From Classroom to Clinic: A Discussion of Mental Health Access for Refugee Youth in Charlottesville, Virginia

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Nicele E. Puente

Introduction

As one of Virginia's main refugee resettlement agencies, the International Rescue Committee (IRC) in Charlottesville has resettled over 3,000 refugees fleeing violence or persecution since 1998[12]. Frequently, refugee flight is due to violent or hostile circumstances in their home countries, putting refugees at increased risk for emotional and psychological stress. But as a whole, this population consistently under-utilizes mental health resources after resettlement[4,6]. Studies have shown that refugees who resettle into a Western culture distinct from their own face both functional and social barriers to the effective use of healthcare[1,9]. For younger refugees, the family separations, cultural upheaval and post-migration challenges associated with refugee migration have profound impact because they often experience disruption and loss beyond their control during formative periods in their development. These pressures challenge mental resilience and the healthy formation of identity and attitudes[3,7]. They also increase susceptibility to mental, behavioral, and even physical disorders that may persist into adulthood[7].

Past studies have been done in Western host countries to identify the needs of young, non-Western refugees, assess the adequacy of existing resources, and/or evaluate pilot programs to improve the lives and social integration of this population. The growing consensus recommends an integrated approach linking community resources such as teachers, primary care providers, and refugee support services to identify issues that may inhibit healthy development[4,5,7]. Our study attempts to contribute to this body of evidence by assessing the integrated mental health support available for refugees aged 14-20 in Charlottesville, Virginia. Our primary research question was: "What are the facilitators and barriers to mental health access for Charlottesville's young refugee population?" Direct interaction with the vulnerable young refugee population was not possible in this study, so we aimed to answer this question by collecting and examining responses from groups that provide key services to this group in Charlottesville. The goals were to determine the perception of need in this population, how effectively existing resources connect patients to care, and how the process of patient identification and referral can be improved.

Method

We conducted community-based, qualitative data collection to obtain subjective responses from key providers in the community. Participants were recruited from three groups: primary care providers at the International Family Medicine Clinic (IFMC), school faculty or coordinators who work with refugee students through ESL/ESOL[‡], and community managers who coordinate refugee classroom support through the school districts, the International Rescue Committee (IRC), or Region Ten[§]. We asked supervisors within each organization and the school boards to identify eligible participants with knowledge of classroom or clinical experiences of young refugees. The identified personnel were invited by e-mail to participate in the study, and our participants volunteered and consented by activating their survey link.

A base survey was created to elicit attitudes and experiences relevant to the primary research question. This was used to create a clinic-oriented version for health providers, and an education-oriented version for school faculty. The surveys were administered using SurveyMonkey online software, which collected and aggregated the responses. Survey questions were a combination of multiple choice, ranking, and free response. Community managers, who were less likely to work with refugees on a regular basis, were interviewed using a script addressing the same themes as the base survey, but with a broader perspective more relevant to their positions. These interviews were conducted either in person or over the phone and were later transcribed.

Survey and interview responses were coded and analyzed qualitatively for trends. Common themes were identified (defined as greater than 50% of respondents expressing a similar sentiment, either within a respondent group or across multiple groups). The UVA Institutional Review Board approved all methods, questionnaires, and recruitment materials for this study in 2014.

[‡] English as a Second Language (Charlottesville City Schools)/ English for Speakers of Other Languages (Albemarle County Schools)
[§] The region's Community Mental Health Services Board

Participant Sources

Clinical professionals were recruited from the IFMC within the University of Virginia Health System with the approval of the clinic director, who was also an advisor on this project. ESL/ESOL educators were recruited from Charlottesville City Public Schools and Albemarle County Public Schools with the approval of both school districts. Community managers were recruited for their role as coordinators in refugee support organizations with insight to patient access and overall trends.

Supporting Information

In addition to the respondent portion of this inquiry, other contextual information was collected during site visits to the Health Department, Region Ten, the International Family Medicine Clinic, Charlottesville IRC office, Refugee Dialog Meetings (attended by various Charlottesville agencies that serve or represent refugees), a Refugee Coordinating Committee meeting, as well as a meeting with the ESOL liaison for County schools. Finally, a literature review was performed in 2014 and again in 2017 into the growing body of research related to this topic.

Limitations

The time frame and scope of this study posed several limitations. The greatest limitation was our inability to directly collect data from the population of interest (refugee youth aged 14-20) due to IRB constraints. Our respondent pools were small in size due to reduced summer availability of faculty and clinicians. The author of this paper generated the surveys, interviewed respondents, and was also the single source of coding and organizing the responses into themes. With a longer time frame, this study could be improved by collecting responses directly from students and their parents and recruiting more participants, coordinating focus groups for respondents to foster group discussion, and enlisting the aid of objective resources to codify and analyze the responses.

Results

A total of 18 respondents participated in this research inquiry, consisting of IFMC Clinicians (n=6), Public School Faculty (n=9), and Community Managers (n=3).

IFMC Clinicians (n=6):

The IFMC was established in 2002 specifically to ease some of the health care barriers for Charlottesville's growing refugee population and is the primary care clinic for all refugees in Charlottesville resettled by the IRC. It now has a population of over 2,000 immigrant and refugee patients[17]. IFMC clinicians receive training and experience in cultural awareness and special health considerations for refugee and immigrant patients. Language support is readily available through interpreters and telephone support for a wide range of languages[17,18]. The staff includes a dedicated social worker and nurse care coordinator who provide assistance with transportation, paperwork, and resource coordination (UVA-IFMC article), and a partnership exists with UVA Psychiatry to support referrals with a resident team assigned to the IFMC. There were six clinical respondents from the IFMC to the Clinical Survey that included physicians (n=3), nurse practitioners (n=2), and one psychologist (n=1) from the associated Family Stress Clinic (FSC), which offers counseling and behavioral health support.

Clinician Common Themes: Selected Highlights

- 100% of clinical respondents reported that "some" or "most" of their young refugee patients had been exposed to either physical or emotional trauma (as opposed to "few" or not knowing).
- 100% of respondents felt that history of their patients' flight was helpful in approaching and managing their care, but none reported having such information when first meeting a refugee patient.
- 100% of respondents "disagree" or "strongly disagree" with the statement: "I am able to conduct a mental health screening for all young refugee patients soon after arrival, and I continue to assess them with each subsequent visit".
- There was no single instrument that all clinician respondents used to conduct mental health screens.
- Clinicians unanimously rated teachers as the second most useful source of "collateral history" when evaluating the total well-being of a patient, right after the patient's parents, and just before school counselors.
- Of the five clinical respondents who answered this question: "Do you find that behavioral, social, or mental disturbances in young refugees tend to present as physical symptoms in clinic?", all five answered affirmatively, reporting complaints of headache, stomach pain as the most common complaints.
- All clinicians with patients who were receiving mental health services used in-house services, primarily via the existing IFMC partnership with Psychiatry residents or the Family Medicine Stress Clinic, citing language barriers and insurance issues

as reasons that other options do not benefit their patients.

