Kentucky Statewide Refugee Mental Health Needs Assessment: Provider Perspectives

Technical Report

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Executive Summary

This needs assessment sought to inform the development and implementation of mental health program goals, scope of services, and activities for the Kentucky Office of Refugees (KOR) by gathering the perspectives of service providers about refugee mental health needs in Kentucky. Ten Focus groups were conducted between October and December 2022 to gather input from stakeholders in mental health provider organizations, refugee resettlement agencies, community organization serving refugees across the state, particularly those in Louisville, Lexington, Bowling Green, and Owensboro. Four areas of need were identified through the focus group interviews.

Mental Health Needs of Refugees. *S*everal factors figure into persistent unmet mental health needs of refugees and accessing and using mental health services challenging. These include lack of or limited provider cross-cultural knowledge and understanding of refugees' perspectives on mental health, interpreter training needs in mental health literacy that enhances refugee understanding of mental health services, and payer source (ability to pay or insurance coverage).

Workforce Needs to Support Mental Health of Refugees. Capacity building and training to support mental health of refugees were identified as major workforce needs. Training needs identified focused on knowledge (i.e., cultural competency) and skills acquisition (i.e., crisis management) while capacity building emphasized increasing the number (i.e., staff) and strengthening the workforce (i.e., with volunteers, and interpreters) providing services to refugees. More specifically:

Infrastructure Needs to Support Refugee Mental Health. To strengthen the overall infrastructure to support refugee mental health, emphasis on improving mental health care coordination and partnerships, addressing gaps in technology literacy, increasing visibility of and accessibility to language and interpreter services, changing policies, innovating programming, and cultivating allies were identified as needs to be met. More specifically, the identified needs are to:

Needs and Perspectives on the Refugee Health Screener-15 (RHS-15) to Support Refugee Mental Health. The Refugee Health Screener-15 (RHS-15) (Hollifield et al., 2013; Hollifield et al., 2016), is extremely helpful in normalizing mental health needs. However, its use can be challenging due to where, who, how, and what resources are available for its administration.

Introduction

Kentucky ranks 4th per capita in refugee arrivals (325 refugee arrivals per 100,000 state population) in the United States[1]. The major resettlement regions for refugees in the state are Metro Louisville (most populous with 1.4 million people), Lexington (2nd most populous with 325,330 people), and Bowling Green (the 3rd -most populous city with a population of 76, 273) with recent trend of increased number of resettlements taking place in Owensboro (north of Bowling Green, with a population of 61,289) and Covington (north of Lexington, with a population of 40,101)[2]. Kentucky is home to three major refugee resettlement agencies (Catholic Charities, Kentucky Refugee Ministries, and International Center) with five offices (Louisville, Lexington, Bowling Green, Owensboro, Covington) across the state. Since 1994, over 30,800 refugees have been resettled in Kentucky, many of whom were initially resettled in another state.

Refugees resettled in Kentucky are from countries with ongoing significant social, political and/or economic strife. These countries include but are not limited to the Democratic Republic of Congo, Burma/Myanmar, Burundi, Somalia, Cuba, Ukraine, Afghanistan, Syria, Eritrea, Iraq, Bosnia, and countries in Latin American. They often arrive in Kentucky traumatized having been subjected horrific events including war crimes and torture. They suffer from or are at risk for a whole host of physical (i.e., diabetes, high blood pressure and heart disease, chronic pain) and mental health problems (i.e.,PTSD, major depression, severe anxiety, generalized anxiety disorder). They require assistance with housing, transportation, education resources/services, food, clothing, medical care coordination, federal/state benefits, socialization activities, interpretation/ translation, and immigration/ citizenship (N-648 waiver) applications. Furthermore, they are vulnerable to resettlement and acculturation stressors which can result in displacement trauma, limited access to formal and non-formal supports, social and economic stress, poor family communication and intergenerational conflict.

Connecting to health and mental health services is often a long process for newly arrived refugees. Underlying physical and mental health needs are often not detected or addressed at initial health screenings. Health and mental health problems can and do impact resettlement and integration into the community. Various post-migration factors--

[1]https://immresearch.org/publications/refugee-resettlement-per-capita-which-states-do-the-most/

[2] https://worldpopulationreview.com/us-cities

socioeconomic and interpersonal difficulties as well as resettlement stressors- affect mental health in refugees. And, together with past trauma exposure such as war trauma and torture, they may interact to negatively impact mental health and well-being. For example, temporary visa status or discrimination may restrict an individual's employment opportunities, and this may affect a refugee's ability to find stable affordable housing, lack of which may then result in greater social isolation[3] and mental health distress.

Many refugees have experienced extremely stressful events due to war, migration, and resettlement resulting in a significant minority suffering from diagnostic-level psychiatric disorders (Hollifield et al., 2013). Displacement leaves lasting physical, emotional, social, and psychological residues that exacerbate health and mental health issues, impeding resettlement in a new country (Kantor et al., 2017; Hilado &Lundy, 2018). Despite growing evidence for disparities in mental health care access, there is limited knowledge on the specific mental health needs of refugees in general, and in Kentucky, in particular.

Purpose of Needs Assessment

This statewide needs assessment was conducted to inform the Kentucky Office of Refugees (KOR) in its planning and setting of mental health program goals, scope of services, and activities as required in the ORR's Refugee Mental Health Initiative within the Health Promotion Program Policy Letter 22-06 (P.L. 22-06). It gathered information from community partners providing services to refugees. Based on the needs areas sought information on in the Health Promotion Program Policy Letter 22-06 (P.L. 22-06), we asked providers to identify the refugee population(s) in need of mental health services, mental health literacy and mental health care needs of refugees, as well as what is needed to successfully organize wellness groups, enhance equity and inclusion, and conduct mental health screenings. Therefore, the aims and objectives were to: A) To identify the mental health needs of newly arrived and already resettled refugees in Kentucky, and B) To explore the experiences of providers using the Refugee Health Screener-15 (RHS-15) in refugee mental health screenings.

Methodology

This community needs assessment employed case study (Baxter & Jack, 2008) with focus group methodology with mental health provider organizations, refugee resettlement agencies, and community organization serving refugees. Focus groups took place in four

[3] https://link.springer.com/article/10.1007/s11920-016-0723-0

locations including Louisville, Lexington, Bowling Green, and Owensboro. The study team implemented a two-phase participant enrollment process. In Phase One, through Kentucky Office of Refugees' (KOR) invitation (see below under recruitment), providers were recruited to participate by providing informed consent and completing a screening questionnaire (Appendix A). In Phase Two, participants who met eligibility criteria via screening questionnaire (see under Sampling and Inclusion Criteria), were invited to participate in a focus group interview (Appendix B).

Recruitment

Purposive, convenience, and snowball sampling were used to recruit participants for the needs assessment using specific inclusion and exclusion criteria. KOR led the recruitment efforts and referred participants for the focus groups. Potential participants, once identified, were also encouraged to refer other individuals/ organizations potentially eligible for focus group participation.

Refugee Serving Organizations from which Focus Group Participants were Recruited		
Mental Health Organizations	Refugee Resettlement Agencies	Community Organizations
○ KY STEPS - Bowling Green ○ Survivors of Torture Recovery Center (STRC) in Bowling Green ○ Refugee Mental Health Alliance (Louisville) *	○ International Center – Bowling Green ○ International Center – Owensboro ○ Kentucky Refugee Ministries – Lexington	○ Community Action of Southern Kentucky – Bowling Green ○ Green River District Health Department – Owensboro ○ Bluegrass Community Health Center – Lexington

*Note: Service provider representatives from refugee and immigrant-serving organizations in Jefferson County, including, Kentucky Refugee Ministries, Catholic Charities, Family Health Centers, Americana Community Center, and Seven Counties Services.

Participant Selection and Inclusion criteria

Potential participants were screened using the following inclusion criteria:

- 18 years of age or older and speak, read, and write English
- Current refugee services provider, service administrator, and/or key stakeholders[4].

[4] This includes direct refugee services providers; providers who screen, assess, and provide treatment for refugee mental health, social, educational needs; providers who use the RHS15 to conduct health and mental health screenings; refugee community leaders; community health workers; and case managers.

