may lead to innovative ways to help adapt Western mental health services.

Organized Religious Activity. As previously noted, refugees of Islamic faith attribute the cause of mental health to Allah. Researchers found organized religious activity among Muslims to be a protective factor and early intervention for those who have witnessed and experienced significant traumatic events in their life. Organized religious activity among Muslims has been found to be a coping mechanism (Adedoyin et al., 2016).

Reading the Quran. More widely studied is the how specifically reading the Quran is used by the Somali people to treat mental health (Freeman et al., 2013 & Bettmann et al., 2015) Through open-ended qualitative interviews researchers found the Quran as medicine for both physical and mental illness (Freeman et al., 2013). In one study, participants discussed seeking

Western medical services only after the Quran treatment did not improve someone's health while others described using the reading of the Quran simultaneously while seeking Western medical care (Freeman et al., 2013). Additionally, participants discussed who reads the Quran. Some participants noted the ill person themselves, family members or groups of people, and for a serious illness, the Imam is expected to read the Quran to the person (Freeman et al., 2013). From the western mental health point of view, this reading and reciting can be seen as a meditative intervention (Adedoyin et al., 2016).

Psychosocial Resources. In addition to religious beliefs, traditional beliefs are used to deal with mental illness in the community. Mobilization of social networks is used to deal with problems. Community members noted using families and social support to discuss problems. Therefore, again this socialization can be seen as an early intervention (Johnsdotter et al., 2010). However, in this same study participants described if someone is more severely mentally ill, such as talking to themselves, taking their clothes off or behaving strange, then the illness is concealed within the family and not disclosed to the rest of the community (Johnsdotter et al., 2010).

Further, research has found programs to address the psychosocial factors in a refugee's lives will improve mental well-being. Housing, poverty, isolation, and lack of employment were reported by Somali community members as their biggest worries as opposed to past trauma. (Palmer, 2007). Therefore, a provider must be willing to help refugees with navigating government programs, housing, and immigration to best serve mental health distress (Schuchman & McDonald). Programming to address the core social needs of the community are best practices for prevention or early interventions.

Narrative Exposure Therapy. Although overall research lacks evidence based interventions for refugees, one study has shown narrative exposure therapy is a promising

intervention being used for the treatment of PTSD in refugees (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Neuner et al. (2004) found one year after Sudanese refugees in Uganda received narrative exposure therapy, only 29% still has PTSD symptoms. Although this study consisted of a small sample size, further attention should be paid to narrative exposure therapy as potentially an evidence-based practice for refugees.

Bio-Psycho-Social-Spiritual Model

The bio-psycho-social-spiritual assessment has long been used by social workers to determine a whole person's needs. This type of assessment is based from the theory that a person's biological information of their family, medical history, psychological self, the types of social supports, community resources, and spiritual beliefs and understanding determine one's behavior (Bisman, 2001). Therefore, using this assessment helps to determine a whole person's needs allowing social workers to better determine appropriate interventions. Kira and Tummala-Nara (2015) conclude current evidence based interventions are inadequate in working with refugees. Although these approaches address past trauma, they ignore the complex continuous victimization and cumulative trauma and stress refugees experience from institutions and social systems. Therefore, as Kira and Tummala (2015) discuss it is vital for clinicians to adopt an ecological model of recovery with understanding of the sociopolitical and cultural context of refugees past and present experience to treat the whole person. Therefore, when working with refugees not only should the individual mental health provider take an ecological approach to address the full needs of refugees, but the whole service delivery should encompass the bio-psycho-social and spiritual needs of refugees to adequately treat a person's mental health.

In summary, research tells us refugees are at higher risk of mental health distress due to the trauma faced from fleeing as well as the unmet social needs after being resettled to a third

country. Research also indicates there is an underutilization of Western mental health services by refugee populations. Many factors contribute to this underutilization such as stigma, cultural understanding of mental health as well as system barriers. Because of this, many refugees suffering from mental health distress are left going untreated. However, researchers have also identified the importance of mental health therapists and programs to be culturally sensitive to refugees understanding of mental health and the importance of addressing the bio-psycho-social-spiritual needs of refugees. Therefore, the purpose of this systematic review is to look at how current mental health service delivery models for refugees are addressing the bio-psycho-social-spiritual needs of refugees.

Methods

Research Purpose

The purpose of this systematic review is to explore the question: How mental health service delivery models are meeting the bio-psycho-social- spiritual needs of refugees?

For the purpose of this study, a refugee is defined by United Nations Higher Commission for Refugees (UNHCR) definition. A refugee is someone who is forced to flee his or her home country based on well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group (UNHCR, n.d.). This study does not look at one particular refugee community but includes research for anyone with a refugee status as defined above. For the purpose of this study, a service delivery refers to a way in which a service agency or service provider has developed, implemented, and continues to operate the delivery of a mental health service or services. Further for the purpose of this study, the bio-psycho-social-spiritual model is defined as the totality of the patient's relational existence and a holistic approach to address the physical, psychological, social, and spiritual needs of a person.

This study does not focus on the specific interventions used by the service provider but rather looks at the infrastructure or model in which the interventions are delivered. Therefore, for this study, service delivery is considered holistically and includes service delivery models that are both familiar to the western psychological model such as day treatment, school-based, and outpatient services but also includes culturally based models used by refugee communities shown to have a mental health benefit. The study did not focus on the service delivery for one particular mental health diagnosis, but any service delivery for mental health disorders defined by the DSM-V.

Types of Studies

To answer the above research question, only peer reviewed empirically based, qualitative and quantitative studies were considered. Studies included participant surveys, in-depth interviews both with participants and providers of the services or cultural practice, as well as the discussion of models adopted by agencies to improve access to care for refugees.

Search Strategy

First, a search of academic journals using databases including SocINDEX, Google Scholar, ERIC, and Academic Search Premier was conducted to conclude no other systematic reviews have already been published on this research question, how are mental health service delivery models addressing the needs of refugees. Both sensitivity and specificity were performed for this study. Although first, a specificity search was conducted, the researcher found a lack of articles as it related to the question. Although a specificity search allows narrowing the focus better, for this question a sensitivity approach was more applicable. A sensitivity approach allowed for a broader range of research topics. For this review, a sensitivity approach that included both the western medical approach to mental health as well as refugee communities

approach to mental health allowed for a broader set of literatures which incorporates culturally sensitivity in the research. Since some refugee communities may not see the western mental health service delivery as the only way to deliver mental health services, delivery of cultural practices as it relates to mental health were included to answer the research question.

