

Data Collection Offers Opportunities for Unpacking the Refugee Experience

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Discovering best practices for reaching and helping traumatized refugee children involves collaborations between mental health providers and communities, according to providers from the Refugee Trauma and Resilience Center at Boston Children's Hospital, and The Children's Center in Salt Lake City, UT. Their work with the NCTSN Core Data Set (CDS) and other data sets has convinced them of the enormous potential of data collection to inform the delivery of services.

For example, in 2012, Theresa S. Betancourt, ScD, MA, Director of the Harvard School of Public Health's Research Program on Children and Global Adversity, and other NCTSN colleagues, participated in an NCTSN mini-grant project which used the CDS to examine the trauma profiles of refugee children served by participating Network sites.¹ Their study found that many of the 60 war-affected refugee children in the database had high rates of probable PTSD, generalized anxiety, somatization, traumatic grief, and general behavioral problems. Exposure to war or political violence outside the United States frequently co-occurred with forced displacement, traumatic loss, bereavement or separation, exposure to community violence, and exposure to domestic violence. Academic problems and behavioral difficulties were prevalent, but criminal activity, alcohol or drug use, and self harm were rare. These findings highlight the complex trauma profiles, comorbid conditions, and functional problems that are important considerations for providers of mental health interventions for refugee children and adolescents. Given the difficulties associated with access to mental health services for refugees, both preventive and community-based interventions within family, school, and peer systems hold particular promise, Betancourt noted.

A follow-up validation study of the children in the CDS,² currently in press, "speaks to the fact that refugees are being supported more often by in-home counseling, and special classes or school, than U.S.-origin youth," she said. These findings highlight the importance of treatment modalities that are being offered by service providers in the NCTSN. Heidi Ellis, PhD, Director of the Refugee Trauma and Resilience Center at Boston Children's, noted that the CDS findings corroborated what she has observed in her extensive work with Somali refugees in Massachusetts. Among these populations, "there are very low rates of treatment engagement with what we think of as standard mental health ser-

vices," she said. "Other pathways, like seeking support and services through school or community centers, are much more palatable."

The results of Ellis's longitudinal studies underscore the importance of using community advisory boards and other approaches to ensure that the voices of community members are heard. In addition, cultural brokers can help to discern the nuances of language used in the community to refer to mental health issues. These community perspectives are invaluable for the design and delivery of appropriate mental health services for refugees.



The findings from the CDS studies also affirmed that much more research is needed to understand the particular types of trauma and needs of refugee clients. "Given the diversity of refugee settlement in the U.S., there's really an opportunity to do something more broad-based," Betancourt observed. "Working with the Core Data Set has really helped us think through some of those design and methodological issues." According to the Data and Evaluation Program staff, Betancourt and Ellis were instrumental in enhancing the content of the Clinical Improvement through Measurement Initiative (CIMI). Their expertise, lessons learned from their studies, and feedback from their consumers and partners directly informed the new Refugee and Immigrant Families module. These changes have enhanced the quality of the information collected.

Currently, Betancourt and her team linked to the Refugee Trauma and Resilience Center are leading an initiative supported by the National Institute for Minority Health and Health Disparities. The initiative emphasizes community-based participatory research to develop and evaluate family homevisiting programs that may help refugee families succeed in navigating their adjustment to life in the United States.

Additional Considerations

Devon Musson Rose, LCSW, Director of Clinical Services at The Children's Center in Salt Lake City, sees a diverse range of refugees at her center. Now an Affiliate member, The Children's Center continues its trauma-focused work and collaborates with refugee settlement groups and other refugee-serving agencies. Over the years, the center has served refugee and immigrant families from Iraq, Bhutan, Syria, Afghanistan, Burma, Somalia, and the Democratic Republic of Congo, as well as Latino and Hispanic immigrants.

Musson Rose pointed out a distinct difference between “immigrant” and “refugee” clients. The latter have been granted legal refugee status, which is usually accompanied by a package of discrete but time-limited support services. Undocumented economic migrants, or those fleeing their country of origin to escape violence, face an array of different challenges. Whether clients are refugees or immigrants, sensitivity to confidentiality is paramount. Because language is often a barrier, interpreters must be available. Musson Rose recalled one Burmese mother who did not feel safe to disclose her exposure to domestic violence until she was assured that an out-of-state interpreter would assist her. Musson Rose explained, “The Burmese community is very tight-knit, and she was concerned that through a local interpreter, her information might get back to her ex-partner.”

The Refugee Trauma and Resilience Center has now built bridges across language and other barriers to service by employing community members as cultural brokers. In addition, Betancourt and her team are training refugee team members to collect data on tablets programmed in Nepali for use by Bhutanese refugees, as well as in Maay Maay for Somali Bantu refugees.

Making standardized assessments available in the preferred language of clients is a feature made possible by CIMI. The Children’s Center, a pilot site for the initiative, has been a “great resource” for thinking about how to use measurement-based care with refugee and immigrant populations, according to staff at the National Center for Child Traumatic Stress. Ellis and Betancourt acknowledged that measurement can often be perceived by clinicians as overwhelming. But they urged new NCTSN grantees and other Category III sites to avail themselves of tools and shared measurement systems, such as those available in CIMI, to help in the process. In that way, more can be learned about the best ways to serve these vulnerable populations.

1. Betancourt, T. S., Newnham, E. A., Layne, C. M., Kim, S., Steinberg, A. M., Ellis, H., & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress*, 25(6), 682-690.

2. Betancourt, T. S., Newnham, E. A., Birman, D., Lee, R., et al. (2017). Comparing trauma exposure, mental health needs, and service utilization across clinical samples of refugee, immigrant, and U.S.-origin children. *Journal of Traumatic Stress*. *In press*.