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ORIGINAL ARTICLE

Characteristics of Successful and Unsuccessful Mental Health Referrals of Refugees

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Abstract In this community based participatory research study, we explored key characteristics of mental health referrals of refugees using stories of providers collected through an on-line survey. Ten coders sorted 60 stories of successful referrals and 34 stories of unsuccessful referrals into domains using the critical incident technique. Principal components analysis yielded categories of successful referrals that included: active care coordination, establishing trust, proactive resolution of barriers, and culturally responsive care. Unsuccessful referrals were characterized by cultural barriers, lack of care coordination, refusal to see refugees, and system and language barriers. Recommendations for training and policy are discussed.

Keywords Refugee mental health · Refugee service utilization · Refugee mental health screening · Refugee barriers to care · Mental health system navigation

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Introduction

In the past decade, more than 600,000 refugees have resettled to the United States with the largest groups fleeing wars and political conflicts in Burma (92,513), Iraq (74,477), Somalia (61,737), and Bhutan (60,776) (Office of Refugee Resettlement 2012). Between 30 and 50 % of refugees from these countries report experiencing torture and nearly all report war trauma experiences (Jaranson et al. 2004; Schweitzer et al. 2011; Tol et al. 2010; Willard et al. 2013). Refugee trauma survivors are at increased risk of developing serious psychiatric disorders such as post-traumatic stress disorder (PTSD) and major depression (Fazel et al. 2005; Steel et al. 2009). In response to research documenting psychiatric conditions among refugees, the Centers for Disease Control and Prevention (2012) recently included mental health screening guidelines in their recommendations for health screening during the domestic medical examination for newly arrived refugees. As state refugee health programs consider incorporating mental health screening, questions emerge concerning the extent to which refugees are able to access mental health services. This article reports findings from a mixed-methods study that examined providers' perspectives on key characteristics of successful and unsuccessful referral processes for refugees in need of mental health services.

Refugees are fleeing their countries due to a well - founded fear of persecution "for reasons of race, religion, nationality, membership in a particular social group, or political opinion" (The Refugee Act of 1980). Recent refugees have often endured long and violent political struggles with whole generations growing up either internally displaced or in refugee camps (Porter and Haslam 2005). Steel et al. (2009) conducted a meta-analysis of 181 surveys with over 80,000 refugees and reported prevalence

rates up to 30 % for PTSD and major depression. Torture experiences and cumulative exposure to trauma were the strongest factors associated with PTSD and depression, respectively. In addition, numerous resettlement stressors may worsen trauma-related mental health symptoms including the unemployment, unsafe housing, social isolation, discrimination, language and cultural barriers (Miller and Rasmussen 2010; Johnson and Thompson 2008; Silove 1999). Longitudinal studies of refugees in resettlement confirm that some populations may continue to struggle with high rates of psychiatric illness decades later (Carlsson et al. 2006; Marshal et al. 2005).

Health providers and refugees have identified challenges inhibiting mental health assessment and referral of refugees. Physicians and mental health providers have reported difficulty communicating with interpreters, language and acculturation barriers, divergent cultural beliefs about health and mental health, difficulty establishing trust, and feeling uncomfortable asking refugees about trauma histories (Eiseman et al. 2000; Ferguson and Candib 2002; Morris et al. 2009; Rosenberg et al. 2007; Sandhu et al. 2013). Mental health providers have expressed additional concerns that refugees are more likely to be marginalized and less likely to access services (Sandhu et al. 2013). Research with refugees themselves has identified cultural, structural and psychological barriers to care. Cultural barriers include a lack of understanding of mental health conditions related to trauma, a reluctance to initiate conversations about mental health symptoms, and mental health stigma. Structural barriers include language and interpreter difficulties, and the lack of insurance or cost. Psychological barriers included trauma-related symptoms such as avoidance that may inhibit discussions of mental health (Saechao et al. 2012; Shannon et al. 2014; Wong and Tsang 2004). The findings of these studies lead to questions about how the mental health system responds to the structural barriers, cultural norms and trauma-related symptoms of refugees in need of mental health services.

Currently, there is very little refugee-specific research in the area of help-seeking and service utilization (de Anstiss et al. 2009). Research suggests that access to mental health services is a major concern in general, and that it is exacerbated by cultural differences (Satcher 2000). Findings from the national Latino and Asian American study revealed that less than 40 % of noncitizens use any mental health services (Lee and Matejkowski 2012). One large epidemiological survey that did include refugees indicated that all minority groups are less likely to seek treatment and fewer than half of minorities with PTSD seek treatment (Roberts et al. 2011). This study concluded that such large disparities in treatment indicate a need for investment in accessible and culturally sensitive treatment options. In contrast to mental health service use, high utilization of medical health care services has been reported among refugee patients with undetected depression and somatization symptoms (Flynn et al. 2013). In their study of patients requiring interpreters Flynn et al. (2013) recommended that the use of cultural brokers may facilitate the discussion of diagnosis and treatment of mental health issues when the lack of words to describe mental health problems and stigma prevent assessment.

