Int. Migration & Integration (2019) 20:247–259
https://doi.org/10.1007/s12134-018-0603-z

Addressing the Invisible Affliction: An Assessment of Behavioral Health Services for Newly Resettled Refugees in the United States

Amir A. Afkhami[1,2] · **Katy Gorentz**[2]

Published online: 27 July 2018

Abstract The behavioral health needs of refugees in the USA remain insufficiently studied due to a lack of data on their assessment, referral, and treatment during the resettlement process. This study examines the current behavioral health service provisions for this population through individual interviews of refugee resettlement agency staff in the District of Columbia, Maryland, Virginia, and a nationwide survey of state refugee health coordinators. The results reveal shortfalls in behavioral health screening, clinical resources, and other federally mandated services along with linguistic and cultural obstacles facing refugees with potential behavioral health needs. This study offers actionable policy and procedural recommendations on the federal, state, and local levels to address these shortfalls. This includes increasing funding for healthcare entitlement programs and refugee resettlement agencies, improving screening procedures and treatment protocols, expanding federal and state oversight of mandated behavioral health services, and establishing community-partnered programs to reduce cultural and stigma-related barriers to behavior health care.

Keywords Refugee health · Behavioral health · Psychiatry · PTSD · Resettlement · Depression · Integration

By the end of 2015, 24.5 million individuals were forced out of their home countries as refugees or asylum seekers, reflecting a rising trend of displacement in recent years

✉ Amir A. Afkhami
amiafkh@gwu.edu

[1] Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine and Health Sciences, 2120 L Street, NW Suite 600, Washington DC 20037, USA

[2] Department of Global Health, Milken Institute School of Public Health, 950 New Hampshire Avenue, NW, Washington DC 20052, USA

(The Office of the United Nations High Commissioner for Refugees [UNHCR] 2015; UNHCR 2016). The current dominant wave of refugees from the Middle East, Africa, and Central America have suffered through armed conflict and both ethnic and gender-based violence in unprecedented numbers. In addition to causing higher rates of posttraumatic stress disorder (PTSD) and overall decline in physical health indicators, these harrowing exposures and the social stressors that result from displacement and migration, including the loss of traditional communal connections and diminished socio-economic standing, are associated with immediate and long-term mood and anxiety disorders (Steel et al. 2009; Bogic et al. 2012; Nicholson 1997; Mollica et al. 1998; Steel et al. 2006; Scott et al. 2016). A systematic review of research findings on the adult refugee population in the Europe and North America showed PTSD and major depressive disorder occurring at 9 and 5% respectively, with high rates of comorbidity between the two (Fazel et al. 2005). The rate of mental illness among Syrian refugees, the world's largest migrant population, is even more dramatic, with over half reported to suffer from PTSD (Ullmann et al. 2015). In recent years, increasing numbers of refugees arriving at the border of the United States (US) from Central America have also exhibited significant behavioral health disorders due to exposure to armed violence and persecution, with over a third reporting symptoms of depression and almost 12% showing signs of PTSD (Keller et al. 2017; Médecins Sans Frontières 2017). Several studies have demonstrated that early detection and aggressive treatment of these disorders can shorten their course, thereby reducing the risks of long-term disability among resettled refugees and improving their prospects for social integration and economic advancement in their new communities (Kearns et al. 2012; Hall and Wise 1995). These findings point to the importance of rapidly and comprehensively screening and treating refugees for behavioral health disorders and overcoming the numerous barriers they face in accessing care, which have resulted in historically lower utilization rates of available behavioral health services in this population (Derr 2016; Morris et al. 2009).

In 2015, the US accepted over 69,000 refugees, more than any country that year (UNHCR 2015; United States Department of State [DOS] 2015). The State Department, the Department of Homeland Security (DHS), and the Department of Health and Human Services (HHS) are the principal Federal agencies involved in the refugee resettlement process in the US. The DHS's Citizenship and Immigration Services conducts the security vetting of prospective refugees, and the State Department's Bureau of Population, Refugees, and Migration coordinates their initial resettlement, providing the preliminary funds for housing, food, and clothing. Three months after resettlement, the HHS's Office of Refugee Resettlement (ORR) takes over from the State Department, providing cash, subsidies, and other forms of assistance to meet the social, vocational, and health care needs of refugees in the US. Upon arrival, each refugee is assigned to a non-governmental refugee resettlement agency that delivers comprehensive case management and coordination services, including provisions for housing, cultural orientation, and access to health care (DOS 2013). The resettlement agencies are funded by grants from the ORR, which follow specified formulated guidelines on how the grants are allocated by the agencies. These guidelines mandate a medical screening of refugees that includes a behavioral health assessment within 30 days of arrival in the US (Centers for Disease Control and Prevention [CDC] 2014). Individual states in which these agencies are located are ultimately responsible for ensuring that the ORR's directives are carried out by the resettlement agencies.

