# U.S. Programs
# Mental Health & Wellness Manual

A Practical Introduction to Mental Health in USP
First Edition

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IRC USP

# Table of Contents

# Chapter 1

## IRC Mental Health & Wellness: U.S. Programs

*Learning Objectives*

1- *Describe mental health and wellness in the context of IRC's USP*
2- *Outline the guiding principles of mental health programming in USP*
3- *Define key terms pertaining to mental health and wellness in USP*

## Section 1.1 |Introduction

The mission of the International Committee (IRC) is to help people whose lives and livelihoods are shattered by conflict and disaster to survive, recover, and gain control of their future. The IRC serves people forced to flee from war, conflict and disaster and the host communities that support them, as well as those who remain within their homes and communities.

The IRC is one of the leading providers of services for refugees, asylees and asylum seekers, victims of trafficking and other vulnerable immigrants in the United States. The mission of the IRC's U.S. Programs (USP) Department, which provides services in 23 U.S. cities and the Resettlement Support Center in East Asia, is to create opportunities for refugees to survive and thrive in America. USP encompasses a spectrum of support in six program sectors: resettlement, economic empowerment, access and legal rights, education and learning, health and wellness, and community integration and development.

Displacement due to conflict, persecution or disasters may place psychological and social stress on individuals, families and communities. The state of being displaced means something is lost – an identity, a relationship, a family, a community. These experiences of grief and loss may affect one's psychological well-being and/or increase their vulnerability to mental health morbidity.[1]  Under the umbrella of health and wellness, IRC's mental health programming helps clients normalize their experiences and reactions to stress, while providing an opportunity for connection with other individuals, ultimately working to promote healing and reconnection. To help refugees and other vulnerable immigrant populations in the process of healing, many offices provide recreational and/or creative activities, behavioral health services, well-being promotion through community health promoters, and social activities for clients. IRC recognizes that mental health and psychosocial support must be integrated within a larger social and cultural context. As such, affected individuals and communities should be included in planning for appropriate psychosocial interventions in order to ensure comprehensive service delivery.

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[1] UNHCR, 2013 (see *References* section, p. 82)

## Section 1.2 |What can be learned from this manual?

This manual was developed to address a gap in knowledge, practice standards, and guidance in mental health and wellness for USP staff working with vulnerable immigrant populations affected by conflict and disaster. Throughout the following chapters, the reader will learn more about IRC's theory of and approach to mental health and wellness. Additionally, the reader will build skills for working with clients, including referring to services, responding to crises, and the importance of self-care. There will be "Tip (!)" boxes located on the left hand side of the page throughout the manual to alert the reader to important considerations or helpful reminders in working with refugees and immigrants. Additionally, throughout various chapters, there will be "Case in Point" sections which follow three clients and their relatives through mental health struggles and resolutions as they receive services in IRC's U.S. Programs.

### Who is this manual for?

This manual is intended to be used in various settings and across various programs in USP, for those working directly with clients as well as those providing guidance to case management staff. This manual is meant to be accessible, relevant, and practical for all levels of USP staff and can be used during orientation and as an ongoing reference guide for issues arising in daily work.

## Section 1.3 |Defining Mental Health and Wellness

The World Health Organization (WHO) defines **mental health** "as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[2] USP strives to help clients achieve mental health in addition to a general sense of wellness.

**Wellness** can be defined as "a way of life oriented toward optimal health and well-being in which mind, body, and spirit are integrated by the individual to live more fully within the human and natural community" (Meyers et al., 2000). Wellness encompasses five major life tasks of love, spirituality, self-direction, work and leisure, and friendship. It's important to note that an individual can have varying levels of success or wellness in each of the five categories of wellness and can still be considered to be well. Wellness is a cumulative notion of all positive aspects of one's life.[3]



*Figure 1. Components of Wellness*

Being well in emotional and mental health means individuals can find safety in relationships and their environment in addition to learning how to positively cope with life's challenges. According to the World Health Organization, positive mental health is linked to a range of development outcomes, including better health, higher educational achievement, enhanced productivity and earnings, improved interpersonal relationships, better parenting, and improved quality of life.

Below is an explanation of wellness in each of the five major life tasks.

| Life Task | Description |
|---|---|
| Spirituality | Awareness of a being or force separate from material aspects of life that gives one a deep sense of wholeness or connectedness to the universe. |
| Self-Direction | • Sense of control and worth, sense of humor<br>• Realistic beliefs, problem solving and creativity<br>• Emotional awareness and coping<br>• Nutrition, exercise, and self-care<br>• Gender and cultural identity |
| Work & Leisure | • Economic support, social benefits<br>• Challenge or engage senses, skills, and interests<br>• Physical, social, intellectual, volunteer and creative activities |
| Friendship | Incorporates all social relationships that involved connection with others individually or within a community. |
| Love | Relationships that are formed on the basis of sustained, long-term mutual commitment and involve intimacy. |

*Table 1. Wellness[4]*

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[2] Mental health (see *References* section, p. 82)

[3] Myers, Sweeney, & Witmer, 2000 (see *References* section, p. 82)

[4] Myers, supra note 3

## Section 1.4 |Guiding Principles for Mental Health Services

IRC's client populations have all endured stressful experiences that may or may not be traumatic in nature (for more on the difference between stress and trauma, see Section 3.1); however, IRC's U.S. Programs strive to uphold the principles of trauma-informed work. In working with clients, USP works to embrace, acknowledge, and explore clients' understanding of their situation and all of the potential solutions that they already have. This approach to services is known as the strengths-based approach, which is further expanded upon in Section 5.1(b). In focusing on the inherent resiliency and strengths of IRC clients, USP mental health programming seeks to promote healing and reconnection.

As Judith Herman highlights in *Trauma and Recovery* (1992), the "core experiences of psychological trauma are disempowerment and disconnection from others" (p.133). Therefore, recovery must place emphasis on empowerment and reconnection with others, in a healing relationship. In "renewed connections with other people," one may develop the basic capacities "for trust, autonomy, initiative, competence, identity, and intimacy."[5]

IRC's guiding principles for mental health and wellness are based upon Judith Herman's (1992) seminal work on the social impact of psychological trauma and the process of healing, emphasizing the three phases of recovery :

1. Establishment of safety

2. Remembrance and mourning

3. Reconnection with ordinary life

Healing and recovery from traumatic events does not occur in a linear fashion. IRC mental health and wellness programs seek to highlight and promote dynamic, culturally sensitive environments in which healing may take place, through strengths based and client centered approaches to service delivery. In this supportive process, staff may continue to establish safe environments for clients, whether in one on one conversations or in meetings with families – affirming and respecting the variety of experiences and perspectives of clients from all over the world. Services to clients in USP may fall into one or both categories of clinical and non-clinical services.

### Clinical and Non-clinical Services

It is hoped that clients will view USP offices as 'Centers for Well-Being' in that they are able to receive services at IRC that enhance their well-being. In USP offices, there are two categories of mental health services: clinical, often referred to as behavioral health services, and non-clinical, which can be referred to as generalized support.

Clinical services include trauma and culturally informed individual, family and group psychotherapy. Some offices have physical spaces referred to as a Center for Well Being, where clients can receive services provided by licensed, trained clinicians such as mental health screening and assessment and behavioral health treatment.

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[5] Herman, 1992b (see *References* section, p. 82)

Other offices may provide wellness services in a non-clinical manner, integrating wellness into existing IRC programming. These offices will most likely not have a physical Center for Well-Being or licensed clinical staff, but they are still viewed as locations where services promote and enhance wellness. For this reason, non-clinical services, such as community based activities, adjustment support groups, and/or educational groups (which can incorporate aspects of psychoeducation) may be more accessible for many clients in USP.

## Culturally Competent Services

It would be remiss for there to be no mention of cultural competence or cultural humility in this manual; however, this section is by no means an all-encompassing presentation of what it means to be a culturally aware professional. Cultural differences and interplays must be regularly and consistently evaluated in everyday practice. For this reason, this section touches briefly upon issues to keep in mind when working with refugees; however, there will be "Cultural Consideration (CC)" boxes throughout the document to alert the reader to areas in daily practice where the impact of culture should be investigated.

Culture can be defined as a product of group values, norms, and expectations as well as individual innovations and life histories. Culture is a fluid concept; it is both a process and a 'thing' that encompasses various areas of ones' life, such as religion, language, attitudes, world views, and community expectations. Culture can often dictate group behaviors and places in society. For example, in many cultures, age and gender influence power and authority and therefore influence the role one assumes in a society. While one may know of many cultural practices, norms, and world views from working with refugees, one's own cultural identity, or one's experiences with certain cultures, it is important to avoid overgeneralizations of cultures. [6]

**Cultural humility**, which is defined as being 'other-oriented,' refers to one's ability to allow and help clients in forming and explaining their cultural identity. An example of cultural humility includes ensuring that prior experiences working with a group of clients does not overshadow exploring and learning about that group's culture with a new client from the same group. Culturally humble case managers maintain a 'respectful openness' when working with clients and approach cultural understanding from a stance of curious naivety[7].

In working from the perspective of cultural humility, it is important to explore the interplay of culture and mental health with clients. Case managers can work with the client to explore normal and abnormal behaviors in their culture so interpretations of their behaviors are not only respectful, but are also congruent with how they interpret their behaviors and those of the people in their lives. This includes learning about the client's cultural explanations of the causes and consequences of mental illnesses, names and categories of mental illnesses, attitudes towards care-taking for the mentally ill, and community responses to mentally ill individuals[8]. [CC Box[9]]

> CC Keep a running list of common ways refugees have expressed symptoms of mental health troubles and use it to help guide your assessments.

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[6] Guarnaccia, & Rodriguez, 1996 (see *References* section, p. 82)
[7] Hook, Davis, Owen, Worthington, & Utsey, 2013 (see *References* section, p. 82)
[8] Hook, et al., 2013, supra note 7
[9] UNHCR, WHO, 1996 (see *References* section, p. 82)

## Do No Harm
IRC strives in every way to help and benefit those populations with which it works and to do no harm to those populations. When conflicts occur in the professional realm, one must attempt to resolve those conflicts in a responsible, professional manner that avoids or minimizes harm to the client and/or professional relationship. The work done in USP greatly affects the lives of the clients; for this reason, it is imperative be alert to the positive and the unintended negative consequences of the ways work is completed. This includes being aware of the possible effect of one's own mental and physical health on one's ability to complete professional duties.[10] A component of being aware of the effects of services includes reducing the opportunity for retraumatization. This can be done by allowing the client to set the pace of his or her disclosure of the traumatic history.

## Community-Based
IRC programs throughout the U.S. strive towards being designed, implemented and adapted based on the needs, priorities, aspirations, motivations, and capacity of local stakeholders – both individual clients, and the institutions of state and civil society which legitimately address issues that face refugee and immigrants and their host communities. USP offices are not silos in the communities in which they work, but instead serve as a convener of community resources, organizations, and stakeholders in an effort to improve access to services for the people they serve.

## Equity in Care and Access
Mental health programming in USP supports the long-term integration of well-being of all clients by ensuring that resources are distributed fairly among clients; this includes, but is not limited to, equity across gender, age and ethnicity.

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[10] American Psychological Association, 2010 (see *References* section, p. 82)

## Section 1.5 | Glossary of Terms

**Adjustment** – The process of slowly becoming familiar and comfortable with a new situation.

**Appreciative supervision** – A form of supervision that involves using solution focused questions and approaches in creating and troubleshooting the client's service plan.

**Asylee** – An alien in the United States or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on the alien's race, religion, nationality, membership in a particular social group, or political opinion.

**Asylum seeker** – An immigrant claiming to be a refugee in the United States without having that claim definitively evaluated.

**Burnout** – Feeling fatigued, hopeless and overwhelmed by unsupportive work environments and excessive workloads. This builds over a long period of time and leads to dissatisfaction with the work. Burnout is not directly related to working with trauma survivors and can occur in any setting.

**Case management** – A systematic process in which a trained an supervised caseworker assesses the needs of a client and then arranges, provides, coordinates, monitors, evaluates, and advocates for services to meet the client's needs.

**Case worker/ case manager** – An individual working within a service providing agency, tasked with the responsibility of providing case management services to clients.

**Child abuse/neglect** – Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

**Collective trauma** – The negative impact of one or more traumatic events at the collective, or community level.

**Compassion fatigue/vicarious trauma** – The feeling of preoccupation with the traumas that clients have shared. This leads to clinical symptoms similar to those of the clients and can make it very difficult to continue to work with trauma survivors.

**Complex trauma** – A series of traumatic events that occur repeatedly and cumulatively, over a period of time.

**Confidentiality** – Ethical principle in which service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission.

**Cultural humility** – Being 'other-oriented,' referring to one's ability to allow and help clients in forming and explaining their cultural identity.

**Developmental Trauma** – Neuropsychological disorder occurring after multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences that affect many areas of functioning.

**Elder abuse/neglect** – Any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.

**Empathy** – The ability to imagine oneself in another person's situation, including imagining their world views, assumptions, and beliefs in that situation.

**Engagement** – The process of developing agreement between the helper and the client in which the client views their treatment as meaningful and important.

**Gender based violence** – An umbrella term for any harmful act that is perpetrated against a person's will; it is based on socially ascribed (gender) differences between males and females.

**Internally Displaced Person (IDP)** – Someone who has not crossed an international border to find sanctuary from danger such as armed conflict, generalized violence, and human rights violations. IDPs legally remain under the protection of their own government – even though that government might be the cause of their flight.

**Mandated reporting** – The state laws and policies which mandate certain agencies and/or persons in helping professions to report actual or suspected child abuse and neglect and elder abuse and neglect.

**Mental Health** – A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.[11]

**Post-Traumatic Stress Disorder (PTSD)** – A neuropsychological disorder that may develop following a traumatic event. Symptoms include changes in emotional, behavioral or psychological functioning.

**Psychosocial Support** – Non-clinical services provided to enhance the psychological and social functions of a client.

**Refugee** – Someone 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.[12]

**Resilience** – The ability of a person to successfully adapt or recover from stressful and traumatic experiences whereas community resilience is seen as the collective ability to adapt and recover from adversity as a population or a community.[13]

**Safety plan** – A written compilation of coping strategies and sources of support that clients can use during, preceding, or after a crisis situation.

**Self-care** – The regular, mindful engagement in practices and activities that reduce personal levels of stress and maintain and restore balance in all aspects of one's life, professionally and personally.

**Strengths-based practice** – A method of psychosocial practice that is founded upon the belief that individuals have the capacity to grow and change and that all individuals have a range of experiences and roles that contribute to their world views.[14]

**Stress** – A state of mental or emotional strain or tension resulting from adverse or very demanding circumstances.

**Supervision** – The process by which one's work is supported, informed, and maintained through regular interaction with a superior staff member with developed expertise.

**Survivor/victim** – A person who has experienced violence or a violation of rights. The terms survivor and victim can be used interchangeable, although victim is usually preferred in legal and medical settings whereas survivor is preferred in psychological and social support sectors. The individual ultimately decides how s/he wants to be identified.

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[11] Mental health, supra note 2
[12] UN, 1951 (see *References* section, p. 82)
[13] Rolfe, 2006 (see *References* section, p. 82)
[14] Saleeby, 1992 (see *References* section, p. 82)

**Trauma** – A deeply distressing or disturbing experience caused by an event or experience that involves severe stressors and usually involves a loss or a major change and also affects every aspect of human functioning, from the biological to the social.

**Triple trauma paradigm** – An explanation of the three phases refugees go through to reach safety; pre-flight, flight, and post-flight.

**Wellness** – A way of life oriented toward optimal health and well-being in which mind, body and spirit are integrated by the individual to live more fully within the human and natural community.

# Chapter 2
## Mental Health & Wellness for IRC Clients

*Learning Objectives*

1- *Identify IRC's USP client populations*
2- *Recognize the unique stressors each population faces*
3- *Describe the adjustment process for learning to live in the U.S.*

## Section 2.1 | The IRC Client's Experience

The IRC's focus population is defined as people forced to flee from war, conflict and disaster and the host communities that support them, as well as those who remain within their homes and communities. IRC actively serves populations who have been directly affected by conflict or disaster and indirectly affected by the ensuing breakdown of services and markets. In USP, the focus populations extend beyond refugees to asylum-seekers, victims of trafficking, vulnerable immigrants and their communities in the United States. As geopolitical conditions change and marginalized populations become more visible throughout the world, the prominence and needs of certain populations fall into and out of the spotlight. Below is a closer look at refugees in addition to a few specific sub-populations that USP works with on a regular basis.

Many IRC clients in the United States are considered to be refugees; a **refugee**, by definition, is someone 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"[15]. Refugees have endured extraordinary circumstances in their home countries which often include death, devastation, loss and exile. The experiences in their home countries cause refugees to flee for their safety; however, once a refugee is out of the area of conflict, their journey is far from over.

Many refugees are survivors of torture, as will be discussed in the following sections; however, many survivors of torture enter the United States without refugee status. These survivors must petition for asylum upon entry, proving that their circumstances merit the protections of refugee status. The Department of Homeland Security (DHS), defines an asylee as:

> "An alien in the United States or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on the alien's race, religion, nationality, membership in a particular social group, or political opinion."[16]

The process of applying for and being granted asylum is a lengthy process, at times spanning years, during which the individual faces an uncertain future and limited opportunities. Asylum-seekers present a different set of needs than refugees since they are often not eligible for services due to their lack of immigration status. Staff should consult their local public benefits office for updated information on service eligibility.

### The Triple Trauma Paradigm[17]

Developed in the early 1990s, the Triple Trauma Paradigm is widely used to describe the unique stressors refugees and immigrants fleeing violence or persecution face during their three phased journey to safety. [18] The Triple Trauma Paradigm encompasses the three phases refugees go through to reach safety; the first, 'pre-flight' occurs in the home country as refugees experience persecution, violence, fear and an absence of safety and control. Once refugees have fled their home countries, they enter

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[15] UN, supra note 12
[16] Portman, & Weyl, 2013 (see *References* section, p. 82)
[17] National Capacity Building Project, 2005 (see *References* section, p. 82)
[18] Hunt  (see *References* section, p. 82)

the 'flight' phase which is characterized by extreme uncertainty, great levels of stress, and the potential for re-victimization. Contrary to what one would expect, the final phase of the triple trauma paradigm during which resettlement occurs, 'post-flight' is not characterized by a complete absence of stressors, but rather a whole new set of stressors related to adjustment, loss, confusion, and culture shock. The table below lists some of the common feelings, experiences, and fears in each of the three phases.

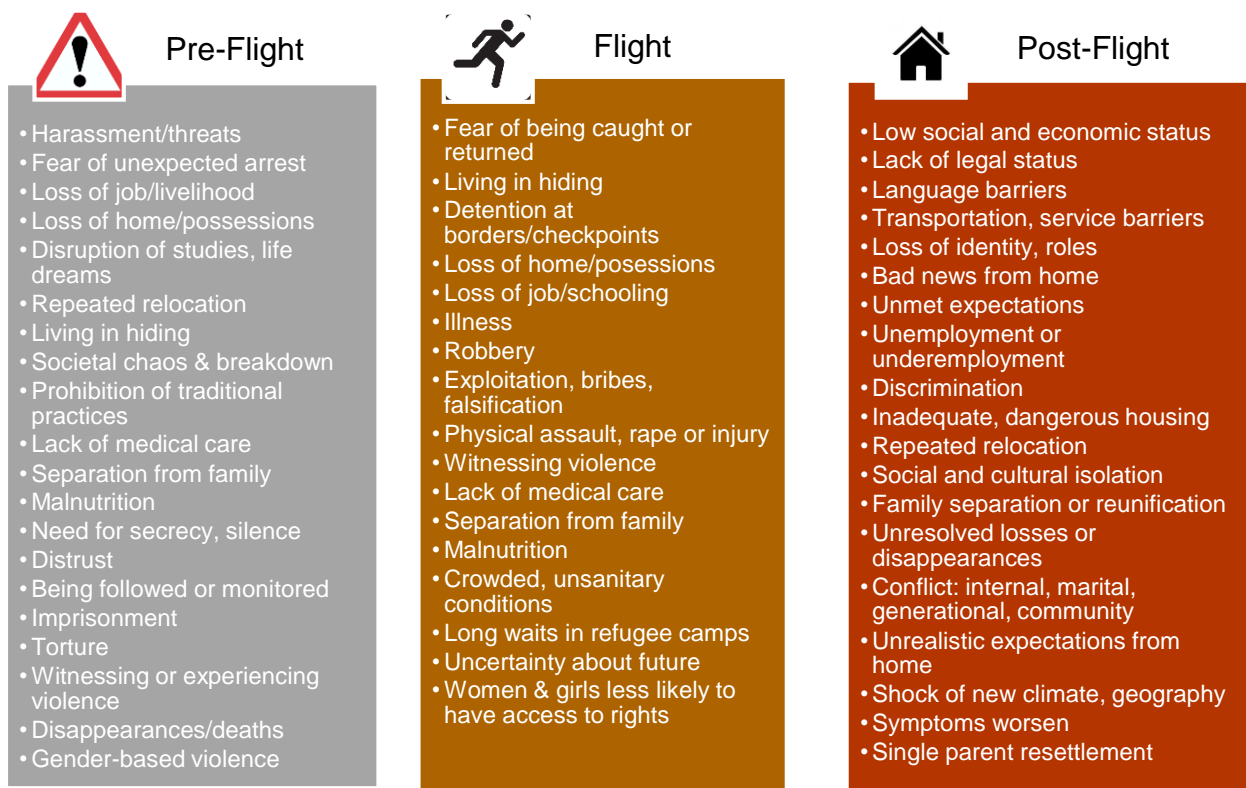| ⚠ Pre-Flight | 🏃 Flight | 🏠 Post-Flight |
|---|---|---|
| • Harassment/threats<br>• Fear of unexpected arrest<br>• Loss of job/livelihood<br>• Loss of home/possessions<br>• Disruption of studies, life dreams<br>• Repeated relocation<br>• Living in hiding<br>• Societal chaos & breakdown<br>• Prohibition of traditional practices<br>• Lack of medical care<br>• Separation from family<br>• Malnutrition<br>• Need for secrecy, silence<br>• Distrust<br>• Being followed or monitored<br>• Imprisonment<br>• Torture<br>• Witnessing or experiencing violence<br>• Disappearances/deaths<br>• Gender-based violence | • Fear of being caught or returned<br>• Living in hiding<br>• Detention at borders/checkpoints<br>• Loss of home/posessions<br>• Loss of job/schooling<br>• Illness<br>• Robbery<br>• Exploitation, bribes, falsification<br>• Physical assault, rape or injury<br>• Witnessing violence<br>• Lack of medical care<br>• Separation from family<br>• Malnutrition<br>• Crowded, unsanitary conditions<br>• Long waits in refugee camps<br>• Uncertainty about future<br>• Women & girls less likely to have access to rights | • Low social and economic status<br>• Lack of legal status<br>• Language barriers<br>• Transportation, service barriers<br>• Loss of identity, roles<br>• Bad news from home<br>• Unmet expectations<br>• Unemployment or underemployment<br>• Discrimination<br>• Inadequate, dangerous housing<br>• Repeated relocation<br>• Social and cultural isolation<br>• Family separation or reunification<br>• Unresolved losses or disappearances<br>• Conflict: internal, marital, generational, community<br>• Unrealistic expectations from home<br>• Shock of new climate, geography<br>• Symptoms worsen<br>• Single parent resettlement |

*Figure 2. Triple Trauma Paradigm[19]*

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[19] National Capacity Building Project, supra note 17

<u>Phases of Adjustment</u>[20]

The third phase of the triple trauma paradigm, 'post-flight' is further expanded through the phases of adjustment. While the phases of adjustment are portrayed in a linear fashion, an individual can cycle and move through the various stages in non-linear forms, as they experience life events, outside stressors, and changes in their world views.

