BOSTON COLLEGE
School of Social Work
RESEARCH PROGRAM ON CHILDREN AND ADVERSITY

Family-Based Mental Health Promotion for Refugees Resettled in the US:
Implementation Science in collaboration with Somali Bantu and Bhutanese communities

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Presentation Overview

- Background on RPCA and Conceptual Drivers
- The Family Strengthening Intervention (FSI)
- Community Based Participatory Research & mixed-methods
- Results of Pilot and Snapshot of Hybrid Trial focused on implementation questions
- Challenges from COVID-19 & need for Digital Innovation
- Potential New Directions

Research Program on Children and Adversity (RPCA)

- Identify factors contributing to **risk** and **resilience** in children, families, and communities facing adversity globally
  - Focus on **capacities**, not just deficits
- Contribute to developing an evidence base on intervention strategies:
  - Help **close the implementation gap**
  - Support development of **high quality and effective programs and policies in low resource settings, including in the US**

Current Research

- **Children Affected by Communal Violence/Armed Conflict**
  - **Chechen IDPs, Ethiopia-Eritrea border, N Uganda, Sierra Leone (NICHD R01HD073349, U19 NIMH MH109989)**
    - Longitudinal study of war-affected youth (3 waves of data collected 2002-2008 (*Child Development, 2010; JAACAP, 2010; Social Science & Medicine, 2009*)
    - Randomized controlled trial published in *JAACAP* in 2014
- **ECD + Violence Prevention home visiting Rwanda (LEGO Foundation, Echidna Giving, Oak Foundation)**
    - Evaluation of an evidence-based Family Strengthening Intervention for families affected by HIV (*AIDS Care, Pediatrics*)
    - Pilot and current scale-up of the *Sugira Muryango* early childhood development home-visiting intervention
- **Promoting resilience and healthy parent-child relationships in refugee families**
  - **New England (NIMHD R24MD008057, R01MD010613)**
    - CBPR study of a Family Strengthening Intervention for Refugees (Somali Bantu and Bhutanese refugees)

Refugee children and mental health:

- Traumatic events, separation and loss increase risk of **poor mental health** difficulties in refugee children and families
- **Depression** (10-33%), **PTSD** (19-53%) is much higher than general population (6-9% depression and 2-9% PTSD)
  (Kien et al. 2018; Bronstein and Montgomery, 2011)
- **Children in US have poor access to mental health services**; situation **exacerbated in refugees**
  (Betancourt et al., 2012; de Anstiss et al., 2009)

- **Reluctance to seek out services**
  - Stigma around mental health
  - Lack of resources
- **Families overwhelmed** by their own migration experiences
  - Services access is very poor; especially for children—families may not be able to recognize needs
  - Unaware of what services are available
- **Limited referral networks** from schools, pediatric clinics, health centers, etc.
- New challenges to accessing care due to COVID-19 implications

(Fazel et al., 2012; Edberg et al., 2010)

Community-Based Participatory Research (CBPR)

(Rilwan)

*"**Collaborative** approach to research that equitably involves all partners in the research process and **recognizes the unique strengths that each brings**. CBPR begins with a research topic of importance to the community, has the aim of **combining knowledge with action and achieving social change** to **improve health outcomes and eliminate health disparities**."*

WK Kellogg Foundation Community Health Scholars Program

SOMALI BANTU REFUGEE COMMUNITY

Somalia

- Somali Bantu have a history of slavery in Somalia – likely from Mozambique, Tanzania, Rwanda, and other African Nations
- Denied access to education, healthcare in Somalia; jobs limited to farming
- 1991 civil war erupted affecting all
- Instability continues to date
- Prolonged brutal fighting, disruption of basic food production and services, movement is prohibited

Source: https://somalibantumaine.org/

Kenya – Refugee Camps (Daadab, Kakuma)

- Massive population displacement; dependence on UNHCR rations
- Somali Bantu in very insecure areas of the camps
- No access to Kenyan society, citizenship, jobs, limited education; slow resettlement of both Somali majority and Somali Bantu to host countries

Somali Bantu Refugees in the US

- **Somalis** are **largest single group of resettled African refugees** in U.S. history
- In 2004, **over 13,000 Somali Bantu** were resettled in 50 communities across 38 states
- Resettlement in the Boston area began in February 2004 with two families; now over **400** in the greater Boston area
- Significant **secondary migration** to Maine and other states

(Department of State. Bureau of Population. Refugees and Migration Office of Admissions. Refugee Processing Center. Summary of Refugee Admissions, 2018)

BHUTANESE REFUGEE COMMUNITY

Bhutan

- Bhutan is a geographically and politically isolated kingdom
- **Ethnic cleansing** initiated by government in early 90's evicting over 100,000 ethnic Nepalese (Lhotshampas)
- "Bhutanization" targeted cultural and religious traditions
- **Eliminated citizenship rights**
- Many forced to leave Bhutan to neighboring countries – mostly Nepal

Nepal – Refugee Camps

- Settled in eastern part of Nepal in refugee camps
- Long stay - 20 years+
- Many escaped violence, and experienced further violence in refugee camps
- Difficulties in education, employment, discrimination, etc.

Bhutanese Refugees in the US

- Third country **resettlement began in 2007** and **nearly 100,000 Bhutanese resettled in the US** (Embassy of the US, 2016)

- **Alarming rate of suicide among resettled Bhutanese** in the US (21.5 per 100,000); higher than national average (12 per 100,000) (CDC, 2013)
- Suicide may be connected with experiences of separation, integration difficulties (i.e. unemployment), and perceived lack of social support (Hagaman et al., 2016))

Program History

2004-2008

Partnered with Lynn public schools to address the emotional & behavioral needs of school-aged refugee youth.

