Webinar: Mental Health and Psychosocial Support (MHPSS): Foundations for Resettlement Caseworkers

March 21, 2024, 1:00 – 2:15 PM ET

Transcript

Introduction

Megan Rafferty: Hello and welcome, everyone. I see that the numbers are going up, so we'll just give it a little bit of time for everyone to get into the room and join us from other meetings.

[pause]

MR: Okay, welcome, everyone. We'll wait another 30 seconds or so as we wait for more people to hop over and join us.

[pause]

MR: All right, well, let's go ahead and get started. Hello and welcome. Thank you for joining today's training, Mental Health and Psychosocial Support: Foundations for Resettlement Caseworkers. This training is presented to you by Switchboard, a one-stop resource hub for refugee service providers in the United States.

Zoom Orientation

MR: We'll go ahead and start with a quick overview of our settings in Zoom for today. You are joining us on listen-only mode since this is a webinar, and we've also disabled the chat due to the large number of learners that we have expected today. Please write your questions in the Q&A box, and we do hope that there will be a little time at the end to take a few of your questions.

MR: This webinar will run for 75 minutes and is being recorded. Everyone who registered will receive an email with a replay link and the slides within 24 hours. In the following days, that recording and slide deck will be posted to the resource library on the website as well. Finally, at the end of our webinar today, we kindly ask that you stick around and complete our short webinar satisfaction survey.

Today's Speaker

MR: All right, so I will start by introducing myself. My name is Megan Rafferty. I'll be your speaker for today. I am Switchboard's training officer focused on mental health and wellness. My background is that I'm a licensed professional counselor, and I've provided strengths-based, trauma-informed mental health services to refugee and immigrant populations in Colorado for over a decade. I've also worked as an intensive case manager for a

local community mental health center for over two years. I just wanted to note that. Given that today's training is geared towards caseworkers, I wanted to let you all know that I'll be bringing that lens to this training today as well.

Learning Objectives

MR: All right, and here are our learning objectives. By the end of today's training, if I've done my job, you will be able to recognize common signs and symptoms of emotional distress in refugee populations, summarize practical approaches to support newcomer clients with various mental health needs, and apply strategies for appropriate community referrals addressing common barriers to treatment for refugee and newcomer clients.

1. Recognizing Emotional Distress

MR: Let's just go ahead and dive into our first learning objective and find out how we can recognize emotional distress and mental health needs of clients. Let's start with a definition of mental health first. Mental health is viewed and talked about differently across cultures and among individuals. This definition can give us a shared understanding of what we're here to talk about today. Our definition says, “Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, and work well, and contribute to their community.”

MR: As you can see from this definition, mental health goes beyond the absence of illness. It encompasses a positive state of well-being, feeling confident and competent to cope with life's stressors and to function well in society. Our mental health affects how we think, how we feel, and act. It's important throughout the lifespan, from childhood through adolescence and into adulthood. Our mental health can have consequences on the choices that we make, how we interact with people, how we handle stress and so many other things.

Discussion Question

MR: We have a question for you, and to answer this question, we're going to be using a tool called Slido. If you're familiar with our webinars at Switchboard, we use Slido quite often. If you would like to participate and answer this question, you can join us at slido.com, and you can enter the code 1086 769, or you can take out your mobile device, you can scan that QR code and join us there. When we're done with this Slido, we have several more throughout the webinar, so just keep that window open, and it will automatically progress as we go on.

MR: I see some answers are coming through. Our question, now that we've talked about the definition of mental health,

What factors contribute to a person’s mental health?

MR: I see environment is coming through really big. Trauma is another common response. Past experiences, religious beliefs, financial health, positive connections, medical health, family of origin, systems of oppression, genetics. Amazing. You all have really nailed it. Education, war. So many answers coming through.
Okay, fantastic. Thank you all. We're going to go ahead and move forward for the sake of time.

What factors influence mental health?

MR: Yes, you all really nailed it in your responses, as you'll see here on the screen. A lot of what you've mentioned is here. Everyone's mental health is made up of unique factors that are just specific to you. We've all had different life experiences, beginning with the genetics that we received from our parents. We've all had different life experiences, exposure to different environmental factors. All these things make up who we are.

Risk Factors and Protective Factors

MR: We may have had positive experiences with friends, family, community, society, which we think of as protective factors. We might have had negative experiences, which we might think of as risk factors. All of these combine together to make up our mental health. There are so many factors to consider. What you see here on the screen are really only a few examples. There's so much more than this. Also important to think about is that mental health conditions don't discriminate. They can impact anyone, regardless of their age, gender, ethnicity, social status.

MR: It can be helpful to think of risk and protective factors as opposing sides of a scale. When a person's stressors start to exceed their ability to cope, that's when we might start to see mental health being impacted. Just something to keep in mind as you're trying to identify your clients and finding out who's in need of some additional support.

MR: All right, but we've talked about risk and protective factors in a general way so far. What about risk and protective factors that are more specific to refugees and newcomers?

MR: Everyone's experience is different, but some common risk factors include traumatic experiences of forced displacement. Many examples like exposure to violence, war, sexual assault, grief, and loss. That can be the death of loved ones, of course, but it can also be that loss of status, career, culture, country, and so much more. Gender-based violence, torture, limited resources, disruption of social networks as families relocate in different places, and shifting family dynamics.

