An Innovative Community-Oriented Approach to Prevention and Early Intervention With Refugees in the United States

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Thousands of refugees from around the world resettle in the United States every year. Many refugees suffer from mental health disorders as a result of experiences living in or escaping from their turbulent homelands, and many also experience mental health issues as they settle in their new host countries. As such, it is important to intervene during the early stages of refugee resettlement to help prevent or mitigate mental illness symptoms. However, because of several access and utilization barriers, such as stigma, refugees are not apt to receive needed mental health services. Moreover, the traditional Western model of treatment can be culturally incongruent with refugee practices. Alternative, culturally sensitive, community-based approaches must be considered. This article presents a community-oriented prevention and early intervention model that can be used with newly arrived refugees with limited English proficiency. Goals of the model are to increase knowledge of mental health and mental health service options to refugees, as well as support the process of adjusting to life in the United States. The New Refugee Services Project, developed by the Center for Survivors of Torture department of Asian Americans for Community Involvement (AACI) in San Santa Clara County, California is presented as an example case study. The structure outlined in this article aims to support the development, implementation, and assessment of future preventative interventions for refugee populations.

Keywords: prevention, early intervention, refugees, stigma, community mental health

For over 3,000 years, individuals have fled from their places of birth in order to escape violence and seek refuge in foreign lands (United Nations Human Rights Council [UNHRC], 1950). In 1950, in an effort to further protect the well-being of these individuals, known as "refugees," the United Nations General Assembly created the Office of the United Nations High Commissioner for Refugees (UNHRC, 1950). Furthermore, during the 1951 Refugee Convention, UNHCR solidified the world's understanding of a "refugee" to mean the following:

> [Individuals who] owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country. (UN General Assembly, 1950)

Many first-world nations, including the United States, offer refugees opportunities to resettle in their countries. The United States established the Office of Refugee Resettlement for this purpose. The Office of Refugee Resettlement grants "special humanitarian concern entrance" to thousands of refugees from around the world every year (Office of Refugee Resettlement, n.d.). In fact, since 2000, the number of refugees entering the United States annually has ranged from 39,201 to 94,222 people (Office of Refugee Resettlement, 2000, 2003). The most recent data indicate that 58,238 refugees entered the United States in 2012 (Office of Refugee Resettlement, 2012). Despite fluctuations, a significant number of refugees have entered, and continue to enter, the United States on a yearly basis.

Heightened Risk for Mental Health Problems Among Refugees

Although the United States serves as a safe haven for refugees, many refugees still come with painful experiences from their homelands that impact their mental well-being, even after resettlement. Refugees who were often exposed to severe violence in their homelands are at risk for trauma-related disorders, including posttraumatic stress disorder and somatic illnesses (Kirmayer et al., 2011). According to Ehntholt and Yule (2006), refugee children who have experienced war report high levels of depression and anxiety. These children continue to experience psychological disturbances into adulthood. In a long-term study on populations

impacted by war, Priebe et al. (2013) found that psychological symptoms remain elevated years after war; this finding was especially true for refugees. This research suggests the prevalence of long-term psychological ramifications for refugees exposed to war in their homeland. Moreover, refugees can be affected by grief and loss. Ellis et al. (2013) noted the unique challenges refugees face regarding the loss of family members; loss can come from the death of loved ones and/or the feelings of loss due to leaving family members behind in the home country.

Refugees must also contend with the stress of immigrating, or moving to a foreign land. Psychosocial stressors involved in migrating from one's native land to a foreign land can lead to greater occurrence of mental health issues (Al-Issa, 1997). Suárez-Orozco (2000) spoke about the high level of stress that immigrant children experience, and how the immigration process can become a traumatic experience in immigrants' lives. Donnelly et al. (2011) further explained that due to the process of migration, a number of immigrant and refugee women develop mental illness, including depression, psychosis, and suicide, among other disorders. Despite the obstacles that many immigrants experience, it is important to note the differences between a migrant who moves from their homeland in order to improve their economic situation and a refugee who resettles in a different country because they were fearful for their life and freedom (United Nations High Commission for Refugees, n.d.). This difference can lead to refugees facing increased challenges to adjusting to life in the United States.

In addition to premigration trauma and migration stress, Saechao et al. (2012) identified a plethora of other postmigration stressors that can impact refugees' adjustment to life in the United States: economic difficulties, discrimination, acculturation (language differences), enculturation, parenting, and employment (Saechao et al., 2012). Ellis et al. (2013), in particular, emphasized the complications that arise due to cultural differences between home and host countries. Overall, postmigration stressors may further increase vulnerability to mental illness and exacerbate existing symptoms.