Edward and Hines-Martin (2014) recently studied providers' perspectives on availability of health and social services for immigrants and refugees in a southern community. They identified needs related to accessibility (geographic and system navigation), availability (access to cultural competence and interpreters), affordability (employment and insurance), and acceptability (related to immigrants' fears of deportation and discrimination). Service utilization was facilitated by community outreach, partnership with ethnic organizations, advocacy, funding, and building trust.

Efforts to integrate or coordinate behavioral health with primary care are relevant to this population due to the emphasis of previous research on the need to improve accessibility. Access is one of the most important and significant outcomes of integrated or co-located behavioral health and primary care models (Blount 2003). One study in which physicians personally introduced their patients to behavioral health providers found that 76 % of introduced patients kept the first behavioral health appointments, as opposed to 44 % of non-introduced patients (Apostoleris 2000). Research also indicates that when physicians have access to mental health resources, their confidence increases, they are more likely to refer to specialists, and patients with PTSD are more likely to obtain treatment (Meredith et al. 2009).

One study of a refugee health clinic described integrated care as patient-focused care that is comprehensive and delivered through inter-professional teams with strong communication (McMurray et al. 2014). This dedicated refugee clinic led to a decrease in wait time to see health providers, an increase in the establishment of primary care for refugees, and an increase in referrals to needed ancillary services such as mental health. They concluded that refugees require an integrated community-based approach to health that includes dedicated system navigators to support timely and culturally appropriate care. In their recent systematic review of the literature, Williams and Thompson (2011) also found that community-based interventions in schools, homes or group settings successfully improved mental health outcomes for refugees.

Although this research calls for accessible, culturally sensitive, and coordinated care for refugees in need of mental health services, to our knowledge, the characteristics of successful referrals to mental health care have not

been studied. For example, how do providers define care that is accessible, culturally sensitive and coordinated when refugee mental health referrals are successful? In preparation for implementing routine mental health screening of newly arriving refugees, this study examined what providers did across diverse practice settings when referrals of refugees to mental health services were successful and what happened when referrals were unsuccessful.

Method

We conducted a community based participatory research (CBPR) study using mixed methods to investigate characteristics of successful and unsuccessful refugee mental health referral processes (Minkler and Wallerstein 2010).

Setting

This study was conducted in a Midwestern state that resettles thousands of refugees each year from war torn areas. Health care is provided to refugees through prepaid medical assistance, managed care networks. Upon arrival, refugees choose one of five managed care health plans. A small number of health clinics have imbedded mental health services, however, in practice, refugees are often referred out to mental health services when the wait for imbedded mental health is too long. Other clinics are primary care or public health clinics that make mental health referrals to community clinics and health plan networks of private practitioners.

Design

We chose a mixed methods design because this study involved eliciting stories of referrals that could be coded qualitatively and analyzed using quantitative strategies to identify factors related to the success of referrals. Eliciting and coding referral stories draws upon the strengths of qualitative analysis, while using factor analytic techniques to explore the components of stories builds on the strengths of quantitative analysis (Palinkas et al. 2011).

First, we composed a steering committee comprised of primary care and public health physicians who complete health screenings with newly-arrived refugees, cultural leaders, state refugee health department staff, health plan representatives, social work and research staff from the Center for Victims of Torture, and refugee resettlement agency staff. This committee met quarterly to develop an on-line survey, recruit participants, monitor study progress, interpret findings, and consolidate recommendations.

The study methods combined the participatory goals of CBPR with the critical incident technique (CIT) to elicit detailed stories of client referrals. CIT has been used in recent years to explore service research issues (Gremler 2004). The steering committee decided that critical incident methodology using a survey format allowed participants the time needed to think about real referral stories in detail rather than providing generalizations in interviews. The technology allowed providers to return to the survey multiple times to add detail or new stories prior to the closing of the survey. This study protocol was approved by the University of Minnesota Institutional Review Board.

Data Collection

An anonymous survey was created using Qualtrics software (http://www.qualtrics.com/). The survey first asked participants to indicate whether they had ever: (1) made a successful refugee mental health referral, (2) made an unsuccessful refugee mental health referral, (3) received a successful refugee mental health referral, or (4) received an unsuccessful refugee mental health referral. A referral was defined as successful if the refugee attended at least one appointment. A referral was defined as unsuccessful if the refugee did not attend one mental health appointment. The survey used separate sets of questions for each of these four categories. For example, participants who indicated that they had made a successful referral were asked (a) Briefly describe the person for whom you made the referral (e.g. age, langauge/literacy, time in the U.S., country of origin, reason for referral), and (b) Describe in detail the steps that were taken in the referral process (i.e. what happened). Data was collected from June to September, 2013.

Multiple sampling strategies were used. Purposive sampling was used to systematically search all pre-paid medical assistance mental health providers using online provider databases. Inclusion criteria for mental health providers were those who were located in one of the two largest cities or counties in the metro area who spoke one of the following languages: Amharic, Arabic, Burmese, French, Hmong, Khmer, Karen, Laotian, Russian, Somali, and Vietnamese; and/or who identified PTSD as an area of expertise. Individual providers and mental health agencies were invited by phone to participate in the study. A survey link was sent to interested providers via e-mail.