- Two respondents felt less than adequately confident about identifying and addressing mental wellness in young refugee patients with one saying, "I am sure that I miss a great deal of mental illness...there is generally so much information to cover that I don't have enough time… to perform an adequate screen".
- All respondents felt that input from cultural leaders from the refugee community and imagonal training opportunities specific to the wellness of this population would provide useful insight to addressing their patients' needs.

ESL/ESOL Faculty (n=9):

Most refugee students participate in ESL/ESOL programs at school, some of who have never experienced a structured classroom before. In 2013, Albemarle County's International/ESOL (English for Speakers of Other Languages) program enrolled 879 students, 13% of which were refugees[19]. In 2014, Charlottesville City's ESL (English as a Second Language) program enrolled 438 students, 74% of which were refugees [16]. The teachers in these programs are frequent observers of this population's response to social pressures and academic challenges over time. According to an interview with ESL /ESOL coordinators, faculty in both divisions establish long-term relationships with their students, working with both inside and outside of the classroom to support integration and success in their new setting. There were nine respondents to the School Faculty Survey, split evenly between Charlottesville City ESL faculty (n=4) and Albemarle County ESOL faculty (n=4), with one respondent (n=1) associated with both school districts.

ESL/ESOL Common Themes: Selected Highlights
- 100% of respondents reported that background information about refugee flight history is relevant in a school setting, citing opportunities for early support and intervention as the most important reasons.
- Most faculty reported that the IRC was the main source of background information about incoming refugee students, but IRC personnel reported via interview that this information is often incomplete, if they receive it at all. Teachers in the Albemarle County school district receive consolidated "intake reports" from their ESOL office, but may not specifically include a history of hardships or emotionally difficult experiences for the same reason.

- Seven of the nine survey respondents felt that "some" or "most" of their refugee students have been exposed to physical or emotional trauma. The remaining two did not feel like they had a good enough perception to respond.
- No school-based mental health or stress assessments exist for newly arriving refugee students, which was assumed by at least one respondent to be a part of the arrival process or clinical intake process at UVA.
- When asked if educators were trained to identify potential signs of mental stress in the general student population, four respondents answered "No" and five answered "Other", citing optional training opportunities or other trained personnel within the school.
- 60% of respondents "did not know" if behavioral, social, or mental disturbances in young refugees present as physical symptoms that may bring them to the school nurse. One respondent who responded "yes" did note that "headaches and stomach aches" were most common.
- While some respondents felt familiar with referral procedures to mental health services, the need for a "clear referral process" was echoed in several comments. No respondents felt that referrals were easy to make, or that the services were conveniently accessed by refugees. Language was cited as the most frequent barrier. Two participants responded that "there are no referral procedures in place that provide access to mental health services". When asked what made the referral process difficult, one response was, "I honestly wouldn't know where to begin".
- When teachers suspect the need for a formal mental health assessment, they tend to rely on schoolhouse resources (school counselor, psychologist) and do not utilize direct contact with the student's primary health care provider.

Community managers (n=3):

Community managers were recruited from Region Ten, the IRC, and ESL coordinators for their perspectives on access and use within their organizations, and knowledge of coordination with other agencies, schools, and the IFMC. Region Ten is a state agency that provides mental health services to Charlottesville and surrounding counties including school-based therapeutic day treatment. IRC Charlottesville provides resettlement services and initial support for newly arrived refugee families, including housing, medical coordination, and school enrollment. ESL/ESOL managers on the school district level analyze

trends and developing needs for their students, allowing them to coordinate support for their teachers. The three respondents we recruited from these groups contributed responses via interview.

Community Manager Common Themes: Selected Highlights

- The community managers from all three sources endorsed the sentiment that access to mental health resources is challenging for the refugee population as a whole.
- Managers from IRC and Region Ten both commented on language limitations as a barrier to coordinating services for refugees through Region Ten:
  - At the time of the interview, Region Ten's non-English speaking clients were all Spanish speakers due to the fact that there is "not much support for other languages [other than Spanish]"
  - A Region Ten representative stated, "There are retention issues in [Region Ten] services for non-English speakers because they find the barriers too great".
- Respondents from both Region Ten and the IRC commented on accessibility issues with Region Ten services:
  - An IRC representative reports reluctance to utilize Region Ten services because "accessibility is poor".
  - Region Ten requires families of students to "self-identify" by calling the 1-800 number themselves to access services. While they can be "encouraged to call", services cannot be initiated by a third-party social worker or physician, which are both points of access to interpreter assistance.
  - A Region Ten respondent admitted that their school-based services were prohibitively costly, and only Medicaid insurance was accepted.
  - Refugee families receive only eight months of Medicaid services after arrival[8].
- ESL/ESOL respondents from both districts focused on the challenges of mandatory SOL testing as a major classroom stressor for this population (see Table 3).
- IRC and ESL/ESOL respondents commented on inefficiencies and uncertainties in the identification of at-risk children in schools, citing unclear roles, procedures, and confounding language issues as barriers.

Discussion

The responses collected in this investigation show that Charlottesville has some clear strengths as a resettlement site, but also that significant coordination issues exist between its resources, making an integrated approach to support difficult. Responses were grouped into Limiting Factors (Table 1) and Facilitating Factors (Table 2). Each of these categories was further broken down into characteristics of the youth themselves and their families, the various Providers, or the System through which available services were provided.

Patient/Student Factors

Responses that described youth factors were actually more related to the parent/guardian's role as the "gatekeepers" of access, since these minors depend on their guardians to seek out appropriate resources on their behalf. Therefore, many of the factors in this category are related to the beliefs, practices, and priorities of parents or guardians who are simultaneously navigating the pressures of resettlement for the family. Respondents from all groups commented at length on the reluctance of some refugee families to volunteer information about their children's behavior, experiences, or mental health. Recurring themes included unfamiliarity or cultural discomfort with mental health issues in children, inadequate English skills to engage in meaningful dialog, and distrust or misconceptions about the educational or health care systems. These factors are often interrelated and should be addressed at the parental level before any meaningful progress can be made to reach their children.

Teachers often have the opportunity for first contact, after behavioral issues occur in the classroom. A school respondent reported that refugee parents often consider classroom concerns to be the teacher's responsibility, and therefore not an immediate concern of theirs. Since faculty may view such a mindset as parental avoidance or apathy, it is important to ensure that providers have an awareness of the other, simultaneous challenges faced by refugee parents (Table 3). The perspectives described above can make it hard to fully appreciate the concerns raised by a provider, and require extra efforts on the provider's part to establish dialog and trust. It was noted by school faculty that when parents were invited to the school with an interpreter to discuss concerns and a clear plan, parents became more willing to cooperate and share information about their past.

Systemic Factors

The vast majority of responses we collected were about systemic factors. Matters of procedure, workplace

practices, or the resources and training available to respondents seemed to generate the greatest discussion. Charlottesville has many systems-based advantages as a resettlement site, and respondents shared examples of how their organizations use resources and planning to provide support for refugee youth (Table 2). The International Family Medicine Clinic is a resource that, in the words of one respondent, "is unique to Charlottesville" in that it exists to provide primary care to refugee families with an awareness of the refugee experience, strong interpreter services, and a close partnership with mental health specialists. The IRC and IFMC have dedicated liaisons who function to help refugees navigate between the IRC, hospital, and the school systems.

