

IDENTIFYING THE UNMET BEHAVIORAL HEALTH NEEDS OF RESETTLED REFUGEE  
YOUTH IN PRIMARY HEALTH CARE SETTINGS

by

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July, 2019

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The following is a six-chapter dissertation explores the behavioral health needs of resettled refugee youth in primary health care settings. All six chapters were based in Urie Bronfenbrenner's Ecological Systems Theory. A literature review was completed examining current research on the behavioral health needs of resettled refugee youth globally to inform treatment of refugee youth in primary care settings. Literature was organized using Ecological Systems Theory. Systematic implications were provided which included need for assessment tools for primary care, focus on family functioning and benefits to primary care behavioral health interventions as a means of addressing barriers to behavioral health care utilization. A systematic review was also conducted analyzing the unmet behavioral health needs in primary health care settings among racial and ethnic minority children in the United States. This systematic review was conducted to examine what themes are currently in the literature regarding racial and ethnic minority children, which is the larger group that refugee youth belong to. As part of the inclusion criteria for this systematic review, studies only including samples of racial and ethnic minority samples that were 50% or more were included. A methodology outlined the details to the explanatory, sequential, mixed-methods design created to assess the behavioral health needs of resettled refugee youth in primary health care settings. As the quantitative portion to the mixed-

methods study, the North Carolina Child Health Assessment and Monitoring Program (CHAMP) 2005 was analyzed to determine certain factors that may increase the likelihood of diagnosis of a behavioral health need in a general pediatric population. The results of the quantitative phase were used to construct an interview guide for the semi-structured interviews with primary health care providers who treat refugee youth and families. Results of the two-phase analysis were compared. There were similarities and differences among the two results along with new themes arising from the qualitative analysis. At the close of the study, implications were made including ways that key concepts of Medical Family Therapy could be applied to the treatment of this population in primary health care setting along with the need for trauma-informed, family-focused, culturally attuned care.



IDENTIFYING THE UNMET BEHAVIORAL HEALTH NEEDS THAT RESETTLED  
REFUGEE YOUTH PRESENT WITHIN PRIMARY HEALTH CARE SETTINGS

A Dissertation

Presented To the Faculty of the Department of Human Development and Family Science

East Carolina University

In Partial Fulfillment of the Requirements for the Degree

Doctorate in Medical Family Therapy

by

Florence Joy Olabece Lewis

July, 2019

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## **CHAPTER 1: INTRODUCTION**

### **Defining Refugee Youth**

The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as an individual who is forced to leave their country of origin to “escape persecution, war or violence” (UNHCR, 2018). The traditional resettlement process is a legal one orchestrated by the host countries so that refugees can be placed in a lawful and secure way (UNHCR, 2018). Individuals and families must meet one of four criteria in order to be resettled which include having a pressing medical need, being a female who is at risk of harm, being a child who is at risk of harm or being a survivor of violence or torture (UNHCR, 2018). According to the UNHCR, more than half of the world’s displaced people, meaning those who no longer live in their host country or city because they have to flee from danger, are children (UNHCR, n.d.). In 2016, UNHCR reported that there were 22.5 million refugees worldwide and a portion of them were legally resettled in the United States (UNHCR, 2017). Resettled persons represent a mixed, heterogenous group. Roughly 85,000 refugees were resettled in the U.S. in 2016 predominately coming from the Democratic Republic of Congo, Syria, Burma, Iraq and Somalia (U.S. Department of State, 2017 January 20).

UNHCR has instrumented the process of setting standards for the treatment of refugee youth for the world. Before creating a specific policy for refugee children in 1988, children were seen having the same rights as adults. In order to improve and enhance the protection and care of refugee children created in 1988 and adopted in 1993. Going forward, refugee children were seen as a special population with precise rights because they were “vulnerable, dependent and developing”. Furthermore, the policy stressed the need for community-based primary health care services to promote the child’s overall development (UNICEF, 2005).



## **Ecological Systems Theory**

As the literature highlights the unique needs of resettled refugee youth upon resettlement, the complexity of the needs of this population can be comfortably conceptualized through a theory that lends itself to intricacy and multi-layered influences. Ecological systems theory (EST; Bronfenbrenner, 1979, 1977) describes the identity of an individual being shaped by the interactions of multiple levels of society. These levels of society are considered to be living organisms that grow and develop and the individual develops. There are six levels of EST ranging from the ontogenic level, micro system, mesosystem, exosystem, macrosystem and chronosystem. As youth develop, they are constantly being impacted by the interaction of these multiple systems. These systems are continuously influencing their development and, in turn, as they grow, they are also affecting the revolving systems around them as well. As EST surpasses over 40 years since its creation, it is still being used as a theory to conceptualize children's development in research. Endless studies have used EST as a foundation to conceptualize factors that capture the systemic nature of the human experience (e.g. Graves & Sheldon, 2018; Schneiderman, Smith, Arnold-Clark, Fuentes & Duan, 2013; Tzeng & Gau, 2012). For the purpose of this study, EST will be used as a base through each chapter of this dissertation which include a literature review of the behavioral health needs of resettled refugee youth through a EST lens, a systematic review with results yielded categories through the levels of EST and then an explanatory, sequential mixed-methods design research study guided by EST principles.

### **Needs of Resettled Refugee Youth and Pediatric Primary Healthcare**

Resettled refugee youth are highlighted globally as having significant health concerns upon resettlement (Taseen & Beaulieu, 2017; Sheikh et al, 2009). This may be caused by various factors, one being the lack of consistent, comprehensive preventative care upon resettlement

(Watts, Friedman, Vivier, Tompkins & Alario, 2011). Since lack of physical health care is a priority during the resettlement process, often times behavioral health concerns may be overlooked in treating resettled refugee youth in primary health care settings. When it comes to the behavioral health needs of refugee youth, trauma exposure is one of the major themes within the literature and the negative impact that it has on the mental health of refugee youth globally (Xu, 2007; Lustig et al, 2004). Trauma exposure, as explained in the literature, could potentially have negative effects on the child's overall development (Kaplan, Stolk, Valibhoy, Tucker & Baker, 2016; Seery, Boswell & Lara, 2015; Betancourt et al., 2012; Kira, Lewandowski, Somers, Yoon & Chiodo, 2012) which suggests the need for specialized intervention. Exposure to traumatic experiences is a major theme punctuated by many researchers in discussion of the mental health needs of this population, particularly emphasizing the gap in tools to assess the psychological impact of trauma exposure in a culturally appropriate, valid and reliable way (Gadeberg, Montgomery, Frederiksen & Norredam, 2017; Ehntholt & Yule, 2006; Hollifield et al, 2002). Since youth often see providers frequently as they develop, pediatric primary health care settings have the potential of providing a collaborative and holistic approach in addressing behavioral health needs among this population (Murray, 2016).

### **Unmet Mental Health Needs of Racial and Ethnic Minority Children in Primary Care**

There is limited literature on the unmet behavioral health needs of resettled refugee children in primary care within the U.S. In order to get a sense what these needs are and how best to intervene, its beneficial to examine the larger category that many resettled refugee youths may belong to, being racial and/or ethnic minorities. Much of the literature has highlighted the mental health disparities for racial and ethnic minority (REM) youth, including underutilized behavioral health services (Pires et al, 2013; Kataoka, Zhang & Wells, 2002). REM youth have

been found to have significant mental health needs as they present in primary care ranging from substance use concerns (Kelly et al, 2014), nightmares triggered by trauma exposure (Peterson, Lewandowski & Chiodo, 2011), depressive symptoms at a higher prevalence rate compared to the general population (Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith, 2010) and overall emotional and/or behavioral problems surpassing the screening cutoffs (Hourigan, Southam-Gerow & Quinoy, 2015). Additionally, various screeners have been validated to ensure that youth are assessed with culturally appropriate screeners in primary care (e.g. Castro, Billick & Swank, 2016; Rausch, Hametz, Zuckerbrot, Rausch & Soren, 2012). Overall, there has been a general theme in the literature exploring the behavioral health needs of REM youth in primary care, that there are multiple factors influences the ability for them to be screened and access treatment. For this reason, a systematic review was conducted exploring prominent themes in the literature. Once the review was completed, 2,016 articles were examined. Once all of the articles were reviewed. 40 articles remained that fit within the inclusion criteria. Themes that arose from the analysis included: provider selected screenings, stigma and patient-provider communication, provider selected treatment and, prevalence and need. Each theme was conceptualized through a level of EST and implications were made for clinical practice and research.

### **Purpose and Design**

The explanatory, sequential mixed-methods design was elected to examine the behavioral health needs of resettled refugee youth in primary health care settings. and how they compare to that of a general pediatric sample. An explanatory, sequential, mixed-method study design is defined as a type of mixed-methodology with two parts, first quantitative data is collected and analyzed, then a qualitative analysis is conducted to explain the quantitative results (Miller & Johnson, 2014). For this study, the quantitative data involved a secondary dataset, the North

Carolina Child Health Assessment and Monitoring Program (CHAMP) 2005 to examine factors that increase the likelihood that a child is told that they have a behavioral health need. Once the results were collected, they were used to guide the semi-structured interviews with primary health care providers treat resettled refugee youth. During the course of the qualitative data collection process, the population of interest was expanded to include all displaced youth since the immigration status of being traditionally “resettled” could not be determined along the majority of the participants discussed their experiences with youth that could be identified as refugees within the definition provided by UNHCR. Research question was “what are childhood factors increased the likelihood of being identified with a behavioral health need and how did those factors compare to the behavioral health needs of resettled refugee youth as reported by primary health care providers?”. The hypothesis was also two part:

- H1: There will be significant ontogenic and mesosystem level differences in the endorsement of either being told or being diagnosed with a mental/behavioral health problem.
  - H1a: On the ontogenic level, there will be significant race, ethnic, gender and parental reported child’s physical health differences in the endorsement of either being told or being diagnosed with a mental/behavioral health problem.
  - H1b: Once mesosystem level, there will be significant differences in whether the child has a personal doctor/nurse, spoke to their school nurse about health needs and if they have attended a preventive care visit and if the child endorsement of either being told or being diagnosed with a mental/behavioral health problem.

- H2: Behavioral health needs will be discovered during the exploration of lived experiences of primary care providers who treat resettled refugee youth will along with factors that may increase the likelihood of youth who are identified with needs.

Once the study was completed, there were significant results related to gender, age, ethnicity and health care utilization that were consistent between both quantitative and qualitative phases of analysis. Several new themes arose out of the qualitative analysis that were not present in the quantitative analysis. These themes included the presence of psychosomatic symptoms among youth, resiliency, adjustment challenges, language barriers and deficiencies in addressing behavioral health needs of displaced youth in primary health care settings. This study was conceptualized through EST and the discussion of results align with core concept of EST.

### **Summary**

Conclusively, this dissertation includes six chapters exploring the unmet behavioral health needs in order to support the assessment, diagnosis and treatment of this population. First is the introduction including a brief overview of the dissertation as a whole. Chapter two which is a literature review on the unmet behavioral health needs of resettled refugee youth through an EST lens.. Chapter three is a detailed explanation of the methodology of the mixed-method design. Chapter four is a systematic review of the unmet behavioral health needs of racial and ethnic minority youth. Chapter five summarizes the results of the analysis and chapter six is a discussion of the results and conclusion of the dissertation.

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## CHAPTER 2: LITERATURE REVIEW

*“The best way to help refugee children is to help their families, and one of the best ways to help families is to help the community”*

(United Nations High Commissioner for Refugees, 1994)

### Introduction

There is an increasing need to promote the awareness of the psychosocial needs of resettled refugee youth in pediatric primary health care settings (Murray, 2016). According to the United Nations High Commissioner for Refugees (UNHCR), more than half of the world’s displaced people are children (UNHCR, n.d.) and among the 22.5 million refugees reported by UNHCR in 2016 a segment (approximately 85,000) of those were resettled in the U.S. (UNHCR, 2017). Unfortunately, there are no current statistics of how many of those resettled within the U.S. were children. Refugee youth that formally resettled in host countries, like the U.S. have been identified in the literature as having various behavioral health needs and negative behavioral health outcomes as a result of multiple factors including forms of trauma related to forced displacement (Seery, Boswell & Lara, 2015, Betancourt et al., 2012, Xu, 2007; Lustig et al, 2004).

Pediatric primary care is seen as the patient’s first and the closest level of engagement with the health care system (Institute of Medicine, 1996). Internationally, the behavioral health needs of refugee youth as they present in primary health care settings is a growing topic of discussion and investigation. Pediatric primary health care settings present a unique and necessary setting to address behavioral health needs because resettled youth may frequent their

primary medical clinic often during their development (Murray, 2016). Pediatric primary care creates an ideal environment for the identification of behavioral health needs among resettled refugee youth. The literature has described various aspects that impact poor health outcomes among resettled refugee youth, ranging from familial influences to societal ones (Eruiyar, Maltby & Vostanis, 2017; Sangalang, Jager & Harachi, 2017; Garakasha, 2014). Given the multiple levels of needs that resettled refugee youth present in primary health care settings, it may be difficult to prioritize needs, especially behavioral health needs. There is a need to organize the developing literature on resettled refugee behavioral health needs to inform the practices within pediatric primary care settings. To do so, a theory is needed that can capture the multi-levels of influence within the literature. The purpose of this paper is to review the literature through a theoretical lens and provide suggestions for behavioral health screening practices within primary health care settings for providers who treat resettled refugee youth.

### **Application of Ecological Systems Theory**

Created by Urie Bronfenbrenner, Ecological Systems Theory (EST) is based on the premise that a person's development is impacted through various levels of their environment (Bronfenbrenner, 1977; 1979). As explained in Bronfenbrenner's work (1977; 1979), there is an existing need to assess human development in the context of an individual's changing environment and the ever-shifting social context that is present within that environment. Within the literature on refugee youth and behavioral health needs, researchers address the multiple factors that impact these populations and systems that influence the presentation of behavioral health concerns. These could be considered the external factors that may influence their overall psychosocial or socioemotional development. This environment, in EST, consists of a series of structures that are nested within each other (Bronfenbrenner, 1977). Bronfenbrenner labeled six

levels of the systems within the environment impacting human development: ontogenetic level, microsystem, mesosystem, exosystem, macrosystem and chronological system (Bronfenbrenner, 1977). In completing this literature review, there is a need to organize the various needs that these populations have been reported, and EST provides a great platform to discuss these needs.

### **Individual - Ontogenetic**

The *ontogenetic* consists of characteristics that identify the youth as an individual including like their age, biological sex, behavioral and physical health (Bronfenbrenner, 1979). For refugee children, there are major health disparities that have been identified, and physical health needs tend to be the focus when youth are being resettled. In healthcare, a high disease burden has been reported for refugee children like infectious diseases (Sheikh et al, 2009) and vitamin D deficiency (Taseen & Beaulieu, 2017; Sheikh et al, 2009). Additionally, vaccinating resettled youth is a concern during the resettlement process (Watts, Friedman, Vivier, Tompkins & Alario, 2011). Refugee youth may not have received needed vaccinations or have documentation of having received certain vaccinations, and both instances produce unique health concerns. Although, refugees are required to meet certain health requirements when they enter the U.S., vaccinations for children is not one of them (Watts, Friedman, Vivier, Tompkins & Alario, 2011). Given the focus on physical health needs among resettled youth upon arrival, particularly vaccination disparities, behavioral health needs often may not be a priority until psychopathology is evident.

In addressing behavioral health needs of refugee youth, negative outcomes have been found as a result of exposure to traumatic experiences (Xu, 2007; Lustig et al, 2004). Experiences of trauma pre- or post-resettlement is at the core of unmet behavioral health needs

of resettled youth because of its rippling effect on other aspects of the youth's development. For example, the experiences of trauma have been found to impact children's IQ (Kira, Lewandowski, Somers, Yoon & Chiodo, 2012) and ability to learn a new language (Kaplan, Stolk, Valibhoy, Tucker & Baker, 2016). The complex trauma faced by refugee youth may include loss, grief and separation from loved ones. Trauma-related symptoms have the potential of impacting their overall development along with harboring attachment deficiencies with their caregivers (Betancourt et al., 2012) and an overall sense of security (Seery, Boswell & Lara, 2015). Additional behavioral health concerns found among youth include posttraumatic stress disorder (PTSD), depression and anxiety (Seery, Boswell & Lara, 2015). Trauma is one of the key points discussed in the literature of resettled youth yet, there are not many culturally appropriate, valid and reliable assessments available to assess the behavioral health impact of the trauma exposure (Gadeberg, Montgomery, Frederiksen & Norredam, 2017; Ehntholt & Yule, 2006; Hollifield et al, 2002).

### **Microsystem**

The *microsystem* describes the interactions that an individual has in immediate settings (Bronfenbrenner, 1977), such as those with immediate family, peers and/or community resources like church organizations. Much of the literature on the microsystem discusses the impact of parental relationships with the refugee youth or the lack thereof. Unaccompanied refugee minors, defined as youth separated from their parents or caregivers during migration and resettlement, are particularly susceptible to behavioral health concerns. Adolescents who fled without their parents were found to experience more trauma compared to those who were accompanied. Unaccompanied girls experience more trauma than unaccompanied boys (Derluyn, Mels & Broekaert, 2009). The complex stressors of being unaccompanied refugee adolescents lead to

outcomes such as higher rates of depression, anxiety, behavioral problems, and PTSD symptoms (Seery, Boswell & Lara, 2015). During post-resettlement in Norway, higher depressive symptoms were reported among Afghani, Somali, Sri Lankan and Iraqi youth resettled in areas where a higher portion of people had higher levels of education (Seglem, Oppedal & Raeder, 2011). Also, in Norway, among primarily Afghani, Eritrean, Somali and Sri Lankan adolescents and young adults, youth reported increased stress and suicide ideation post-resettlement (Jensen, Skårdalsmo & Fjermestad, 2014). Among unaccompanied resettled minors in the U.K., a sample of predominately Black African youth were found to have a higher risk for PTSD and depressive disorder (Sanchez-Cao, Kramer & Hodes, 2012). Conclusively, unaccompanied youth are at risk for increased behavioral health concerns post-resettlement compared to youth that are accompanied by a caregiver. One area that wasn't identified in the literature discussing unaccompanied minors was who tends to provide them with support if they do not have a parent or caregiver with them.

For resettled youth whose parents were present post-resettlement, their presence has been found to support both positive and negative behavioral health outcomes. Even though a sample of U.S. resettled Iraqi youth were found to have increased traumatic stress and depressive symptoms when they reported experiencing a possibly traumatic event, depressive symptoms were fewer among youth who had "positive feelings" toward school and felt supported by their parents (Trentacosta, McLear, Ziadni, Lumley & Arfken, 2016). Refugee children of divorced parents resettled in Sweden scored significantly higher on internalization and somatization symptoms compared to immigrant children and Swedish children (Svedin, Back & Wadsby, 1994). Among children of Southeast Asian refugee families in the U.S., family functioning was significantly found to impact child's depressive symptoms, antisocial behavior, and delinquent

behavior in a longitudinal study (Sanglang, Jager & Harachi, 2017). When it comes to assessments, parents were found to rate a sample of Denmark resettled Middle Eastern youth lower on the externalizing behaviors compared to how youth would rate themselves (Montgomery, 2008). Moreover, among a sample of Syrian refugee children resettled in Turkey, parental mental illness was found to negatively impact their child's mental and emotional health (Erucar, Maltby & Vostanis, 2017). There seems to be literature supporting the protective factors that parents provide for youth along with the struggles that children face that are influenced by their parents.

### **Mesosystem**

The *mesosystem* constitutes the interaction between the multiple systems in the microsystem (Bronfenbrenner, 1977). Within the mesosystem, this includes the family's interactions with outside systems, like the health care system. Although much of the literature discusses barriers to care as the cause of underutilization of behavioral health services, there are not many studies that have specifically examined what these barriers are (e.g. Ellis et al., 2011). As articles have examined low behavioral health care utilization among resettled refugee youth, some have concluded that there is a lack culturally sensitive care and resources for resettled families (Ziaian et al., 2012; Davies & Webb, 2000). Some families may have a difficulty navigating the health care system to receive behavioral health services (de Anstiss et al., 2009). The way in which families identify and define behavioral health problems has also been identified, given that many behavioral health diagnoses are based in Westernized conceptualizations (May et al., 2014; Pacione, Measham & Rousseau, 2013). Resettled families may also underreport the psychological symptoms of youth because they fear it may impact their resettlement status in the host country (Ziaian et al., 2012). Since referrals for behavioral health



treatment may not be utilized, there has been a promotion of integrated health care approaches in address these unmet needs (Minhas et al., 2017). How resettled youth are referred to psychiatric services has also been assessed (Barghadouch et al, 2016; Howard & Hodes, 2000). One theme within the literature is that there is an underutilization of psychiatric (Bean, Eurelings-Bonteke, Mooijaart & Spinhoven, 2006) and behavioral health services (de Anstiss et al, 2009) among resettled refugee youth worldwide. Much of what was gathered and written about this population is how there were barriers to behavioral health care utilization.

### **Exosystem**

The *exosystem*, considered to be an extension of the mesosystem, outlines the influence of the social structures influencing an individual's development that the individual is not immediately included in (Bronfenbrenner, 1977, 1979). In primary care, there are clear concerns regarding access to care as a result of insurance types, ethnic background (Kataoka, Zhang & Wells, 2002), access to behavioral health services (Pires et al, 2013), language barriers (Herbst, Margolis, Millar, Muther & Talmi, 2016), and higher levels of various behavioral health symptoms among racial and ethnic minority groups (e.g. Merikangas et al, 2010). Caring for resettled youth's overall health needs is complex because of cultural differences related to health and the ability of resettled people in navigating the health care system (Seery, Boswell & Lara, 2015). In addition, toxic stress accumulated post-resettlement may also impact the youth's overall health (Murray, 2017). In the U.S., refugees are provided health care upon arrival but may have trouble accessing care (e.g., provide a few examples why here). This program is called the "Refugee Medical Assistance" and is available for the first eight months within the U.S (Office of Refugee Resettlement, n.d.). After those eight months have expired, the adult refugee may need to buy their own health insurance through the Affordable Care Act (ACA). For

resettled refugee children, they are eligible for Medicaid or the Children's Health Insurance Program (CHIP). Although resettled refugee children have care coverage in the U.S., there still is a need to assist families in being able to navigate the U.S. health care system as Medicaid or CHIP recipients (Office of Refugee Resettlement, n.d.). Troubles navigating these services alongside many of the other barriers mentioned adds another level to addressing behavioral health needs within primary care settings with this population.

### **Macrosystem**

The *macrosystem* addresses the existing, shifting culture that governs the environment impacting an individual's development (Bronfenbrenner, 1977). Pew Research Center (Krogstad & Radford, 2017) has found that the majority of Americans have generally disagree with refugee resettlement within the U.S. This statistic mirrors the negative U.S. sentiment towards refugees in the country. Given this overarching tone towards refugees, children may be aware and negatively impacted by these messages. Acculturation stress is among one of the stressors among refugee families, particularly parents fearing that their children will not uphold the beliefs and traditions from their culture of origin (Garakasha, 2014) and distrust of authority (Ellis, Miller, Baldwin & Abdi, 2011) may be a real aspect of the realities that refugee youth face. Refugee youth may also be experiencing toxic stress as they try to cope with previous and current, burdensome stressors and traumas (Murray, 2017). With the overall culture and negativity towards refugee populations within the U.S., there is a need to engage refugee youth in a culturally sensitive way, incorporating family treatment to manage the daily stressors they may face in the U.S. (Marshall, Butler, Roche, Cumming & Taknint; 2016). These societal influences would be an important factor to consider in creating systems to support resettled youth and families within primary health care settings.

## **Chronosystem**

Lastly, the chronological system addresses how in individual development is impacted by their environment overtime (Bronfenbrenner, 1977). Aside from the political shifts and conflict that have encouraged the increasing displacement of peoples globally, there have been policies that have taken place over time, nationally and internationally, by the UNHCR to support the care of refugee children. Since the U.S. refugee program opened in 1980 with the Refugee Act, 3 million refugees have been resettled in the U.S. To date, the U.S. is said to operate one of “the world’s largest formal refugee resettlement program[s]” (Hooper et al, 2016). A major milestone in the U.S.’s refugee resettlement program is The Refugee Act of 1980 which was created to help refugees resettle in the U.S. by achieving economic stability and self-sufficiency post-resettlement (Office of Refugee Resettlement, 2012). Since 1980 until now, 2018, many shifts have taken place that influenced the number of refugees that have been resettled within the United States including the restriction of refugee resettlement from Middle-Eastern, Muslim dominant countries post-September 11<sup>th</sup> 2001 and just recently at the beginning January of 2017 by the Trump Administration (Felter & McBride, 2017; Off, 2017). As these political and societal shifts continue to take place, there is a need to acknowledge the possibility that they too may impact a resettled youth’s overall development.