The focal point of this research was around how service agencies and communities are serving the bio-psycho-social-spiritual needs of refugees despite the significant number of barriers refugees have in accessing appropriate mental health services. Therefore, again, service delivery was looked at both from the lens of a western mental health professional as well as through a lens of how a refugee community would define mental health service delivery.

Review Protocol

Peer-reviewed, full-text articles published between the years of 2000 to 2016 were considered for this review. Because mental health for refugees is a new and emerging area of research, dissertations were also included in the study. Articles were found using search databases, SocINDEX, Academic Search Premier, and ProQuest Dissertations & Theses. Articles were searched and collected the beginning of October of 2016. The data parameters used to address the issue of validity for this study.

Inclusion Criteria. In both databases, SocIndex and Academic Search Premier the following combinations of search terms were used, “mental health service delivery models” AND “refugees.” Articles were narrowed to the date range of 2000 to 2016, and only peer-reviewed articles were searched. In SocIndex 66 articles were produced, and 16 were produced using Academic Search Premier. For ProQuest Dissertation and Theses search terms “mental health models” AND “refugees” AND “mental health” produced 47 results including requirements of only full article dissertations published between 2000 and 2016.

Exclusion Criteria. Of the 129 dissertations and peer-reviewed articles that met the inclusion search criteria listed above, only 14 met the criteria to be included in this study. Articles that were excluded included: studies that focused on intervention rather than service delivery models; articles that focused on immigrant groups that did not meet the UNHCR definition of a refugee; articles that focused solely on the barriers to receiving mental health services. Non English articles were also excluded from the study.

First, the researcher reviewed the title and abstract of each produced article inclusion, and exclusion decisions were based accordingly. 23 articles were identified as potential articles for the study. After a full body text review of these 23 articles and dissertations, the researcher identified thirteen articles and one dissertation having fully met the inclusion and exclusion criteria and are included in this review. Articles that were excluded from this second round of exclusion included; studies that only discussed recommendations to develop service delivery models for refugees; studies that excluded a mental health service delivery model. Table one outlines the completed list of articles and dissertation that met the search criteria. Table 2 provides a detailed list with a content summary.

Table 1: Included Articles

Database	Title	Author(s)
SocINDEX	Developing a mental health programme for refugees based on participatory action research: an experience from Sao Paulo, Brazil	Carmen L.A. De Santana & Francisco Lotufo Neto
	Creating a safe haven in schools: Refugee and Asylum-Seeking Children's and Young People's Mental Health	Carl Dutton
	Common threads: improving the mental health of Bhutanese refugee women through shared learning	Diane Mitschke, Regina Aguirre & Bonita Sharma
	Refugees Convoy of Social Support	Behnam Benia
	The effects of cultural adjustments and trauma services (CATS): generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth	Sarah Beehler, Dina Birman & Ruth Campbell
	Psychotherapy with Traumatized Southeast Asian Refugees	Yu-Wen Ying
	Working with refugees and survivors of trauma in a day hospital setting	Jane Derges & Fiona Henderson
	Cultural consultation: a model of mental health service for multicultural societies	Laurence Kirmayer, Danielle Groleau, Jaswant Guzder, Caminee Blake, & Eric Jarvis
	Adapting Clinical Services to Accommodate Needs of refugee populations	Jessica Kaczorowski, Ann Shah Williams, Taylor Smith, Niloofar Fallah, Julia Mendez, & Rosemary Nelson-Gray
Academic Search Premier	Mental health treatment for resettled refugees: a comparison of three approaches	Eusebius Small, Youn Kyoung Kim, Regina Praetourius & Diane Mitschke

	Two psychosocial assistance approaches for Iraqi urban refugees in Jordan and Lebanon: center-based services compared to community outreach services	Karen Le Roch, Emmanuelle Pons, Jason Squire, Josephine Anthoine-Milhomme, Yann Colliou
	The role of Muslim faith-based programs in transforming the lives of people suffering with mental health and addiction problems	Ehsan Jozaghi, Muhammad Asadullah & Azim Dahya
	International Family, Adult, and Child Enhancement Services (FACES): A Community-Based Comprehensive Services Model for Refugee Children in Resettlement	Dina Birman
ProQuest Dissertation and Thesis	Culture and Mental Illness: A Review of a Model For Providing Mental Health Services To east African Refugee/Immigrants	Gebaynesh Gelila Gashaw-Gant

Research Synthesis

The purpose of this systematic literature review was to explore how mental health services delivery models address the bio-psycho-social-spiritual needs of refugees. Using the databases SocINDEX, Academic Search Premier, and ProQuest Dissertations & Theses, and working within the inclusion and exclusion criteria described under the methods section, 14 peer-reviewed articles and dissertations met criteria and were reviewed.

Of the 14 articles, the majority discussed mental health service delivery models for adults (36%, n=5). Four (29%) discussed service delivery models for youth, and three (21%) mental health service delivery models were for both youth and adults. In two articles (14%) the authors did not make clear if the service delivery was for both adults and children. Further all articles except for one, (93%) reported on male and female participants. One article (7%) had only women participants and none of the articles focused specifically on men.

Mental health service delivery models included three (21%) articles discussing community based mental health services, three articles (21%) on school-based mental health services, three articles (21%) reported on more than one mental health service delivery model within each article. One article (7%) discussed a day hospital setting, one article (7%) discussed a skill based group model, one article (7%) discussed a consultation service for mental health professionals, one article (7%) discussed an outpatient mental health program, and one article (7%) discussed a faith -based harm reduction and prevention model.

Most of the articles provided data on mental health service delivery models here in the United States (50%, n=7). Three articles (21%) provided research on models in Canada, and two articles (14%) on service delivery models in England. One article (7%) provided data on a

service delivery model in Brazil. One article (7%) provided data on a service delivery in both Jordan and Lebanon.

The majority of the research included in the review (57%, n= 8) provided qualitative data. Of the eight qualitative articles, four conducted interviews with open-ended questions. Of those four, one interviewed volunteers rather than program participants and one interviewed both participants and professional community partners. Three of the eight articles were case studies and only provided an overview of the service delivery model and program participants. One of the eight articles conducted both interviews and focus groups.

Six articles (43%) provided quantitative data. Of the six quantitative articles, three used an assessment measure to measure a reduction in mental health symptoms. Two of the six used program data and one article used both program data and assessment measurements.

Table 2 below provides a summary of the articles.