2008-2013

Conducted a mixed methods needs assessment of Somali Bantu children in Greater Boston area, partnering with the Chelsea Collaborative
Funding: NIMH

2013-2018

CBPR Collaboration to develop and pilot test the FSI-R, adapted from work with Dr. William Beardslee at Boston Children's Hospital, Jewish Family Services, The Chelsea Collaborative, and The Refugee and Immigrant Assistant Center

2017-2022

CBPR Collaboration & Hybrid Implementation Effectiveness Trial of FSI-R in New England with Jewish Family Services and Maine Immigrant and Refugee Services
Funding: NIMHD

2019-PRESENT

Leveraging technology to adapt the FSI-R paper manual into a digital application
Funding: Boston College

CBPR and Mental Health

(Lila)

- **Limited use** of CBPR so far in mental health research or with refugee communities
- Promising approach, given **stigma** around mental health
- **Understanding local context and language** (i.e., around mental health problems) can improve community **engagement** and **inform intervention development** (Betancourt et al., 2010)

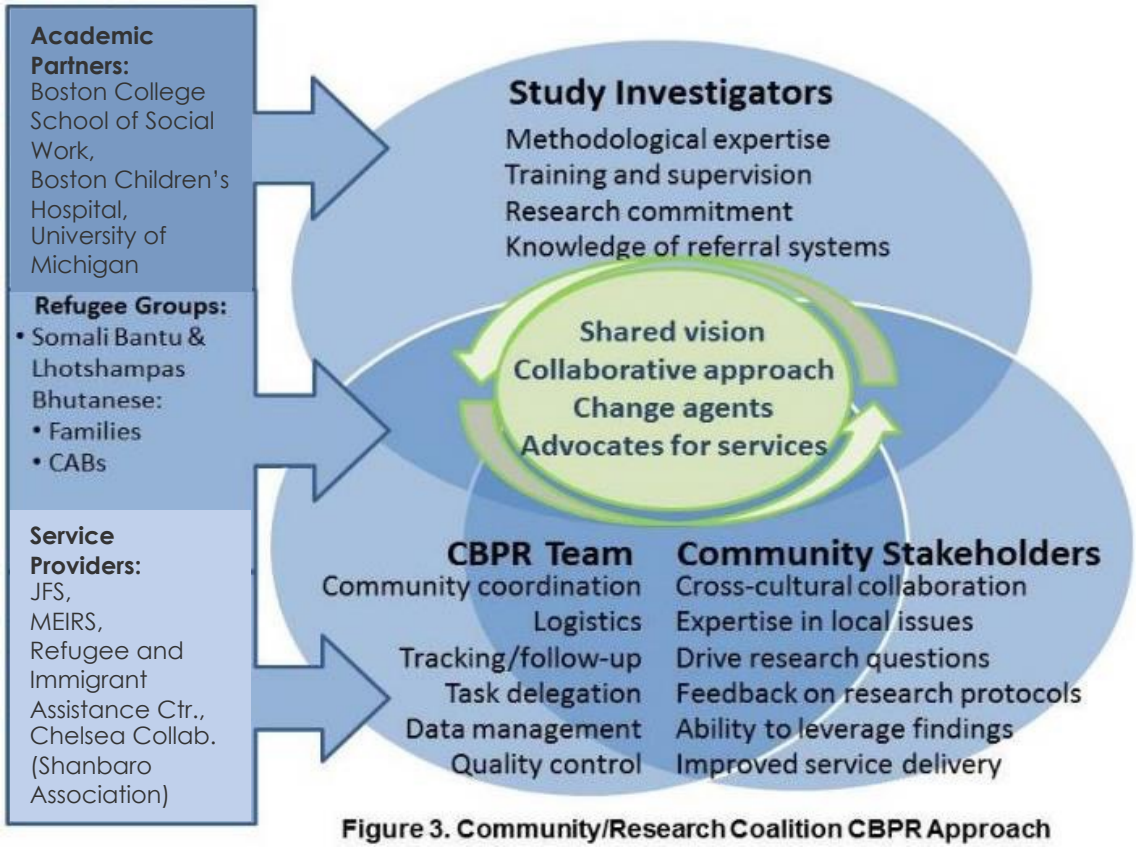
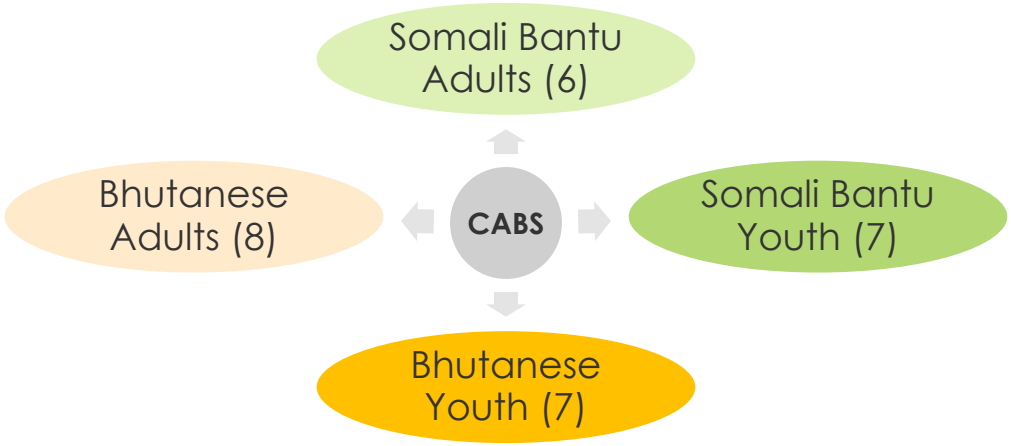