**Phase I. Arrival.** This phase is often referred to as the 'honeymoon' phase and is the phase during which refugees experience the greatest amount of hope, excitement, and satisfaction with their situation.

**Phase II. Reality**. This phase is often referred to as 'culture-shock' and is the phase during which refugees become acutely aware of the challenges they face in their new lives. Refugees will often feel resentment, anger, and frustration due to their unmet expectations of ease and comfort in their new homes. This phase is characterized by increased stress due to the added difficulty of coping with the shock.

At this point in the adjustment process, refugees can go in one of two directions, denoted on the graph (below) as 'positive' and 'negative' adjustment.

*Positive Adjustment Trajectory*
**Phase IIIa. Negotiation.** This phase is characterized by refugees coming to terms with their situation, regaining hope, and beginning to heal from their past experiences.

! Keep in mind that adjustment is a non-linear process and refuges can cycle between the two trajectories throughout their lives.

**Phase IVa. Integration.** This phase is characterized by a healthy achievement of acculturation. The refugee is self-sufficient, has a strong support system and is active in his or her community.

*Negative Adjustment Trajectory*
**Phase IIIb. Alienation.** This phase is characterized by isolation, sadness, and a preoccupation with those elements of one's past life that were lost (social standing, loved ones, sense of culture/community, etc.).

**Phase IVb. Marginalization.** This phase is characterized by unemployment, dependence, legal struggles, the assumption of negative roles, and social support/family breakdown.

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[20] Hunt, supra note 18
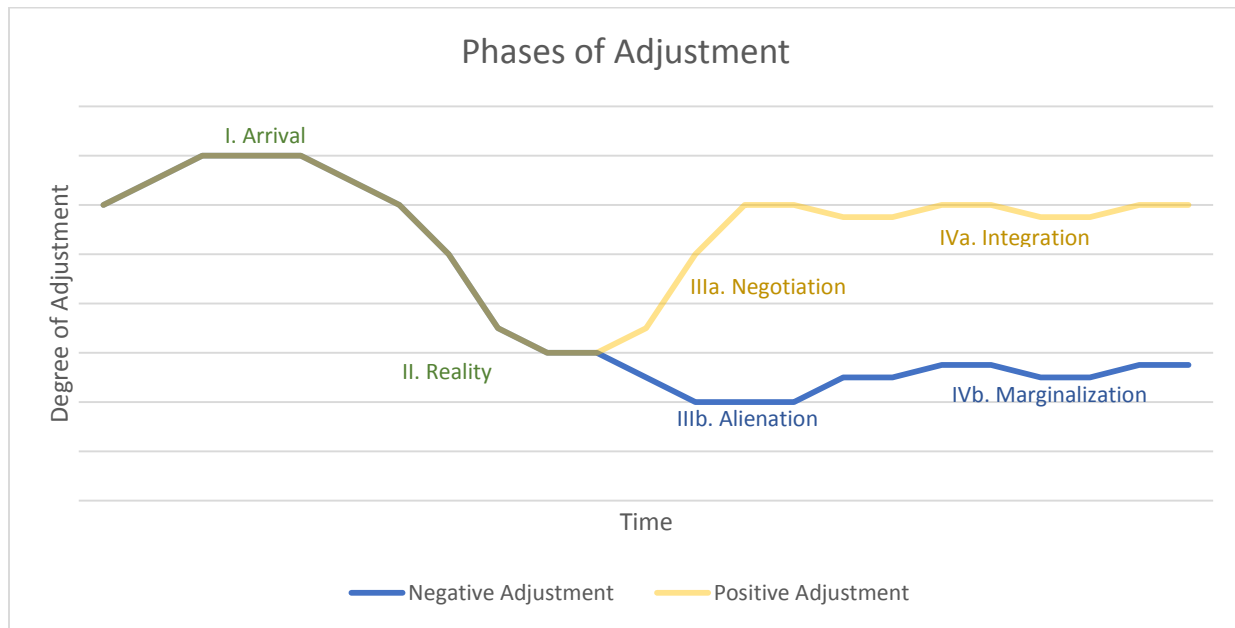
*Figure 3. Phases of Adjustment[21]*

## Challenges through Life Stages

Refugees in different life stages experience unique sets of challenges during the resettlement process. For the purpose of this discussion, the population is divided into age sub-categories as follows:

- Youth- ages 0-17
  - Young children- ages 0-5
  - School aged youth- ages 6-17
    - Children- ages 6-12
    - Adolescents- ages 13-17
- Adults- 18-50
- Elders- 50 and beyond

> **CC** The designation of being an "elder", "teenager" or "adult" is not bound by age in many cultures; for this reason, an elder can be as young as 30 years old and an adult as young as 10. Be sure to discuss with the client his or her perception of age.

There are some challenges that are common to many refugees in the U.S., regardless of their age. These challenges include language barriers, receiving bad news from home, exploitation and/or abuse, discrimination, living in a low income/high crime area, working towards family reunification, and the continued unpredictability of life events. However, there are some stressors and challenges that are associated with one of three life stages[22].  [CC Box[23]]

Below, you'll find a table listing some of the challenges that are unique to each age group's experience during resettlement.

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[21] Hunt, supra note 18
[22] Hunt, supra note 18
[23] Chenoweth, & Burdick, 2001 (see *References* section, p.82)

| Youth (0-17) | Adults (18-50) | Elders (50 and beyond) |
|---|---|---|
| • Intergenerational value conflict<br>• Role reversal/ambiguity/child as interpreter for family<br>• Inadequate educational preparation/cognitive limitations<br>• Peer pressure<br>• Pressure to excel in school<br>• Family conflict/inadequate parental figures<br>• Surrogate family issues<br>• Rejection by family or sponsor | • Gender role shifts<br>• Lower social status in new country<br>• Pressure to work<br>• Language acquisition<br>• Family role shifts<br>• Intergenerational value conflict<br>• Need to take care of elders and youth<br>• Pressure to hold family together | • Retirement as a concept<br>• Abruptness of retirement<br>• Loss of independence<br>• Loss of support system<br>• Personal meaning of life<br>• Coping with death<br>• More losses and fewer gains than their younger counterparts<br>• Difficult language acquisition<br>• Status shift<br>• Pressure to contribute financially |

*Table 2. Stressors through Age Groups* [24] [25]

## LGBTI Refugees

At present, there is a growing need for culturally sensitive and inclusive services for the lesbian, gay, bisexual, transgender and intersex (LGBTI) refugee communities. There continues to be widespread persecution against LGBTI populations; at least 76 of the United Nations Member States criminalize homosexual acts among consenting adults.[26] In 2010, UNHCR affirmed that:

"LGBTI persons are entitled to all human rights on an equal basis as others. These rights are enshrined in international human rights and refugee law instruments. States have a duty to protect asylum seekers and refugees from human rights violations regardless of their sexual orientation and gender identity."

Despite UNHCR's affirmation and guidance, there remains much progress to be made in recognizing the rights of LGBTI individuals under the broader definition of human rights.

! LGBTI refugees are not predisposed to mental health issues based on their sexual orientation or gender identity, but rather, these individuals are more susceptible to mental illness as a result of discrimination.

In addition to the harrowing journey most refugees face during their pursuit of safety, LGBTI refugees frequently face additional hardships, persecution and harm. Often, LGBTI individuals are specifically targeted in their home countries due to their sexual preferences and gender identities. Once in refugee camps, LGBTI refugees may be among the most isolated and marginalized individuals in the camp due to their fear of being further ostracized and harmed.

Many LGBTI refugees initially obtain refugee status for reasons unrelated to their sexual orientation and gender identity and may be reluctant to disclose such information to family members or caseworkers due to fear of continued harassment or discrimination. For these reasons, they often resettle alone and remain segregated from other

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[24] Mueller, & Okawa (see *References* section, p. 82)
[25] Porter, & Haslam, 2005 (see *References* section, p. 82)
[26] Buscher, 2011 (see *References* section, p. 82)

immigrants from their home countries due to mistrust and fear of continued discrimination. Best practices indicate the success of linking LGBTI refugees with sponsors or mentors in the LGBTI community in addition to the success of 'mainstreaming' LBGTI services. By integrating LGBTI services into regular service provision, for example in cultural orientation or ESL classes, resettlement services can encourage LGBTI refugees to be comfortable with their identities and create meaningful, lasting relationships with others.[27] For more information regarding creating inclusive programming and communities, please contact the LGBTI Liaison for USP.

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[27] Portman, supra note 16

## Section 2.2 |Victims of Trafficking (VoT) [28]

Human trafficking is becoming a more visible practice and problem in developing and developed countries alike. The United Nations *Convention Against Transnational Organized Crime* (2000) defines human trafficking as

> "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purposes of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs." [29]

Victims of trafficking, similar to survivors of torture, face a unique set of stressors and challenges that must be addressed through appropriate service provision. Trafficking victims have usually faced victimization in their home countries and abuse while traveling, including but not limited to psychological abuse, deprivation of basic needs, and physical and sexual violence, and further victimization under the constraints of their trafficked destination. Trafficking most often results in circumstances of forced labor and/or forced sex work that lasts for multiple years before any relief or assistance is provided.[30]

Many trafficking victims are brought to the United States under secrecy, during which their identifying documents are confiscated and they are placed under complete control of the trafficker and/or eventual 'owner'. Many times, the victim accrues smuggling debts that feed into the position of indentured servitude.

Once a victim is able to leave the abusive and oppressive situation he or she is in, service providers must be attuned to the heightened vulnerability of the individual to be exploited again in other situations. Victims of trafficking often blame themselves for the years of abuse they have endured and function under a sense of learned hopelessness, much like survivors of domestic violence. For these reasons, it is important to work with the victim to reestablish his or her sense of hope and self-efficacy. Much like work with refugees and survivors of torture, work with victims of trafficking must be done from a strengths-based perspective that focuses on establishing trust, support, and empowerment. [31]

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[28] Hopper, 2004 (see *References* section, p. 82)
[29] Gallagher, 2002 (see *References* section, p. 82)
[30] Hopper, supra note 28
[31] Hopper, supra note 28

## Section 2.3 | Survivors of Torture (SoT)

It is estimated that between 5% and 35% of refugees have been tortured at some point in their lives and that at least 500,000 survivors of torture reside in the United States.[32] The United Nations' *Convention Against Torture* (1984) defines torture as:

> "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed…, or intimidation or coercing him or a third person, for any reason based on discrimination of any kind, where such pain and suffering is inflicted by or at the instigation of… a public official or other person acting in an official capacity."

Survivors of torture are made to endure mental and physical torture that is aimed at breaking down the spirit, sense of self, and efficacy they once had. These individuals are most often targeted because of their beliefs, activism and conviction and are systematically disempowered through heinous acts. Survivors are often left with a feeling of overwhelming isolation, loss of trust, loss of a sense of self, and loss of control.[33]

For these reasons, it is imperative that services for torture survivors are provided from a client-centered, strengths-based perspective so as to restore survivors' sense of control over their lives. When working with torture survivors it is important to recognize the extreme and enduring resilience and resourcefulness these individuals possess, rather than pathologizing their symptoms and relying on a diagnosis for services. As survivors gain trust in service providers, they may retell their histories of torture; during this process, it is important to allow the survivor to dictate the pace and extent of their sharing. Often, after recounting torture histories, survivors will experience an intensification of symptoms related to their abuse, such as nightmares, avoidance, flashbacks, and hypervigilance.[34]

Many survivors of torture enter the United States without refugee status and must petition for asylum upon entry, effectively proving that their circumstances merit the protections of refugee status.

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[32] Engstrom, & Okamura, 2004 (see *References* section, p. 82)
[33] Engstrom, supra note 32
[34] Engstrom, supra note 32

## Section 2.4 | Case in Point: Introduction to 3 Case Studies

Throughout the following chapters, there will be "Case in Point" sections. Each case in point section will follow three clients and their relatives through mental health struggles and resolutions in the context of the information being shared in the chapter. The reader will follow the clients as they receive mental health services in accordance with IRC's U.S. Programs' theories and approaches to mental health and wellness.

### Cesarine

Cesarine is a pregnant 25 year old young woman from the Democratic Republic of Congo. She arrived in the U.S. a few weeks ago with her 2 year old daughter and brother, who is also in his 20s. Cesarine speaks limited English and must mainly rely on her brother or an interpreter to communicate with service providers. Cesarine's husband remains overseas, which continues to be a great stressor on the family. Cesarine is in the process of petitioning for her husband to be reunified with her and their children; however, the process has been slow. Cesarine, her brother and her daughter live together in a moderately safe neighborhood in town.

### Tsegaye

Tsegaye is a 23 year old man from Eritrea. He is a recent arrival, leaving a refugee camp in Kenya with his mother, two brothers and sister. Tsegaye's brothers and sister were all resettled in different cities resulting in Tsegaye and his mother residing together in an apartment in a violent neighborhood. Tsegaye presents as a very friendly young man; educated, fluent in English, humorous and liked by all. Tsegaye's mother is elderly and frail; she is not literate, doesn't speak English and has battled with alcoholism for decades. Tsegaye acts as his mother's main caretaker, a role he also took on as a child in the refugee camp.

### Pema

Pema and her family recently arrived in the United States after spending much of their lives in a refugee camp in Nepal. Pema, now 8 years old, only remembers living in the refugee camp where she was able to attend school, learning to speak English in addition to Nepali. Pema resettled in the U.S. with her father, mother, older brother Tenzin, age 24, older sister Sonam, age 19, and younger brother Jigme, age 5. Pema's mother was diagnosed with Schizoaffective Disorder (a combination of mood disorder symptoms and a psychotic symptoms) and, through the connections and advocacy of their local IRC office, is receiving services at a local adult day treatment facility in which a Nepali speaking nurse is employed. Pema's family is in the process of applying for social security disability (SSD) benefits to help care for the family as her father is struggling to support his wife and four children on his own.

# Chapter 3

## Potential Mental Health Struggles

*Learning Objectives*

1- *Discuss common reactions to loss and trauma*
2- *Integrate client resilience into daily practice*
3- *Explore factors affecting symptoms and recovery*

## Section 3.1 |Common Reactions to Loss and Trauma

In working with refugees, one may frequently hear two words that are commonly used interchangeably – stress and trauma. However, for the purposes of the IRC's work with refugees and other vulnerable immigrants, it is important to make the distinction between these two terms.

Many refugees have experienced one or more traumatic events in their lives and often find themselves in situations that involve great levels of stress upon their arrival in the United States. It is important to not overuse the term trauma when describing the clients' experiences, emotional states, and struggles.

**Stress** is defined as a "state of mental or emotional strain or tension resulting from adverse or very demanding circumstances."[35] Stress is typically triggered by a stressor that may range in intensity from mild to moderate to severe.

**Trauma** is defined as a "deeply distressing or disturbing experience."[36]  Trauma involves an event or experience that involves severe stressors and usually involves a loss or a major change and also "affects every aspect of human functioning, from the biological to the social" (p. 156).[37] Herman (1992) concludes that trauma overwhelms an ordinary system of care that gives people a sense of control, connection, and meaning in the world.[38]

In working with severely traumatized individuals and/or groups, the term complex trauma must be introduced and understood. **Complex trauma** refers to a series of traumatic events that occur repeatedly and cumulatively, over a period of time.[39] Complex trauma is, by nature, extended over a length of time during which the individual is entrapped and conditioned to expect and acclimate to the trauma. Examples of situations in which complex trauma occurs are ongoing armed conflict, extended displacement, trafficking, torture, domestic violence, and child abuse. Complex trauma results in many severe symptoms, some of which are outlined below. [40]

- Emotional Regulation: Alterations in one's ability to regulate emotional reactions, including self-harming coping mechanisms
- Attention and Consciousness: Alterations in one's ability to maintain focus; dissociative reactions

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[35] Stress (see *References* section, p. 82)
[36] Trauma (see *References* section, p. 82)
[37] Mueller, supra note 24
[38] Herman, 1992a (see *References* section, p. 82)
[39] Courtois, 2008 (see *References* section, p. 82)
[40] Courtois, supra note 39

- Self-Perception: Negative alterations in one's view of self; often including guilt, feelings of responsibility, internalization of the perpetrator's view
- Perception of Perpetrator: Alterations in one's view of the perpetrator, often incorporating the perpetrator's views, defending the perpetrator, etc.
- Relationships: Alterations in one's ability to form and sustain healthy and meaningful relationships; distrust of others
- Somatization: Physical manifestation of psychological symptoms
- Systems of Meaning: Alterations in one's worldviews; hopelessness
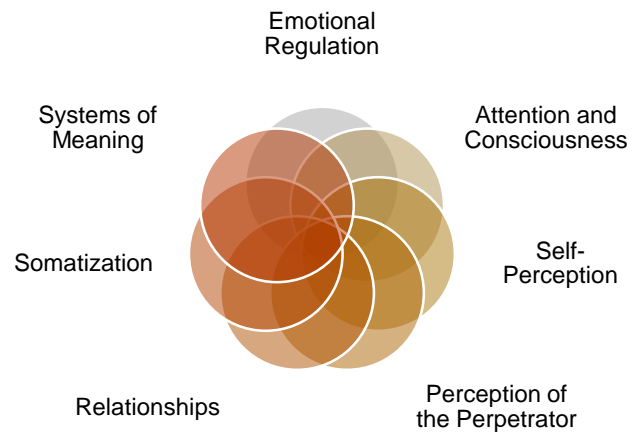


*Figure 4. Alterations of Complex Trauma[41]*

An individual's reactions to a traumatic event or a set of stressors can range from mild, in which the individual is able to adequately use his or her coping skills, to moderate, in which the reactions impact the individual's life but do not interfere with the individual's daily activities, to severe, in which the reactions greatly inhibit the individual's daily activities and reach a level which merits a clinical diagnosis of a mental disorder.[42]

The difference between mental distress and a mental disorder is the duration of symptoms, persistence and severity of symptoms, and the impact of symptoms and impairment on school performance, work, interpersonal relationships, home, and leisure activities.

Mental disorders produce symptoms that sufferers or those close to them may notice.  These symptoms may include:[43]
- *Physical symptoms* – aches and sleep disturbance
- Emotional *symptoms* – feeling sad, scared, or anxious
- *Cognitive symptoms* – difficulty thinking clearly, abnormal beliefs, memory disturbance
- *Behavioral symptoms* – behaving in an aggressive manner, inability to perform routine daily functions, excessive use of substances
- *Perceptual symptoms* – seeing or hearing things that others cannot

The most common diagnoses of mental disorders in the refugee population, based on diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), are depression and anxiety disorders, including post-traumatic stress disorder.[44] While the case manager's role is not to diagnose clients, one should be aware of the various signs and symptoms associated with each diagnosis so as to make appropriate and informed referrals to

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[41] Courtois, supra note 39
[42] Mueller, supra note 24
[43] HealthNet TPO, 2011 (see *References* section, p. 82)
[44] Mollica, et al., 2001 (see *References* section, p. 82)

follow-up services. The full criteria for Major Depressive Disorder, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD) can be found in Appendix 1.

Trauma, while often seen through an individual lens, can also have profound effects on communities. The term **collective trauma** refers to the negative impact of one or more traumatic events at the collective, or community level.[45] Trauma affects communities in various ways, through social processes, networks, relationships, institutions, dynamics, practices, and resources; it is often described as a tear or wounding of the social fabric that encompasses a community.

When a community experiences a trauma as a whole, it can foster a greater sense of community, and a stronger adherence to cultural norms, comforts and practices; however, it can also lead to changes in social norms, collective silence, and collective survivor guilt. It is important to remember that many clients have come from communities who have experienced a collective trauma in a way that has altered the community's ability to adapt, adjust, and recover.

> CC Talk to clients about the culture of the camp or community he or she was in before resettling; how did it help or harm his/her well-being?