The network administrators at the five managed care providers in the two largest counties were also contacted and asked to identify staff with knowledge related to mental health referrals for refugees. These individuals were invited to participate by email or phone. All of these health plans returned the survey. We also identified refugee providers who make mental health referrals using a directory of community-based organizations and mutual assistance associations (MAA) serving refugees. Of the 158 providers who received a link to the survey over email, 64

Table 1 Demographic characteristics of participants ($N = 64$)

Demographic characteristic	*N*	%
Gender		
Male	19	29.7
Female	45	70.3
Total	64	100
Professional education		
High school degree or GED	3	4.7
Associate's degree	1	1.6
Bachelor's degree	23	35.9
Master's degree	28	43.8
Nurse practitioner	1	1.6
Ph.D.	5	7.8
M.D.	3	4.7
Total	64	100.1
Languages spoken by participants[a]		
Spanish	12	18.8
Hmong	6	9.4
Somali	6	9.4
French	6	9.4
Karen	2	3.1
Burmese	2	3.1
Thai	2	3.1
Hindi	2	3.1
Arabic	2	3.1
Khmer	2	3.1
Other	7	10.9
Years of experience working with refugees		
Less than 1 year	3	4.7
2–5 years	19	29.7
5–10 years	13	20.3
More than 10 years	29	45.3
Total	64	100
When completed training on refugee mental health[a]		
Never	17	26.6
In the past year	30	46.9
In the past 5 years	18	28.1
More than 5 years ago	6	9.4
Agency type		
Mental health agency	13	20.3
Mutual assistance association (MAA)	9	14.1
Health plan	9	14.1
Primary care clinic	8	12.5
Resettlement agency	7	10.9
State or county public health department	6	9.4
Social service agency	5	7.8
Public school or ELL	4	6.3
Legal clinic	1	1.6
Private practice mental health	1	1.6
Public health clinic	1	1.6
Total	64	100.2
Professional role		
Social service provider	19	29.7
Social worker (non-clinical), case manager, or care coordinator	17	26.6
Mental health provider	16	25.0
Nurse or public health nurse	5	7.8
Primary care provider or nurse practitioner	4	6.3
School social worker or ELL program staff	3	4.7
Total	64	100.1

Percentages may not total 100 due to rounding

[a] Variables that included non-mutually exclusive response choices

(40.5 %) completed the survey. An additional 43 mental health agencies were contacted by phone and invited to participate in the survey but did not respond and did not receive a link to the survey. Table 1 describes the sample characteristics.

Data Analysis

The CIT is a systematic way to take observations of the world and distill them into sensible, data-driven categories (Anderson and Wilson 1997; Bownas and Berdain 1988). This pile sort method has traditionally been used to define and exemplify domains. Using this method, participants described successful and unsuccesful mental health referral experiences in the online Qualtrics survey via behavioral examples. These data were downloaded into a spreadsheet where they were divided into discrete, codable units called critical incidents. For example, "I called to make the appointment for the client, then I used an interpreter to inform the client of the appointment time" was separated into two critical incidents: "I called to make the appointment for the client" and "I used an interpreter to inform the client of the appointment time."

Sixty stories of successful referrals contained 250 critical incidents, and 36 stories of unsuccessful referrals yielded 111 critical incidents. To assist accurate coding, the critical incident cards contained referral context such as, "physician making referral". Ten experienced refugee mental health professionals independently sorted the critical incidents into categories of their choosing based on their own understanding of the phenomena (Flanagan 1954). The sorters took an average of 7 hours to complete the sorts and were compensated for their time.

We used an analytic procedure that simultaneously considered data from all sorters and incidents equally to prevent bias related to group processes (Bjarnadottir and

Campbell 2001; Vinson 2012). Because all sorters sorted the same incidents, a proportion agreement matrix was created where each pair of incidents has a proportion value equal to the number of sorters that put those two incidents together in the same category (e.g., 0.9 would mean 9/10 of sorters put the two incidents in the same category). This matrix has as many rows and columns as there are incidents in the sort. The proportion agreement matrix is further transformed into a standardized mean inner product (SMIP) agreement matrix, where the association between incidents is determined by the equation for Pearson correlations, except that the means are not subtracted from the individual elements. Means are not used as a reference point, as the proportions of agreement have an absolute zero (i.e., zero equals no agreement between all sorters) (Borman and Brush 1993; Olson 2000). The values in the SMIP agreement matrix are akin to correlations between incident pairs, where higher values correspond to sorters relating the pair similarly to each other and all other incidents. Compared to simple proportions, it better summarizes the relationships between a given incident pairs by including how those two incidents also relate to all other incidents in the set (Vinson 2012).