Informed consent

This needs assessment study was reviewed and approved by the University of Louisville IRB. All recruited participants were provided with an unsigned preamble consent form asked to read it. A member of the research team reviewed the study procedures as outlined in the informed consent form with the recruited participants (Appendix A). Recruited participants were informed that by giving their verbal consent and completing the demographic questionnaire, they were consenting to participate in the study which involved participating in an in-person or online interview or focus group. Research team members sought informed consent from those meeting the inclusion criteria. Those participants agreeing to participate then completed a brief demographic questionnaire prior to start of the focus group interview.

Data collection

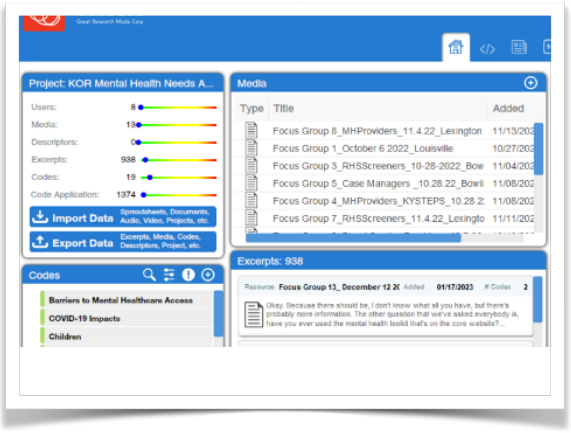
Screening and Demographic Questionnaire. A total of n = 49 providers completed the screening and demographic questionnaire which was completed in person at the various recruitment sites throughout the state. Demographic questions include items such as the respondent's age, gender, race ethnicity, education level, length of employment and current job title (Appendix B).

Focus groups. A total of n=48 providers met the screening criteria and participated in the focus groups. They consisted of refugee resettlement workers (n = 24), mental health providers (n = 11), direct service providers (n = 7), healthcare workers (n = 3), and program directors (n = 3). Ten focus groups, each lasting up to two hours, were conducted in a private room at a mental health, resettlement, or at a community agency. Topics included obstacles to mental health care access for refugees, use of mental health screening tools, barriers to equity and inclusion for different groups, impact of COVID-19, access to technology, pre-migration and post-migration resettlement stressors, among other topics (see Appendix C).

Data Analysis

Quantitative Data Analysis. Descriptive statistics (frequency, mean, range) were performed on the collected demographic data using SPSS, v.26 to describe the focus group participants.

Qualitative Data Analysis. Interviews were transcribed by a professional service (REV.com), and all identifying information was removed prior to engaging in the analysis of the data. The analysis (Merriam, 2015) aimed to describe participants' experiences and perspectives related to refugees' and community needs. The analysis consisted of research team members coding line by line half of the transcribed focus group interviews. Then, these first



cycle codes were clustered by topic to develop the second cycle thematic codes. The most frequent and significant thematic codes were used to construct a codebook containing 19 codes with definitions (Appendix D). Dedoose™ (Version 9.0.17, 2021), a web-based qualitative data analysis platform, was used to facilitate data organization and coding (Sociocultural Research Consultants, 2021). The codebook was uploaded onto Dedoose, and Dedoose's coding functions were used to code fifty percent of the interview transcripts. The finalized codebook was based on iterative discussions of interview transcripts (Hsieh & Shannon, 2005; Joffe & Yardley, 2004). Next, inter-rater reliability tests were performed using the other research team members' coded transcripts to ensure that agreement was reached among coders. After obtaining a pooled Cohen's kappa statistic of 85% (Cohen, 1960), the coders met as a team to discuss and adjudicate each excerpt where the researchers did not obtain an agreement. Cohen's kappa statistic is a widely used measure to evaluate intercoder agreement as compared to the rate of agreement expected by chance. According to Landis and Koch (1977), the Kappa statistic achieved by the researchers is considered 'excellent agreement.' After the adjudication process was complete and reached 100% agreement, the remaining interview transcripts were coded. Next, a thematic analysis was conducted on the coded transcripts, iteratively refining themes until reaching a consensus. Research team members maintained memos related to analytic decisions, consulted with other team members, and discussed the relationships among codes that emerged from the data (Charmaz, 2014; Strauss & Corbin, 2015).

Results

Description of Focus Group Participants

Forty-eight people participated in the focus groups. The focus group participants were primarily women, White, and on average are nearing 40 years of age (mean age: 39.06; SD=11.826). Half of them were resettlement workers while the other half were mental health care providers, direct service workers, healthcare workers, or program directors. Almost all of them (89.5%) had earned either a graduate (Masters, JD, or PhD) or undergraduate (Bachelors or Associate) degree. Their length of employment at their respective agencies ranged from 3 months to 38 years with an average of 7.59 (SD= 8.78) years (see Table 1).

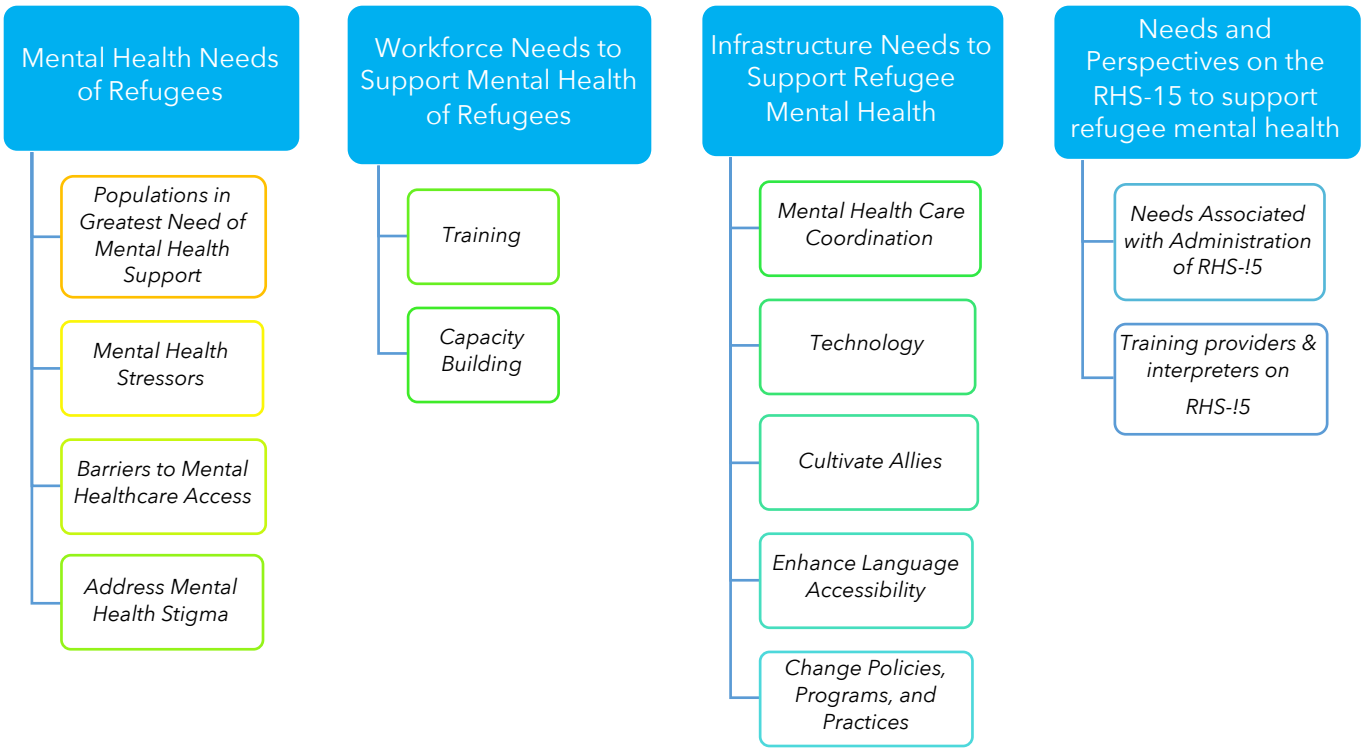
Table 1. Demographic Characteristics of Focus Group Participants (n=48)

