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Connecting Refugees to Substance Use Treatment: A Qualitative Study

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Abstract

An emerging body of literature identifies substance use as a growing concern among refugees resettling in the United States. Like immigrants, refugees may face cultural, linguistic, or systems barriers to connecting with mainstream substance use treatment programs, which may be compounded by refugees' unique experiences with exposure to trauma, displacement in refugee camps, and resettlement. This qualitative study explores factors that support and prevent refugees from connecting with chemical health treatment. Fifteen participants who identified as social service or public health professionals who work with refugees responded to an online, semistructured survey about their experiences referring refugees to substance use treatment. Resulting data was analyzed using thematic analysis. Themes emerged identifying a lack of culturally informed treatment models, policy issues, and client characteristics such as motivation and past trauma as barriers to engaging with treatment. Ongoing case management and coordination were identified as important to successful linkage. Findings from this study contribute to a better understanding of how to support refugees seeking substance use treatment and suggest that developing trauma informed, culturally relevant models of treatment that are integrated with primary health care and geographically accessible may enhance treatment linkage.

Keywords

Refugees; substance use treatment; referrals; coordination of care

Literature review

Substance use is a growing concern among populations displaced by conflict (Ezard, 2012; Weaver & Roberts, 2010). Although the scholarship on refugee substance use is limited, high rates of alcohol and drug consumption have been documented in refugee camps (Ezard et al., 2011; Luitel, Jordans, Murphy, Roberts, & McCambridge, 2013), and social service and public health professionals in the United States are recognizing an increased need for effective substance use treatment for resettled refugees (Weaver & Roberts, 2010).

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A number of factors contribute to displaced people's elevated risk of problematic alcohol and drug use. First, many of the more than 50 million people displaced by conflict worldwide have been exposed to trauma and violence (Porter & Haslam, 2005; United Nations, 2014), placing refugees at risk of developing posttraumatic stress disorder (PTSD), depression, anxiety, and somatic symptoms (Fazel, Wheeler, & Danesh, 2005; Johnson & Thompson, 2008), as well as substance use problems (Ezard, 2012; Weaver & Roberts, 2010). Refugees may use substances as a coping strategy to mitigate trauma symptoms (Weaver & Roberts, 2010). Second, refugees often spend years in protracted refugee camp situations (United Nations, 2014) where stress, isolation, and uncertainty may contribute to elevated levels of alcohol and drug consumption (Ezard, 2012). Finally, refugees who resettle in Western countries may face stressors including separation from family, adjusting to a new culture, and finding stable employment. These stressors, as well as acculturation to Western consumption patterns, can contribute to elevated risk of substance misuse (Ezard, 2012).

More than 50,000 refugees resettle in the United States every year from a host of countries including Burma, Bhutan, Iraq, Ethiopia, and Somalia (U.S. Department of State, 2014). To meet their mental health needs, public health and social service professionals have begun to screen for mental health symptoms (Shannon et al., 2012) and to develop and test culturally informed models of mental health treatment for PTSD, depression, and somatic symptoms (Murray, Davidson, & Schweitzer, 2010). Despite a growing awareness of need, this effort has not yet translated to substance use assessment and treatment. There remains little understanding of the ways in which refugees use drugs and alcohol in resettlement and few culturally informed treatment programs for refugees (Weaver & Roberts, 2010).