MR: For example, in a family where a husband was the typical breadwinner, and then a wife or teenage children start working, or in examples where children are asked to interpret for their parents, both of those examples can really shift the power dynamics in families and lead to some stress as things get renegotiated.

MR: Okay, and protective factors. Most newcomers have a great well of protective factors, which is why there is so much resilience among our clients. Strong community ties—many newcomers come from collectivist cultural backgrounds, and community is very important and a huge strength, which I think leads directly to family support.

MR: Having close family ties and intergenerational support can be another really big protective factor. Faith and religious beliefs can be very important for our clients. Access to education or to employment, good health, hope, determination, and so many other personal strengths that our clients hold and carry with them. All important protective factors.

Signs of Emotional Distress

MR: All right, so after recognizing that balance of risk and protective factors that can contribute to someone's overall state of mental health, I think now we're ready to talk about how to recognize some common signs of emotional distress.

MR: These might include difficulty sleeping, worrying a lot, or even extreme fearfulness, frequently feeling sad or tearful. Many clients will say that they're thinking too much. This is a really common way that our clients express their feelings of anxiety or depression. Unexplained body pain—again this is really common with refugee clients who will often cite headaches, stomach aches, or unexplainable pains or burning sensations in their bodies. Difficulty concentrating or learning new things, wanting to be alone all the time, or isolating. A long list of possible experiences.

MR: What's really important here is that emotional distress is not the same thing as having a disorder. These are just normal responses to stressful situations. Everyone is going to experience some degree of these things from time to time. Most newcomers will not develop diagnosable mental health problems. When you see that a client is experiencing high levels of distress over longer periods of time, that might indicate that an individual needs some additional support. It's important to pay attention to these signs of emotional distress through the lens of severity and length of time that they've been experiencing them.

More Serious and Rare Reactions

MR: Also, everyone's mental health exists on a continuum with healthy functioning at one end and more extreme distress and problems functioning at the other end. Some other possible reactions on the farther end of that spectrum include suicidal thoughts, self-harming behaviors, such as cutting oneself or hurting oneself, paranoia, which might look like someone is always looking over their shoulder, maybe they're seeing shadows where they think people are following them, delusions or having beliefs that are not based in reality, hallucinations, or which we can think of as seeing or hearing things that other people don't hear or see, and an inability to care for yourself.

MR: Not attending to things that are necessary for survival, such as eating or drinking, and that's not due to a lack of access to food or water. Really what that is that someone is so sick that they're not responding to those basic survival instincts. Then the last we have here is substance use. Using substances like alcohol or recreational drugs, it's a pretty common way that people cope with emotional distress or mental health challenges. In my experience, I find that it's much less common in newcomer populations than U.S.-born populations. Again, it's certainly something for us to be paying attention to if it's impacting someone's ability to function well.

MR: These responses to emotional distress are much less common, but they do show up from time to time. After attending to any immediate safety concerns, doing any safety planning, these might be important reasons to seek mental health support for your client.

Cultural Expressions of Mental Health

MR: Okay, so now that we've outlined some common ways that we see emotional distress show up for people, we want to spend a little bit more time talking about those cultural expressions of mental health. Because

mental health and mental illness can look different for different people, it's not the same across all cultures. We need to be aware of that.

MR: As we discussed, newcomers can often report a lot of physical or somatic complaints like headaches, stomach aches, pains. We all know that there's a connection between our minds and our bodies. In different cultures throughout the world, even for people born in the U.S., physical symptoms often accompany psychological distress.

MR: It's common for people with depression to have a low appetite, to experience physical aches and pains. People with anxiety often report feeling dizzy or having a fast heartbeat. The explanatory model for these physical symptoms, or the way that people view, interpret, and respond to these symptoms can really vary across cultures. The high amount of physical symptoms that refugee clients report might also be because it's more comfortable to talk about physical pain than emotional pain due to the stigma around mental health. That's another reason why we often see more of these physical symptoms.

MR: Next bullet point. It's also important to remember that refugee clients may come from cultures where there's not a lot of language that describes mental health or traumatic experiences, or that the language that they use might be very culturally based. It might be unfamiliar to you. Instead of saying, "Oh, I'm feeling so depressed," someone might say, "Gosh, I've been thinking too much. I just can't stop thinking."

MR: Another example for the lack of terminology around mental health is when I worked with Korean clients in the past, I was informed by my interpreter that there's no word in the language for therapist or counselor. Instead, they referred to me, the therapist, as teacher, because that was just the word that fit the most closely. Just understanding that there's maybe not always a direct translation for the words that we commonly use.

MR: All right, and last point on this slide is high- and low-context communication. Most places in the U.S. tend to be more low-context communication, meaning that what people say is often very direct. They say exactly what they mean when they speak. This may come up as very blunt or very rude in a lot of other cultures that have more high-context communication. High-context communication means that what is said is not always exactly what somebody means, and it often includes a lot more details before the speaker gets to the main issue that they want to discuss.