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[45] Somasundaram, 2010 (see *References* section, p. 82)

## Section 3.2 | Factors affecting the Severity of Symptoms

There are many factors that can contribute to the severity of any refugee's reaction to a stressor or traumatic event. Research has found that the severity of a refugee's diagnosis is correlated to his or her exposure and proximity to pre and post-migration traumatic events in addition to the duration and intensity of the event(s).[46] Those closer to the traumatic event tend to have more severe reactions to the event:

A. Injured survivors, bereaved family members
B. Survivors with high exposure to disaster trauma or evacuated from disaster zones
C. Bereaved extended family and friends, first responders
D. People who lost homes, jobs, possessions; people with preexisting trauma and dysfunction; at-risk groups, other disaster responders
E. Affected people from the larger community.
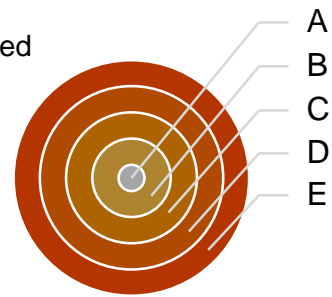


*Figure 5. Population Exposure Model[47]*

Some common risk and protective factors associated with better or poorer mental health outcomes for refugees are listed in the table below:

| Risk Factors | Protective Factors |
|---|---|
| • Poverty<br>• Unemployment<br>• Isolation<br>• Female<br>• Elder (65 and older)<br>• Pre-Migration rural setting<br>• Pre-Migration high socioeconomic status*<br>• Pre-Migration high education* | • Prior success with stress<br>• Strong support system<br>• Appropriate development (youth)<br>• Meaning attached to the event<br>• Spirituality/religion<br>• Child or Adolescent (0-17)<br>• Stable environment<br>• Sense of control over future<br><div style="text-align:right">48 49 50 51</div> |

*Table 3. Risk and Protective Factors*

*Research has suggested that those refugees with a higher education and socioeconomic status before the traumatic event have a more difficult time adjusting to life in the United States and exhibit more negative symptoms because they face a greater loss of status than their counterparts who are less educated and come from a lower socioeconomic status.[52]

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[46] Pumariega, Rothe, & Pumariega, 2005 (see *References* section, p. 82)
[47] Kelly, & Booth, 2013 (aww *References* section, p. 82)
[48] Mueller, supra note 24
[49] UNHCR, WHO, supra note 9
[50] Pumariega, supra note 46
[51] Porter, supra note 25
[52] Pumariega, supra note 46

## Trauma through the Developmental Stages

The signs and symptoms of trauma are expressed and experienced in different ways based on the developmental age of the individual who endured the traumatic event. Trauma, whether due to the absence of appropriate care, or as a result of chronic dysfunctional relational patterns, negatively impacts children's efficacy as well as their process of determining an identity (Perry, 2009). Chronic childhood trauma results in an altered sense of self in relationship to others. Herman (1992) describes childhood survivors of abuse who are approaching young adulthood as "burdened by major impairments in self-care, in cognition and memory, in identity, and in the capacity to form stable relationships" (p. 110). Youth have the most variability in the expression of trauma; the table below summarizes some common trauma reactions in the different age groups:

> CC Speak with adults and children to learn how children are usually cared for in their culture, what rituals are performed, what cultural celebrations there are and what the child's role is in the family.

CC Box[53]

| Ages 1-6 | | |
|---|---|---|
| • Bedwetting | • Crying | • Excessive clinging |
| • Thumb sucking | • Wetting Pants | • Loss of bowel control |
| • Fear of animals | • Fear of crowds | • Fear of being left alone |
| • Speech difficulties | • Re-enacting event | • Wants to go to heaven |
| **Ages 7-12** | | |
| • Bedwetting | • Irrational fears | • Irritability |
| • Defiance | • Excessive clinging | • Vision/hearing impairment |
| • Distractibility | • Fighting | • Refusal to go to school |
| • Avoids talk of event | • Re-enacts the event | • Wanting to die |
| • Regression of language, skill, or cognitive ability | | |
| **Ages 13-17** | | |
| • Running away | • Suicidal thoughts | • Stealing |
| • Increased sleep | • Violent fantasies | • Avoids talking of event |
| • Use of drugs | •Use of alcohol | • Sexual acting out |
| • Aggressiveness | • Relationship trouble | • Risk-taking behavior |
| • Truancy | | |

*Table 4. Traumatic Reactions in Children[54]*

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[53] UNHCR, WHO, supra note 9
[54] Mental Health America of Colorado (see *References* section, p. 82)

## Section 3.3 |Resilience

It has been established that many of those who experience conflict-driven, often highly traumatic forced migration do not develop mental disorders despite being at risk.[55]  Factors such as individual and/or community resilience and social support have been highlighted as potential mediators between forced migration experience and subsequent mental health impact.[56]

**Resilience** is defined as the ability of a person to successfully adapt or recover from stressful and traumatic experiences whereas community resilience is seen as the collective ability to adapt and recover from adversity as a population or a community.[57]

> CC The maintenance of cultural identity has been a widely used 'strategy' by refugees that serves as a source of resilience.

When working with refugees, it is imperative to not neglect to acknowledge, incorporate, and build upon their resiliency. Some examples of supportive factors that contribute to resiliency are incorporated into the diagram below.

Sense of coherence

Strengths of community support

Family and Social Support

Personal Qualities

Strong family and social networks

Religion and Belief Systems

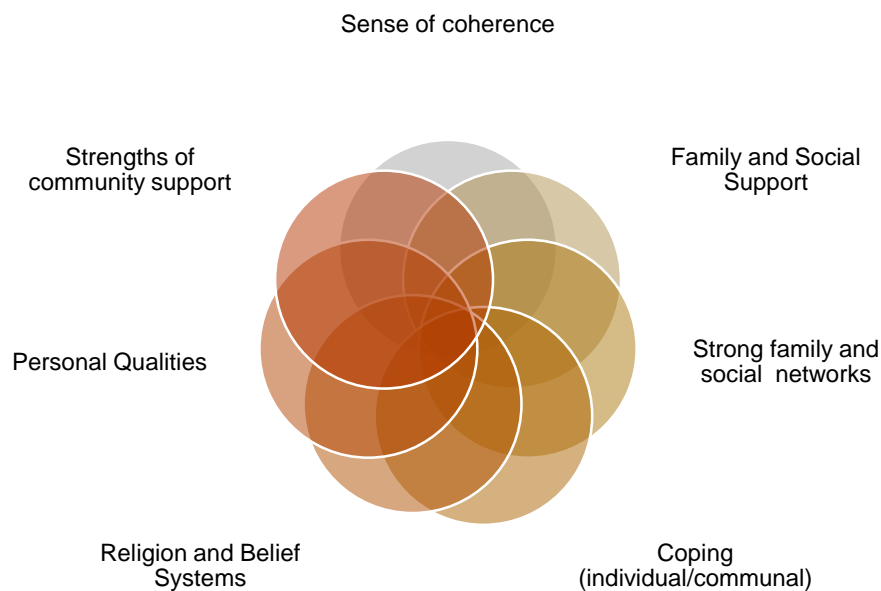Coping (individual/communal)

*Figure 6. Resilience: Supportive Factors*

Resiliency is one of the foundations upon which strengths based case management functions. See Section 4.1 (b) for more information on the strengths based case management model.

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[55] Bhugra, 2004 (see *References* section, p. 82)
[56] Siriwardhana, & Stewart, 2013 (see *References* section, p. 82)
[57] Rolfe, supra note 13

## Section 3.4 | Substance Abuse in Refugee Populations

While research suggests that many immigrants exhibit alcohol consumption patterns similar to those of the host country and consistent with their level of acculturation, indicating a 'normal' use of alcohol, substance abuse is still considered a problem in immigrant populations.[58]

Most clients will not develop substance abusing habits; however, there is the potential for the individual's coping mechanisms to include substance use/abuse in an effort to self-medicate or to avoid remembering their experiences. Additionally, the process of resettling for a substance abusing immigrant may lead to symptoms of withdrawal as the substance becomes less readily available or more expensive. A common example of withdrawal among immigrant populations is that of nicotine withdrawal as the price of tobacco products is increased in the US.

CC In certain populations, there are trends regarding which substances are typically abused and by whom they are abused. Speak with cultural liaisons and clients about what substance abuse looks like in their culture.

Alcohol abuse has been documented as a frequent problem with single refugees as they are most at risk for having underdeveloped social supports. Refugee youth often struggle with drug use and abuse, citing social marginalization and anger with issues related to acculturation and integration as motives for the drug habits.[59]

When working with refugees struggling with substance abuse there are some important tips to remember:
1) Don't assume that the substance use is related to the trauma. The client may have struggled with substance abuse throughout his or her life.
2) Work to promote understanding and to facilitate interventions. Approach the client openly, and engage them in a non-judgmental conversation about substances.
3) Integrate substance abuse prevention horizontally, not vertically. Address substance abuse in pre-existing programming about coping, interventions, and resources.[60]

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[58] Arfken, Arnetx, Fakhouri, Ventimiglia, & Jamil, 2011 (see *References* section, p. 82)
[59] Carballo, & Nerukar, 2001 (see *References* section, p. 82)
[60] Streel, & Schilperoord, 2010 (see *References* section, p. 82)

## Section 3.5 |Case in Point: Mental Health Struggles

### Cesarine

Cesarine comes to the office with issues mainly revolving around financial struggles such as paying for rent and providing for basic familial needs. Cesarine attributes much of her financial hardships to not having her husband with her to help support their young family. Cesarine's brother tries to help out as much as possible, but he is struggling to find consistent, gainful employment. Cesarine generally seems to be happy in her new life despite the financial hardship and separation from her husband; however, as time goes on, it becomes evident that Cesarine has been experiencing serious mental health symptoms. Cesarine eventually discloses to her case manager that she has been experiencing intrusive thoughts, is having trouble sleeping and is hearing voices related to her family's trauma. These disclosures came over time, and were met with the open, non-judgmental stance of the case manager. As the more serious symptoms were disclosed, such as hearing voices and experiencing intrusive thoughts, the case worker sought guidance from her supervisor and they planned together for the case manager to conduct a mental health assessment. Additionally, after the previous weeks of working with IRC and creating a strong working relationship with her case manager, Cesarine was comfortable enough to disclose that she and her brother are the last living members of their family; they escaped their home country together after watching their house, with family members still inside, burn to the ground. They also witnessed the death of their younger sister, who was killed as she was trying to escape the burning home.

### Tsegaye

One day, Tsegaye's case manager hears of an incident between Tsegaye and his mother involving an argument and either Tsegaye or his mother pulling out a knife on the other person. Confused by this extreme violence and contradictory behavior from a seemingly well-adjusted and well-liked young man, the case manager reaches out to the office's social worker and staff therapist to arrange a home visit with Tsegaye's mother and an intake for psychological services for Tsegaye. Tsegaye agrees to go to the intake appointment, stating that he could benefit from talking to someone and Tsegaye's mother welcomes the visit of an Amharic-speaking social worker.

### Pema

Pema's case manager hears from Pema's school that she is having a difficult time. The school explains to the case manager that Pema is not learning to read, has poor attention in class, and can be disruptive, starting fights with her classmates and teachers. Pema's case manager talks with Pema and her family members to get an idea of her behavior at home and her prior behavior in the refugee camp. It seems that Pema has always been a very big help in the family and never had any behavioral problems in the camp. Pema's siblings all seem to be adjusting to school and life in the United States without problem, but it seems as though Pema is regressing. The case manager consults with her supervisor and schedules a visit to Pema's school to further discus Pema's behavior.

# Chapter 4

# Working with Interpreters

*Learning Objectives*

1- *Utilize different modes of interpretation*
2- *Acquire skills for effectively working with interpreters*
3- *Provide support for interpreters and clients*

## Section 4.1 |Modes of Interpretation

Successful work with IRC's clients is based on trust which is achieved through thoughtful, personalized conversations. Many of IRC's clients do not speak English fluently and therefore necessitate the use of an interpreter to facilitate effective communication. Research has shown that memories, including traumatic memories, are more easily recalled in the language that the individual was speaking when the memory was formed. [61] In order to best address the mental health needs of clients, speaking in their first language can often be the best way to help them recall, address, and overcome their struggles. **Interpretation** is defined as the action of explaining the meaning of something whereas translation is defined as the process of translating words or text from one language into another.[62] The main difference between the two acts of language change are the mode in which the change is being made. Interpretation involves spoken word and translation involves written word.

There are multiple modes of interpretation that can be used in different settings. These different types of interpretation depend largely on the training and capacity of the interpreter and the appropriateness of the situation in which the interpretation is being conducted. The method of interpretation can be categorized into two of four different, dichotomous categories:

| Consecutive: interpreting occurs immediately after the speaker has finished speaking | OR | Simultaneous: interpreting in real-time as the speaker speaks (two voices at one time) |
| --- | --- | --- |
| Proximate: interpreter is physically present | OR | Remote: interpreter is not physically present (phone, web, Skype, etc.) |

The style of interpretation can be further categorized based on the content of the interpretation:

Word-for-Word interpretation, also known as "black box" interpretation, is a verbatim interpretation in which the interpreter relays every word spoken. This style of interpretation is best used during assessments, when factual information is being discussed or when technical procedures are being explained. The drawbacks to using word-for-word interpretation are that it takes a long time, it may require interruptions to ensure the interpreter can interpret every word, and it does not allow for the explanation of cultural information or words or concepts for which there are no direct translation.[63]

Summary interpretation is a loose interpretation of the important points and concepts. This style of interpretation is best used when there is an established level of trust and experience between the provider and interpreter and the client and interpreter. It is also helpful in group settings in which many people are sharing thoughts. The drawback to using summary interpretation is that not all information is interpreted so the content may be less accurate.

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[61] Marian & Kaushanskaya, 2007 (see *References* section, p. 82)
[62] Interpretation (see *References* section, p. 82)
[63] Murakami, 2015 (see *References* section, p. 82)

Within interpretation styles, interpreters can provide the added cultural assistance needed to fully explain concepts or words. This is known as bi-cultural or cultural broker interpretation in which the interpreter incorporates cultural definitions and nuances into the interpretation, ensuring that concepts are understood across languages and cultures. In these instances, the interpreter may act as more of a collaborator by providing recommendations and advocacy.

CC Do the client and interpreter know each other from the community? If so, how does that affect the client's comfort disclosing mental health needs?

## Who is the Interpreter?

Part of preparing for working with a client is to also prepare for working with an interpreter. It is important to know who the interpreter is and what, if any, relationship the interpreter has with the client. In an ideal situation, it is best to use a trained, professional interpreter with whom the client does not have any prior relationship to ensure professionalism, confidentiality, and comfort; however, there may be times when one must use family or friends of the client to help with interpretation. It is imperative that children and/or parents of a client are never used as interpreters for IRC's purposes.

It is important to remember that the interpreter is a person with feelings, experiences and needs that are just as salient as those of clients. The figure to the left outlines a few things to be aware of when working with interpreters.

Shared cultural or trauma history

Community role

Feelings about the client

Vicarious Trauma

Personal disagreements with the content or process

Feeling overwhelmed

Finding the right words

*Figure 7. Interpreter Challenges[64]*

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[64] Murakami, supra note 63

## Section 4.2 |Best Practices

It is important to note that while many case managers have had numerous experiences working with interpreters, some clients may have not had any experiences communicating through an interpreter. For this reason, it is always important to ensure that there are agreed-upon rules and guidelines that are followed in the session to ensure the client is comfortable and empowered during the conversation. Below is a graphic depicting things to attend to when using an interpreter before, during and after meeting with a client.
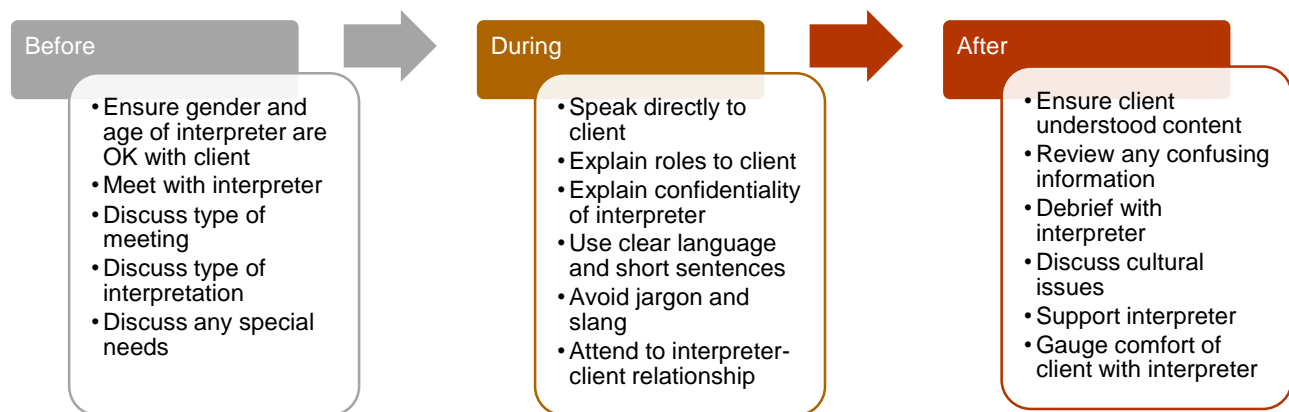
**Before**
- Ensure gender and age of interpreter are OK with client
- Meet with interpreter
- Discuss type of meeting
- Discuss type of interpretation
- Discuss any special needs

**During**
- Speak directly to client
- Explain roles to client
- Explain confidentiality of interpreter
- Use clear language and short sentences
- Avoid jargon and slang
- Attend to interpreter-client relationship

**After**
- Ensure client understood content
- Review any confusing information
- Debrief with interpreter
- Discuss cultural issues
- Support interpreter
- Gauge comfort of client with interpreter

*Figure 8. Interpretation Considerations[65] [66]*

### Trauma Informed Interpretation [67]

To ensure that the interpretation being provided is aligned with the trauma-informed services being provided, it is necessary to implement trauma informed interpretation. Trauma informed interpretation takes into account the client's experiences of betrayal by authority figures and the distrust that it fosters in service providers. Additionally, as a case manager, it is important to remember that the stigma of receiving services can impact the client's disclosure of his or her experiences and symptoms.

In order to address the aforementioned concerns in a trauma-informed manner one can implement the following suggestions:

- Clearly define the interpreter's role in front of the client and the interpreter.
- Arrange the space and positioning of yourself, the interpreter and the client to account for the client's experiences
- Explain confidentiality and the consequences of breaches in confidentiality in front of the client and the interpreter
- Ensure that the interpreter has been trained in trauma and its impact on survivors

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[65] NSW Refugee Health Services, 2004 (see *References* section, p. 82)
[66] Hunt, supra note 18
[67] Murakami, supra note 63

## Do's and Don'ts of Interpretation

Below you'll find a table listing some of the common do's and don'ts of interpretation.

| Do's | Don'ts |
|---|---|
| • Immediately establish client/service provider dyad<br>• Speak directly to the client in the first person<br>• Allow the interpreter to stand or sit close to you so the client can see your expressions<br>• Look at the client, not the interpreter<br>• Speak at a normal speed<br>• Speak in short sentences<br>• Interrupt if something seems to be off | • Depend on relatives or friends when possible<br>• Ask the interpreter to do something outside of his or her role<br>• Ask the interpreter for his or her opinion about the client<br>• Hold personal conversations with the interpreter<br>• Make unnatural pauses in speech to wait for interpretation (unless interpreter signals for you to do so) |

*Table 5. Do's and Don'ts of Interpretation[68]*

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[68] Murakami, supra note 63

## Section 4.3 |Case in Point: Working with Limited English Ability

### Cesarine

Since Cesarine does not yet have a strong command of the English language, an interpreter must be used to communicate effectively with her. Early in Cesarine's case, her case manager was able to connect her to a female interpreter with whom Cesarine was able to create a trusting relationship. Cesarine has continued to communicate with IRC staff through this same interpreter since she arrived in the US. Slowly, her English skills are improving; however, with her pregnancy and mental health symptoms, Cesarine is finding it difficult to retain the information she is learning in ESL classes. Cesarine's case manager regularly checks in with the interpreter before and after each meeting to ensure there were no miscommunications, lost cultural nuances, or points that the case manager should be aware of. Additionally, the case manager regularly checks-in with the interpreter to ensure she is feeling comfortable with the working relationship and the information discussed. As a refugee herself, the interpreter needs some time after particularly difficult conversations to utilize deep breathing to help remain calm and centered.

### Tsegaye

Fortunately, the social worker on staff is fluent in Amharic and is able to communicate with Tsegaye's mother without help from an interpreter. Through weekly home visits with Tsegaye's mother, the social worker is able to slowly help her meet her case management needs as well as work with her to decrease her alcohol dependency. Due to lack of linguistically appropriate resources in the community, the social worker is unable to refer Tsegaye's mother to an alcohol treatment program and instead focuses on improving her coping skills to minimize her negative reaction to stressors and thus reduce her need to self-medicate through alcohol consumption. The social worker continues to work in close contact with Tsegaye's case manager, the on-staff therapist and other resources within and outside of IRC.

### Pema

Since Pema and Sonam are the only members of the family who can speak English fluently, the case manager regularly utilizes an interpreter in interactions with the family. Only in an emergency situation, when an interpreter cannot be secured in a timely manner, would the case manager resort to using either Pema or Sonam as an interpreter for the family. The case manager regularly requests that the interpreter also be present for conversations with Pema and Sonam so that either child is able to speak in her native language. The case manager knows that it can be difficult to explain traumatic or difficult concepts in a language other than the first language, which is why an interpreter is available even when the case manager only needs to speak with Pema or Sonam.

# Chapter 5

## Assessment & Engagement with IRC Clients

*Learning Objectives*

1- *Integrate engagement skills in working with clients*
2- *Develop skills to work with clients of all ages*
3- *Identify mental health needs for all clients*

## Section 5.1 |Helping Skills

As a helping professional, it is important to be mindful of the skills being used on a daily basis in addition to those skills that still need to be developed. When working with vulnerable immigrants, it is particularly important to utilize specific skills to help bring those immigrants to a state of safety and wellness. The skills discussed below will help professionals be mindful of communications with clients in an effort to understand why a client may be experiencing struggles or difficulties and how to best help them find stability.

Engagement

**Engagement** in the context of social services is often defined as developing agreement between the helper and the client in which the client views their treatment as meaningful and important.[69] In the process of achieving positive engagement with a client, a combination of core interpersonal qualities and skills are used to make the client feel comfortable, respected and valued.
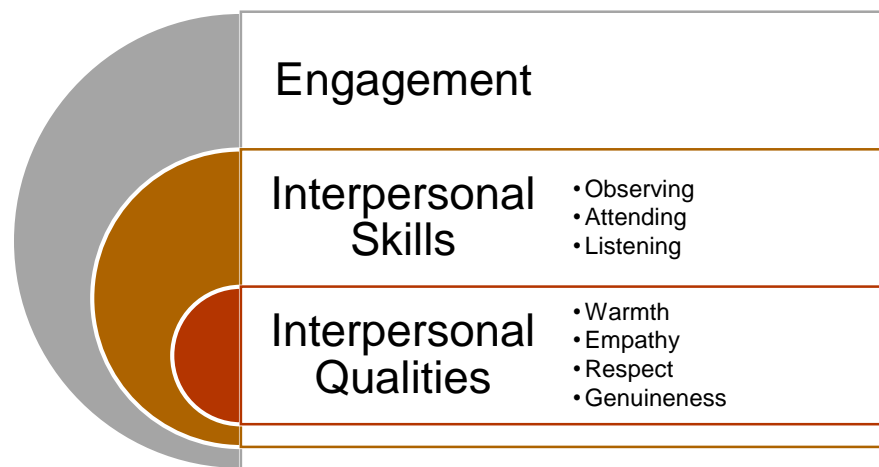


*Figure 9. Engagement: Interpersonal Skills and Qualities[70]*

**Core Interpersonal Qualities** are the qualities or attitudes that are essential in developing a good working relationship. Below are the four key interpersonal qualities needed for positive engagement with clients:

- Warmth can be expressed through appropriate facial expressions, giving one's full attention to the client, and using a calm, kind tone of voice.