The domestic medical screening is meant to follow up with concerns identified in the mandated overseas medical exam, conducted in the process of evaluating applicants for refugee status prior to resettlement in the US, and to connect newly resettled refugees with ongoing care if needed. It is also meant to address acute or communicable illnesses that could either directly affect a refugee's well-being or impact the health of others. The screening is currently guided by the 2012 ORR's Revised Medical Screening Protocol (State Letter 12-09). The protocol is informed by the Guidelines for the US Domestic Medical Examination for Newly Arrived Refugees developed by the Immigrant, Refugee, and Migrant Health Branch of the Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine. The ORR grants provide funding for screening activities that follow these guidelines, and individual states can develop medical examination procedures based on the ORR reimbursement framework (Office of Refugee Resettlement [ORR] 2012).

Behavioral health assessments are recommended in the ORR protocol, and the CDC provides more specific guidelines, including medical record review, a mental status evaluation, screening for depression and PTSD, and referrals for specialized treatment when necessary (CDC 2014; ORR 2012). However, due to the flexibility of the CDC recommendations, which encourage providers to tailor the implementation of its behavioral health guidelines to site-specific limitations in expertise, time, and language, it is unlikely that all refugees receive the full spectrum of the CDC and ORR recommendations in their mandated domestic medical screening (CDC 2014). Making matters worse, the ORR protocol only includes a brief behavioral health assessment within its broader medical examination recommendations and its current procedural terminology (CPT) codes do not include behavioral health diagnostic services (ORR 2012). Without CPT codes, providers cannot bill the federal government for assessing psychiatric conditions, which further disincentivizes them from conducting lengthy behavioral health assessments of newly resettled refugees during their medical screening. These shortfalls explain the wide variance between states in how behavioral health assessments are included in the Domestic Medical Examination for Newly Arrived Refugees. A survey of state refugee health coordinators in 2012 found that only a little more than half of states screened refugees for behavioral health symptoms (56.8%), and less than half assessed refugees for traumatic exposures, such as armed conflict or torture (47.7 and 43.2%, respectively) (Shannon et al. 2012). Although this data was collected shortly before the inclusion of the CDC guidelines in the ORR domestic medical screenings protocol, a follow-up study in 2015 found persistent shortfalls in the inclusion of behavioral health assessments in the domestic medical screenings of refugees (Shannon et al. 2015a).

States also face a variety of unique financial and logistical challenges that can affect their ability to support the behavioral health needs of their refugee populations. For example, the ORR's Services for Survival of Torture Program provides about $10.5 million in grants annually to resettlement agencies and partnered organizations to provide behavioral health services to torture survivors and their families, but this support varies significantly at the state level (Ostrander et al. 2017). State-to-state differences in public sector health care funding, refugee numbers, and resettlement distribution can also affect the

provision of behavior health services. The District of Columbia, Maryland, and Virginia, examined as representative jurisdictions for the rest of the country in this study, illustrate these differences. Maryland and Virginia have moderate refugee populations, with 1508 and 1312 refugee resettled respectively in each state in 2015 (Office of Refugee Resettlement [ORR] 2016). Maryland, which has expanded Medicaid eligibility, has the bulk of its refugee population placed relatively close to urban areas with better access to behavioral health services and has created a Refugee Mental Health Coordinator position to manage the complex behavioral health needs of its refugees. Alternatively, Virginia has not expanded Medicaid eligibility in the state and has a larger population of refugees resettled in rural, lower-resourced areas where access to appropriate behavioral care is difficult. The District of Columbia has a much smaller refugee resettlement program, with only five newly arrived refugees resettled in 2015 (ORR 2016).

Resettlement agencies, by virtue of being the principal healthcare coordinators for the refugee population in the US, are an ideal setting where shortfalls in refugee behavioral health screenings and treatment services can be evaluated. This study sheds light on the current state of refugee behavioral health services in the US and offers actionable recommendations on ways to improve the current system by examining the practices of state refugee health coordinators and refugee resettlement agencies.