MR: Oftentimes, a high-context message can't be fully understood without also knowing some significant cultural background information, taking into consideration body language, tone of voice, power dynamics. Really, there's a lot more that goes into it that we need to be considerate of. Main takeaway message from this slide: you don't have to be an expert in every culture. Just know that every culture expresses their mental health differently, and sometimes you have to read between the lines to really understand what's going on for your client.

Newcomers Are Resilient

MR: Okay, and after saying all that, this is very important. Newcomers are resilient. There's a danger in assuming that someone who has experienced a significantly potentially traumatic event automatically must need counseling. I see this a lot as a therapist. Often, well-meaning community members, when they hear someone's story, they assume that they must have PTSD. They must need treatment. They think, "Well, if that happened to me, I would definitely need counseling, so this client must need counseling."

MR: Oftentimes, that's just not the case. Oftentimes, people are functioning quite well, and they don't need additional support. Other times, people may assume that a client's primary goal is going to be to work on the trauma. If they say, "Yes, I want counseling," they think must be because of that trauma you experienced. In fact, a client might want to work on family-functioning issues or making new friends. Our clients' goals might be different than what we assume that they should be. It's just really important to listen to our clients and what they say that they need.

Case Study: Sylvie

MR: Okay, and so now I'm going to introduce you to our case scenario for today. Sylvie is a 33-year-old woman [who] fled with her family from violence in their home country, the Democratic Republic of Congo, DRC. They then lived in a refugee camp in Uganda for seven years. While living in the camp, Sylvie's husband died from illness, leaving her with four young children. Sylvie and her children were resettled in the U.S. nine months ago. During your routine home visits, Sylvie complains about frequent headaches and exhaustion. She also shares that she avoids going to church, an activity that she used to enjoy. Her children tell you that their mother just feels different and that she doesn't sing or laugh like she used to.

Discussion Questions

MR: Okay, so we're back to another Slido for you:

What signs and symptoms of emotional distress do you notice?

MR: Isolation, headaches, grief, avoiding community, lonely, she's acting differently, mood changes, lack of interest, crying, exhaustion. Yes. Not singing like before. Losing her interest in things, physical pain, distress, headaches. Yes, awesome. Yes, I think y'all really picked up on all of the signs of emotional distress that we know from the case scenario. There might be a lot more. We don't know a lot about Sylvie, but yes, amazing. Thank you all so much.

MR: We're going to move on to our next question for you.

What are some of Sylvie's potential protective factors?

MR: Again, we don't know a lot about Sylvie, but what would we guess might be some of her protective factors? Children, yes. Faith, resilience, family. Her church community or religious beliefs. Church, yes. Amazing. We don't have a lot to go on, but you all have really picked up on what there was. Hope and resilience. Her kids are going to be a really big one. Yes, hobbies and interests, right. She used to enjoy singing. We can assume that might be something that would be a protective factor for her if we could help her rediscover that.

MR: Yes, awesome. Okay, thank you all so much. We're going to just go ahead and keep moving forward.

2. Providing Support

MR: Next section, providing support. How can you provide support to your clients when they're experiencing emotional distress? We've got one more Slido for you just to start out with a little bit of self-reflection.

Discussion Question

What helps you when you're going through a difficult time?

MR: Talking to somebody. I assume that's receiving active listening. Therapy, bike riding, napping. Love these. Exercise, praying, engaging with hobbies, going to the gym, taking breaks, going outside, talking to therapists, painting.

MR: Positive behavior like singing, even when I don't feel like it. Wow. Hanging out with the cat, boxing, baking. Wow, this is so great. Listening to the Quran. I saw swimming, laughing, getting a dog, cooking. Wow, so many ideas.

MR: All right, thank you all so much. I really appreciate that. I'll say for me, when I'm going through a tough time, I appreciate people who are willing to just listen, and I usually don't like it when people want to give me advice or tell me how to solve the problem. I saw a lot of people appreciate active listening or being able to talk. Great, go ahead and move on.

Developing Trust

MR: When we're talking about how to provide support to our clients, first things first, we have to develop trust. This is also often referred to as rapport building. Some key steps to developing trust with our clients are normalizing the client's experience by reminding them that anyone who's experienced these types of difficult events might be feeling the way that they feel. It's totally normal, whatever they're feeling. It's okay to feel overwhelmed sometimes.

MR: It can be really helpful to validate the client's emotions. Just like when I'm feeling upset, I don't want advice, I just want someone to listen to make me feel that what I'm experiencing is okay. I think that advice can make people feel like what they're doing is wrong, might make people feel judged, and nobody wants to feel judged. Make sure that you're reserving your judgment and just meeting clients where they're at.

MR: In my years of experience working with clients, when I was first starting to work with people, I ended up doing a lot of case management. Even when my job was to be a therapist, I was doing case management a lot for clients. What I found was that providing practical assistance with whatever problems clients were experiencing just went a long way to developing trust. That might look like helping them read their mail or scheduling a doctor's appointment for something that's been bothering them. Even little things that take just a couple of minutes can mean a whole lot to clients who are new and have few resources.

MR: Of course, follow through with what you say you'll do. Nothing will destroy trust faster than when you don't follow through on what you say you'll do.