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[69] Jacobsen, 2013 (see *References* section, p. 82)
[70] Chang, Scott, & Decker, 2009 (see *References* section, p. 82)

- Empathy, which is the described as being able to imagine oneself in another person's situation, including imagining their world views, assumptions, and beliefs in that situation. Empathy is different from pity or sympathy. Pity involves feeling bad for the other person and sympathy involves being and feeling affected by the same thing the other person is affected by.

CC Be sure to investigate how these qualities are expressed in various cultures. For example, making eye contact in America is considered to be respectful; however, that is not true across cultures.

- Respect, also referred to as unconditional positive regard, involves being accepting of the client and highlighting the client's good traits (strengths).
- Genuineness can be expressed by being sincere and authentic. Part of being genuine is accepting and admitting being wrong or making mistakes. Helpers are human and therefore do not know all of the answers and do make mistakes from time to time.[71]

**Core Interpersonal Skills** are the methods in which case mangers interact with clients that facilitate positive engagement by conveying the interpersonal qualities of warmth, empathy, respect and genuineness.

- Observing nonverbal communication is an important aspect of creating a positive working relationship. Notice things such as facial expressions, eye movement, body positioning, breathing patterns, and hand gestures as they are often great clues as to the emotions the client is experiencing.
- Attending is the act of being completely focused on the client. This involves not only verbal focus, but also body positioning, hand gestures, facial expressions and nonverbal communication, such as head nodding.
- Listening, while a common concept, is a skill that many people don't use on a daily basis. Listening bridges the gap between hearing the words someone is saying and understanding what they mean by saying those words. Ways to be a good listener include focusing on what the client is saying instead of what you're thinking, not talking about oneself, and avoiding asking too many questions.[72]

## Strengths Based Practice

The strengths based perspective was pioneered in the early 1990s for specific use with recently discharged severely mentally ill individuals; however, it is now widely use and recognized throughout social services.[73] The strengths perspective is founded upon the belief that individuals have the capacity to grow and change and that all individuals have a range of experiences and roles that contribute to their world views. It is important that service providers embrace, acknowledge, and explore clients' understanding of their situation, or problem, and all of the potential solutions that they already

! The strengths perspective helps us understand that individuals in a crisis can survive and thrive.

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[71] Chang, supra note 70
[72] Chang, supra note 70
[73] Saleeby, supra note 14

have. One can do so by tailoring each intervention to help the client realize and augment the many solutions he or she already has.[74] Within the realm of strengths based practice and utilizing a strengths based perspective, one can employ the model of strengths based case management.

There are six 'hallmarks' of strengths based case management[75]:

1) The case management process is <u>goal oriented</u>, not problem focused.
2) The client's strengths are <u>systematically assessed.</u>
3) The client's <u>environment</u> is recognized as being rich in resources.
4) Both <u>client and environmental strengths</u> are used to achieve goals.
5) The professional <u>relationship</u> fosters a sense of hope.
6) The client is <u>able and encouraged</u> to make meaningful choices.

Strengths based case management focuses on looking for the positive aspects in a client's life and how to then use those positive aspects to overcome whatever obstacle is in the client's path. Often, building upon the client's prior successes in overcoming a stressful or traumatic event is a great way to begin to shift the focus from the weaknesses or problems to the strengths. Strengths based case management is a great approach to building and recognizing resilience in clients.[76]

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[74] Rangan Aarti, 2006 (see *References* section, p. 82)
[75] Rapp, Saleeby, & Sullivan, 2005 (see *References* section, p. 82)
[76] Rapp, supra note 75

## Section 5.2 |Working across Life Stages

### Young Children

When working with families who have young children (infant to 5 years old), it is important to remember the needs of the young children. Just because the child does not yet speak or engage in conversation, it does not mean that he or she does not need services. When evaluating young children's needs, it is important to speak with their caretakers, parents, and family members about their habits, mannerisms, and development.

In addition to engaging parents in discussions about their children's needs, one can also attend to young children's need by identifying and monitoring for developmental milestones. The table below outlines the developmental tasks for the ages 0-5 years old.

| Age | Developmental Tasks |
| --- | --- |
| 0-6 months | Learning to trust others and be secure in the world<br>Learning (subconsciously) to get personal needs met |
| 6 months- 1 year | Learning to trust others and be secure in the world<br>Improving muscle coordination and becoming mobile<br>Acquiring increase control of extremities (head, hands, legs, etc.)<br>Learning special concepts (up, down, near, far) and how to move<br>Learning to adjust to short periods of separation from the caregiver(s) |
| 1-2 years | Discovering and establishing sense of self through exploration of the world<br>Developing communication skills and experiencing responses of others<br>Learning to use memory<br>Acquiring basics of self-control |
| 2-3 years | Discovering and establishing a positive, distinct self<br>Developing communication skills and experiencing responses of others<br>Using memory and acquiring the basics of self-control<br>Becoming aware of limits<br>Creating personal solutions to simple problems (choosing food, clothes, etc.) |
| 3-4 years | Learning to distinguish between reality and fantasy<br>Becoming comfortable with personal sexual identity<br>Learning to make connections and distinctions between feelings, thoughts, and actions<br>Learning to solve problems by initiating and creating |
| 4-5 years | Learning to distinguish between reality and fantasy<br>Becoming comfortable with personal sexual identity<br>Learning to make connections and distinctions between feelings, thoughts and actions<br>Learning to solve problems by initiating and creating |

*Table 6. Developmental Tasks from age 0 to 5* [77]

Promotion of healthy attachment and bonding among mothers and their infants in the first five years of life is crucial for the development of the child. To ensure the development of healthy attachments caregivers should be sensitive, affectionate, and

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[77] Center for Development of Human Services, 2002 (see *References* section, p. 82)

responsive to their child's needs. Children with responsive caregivers develop a stronger ability to manage stress, form healthier relationships, perform better in school, and have a strong sense of self-worth.  Furthermore, strong attachments with a caregiver can act as a resiliency mechanism throughout life.[78]

If a child is not meeting developmental milestones, be sure to discuss the milestone with the child's parents and, if needed, refer the family for follow-up assessments and services.

## School Aged Youth

As children enter the school aged years, their needs and capabilities naturally shift; this shift necessitates a shift in the ways in which one interacts with them. USP divides school aged youth into two categories: children (age 6-12) and adolescents (age 13-17); however, due to the wide prevalence of interrupted formal education, many school aged youth are older than 17, which presents another set of challenges and considerations. Before getting into more detail about working with children and adolescents in particular, some helpful suggestions for working with all school aged youth will be discussed.

Despite being a great part of youth's lives, people often underestimate the power of the youth's school. Schools are wonderful places in which youth are given the opportunity to enhance their resiliency by interacting with others and building off of their strengths. Schools are also helpful in monitoring youth's well-being in the form of academic progress and behavioral and social adaptation. As a service provider, it is important to create and maintain a relationship with the youth's school to help guide assessment and interventions with the youth.[79]

One of the most important steps in creating a relationship with individuals at the youth's school is gaining a solid understanding of the available resources in the local school district and becoming familiar with parents' rights. This is accomplishable by researching local districts, reaching out to education-oriented CBOs, and connecting with district representatives. An excellent resource can be a department of English Language Learners within some school districts. Ideally, each office should build a group of advocates and supporters in school districts who can help welcome and support these families.

When children begin school there is often a large culture shock; youth are being asked to do things that might be incredibly foreign and disconcerting to them, and to do them while being watched by their peers. By arming students with a better understanding of school culture, they may feel more empowered in the classroom and have less anxiety. Reaching out to teachers and educating them about the specific needs of this population is not only helpful for the student, but it may make the teacher feel more supported and empowered. Additionally, it may lead to school staff being more forthcoming about making a referral for additional services[80].

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[78] Ainsworth, Bell, & Stayton, 1974 (see *References* section, p. 82)
[79] Fazel, & Stein, 2002 (see *References* section, p. 82)
[80] Bridging Refugee Youth, 2007, (see *References* section, p. 82)

One common additional service provided for school aged children in need is an Individualized Education Plan (IEP). The goal of an IEP is to help students attain educations goals by assisting them with a tailored suite of support. An IEP is usually developed in a collaborative manner with the child, the child's teacher, parent(s), school counselor, and any educational staff who may be a part of the child's school life. A school may recommend a child for an IEP if they have concerns about the child's development and/or behavior in the classroom (such as being potentially withdrawn or highly reactive to others). Many times parents will become frightened or upset if a school suggests an evaluation; it is important to discuss this with families and help them realize that all children learn differently and that does not mean that there is anything 'wrong' with their child, simply that they need a different type of support[81] [82].

In general, work with youth can be done using the same principles of strengths-based case management that are used when working with adults; however, it is important to adapt those techniques to be used with youth. For example, when asking a child or adolescent about his or her history, it may be easier for the youth to think in pictorial terms. One can use a piece of string or a line on a piece of paper to represent the passing of time and pictures of rocks and flowers to represent bad and good life events.[83] One may also ask the child to create his or her own representation of life events with art materials. Sometimes allowing the child to reflect on and design his or her own images may be helpful in the development of a self-narrative for the child to refer back to over time.

When working with children, it is important to create a safe space for the child by positioning oneself on the child's level, using a friendly, low-key approach, and allowing the child to set the pace of the conversation. The most important component of working with any child is listening practically – observing the child's body language, listening to the types of words and ways in which the child describes him or herself, and responding in an open and supportive manner. Allow a child more space and time to respond to questions in order to set the tone of the conversation. To engage the child, one can first begin with showing respect for the child by identifying oneself, explaining the purpose for speaking with them in concrete terms, and sharing with the child that his or her point of view is important. Second, one can convey interest in the child by asking about and actively listening as s/he talks about personal preferences and thoughts, such as favorite books, shows, games or places to go. It's important to not confuse a mature conversation with a child with the child's ability to master abstract thinking; many times, children in this age range act and appear wise beyond their years, but they are still developmentally children. When speaking with a child about an emotionally charged subject, don't forget to allow the child time to calm down and to assist him or her in regulating those emotions at the end of the conversation.[84]

*Adolescents* need to be treated with respect and need to feel safe which is why it is important to not rush into the professional relationship with them.  It may be helpful to

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[81] Office of Special Education, 2000, (see *References* section, p. 82)
[82] Blatchley & Lau, 2010, (see *References* section, p.82)
[83] Onyut, et al., 2005, (see *References* section, p. 82)
[84] Center for Development of Human Services, supra note 77

remember that the main psychological task of adolescence is the "successful development of one's identity and transition into the adult world of productivity."[85]   This developmental period is also one of separation from parents and authority figures as adolescents try to determine how they want to align their thoughts and feelings in the adult world.  When engaging adolescents, it's best to show respect by being direct and honest about the purpose of working with them. One can clearly explain one's title, role and goals in speaking with them. To help adolescents feel more comfortable speaking, one can join in on the youth's activities and show interest in their concerns and needs; however, it's important to be sensitive to the youth's potential fear of embarrassment for being seen receiving services; for this reason, it may be best to meet in an office or space away from the youth's peers. It can be difficult to create meaningful, trusting relationships with adolescents as it takes time, patience and persistence; however, it is important to not forget the needs of adolescents as they are often caught in the middle of their past experiences and the immense pressure to fit in and adapt to their new American lives.[86]

## Students with Interrupted Formal Education (SIFE)

Many of the youth that receive services at IRC will be considered SIFE, or have interrupted formal education. The definition of SIFE can vary, but generally refers to a gap of greater than three months in a child's education. The broader definition of SIFE can include situations where the child has never had access to formal, classroom education, has only attended sporadically, or had attended regularly up until migration.

SIFE often have a lower literacy rate in their home language, low-to-no English proficiency, and perform below grade level in academics. Additionally, they may have difficulty adapting to school culture and may have a deep distrust of the education system.[87]

It is often difficult for these children to adapt to schools in the United States, due in no small part to their grade placements. In areas where students are placed in an 'age-appropriate' grade, such as all 5 year-olds being placed in kindergarten, many children feel vastly out paced by their peers and struggle to catch up. Alternatively, in contexts where children in placed in classrooms based on the years of schooling completed, the student may be much older than their peers. This can lead them to feeling ashamed, alienated, and can lead the student to dismiss school entirely.

Typically, students with interrupted formal education thrive in ESL-based programs with small classes and thematic instruction. It is also vital for these youth to be enrolled in out of school time programming to offer them additional opportunities to not only catch up academically but socially as well. It's important to help these youth to access the resources needed to get to grade level and to normalize school culture and expectations. Some examples of situations to review with SIFE are: [88] [89]

- Expectations in homework

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[85] Erickson, 1968 (see *References* section, p. 82)
[86] Center for Development of Human Services, supra note 77
[87] Advocates for Children, 2010, (see *References* section, p.82)
[88] Office of English Language Learners, 2009, (see *References* section, p. 82)
[89] The New York State Education Department, 2011 (see *References* section, p. 82)

- Appropriateness in speaking to teachers
- Asking to use the bathroom

In working with youth and families it is important to first understand the school district in which they reside:

- What types of opportunities and schools are available?
- What services are offered to English Language Learners (ELLs)?
- Are there OST opportunities?
- How are students enrolled in programs?

Once the family is made aware of this information and empowered to make the best decisions for their child, it is also important to review the child's academic trajectory. By reviewing the child's academic trajectory, an academic roadmap can be created, alleviating stress for the family and helping to solidify the child's academic future.

## Adults

Throughout this manual, adult clients are considered to be the normative client and are therefore discussed across many of the earlier and later sections; however, there are considerations that need to be taken when working with adults. Many adults struggle with a great pressure to rebuild their lives in an extremely short period of time and without many of the supports they had in their home countries or even in refugee camps.[90]

Many adult clients feel the need to provide for family members, whether here in the US or in another country. This pressure is exacerbated by the common loss in status immigrants face. A client who was a practicing medical doctor in his or her home country may need to take a cleaning job since their credentials are not fully recognized in the US. [91]

Some ways to help adult clients manage their stressors and regain control over their lives is to encourage participation in activities they enjoyed in their home country and to help them reconcile their prior life goals and accomplishments with their current life goals and hopes.

## Elders

As mentioned in earlier sections, the designation of being an elder is culturally specific and greatly relies upon the individual's perception of his or her place in society. While the age of the elder plays a great role in how to best work with him or her, there are some general struggles and considerations to be mindful of when working with the elderly, regardless of age.

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[90] Mueller, supra note 24
[91] Porter, supra note 25

Many elders in refugee communities have experienced the same traumas, stressors, and challenges that most refugees experience, however, the role change they experience is often the most shocking of the stressors and most difficult to overcome. Elders are often removed from a context in which they were considered an integral member of their family.[92] In pre-resettlement contexts, elders are more likely to give aid to others and to function as the 'glue' that holds a community together; however, upon resettling, this role of importance is quickly lost and replaced with feelings of isolation, confusion, and being burdensome. For these reasons it is important to pay particular attention to delivering services that are respectful, culturally appropriate, useful, and life enhancing for elder refugees. [93]

> ! The goal in providing services to elder refugees is to enhance the elder's dignity as a survivor.

Due to familial financial constraints, many elder refugees feel burdensome to their families and often seek to contribute by providing childcare, seeking employment, and helping around the home. While these may seem like normal functions of the elderly in American society, this is often a great shift from the expectation of a relaxing retirement of ease in their country of origin. When elders are confined to the home, whether from childcare obligations, inability to navigate public transportation, or general isolation, they are unable to achieve normal accomplishments such as learning English, making community connections and finding ways to integrate into their new communities. It is important to assess for barriers in accessing services for elders and to address those barriers in respectful, culturally sensitive manners.[94]

Some ways to reinforce elders' roles in society are to actively solicit the elder's opinion on what services are needed and what barriers exist, promote intergenerational activities within the family and the community, and encourage the family to continue to emphasize the value of elders' cultural contributions.[95] It can also help to encourage and promote support and recreational activity groups for elders led by elderly community leaders.

## Families

Working with families requires a great degree of skill in attending to the various needs of all family members, regardless of English ability, age, and visibility in the family dynamic. For this reason, it is important to try to speak with each family member individually to gain an accurate and adequate understanding of his or her understanding of individual and family needs. It can be helpful to explore the expectations set within the family; what roles each family member fulfills, and how the case worker's role fits into those expectations. [CC box][96]

> CC Ask the family about common family traditions in their home country and how they can incorporate those traditions into their lives here.

The stress of migration and resettlement can lead to a breakdown of family roles and norms. Often, the mental health

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[92] Altinkaya, & Omundsen, 1999 (see *References* section, p. 82)
[93] Chenoweth, supra note 23
[94] Chenoweth, supra note 23
[95] Chenoweth, supra note 23
[96] Sveaass, & Reichelt, 2001 (see *References* section, p. 82)

symptoms of parents and/or caretakers can greatly affect their ability to adequately care for their children which is why it is important to assess the family individually and as a unit.[97]

Family consequences of refugee/migrant trauma span across four main realms of family life: family roles and obligations, family memories and communications, family relationships with other family members, and family connections with their ethnic community and nation state. The table below summarizes some of the positive and negative manifestations of these consequences of trauma. [98]

| Roles and Obligations | Memories and Communications | Relationships with Other Family Members | Connections with Ethnic Community and Nation State |
|---|---|---|---|
| • Dependence on children<br>• Less family time<br>• Challenges to patriarchalism<br>• Children are hope<br>• Increase in flexibility, tolerance, and trust<br>• Increase in family togetherness<br>• Grandparents parenting | • Memories are painful<br>• Adults want to forget<br>• Children don't talk about the past<br>• Fear of being burdersome<br>• Improvement in talking with children<br>• Increase in expressing emotions<br>• Trust built through sharing | • Family in home country<br>• Family scattered in Diaspora<br>• Caring for vulnerable family members<br>• Single mothers<br>• Plan to return/reunify<br>• Sending money home<br>• Maintaining large family despite geographic distance | • Losing touch with the way of life<br>• Children changing languages<br>• Children becoming 'Americanized'<br>• Teaching children history of culture/home country<br>• Teaching children native lanugage<br>• Religion<br>• Strengthening identity |

*Figure 10. Family Consequences of Trauma[99]*

[97] Fazel, supra note 79
[98] Weine, et al., 2004 (see *References* section, p. 82)
[99] Weine, supra note 98

## Section 5.3 |Identifying Mental Health Needs

Despite the likelihood of refugees and immigrant populations having undergone significant stress and trauma, as well as being at a higher risk of developing certain mental health conditions, newly arrived refugees rarely undergo early mental health and wellness screenings.[100] Due to the absence of a mandated mental health screening method, refugees typically do not receive interventions and/or services for emotional distress early on in the resettlement process and are therefore treated later in their resettlement process, when experiencing a crisis. IRC recommends universal, systematic mental health screening for all clients; however, when that is not possible, there are certain signs and symptoms that caseworkers should look for that may indicate mental health needs. These symptoms may include:[101]

- *Physical symptoms* – aches and sleep disturbance
- Emotional *symptoms* – feeling sad, scared, or anxious
- *Cognitive symptoms* – difficulty thinking clearly, abnormal beliefs, memory disturbance
- *Behavioral symptoms* – behaving in an aggressive manner, inability to perform routine daily functions, excessive use of substances
- *Perceptual symptoms* – seeing or hearing things that others cannot

As mentioned in Section 3.1, the full criteria for Major Depressive Disorder, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD) can be found in Appendix 1 and may be useful in identifying symptoms that may warrant further mental health assessments.

### Assessing for Mental Health Needs in Adults (ages 14 and up)

Existing mental health screening tools are often too difficult to be administered within health care settings (due to time intensity, language needs or lack of resources), and most have not been designed with refugees in mind; however, the Refugee Health Screener-15 (RHS-15) is a validated mental health and wellness screening tool designed and tested specifically for refugees.  The RHS-15 was developed by *Pathways to Wellness*, a program of Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Dr. Michael Hollifield, to bridge a gap in screening tools designed for the refugee populations. Using three common assessment and screening tools and a rigorous assessment of the classification abilities of the tools' measures, *Pathways to Wellness* developed a 15 item questionnaire that is easy to use and can indicate anxiety, depression and/or PTSD in refugees. [102]

The RHS-15 can be administered by anyone working with refugees and can be used to assess the mental health needs of clients aged 14 years old and older. It was created to efficiently (with only 15 questions) and effectively determine emotional distress among refugees. The RHS-15's purpose is not as a diagnostic tool and it therefore cannot diagnose individuals with a mental health condition. Instead, it identifies an individual's level of emotional distress and suggests when the distress warrants a referral to mental

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[100] Refugee Health Technical Assistance Center, 2015 (see *References* section, p. 82)
[101] HealthNet TPO, supra note 43
[102] Pathways to Wellness, 2011 (see *References* section, p. 82)

health services for further evaluation and treatment[103]. The RHS-15, along with a guide to completing the screening can be found in Appendix 2.

IRC recommends the RHS-15 be delivered by individuals who are comfortable talking about emotional distress due to the likelihood of clients asking questions either during or following the screening. Additionally, IRC recommends for USP offices to identify a protocol for conducting the screening in order to standardize the practice in the office. IRC HQ is available to support training for utilization of this tool in offices.

## Assessing for Mental Health Needs in Children

While the RHS-15 is an excellent tool for assessing mental health needs in adults and youth aged 14 years old and older, it is not suitable for use with children under the age of 14. As referenced in Section 3.2, (a), children express stress and trauma in different ways depending on their age and developmental stage. An important step in understanding and recognizing mental health needs in children includes recognizing anomalies in child behavior and following-up with the use of an assessment tool. Here are some tips to help identify mental health needs for children:

- Observe the child as he or she plays; does the child have normal interactions with others?
- Does the child behave like other children his or her age?
- Speak with the adults in the child's life; are they concerned about the child's behavior?
- Speak with the child's school; are they concerned about anything?
- Speak with the child; can he or she engage in an age appropriate manner with you?[104]

When there are indications that a child may have mental health needs, the IRC recommends using the Strengths and Difficulties Questionnaire (SDQ).[105] The SDQ was developed as an easy-to-use tool that can be used by anyone working with children; however, it is recommended that the individual administering the questionnaire works closely with a supervisor, a peer who has worked clinically with children, or HQ support, such as the Mental Health Technical Advisor. It assess children aged 2-4, 4-10, and 11-17 years old in five areas:

1. Emotional symptoms
2. Conduct Problems
3. Hyperactivity/inattention
4. Peer relationship problems
5. Prosocial behavior

For the age groups of 2-4 years old and 4-10 years old, the questionnaire is only administered to parents and teachers/educators; however, there is an additional questionnaire administered to youth aged 11-17 years old.[106]

*A frequently fielded question at HQ regarding the RHS-15 (and other screening tools for mental health) is: Why would someone screen a client if there are no referrals available in the community to support the mental health needs of the client?*

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[103] Pathways to Wellness, supra note 102
[104] UNHCR, WHO, supra note 9
[105] SDQ (see *References* section, p. 82)
[106] SDQ, supra note 105

*Answer: IRC is already working with clients in emotional distress and has opportunities to find non-clinical support for clients.* While this doesn't address the larger concern of appropriate clinical options for clients with mental disorders, IRC needs to start somewhere in addressing the generalized emotional distress of clients – which may simply be a referral to a New Roots Community garden, an invitation to join a support group in the office, or additional support in finding employment or building skills for the job market.