Characteristic			n	%
Gender (n=48)	Female		33	67.3
	Male		14	28.6
	Not Stated		1	2.0
Race (n=48)	White/Non-Hispanic		31	63.3
	Black/African American		12	24.5
	Hispanic		3	6.1
	Not Stated		2	4.1
Highest Degree Earned (n=48)	High School Graduate		1	2.0
	Bachelors		20	40.8
	Masters		20	40.8
	Doctorate		4	8.2
	Associate degree		1	2.0
	Not Stated		3	6.1
Role/Position(n=48)	Refugee Resettlement Worker		24	50.0
	Mental Health Care Provider		11	23.0
	Direct Service Provider		7	15
	Health Care Provider		3	6
	Program Director		3	6
Age (n=48)	Mean: 39.06	SD= 11.826	Range =23 years- 60 years	
Length of Employment (n=36)	Mean: 8.28 years	SD= 9.01	Range = 3 months to 38 years	

Findings from Focus Group Interviews

The thematic analysis yielded thirteen needs which were then categorized into four need areas: (I) Mental Health Needs of Refugees, (II) Workforce Needs to Support Mental Health of Refugees, (III) Infrastructure Needs to Support Refugee Mental Health and (IV) Needs and Perspectives on the Refugee Health Screener-15 to support refugee mental health (See Figure 1)

Figure 1: Refugee Mental Health Need Areas



I. Mental Health Needs of Refugees

Populations in Greatest Need of Mental Health Support. Focus group participants reported that the most recent and currently arriving refugees, specifically Afghani, Ukrainian, and Congolese populations were in most need of support. They are reported to be experiencing a range of stressors in resettlement as they are having to contend with changes in their role, changes in power dynamics, and experiencing isolation, and loss of extended family and social system supports. This is compounded at times by ongoing family tensions and family conflict which may have originated pre-transit, during transit, and is most visible now in resettlement. Both women and men need mental health support, particularly women at home caregiving for children and men who often go unnoticed because they are not vocal about their needs. Persons with serious health issues and manifesting symptoms of past traumatic experiences were specifically mentioned as having the greatest need of mental health support.

> *"Specifically, Afghan population and Ukrainian population have very recent traumas with just war and separating from families when they escape Afghanistan or Ukraine, leaving behind and some not even knowing where their family is or if they're alive".*

Mental Health Stressors. Providers were asked about the pre-migration and post-resettlement challenges and stressors and challenges contributing to newly arrived refugees' distress. Participants identified the stressors to be arising from pressures of a) acculturation and/or b) family circumstances that were impacted by the acculturation process. Financial-related issues, securing employment, paying household bills, finding childcare, and experience of socioeconomic inequity were notable mentions. Challenges and distress faced by refugees in accessing language or interpreter services was ever present and were even more significant when trying to access services for serious mental health issues. These and other mental health stressors are stated to be significant issues for refugee clients, indicating a need for programmatic support.

Barriers to Mental Healthcare Access and Use. Major system barriers/challenges identified were provider expertise, language/ interpretation, payment issues (cost/ Medicaid/ insurance), existing service availability and delivery system. Overall participants mentioned limited provider expertise, either noting that providers were limited in expertise in working with refugee clients or limited in cross-cultural knowledge and treatment expertise, which impacted their ability to provide mental health care that is best practice and culturally responsive. Relatedly, it was shared that not all providers who have the expertise accept the insurance payment method (Medicaid) that refugees are covered under in Kentucky, making access and timely appropriate referrals are a challenge.

"It's one thing to be poor and struggling in a refugee camp where everyone around you is poor and struggling, and it is another thing to get to the United States and be poor and struggling and then see what the United States could be. And there is this difference there that I think is a big stressor for clients. And then when they have children that are going to school with other kids that are having these really different life experiences, I think there's a lot of stress there."

"The model of healthcare we have currently is not conducive to really meeting the needs of clients that truly have the risk factors. So I think a lot of what our refugee population needs is they need to build that trust with you and you're not going to do that in 15 minutes. So if you can really sit down and take 45 minutes with an interpreter to really build that relationship, you're going to do a lot more good for them. But it's just sad that our healthcare system doesn't allow that. It's very task oriented and it's about reimbursement and I mean I could go on but I won't."

When refugees are able to get the mental health care, they often face some sort of language barrier such as 1) no interpreter, 2) lack of providers who are bilingual and/or willing to see a client who is not fluent in English, and 3) interpreters who are not able to translate the mental health concern and lack training on how to convey mental health concerns (in a non-stigmatizing way), as they only have received medical interpreter training. Additionally, some mental health providers who are able to provide mental health care find themselves providing case management and other

services rather than therapy because the client does not have their basic needs met. Without addressing basic needs, mental health therapists find that the client is not able to focus on their mental health issues and fully participate in treatment. This is compounded by the lack of other existing service delivery systems operating in a manner that is understanding of the refugee lived experience (i.e., trauma).

"And if everyone around you has the same symptoms, maybe you don't see it as being a mental health issue. If everyone around you has trouble sleeping because they're having flashbacks to these events that have happened, then it's normalized in the community. And so maybe it doesn't register as being a problem".

Participants identified different aspects of mental health literacy[5] that hindered or facilitated the mental health services provided to and received by refugees. Participants spoke about the need for refugee clients to increase their knowledge and education to bridge the gap in their knowledge of mental illness and mental health services. They noted that there is a distinct difference made between service providers and some refugees on what is considered mental illness. This is a challenge when making referrals and recommendations for treatment. Some refugees are not in agreement with Western notions of mental health distress, mental illness, or what to do about such problems and issues. It is difficult for them to accept mental illness as a possible explanation for mental health symptoms and behaviors they experience because they also observe them to be common in their immediate and extend family members, friends, and community members. Similarly, symptoms are coped with as opposed to dealt with as they are not perceived as not being any worse compared to past experiences of these symptoms (which are often dealt with by relying on

"Some people they're not comfortable with some things that we do because of they have their own religion and culture that we don't have to intervene. It's just like we have to respect that. At the same time it can be a little bit gap for us to deliver the service because you don't want to anger them and intervene their religion and culture and then you... You doing a positive thing helping them. But at the same time they might think that you are enforcing something that can harm their religion and cultures is also another barrier."

"Their willingness to actually go through and do it. A lot of them never heard what therapy or mental health, that kind of stuff is before and just maybe their lack of knowledge and understanding of what it is, how the process goes and how it will help them I think is a big issue."

[5]Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking. (p. 182, Jorm et al., 1997)

cultural practices). Consequently, this hinders service-seeking resulting in reduced perceived need or urgency to seek treatment.

Limited or lack of mental health literacy was identified as a factor in refugees' social isolation as well as lack of willingness to receive mental health treatment. Reaching refugees who needed mental health services was made more difficult as a result. Participants mentioned engaging with refugees at their medical appointment locations or at their children's schools to check-in and identify their mental health needs and provide support and services.

Mental Health Stigma. Participants also noted that taboo/stigma associated with mental illness is a barrier and becomes a challenge recognizing, accepting, and addressing mental health problems and concerns. Often professionals' efforts are thwarted by culture "bumps", where cultural rules/protocols/ gender role expectations, etc. dictate behaviors and actions that impede the ability of refugees to access mental health care services. Overall, participants responses indicated that mental health stigma is pervasive. It is a factor, if not the major factor, underlying the barriers and challenges faced in the mental health care of refugees. Mental health stigma was a consistent hurdle to overcome when addressing mental health/ mental illness in the cross-cultural context. In some cultures, it was stated, no one wants to acknowledge mental illness or talk about it, so far as to not have specific words to name it or refer to it. In other cultures, mental health/ mental illness is acknowledged, but is equated with terms such as "crazy", "mad", and so bringing it up is taken to imply dishonoring and bringing shame to the individual and his /her family.

> *No one wants to talk about mental health. It's very stigmatized. It would be insulting. It was almost like it would be an insult to the client if we referred them to you.*

II. Workforce Needs to Support Mental Health of Refugees

Participants identified the need for increased training in cultural competency, intervention strategies, and identifying and responding to mental health concerns. Participants also identified training ideas for interpreters and refugees and the need to build the professional capacity of individuals and community members with lived experience to become mental health providers.