Safety and Stabilization

MR: Okay. Next, safety and stabilization. Now that your clients are starting to trust you, you're developing a good relationship with them, it's important to continue working on this safety and stabilization. I feel like the response from case managers might be like, "What does this have to do with mental health? I thought this was a training on mental health. This is just what I do every day as a caseworker."

MR: I want to validate that what you're doing when you're doing safety and stabilization is actually really important for clients' mental health. It's actually the first phase of trauma therapy. Caseworkers are really instrumental partners in this work. Counselors can't move on to helping people process difficult emotions or past experiences if their basic needs haven't been met. If someone is sitting in the counselor's office, talking to the counselor, if they're sitting in a wellness group, but their stomach is grumbling with hunger, if they're stressed about their housing, they don't have a winter coat, that's what they're going to be thinking about. They're not going to be focused on counseling or talking about something that happened 10 years ago.

MR: Of course, caseworkers should also be regularly assessing clients' safety needs, assisting clients in developing safety plans whenever needed. Of course, some examples might be, there are incidents of gender-based violence, child abuse, suicidal thoughts, those types of things. Then finally, remember that clients often experience a honeymoon phase when they're first resettled to the U.S. We've noticed that a lot of clients, their mental health concerns did not become apparent until after a longer period of adjustment to the U.S. Just a reminder to continue to screen clients for mental health concerns well beyond that 90-day screen.

Psychoeducation

MR: Okay, the next approach that case managers can take to support their clients who are experiencing distress is psychoeducation. That's just a big word that means teaching clients about mental health, teaching clients about their symptoms and approaches that might help them feel better. This is a skill that mental health providers use all the time. It's very helpful. When you're educating clients about mental health, just remember to use language that's easy to understand since many cultures might not have the same language around mental health, so simple explanations will translate best.

MR: This tool can also be really helpful in reducing stigma, which we're going to talk about a bit more later today. We all know that there's a lot of stigma towards receiving mental health support. Continuing to provide this type of information in a very supportive, non-judgmental way can be really helpful. One example that we have on the screen of what psychoeducation can sound like: “Things that happened to us in the past can still affect us in the present. It can be helpful to talk about the past to heal from it.”

Teach Coping Skills

MR: Finally, this is our last skill to present for you today that caseworkers can use to support their clients' mental health needs. It's teaching coping skills. If you have a client that no matter what you do, you've talked to them about counseling and they're like, "No way," or wellness groups, support groups, and they're like, "I don't want to do that, no way," this is a skill that you can still use to help your clients. Case managers can teach clients how to use coping skills to manage their emotions independently.

MR: We don't have enough time to go into this whole list. This is a nice list of some common coping tools. We're going to drop two links in the chat where you can go to learn more about each of these. There's lots of resources, lots of videos online where you can learn more about coping skills yourself that could help you, and also how you can model these for your clients.

Case Study, Continued: Sylvie

MR: All right, so now we're going to go back to Sylvie. We have a little update. At your recent routine meeting, Sylvie is tearful and mentions having trouble sleeping due to nightmares. She says she feels exhausted every day and points out the increasing mistakes she's been making at work as a result.

MR: She also shares about getting her children to school late on several occasions. Sylvie talks at length about how things would be different if her husband were here, and you must often redirect her to stay on track, and you have to remind her about appointments and meetings.

Discussion Question

MR: Thinking back on this past section,

How would you support Sylvie's mental health needs?

MR: All right, number one, I see listen. I think that's a great idea. Reminder calls. She said she's been missing appointments. Let's help her out with some reminder calls.

MR: Therapy might be helpful. Active listening. Validate her feelings. Ask her if she'd like to talk to someone. Listening. Ask her what she thinks would help. Maybe connecting with community and family. Let's see what else. Affirmation. Reassure her that she's not alone. So many good ideas here. Give her awareness about mental health. Be there to help. Validate her emotions. Empathy. Teach about positive coping strategies. Connecting to a women's support group. Reminders about church events. These are all great ideas. Let her know that her feelings are valid. Thank you all so much. Appreciate all these great ideas.

3. Making Referrals and Addressing Barriers

MR: We'll go ahead and move on to our final objective for the day. We'll talk about making referrals and addressing barriers.

Levels of Support in Resettlement

MR: To start, let's talk about some of the different types of support that are available. If someone wants and needs additional support beyond what we can provide in case management sessions, where might we refer people?

MR: First of all, healing does not have to equal therapy or counseling. Healing happens in relationships, and that does not always have to mean a counselor-to-client type of relationship. It can look like relationships that are developed at a workplace or school. Maybe getting support from kind teachers or making new friends. Faith or spiritual leaders. This can be a very familiar and positive source of support for many of our clients. Psychosocial groups. A lot of you mentioned groups, women's groups, arts-based groups, youth mentoring groups, lots of options out there that we can connect clients with. Individual therapy—what we might think of as traditional Western treatment, one-to-one in a private setting.

MR: Psychiatry. A psychiatrist is a doctor who prescribes medications for mental health conditions. This can be especially helpful in combination with counseling. Remember that not everyone needs medications. In fact, most clients can be best served in the first three settings, with fewer people needing support from the counselor and even fewer people needing medications. Getting support for emotional wellness does not have to be just one of these things. It might be a combination of multiple types of support that someone's getting.