Globally, UNHCR has played a crucial role in setting standards for the treatment of refugee children. Historically, rights for refugee children have not always been overt and visible as it is related to policy. A set of standards first arose from the 1951 Refugee Convention and 1967 Protocol Relating to the Status of Refugees that applied “to children in the same way as to adults” supporting child rights as refugees as well as adults (United Nations High Commissioner for Refugees, 1994). One of the influential events that occurred supporting the rights of refugee

children was the 1989 Convention on the Rights of the Child (CRC) in which proposed a treaty that set the most standards concerning children worldwide, refugee or non-refugee. This was considered a “major innovation” because it gave human rights to children. The UNHCR adopted the standards set as a result of the CRC and uses them as “guiding principles” for the treatment of refugee children (United Nations High Commissioner for Refugees, 1994). Among these standards set by the CRC, children are supported in “physical and psychological recovery and social reintegration” and the “highest attainable standard of health” also “to diminish infant and child mortality”, to develop “primary health care and to tach child health and nutrition” (United Nations High Commissioner for Refugees, 1994).

In order to improve and enhance the protection and care of refugee children, UNHCR has adopted a Policy on Refugee Children, endorsed by the UNHCR Executive Committee in October 1993. The UNHCR Guidelines on Refugee Children, first published in 1988, have been updated in the light of the new Policy and are presented in this document. Ideally, children need special attention because they are vulnerable, dependent and developing. To reach all children emphasizes implementation of community-based primary health care services, which, through out-reach, focus on monitoring risks to health and on preventive health interventions. As a result of this Convention, approximately 192 countries have ratified this human rights treaty, the U.S. has yet to ratify it, meaning that the U.S. is not bound to these standards set by the UNHCR (UNICEF, 2005).

### **Implication for Clinical Practice**

EST provides a great platform to discuss the multifaceted needs of resettled refugee youth, highlighting that the literature has considered these needs on multiple levels. From this

literature review, key implication can be deduced to inform screening practices in primary health care settings within each level.

### **Focus on Functioning**

As discussed in the literature on the ontogenic level, there is a heavy disease burden among resettled youth (Sheikh et al, 2009) which often takes priority over behavioral health needs. Trauma exposure, pre- and/or post- resettlement was a prevalent theme within the literature with this population. Gadeberg et al (2017) that trauma assessments that focus more on resiliency and/or functioning may be a better gauge of behavioral health need compared to tools that are more geared towards symptom identification. With the mental health stigma in many refugee communities in discussing behavioral health need, particularly in regard to depressive and anxious symptoms, more of a functioning based approach could be much more culturally appropriate. For youth, functioning items for screening could include the client's ability to maintain social relationships, academic achievement, and completing tasks around the home depending on what is developmentally appropriate. To expand the assessment of the youth's functioning to screen for behavioral health concerns in a culturally sensitive way, this functioning assessment can include family relationships as well.

### **Family Functioning**

As identified in the literature within the microsystem, there is a clear line drawn in the development of behavioral health needs between youth who are accompanied (e.g. Sanglang, Jager & Harachi, 2017; Trentacosta et al, 2016) versus unaccompanied (e.g. Seery, Boswell & Lara, 2015; Seglem, Oppedal & Raeder, 2011; Derluyn, Mels & Broekaert, 2009). In screening behavioral health needs, familial relationship would be important to consider, specifically how

these relationships may contribute to poorer behavioral health outcomes. For example, one element of resettled refugee families that is unique is that familial composition upon resettlement may not only vary from family to family, but also during the resettlement process. Families may have been broken up and youth may be dealing with feelings of grief that may enable them to perform certain tasks and/or assume new roles upon resettlement. Discussing this new role with youth and the families that they belong to may allow for a better understanding of stressors and/or protective factors. Discuss any conflicts within the family, who the youth feels most comfortable talking to and how the youth's communication is within the home. According to assessment tools, there is more research needed on assessing family functioning with refugee families.

### **Finding Treatment**

As outlined by the mesosystem, there is a significant barrier to behavioral health services for resettled refugee families (May et al., 2013; Pacione, Measham & Rousseau, 2013; de Anstiss et al., 2009) and underutilization of behavioral health services (Minhas et al., 2017; Ellis, et al., 2011). One of those barriers is the difficulty navigating the health care system. As youth are screened, their ability to navigate services offered is crucial along with their comfortability in accessing services. Given the behavioral health stigma, accessing behavioral health services may not be a priority even once behavioral health needs have been identified but, asking questions about the family's knowledge of these services can be useful during screening. Additionally, asking if the family has once tried to utilize services but were not able to, this may bring to light other present barriers.

## **Global Influences**

As identified in the chronosystem, there are shifts taking place within the treatment and care of refugee youth that has taken place over the course of many decades. One of the privileges that primary health care providers have in working with resettled refugee families is that this work then contributes to a larger, global community. Global health issues are being addressed every-time a resettled refugee is treated within the U.S., it is inevitable. Additionally, there are policies that are currently being developed that impact resettled families locally and internationally. For screening purposes, primary care providers may be addressing behavioral needs that are influenced by events that took place in another country and cultural context along with occurring at a different development stage because youth move through various developmental stages quickly. It may be incredibly helpful to discuss cultural factors that are influencing the client's functioning and impairment. Daily functioning and impairment can be culturally sensitive, so it would be usual to assess for the family's means of measuring that.

## **Limitations and Future Research**

Limitation to this literature review include that it was that literature discussed was global and each county that accepts refugees has their own policies related to how those individuals will be treated within health care settings. Since the treatment of refugee youth is a global concern, there is a need for more literature on how to support this population in health care settings in the U.S. Another limitation to this review was that the samples included covered a broad span of ethnic backgrounds. Grouping all refugee youth into one group and seeking to make clinical implications upon those collective findings is difficult because is a variable that may shift dramatically from one refugee family to the next. Lastly, a limitation of this review was that the authors solely focused on literature that included youth identified as "resettled refugee" which a

category underneath a larger category of displaced people. Since this review gathered literature from multiple countries, definitions of what a refugee is may vary along with how refugee status could be achieved.

For future research, much of the literature identified discusses adolescents (Garakasha, 2014; de Anstiss et al, 2009; Bean, Eurelings-Bonteke, Mooijaart & Spinhoven, 2006 ) and there is limited research on younger children. This finding is consistent within the literature as well (Gadeberg et al, 2017). Future research should include building culturally sensitive tools and guides for primary health care providers to use in screening resettled refugee youth for behavioral health needs. There is a need to develop trauma-focused tools specifically catered to primary health care to assess behavioral health needs, particularly considering the impact of displacement. There is also a huge gap in the literature regarding younger children who are not adolescents and would also be a recommendation for future research.

### **Conclusion**

As the behavioral health need increases, primary health care settings present a great environment to interact with resettled refugee youth and address these needs. EST presents a great foundation and model to conceptualize the multiple environmental levels that could potentially impact the overall development of refugee youth. The literature thus far has helped create a strong base to identifying factors within each of EST's levels. More research is needed how to support refugee youth and their families upon resettlement. Improving care for this population may be able to aid the transition post-resettlement which could reduce the presence of negative behavioral health outcomes as they grow.



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## **CHAPTER 3: METHODOLOGY**

Globally there is a large gap in the literature on the behavioral health needs of refugee youth in primary health care setting. Since resettled youth may attend pediatric primary care more frequently as they develop, there is an increasing need to promote the awareness of the psychosocial needs of resettled refugee youth within this setting (Murray, 2016). Although the U.S. resettles a small portion of the nearly 20 million refugees each year (Cepla, 2019), there are not current statistics of how many of those are children. Globally, refugee children represent more than half of the world's displaced people (UNHCR, n.d.). Within the literature on the behavioral health needs of refugee youth, there are various emotional and social needs that have come forth because of negative experiences pre- and post-migration along with upon resettlement into a host country (Kaplan et al, 2016, Seery et al, 2015, Xu, 2007, Ehntholt & Yule, 2006). To better address behavioral health needs among various pediatric populations, pediatric primary care has been identified as the ideal setting for addressing mental health needs (Arora, Godoy & Hodgkinson, 2017). Since youth tend to see their primary care providers regularly for medical care, health care professionals like pediatricians often identify behavioral health needs in children (Heinly et al, 2018).

### **Defining Refugee Youth**

Before discussing the research study design, there is a need to create a clear definition of what the term “refugee” will be to complete this study. Influential in the creation of the global definition of refugee, United Nations High Commissioner for Refugees (UNHCR) 1951 Geneva Convention has an instrumental role in the creation of the current definition for refugee.

UNHCR's (1951) a refugee as someone who is :

“owing to wellfounded 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 or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.” (pg. 14).

The United Nations High Commissioner for Refugees (UNHCR), established in 1950, still maintains this definition today, defining a refugee as an individual who is forced to leave their country of origin to “escape persecution, war or violence” (UNHCR, 2018). For the purpose of this study, this definition of refugee will be used.

UNHCR has also set standards for the treatment of refugee youth for the world. Before 1988, children and adults had the same rights as refugees. To protect children and identifying them as a much more vulnerable population compared to adults, standards were created in 1988 and adopted in 1993. Refugee children were then defined as being “vulnerable, dependent and developing” which set them aside as an even more specialized group. Additionally, policy emphasized the potential benefit of community-based primary health care services to support adequate child development (UNICEF, 2005). The term “youth” was defined as children under the age of 18 even though some, particularly UNHCR, has referred to the term “youth” as representing a social construct dependent on each local culture (Evans, Lo Forte & Fraser, 2013).

### **Mixed-methods Rationale**

Once the population of interest was defined, it was time to create a research design to examine their needs. Although quantitative and qualitative methods have been noted as supporting contrary views, there are various commonalities between the two that, when used together, complement one another by adding a unique depth as a specified research methodology (Johnson & Onwuegbuzie, 2004; Onwuegbuzie, 2002). Quantitative research is largely grounded in the assumption that “that social observations should be treated as entities in much the same

way that physical scientists treat physical phenomena” (Johnson & Onwuegbuzie, 2004). The role of the researcher is to expel their own biases to separate themselves entirely from what is being studied. On the contrary, qualitative research is based in the assumption that the kind of separation from the data being examined, supported by quantitative research, is not realistic and does not lend useful to effective result interpretation (Johnson & Onwuegbuzie, 2004). The purpose of qualitative research is to marry the multiple realities of both researcher and the subjects being researched to build a thicker, and what is thought to be a more comprehensive, narrative (Creswell & Poth, 2018; Lincoln & Guba, 1985). In the conceptualization of this study, the researcher felt that both paradigms, quantitative and qualitative approaches, could potentially add value particularly to the field of refugee youth behavioral health.

There is limited literature on the behavioral health needs of resettled refugee youth in primary health care and originally this study was first conceptualized as a purely qualitative study because of the scarcity of research that currently exists. As there are many types of qualitative research designs, the phenomenological approach was selected because of its focus on a specific “phenomenon” to identify a common experience among participants (Creswell & Poth, 2018), in this case, that common experience sought to identified is that of primary health care providers and their lived experiences treating resettled refugee youth emphasizing the behavioral health needs that they encounter. The research question became, “What are the behavioral health needs of resettled refugee youth as recounted through the lived experiences of primary health care providers who treat them?”

Upon a careful examination of the literature, the study design moved from a purely qualitative, phenomenological design; to an explanatory, sequential, mixed-method study. An explanatory, sequential, mixed-method study design is a type of mixed-methodology in which

the quantitative data is collected and analyzed first. After the quantitative data collection and analysis is complete, its results guide the qualitative data collection process (Miller & Johnson, 2014). For this study, this research design was used to compare general behavioral health needs of a sample of youth to the reported lived experiences of primary health care providers as they treat resettled refugee youth and encounter behavioral health needs within this population. The research question for the quantitative phase of analysis is, “what are childhood factors increased the likelihood of being identified with a behavioral health need?” Results from the quantitative analysis was used to inform the qualitative phase of this study.

### **.Theoretical Orientation**

As the foundation for this study, Ecological Systems Theory (EST) is used. EST was chosen because it is based in the assumption that individuals develop in a complex, multilayered environment (Bronfenbrenner, 1977). The literature on refugee youth behavioral health needs within primary health care has punctuated how complex the needs of this population are because of factors such as histories of displacement, psychological trauma and social needs upon resettlement (e.g. Eruyar, Maltby & Vostanis, 2017; Taseen & Beaulieu, 2017; Seery, Boswell & Lara, 2015; Sanchez-Cao, Kramer & Hodes, 2013; Ziaian et al., 2012; Sheikh et al, 2009; Xu, 2007; Lustig et al, 2004). The multiple levels of an individual’s environment can influence the identification of behavioral health needs. Bronfenbrenner labeled six levels of the systems within the environment impacting human development: ontogenetic level, microsystem, mesosystem, exosystem, macrosystem and chronological system (Bronfenbrenner, 1977; 1979). For this study, the variables within the quantitative portion of the study represented the ontogenic system, characteristics that identify the youth as an individual including like their age, biological sex, behavioral and physical health, and mesosystem, symbolizing the interactions of multiple

systems within the microsystem, of EST. The research question is, on both the ontogenic and mesosystem levels, “what are childhood factors increase the likelihood of a child being identified with a behavioral health need?”.

### **Research Hypotheses**

For this mixed-methods research study, there was two hypotheses:

H1: There will be significant ontogenic and mesosystem level differences in the endorsement of either being told or being diagnosed with a mental/behavioral health problem.

H1a: On the ontogenic level, there will be significant race, ethnic, gender and parental reported child’s physical health differences in the endorsement of either being told or being diagnosed with a mental/behavioral health problem.

H1b: Once mesosystem level, there will be significant differences in whether the child has a personal doctor/nurse, spoke to their school nurse about health needs and if they have attended a preventive care visit and if the child endorsement of either being told or being diagnosed with a mental/behavioral health problem.

H2: Behavioral health needs will be discovered during the exploration of lived experiences of primary care providers who treat resettled refugee youth will along with factors that may increase the likelihood of youth who are identified with needs.

### **Study Design**

#### **Methodology for Quantitative Portion**

The purpose of quantitative inquiry is to test a developed theory through independent observation with a predetermined hypothesis with a sample size that will allow the finding of the research to be generalizable to the larger population of interest (Field, 2013; Johnson &

Onwuegbuzie, 2004). There are various strengths that quantitative analysis provides which include the precise results because of the numerical data and the independence that the data has from the researcher. Additionally, within quantitative analysis, larger samples can be used to come to more generalizable conclusions (Johnson & Onwuegbuzie, 2004). For the purpose of this study, a logistic regression will be utilized to examine a pediatric sample to determine their likelihood of being identified with a behavioral health concern.

**Source of Data.** The North Carolina Child Health Assessment and Monitoring Program (CHAMP) 2005 will be used for the purpose of this study which is a secondary dataset. The CHAMP is considered to be the first of its kind in North Carolina created to examine health characteristics of youth (0-17). CHAMP was first implemented January of 2005, with data collected independently each calendar year until 2014 in both Spanish and English. Subscales present in study include general health information, school performance, health conditions, mental health needs and nutrition. For this study, the 2005 version of the CHAMP is used because the survey iteration provided the most depth of mental health variables when compared to other versions of the dataset.

Children that were eligible for the CHAMP survey were chosen from a monthly drawing, or by random assignment, using the North Carolina Behavioral Risk Factor Surveillance System for adults. All adults chosen reported to have children living within the home. A requirement for the adult to participate in the study was that the adult had to be knowledgeable of the child's health needs. The overall mission of the CHAMP was to establish continued health surveillance on the needs of North Carolina's youth. Goals of the survey included: monitoring the status of child health (ages 0 through 17) and identifying health problems in North Carolina, measure parent's perspectives on child health issues, providing accurate and valid data, and assess the

relationships between parent health and child health (North Carolina State Center for Health Statistics, n.d.). Questions used in analysis are included in Appendix E

**Participants**

In the CHAMP 2005 dataset, the sample includes a sample size of 3,964 children.

Table 1

*Demographics of sample with the CHAMP 2005 (N = 3,964)*

<u>Sex/Gender</u>	
Female	1,933
Male	2,031
<u>Ages</u>	
0-6 years old	1,470
7-12 years old	1,225
13-17years old	1,268
<u>Race/Ethnicity</u>	
White, Non-Hispanic	2,630
Black, Non-Hispanic	706
Hispanic	379
Other	249

**Predictors**

**Ontogenic level.** The predictors included are race/ethnicity (Latino/non-Latino), and sex (male/female) that have been identified in the literature. For example, racial and ethnic minority female youth have been identified as having high levels of depressive symptoms (Champion, Young & Rew, 2016; Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith, 2010). Ethnically, Latinos have been found to be at risk for mental health concerns in primary care

(Ramos et al, 2017) and various racial minority groups have been found to be at risk for mental health concerns as well (Hourigan, Southam-Gerow & Quinoy, 2015; Kelly et al, 2014). All of the predictors are categorical variables aside from variable of age and child's health which were continuous. The variable identifying the parent's/caregiver's perception of child's health was a traditional 7 point Likert scale (1=Excellent; 2=Very Good; 3=Good; 4=Fair; 5=Poor; 7=Don't know/Not sure; 9= Refused). Variables within this level were designed to comprise of items related to the individual characteristics of the child thus representing ontogenic level within EST.

**Mesosystem level.** The predictors included in this level of analysis were all dichotomous. There were three variables included: whether the parent reported that the child had a consistent doctor or medical provider, if the parent/guardian spoke to the client's school nurse about health concerns and if the client had a preventative care/well child check within the past 12 months. Literature has shown that behavioral health needs have been identified within school settings by health professionals like school nurses specifically within the state of North Carolina (Villalba, 2011), for this reason, the researcher felt that it was an important variable to include within this study. Predictors within this level of analysis represent times when the child and the child's family have interacted with systems outside of the home like the health care and academic systems and how those interactions may have aided in the identification of emotion and/or behavioral needs in youth.

**Outcome Variable.** The outcome variable in all three analysis is "Has a doctor, other health professional or school representative ever told you that (CHILD) has an emotional or behavioral disorder, or problem(s) with social skills such as depression, anxiety, ADHD, or ADD (Attention Deficit Disorder)?" This variable will be utilized to represent the perceived mental



health need(s) of the child through the perspective of the health care provider or school official. Within the CHAMP dataset, further information is not provided on the type of health care provider (i.e. pediatrician, family nurse practitioner, medical assistant, etc.) or school representative (i.e. teacher, teacher's assistant, principal, office staff, etc.) that identified the child with this need.

## **Analysis**

A binary logistic regression was used for this study because the outcome variable is categorical allowing the data to uncover “membership” into a specific group (Field, 2013), in this case whether the child has been identified with an emotional, behavioral or social problem given a number of predicting, continuous and categorical variables. To date, there have been several studies that have successfully utilized a logistic regression in pediatric primary health care because the outcome variable is a specific diagnosis and/or diagnostic category (e.g. Herbst et al, 2016; Snedden, Pierpoint, Currie, Comstock & Grubenhoff, 2019; Sorg, Coddington, Ahmed & Richards, 2019). Before the study was conducted, assumptions for logistic regression were tested. These assumptions were (1) no perfect multicollinearity, (2) no specification errors and (3) specifications of how the independent variables can be measures (Meyers, Gamst & Guarino, 2016). Once the assumptions were tested and maintained, the researcher moved forward in completing the analysis. In order to test the two-part hypothesis, one logistic regression was ran to identify the likelihood that each predictor contributes to a doctor, other health professional or school representative has told the caregiver that the child has an emotional, behavioral disorder or problem with social skills. Since the assumption of EST is that multiple levels contribute to an individual's development, the ontogenic variables were included in the same logistic regression alongside the mesosystem variables. For this study, the goal was to identify if these ontogenic

and mesosystem variables increased the membership that youth had in being identified as having an emotional/behavioral health problem.

## **Methodology for Qualitative Study**

### **Qualitative Research**

The purpose of qualitative research is to explore the meaning that individuals or groups ascribe to a certain problem (Creswell & Poth, 2018). The qualitative approach was chosen for the examination of behavioral health needs and screening of resettled refugee youth through the perspective of primary health care providers to better understand unmet needs. There is currently very little research examining the health needs of resettled refugee youth in Southeast region of the United States. In utilizing the qualitative method, it is hoped that the complexities related to resettled refugee youth development, cultural factors and barriers within health systems will arise through the accounts of health professionals that work largely with this population. It is also hoped that the health professionals will be provided with a place to discuss their experiences with this population and ways in which processes could be improved. For this study, the phenomenological qualitative method was employed to summon the lived experiences of primary health providers who treat resettled refugee children have.

### **Phenomenological Approach**

The defining feature of a phenomenological approach is that it explores participants lived experience with a certain “phenomenon” to identify common experiences among the participants (Creswell & Poth, 2018). The phenomenological approach was chosen for this study because the main phenomenon to be explored was the encounters that primary health care providers had with resettled refugee youth in health care settings. Given the focus on this specific topic and experience, the sample needs to be heterogeneous, only including pediatric primary health care

providers. It is recommended that the sample includes approximately 10-15 participants (Creswell & Poth, 2018).

There are various procedures dedicated to employing the phenomenological approach. For this study, the Clark Moustakas (1994) procedures of executing a descriptive phenomenological study will be applied. The Moustakas method is considered to be among some of the stricter methods applied for phenomenological approach (Creswell & Poth, 2018, Moustakas, 1994). Steps in this method include (1) topic discovery, (2) reviewing relevant literature, (3) composing inclusion criteria for participants, otherwise known as “co-researchers”, (4) informed consent, confidentiality and ethical responsibilities, (5) formulating an interview guide, (6) interview completion and (7) organizing and analyzing the data (Moustakas, 1994).

The first step of topic discovery and the second step of reviewing the relevant literature almost went hand in hand as the researcher prepared to set the foundation for this study. Within these two steps, a research question was formed. There direct service with refugee families, the researcher found that there was a large behavioral health disparity among resettled refugees. There was particularly one case that stood out to the researcher of a young refugee adult who after being resettled experienced significant adjustment issues that manifested through somatic concerns. Instead of seeking behavioral health treatment to find positive ways to cope with severe levels of adjustment related stress, this young adult made multiple trips to her primary care provider and even went to the emergency room for concerns. Once she was examined, the doctors reported that they did not know what was wrong with her and sent her home with medication to help reduce the physical pain she felt. At the time, no one intervened regarding her mental health. Even if they would have, there was a cultural difference in her understanding of mental health treatment and stigma related to discussing it. When the researcher went into the

literature, it reflected barriers that refugee families faced in seeking behavioral health treatment (May et al., 2014; Pacione, Measham & Rousseau, 2013; de Anstiss et al., 2009 ). Furthermore, there was a huge deficit in the literature educating health care providers on the needs of resettled refugee youth as they make up a large portion of displaced peoples around the world (UNCHR, n.d.). Between the gap in the literature, personal experiences with refugee families and passion for increasing the presence of behavioral health awareness in medical settings, a research question was formulated. The research question became, “what are the behavioral health needs of resettled refugee youth through the lived experiences of primary health care providers who treat them?”

### **Data Analysis**

To execute the qualitative data analysis, Colaizzi’s (1978) seven step phenomenological method of analysis will be executed. This seven step method includes: (1) transcribing the interviews, (2) separating *significant statements*, or direct quotations that express the participants experiences of said phenomenon, (3) generating *formulated meanings*, or brief summaries of meanings of significant statements, (4) pulling formulated meanings into *thematic clusters*, or grouping similar meanings together, (5) creating an in-depth description, (6) determining a structure and (7) returning summary to the participant to confirm that lived experience was captured correctly. This process is to be conducted after each interview is completed.

### **Participants**

#### **Sample size**

A purposive sample of 10 – 15, recommended by Creswell and Poth (2018), primary health care professionals who work with and contribute to treatment plans benefiting resettled refugee children and adolescents was desired. At the conclusion of data collection, 12 participants were

included within the sample. At this point, the researcher reached a level of saturation and there was no need to continue sampling. Defined by Creswell & Poth (2018), saturation is the point that the themes are solidified by all participants. At this point, sampling ceased because saturation was reached. For this sample of primary health care providers that worked with resettled refugee youth, saturation included similar themes that arose during the various interviews related to common behavioral diagnosis, repetition of similar presentation of symptoms among refugee youth treated, commonalities among the general triggers to behavioral needs, a recurrence of a discussion of parental/guardian reactions to behavioral health needs and a common theme related to areas of potential improvement in the care of refugee youth in primary care regarding behavioral health.

## **Procedures**

### **Recruitment**

The researcher sought ECU IRB (East Carolina University Institutional Review Board) approval before moving forward to complete the qualitative portion of the study. Before seeking ECU IRB approval, the researcher completed the quantitative portion of this study in order to submit the qualitative interview guide for IRB approval. In order to recruit participants for the study, the researcher contacted the North Carolina Refugee coordinator for a list of health care providers in the state, sent the recruitment flyer (Appendix C) through the North American Society of Refugee Health Care Providers, contacted refugee resettlement agencies and resettled refugee service providers throughout the Southeast region. States contacted for recruitment were North Carolina, South Carolina, Virginia, West Virginia, Tennessee, Alabama, Arkansas, Mississippi, Louisiana, Florida and Georgia. Flyers were not only sent electronically by email

but were also faxed to various health clinics that were known for treating refugee families. Snowball sampling was utilized for participant recruitment as well. Inclusion criteria encompassed primary health care providers who provide medical treatment for resettled refugee youth. Included providers for this study were requested to be Pediatricians, M.D.s and D.O.s, Nurse Practitioners, Physician Assistants, Family Medicine Practitioners and Integrated Behavioral Health Care Providers.