Considering refugees' violence exposure in their countries of origin, along with psychological sequelae and the enduring stressors of immigration (e.g., Kirmayer et al., 2011; Saechao et al., 2012), it can be beneficial for mental health agencies to get involved during the early years of refugees' settlement to prevent mental illness or intervene when mental illness arises. However, several barriers make it difficult for new refugees to access and utilize mental health services in the United States.

Barriers to Mental Health Services Access for Refugees

Limited knowledge and information about mental health and mental health services hinder utilization of those services among refugees (e.g., Jorm, 2012; Saechao et al., 2012). For example, Durà-Vila, Klasen, Makatini, Rahmini, and Hodes (2013) pointed out that refugees might interpret their psychological issues as physical rather than psychological, as psychological problems often manifest somatically. Donnelly et al. (2011) also revealed that lack of awareness of issues related to mental health, among other factors such as fear, impacts help-seeking and management of mental health symptoms. Durà-Vila et al. identified language as a barrier to accessing services. Often, refugees come to the United

States with little to no English skills, which impacts their ability to communicate with health care providers. Donnelly et al. highlighted this same issue with immigrant and refugee women in Australia, who reported not participating in available services due to those services being offered in English, as well as the lack of interpretation services in their native tongues.

Refugees' socioeconomic status can also prohibit utilization of services. Financial barriers are often related to limited use of preventive care, which, in turn, is related to health care utilization at higher levels and later stages of illness (Leclere, Jensen, & Biddlecom, 1994). Drummond, Mizan, Brocx, & Wright (2011) found a number of barriers that prevented West African refugee women living in Western Australia from accessing health care services, including logistical challenges and fear of being hospitalized. White (2012) also found fear to be a barrier to help-seeking, as well as cultural conflicts in treatment. Many refugees groups have traditional practices for treating aliments that drastically differ from the Western model of treatment. In addition, Donnelly et al. (2011) discussed the lack of appropriate services available to immigrant and refugee women that encumber help-seeking.

Stigma, in particular, can play an important role as a barrier to service utilization for immigrants and refugees. Stigma, or a "prejudice or negative stereotyping" (Corrigan & Penn, 2004, p. 766), has been found to adversely impact service utilization at a higher rate for non-Caucasians than Caucasians (Corrigan, 2004), and the vast majority of refugees entering the United States are non-Caucasian (Office of Refugee Resettlement, 2012). Stigma has not only been implicated in underutilization of mental health services, but it can also explain why individuals are noncompliant with treatment (Corrigan & Penn, 2004). In particular, stigma may discourage people from seeking treatment because of a discomfort around public identification with the label "mentally ill" (Corrigan, 2004). Due to the collectivistic nature and concern about community perception of many refugee groups, the "mentally ill" label can be a large deterrent for individuals to seek out treatment. For example, Drummond et al. (2011) discovered that one of the primary reasons Western African immigrant and refugees women in Australia do not seek services is shame and fear of what the community would think.

Access and utilization barriers can explain why new immigrants are much less likely to use health care services initially and have fewer contacts with health care professionals compared with native-born individuals (Leclere et al., 1994). White (2012) emphasized this point in relation to the Burmese refugee population living in Indianapolis. White stated that Burmese refugees often opt to care for themselves, as opposed to seeking assistance from health care professionals who utilize Western models of care. Ellis et al. (2013) also pointed out the challenge of engaging and treating refugees in traditional health service models. Jorm (2012) reported that even among developed countries, only a minority of people receives treatment for mental health issues within a year of onset. Jorm reported that it takes 1 to 14 years for those diagnosed with a mood disorder to actually receive treatment, 3 to 30 years for those afflicted with an anxiety disorder to receive help, and 6 to 18 years for those that have a substance use disorder to get support for their substance issue.

A Need for Community-Oriented Interventions

Although it is uncommon for refugees to seek help, Ellis et al. (2013) stressed the need for services. Drummond et al. (2011) encouraged the development of strategies to overcome barriers. Community-oriented intervention services offered in the early stages of refugee resettlement to prevent or detect beginning stages of mental illness may be one way to help refugees that have resettled in the United States.