How to Discuss a Referral with a Client

MR: Okay. Because it's important to know how to make a referral to additional services when needed, let's talk about the steps of a successful referral. For this example, we're going to talk about how to make a referral to mental health counseling since that's the most common question that we get. Although it's not explicitly stated in these instructions here, I would start this conversation after your client identifies a problem that they want help with. A client might say, "I'm so tired today. I can't sleep. I'm just up all night thinking too much."

MR: When that happens, the first thing that you might do is reassure the client that what they're feeling is normal and that support's available. You might say something like, "What you're experiencing is a normal reaction to an abnormal event. All this stuff that you've been through, it's so much. It makes sense that you're thinking too much and that you're having trouble sleeping. That happens to a lot of newcomers."

MR: Second, you might acknowledge the client's strengths. Saying something like, "Surviving war, leaving your home, coming to a new country, all of that must have been so hard. You are so strong to have made it all the way here."

MR: Next, explore culture and context. "What ideas do you have about what might help you? How can I support you? If you were back home, what would you do?" In Sylvie's case, you might ask, "How do people from your family or from your culture cope with grief?"

MR: Fourth, offer education and information about services that are available. Back to that psychoeducation. For an external referral, you might say, "In our community, we have a counselor named so-and-so who might be able to help you with your sleep and your worries. She's helped many of my other clients with these same concerns."

MR: Fifth, encourage choice, and answer any questions that your client might have. Say, "It's your choice if you want to meet with a counselor or not. You can just try it and see how it goes. You can stop anytime you want. It's always your choice. What do you think about that? Do you have any questions that I can answer?"

MR: Sixth, obtain consent. Make sure that you are getting permission from your client before you're sending any referrals. You might specifically ask, "Do you want me to make a referral?" If the client agrees, then it's helpful to share with them a little bit of information about what they can expect or what might happen next. You can say, "Okay, I'm going to send in this referral today. Someone from the counselor's office will call you within a week. They'll call you with a professional interpreter and ask you some questions to get to know you and make an appointment for you to come and meet with them."

MR: A couple of extra tips. Oh, sorry. We can just go back really quick. Just a couple of extra tips here. If you have a reluctant client, it can be helpful to do a warm handoff. If you happen to know a counselor in the community, if you could have them come into your office and meet with the client in a more neutral space or a

space that's more comfortable to them, sometimes that's a nice way to start, and your client might be more willing to try an appointment.

MR: When you're making a referral, it's also important to help your client think through the types of barriers that might prevent them from then accessing those services, and then to help them address those barriers, which we're going to talk about now.

Discussion Question

MR: We can go on to our Slido question, which is,

What barriers prevent newcomers from accessing mental health services?

MR: Okay, I see financial situation. Stigma is coming through really big, so that one a lot of people are agreeing with. Language, that's also another really big barrier that's coming through. Transportation, I see that one loud and clear. What else? Insurance access.

MR: What else haven't we talked about yet? Yes, money for transportation, lack of awareness, misunderstandings, not fully understanding mental health services. Differences in therapy strategies. Okay, yes. I'm seeing a lot of barriers filling up our screen here. Pressure from spouse or family, not trusting, shame, other priorities. Yes, you've all nailed it. Yes, I think we've got them all.

Barriers to Accessing Care

MR: Okay, let's go ahead and move on to our next slide. We're going to run through the common barriers, but I think you've all already pretty much hit on. First, we have physical, which can include transportation. It might also include child care. If families have young children, and they don't have child care options, that can certainly be a barrier. Health—so for folks who have some health issues, or accessibility issues that make it difficult for them to leave the house, that can be a barrier.

MR: I'm going to also add in here access to technology. We know that a lot of providers these days offer telehealth, or remote services, but there are still a lot of barriers for our newcomer clients to attend those sessions, such as access to technology or low levels of digital literacy.

MR: Okay. Next, we have time. Clients are often just very focused on self-sufficiency. They're working long hours, spending long hours on the bus, getting around. They might be going to school, trying to learn English, or they might have children or other family commitments, and they're just having trouble finding the time for therapy.

MR: Third, the provider network could be a barrier in your community. It really depends on where you're located in the U.S., but there might be a lack of culturally aware providers in your area, and there might be a lack of interpretation services that are available within your existing mental health network.

MR: Four, financial. A lack of medical insurance, or a lack of funds if you have to pay out-of-pocket sliding scale, or copays. That's a huge barrier.

MR: Fifth, emotional and mental barriers might exist, too. Sometimes clients are just not emotionally ready to talk about their trauma or other mental health concerns. There is nothing wrong with that. Many of our clients have been in survival mode for years, and going to counseling to open up those wounds and be vulnerable just might not feel safe for them right now. That's okay.

MR: Lastly, we have stigma, the really big one. Stigma or shame often plays a very big part in how our clients feel about getting help. Personal beliefs about what it means to seek mental health support, or worries about what their family or community might think about them getting support, can stop people from getting care.

What Stigma Sounds Like

MR: Okay. To continue with stigma, it's a really big concern for caseworkers. People ask us about it a lot, so we wanted to make sure that we spend a little bit of extra time on it. For a lot of newcomers, maintaining face or appearing very capable is very important to them. I find this—well, I found when I was working as a clinician, especially true for older men.