### **Data Collection**

Data will be collected through 30-60-minute semi-structured interviews once informed consent is received (See Appendix F). The interviews were conducted in person (for two interviews) and by phone (for 10 interviews) with the researcher as the primary interviewer. For the in-person interviews, the researcher met at their place of work to conduct the interview. For the interviews conducted by phone, a time was scheduled between the researcher and participant by email. The researcher recorded the interviews with three separate recording devices to ensure that the contents of the interview are obtained. The recording instruments included an electronic hand recorder, a cellphone application to record phone calls and an electronic tablet (i.e. iPad). During the informed consent process, the participant was informed that the interview would be recorded. Additionally, the researcher took notes on a notepad to recorded general themes that will arise from the interview.

Once the semi-structured interview was completed, the participant will be asked to complete a brief quantitative, Qualitrics survey to provide information about their background as an individual, their experience as a health professionals and general information regarding the resettled refugee youth population that they serve (see Appendix G). These quantitative surveys will be completed electronically. A web-based link was provided before the interview was

completed with both the informed consent, completed at the beginning of the interview, and short demographic survey. At the end of the semi-structured interview, the participant was given time to complete the quantitative survey. Several participants read the informed consent, agreed to treatment and then completed the demographic survey before completing the semi-structured interview. This information was stored electronically and was not utilized for any data analysis. Information was only be reported as demographics in reporting the study results. Once each interview was completed, the researcher will transcribe using the Rev transcription service (<https://www.rev.com/>) and code the interview to deduce themes according to step seven of Colizzi's (1978) method for phenomenological data analysis.

### **Addressing Trustworthiness**

In order to ensure validity of the results obtained during the qualitative phase of analysis, three forms of trustworthiness were performed. This three steps included using a triangulated researcher to review the transcripts and themes created, maintaining an audit trail and member checking.

#### **Triangulated Researcher**

Triangulation is a manner of ensuring that the data will be credible (Lincoln & Guba, 1985). The researcher triangulated the data by having another researcher review the transcript. This triangulated researcher was a professor in qualitative research and has had years of experience conducting qualitative research. As a result of the reflexivity project, the researcher (FL) acknowledged various personal biases, which included being a African-American female who was born in the U.S./western society to an English speaking, immigrant family who may be culturally different from many of the refugee groups discussed. FL also identified as being a

mental health professional that has a slightly different professional culture compared to primary care medical providers. She felt that she partially understanding the concept of acculturation second-hand because have one parent who immigrated to the U.S. during adulthood and only being fluent in one system of spirituality/religiosity which is Christianity. To make sure these biases were monitored during the data analysis process. Once the data analysis is complete, the researcher provided the triangulated researcher with the transcription of the results of the interviews once collected and compare them with the themes derived from the data. This individual was added onto the ECU IRB application for approval. The purpose of these steps was to ensure that the triangulated researcher was able to constructively critique the themes deduced from the data and solidify the credibility of the results. The triangulated researcher was this person because of their lengthy experience in qualitative research data collection, data analysis and education in qualitative research methods.

### **Audit Trail Documents**

An audit trail is the process of memoing or journaling all of the steps taken throughout the data collection and theme creating process (Creswell & Poth, 2018). In order to ensure validity of the study results, the researcher completed an electronic audit trail. The documents that will be used in the audit trail are: a research log with dates and times of all activities contacts and decisions made throughout the study, handwritten field notes taken during and after each interview (participants names will be used as pseudonyms in order to protect confidentiality) and an electronic reflexive journal to record the researcher's reactions, assumptions, biases and overall self-awareness.



## **Member checking**

In qualitative research, member checking is defined as the process that participants are able to provide feedback in order to validate the themes found through the interviews (Creswell & Poth, 2018). This process can be done either formally, or informally. The benefits of member checking include the participants being able to confirm the responses collected, provides the respondents an opportunity to correct errors and allows the researcher to be certain of direction of the data collection process align with the research question. For this study, the member checking process was be utilized. After each interview is completed, the recordings were transcribed, coded and a summary was sent to each participant electronically. The participants was be able to send their additions or corrections electronically or make those changes by phone.

## **Data Storage**

Data was stored electronically on the researchers password protected personal computer. In the files stored, the participants included in the study will be de-identified. The researcher is the only one with access to this computer.

## **Summary**

The aim of this project was to assess and examine the mental health needs of resettled refugee children in the Southeast region. In order to do so, there was a need to analyze data on a general pediatric population within the region in order to inform the qualitative data collection among pediatric primary health care providers. Since the literature supports the behavioral health need of resettled refugee children globally, there was a need to assess how those concerns present in primary health care. It is hoped that the findings from this study will provide more concrete information on the behavioral health need of refugee children in the state and promote

the implementation of specified behavioral health assessments and treatments within these settings.

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## **CHAPTER 4: SYSTEMATIC REVIEW**

### **Introduction**

Behavioral health care is a growing health-related issue among children under the age of 18. Currently, behavioral health care for children accounts for one of the fastest growing health care expenditures (Alegria, Green, McLaughlin & Loder, 2015). In terms of Medicaid spending, child behavioral health services represent approximately 38% of Medicaid cost while children only represent 10% of the overall Medicaid population (Pires et. al., 2013). To meet the behavioral health needs with various pediatric populations, there has been significant growth in the literature within the topics of assessment and treatment of behavioral health needs in primary health care settings (e.g. Habeger & Venable, 2018, Yogman, Betjemann, Sagaser & Brecher, 2018, Watanabe-Galloway, Valleley, Rieke & Corley, 2017). There have been several systematic reviews (e.g. O'Brien, Harvey, Howse, Reardon & Creswell, 2016; Richardson, McCarty, Radovic & Suleiman, 2016; Webb, Kauer, Ozer, Haller & Sancu, 2016; Bower, Garralda, Kramer, Harrington & Sibbald, 2001) and a meta-analysis (Asarnow, Rozenman, Wiblin & Zeltzer, 2015) conducted on addressing behavioral health needs in pediatric primary health care settings. It is clear that the pediatric population have benefited from the implementation of behavioral health assessment and intervention in primary health care settings.

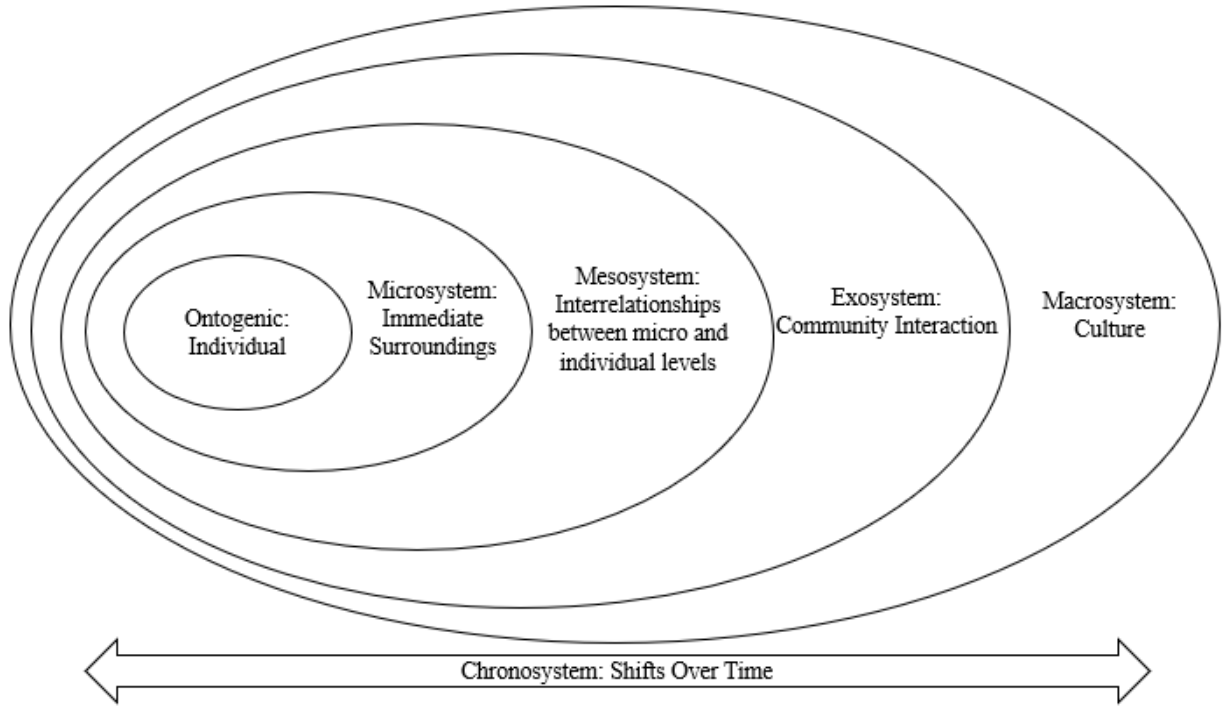
As this area of literature continues to gain momentum, children representing minority groups are still found to experience significant behavioral health needs including being under-diagnosed and other significant barriers that prevent access to adequate behavioral health care (Alegria, Vallas & Pumariaga, 2010). Predominately racial and ethnic minority populations have been found to have a significant rate of substance use disorders (Champion, Young & Rew, 2016; Kelly et al, 2014), prevalent depressive symptoms (Amaral et al; 2011; Villalba, 2011;

Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith, 2010), trouble coping with stress (Ramos et al, 2017) and overall emotional and/or behavioral problems (Hourigan, Southam-Gerow & Quinoy, 2015). As the behavioral health needs for minority youth persists, there is a need to examine the current literature available to support the evidence-based treatment of racial and ethnic minority youth in pediatric primary care settings.

### **Ecological Systems Theory**

As the theoretical foundation to this systematic review, Urie Bronfenbrenner's Ecological Systems Theory (EST; Bronfenbrenner, 1977; 1979) is utilized to conceptualize the multi-level factors impacting racial and ethnic minority youth and their behavioral health needs in primary health care. This theory, EST, was chosen as the theoretical basis for this study because of the documented societal factors that influence the health and development of racial and minority youth. Various social influences like direct and indirect racism (e.g. Priest et al, 2013; Heard-Garris, Cale, Camaj, Hamati & Dominguez, 2018, Pachter & Coll, 2009) and various types of discrimination (e.g. Carlson et al, 2017; Cooke, Bowie & Carrère, 2014; Tran, 2014) have been found to negatively impact child health outcomes. As explained in Bronfenbrenner's work (1977), there is an existing need to assess human development in the context of an individual's changing environment and the ever-shifting social context present within that environment. This environment was further defined and labeled within six systems: ontogenetic, microsystem, mesosystem, exosystem, macrosystem and chronosystem (See Figure 1). The research question for this systematic review was "*from an EST lens, what are the unmet behavioral health needs of racial and ethnic minority youth in primary care healthcare settings?*"

Figure 1: *Ecological Systems Model*



### **Aim**

The aim of this systematic review was to: (a) gather recent literature meeting specific inclusion criteria focused on racial and ethnic minority behavioral health needs in primary care, (b) thoroughly examine and summarize results through the EST lens and (c) make recommendations for clinical practice and future research as it relates to racial and ethnic minority youth behavioral health in primary care and various levels of EST.

### **Methods**

#### **Inclusion and Exclusion Criteria**

Studies included within this systematic review met the following criteria: (a) peer-reviewed, (b) written in English, (c) published in the last 10 years to obtain the most recent

literature, (d) conducted in the United States to focus on a specific healthcare system, (e) original empirical research, (f) study sample of racial and ethnic minority youth represent 50% or more, or the majority, of the total sample included within the study. This inclusion criteria were added to ensure that the studies included were able to capture on the needs of racial and ethnic minority youth and could be generalized to other racial and ethnic minority groups effectively. (g) Either qualitative and/or quantitative research, (h) study conducted in primary healthcare/pediatric settings, (i) articles discussing a mental, behavioral, social and/or emotional need. Articles not included in this systematic review were articles that (a) presented youth with a developmental disorder (e.g. Autism Spectrum Disorder or other developmental disorders), (b) involving telehealth, case studies and health clinics in juvenile or detention centers, (c) peer-reviewed articles that were not studies (i.e. conceptual papers).

### **Search Strategy**

Since this systematic review did not include human subjects but the analysis of various studies, the protocol for this study was not submitted or reviewed by an institutional review board. This study was conducted as a part of a doctoral dissertation and was reviewed and approved by a dissertation committee (DR, KD, NS and JB) to ensure that the methodology and representation of the results were ethically sound. There was also no conflict of interests related to this study and there was no funding received for the completion of this study. Cooper's (2010) seven-step protocol for research synthesis was utilized to complete this systematic review. Six databases were utilized: Medline via PubMed, PsycINFO via EBSCO, CINAHL via EBSCO, Scopus, ProQuest and Google Scholar. Search terms included Medical Subject Headings (MeSH) relevant to "primary health care", "mental health", "RACIAL AND ETHNIC MINORITY" and "children" (See Table 2). Search was conducted during November and

December of 2017. Author (FL) conducted the search under the supervision of a research librarian and analyzed the articles with an undergraduate research assistant (AB) between January and March of 2018. Articles were stored and organized through two programs, RefWorks and Rayyan.

Table 2

*Search terms used for systematic review*

Primary Care	"Primary Health Care" OR "Patient-Centered Care" OR "Family Practice" OR "Pediatrics" OR "Internal Medicine" OR "primary healthcare" OR "primary health care" OR "primary care" OR "internal medicine" OR "pediatrics" OR "family medicine"
Mental Health	"Mental Health" OR "Behavioral Medicine" OR "Attention Deficit and Disruptive Behavior Disorders" OR "Child Behavior Disorders" OR "Schizophrenia, Childhood" OR "Reactive Attachment Disorder" OR "Stress Disorders, Post-Traumatic" OR "Self-Injurious Behavior" OR "Depression" OR "Anxiety Disorders" OR "Aggression" OR "mental health" OR "behavioral medicine" OR "behavioural medicine" OR "attention deficit disorder" OR "attention deficit hyperactive disorder" OR adhd OR "disruptive behavior disorder" OR "disruptive behavior disorders" OR "child behavior disorder" OR "child behavior disorders" OR depression OR anxiety OR schizophrenia OR ptsd OR "posttraumatic stress disorder" OR "post-traumatic stress disorder" OR aggression
Racial and Ethnic Minority	"Ethnic Groups" OR "Minority Groups" OR "Continental Population Groups" OR "African American" OR "African Americans" OR Blacks OR "Asian American" OR "Asian Americans" OR "Hispanic American" OR "hispanic americans" OR latino OR latinos OR latina OR latinass OR "Native American" OR "native americans" OR "american indian" OR "american indians" OR "middle eastern" OR "arab american" OR "arab americans" OR "middle eastern descent" OR minority OR minorities OR underserved OR immigrants OR immigrant
Children	"Child" OR "Adolescent" OR youth OR child OR children OR infant OR infants OR toddler OR toddlers OR teen OR teens OR teenager OR teenagers OR adolescent OR adolescents OR adolescence OR girl OR girls OR boy OR boys

**Data Extraction**

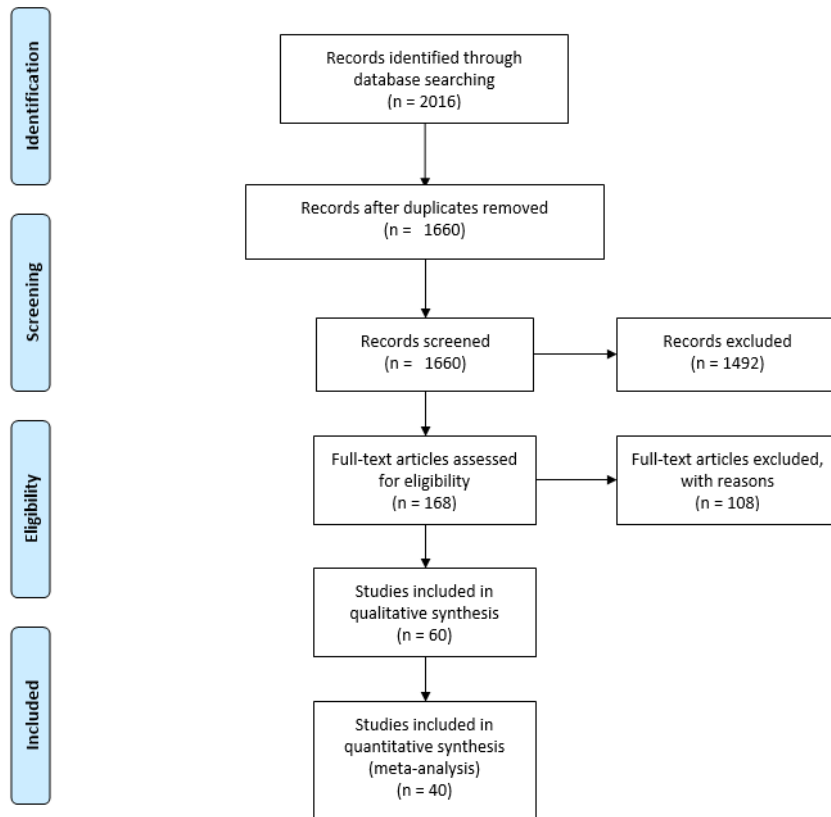
To analyze the articles found within the inclusion criteria and compare them, author (FL) created an excel spreadsheet that included headings relevant to the inclusion criteria for the

review. Authors (FL and AB) utilized this excel spreadsheet to organize the articles obtained. Headings in this excel spreadsheet included but were not limited to specification of racial/ethnic minority group represented, at what percentage or amount that this minority population is represented, behavioral health need, type of primary care setting and a summary of findings was populated within the spreadsheet.

### **Data Analysis**

When all the articles were obtained, the search yielded 2,016 articles which was reduced to 1,660 articles once duplicates were removed. The researcher (FL) and undergraduate research assistant (AB) first examined articles based on title and abstract according to Cooper's (2010) method. Those that met all inclusion criteria after the titles and abstracts were reviewed and kept resulting in 168 articles eligible for full text review. At this stage, many articles were excluded based on the racial and/or ethnic minority representation within the sample. One of the inclusion criteria was to have a sample size of over 50% racial and/or ethnic representation. In many articles, this representation was identified within the abstract. Articles were also excluded at this stage because they did not focus on behavioral health needs. In order to focus the scope of this study, developmental disorders were not defined as a behavioral health need within this study. Once the full text review was complete, 40 studies remained meeting inclusion criteria. Articles yielded throughout search process was presented in PRISMA diagram (See Figure 2). Once 40 articles were obtained, they were evaluated, interpreted and the results were presented in common themes. Creation of themes were grounded in EST, specifically utilizing the 6 levels presented within EST as a guide to help cluster the articles included.

Figure 2: *PRISMA Diagram for Systematic Review*



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit [www.prisma-statement.org](http://www.prisma-statement.org).

## Results

Forty articles were identified at the end of the search. All 40 articles fit within 4 themes: screening (n=9), treatment (n = 13), prevalence and need (n = 10) and stigma and patient communication (n = 8). All articles include youth as young as one year old and as old as 20 years old. All studies included racial and ethnic minority youth samples that were either predominately African American and/or Latino.

**Microsystem: Provider Screening Tools**

Nine articles were found addressing screening racial and ethnic youth and screening (see Table 3; Kelly, O’Grady, Gryczynski, Mitchell, Kirk & Schwartz, 2017; Castro, Billick & Swank, 2016; Koshy, Mautone, Pendergast, Blum & Power, 2016; Marie-Mitchell, Studer, & O’Conner, 2016; Angold et al, 2012; Rausch, Hametz, Zuckerbrot, Rausch & Soren, 2012; Ozer et al, 2009; Leiner, Balcazar, Straus, Shirsat & Handal, 2007; Wren et al, 2007). Most of the studies (n = 5) discussed the validation of various tools with these minority groups (Castro, Billick & Swank, 2016; Rausch, Hametz, Zuckerbrot, Rausch & Soren, 2012; Leiner, Balcazar, Straus, Shirsat & Handal, 2007). The Child Behavior Checklist (PSC) was used alongside several measures to validate them in screening Latino youth specifically: the Spanish versions of the Reporting Questionnaire for Children (RQC; Castro, Billick & Swank, 2016), Pediatric Symptom Checklist (PSC; Castro, Billick & Swank, 2016) and the Pictorial Pediatric Symptom Checklist (PPSC; Leiner, Balcazar, Straus, Shirsat & Handal, 2007). Few studies identified external factors that were influenced by screening mental health need (Marie-Mitchell, Studer, & O’Conner, 2016, Ozer et al, 2009).

Table 3

*Provider Screening Tools Results Found in Systematic Review*

	Author(s) (Year)	Scale/Tool	Summary of tool	Population	Key Findings
1	Rausch, Hametz, Zuckerbrot, Rausch & Soren (2012)	Columbia Depression Scale	Screen for adolescent depression	Predominately Latino adolescents; 13 to 20 years old (N = 636)	Screening was accepted in the majority (92%) of the sample and providers (89%) identified the screen as feasible



2	Castro, Billick & Swank (2016)	Unified Reporting Questionnaire for Children-Spanish (RQC-SP) & Pediatric Symptom Checklist-Spanish (PSC-SP)	Psychopathology in children and adolescents	Spanish-speaking parents; ages of children unknown (N = 22)	The PQC-SP and PSC-SP were found to be readable and comprehensible among the parent sample. Validation was conducted alongside the Child Behavior Checklist-Spanish
3	Leiner, Balcazar, Straus, Shirsat & Handal (2007)	Pictorial Pediatric Symptom Checklist	Psychosocial problems	Predominately children; ages of youth 4-16 years old (N = 468)	Successfully identified psychosocial and behavioral problems. Validation was conducted alongside the Child Behavior Checklist
4	Koshy, Mautone, Pendergast, Blum & Power (2016)	Behavioral Health Checklist (BHCL)	Internalizing, Externalizing and Attention-Deficit/Hyperactivity Disorder (ADHD)	Predominately African American Youth (63.2% 4-7 years old, 51.3% 8-12 years old; N = 1274)	Supports the validity of the (BHCL) as a screener for behavioral health concerns among youth 4-12 years old in urban and suburban communities. Validation was conducted alongside the Child Behavior Checklist.
5	Wren. et al. (2007)	Screen for Childhood Anxiety and Related Emotional Disorders (SCARED)	Anxiety Disorder	Predominately Minority Sample (Hispanic 33.2%, Asian/Pacific 10.5%; Biracial	Across all racial/ethnic groups, children reported higher levels of anxiety than

				8.5%, Black 5.0%; N = 515); ages 8 to 12 years old	the parents included in the study. Overall, there were no significant differences among child nor parent report among the various racial/ethnic groups. But, there were generally higher scores among the Hispanic group and lower scores among the Asian/Pacific group.
6	Kelly, O'Grady, Gryczynski, Mitchell, Kirk & Schwartz (2017)	Problem Oriented Screening Instrument for Teenagers (POSIT) 17-item scale substance use/abuse subscale; Revised 11-item version of the POSIT subscale	Substance Use Disorder and Cannabis Use Disorder	Predominately African American (93%); 12-17 years old (N = 525)	When compared against the DSM-5 Substance Use Disorder criteria, both the 17-item subscale and the revised 11-item subscale were found to be valuable in screening youth for substance use concerns.
7	Angold, Erkanli, Copeland, Goodman, Fisher & Costello (2012)	Types of interview styles: Diagnostic Interview Schedule for Children	Data collection to make a clinical diagnosis; Behavioral and/or concerns; Anxiety (MASC); Attention-Deficit	Predominately Racial/ Ethnic Minority (58.6% Non-White; among those minorities,	Among the various demographic variables, including race/ethnicity, there were no

		(DISC), the Child and Adolescent Psychiatric Assessment (CAPA), and the Development and Well-Being Assessment (DAWBA); Child Behavior Checklist (CBCL); the Multidimensional Anxiety Scale for Children (MASC); the Vanderbilt ADHD Diagnostic Parent Rating Scale (VADHD); and the Mood and Feelings Questionnaire (MFQ)	Hyperactivity Disorder (VADHD); Recent feelings and Behaviors (MFQ)	African Americans were largely represented); 9-12, & 12-13 years old.	difference in prevalence of mental health concerns.
8	Marie-Mitchell, Studer, & O'Conner (2016)	Child Adverse Childhood Experiences (C-ACEs); Pediatric Symptom Checklist (PSC); Vocabulary subscale of the Wechsler Preschool and Primary Scale of Intelligence (WPPSI-III)	Childhood exposure to adverse experiences (C-ACEs); Behavioral Problems (PSC); Language Expression (WPPSI-III)	Predominately African American infants (40 % with Low C-ACEs, n = 5; 77% High C-ACEs, n = 13); Ages 4 to 5 years old N= 18	Children with high C-ACEs scored were less likely to participate in mental health treatment and developmental programs.
9	Ozer, Zahnd, Adams, Husting, Wibbelsman	Adolescent Report of the Visit Survey which were specific	Emotional distress (report items from the CHIS); Depression (CES-D)	Predominately Racial/Ethnic minority (29.6 % Latino/Hispanic	Latino adolescents were 1.5 times more likely to

	, Norman & Smiga (2009)	California Health Interview Survey (CHIS) items; Center for Epidemiologic Studies Depression Scale (CES-D)		, 22.9% African American and 15.2% Asian) Ages 13 to 17 years	receive a depression screening compared to Whites. African American teens were less likely to be screened for emotional distress than white adolescents. After controlling for age and gender, There were no significant differences in provider rates of screening.
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**Mesosystem: Stigma & Patient-Provider Communication**

Eight articles were found to address stigma and patient-provider communication regarding mental health needs in primary care (Molleda et al, 2016; Lim, Silver, Leo, Kusulas, M. & Alderman, 2016; DeFrino, Marko-Holguin, Cordel, Anker, Bansa & Van Voorhess, 2016; Dempster, Davis, Jones, Keating & Wildman, 2015; Butler, 2014; Lê Cook, Brown, Loder & Wissow, 2014; Godoy, Mitchell, Shabazz, Wissow & Horn, 2014; Larson et al, 2013). The role that parent’s play in reporting mental health concerns to their health care provider is key in activating available resources and treatment options.