Durà-Vilà et al. (2013) found that community-based mental health services appeared to be more effective for young refugees than the traditional primary-care model of treatment. The Centers for Disease Control and Prevention (2013) discussed the issue of suicide and suicidal ideation in the Bhutanese refugee community in the United States and made recommendations on how to deal with this issue, including using a nonclinical, community support approach. Donnelly et al. (2011) reported that informal support systems are one way immigrant and refugee communities cope with distress; a community-oriented intervention is in line with this naturally occurring process. Weine (2011) further emphasized a community support approach by suggesting community collaboration. The author highlighted the importance of specifically designed, empirically based services for refugee families, explaining that preventative mental health interventions, using community collaboration, are an effective way to do this. According to Weine, community collaboration not only helps to build relationships with community leaders and service organizations but also is key to making prevention a success, as it provides refugees with direct access to information from their own community members. Kirmayer et al. (2011) discussed similar views and suggested that links to ethnic or religious groups could help mitigate the negative effects that come with migration, including losses the individual incurred. The authors also stated that connecting with similar ethnic or religious groups can help one from feeling isolated, alone, and discriminated against.

Due to the multiple stressors that refugees in resettlement experience, as well as barriers to help-seeking, it is essential that mental health agencies serving refugees in the United States become better equipped to outreach and support newly arrived refugee communities in order to prevent or mitigate mental health issues in a community-oriented fashion.

Key Steps to a Community-Oriented Prevention and Early Intervention Model for Refugees

Aims of the present article are to propose essential steps and components for the development of community programs targeted toward preventing mental illness and promotion of improved psychosocial adjustment among newly arrived refugee populations with limited English proficiency. Existing research suggests that such outreach to refugee populations should be culturally competent, community-based, and prevention oriented (Weine, 2011). However, to date, no standards for community-based prevention and early intervention (P&EI) programs have been developed for diverse refugee communities with limited English. To demonstrate applicability of our proposed innovative approach, the New Refugee Services Project, developed by the Center for Survivors of Torture department of Asian Americans for Community Involvement (AACI) in San Santa Clara County, California is presented to assist other agencies looking to develop such programmatic efforts.

Step 1: Advocacy and Funding

Community-based P&EI programs are ideal for areas with higher populations of refugees. The U.S. Office of Refugee Resettlement collaborates with a number of contracted agencies to relocate refugees to cities and towns throughout the United States (U.S. Committee for Refugees and Immigrants, 2014). It is becoming more common for refugees to be relocated to smaller communities in the United States due to better affordability than larger cities (U.S. Committee for Refugees and Immigrants, 2014). As an example, the California Department of Social Services (n.d.) has a list of counties that are assigned as "refugee-impacted." This means that large numbers of refugees are resettled in those counties annually. Refugee-impacted counties are generally more receptive and welcoming of refugees. A community agency that is located in a refugee-impacted county in California may be able to make a stronger case for funding a community-based P&EI program for refugees than a California county without that same designation.

Once a particular refugee population in a community agency's catchment area has been identified, the next step would involve advocating for the unique needs of that population that are not being addressed through mainstream mental health or public health systems of care. Advocacy must focus on highlighting refugees' experiences of flight, relocation, loss of home, cultural and language differences, all overlaid with trauma. These refugees' unique circumstances and experiences set them apart from other underserved populations, and draw attention both to the mental health issues faced by this population and the myriad of practical resettlement needs that affect basic functioning.

It is important for agencies to provide data to support advocacy efforts (Community Tool Box, 2014. The Community Tool Box is a service of the Work Group for Community Health and Development at the University of Kansas. Licensed under the Creative Commons Attribution-Noncommercial-Share Alike 3.0 United States License. http://communityhealth.ku.edu). In identifying the need for such P&EI programs, community agencies must provide actual data on the refugee population's paucity of resources and inadequacy of programming provided throughout the resettlement process. When data are not already available, agencies can opt to first perform a pilot study to validate and support the need for a P&EI program. This information can be collected in a number of ways, including community-based participatory research, whereby a community agency collaborates with community members to conduct research on an issue (Filippi et al., 2014). Moreover, utilizing community-based participatory principles can be a useful research method with immigrants and refugees, such as with Africans immigrants and refugees in the United States; as aforementioned, sparse health data exist pertaining to this subgroup (Filippi et al., 2014). Thus, advocacy can be boosted by having refugee community members join the effort, emphasizing positive outcomes in terms of refugees becoming productive citizens contributing to their new communities. Important components to this community research and needs assessment include familiarity with the various refugee groups, a background in serving refugee and immigrant groups, and engagement with the refugee community.