Training. Participants from all regions of the state identified the need for increased cultural competency training. Cultural competency was mentioned as a significant need in some form for all staff and agencies (i.e., resettlement staff, mental health care providers,

healthcare providers, community-based service staff, and law enforcement) who interface with refugees. Some participants also spoke about the need for training for traditional mental health providers to bridge their knowledge gap of various refugee cultural groups and refugee cultural groups' views of mental illness and receptivity to mental health services. This stemmed from observations of some of the discrepancies in understanding displayed by traditional mental health providers about refugee mental health. One such example provided was the lack of knowledge and understanding of cultural differences between refugee groups and how different refugee groups understand and manage their mental health. Training topics requested include language access (e.g., the use of interpreters), multicultural education, and understanding the refugee experience.

"Afghans and, or Congolese, both share in that. Specifically, the Afghans, I think more so, because of the trauma that they incurred, being in the heart of a war zone and not having a lot of services at the time offered to be able to really assist with that. I think there's a really great need because of the fact that this is unprecedented for many of our mental health services here. We've heard from several different therapists and providers that they just don't understand the type of trauma that these individuals have been through firsthand. So, they don't know how to address that in accordance with knowing the cultural background, how they feel about it and how they would normally handle things".

Furthermore, participants indicated that resettlement workers and mental healthcare providers would benefit from training focused on specific intervention strategies and skills to support refugee mental health. Topics suggested include training on adapting motivational interviewing, and trauma-informed care strategies. Along the same lines, skills trainings on crisis management, mandatory reporting ,as well as identifying and responding to mental health issues were highlighted that would benefit direct service providers, including resettlement workers.

"We have such a wealth of knowledge and experience in our communities already, but not the official license or whatever it may be to do the services. Funding could go towards recruiting people from those cultures. I know a number of people who informally do therapeutic services, but they're like, 'I don't have the license so I can't work at a practice.' And it's like, is funding the issue? Or are there other things? But yeah, I think there could be more space created for more."

Participants also suggested training interpreters and refugees– individuals and community members with lived experience--on increasing their awareness, knowledge, and skills to enhance their mental health knowledge and skills to work with fellow refugees. Likewise, participants suggested raising awareness in their communities about the presence and needs of locally resettled refugees, including conducting community awareness campaigns.

Lastly, workforce well-being training, focusing on stress management and work-life balance, was also identified as a need in order for the workforce to be best prepared to support refugee mental health.

Capacity Building (Staff, Volunteers, Interpreters). Participants identified the need for increasing staff, interpreters, and volunteers in addition to training needs. Resources are needed to organize and sustain services such as wellness groups. These include providing access to transportation, leveraging resources (e.g., childcare and meeting space) through community partnerships, reliance on volunteers, and arts-based programming for group work. There is also a need for establishing greater collaboration as well as exchange of peer support among those working with refugees across disciplines.

"I think overall, the opportunity to share with regular collaboration among different providers as far as case workers and mental health providers and physical health providers and social workers, just so that we're all aware of what the situation is, instead of trying to do things piecemeal, that that's the most

Strategies offered to accomplish this included training/cross-training and education about each other's agency's mission, goals, and objectives, and sharing of knowledge of the lived experience of refugees who need and are seeking mental health care. Supporting worker well-being by focusing on work stress management and work-life balance to enhance the workforce's ability to support refugees' mental health and wellness were strongly emphasized as means to sustain and increase capacity.

"One of the ways that is effective is connecting with other agencies that are doing other forms of work and leveraging resources together. Right now, we are thinking of implementing two parenting groups, and we have contacted one group, Refuge Bowling Green, that provides childcare because we understand that we don't have the capacity at this time to provide childcare, but they do. So how do we partner with them? They provide the childcare. We provide the parenting class. It's a win-win situation. So being open to leveraging with other community partners like how the Bowling Green International Center bring the clients to their clinic, and they will meet them there. And we do... So having those connectivity has been very, very good. That siloed mentality doesn't work".

III. Infrastructure Needs to Support Refugee Mental Health

Emphasis on improving mental health care coordination and partnerships, addressing gaps in technology literacy, increasing visibility of and accessibility to language and interpreter services, changing policies and innovating programming, and cultivating allies were identified needs to be met in order to expand and strengthen the overall infrastructure to support refugee mental health.

Mental Health Care Coordination. Participants reported that improving and enhancing coordination of mental health care is needed and will require addressing a number of factors that are interrelated. Overall agency workforce capacity needs to increase in order to handle the increased demand for mental health coordination. To accomplish this, it was noted hiring practices need to change to be more specific and targeted to hire persons who are representative of the cultural groups being served, have a specific set of skills (i.e. language, brokering, knowledge of culture). In addition to increasing capacity, examination of current practices was recommended to be undertaken to assess the strengths and challenges of existing partnerships and coordination by examining what partnerships are working well, and what strategies can/could be implemented to strengthen existing partnerships. Strategies offered to accomplish this included training/cross-training and education about each other's agency's mission, goals, and objectives, and and sharing of knowledge of the lived experience of refugees who need and are seeking mental health care.

Mental Health Care Coordination & Partnerships
1. Strengthen existing partnerships
2. Promote Teamwork

Technology. Improving technology literacy of refugees is needed. Providers identified various challenges that the refugees experience in accessing and using technology and digital services. These challenges are mostly related to cultural barriers, which are intertwined with other factors such as language barriers, age, limited or lack of education, technology literacy, limited Wi-Fi access/equipment, and difficulties understanding how the American system or the technology processes work. The struggles with technology are prevalent among older refugees, especially those with limited levels of education. Young refugees may be more familiar with technology, but limited English skills may limit them from navigating the process. However, they may struggle with process steps even when they are skilled in English. Participants also discussed that some refugees have little access to Wi-Fi or equipment at home. Policy or institutional barriers and lack of empathy were also mentioned as barriers to refugees' access to technology. Participants pointed out that refugees are skilled in working with smartphones, google maps, google Translate,

Technology
1. Improve technology literacy
2. Funding for increasing internet access
3. Change agency IT policies
4. Create trauma Informed IT services/networks

"Technological literacy is really low among especially our older clients. And we're very, very quickly getting up into a digital world. So when you only have one cell phone and it's kind of a $30 Walmart phone, it's really difficult for me to show you how to pay your water bill, how to pay your rent online, how to pay your electric bill online."

WhatsApp, Facebook, and Facebook messenger. However, providers need more support from their IT system or allowances by their agency's internal policies to use these means of technology in communicating with refugees. Similarly, people responsible for the IT system are said to minimize the difficulties with technology that refugees experience when they are being trained, fueling refugees' frustrations. Creating trauma informed services/network support and identifying allies within IT system personnel could empower the refugee community towards full participation by addressing some of the barriers in the existing technology infrastructure.

Cultivating allies from and within refugee communities (including extended family members) was identified to be part of the strategy to increase the body of culturally competent staff who are part of the mental health care team. Individuals with lived experiences should be sought out to increase their professional capacity and to partner with community members in designing programming and interventions. Allies can be recruited to fill existing service gaps and/or support different types of care that are either no longer available to refugees or provided to refugees (i.e., not covered by insurance). Relatedly, peer-to-peer services that are specific to national origin and culture of a particular cultural group are needed.

Allies

1. Cultivate Allies within refugees communities
2. Include extended family as part of holistic mental health services
3. Engage individuals with lived experience in design of services
4. Recruit allies to support gaps in services
5. Develop peer -to-peer services

When it comes to interpreters, getting the right interpreter will be helpful. Or by right interpreter, I mean some interpreters may interpret word by word the way the provider said it and if they may interpret based on how they understood. I hear sometimes interpreters interpreting what I didn't say to the client. Then I have to repeat and say, "This is what I mean, can you interpret like this?" It is based on how they understood."

There is a need to make interpreter services more visible to the refugee population. An important aspect of this is to working with interpreters to provide translation and interpretation using trauma-informed care principles and practices.

Language Accessibility

1. Improve interpretation using trauma-informed care practices
2. Make interpreter services more visible to refugees

Programming. Gaps in programming were identified for clients, providers, and the broader community. Institutional policies that limit refugees' full participation in mental health care. (e.g., showing up for appointments policy) need to change. Funding should be dedicated to the accurate and timely dissemination of information about mental health and trauma and navigating systems to access mental health care. Providing mental health information in language spoken, ensuring that food and other basic needs are available, and training in using

public transportation are ways to strengthen infrastructure to empower refugees with the means to fully participate in services. Funding should be also dedicated for services –-interpretation, intensive case management– as well as for programs for those who provide those services to attend to their self-care and secondary trauma and stress. More specific and targeted hiring practices resulting in hires who are representative of the cultural groups be-ing served and who have a specific set of skills (i.e., language, brokering, knowledge of culture) should be pursued to increase overall agency work-force capacity to provide services to refugees.