Stigma was found to be a barrier for African American caregivers in discussing behavioral problems with their health care provider (Dempster, Davis, Jones, Keating & Wildman, 2015) and following through with referrals for mental health evaluations (Larson et al,

2013). Higher self-efficacy was significantly associated with the likelihood for African American mothers of 2-5 years old children in disclosing psychosocial issues (Godoy, Mitchell, Shabazz, Wissow & Horn, 2014).

Patient-provider communication was found to be impacted by language and acculturation (Lê Cook, Brown, Loder & Wissow, 2014), shared decision making (Butler, 2014) and trust (DeFrino, Marko-Holguin, Cordel, Anker, Bansa & Van Voorhess, 2016). The articles found within this theme indicate that identifying behavioral health concerns in primary care is a multi-dimensional issue. It not only consists of parents and children coming to primary care with behavioral health concerns but, also feeling comfortable enough to talk about them with their health care provider. As the family system encounters the health care system, open and clear communication is a key factor in getting behavioral health treatment. Among a sample of predominately Latino parents that spoke Spanish at home were less likely to discuss behavioral problems with their physician or medical assistant whereas those who those parents who lived in the U.S. for more than 10 years or who were born in the U.S. were more likely to discuss behavioral problems with their child (Lê Cook, Brown, Loder & Wissow, 2014). Shared decision making between Latino and African American parents of two to seven year olds and health care providers was increased with externalizing behavioral problems along with lowered mental health stigma (Butler, 2014). But, Hispanic and African American adolescents and young adults (13-21), reported preferring to talk to a mental health professional instead of their primary care provider for mental health concerns (Lim, Silver, Leo, Kusulas, M. & Alderman, 2016). Additionally, African American and Latino teens (ages 13-17 years old) who were experiencing internal, depressive symptoms, were less likely to share their feelings with their health care provider when they felt that they would be judged, there was a lack of trust and if they were

fearful of an “intense reaction” from their parents deterred them from disclosing from a health care provider (DeFrino et al, 2016). Lastly, one study identified a program that increased trust among Hispanic mothers and adolescents through an internet and family based preventative intervention called the eHealth Families Unidas program (Molleda et al, 2016).

### **Exosystem: Provider Selected Treatment**

Thirteen articles examined treating racial and ethnic minority youth in primary care within this system. These treatments included parenting interventions (Scholer, Hudnut-Beumler, Mukherjee & Dietrich, 2015; Berge, Law, Johnson & Wells, 2010), depression treatment for adolescents (Mufson et al, 2017; Mufson, Yanes-Lukin & Anderson, 2015; Chandra et al, 2009; Ngo et al, 2009), ADHD treatment (Walton, Mautone, Missley-Tsiopinis, Blum & Power, 2014; Power et al. 2010), substance use reduction (Mason, Sabo & Zaharakis, 2017) and a mindfulness-based stress reduction program (Sibinga, Kerrigan, Stewart, Johnson, Magyari & Ellen, 2011). Parenting interventions included the effective implementation of the “Love, Limits, and Latitude: A Thousand Small Moments of Parenting (LLL)” parenting program for behavioral problem reduction within a predominately African American, urban sample of parents of five to ten year old children (Berge, Law, Johnson & Wells, 2010) and a brief video-based intervention about discipline strategies for Latino and African American parents of one to five year old children (Scholer, Hudnut-Beumler, Mukherjee & Dietrich, 2015). Depressive symptoms decreased for urban, low-income Latino adolescents engaged in a brief version of Interpersonal Psychotherapy for Depressed Adolescents (BIPT-A; Mufson, Yanes-Lukin & Anderson, 2015) but did not decrease for Latino adolescents who participated in a quality improvement intervention program (Ngo et al, 2009). African American and Latino parents of teens were

significantly less likely to have knowledge of anti-depressants and counseling compared to Whites (Chandra et al, 2009).

Several studies identified the benefits of treatments that incorporated others present in the youth's environment or apart of the health care team. One study addressing substance use for adolescents, specifically an intervention that incorporates the influence of an adolescent's peers, was found to decrease cannabis for African American teens (Mason, Sabo & Zaharakis, 2017). African American (Walton, Mautone, Missley-Tsiopinis, Blum & Power, 2014; Power et al. 2010) and Latino (Walton, Mautone, Missley-Tsiopinis, Blum & Power, 2014) parents of kindergarten to sixth graders were more likely to follow through for behavioral health treatment when there was a collaborative effort among health care professionals (Walton, Mautone, Missley-Tsiopinis, Blum & Power, 2014; Power et al. 2010). Additionally, two studies examined physician prejudice using case vignettes, one finding no racial difference in diagnosing and treating childhood disruptive disorders (Garland et al, 2015) and the other identifying that African American were more likely to be diagnosed and treated for ADHD (Morley, 2009). Lastly, one study identified that benefit of seeking mental health treatment for African American (45%) and Latino (55%) male adolescents in school-based health centers (Bains, Frazen & White-Frese', 2014).

### **Macrosystem: Prevalence & Needs**

Ten articles discussed the prevalence of concerns among racial and ethnic minority youth in primary care (Ramos, Sebastian, Stumbo, McGrath & Fairbrother, 2017; Bauer, Yoder, Carroll & Downs, 2016; Champion, Young & Rew, 2016; Hourigan, Southam-Gerow & Quinoy, 2015; Kelly et al, 2014; Weitzman, Edmonds, Davagnino & Briggs-Gowan, 2014; Amaral, Geierstanger, Soleimanpour & Brindis, 2011; Peterson, Lewandowski & Chiodo, 2011; Villalba,

2011; Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith, 2010). By race, African American teens were found to have a higher prevalence of meeting the DSM-5 criteria for nicotine, alcohol and cannabis use (Kelly et al, 2014) and nightmares because of trauma exposure (Peterson, Lewandowski & Chiodo, 2011). A sample of predominately African American (91%) urban sample of youth between the ages of eight to 17 were screened and surpassed the cutoff criteria indicating emotional and/or behavioral problems (Hourigan, Southam-Gerow & Quinoy, 2015). Urban female African American youth (ages 12-19) had a prevalence of depressive symptoms higher than the national average (Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith, 2010). The racial and ethnic minorities studies had mixed samples of African American and Latinos (Bauer, Yoder, Carroll & Downs, 2016; Champion, Young & Rew, 2016; Weitzman, Edmonds, Davagnino & Briggs-Gowan, 2014). Depressive symptoms were associated with substance use in a sample of African American and Latino female teens (ages 14-18; Champion, Young & Rew, 2016).

Several articles addressed the environmental factors that may be contributing to mental health needs among racial and ethnic minority youth. In examining youth, parental report is one of the main sources of behavioral health need. More socioemotional and behavioral concerns were reported by African American and Latino parents of infants (ages 12-48 months) who had lower education levels, were teenage parents, had low social support, significant medical problems and parental depression (Weitzman, Edmonds, Davagnino & Briggs-Gowan, 2014). Additionally, Hispanic parents were more likely than Black parents to endorse anxious symptoms in their children (Bauer, Yoder, Carroll & Downs, 2016).

Mental health services embedded in school-based health centers (SBHC) were found to be utilized by racial and ethnic minority students with mental health concerns. A mixed sample

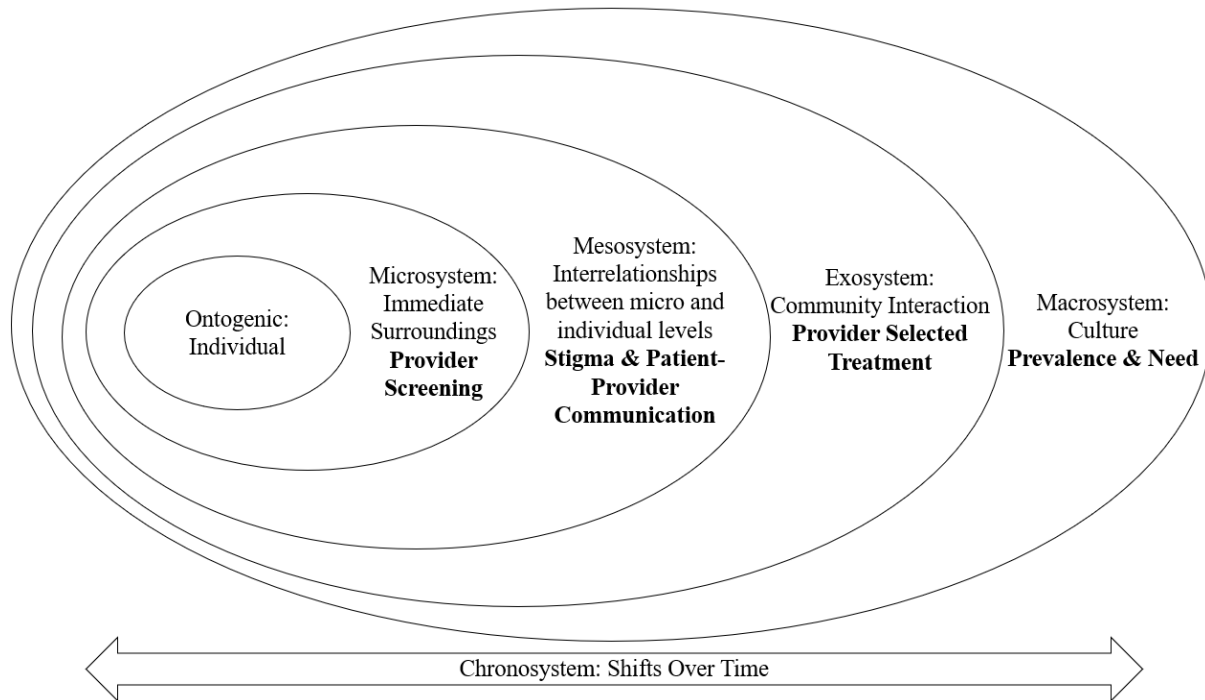


of African American (14%), Hispanic (25%) and Asian American (34%) were more likely to seek mental health services in their SBHC when they reported suicide ideation, depressive symptoms, parental divorce/separation, and losing a close friend (Amaral et al; 2011). A sample of predominately Hispanic (60.9%) high school students reported that among their unmet health needs, coping with stress was one of the most prevalent (Ramos et al, 2017). Lastly, a sample of school counselors and school nurses identified 23 mental health disparities among Latino/a youth which included adjustment concerns, poor interpersonal skills, anxiety, depression, substance use, grief/loss and physical and sexual abuse (Villalba, 2011).

### **Discussion: Application of Ecological Lens**

The purpose of applying EST to the results of this systematic review is to emphasize the multiple levels of care highlighted in the literature regarding the assessment and treatment of behavioral health concerns of racial and ethnic minority youth in primary health care settings. Four themes that arose from the results were synthesized: provider screening, provider selected treatment, prevalence & need, and stigma & patient-provider communication. In applying EST, each of these themes were found to be related to at least one of the levels of EST (See Figure 3).

Figure 3: *Ecological Model and Categorized Themes in Systematic Review*



### **Validated Screeners for Racial and Ethnic Minority Youth**

Within the microsystem, much of the literature discussed screening tools that were utilized to assess behavioral health needs of racial and ethnic minority youth. One of the first notable aspects of the results included a developing area of literature not only supporting the use of validated screening measures for racial and ethnic minority youth but also measures that are feasible in primary health care settings. For youth in general, regardless of racial or ethnic background, researchers have advocated for the screening of social-emotional needs in primary health care (e.g. Williams et al, 2018; Kruizinga, Jansen, Carter & Raat, 2011) and that youth may be under-screened in this area (Sekhar, Ba, Liu & Kraschnewski, 2018). For example, Briggs et al (2012) promoted the socio-emotional screening of infants and toddlers in primary care as the focus tends to be on developmental needs. One major concern when it comes to screening youth in a primary health care is feasibility (such as time spent performing screener,

cost of screener, recommendations to when to use screener during the medical visit, who generally performs screener, etc.) since the average time for a pediatric visit is approximately 16 minutes (Merline, Olson & Cull, 2009). There is more research needed validating screening tools with these populations, particularly focused on feasibility of the use of these screening tools in primary care settings for racial and ethnic minority youth. In terms of the screeners supported, there were not enough studies to support a specific tool. For this reason, the authors do not endorse any one screener to be used with a specific racial and ethnic minority group but emphasize that more validation studies are needed assessing screening and diagnostic tools for racial and ethnic minority populations.

Additionally, given that EST was utilized for this review, there seems to be missing systemic influences in the instruments used. For example, there is evidence that parent's mental health symptoms may influence the presence or intensity of the mental health symptoms of their children (Palm et al, 2019; Acri & Hoagwood, 2015; Bennett, Brewer & Rankin, 2012). Since an assumption of EST is that an individual develops in the context of their environment, it may be beneficial for assessments to also ask questions about a history of mental illness or behavioral issues within the immediate family like among parents/guardians and/or siblings within the home. In order to effectively assess the child, a brief assessment on the child's environment. This would also include tools for family functioning. Unfortunately, several tools that were created to evaluate family functioning, have not been validated extensively with racial and/or ethnic minority groups. For example, Mirnics, Vargha, Tóth & Bagdy (2010) reported that some assumptions of the FACES IV (Family Adaptability and Cohesion Evaluation Scales, Version 4; Olson et al., 1979; Olson, Gorall, & Tiesel, 2004) may be based in individualistic family values, limiting its potential cross-cultural application to assess families that may support more

collectivistic familial views. To promote a more systemic view to educate diagnostic and treatment efforts with these minority groups, more literature is needed on culturally adaptive family functioning assessment tools.

Additionally, these results highlighted a need for early intervention services for racial and ethnic minority youth as it related to behavioral health treatment and screening in primary health care settings. Among the 40 studies included within the study, 11 included age groups five and under within their samples. As an effort to improve the behavioral health support of racial and ethnic minority youth within primary health care settings, there is a need to encourage consistent assessments of behavioral health needs for children under five years old.

### **Presence of Culturally Attuned Integrated Behavioral Health Providers**

To balance responsibility within the health care setting to ensure that patients are provided with comprehensive care, integrated behavioral health providers can be added to the health care team to support pediatric screening and treatment. In 2015, Asarnow, Rozenman, Wiblin and Zeltzer published a systematic meta-analysis examine the recorded effectiveness of integrated behavioral health care compared to “usual” care where integrated behavioral health care wasn’t present. They found that incorporating a form of integrated behavioral health care was found to benefit youth’s health with a collaborative care program model showing the strongest impact. Adding professionals who present expertise in behavioral health like mental health clinicians can add additional support to the overall health care team.

As it is suggested that integrated behavioral health care professionals be added to the treatment team, connecting this recommendation to the results of this systematic review, there may be a need for those providers to also be “culturally attuned” to improve the care of racial and ethnic minority youth. The term *cultural attunement* was first introduced in Hoskins’s (1999)

article that was meant to help professionals implement specific skills in their encounters with other from difference ethnic and racial backgrounds. Although this concept could potentially be adopted by all health care providers who treat racial and/or ethnic minority youth, this is specifically directed towards integrated behavioral health care in order to adequately address the mental health disparity. Hoskins stated,

“My intent is not to attempt to eliminate the tension that arises through “difference,” but instead, to deepen our understanding of the complexities so that as academics, practitioners and human beings we can continue to step into the turbulent waters-not with an attitude of smug competence- but with an attitude of cultural attunement.” (p. 73)

Hoskins’s outlines 5 parts of developing cultural attunement, (1) recognizing the negative effects of oppression, (2) humbling one’s self by acknowledging dominant culture influence, (3) portraying respect for differences, (4) participating in “mutuality” or sharing similar experiences, and (5) fostering a connection through the “not knowing” stance. In making recommendations for care, developing a standard of cultural attunement within the medical culture could potentially help address the health care disparity (Oakes, 2011). For integrated behavioral health providers, this could include actively incorporating literature and statistics on the behavioral health care disparities among various racial and/ethnic minority, talking to families about how they define mental health and what exactly “good health” would look like for them. Assuming the “not knowing” stance for integrated behavioral health care providers may include discussing effective coping skills and what they know to be helpful. Although some has been published in the area of culturally awareness in behavioral health care (Arora, Godoy & Hodgkinson, 2017; Duch, Cuno & Germán, 2016), there is more research needed on how concepts supporting cultural attunement in integrated behavioral health care could benefit overall patient outcomes.

## **Family-Centered, Culturally Attuned Care**

Within the mesosystem, results from this systematic review highlighted various barriers to disclosure of behavioral health needs within primary care. Topics of stigma as a barrier to youth behavioral health care (e.g. Villatoro, DuPont-Reyes, Phelan, Painter & Link, 2018; Johnco & Rapee, 2018; Chavira et al, 2017) and parental help seeking behaviors (Thurston et al, 2018) have been discussed throughout the literature. Particularly with racial and ethnic minority youth, the family-centered approach may be relevant as parents/caregivers typically voice behavioral health need during visits. There is a growing area of literature that discusses the family-centered approach in working with youth (Hielkema, De Winter & Reijneveld, 2017; Harrison, T. M., 2010). The results of this review punctuate the need for family-centered care that is culturally attuned. Since there is limited research on how to provided family-centered care, according to the core concepts of family-centered child care supported by the American Academy of Pediatrics (American Academy of Pediatrics Committee on Hospital Care; 2003) in a culturally attuned way this is a recommendation for future research.

## **C.J. Peek's Three World View**

Although many of the recommendations that can be made are clinical, when implementing any program within a health care setting there a multiple facets that influence care effeciency that may be helpful to consider. C. J. Peek's (2008) Three World View has three components clinical, operational and financial that creates a framework of organizing how to effectively implement a program because all three are intertwined in health care settings. The clinical view encompasses the health care systems ability to provide health related services to patients like medical treatment or mental health treatment. For example, in this context this would involve being explicit about assessment, diagnostic and intervention procedures. The

financial view relates to health care facilities being economically stable and meeting the financial requirements to stay open and functioning. In this context, the financial realm would encompass how adding behavioral health support like integrated behavioral health providers would be funded. The operational view is the way that health care systems are organized or managed that allow them to perform day to day function to meet patient needs. Generally, any addition, amendment or reduction of services in a health care setting changes the overall work flow of the medical facility. Including in the development of programs for this population is crucial so that the primary health care setting can still maintain its organization and establish a productive routine. To improve the care of racial and ethnic minority youth, action may need to take place within all three worlds for change to be sustainable.

### **Health Care Policy Development**

Lastly, at the macrosystem level, the results of this systematic review identified prevalent behavioral health concerns among racial and ethnic minority youth in primary health care. As literature continuously produces evidence on the prevalence of behavioral health needs of racial and ethnic minority youth, there is a need for health care policy that addresses that quality and consistency of care provided to racial and ethnic minority youth. Beal (2004) presented various recommendations on how health care policy could be catered to support the health needs of children of color, one of those included improvements in quality of care and many children of color may not have it. For example, a potential policy change could be, given the high levels of behavioral health need among racial and ethnic minority youth, that all racial and ethnic minority youth should be screened during their visit using a validated behavioral health screener. Furthermore, as integrated behavioral health care in primary health care settings are increasing in its application, there could be requirements with the amount of behavioral health support needed

a primary care clinic that has a certain percentage of behavioral health need. Future research could advocate for ways to support the care of racial and ethnic minority youth in primary care settings.

### **Limitations and Future Research**

This systematic review was successful in answering the research questions and making recommendations for future research in racial and ethnic minority youth behavioral health in primary care. Limitations to this study include that the intersectionality of multiple demographics was not summarized within this study. For example, many of the studies found had high female youth samples (e.g. Sibinga et al, 2011 77% females; Mufson et al, 2014 82.8%; Amaral et al., 2011 60% female; Ramos et al, 65.3% female). Differences comparing racial and ethnic minority youth populations within other demographics, like gender, age, geographical location (urban versus suburban versus rural), etc., may have present even more useful information for those in clinical practice. Since much of the results identified literature supporting African American and Latino populations, future research could address the unmet needs of other racial and ethnic minority youth in primary care including Asian American and Native American.



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## **CHAPTER 5: RESULTS**

### **Background**

Upon resettlement, refugee youth have been identified as having major health problems that contribute to health disparities for this population (Sheikh et al, 2009). The United Nations High Commissioner for Refugees (UNHCR) defined a refugee as an individual who is forced to leave their country of origin and is afraid of returning because of persecution, war or violence (UNHCR 1951). UNHCR estimates that more than half of the world's displaced population are children (UNHCR, n.d.) and of the approximately 20 million refugees are resettled across the globe annually (Cepla, 2019). While only a small portion of that 20 million are traditionally resettled in the U.S., there are no current statistics on how many of those resettled in the U.S. are children. Resettled refugee youth may have various health deficiencies (Taseen & Beaulieu, 2017; Sheikh et al, 2009) and lack of adequate preventative care before resettlement (Watts, Friedman, Vivier, Tompkins & Alario, 2011). As youth are resettled, there is a priority taken towards the youth's medical health which may under prioritize behavioral health concerns. Within the literature, refugee youth may have been exposed to traumatic experiences, either pre- and/or post-resettlement, that can contribute to negative behavioral health outcomes (Xu, 2007; Lustig et al, 2004). These negative behavioral health outcomes have the potential of impacting the youth's overall development (Kaplan, Stolk, Valibhoy, Tucker & Baker, 2016; Seery, Boswell & Lara, 2015; Betancourt et al., 2012; Kira, Lewandowski, Somers, Yoon & Chiodo, 2012). Trauma exposure is becoming a priority in the literature on refugee youth behavioral health including how to properly assess the impact of trauma in a culturally appropriate, valid and reliable way (Gadeberg, Montgomery, Frederiksen & Norredam, 2017; Ehntholt & Yule, 2006; Hollifield et al, 2002). Pediatric primary care has been identified as a medical setting that

is nearest to the communities that children live in and seen as most fit to be the first place of contact to identify behavioral health needs among youth (Arora, Godoy & Hodgkinson, 2017). As literature grows within the area of identifying behavioral health needs among resettled refugee youth in primary care settings, there is still more literature needed to contribute to the development of tools and brief treatments for refugee youth in these settings.

### **Theoretical Underpinnings**

Resettled refugee youth face complex needs that are best conceptualized through a theory that can identify the youth as growing and developing beings whom interact and are influenced by multiple levels of society. For this study, Ecological Systems Theory (EST) will be used. Six levels of Urie Bronfenbrenner's theory will be utilized in this study: the ontogenetic, micro-, meso-, exo-, macro- and chrono-systems (Bronfenbrenner, 1979; 1977). The *ontogenetic* level represents the identifying characteristics of the individual, or in this case the refugee youth like physical health along with age, biological sex and mental health (Bronfenbrenner, 1979). Specifically related to mental and physical health, refugee youth have been identified with significant physical health needs upon resettlement (e.g. Taseen & Beaulieu, 2017; Sheikh et al, 2009) and mental health needs because of trauma exposure (e.g. Xu, 2007; Lustig et al, 2004). The *microsystem* describes the interactions that an individual has in immediate settings (Bronfenbrenner, 1977) like with immediate family, at school, peers and/or direct engagement with community resources like through church organizations. Within the literature, the refugee youth's microsystem have been found to impact their ability to manage behavioral health concerns, whether they are unaccompanied (e.g. Seery, Boswell & Lara, 2015, Sanchez-Cao, Kramer & Hodes, 2012) or accompanied with their parents upon resettlement (e.g. Eruyar, Maltby & Vostanis, 2017, Sangalang, Jager & Harachi, 2017, Trentacosta, McLear, Ziadni,

Lumley & Arfken, 2016). The *mesosystem* constitutes the interaction between the multiple systems in the microsystem (Bronfenbrenner, 1977). Within the mesosystem, this could include the family's interactions with the health care system and discussing mental health needs with their child's primary care provider. Within the mesosystem regarding the behavioral health needs of refugee youth in primary health care, there are limited studies discussing the barriers to mental health services utilization (e.g. Ellis et al., 2011) but, several researchers have identified barriers such as a deficit in culturally sensitive treatment (e.g. Ziaian et al., 2012; Davies & Webb, 2000) and overall trouble navigating the healthcare system (de Anstiss et al., 2009). The *exosystem*, considered to be an extension of the mesosystem, outlines the influence of the social structures influencing an individual's development. One of the main concerns that arises from this exosystem is helping families navigate medical insurance. For many refugee youth, they are given Medicaid upon arrival but, refugee families may still have difficulties navigating services that are supported by Medicaid. The *macrosystem* addresses the existing, shifting culture that governs the environment impacting an individual's development (Bronfenbrenner, 1977). For refugee youth, acculturation stress has been identified in the literature, specifically for youth that have differing beliefs and traditions than their host country (e.g. Garakasha, 2014). Additionally, in the U.S. there may be a negative sentiment towards resettled individuals (e.g. Krogstad & Radford, 2017) that youth could internalize. Lastly, the *chronosystem* acknowledges how the youth's development may be impacted overtime by their environment (Bronfenbrenner, 1977), particularly for refugee youth how they may be impacted as policies shift over time.