Because the SMIP agreement matrix is akin to a correlation matrix between all incident pairs as determined by the sorters, clusters of incidents can be analytically investigated using any common data reduction method, such as principal components analysis (PCA) (Davison 1992). This is a way of deriving a common structure across all sorters and incidents. We conducted a PCA with a varimax rotation to extract common components, retaining components that had at least one primary loading incident and made theoretical sense. Components contain many incidents, rich in content, categorized by the sorters, and corresponding to categories defined by the researchers interpreting both the results and feedback about possible categories provided by the sorters. Quantitative data were analyzed using SPSS 21.

The PCA yielded 17 components that described aspects of successful referrals accounting for 87.34 % of total variance in responses (see Table 2) and 13 components of unsuccessful referrals accounting for 94.25 % of the total variance in responses (see Table 3). To investigate a higher-order categorical structure that could summarize these categories, an additional higher-order PCA was conducted on results derived from the initial PCA results. The initial results were used to create an oblique component structure using a procedure described by Overall and Klett (1972). This created a component cosines matrix between all categories, which is akin to a correlation matrix between the 17 successful and 13 unsuccessful categories

Table 2 Factor loadings for varimax orthogonal four-factor solution and critical incidents for characteristics of successful referrals ($N = 250$)

Item	Factor loading	Number of critical incidents
Category 1: active care coordination		90
Direct referral to mental health provider	0.753	20
Communication between providers	0.643	30
Emergency mental health system responds to refugee crisis	0.549	13
Scheduling of first appointment	0.542	19
Case management provided by health plan staff	0.496	8
Category 2: Establishing trust and identifying mental health symptoms		55
Trust developed by non-health provider	0.792	4
Trust developed by health provider	0.552	4
Proactive identification of mental health symptoms	0.524	27
Trust developed by family or ethnic community leaders	0.507	8
Access to imbedded mental health or referral coordinators	0.387	12
Category 3: Proactive resolution of access barriers		73
Follow-up to ensure success of referral	0.700	15
Psychoeducation	0.604	21
Interpreters	0.536	20
Transportation	0.478	17
Category 4: Culturally responsive care		32
Flexibility to meet in client's home	0.752	11
Multidisciplinary care	0.662	9
Knowledge of refugees' cultures and trauma treatment	0.532	12
Total		250

$N = 250$ for the higher-order analysis corresponds to the number of incidents in the lower-order sort

Table 3 Factor loadings for varimax orthogonal six-factor solution and critical incidents for components of unsuccessful referrals ($N = 111$)

Item	Factor loading	Number of critical incidents
Category 1: Cultural barriers to refugees accessing care		32
Clients decline treatment that is not relevant to cultural beliefs	0.856	24
Failure to provide education about Western mental health services	0.847	4
Clients decline treatment that is not relevant to religious beliefs	0.833	4
Category 2: Lack of care coordination		31
Provider or client unable to initiate first appointment	0.757	4
Failure to resolve transportation barriers	0.746	10
Failure to coordinate adequate or timely care	0.648	17
Category 3: Provider is unable or unwilling to serve refugees		11
Provider declines to make or accept a refugee mental health referral	0.862	8
Provider lacks competence to work with refugees or trauma	0.817	3
Category 4: System barriers or lack of available care		14
Appointments not available or wait is too long	0.738	8
Insurance or eligibility barriers	0.723	4
Outpatient services unable to engage severely mentally ill patient	0.687	2
Category 5: Language barriers or failure to utilize interpreters		21
Language barriers or failure to utilize interpreters	0.864	21
Category 6: Inappropriate requests of MAA staff		2
Inappropriate requests of MAA staff	1.00	2
Total		111

$N = 111$ for the higher-order analysis corresponds to the number of incidents in the lower-order sort

derived in the initial analysis. The PCA on this matrix yielded 4, broader, higher level categories (Table 2) for successful referrals with eigenvalues of 4.45, 1.49, 1.23, and 1.09. The PCA on the unsuccessful referrals category yielded six, higher level categories (Table 3) with eigenvalues of 3.49, 1.63, 1.42, 1.24, 1.0, and 0.88. The original primary categories were nested within these sets of broader, higher-level, categories. This is a data-driven way of creating a higher-order structure from the sort data (Bjarnadottir and Campbell 2001).

Results

Survey respondents described their experiences making or receiving mental health referrals for individuals from the following refugee populations: Cambodians, Congolese, Eritreans, Ethiopians, French-speaking Africans, Hmong, Iraqis, Karen, Laotians, Liberians, Russians, Somalis, Ugandans, and Vietnamese.

Factors that Contribute to Successful Referrals

The higher order category names and total number of critical incidents accounted for by the commensurate components for successful referrals (Table 2) include: (1) active care coordination ($n = 90$), (2) establishment of trust ($n = 55$) (3) proactive resolution of access barriers ($n = 73$), and (4) culturally responsive care ($n = 32$). These categories and corresponding components are described below.

Active Care Coordination

Actions taken by participants who made and received referrals involved strong communication, scheduling appointments for refugees, a responsive emergency system, and case management provided by health plans.