Policies, Programs, & Practices

1. Adjust institutional policies that are limiting refugees' full participation in mental health care
2. Review/Establish standards of Practice (SOP)
3. Fill gaps in programming with dedicated funding
4. Address Programming Gaps between well-established vs growing resettlement communities
5. Develop new programming to address current and anticipated needs
6. Support a centralized resource entity
7. Increase workforce capacity with culturally responsive targeted hiring practices
8. Empower refugees to fully participate in services

Suggestions were made to fill in programmatic gaps. These include reviewing existing and establishing new standards of practice (SOPs) for programs, and addressing programming gaps between well-established versus growing resettlement communities. New programming was also recommended such as developing plans to pivot to address future unanticipated events (i.e., COVID-19), establishing peer-to-peer services that are specific to national origin and culture, setting up just-in time pop-up mental health care/ wellness programming in local communities and neighborhood locations, and increasing provider capacity via supporting a central entity that could serve as a hub and a resource to refugees and practitioners.

"I think we need to look at different avenues in support groups. I mean that could be, or churches or things like that because the healthcare system. Churches are helpful here."

"I'd love a center to open up, that works directly with immigrants and refugees, and all of their staff would be trained, and have expertise in this area."

IV. Needs and Perspectives on the Refugee Health Screener-15 (RHS-15)

To gather needs and perspectives on the Refugee Health Screener-15 (RHS-15), focus groups were conducted only with participants who administer the Refugee Health Screener-15 (RHS-15). The RHS-15, which is an "empirically developed to be a valid, efficient and effective screener for common mental disorders in refugees" (p. 202, Hollifield et al., 2013) consists of 15 items, 13 of which ask about mental health symptoms which are rated on a Likert scale from 0 (not at all) to 4 (extremely).; 1 of which asks about coping- with "whatever comes" (0= able to cope with anything; to 4 =able to cope with nothing). Ratings

are summed for a total score which can range from zero (0) to fifty-six (56). A total score of 12 or greater is an indication of risk for emotional distress associated with anxiety, depression, and/or post-traumatic stress disorder. The 15th item is a "distress thermometer" which screen for distress on a scale from zero (0 =no distress) to ten (10= extreme distress). A rating of 5 or greater is considered positive for distress experienced in the past week (Hollifield et al. 2013; Hollifield et al. 201 6).

Administering the RHS-15. Participants described their typical processes for administering the RHS-15, the perceived benefits and challenges using the RHS-15, experiences in working with interpreters, and refugees' responses to the questions (RHS-15 items) asked by screeners. Participants identified several positive aspects of the RHS-15. Most notably, they indicated that the use of the instrument was extremely helpful in normalizing mental health needs and provided screeners with an opportunity to de-stigmatize refugees' mental health needs. Additionally, the utility of the RHS-15 in providing information about the symptoms and experiences with distress, while focusing on the experiences (e.g., War and migration) was most relevant to refugees. Lastly, one of the greatest benefits of using the RHS-15 was its availability in different languages.

> *"That's right. And to ask that having the competent people administer the instrument is crucial. There should be some minimum baseline of who qualifies to do to administer. Because when [Name of Agency] came to us, one of the issues on the table is nobody's testing positive for the thing. And it wasn't the instrument, it was the person administering the instrument".*

Participants reported different processes for administering the RHS-15 and storing the data following its administration. They described instances when clients self-administered, when interpreters were present (in-person), and when interpreters were used over the phone to facilitate completion. Processes varied based on whether the RHS-15 was available in a language in which the client was fluent as well as the availability of interpreters for that particular language. Participants indicated that discretion was often required when assessing clients, as they often made observations about clients' mental health that did not screen positive using the RHS-15. Similar to administration, how screeners stored the RHS-15 data varied by site, with follow up procedures (e.g., further assessment by a provider) often determining how the data was used and stored. For example, some indicate that the RHS-15 was scanned and put into the chart but were looking into an electronic form that could record their responses. Additionally, screeners

> *Now sometimes they're not positive on the form but the provider sees that there is things going on and then they'll ask us to check with them too".*

described how COVID-19 had altered their assessment procedures, particularly when working with in-person interpreters.

Use of the RHS-15 demonstrated greater utility for some screeners compared to others. Respondents indicated that screeners with mental health experience were the best suited to administer the RHS-15 because of their prior knowledge about mental health symptoms, and trauma in particular, and could often provide examples to clarify questions or instructions. Respondents expressed that clients often did not receive needed services in the past because of problems associated with correctly administering the RHS-15 due to a lack of experience. In addition to mental health experience, respondents also indicated that a system or standardized set of procedures was needed when working with interpreters. Screening using the RHS-15 appeared to differ between in-person and phone administration. Screeners often described needing a specific set of procedures they could use to bring consistently to the process.

As indicated above, access to interpreter services differed between screeners based on location with some only having access to phone-based interpreter services. Overall, in-person interpreters were preferred to phone-based services. All screeners spoke about the importance of interpreters; however, some providers indicated that cultural groups varied in their ability to read and write in their primary language, which elevated the importance of interpreter services. This was further complicated when the RHS-15 was not available in the needed language, which required providers to read the items in English to an interpreter, who would then translate them for the client. As indicated above, standardizing procedure were an important organizing element when working with interpreters to minimize confusion, maximize with interpreters, and ensure a quality mental health assessment.

"But if they do not understand or they cannot read in their language, I read these questions to them and then, between me and the interpreter, we just tell them what zero represents…".

While screeners reported that the RHS-15 has several benefits, they also identified several challenges during administration. Screeners often reported that clients had difficulties understanding the items that were being asked. Oftentimes, screeners had difficulties clarifying these items and providing cultural relevant examples that resonated with clients' experiences. Screeners often did not understand the relevance of the time period in which clients were asked to reflect, or misinterpreted the instructions, thereby, narrowing the assessment. For example, screeners often thought the events relevant to assessment were

"It felt emotionally numb. This is a particularly very difficult question to understand them. This is very difficult to explain".

restricted to war or migration or that the events must have occurred within the last month. Screeners felt that several stressful experiences often indicative of those reported by refugees were missing from the assessment. Stressful and traumatic experiences related to stays in refugee camps or associated with difficulties in their resettlement communities were missing. Overall, the use of the distress thermometer created the most difficulties during assessment. The paper use of the thermometer did not provide a useful visual for clients and the meaning of the numbers (0 to 10) relative to distress was difficult to describe to clients. Lastly, the overall length of the assessment was a challenge for some screeners, who found it difficult to keep clients focused.

The RHS-15 asks clients whether they have experienced specific symptoms within the last month. Many screeners felt that the period of assessment was too short and often administered to clients after having been in their resettlement community for some time. Screener felt that many of refugees' experiences and symptoms occurred beyond the 30-day assessment period or occurred during a "honeymoon" period where clients were still positively adjusting to their new communities. Screeners felt that a lengthier assessment period beyond 30-days should be considered. Additionally, screeners felt that the timing of the assessment was critical to capture clients' symptoms and making referrals to appropriate mental health services. Many screeners interpreted this as a limited period of assessment rather than an assessment of symptom acuity. Screener believe that the assessment could benefit for a longer assessment period to better understand whether difficulties were experienced beyond 30 days.

" Sometimes I do wish, because lately it seems like we're getting people that had already been here three months, six months, that this went back a little bit longer, maybe six months, I feel like we can catch a different view or mental state that they may have been if it went back a little further than 30 days".

RHS-15 Training and Improvements. Screeners were directly asked about the types of training they had received to prepare them to administer the RHS-15, and whether additional training was needed to facilitate interpretation and improve administration. Some screeners felt that the use of the RHS-15 was limited and only provide a single assessment opportunity for evaluating refugees' mental health. One suggestion was to use the RHS-15 in additional follow up assessments to determine whether refugees' mental health had changed over time. Similar to other statements, the

" Well even the screenings at the time that they're done is pretty early in their stay here. It would be really interesting to…repeat those 90 days later because I think that honeymoon stage sometimes can give us some false results…"

"Whatever training you offer, we would be completely open to it".

rationale was associated with the relatively early assessment of refugees' mental health, which may not account for the post-migration difficulties experienced in their new resettlement communities. Overall, most screeners express a willingness to participate in any types of training related administering the RHS-15.