## Methods

### Study Design and Aim

As the literature within the area of the behavioral health needs of refugee youth in primary health care settings continues to develop, there is a need for more literature to support the behavioral treatment of refugee youth in primary care settings. In creating a study that would support this purpose, a qualitative study seemed to be a great fit because there is limited literature in this area of research. A qualitative study would help assess the needs present among the providers that serve this population so implications could be made for future research. As the phenomenological qualitative research design was being created, the hope for this study was to punctuate the lived experiences of pediatric primary care providers as they treated resettled refugee youth and if there were behavioral health needs present in their practice. Once the qualitative study was created, although the qualitative analysis seemed necessary, there still seemed to be a need to add structure to the questions being created for the semi-structured interviews. As a way to create a structure to the interviews, the option of analyzing a secondary dataset was discussed as a potential solution to this dilemma and was found to be a way that would also give this study more merit. This solution would allow for a comparison to be conducted between the quantitative and qualitative results, specifically how the behavioral health needs of refugee youth may be similar or different from that of those within the general pediatric sample. Through this process, this study shifted from a purely qualitative study to an explanatory, sequential mixed-methods design. An explanatory, sequential mixed-method design is a particular type of mixed-methodology where the quantitative analysis is completed first and guides the collection of the qualitative analysis (Miller & Johnson, 2014).

The aim of this study was to conduct an analysis with two phases. First examine the factors that increase the likelihood of behavioral health need within a generalizable pediatric sample. Second, conduct a qualitative needs assessment on what behavioral health needs were present among refugee youth as they present in primary health care settings through the lived experiences of primary health care providers and compare the factors identified in the generalizable pediatric sample to those of refugee youth reported by primary care providers. The research questions for this explanatory, sequential mixed-method study were: 1.) what are the factors that increase the likelihood of behavioral health need among a generalizable pediatric sample and 2.) how do they compare with the lived experiences of pediatric primary healthcare providers who treat resettled refugee youth?

### **Quantitative Phase**

#### **Data Source and Participants**

For the quantitative analysis, a generalizable pediatric sample was utilized in order to retrieve data summarizing the factors that may increase the likelihood for youth to be identified with a behavioral health need. The secondary dataset used was The North Carolina Child Health Assessment and Monitoring Program (CHAMP) from 2005. This program was implemented annually from the year 2005 to 2014 as a way to continually monitor the health needs of North Carolina's youth (ages 0-17). There were several subscales within the study that not only included behavioral health needs but also general health information, school performance, nutrition and other health conditions. Data was collected was per parental/guardian report. (North Carolina State Center for Health Statistics, n.d.).

Table 1 shows the demographics of the 2005 CHAMP dataset that included a total of 3,964 children. There were 2,031 males and 1,933 females in the dataset with the most being between the ages of 0-6 years of age (n = 1,470), then ages 13-17 (n = 1,268) and then those between 7-12 years old (n = 1,225), with one participant not reporting the age of the child. The sample was predominantly White, Non-Hispanic (n = 2,630), second to those who were Black, Non-Hispanic (n = 706) with smaller sample representation for those who were Hispanic (n = 379) and those who reported as Other (n = 249).

Table 1

*Demographics of sample with the CHAMP 2005 (N = 3,964)*

<u>Sex/Gender</u>	
Female	1,933
Male	2,031
<u>Ages</u>	
0-6 years old	1,470
7-12 years old	1,225
13-17years old	1,268
<u>Race/Ethnicity</u>	
White, Non-Hispanic	2,630
Black, Non-Hispanic	706
Hispanic	379
Other	249

### **Quantitative Analysis**

In order to test the first research question, a binary logistic regression was found to be the best fit to reach these conclusions. Since the outcome variable of identified behavioral health

need was categorical, a binary logistic regression allows for “membership” into a particular group or group(s) to be discovered (Field, 2013). A binary logistic regression was also found to be the best fit for this analysis because this specific analysis has been used in another studies with data derived from pediatric primary health care settings with the outcome variable being a specific diagnosis or diagnostic category (e.g. Herbst et al, 2019; Snedden, Pierpoint, Currie, Comstock & Grubenhoff, 2019; Sorg, Coddington, Ahmed & Richards, 2019). Before beginning the study, the general assumptions of this analysis were tested and maintained which were (1) no perfect multicollinearity, (2) no specification errors and (3) specifications of how the independent variables can be measures (Meyers, Gamst & Guarino, 2016). Levels of significance levels were established at 0.05 and 0.001.

### **Quantitative Predictor and Outcome Variables**

As previously mentioned, EST was used as the theoretical foundation for this study. For this reason, the predictors for this analysis were organized according to two-levels within EST (ontogenic and mesosystem) ran within the same model. Ontogenetic level predictors included race, ethnicity (Latino/non-Latino), sex (male/female) and reported child’s health by the child’s parent/guardian. Ontogenetic variables represent the individual characteristics of an individual (Bronfenbrenner, 1977), in this case children. All ontogenic level predictors have been identified in the literature as potential factors that may influence the identification or prevalence of behavioral health need (Ramos et al, 2017; Champion, Young & Rew, 2016; Hourigan, Southam-Gerow & Quinoy, 2015; Kelly et al, 2014; Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith, 2010). All of the predictors are categorical variables aside from variable of age and child’s health which are continuous. The variable identifying the parent’s/caregiver’s perception of child’s health was a traditional five-point Likert scale (1=Excellent; 2=Very Good;

3=Good; 4=Fair; 5=Poor). Mesosystem level predictors included three dichotomous three variables: whether the parent/guardian reported that the child had a consistent doctor or medical provider, if the parent/guardian spoke to the child's school nurse about health concerns and if the child had a preventative care/well child check within the past twelve months. Predictors within the mesosystem level of analysis represented times when the child and the child's family have interacted with systems outside of the home like the health care and academic systems and how those interactions may have aided in the identification of emotion and/or behavioral needs in youth. Adding these mesosystem level predictors in the model allowed for an assessment to see if increased interaction with the health care system was a factor that increased the likelihood that a child would be identified with a behavioral, emotional and/or mental health needs. In total, there were seven predictors used in the binary logistic regression.

The outcome variable in this analysis was the assessment of behavioral health need summarized by this direct question from the study, "Has a doctor, other health professional or school representative ever told you that (CHILD) has an emotional or behavioral disorder, or problem with social skills such as depression, anxiety, ADHD, or ADD (Attention Deficit Disorder)?" Within the CHAMP dataset, further information is not provided on the type of health care provider (i.e. pediatrician, family nurse practitioner, medical assistant, etc.) or school representative (i.e. teacher, teacher's assistant, principal, office staff, etc.) that identified the child with this need. Additionally, the dataset did not give detail to what would be considered to be an emotional or behavioral disorder aside from the examples within the question. The inclusion of "problem with social skills" was not clear within the dataset either, particularly whether this was directed towards developmental disorders like Autism Spectrum Disorder. This lack of specificity will be discussed further in the limitations of this study.



## **Qualitative Phase**

### **Approach**

There are multiple types of qualitative inquiry and the phenomenological approach was elected to examine the lived experiences of primary health care providers who treat refugee youth particularly related to their behavioral health needs. Literature has discussed how youth's behavioral health concerns are generally discussed with their primary health care provider (Heinly et al, 2018). For this reason, this population was chosen for this study. Seen as one of the stricter methods of the phenomenological approach, Clark Moustakas' (Moustakas, 1994) procedures were utilized to execute which includes seven stages.

### **Recruitment**

A total of twelve participants were included in the qualitative portion of this study, all from the Southeast region of the United States. Snowball sampling was utilized. Flyers for the study were sent to refugee resettlement agencies and non-profit organizations serving refugee families by both fax and sent electronically. Electronic flyers were sent to the directors of refugee resettlement throughout various states in the Southeast region, organizations listed on the Office of Refugee Resettlement's website and an ad was posted on the Society of Refugee Healthcare Providers listserv requesting voluntary participation in the study. Primary care providers were recruited from the following states Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. Primary care providers of interest included a list of the following providers in all recruitment materials: Pediatricians, Medical Doctors (M.D.s) and Doctors of Osteopathic Medicine (D.O.s), Nurse Practitioners, Physician Assistants, Family Medicine Practitioners and Integrated

Behavioral Health Care Providers. Inclusion criteria stated the requirement of the potential participant having treated resettled refugee youth.

## **Participants**

Of the twelve participants within the study all from the Southeast region of the U.S., there were nine females and three males. Ages of participants ranged from 33-61. Participants reported to have been practicing as a health care provider for an average of 12 years, ranging from one year to 30 years of practice. When asked how long they have been treating resettled refugee patients, there was an average of approximately five years, ranging from one year of experience to 18 years of experience. Primary care providers included those who reported to identify as Pediatricians (n = 3), a Medical Doctor (n = 3), Family Physicians (n = 1), Behavioral Health Providers (n = 2), Physician Resident (n = 1), Family Nurse Practitioner (n = 1), Physician Assistant (n = 1). Seven providers reported to treat patients in either a federally qualified health center or community clinic medical setting with the remaining treating patients in either a private clinic (n = 2), woman's health facility (n = 1), or academic medical setting (n = 2). When asked what percentage of your caseload was of resettled refugee patients, responses ranged from five percent to 100% with an average of approximately 37%. Participants reported treating the following ethnic groups: Burmese, Bhutanese Congolese, Iraqi, Sudanese, Somali, Syrian, Swahili, Afghani, El Salvadoran, Honduran, Eritrean, Montagnard, Rwandan, Vietnamese, Ethiopian, Turks, Columbian, Iranian, Latinos and Haitian. When asked what the average age range was of refugee pediatric patients seen, seven participants reported between the ages of birth through approximate 16, 17 or 18 years old with eight participants stating that they used an interpreter between 90% - 100% of the time during their visits with refugee families.

## **Data Collection**

Data was collected through semi-structured interview, that ranged from 25-46 minutes and averaged approximately 38 minutes between July 2018 - March 2019. Interviews were recorded on three devices, a voice recording application on the smartphone, a voice recording app on an iPad and a hand-held voice recording device. Additionally, the interviewer took notes on a notepad during data collection. To protect the confidentiality of the participants, only one researcher had access to identifiable information related to the participants (e.g. phone number, name, location, email). All data was stored on one password protected device. At the beginning of each interview, the informed consent was discussed and was provided to the participant electronically through a Qualtrics survey. Once consent was given by the participant, the interview was semi-structured interview was conducted using the questions developed from the quantitative analysis as a guide (see Appendix F). At the end of each interview, the participant was asked to complete a brief demographic survey through the same link as the informed consent provided via a Qualtrics survey link.

## **Data Analysis**

Once each interview was completed, each was transcribed and coded the interview to deduce themes according to step five of Moustakas' method (Creswell & Poth, 2018, Moustakas, 1994). Among the various methods of phenomenological analysis, Colaizzi's (1978) seven step method of phenomenological analysis was utilized. This analytical method, in summary, includes identifying *significant statements* from each of the transcripts of the participants, or co-researchers, after the interview is transcribed. These significant statements are direct quotes from each interview that relate directly to the participant's experience of said phenomenon. Developing *formulated meanings* or summarized, brief explanations of each significant

statement. Formulated meanings are then grouped into *thematic clusters*, or groups of similar meanings that are labeled by a unifying term or phrase. Thematic clusters are then written in a description and an overall structure is identified. Once completed for each participant, information is sent to the participant for validation, in this case this is part of the *member checking* process of trustworthiness. At the end of all of the interviews, a composite description is constructed to represent the overall experience of this phenomenon among the sample. The confidentiality of the participants was preserved using a letter “P” and one- and two-digit numbers instead of the participants name or any other identifying information. An outside transcription service was used to transcribe the interviews (www.rev.com) and the researcher (FL) reviewed the transcriptions while listening to the audio to confirm accuracy.

To ensure trustworthiness a triangulated researcher, audit trail documents and member checking were all utilized. The process of triangulation defined by Lincoln and Guba (1985) involves another researcher during the analysis process in order to ensure that similar themes are derived to maintain the credibility of the study. This triangulated researcher was a professor in qualitative research and has had years of experience conducting qualitative research. The audit trail (Creswell & Poth, 2018) included documenting steps taken throughout the course of data collection and analysis which included journaling personal reactions and feelings after each interview and a detailed account of all steps taken throughout the data collection process. Lastly, member checking (Creswell & Poth, 2018) took place after each interview. Each participant was provided with a summary of the themes and supporting statement clusters after the completion of each interview. Participant was instructed to provide feedback if they wanted to add, change or delete information from the summary that will, in turn, be amended in the results of the study.

## **Research Hypotheses**

Before the analyses were conducted the following two hypotheses were created:

H1: There will be significant ontogenic and mesosystem level differences in the endorsement of either being told or being diagnosed with a mental/behavioral health problem.

H1a: On the ontogenic level, there will be significant race, ethnic, gender and parental reported child's physical health differences in the endorsement of either being told or being diagnosed with a mental/behavioral health problem.

H1b: Once mesosystem level, there will be significant differences in whether the child has a personal doctor/nurse, spoke to their school nurse about health needs and if they have attended a preventive care visit and if the child endorsement of either being told or being diagnosed with a mental/behavioral health problem.

H2: Behavioral health needs will be discovered during the exploration of lived experiences of primary care providers who treat resettled refugee youth will along with factors that may increase the likelihood of youth who are identified with needs.

## **Results**

### **Quantitative Phase Results**

All results from this quantitative phase of analysis are listed in Table 4. Within the sample of 3,964 children, 88.5% (n = 3,509) reported that their child had not been told that they had an emotional, behavioral or social skills problem while 11.5% (n = 455) were told that their child had been told that they had an emotional, behavioral or social skills problem by a professional. Combining both the ontogenic and mesosystem variables into one model, males were significantly less likely than females to be told that they had an emotional, behavioral or

social skills problem ( $b = -.880$ ,  $p < .001$ ,  $OR = .42$ ). Increased age significantly impacted the child's odds of being told that they have an emotional, behavioral or social skills problem but at a lower rate of 7% ( $b = .068$ ,  $p < .001$ ,  $OR = 1.07$ ). White, non-Hispanic children were significantly more likely to be told that they have an emotional, behavioral or social skills problem than children of other races or ethnicities ( $b = -.178$ ,  $p = .016$ ,  $OR = .84$ ). Parents who reported to have one person that they would say is their child's doctor or nurse were 40% less likely to be told to have an emotional, behavioral or social skills problem compared to those who did not ( $b = .336$ ,  $p = .03$ ,  $OR = 1.40$ ). Parents who reported to have talked to a school nurse about their child's health were 73% more likely to have been told that their child has an emotional, behavioral and/or social problem ( $b = .549$ ,  $p < .001$ ,  $OR = 1.73$ ). Children who attended a preventative care visit/ well child check in the past 12 months were 31% more likely to have been told they had an emotional, behavioral and/or social skills problem ( $b = .271$ ,  $p < .001$ ,  $OR = 1.31$ ). Children who were reported to have better general health were 48% more likely to be told that they have an emotional, behavioral and/or social skills problem ( $b = .389$ ,  $p < .001$ ,  $OR = 1.48$ ) compared to those who had poorer health outcomes. This set of predictor variables explained approximately 10% of the variation in emotional, social and behavioral problems. From the results of this quantitative analysis, an interview guide was created to for qualitative, semi-structured interviews (see Appendix F)

Table 4

*Results of Binary Logistic Analysis*

	B	S.E.	Wald	df	Sig.	Exp(B)
Constant	-2.285	.351	42.392	1	.000	.102
Age (years)	.068	.016	18.149	1	.000**	1.071
Child Sex	-.880	.123	51.605	1	.000**	.415
Race/Ethnic Group	-.178	.074	5.770	1	.016*	.837
Personal Doctor/Nurse	.336	.153	4.801	1	.028*	1.399
School Nurse	.549	.133	17.152	1	.000**	1.732
Preventative Visits	.271	.137	3.917	1	.048*	1.311
Child's Health	.389	.077	25.622	1	.000**	1.476

\*\*significance level at .001; \* significance level at .05

**Qualitative Phase Results**

Among the responses of the twelve participants, the findings unveiled 11 thematic clusters, 37 formulated meanings, and 560 significant statements. One aspect of this qualitative data collection process and analysis was that when the participants were asked to describe their experiences with refugee youth and the behavioral health needs within this population, there was no way for the provider to identify whether the patient was considered a “resettled refugee” or not. Some participants stated that they were not sure if the youth they had described were traditionally resettled refugees but in some cases, the participants concluded that the youth were traditionally resettled refugee because of a combination of various elements which included: the family or youth disclosing that they were a refugee resettled by the U.S. government, specific details within the patient’s migration story (e.g., living in a refugee camp, traveling through multiple countries, escaping war, violence or persecution), ethnicity (i.e. coming from a region where there are high numbers of refugees resettled in the U.S. like the Middle East, Central Africa or certain parts of Asia), arriving to the U.S. with certain social services already in place like Medicaid, housing, U.S. identification documents, assistance securing employment or

enrollment in school, etc.) and/or the patient's family being connected with a refugee resettlement agency who helped the new arrivals coordinate the medical visit. Another aspect that was brought to the attention of the researcher during the recruitment and data collection process was that, in various areas within the Southeast, certain medical facilities were known for treating refugee patients. In these cases, the participants that treated patients in these type of facilities felt more confident in labeling the youth described as resettled refugees. On that note, many of these same facilities also had a history of treating other immigrant populations as well. With that being said, many of the lived experiences discussed by participants placed the youth population being discussed in this study within the broader definition of "displaced youth" rather than resettled refugee youth because of their immigration status, whether they were traditionally resettled or not, was not clear. The majority of what was disclosed by participants in their interactions with their displaced youth patients and their families would fit under the definition of refugee outlined by the UNHCR 1951 Geneva Convention's definition of refugee which includes persons who had to escape their country of origin and are fearful of returning to their country of origin because of persecution, war or violence (UNHCR, 1951). For this reason, throughout the results section, youth and their families will be called "displaced" rather than "resettled refugee" because their immigration status was unclear. The data displayed the core of the factors that influence the behavioral health needs of displaced youth within primary health care settings. Among the thematic clusters uncovered, there were three overarching categories of these themes: (a) experiences of displaced people; (b) care & assistance for displaced youth and families; and (c) behavioral health support.



Table 5

*List of Qualitative Analytic Categories and Amounts*

Analysis Categories	Amount
Thematic Clusters	11
Formulated Statements	37
Significant Statements	560

Table 6

*Examples of Formulated Meanings from Significant Statements*

Significant Statements	Formulated Meanings
<p>“More often than not, I would say it's in the spectrum of an adjustment disorder or another big one psychosomatic complaints, chronic abdominal pain or chronic headache or chronic backache that we really cannot pin down to physical problem as much as mental health disturbance is creating these symptoms. Then gosh, there's a range, I would say, of the depression, anxiety disorders.” (Transcript 5, page 1, lines 31-36).</p>	<p>Provider identifies connection between behavioral health concern and physical symptoms.</p>
<p>“Different kids from different backgrounds may have had negative school experiences before coming here. They might use different kinds of physical punishment for discipline or education purposes, so kids will be afraid of that.” (Transcript 5, page 1, lines 23-26).            “Like I have one who shared with me that when she came, kids pick on them at school, this is like in middle school. And somebody like pulled her scarf and ran away. Just one boy pulled her scarf and ran away.” (Transcript 4, page 6, lines 120-122).</p>	<p>Provider develops knowledge of negative experiences pre-resettlement            Provider learns of negative post-resettlement experiences.</p>
<p>“After this period of time. I think they're need to be more support and there needs to be more mental health services and screening.” (Transcript 9, page 14, lines 432-433).</p>	<p>Provider notes that there is a need for behavioral health support in primary care.</p>
<p>“Most of the conversations I would have with those youth is usually about the frustration going to school and you don't understand the language and they feel unwelcome by their classmates because they don't speak the language, they cannot communicate with their classmates. So it makes them difficult to</p>	<p>Provider describes language challenges that refugee youth report</p>

adjust right away. They feel the pressure to learn the language to get adjusted because no one wants to be left out” (Transcript 8, page 5, lines 161-166).

Table 7

*Development of Thematic Clusters*

Formulated Meanings	Thematic Clusters
Provider identifies connection between behavioral health concerns and physical symptoms.	Psychosomatic Concerns
Provider develops knowledge of negative experiences pre-resettlement	Experiences Pre-/Post-Arrival
Provider learns of negative post-resettlement experiences.	
Provider notes that there is a need for behavioral health support in primary care.	Suggestions for Better Care

**Experiences of Displaced People**

**Thematic Cluster 1: Resilience.** When discussing displaced youth overall, many of the participants identified the youth that they treat as resilient, with most youth not presenting with behavioral health concerns. One participant (P1) reported “refugee children really do well in a lot of things and don't necessarily act out as far as like aggressive behaviors”. Another participant (P7) expressed a similar statement, “I mean they're pretty tough, resilient kids”. Several of the participants (n = 9) expressed that displaced youth seemed to handle the transition to the United State well. One participant (P9) identified that the displaced youth in their practice tended to be very reserved and not particularly verbally expressive. It took time for the youth to “open up” about concerns that they had. Furthermore, when youth began to discuss life difficulties, they were serious situations and seemed to bother them immensely. Several participants (n =3)

mentioned that the children's resiliency may be a product of their stage of development and how formative their brains were. Several participants (n = 8) disclosed that some of the children did have significant trauma histories but, many of the refugee children seen did not present with negative behaviors that would indicate experiences of severe trauma.

**Thematic Cluster 2: Displaced Parents and Families.** The overall attributes of displaced parents were also discussed, and a few (n = 3) participants reported that they were found to be supportive of their children, particularly in school. Even though the displaced parents seen by the providers may not fully understand the U.S. academic system or may have very limited educational background themselves (e.g. not being literate or not having much formal education U.S. pre-arrival), they still supported their children participants explained. One participant (P6) disclosed that “most people who come and become refugees and have children, say they, of course and I believe, do it to give their children a better life. For them, getting their children educated is part of their process. ”

Several of the participants revealed that overall displaced families are happy to be in the U.S. (n = 3) and tend to do fairly well given the traumatic situations that they may have witnessed and/or been victim to in their pasts. One concern presented by participants (n = 11) was that families generally do not come in for preventative visits, only when their medical need has progressed to the point of being extremely urgent. One participant (P7) stated “ they're really sick when they finally get to my office.

**Thematic Cluster 3: Relocation Challenges .** Many participants (n = 11) identified various challenges that displaced youth and families face upon arrival that were discussed in primary care settings. For youth, one of the primary challenges, according to participants, was

the adjustment to the U.S. school system and U.S. culture. Eleven of participants noted that refugee youth struggled to adjust to the school setting, relating to other children at school and learning the language. One participant (P4) explained “Their [adolescents] issues are a little different, especially with the girls wearing scarves, the boys they are taught not to mix with other sex, and now they are in a school that has two sexes, definitely parents are worried.” Bullying at school was a large part of this struggle, like one participant mentioned (P12) youth may get bullied because of their “language barrier or the clothes that they wear or the color of their skin”. Furthermore, eight participants noted that learning English was reported to be a difficult transition for youth. One participant (P8) explained that learning English was also a concern that negatively impacted youth, “most of the conversations I would have with those youth are usually about the frustration going to school and not understanding the language. They feel unwelcomed by their classmates because they don't speak the language. They feel like their back is against the wall.”

Most participants (n = 10) discussed parental challenges as well. Not being able to go to communicate with the school because of the language barrier was a common challenge discussed by providers. Another challenge was disciplining differences and adapting to U.S. disciplining standards. One provider (P6) mentioned that parents sometimes are reluctant to discipline their children because they feel sad about what their children have been through. Several other providers (n = 3) mentioned that this may be the first time that parents had to parent their children on their own. Many refugee families may have come from communities that engaged in communal parenting, meaning that other family members or other adults within their community would help rear the children. Explained by (P4), “I do feel that parents are now more burdened,

because when they are back home, there was a big family around. Everybody really takes part in teaching these kids and playing a role in taking care of these kids.”

**Thematic Cluster 4: Displaced Youth Experiences Pre- and Post- Arrival.** Many of the participants (n = 10) recounted stories that displaced families and youth disclosed during their visit about various experiences that they had pre- and post-arrival into the U.S. Pre-arrival, youth were reported to have lived in refugee camps and often traveling through multiple countries before being resettled in the U.S. There were also stories of traumatic experiences. One participant (P1) explained a story of a young child with a bullet lodged in his abdomen, another participant (P12) discussed experiences of youth witnessing the fighting between the drug cartels and kidnappings, two participants (P2 and P10) discussed experiences of being separated from family members and for a family (P10) not knowing where the father of the family is. One participant (P6) reported, “many of them have been dislocated from their family. Many of them, in fact, personally suffered trauma, or witnessed trauma.”

Additionally, participants (n = 9) highlighted negative experiences post-arrival in the U.S. as well. Bullying was a common theme among the participants, one (P4) explaining that, “I have one who shared with me that when she came, kids pick on them at school and somebody pulled her scarf and ran away.” Another (P12) explained how some adolescent girls were being bullied related to their sexual identity. Several providers (n = 3) also discussed how adolescents were being pressured into joining local gangs, mostly males.