## Section 5.4 | Case in Point: Assessing for Mental Health Needs

### Cesarine

After recognizing that Cesarine has been unsuccessfully managing some signs of mental health problems, the case manager administers the RHS-15. The case manager first meets with the interpreter to debrief her on the purpose of the meeting and then carefully describes to Cesarine that they will be completing a form asking Cesarine questions about how she has been feeling over the past 30 days. The case manager explains that this form will help them understand how Cesarine is feeling so they can find services to help her feel better. The case manager reminds Cesarine to ask for help or clarification if she is confused about any of the questions. Once the screening is conducted, the case manager quickly tabulates the score, which was over 12, the threshold for being 'positive'. The case manager then takes her time in explaining and normalizing Cesarine's symptoms by reviewing her answers to the screener and providing psychoeducation regarding the mind-body connection. The case manager and Cesarine then begin to discuss possible services and referrals.

### Tsegaye

From the onset of psychological services, it is apparent that Tsegaye has severe symptoms that he was able to successfully hide from his service providers. Tsegaye explains to the therapist that he is unable to sleep, often getting only 3 to 4 hours of sleep each night and that he feels hopeless and that life is just one hardship after another. After gaining a level of comfort in the therapeutic relationship, Tsegaye reveals a long history of trauma, spanning nearly his entire life. After fleeing violence in which his father was killed in Eritrea, Tsegaye and his mother were separated from his siblings, leaving young Tsegaye responsible for protecting his alcoholic, and verbally and emotionally abusive mother on his own. Tsegaye was further persecuted in the camp by another camp member; he endured years of physical and sexual abuse with no one to turn to for protection. The camp in which he lived was plagued with frequent ethnic massacres and near constant famine, violence, and extortion.

### Pema

Pema's case manager arranges a meeting at Pema's school with her father, the school social worker and Pema's teacher. The case manager's office has created a lasting, productive relationship with the local school districts, which has led to Pema's school being proactive in inviting parents and case managers in to discuss refugee children's problems before using disciplinary action. Together, the group decides to initiate the process for an IEP evaluation to ensure that Pema was placed in the correct grade level. She is one of the younger students in her class which, combined with her semi-formal education in the refugee camp, may put her at an educational and developmental disadvantage. The school social worker also agrees to add Pema and her family to the home visit case load, to establish biweekly visits with the family in their home with an interpreter. Pema seems happy with the extra attention and states that she is happy to meet with the school social worker. Pema's father is grateful for the added assistance and states that he hopes to be home more often once the family is able to collect SSD for his wife.

# Chapter 6

## Connecting Clients to Resources

*Learning Objectives*

1- *Describe common referral sources*
2- *Identify and address barriers in referring clients for services*
3- *Build an effective referral network*

## Section 6.1 |Referring Refugees

In completing the RHS-15 or through interactions with clients one may recognize the need for further mental health services. As referenced in other sections, different clients will express mental health needs in different ways. Situations in which clients are experiencing symptoms and have high scores on the RHS-15 or the SDQ merit a conversation in which mental health referrals can be explored.

> ! Normalize what the client is feeling- "It is a normal reaction to an abnormal experience."

The ways in which mental health symptoms and services are discussed with clients can serve to encourage or discourage them to follow-through on the referrals they receive. Here are some steps and tips to follow when talking with clients[107]:

1) Identify what can be seen.
   Instead of saying 'depressed' or 'anxious,' use descriptive words such as sleep, sadness, and worry.
2) Explain what services are available.
   Explain what mental health means in the U.S. (In the United States, mental health covers a whole range of problems and emotions from not sleeping at night, to crying, and feeling scared for no reason — all the way to hearing voices.) Explore what health looks like for the client. Connect the service to a concrete benefit, such as sleeping better.
3) Explain referral procedures.
   Explain how to receive services, what different services look like, and how the service providers work.

> CC Check in with the interpreter to see how different word choices translate literally and culturally.

4) Match the client with service providers.
   Evaluate the client's needs: provider gender, language, transportation, etc.
5) Obtain the client's consent.
   Have the client fill out the client consent form. Explain that only the client can give permission for anyone to know that they are receiving mental health services.
6) Provide clear instructions.
   Ensure the client knows how to physically find the service provider, what to do upon entering the building, and how the appointment will go.
7) Ensure expectations are realistic.
   Explain the limits of services and assistance to the client.
8) Follow-up with referrals.
   Talk to the client about his or her experiences receiving services; what worked; what didn't work?

### Common Referrals

As explained earlier in Chapter 2, IRC approaches mental health services from the perspective that they can be divided into two categories: clinical and non-clinical. Neither category is considered better than the other in terms of efficacy, cultural understanding, or quality of services. Making a referral to clinical or non-clinical services is wholly dependent upon the conversation with the client and the client's preferences for how to go about achieving mental health and wellness.

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[107] NSW Refugee Health Services, supra note 65

Common sources of non-clinical referrals are community based organizations (CBO's), cultural organizations, religious institutions and services in the IRC office. Many times, clients can find substantial benefits from engaging in non-clinical services.

In referring clients for clinical mental health services, it is important to ensure that the provider is not only competent, but that the provider can offer the services the client needs. Below is a table listing some of the more common clinical referrals.

| Practitioner Title | Services | Prescribe medication? |
|---|---|---|
| Primary Care Physician (PCP) | General/internal/family medicine; Medical evaluations Monitor psychiatric medications for stable outpatients | Yes |
| Psychiatrist | Medical & psychiatric evaluations; Treat psychiatric disorders (mental disorders); Psychotherapy; Prescribe & monitor medications | Yes |
| Psychologist | Psychological testing & evaluations; Treat emotional/behavioral problems & mental conditions Psychotherapy | No |
| Psychiatric/Mental Health Nurse Practitioner | Sometimes work under psychiatrists; Assess/diagnose/provide medicine and therapy for psychiatric disorders & substance abuse | Yes |
| Clinical Social Worker | Assess/treat psychiatric illnesses; individual, family and/or group psychotherapy; Case management; Hospital discharge planning; | No |
| Licensed psychotherapist (including art, dance/movement, music) | Assess/treat psychiatric illnesses, individual, family and/or group psychotherapy; case management; hospital discharge planning | No |
| Licensed Clinical Professional Counselor | Assess & diagnoses mental health conditions; Individual, family and/or group psychotherapy | No |
| Occupational Therapist | Skills for daily living and working; Facilitate adjustment groups | No |

*Table 8. Common Practitioners*

## Affirming Client Choice

Throughout the referral process it is important to affirm a client's choice to receive services or decline them. Clients may feel powerless by their current and past situations; therefore, it is important to remember the importance of allowing clients to make decisions for themselves. Whenever possible, provide multiple options for referrals and seek clients' opinions on such important topics as the setting in which they receive services (hospital vs. community clinic), the gender of the service provider, hours to visit the service provider, and language services.
In providing referrals for clients, there are some common barriers that one will usually encounter. Below is a table with common barriers and ways to address them.

| Barrier | Ways to overcome the barrier |
|---|---|
| Language | Secure interpretation services, find trusted interpreter in community/client's support system |
| Culturally competent services | Obtain consent, speak with service provider, build capacity of provider through training |
| Payment | Find free clinics, assist client in applying for health insurance |
| Transportation | Map out route with client, find community resources |
| Limited capacity | Prioritize needs, encourage client to take control of manageable services |
| Stigma | Discuss cultural stigmas with client, use simple vocabulary |
| Lack of client follow-up | Discuss need for services with client, explore barriers |

*Table 7. Barriers to Services*

## Clients Who Decline Services

Occasionally clients will decline referrals for further services. While this can be a frustrating experience, it is important to approach this from a nonjudgmental, open stance.

! Remember that clients are very resourceful and may already be connected to formal or informal networks of services. Acknowledge their connections and resources and ask if there is anything else they would like help with.

Gently explore with the clients their reasons for declining the services. Perhaps they are afraid of the consequences of accepting a referral or perhaps they do not fully understand what the service would entail. Approach clients in a non-judgmental way:

*"I appreciate that you want to handle this on your own but I'm wondering if there's something that makes you hesitant to receive services."*

Ultimately, it is the case manager's responsibility to give the client the opportunity to make decisions about his or her services. Refrain from pressuring clients to receive services. It is always possible to try revisiting service referrals again at another time if the client's symptoms continue or worsen. It's also a good idea to offer to the client that if they ever change their mind, they are more than welcome to request services – it is not a onetime offer.

CC Make sure the client is comfortable speaking with the case manager and/or the interpreter about mental health referrals, ask if they would be more comfortable discussing it someone else in the office or with their primary care provider.

Here are a few tips for bringing up mental health referrals with a client who has declined services in the past:

- *Reference past discussions with the client and make it clear why it's being brought up again – "I know that we have talked about this in the past and you said you were okay, but I am worried about you and wanted to see if you had changed your mind."*
- *Connect it to concrete benefits/something that they value (again).*
- *Politely ask again what their reason is for declining the referral.*
- *If possible, see if they just want to meet with the mental health provider informally to see if the services would be a good fit.*

## Section 6.2 |Building a Referral Network

Often times, the most difficult part in referring clients for services is finding an appropriate organization to which one can refer them. Many organizations will offer the services clients need, but won't have language capabilities; or there will be appropriate services but they are too expensive for the client. At times, clients may live in such remote areas, it seems as though it is impossible find them the services they need in their surrounding community. When running into issues like this, having an office or program-wide list of common referral organizations is extremely useful.

When building a referral network, it is important to utilize pre-existing resources. Perhaps there is already has a list of organizations that have linguistically appropriate services or free or low cost services in the office; use this list as a starting point upon which to build a network of service referrals for clients. Before sending clients to new service providers, it is important to call the service provider to ensure they are capable of working with the client in need.

CC Assess referral organizations for cultural awareness. If they seem lacking, consult with a supervisor and offer to provide a training to the organization.

! Don't forget to incorporate the clients' identified strengths and coping mechanisms into their referrals. For instance, if a client was able to find comfort in singing with friends and family in her home country and also finds strength in her Christian faith, explore referrals to church choirs with the client.

Many times, when creating referral networks, it is important to coordinate closely with the partner organization; this not only helps the client receive the best services possible, but it also strengthens the inter-organizational relationship. When offices achieve strong community based networks of services, everyone benefits: services are better coordinated to reduce duplication while improving quality, and the community's capacity for problem solving is increased by the strong network communication and involvement.[108]

Referral networks can be as simple as a typed list of service providers and as technical as an organizational Google maps page with icons and pins for each organization. Staff should use their office's capacity, resources, and expertise to develop a referral network.

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[108] Graddy, & Chen, 2006 (see *References* section, p. 82)

## Section 6.3 | Case in Point: Referring Refugees

### Cesarine

Cesarine and the case manager discuss potential referrals, including a connections to a doula, an IRC women's group, a local church, a family mentor and a referral to a local behavioral health agency, which is described as an organization with special doctors who can help Cesarine manage her difficulties sleeping and her worries and sadness. Cesarine agrees to follow-up on the various connections made at IRC and to attend an intake/assessment at the behavioral health agency accompanied by an IRC intern.

Once at the appointment, Cesarine is quiet and has a difficult time answering simple questions during the assessment. After a seemingly non-threatening question posed by the therapist regarding Cesarine's sleeping habits, Cesarine stops talking and interacting with anyone in the room, staring straight ahead. The intern accompanying Cesarine on the appointment calls Cesarine's case manager, who is able to come to the agency. Cesarine appears to be dissociating and in an effort to bring her back to the present moment, the case manager, therapist and intern work together to use grounding exercises such as placing both feet firmly on the ground and both hands on your knees, deep breathing, drinking water, and using hand sanitizer. Cesarine comes out of the dissociation for moments, but then slips back into her distant stare. At one point, Cesarine stands up and simply walks out of the agency without saying a word.

### Tsegaye

After understanding the severity of Tsegaye's symptoms, the therapist works in partnership with the case manager to refer Tsegaye for a psychiatric evaluation at a partner office to assess for the potential of medication to aid in managing Tsegaye's recurring, intrusive thoughts, inability to sleep, depressed affect, and other symptoms of both PTSD and Depression. In working to identify referrals to help Tsegaye cope with stressors and find joy in life, the case manager and therapist ask Tsegaye to identify three things he likes most about himself. Tsegaye replies that he is a good deacon, a good soccer player, and is nice to other people. Using this information as well as other information gained in conversations with Tsegaye and his team of service providers at IRC, the case manager and therapist connect Tsegaye to a local church where he can serve as a deacon as well as a local soccer league in an effort to help him create connections with other, to find a sense of belonging and to find meaning in life. Tsegaye begins to sporadically attend church services, and continues to attend regular counseling sessions and case management meetings at IRC.

### Pema

After meeting with the school, Pema's father and the case manager meet in the office to discuss further services. The case manager provides the family with referrals to the youth programs offered at IRC as well as outside youth groups to help Pema socialize and make friends. After discussing family dynamics with Pema's father, the case manager also provides the family with a referral for family counseling services as it seems that there has been much tension in the home lately, mostly between Tenzin and his father. The father quietly explains that Tenzin has been acting more and more like his mother. Knowing the importance of family history and mental illness, the case

manager gently asks the father to provide more information about Tenzin's behavior. The father explains that Tenzin was fired from his job for thinking the whole company was against him and wished bad things upon him. It was further explained that Tenzin hasn't been sleeping much and speaks very quickly and says confusing things. The case worker provides the father with a referral for a local clinic that provides psychiatric assessments and treatment. The father happily agrees to go to the intake appointment with Tenzin.

# Chapter 7
# Supportive Interventions

*Learning Objectives*

1- *Describe the therapeutic role of case management*
2- *List the components of professional clinical services*
3- *Explain the utility and foundations of group work*

## Section 7.1 |Casework Counseling

In addition to providing clients with referrals to services, there are other ways to support clients in their journey to adjustment and security. Examples of these non-clinical and clinical interventions include casework counseling, individual counseling, and group work.

Case management is one of the many <u>non</u>-clinical ways in which IRC supports and works with clients. A component of case management is casework counseling or clinical case management. These terms are somewhat of a misnomer in the context of IRC services since they do not indicate professional therapeutic or clinical services, but instead emphasize the healing nature of the relationship created between the case manager and the client.

**Clinical case management** is defined as a component of mental health practice, conducted in coordination with traditional psychotherapeutic and psychiatric services, which addresses the maintenance of an individual's physical and social environment with the goal of facilitating wellness, personal growth, community participation and recovery from or adaptation to mental health struggles.[109] The five core functions of clinical case management are outlined below.[110]

1. <u>Promote engagement & involvement</u>: promoting the client's involvement in his or her treatment plan by creating a working alliance with the client and setting clear boundaries.
2. <u>Primary client contact within agency</u>: maintaining regular communication with the client and ensuring s/he is engaged with the agency.
3. <u>Brokering of services</u>: coordination of services such as benefits in addition to promoting follow-through on referrals.
4. <u>Advocacy and liaison</u>: supporting and assisting clients in navigating systems in addition to safeguarding their rights.
5. <u>Psychotherapeutic support</u>: assessment, treatment planning, monitoring, crisis response, and teaching skills to promote independence.
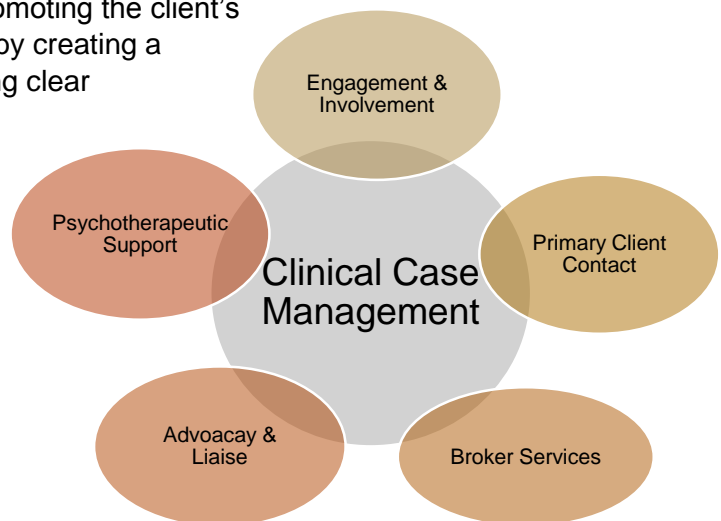


*Figure 11. Functions of Clinical Case Management*

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[109] Kanter, 1989 (see *References* section, p. 82)
[110] Mueser, & Jeste, 2011 (see *References* section, p. 82)

## Section 7.2 |Counseling by a Licensed Professional

Clinical counseling falls under the larger umbrella of clinical services that are offered in various IRC offices across the United States. Counseling, or psychotherapy, requires a certain level of education, training, and expertise and can only be conducted by a licensed clinician. Psychotherapy, which is used in individual, group and family contexts, is defined as "the treatment of mental disorder by psychological rather than medical means."[111]

In the context of IRC's work with immigrants, psychotherapy is seen as a compliment to other non-clinical services in situations of elevated need. For example, many clients will not need or want counseling services and will be able to adjust and heal through non-clinical services; however, there are also many clients who suffer from symptoms that interfere with their daily functioning to such an extent that they require specialized, individualized clinical services.

Psychotherapy, individual therapy, group therapy and family therapy can be conducted by licensed clinical professionals, including, but not limited to: psychologists, licensed clinical social workers, psychiatrists, licensed mental health counselors, licensed psychotherapists, licensed creative arts psychotherapists, and licensed marriage and family therapists. Each state has different licensing requirements that outline the clinical abilities of each clinician. Therapy with a licensed clinician includes assessment, diagnosis, treatment plans and ongoing counseling, in addition to the writing of regular and detailed case notes, regular supervision, and regular clinical case conferencing to evaluate the appropriateness and efficacy of the treatment plan.

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[111] Psychotherapy (see *References* section, p. 82)

## Section 7.3 | Group Work

Group work falls under both categories of clinical and non-clinical services depending on the focus of the group. As mentioned in Section 7.2, groups are considered clinical when facilitated by a licensed, trained professional for the purpose of clinical treatment. Most of the groups that are conducted in USP offices, however, are non-clinical in nature and seek to provide information, support, and connection. These groups can be facilitated by anyone in an office, including volunteers and interns (under proper supervision, of course). Group and community interventions have been proven to be widely successful in refugee and immigrant communities for various reasons, including the communal characteristic of many non-Western cultures, the need for connection and support in traumatized refugee groups, and the sheer ability to reach more clients in groups than individually.[112] Groups can be fantastic platforms for change, providing a space for social learning, fostering of mutual support and mutual problem solving, allowing members to try new roles, and providing the opportunity for the development of resources and abilities.[113]

When facilitating a group, the facilitator's role is to communicate intentionally, listen empathically, and accommodate different thinking and operating styles.[114] Some skills that are important to utilize when facilitating groups are:

- Expect the unexpected
- Improvise
- Be present
- Create and sustain a participatory environment
- Demonstrate respect for group members

- Be yourself
- Utilize "I" statements
- Work with conflict
- Acknowledge and affirm
- Have a sense of humor

There are five distinct stages of group development as outlined by Bruce Tuckman (1965).[115] While the stages are presented in a numerical, sequential manner, the process does not have to be sequential as groups will move through the stages at different times in the life of the group. The stages are as follows:

1. Forming (group bonding): This stage is one of individual exploration in which group members begin to practice their roles. The facilitator's role is to ensure group members feel welcome, to establish outcomes with the group members, and to be aware of the cohesion of the group.

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[112] Murray, Davidson, & Schweitzer, 2010 (see *References* section, p. 82)
[113] Murray, supra note 112
[114] Bostrom, Anson, & Clawson, 1993 (see *References* section, p. 82)
[115] Tuckman, 1965 (see *References* section, p. 82)

2. <u>Storming (group conflict and fragmentation)</u>: This stage is characterized by individuals within the group working to establish their identities, which can occasionally lead to conflict. The facilitator's role is to remind the group members of the purpose of the group and to redirect the group as needed to reinforce cohesion.
3. <u>Norming (group maintenance)</u>: This stage is a period of negotiation in which the group is working out the norms; it is usually characterized by stability and positive interactions. The facilitator's role is to help the group recognize the purpose of the group and to affirm each member's place in the group.
4. <u>Performing (group working well)</u>: During this stage, the group will be occupied with carrying out the primary purpose of the group. Group members will most likely be working well together with a higher degree of cohesion and trust. The facilitator's role is to be open to your shifting role as group members take on leadership roles. The facilitator will also need to attend to the potential for group dynamics to shift away from the focus of the group.

*Figure 12. Group Stages*

5. <u>Adjourning (group disbanding)</u>: This stage can be a period of sadness and mourning for some group members as the group ends or a period of celebration and recognition of the life of the group. The facilitator's role is to remind the group members of the progress made and to model the process of beginning and ending in a healthy manner.
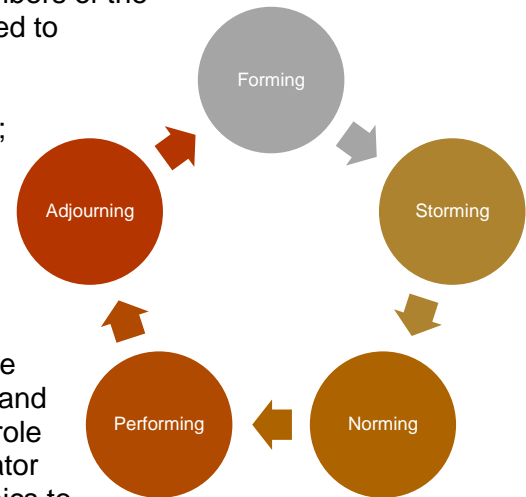
## Pathways to Wellness Community Adjustment Support Group Curriculum

IRC recommends the use of the Pathways to Wellness Community Adjustment Support Group Curriculum, an 8 week curriculum that falls in the category of non-clinical services. The group can be facilitated by anyone under proper supervision. The curriculum focuses on issues related to emotional distress and emotional well-being by discussing such categories as culture shock, refugee experiences, mental health, the mind body connection, client goals and dreams, and creating wellness individually and as a community. Please reach out to the Mental Health TA for further information regarding the curriculum and starting the Community Adjustment Support Group. [116]

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[116] Pathways to Wellness, 2013 (see *References* section, p. 82)

# Chapter 8

## Crisis Response

*Learning Objectives*

1- *Explore the limits of confidentiality*
2- *Implement safety plans*
3- *Respond to disclosures of violence*

## Section 8.1 |Understanding Confidentiality

Confidentiality, in the context of social services, is the pledge made to clients to keep all information discussed between the client and service provider private and to not disclose that information to anyone outside of the client-service provider dyad unless explicit permission is given by the client. Maintaining confidentiality is of utmost importance when working with clients, especially vulnerable clients as it directly impacts trust and the ability of many clients to share their struggles and stressors.