MR: Discussing a personal problem, a feeling, or crying, they worry that it might be viewed as a weakness, and they might be afraid of how it looks to other people if they find out that they're getting help. For this reason, many people might hide their emotional pain until things get really severe and it's really hard to function.

MR: People have lived in places where people who had mental health issues were treated very badly. They might have been locked away for many years, sadly even experimented on. Some people lived in places where psychological medication or psychiatric institutions were used as forms of torture and political detention. If we keep that in mind, it makes sense that if people think that that's what we're talking about when we bring up counseling services in the U.S., it makes sense, of course, they might get upset when we mention that.

MR: Again, back to that psychoeducation, letting people know that that's not what we're talking about when we're talking about treatment care. Many clients come from tight-knit communities as well, and many have collectivist cultural backgrounds, like we've already mentioned. There can just be a lot of worry about how the community might view them seeking mental health, even if they themselves think like, "Oh, I'd be willing to try that. That might be helpful, but I'm worried if anybody finds out what they might think."

MR: I've even had clients say or express concerns about, "Well, if people in the community find out, that might have repercussions that go down to my children. That might mean that my daughter or son is not able to marry into a good family, and I don't want to mess up their future." There's just a lot that goes into this. The shame and the fears that people have about the perceptions of seeking mental health treatment can really lead people to be uncomfortable to get services, even when they're having symptoms and need support.

How to Help Reduce Stigma

MR: A few tips on how to reduce stigma. Can you go on? Yes. Number one, start by educating yourself about your clients' beliefs about mental health, and acknowledge your clients' views. This can be coupled with that psychoeducation, again, about what services really look like.

MR: Next, the term "mental health" is a term that has a lot of stigma attached to it. I know I've used it throughout this entire presentation. It's because I want us to have an understanding as service providers about

what we're talking about. But when we're talking to clients, I recommend not using the term "mental health." Instead, you might use the term "counseling," and you might talk about how common it is for people in the U.S. to get counseling just when they're dealing with any kind of stressful situation.

MR: Next, it can be productive to focus on the client's goals. When your client says, "I want to learn English, but I'm having trouble concentrating," I would focus on that goal, and how their goal of wanting to learn English might be helped with counseling. You might say to your client, "Gosh, how might your life improve if you could learn English? I bet that would make your life so much easier. What if we got you some help for that concentration problem that's really standing in the way of you meeting your goal? Counselors might be someone that could help you with that concentration problem."

MR: Okay. Our next point here is to talk to your client about confidentiality. Again, if they have that stigma and they're worried about what other people might think, let them know that counselors are going to keep what they talk about private, unless there's any major safety concerns.

MR: When talking about mental health, use a strengths-based approach. Let people know that facing their trauma, or getting help when you need help is a sign of strength, not a sign of weakness.

Recall Sylvie

MR: We're going to go on to our case scenario. Perfect. This is just a refresher on Sylvie. This is the same text as the last time when we talked about Sylvie, so I won't read it again. For a reminder, she's having nightmares, she's having trouble sleeping, she's exhausted, she's making mistakes at work. She is talking a lot about her emotional distress and how hard things are in your meetings with her.

Discussion Question

MR: For our next Slido questions—if we can pull that up—here we go:

How might you begin to talk with Sylvie about seeking additional mental health and psychosocial support?

MR: We've got some multiple choice answers here. All right. I'm seeing results coming in. A lot of people are agreeing, both A and C. Well done. A and C. We have, A, “Ask her what her biggest priority is right now and focus on that,” and C, “Help her identify options for support.”

MR: We had a trick answer in there, which was, "Tell her that she needs to see a counselor." We don't want to tell her what to do, but we might let her know that it's an option. Awesome. We'll move on to our last Slido for the day. After all this, we're here, we're at the end of our presentation for the day.

Poll Question

How confident do you feel supporting clients with their mental health needs?

MR: I'm wondering if you're already doing some of these things. I imagine you're already doing a lot of them. If not, I hope that they feel like some strategies that you might be able to implement. I'm super happy to see that

most people are feeling at a four and a five, feeling confident that you can support your clients with your mental health needs. We didn't do a pre-test, but I'm going to say this is a win. This is great. Glad to see it. Okay, excellent. Thank you, all.

Q&A

MR: Now, I really buzzed through our presentation. We have plenty of time available for questions. I'm going to turn to our Q&A and see what we've got in the Q&A. Feel free to add some more questions here. I also have a few questions that came through our pre-registration, so I can go for those, too.

[silence]

MR: We have a question:

How do we get local therapists and local mental health resources to be more willing to work with refugees? I often feel like they don't want to work with this population due to translation fees and, I would say, maybe their unfamiliarity with our client backgrounds.

MR: This is a really great question. Let me think on this.

MR: I think that one thing that we find really helpful is just more education and doing outreach to your local community mental health centers, your local community resources. Talking about our refugee clients, describing more about who they are or what they're coming from, what they're dealing with, and how therapists can effectively work with these populations.