Table 2: Included Articles and Summary

Article: Developing a mental health programme for refugees based on participatory action research: an experience from Sao Paulo, Brazil					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Carmen L.A. De Santana & Francisco Lotufo Neto	The aim of this study was to understand refugees' perceptions about their experiences using a psychodynamic framework.	Brazil	Qualitative, Participatory Action- 24 focus groups and 12 in-depth interviews were conducted	Community Mental Health Center	Adults between the ages of 18-65. Participants were from Angola, Colombia, Liberia, Iraq, the Democratic Republic of Congo, Sierra Leon, Yugoslavia, and Nigeria
Summary of Article					
The purpose of this study was to develop a mental health program for refugees within an already established community mental health center in Sao Paulo Brazil. Psychodynamic theory was used as a theoretical framework when analyzing the data. Mental health activities implemented included, psychiatry and psychological care at a transcultural clinic, psychological support of Caritas/UNHCR staff, and art therapy groups for refugees. Further the researchers discussed the importance of training staff members and increasing cultural sensitivity by conducting seminars on African cultures.					
Article: Creating a safe haven in schools: Refugee and Asylum-Seeking Children's and Young People's Mental Health					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Carl Dutton	The aim of this article was to provide an overview of the child and adolescent mental health services program and how they serve program participants.	England	Qualitative – Case study. Author provided an overview of the school-based mental health program for refugees	School-Based	N/A – No study participants.
Summary of Article					
Article provides an overview of the Haven Project; a school-based mental health program being implemented in Liverpool for refugee and asylum seeking children. The author discusses the use of a non-pathologizing model with strong collaboration between the school and the parents. The author discusses the importance of therapies that do not rely on spoken word and understanding social problems the families face as being part of what makes this program successful.					

Article: Common threads: improving the mental health of Bhutanese refugee women through shared learning					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Diane Mitschke, Regina Aguirre & Bonita Sharma	The aim of this study was to examine the effect of a group-based financial education program for Bhutanese refugee women	United States	Quantitative, quasi-experimental research design with a non-equivalent groups design	Group /Skills - Based	65 Bhutanese adult women each woman was assigned to one of three groups.
Summary of Article					
The purpose of this study was to assess the impact of a group-based financial education course on the mental health (PTSD, depression, anxiety, and somatization) of Bhutanese women refugees resettled in the United States. Researchers found at 6-month follow-up, participants in the group receiving the intervention had significant reduction in PTSD, depression, anxiety, and somatization symptoms compared to the control group. Further, authors found all participants in all groups experienced gains in social support.					
Article: Refugees Convoy of Social Support					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Behnam Benia	The aim of this article was to discuss the factors that shape survivors' use of mental health services as well as the functions and benefits of community peer groups.	Canada	Qualitative, exploratory study. Face to face interviews were conducted asking open ended questions.	Community Peer Groups and Formal Mental Health Services	36 adult survivors of war and torture from Bosnia, Cambodia, El Salvador, Iran, and Somalia
Summary of Article					
Authors conducted an exploratory study with 36 survivors of war and torture. Researchers asked open-ended questions in person to gather information on support systems and help seeking experiences. Researchers found lack of faith in mental health services, previous negative experience with mental health professionals and current difficult life situations as reasons as to why participants are not seeking mental health services. Researchers also found participants being satisfied with community support groups such as cooking groups, sewing, women's and senior groups provide emotional support, and practical information.					

Article: The effects of cultural adjustments and trauma services (CATS): generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Sarah Beehler, Dina Birman & Ruth Campbell	The aim of this research was to one, describe the comprehensive model and its client base and two, test the relationships between distinct treatment elements and outcomes	United States	Quantitative, two clinical measures were used to track client progress, CAFAS and the PTSD-RI.	School-Based	149 refugee/immigrant children
Summary of Article					
<p>The purpose of this study was to describe and evaluate, a comprehensive school based mental health program. Effectiveness was assessed by client functioning and symptoms improved after seven separate service elements. Clinical services included CBT, supportive therapy and coordinating services. It was found that greater quantities of CBT and supportive therapy increased functioning while coordinating of services decreased PTSD symptoms. Additionally, model components used included relationship building; outreach services, and comprehensive clinical case management.</p>					
Article: Psychotherapy with Traumatized Southeast Asian Refugees					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Yu-Wen Ying	The aim of this article was to identify techniques for time-limited mental health treatment with Southeast Asian Refugees	United States	Qualitative- Author described best practices based on personal experience	Outpatient mental health	Participant is author describing her personal experience
Summary of Article					
<p>This article highlights the psychotherapy techniques used by the author on her work with the Southeast Asian refugee community in a community mental health center in California. The author discussed at first session, instead of completing a lengthy assessment, it is important to keep the assessment small and shift to normalizing the symptoms, providing a medication referral help give the client a sense of hope and trust in the mental health treatment. Author discussed the power of touch as an intervention that can be given as homework to a family member and the client themselves. Next it is important that social needs are met before the treatment of trauma. The author also highlights the importance of relationship between the client and the interpreter as part of what makes their work successful.</p>					

Article: Working with refugees and survivors of trauma in a day hospital setting					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Jane Derges & Fiona Henderson	The aim of this article was to recognize refugees' cultural beliefs and attitudes about concepts of health and illness and the effects of social and cultural dislocation.	England	Qualitative, personal testimonies	Day Hospital	6 females and 4 males from Iraq, Iran, Egypt, Ethiopia, Uganda and Laos
Summary of Article					
<p>This study interviews refugee whom are receiving services through a day hospital setting in the United Kingdom. explore through their personal testimonies, what had occurred to them both pre and post-exile, what were their views about the treatment they had received and what factors were preventing them from being able to live satisfactory lives after so many years. Ten case histories were used. Researchers found music, art, sculpting, work, and domestic activities such as cooking were appropriate therapeutic interventions that also helped build trust. Further researchers discussed the important of addressing social problems that perpetuate PTSD.</p>					
Article: Cultural consultation: a model of mental health service for multicultural societies					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Laurence Kirmayer, Danielle Groleau, Jaswant Guzder, Caminee Blake, & Eric Jarvis	The aim of this research was to evaluate a cultural consultation service for mental health practitioners and primary care clinicians.	Canada	Quantitative, systematic evaluation of the first 100 cases referred to the service.	Cultural Consultation Services for Mental Health Practitioners	N/A – 100 cases where evaluated from program effectiveness
Summary of Article					
<p>Researchers reported on the results of an evaluation of a cultural consultation service (CCS) for mental health practitioners and primary care clinicians. 100 cases were systematically evaluated to establish reasons for consultation, types of cultural formulations and recommendations, and consultation outcomes in terms of the referring clinician's satisfaction and recommendation.</p> <p>Researchers found cultural misunderstanding, incomplete assessments, incorrect diagnosis, inadequate treatment, and failed treatment alliances were found among practitioners. Researchers found the cultural consultation model an effective supplement to services to improve diagnostic assessment and treatment.</p>					