! Maintaining confidentiality extends to not excessively talking about more troubling or needy clients with colleagues. In contexts in which more intensive cases need to be discussed, the best place to do so is during supervision.

While maintaining confidentiality should always be a focus of caseworkers, there are situations in which it is necessary to break confidentiality. The USP Client Confidentiality Policy states, "While maintaining confidentiality is a key principle of service provision, in certain situations, caseworkers may be mandated by law to report information revealed to them during interactions with clients. These situations would include a client expressing the intention of hurting her/himself or others or if the welfare of a minor is at risk."

### Risk of Harm to Self/Others

Refugees face an abnormal amount of stress which can, at times, lead to destructive behaviors, including violence against others or self-harm, including suicide. Disorders commonly associated with suicide in the United States include mood disorders, such as depression; however, this common association does not always hold true in immigrant communities. For example, disorders commonly associated with suicide in Asia include impulse control disorders. [117]

CC Talk with clients or a community liaison about self-harming behaviors and what the 'warning signs' are in their culture and community.

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[117] Kohrt, Maharjan, Timsina, & Griffith, 2012 (see *References* section, p. 82)

When a client expresses that he or she has thoughts of suicide, it is imperative to conduct a thorough assessment of the client's intent to harm him or herself or reach out to a supervisor immediately for support in conducting an assessment. When faced with a situation in which a client wants to commit suicide, one must follow the office's protocol for suicidality, contact a supervisor, and also keep in mind the following steps for suicidality assessment (See Suicidal Ideation Questionnaire, Appendix 5):



*Figure 13. Assessing for Suicide*

1. <u>Assess the client's desire to die</u>: Does the client express thoughts or sentiments about not wanting to be alive, or a wish to go away or fall asleep and not wake up?
2. <u>Assess the client's thoughts of suicide</u>: Does the client have a general, non-specific thought of wanting to end his or her own life?
3. <u>Assess the client's method and intent for suicide</u>: Does the client have active suicidal thoughts and at least one known method of committing suicide?
4. <u>Assess the client's plan for suicide</u>: Does the client have a detailed plan partially or fully worked out and does the client indicate that s/he has some intent to carry it out?
5. <u>Assess past suicidal behaviors</u>: Has the client attempted suicide in the past?
6. <u>Assess protective factors</u>: Does the client have internal protective factors (coping mechanisms, religious beliefs, resilience, hope)? Does the client have external protective factors (responsibility to children/family, community, social supports)?
7. <u>Contract/Safety Plan</u>: Create a safety plan with the client to ensure safety for future instances of suicidal ideation. See Section 8.2 for further information about safety planning.

While these steps are quite extensive, it is imperative for someone to immediately address the client in this situation. If a client is actively suicidal, staff should accompany them to the nearest emergency room or call 911. If a client expresses intent to harm someone else, staff should follow their office's protocol for reporting the individual and/or safety planning with the community.

## <u>Mandated Reporting</u>

Another reason for which one would break confidentiality is if a child or an elderly person's welfare is at risk. If a staff member learns that a child or elder is being abused or neglected, s/he must respond according to her/his office protocols and state laws. Child and elder abuse and neglect are defined at both federal and state levels.

The federal definition of **child abuse and neglect** is:

> "Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm."[118]

IRC has developed a compendium of the child abuse mandated reporting state laws for each of the states in which it operates. This can be found on RescueNet and in Appendix 6.

In some states, a child witnessing domestic violence between caretakers or others in the home is considered a form of neglect and requires a mandated report. Check with each office's local policies to ensure an understanding of what mandated reporting requirements IRC staff are subject to.

> **CC** When working with families involved with child welfare systems, it is important to act as the cultural liaison and advocate for the family as many child welfare systems are not aware of cultural differences and customs.

The federal definition of **elder abuse and neglect** is:

> "Any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult." [119]

Staff should refer to their office's policies and their state's mandates for guidance on reporting instances of elder abuse.

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[118] Child Welfare Information Gateway, 2014 (see *References* section, p. 82)
[119] Administration on Aging (see *References* section, p. 82)

## Section 8.2 |Safety Planning

When working with a client who is going through a crisis or is in an unsafe situation, it is best to complete a safety plan with that client to ensure that they are planning for their own safety and that of those around them. A **safety plan** is defined as a written compilation of coping strategies and sources of support that clients can use during or preceding a crisis situation.[120] Safety plans can be used in many different situations. Some examples of times when a safety plan would be appropriate include situations of intimate partner violence (expanded upon in Section 8.2 (b)), situations in which a client expresses thoughts of suicide, situations in which a client identifies difficulty in one particular area of life that is causing emotional distress, and situations in which a client lives in a dangerous neighborhood.

The process for developing a safety plan involves problem solving and critical thinking skills; it is a guided conversation that results in a written plan for avoiding and responding to unsafe situations. All safety plans should be realistic, easy for the client to remember, and tailored to that client's unique situation and resources.
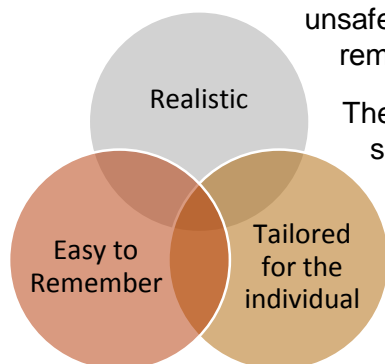
The main components of any safety plan include recognizing the warning signs or triggers of an unsafe event, identifying and utilizing established coping strategies, seeking the help and support of others, including being in a public place or reaching out to friends and family, and finally seeking professional help, whether that means calling the police, a mental health practitioner, or 911.[121]

Realistic

Easy to Remember

Tailored for the individual

*Figure 14. The Safety Plan*

Safety plans are an extremely useful tool to use in working with clients and can be implemented in the most severe and most benign of circumstances. Do not underestimate the importance of having a plan in place for unexpected moments in a client's life. See Appendix 3 for a general safety plan worksheet.

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[120] Stanley, Brown, Karlin, Kemp, & VonBergen, 2008 (see *References* section, p. 82)
[121] Stanley, supra note 120

## Section 8.3 |Disclosures of Domestic and Sexual Violence

(Adapted from USP WPE Bridge to Safety Pilot Materials)

As relationships are built with clients, one may encounter a situation in which a client discloses experiences of violence. If this happens, it is important to respond with empathy and care, while at the same time prioritizing safety. While gender-based violence (GBV) can be perpetrated and experienced by both men and women, the frequency of violence perpetrated against females is much higher than that against males. At least one in three women has been beaten, coerced into sex, or otherwise abused in her lifetime.[122]

Women and girls are at-risk of violence across their lifespan – from childhood, to adolescence, to adulthood – and throughout the migration process – from country of origin, to fleeing, to refugee camps, to resettlement. Violence against women happens in all cultures and societies. The physical, psychological, and social impacts of violence against women can be devastating which is why it is important to pay particular attention to responding in an appropriate and supportive manner when a client discloses experiencing violence. Regardless of the gender of the individual disclosing experiences of violence, it is important to keep in mind the following tips to ensure services are appropriate and mindful:

> Don't assume**.** When working with refugees, consider a history of rape and abuse as possible, not universal. Do not assume all clients have a history of domestic or sexual violence.
>
> Follow the client's lead**.** Survivors have many conflicted emotions regarding talking about their experiences of violence. Allow the survivor to determine how much of her/his story s/he wants to tell. When discussing ways to get help, respect the survivor's decisions and do not make decisions on the client's behalf.
>
> Reaffirm confidentiality. Let the survivor know exceptions to the confidentiality policy so that s/he can decide what s/he wants to disclose. Reassure the survivor that information is kept confidential from other family members IRC may be working with.
>
> Recognize differences**.** Be sensitive to gender differences, and allow the client access to female and male caseworkers. Assess the client's gender preference in terms of interpreters when possible and as a default, use female interpreters.
>
> Listen without judgment**.** Survivors are not at fault or to blame for the violence they experience. Be aware of cultural norms that may influence survivors. Listening to and believing a survivor can be very powerful.
>
> Provide validation**.** Use affirming statements to express support for the survivor, such as:
>
>> *"What happened to you is not your fault."*
>>
>> *"It is okay to feel afraid."*
>>
>> *"You are not alone."*
>>
>> *"You do not deserve to be treated this way."*

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[122] General Assembly, 2006 (see *References* section, p. 82)

Provide information. Educate the survivor about available services and options for getting help, US laws, and dynamics of violence.

Respond to safety concerns. Help survivors develop a plan to increase their safety. If the client is in immediate danger, discuss the situation with a supervisor.

Address service needs. Survivors typically have safety, support, health, and/or legal service needs. Explore these four service needs and guide the survivor to make decisions. Be sensitive to the economic, social, and legal realities of the client and her/his family.

## Case Management Concerns around Disclosures

Caseworkers may encounter a situation in which they discover that they are working with both the survivor and the abuser in cases of domestic violence. This presents a conflict of interest because it is very difficult to remain neutral when both parties are confiding in the same person. In these situations, it's best for support around issues of violence to be split with the two involved individuals meeting with different case workers at IRC, or with either/both receiving external support. In order to do this, the caseworker will need to work with his or her supervision to request a new case management arrangement; while this may complicate service delivery, it is important for the safety and well-being of the clients and their family. An example of creating new arrangements is separating out direct assistance payments to be distributed to more than one adult in the family unit.

In these situations and any other situations of gender-based violence, it is important to create a safety plan with the affected client(s).

A GBV safety plan will result in a concrete list of activities the survivor will undertake in various circumstances to maximize her or his safety and that of his or her children. It's important to remember that safety plans look different for every survivor. As with a general safety plan, the process for developing a safety plan in instances of GBV involves problem solving and critical thinking skills; it is both a conversation and a document.

IRC has developed a GBV safety plan worksheet in conjunction with the Bridge to Safety project to aid staff in creating a safety plan with clients in violent situations. The GBV safety plan worksheet can be found in Appendix 4. For more information about responding to GBV disclosures and safety planning, please contact the Women's Protection and Empowerment Technical Advisor.

## Section 8.4 |Case in Point: Crisis Response

### Cesarine

The case manager and intern quickly decide to have the intern follow Cesarine while the case manager calls an ambulance for Cesarine. Both are very worried for Cesarine's health because it is a very hot day outside and Cesarine is nearly 8 months pregnant. The intern continues to follow Cesarine down the street as she walks on the sidewalk and eventually comes to rest on a shaded curb on the side of the road. The intern sits near Cesarine and attempts to talk to her; however, Cesarine still isn't responding. The ambulance comes and takes Cesarine to the hospital where she quickly comes out of her dissociative state and affirms that she is not suicidal. Cesarine stays in the hospital overnight and is allowed to return to her home the next day. A case conference is held the next day with Cesarine's brother who explains to the team that Cesarine had similar reactions after her first pregnancy but they stopped after she gave birth. He agrees to maintain careful watch over his sister when she was home and to call an ambulance if Cesarine begins to walk around in a dissociative state again. Cesarine's brother also agrees to call the case manager at the first sign of a dissociative reaction and to use grounding techniques taught to him by the team when needed. With the safety plan in place, Cesarine's brother returns home and case management activities resume as normal.

### Tsegaye

During a meeting with his IRC therapist, Tsegaye reveals that he no longer sees the point in struggling through life. Knowing that Tsegaye has a history of suicide attempts in the refugee camp, the therapist immediately begins to assess Tsegaye's suicidality. By asking Tsegaye about how he would kill himself, including such details as when and where he would take his own life, the therapist concludes that Tsegaye has a firm and plausible plan in place and carefully and calmly offers to accompany Tsegaye to the local Emergency Room to be admitted. Tsegaye agrees to go to the ER with the therapist and is admitted for treatment.

Tsegaye returns to IRC a few weeks after his hospitalization, and appears to be doing better. He explains to his IRC team that he is on a new medication that seems to be helping. Together with the team, Tsegaye creates a plan for future services and methods to enhance his coping mechanisms. Tsegaye agrees to reach out to his therapist if he is feeling suicidal, to attend regular counseling, to attend church services, and look into playing soccer on a regular basis.

### Pema

The case manager receives a voicemail from Pema's father over the weekend explaining that Tenzin tried to attack him and was arrested for assault. Tenzin is currently incarcerated and child welfare was called because the incident happened in the home with Pema and Jigme present. The case manager speaks with a supervisor to

plan for the conversation with Pema's father. The case manager then calls Pema's father back and gathers more information about the specifics of where Tenzin is incarcerated, the name of the child welfare worker, and the family's well-being. Everyone in the family is safe and is working together to manage the stressors of the weekend. With Pema's father's consent, the case manager agrees to provide advocacy for the family and proceeds to contact an IRC ally within the local judicial system. The case manager is able to advocate for Tenzin to be treated for his mental illness and for the public defender to work with Tenzin through an interpreter. The case manager is also able to advocate for Tenzin's hearing to be expedited with the aim of having the trial lead to psychiatric services for Tenzin as opposed to further incarceration. The case manager also reaches out to the child welfare worker to provide background information on the family and to advocate for culturally competent services, such as ensuring an interpreter is present for all child welfare meetings and visits. The case manager calls Pema's father back and relays the information to him, arranging for a day and time that they can go to the jail to visit Tenzin to ensure he is being well cared for.

# Chapter 9

## The Wellness of Helpers

*Learning Objectives*

1- ***Describe and recognize the effects of compassion fatigue***
2- ***Establish and maintain self-care routines***
3- ***Utilize supervision to support daily work***

## Section 9.1 | Defining Compassion Fatigue

Providing direct services can be extremely stressful, especially when working with refugee clients who have experienced significant trauma. Dealing with the day-to-day case management needs of clients, managing crisis situations, and working within time and resource constrained settings can leave one feeling depleted. However, by practicing self-care techniques personally and as an office, it is possible restore and sustain staff.

The most common issues to beware of as a direct provider working with refugees and people in general are burnout, vicarious trauma, and compassion fatigue, each of which are described further below.

- **Burnout** involves feeling fatigued, hopeless and overwhelmed by unsupportive work environments and excessive workloads. This builds over a long period of time and leads to dissatisfaction with the work. Burnout is not directly related to working with trauma survivors and can occur in any setting.[123]
- **Vicarious or secondary trauma,** also called **compassion fatigue**, refers to the feeling of preoccupation with the traumas that clients have shared. This leads to clinical symptoms similar to those of the clients and can make it very difficult to continue to work with trauma survivors.[124] Signs and symptoms include (compiled by NYU Graduate Art Therapy Program):
  - Loss of sense of humor; cynicism
  - Disconnection from colleagues, family, and friends
  - Poor self-care; personal needs ignored
  - Disconnection from self: dissociative processes; depersonalization
  - Memory impairment
  - Concentration difficulties
  - Feelings of helplessness and hopelessness
  - Intrusive thoughts and imagery: of clients' experience, as well as one's own past traumas
  - Somatic ailments
  - Heightened emotionality: irritability, rage, distress
  - Increased use of alcohol or drugs to self-medicate
  - Denied feelings of helplessness, such as:
    - Attempting super-human work
    - Inability to set limits in professional live
    - Taking unnecessary personal risks

Prevention of and coping with vicarious traumatization includes exploring reactions to clients with someone who is attentive and may offer empathic support, such as a supervisor or trusted colleague. One may also try to reconnect with the original reason for entering the profession.

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[123] Figley, 2002  (see *References* section, p. 82)
[124] Newell, & MacNeil, 2010 (see *References* section, p. 82)

## Section 9.2 |Defining Wellness and Self-Care

**Self-care** is the regular, mindful engagement in practices and activities that reduce personal levels of stress and maintain and restore balance in all aspects of one's life, professionally and personally. It is not just an emphasis on the actions taken, but also a state of mind in which one recognizes being stressed and makes changes accordingly.[125]

Promoting self-care is important for individuals <u>and</u> for organizations. On a personal level, not practicing good self-care can lead to physical, emotional, mental and spiritual harm. It can disrupt overall well-being, quality of life and personal relationships. Productivity and work also suffer. It may lead to one jumping unsatisfactorily from job to job. It's not possible to be effective in work with clients if the worker's needs are not taken care of first.

### Staff who are also from Refugee Communities

Many people in the social service field tend to come from the community or population which they are serving. They often have been through the same struggles and conflicts that the clients have been through and have received help from a professional, like the professional that they are now.

Despite good intentions and well-developed professional skills, working with clients who have similar backgrounds and life histories as oneself can present extra difficulties that may not have been anticipated. Bearing witness to clients' traumatic histories can lead to vicarious trauma in any individual, but for those who have experienced similar traumas, clients' histories can bring up emotions, fears, and preoccupations from the past. In working with clients with similar backgrounds as one's own background, one technique to help manage emotions is to use the '3 P's': Perceive- notice thoughts and behaviors that are associated with both positive and negative emotions, Process- recognize the intensity of feelings when experiencing the negative emotions, and Practice- work on controlling negative emotions and the thoughts and behaviors that are associated with them:

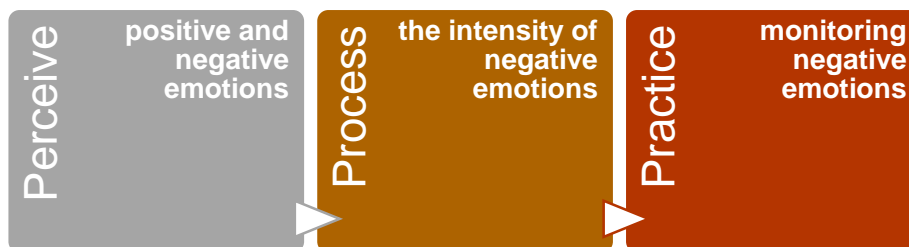| Perceive | positive and negative emotions | Process | the intensity of negative emotions | Practice | monitoring negative emotions |

*Figure 15. 3 P's of Emotional Awareness[126]*

If a staff member feels that her/his personal history and past may interfere with working with clients, it is important to work closely with a supervisor to manage reactions to the clients and the work.

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[125] University of Buffalo School of Social Work, 2015  (see *References* section, p. 82)
[126] Kelly, supra note 47

## Section 9.3 |Supportive Supervision

Supervision is an essential part of any social service model. All staff members have a supervisor to whom they report; that person should be part of a network of supporters available to provide supervision in a host of job-related tasks. In the following sections, there are brief outlines of two traditional models of supervision developed by Kadushin and Hawkins, which will help lay the foundational understanding of the purpose of supervision. Those sections will be followed by an exploration of Appreciative Supervision, which is the model upon which USP bases supervision.

### Basics of Supervision

Kadushin posited that there are three main functions of supervision. [127] The three main functions were originally written from a deficit focused perspective, but are rephrased here from a solution focused lens.

Supportive: Support for practical and psychological elements of the professional role.

Educational: Encourage reflection and exploration of the work and develop new insights, perceptions, and ways of working.

Administrative: The promotion and maintenance of good standards of work.

Hawkins then expanded upon Kadushin's three functions of supervision to include ten foci of supervision. [128] The ten foci are most often seen next to the corresponding Kadushin function of that supervisory focus, as seen below.

| Focus | Function |
|---|---|
| To provide a regular space for the supervisee to reflect upon the content and process of their work | Educational |
| To develop understanding and skills within the work | Educational |
| To receive information and another perspective concerning one's work | Educational/Supportive |
| To receive both content and process feedback | Educational/Supportive |
| To be validated and supported both as a person and as a worker | Supportive |
| To ensure that as a person and as a worker one is not left to carry, unnecessarily, difficulties, problems and projections alone | Supportive |
| To have space to explore and express personal distress, restimulation, transference or countertransference that may be brought up by the work | Supportive |
| To plan and utilize their personal and professional resources better | Administrative/Supportive |
| To be proactive rather than reactive | Administrative/Supportive |
| To ensure quality of work | Administrative |

*Table 9. Foci of Supervision[129]*

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[127] Kadushin, 1992 (see *References* section, p. 82)
[128] Hawkins, & Shohet, 1002 (see *References* section, p. 82)
[129] Hawkins, supra note 128

<u>Appreciative Supervision</u>[130]



*Figure 16. Shifts in Supervision*
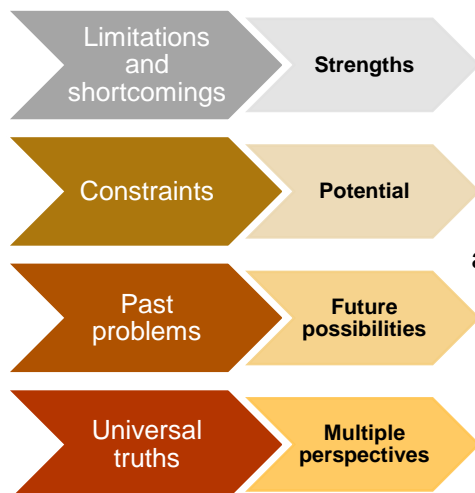
USP recommends using Cojocaru's model of 'appreciative supervision' for supervision of direct services staff. The appreciative supervision model was developed from the strengths-based, or appreciative inquiry model of case work. It involves using solution focused questions and approaches in creating and troubleshooting the client's service plan. By utilizing appreciative supervision, USP is able to maintain a strengths-based, solution-focused approach to working with clients by modeling that approach in supervision.

Appreciative supervision is comprised of four stages which are completed by the supervisor and supervisee working in conjunction. The four stages are as follows:

1. <u>The Knowledge Stage</u> (solution focused knowledge gaining)
   - What do you appreciate most about your client? About his/her family?
   - What successes has your client had since you've started working with him/her? How do you explain these successes?
   - What do you appreciate most in yourself as a case manager for the client's situation?
   - What is the most important thing you have contributed to changing your client's situation? The organization?
   - Which of the work procedures have been most useful to you?
   - Which of your qualities have you used in order to change your client's situation?