Communication Between Providers Active communication between referring and receiving providers included sharing case files, diagnostic and functional assessments, phone consultation, ongoing contact after the initial referral, case-specific education, and taking the time to discuss referrals. For example, a mental health provider making a referral described, "several external consultations have occurred to discuss this client's current psychosocial stressors". Ongoing relationships between referring agencies and mental health providers created opportunities for successful referrals.

Direct Referral to Mental Health Provider and Scheduling of First Appointment Referring providers searched for appropriate referrals on the client's behalf and made referrals directly to mental health providers that they thought were appropriate. Instead of handing the referral information to the client, the referring provider contacted the mental health provider directly. They also assisted with registering the patient and scheduling the first appointment for the client.

Emergency Mental Health System Responds to Refugee Crisis Refugees engaged the crisis system, including the emergency room, for several reasons, including appropriate use in the case of an emergency. Participants also described clients accessing the emergency room after failed attempts at advocating for a health provider to make a mental health referral, or when outpatient services, such as Intensive Residential Treatment Services, did not have language capacity to serve refugees.

Case Management Provided by Health Plan Staff Care coordinators employed by health plan staff provided support for successful mental health referrals. Services included identifying appropriate services, providing coaching and education to the client about mental health services and how to access them, and coordinating appropriate discharge planning after psychiatric hospitalization. Health plan staff described providing services over the phone through interpreters.

Establishing Trust and Identifying Mental Health Symptoms

Successful referrals involved providers taking the time to build trust and rapport with clients before making a mental health referral. Inherent in this category is individuals and agencies possessing skills to identify and refer clients needing mental health services.

Proactive Identification of Mental Health Symptoms Refugees accessed mental health services through people with whom they had established trusting relationships, who were knowledgeable and skilled enough to identify mental health symptoms and respond. For example, staff of a mutual assistance agency noticed that a client was suicidal, and staff of a resettlement agency identified a client as having difficulty sleeping and being unable to follow through with resettlement tasks due to anxiety.

Access to Imbedded Mental Health or Referral Coordinators Having mental health providers embedded in health or non-health settings created opportunities for care coordination, including internal mental health referrals. For example, an employment counselor made internal referrals to a mental health provider working in the same agency. Mental health professionals or referral coordinators embedded in various sites also offered referral support. A primary care provider described, "I generate referrals from my clinic and have help from onsite employees, including our social worker, healthcare home navigators, specialty schedulers, and interpreters." On-site mental health providers offered immediate consultation and assistance on specific cases.

Trust Developed Through Family or Ethnic Community Leaders, Health or Non-health Providers Refugees received assistance accessing mental health referrals by contacting people from their own ethnic group that they knew and trusted, including family members, MAA staff, and professional interpreters. Refugees also accessed mental health referrals through providers working in a variety of health and non-health settings, for example refugee resettlement agencies, public health nurses, and English Language Learning (ELL) programs. Providers developed trust and rapport with clients, and used the alliance they developed to create opportunities for mental health care coordination. For example, a participant described, "The patient met with the primary care provider here multiple times and developed a trusting relationship before the patient agreed to meet with a mental health provider."

Proactive Resolution of Access Barriers

Referring and receiving parties and health plan staff proactively identified access barriers that are commonly experienced by refugees and assisted to resolve those barriers in the process of making the referral. Access barriers included language, transportation, and patient misinformation and lack of information. Providers offered assistance, reminders about mental health appointments, and follow-up after the initial appointment.

Psychoeducation In addition to making the referral, psychoeducation was given to clients about the process of accessing mental health services, benefits of utilizing mental health services, differences between Western and cultural mental health concepts, roles of different health providers, and payment for mental health services. Participants described psychoeducation in these ways: "much time is spent orienting clients to the [mental health] services we provide and how these services can benefit clients and their families" and "I explained that individual therapy with an interpreter is covered by her insurance plan."

Interpreters Providers ensured that interpreter support was available for mental health appointments. Some agencies utilized staff interpreters, and others requested a contract interpreter through an interpreter agency. Providers communicated with the client through an interpreter throughout the process of making the referral. In some cases, the referring provider or agency provided transportation or interpretation when assistance was not arranged, for example, providing interpretation for clients during psychiatric hospitalization.

Transportation Providers ensured that transportation was arranged for the mental health appointment. This included calling the health plan transportation number to request medical transportation (taxi). Utilizing medical taxi drivers who spoke the client's language was identified in stories of successful referrals.

Follow Up to Ensure Success of Referral

Providers followed up with clients, including calling with reminders about the appointment, contacting clients after the initial appointment to inquire about how the appointment went, and offering additional resources when necessary. For example, "I follow up to make sure the client attended and reschedule the (mental health) appointment for the client if necessary."

Culturally Responsive Care

In successful referrals, referring providers intentionally made referrals to mental health providers that they identified as able to provide care in a culturally-responsive way. This included mental health professionals from the client's ethnic group and providers who had experience working with a particular ethnic group and interpreters. Providers also provided multidisciplinary care that was flexible to meet the needs of refugees.