Once an agency has sufficient evidence to support the case for a community-oriented P&EI program, they must identify prospective funding sources and take appropriate steps to follow the advocacy and funding protocols of their agency. An example of an entity that can fund such refugee programs is a county's department of mental health. Because there are many competing projects vying for public dollars, advocacy is an essential element for securing funding for the program.

Step 2: Select Key Community Partners

Altman (1995) stressed that a good first step to researching and understanding a community is to collaborate with its leaders. Weine (2011) emphasized the importance of community collaboration when developing mental-health-based preventive interventions for refugees in resettlement. The author explained that liaising with the community that preventive interventions aim to help gives direct access to the specific experience of the targeted refugee population and offers insight into new information about the population.

Engaging with the refugee community through community leaders needs to be an ongoing process to inform programming as well as build trust with the refugee community. For a P&EI program to be successful, the agency must collaborate with, hire, or contract with members of the community who can represent the refugee population. Trust building and the ongoing engagement process with the community will help recruit the ideal community partner. A community partner should have direct links to the targeted refugee community, and should be someone that the refugee community is familiar with and trusts. This community partner can either be an individual or a small agency already servicing the refugee population, with specific, specialized, and culturally sensitive knowledge about the refugee group in question. They should also be able to communicate both in English and the language of the refugee group. Ideally, this person or entity would also have professional skills and experience with mental health and mental health services. The core purpose of contracting with community partners is to get cultural expertise and buy-in from the community they represent, to help mitigate the shame and stigma about mental health prominent among new arriving populations.

Al-Krenawi and Graham (2000) suggested that connecting to community leaders of populations who underutilize psychological services, such as Arab Americans, may help gain the confidence of community members. Weine (2011) specifically discussed that engaging and collaborating with leaders in specific refugee communities is a vital component to having a successful prevention program. Moreover, by collaborating with refugee community leaders and members, it also allows for relationship and trust building to occur (Weine, 2011), which can be advantageous during the implementation stage of the program.

Step 3: Development and Implementation of a P&EI Plan

The core piece of the community-oriented P&EI project is to establish an individualized, culture-specific plan that details community intervention strategies. The intention of the plan is to identify specific community activities that serve to buffer refugees from developing mental illness, or to mitigate symptomology for those with mental illness. A community-oriented, culture-specific approach reduces many of the aforementioned access and utilization barriers that have been found to impact refugee populations in the United States.

Community partners should gather and utilize input from refugee group stakeholders to craft specific P&EI activities and the larger intervention plan. This stakeholder input will ensure that plans are culturally sensitive and account for the specific needs of that particular refugee group. If a program plans to serve more than one refugee group in a catchment area, it is recommended that a plan outline be provided to each community partner to ensure consistency in basic program structure and goals. In summary, the P&EI plan should be developed and implemented with the community partners that have direct connection with the refugee community. The community agency monitors, coordinates, and supports the community partner at every stage.

Goals and plan structure. Although plans typically begin with goals identified by the funder, the overall goal of any community-oriented P&EI project should focus on unique strategies to increase service access, reduce utilization barriers, and strengthen refugee communities by promoting psychosocial adjustment and reinforcing cultural protective factors. Corrigan and Penn (1999) identified three strategies to reducing barriers related to mental health stigma: protest, education, and contact. Protest can come in the form of advocacy, and directly challenges misrepresentations in the media and other related realms. Education can use various mediums (e.g., videos, information sessions) to debunk misconceptions of mental health and mental health treatment. Finally, contact puts the majority population in contact with people with mental illness in order to challenge negative stereotypes. Of these, Corrigan and Penn highlighted that contact appears to be the most effective means for reducing stigma, followed by education, then protest.

Community partners should construct P&EI activities that integrate elements of these protest, education, and contact strategies to help meet goals of reducing barriers to treatment. The following is a recommended structure for P&EI plans:

1. Goals

2. Objectives (ties to one of the identified goal)

3. Description of community activity related to the objective

4. Materials needed to conduct the event (e.g., tables, DVD player)

5. Date and setting of the activity

6. Projected outcome of the activity (e.g., how event will meet objective)

7. Outcome measure

In essence, plans are contracts between the community partner and the agency; they stipulate all the actions community partners will take as part of a community-based P&EI project.