Because they had not received any formal training, screeners were interested in any materials that could be provided that further their understanding and ability to administer the RHS-15. Some screeners felt comfortable with the level of training that they have received and felt that administering the RHS-15 was relatively direct as long as more experienced screeners were available to shadow and answer questions. Screeners described their training as occurring "on the job" by shadowing an experienced screener and learning their process through direct practice. Screeners pass on practice wisdom on how questions can be asked to best answer difficult or confusing questions on the RHS-15.

"Yeah, we' ve not had a lot of training. A lot of us have come into these positions and just learn from people that were previously in the position. So we're actually working to improve some stuff in our clinic for the refugee process".

"But yeah, I mean we've talked about we would love to go to another clinic and even just watch a clinic in [large Southeastern city] or somewhere where they have more volume doing some of these assessments just so we can see how other people word things".

Most report receiving no formal training regarding the administration of the instrument. Some screeners report using additional information (e.g., non-verbal cues) to supplement assessments when they are unsure about the client's responses (e.g., quickly provide the same response across all questions). Screeners express the most interest in training that would help them navigate the barriers and challenges expressed during the focus group. For example, navigating difficult items associated with the RHS-15 and providing examples have been proven effective in helping different groups understand what is being asked. Newer screeners felt it might be helpful to shadow another clinic and learn from their practices. Additionally, screeners requested information about the experiences of different populations and how their response may vary based on the nature of their traumatic experiences (e.g., primary versus secondary trauma survivors). For example, some were interested in knowing whether some groups are more likely to express physical symptoms rather than mental health symptoms. Screener also expressed interest in trauma informed training for those who were conducting the RHS-15 screenings.

Summary of Findings

Four areas of need were identified through the thematic analysis of the focus group interviews: (I) Mental Health Needs of Refugees, (II) Workforce Needs to Support Mental Health of Refugees, (III) Infrastructure Needs to Support Refugee Mental Health, and (IV) Needs and Perspectives on the Refugee Health Screener-15 to support refugee mental health.

Mental Health Needs of Refugees. Several factors figure into persistent unmet mental health needs of refugees and accessing and using mental health services challenging. These include lack of or limited provider cross-cultural knowledge and understanding of refugees' perspectives on mental health, interpreter training needs in mental health literacy that enhances refugee understanding of mental health services, and payer source (ability to pay or insurance coverage). Of note:

1. Most recent and currently arriving refugees, specifically Afghani, Ukrainian, and Congolese populations are in most need of mental health support due to experiencing a range of stressors (i.e., role changes, isolation, loss of extended family and social system supports) pre- transit, during transit, and now in resettlement. Women at home caregiving for children, men who often go unnoticed because they are not vocal about their needs, and persons with serious health issues and manifesting symptoms of past traumatic experiences were specifically mentioned as having the greatest need of mental health support.

2. Mental health needs and distress are brought on by pressures of acculturation, difficulty accessing language or interpreter services, when seeking services for serious mental health issues, family conflict, financial needs, unemployment, unpaid bills, childcare needs, and experience of socioeconomic inequity.

3. Mental health needs of refugees go unmet because of limited provider expertise--limited in expertise in working with refugee clients or limited in cross-cultural knowledge and treatment expertise—which impacts their ability to provide mental health care that is best practice and culturally responsive. Not all providers who have the expertise accept the insurance payment method (i.e., Medicaid) that refugees are covered under in Kentucky, making access and timely appropriate referrals challenging.

4. Refugees ,even when they can get the mental health care, often face service barriers due to 1) lack of available interpreters, 2) lack of providers who are bilingual and/or willing to

serve a client who is not fluent in English, and 3) interpreters lacking expertise to convey mental health concerns.

5. There is a need for refugee clients to increase their Mental Health Literacy , knowledge, and education to bridge the gap in their knowledge of mental illness and mental health services. This hinders their service-seeking resulting in reduced perceived need or urgency to seek treatment, and factors in their social isolation as well as receptivity to mental health treatment.

6. Mental Health Stigma is pervasive, and it is a factor, if not the major factor, underlying the barriers and challenges faced by refugees seeking and accepting mental health care.

Workforce Needs to Support Mental Health of Refugees. Training and capacity building to support mental health of refugees were identified as major workforce needs. Training needs identified focused on knowledge (i.e., cultural competency) and skills acquisition (i.e., crisis management) while capacity building emphasized increasing the number (i.e., staff) and strengthening the workforce (i.e., with volunteers, and interpreters) providing services to refugees. More specifically:

1. There is a significant need for increased cultural competency training in some form for all staff and agencies (i.e., resettlement staff, mental health care providers, healthcare providers, community-based service staff, and law enforcement) who serve/interface with refugees to improve engagement with refugee clients.

2. There is need for training for traditional mental health providers to bridge their knowledge gap of various refugee cultural groups and refugee cultural groups' views of mental illness and receptivity to mental health services. Training topics suggested/ requested include language access (e.g., the use of interpreters), multicultural education, and understanding refugees' lived experience.

3. Providers would benefit from critical self-reflection and programmatic review on how mental health issues are brought up and discussed with refugee clients. They should receive training in the mental health perspectives held by refugees in the community and communication approaches that expand refugee understanding of services to increase refugee receptivity to mental health care.

4. Resettlement workers, direct service providers, and mental healthcare providers would benefit from training on adapting motivational interviewing, trauma-informed care

strategies, crisis management, mandatory reporting ,as well as identifying and responding to general mental health issues experienced by refugees.

5. There is a request for training of interpreters and refugees,--individuals and community members with lived experience-- to become mental health providers to build their mental health knowledge and skills to work with fellow refugees.

6. There is a call for raising awareness in the community about the presence and needs of locally resettled refugees using community awareness campaigns.

7. Actions are needed to increase agency and service capacity (Staff, Volunteers, Interpreters) to sustain and address the ongoing refugee mental health needs.

8. Resources are needed to organize and sustain services such as wellness groups. These include providing access to transportation, leveraging resources (e.g., childcare and meeting space) through community partnerships, reliance on volunteers, and arts-based programming for group work.

9. There is a need for establishing greater cross- discipline and agency collaboration and peer support among those working with refugees across disciplines.

10. Focus on worker stress management and work-life balance is needed to enhance the workforce's ability to support refugees' mental health and wellness.

Infrastructure Needs to Support Refugee Mental Health. To strengthen the overall infrastructure to support refugee mental health, emphasis on improving mental health care coordination and partnerships, addressing gaps in technology literacy, increasing visibility of and accessibility to language and interpreter services, changing policies, innovating programming, and cultivating allies were identified as needs to be met. More specifically, the identified needs are to:

1. Improve and enhance coordination of mental health care which will require increases in overall agency workforce capacity, with more specific and targeted hiring practices with hires who are representative of the cultural groups being served and who have a specific set of skills (i.e., language, brokering, knowledge of culture).

2. Examine current practices to assess the strengths and challenges of existing partnerships and coordination by examining what partnerships are working well, and what strategies can/could be implemented to strengthen existing partnerships.

3. Improve technology literacy of refugees. Elderly refugees with limited education are more vulnerable to struggles with technology. Young refugees may be more familiar with technology, but limited English skills may limit them from navigating the process.

4. Develop funding streams to purchase/subsidize WIFI and computer equipment to increase refugees' internet access.

5. Change/adjust refugee serving organizations' IT system and/or its internal IT policies to accommodate technology that refugees are skilled in using such as smartphones, google maps, google Translate, WhatsApp, Facebook, and Facebook messenger.

6. Identify allies within refugee communities (including extended family members) to increase the body of culturally competent staff in organizations serving refugees including considering the role of the extended family in the delivery of mental health services, as part of working collaboratively within a more holistic approach.

7. Make interpreter services more visible to the refugee population including working with interpreters to improve translation and interpretation using trauma-informed care practices.

8. Empower refugees with means to fully participate in services (e.g., providing literature in every language, food/basic needs, and training in using public transportation) including reviewing institutional policies that limit refugees' full participation in mental health care. (e.g., showing up for appointments policy) and disseminating information to refugees accurately and in a timely manner.