Methods

Data was gathered from two key groups: refugee resettlement agency staff and state refugee health coordinators. Information from the HHS's Office of Refugee Resettlement (ORR) on its voluntary agency affiliates was used to construct a list of refugee resettlement agencies in DC, Maryland, and Virginia. To ensure confidentiality, the District of Columbia is henceforth referred to as a state.

Each of these agencies was contacted by phone or email to participate in the study. Each agency that wished to participate suggested a key staff person who was most familiar with the behavioral health practices of the agency. These representatives completed a 20-min semi-structured phone interview on their organization's behavioral health practices.

A 20-min unstructured interview was also conducted with each of the state refugee health coordinators for DC, Maryland, and Virginia. These interviews provided information on how each jurisdiction approached behavioral health assessment and treatment of its refugees in the resettlement process.

A simplified version of the unstructured interviews in survey form was sent by email to every state refugee health coordinator in the country.

For non-open-ended interview and survey questions, descriptive statistics were used to illustrate results. Responses to open-ended questions were coded and analyzed qualitatively for trends and themes.

The George Washington University Committee on Human Research Institutional Review Board determined that this research was exempt from IRB review under DHHS regulatory category 2.

Results

Refugee Resettlement Agency Staff

Interviews were conducted with 16 of the 23 organizations identified in the three key project states. Of those 16 agencies, 10 provided direct refugee resettlement services. Within these ten agencies, behavioral health support services varied, as shown in Table 1.

Only one agency had a medical professional on staff to provide on-site behavioral health services, while two other agencies contracted with outside organizations to provide in-house behavioral health services on a recurring basis. Eight of the ten agencies provided behavioral health referrals, either by request or as deemed appropriate by agency staff based on presentation of behavioral health symptoms. The frequency of referrals was generally low; most agencies reported that 1–10% of refugee clients received behavioral healthcare referrals, though one outlier estimated that 15–20% of its agency's refugees received referrals. This outlier agency utilized a common screening tool, the Refugee Health Screener-15 (RHS-15), to identify clients in need of further behavioral health assessment and treatment.

Each agency held a cultural orientation seminar with every newly arrived refugee that incorporated instructions on how to successfully navigate the complexities of the US healthcare system. Three of the interviewed agencies reported that their cultural orientation seminar had information on behavioral health. This included the agency that implemented the RHS-15 screening tool, an agency that provided general information to each client on behavioral health resources in the event they experienced symptoms, and an agency that reported that behavioral health was informally touched on in its cultural orientation. The remaining agencies reported that behavioral health was left to the domain of providers who conducted the domestic medical screening of the refugees.

Every agency interviewed reported obstacles in their efforts to meet the behavioral health needs of newly arrived refugees. The most common barrier described was the difficulty of identifying individuals that needed behavioral health care, made worse by the overall lack of direct requests for behavioral health services by their clients. One agency explained, "Every client receives information on where they can go [for behavioral health assistance]. A lot of the time they won't request that help because there is so

Table 1 Methods of behavioral health support in refugee resettlement agencies in the District of Columbia, Maryland, and Virginia

Service	Number of agencies that provide service	Percentage of agencies that provide service
Behavioral health services in house: available at all times by request	1	10%
Behavioral health services in house: available once a week	2	20%
Provide direct behavioral health referrals as necessary	8	80%
Include behavioral health in cultural orientation	3	30%

much stigma from their culture." Another agency noted that the most common impetus for providing a behavioral health referral is a request from a client's family, rather than from the client involved, due to both the stigma of behavioral health disorders and a lack of knowledge that assistance is available.

Half of the agencies reported difficulty identifying linguistically and/or culturally appropriate behavioral healthcare services for refugee referrals. These agencies were concerned that healthcare services in their area would not even have the language capability to meet the behavioral health needs of their clients, let alone the correct cultural nuances and social contexts of the various traumas that they may have experienced. One agency noted the pervasive lack of behavioral health screening tools for refugee children.

State Refugee Health Coordinators

Of the 48 states contacted for the short coordinator survey, only six responded. Because of the limited sample size, these results can be only seen as a partial reflection of the national trends in behavioral health screenings and services in states. In 2015, one of the participating states resettled fewer than ten refugees, three states resettled between 100 and 1000 refugees, and two states resettled between 1000 and 2000 refugees. Five of the six states had expanded Medicaid coverage.