Figure 3. Community/Research Coalition CBPR Approach

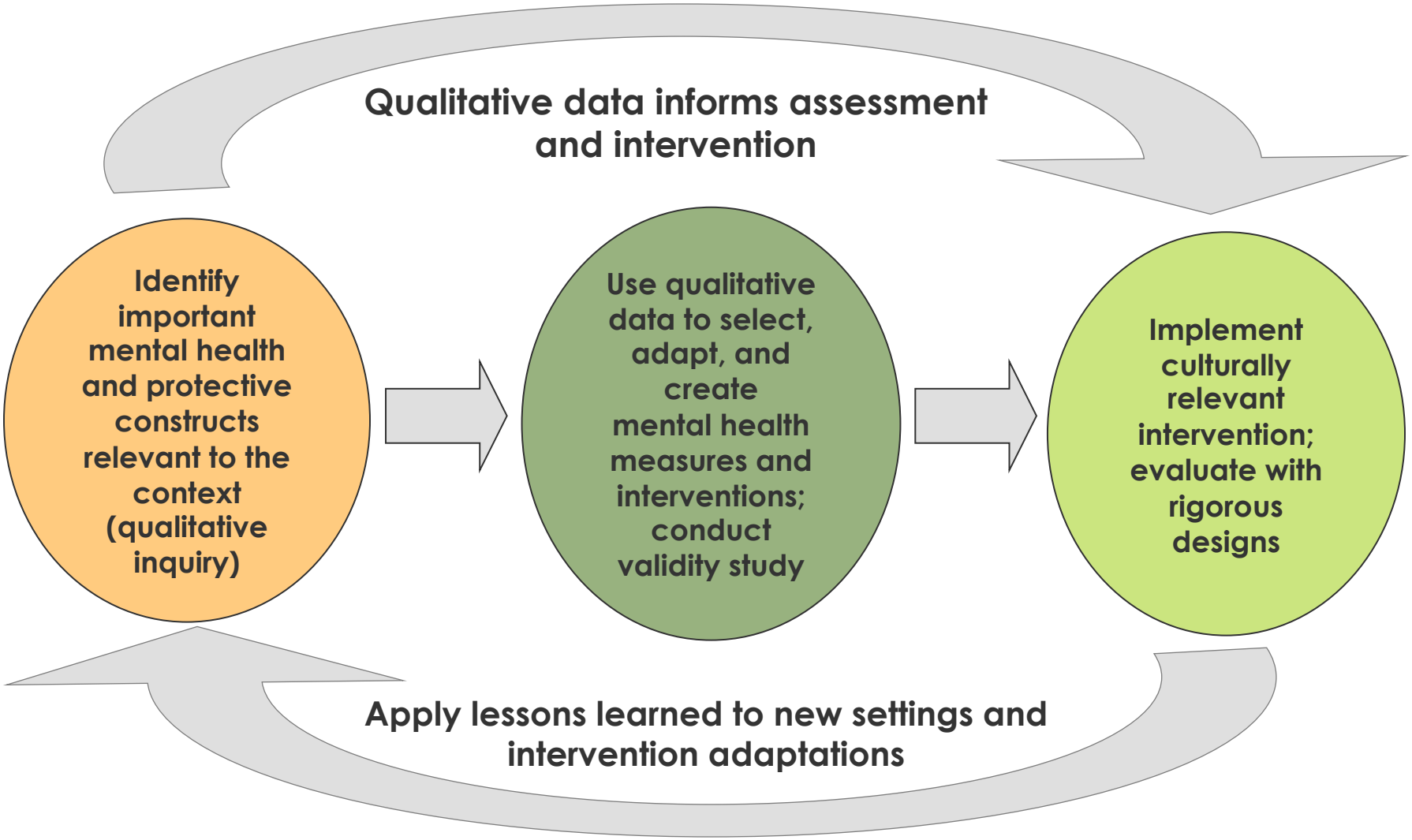
Our CBPR Approach: *"For Refugees By Refugees"* (Lila)

- Hire CHWs and research assistants from the communities --train non-specialists
- Host community outreach events to engage community members
- Build and utilize ***Community Advisory Boards (CABs)*** at every step:
  - Quarterly meetings
  - Liaison between researchers and the community
  - Advise on needs, culture, etc.