Article: Adapting Clinical Services to Accommodate Needs of refugee populations					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Jessica Kaczorowski, Ann Shah Williams, Taylor Smith, Niloofar Fallah, Julia Mendez, & Rosemary Nelson-Gray	The aim of this article was to discuss how treatments were adapted to help overcome access barriers to mental health treatment, and provide specific examples of how existing treatments were used with refugee populations.	United States	Qualitative, case study authors provided an overview of a school-based model	School-Based	N/A-No Study Participants
Summary of Article					
<p>This study discusses a training clinic for graduate students in an APA approved doctoral psychology program serving refugees. Program participants are refugees from Iraq, Bhutan, Burundi, Somalia, Morocco, Liberia, Congo, Vietnam, Cambodia, and Mexico. To overcome access barriers, the clinic established a school based program for refugee youth. Further providers had training to increased their cultural awareness, knowledge, and skills to serve refugee youth. Further a tiered system of services allowed for a broader and more intense services. Authors also discussed the importance of consulting with refugees in the community and agencies serving the populations. Intervention wise, the program adapted its clinical measures to assess change and explaining the context of therapy and how it can help with adjustment to the United States.</p>					
Article: Mental health treatment for resettled refugees: a comparison of three approaches					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Eusebius Small, Youn Kyoung Kim, Regina Praetourius & Diane Mitschke	The aim of this study was to assess the impact of three different mental health interventions among refugees.	United States	Quantitative, quasi-experimental. Participants were randomly assigned to one of three intervention groups. Pre-and post-testing was used to measure intervention effectiveness.	Outpatient Mental Health, Home Based Counseling, and Community Based Psycho-Education Group	Participants included 116 randomly assigned refugees from Burundi, Burma, The Democratic Republic of Congo, Rwanda, and Bhutan
Summary or Article					
<p>The purpose of this quasi-experimental study was to assess the impact of three different mental health interventions among refugees. The effects of eight weeks of randomly assigned office-based counseling treatment as usual (TAU), home-based counseling (HBC), and a community-based psycho-educational group (CPG) on posttraumatic stress symptoms, depression, anxiety, somatization, and social support were evaluated using a pre–post design. Results indicate merit in each of the treatment modalities, with varying efficacy across intervention per mental health symptoms. Participants in HBC and CPG demonstrated greater overall improvement in mental health outcomes than participants receiving TAU.</p>					

Article: Two psychosocial assistance approaches for Iraqi urban refugees in Jordan and Lebanon: center-based services compared to community outreach services					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Karen Le Roch, Emmanuelle Pons, Jason Squire, Josephine Anthoine-Milhomme, Yann Colliou	The aim of this study was to display the strengths and weaknesses of two different psychosocial assistance devices with similar objectives, from the data collected about the Iraqi refugees who were the beneficiaries of these services	Jordan and Lebanon	Quantitative Data was collected from both programs database.	Home-based, community based, community outreach	Iraqi refugees For Jordan, data was collected on 420 program participants. For Lebanon, data was collected on 875 program participants.
Summary of Article					
<p>The purpose of this study was to display the strengths and weaknesses of two different psychosocial assistance devices with similar objectives, from the data collected about the urban Iraqi refugees receiving services in Lebanon and Jordan. In Jordan, the psychosocial intervention was a combination of center-based services such as psychological support and social assistance as well as community outreach through home visits. In Lebanon, the access to beneficiaries was more focused on home and community-based services due to a different context for Iraqi refugees who have restricted access to available support services. Authors found both programs improved level of distress, general well-being, social skills, and adjustment skills.</p>					
Article: The role of Muslim faith-based programs in transforming the lives of people suffering with mental health and addiction problems					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Ehsan Jozaghi, Muhammad Asadullah & Azim Dahya	The aim of this article was to determine how a faith-based harm reduction/prevention program operates and what they offer to Muslim youth and Muslim prisoners at risk	Canada	Qualitative in depth interviews with eight faith based program volunteers. NVivo 10 was used for coding and analysis	Faith-based harm reduction/prevention program	Participants are program volunteers. Volunteers are mental health and addiction case workers and one psychiatrist.
Summary of Article					
<p>Due to many countries having trouble addressing both mental health and addition issues of refugee and immigrant populations who are part of a religious minority authors wanted to explore the HOPE project which works on mental health and addition issues in the Muslim community. Services are provided by volunteers who are mental health professionals. Therefore, researchers conducted interviews asking sixteen open ended questions on the following themes: 1.) the work of the volunteers 2.) perceived effects of the program on the client 3.) the challenges they face in the community 4.) educational aspect of the program' and 6.) open discussion about anything raised during the interview. Researchers found the project has transformed the discriminatory rhetoric, shaming and stigma around mental health problems and substance abuse in the Muslim community. These findings also support the efficacy of delivering public health campaigns through faith based organizations that are sensitive to their client's cultural and religious needs.</p>					