Activity types. Although each prevention plan is unique to its targeted refugee population, community agencies directing the

community-oriented P&EI program should work collaboratively with community partners to produce a list of potential activity types that can provide culturally sensitive outreach and education/promotion and overcome service access barriers. The following is a list of potential activity types that community partners can utilize to create their plans:

1. *Outreach* should be a required activity. With consultation from community partners, the agency should create appropriate brochures, posters, and so forth that can be used as mental health promotion materials. Community partners will need to translate materials and distribute or display materials where their specific refugee communities are found.

2. *Cultural shows* incorporate music, dance and other forms of art from refugees' native land and can be used as a means to destigmatize mental illness and mental health treatment.

3. *Community gatherings* bring refugees together to celebrate religious or cultural events, which can help reduce refugee isolation and strengthen the refugee community. These types of events can also be used as an opportunity to display outreach materials.

4. *Films* related to the refugee experience can be followed by discussion or a question/answer session after the film concludes.

5. *Community dialogues* are informal discussion groups on topics relatable to refugees, such as child rearing in the United States. This type of dialogue allows refugees to express their own challenges in a comfortable and culturally acceptable environment.

6. *Educational panels and workshops* help to educate refugees or those assisting refugees on topics associated with the mental health of refugees from specific countries. It would be appropriate to have a speaker from the refugee group willing to speak about his or her experiences with mental health treatment.

In addition to these activities, the agency should sponsor training for community partners and community volunteers on mental illness and treatment in order to increase mental health literacy. This will prepare community partners to better serve their communities. These trainings will also equip community partners to develop stronger community-oriented P&EI plans.

Step 4: Monitoring and Program Evaluation

The last step to establishing a community-based P&EI program for refugees is monitoring and evaluating progress of the project. An understanding of the funder's, the agency's, and the community partners' goals for the program should inform outcome measures that assess progress toward these goals. These outcome measures should be incorporated into the "outcome measure" section of the plan and, when available, already-validated outcome measures should be used; otherwise, outcome measures can be developed by the agency. Each type of activity in the plan can require a different type of outcome measure depending on the aim of the event. Outcome measures should be administered during every activity listed in the plan, and because consumers will be completing them, it is recommended that measures are user friendly, short, and translated into refugees' native tongue. The community partner should provide completed outcome measures to the agency, whereby results can be generated to determine whether funder or agency goals are being met.

Although quantitative data deriving from outcome measures are important for program evaluation, qualitative data are also important. As such, it is recommended that agency staff sponsor regular meetings with all community partners to discuss progress and challenges of implementing the program, and to collect qualitative data. It is also important to build camaraderie among community partners, as they are likely facing similar experiences rolling out the program.

Finally, a staff person working for the community agency should be selected to help with monitoring the program process. It is essential that the community partners provide the agency with progress reports to ensure that activities are being completed as they were stipulated in the P&EI plan from Step 3. If community partners are not fulfilling the deliverables laid out in the plan, agency staff should offer support so that community partners stay on track to meet program aims.

Case Study: New Refugee Services Project

The AACI's CST department's New Refugees Services Project is presented as an example of the proposed community-oriented P&EI model for working with newly arrived refugees with limited English proficiency in the United States. The following case describes each step of this unique PE&I practice at AACI's CST department. It focused on the nine largest and newly arrived refugee communities in Santa Clara County, California. In addition, challenges that arose during the development and implementation phases of the project will be discussed. The purpose of this case study is to assist other community-based mental health agencies to best serve this specific and growing population in a preventative, culturally sensitive, and community-focused manner.

Example of Step 1: Advocacy and Funding

For several years, supporters of the refugee populations in Santa Clara County encouraged Santa Clara's Department of Mental Health to increase services to this disenfranchised population. According to the California Department of Social Services (n.d.), Santa Clara County is designated as a "refugee-impacted county," with large populations of refugees residing in the catchment area. The Refugee and Immigrant Forum of Santa Clara County advocated to recognize "refugees" as a "priority population" in order to receive services through the Mental Health Services Act of 2013 (MHSA, 2013), a proposition passed by California voters in 2004 that levies a 1% tax on California residents who earn over $1 million annually. MHSA money is allocated to California counties for the purposes of improving mental health services to underserved populations.

Advocacy efforts resulted in the Refugee and Immigrant Forum acquiring a seat on the Stakeholder and Leadership Committee,

which votes on plans for use of MHSA dollars in Santa Clara County. Further advocacy ultimately led Santa Clara County's Department of Mental Health to allocate MHSA funds in 2009 for the provision of outreach, education/promotion, and direct services to refugees in Santa Clara County. This project became known as the New Refugee Services Project.