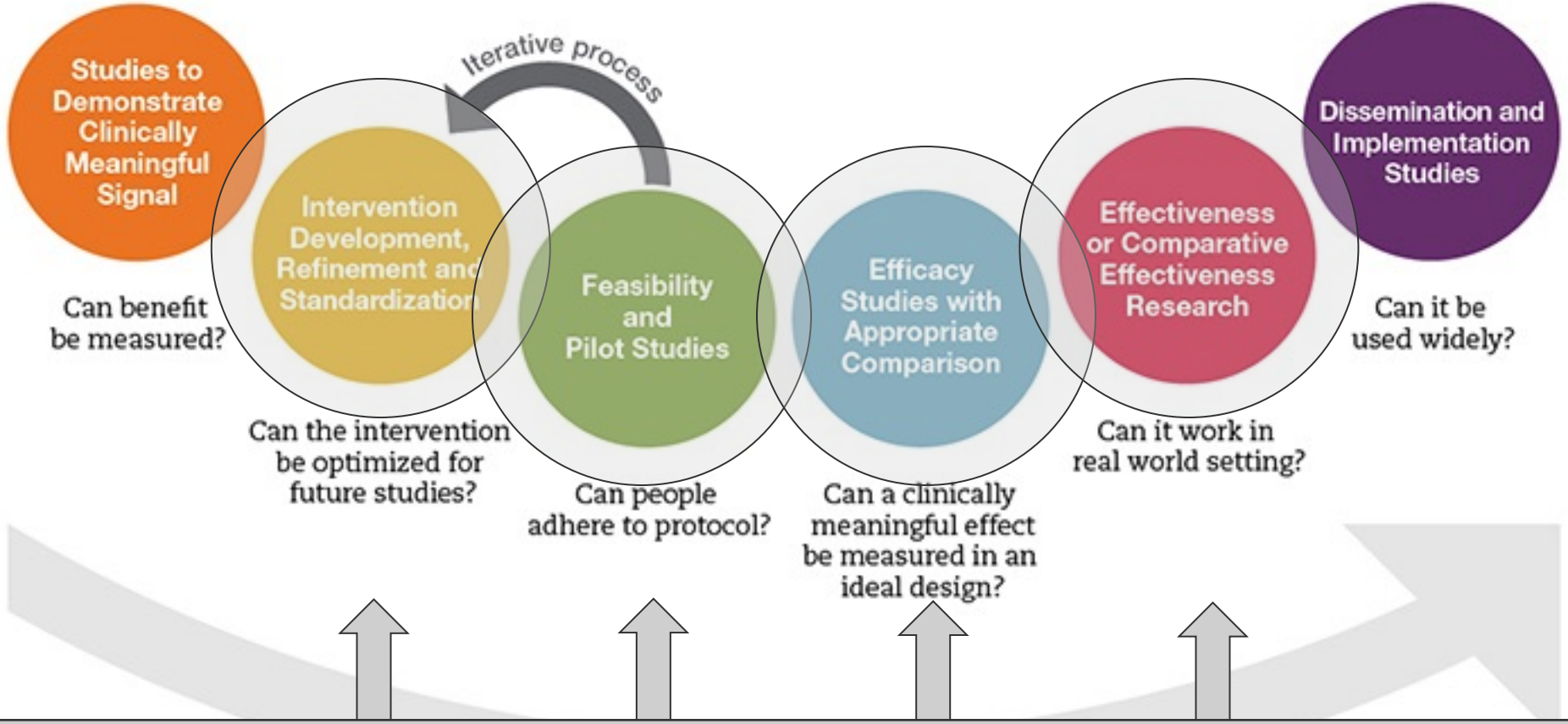


A Model for Designing and Evaluating Mental Health Services in Diverse Cultural Settings

(TSB)



Considering Implementation Science earlier



Designing for Implementation https://nccih.nih.gov/grants/mindbody/framework

- Who's going to deliver it?-→ **Deployment Focused!**
- Fit with ultimate patient population→ **Acceptability/Feasibility**
- Testing **STRATEGIES** to improve training, support/supervision, adherence
- What are factors that **mediate and moderate impact? Quality?**
- **Hybrid designs** (blend effectiveness AND implementation at the same time)

Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities

American Journal of Public Health (AJPH), 2015

Theresa S. Betancourt, ScD, MA, Rochelle Frounfelker, MPH, MSSW, Tej Mishra, MPH, Aweis Hussein, and Rita Falzarano, BA

Objectives. We sought to understand the problems, strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees and determine local expressions of mental health problems among youths in both communities.

Methods. We used qualitative research methods to develop community needs assessments and identify local terms for child mental health problems among Somali Bantu and Bhutanese refugees in Greater Boston and Springfield, Massachusetts, between 2011 and 2014. A total of 56 Somali Bantu and 93 Bhutanese refugees participated in free list and key informant interviews.

Results. Financial and language barriers impeded the abilities of families to assist youths who were struggling academically and socially. Participants identified resources both within and outside the refugee community to help with these problems. Both communities identified areas of distress corresponding to Western concepts of conduct disorders, depression, and anxiety.

Conclusions. There are numerous challenges faced by Somali Bantu and Bhutanese youths, as well as strengths and resources that promote resilience. Future steps include using culturally informed methods for identifying those in

There are disparities in the mental health of refugee children and adolescents resettled in the United States compared with youths in the general US population. For instance, the prevalence of posttraumatic stress disorder and depression among resettled refugee children is estimated to be as high as 54% and 30%,[1] respectively, compared with an estimated 5% (posttraumatic stress disorder) and 11% (depression) of youths with these disorders in the general population.[2] In addition to specific psychiatric disorders, refugee youths experience overall greater psychological distress than those in the general population.[3]

FAMILY STRENGTHENING INTERVENTION FOR REFUGEES

A family-based preventive mental health intervention for use with children and families with a refugee life experience