9. Examine/review current programming with particular attention to teamwork conflicts among among providers, dedicating funding to particular program needs (i.e., interpretation, intensive case management, self-care and secondary stress), established standards of practice (SOPs), gaps between well-established versus growing resettlement communities, including individuals with lived experiences to (a) increase their professional capacity and (b) partner with to design interventions, and developing peer-to-peer services that are specific to a refugee's national origin and culture.

10. Recruit and sustain allies to supplement to access to different types of care that are either no longer available to refugees, is not provided to refugees (i.e., not covered by insurance), or because of an existing service gap in the community in medical, mental health, legal, or educational domains.

11. Develop plans to pivot to address future unanticipated events (i.e., COVID-19) as well as offering just-in-time pop-up mental health care/wellness programming in local communities and neighborhood locations to address emerging and unanticipated mental health issues afflicting refugee communities.

12. Increase community capacity by supporting a central entity/hub that provides opportunities for mental health information exchange, trainings, and resources for practitioners and refugees.

Needs and Perspectives on the Refugee Health Screener-15 (RHS-15) to Support Refugee Mental Health. The Refugee Health Screener-15 (RHS-15) (Hollifield et al., 2013; Hollifield et al., 2016), is extremely helpful in normalizing mental health needs. However, its administration can be challenging due to where, who, how, and what resources are available for the administration. Specifically, there is a need for:

1. Establishing a system or standardized set of procedures to follow when using the RHS-15. Screening using the RHS-15 appeared to differ between in-person and phone administration. Screeners often described needing a specific set of procedures they could use to bring consistently to the process.

2. Ensuring availability and access to interpreter services. The type of availability and access (in person or phone) factor heavily in whether the RHS-15 is used and how it is used to assess for mental health distress in refugees.

3. Thoroughly reviewing the items that make up the RHS-15 as well as guidelines, criteria, timing of the screening, timeframes for using the RHS-15, and how to interpret the responses on the RHS-15 to ensure that the RHS-15 is appropriately being applied to screen in or screen out mental health symptoms and distress.

4. Trainings on administering the RHS-15 in addition to reading materials and learning "on the job" . Experiential training using strategies such as problem-solving, case studies, modeling, and shadowing is needed to help screeners navigate difficult items associated with the RHS-15, understand, and apply how mental health distress and symptoms are

expressed in different cultures, and between individuals within a particular cultural group based on their gender, age, and experiences with traumatic experiences, etc.

5. Setting up a system for collecting, storing ,and analyzing the completed RHS-15 in a central location for reporting and using the information gathered for planning and programming to strengthen and enhance service delivery.

Limitations

The findings of this needs assessment should be understood within the context of its design and implementation. The recruitment approach, self-selection, and agreement to participate may have been a factor in who decided to participate in the focus group. Since the inclusion criteria specified that participants be able to speak, read, and write English, some non-fluent English providers may have opted out and their voices not captured. Additionally, some participants worked in KOR-funded organizations and programs, and they may have been judicious about what they shared in the focus groups. The focus group questions were attempting to respond to policy requirements and thus may not have fully captured the full range of refugee mental health needs observed and dealt by the participants. Likewise, not all geographic locations in Kentucky with a refugee population (i.e., Covington) were represented in the focus group. Results focus on the needs of clients here less than five years from the provider perspective and thus do not reflect the needs of refugees who have been here longer, and lack refugee voices. The analysis of the interviews did not include checking the accuracy of the information provided with the participants by having them review the transcripts of the interviews or the results to ensure that they resonated with their experiences.(i.e., member checking).

Conclusions

This needs assessment sought to inform the development and implementation of mental health program goals, scope of services, and activities for the Kentucky Office of Refugees (KOR) by gathering the perspectives of service providers about refugee mental health needs in Kentucky. Ten Focus groups were conducted between October and December 2022 with 48 stakeholders working in mental health provider organizations, refugee resettlement agencies, community organization serving refugees across the state, particularly those in Louisville, Lexington, Bowling Green, and Owensboro[6]. Four categories of need were identified through thematic analysis of focus group interviews. Future needs assessments

[6]Sites with the largest and/or growing refugee resettlements

should consider surveying the perspectives of all service providers from all parts of Kentucky using the focus group survey results to inform the survey questions to add to, complement, and corroborate the results from the focus group interviews. Additionally, focus groups with refugees about their mental health needs would be important to conduct to more directly give voice to their needs and inform policy, program, and practice decisions.

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Appendices

Appendix A: Screening, Demographics, Questions for Interviews/ Focus Group Statewide Mental Health Needs Assessment

Mental Health Needs Assessment Screening Questions

Have you engaged and/or interacted with refugees in your role as direct services provider, mental health screener, mental health services provider, community leader, or case manager?

YES or NO

If answered Yes, proceed to with consent procedures, have participants complete the Demographic questions, and then start with asking interview/focus group questions.

If answered No, explain that the purpose of the interview/focus group is to gather input from those that have engaged and/or interacted with refugees, so he/she will not be asked to participate. Thank them for their interest and willingness to take time to participate.

Mental Health Needs Assessment Demographic Information

Gender _____

Age _____

Race/Ethnicity _____

Cultural Group _____

Education Level _____

Highest Degree Earned _____

Length of Employment (in years) _____

Current Job/Title/ _____

Type of Work Currently Doing _____

_____

Appendix B. Questions for focus groups/interviews Statewide Mental Health Needs Assessment

Interview/Focus Group Questions for Direct Service Providers

- Who are the individuals that have the most persistent, pressing, or underserved mental health needs?
- What are the challenges or barriers you have encountered when working with different cultural groups?
- Are some populations more difficult to reach or engage than others?
- What are the challenges or barriers that may influence the equity and inclusion of different groups?
- What are the pre-migration and post-resettlement stressors that contribute to newly arrived adult refugees' emotional distress that you have witnessed/observed?
- Would these also apply to already resettled adult refugees?
- What pre-migration and post-resettlement stressors that contribute to newly arrived refugee children's emotional distress that you have witnessed/observed?
- Would these also apply to already resettled refugee children?
- What are the pre-migration and post-resettlement stressors that contribute to newly arrived elderly refugees' emotional distress that you have witnessed/observed?
- Would these also apply to already resettled elderly refugees?
- How is the COVID-19 pandemic impacting the mental health vulnerabilities of refugees?
- What impact has COVID-19 had on refugees with children?
- What types of access to technology, digital services, and knowledge of technology do refugees need to have in order to for them to access and receive services from you?
- What are the barriers you have experienced in this regard (providing services to refugees)?
- What has been your experience working with other refugee serving organizations in providing mental health care of refugees?
- What will provide greater access and opportunity to ensure full participation by all cultural groups?
- What are the stressors you and others doing this work experience? How do you and others cope?
- What types of supports do you need to maintain your level of performance on this job?
- Is there something else that you can share with us today that we have not asked about that addresses mental health needs within the communities you work with?

Interview/Focus Group Questions for Case Managers

- What are the mental health needs of refugees for whom you provide case management services?
- Please walk us through the process of a typical day of working as a case manager.
- What do you like most about being a case manager?
- What are the stressors you and others doing this work experience? How do you and others cope? What supports do you need to cope with the demands of this job?
- What types of supports do you need to maintain your level of performance on this job?
- What are the major barriers you experience in carrying out your role and responsibilities of this job?
- What would make it easier for you to provide case management services?
- What other trainings would you want to receive to provide case management services?
- Is there something else that you can share with us today that we have not asked about that addresses mental health needs within your community?

Interview/Focus Group Questions for RHS-15 Screening Providers

- Please walk us through the process of a typical refugee health screening at your clinic.
- What are the benefits and challenges associated with use of the RHS-15 as part of health screenings?
- What parts (items) of the RHS-15 do you find most useful? Most difficult to administer? Least understood by refugees in your opinion? Hardest to communicate during the screening?
- What issues come up if/when using interpreters in administering the RHS-15?
- What questions do you get from refugees when you ask the questions on the RHS-15, if any?
- How do you use RHS-15 data and information?
- What training would you like to receive on administering the RHS-15?
- How about interpreting the RHS-15?
- How about improving administration of the RHS-15?
- What aspects of mental health would be most helpful to assess in newly resettled children?
- What mental health screenings are being used for children during health screenings?
- What are the benefits and challenges associated with the use of those screenings with children?