Knowledge of Refugees' Cultures and Trauma Treatment Culturally responsive providers were knowledgeable about a refugee's culture and possible trauma histories. For example, a staff from a resettlement agency was able to identify a vulnerable woman and pregnancy by being familiar with the prevalence of gender-based violence in one refugee community. Being knowledgeable about a client's culture and able to work with trauma also facilitated trust and rapport building and helped the client to feel understood, validated, and safe. Providers were also able to adapt western treatment approaches to be culturally relevant, including using cultural syntonic language to discuss mental health and wellbeing.

Flexibility to Meet in Client's Home Providers demonstrated cultural responsive care by being willing to meet with clients in their homes for the initial appointment or to provide ongoing services when necessary or requested. For example, a mental health provider described, "Because this client has very complex needs and had a Public Health social worker, nurse and others coming into the home, the social worker and I arranged to make a joint home visit for the first visit." In another instance, a mental health provider agreed to do an initial assessment in the home of a client who was not willing to go to a mental health clinic for fear of being stigmatized.

Multidisciplinary Care Culturally-responsive providers performed thorough diagnostic assessments to understand clients' needs and offered multi-disciplinary care. This included advocacy and assistance for clients to receive additional services and resources, such as services to locate relatives overseas or immigration assistance. Providers also assisted with completing paperwork, for example, for medical assistance.

Factors that Contribute to Unsuccessful Referrals

The higher order category names and total number of critical incidents accounted for by the commensurate components for unsuccessful referrals (Table 3) include: (1) cultural barriers to accessing care ($n = 32$), (2) lack of care coordination ($n = 31$), (3) providers being unable or unwilling to work with refugees or trauma ($n = 11$), (4) system barriers or lack of available care ($n = 14$) (5) language barriers or failure to utilize interpreters ($n = 21$), and (6) providers making inappropriate requests of MAA staff ($n = 2$).

Cultural Barriers to Accessing Care

Cultural barriers existed when services were not able to incorporate refugees' religious and cultural beliefs about mental health, wellbeing, and treatment, or when the system failed to establish trust or provide education about the mental health referral or process.

Treatment is not Responsive to Cultural or Religious Beliefs Clients declined or discontinued recommended treatment that they viewed as not being culturally responsive or that failed to incorporate their religious beliefs about mental illness or treatment. For example, a primary care provider described, "I set them up with therapy, but culturally it didn't really work with them. When I asked, the patient said, 'the woman just asked me questions and I don't want to go back and talk about it". In another instance, a client declined treatment because he believed that

mental illness was spiritual punishment. Family members or religious leaders sometimes influenced a client's decision to decline or discontinue mental health services. Clients also declined treatment when an appropriate level of trust was not established. For example, a client described to a staff member of an MAA that she did not trust mental health professionals.

Failure to Provide Education About Western Mental Health Services Failure to provide education about Western mental health services or to adapt Western approaches to therapy to a client's culture created barriers to refugees accessing care. For example, a primary care provider reported that her patient did not engage with treatment when the provider failed to adapt western approaches to therapy, which did not make sense to her patient. Refugees who lacked familiarity with Western systems, did not know what services were available to them, how to access them, or how a specific resource could help them were unable or unwilling to follow through on mental health referrals. A mental health provider reported, "Our clients are often struggling with finances and many times are very concerned that accessing services will incur debt that they will not be able to pay."

Lack of Care Coordination

A lack of care coordination by providers was identified as a major barrier to refugees accessing mental health services, especially for newer refugee groups who were unfamiliar with Western systems or clients with limited English proficiency.

Failure to Coordinate Adequate or Timely Care The two most frequently reported scenarios were providers failing to contact clients referred to them in a timely manner, e.g. "child protection case manager/worker did not contact the client for 2 weeks," and hospitals failing to establish aftercare plans for patients who were psychiatrically hospitalized. Numerous participants described instances such as: "[client] was discharged from the hospital the second time without a discharge treatment plan."

Failure to Resolve Transportation Barriers Factors that created transportation barriers included health insurance not offering medical transportation (e.g. "because her insurance didn't pay medical transportation, then it was difficult for her to come back"), clients not being able to use their health plan's transportation benefit (e.g. not knowing how to take the bus), or problems with medical transportation (e.g. taxi not arriving when requested). In some instances, clients were eligible for medical transportation to mental health appointments, but providers refused to assist clients with requesting this benefit. One participant described, "Providers refused to set up transportation for the client to come to an appointment at their office. They said they 'don't do that kind of work.'"

Provider or Client Unable to Initiate First Appointment Coordination barriers included providers or clients missing appointments and providers being unable to contact a client referred to them. In one instance, a psychiatrist missed three scheduled appointments in a row for a client, who then refused to be scheduled again. In another instance, a mental health agency no longer allowed referral coordinators from a primary care clinic to schedule appointments for clients due to too many missed appointments.

Provider is Unable or Unwilling to Serve Refugees

Referrals were unsuccessful when providers failed to make a referral, were unwilling to accept a referral, lacked the competence to work with refugees, or made inappropriate requests of MAA staff.