Five of the six states (83.33%) that responded reported that their domestic health screenings followed the CDC behavioral health screening guidelines, while one state reported that the guidelines were followed inconsistently. This state had a relatively small number of incoming refugees and lacked the capacity to promote and enforce the consistent application of the CDC behavioral health screening guidelines by partnered refugee resettlement organizations. The screening rates of various behavioral health-related conditions and the screening methods used are shown in Table 2.

All six states reported that they consistently screened for behavioral health symptoms, war trauma, and torture. Five states reported the use of the RHS-15 screener as a formal standardized questionnaire to assess the behavioral health of their refugee population. However, the RHS-15 only detects emotional distress and a limited number

Table 2 Frequency and method of screening for behavioral health components in the domestic medical screening

	Formal standardized questionnaire	Self-developed formal questionnaire	Formal interview	Informal conversation	Do not screen
Mental health symptoms	5 (83.33%)	0 (0.00%)	1 (16.67%)	2 (33.33%)	0 (0.00%)
War trauma	2 (33.33%)	0 (0.00%)	0 (0.00%)	4 (66.67%)	0 (0.00%)
Torture	2 (33.33%)	0 (0.00%)	0 (0.00%)	4 (66.67%)	0 (0.00%)
Alcohol /drug abuse	1 (16.67%)	1 (16.67%)	0 (0.00%)	3 (50.00%)	1 (16.67%)
Domestic violence	1 (16.67%)	1 (16.67%)	0 (0.00%)	3 (50.00%)	1 (16.67%)

Percentages for methods per category may exceed 100% due to multiple responses (i.e., a state may use different methods to screen for a category in different situations)

of common symptoms associated with mental disorders in the refugee population, so there may have been reporting errors on the use of formal standardized questionnaires for the detection of the other specific categories of behavioral health diagnosis and trauma that the states purported to screen for. Alcohol/drug abuse and domestic violence were the only categories that these states reported to not include in their behavioral health screening.

Two of the six coordinators felt their state had enough resources to conduct the mandated behavioral health screenings. One of these coordinators was from the state with the fewest refugee resettlements in this study. The coordinator noted that having fewer than ten refugees per year allowed the state to meet each refugee's behavioral health needs with the existing resources. The other coordinator was from a state that had not expanded Medicaid, though the state government had made a policy commitment to addressing refugee-specific needs that may have compensated for the lack of overall Medicaid funding behavioral health.

The remaining four coordinators felt their state lacked adequate resources to conduct the appropriate behavioral health assessment of their refugee population. These coordinators noted barriers that included a lack of linguistically and culturally sensitive providers, providers' discomfort with assessing war trauma and torture, limited funding, and lack of behavioral health and primary care providers in general. One coordinator also noted the lack of appropriate screening tools for child refugees under the age of 14. Another coordinator also highlighted the difficulty of implementing the CDC guidelines when they can be so loosely implemented: "Funding and interpreting needs are big challenges. Health providers do try to come up with ways to supplement the funds and provide interpreting services at their own cost, but these can really add up quickly. The funding resources we have had in place to provide such services has been dwindling, and because mental health screening is only recommended and not mandatory by the CDC, it makes it a little challenging to enforce consistency."

Interviews with Refugee Health Coordinators in Representative Jurisdictions

Health coordinators in the District of Columbia, Maryland, and Virginia identified similar barriers to refugee behavioral health screening. Two of the states used the RHS-15 screening tool, though to varying degrees; one state used the tool consistently state-wide, while the other state reported that the screening tool was usually, though not always, used. The states also reported that while RHS-15 had been integral to their behavioral health screening success, it had its limitations. Health coordinators explained that the RHS-15 had not been validated as a tool for the behavioral health diagnosis of refugees under the age of 14 and had not been translated into the predominant languages spoken by their refugee populations. The states also reported that it was often difficult to identify professionals who could deliver the appropriate behavioral health care to refugees. One state reported that the mandated behavioral health assessments were inconsistently applied because of the lack of a referral network for treatment, which made any diagnosis futile and therefore a waste of the state's resources for this population. Furthermore, the coordinators noted that the CDC guidelines' emphasis on communicative diseases instead of primary care stretched the state's limited healthcare resources and reduced the momentum to implement the mandated behavioral health services.