- How are learning differences/disabilities being assessed in the health screening of children?
- Is there something else that you can share with us today that we have not asked about that addresses mental health needs within the communities you work with?

Interview/Focus Group Questions for Mental Health Providers

- What are the ways to build capacity within communities to address the mental health needs of refugee populations?
- What are the limitations associated with mental health care?
- What are the ways to assist clients to overcome limitations associated with accessing mental health care?
- What are ways to help cultural communities overcome limitations associated with accessing mental health care?
- What types of programs and opportunities should be developed to help overcome limitations associated with mental health care, reduce isolation, and increase social engagement?
- What should a mental health literacy program (for adults and children?) include and how should it be implemented?
- Who are the mainstream mental health providers/partners in the community that are versed in trauma-informed services (for refugee adults and children)?
- What do mainstream mental health agencies need to have in order to provide services that are client-centered, trauma-informed, strengths-based, and culturally and linguistically appropriate?
- What do providers who are serving families need in order to provide the highest level of care (client-centered, trauma-informed, strengths-based, and culturally and linguistically appropriate)?
- What do providers serving children need in order t provide the highest level of care (client-centered, trauma-informed, strengths-based, and culturally and linguistically appropriate)?
- What has been your experience working with other refugee-serving organizations in providing mental health care to refugees?
- What should a training curriculum include for mainstream providers on refugee mental health?
- How should a training curriculum be delivered and implemented?
- What ways can coordination of mental health care for refugees be improved/enhanced?
- What resources are needed to organize and sustain wellness groups?
- How are the mental health needs of refugee children being assessed?

- Often people who work within educational systems are challenged by differentiating between language, differences in learning, and exposure to trauma as a source of difference in a classroom. What supports are working to help identify the source of difference? What are areas of need?
- What additional mental health training do you need to continue to work effectively with ORR populations?
- What are the strongest and weakest aspects of the training you have received thus far?
- Have you accessed the resources available through KOR website -the Mental Health Toolkit?
- Is there something else that you can share with us today that we have not asked about that addresses mental health needs within the communities you work with?

Appendix C. Informed Consent

KENT SCHOOL OF SOCIAL WORK

UofL Institutional Review Boards
IRB NUMBER: 22.0669
IRB APPROVAL DATE: 10/05/2022

Statewide Refugee Mental Health Needs Assessment Study

Introduction and Background Information
You (referred to as you in the rest of this document) are invited to take part in a research study about the mental health needs of refugees in Kentucky. The study is being conducted under the direction of Dr. Bibhuti K. Sar at the University of Louisville**.**

Why is this study being done?
The purpose of this study is to identify the mental health needs of refugees residing in Kentucky. The information gathered will be used to inform planning of future refugee mental health services, filling gaps in current services, as well as determining what is needed to be successful in organizing wellness groups, equity and inclusion, and mental health screening of refugees.

What will happen if I take part in the study?
Your participation in the study will first involve responding to demographic questionnaire items which will be followed by in-person or online interview or focus group questions . Your participation in this study will last for up to two hours. Your responses will be audio recorded and later transcribed and analyzed to determine refugee mental health needs.

What are the possible risks or discomforts from being in this research study?
There are no known risks for participation in this research study.

What are the benefits of taking part in the study?
You may not benefit personally by participating in this study. The information collected may not benefit you directly; however, the information may be helpful to others.

Will I be paid?
You will not be paid for your time, inconvenience, or expenses while you are in this study.

How will my information be protected?
The data collected from you will be kept private and secure by storing it in an encrypted and password protected computer to ensure individuals outside the research team cannot access data.

Individuals from the School of Social Work and Family Science, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), the University of Louisville, and other regulatory agencies may inspect these study records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Will my information be used for future research?
Your data will be stored and shared for future research without additional informed consent if identifiable private information, such as your name and medical record number, are removed. If identifying information is removed from your data, the data may be used for future research studies or given to another investigator for future research studies without additional consent from you.

Version Date: 9-7-22

Oppenheimer Hall • University of Louisville • 2217 S. 3rd Street, Louisville, KY 40292
P: 502.852.6402 • **F**: 502.852.0422 • louisville.edu/kent

Can I stop participating in the study at any time?
Taking part in this study is completely voluntary. You may choose not to take part at all. If you decide to be in this study, you may change your mind and stop taking part at any time. You will not be penalized or lose any benefits for which you qualify.

Who can I contact for questions, concerns and complaints?
If you have any questions about the research study, please contact Dr. Bibhuti K.Sar at b.k.sar@louisville.edu or at 502-852-3932 (Office).

If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call this toll free number: 1-877-852-1167. This is a 24 hour hot line answered by people who do not work at the University of Louisville.

If you have any questions about your rights as a research participant, you may call the Human Subjects Protection Program Office at (502) 852-5188. You may discuss any questions about your rights as a research participant, in private, with a member of the Institutional Review Board (IRB).

Acknowledgment
This document tells you what will happen during the study if you choose to take part. By responding to initial demographic questionnaire items you agree to take part in this study.

You are not giving up any legal rights to which you are entitled by consenting to this study. You can save this consent form for your records.

Bibhuti K. Sar, PhD
Professor
Principal Investigator

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Appendix D. Dedoose Codes Export for Project: KOR Mental Health Needs Assessment

Barriers to Mental Healthcare Access: Challenges identified that could impede the ability for clients to access mental health care services and for providers to provide culturally responsive care

Children: Description - Descriptions of children's health, mental health, dis/ability, and education (child care, preschool, K-12 school) and practices that schools/systems use with children

COVID-19 Impacts: Descriptions of the impacts of the COVID-19 pandemic on the mental health experienced by refugees

Ideas for programming: Suggestions about what a mental health literacy program should include and how it should be implemented

Identification of Allies: Descriptions of the mental health providers and partners in the community that are versed in trauma-informed services and acceptable to various refugee communities

Increasing Access: Understandings of ways providers can provide greater access and provide full participation by all cultural groups to address mental health needs

Mental Health Care Coordination: Descriptions of the ways coordination of mental health care can be improved or enhanced

Mental Health Literacy: Description of challenges involving mental health literacy. This can include challenges related to cross-cultural understandings of mental health from both providers and clients

Mental Health Stigma/Programming: Explanation of how stigma operates in various refugee communities. Including ideas for programs and opportunities to help overcome stigmas associated with mental health care, reduce isolation, and increase social engagement

Opportunities to Build Capacity: Ideas and suggestions to build capacity within communities to address the mental health needs of refugee populations

Parenting: Descriptions of changes in parents' roles with their children, expectations of parents, or parent supports upon arrival/integration in the U.S. that influence parents' mental health needs

Population in Need of MH Services: Descriptions of individuals and groups with the most significant mental health needs. This can include but is not limited to an ethnic group, age, gender, country of origin, etc.

Provider Needs: Identification of the needs of mainstream providers, understanding needs to help provide client-centered, trauma-informed, strengths-based, and culturally and linguistically appropriate services

RHS-15: Descriptions of the RHS-15 that do not involve administering, training or identifying needed improvements (this is a general code that can be refined as we move along but should serve as a parent code for the RHS-15 child codes). In addition to coding about screening for mental health, please code or double-code any place where the RHS process demonstrates where and how MH issues are not being understood or addressed.

> **Administering the RHS-15:** the benefits, challenges, and utility (i.e., usefulness) of the RHS-15 in assessing the mental health symptoms and needs of refugees, including its use with interpreters.
>
> **RHS-15 Training and Improvements:** the education and preparation needed to administer and interpret the RHS-15, along with potential improvements in the instrument, that increase its usefulness as a mental health screener for refugees.

Stressors: Explanation of the pre-migration and post-resettlement stressors that contribute to newly arrived refugees' distress. This can include alcohol and other drug use (AOD) use, or someone experiencing a substance use disorder (SUD).

Technology: Challenges and opportunities involving the use of and access to technology, digital services, and digital literacy among refugee populations and providers

Training Ideas: Suggestions about implementing a training curriculum for mainstream providers on refugee mental health. Ideas for how training curriculum should be delivered and implemented (Not related to the RHS-15 Mental Health Screener)