Table 1: Limiting Factors

RESPONDENT COMMENTS: LIMITING FACTORS	
Limiting Patient/Student Factors	
Cultural Discomfort/Unfamiliarity with Mental Health Issues	
Schools	"This is a recurring issue in schools. Many refugee students struggle with what appears to be depression, anxiety, anger management issues and/or PTSD, but it is hard to know for certain. Families are usually unaware or reluctant to discuss such issues and students themselves rarely come forward to ask for help... often the student is hesitant"
	"I don't believe many [refugee parents] would volunteer informaiton unless they were directly asked"
	"Refugee students and their families are extremely diverse…some are quite open to discussing mental health issues and other have very clear reluctance to talk about these issues in any setting"
	"Greater awareness of mental health needs is needed in the reugee community and in the community at large"
	"Mental health is not addressed in many cultures"
	"From my experience, many children go untreated for mental health issues because of the taboo of mental illness in many cultures. It is very difficult to communicate this with families, especially if there are negative feelings around mental illness"
	"Avoidance is an issue, where refugees may tend to stay at home [if they drop out/ age out of school] and it can be hard to get in touch with them. Some have little English"
Managers	"Depends on how much insight they have, which is not related to level of education. Parents from [some cultures] can be especially resistant to accepting any cognitive issues… This can be a significant barrier."
Clinic	"There is lots of variation here. Some cultures seem very comfortable talking about depression and anxiety; others seem to focus on physical complaints and are uncomfortable with mental health issues"
	"Children do not present for mental health care as much as refugee adults do"
Poor English Language Skills	
Schools	"Even if the student agrees to counseling, there is no first language counseling available for almost all of our refugees"
	"There is lack of convenient communication between home and school due to language and literacy barriers"
	"Difficulty in communication [is a challenge], particularly in the ability to contact schools and ask questions of teachers/staff"
	"It is very hard for the counselors to communicate with children who have complicated stories and experiences…when they don't speak the same language"
	"Too often the voices of immigrant parents are unheard by schools… Schools that are not able to communicate with immigrant families will struggle to meet the needs of their children"
	"Cultural and language barriers can confound assessments"
Parents as the Gateway	
Schools	"Parents may know that the students have always had trouble learning, but don't always share that. This can be a significant problem"
	"Parenting is completely different in refugee cultures"
	"In order for kids to be successful, parents need to be successful"
	"[Parents can] lack knowlege about U.S. school system and processes"
	"[Parents can] lack of awareness regarding the school system, the healthcare system, the mental health system, services available for their children
	"Parents have difficulty in making appointments for help"
Managers	"Parents often do not worry about what happens in school. That is considered the teacher's job"
	"[Refugee parents] have barriers that other parents don't have to worry about"
	"Parents have a lack of awareness regarding the school system, health care system, mental health system, services vavailable for their children"
	"Some refugee parents hesitate to use resources [for their children] out of a distrust of public entities"

Limiting System Factors

Access Limitations

Managers	"Region Ten has some programs in schools but accessibility is poor, and often these children do not qualify"
	"[To access Region Ten services] Families of students need to self-identify and must call our 1-800 number themselves"
	"Mental health care is rocky. Pediatric PTSD is difficult. [Shares anecdote about a 16 year old girl who "is really struggling" and has had little success accessing the services she needs]"
	"[Region Ten's] school based therapeutic day treatment…is very intensive and therefore quite costly. Medicaid is the only payer source for this service because commercial insurance does not pay for therapeutic day treatment either"
	"I wouldn't say that anything is conveniently accessed by the IFMC population"

Missing Key Experiences/Flight Histories

Schools	"Sometimes we do not receive intake reports for some students"
	"It really often depends on who brings the child from the IRC, and whether we have a moment to talk"
	"Any traumatic expeience we usually pick up... when we see a problem with the child… then [IRC the schools liaison] will share what she know about the child's background"
	"When we ask, the family liaison can sometimes provide further information on past experiences"
	"I'm sure that some [refugee students] do have traumatic experiences, but it does not come up directly in interviews and is not information we can expect to receive ahead of time"
	"It would be helpful to receive information on family history and any trauma the child may have experienced before we start working with her/him, and if there is considered to be a mental health problem…which some kind of basic screening might find. It would be great for some kind of support to be put in place for her/him before she/he is placed in school"
Managers	On new arrivals to the IRC: "If a child has experienced violence it may or may not be documented. We may not be aware of it"
	"[As the sole IRC schools Liaison] I work directly with 25-30 families at one time, each with up to five children. My job is easier now than it used to be after learning to make the necessary connections"
Clinic	"I think it is important for [teachers] to know what the life experience of each child was prior to arriving to the US. It is easy to expect a child to adapt to our culture. Education was likely not the most important aspect of childhood for them…It is also important for the children to have a person to reach out to at school if they are feeling threatened, bullied, scared, or alone. Often the school age and teenage newly arrived refugees have expressed that they feel like outsiders"

Inconsistent Mental Health Screening

Schools	"Mental health [screening in school] is only initiated if there's a referral by a teacher or school personnel"
	"As far as I know, mental health is usually addressed with UVA hospital and not at school unless they are older"
	"No health screens are conducted by the school or within the school upon registration. These are conducted by licensed physicians in the community as part of a physical for students"
	"An initial mental health screening should be done in home country, but is often cursory"
Clinic	"I ask about exposure to violence; behavior and vague questions on sadness and interactions with others. I do not formally do a mental health screen"
	"[I use] general history and HEADDS model for adolescent history-taking [as a mental health screen]"
	"I have used the PHQ9"

Not Enough Language Support in Mental Health Services

Schools	"There is a dearth of bilingual therapists in our community"
	"Most often when a referral is attempted we find that there are no services available in the necessary language, and the referral is not completed"
Managers	"Language is a cultural challenge. Available interpreters [at Region Ten] mostly speak Spanish and there is not much support for other languages"
	"There are retention issues in our [Region Ten] services for non-English speakers because they find the barriers too great"
	"Charlottesville is not really the best place to choose as a resettlement site. The resources in language, skill sets, and community are limited"
Clinic	"Often the referral is made and the family does not make it to appointment because they are not aware of the place/time due to the language barrier"
	"Barriers to referrals primarily relate to language barrier if an outside referral is made"
	"It is hard to find providers who use translators and accept Medicaid"
	"There is good communication of the child is able to stay with the IFMC Psychiatry team or with the Family Stress team but it becomes difficult when they are out of our office"