Article: International Family, Adult, and Child Enhancement Services (FACES): A Community-Based Comprehensive Services Model for Refugee Children in Resettlement.					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Dina Birman	The aim of this article was to describe the program participants and service delivery model of FACES a comprehensive, community based mental health program for refugee youth and to assess whether participants improved over time	United States	Quantitative	Community-Based	68 children and youth. 47% of program participants were from Africa, 30% Europe, 15% Latin America, 3% Middle Eastern/Central Asia, 4% South Asia
Summary of Article					
<p>A collaborative study of International Family, Adult, and Child Enhancement Services (FACES), was conducted to describe the program participants, service delivery model and to assess whether participants improved over time as a function of services. Researchers collected demographic and diagnostic data on clients, the child and adolescent functional assessment scale was used to rate a child’s function, the trauma events checklist of the Harvard Trauma Questionnaire was used to document the type and number of traumatic events experienced by the children, and the agency billing system was used to describe the nature and extent of services provided. Most the program participants had an anxiety disorder, adjustment disorder or major depressive disorder. On average, each participant received 92.55 services hours. Overall researchers found that children receiving services improved overtime, but researchers did not find if improvement was a function of the quantity of services received.</p>					
Article: Culture and Mental Illness: A Review of A Model For Providing Mental Health Services to East African Refugee/Immigrants					
Author(s)	Research Aim	Country	Research Design	Service Delivery Model	Participants
Gebaynesh Gelila Gashaw-Gant	The aim of this research was to evaluate project ESSA, a integrative mental health service delivery program, to determine if the programs framework is effective for mental health prevention and service delivery for immigrants and refugees	United States	Qualitative – 15 participants were interviewed for this study, six professionals working with the program were also interviewed.	Community-Based	Five adult males and nine adult women and one female youth from Ethiopia, Sudan, Somalia and Eritrea. Six professionals working in collaboration
Summary or Article					
<p>Evaluative study examining the successfulness of ESEA, which serves East African refugees in San Diego California. Themes found through interviews included, importance of establishing rapport, the need for social support, underutilization of mental health services by refugees, enhancing cultural competency and concepts of illness and treatment and cultural bridging. Author found the model to be effective and successfully provides mental health services by using a comprehensive approach and cultural specific techniques to supplement and/or enhance mental health services including spiritual interventions and social support services.</p>					

Thematic Analysis

Through analyzing the data, it was found that all service delivery models addressed the psychological needs of refugees considering the cultural factors of the populations served. Further nearly all, twelve of the fourteen articles, discussed the importance of providing services to meet the social needs of refugees as part of their mental health treatment. Less was discussed in the articles regarding meeting their biological and spiritual needs. Four articles addressed the biological needs and three articles addressed the spiritual needs

Biological Needs. As stated above, little was discussed in the literature about meeting or addressing the biological needs of refugees. However, of the four articles that did discuss meeting biological needs, there was an underlying theme of the importance of doing so since many cultures do not make a distinction between the mind and the body. Therefore, these articles discussed blending both the western medical model and traditional healing practices as part of their mental health treatment model (Gashaw-Grant, 2004; Kirmayer, 2003; Ying, 2001). Researcher Yu-Wen Ying (2001) discussed the issue of her patients coming from cultures where Western concepts of mental health distress do not exist. Therefore, it is typical for her clientele, Southeast Asian refugees, to first seek the care of medical practitioners. She discussed helping her clients with navigating the medical system for their physical aches and pains while also providing psychotherapy (Ying, 2001). Further Gashaw-Grant (2004) interviewed a psychiatrist who works in partnership with a San Diego mental health program serving East African refugees. He stated,

Individuals from these communities have different illness concepts and present their problems in a cultural context making it difficult for providers who are not aware or who do not have the competency needed to understand them. To service individual from other

cultures you have to be able to understand their body language when they are expressing their illness, or when they are telling what has possessed them (p.83).

A Sudanese participate from this same study discussed being diagnosed with depression, a concept not familiar to her and the projects staff involvement. She stated,

My husband was killed in Africa in a refugee camp. I was sad all the time and cried a lot. I was hospitalized once. When I told people about my problem all they told me was I was missing my husband. I was told they needed to treat me for depression. I did not know what that meant...The project staff helped me get to a doctor and medication (p.74).

Researchers Kirmayer, Groleau, Guzder, Blake and Jarvis (2003) reported on an innovative model of mental health service delivery in Canada, based in a hospital setting, which provides consultation to mainstream service providers who are seeing refugee clients. Providers are able to consult with this service when they have concerns on how to best treat their refugee patients. One of the frequently raised issues is when clinicians focused on a single treatment that did not align with refugees understanding of the biomedical model and culturally traditional ways of healing. Kirmayer et al. (2003) Found when practitioners were taught about health care and healing practices in the client's country of origin, clinicians could start to blend this knowledge with their western treatment. This more culturally sensitive approach lead to clients reporting improvements

Similarly, Gashaw-Grant (2004) discussed how project ESSEA, allow and support clients to practice traditional ways of healing. In addition to the traditional ways, the program provides medication management services, patient education, and helps participants communicate with their doctors (Gashaw-Grant, 2004). One refugee participant of the program suffering from depression and a terminal illness stated,

I owe my life to the project staff; if it were not for their coordination I would have died from cancer. They took me to see the doctor and helped me complete all the tests ordered. They explained what I had and what type of treatment is good. I was able to understand and make decisions (p.71).

A female Ethiopian participant stated, *“I didn’t know going to the doctor would help my problem. The project staff talked to me, explained my problem, and told me I can see a doctor and also continue with holy water treatment”* (p.76).

Psychological Needs. All the literature discussed meeting the psychological needs of refugees. To accomplish this, six studies discussed the importance of first building trust (Beehler, Birman & Campbell, 2011; Behnia, 2004; Birman et al., 2008; Gashaw-Grant, 2004; Kaczorowki et al., 2001; Small et al., 2016). Further seven of the studies examined suggest group work (Beehler, Birman& Campbell 2001; Behnia, 2004; Birman et al., 2008; Dutton, 2012; Kaczoroki et al., 2011; Mitschke, Aguirre & Sharrma, 2013; Small, Kim, Praetorius & Mitschke, 2016) and five studies discussed nontraditional non-verbal forms of therapeutic interventions, such as art therapy, gardening, and massage, are interventions utilized at a variety of mental health settings. (Birman et al., 2008; Derges & Henderson, 2003; De Santana & Neto, 2015; Dutton, 2012; Ying, 2001).

Trust. Six of the fourteen articles discuss trust. Due to past persecution, many refugees lack trust. Researcher Behnia (2004) found participants in the study stating their past circumstances have taught them to be cautious who they talked to and to hide their emotions. Therefore, several participants of the study stated not trusting service providers. This mistrust is a barrier for refugee populations when seeking psychological services. Therefore, six articles suggests before any intervention can happen, trust needs to be built through relationship building

(Beehler, Birman & Campbell, 2011; Behnia, 2004; Birman et al., 2008; Gashaw-Grant, 2004; Kaczorowki et al., 2001; Small et al., 2016).

To overcome mistrust programs are hiring cultural brokers, cultural ambassadors, liaisons, or outreach workers from the ethnic groups being served. Gashaw-Grant (2004) reported project ESSEA used behavioral health outreach workers from East African communities to conduct outreach and conduct in-home assessments to build trust first with program participants before starting any clinical services. Similarly, a school-based mental health program titled Cultural Adjustment and Trauma Services (CATS) hired cultural brokers to be positioned in the school so both teachers and students can utilize them for consultation. Again, the cultural brokers helped build trust with the students before entering clinical services (Beehler, Birman & Campbell, 2001).