2. <u>The Vision Stage</u> (Supervisor and case manager build a joint vision)
   "Challenging Phrases"
   - The client knows his/her situation and resources, and copes well with the situation.
   - The client appreciates the support received form the organization.
   - The case manager is receptive to the client's successes and appreciates them.
   - The supervisor is open, available and interested in the work of the supervisee.
   - The client is the individual most interested in changing his/her own situation.

3. <u>The Programming Stage</u> (Establish specific plans to make the vision a reality)
   - What can we do to help the client know his/her resources and overcome it?
   - What can we do to help the client appreciate the support he/she gets from the organization?
   - What practices should we promote to help the case manager work with the client?
   - What the supervisor do to recognize the efforts, successes, and qualities of the supervisee?
   - What can the case manager do so that the client knows s/he appreciates the client?

4. <u>The Action Stage</u> (Apply the plan in a strengths focused manner)

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[130] Cojocaru, 2010 (see *References* section, p. 82)

- The case manager meets with the client bi-monthly and encourages the client to discover his/her own resources and successes.
- The case manager appreciates the client's experience and lets the client know when such a success is identified.
- The case manager helps the client build in his/her own environment a vision of what he/she desires for himself/herself and supports him/her in drafting an action plan etc.

## Section 9.4 | Case in Point: Celebrate the Small Stuff

### Cesarine

It is now 4 months later; Cesarine gave birth to a beautiful, healthy baby boy. She and her family moved to a more affordable apartment in a safe neighborhood. Cesarine's brother continues to be a great source of support for her and her children. Cesarine has begun participation in IRC's childcare co-op and is looking forward to starting her own childcare business to help cover her family's expenses. Cesarine's dissociations have ceased and she is attending regular counseling sessions at an IRC partner agency in addition to attending support groups at IRC. Cesarine's husband has still not been reunified with the family; while this continues to be difficult for Cesarine, she finds strength and support from her family and her mosque, where she is connected with the local community.

### Tsegaye

It is now 2 months later; Tsegaye is happily working at a church a few towns away in exchange for room and board. Tsegaye states that he finds peace and tranquility in the quiet of the church and support from the church community. Tsegaye's mother remains in her apartment where she continues to struggle with alcoholism but is receiving regular home services to ensure her needs are being met. Tsegaye continues to take medication to help manage his symptoms of depression and attends counseling on a less frequent, but regular basis. Tsegaye has begun playing soccer with youth in his new town and is now able to sleep for 6 to 7 hours most nights.

### Pema

It is now a few months after Tenzin's arrest and he is currently placed in a psychiatric care facility near his family's home. He receives regular visits from his parents and siblings and is doing much better. The family was approved for SSD and is now receiving that financial aid which allows Pema's father to spend more time with her and her siblings in the home. Pema was moved to a different class and is doing much better in school, acting out infrequently and making progress in her reading skills. Sonam continues to work and help out around the home and Jigme is happily learning his shapes and colors in both English and Nepali. Pema's mother continues to attend her day treatment program and is managing her symptoms well.

# References

Administration on Aging. (n.d.). What is Elder Abuse? Retrieved from http://www.aoa.gov/AoA_programs/elder_rights/EA_prevention/whatisEA.aspx)

Advocates for Children of New York. (2010). Students with interrupted formal education: A challenge for the New York City public schools.

Ainsworth, M. D. S., Bell, S. M., & Stayton, D. (1974). Infant-mother attachment and social development. In M. P. Richards (Ed.), The introduction of the child into a social world (pp. 99-135). London: Cambridge University Press.

Altinkaya, J., & Omundsen, H. (1999). "Birds in a Gilded Cage": Resettlement Prospects for Adult Refugees in New Zealand. *Social Policy Journal of New Zealand*, 31-42.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2010). *Ethical Principles of Psychology and Code of Conduct*. Retrieved from http://www.apa.org/ethics/code/principles.pdf

Arfken C. L., Arnetz B. B., Fakhouri M., Ventimiglia M. J., & Jamil H. (2011). Alcohol use among Arab Americans: What is the prevalence? *Journal of Immigrant and Minority Health, 13*, 713-718.

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavia, 109*, 234–258.

Blatchley, L.A., & Lau, M. Y. (2010). Culturally competent assessment of English language learners for special education services. National Association of School Psychologists: *Communiqué, 38*(7).

Bostrom, R. P., Anson, R., & Clawson, V. K. (1993). Group facilitation and group support systems. *Group support systems: New perspectives*, 146-168.

Bridging Refugee Youth and Children's Services. (2007). Involving refugee parents in their children's education.

Buscher, D. (2011). Unequal in exile: Gender equality, sexual identity and refugee status. *Amsterdam Law Forum, 3*(2).

Carballo, M., & Nerukar, A. (2001). Migration, refugees, and health risks. *Emerging Infectious Diseases, 7*(3), 556–560.

Center for Development of Human Services. (2002). *Child Welfare Guide*. Buffalo, NY: Research Foundation of SUNY/CDHS.

Chang, V., Scott, S., & Decker, C. (2009). *Developing Helping Skills: A step-by-step approach*. Belmont, CA: Brooks/Cole, Cengage Learning.

Chenoweth, J., & Burdick, L. (2001). The path to integration: Meeting the special needs of refugee elders in resettlement. *Refuge 20*, 20-29.

Child Welfare Information Gateway. (2014). Definitions of Child Abuse and Neglect. Washington DC: U.S. Department of Health and Human Services, Children's Services.

Cojocaru, S. (2010). Appreciative supervision in social work. New opportunities for changing the social work practice, *Revista de cercetare si interventie sociala*, 29, 72-91.

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 412–425.

Engstrom, D.W., & Okamura, A. (2004). A plague of our time: Torture, human rights, and social work. *Families in Society: The Journal of Contemporary Social Services, 85*(3), 291-300.

Erikson, E.H. (1968). *Identity: Youth and Crisis*. New York: W. W. Norton.

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Archives of disease in childhood*, *87*(5), 366-370.

Figley, C. R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. *Journal of Clinical Psychology, 58*, 1433–1441.

Gallagher, A. (2002). Trafficking, smuggling and human rights: tricks and treaties. *Forced Migration Review*, *12*(25), 8-36.

General Assembly. (2006). In Depth Study on All Forms of Violence Against Women: Report of the Secretary General.

Graddy, E. A., & Chen, B. (2006). Influences on the size and scope of networks for social service

delivery. *Journal of Public Administration Research and Theory*, *16*(4), 533-552.

Guarnaccia, P., & Rodriguez, O. (1996). Concepts of culture and their roles in the development of culturallycompetent mental health services. *Hispanic journal of behavioral services, 18*(4), 419-443.

Hawkins, P., & Shohet, R. (1989) Supervision in the Helping Professions: An individual, group and organizational approach, Buckingham, Open University Press.

HealthNet TPO. (2011). *Building Capacity in Mental Health and Psychosocial Care.* Geneva, Switzerland: UNHCR.

Herman, J. L. (1992). Complex PTSD: a syndrome in survivors of prolonged and repeated trauma*. Journal of Traumatic Stress, 5*, 377-391.

Herman, J. L. (1992). *Trauma and recovery.* New York: BasicBooks.

Hook, J., Davis, D., Owen, J., Worthington Jr., E., & Utsey, S. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of counseling psychology*. Advance online publication.

Hopper, E. K. (2004). Underidentification of Human Trafficking Victims in the United States. *Journal of Social Work Research and Evaluation*, *5*(2).

Hunt, D. (n.d.). Refugee adaptation in the resettlement process. In National Alliance for Multicultural Mental Health (Ed.), *Lessons from the Field: Issues and resources in refugee mental health*, 17-26.

Interpretation. (n.d.) In *Oxford Dictionaries online*. Retrieved from http://www.oxforddictionaries.com/definition/english/interpretation

Jacobsen, C. A. (2013). Social workers reflect on engagement with involuntary clients. Master of social work clinical research papers. Paper 198.

Kadushin, A. (1992) Supervision in Social Work (3rd edition), New York, Columbia University Press.

Kanter, J. (1989). Clinical case management: definition, principles, components. *Psychiatric Services*, *40*(4), 361-368.

Kelly, N. E., & Booth, C. L. (2013). *When helping hurts: Self-care strategies for refugee community leaders and service* [PowerPoint slides]. Retrieved from https://www.youtube.com/watch?v=3Lo9xMptouQ

Kohrt, B. A., Maharjan, S. M., Timsina, D., & Griffith, J. L. (2012). Applying Nepali ethnopsychology to psychotherapy for the treatment of mental illness and prevention of suicide among Bhutanese refugees. *Annals of Anthropological Practice*, *36*(1), 88-112.

Marian, V., & Kaushanskaya, M. (2007). Language context guides memory content. *Psychonomic Bulletin and Review, 14*(5), 925-933.

Mental health: a state of well-being. (2014). World Health Organization. Retrieved from http://www.who.int/features/factfiles/mental_health/en/

Mental Health America of Colorado (n.d.). Children and emotional distress. Denver: MHAC.

Mollica, R., Sarajlic, N., Chernoff, M., Lavelle, J., Vukovic, I., & Massagli, M. (2001). Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *Journal of the American Medical Association, 286*(5), 546-554.

Mueller, R., & Okawa, J. (n.d.). Potential mental health issues for refugees. In National Alliance for Multicultural Mental Health (Ed.), *Lessons from the Field: Issues and resources in refugee mental health*, 27-35.

Mueser, K. T., & Jeste, D. V. (Eds.). (2011). *Clinical handbook of schizophrenia*. Guilford Press.

Murakami, N. (2015). Working with Interpreters. [PowerPoint slides]. Retrieved from https://gulfcoastjewishfamilyandcommunityservices.org/refugee/files/2015/02/Working-with-Interpreters-CG-edit.pdf

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

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development*, *78*(3), 251-266.

National Capacity Building Project. (2005). *Healing the Hurt*. Minneapolis: Center for Victims of Torture.

National Suicide Prevention Lifeline. (2009). *Suicide Assessment Five-Step Evaluation and Triage for Mental Health Professionals*. USA: Education Development Center, Inc.

New York State Education Department. (211). Guidelines for educating limited English proficient students with interrupted formal education (LEP/ELL/SIFES). The University of the State of New York.

New York State Psychiatric Institute. (2008). *Columbia-Suicide Severity Rating Scale*. New York: The Research Foundation for Mental Hygiene, Inc.

Newell, J.M., MacNeil, G.A., 2010. Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: a review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health 6*, 57–68.

NSW Refugee Health Services. (2004). Working with Refugees: A guide for social workers. Sydney, Australia: NSW Refugee Health Services.

Office of English Language Learning and Migrant Education. (2009). Effective programs for English language learners (ELLs) with interrupted formal education. Indiana Department of Education.

Office of Special Education and Rehabilitation Services. (2000). A guide to the individualized education plan. United States Department of Education.

Onyut, L. P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., & Elbert, T. (2005). Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BMC psychiatry*, *5*(1), 7.

Pathways to Wellness. (2013). *Community Adjustment Support Group: Training Manual and Curriculum*. Seattle, WA: Pathways to Wellness.

Pathways to Wellness. (2011). *Refugee Health Screener-15: Development and use of the RHS-15*. Retrieved from http://refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf.

Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss & Trauma, 14*(4), 240-255.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with the mental health of refugees and internally displaced persons. *JAMA, 294*(5), 602-612.

Portman, S., & Weyl, D. (2013). LGBT refugee resettlement in the US: Emerging best practices, *Forced Migration Review*, 44.

Psychotherapy. (n.d.) In *Oxford Dictionaries online*. Retrieved from http://www.oxforddictionaries.com/definition/english/psychotherapy

Pumariega, A., Rothe, E., & Pumariega, J. (2005). Mental health of immigrants and refugees. *Community mental health journal, 41*(5), 581-597.

Rangan Aarti, S. K. (2006). Strengths perspective in mental heatlh (evidence based case study), *Strengths Based Strategies*.

Rapp, C.A., Saleeby, D., & Sullivan, W.P. (2005). The future of strengths-based social work. *Advances in Social Work*, 6(1), 79-90.

Refugee Health Technical Assistance Center. (2015). *Mental health*. Retrieved from http://refugeehealthta.org/physical-mental-health/mental-health/.

Rolfe, R.E. (2006). Social cohesion and community resilience: A multidisciplinary review of literature for rural health research. Halifax: Department of International Development Studies Faculty of Graduate Studies and Research Saint Mary's University.

Saleebey D. (1992). *The strengths perspective in social work practice*. New York: Longman.

SDQ: Info for researchers and professionals about the strengths & difficulties questionnaires. (n.d.). Retrieved from http://www.sdqinfo.org/.

Siriwardhana, C., Stewart, R., (2013). Forced migration and mental health: prolonged internal displacement, return migration and resilience. *Health Promotion International 5*, 19–23.

Somasundaram, D. (2010). Collective trauma in the Vanni-a qualitative inquiry into the mental health of the internally displaced due to the civil war in Sri Lanka. *International journal of mental health systems*, *4*(22), 1-31.

Stanley, B., Brown, G. K., Karlin, B., Kemp, J. E., & VonBergen, H. A. (2008). Safety plan treatment manual to reduce suicide risk: veteran version. *New York Suicide Prevention Center, Department*

*of Psychiatry: Columbia University & New York State Psychiatric Institute*.

Streel, E., & Schilperoord, M. (2010). Perspectives on alcohol and substance abuse in refugee settings: lessons from the field. *Intervention, 8*(3), 268-275.

Stress. (n.d.) In *Oxford Dictionaries online*. Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/stress

Sveaass, N., & Reichelt, S. (2001). Refugee families in therapy: from referrals to therapeutic conversations. *Journal of Family Therapy*, *23*(2), 119-135.

Trauma. (n.d.) In *Oxford Dictionaries online*. Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/trauma

Trumbul, E., Rothstein-Fisch, C., & Greenfield, P.M. (2000). Bridging cultures in our schools: New approaches that work. WestEd.

Tuckman, B. W. (1965). Developmental sequence in small groups.*Psychological bulletin*, *63*(6), 384.

UN General Assembly, Convention Relating to the Status of Refugees. (1951). United Nations, Treaty Series, 189, 137.

University of Buffalo School of Social Work. (2015). Introduction to our self-care program. Retrieved from http://socialwork.buffalo.edu/resources/self-care-starter-kit/introduction-to-our-self-care-program.html.

UNHCR. (2013). *Operational Guidance Mental Health and Psychosocial Support Programming for Refugee Operations*. Geneva, Switzerland: UNHCR.

UNHCR, WHO. (1996). *Mental Health of Refugees*. Geneva, Switzerland: UNHCR.

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A. et al. (2004). Family consequences of refugee trauma. *Family process*, *43*(2), 147-160.

# Appendices

## Appendix 1 |DSM-5 Criteria for MDD, GAD, PTSD[131]

### (a) Major Depressive Disorder (MDD)

**Criterion A:** Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

1. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
2. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
3. Insomnia or hypersomnia nearly every day.
4. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
8. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

**Criterion B:** The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

**Criterion C:** The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

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[131] American Psychiatric Association, 2013 (see *References* section, p. 82)

**(b)** Generalized Anxiety Disorder (GAD)

All of the below features must be present in order to make a proper diagnosis of GAD:
- Excessive anxiety and worry, occurring more days than not for at least 6 months, concerning a number of events;
- The individual finds it difficult to control the worry;
- The anxiety and worry are associated with at least three of the following six symptoms (only one item required in children):
- Restlessness, feeling keyed up or on edge.
- Being easily fatigued
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance
- The anxiety, worry or physical symptoms cause clinically significant distress or impairment in important areas of functioning;
- The disturbance is not due to the physiological effects of a substance or medical condition;
- The disturbance is not better explained by another medical disorder

### (c) Post-Traumatic Stress Disorder (PTSD)

**Criterion A: Stressor**
The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: **(one required)**
1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

**Criterion B: Intrusion symptoms**
The traumatic event is persistently re-experienced in the following way(s): **(one required)**
1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

**Criterion C: Avoidance**
Persistent effortful avoidance of distressing trauma-related stimuli after the event: **(one required)**
1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

**Criterion D: Negative alterations in cognitions and mood**
Negative alterations in cognitions and mood that began or worsened after the traumatic event: **(two required)**
1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

### Criterion E: Alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: **(two required)**
1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

### Criterion F: Duration

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

### Criterion G: Functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

### Criterion H: Exclusion

Disturbance is not due to medication, substance use, or other illness.

*Specify if*: With dissociative symptoms:
In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
- **Depersonalization**: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- **Derealization**: experience of unreality, distance, or distortion (e.g., "things are not real").

*Specify if*: With delayed expression:
Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

## Appendix 2 |Refugee Health Screener – 15 (RHS-15)

### (a) Administering the RHS-15

### I.    ABOUT THE RHS-15

The [RHS-15](#) is a culturally-appropriate, short screening instrument that detects symptoms of anxiety and depression in refugee populations from different countries; it is not a diagnostic tool and should not be used as a stand-alone screener. The RHS-15 will produce maximum benefits for recently arrived refugees aged 14 and older when this type of assessment is not available by the local health agency.

**Things to Consider**

Before beginning to use and administer the RHS-15, it is important that you familiarize yourself with the screening tool and its purpose. Begin by reading through all of the questions and gauge your own level of comfort with asking these questions of a client. Review the instructions and the scoring process. Use the [script](#) provided as a guideline and practice administering the tool in your own words.

The RHS-15 may be administered in a variety of settings: as part of an intake session, referral, client interview/consultation, or health screening. Best practice recommends that the RHS-15 be administered in a private, individual setting where only the client and administrator (of the tool) is present; exceptions may be made for families, but please use best judgment.

### II.    LEARNING AND LITERACY NEEDS

Below are helpful tips to consider when supporting pre-literate and literate clients:

**Pre-literate Clients**

- Speak slowly and clearly when explaining instructions; repeat if needed
- Review the scale and use a visual aid if needed (see [Appendix B](#))
- Position yourself close to the client and read items out loud
- Check that the client understands, ask if he/she/they has any questions
- Remind each family member to answer their own questions individually

**Literate Clients**

- Do not assume the client does not want interpreter assistance, offer interpretive services at the beginning of the screening, and again if the client seems to be having difficulties
- Do not assume that a patient is literate in their native language or the national language or their country of origin

Review instructions and use visual aid if needed.

### III.    STEP-BY-STEP GUIDE FOR ADMINISTERING THE RHS-15

Although the RHS-15 is designed to be a non-triggering tool, clients may react in a variety of ways when engaging in the screening process. Please be aware of any signs of distress or uncomfortableness from clients and advise them that you may stop the process at any time.

**STEP 1: Introduce the RHS-15 & its Purpose**

At the beginning of a consultation, communicate to the client what will be happening during the visit including any client intake, review of medical history, psychosocial evaluation, etc. Communicate to the client that one portion of the consultation will involve questions about how they are doing both in their body and in their mind. When you arrive to the part of the consultation where you will be administering the RHS-15, re-introduce the tool and its purpose.

**STEP 2: Explain the Instructions**

Review the instructions for the RHS-15 screening tool including the time frame (within the last 30 days), scale, and manner in which to answer questions on the tool (circling the appropriate answers).

**STEP 3: Administer the RHS-15**

Administer the tool only using the questions on the tool; do not make any additions or deletions. Questions on the RHS-15 should be completed in the order in which they are given. You may need to assist the client at the beginning by re-explaining the scale as necessary or listing each answer as a possibility. Remember to introduce question 14 by explaining that this question has different answers, and that the patient will need to listen to you read each possible answer before answering the question.

While the client is completing the questionnaire, look for errors or non-completed items. If you find errors or non-completed items, wait until the client is finished and then ask them to complete unanswered questions or make sure they understand the instructions.

## IV. SCORING THE RHS-15

Directly after the client completes the RHS-15, proceed to scoring the screener. Describe the scoring process and provide an overview of what you are looking for to the client. Score the answers in the scoring box on the last page of the RHS-15.

1. Total the item score for items 1-14. If they have a **score of 12 or greater**, they are considered "POSITIVE."
2. Note the number circled or marked for question 15. If the client circles a **score of 5 or greater**, they are considered "POSITIVE."
   - A "POSITIVE" score means they may be experiencing symptoms of anxiety and/or depression and a referral is needed.
3. Then, circle if the client's screen is **NEGATIVE** or **POSITIVE**.

Record whether the client completed the screener with assistance by marking "not self-administered" or completed the screener without assistance by marking "self-administered."
If a client's screen is NEGATIVE, inform the client and you may choose to provide them with referral information for future use. This may be dependent upon your office and resources available in the community. If a client's screen is POSITIVE, proceed to referral. You may choose to provide additional support regardless of client outcome.

## V. REFERRALS [script]

If a client has a POSITIVE score (a score of 12 or above on the symptoms OR a 5 or greater on the Distress Thermometer) on the RHS-15, refer them for additional services.

1. Offer support by referring back to the symptom items on the RHS-15
2. Normalize their experience
3. Educate and re-emphasize

4. Allow all decisions to be self-determined

## VI.   WORKING WITH AN INTERPRETER

Take time before, during and after an interpreted session allows clinicians, health providers, and interpreters the chance to collectively problem solve, creates avenues for adequate preparation and ongoing communication which can reduce greater chances of cross-cultural miscommunication.

If possible, provide a training beforehand for mental health interpreters that will be assisting in RHS-15 screening processes and engage in individual or group peer debrief when possible.

### Screening Session:

Interpretation assistance during the screening visit entails supporting literate clients in self-administering the RHS-15, or supporting pre-literate clients with language assistance using the language as it has been translated on the bilingual or native language version of the PHS-15.