The state that reported the consistent state-wide implementation of the RHS-15 had trained screening providers and interpreters on the RHS-15 and refugee behavioral health care. Another coordinator noted that it had been important to educate healthcare

providers specifically on the availability and necessity of interpretation services. The states also promote behavioral health of their refugee populations outside of the screening process, including support groups, health and wellness seminars and trainings for refugee resettlement staff to better identify behavioral health symptoms and provide referrals.

Discussion

Federal and State Policy Recommendations

This study exposes the many barriers that prevent refugees in the US from accessing the appropriate levels of behavioral health screening and care, despite improvements in the evaluation process since the release of the CDC's guidelines. Resolving these shortfalls is contingent on implementing new state and national policies to expand the healthcare resources available to refugees. This can begin by consolidating the US State Department's workup of prospective refugees, which currently entails multiple clinical evaluations and interviews, into one exam that includes a robust behavioral health screening component. The State Department should also consider contracting this work to capable local clinics or practitioners that are better equipped to conduct culturally informed behavioral health assessments. This would reduce the burden placed on domestic agencies, especially in low-resource areas, that might not have access to specialists and culturally informed providers during the resettlement process.

Funding shortages were also noted by both refugee resettlement agency staff and state refugee health coordinators, highlighting the need for Congress to increase its appropriations towards Medicaid reimbursement for refugee behavioral health services and the HHS's Office of Refugee Resettlement (ORR). A model for this already exists in Section 223 of the Protecting Access to Medicare Act of 2014 (Public Law 113-93). The law mandates that selected demonstration states adopt an enhanced Prospective Payment System, a method of reimbursement in which Medicaid payments for behavioral health services are made on a predetermined enhanced rate that has been shown to incentivize clinics and providers to provide high-quality behavioral healthcare to their Medicaid insured populations. The law also mandates a series of core services to qualify for the enhanced reimbursements, including comprehensive screening and treatment for behavioral health and addiction disorders and crisis mental health support (Substance Abuse and Mental Health Services Administration [SAMHSA] 2017). Our study indicates that such funding increases need to be coupled with more oversight of refugee resettlement agencies by the ORR to ensure that federally required behavioral health services are appropriately delivered on a local level.

While the flexibility of the CDC's guidelines for assessing the behavioral health of newly arrived refugees may be convenient for providers who lack the capacity to conduct its entire scope, it does lend itself to glaring inconsistencies and omissions in screening practices between states and agencies as evidenced in this study. ORR should call for a designated minimum number of components in the CDC guidelines to be carried out in every US Domestic Medical Examination for Newly Arrived Refugees, which would bring much needed uniformity and efficacy to the mandated behavioral health assessment process. The ORR can also supplement its RHS-15 screening tool,

which has been shown to have linguistic and diagnostic limitations, with other screeners such as the Harvard Trauma Questionnaire and the Beck Depression Inventory, as both have been adapted to varied cultures and shown to be effective in assessing refugees (Fellmeth et al. 2018).

As highlighted by the participants in this study, the RHS-15 has not been validated for children under 14, thereby excluding some of the most vulnerable refugees in the US from being adequately assessed for behavioral health disorders. Children often have limitations in cognition, vocabulary, and insight relative to adult subjects, making them particularly difficult to evaluate. The ideal behavioral health screener needs to be conducted on parent-child pairs, with the parent's observational report supplementing the child's self-reported symptoms. This makes the Strengths and Difficulties Questionnaire (SDQ) the most practical solution to evaluating the behavioral health status of this population. The SDQ is a brief emotional and behavioral screener that can be administered to 11- to 17-year-old children and includes a version that can be given to parents of children 3 to 17 years of age. Its reliability and validity has made the SDQ one of the most widely used measures of adjustment and psychopathology of children and adolescents, and it has been translated into more than 80 languages (Goodman 2006). The ORR should mandate the use of SDQ during the initial domestic medical exam of refugee children as a first step to determine whether other more disorder-specific scales (such as the UCLA Child/Adolescent PTSD Reaction Index) need to be administered or more in-depth clinical evaluation of a child's behavior health by a specialist is warranted.