Group Work. Seven research studies reported that the use of group work was a common intervention being used to address the psychological needs of refugees (Beehler, Birman & Campbell 2001; Behnia, 2004; Birman et al., 2008; Dutton, 2012; Mitschke et al., 2013; Small et al., 2015; Ying, 2001). Mitschke et al. (2013) discuss a group context as being one that aligns with the strength perspective. She states in her research refugee communities have a collective society; therefore, group work builds upon this community strength and can be used to improve refugee mental health in a way that is familiar to them. Mitschke et al. (2013) developed a 12-week skills based group for Bhutanese women resettled to the United States which focused on financial literacy. At a 6-month follow-up, those in the intervention group had significant reductions in post-traumatic stress, depression, anxiety, and somatization compared to the control group (Mitschke, Aguirre, Sharma, 2013).

Small et al. (2016) also discussed the added benefit of group work. For example, it can be used to decrease barriers many refugees face in accessing mental health services since it can be easily held within a refugee's community, can be held outside typical work hours and it is cost effective. Further, Small et al. (2016) states groups have the added benefit of social support which is an important and often overlooked aspect of improving mental health. In their study, they also found improvements in the mental health of refugee participants. Members of a psychoeducation group showed improvements in anxiety, somatization and posttraumatic stress (Small et al., 2016).

Four of the research studies discussed groups are being used with refugee children in school-based mental health programs. (Beechler et al., 2011; Birman et al., 2008; Dutton, 2012; Kaczorowki et al., 2011). Two school-based programs used skills groups to discuss acculturation and the impacts of moving to a new country has on one's emotional health (Beechler et al., 2011; Kaczorowki et al., 2011). Although neither of these articles measured the effectiveness of the groups, researchers discussed such groups normalize and validate the experiences the children are having and increase hope. Beechler et al. (2011) also reported the use of cognitive behavioral therapy, a well-researched evidence-based intervention, being used at times within the group setting to teach refugee children about the cognitive model and coping skills to deal with the adjustment to life in America.

Non-Verbal Therapy. Five articles report that non-verbal and non-talk therapies are also being used across many different mental health service delivery models for both adults and children (Birman et al., 2008; De Santana & Neto, 2015; Derges & Henderson, 2003; Dutton, 2012; Ying, 2001). De Santana and Neto (2015) report art therapy is being utilized with refugees. They suggest one advantage of art therapy is that it allows for the expression of feelings for

refugees despite the language barrier. Degres and Henderson (2003) reported on a day treatment program in the United Kingdom serving refugees; they state using art, music, sculpting, recreational and domestic activities in the beginning stages of working with refugees helps build the therapeutic relationship and establish trust. After a while once trust had been established participants began to talk of their past suffering, sometimes taking three years or more. A member of the program discussed her experience with an art therapist.

Slowly, slowly try it in little bits, feel more comfortable...all the things came out...(art therapist) good listener, understand my problem. 'I know a lot of things happen to you' she make me feel free' I want someone to know my pain. I feel good someone understand, advise, and hope that I'll get better (p. 94).

Ying (2001) discussed the use of touch with her refugee clients. Although Western mental health professionals are often fearful of violating ethical principles and to not touch clients, touch is a healing method common in many cultures. Ying (2001) discusses using touch only with her female clients, but it has a powerful impact and does not require an interpreter. She described a client suffering from severe headaches started to make eye contact with her after she gently massaged her shoulders. Ying taught her client and her client's husband how to continue this practice at home. This same client made quick progress in only a two month period. She started to reengage with her child. Learning to sooth herself allowed her to do the same for her daughter (Ying, 2001).

Dutton (2012) also shows utilizing activities that are familiar and meaningful to refugees such as horticulture, music, storytelling, and sports have a substantial therapeutic impact. Many refugees were farmers before resettling; therefore, gardening can be a way to help

them connect their past and stay hopeful about the future. Ying (2001) reported on a client who self-reported he had fewer nightmares and slept better while attending to his plant.

Social Needs. The discussion of meeting the social needs simultaneously or before meeting the psychological needs of refugees was a large theme throughout nearly all the literature. Nine of the fourteen articles discussed in addition to providing psychological support, service delivery models need to provide social support by providing case management and care coordination to help refugees address their social concerns such as unemployment, lack of housing and help with navigating many new systems. (Beehler et al., Behnia, 2003; Dutton, 2012; Gashaw-Grant, 2004; Jozaghi et al., 2016; Kaczorowski et al., 2011; Le Roch, Pons, Squire, Anthoine-Milhomme & Collious, 2010 Mitschke et al., 2016; Small et al., 2016; Ying, 2001).

Le Roch et al., 2010 studied two mental health service delivery models in Jordan and Lebanon. They concluded Iraqi refugees sought services offered not due to concerns over their psychological distress but rather to meet unmet social needs. Participants often perceived their difficulties were social causes and physical health issues rather than psychological concerns. Le Roch et al. (2010) found a psychosocial approach had a greater impact on participant functioning over a purely psychological approach. They stated, “*A two-level intervention for a psychosocial comprehensive approach seems to lead to greater impact. It interweaves the individual into a the collective resources and recovery that are multifaceted and complex.*”(p.117).

Beehler et al. (2012) found similar results among youth. Service coordination and case management contributed to student’s improvements within a school-based mental health service programs. In their quantitative study, greater quantities of service coordination and case management reduced PTSD symptoms.

These researchers inform us the value psychosocial approaches to treatment. Researches state that refugees they interviewed preferred social support. Behnia (2004) found past torture and war trauma survivors indicated their current stressful life conditions were of more concern to study participants instead of their past trauma. Participants wanted practical help over traditional Western mental health services. One war trauma survivor of the study described their experience seeking therapy.

I talked to a counselor...about my sufferance caused by being separated from my wife and daughter and told her I needed help. I needed money to sponsor my wife and child... Counselor told me that she understood me and was sorry for my situation [but she couldn't help me]. I got angry with her because she was there only to talk. I know she could not provide me money but she could direct me to government agencies to receive help. She knows the system...I did not go back to that worker because I needed her help to find money (p. 13).

Further, care coordination and case management are also used to help overcome the access barriers many refugee families face when trying to access mental health and mainstream services. Kaczorowski et al. (2011) and Gashaw-Grant (2004) found for professionals to work with refugee communities, they must be willing to assist with transportation, help with overcoming language barriers, read mail, and help refugees navigate the many systems they are interacting with.