Provider Declines to Make or Accept a Refugee Mental Health Referral Participants described that providers were dismissive of the mental health needs of refugees and of their requests to make a mental health referral for a refugee patient. For example, staff from a resettlement agency described the experience of trying to get a mental health referral for a client who was pregnant as a result of gender-based violence, "We talked to the prenatal care provider and he was not helpful in that he did not or would not refer her to mental health services." In another example, a resettlement agency described, "inpatient mental health staff at the hospital was dismissive of a client's mental health crisis as adjustment related to being a refugee." Participants who were former refugees themselves described particular challenges in being able to advocate successfully for mental health referrals for their clients. In one instance, a staff who was a former refugee was told by a mental health crisis worker that the matter he called about was not a mental health crisis and therefore he should not have called. When the staff's U.S. born supervisor called back, they were able to mobilize crisis services for the client.

Provider Lacks Competence to Work with Refugees or Trauma Referrals were unsuccessful when mental health providers did not possess competence to work with refugees or trauma. For example, "the therapist did not have a background in working with clients who had survived traumatic experiences." In another instance, a provider refused a referral of a refugee client, stating that she "does not work well with refugees."

System Barriers or Lack of Available Care

Mental health services were unavailable to refugees due to the lack of available appointments, insurance barriers, and the severity of mental health symptoms.

Appointments Unavailable or Wait is Too Long Some mental health providers were unable to accept a referral due to an already full caseload. In other instances, long wait times posed access barriers, for example, "long-term facilities…had a 3–4 month wait" and "the next available outpatient psychiatry appointment was 8 weeks out."

Insurance or Eligibility Barriers A lack of health insurance prevented clients from being able to access needed mental health services. For example, "while the client was in psychiatric inpatient at the hospital, the hospital found out the client's medical assistance was not approved yet and they were going to discharge him." Specifically, a resettlement agency described that the length of time it took to process medical assistance applications for new refugee arrivals created barriers for clients who needed more immediate care. A lack of eligibility for agency services also resulted in unsuccessful referrals.

Outpatient Services Unable to Engage Severely Mentally Ill Patient Finally, participants perceived that the severity of a client's mental illness could prevent them from connecting to traditional mental health services. A primary care provider described: "I can't get him hooked up to outpatient services. He can't stay stable long enough."

Language barriers or failure to utilize interpreters

When providers failed to utilize interpreters, or when interpreters did not show up for an appointment, refugees were not able to access mental health services in a timely way or at all. Some providers did not understand their legal obligations to provide language services. For example, a participant described an adult crisis mental health worker as saying, "I don't speak (the client's language) so I can't call him."

Numerous participants described providers refusing referrals of limited English speaking clients. For example, "I have tried to refer and I've had to go through a long list of people because they refuse to work with refugees or those who don't speak English." Additionally, participants described that whole mental health systems were unavailable to non-English speaking individuals. A primary care provider described, "none of the long term, community facilities felt like they could take the patient because of the language."

Inappropriate Requests of Mutual Assistance Agency Staff

MAAs, by definition, possess linguistic and cultural competency to serve members of their community. However, MAA staff expressed frustration that providers did not understand their role and made inappropriate requests of their time. Attempts by MAA staff to refer to mental health were unsuccessful when they were unable to hand-off the referral because of provider requests that agency staff take on multiple responsibilities related to the mental health appointment. For example, MAA staff described that an adult mental health crisis worker to whom he made a referral asked him to call the client to coordinate the appointment, provide transportation for the client, and interpret for the crisis appointment.

Discussion

This study explores characteristics of successful and unsuccessful refugee mental health referrals in a Midwestern state preparing for the implementation of routine mental health screening with arriving refugees. Findings related to characteristics of successful referrals confirm previous research that emphasizes providing coordinated care, establishing trust, resolving access barriers, and providing culturally competent care. However, unlike previous research, findings derived from accounts of real referrals contribute new knowledge that describes detailed dynamic processes occurring in relationships between multiple providers and refugees. Similarly, findings related to unsuccessful referrals confirm barriers to care including lack of coordinated care, trust, transportation, language interpretation, insurance and culturally competent care. These findings also describe new barriers such as providers being unwilling to see refugees, and more detailed knowledge of how these barriers contribute to unsuccessful referrals.

Successful mental health referrals involved more than handing refugees a piece of paper with the contact information for a mental health provider. Appropriate care coordination was described as active and ongoing relationships and communication between referring and receiving providers concerning the details of the referral. Successful care coordination starts with actually scheduling the first mental health appointment for the refugee client. Given that new populations often arrive with limited English proficiency, and mental health service providers may not have access to interpreters for initial appointments, scheduling appointments for refugees may be crucial to assuring access to mental health services. Health plan staff can also play an important role by providing ongoing coaching, education, and assistance with navigating the mental health system.