AACI's CST department bid for, and was awarded, the $2.6 million New Refugee Services Project contract, which called upon CST to provide both culturally competent treatment services and community-based P&EI activities to the nine largest refugee populations residing in Santa Clara County: Afghans, Burmese, Chinese, Eritreans, Ethiopians, Indians, Iranians, Iraqis, and Vietnamese. This article describes only the community-based P&EI portion of the New Refugees Services Project.

Example of Step 2: Select Key Community Partners

Once funding was identified, the CST next identified community partners, or service delivery providers, who partook in the development, implementation, and monitoring of P&EI activities for specific refugee groups. Community partners included individuals and agencies involved in the nine specific refugee communities.

Because CST's departmental mission is to provide culturally sensitive services to refugees, it had already established a network with entities involved in supporting newly arrived refugees. For example, CST actively participates in the annual celebration of Refugee Day and is a member of the aforementioned Refugee and Immigrant Forum. This active participation eased the development of community partnerships for the New Refugees Services Project. However, word-of-mouth recruitment was also needed to identify additional community partners. CST reached out to community members from the remaining refugee groups and other agencies outside Santa Clara that work with the refugee groups in question to identify applicable leaders who understood and had the skills to support the P&EI project in a service-delivery role. This snowball recruitment strategy proved to be an effective means to identify remaining community partners.

CST considered community partners as paid contractors of the agency. Community partners were funded for approximately a year to complete the deliverables laid out in their contracts with AACI's CST department

Example of Step 3: Development and Implementation of a P&EI Plan

P&EI goals. Santa Clara County's Department of Mental Health gave the CST two overarching goals for the P&EI portion of the New Refugees Services Program: (a) increase access to mental health services by reducing stigma associated with mental health treatment, and (b) reinforce cultural protective factors that will address early onset of mental illness related to resettlement and trauma. CST worked with each community partner to develop a prevention plan for each of the nine refugee groups, in order to meet the stated goals. Components of each prevention plan are described in more detail.

Prevention plan. Guidelines for the structure of prevention plans were given to each of the nine community partners to establish consistency. Community partners were told that prevention plans should encompass culturally appropriate local mental health awareness-raising events, and psychoeducational and informational groups on mental health concerns and stigma. Each plan incorporated (a) objectives associated with one of the two program goals, (b) a detailed description of the activity related to the objective, (c) materials needed to conduct the event, (d) the date and setting in which the activity would take place, (e) the projected outcome of the activity, and (f) a data source that would measure the outcome of the event. A separate section of the prevention plan included a list of ethnic-specific local and media resources.

Each of the nine community partners was responsible for developing and implementing prevention plans for his or her specialized community. Development included actions such as identifying an appropriate topic for a community discussion, to selecting culturally appropriate films to show the community. Although some community partners had support from CST for implementation, including use of CST's facilities, they independently orchestrated the majority of event logistics. Events often took place in cultural or religious centers that were frequented by targeted refugee communities.

Although each prevention plan was unique to the targeted refugee population, most plans composed of many events taking place over several months and had the following types of culturally appropriate activities: outreach, cultural shows, community gatherings for religious and/or ethnic celebratory occasions, film screenings, community dialogues, educational panels/workshops, and Mental Health First Aid training. Though CST recommended these activity types, community partners had freedom to mold prevention plan activities to best fit their communities. Table 1 provides activity types, activity descriptions, and specific examples of activities designed and executed by community partners in their prevention plans.

All activities interwove the theme of mental health and met Santa Clara County's Department of Mental Health's aims by emphasizing identification and normalization of mental health issues, endorsing protective factors, and describing ways to get help. Moreover, the multifarious events strengthened communities. They offered new arrivals an opportunity to engage with other new arrivals that came from the same country, spoke the same language, and experienced similar trauma.

Example of Step 4: Monitoring and Program Evaluation

Outcome measures. Outcomes for the community events were measured using two outcome measures. The first outcome measure targeted the need for mental health awareness among the targeted participants of outreach events with one yes–no question that asked, "Do you know a place where someone can get help with mental health issues?" As there is limited information on newly arrived refugees of Santa Clara County, this question helped determine whether this population had knowledge of available mental health services. This question was also relevant in that it helped prompt conversations between community partners and the refugee population attending outreach events. For the fiscal year spanning July 2011 to June 2012, 1,956 people completed this question. Data indicated that the community events reached a population in need of awareness and outreach, with approximately half of participants having no knowledge regarding access to