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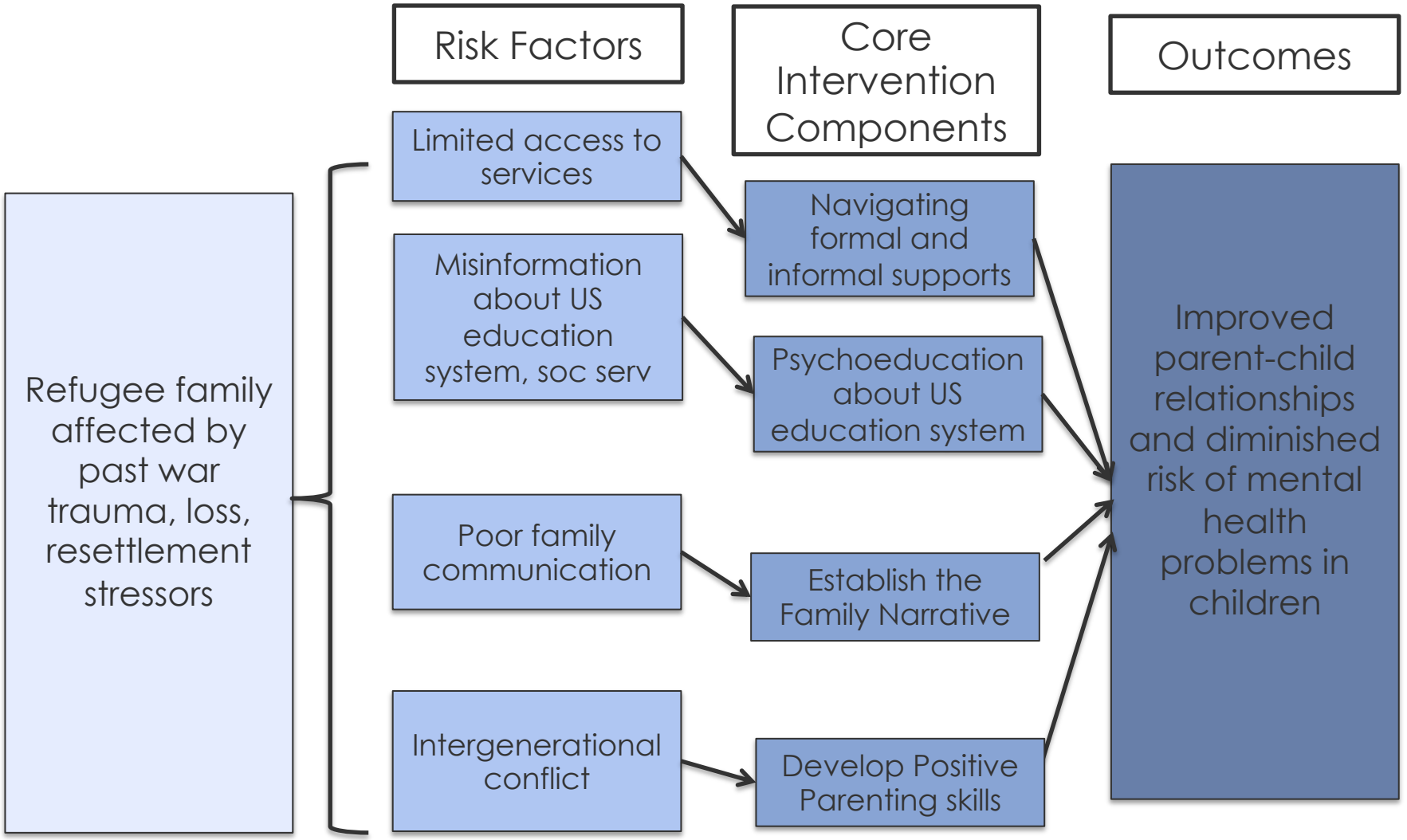
The FSI-R: An adaptation of the Family-Based Preventive Intervention (Family TALK)

- **Evidence-based intervention** (National Registry of Effective Programs & Practices) originally developed for offspring of depressed caregivers by Dr. William Beardslee
- Designed to be administered by a **wide range of providers**
- As a **family-based** preventive model, it focuses on identifying and enhancing resilience and communication in families who are managing stressors due to parental illness→ adapt to refugee experience of families
- Had shown effects in reducing depression among children in HIV-affected families in Rwanda
- Good "fit" for the setting and context of resettled refugee families

Core Components of the Family-Strengthening Intervention for Refugees (FSI-R)