Spiritual Needs. Only three of the fourteen articles discussed meeting the spiritual needs of refugees. Therefore, overall the literature lacked the discussion about how mental health service delivery models are meeting the spiritual needs of refugees. However, all three discussed the importance of doing so since religious meaning is often how many cultures make sense of

mental health concerns and are treated through religious rituals (Gashaw- Grant, 2004 & Jozaghi, Asadullah & Dahya, 2016; Kirmayer et al., 2003). Of the three articles one theme emerged; to help address the spiritual needs of refugees it is important to collaborate with community religious leaders. Gashaw-Grant (2004) conducted interviews with both program participants and outside professional partners who work in collaboration with an East African mental health program. Gashw-Grant (2004) interviewed Aba, a religious leader of the Coptic Orthodox Religion. He stated his role with program participants.

The project is vital for the community. I did not know that religion and counseling were intertwined. Religion has a healing effect and provides treatment for mental illness. The Project works with me closely to provide healing for individuals who need healing services. They help participants young or old to reconnect with their belief system.

Working on cases with the project has helped me to understand the Western system of help. We cohesively attend the sick and counsel marriage disputes (p.84).

Similarly, this was true within the Islamic faith as well. An Imam from a local mosque working with the program was also interviewed on his role by Gashaw-Grant (2004). He stated,

I am proud of the project for integrating religion with treatment. This is the first project that has truly served the community. Religion has a healing effect and provides treatment for mental illness. The Project works with me closely to provide healing for individuals who need healing services. They help participants young or old reconnect with their belief systems. That provides who to the participants,' which is very important to the well-being of an individual. A project that respects religion and works with religion is good for the community (p. 84).

In a more recent study Jozaghi et al. (2016) researched a Muslim faith-based program for people of the Islamic faith who suffer from mental health concerns and addiction problems in Canada. Jozaghi et al. (2016) discuss some Imams may view psychiatry to be anti-religious and fear therapists may undermine client's beliefs. One mental health professional volunteer of the program discussed how this faith-based program has helped destigmatize mental health and provide more culture sensitive care. By incorporating faith, Mosques have even started to contact the program to learn more and to refer individuals.

Discussion

This systematic review was conducted to determine how mental health service delivery models are meeting the bio-psycho-social-spiritual needs of refugees. This study was conducted in a systematic way using inclusion and exclusion criteria to gather research on this topic systematically. While conducting the systematic search, it became evident there is a lack of literature, in general, discussing mental health service delivery models for refugees. The bio-psycho-social-spiritual assessment has long been used by social workers to determine a whole person's needs. It is through this assessment social workers can gain an understanding of one's ecological system which in turn guides appropriate intervention. Researchers Kira and Tummala (2015) discuss this is particularly the case for refugees. They conclude it is vital for clinicians to adopt an ecological model of recovery with an understanding of the sociopolitical and cultural context of refugees past and present experience to treat the whole person. Therefore, mental health service delivery models serving refugees need to consider an integrated approach to treatment rather than purely a psychological approach.

Using the bio-psycho-social-spiritual framework the research aim was to understand how mental health service delivery models are meeting the vast needs of refugees. Only one mental

health service delivery model, project ESSEA a community mental health clinic in San Diego CA, discussed meeting all of those domains. Most of the articles in this study only addressed the psycho-social needs of refugees leaving out the biological and spiritual needs.

As stated above, little was discussed in the literature on spiritual and biological needs. Of the fourteen articles included in the study, there is little research on meeting the biological and spiritual needs of refugees as part of mental health treatment. However, of the articles that did discuss meeting biological needs, there was an underlying theme of the importance of doing so since many cultures do not make a distinction between the mind and the body. Researcher Yu-Wen Ying (2001) discussed the issue of her patients coming from cultures where Western concepts of mental health distress do not exist. Therefore, many cultures first seek medical care for psychological distress presenting in the form of somatization. Culture clashes can exist when a provider and refugee perceive their condition different and only western psychological treatment is given. Project ESSEA in San Diego acknowledges this difference in understanding; therefore, they support clients by encouraging them to continue their cultural, traditional ways of healing while providing medical case management services and education to bridge the cultural divide between both the patient and the provider (Gashaw-Grant, 2004).

Similarly, although there was a lack of literature discussing how mental health service delivery models are meeting the spiritual need, the research indicated the importance of doing so since religious meaning is often how many cultures make sense of mental illness. Therefore, in many cultures, mental health is often treated through religious rituals. Of the limited literature discussing how service delivery models do meet the spiritual needs, one theme emerged; to help address the spiritual needs of refugees it is important to collaborate with community religious leaders. Jozaghi et al. (2016) discuss some Imans view psychiatry to be anti-religious and fear

therapists may undermine client's beliefs. There is often a misconception that treatment must be either religious or take a Western psychological approach instead of the blending of the two. Project ESSEA in California works with religious leaders and refers individuals to religious healing practices honoring that religion does, in fact, have a healing effect. Further, a harm reduction program in Canada is taking a Muslim faith-based approach. This culturally sensitive approach has been more accepted among the community as well as help with destigmatizing mental illness.

From what the literature tells us, service delivery models are failing to address the biological and spiritual needs of refugees. Failing to meet these aspects of a refugees' lives is a disservice to these populations. The literature informs us refugees seek religious and medical care when mental health concerns arise, failure to understand this help-seeking behavior may contribute to the underutilization of Western mental health services by refugee populations. Further, not considering these domains as part of treatment shows a lack of cultural sensitivity. Addressing these concerns should not solely lie in the hands of individual providers, but mental health service delivery programs need to consider overall service delivery programming to meet these areas of a refugee's life. An integration of the western biomedical model and traditional cultural healing practices would provide a more holistic approach and better adequately serve refugees.

Although little was discussed on addressing the biological and spiritual needs of refugees, more was discussed in the literature on how service delivery models are addressing the psychosocial needs. Three themes emerged from the literature for meeting the psychological need. 1. The importance of building trust 2. Group work is being utilized across different mental health

service delivery models for both adults and children. 3. Non-verbal therapeutic interventions are also being used across mental health service delivery models for both adults and children.

Building trust with refugees is the first and foremost important factor in working with refugees. Although this applies to any population, this is particularly the case for refugee's populations since literature indicates the severe lack of trust many have with service providers. Traditional western mental health services begin typically with a diagnostic assessment which asks an individual to discuss openly many aspects of their life. For refugee's their past circumstances have taught them to be cautious who they talked to, limit what they say to others, and to hide their emotions. To help overcome this mistrust barrier nearly all discussed employing individuals from the communities they are serving. Hiring ethnic workers as interpreters, cultural brokers, and community liaisons to help create a sense of safety and trust in the service delivery.