To avoid common pitfalls, IRC staff can prompt the interpreter to:

A. Position themselves next to the client to prevent having to "tennis match"
B. Discuss interpreter and healthcare confidentiality in detail
C. Establish that anything anyone says will be interpreted

**(b)** RHS-15

## REFUGEE HEALTH SCREENER (RHS-15)

**Instructions:** Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

| SYMPTOMS | NOT AT ALL | A LITTLE BIT | MODER-ATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 1. Muscle, bone, joint pains | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling down, sad, or blue most of the time | 0 | 1 | 2 | 3 | 4 |
| 3. Too much thinking or too many thoughts | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling helpless | 0 | 1 | 2 | 3 | 4 |
| 5. Suddenly scared for no reason | 0 | 1 | 2 | 3 | 4 |
| 6. Faintness, dizziness, or weakness | 0 | 1 | 2 | 3 | 4 |
| 7. Nervousness or shakiness inside | 0 | 1 | 2 | 3 | 4 |
| 8. Feeling restless, can't sit still | 0 | 1 | 2 | 3 | 4 |
| 9. Crying easily | 0 | 1 | 2 | 3 | 4 |

*The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:*

| | NOT AT ALL | A LITTLE BIT | MODER-ATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|
| 10. Had the experience of reliving the trauma; acting or feeling as if it were happening again? | 0 | 1 | 2 | 3 | 4 |
| 11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma? | 0 | 1 | 2 | 3 | 4 |
| 12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)? | 0 | 1 | 2 | 3 | 4 |
| 13. Been jumpier, more easily startled (for example, when someone walks up behind you)? | 0 | 1 | 2 | 3 | 4 |

## REFUGEE HEALTH SCREENER (RHS-15)

14. Generally over your life, do you feel that you are:

    Able to handle (cope with) anything that comes your way ...................................................0

    Able to handle (cope with) most things that come your way .................................................1

    Able to handle (cope with) some things, but not able to cope with other things...................2

    Unable to cope with most things........................................................................................3

    Unable to cope with anything .............................................................................................4

15.

## Distress Thermometer

**FIRST:** Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.
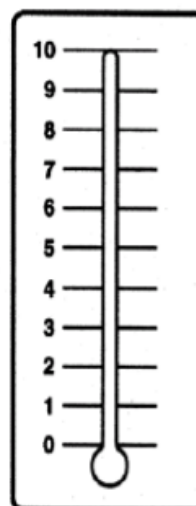
10 — Extreme distress

"I feel as bad as I ever have"

9
8
7
6
5
4
3
2
1
0 — No distress

"Things are good"

**ADD TOTAL SCORE OF ITEMS 1-14:** ___

| SCORING | |
|---|---|
| **Screening is POSITIVE** | |
| 1. **If Items 1-14 is ≥ 12 OR** | Self administered:      ____ |
| 2. **Distress Thermometer is ≥ 5** | Not self administered:____ |
| | |
| **CIRCLE ONE:**         SCREEN NEGATIVE | SCREEN POSITIVE<br>REFER FOR SERVICES |

## Appendix 3 |Safety Plan[132]

**Warning signs (thoughts, images, moods, situations, behaviors) of a crisis:**

1. _____

2. _____

3. _____

**Internal coping strategies (relaxation techniques, physical activity, prayer):**

1. _____

2. _____

3. _____

**People and places that provide distraction:**

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

3. Place: _____ Place: _____

**People who can help:**

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

3. Name: _____ Phone: _____

**Professionals or agencies who can help:**

1. Name: _____ Phone: _____

   Emergency Contact: _____

2. Name: _____ Phone: _____

3. Local Urgent Care: _____

   Address: _____

   Phone: _____

4. Suicide Prevention Hotline: 1-800-273-TALK (8255)

**Making the environment safe:**

1. _____

2. _____

**One thing that is most important to me:**

1. _____

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[132] Stanley, supra note 120

## Appendix 4 | Gender Based Violence Safety Plan

<div style="border: 2px solid black; border-radius: 10px; text-align: center;">

**Safety Plan**

</div>

**Directions**: Complete this safety plan if there are threats to the safety of the survivor. The safety plan should be realistic, easy to remember, and based on the survivor's situation and what she wants to do. Safety plans look different for every survivor. This means survivors do not need to answer every question on the safety plan, only the questions that are useful for them. Prioritize the questions most supportive of each individual survivor's safety. Safety plans must be completed in-person in a private space with no one else present other than the survivor, the IRC staff member, and an interpreter (in-person or phone) if needed and if the client consents. Information from this safety plan MUST BE KEPT CONFIDENTIAL and can only be shared if the survivor signs a release of information or if the client is a danger to herself or others.

As safety decisions are made together, the survivor can fill in the safety plan herself if she wants to and is able. If the survivor keeps a copy of the safety plan, help her to keep it in a safe place. Review all safety decisions multiple times to help the survivor clearly remember her plan. Clearly explain when a survivor should call her case worker and when she should call an emergency contact.

**Introduction**: *"It is important to know that [the perpetrator's] behavior is not your fault. While you cannot control their violent behavior, let's think about ways you can increase safety for you and your children and be prepared if there is an emergency. I will ask you questions to help you think about a plan. You can decide what will work best for you and your children. I will be here to support your decisions no matter what they are.*

*As always, everything you tell me is confidential, which means that I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are in danger. [Explain mandatory reporting requirements as they apply in the local setting.] I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations. Do you have any questions?"*

1. **What phone numbers do you need to memorize in case of emergency?** The survivor should memorize 911 and know how to dial from a cell and landline phone. If needed, the survivor may also memorize numbers to call people she trusts, or local emergency response or shelter providers.

2. **Whom do you trust if you need help?** Think about anyone (neighbors, friends, family, or organizations) that the survivor can trust and how these people can help keep her safe. Think about people the survivor might not be embarrassed or ashamed to contact. For example, discuss having a signal with helpful neighbors. Upon seeing this signal from the survivor, neighbors would plan to visit in a group. Survivors can also establish a codeword to let someone know to call for help.

3. **What community or faith leaders, members, or organizations might you involve?** Think about community or religious resources that might be involved in helping keep the survivor safe.

4. **Are there specific signals or triggers that indicate [the perpetrator] may become more violent?** Help the survivor identify triggers and ideas for avoiding these triggers if possible.

5. **Where are potential weapons in your home? How can you protect yourself against potential weapons in the home (ex: knives, pans, sticks)?** If there are potential weapons in the house, the survivor should know where they are and try to guide any fights away from potentially dangerous areas (kitchen, bathroom, etc). **What**

**important documents do you have?** This includes documents for the survivor and her children, including birth certificates, ID (driver's license), proof of immigration status, Social Security card, SNAP card, Medicaid card, passport, marriage certificate, and medical and school records. If the survivor does not have access to these documents, help the survivor brainstorm how to make copies and hide them. She may consider keeping copies with people she trusts. Caseworkers might also keep copies of important documents locked and confidential at the office.

6. **How can you involve your children in planning for safety?** The children should know not to try to stop the fighting and that the fighting is not their fault. The children should know how and when to call 911. The survivor should tell the children's school or daycare provider who is allowed to pick them up. If the survivor goes to a safe shelter, the children should know to keep their new location a secret.

7. **How will you know when you need to call the police?** It is best if the survivor decides on specific circumstances under which she will involve the police. Make sure to discuss any barriers to calling the police (access to a phone, language barrier, fear of consequences) so that the survivor feels capable of calling the police if and when needed. You may role-play how this call might sound.

The following questions are for survivors who are considering leaving a violent setting or are ready to leave:

8. **If you are in danger and need to leave, is there a safe place you can go?** Think about temporary and long-term options and review both benefits and risks. If the survivor plans to stay temporarily at someone else's house, discuss whether or not the perpetrator might come look for the survivor there and whether or not the community will inform the perpetrator of the survivor's whereabouts.

9. **If you need to leave, what belongings will you bring?** Consider all important documents for the survivor and her children, as well as clothing, food, medication, and money. Include specific plans for how to transport the belongings, and explain that survivors may not be able to return home to get their belongings if they enter a domestic violence shelter.

10. **If you need to leave, how will you do it?** If the survivor drives, consider keeping gas in the car and extra copy of the keys in a secret location that is easily accessible. If the survivor does not drive, make a feasible transportation plan. This may involve friends or neighbors that the survivor trusts.

11. **If you need to leave, what will happen to your children?** If she has custody of the children, the survivor should make every effort to bring the children with her if she leaves so that the perpetrator cannot use the children to threaten the survivor.

12. **Who else might be in danger if you leave?** The survivor may be hesitant to leave a dangerous situation because she is worried about consequences for others both in the US and in other countries. Help the survivor to prioritize her own safety.

13. **A protection order is a legal document in the United States that can prohibit [the perpetrator] from coming near, attacking, sexually assaulting, or contacting you, your children, or other family members. Along with this protection order, you may also be able to ask for custody of your children, child support, that [the perpetrator] be removed from your home, and that [the perpetrator] not interfere with your immigration status. These are legal options, which means that the police or courts would be involved. I am not an attorney, but I can connect you to someone who can give you more information about legal options. Would you like more information about protection orders or other legal options?** If the survivor already has a protection order, make sure she is aware of what it contains and consequences for not adhering to the protection order. Explain that she and her children should have copies with them at all times.

**For the interviewer**:

| Client Name/ID: | Completed By: | Date: | Staff Time Spent: |
|---|---|---|---|
| Language Used: | Interpreter Present? ☐ Phone   ☐ In-person   ☐ No | | Interpreter Time Spent: |

1. I will memorize these phone numbers to be prepared for emergencies:

2. If I need help, I trust:

   If I need help, I can contact them by:

3. A community leader who can help is:

   This is how they can help:

4. S/he is more violent when:

   When I see signs that s/he will become violent, I will:

5. Potential weapons are:

   I can try to avoid the weapons by:

6. These are the important documents I need to have:

   I will keep copies at:

7. I will tell my children:

   I will tell the school, daycare, or babysitter:

8. I will call the police if:

   This is how I will call the police:

9. If I need to leave, I can stay:

   I will keep this location a secret by:

10. If I need to leave, I will bring:

    To make it easy to leave quickly, I will keep my things:

11. If I need to leave, this is how I will do it:

12. If I need to leave, my children will:

13. Anything else I can do to increase safety:

# Appendix 5 | Suicidal Ideation Questionnaire[133]

## Suicidal Ideation Questionnaire

| Steps and Prompts (Suggested Questions in **bold**) | Yes | No |
|---|---|---|
| 1. Desire to be Dead<br>Client expresses thoughts or sentiments about not wanting to be alive or a wish to go away or fall asleep and not wake up.<br>**Have you been thinking that life is not worth living anymore?**<br>**Have you wished that you weren't here/alive anymore?** | _____<br>Ask question 2 | _____<br>Go to Low Risk |
| 2. Suicidal Thoughts<br>Client has general <u>non-specific</u> thoughts of wanting to end his or her own life.<br>**Have you thought about killing yourself?**<br>**Have you thought about taking your own life?** | _____<br>Ask question 3 | _____<br>Go to Low Risk |
| 3. Suicidal Thoughts with Method and Intent<br>Client has active suicidal thoughts and has thought of at least one method.<br>**Do you have a plan for how you would kill yourself/end your own life?**<br>**Do you have any ideas for how you would kill yourself/end your own life?**<br>**If you were to kill yourself, how would you do so?** | _____<br>Ask question 4 | _____<br>Ask question 6<br>Go to Moderate Risk |
| 4. Suicidal Intent with a Plan<br>Client has thought of killing him or herself with the details of a plan partially or fully worked out and indicates that he or she has some intent to carry it out.<br>**Have you thought about the details of how and when you would kill yourself?** | _____<br>Ask question 5 | _____<br>Ask question 6<br>Go to Moderate Risk |
| 5. Suicidal Behaviors (past)<br>Has the client been suicidal in the past (risk factor)?<br>**Have you ever done anything or prepared/started to do anything to end your life?**<br>**What? When? How?** | _____<br>Go to High Risk | _____<br>Ask question 6<br>Go to Moderate Risk |
| 6. Protective Factors<br>Internal: coping mechanisms, religious beliefs, resilience, hope<br>External: responsibility to children/family, pets, or community; social supports<br>**What has kept you from killing yourself?**<br>**What has kept you from following through with the plan?** | | |

## Risk Levels and Interventions

| Risk Level | Intervention |
|---|---|
| Low | Provide the client with the National Suicide Prevention Lifeline 1.800.273.TALK (8255) and explain how the hotline works. Contract with the client to ensure that they will call a trusted professional and/or the hotline if they are feeling suicidal. Refer the client to counseling. |
| Moderate | Provide the client with the National Suicide Prevention Lifeline 1.800.273.TALK (8255) and explain how the hotline works. Contract with the client to ensure that they will call a trusted professional and/or the hotline if they are feeling suicidal. Refer the client to counseling. Follow-up with the client weekly. |
| High | Contract with the client in the moment to not do anything to harm him or herself. Utilize relaxation techniques to help keep the client calm (breathing, guided imagery, etc). Keep the client as calm as possible while you either alert a colleague to call 911 or leave the room and call 911. Follow-up with the client regularly. |

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[133] Adapted from Columbia Suicide Severity Rating Scale and SAFE-T (see *References* section, p. 82)

## Appendix 6 |Mandatory Reporting Compendium

**Mandatory Reporting Laws**
Introduction

IRC is committed to protecting the well being of its beneficiaries and most especially that of the minors it serves.   Consistent with this commitment, IRC has compiled this compendium summarizing the "mandatory reporting laws" in each state in which IRC works.  Mandatory reporting laws refer to the laws in each state that describe who is required to report suspected abuse and/or neglect.

This compendium will provide state specific information regarding who is a mandatory reporter, what needs to be reported and how the report is to be made.  Many states have very inclusive mandatory reporting laws requiring almost all individuals who come in contact with a child in the course of their work to report suspected abuse and/or neglect of a minor.  Others are less inclusive and only designate certain professionals or those performing certain types of work to report.   In most states, the type of work that IRC staff performs will require that staff members report suspected abuse and/or neglect.   In addition, the laws in all states in which IRC works protect individuals who make good faith reports of suspected abuse and/or neglect from any liability if those reports are unsubstantiated.  Given IRC's commitment to the protection of minors and the protection afforded by state statutes to good faith reporters of abuse and/or neglect , all staff members, regardless of the specific state in which they work, are obligated to report when they suspect that a minor is being abused and/or neglected.

Links to state-specific information on mandatory reporting laws:

- Arizona
- California
- DC
- Florida
- Georgia
- Idaho

- Maryland
- New York
- Texas
- Utah
- Virginia
- Washington

**From Harm To Home | Rescue.org**                                            **March 2013**

Link to full Compendium on RescueNet:
https://rescuenet.rescue.org/programs/usprograms/resettlement/Public%20Documents/Mandatory%20Reporting%20Compendium.pdf

## Appendix 7 |Wellness & Self-Care Recommendations for Staff

### Time Management

As a case manager serving refugee clients it can be hard to say "no" when clients come into the office unannounced with urgent needs.  It can also be difficult to prioritize tasks when particular clients are requiring the bulk of your time. Feeling as if you have little control over your schedule and that you can never make progress on your to-do list can quickly lead to burnout. However, there are ways to reassert (some) control over your time and work schedule:

Look at your schedule and evaluate how you are managing your time:
- o  Are you prioritizing the right tasks?
- o Are you spending too much time on a particular client or project?
- o Are you trying too hard to multi-task?

Collaborate with your supervisor to implement the tips below:
- o Make a manageable **to-do list** for each day. Adding too many things to the list that are impossible to accomplish in one day will discourage you.
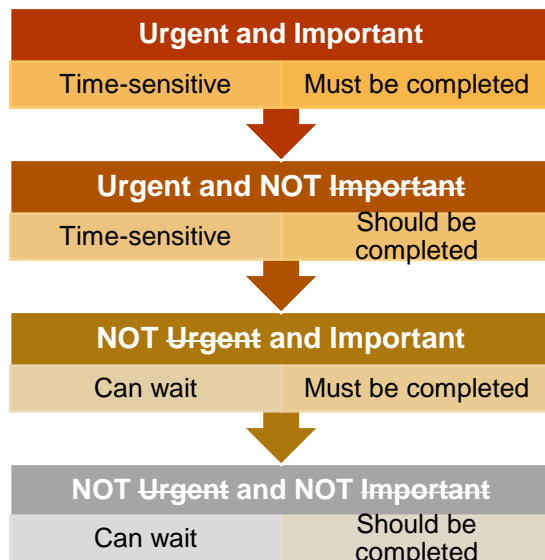
| Urgent and Important | |
|---|---|
| Time-sensitive | Must be completed |

| Urgent and NOT ~~Important~~ | |
|---|---|
| Time-sensitive | Should be completed |

| NOT ~~Urgent~~ and Important | |
|---|---|
| Can wait | Must be completed |

| NOT ~~Urgent~~ and NOT ~~Important~~ | |
|---|---|
| Can wait | Should be completed |

*Figure 1. Prioritizing Tasks*

- o **Prioritize** the tasks that you need to complete within a given day/week into categories of their importance and time-sensitivity.

- o **Delegate** tasks where possible (to interns, colleagues, clients).

- o Know when to **say "no"** to colleagues' and supervisors' requests or projects that are beyond your capacity.

- o Know when to say "no" to clients' requests.  Sometimes the best way to serve our clients is to allow them to try to complete a task independently.

- o **Focus** on one task at a time for a designated amount of time. "Multi-tasking" often makes you take longer to complete each task and leads to mistakes.

- o Leave **buffer space** in your daily schedule for interruptions or other unexpected situations that will require your immediate attention.

- o Create a **routine** in your weekly schedule. Block off time for dedicated case file review, email/voicemail follow up or other projects where you are not seeing clients. If you find that most of your time is spent meeting with clients who come in without appointments, consider having an appointment-only policy or set aside consistent blocks of time for client walk-ins.

o Evaluate how frequently you end up meeting with clients unexpectedly for urgent needs or crises. Did the situation actually warrant your immediate response? Can you change how you are triaging clients to better identify the ones who really need your immediate attention versus the ones who could be scheduled for another time? Could you use assistance from colleagues/supervisors with dealing with crisis clients when you have set aside time to complete some other very important task?

o Identify the clients who are utilizing the majority of your time. Perhaps it is a client who repeatedly comes into the office without an appointment and gets very angry when you are unable to see him/her. Make an agreement with your client that a certain number of times a week they have a time set aside in your schedule for him/her to walk in and see you. At all other times you will be unavailable and serving other clients.

> CC Although it is important to validate clients' feelings about the importance of their needs, it is equally important for clients to respect your time and other clients' need for your time. It also helps clients learn how to navigate within the greater United States system that largely runs on appointments.

> ! Be comfortable with the idea that there will always be more tasks to complete than you can ever possibly accomplish. Prioritize the important ones and forget about the unimportant ones.

There will definitely be client emergencies and other urgent situations where it will be hard to stick to these rules/schedules. However, by having a framework that you try to stick to it can help you feel like you have more control over your schedule, help you to accomplish more, and to ultimately reduce your stress level.

## Create a Comfortable Space

**Take a lunch break:** set aside time in your day for lunch and use it! Eat away from your computer and desk. Take lunch outside (weather permitting) or in a different area of the office. Use that time to sit and recharge quietly by yourself or to socialize with coworkers.

**Stretch & take exercise breaks:** if you find yourself having a hard time concentrating or your mood is low, take a stretch break. Take 5-10 minutes to walk around the office or a walk around the block. In the end you will save yourself time because you will feel rejuvenated and more productive, rather than struggling through the task and feeling poorly.

**Set up a green space/decorate your office:** create a soothing, stimulating and comfortable environment for both you and your clients.

## Maintain a Healthy Work/Life Balance

Try not to take work or client issues home with you. If possible, limit how much you check your work phone and email. Take time for yourself and have hobbies that are completely unrelated to work. Sleep, read, laugh, meditate, or engage in any other activity that you find relaxing and rejuvenating. Make time for family and friends. Some people find it helpful to establish a symbolic routine to help them transition from work to home (i.e., changing out of your work clothes as soon as you get home, going for a run, etc.).

**See a counselor:** our clients have experienced profound trauma. It can be normal for case managers to have a difficult time forgetting about a traumatic story a client has shared or to feel guilty because they are "not doing enough." If talking through these feelings with your coworkers and supervisors is not helping, you might find it beneficial to see a counselor. A counselor can help you to work through these feelings and to recognize that you <u>are</u> providing the best services you can within your capacity.

**Make a change!** In the short term, take some time off from work to recharge. For the long term, talk with your supervisor about the possibility of tweaking or re-prioritizing your job responsibilities.

## **Appendix 8 |** Wellness & Self-Care Recommendations for Offices

At an organizational level, it is important to address staff self-care needs because of the increased risk of staff burnout. Research has found that workers who are experiencing burnout take more days off from work, have poor client care, and do not complete their work duties as required.[134] Taking time to promote self-care through activities and organizational restructuring can save time in the end by allowing staff to work more productively. Below are some tips to help improve self-care as an office:

- **Support each other as colleagues**: discuss difficult clients together, listen and offer support for each other's work and the feelings staff are having.

- **Empower staff**: create organizational structures that empower staff to say "no" to clients' and colleagues' requests that are beyond their job description and/or capacity. Help case managers identify designated time for completion of certain tasks. If a client comes in at that time with a crisis, have colleagues and supervisors assist with the situation. Use a team approach for handling crisis situations rather than it always falling on one or a few recurring staff members.

- **Implement staff teambuilding activities:** such as picnics, weekly yoga sessions, thank you cards for fellow staff members, day retreats focused on self-care/time management. Incorporate self-care activities into staff meetings.

- **Provide trainings for staff:** on time management, self-care, meditation, dealing with crisis or demanding clients, coping with secondary trauma.

- **Encourage/enable staff to take lunch breaks**: away from their desks. Promote group lunch outings in nice weather, make sure there is space in the break room or set aside larger space (such as reserving conference rooms during lunchtime) for staff lunches.

- **Recognize staff contributions:** create opportunities for extraordinary actions by staff to be recognized and applauded by the office (i.e., during staff meetings).

- **Provide extra support to staff:** during times of very high stress (high arrivals, case file audits). Use a team approach to preparing for these high stress times rather than relying on a few staff members. Ensure that staff know about flex time and overtime. Help case managers re-delegate less important tasks to colleagues/interns so that they can focus on the more pressing needs. If staff are staying late for case file review in preparation for an audit, provide something extra such as bringing in dinner.

### **(a)** Staff Wellness & Self-Care Committee

One way to incorporate self-care into your daily routine is to create a self-care committee. Encourage staff/colleagues who are passionate about self-care to brainstorm and implement changes and activities that suit your office's unique context and staff personalities. Here are some tips for starting a self-care committee:

- Start small. Self-care can be inexpensive and does not require a large budget.

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[134] Newell, supra note 124

- Make sure there is actually a need/want from the office. Do not impose the idea of a self-care committee or activities on staff.
- Find interested individuals not within senior management to take the lead.
- Do not make self-care (either leading the activities or participating) extra work for people unless they want to do it.
- Create activities that are as inclusive as possible (i.e., make them during office hours/other events; do not make them purely social events that involve going out after hours).
- Encourage teambuilding and staff mental wellness as the goal of your activities.
- Bring ideas back up to senior level and make sure it makes sense.