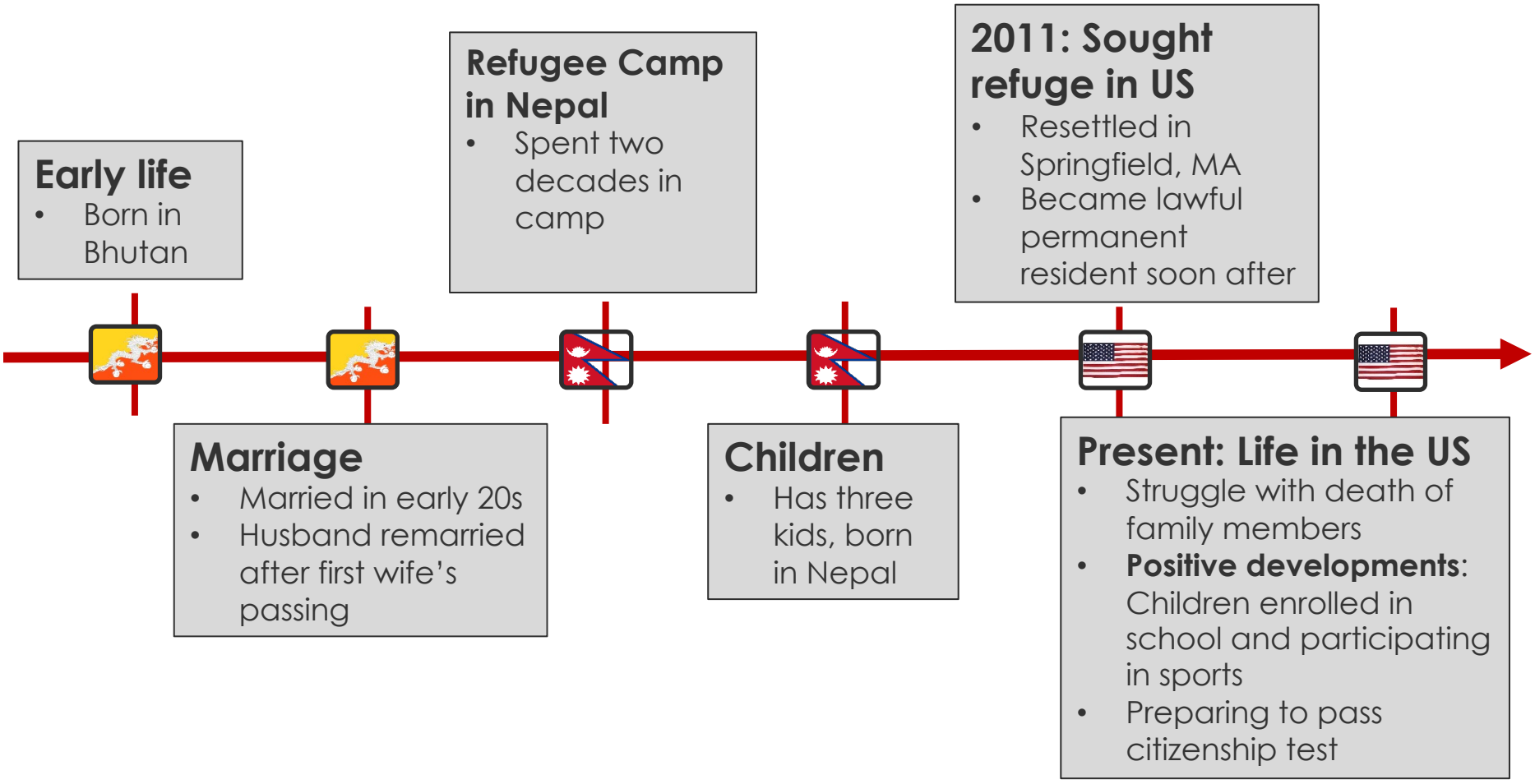
FSI-R Module Characteristics

- Brief, **strengths-based** approach
- Recognize and build on existing family strengths to enhance **resilience**
  - Protective resources = "**active ingredients**" for preventing mental health problems
- **Manualized** protocol
  - Includes detailed set of materials Manual and Workbook
- **Weekly** meetings between family and interventionist
- Separate sessions for **children and adults**
- Two major concepts: **Family Narrative and Family Meeting**

1 – 2	Introduction; Family Narrative
3	Children and Family Relationships
4	Responsive parenting and caregiving
5	Engagement with the US education system
6	Promoting Health, Wellbeing, and Safety
7 – 8	Communicating with Children and Caregivers
9	Uniting the Family
10	Bringing It All Together

Example Bhutanese refugee family Narrative

(Lila)



NIMHD R24: Feasibility and Acceptability Pilot of the FSI-R

National Institute on Minority Health and Health Disparities

- **N= 80 families with children ages 7-17** to test feasibility and acceptability

Bhutanese: *Springfield, MA*

Somali Bantu: *Lewiston, ME*

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Original article

Family-Based Mental Health Promotion for Somali Bantu and Bhutanese Refugees: Feasibility and Acceptability Trial

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Article history: Received May 10, 2019; Accepted August 20, 2019
Keywords: Refugees; Family functioning; Youth mental health; Prevention; Intervention

ABSTRACT

Purpose: There are disparities in mental health of refugee youth compared with the general U.S. population. We conducted a pilot feasibility and acceptability trial of the home-visiting Family Strengthening Intervention for refugees (FSI-R) using a community-based participatory research approach. The FSI-R aims to promote youth mental health and family relationships. We hypothesized that FSI-R families would have better psychosocial outcomes and family functioning post-intervention compared with care-as-usual (CAU) families. We hypothesized that FSI-R would be

IMPLICATIONS AND CONTRIBUTION

This study used a community-based participatory research approach to engage communities in the delivery and testing of

NIMHD R24: Feasibility and Acceptability Pilot of the FSI-R

- **Enroll** 80 families (40 Bhutanese and 40 Somali Bantu)
- **Assess** 2 time-points: pre and post-test
- **Randomize** half to control group, half to family based prevention (FSI-R)
- **Engage** CABs
- **Implement** FSI-R using CBPR
- **Document feedback** from community stakeholders and challenges to **refine intervention**

Pilot preliminary results

FSI-R Evaluations

PILOT 1: Feasibility and Acceptability Pilot

- CBPR, trained CHWs
- Pre-post test
- 80 families:

40 Somali Bantu (n=102 children, 58% female; n=43 caregivers, 79% female)

40 Bhutanese (n=53 children, 55% female; n=67 caregivers, 54% female)

- Randomized design

Key Findings: Child Outcomes

- FSI-R Children reported **less traumatic stress** reactions (β=-0.42; *p*=0.03)
- FSI-R caregivers reported **fewer child depression symptoms** (β=-0.34; *p*=0.001)
- Bhutanese FSI-R caregivers reported **fewer conduct problems** in children (β=-0.92; *p*=0.01)
- Somali Bantu **CAU caregivers reported improved child conduct** compared to FSI-R children (β=-1.48; *p*<0.001)

Family outcomes

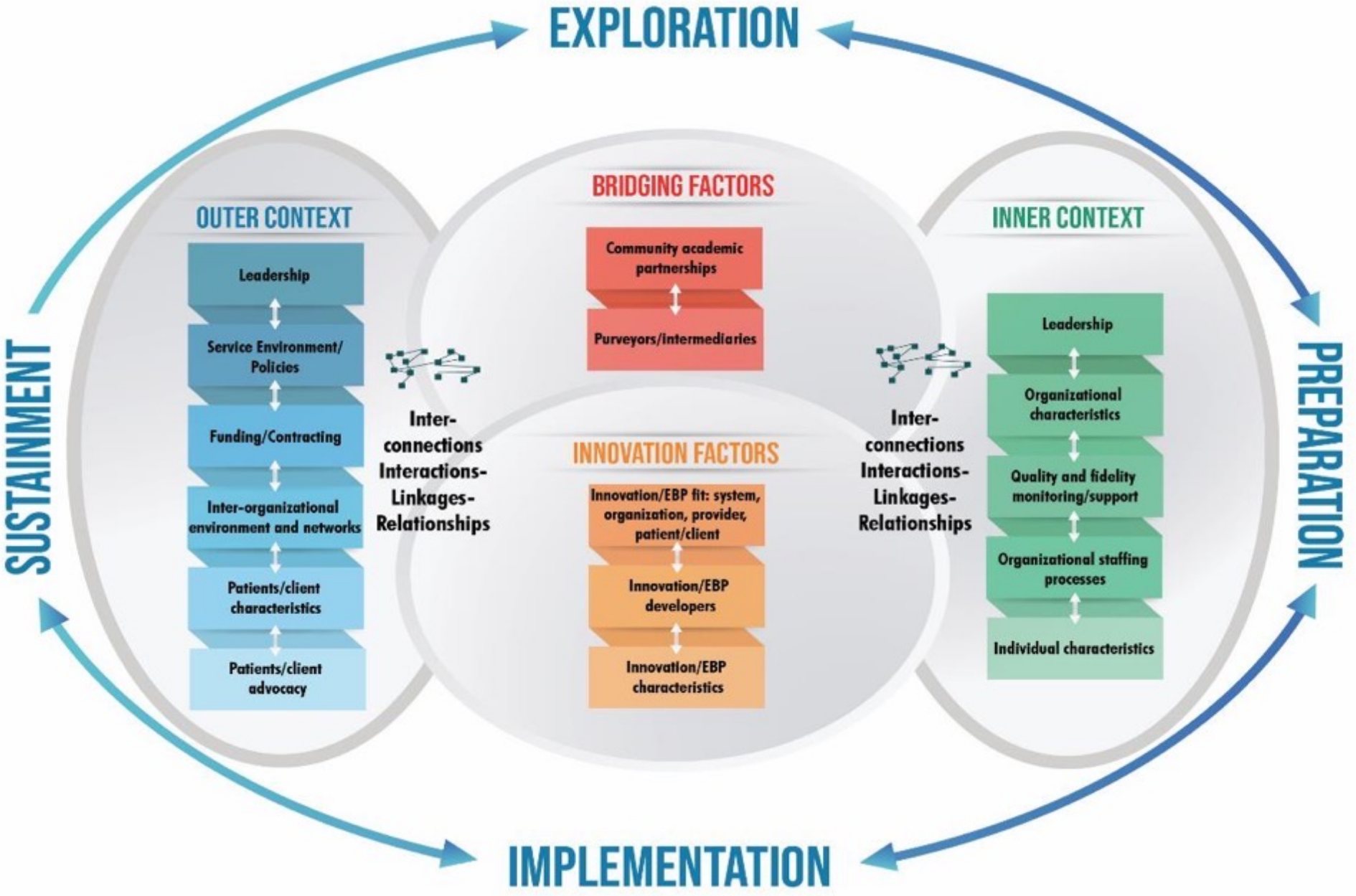
- Bhutanese FSI-R children reported **reduced family arguing** (β= -1.32; p=0.04).