Our study participants often indicated that the lack of linguistic fluency also presented a barrier to assessing the behavioral health of refugees. This is consistent with previous research which demonstrated that refugees often have difficulty communicating with healthcare providers and, even those with limited English fluency, may not have the requisite vocabulary to communicate their emotional distress (Asgary and Segar 2011; Worabo 2016). According to the Centers for Medicare & Medicaid Services, "All providers who receive federal funds from HHS for the provision of Medicaid/CHIP services are obligated to make language services available to those with Limited English Proficiency (LEP) under Title VI of the Civil Rights Act and Section 504 of the Rehab Act of 1973" (Centers for Medicare and Medicaid Services [CMS] 2018). The deficit of interpretive services in the health assessment of newly arrived refugees highlights the lack of oversight on both the ORR and state Medicaid administrators who should ensure that contracted refugee healthcare providers meet the HHS's mandate for language services. In low-resource states where public sector healthcare is already overstretched, refugee resettlement agencies could shoulder some of the administrative responsibility for language services by identifying appropriate in-person or remote interpreters for the provision of healthcare services to their clients.

Procedural Recommendations at the Refugee Resettlement Agency and Practitioner Levels

Many factors can be associated with the reported reluctance of refugees to engage with healthcare professionals and case managers on behavior health issues, including the atypicality of using behavior health services in a refugee's country of origin, prevailing fears of disempowerment stemming from a refugee's past authoritarian doctor-patient

experience, or a lack of medical insight and navigation skills to proactively seek the appropriate care (Shannon et al. 2015b; Saechao et al. 2012). This is made worse by agency-level shortfalls in communicating the availability of behavioral health services (Bartolomei et al. 2016). Resettlement agencies can lower these barriers by educating refugees to be aware of behavioral health conditions in their module on healthcare and Medicaid insurance plans held during every initial cultural orientation for newly resettled refugees in the US (Worabo 2016). Specifically, agencies need to show their clients that these conditions are a valid medical concern that can have both emotional and somatic presentations and, if left untreated, can have long-term consequences. Agencies also need to shed light on available treatment resources in their area and assure their clients that their behavioral health care will be conducted in a safe and confidential manner. A clear algorithm to aid refugees in navigating the behavior health terrain, starting at the point of contact with a refugee's case worker or medical examiner, should be developed and distributed by every resettlement agency.

Agency staff in this study also highlighted the role of cultural prejudices and social stigma as major barriers against detecting and treating behavioral health disorders among refugees, leading to the underreporting of symptoms and low utilization rates of healthcare resources. Sociologist Erving Goffman characterized stigma as any physical or social attribute that diminishes the identity of an individual in society, disqualifying the person from full social acceptance. The accompanying shame of not having met expected societal standards often causes the individual to not reveal their shortcoming (Goffman 1963). Prior work on stigma among refugees has shown that they often avoid expressing emotional distress out of fear of being labeled insane and shunned from their community, being incarcerated in a psychiatric ward, or losing their jobs or housing because of a psychiatric diagnosis (Shannon et al. 2015b). This stigma also extends to providers in the US healthcare system, who often miss signs of depression and trauma, which can be masked by culture-specific expressions of distress. Similarly, they can misjudge normal variations in behavior, belief, or experience that are particular to a refugee's background as psychopathology. This diagnostic distortion is worsened by broader societal prejudices to which healthcare professionals are unlikely to be immune, such as an unfavorable view of certain ethnic or religious groups (Kaleem 2015).

The use of evidence-based and cross-culturally validated behavioral health screening tools can play an effective role in reducing caregiver missives and biases. This can start at the agency level, with a more consistent application of the RHS-15 screening tool. The RHS-15's brevity and uncomplicated scoring methodology makes it a useful initial screening tool for non-medical resettlement agency staff to detect signs of emotional distress among newly arrived adult refugees (Pathways to Wellness 2011). This can be followed up in the clinical setting with more targeted and validated cross-cultural instruments capable of measuring psychiatric disorders (Afkhami 2016).

The prevailing stigma among refugees, practitioners, and other client facing staff can also be mitigated if resettlement agencies supplement the broader use of screening tools with community-partnered and culturally tailored programs that foster bi-directional learning between the refugee population, agency staff, and partnered healthcare providers. This can help staff and providers better understand the culture-specific idioms of distress and social mores associated with traumatic experiences and mental illness among the population of refugees they serve (Murray et al. 2010). Community-

partnered interventions can also help reduce the taboo and stigma that refugees often associate with mental health conditions. They can also engender trust, dispel myths associated with behavioral health care, and increase community support and resilience (O'Mahony and Donnelly 2010). To accomplish this, it is critical for all resettlement agencies to seek out community partners who have the capacity to train their staff in the basic concepts of psychological first aid and cross-cultural behavioral health, allowing resettlement agencies to play a more effective role in meeting the behavioral health needs of their clients.