Need for Improved Inter-Organizational Coordination

Schools	"Collaboration between entities would be very helpful because things fall through the cracks"
	"The head of ESL is trying to get collaborating agencies to get together to talk"
	"There is evidence that these systems are collaborating to meet the needs of these children, however we still have a long way to go to meet our full potential"
Managers	"The only formal meeting between IRC and IFMC is with the director at the quarterly [Refugee Coordinating Committee] meeting. [Getting responses] from the clinic depends on the particular resident who receives my e-mail inquiries or requests, which are not always honored and often delayed"
Clinic	"There is good communication [regarding mental health referrals] if the child is able to stay with the IFMC Psychiatry team or with the Family Stress team but it becomes difficult when they are out of our office"
	"It is very difficult for a provider to get a sense of what is going on at school because the parents frequently have not been able to communicate with the teacher, and we are not sure who to call to ask for a report--plus do not have enough time during clinic to call for a report. If there are any concerns at all about nely arrived refugees, I would appreciate notification, either by calling the clinic and leaveing a message for me or by sending me a letter"
	"I particularly like the idea of having more input from refugee community leaders. From the clnic, we only have a tiny window into what is happening in the community, and I would love a fuller picture"

Schools	**Unclear Referral Process**	
	"Often issues will come up in their ESOL class, and it is clear that students need some outside counseling, or professional help, but we don't really know who to turn to to get this help"	
	"There are many organizations in the community with overlapping missions who can provide mental health support to struggling students. Unfortunately, the greatest challenge is a lack of supply for these services relative to the demand…as well as an often difficult to navigate referral system"	
	Time Constraints	
	"There is only so much time in the school day"	
Clinic	"I am sure that I miss a great deal of mental illness, particularly in the first visit, because there is generally so much information to cover that I don't have enough time to ask the right questions to perform an adequate screen"	

<div style="text-align:center; background:red; font-weight:bold;">Limiting Provider Factors (School Faculty, Clinicians, and Support Agency Staff)</div>

Schools	**Readiness to Identify At-Risk Youth**	
	"[Everyone is] not on the same page about whether [identifying mental stress] is part of the teacher's role"	
	"Sometimes teachers don't want to know. You feel helpless if you can't help them... The children come from different countries and different traumas"	
	"Mental health is not something the ESL team discusses. Individual schools may have their own ways of identifying [signs of mental stress]"	
	"In my four years at my school, we have had zero refugee students identified for 504s or IEPs. I believe that my school is under-identifying refugee students due to 'watch and see' and red tape associated with the identification process"	
Managers	"The process is not entirely smooth when dealing with cognitive issues [in schools]. There is a reluctance to evaluate due to difficulties with cultural differences…uncertainty with language difficulties and bilingual learners"	
	"School nurses/ counselors don't seem to be particularly involved [in the screening/referral process]"	
Schools	**Lack of Training to Recognize Mental Stress**	
	"Teachers often need support in understanding how to differentiate between issues that may result from the process of language acquisition vs. those that may result from mental health"	
	"Teachers are not exclusively trained to look for trauma in refugees"	
	"If there are problems in the classroom it takes a long time for them [school teachers, social workers, counselors, and psychologists] to figure out if language plays a role"	
	"I'm not aware of formal training for teachers regarding the stresses or mental health issues that refugees may have"	

Opportunities for communication do exist between community managers and the IFMC: The quarterly Refugee Coordinating Committee is a voluntary-attendance opportunity for support entities such as CHIP, the public health department, IRC, and UVA interpreter services to discuss current issues from a medical perspective, or the schools and the IRC: Refugee Dialog Meetings are mandated, IRC-led meetings that invite ESL coordinators and host a changing panel of community agencies involved in refugee support. In the schools, respondents report that attempts are made to elevate concerns through school counselors when a child's behavior seems worrisome. Charlottesville has even been recognized in the past for its Refugee Mental Health Referral System, part of Virginia's Refugee Healing Partnership, which intends to "address refugee risk factors and strengthen mental health partnerships". This was started in 2014 as "a local partnership of the IRC, Charlottesville/Albemarle Health Department, and [the IFMC]" to support mental health screening for refugees (web page). But despite these initiatives at the school, clinic, or at the community level, responses from all sources indicated that coordination between their organizations still has shortcomings that ultimately limit the potential of these efforts.

Responses suggested at least three points where the flow of valued information is interrupted. The first occurs shortly after arrival and concerns the collection and communication of refugee histories. Clinicians and teachers both commented that background information and mental health screenings provide helpful insight for meeting the needs of their patients and students, but as one teacher put it, this "is not information we can expect to receive ahead of time". Faculty members did state that if an issue or suspicion arose, requesting such information from the IRC would give them access to any information they have. But the reality is that such information is not always available.

Upon families' arrival to the U.S., the resettlement agency receives all supporting documents, including those containing their past educational and medical histories. According to an IRC respondent, any overseas mental health screens conducted prior to departure are "often cursory" and "if a child has experienced violence, it may or may not be documented. We may not be aware

of it".   After arrival the IRC schools liaison, who has a background as a licensed professional counselor, conducts an initial home visit. While a general impression of the family dynamic is obtained during this visit, no formal assessment is generated and a flight history is not obtained for the record.

The health department conducts mandatory post-migration health screenings, and according to the intent of the Charlottesville Mental Health Referral System[17], this should include a mental health screen that get passed on to the IFMC. However, our own observation of these visits and reviews of documentation received by the IFMC did not confirm this practice. Few intake packets received by the IFMC included an outside mental health screen.

Clinicians at the IFMC often do obtain their own history of refugee flight of each family over time. From observation of visits and clinician notes, doing so at the initial visit is provider-dependent and may occur only retroactively if mental stress is suspected. Clinicians reported that time limitations sometimes prevent them from conducting mental health screens on every patient. If screening is done, clinic responses indicated that no single standard instrument is being used for these assessments. One respondent reported using "vague questions about sadness and interactions with others" without a formal assessment, as a way to subjectively evaluate risk.

By the time refugee children get to school, where faculty reports there is no established procedure for screening, there may have been multiple missed opportunities to establish a baseline assessment. Our responses indicated that existing protocols are inconsistently utilized, perhaps worsened by the perception that these issues are being addressed at some other point in the process. Despite the unanimous commentary about the importance of screening and knowledge of past experiences, this information is not routinely collected or shared before post-migration stressors (Table 3) begin to place additional pressures on newly arrived young refugees.

Once a concern is identified, respondents also reported issues coordinating between the entities to secure assistance. Getting at-risk youth from the classroom to the clinic can be challenging. School responses described an unclear referral process, with one teacher saying, "we don't really know who to turn to to get this help", and others mentioning that ESL leadership has favored improved collaboration with other supporting entities to improve support. Similarly, clinicians at the IFMC reported that mental health referrals outside of their established partnerships with UVA Psychiatry and the Family Stress clinic are known to be difficult. Region Ten was the leading non-IFMC resource mentioned by respondents, and was often cited as having significant access limitations. Region Ten utilizes mainly Spanish interpreters and by their own admission, "there is not much support for other languages". In light of the fact that ESOL reports a refugee community that speaks over 60 languages[2], this becomes a major barrier, turning most youth referrals to their mental health services into virtual dead ends for this population.