Feasibility and Acceptability

- **Feasibility**: Retention rate = 82.5%
- **Acceptability**: High reports of satisfaction = 81.5% with FSI-R overall

NIMHD R01: Hybrid Type II Effectiveness-Implementation Study of FSI-R

- **Enroll** 100 families (50 Bhutanese and 50 Somali Bantu)
- **Assess** 3 time-points: pre and post-test, 6 month follow up
- **Randomize** half to control group, half to family based prevention (FSI-R)
- **Engage** CABs
- **Implement** FSI-R using CBPR
- **Test Strategies for Quality Improvement** two different agency configurations (i.e. existing CHWs, staff dedicated only to FSI-R



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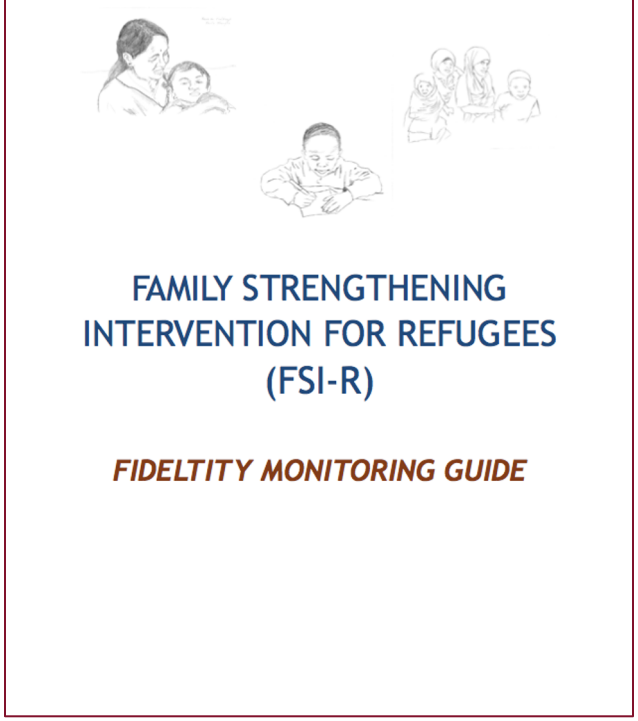
Fidelity Monitoring Steps

- 2 Expert supervisors from each community used "**Fidelity Monitoring GuideBook**"
- **Seed Team Experts** Reviewed **Audio-tapes** to gain insight into CHW level of FSI-R competence, strengths and also identify areas for growth– (useful info for booster training)
- **Weekly Supervision call** with each interventionist to review core content
- **Weekly Group supervision** with each community→ Constructive Feedback, PDSA cycles of problem solving



Hybrid Type II Effectiveness-Implementation Trial Sample Characteristics

Bhutanese Community

- Bhutanese: N=186 (CG=98 / Child=88)
- **Household size=4.7**, mean number of children=2.2
- 59% female
- mean age=39.5 (sd=8.6)
- **93% caregivers were married or living with partners**
- **10% US citizenship status**
- **53% Caregiver had no formal education**
- **62% Caregiver can speak English**

Somali Bantu Community

- Somali Bantu: N=168 (CG=50 / Child=118)
- **Household size=6.9**, mean number of children=5.9
- 78% female
- mean age=42.8(sd=10.1)
- **56% caregivers were married or living with partners**
- **89% US citizenship status**
- **31% Caregiver had no formal education**
- **31% Caregiver can speak English**

Process Data from FSI-R Pilot

- 36 Exit-interviews with **caregivers and children** from the **intervention group**
- Interview questions assessed:
  1. **Acceptability/ Feasibility**
  2. **Outcomes of intervention**
  3. **Suggestions for improving the intervention**

- All 36 interviews were **double coded** using a combination of **Grounded theory and thematic content analysis** to:
  1. Address the research questions about: acceptability, feasibility, outcomes, and suggestions to improve the intervention
  2. Identify additional themes throughout the interview transcripts