MR: I know that some local offices have developed outreach presentations I've seen that are really fantastic, and that those seem to be helping. I also will note that we have in our recommended resources, we have a slide coming up, we have a great resource from the Center for Adjustment, Recovery and Resilience. It's a guide on mental health and psychosocial support service mapping. They go into a lot of detail about how to map local community providers, how to work with them, how to develop these relationships, how to find out if they might be suitable or a good fit for sending your clients. I recommend that you check that out.

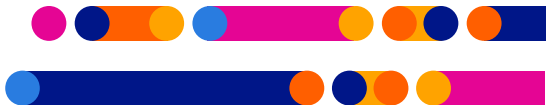
MR: Let me see here.

I also think that instead of saying "counselor," it can help to say, "I appreciate you trusting me, and sharing your thoughts and feelings. Would you be interested in meeting with someone who can listen to you and work through your thoughts?"

MR: That is great. Really a wonderful way of putting that. I think that a question that we get a lot from case managers is,

How do I redirect my clients when they want to talk to me a lot about their trauma?

MR: You did a really great job developing that rapport, or developing trust with your client, and now your clients are coming to you and talking to you about some of their mental health concerns. Then, it's like, "Well, that's not really my role. Now, what do I do?" I think that that's a comment that we had there in chat, is a really great



way to do that. "I so appreciate you opening up to me," and then maybe setting some boundaries around your role. "Unfortunately, I'm not trained," or, "It's not my role to talk with you about these kinds of things. Is there someone else that I might be able to refer you to?"

MR: What else do we have here in the Q&A?

[silence]

MR: Let's see here.

How do you incorporate religious or spiritual practice within the treatment plan? Can you somehow involve a community or spiritual leader into the process without breaking HIPAA?

MR: That's a really interesting question. I think that you could certainly talk to your clients, and if that was something that your client wanted, you could consider getting a release of information for a specific community leader, and you could consider calling them and bringing them in. That's definitely an option.

MR: I know that we also have a really helpful guide that we developed, I think maybe about six months ago. My colleague Madina I know is on the call with us, and she might be able to help link that guide that she helped work on, but it was about working with Muslim clients and faith-based healing. I would maybe look to that guide as well to think through how we might incorporate some of those healing practices in counseling sessions.

MR: From my personal experience, I'll also state, I'm not a religious person, but I worked with a lot of clients who were, and some ways that we incorporated that in was just asking clients about their religious views, how that was helpful, what was helpful? A lot of clients said listening to the Quran was really helpful, reading the Quran. Maybe talking to clients about, "Okay, I know that you've had a really tough week. Is there somewhere in this week that you might be able to find time to sit down and listen to the Quran, since I know that that's something that's helpful for you?" I wouldn't say that was necessarily in our formal treatment plan, but just—that's a coping tool, and so reminding clients to use their coping tools, whatever they might be.

[pause]

MR: I'm looking through the questions here. Forgive me for my silence. Oh, oh, they're popping around.

Do you have any advice for how to help elderly people overcome homesickness? They often feel alone even living with their children. They're unable to pay as much attention to their parents as needed.

MR: Certainly, in the U.S., a common barrier is feeling strapped for time. We're all working full-time and have a lot of priorities. I think that a lot of elderly clients that come, even when they're living with kids, can experience a lot of loneliness, which is a big mental health concern. I know that in my community, we have some really amazing elder care services for refugee clients. I know that they used to do Zumba classes. They have lots of really fun groups. There's also daycare options. It depends on whether or not the client would be eligible for those services and whether those exist in your community, but a lot of our elderly refugee clients in my community would go to adult daycares through the day.

MR: There were specific daycares based on cultural groups. There were daycares where a lot of Iraqi and Syrian clients went, daycares for Bhutanese clients, and then they had staff, of course, that spoke their languages. That was a really, really great way for them to get some social support and be around people in their community. I think that helps a bit with the homesickness.

MR: It's definitely—yes, it's a big problem and a big barrier. Trying to think through if there's anything else that I might recommend. I think just also talking with clients about what they missed from back home, or what their lives were like back home, what their houses looked like, what things were like during Ramadan. I know that this was often a really hard time for clients, because in the U.S., it's completely different than some home countries where people were coming from. We don't have the atmosphere of this being a time of celebration or everybody going out at night and getting together, like exists abroad. I think just spending some time talking with people, if you can, can be really helpful.

[silence]

What is the best way to handle mind-body issues? Do mental health drugs normally help the pain, or do they need to see a physician as well for the ailments?

MR: When we're talking about some of those somatic symptoms that often come up for clients, I think that a good place to start is validating your clients' experiences. You might let them know, "Hey, I worked with a lot of other clients who had the same thing, and it was really related to emotional distress, or not feeling well emotionally. Do you think that might be going on for you?"

MR: The client might say, "Yes, that could be true." Then, you can talk about some strategies to support with their mental health. But if a client said, "I'm not really sure, and these headaches are really bothering me." I think it's a great idea to refer people to their PCP, their primary care provider, at least to rule out what's going on, anything that might be going on, or see if there's any medications that can help. I think that that's a really good way that we can start working with some of those somatic concerns.