Conclusion

The sampled subjects in this study provided enough data to construct a multilevel set of policy recommendations to address the shortfalls in the allocation of behavioral health services to refugees in the US. On the national level, more federal funds are needed to expand healthcare entitlement programs such as Medicaid and the Children's Health Insurance Program (CHIP), which refugees depend on for their medical coverage. More funds are also needed to allow the ORR to tackle the deficiencies in the assessment and treatment of refugees. Both state and federal agencies also need to take a more active role in ensuring that behavioral health mandates for refugees are universally and consistently applied. On the local level, resettlement agencies can rapidly implement community-partnered programs, at a relatively low cost, to reduce client and provider stigma and to enable their staff to detect early signs of emotional distress that warrant more specialized clinical behavioral health interventions. These local measures should reverse some of the observed trends in low service utilization and cultural barriers to behavioral health screening and treatment in the short term. Future research is needed to look at these barriers in a larger sample size of states to increase our understanding of these barriers in the context of the varied social, economic, and environmental settings in the country.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors. GWU IRB#: 101610, determined research not involving human subjects.

Informed Consent Informed consent was obtained on all questionnaires.

References

Afkhami, A. A. (2016). Can academic medicine lead the way in the refugee crisis? *Academic Medicine, 91*(12), 1595–1597.

Asgary, R., & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved, 22*(2), 506–522.

Bartolomei, J., Baeriswyl-Cottin, R., Framorando, D., Kasina, F., Premand, N., Eytan, A., & Khazaal, Y. (2016). What are the barriers to access to mental healthcare and the primary needs of asylum seekers? A survey of mental health caregivers and primary care workers. *BMC Psychiatry, 16*(1), 336.

Bogic, M., Ajdukovic, D., Bremner, S., Franciskovic, T., Galeazzi, G. M., Kucukalic, A., Lecic-Tosevski, D., Nexhmedin, M., Popovski, M., Schutzwohl, M., Wang, D., & Priebe, S. (2012). Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK. *The British Journal of Psychiatry, 200*(3), 216–223.

Centers for Disease Control and Prevention [CDC]. (2014). Guidelines for the U.S. domestic medical examination of newly arriving refugees. http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html. Accessed 25 June 2018.

Centers for Medicare and Medicaid Services [CMS]. (2018). Translation and Interpretation Services. https://www.medicaid.gov/medicaid/finance/admin-claiming/translation/index.html. Accessed 25 June 2018.

Derr, A. S. (2016). Mental health service use among immigrants in the United States: a systematic review. *Psychiatric Services, 67*(3), 265–274.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: a systematic review. *Lancet, 365*(9467), 1309–1314.

Fellmeth, G., Plugge, E., Fazel, M., Charunwattana, P., Nosten, F., Fitzpatrick, R., Simpson, J. A., & McGready, R. (2018). Validation of the Refugee Health Screener-15 for the assessment of perinatal depression among Karen and Burmese women on the Thai-Myanmar border. *PLoS One, 13*(5), e0197403. https://doi.org/10.1371/journal.pone.0197403.

Goffman, E. (1963). *Stigma; notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

Goodman, R. (2006). The strengths and difficulties questionnaire: a research note. *The Journal of Child Psychology and Psychiatry, 38*(5), 581–586.

Hall, R. C. W., & Wise, M. G. (1995). The clinical and financial burden of mood disorders. *Psychosomatics, 36*(2), S11–S18.

Kaleem, J. (2015) More than half of Americans have unfavorable view of Islam, poll finds. Huffington Post. http://www.huffingtonpost.com/2015/04/10/americansislam-poll_n_7036574.html. Accessed 1 June, 2018.

Kearns, M. C., Ressler, K. J., Zatzick, D., & Rothbaum, B. O. (2012). Early interventions for PTSD: a review. *Depression and Anxiety, 29*(10), 833–842.

Keller, A., Joscelyne, A., Granski, M., & Rosenfeld, B. (2017). Pre-migration trauma exposure and mental health functioning among Central American migrants arriving at the US border. *PLoS One, 12*(1), e0168692.

Médecins Sans Frontières. (2017). Forced to flee Central America's northern triangle: a neglected humanitarian crisis. https://www.msf.org/sites/msf.org/files/msf_forced-to-flee-central-americas-northern-triangle_e.pdf. Accessed 25 June 2018.