Clinicians also report issues with reaching the classroom for information once mental stress is suspected in clinic. They unanimously endorsed the value of a teacher's insight in the evaluation of behavioral issues, but as one clinician put it, "it is very difficult…to get a sense of what is going on at school because the parents frequently have not been able to communicate with the teacher, and we are not sure who to call to ask for a report". Only one of our faculty respondents had ever provided collateral information to a health care provider, with the rest citing nonexistent avenues of communication with the clinic or the fact that they had never been asked. Despite the existence of the Refugee Dialog Meeting, the Coordinating Committee, and liaisons between organizations for planning purposes or to meet specific needs, it appears that when a child suspected of having mental health needs has been identified, the next steps are often unclear and/or the information available to evaluate this need may be incomplete. Overall, the responses seem to indicate that while the IFMC has established, convenient access to culturally available counseling and psychiatric support, schools are not consistently aware of this resource, and have relied on either internal counseling channels or alternate pathways to services that have been less easily accessed by refugees.

Table 2: Facilitating Factors

		RESPONDENT COMMENTS: FACILITATING FACTORS
		Facilitating Patient/Student Factors
		Child/Parent Characteristics
School		"Most parents want help for their children, so if we bring parents into school because of a concern and we have a good interpreter, they will open up and share their stories, information, concerns with us"
Clinic		"Mental disturbances in young refugees tend to present as physical symptoms. I typically see complaints of headache, stomachache, and body aches. Sometimes there other symptoms like dizziness or fatigue"
		Facilitating System Factors
		Community Programs
Schools		"There is a language exchange program between parents who are learning English and teachers who want to learn [another language]"
		"We [Charlottesville City Public Schools] have a one week civics summer camp for refugees and immigrant children"
		"UVA's Bridging the Gap program and Madison House ESOL tutors are support tools for our refugee students"
		"Our International Club provides a welcoming extracurricular activity [for refugee students]"
		"We have a summer Newcomer Academy* designed to support students in feeling welcomed to the community, acquiring English, becoming involved… building both bonding and bridging social capital, and forming post-secondary goals and graduation plans…"
		Dedicated Refugee Resources/Coordinators
Schools		"I do believe the IRC work hard to set up their newcomers with the support they need"
		"This past year we started receiving "intake reports" written by our ESOL office team… it was helpful in protecting the student from others' questions and checking in with the student regarding his/her well-being"
Managers		"The IRC has a medical liaison who sets up the initial appointments at the IFMC, sets up school physicals"
		"For their first few months, I [the IRC Schools Liaison] help enroll refugee children, conduct school orientation, and take them to school on the first day. I take parents to parent-teacher conferences. I have open office hours [for refugee visits] twice a week.
		"[The IRC has] a refugee health care coordinator who works with the IFMC's nurse care coordinator"
		"The IFMC is unique to Chalottesville. It is good that the refugee population here has a clinic dedicated to them"
Clinic		"…[The IFMC] has a dedicated social worker and nurse care coordinator who provide additional services... for example, having patients return with their medications to make sure they are taking them properly, arranging for transportation to clinic visits, and helping secure insurance coverage, to name just a few.."
		"[As the IRC schools liaison] I talk with ESL coordinators and residents at the IFMC to discuss relevant student history"
		Inter-Organizational Advocacy and Communication
Schools		"Our [APCS'] Summer Newcomer Academy* for refugee students...received a grant from the UVA Batten school upon IRC's recommendation"
		"I [ESL coordinator] talk a lot with [the nurse care coordinator] at the IFMC, for example to help moms go to Family Stress Clinic"
		"Often the school contacts the IRC if there is an issue"
		"[The IRC schools liaison] gets in touch with me [ESL coordinator] to ID special circumstances, if known...We meet informally over lunch. That really helps."
		"We receive information on newly arrived refugee students' medical and health conditions…through the IRC"
		"I think [Charlottesville] has a strong foundation that can keep getting better"
Managers		"The Refugee Coordinating Committee is run by the IFMC director, attended by UVA interpreter Services, the Public Health Department, CHIP [and others]. It's really good to get them in the same room."
		"There is a Refugee Dialog Meeting mandated by the Office of Newcomer Services [voluntary, attended by various services in the community, run by the IRC director]. The attendees seem to like it."
Clinic		"Generally someone from IRC contacts myself or the team nurse with a concern"
		[Shared anecdote in which a child from the Congo with a behavioral issue was helped by the clinic, IRC, school, parent, and patient working together to determine an identifiable cause of stress (bullying at school) and succeeded in resolving it.]

Integrated Multidisciplinary Services		
Schools	"We are not specifically trained [to identify signs of mental stress] but we have a wealth of counseling resources in our schools to help us if we detect a problem"	
Mgrs	"The Psychiatry residents working directly wih the IFMC is a sustain, as opposed to the Stress Clinic which may carry a stigma. We see better follow-through if going to the IFMC"	
Clinic	"I primarily refer to our in-house mental health services (…IFMC psychiatrists or the Family Stress Clinic)."	
Language Support		
Clinic	"Once they are here with a translator I feel reasonably confident [addressing mental wellness in young refugees], not to say it is not time consuming and challenging"	
	"We are very fortunate that UVA contracts for phone interpreter services 24/7 and during working hours we have access to live interpreters for all of our most needed languages"	
Facilitating Provider Factors		
Provider Awareness/ Involvement		
Schools	"ESL has good, strong teachers who do what they can. Some are limited by their own families and don't get out into the homes, but others do"	
	"ESL teachers know their students pretty well"	
	"APCS's [Albemarle County Public Schools] dedication to embracing multiculturalism…reduces the full force of the acculturation crisis that can occur with refugees"	
	"Our ESL program strives to provide as much individualized support as possible for all ELLs and particularly reugees…so that these students have a possibility to graduate before aging out of high school"	
	"It is imortant to become familiar with cultural noms of the home country to discern which behaviors are out of the norm and of concern"	
Mgrs	"Refugees in Charlottesville are fortunate to be able to receive health care in a culturally sensitive environment with [IFMC] practitioners who are aware of their special needs and comfortable working with patients who require language interpretation as a condition of service"	
Provider Experience/training		
School	"Teachers receive some basic training in identifying students who may be at risk of harming themselves and the proper protocol for dealing with this"	
Clinic	"Being a family practice NP... and prior to that a family pediatric nurse, I have developed the skills of identifying a problem [with mental wellness]"	
	"Our providers are trained in refugee health conditions...to provide comprehensive care"	
	"We have instituted a comprehensive cultural competence and refugee health education curriculum for our residents and students, including monthly seminars called "International Rounds," resident workshops, and faculty and staff development workshops"	

*was renamed the "Immersion Excursion Summer Program"

Provider Factors

Finally, respondents commented on factors related to the providers themselves. Nearly all survey respondents perceived that at least some of their young refugee patients/ students had experienced some form of physical or psychological trauma. Both clinicians and teachers reported that student/ patient cases are commonly referred to them for some action by an external source, but individuals in both groups reported uncertainty about recognizing mental distress in refugee youth as a first-line resource.

Responses from community managers described the dedication of ESL/ESOL teachers who work hard to help their refugee students integrate and meet SOL standards, sometimes even "getting out into the homes" when possible. As acknowledged first line observers, however, teachers reported a lack of specific training about the stresses or mental health issues that refugees face. One described a need to know the difference "between issues that may result from the process of language acquisition vs. those that may result from mental health". Other discussion described a hesitancy to identify due to uncertainty about their role in the process, or a reluctance to label bilingual learners.