Table 1
Prevention Plan Activity Descriptions and Examples

Activity name	Description	Example(s)
Outreach	Outreach includes distribution of translated mental health materials (i.e., posters, brochures, handouts) to areas where refugees often spend time, such as religious institutions, markets, and cultural events.	Burmese community partner set up a table with mental health materials during a festival at the local Buddhist temple. Iranian and Iraqi community partners displayed mental health posters in Middle Eastern specialty food stores.
Cultural shows	Cultural shows are artistic expressions used to destigmatize mental health and mental health treatment. Shows incorporate music, dance, and other forms of art from refugees' native land.	Eritrean and Ethiopian community partners organized a one-woman dance that depicted the life of a woman in premigration Africa, her initial postresettlement elation, the depression she experienced when she realized the reality of her new life in a foreign country, and the hope she found when she accepted treatment for her depression. The dance and music derived from the African region and were relatable to refugees from this area.
Community gathering	In addition to promulgating information on mental health and mental health treatment (e.g., displaying mental health brochures), community gatherings are used to bring refugees together to celebrate religious or cultural events.	Iranian community partner organized an event for Nawrooz, the Iranian New Year. During this festivity, Iranian refugees were brought together to participate in Nawrooz traditions and to eat Iranian food. This event gave refugees the opportunity to feel less isolated and alone on an important holiday and to meet other people of similar backgrounds.
Film screenings	Film screenings are events featuring films relatable to refugees that involve stories about the struggles and the triumphs of refugee resettlement life. Discussion about the film ensues after the screening.	Burmese community partner organized a film screening that depicted a Burmese man's journey as a refugee from Burma to the United States. Discussion followed after completion of the film.
Community dialogues	Community dialogues offer refugees a platform to express their own struggles in a culturally acceptable manner on subjects pertinent to the community in question.	Iraqi community partner facilitated dialogues with Arab women on subject matters impacting that community, such as acculturation and child rearing in the United States.
Educational panels and workshops	Educational panels and workshops educate refugees or those assisting refugees on topics associated with mental health.	Indian community partner spoke to mental health service providers in Santa Clara County about the history of Indian resettlement and cultural factors to be aware of when treating Indians.
Mental health first aid training	Mental Health First Aid Training, a 2-day course on mental illness, was required of all community partners and community volunteers by the County as part of the New Refugees Services project. This training helped increase mental health literacy of P&EI leaders, allowing them to better serve the overall refugee community.	Not applicable

Note. P&EI = Prevention and Early Intervention.

mental health services. Specifically, 54% endorsed having knowledge of where to acquire mental health resources, 45% endorsed not having knowledge of where to get help with mental health issues, and 1% did not respond to the question.

The second outcome measure was administered to a random subset of 90 participants, and assessed project goals and changes in participants' perceptions of mental illness and mental health services as a result of attending the community events (i.e., cultural shows, film screenings, and community dialogues). The outcome measure included five questions adapted from Sadik, Bradley, Al-Hasoon, and Jenkins (2010), which assessed public perceptions of mental illness. Survey questions accounted for participants' views on the following topics: causes of problems related to mental health, knowledge of others with mental health issues, attitudes toward those with mental health, and care and manage-

ment beliefs for the mentally ill. Questions were developed and adapted with these topics in mind for the aforementioned purpose of establishing event impact on participants' perceptions of mental illness. All survey items were scored on a 5-point Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*.

Results are presented in Table 2. As a result of attending a P&EI community event, on average, participants indicated agreement that their understanding of causes of mental illness ($M = 3.87$, $SD = 1.03$) and understanding of mental health problems within their community ($M = 3.78$, $SD = 1.04$) increased. Participants were also more likely to agree than disagree that the content of the event reminded them of their own pre- and/or postmigration experiences ($M = 3.67$, $SD = 1.18$). Survey respondents agreed or strongly agreed that their attitudes toward emotional and mental health issues were impacted as a result of attending a P&EI event

Table 2
Outcome Measures for Prevention and Early Intervention Community Events (N = 90)

Question	Mean	SD
The film and/or discussion increased my understanding of what causes mental health problems	3.87	1.03
The film and/or discussion have improved my understanding of mental health problems within my community	3.78	1.04
The stories presented in the video and/or discussion reminded me of my own experiences	3.67	1.18
The film and/or discussion have changed my attitude toward emotional & mental health problems	4.22	0.85
Because of the film and/or discussion, I am more open to talking to a doctor or counselor if I ever feel completely lost	3.42	1.51

Note. All items were scored on a 5-point Likert scale from 1 = *strongly disagree* to 5 = *strongly agree*.