**Care & Assistance for Displaced Youth and Families.** All providers (n = 12) identified that caring for displaced youth and families in primary health care settings was unique compared to caring for other populations. In primary care, there was a need among providers to shift their

delivery of services to make processes fair easier for displaced families to access. For example, one participant (P1) explained, “we try and make everything as convenient as possible for them. That's the nature of our work.” How providers and their respective agencies provided interpretation services during visits was discussed by all the providers (n = 12) in this study. Since many displaced youth and their parents take time to “warm up” or get comfortable and familiar with how to discuss health information with their provider, more time was generally needed during medical visits. Additionally, many may come from places that do not have as many resources as we do in the U.S. so these resources take time to explain as well. For example, one participant (P12) stated, “when they're learning about resources, some of them come here for the resources alone”. Getting refugee families accustomed to how U.S. health care systems operate was found to be a challenge that was reported by the majority of the providers. Six participants identified various outside agencies that provided support to refugee families, like volunteers through local refugee resettlements agencies and program in the academic system that help support youth.

**Thematic Cluster 5: Care & Assistance Challenges** Nearly all the participants (n = 11) identified various challenges while treating displaced youth. Overall, working with displaced families in general was found to be more time consuming because translation often needed by an interpreter. One participant (P2) explained that many other medical clinics that do not fall within the two categories of being either a Federally Qualified Health Center (FQHC) or a university medical clinic so, they will not see displaced youth because of the financial burden it takes to support interpreters. Several participants (n = 4) identified difficulties in not having a comprehensive medical record for youth seen and one participant explained the challenge of having refugee parents fill out forms in the office because of the language barrier. Most

participants (n = 10) also identified significant social needs among refugee youth and their families which compounds making treating refugee youth in primary care settings fairly complex. One participant (P5) explained various difficulties that refugee families face, “It's social needs. There's financial problems. There's acculturation problems. There's just difficulties navigating the healthcare system, that and of itself. Then there's the physical problems.”

**Thematic Cluster 6: Behavioral Health Support** All participants (n = 12) within the study discussed the presence of behavioral health support for displaced youth. When counseling was brought up as a treatment option, many families reported to their providers that they were not interested. Ten participants reported a high stigma of mental health among displaced communities. Some displaced families were reported to prefer resolving the behavioral health issues within the family and had the belief that they should not talk to individuals outside of their family about their problems. Five participants also reported limited behavioral health screeners for youth. One provider identified using the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder -7 (GAD-7) to help assess for overall depressive and anxious symptoms. The other participant identified using the Refugee Health Screener 15 (RHS-15) for older teens.

A few participants (n = 5) explained that behavioral health needs are difficult to identify within this population because there are other contributing factors like the language barrier and cultural differences, particularly when discussing mental/behavioral health. For example, sometimes needs are not attributed to anxiety but language and culture. One participant (P10) recounted, “I have to ask questions in a particular way in order to get the answers that I need. I know that there's not just a language barrier, but there's also a cultural barrier.” Another participant (P11) expressed a similar sentiment, “And then still, there is information locked in

translation, as well as cultural norms and our inherent biases that are making it hard to have the full therapeutic effect

**Thematic Cluster 7: Refugee Care & Assistance & Language .** Among the challenges within primary care in treating displaced youth, one of the major themes among all the participants was the language barrier. All of the participants (n = 12) reported using the language line, which is a language interpreting service available by phone when live interpreters were not available to interpret. Many (n = 7) reported that displaced youth tend to sometimes speak English but, participants prefer having interpreters when talking to parents instead of allowing the children to translate. Additionally, one participant (P5) reported that using live interpreters may present a conflict because the live interpreter may belong to the same ethnic community as the displaced patient which may make the patient feel uncomfortable about sharing intimate health information. This participant stated specifically, “It’s a small community here and sometimes, they want to keep this business private, so it helps having a more anonymous person on the phone. It depends on the patient.” Overall, several participants (n = 5) identified both a language and cultural barrier present in working with refugee youth and their families, with one participant (P2) stating, “in some of the southeastern Asian languages, there is no word for depression so how do you talk about mental health disorders when that’s not something that someone even has a language for”.

### **Behavioral Health Support**

All participants (n = 12) within the study spoke about ways that they work to support patients’ behavioral health needs in primary care settings. In all cases, the participants ability to support behavioral health needs was dependent upon the resources provided by the medical



facility in which they worked and community resources available. Participants reported working in facilities that were on a spectrum, with some being very supportive of treating behavioral health needs in primary care, equipped with a number of resources, while others did not have that kind of support. Within this category, there were four thematic clusters: displaced child psychosocial response, psychosomatic concerns, trends and suggestions for better care

**Thematic Cluster 8: Displaced Child Psychosocial Response.** Most participants (n = 11) identified various psychosocial needs among displaced youth when they presented in primary care. Displaced youth treated by providers were reported to have had experienced a number of traumatic situations that could have impacted their overall mental and behavioral health. Youth have experienced loss and separation of loved ones and don't really have the vocabulary to express their negative emotions. Adjustment disorder was identified as a prevalent diagnosis among refugee youth. Several participants identified PTSD as another diagnosis that is given, sometimes rarely. School avoidance was another with a great deal of depressive and anxious disorders. One participant (P7) identified the prevalence of suicide ideation and attempts among youth as well. Another explained that they have seen eating disorder, primarily anorexia nervosa among refugee youth, both boys and girls (P4). Several providers (n = 4) reported that ADHD was not as common among refugee youth. Another (P12) explained incidences of schizophrenia and depression with psychotic features.

**Thematic Cluster 9: Psychosomatic Concerns.** Many of the participants (n = 10) reported the presence of psychosomatic complaints. Several participants (n = 5) discussed that it may take some time to reach the conclusion that an acute medical concern is a psychosomatic complaint because displaced youth tend to have minimal, vague medical history records, so

many evaluations are done to figure out what the cause of the acute symptoms. One participant (P5) explained, “another big one is psychosomatic complaints, chronic abdominal pain or chronic headache or chronic backache that we really cannot pin down to physical problem as much as mental health disturbance is creating these symptoms.” Psychosomatic complaints were common among the displaced youth patients seen by most of the providers (n = 11). Another participant (P1) explained, “I have another little one I was just thinking about that he, every day on the way home from school he gets a headache.” and another (P10) identifying a similar pattern “I do see somatic concerns of some children”. It seems like the discussion of these symptoms went hand in hand with mental health symptoms.

**Thematic Cluster 10: Trends.** All participants (n = 12) within the study discussed the needs of specific populations that they see and youth from various ethnic backgrounds. Overall participants discussed how the federal refugee admittance policy has changed the types of ethnic groups that they see in their practice. Participants identified the cultural and religious differences as it relates to openness to mental health treatment and their utilization of various coping skills (e.g. like prayer and using family to resolve mental health symptoms when refugee parents become aware of refugee youth’s mental health concerns). Several participants (n = 4) identified that there are limits to the kind of support displaced parents can give to their children because of their own educational background, for example how to advocate for their children in school. Several participants (n = 3) identified conflict between refugee youth and their parents because refugee parents do not want their children to adopt some U.S. values, particularly if they come from a culture that is more conservative compared to U.S. culture. For example, one participant (P3) stated, “many times, to us it seems like, well she's just being a teenager. But I don't think those liberties are normally expected in their culture.”

For displaced youth, several providers (n = 8) identified various trends when behavioral health needs are discussed in primary care settings. Some providers (n = 4) identified various gender differences when it came to the disclosure and presentation of behavioral health needs. One provider (P1) discussed the presence of sexual trauma among female youth which may contribute to behavioral health needs, for boys, particularly teen boys, they were reported to be a little more closed off than the girls were and when a behavioral health need was identified among them, it was very severe. One participant (P3) discussed the gender differences related to disclosure of needs, “The girls are definitely more open to talking about it. Like talking about their emotions or a lot of times the boys, especially the older ones are very just closed off.” Several participants (n = 6) identified adolescent displaced youth as a group of concern, one participant (P9) stated, “the younger kids adapt a little bit easier, the older kids, maybe because they knew a different life style, it's more difficult for them”.

**Thematic Cluster 11: Suggestions for Better Care.** As participants discussed challenges within primary care in treating displaced youth, the majority (n = 11) highlighted specific practices that could be added to the primary care setting that would help better support the treatment of behavioral health needs of the displaced youth that they see. One participant (P5) stated, “I do think having dedicated case managers would be great. I think having on-site mental health services would also be great.” Another participant (P7) made a statement about incorporating more case workers in the clinic and noted, “that would be great for the caseworker to have the Ages and Stages [child development assessment tool] that they give, to have the MCHAT [questionnaire assessing for Autism Spectrum Disorder] and the PHQ-9 [depression screening tool] for teenagers before they even came to that initial appointment.” Lastly, another

participant (P9) echoed the same need in primary health care settings, a need to have “ more mental health services and screening.”

One participant (P7) explained a specific recommendation for clinics to support the cost of behavioral health support in primary care settings, “again, not everywhere, but I think most medical centers, where you've been talking to people, should be able to do something like that [a level of integrating behavioral health care]. The way we do it is, the psychiatry people, they use our clinic, but they're still billing directly, so they don't lose any money in the process and we don't have to pay them any extra, kind of thing. Some clinics might elect to hire someone directly. Then, they would pay them. There's I'm sure, different payment models. I think the bottom line is, that we wanna make these services available fairly easily for the refugees. Also, bending the rules [amending current clinic policies] a little bit.” In addition to finding ways to financially support the use of behavioral health personnel in primary health care settings, several participants expressed a need for the overall shift in mindset and increase in cultural sensitivity needed among office staff and community overall.

## **Discussion**

The purpose of this explanatory, sequential mixed-methods study was to determine potential factors that increase the likelihood of behavioral health needs in a generalizable, pediatric population and compare them to the behavioral health needs of resettled refugee youth through the lived experiences of primary health care providers. Through the qualitative data collection and analysis process, youth were defined as displaced rather than resettled refugees because of the uncertainty of the youth’s resettlement and immigration status. Overall, the use of the explanatory, sequential mixed-methods design was effective in creating structure and comparison in exploring this limited area of study.

As the results of the quantitative phase of analysis indicate, there are several consistencies and inconsistencies as the results are compared with the pediatric behavioral health literature. When the ontogenic and mesosystem were combined into one model, the predictor variables went from explaining 15% of the variance within a model only containing ontogenic variables model to 10% of the variance within the combined ontogenic and mesosystem model. Although there was a 5% variance explanation decrease within the two models, many of the results were similarly significant between the two models. Overall, females were found to be less likely to be told that they had a behavioral health concern compared to males which is contrary to the literature that identifies females as having more behavioral health need than males (e.g. Blomqvist, Henje Blom, Hägglöf & Hammarström, 2019). White, non-Hispanic children, in this sample, had significantly greater odds of being told that they had a behavioral and/or emotional health needs compared to non-Hispanic Black children, Hispanic children and children who identified as “another”. In this sample, the majority of participants were non-Hispanic, White children (66.3%) and a conclusion that can be drawn from this finding is that there is literature supporting that many racial and ethnic minority children may present with behavioral health needs but are underdiagnosed compared to their White counterparts (Chandra et al, 2009; Ozer et al, 2009). Increased age was also found to increase the child’s likelihood of being told to have an emotional, behavioral or social skills problem which mirrors the behavioral health needs among adolescents and emphasizing them as an at risk population (Mason, Sabo & Zaharakis, 2017; Mufson et al, 2017; DeFrino et al, 2016; Lim, Silver, Leo, Kusulas, & Alderman, 2016; Mufson, Yanes-Lukin & Anderson, 2015; Ngo et al, 2009; Ozer et al., 2009).

Children with better overall health outcomes, reported by their parents, were found to be significantly less likely to be told by a professional that they had a behavioral/emotional health

problem. Additionally, children whose parents could report one person as their child's primary doctor were significantly less likely to have been told that their child had an emotional, behavioral or social skills problem, along with parents who did not talk to their child's school nurse about the child's health and children who did not attend their preventative care visits. In considering these results, it seems like the more interaction that youth and their parents/guardians have with professionals, whether at the doctor's office or at school, allows for the increased identification of behavioral health, emotional health or social skill needs. Another interesting finding from this quantitative phase of analysis was the relationship between physical health and being identified with a behavioral health need. As reported in the results, higher levels of physical health reported by the child's parent/guardian was a significant predictor of the child being identified with a behavioral, mental, emotional or social skills problem. This finding is contrary to literature connecting poorer physical health and behavioral health needs, specifically highlighting the presence of psychosomatic concerns (e.g. Barkmann et al, 2015; Bergström et al, 2015; Gini & Pozzoli, 2013). According to the results of the quantitative factors of analysis, all variables included in the analysis were significantly found to increase the likelihood that a child would be identified with an emotional, behavioral or social skills concern. These factors included: age, sex, racial/ethnic group, having a reported personal doctor or nurse, discussing health with a school nurse, attending preventive visits and child's reported overall health. From these results, an interview guide was created for the qualitative phase of analysis (see Appendix F)

### **Comparing the Quantitative and Qualitative Results**

The purpose of a sequential, explanatory mixed-methods design is to collect and analyze quantitative data first to "explain" those results with the qualitative data collected (Miller &

Johnson, 2014). In this case, the quantitative data represented a sample of youth located in a state in the Southeast region of the U.S., North Carolina, to compare those results with the experiences that primary health care providers had within the region pertaining to the behavioral health needs of resettled refugee youth. Since the foundation of this study was grounded in EST, one binary logistic regression was utilized including two levels of EST, the ontogenic and mesosystem. As the results of both analyses were compared, all hypotheses were supported and there were similarities, differences and other themes that arose from the findings.

On the ontogenic level, some of the quantitative results were affirmed and others were reported not to have been present among the displaced youth that they treat. As the participants discussed various concerns reported to them by displaced youth and their families, several providers identified two age groups that present with unique needs. The first was adolescents or teens. Participants described various reasons why this age group was one that concerned them. Some refugee adolescents presented with emotional distress because they had a difficult time adjusting to us culture and developing peer groups as reported by participants. Many participants also highlighted that some youth were at odds with their parents and felt split between two cultures. As one participant (P9) stated, “issues with cultural differences in the school setting; in the home setting. Which causes problems in the household settings and conflicts with the parents”. At times, the American values would pull the youth away from the values of their parents that may be categorized as more traditional compared to American values as participants reported. Additionally, displaced youth were found to experience bullying and peer pressure to engage in risky behaviors like substance use and gangs. For example, one participant (P6) expressed, “high schoolers have joined some gangs, which is kind of unheard of and they might feel a little less connected to their families of origin, adolescence, they're trying to break away.

They're more Americanized. They're perhaps doing some behaviors, like smoking, or whatever, that their parents would not agree with.”. Not only do these qualitative results affirm the results of the quantitative analysis, that increased age increased the likelihood of being identified with a behavioral, emotional or social need, but it is also supported by the literature on displaced youth needs globally. Displaced adolescents are among the age groups most published (Jensen, Skårdalsmo & Fjermestad, 2014; Sanchez-Cao, Kramer & Hodes, 2012; Seglem, Oppedal & Raeder, 2011; Derluyn, Mels & Broekaert, 2009).

Qualitative participants also mentioned intersectionality between age, gender, ethnicity and religion that also present unique emotional and social needs. This intersectionality was not examined as a part of the quantitative phase of analysis, even though age, sex and race/ethnicity independently were found to significantly increase the likelihood of behavioral need within the quantitative sample. Participants discussed gender-specific differences in the presentation of mental and emotional needs due to cultural background as well. For example, many participants discussed the struggles that some Middle-Eastern, Muslim teenage males face and at times some with this background have difficulty adjusting academically and socially. This is a unique theme that arose from this study because in the limited literature discussing the behavioral health needs of displaced youth, there is not much discussion of intersectionality and implications of how this intersectionality may be a risk factor for behavioral health need. Among teen girls from multiple ethnic backgrounds, several providers discussed sexual trauma histories among several displaced female patients that they treated as well. This is consistent with the literature on the experiences of sexual based violence pre- and post-resettlement (Williams, Chopra & Chikanya, 2018; Lay & Papadopoulos, 2009; Thomas, Thomas, Nafees & Bhugra, 2004).



One qualitative theme partially contradicted the quantitative results. Many qualitative participants discussed the presence of somatic concerns among displaced youth. Often times unexplained physical pains were related to emotional distress among youth of all ages, genders and ethnicities. Two prevalent concerns mentioned by qualitative participants was headaches and abdominal pain. Participants explained that displaced youth and their parents generally did not bring up behavioral health concerns during initial visits but, after building rapport with their provider they disclosed these specific physical concerns. These physical health concerns opened conversations about emotional and social distress. The quantitative results indicated that youth with better health outcomes were significantly more likely to be identified with a behavioral, emotional and social needs. This was found to be the opposite among displaced youth which is an area for future research as psychosomatic symptoms have been discussed in the literature predominantly among displaced adults (Hinton, Kredlow, Pich, Bui & Hofmann, 2013; Hinton, Kredlow, Bui, Pollack & Hofmann, 2012; Westermeyer et al, 2010).

On the mesosystem level of analysis, one theme that arose, consistent with the quantitative findings, was the consistency of health care utilization among displaced families. In the quantitative phase of analysis, increased utilization and interaction with health care professionals significantly increased the likelihood that a child would be identified with a behavioral, emotional or social skills need. Many qualitative participants reported that displaced families did not attend preventative or follow-up appointments when scheduled. Often, families came to the clinic for urgent medical issues that did not allow for the consistent surveillance and discussion of behavioral health overall. Qualitative participants discussed multiple factors that may have contributed to this challenge that included the unfamiliarity with the U.S. healthcare system and preventative care, lack of availability because of intense work schedules, lack of

transportation and cultural ideas related to seeking health care treatment. Health care access and utilization of displaced families is a global topic of concern within the literature (Betancourt et al, 2017, Hermans et al, 2017; Doocy, Lyles, Akhu-Zaheya, Butron & Weiss, 2016). Several qualitative participants discussed initiatives taken by resettlement agencies and medical offices to increase the resources, like transportation and following-up with families more often, in order to increase the number of follow up visits that the family can attend.

Lastly, the results of the quantitative analysis indicated that children who spoke with a school nurse about their child's health were significantly more likely to be identified with an emotion, behavioral or social problem. Among the qualitative participants, there were mixed comments about the school's involvement in identifying behavioral needs. Some providers reported that they've received referrals from the school regarding the needs of refugee youth, others reported that they rarely get notified by school officials about youth's needs. For youth overall, school identified behavioral health concerns is key, particularly among racial/ethnic minority students within the U.S. (Ramos et al, 2017; Amaral et al, 2011; Villalba, 2011). This finding highlights the need to strengthen the connection between school officials and medical providers as a means of creating a stronger, collaborative network to increase the behavioral health needs among displaced youth.

### **Limitations**

There are several key limitations that should be mentioned. First, this study was meant to focus solely on primary care providers experiences with behavioral health needs among the resettled refugee youth who they treat. This definition was expanded to encompass displaced youth since immigration or resettlement status could not be confirmed by primary health care providers. Moreover, many qualitative participants discussed refugee youth and adults

interchangeably during interviews. The researcher tried specifying the needs of youth during the interview but often times participants blended the two because, as many participants within the study stated that adults had unique emotional needs as well. During the recruitment process, youth were defined as an individual under the age of 18 years old, but through a Global Review published by UNHCR, the term youth is identified as a social construct (Evans, Lo Forte & Fraser, 2013). The second limitation was the usefulness of the secondary dataset used for the quantitative phase of analysis. The data was from 2005 which may be a little outdated in using the results as a comparison for the qualitative data that was collected from 2018-2019. Additionally, the outcome variable may have been too broad for this analysis because it included social skills problems that may have encompassed developmental disorders which was outside of the scope of this study. These limitations leave a great deal of opportunities for future research directions.

### **Conclusion and Future Research**

There are multiple areas that future research could build upon the information revealed within this study. One area of future research is exploring displaced parents thoughts and experiences related to discussing the behavioral health concerns of their children with primary care providers. Another area of exploration is developing and validating tools for assessment and screening of displaced youth in primary health care settings. There are very few tools that have been validated with this population worldwide (Gadeberg et al, 2017), which leaves much opportunity. Additionally, treatment options for displaced youth in primary care settings is also an area that could be explored as many other behavioral health intervention programs that include largely racial and ethnic minority populations have mostly focused on African American and Latinx populations without clarification of refugee status (Mufson et al, 2017; Scholer,

Hudnut-Beumler, Mukherjee & Dietrich, 2015; Berge, Law, Johnson & Wells, 2010; Power et al. 2010). Lastly, even though there were several limitations that restrict the applicability of this study to the displaced population, future research could replicate this study design and compare findings.

Conclusively, the sequential, explanatory mixed-methods design was shown to be effective in illustrating the experiences of primary care providers with displaced youth and their behavioral health needs. Although the study was focused on the behavioral health needs of youth, various other needs arose such as social, cultural and familial. Future research has the opportunity to build on the limited literature on this population within the United States and could potential of improving the universal care of resettled refugee youth.

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## **CHAPTER 6: DISCUSSION**

### **Introduction**

In summary, the six chapters of this dissertation brought awareness to various aspects of the overall needs of displaced youth within the U.S. and globally. Beginning with the literature review, Ecological Systems Theory (EST; Bronfenbrenner, 1977; 1979) provided a platform to examine the literature related to the behavioral health needs of resettled refugee youth globally to inform the treatment of these needs within primary health care settings. A study was created through this dissertations to adequately and comprehensively assess the behavioral health needs of displaced youth reported by primary health care providers who treat them. In order to precisely examine the literature on addressing behavioral health needs of youth in primary health care settings, a systematic review was completed focusing on racial and ethnic minority youth. Lastly, an explanatory, sequential mixed-methods design research study was conducted comparing the ontogenic and mesosystem level factors that increased the likelihood that children within a secondary dataset would be identified as having a behavioral, emotional or social skills need and how that compared to the factors influencing the behavioral health needs displaced youth reported by primary health care providers.

### **Literature Review**

In reviewing the literature on the behavioral health needs of resettled refugee youth globally, EST provided a theoretical foundation in organizing the literature and an avenue to guide research and clinical implications for primary care interventions. Collectively, literature in this area punctuated the need for adequate, culturally-attuned assessment in regards to refugee child's daily functioning (Gadeberg et al., 2017) and family functioning (Sangalang, Jager & Harachi, 2017; Trentacosta et al, 2016). There is a need to make behavioral health services more

accessible for resettled refugee families as the literature points out significant barriers in utilization of behavioral health services (May et al., 2013; Pacione, Measham & Rousseau, 2013; de Anstiss et al., 2009). One of those barriers being mental health stigma, integrated behavioral health care may be a fitting solution to assess, diagnosis and treat refugee youth.

### **Methodology for Mixed-Methods Study**

At the conclusion of the literature review, it was evident that very little research had been conducted in the area of treating the behavioral health needs of resettled refugee youth in primary health care settings. For this reason, a mixed-methods study was created in order to fulfill two parts to a single overarching goal which was to first, identify factors that increased the likelihood that children would be identified with a behavioral health need and, second, compare those to reports of the behavioral health needs of resettled refugee youth recounted through the lived experiences of primary health care providers. The explanatory, sequential mixed-methods design was chosen because it contained a quantitative and qualitative phase that allowed for the qualitative to be compared to the quantitative. As a theoretical base for this study, EST was used. For the quantitative phase of the study, a binary logistic regression examined the likelihood that seven ontogenetic and mesosystem variables would significantly increase the possibility that a child was identified with a behavioral, emotional or social skills needs. Consecutively, once the quantitative phase was completed, the results of this phase informed the interview guide for the semi-structured, qualitative interviews with primary health care providers who treat resettled refugee youth. For the qualitative phase of analysis, Moustakas' (1994) phenomenological approach seven step method was employed and Colaizzi's (1978) seven step phenomenological method for phenomenological data analysis. Trustworthiness was upheld through including a triangulated researcher on the project, maintaining a detailed audit trail and member checking.

## **Systematic Review**

Although the methodology for the study was completed, there was still a need to systematically review the literature on studies that had already been published in youth behavioral health and primary health care. Additionally, a systematic review ensured that this study had not been conducted before and determined general themes within the literature that intentionally included study samples with at least 50% or more of racial and ethnic minority youth representation. The review included 40 articles after a review of 2,016 articles. EST was also used as a theoretical foundation for the systematic review and the results of the systematic review were organized according to this theory. Among the 40 articles included in the review, four themes arose from the results (1) provider screening tools (microsystem), (2) stigma and patient communication (mesosystem), (3) provider selected treatment (exosystem), and prevalence and needs (macrosystem). Similar implications were drawn from the literature review and the systematic review. The literature calls for more validated screening tools for racial and/or ethnic minority youth in primary health care settings. There is a need for culturally-attuned medical providers and integrated behavioral health care providers. Lastly, the call for family-centered, culturally-attuned care given the significant presence of mental health stigma as a barrier to treatment within various racial and/or ethnic minority populations (Villatoro, DuPont-Reyes, Phelan, Painter & Link, 2018; Johnco & Rapee, 2018; Chavira et al, 2017) and notable influence that parental help seeking behaviors have on youth (Thurston et al, 2018).