IFMC clinicians provide care in an environment where refugees are their primary patients, but some lack of confidence was still reported when it came to evaluating children's mental resilience during a primary care visit. Two respondents felt less than confident about identifying patients who may need help, while another cited confidence stemming from previous familiarity with such issues, suggesting that such confidence may come from experience rather than training available via the IFMC. Such targeted training for primary care physicians from the IFMC-associated psychologists and psychiatrists, along with better background information and input from the classroom, could make the difference needed in these cases.

TABLE 3: Post-Migration Stressors

Respondent Comments: Post-Migration Stressors
Parent Factors/ Home environment
"Many of the parents of refugee students are seeking asylum here because of extreme and violent situations in their home countries. Of course this impacts their children"
"Inability to find work for parents causes stress for children and often requires them to help provide for family. Many children may act as caregivers for parents who have difficulty finding/paying for childcare, causing frequent absences"
"Loss of structure in the home"
"Use of copororal punishment in the home"
"Many children may acta as caregivers for parents who have difficulty finding/paying for childcare. Causes frequent absences"
"Parents may face a great number of challenges in supporting the transition of their children, including language barriers, resentment of the child in being brought to a new country, exacerbated parent/child conflict due to cultural differences between the home country and the United States, and a loss of social capital associated with rupturing ties in the native country"
Pressure to work
"The primary challenge that I observe is inability to find work -- causes stress for chidren and often requires them to help provide for family"
"Many choose to enter the wokforce to support their families (pressure from families to contribute)"
"18-21 is a good age group to focus on. There is definitely a need for services for that age group. After 18 they are not allowed in high school, they have to go to adult educations classes instead. They are often living with their parents and are expected to work to help [financially]... People often quit due to apathy [about English or education] and a greater interest in making money"
"Parents sometimes want an adolescent to get a job more than wanting him/her to graduate from high school"

School Requirements
On SOL testing: "Data shows that students need 5-10 years to become fluent in a language. The [school years] are a short time to …master the content of all their courses for the purpose of SOL testing"
On refugee student drop-outs: "Many [students] are very engaged in the classroom and the school community but cannot pass the multiple choice exams. Remaining options are work or vocational schooling"
"Kids have to be here long enough to detect learning disabilities, but they begin testing almost immedately at grade level"
"Evaluations in school come very quickly, putting pressure on students and teachers"
Peer Environment
"An ongoing issue we have is better integrating our refugee population with the general population"
"In general, they are well integrated into the ESL program…but rarely integrate with the general mainstream student population"
Often the school age and teenage newly arrived refugees have expressed that they feel like outsiders"
Shifting Family Roles
"Loss of social capital associated with rupturing ties in the native country"
"Exacerbated parent/child conflict due to cultural differences between the home country and the United States
"It is difficult when the parents do not speak English and hcildren have to become their parent's proxies. They deal with adult issues when it may not be appropriate under other circumstances"
"Students very quickly take over from their parents in their acquisition of language…so parents rely on their children to understand their new environment which puts a lot of pressure on both parents and children"
New environment
"Moving to a different country in challenging pre-teen/teen/young-adult years would be emotionally overwhelming for almost everyone"
"There is sometimes conflict between other refugees and other [local] low income people, competition for the same benefits."

Implications and Recommendations

This study has potential implications for quality improvement in systems supporting mental health resources for school-age refugees. We believe these responses provide valuable insight from providers about existing strengths at each site, how they can be improved, and the benefits of better integration between complimentary resources. Therefore we offer these recommendations with an emphasis that early intervention is key to any approach:

1) **Perform a standard baseline mental health screen on all eligible family members.** The CDC recommends PTSD and depression screening on all refugees 16 and older[20]. For PTSD, it endorses the use of PCL-C-17 PTSD screening or the PTSD portion of the Harvard Trauma Questionnaire[20]. For depression, the CDC reports favorable results across cultural groups with the PRIME-MD PHQ-9 for depression, or the depression section of the Hopkins symptom checklist[20]. Because time is often limited during the initial clinic visit, it would be ideal if such screens could be conducted during the Department of Health intake exam so it would be available at the initial clinic visit. The introduction of these screening assessments may require some introduction and normalization, and in some cases may need to be re-attempted by a resettlement counselor with interpreter after intake. Completed screens should be dated, forwarded to the primary provider, and entered into the medical record. Any counselor or physician concerns arising from the screens and relevant to the classroom could be shared with the patient's primary teacher using established avenues of communication (#3).

2) **Make it a priority to obtain the family flight history soon after arrival** (preferably within the first month). The flight history is background information about events leading up to and during their refugee status including any violence, family separations, witnessed death, bombings, etc. experienced by family members, including children. Ideally, a counselor or physician in an established position of trust would obtain this with an interpreter if needed. While a paper form might be useful for documentation purposes, a transcribed narration would be preferred to encourage dialog and allow for direct observation. Children themselves may or may not be included in this collection according to parent's discretion, although any input from school-aged youth is helpful in determining their understanding of events. Patients who do not wish to disclose this information should not be pressured to do so, but this deferment should be noted. A version of this history could then be placed into the medical record for future reference. A version of this history should also be available to teachers or school guidance counselors as deemed appropriate.

3) **Establish early contact between the primary care physician and the ESL and/or primary teacher.** Clinicians in our study unanimously rated teachers as the second most useful source of "collateral history" (after parents) and welcomed their input. Additionally,

responses with insight to post-migration stressors came overwhelmingly from school faculty (Table 3), demonstrating a depth of awareness of home-life factors. But teachers commented that they were largely unfamiliar with how to communicate with the appropriate clinical contact. Comments about the referral process indicate that school faculty may be unaware of how the IFMC's "one-stop shop" differs from other sources being utilized such as Region Ten or Children, Youth, & Family Services where referrals can become dead ends due to lack of language support or coverage limitations. And conversely, clinicians did not seem to have a good way to contact teachers for the classroom perspective. Introducing teachers to the IFMC as a working partnership would help solve these problems. A collaborative, familiarizing event between IFMC providers and teachers (such as group orientations to the IFMC, or an information session at each school) could establish such connections and would be an opportunity to reinforce the link between classroom behaviors, mental distress, and physical health. It would also allow teachers to realize the specialized network of support available to their students through the IFMC, streamlining communication and simplifying referral procedures through direct contact.

4) **Normalize mental wellness concepts and assessments with refugee families early and often.** Clinicians and teachers felt that refugee families rarely initiate mental health discussions. They felt that parents were unfamiliar or uncomfortable with the different forms of emotional distress and its effects, and this imposed an additional barrier to intervention. Some of this may be improved gradually by familiarizing parents with mental wellness concepts and support options, and normalizing the desire to address concerns about their children. Teachers expressed reluctance to approach these topics within their current roles, and some clinicians were unsure about the presentation of mental stress in children. To facilitate discussions and increase confidence about approaching mental health concerns, teachers and clinicians would benefit from continuing educational materials or an annual integrated workshop with mental health professionals to help identify general signs of distress in children and young adults. This could also help define the actions appropriate for their roles, as well as when to refer. Once teachers and clinicians reach a level of comfort with the scope of their own roles, they themselves, as trusted agents could better familiarize parents with mental wellness concepts and support options. This could occur during parent-teacher meetings or child wellness visits, with each

setting reinforcing the other as equally acceptable entry points to services.