(M = 4.22, SD = .85). Reports of openness to talking to a medical doctor or counselor also increased from participating in the community events, though agreement with this survey item was the weakest of the five (M = 3.42, SD = 1.51).

Weekly reports and monthly status reports. Community partners were responsible for submitting to CST short descriptions of weekly activities to ensure activities were accomplished within their prevention plans' stipulated time frames. If issues completing activities within designated timeframes arose, CST administrative staff offered community partners support and assistance.

Outcome measures, as well as weekly status reports, helped CST account for the P&EI program's progress in monthly reports sent to Santa Clara County's Department of Mental Health. The monthly reports included qualitative information such as a description of the events that took place that month, data reflecting consumer changes in attitude toward mental illness as a result of attending events, and a qualitative section on implementation challenges experienced by community partners. In essence, the reports depicted the effectiveness of the aggregate New Refugees Services Program.

Program challenges. Monthly meetings between CST staff and community partners created an open forum to express some of the struggles and challenges of P&EI project implementation. One consistent challenge among all groups included difficulties motivating community members to complete outcome measures after events. Measures are a foreign concept to many refugees. Furthermore, although measures were translated, many attendees were illiterate in their own language. Other refugees hesitated to provide feedback because their countries of origin punished or did not value criticism and feedback. Efforts to simplify measures by keeping them succinct and short, and explain the intention of the measures before and after each P&EI activity, helped to address the ongoing challenge of completing outcome measures.

The P&EI project strived to break access and utilization barriers, especially related to mental health stigma. Despite these efforts, community partners experienced various levels of pushback from their community members on certain event topics. For example, the Afghani community sponsored an event in which a world-renowned psychiatrist spoke about the impact of trauma on the mental well-being of both adults and children. Some community members appeared to be uncomfortable with this topic and either left the talk or interrupted the presentation. Moreover, others groups had a difficult time motivating refugees to attend mental health-related events.

Although stigma was an ongoing challenge, community partners tried to make the subject matter less obtuse and more digestible for community members. For example, community dialogues often emphasized "stress" as opposed to depression, anxiety, or trauma. Community partners also tried to conduct events in comfortable formats, with less stigmatizing topics. For example, the Iraqi community partner organized presentations on topics such as raising children in America; at these events, tea and sweets, a common Iraqi practice, were served. Marketing events in less stigmatizing language and emphasizing culturally acceptable subjects proved to be the most effective method for overcoming some of the issues that came from stigma.

In addition to challenges that arose from the refugee communities, other challenges were encountered in program administration and implementation. First, securing funding required considerable advocacy; community agencies should prepare themselves for an extensive and lengthy effort. Second, recruiting community partners with the skills needed to implement the programs can be difficult. Continued community networking helped to minimize this struggle. Third, some community partners were more connected than others to speakers, facilities, and other resources needed to execute prevention plans. CST staff members were called to help identify speakers or facilities for community partners who were less connected and had fewer resources. Fourth, a dearth of mental health materials about mental well-being (i.e., videos) already created and tested in the languages of refugees groups posed problems with implementation of outreach and planning events.

The main challenge CST experienced at the project's conclusion was a feeling of premature termination by community partners. Almost all community partners reported that their community members were just beginning to feel more comfortable attending events. Unfortunately, despite CST's advocacy efforts, the P&EI project was not given a time extension past approximately one year.

Conclusion

In addition to premigration and migration trauma, refugees face unique postmigration stressors that often exacerbate mental health issues and disrupt family systems, especially after the initial excitement of resettlement wears off. As such, helping to prevent mental illness or intervening in the early stages of mental illness is of the utmost importance. Research has suggested that preventative, community-focused interventions can be a successful approach.

This article described a community-oriented P&EI model that can be used with newly arrived refugees. This model is comprised of four main steps: (a) advocacy and funding, (b) selection of key community partners, (c) development and implementation of a

P&EI plan, and (d) monitoring and program evaluation. A case study, featuring AACI's CST department's New Refugees Services Program in Santa Clara County, California, was provided to offer a real-life example demonstrating model application.

Despite various challenges, this innovative, community-oriented P&EI model has a variety of benefits for newly arrived refugee groups, as it incorporates specific, culturally congruent interventions that can be helpful to preventing or mitigating mental health issues in refugee populations. As such, it is hoped that this model can assist other community agencies in developing, implementing, and assessing community-based preventative interventions for refugee populations in the future.

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