### **Implications for Medical Family Therapy (MedFT)**

As a contribution to the field, the interpretation of these dissertation results are meant to expand the field of MedFT. A concept such as family-centered, culturally-centered, trauma-informed care within primary health care settings is well within the scope of a MedFT because of

its systemic nature. MedFT concepts include the biopsychosocial (BPS) framework (Engel, 1980; 1977), agency (Totman, 1979; McDaniel, Doherty & Hepworth, 2014), communion (McDaniel et al., 1992, 2014; Pratt, Phelps, Baird & Younkin, 2014) and C.J. Peek's Three World View (Peek, 2008) can be expanded to include models that are trauma-informed, culturally sensitive and family focused collectively. Integrated behavioral health care is also a concept that is strongly support by MedFT and is needed in treating displaced youth in primary care settings. Each of these concepts can be utilized to improve the behavioral health treatment of displaced youth within primary health care settings.

### **Need for Family-Centered, Culturally Centered Care**

Since MedFT is a field that supports increasing agency and communion in treatment, family-centered care is somewhat built into the foundation of the field. Agency is defined as “active involvement and commitment to one’s own health care” (Totman, 1979; McDaniel, Doherty & Hepworth, 2014) and communion is defined as being “cared for, loved, and supported” by those who are close around you, whether that be friends, family or professionals, to help promote healthy emotional coping in managing illnesses, disabilities, and/or contact with the healthcare system (McDaniel et al., 1992, 2014; Pratt, Phelps, Baird & Younkin, 2014). In order to promote family centered treatment among displaced families in primary health care, there is a need to promote agency and communion as displaced youth are being treated. Currently, there is limited literature on how to promote agency and communion among populations that may have a combination of experiences of various types of trauma and cultural diversity, particularly when a patient is coming from a significantly different health care culture and experience.

As the qualitative data was collected, many of the participants not only discussed the health needs of displaced youth but stressors within their familial context that contributed to behavioral health needs. Displaced parents were reported to have various difficulties, one major one being parenting and disciplining their children in a new country. On one end, the participants reported that displaced parents felt guilty that their children had to endure difficult experiences pre-resettlement which lead to them being somewhat permissive at times. Inversely, displaced parents were reported to have trouble disciplining their children appropriately. Literature has highlighted the difficulties that displaced parents face in rearing their children in a new cultural context. Tingvold, Hauff, Allen & Middlethorpe (2012) found that among a sample (n = 55) Vietnamese refugee parents worked to instill certain values within their teens that support themes of resilience and psychosocial health. Smetana & Ahmad (2018) found that among a cohort of Arab adolescents, certain parenting styles (one parent being authoritative and the other nonauthoritative) supported overall wellbeing particularly as they worked to blend into a new culture. Additionally, participants identified refugee adults as having severe mental health concerns, in some cases, like posttraumatic and depressive symptoms that impact their overall wellbeing and functioning as they transition to U.S. culture which is also reflected in the literature (Erucar, Maltby & Vostanis, 2017). As these co-occurring themes arose, the needs of both displaced youth and parents, it is suggested that an intentional family-centered care approach be utilized to address the behavioral health needs among youth which is within the scope of MedFT.

Family-center care is an approach that seeks to heighten the family's involvement in the care of children in medical settings, increasing their participation in decision-making and improving the family's relationship with health care professionals and the system overall (Coker,

Rodrigues & Flores, 2010). In addition to the implementation of a family-centered care approach with displaced families to support the needs of refugee youth, there are other significant components that are needed in order to support successful care delivery as revealed by the qualitative results. A family-centered approach that is both trauma- and culturally- sensitive may be necessary to help improve care for this population. The literature regarding the behavioral health needs has internationally identified the presence and negative impact of trauma events on displaced youth (Betancourt et al., 2012; Kira, Lewandowski, Somers, Yoon & Chiodo, 2012; Xu, 2007; Lustig et al, 2004) and the same could be said for displaced adults (Richter et al, 2018; Shawyer, Enticott, Block, Cheng & Meadows, 2017). There has been quite a bit of literature published on family-centered care over the recent years, particularly among children with special needs (Russell, Beckmeyer & Su-Russell, 2018; Lindly, Zuckerman & Mistry, 2017; Zajicek-Farber, Lotrecchiano, Farber & Rodkey, 2017) but, there are limited examples of trauma-focused, family-centered pediatric care within the literature. The intersection of cultural sensitivity, family-centered, trauma informed health care models are needed and may be highly beneficial with displaced families.

### **Trauma-Informed Care**

As the recognition of the compelling findings of the Adverse Childhood Experiences Study (ACEs; Felitti et al., 1998) continues to gain relevance in both behavioral health and medical arenas, there is an increased call of action towards implementing integrated, trauma-informed care models. Research continues to develop the link between psychological trauma and physical health which reaffirms Engel's (1980; 1977) BPS model. Trauma related to forced displacement is discussed repeatedly within the literature in regards to this population (Seery, Boswell & Lara, 2015; Betancourt et al., 2012; Kira, Lewandowski, Somers, Yoon & Chiodo,

2012; Xu, 2007; Lustig et al, 2004) and was also discussed by many of the qualitative participants in the study in discussing factors that may influence the presence of behavioral health needs. Integrated, trauma-informed care models are being established as a way to increase access to behavioral health assessment, diagnosis and treatment along promoting a collaborative, holistic method to treating patients with psychological trauma backgrounds. Ades et al., (2019) discussed an integrated, trauma-informed care model informed by the needs of survivors of sexual and gender-based violence in an OB/GYN (obstetrics and gynecology) clinic. As a direct response to the ACEs findings, the Trauma-Informed Primary Care (TIPC) model was created to outline a way to screen and collaborate with patients with childhood trauma histories (Roberts, Chandler & Kalmakis, 2019). Marsac et al. (2016), encourage the use of a trauma-informed approach in pediatric care that includes family-centered objectives particularly since it is estimated that a high rate of children may have been exposed to a traumatic event that could negatively impact them. This growing area of literature allows for a vast amount of opportunity for MedFTs to expand the literature, inform clinical practice and educate health care policy on how to effectively marry both trauma-informed and family-centered care in pediatric settings. Additionally, there are various organizations that have created material that could potentially inform these practices like the National Child Traumatic Stress Network (<https://www.nctsn.org/>) and organizations that specifically focus on work with refugee families like Bridging Refugee Youth & Children's Services (<https://brycs.org/>).

### **Need for Integrated Behavioral Health Care Providers**

Many of the qualitative participants discussed the pressure that they have to attend to physical needs of refugee youth that sometimes behavioral health are not as prioritized. This may be a call for the expansion of health care teams so that all pediatric primary care settings have

behavioral health specialists to help support the need. Literature has supported the integration of integrated care for various racial and ethnic minority groups (Benuto & O'Donohue, 2016; Pollard et al, 2014). When promoting integrated behavioral health care for refugee youth, there are a few key factors that would allow for specialized care identified by the participants within the qualitative study. As mentioned earlier, an integrated care model is needed that is trauma-focused, culturally-sensitive, family-centered and accommodates for the use of interpreters. More models are being discussed and introduced into the literature that promote integrated behavioral health care that is trauma-informed or trauma-focused. In the behavioral health realm, there is the existence of trauma systems therapy, supported by the National Child Traumatic Stress Network, that defines a model for working with youth that have been traumatized (Wu, 2018) that may be beneficial in working with this population in primary health care settings. More literature is needed exemplifying integrated behavioral health models for the treatment of displaced youth in primary health care settings.

### **Effective Ways to Manage the Language Barrier**

One of the major barriers to care discussed by nearly all of the qualitative participants in was the difficulty in managing the language barrier in primary health care settings. Many identified the time it took to secure a phone interpreter was a challenge and that visits generally take double the time because of the interpretation. Many providers explained that there was a language barrier/cultural barrier and having live interpreters often help reduce that obstacle. The presence of language barriers in healthcare settings has been discussed in the literature. Language barriers have been identified as a huge obstacle in treatment (Ali & Watson, 2018; Vermette, Shetgiri, Al Zuheiri & Flores, 2015). Limited English proficiency may also contribute to negative health outcomes in children (Levas et al, 2014) and has the potential of contributing



to clinician bias (Flores, 2014), widening the health care disparities gap for marginalized populations. One recommendation given by authors and researchers to help alleviate the language barrier was policy changes and suitable interpretation services (Vermette et al, 2015; Flores, 2014). The language barrier seemed to be three-fold, impacting clinical interactions, slowing down the overall operation of the clinic's patient flow and being quite expensive to secure an interpreter. Given the complex nature of this need, C.J. Peek's Three World View (Peek, 2008) would be a great way to conceptualize and potentially address this concern.

One valuable tool that could potentially improve the effectiveness of behavioral health treatment in primary health care settings for refugee youth is C.J. Peek's Three World View (Peek, 2008). Peek's Three World View has three components clinical, operational and financial. The clinical view encompasses the health care systems ability to provide health related services to patients like medical treatment or mental health treatment. The financial view relates to health care facilities being economically stable and meeting the financial requirements to stay open and functioning. The operational view is the way that health care systems are organized or managed that allow them to perform day to day functions to meet patient needs (Peek, 2008). To improve the care of refugee youth, initiatives can be incorporated on each level, operational, clinical and financial to create seamless linguistic support within the clinic.

It should be noted that even though Peek's Three World View could potentially promote effectiveness in managing the language barrier in primary health care settings, this model has potential limitations, particularly for providers and/or administrative personnel who do not have any control over the organizational aspect of how their clinic operates on a daily basis. To highlight EST, the microsystem and mesosystem with displaced youth and their families may also be a much stronger place of influence. Additionally, one aspect brought out by many

providers was that displaced youth tend to learn English fairly quickly. Often times within a year, youth learn English fluently. Given this trend highlighted by participants, more research is needed in engaging youth in behavioral health assessments initially, once they are resettled to help manage initial cultural adjustment but also comparing assessments and interventions to a time when the youth has learned the language, approximately a year post-arrival.

### **Screeners and Diagnostic Tools**

Part of integrated behavioral health care is using screening and diagnostic tools consistently. Many of the qualitative participants either not screening refugee youth at all or not have consistent screeners. Screeners identified by providers that were used included the Patient Health Questionnaire 9 (PHQ-9; Spitzer, et al., 2000), Generalized Anxiety Disorder -7 (GAD-7; Spitzer, Kroenke, William & Löwe, 2006), and Refugee Health Screener – 15 (RHS-15; Hollifield et al., 2013). One provider also mentioned using the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble; Knight, et al, 1999), Alcohol Use Disorders Identification (AUDIT;Saunders, Assand, Babor, de la Fuente & Grant, 1993) and Drug Abuse Screening Test (DAST; Skinner, 1982). There are limited studies on screeners for refugee youth and not much research on the use of validated screeners in primary health care for this population. Gadeberg, Montgomery, Frederiksen & Norredam (2017) published a notable systematic review on mental health screeners for refugee children and youth. Within this review, the study yielded nine validation studies and authors summarized that there wasn't strong evidence to recommend specific tools for clinical practice. Over and above the needs of validated screeners for displaced youth, is the need to separate youth into developmental categories, for example ages 0-6, 7-12, 13-18, in order to make developmentally appropriate assessment and diagnostic tools for this

population given the theme of displacement that separates their needs from the needs of the general pediatric population. This is an area for future research.

More validation studies are needed. Since this current study focuses specifically on primary care settings, validation studies within this health care context may be helpful as well. Primary health care settings are unique because of the time limits that providers can spend with patients for example, the average time of a pediatric health care visit is approximately 16 minutes (Merline, Olson, Cull, 2009). Many qualitative participants included within the study reported that visits often take longer than average because of translation. There is a need to continue to support the treatment of the behavioral health needs of youth within primary care through the validation of screening and diagnostic tools for this healthcare setting. Furthermore, C.J. Peek's Three World View could also be implemented in employing a consistent behavioral health screening procedure for displaced youth.

### **Physician Burn-out & Implicit Bias**

Just a small few of qualitative participants discussed both the presence of potential physician burn-out and implicit bias. Although just a few participants mentioned the presence of these concerns, it may be beneficial to incorporate to support educational efforts against them which is within the scope of MedFT. Many of the providers expressed that they enjoyed their clinical work with refugee families and youth, but some of the challenges and barriers to care like Medicaid navigation issues, significant trauma histories and limited resources make it difficult at time to service this population. Rotenstien et al (2018) determined that there were various definitions for physician burnout within the literature, but it can be overall defined as physician exhaustion to the point where the physician may no longer be able to connect with

their patients, negative attitudes towards patients, and a feeling of being ineffective (Maslach & Leiter, 2016).

Efforts have been made to help reduce physician burnout which include a training program for physicians to help manage stress and improve sensitivity (Nguyen et al, 2019). To help reduce implicit bias among providers include specific strategies that include “individuating”, or focusing on specific details about the person being treated instead of the social group they belong to, and “perspective-taking” which is the provider envisioning themselves in the patients position (Chapman, Kaatz & Carnes, 2013; Galinsky & Moskowitz, 2000). As literature continues to develop regarding treating refugee youth in primary health care settings, these two concepts are important to address as with all marginalized, underserved populations. There is a great deal of opportunity for MedFTs to contribute to the field in discussing these topics in a systematic way.

### **Conclusion**

Conclusively, the sequential, explanatory mixed-methods design was shown to be effective in illustrating the experiences of primary care providers with resettled refugee youth and their behavioral health needs. Although the study was focused on the behavioral health needs of youth, various other needs arose such as social, cultural and familial. MedFT concepts create a fruitful environment to address the holistic care of refugee youth within primary health care settings. Future research has the opportunity to build on the limited literature on this population within the United States and could potential of improving the universal care of resettled refugee youth.

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## APPENDIX A IRB APPROVAL

EAST CAROLINA UNIVERSITY  
University & Medical Center Institutional Review Board  
4N-64 Brody Medical Sciences Building- Mail Stop 682  
600 Moye Boulevard - Greenville, NC 27834  
Office 252-744-2914 ☎ · Fax 252-744-2284 ☎ · [www.ecu.edu/ORIC/irb](http://www.ecu.edu/ORIC/irb)

### Notification of Initial Approval: Expedited

From: Social/Behavioral IRB  
To: [Florence Lewis](#)  
CC: [Damon Rappleyea](#)  
[Florence Lewis](#)  
Date: 7/9/2018  
Re: [UMCIRB 18-000994](#)  
NC Refugee Youth Mental Health Needs in Primary Care: A Phenomenological Study

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 7/8/2018 to 7/7/2019. The research study is eligible for review under expedited category #6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/dosure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
Lewis, F IRB Dissertation Proposal.doc	Study Protocol or Grant Application
Lewis, F IRB Informed Consent.doc	Consent Forms
Lewis, F IRB Interview Protocol.doc	Interview/Focus Group Scripts/Questions
Lewis, F IRB Recruitment Flyer.doc	Recruitment Documents/Scripts
Lewis, F IRB Survey.doc	Surveys and Questionnaires

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

**APPENDIX B: SYSTEMATIC REVIEW CHART**

	Authors (year)	Theme/ Study aim	Study design, N	Measures	Source/ Study population	Race/Ethnicity/ Ages	Mental health Need	Findings
1	Mufson, Yanes-Lukin & Anderson (2015)	Effectiveness of a brief version of the Interpersonal Psychotherapy for Depressed Adolescents (BIPT-A) in primary care	Cohort Study; N= 10	Schedule for Affective Disorders and Schizophrenia for School-Aged Children — Present and Lifetime Version; Beck Depression Inventory, Second Edition (BDI-II); Clinical Global Impression scale; The Social Adjustment Scale — Self-Report (SASSR)	Referred by their pediatric providers and met criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition	All Latino; ages 12 to 19 years old	Depression	Significant improvement in reducing depressive symptoms

2	Marie-Mitchell, Studer & O'Connor (2016)	Follow-up study to Inform the design of pediatric interventions to prevent mental health problems	Cross-sectional study; N = 18	Child-Adverse Childhood Experiences (C-ACEs); WPPSI-III vocabulary subscale; Pediatric Symptom Checklist; a Community Resource Survey	Female primary caretakers of children in an urban northeastern pediatric practice	Black primary caregivers (n = 12); 4-5 years old	Participation in Mental Health Treatment	Children with high C-ACEs scored were less likely to participate in mental health treatment
3	Dempster, Davis, Jones, Keating, & Wildman (2015)	Assess role of stigma in parents' help-seeking behaviors related to perceived child behavior problems	Cross-sectional; N = 101	Pediatric Symptom Checklist (PSC); Obstacles to Engagement Scale (OES); Revised Version of Self-Stigma of Seeking Professional Psychological Help (SSOSH); Revised Versions of Stigmatiz	an academic urban primary care office	African American Parents; 3-8 years old	Perceived Child Behavior Problems	Self-stigma strongest predictor in help-seeking



				ation by other for seeking health scale (PSOSH); Revised Version of Stigma of Seeking Professional Psychological Help (SSPPH)				
4	Butler (2014)	Examine relationship between shared decision making and parental perception of child mental health treatment or child mental health functioning	Cross-sectional; N = 36	Four questions assessing shared decision making; four questions assessing mental health treatment stigma; two-part question assessing severity of externalizing behaviors ; Four modified questions assessing child mental	National Survey for Children with Special Health Care Needs (NS-CSHCN); Families referred to Primary Care-located Mental Health Services	Latino and African American parents; 2-7-year-old	Child Mental Health Functioning and Stigma related to treatment seeking	Higher levels of shared decision were associated with lower stigma towards mental health treatment and lower parent-perceived child mental health impairment

				health impairments				
5	Le^ Cook,. Brown, Loder & Wissow (2014)	Assess relationship between time in the U.S. and number of psychosocial issues discussed with health care team	Cross-sectional; N = 359 (discussed psychosocial problem with Medical Assistant); N = 358 (discussed psychosocial problem with doctor)	Various items indicating level of acculturation (e.g. years parent has been in U.S., language discordance, nativity measures); Strengths and Difficulties Questionnaire (SDQ); Gender-Specific Mental Health Inventory (MHI); Patient Health Questionnaire-9 (PHQ-9)	Federally Qualified Health Center	Latino parents; children ages 1-16	Communicating Psychosocial concerns	“Parent’s length of time in the US was positively associated with their communication of: their child’s psychosocial problems with their child’s MA”
6	Ozer, Zahnd, Adams, Husting, Wibbelsman,	Assess Primary care providers' rates of screening	Cross-sectional;	Adolescent Report of the Visit Survey; Response	(1) well visits in a pediatric clinic (2)	29.6 % Latino/Hispanic, 22.9% African America	Screening for depression and	Latino adolescents were 1.5 times more likely to

	Norman & Smiga (2009)	for emotional distress among adolescent patients	N = 1,089	s to specific CHIS items measuring provider screening for emotional distress; Center for Epidemio logic Studies Depression Scale (CES-D)	2003 California Health Interview Survey (CHIS)	n and 15.2% Asian; adolescents were 13-17 years old	emotional distress	receive a depression screening compared to Whites.  African American teens were less likely to be screened for emotional distress than white adolescents. After controlling for age and gender,  There were no significant differences in provider rates of screening.
7	Rausch, Hametz, Zuckerbr ot, Rausch & Soren (2012)	Examine whether screening adolescent depression is feasible and acceptable	Cros- sectional with pre- and post- asses sments for provi ders;	The Columbia Depressio n Scale (CDS); provider survey about mental health screening and	3 pediatri c and adolesc ent primary care practice s affiliate d with an academ ic	Predomin ately Black/Non- Hispanic (29%). White Hispanic (29%), Other (non- White; 59%); adolesce	Screening for Depression	Feasibility of using Columbia Depression Scale in primary care with Latino adolescents

			N = 636	beliefs on barriers	medical center	nts ages 13 to 20 years old.		
8	Koshy, Mautone, Pendergast, Blum & Power (2016)	Examine the validity and clinical utility of the Behavioral Health Checklist (BHCL),	Cross-sectional; N = 1274	Behavioral Health Checklist (BHCL); Child Behavior Checklist (CBCL)	Pediatric Primary Care Clinic	African American (63.2%); youth ages 4 – 12	internalizing, externalizing, attention-deficit/hyperactivity disorder (ADHD) symptoms; behavioral and emotional concerns	Construct and discriminant validity in using the BHCL with diverse populations
9	Castro, Billick & Swank (2016)	Present unified Spanish versions of the Pediatric Symptom Checklist (PSC) and Reporting Questionnaire for Children (RQC)	Cross-sectional; N = 22	the Pediatric Symptom Checklist (PSC); Reporting Questionnaire for Children (RQC); Child Behavior Checklist (CBCL)	Pediatric Outpatient Care	Latino Parents; ages of children unknown	Psychosocial problems	The Spanish versions of the PQC and PSC were found be effective
10	Scholer, Hudnut-Beumler, Mukherjee &	To determine	Unknown;	Item assessing if intervention helped	Pediatric Primary	Black (37%), Hispanic (26%); children	Parental discipline	Intervention help facilitate conversation about discipline

	Dietrich (2015)	if a 5- to 10-minute intervention, integrated into the well-child visit, can help parents discuss discipline with their physician	N = 130	communication	y Care Clinic	ranged from ages 1-5 years old		between parents and their physician.
11	Weitzman, Edmonds, Davagnino & Briggs-Gowan (2014)	determine rates of clinically significant socioemotional/behavioral problems	Cross-sectional; N = 378	Brief Infant-Social Emotional Assessment; Parental Risk Questionnaire	Pediatric Primary Care Center	41.7% African American/Black, 41.7% Hispanic; 12- to 48-month old children	Socioemotional/ Behavioral problems	Parental medical problems, parent depression/anxiety and extreme parental distress significantly associated with infant socioemotional/behavioral problems
12	Godoy, Mitchell, Shabazz, Wissow & Horn (2014)	Determine association between parents' self-efficacy in communicating with their child's pediatrician	Cross-sectional; N = 231	Roter Interactional Analysis System (RIAS); Perceived Efficacy in Patient-Physician	Urban Pediatric Primary Care Clinics	All African American Mothers; children from ages 2-5 years old	Psychosocial issues	Mother with higher levels of self-efficacy were more likely to discuss psychosocial issues with their child's

		n and willingness to disclose psychosocial concerns during pediatric primary care visits.		Interactions (PEPPI)				health care provider
13	Hourigan, Southam-Gerow & Quinoy (2015)	Identify needs for behavioral health care	Cross sectional; N = 197	Revised Child Anxiety and Depression Scale (RCADS; both child and parent versions); Multidimensional Anxiety Scale for Children (MASC); Strengths and Difficulties Questionnaire (SDQ)	Large, Urban Pediatric Primary Care Clinic	91% African American; youth ages 8-17	Emotional and Behavioral Problems	Significantly high levels of behavioral and emotional symptoms among African American youth presenting at this pediatric primary care clinic
14	Walton, Mautone, Nissley-Tsiopinis, Blum & Power (2014)	Investigated whether treatment engagement was associated	Unknown; N = 43	Clinician-initiated telephone contacts; Number of attempts by parent to connect	Large Urban Pediatric Practice	91% Non-Hispanic Black; School-age children from the	Attention deficit/hyperactivity disorder (ADHD)	Pretreatment telephone contact was partially associated with treatment engagement.

		with specific pretreatment contact		with clinician; Total number of phone time		1 <sup>st</sup> to 6 <sup>th</sup> grade.		
15	Berge, Law, Johnson & Wells (2010)	Test initial feasibility of a parenting psychoeducational group targeting child behavioral problems within a primary care clinic.	Cohort Study; N = 35	Family Functioning Device (FAD); Youth Outcome Questionnaire (Y-OQ); Revised Dyadic Adjustment Scale (RDAS)	Inner-city Primary Care clinic	79% African American; 6% Native American, 2% Hispanic;	Parenting program	Significant improvement in family functioning, child misbehavior and couple functioning after participating in group.
16	Collins, Kelch-Oliver, Johnson, Welkom, Kottle & Smith (2010)	Examine the prevalence of depressive symptoms among adolescent females	Cross-sectional; N = 653	The Center for Epidemiologic Studies Depression Scale (CES-D)	Primary Care Reproductive Health Clinic	African American; Adolescents between ages 12-19 years old	Depressive Symptoms	African American female adolescents presented with significantly higher depressive rates compared to the national average
17	Leiner, Balcazar, Straus, Shirsat & Handal (2007)	Evaluate the use of the Spanish version of the pictorial pediatric symptoms checklist	Cross-sectional; N = 468	Pictorial Pediatric Symptom Checklist (PSC); Child Behavior	University-based clinics	All Mexican mothers or female caretakers; children	Psychosocial and Behavioral Problems	PPSC showed good internal consistency and validity when used alongside the CBCL

		(PPSC) in identifying behavioral problems of children in a population of Mexican children attending well-child		Checklist (CBCL)		ages 4-6 years old		
18	Wren, Berg, Heiden et al (2007)	Explore the impact of child gender and of race/ethnicity on parent and child reports of school-age anxiety	Cross-sectional;	the Screen for Childhood Anxiety and Related Emotional Disorders (SCARED)	Pediatric Primary Care Clinics drawing from urban, suburban and rural populations	33.2% Hispanic, 26.5% Black/ Non-Hispanic, 10.5% Asian, 8.5% Biracial; children 8 to 12 years old	Anxiety	No significant differences within race/ethnicity reports.
19	Morley (2009)	Examine if race and insurance status impacted ADHD diagnosis and treatment	Cross-sectional Vignette-based;				ADHD	African-American cases were more likely to be diagnosed with ADHD but, being both African American and uninsured reduced the probability that patient would be diagnosed.