Providers described anticipating what barriers exist for clients and working to proactively resolve them. This included arranging interpreters and transportation, providing psychoeducation about mental health services, and following up to ensure the referral was successful. The extensive follow through described by these participants is not standard practice in most clinics. In fact, in some managed care health settings, providers are only able to manage one stated need and the patient needs to schedule another appointment for a second complaint (Shannon 2014). This unfortunate reality associated with the time pressures of some medical care settings is not adequate to meet the multidisciplinary needs of refugee trauma survivors (McMurry et al. 2013). Clinics and health plans with care coordinators, system navigators, or imbedded mental health are likely to be more successful at addressing these barriers to care. Providing mental health care in community-based settings may also address some of these access barriers.

Successful referrals begin with identifying mental health symptoms within the context of a trusting relationship between providers and refugees. Trust in the referring provider was key to the success of mental health referrals. Trust was established slowly through multiple meetings over time. For many refugees, trust in authority figures has been eroded due to torture and war trauma (Miles 2008). Providers may need to acknowledge refugees' difficulty with trust as a natural consequence of surviving war. Refugee providers may benefit from training on how to establish credibility and trust with refugee survivors (Eiseman et al. 2000).

These findings also contribute new knowledge about what constitutes care that is not only culturally competent but also responsive to the cultural backgrounds of refugees. Culturally responsive providers were knowledgeable about refugees' histories, cultures and trauma. Such knowledge helped them to build trust, provide education, and adapt treatment methods to be culturally syntonic with refugee backgrounds. They were also flexible to meet in clients' homes and arranged multidisciplinary care, even when that meant stepping outside of conventional professional roles. That flexibility was key to providing care that was responsive to the cultural backgrounds and needs of refugees. For example, a mental health provider might assist with completing paperwork for insurance or arrange transportation.

Findings related to unsuccessful referrals also generated new knowledge describing barriers to care. Cultural barriers included not only the discordant health beliefs of refugees but also the failure of providers to educate refugees about mental health or to culturally adapt western mental health services. The important role of psychoeducation in validating refugees' experiences, establishing trust, and providing information about healing has been underemphasized in the literature on cultural barriers. Although this study was conducted with providers, the author's previous research with refugees confirms that psychoeducation is recommended by refugees as beneficial in initial health appointments (Shannon 2014).

These findings describe a dynamic process between providers and refugees that is responsive to refugees' individual, multifaceted needs and cultural backgrounds. Lee (2012) proposes a cross-cultural model of the treatment alliance that is similarly dynamic, reflecting a mutual negotiation process between clients and therapists. This process involves the exploration of cultural notions and conflicts, and a repair of the alliance based in a shared cultural joining or understanding.

The lack of care coordination in this study seemed to involve not just the failure of providers to communicate but the total lack of concrete services needed to keep an appointment. Chief among them were transportation and language services. Despite their legal right to interpretation in most treatment settings, language barriers affected refugees' ability to access health services at each point in the referral process (making the appointment, completing intake paperwork, arranging transportation through the health plan, completing public assistance paperwork to maintain insurance). Without care coordination to assist with these concrete services, initial appointments may not even happen. The move toward co-location of primary and mental health services and community-based services reduces the need for such extensive care coordination efforts. Health plan navigators or care coordinators can also play a vital role in ensuring the provision of these concrete services.

In addition to the lack of available care, one of the more surprising barriers associated with unsuccessful referrals was providers being unwilling to serve refugees. This included providers who failed to acknowledge the mental health needs of refugees, lacked competence to work with refugees or trauma, refused to work with non-English speakers, and providers who relied too heavily on MAA staff for coordination, transportation and interpretation. These provider barriers have not been previously cited in the literature and substantiate the need for culture and refugee-specific training of providers.

Limitations

Survey responses provided brief stories and not in-depth interviews, which may have yielded deeper knowledge of referral experiences. As our goal was to collect numerous experiences, we were unable to conduct such in-depth interviews. Although the PCA captures the majority of the

variance in successful and unsuccessful referrals, it inherently leaves a small portion of variance undescribed in the final solution. Additionally, the objectivity of the pile sort technique may be limited by the bias of individual sorters. The findings of this study are relevant to this Midwestern state, which has an extensive managed health care system, and may not be generalizable to different state systems. We also did not interview refugee consumers about their experiences with mental health referrals, which would be a fruitful direction for future research.

Conclusions

As state public health systems begin implementing routine mental health screening of refugee arrivals, this research contributes knowledge of the processes involved in making successful mental health referrals. Based on these findings, relevant training for health and mental health providers would include the key aspects of active care coordination, how to establish trust and identify mental health needs, proactive resolution of barriers, and the components of culturally responsive care. Health and mental health providers may also benefit from education on evidence based models of trauma treatment and political and cultural knowledge about newly arriving refugee groups.

These findings also have policy implications beyond training. Since the processes involved in making successful referrals involved time for ongoing communication and establishing trust, public health systems and health insurance plans may need to provide more time for initial health screening processes. Health providers need time to provide education and establish trust with refugees. Health providers need time to establish relationships with mental health providers to share the information necessary for successful referrals. When imbedded mental health services are not available, health plans can also play a key role in developing relationships between refugee providers who practice near each other and who might function like a team to provide needed multi-disciplinary care.

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