5) **Emphasize language support appropriate to the communication needs of refugee youth and their adult representatives.** The language barrier was a persistent concern for all respondent groups. In the classroom, ESL/ESOL reported 30 (2014) and 80 (2015) languages spoken by the students they support, respectively[2,16,219]. Teacher concerns about language primarily arose from difficulties communicating with parents, or how students' English proficiency can confound their detection of mental or emotional distress in the classroom. We recommend assisting parents with communication barriers through language-based initiatives to encourage communication and an ongoing relationship between parents and teachers. A county schools coordinator reported good results with a language exchange program between parents wanting to learn English and teachers wanting to learn other languages. Adult English classes are offered through Charlottesville public schools' Adult Learning Center and should be promoted heavily upon arrival, at school meetings, and at clinic visits as a key step toward eventual citizenship. In 2016, two years after our data collection, Albemarle County Public Schools opened its International and ESOL Welcome Center which is a resource for students, teachers, and their families to encourage English education and is an excellent example of this type of family support that helps parents become more familiar with the school system and supports their ability to interact with it.

Dedicated system navigators are another important way to overcome cultural barriers while English skills are still poor. The IRC schools liaison arranges interpreter services, conducts home visits, and conducts escort to initial clinic appointments or parent conferences at school. Integrating more navigators into the process, possibly through a volunteer corps, helps parents but can also take stress off of children whose English skills have made them family representatives. As one community manager observed, "It is difficult when parents do not speak English and children have to become their parents' proxies. They deal with adult issues when it may not be appropriate under other circumstances". Teacher concerns about identifying mental health needs in a child with a language barrier could be better addressed in the IFMC's Family Stress clinic, and we again recommend direct collaboration with the clinic for this purpose.

For clinicians, the language barrier mainly applied to referrals outside of UVA because referrals through

IFMC partnerships were perceived as effective by its providers. With its own dedicated system navigator, psychiatric and counseling services, and interpreter services that reflect the refugee community, the clinic uses recommended strategies for integrated care from prior studies. This makes it a favorable option for refugee families to explore mental health support. Our study confirmed the need for and perceived effectiveness of such a resource, and remains a strong recommendation for other resettlement communities.

6) **Establish an interdisciplinary protocol specifically for the custody and communication of mental health information between appropriate providers.** As a community manager stated, "There are many organizations in the community with overlapping missions who can provide mental health support to struggling students. Unfortunately, the greatest challenge is… an often difficult to navigate referral system. There is evidence that these systems are collaborating to meet the needs of these children, however we still have a long way to go to meet our full potential". The conclusion from our investigation into key organizations that support Charlottesville's refugee youth (schools, IRC, IFMC) is that despite recognition of the key issue, existence of willing providers, intra-organizational awareness, and existing inter-organizational communications, a degree of uncertainty remains about how to proceed when a provider detects a problem at the earliest opportunity, which is often the classroom. We therefore offer a proposed protocol directly connecting the classroom to the clinic (Figure 1) to help guide decision making so that refugee youth in need of counseling or psychiatric support can receive appropriate support as early as possible. The intent is to improve collaboration and empower providers at every level as valid contributors to this process in a standardized way.

Conclusion

Past studies have identified challenges to effective mental health assessment and treatment including language barriers, differing cultural beliefs about mental health, marginalization of the refugee population, and trust issues[14,15]. Research shows that access to mental health for refugees in need of services is a concern for many providers, and efforts have been made to improve outcomes by utilizing integrated, patient-focused care that is culturally sensitive[14,15]. Our study revealed these same concerns from the primary providers in the refugee support community while eliciting limiting and facilitating factors for the refugee youth population in

Charlottesville. We concluded that Charlottesville's refugees benefit in many ways from a receptive community, an awareness of their needs by providers, and well-developed resources. But these strengths are not enough to meet the estimated mental health needs of this population if they fail to reliably communicate information that enables effective assessment. Active observation, communication, and integrated efforts must occur between parents, teachers and clinicians to address the barriers identified by our respondents.

While the experiences of young refugees are varied and not all have been exposed to trauma or loss, the combination of past upheaval and pressures that occur simultaneously upon arrival can still be challenging and potentially harmful as they adjust to their new lives. We believe we have demonstrated that encouraging communication between physicians and teachers can only streamline efforts to provide help when needed. It is encouraging that when asked what they would like their counterparts in the classroom or clinic to know, both clinicians and educators advised each other on two common points: to consider the "life experience" or "story" of the refugee student/patient, and to improve communication and collaboration amongst themselves to better support the young refugees in their care. With increased collaboration, more children with mental health concerns may be connected to services, less children may be "lost to follow-up" or absenteeism before they can be identified, and as a result, Charlottesville may be better able to help its refugee youth achieve the fundamental and most essential hope behind their resettlement in the first place: the promise of a better future.