In addition to building trust, two therapeutic intervention themes emerged; group work and non-verbal therapies are being used with both children and adult refugee clients across a variety of service delivery models. Refugee communities typically tend to be collective societies. Therefore, group work can be seen as a culturally appropriate intervention that builds on the collective community strength refugee communities possess. The literature also discussed group work in the form of a skills based group teaching basic life skills such as financial literacy and topics that related to acculturation and adjustment were valued by refugee participants. Non-verbal therapies such art therapy, horticulture, music, storytelling, and sports are being utilized stating these interventions still allow for the expression of emotion but can be used to strengthen the therapeutic alliance by building trust. Talk therapy is a foreign concept to many refugees, these interventions are familiar culturally and require less language, therefore, decreasing the language barrier.

The overall theme that emerged from the literature regarding meeting the social needs is a psycho-social approach is needed. Nearly all the literature discussed how the social needs of refugees must be met simultaneously or before addressing the psychological needs due to an overwhelming amount of social concerns refugee families face. Often access barriers such as transportation, language, and lack of knowledge on navigating systems prevent refugees from seeking or continuing services. The literature discussed refugees seek help for social needs over psychological needs and tangible help with stable and affordable housing, employment, and basic tasks such as help with reading mail are wanted over addressing their past psychological trauma.

Overall the literature follows much of what Maslow's theory on hierarchy of needs tells us. Refugees in the United States have a complex history of experiencing and witnessing war trauma and face many challenges here in the United States with the acculturation process being much harder than expected. Maslow discusses the importance of meeting basic needs before moving into the psychological needs. From the literature presented, meeting both the social needs as well as building trust was necessary and preferred by refugees. Most mental health service delivery models addressed these needs discussing the importance of housing, employment, and basic life skills as part of their treatment. Further, the literature indicated the need to build trust before any treatment can begin. This trust is being established through the hiring of ethnic workers from the communities they serve. Hiring ethnic workers not only helps build trust with the program but helps with other access barriers such as language and cultural misunderstandings.

Once basic needs are met, and refugees feel safe, one can start addressing the psychological needs. The literature discusses group work and non-verbal therapy are being used

with refugees. Group work can be seen as a way Maslow would describe as tier three, need to feel belonging. Not only can group work help with a feeling of belonging, but it can help normalize and validate the refugee experience. Further, a group approach aligns with a community strength many refugee communities possess, a collective community. Non-verbal therapies help eliminate the need for talk therapy allowing refugees to express emotions often too difficult to discuss. Art therapies and gardening can give a person a sense of accomplishment and provide forward future thinking which is often hard for refugees to do when having to live in a survival mode state constantly.

Religion is often how people make meaning of adversity, provides a sense of belonging and is often used to treat mental illness. Therefore, it should not be ignored as part of treatment. Programming that also understands traditional ways of healing as well bridges the cultural divide between practitioner and provider is a way to integrate mental health care and primary care better. Therefore, biological needs and spiritual needs should not be ignored when providing mental health care to refugees. Providing a more holistic approach addressing the bio-psycho-social and spiritual needs may help mitigate the underutilization of mental health service by refugees.

Limitations

While this review attempted to look at how different mental health service delivery models are meeting the mental health needs of refugees by using the bio-psycho-social-spiritual framework, limitations of the study arose. First, although the articles discussed how a particular mental health service delivery model meets the mental health needs of refugees, only two articles attempted to evaluate its programs effectiveness. Therefore, although consistent themes were found conducting this systematic review, overall the articles selected for review lack empirical

evidence supporting their true effectiveness of the interventions being provided to their refugee clients.

As a practitioner, we are required to conduct evidence-based practices. Although evidence-based practices exist, often participants of those studies did not include those from non-western cultures. Therefore, one must consider if these best practices can also be utilized with refugees due to cultural differences. While refugees have been resettled in the United States for decades, only recently research to explore and address the mental health of refugees has become a topic. Thus, one of the significant limitations of this study is the small sample size of the review.

Also, although it was included in the inclusion criteria for this study, no research was found on solely a traditional service delivery model for refugees. Little is known in the literature on how refugee communities are addressing mental health concerns outside of the western mental health service systems.

Further Research and Implications

As discussed, while conducting this systematic literature review, overall there is a lack of research on providing mental health services to refugees. Research tells us refugees have higher rates of many western mental health diagnoses due to the trauma faced while becoming forcibly displaced and the difficulty of acculturation. Further, research also indicates underutilization of Western mental health services exists for this population, but little has been researched on evidence-based practices mental health practitioners and service delivery models are using to treat the mental health concerns of refugees. It is necessary to conduct research specifically with this population to understand what interventions are being proven effective and culturally sensitive. Additionally, further research documenting how programs are funded is needed to

better understand how services for refugees can be paid for outside of a third-party billing system.

Prior research, as well as the finding in this systematic review, point out many unmet social needs contributing to the psychological stress refugees face. Social workers need to be aware of these needs as well as both local and national policy issues as it relates to housing, employment, access barriers, and the overwhelming learning curve many refugees face when first arriving in America. Ensuring safe and affordable housing, economic security and providing more cultural orientation are proactive ways to decrease psychological stress among refugees. Further, social workers need to understand help-seeking behavior and traditional modes of healing to provide culturally sensitive services adequately. Better collaboration with leaders in the community as well as religious leaders not only helps address cultural misunderstandings but builds trust and helps destigmatize mental health.

An ecological approach and an understanding of the refugee experience is vital for social workers working with refugees. This should not only be done by each practitioner, but rather service delivery models need to provide culturally sensitive interventions that consider a holistic approach to a person that address bio-psycho-social-spiritual needs as part of treatment.

Conclusion

The increasing presence of refugee populations in the United States requires social workers to understand better the unique challenges and barriers refugees face. The literature indicates most programs are addressing the psycho and social needs through culturally appropriate interventions in the form of group work and non-verbal therapies as well as case management services. However, little has been documented on how spiritual needs and biological needs are being met to serve the whole person better.

Service delivery models need to consider how to modify programming to help refugee populations better to address the bio-psycho-social and spiritual needs of refugees with attention paid to refugees' belief systems rather than solely Western values and concepts of mental health.

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