Data collection was supported by use of MAX QDA Software

Acceptability and Feasibility

- Scheduling and time as an initial barrier to acceptability and feasibility
- Experiences discussing the past
- Experiences with the interventionist

*"**[My favorite part was] when we talk about my grandparents and stuff**… my **mom never talk[ed] about them before ..I like to know about them.**"*

12-year-old Somali girl

*"**I didn't feel comfortable is talking about happened in the past**… **in Somali[a] and in the refugee camp** too**, life wasn't easy** for me and my family."*

Somali Bantu mother

***I don't see anyone else in the community that will be able to do that job…We understand each other.**" -Somali Bantu mother*

Impact on participants

- Family communication
- Spending time together as a family
- Relationship between caregivers

*"I also **learned that we should not avoid children**… **now we understand that we should talk to each other.**. and **ask about how the other person is doing**.. **who he's with, where's he going**… we still share things between mother and son. We now know things happening in each other's lives."*

-Bhutanese mother

*"**Just to talk with my family was the best. I never talk with my parent like that**."*

Somali Bantu 17-year-old girl

Improving the intervention

- *Seeking tangible skills*
- *Extend focus from family to community*

*"**People need actual help**… I think **you need to start service for the people like English class…youth group for both girls and boys, parent group, money saving programs**."*

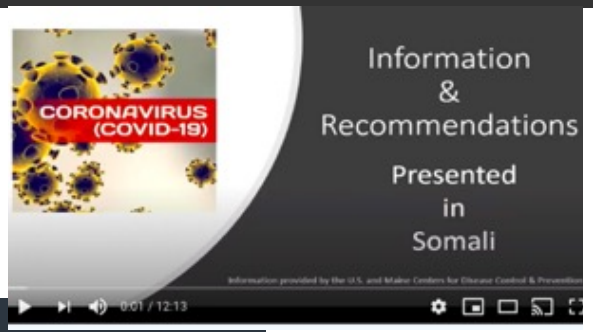
Somali Bantu mother

*"…**group services like youth group or women's group or men's group, or couple groups** .. to **help all the members in the community**.."*

13-year-old Bhutanese boy

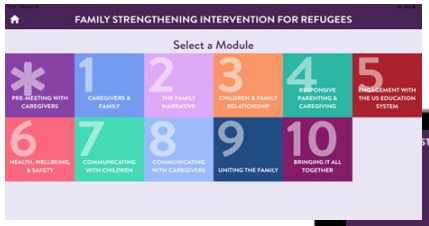
Adapting to COVID-19

- **Remote data collection**, enrollment, intervention delivery
- New **COVID-19 impact assessment scale**
- **Adapting FSI module content for COVID-19** challenges and mental and physical wellbeing
- **Community outreach + education via Facebook Live events for Bhutanese, What's App for Somali Bantu**



Digital Tools can Support Peer Delivery, Nimble Adaptation, Greater Reach and Engagement

- **BC Technology** Development Grant in collaboration with BC Design and Innovation; BC Computer Science and Engineering Depts and VP for Design and Innovation
- **User interface/User experience Testing**
- First developed **Interventionist tool**; Now creating **family-facing tablet-based app (**Using **co-design techniques)**
- Opportunity for **community co-creation** and **engagement** including **user experience and user interface testing**



Pivoting to Collaborate on the Afghan Resettlement

- **SIV and humanitarian parolee population** located in military sites across the US and globally (Germany, Italy, Qatar, UAE)
- The **US has resettled over 62,000 Afghans since the fall of the Taliban**
- Assessment and contextual information gathering conducted at **Ft. McCoy, WI**
- **Have begun cultural adaptation of FSI-R and working with ORR and interested States on investing in prevention** given high trauma exposure in both children and families
- Opportunity for **Learning Collaborative** and other **implementation science innovations**
- Currently Finishing Phase I data analysis, intervention adaptation; planning Phase II Learning Collaborative (Drs. Bunn, Jung)

(Parker, 2021, September; Maizland, 2021, September; Montoya-Galvez, 2021, August; Montoya-Galvez, 2021, September)

Concluding Thoughts

- **CBPR** is a powerful approach for work with refugee communities to promote dignity, hope and good science
- **Family Based Prevention** deserves more attention in the mental health and functioning of refugee families.
- **Collaborative research and community engagement** is critical to strong implementation and innovation
- **Implementation Science** approaches have a huge role to play in extending reach of evidence-based services of all types

We're Hiring! **http://bc.edu/rpca**

If interested, email our Administrative Assistant, Rachel Stram, <stramr@bc.edu>

- **Associate Director, Grants Administration (Boston):** Experience with financial management of NIH and foundation grants. Expert knowledge of international subcontracts and leadership in meeting deadlines.
- **Research Scientist (Boston, with expected travel):** Ph.D. in Public Health, Implementation Science, Social Work, Developmental Psychology, Mental Health, Epidemiology, or related field required. Will support the 'Youth FORWARD Follow-Up Study, and 'Social and Biological Mechanisms Driving the Intergenerational Impact of War on Child Mental Health: Implications for Developing Family-Based Interventions' based in Sierra Leone, with support to other projects as needed. Expertise in implementation science, randomized controlled trials, cluster-randomized trials.
- **Sierra Leone Research Program Manager (Freetown, Sierra Leone):** Master's Degree in Public Health, Global Mental Health, or Social Work required. Will support all aspects of the RPCA's research in Sierra Leone, most notably, an intergenerational study of war/prospective longitudinal study of war-affected youth in Sierra Leone Building on four prior waves of data collection, biological measures of stress reactivity and self-regulation will be collected in a sample of parents exposed to significant trauma in childhood and extended also to intimate partners and offspring.
- **Administrative Manager (Boston)**: Master's Degree in Public Health, Business, Public Administration, or other related field preferred. Excellent written and oral communication skills, ability to build effective teams and working relationships with staff, collaborators and subcontractors in other countries.

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