20	Bagner, Coxe, Hungerford, Garcia, Barroso, Hernandez & Rosa-Olivares (2016)	Address the mental health needs of infants from high-risk families	Unknown; N = 60	Brief Infant-Toddler Social and Emotional Assessment (BITSEA); Wechsler Abbreviated Scale of Intelligence (WASI); Infant-Toddler Social and Emotional Assessment (ITSEA); Dyadic Parent-child Interaction Coding System-Third Edition (DPICS-III); Parenting Stress Index, Fourth Edition, Short	Large, Urban primary care clinic	93% Hispanic mothers; Infants 12-to 15-months old	Mental health needs; Behavioral problems	Participation in treatment was found to significantly reduce negative behaviors and increase positive behaviors among mother compared to standard group.
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				Form (PSI-SF)				
21	Kelly, Gryczynski, Mitchell, Kirk, O'Grady & Schwartz (2014)	Examine impact of DSM-V change to Substance Use Disorder Criteria for adolescents compared to the DSM-IV	Cross-sectional; N = 525	A modified Composite International Diagnostic Interview (Second Edition) Substance Abuse Module (CIDI-2 SAM)	Primary Care Clinic	93% African American; Adolescents 12-17 years old	Substance use disorders	Substance use disorder diagnoses was more prevalent using DSM-5 criteria compared with DSM-IV for nicotine, alcohol, and cannabis. Some considered "diagnostic orphans" meeting the DSM-IV criteria but not DSM-V criteria
22	Power, Hughes, Helwig, Nissley-Tsiopinis, Mautone & Lavin (2010)	Examine the pre-treatment telephone contacts between clinicians and families to determine early indicators of engagement and potential strategies to improve treatment initiation.	Cross-sectional; N = 66	National Initiative for Children's Healthcare Quality (NICHQ); Vanderbilt Assessment Scale	Primary Care Clinic	89% of the children were African American; Mean grade level at time of referral was 3 <sup>rd</sup> grade (SD = 1.7), and mean age was 8.7	ADHD	Findings indicated that success rates of clinician-initiated contact and number of parent-initiated attempts were independent predictors of treatment initiation.

						(SD = 1.9)		
23	Angold, Erkanli, Copeland, Goodman, Fisher & Costello (2012)	Analyze three styles of psychiatric interviews for youth	Cross-sectional; N = 646	Types of interview styles:  Diagnostic Interview Schedule for Children (DISC), the Child and Adolescent Psychiatric Assessment (CAPA), and the	Primary Care Pediatric Clinics in	Approximately half African American (N = 373); youth ages 9 to 16 years old	psychiatric interviews for any depressive disorder, anxiety disorders, oppositional defiant disorder, conduct disorder, and attention-deficit/hyperactivity disorder.	There were no differences in overall prevalence rates by age group, race/ethnicity, sex, or days between interviews, so, the interview groups were analyzed without further reference to these factors.

				<p>Development and</p> <p>Well-Being Assessment (DAWB A);</p> <p>Child Behavior Checklist (CBCL); the Multidimensional Anxiety Scale for Children (MASC);</p> <p>the Vanderbilt ADHD Diagnostic Parent Rating Scale (VADHD); and the Mood and Feelings Questionnaire (MFQ)</p>				
24	Chandra, Scott, Jaycox, Meredith,	Examine racial/ethnic differences	Cross-sectional	Researcher created items related to	Primary care settings	Latino (n = 163) and African	Adolescent Depression	Latino and African American teens had

	Tanielian & Burnam (2009)	in depression treatment preference among parents and adolescents and if parents influence their treatment perspectives	onal; N = 324	depression treatment experience, parent depression advice, family support		American (n = 110); adolescents between 13 - 18 years old		lower average scores on antidepressant knowledge and counseling knowledge than White teens. These racial/ethnic differences were greater among parents
25	Bauer, Yoder & Carrol, Downs (2016)	1.) To examine the prevalence of potential anxiety among patients whose parents originally had concerns of disruptive behavior in a diverse setting  2.) examine differences in anxiety	Cross-sectional; N = 1284	NICHQ Vanderbilt ADHD Diagnostic Rating Scale (VADRS)	Two pediatric community health clinics	Black (57%) and Hispanic/Latino (27%); ages 5 to 12 years old	ADHD and Anxiety	16% of children presenting with disruptive behavior screened positive for anxiety with VADRS. Hispanic parents were less likely to report anxious symptoms compared to the other racial groups and the VADRS identified anxiety at a lower rate among Hispanic.

		across ethnic groups using the Vanderbilt ADHD Diagnostic Rating Scale (VADRS).						
26	Peterson, Lewandowski, Chiodo (2011)	Evaluate the relationships among trauma, nightmares, PTSD severity, and quality of life in African American teens	Cross sectional; N = 151	Multiple measures examining lifetime trauma exposure, PTSD symptoms, nightmares, and quality of life (measures not identified)	Adolescent Primary Health clinic	All African American; ages 14 to 17 years old	Trauma Posttraumatic Stress Disorder (PTSD) symptoms and Nightmares	All youth within the were exposed to trauma and 52% had nightmares. Nightmare frequency predicted increased PTSD symptoms.
27	Mufson, Rynn, Yanes-Lukin, Choo, Soren, Stewart, Wall (2017)	Examine feasibility and acceptability of a stepped collaborative care treatment model (SCRIPT-A)	Cross-sectional; N = 48	Children's Depression Rating Scale, Revised (CDRS-R); the Patient	Urban Pediatric Clinic	96% Latino; Mean age 15.9 years old	Depression	SCRIPT-A shown to be a feasible and acceptable model, benefiting Latino adolescents.

		for adolescents with depression utilizing interpersonal psychotherapy for adolescents (IPT-A).		Health Questionnaire (PHQ-9).				
28	DeFrino, Marko-Holguin, Cordel, Anker & Bansa, Van Voorhees (2016)	Explore how to more effectively recruit teens into a primary care-based, online depression prevention study	Cross-sectional, Qualitative focus groups; N = 54	Qualitative questions developed by research	Recruited from community organizations and website	African American (47%) and Latino (53%); teens between the ages of 13 and 17 years	Depression	Trust and judgment played a role in whether teens would disclose feelings of sadness. Teens reported coping with feelings of sadness on their own.
29	Kelly, Gryczynski, Mitchell, Schwartz & O'Grady, Kirk (2017)	Examine concurrent validity of the Problem Oriented Screening Instrument for Teenagers (POSIT)	Cross-sectional; N = 525	Problem Oriented Screening Instrument for Teenagers (POSIT) substance use/abuse subscale; Modified World Mental Health Composite	Primary Care at a Federally Qualified Health Center	93% African American; ages 12-17 years old	Substance use/abuse	POSIT contains concurrent validity and can be useful in primary care settings

				e Internatio nal  Diagnosti c Interview (WMH- CIDI)				
30	Mason, Sabo & Zaharaki s (2017)	Assess effectivene ss of Peer Network Counseling (PNC) as a brief treatment to reduce cannabis use	Cros s- secti onal; N = 119	the 2011 Adapted version  of the Centers for Disease Control and Preventio n's  Youth Risk Behavior Survey cannabis use item; Interventi on utilized PNC which included motivatio nal interviewi ng	Primar y health care	91% African America n; Mean age 16.7 years old (SD = 1.3)	Cannabis Use	Cannabis use was reduced among treatment group of heavy cannabis users engaged in intervention program.



31	Molleda, Bahamon, St. George, Perrino, Estrada, Herrera, Pantin & Prado (2016)	To understand the feasibility and acceptability of implementing eHealth Familias Unidas, an Internet-based, family-based, preventive intervention.	Cross-sectional, Descriptive qualitative study; N = 9 facilitators and n = 6 parents within a focus group	Researchers created interview questions	Primary Care Clinic	All Hispanic parents in focus groups; ages of children unknown	Parent-adolescent communication, Parental monitoring of peers, To reduce and prevent behavioral problems	Nine major themes arose. eHealth Familias Unidas was found to be feasible and acceptable to use in primary care clinics
32	Larson, dosReis, Stewart, Kushner, Frosch & Solomon (2013)	To evaluate the association of parent-reported barriers on the likelihood of attending a mental health evaluation after referral from	cross-sectional; N = 55	; Barriers to Children's Mental Health Care Survey	Pediatric Primary care clinic	African American 98%; Preschool - adolescent	Mood anxiety, conduct problems, ADHD, Substance Abuse	Intangible barriers including stigma, and fears about medication were associated with decreased odds of attending the mental health evaluation

		pediatric primary care						
33	Lim, Silver, Leo, Kusulas, Alderman & Racine (2016)	Examine urban, minority adolescents' preferences for receiving guidance for mental health issues from primary care providers or from mental health providers	Cross-sectional, qualitative study; N = 135	Researchers created questions for qualitative responses	Primary Care	52% Hispanic, 19% African American, 3% Asian, 15% Mixed ethnic groups, 1% Native American; ages 13-21	Preferences in addressing mental health issues	85% strongly agreed or agreed that their primary care provider was knowledgeable about mental health concerns, 57% preferred to talk to a mental health provider
34	Garland, Taylor, Brookman-Frazer, Baker-Ericzen, Haines-Schlagel, Liu & Wong (2015)	Test for differences in physician diagnostic and treatment decision-making associated with patient family race/ethnicity	Vignette-based study; N = 371 Physicians	Vignette created by researcher	Pediatrics, Psychiatry, Child and Adolescent Psychiatry and Family Medicine	All health care professionals; age identified in vignette not specified	Childhood Disruptive Behavior	There was no significant difference in physician decision-making or treatment of childhood disruptive behavior based on race.

		ty (African American, Hispanic and non-Hispanic White) holding other factors constant.						
35	Ngo, Asarnow, Lange, Jaycox, Rea, Landon, Tang & Miranda (2009)	Examined racial-ethnic differences in the impact of the Youth Partners in Care Quality Improvement Intervention	Cross-sectional; N = 325	the 12-month Composite International Diagnostic Interview (CIDI); Center for Epidemiological Studies Depression Scale (CES-D); The Mental Health Index-5; The Primary Care PTSD Screen; the Medical	five health care organizations, including managed care, the public sector, and academic center clinics	Latino (n = 261), Black (n = 76); Ages 13-21	Depression	

				Outcomes Study 36-Item Short-Form Health Survey.				
36	Sibinga, Kerrigan, Stewart, Johnson, Magyari & Ellen (2011)	Assess potential effect of a mindfulness-based stress reduction program on HIV-infected youth	Cross-sectional, Mixed Methods; N = 33	Child Health and Illness Profile—Adolescent Edition (CHIP-AE); Symptom Checklist -90 (Revised)—SCL-90R; Individual in-depth interviews	Recruited from pediatric primary care	92% African American; Youth from ages 13-21	Stress reduction	For the youth that completed the program, qualitative interviews revealed reduced stress, reduced conflict in interpersonal relationships, improvements in school and physical health.

37	Amaral, Geierstan ger, Soleiman pour & Brindis (2011)	compare the mental health risk and health utilization behaviors of adolescent in a school-based health center	Cross-sectional; N = 4640	California Healthy Kids Survey (CHKS)	Participants recruited from a high school with a school-based health center	14% African American, 25% Hispanic, 34% Asian American; Youth between the 9th and 11th grade	Mental Health Characteristics and Health-seeking behaviors	Students who reported depressive symptoms, trouble sleeping, suicide ideation, parental divorce or separation, losing a close friend and troubles connecting with family or neighbors were more likely to seek services at the SBHC. Also, being on public assistance or being uninsured increased the likelihood that students would seek SBHC services.
38	Ramos, Sebastian , Stumbo, McGrath & Fairbrother (2017)	Describe unmet needs for guidance among adolescents at a school-based health center	Cross-sectional; N = 540	Youth engagement with health services survey	60.9% Hispanic, 15% Immigrant; high school students	School based health center	Unmet health needs	Dealing with stress was one of the topics that students reported as one of the areas of unmet need

39	Villalba (2011)	Examine the impressions of school nurses and counselors regarding health disparities among Latino/a students	Cross-sectional, Qualitative; N = 199	Researcher developed survey related to health disparities	Sample consisted of School Counselors and Nurses working with Latino/a students; high school students	School Based Health Center	Health Disparities	Results identified 23 mental health issues among Latino/a youth including adjustment concerns, poor interpersonal skills, anxiety, depression, substance use, grief/loss and physical and sexual abuse
40	Bains, Franzen & White-Frese' (2014)	Examine the reasons why African American and Latino adolescents seek mental health services at school-based health centers	Cross-sectional, Qualitative; N = 22	Research developed interview questions related to mental health treatment seeking	45% African American, 55% Latino; adolescents age ranged from 13-18 years old	Several School based health Centers	Treatment seeking for mental health concerns	Results indicated that access to mental health services within the SBHC allowed for participants to address mental health concerns in a "safe environment" and that participants valued, and trusted services rendered.
41	Champion, Young, & Rew (2015)	Evaluate the level of psychological distress, violence and substance	Cross-sectional; N = 559	Center for Epidemiologic Studies—Depression Scale;	African American (n = 94), Mexican American	Metropolitan public health clinics	Psychological distress; substance use	Higher levels of depression among those who also reported substance use compared to

		use among African American and Mexican American female youth		10 questions created from ethnographic findings from previous study	an (n = 465); adolescents 14-18 years old			those who did not. Personal substance use was found to be significantly predicted by ethnicity, friend substance use, physical violence history, sexually transmitted infection history and a history of alcohol use.
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## APPENDIX C: RECRUITMENT FLYER



Are you a health professional that works with resettled refugee youth in the Southeast Region of the U.S.?



Recruiting participants for a qualitative research study. Voluntary research participants will provide 30-60 minute interviews (in person, by phone or video conference) regarding the mental health needs of resettled refugee youth (ages birth-18) in the Southeast. Protecting patient confidentiality and participant anonymity is at the core of this study and providers who choose to participate will only be asked to speak about general themes they encounter in their practice without disclosing any protected patient information. These states include: *Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.*

Purpose of this research study:

- Increase the understanding of the complex mental health needs of resettled refugee youth
- Raise awareness of the specific mental health needs that refugee youth present with in primary care
- Execute an interview that outlines the multi-systemic nature of mental health concerns among refugee youth in the Southeast

Participants for this research study can include:

- Primary Health Care Providers
- Pediatricians
- M.D.s and D.O.s
- Nurse Practitioners
- Physician Assistants
- Family Medicine Practitioners
- Integrated Behavioral Health Care Providers

If you are interested or would like more information. Contact Florence Lewis [lewisfl6@students.ecu.edu](mailto:lewisfl6@students.ecu.edu)



## **APPENDIX D: INFORMED CONSENT FORM**

Informed Consent (Provided both Oral Summary and Written)

Experiences with Mental Health Needs of Resettled Refugee Children in the Southeast region: A

Qualitative Phenomenological Study

Dear Participant,

The following information is provided for you to decide whether you wish to participate in the present research study. You should be aware that you are free to decide not to participate in this research study or to withdraw at any time without impacting any relationship with the academic system or East Carolina University located in Greenville, NC.

The purpose of this research study is to understand the lived experiences of you as a health care professional working with resettled refugee children in the Southeast region of the United States, including Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina, Tennessee, and Virginia, to discuss their behavioral, mental, social and emotional needs. The procedure will be a phenomenological research study design. At this stage of the research, the process will be generally defined as the lived experiences of your interpretation of your work with resettled refugee children in the Southeast.

Data for this research study will be collected through semi-structured interviews that will be recorded by an audio recorder and notated themes by hand of the interviewer. One 30-60-minute interview is requested but, if more information is needed, the interviewer may request a second or third interview. Approximately, 4-5 questions will be included in the semi-structured interview but other questions may arise as the conversation develops. After engaging in the interview, you, the participant, will be requested to complete a short survey describing your own demographics (e.g. age, race, professional title, other language spoken if any, etc.) and experiences working with this population (i.e. years of experiences, ethnic groups served, average size of family, average age of children served, etc). This survey will have multiple choice options.

Do not hesitate to ask any questions about this research study whether before participating, during the time that you are participating or after participating. We would be happy to share our findings with you after this research study is completed. However, your name will not be associated with the research findings in anyway, and only the researchers will know your identity as a participant.

There are no known risks and/or discomforts associated with this research study. The expected benefits associated with your participation are the information about the experiences in working with resettled refugee children in the Southeast, the opportunity to participate in a qualitative

research study, and contribute to building awareness of the needs of this population in this region of the U.S. and beyond. If submitted to publication, a byline will indicate the participation of all community and health professionals from the Southeast region of the United States.

Please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep.

Date:

Signature of Participant:

Florence Lewis, MS Doctoral Student, East Carolina University, Principal Investigator.

[lewisf16@students.ecu.edu](mailto:lewisf16@students.ecu.edu) (863) 242-1630

Damon Rappleyea, PhD, East Carolina University, Researcher Advisor

[rappleyead@ecu.edu](mailto:rappleyead@ecu.edu) (252) 737-2416

## APPENDIX E: NC-CHAMP QUESTIONS USED IN STUDY

1. Is (CHILD) Hispanic or Latino?
  - 1 Yes
  - 2 No
  - 7 Don't know/Not sure
  - 9 Refused
2. Which one of these groups would you say best represents (CHILD)'s race?
  - 1 White
  - 2 Black or African American
  - 3 Asian
  - 4 Native Hawaiian or Other Pacific Islander
  - 5 American Indian, Alaska Native
  - 6 Other
  - 7 Don't know/Not sure
  - 9 Refused
3. 1. Is the child a boy or a girl?
  1. Boy
  2. Girl
  9. Refused
4. Has a doctor, other health professional or school representative ever told you that (CHILD) has an emotional or behavioral disorder, or problem with social skills such as depression, anxiety, ADHD, or ADD (Attention Deficit Disorder)?
  - 1 Yes
  - 2 No
  - 7 Don't know/Not sure
  - 9 Refused
5. During the past 12 months did (CHILD) receive all the medical care you felt he or she needed?
  - 1 Yes
  - 2 No
  - 7 Don't know/Not sure
  - 9 Refused
6. Would you say that in general (CHILD)'s health is:
  - 1 Excellent

- 2 Very Good
- 3 Good
- 4 Fair
- 5 Poor
- 7 Don't know / Not sure
- 9 Refused

7. Do you think that (CHILD) has an emotional or behavioral disorder or problem with social skills that has not been diagnosed?

1 Yes

2 No

7 Don't know/Not sure

9 Refused

8. What was the MAIN reason (CHILD) did not get all the medical care that {he/she} needed?

- 01 Cost [includes no health insurance]
- 02 Distance [too far to travel]
- 03 Office wasn't open when I could get there
- 04 Too long a wait for an appointment
- 05 Too long a wait in waiting room
- 06 No child care
- 07 No transportation
- 08 No access for people with disabilities
- 09 The medical provider didn't speak my language
- 10 Some other reason
- 77 Don't know/ Not sure
- 99 Refused

9. Has (child) ever received services or support for this emotional or behavioral problem?  
 INTERVIEWER: if respondent answers YES, please ask, "Currently or in the past?"

1 Yes, currently

2 Yes, in the past

3 No

7 Don't know/Not sure

9 Refused

10. A personal doctor or nurse is a health professional who knows your child well and is familiar with your child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician assistant.

Do you have one or more persons you think of as (CHILD)'s personal doctor or nurse?

1 Yes

2 No

7 Don't know/Not sure

9 Refused

11. Have you ever talked with a school nurse about (CHILD)'s health?

**NOTE:** "talked with" can be either on the phone or in person.

1 Yes

2 No

3 No school nurse at school

7 Don't know/Not sure

9 Refused

12. Preventive care visits include things like a Well Child check-up, a routine physical exam, immunizations, or health screening tests. During the past 12 months has (CHILD) had a preventive care visit, or Well Child check-up?

1 Yes

2 No

7 Don't know/Not sure

9 Refused

13. Does (CHILD) have any kind of health care coverage, including private health insurance, prepaid plans such as HMOs, or government plans such as Medicaid, NC Health Choice or Health Check?

1 Yes

2 No

7 Don't know/Not sure

9 Refused

14. An interpreter is someone who repeats what one person says in a language used by another person. During the past 12 months did you or (CHILD) need an interpreter to help speak with his or her doctors or nurses?

1 Yes

2 No

7 Don't know/Not sure

9 Refused

15. Has (child) ever received services or support for this emotional or behavioral problem?

INTERVIEWER: if respondent answers YES, please ask, "Currently or in the past?"

1 Yes, currently

2 Yes, in the past

3 No

7 Don't know/Not sure

9 Refused

16. 1 Would you say that in general (CHILD)'s health is:

1 Excellent

2 Very Good

3 Good

4 Fair

5 Poor

7 Don't know / Not sure

9 Refused

## **APPENDIX F: INTERVIEW GUIDE FOR QUALITATIVE INTERVIEWS**

- In general, what are your experiences with the behavioral health needs of resettled refugee youth in your pediatric primary care practice?
- Do you notice any gender differences in the behavioral health needs that you encounter within this population?
- Is there a particular age group of concern regarding behavioral health needs within this population in your experience?
- Ethnically, do you notice a difference in the presentation and/or identification of behavioral health needs among the various ethnic groups that you see of resettled refugee youth?
- Have you noticed a connection in the presentation of behavioral/emotional health needs and physical health needs among this population?
- In your practice, have you noticed that behavioral health needs of the refugee youth that you see have been first identified in the school, by a school nurse?
- At what frequency do you generally see resettled refugee youth, particularly those with notable behavioral/emotional health needs? Do they generally attend their yearly, preventative care visits?

## APPENDIX G: QUALITRICS SURVEY

### Default Question Block

Informed Consent (Provided both Oral Summary and Written)

Experiences with Mental Health Needs of Resettled Refugee Children in Southeast: A Qualitative Phenomenological Study

Dear Participant,

The following information is provided for you to decide whether you wish to participate in the present research study. You should be aware that you are free to decide not to participate in this research study or to withdraw at any time without impacting any relationship with the academic system or East Carolina University located in Greenville, NC.

The purpose of this research study is to understand the lived experiences of you as a health care professional working with resettled refugee children in the Southeast region of the United States, discussing the behavioral, mental, social and emotional needs. The procedure will be a phenomenological research study design. This stage of the research process will be generally defined as the lived experiences of your interpretation of your work with resettled refugee children in the Southeast region.

Data for this research study will be collected through semi-structured interviews that will be recorded by an audio recorder and notated themes by hand of the interviewer. One 30-60-minute interview is requested but, if more information is needed, the interviewer may request a second or third interview. Approximately, 4-5 questions will be included in the semi-structured interview but other questions may arise as the conversation develops. After engaging in the interview, you, the participant, will be requested to complete a short survey describing your own demographics (e.g. age, race, professional title, other language spoken if any, etc.) and experiences working with this population (i.e. years of experiences, ethnic groups served, average size of family, average age of children served, etc). This survey will have multiple choice options. Do not hesitate to ask any questions about this research study whether before participating, during the time that you are participating in or after participation. We would be happy to share our findings with you after this research study is completed. However, your name will not be associated with the research findings in any way, and only the researchers will know your identity as a participant.

There are no known risks and/or discomforts associated with this research study. The expected benefits associated with your participation are the information about the experiences in working with resettled refugee children in the Southeast region, the opportunity to participate in a qualitative research study, and contribute to building awareness of the needs of this population in this part of the United States and beyond. If submitted for publication, a byline will indicate the participation of all community and health professionals in the Southeast region of the United States.

Florence Lewis, MS Doctoral Student, East Carolina University, Principal Investigator.  
lewisf16@students.ecu.edu (863) 242-1630

Damon Rappleyea, PhD, East Carolina University, Researcher Advisor



rappleyead@ecu.edu (252) 737-2416

Would you like to continue with this study? By choosing "Yes" you will be consenting with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep. By choosing "No", you will be declining to participate in this research study.

- 
- Yes  
 No

The purpose of this questionnaire is to allow me to describe my sample. Please read and answer each of the following items. Check all boxes that apply to you. Please do not include your name on this document. Please ask any questions that you may have.

What is your gender?

- 
- Male  
 Female

What is your current age?

---

What is your professional title:

---

What type of clinic do you work for (check all that apply):

- 
- Federally Qualified Health Center  
 Community Clinic  
 Private Clinic  
 Health Department

Other (please specify):

Other (please specify):

What is the percentage of resettled refugee families that you serve approximately within your overall workload: \_\_\_\_\_ of 100%

---

What are the ethnicities/nationalities that you serve (Mark all that apply):

---

Burmese

Congolese

Bhutanese

Iraqi

Sudanese

Somali

Syrian

Afgani

Other (please specify):

Other (please specify):

Other (please specify):

Other (please specify):

When you see a refugee family, how many people typically come to the appointment:

---

Who generally accompanies the refugee children when they have a medical visit with you:

---

- Biological parent
- Adoptive parent
- Siblings
- Social worker
- Other (please specify):

What is the average age or age range of the children that you see (example. 8 year olds or 6-11 year olds)

---

To what percentage of the time do you use an interpreter with refugee families:

\_\_\_\_\_/100%

---

How many years have you been practicing as a health care provider?

---

How many years of experience do you have working with resettled refugees?

---

Please provide your contact information to be sent the final report when this study is complete.

---

Email Address or Mailing Address