FIGURE A: PROPOSED COMMUNICATIONS PROTOCOL
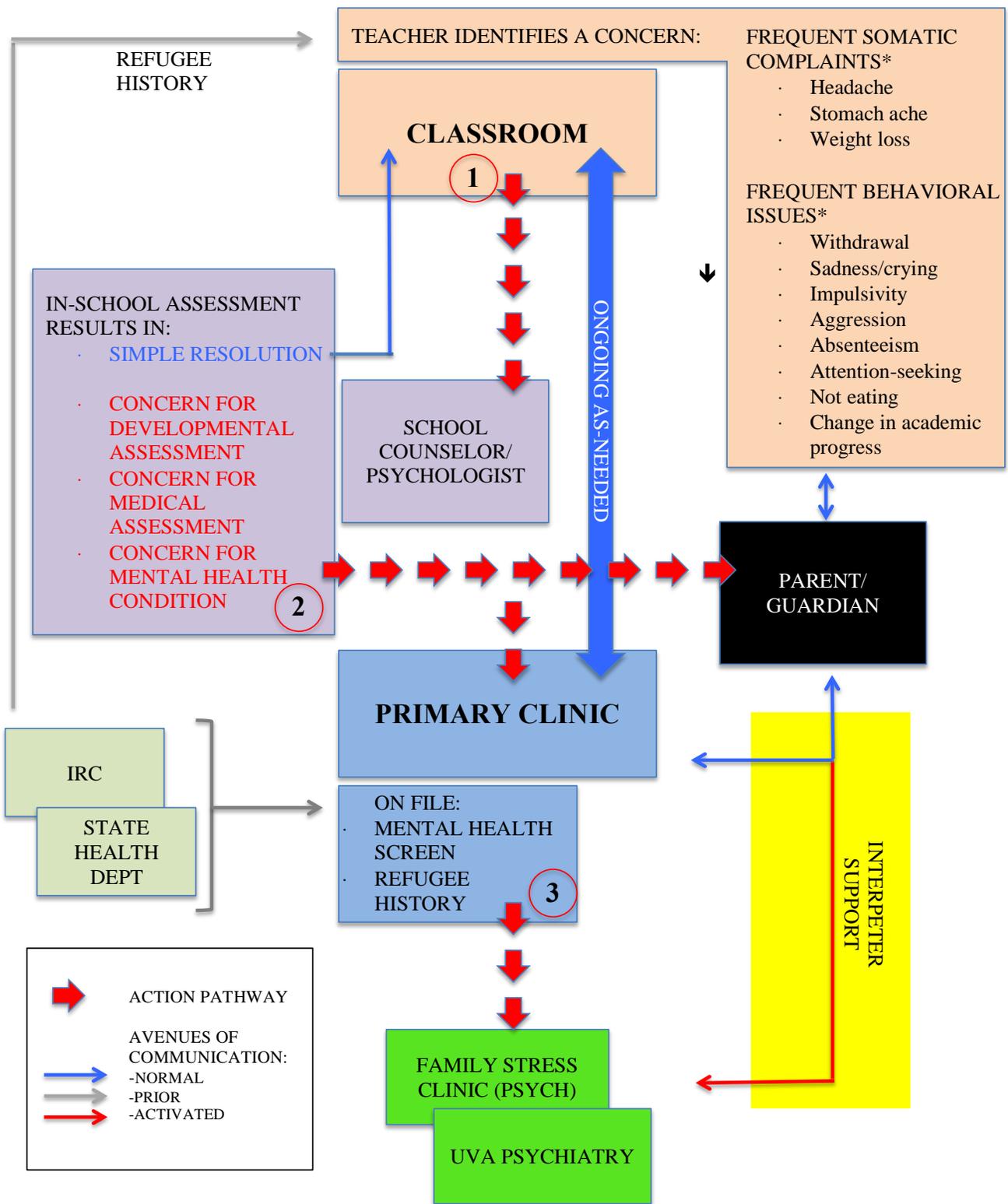
*Somatic and Behavioral observations concerning for mental distress in youth were contributed by faculty and clinician respondents

References

1. Betancourt TS, Newnham EA, Layne CM, et al. Trauma history and psychopathology in war-affected refugee http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=23225034. Accessed 20140701.
2. Carlock, Russell. "Albemarle County's New International and ESOL Welcome Center". Beyond Language – Linguistic Diversity and 21st Century Education [blog]. Albemarle County Public Schools ESOL. posted 2016 Jul 22. http://acpsesol.blogspot.com/
3. Correa-Velez I, Gifford SM, Barnett AG. Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Soc Sci Med*. 2010;71(8):1399-1408. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20822841. Accessed 20140701.
4. Dura-Vila G, Klasen H, Makatini Z, Rahimi Z, Hodes M. Mental health problems of young refugees: Duration of settlement, risk factors and community-based interventions. *Clin Child Psychol Psychiatry*. 2013;18(4):604-623. doi: 10.1177/1359104512462549 [doi].
5. Ehntholt KA, Yule W. Practitioner review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *J Child Psychol Psychiatry*. 2006;47(12):1197-1210. doi: JCPP1638 [pii].
6. Ellis BH, MacDonald HZ, Klunk-Gillis J, Lincoln A, Strunin L, Cabral HJ. Discrimination and mental health among somali refugee adolescents: The role of acculturation and gender. *Am J Orthopsychiatry*. 2010;80(4):564-575. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20950297. Accessed 201410701.
7. Fazel M, Doll H, Stein A. A school-based mental health intervention for refugee children: An exploratory study. *Clinical Child Psychology & Psychiatry*. 2009;14(2):297-309. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med5&AN=19293324. Accessed 20140701.
8. Gilmore, Claudia. "Refugee 101". BRYCS (web). United States Conference of Catholic Bishops. Accessed 2017 March. http://www.brycs.org/aboutRefugees/refugee101.cfm
9. Hauck F, Lo E, Maxwell A, Reynolds P. Factors Influencing the Acculturation of Burmese, Bhutanese, and Iraqi Refugees Into American Society: Cross-Cultural Comparisons. *Journal of Immigrant & Refugee Studies,* DOI: 10.1080/15562948.2013.848007, ISSN-Print: 15562948, Published: 07/01/2014, Vol: 12, Issue: 3, Start Page: 331, Page Count: 22, Language: English
10. Li SS, Liddell BJ, Nickerson A. The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers. [Review]. *Current Psychiatry Reports*. 18(9):82, 2016 Sep. [Journal Article. Review]
11. Lustig SL, Kia-Keating M, Knight WG, et al. Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2004;43(1):24-36. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med5&AN=14691358. Accessed 20140701.
12. McKenzie, Bryan. Daily Progress article 2 Jul 2016. "In Charlottesville, refugees find a place to call home" http://www.dailyprogress.com/news/local/in-charlottesville-refugees-find-a-place-to-call-home/article_d1356f9e-015c-575b-8412-4050734400e5.html. Accessed 20170224.
13. Polcher K, Calloway S. Addressing the Need for Mental Health Screening of Newly Resettled Refugees: A Pilot Project. *Journal of Primary Care & Community Health*. 7(3):199-203, 2016 Jul. [Journal Article]
14. Ross, Lorie E., Simone Vigod, Jessica Wishart, Myera Waese, Jason Dean Spence, Jason Oliver, Jennifer Chambers, Scott Anderson and Roslyn Shields. Barriers and facilitators to primary care for people with mental health and/or substance use issues: a qualitative study. *BMC Family Practice*. 16:135, October 2015.
15. Shannon PJ, Vinson GA, Cook TL, Lennon E. Characteristics of Successful and Unsuccessful Mental Health Referrals of Refugees. *Administration & Policy in Mental Health*. 43(4):555-68, 2016 Jul. [Journal Article]
16. Stewart, Cherry (presenter). "English as a Second Language Services" [handout]. Charlottesville City Schools. Presented at Refugee Dialog Meeting. Summer 2014.
17. Stitt, Eva P. "UVA/IFMC Champions Refugee Mental Health". Charlottesville Mental Health Referral System [web]. Virginia Department of Behavioral Health and Developmental Services. Accessed February 2017. http://www.dbhds.virginia.gov/library/cultural%20and%20linguistic%20competence/refugee/uva%20champions%20rmh%20%20revised%20050115.pdf
18. Yager, Jordy. "Meet the UVA doctors who meet the unique needs of refugees" (blog). WMRA public radio of the Shenandoah Valley and Charlottesville (web). Posted 2016 Feb, accessed 2017 Feb. http://wmra.org/post/meet-uva-doctors-who-meet-unique-needs-refugees#stream/0
19. "Albemarle County's Linguistic Diversity" [handout]. Albemarle County Public Schools. Presented at Refugee Dialog Meeting. Summer 2014.
20. "Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees" (web). Centers for Disease Control and Prevention. Updated 2014 May 8, accessed 2017 March. https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html
21. "How the U.S. refugee vetting and resettlement process really works". International Rescue Committee. Updated 2017 March 24. https://www.rescue.org/article/how-us-refugee-vetting-and-resettlement-process-really-works