MR: As far as whether or not mental health medications help address somatic concerns, I think I'm not the expert to answer that question, since I'm not a psychiatrist. Anecdotally, from my experience, I do think that when people are receiving some support for their mental health symptoms that some of those somatic symptoms start to be reduced as well.

[pause]

MR: Here's a great question:

As a case manager, when you've got a client who wants to only focus on case management assistance and does not seem to want therapy or counseling referral, how do you support them when they keep showing the mental health symptoms?

MR: I think that's probably the most common example of what happens. Most of the time, if a client's having mental health symptoms, you're going to recommend or refer them to therapy. They might say, "No," because they're uncomfortable with it, or might have some stigma.

MR: Really, I would like to go back to that section of the presentation about what you can do. You can keep providing psychoeducation. You can keep validating their concerns, normalizing their concerns, what they're going through, and then teaching them some of those coping skills. Then, even if they never want to go see a counselor, they might have some skills to help them with whatever the mental health symptoms are that they're experiencing, and so they might be able to help themselves.

MR: I also suggest connecting folks with some kind of meaningful activity. It really depends on your individual client, but making sure that your client feels like their life has meaning in some way, that they have hobbies that they enjoy, that they're connected socially with their community, or a community of their choice, and feel like they have social support. Yes, that's really what I recommend, just patience, and meeting your client where they're at.

[silence]

Have you seen success with newcomer clients using telehealth for mental health support, or is it often too complicated with interpretation?

MR: I was a counselor at the time of COVID, and we immediately transitioned to telehealth, which we had never done before, never thought we would ever do with refugee clients. I will say that, yes, overall it was successful. I know that my clinic that I worked for is still doing telehealth, I think, with the majority of their clients and find it to be going very well.

MR: Clients like it, of course, because it eliminates that transportation barrier. It frees up a lot of their time. They're not spending time in transportation trying to get to the clinic. There's a lot of great reasons why telehealth works well, and I think that the strategies that we use to make that successful are what are helpful to think about. We had cultural navigators. We had staff at our office who were able to work with our clients to help them get set up, to teach them how to use our telehealth platform, how to connect using their phone, or whatever device they had to get on the telehealth network. To talk with them, of course, in their language, so that they could understand, and figure out how to use that complicated telehealth platform.

MR: Additionally, yes, we had our interpreters join that telehealth platform as well. At the clinic that I worked with, we almost always used in-person interpreters, and always used the same interpreter throughout the course of our treatment, so that we made sure that we found an interpreter that our client was comfortable with and that we weren't having new people in and out of our sessions all the time. We found that to be the most helpful strategy.

MR: It was easy then to be able to work with a smaller number of interpreters and teach them how to connect on the platform as well. Overall, I would say it was quite successful, but there were still some clients who maybe didn't have access to their phone, or who maybe had really spotty Internet or bad connection, so we were never able to make telehealth work very well for some clients.

MR: I'm going to read it out. I think this looks like a comment here:

It's important to respect what clients want, and finding other ways that can be support like sewing groups, religious groups, connecting them with other community members, possibly other programs like PC. Everyone's on a different journey, and keeping the door open without forcing anything might allow the client to come back at a later time.

MR: That's a lovely comment. I love that. Thank you so much for sharing that.

MR: All right. Well, it looks like we've answered the majority of the questions. I'm going to just go ahead and move us along to wrap up the rest of our presentation.

Conclusion

Reviewing Learning Objectives

MR: I hope that we have now accomplished our learning objectives. I hope that you now feel confident and competent that you have the ability to recognize clients that might be needing some more support, that you have the tools in your toolkit for providing some support yourself, and that you feel pretty confident in making a referral if you need it.

Feedback Survey

MR: Next, we have our feedback survey. We are going to drop the link to our survey in the chat. This is so helpful to us. It's really important to help us improve our future trainings. I take the feedback very seriously. I'm always looking through everyone's comments and responses so that we know how to make things even better for you next time, so really helpful for us.

MR: We really appreciate it if you could fill this out. It's just five questions and takes about 60 seconds to complete. I'm just going to go ahead since we have some time. We'll give you a few seconds here to open that up and get started while still online.

[pause]

MR: All right, we'll go ahead and move forward. Please keep filling that survey out. If you're not done yet, I'm sure you'll be finishing up soon.

Recommended Resources

MR: I'd like to point out some recommended resources that we have for you here. This is really for some just continued learning on this topic. If you want to learn more, all of these links will be in the copy of the slide deck that we send out to you, so you will have access to these very shortly.

MR: We have a lot of resources on trauma-informed care. I know that we didn't talk about trauma today. That was intentional, because I think that it's a big topic that really deserves its own dedicated hour to really do it justice. We did, on purpose, not talk about that. We have a lot more resources in our resource library on that topic. Service mapping and referral, pointing out that resource guide from CARRE that I mentioned earlier, and then just a lot more resources on some practical skills. Psychological first aid and learning about some of those self-care tools that we've dropped in the chat earlier as well.

Stay Connected

MR: All right, and then that brings us to the end. On behalf of all of us at Switchboard, thank you so much for hanging out with us, learning with us today. We really hope to see you all soon. Stay connected. You can visit us at SwitchboardTA.org. You can check us out on our social media, and we hope to see you again soon. Have a great rest of your day.

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