Mollica, R. F., McInnes, K., Poole, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *British Journal of Psychiatry, 173*(DEC.), 482–488.

Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health, 34*(6), 529–538.

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry, 80*(4), 576–585.

Nicholson, B. L. (1997). The influence of pre-emigration and post-emigration stressors on mental health: a study of Southeast Asian refugees. *Social Work Research, 21*(1), 19–31.

Office of Refugee Resettlement [ORR]. (2012). Domestic medical screening guidelines checklist. http://www.acf.hhs.gov/programs/orr/resource/medical-screening-protocol-for-newly-arriving-refugees. Accessed 25 June 2018.

Office of Refugee Resettlement [ORR]. (2016). FY 2015 Served populations by state and country of origin (refugees only). http://www.acf.hhs.gov/orr/resource/fy-2015-refugees-by-state-and-country-of-origin-all-served-populations. Accessed 25 June 2018.

O'Mahony, J., & Donnelly, T. (2010). Immigrant and refugee women's post-partum depression help-seeking experiences and access to care: a review and analysis of the literature. *Journal of Psychiatric and Mental Health Nursing, 17*(10), 917–928.

Ostrander, J., Loomis, A., & Berthold, S. (2017). Working with refugees in the U.S.: trauma-informed and structurally competent social work approaches. *Advances in Social Work, 18*(1), 66–79.

Pathways to Wellness. (2011). Integrating refugee health and well-being creating pathways for refugee survivors to heal. http://refugeehealthta.org/wp-content/uploads/2012/09/RHS15_Packet_PathwaysToWellness-1.pdf. Accessed 25 June 2018.

Saechao, F., Sharrock, S., Reicherter, D., Livingston, J. D., Aylward, A., Whisnant, J., Koopman, C., & Kohli, S. (2012). Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. *Community Mental Health Journal, 48*(1), 98–106.

Scott, K. M., Lim, C., Al-Hamzawi, A., et al. (2016). Association of mental disorders with subsequent chronic physical conditions: world mental health surveys from 17 countries. *Journal of the American Medical Association Psychiatry, 73*(2), 150–158.

Shannon, P., Im, H., Becher, E., Simmelink, J., Wieling, E., & O'Fallon, A. (2012). Screening for war trauma, torture, and mental health symptoms among newly arrived refugees: a national survey of U.S. refugee health coordinators. *Journal of Immigrant and Refugee Studies, 10*(4), 380–394.

Shannon, P., McCleary, J., Wieling, E., Im, H., Becher, E., & O'Fallon, A. (2015a). Exploring mental health screening feasibility and training of refugee health coordinators. *Journal of Immigrant and Refugee Studies, 13*(1), 80–102.

Shannon, P., Wieling, E., Simmelink-McCleary, J., & Becher, E. (2015b). Beyond stigma: barriers to discussing mental health in refugee populations. *Journal of Loss and Trauma, 20*(3), 281–296.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. *Journal of the American Medical Association, 302*(5), 537–549.

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry, 188*(1), 58–64.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2017). About Section 223. https://www.samhsa.gov/section-223/about. Accessed 25 June 2018.

The Office of the United Nations High Commissioner for Refugees [UNHCR]. (2015). UNHCR mid-year trends 2015. http://www.unhcr.org/56701b969.html. Accessed 25 June 2018.

The Office of the United Nations High Commissioner for Refugees [UNHCR]. (2016). Global trends forced displacement in 2015. http://www.unhcr.org/576408cd7.pdf. Accessed 25 June 2018.

Ullmann, E., Barthel, A., Taché, S., Bornstein, A., Licinio, J., & Bornstein, S. R. (2015). Emotional and psychological trauma in refugees arriving in Germany in 2015. *Molecular Psychiatry, 20*(12), 1483–1484.

United States Department of State [DOS], Bureau of Population, Refugees, and Migration. (2013). Refugee Resettlement in the United States. https://2009-2017.state.gov/j/prm/releases/factsheets/2013/203578.htm. Accessed 25 June 2018.

United States Department of State [DOS], Bureau of Population, Refugees, and Migration. (2015). FY15 Refugee admission statistics. https://2009-2017.state.gov/j/prm/releases/statistics/251285.htm. Accessed 25 June 2018.

Worabo, H. (2016). Understanding refugees' perceptions of health care in the United States. *Journal for Nurse Practitioners, 12*(7), 487–494.