As culturally informed assessment and treatment of refugees' mental health symptoms becomes more common, multiple barriers to accessing treatment have been identified (Shannon, Vinson, Cook, & Lennon, 2015; Wong et al., 2006). These barriers include language and lack of interpreters, lack of culturally informed treatment models and cultural beliefs about mental health care (Shannon et al., 2012; Wong et al., 2006). Similar barriers to successful linkage with substance use treatment have been identified in nonrefugee populations including client motivation for treatment, service availability, and agency policies (Rapp et al., 2006). People from racial and ethnic minority backgrounds face language and cultural barriers that compound other barriers to treatment (Yu, Clark, Chandra, Dias, & Lai, 2009). Little is known about the unique challenges refugees face when seeking substance use treatment and differences between the immigrant and refugee experience may contribute to unique challenges for refugees in accessing substance use treatment systems. With conflicts across the globe becoming more protracted, many refugees have lived for years in refugee camps where they may have had little access to education or health services. A lack of familiarity with substance use treatment itself may present a barrier to accessing treatment in resettlement countries. Many refugees have also experienced trauma and torture at the hands of authority figures or physicians, making it difficult to feel safe seeking treatment in resettlement communities. This study aimed to examine factors that either support or prevent refugees from successfully connecting with substance use treatment after referral.

Method

This article reports on data from a subset of participants from a larger study that examined the mental health referral process for refugees in a large, midwestern metropolitan area, the results of which are reported elsewhere (Shannon et al., 2015). The University of Minnesota Institutional Review Board approved this study.

Participants, data collection, and measures

This subset of participants was drawn from a community-based participatory research study that engaged community stakeholders in a process of developing an online survey to investigate mental health referral processes.

An anonymous survey was created using Qualtrics (2015) software. Some demographic information was collected, including participants' highest level of professional education, professional field (i.e., social work, counseling, psychology), languages spoken, professional position, years of professional experience, years of experience working with refugees, and recent training on refugee mental health. Respondents were then asked to describe referral experiences in the following categories: (a) successful substance use treatment referral, (b) unsuccessful substance use treatment referral, (c) substance use treatment referral with unknown outcome, and (4) identified substance use issue but did not refer. For each experience, participants were asked the following questions: (a) Briefly describe the person for whom you made this referral; (b) Describe in detail the steps that were taken in making the referral, that is, what happened; and (c) Why do you think the referral was successful/unsuccessful? Participants were able to describe as many incidents as they liked. Data was collected during 2013.

Multiple sampling strategies were used to recruit participants. Purposive sampling was used to systematically search all prepaid medical assistance mental health providers using online provider databases. Inclusion criteria for mental health providers were those who were located in one of the two largest cities or counties in the metro area who spoke one of the following languages: Amharic, Arabic, Burmese, French, Hmong, Khmer, Karen, Laotian, Russian, Somali, and Vietnamese; and/or who identified treatment of PTSD as an area of expertise. Individual providers and mental health agencies were invited by phone to participate in the study.Asurvey link was sent to interested providers via e-mail.

The network administrators at the five managed care providers in the two largest counties were also contacted and asked to identify staff with knowledge related to mental health referrals for refugees. These individuals were invited to participate by e-mail or phone. All of these health plans returned the survey. We also identified refugee providers who make mental health referrals using a directory of community-based organizations and mutual assistance associations (MAA) serving refugees. Of the 158 providers who received a link to the survey over e-mail, 64 (40.5%) completed the survey. An additional 43 mental health agencies were contacted by phone and invited to participate in the survey but did not respond and did not receive a link to the survey. Of the 64 respondents who completed the survey, 15 answered questions about successful and unsuccessful substance use referral experiences. These respondents constitute the sample on which this article is based.

Data analysis

Demographic data was analyzed using basic descriptive statistics. Referral experience questions were analyzed using thematic analysis (Bradley, Curry, & Devers, 2007). All responses were read through once to get a sense of the whole. Responses were grouped according to referral experience type (successful, unsuccessful, unknown, and identified a need but did not refer) and read through a second time and coded. Codes were then condensed into categories. Categories were compared across groups and found to be the same or similar across all groups so were then analyzed together. Categories were grouped into themes, which are reported here. The first author alone conducted the data analysis for this article. The other authors conducted the analysis of the data in the larger study and reviewed the critical themes presented here.

Results

Participants in this study were asked to report types of referral experiences as well as write detailed notes about those experiences. Fifteen participants wrote detailed descriptions of 16 referral experiences: six successful experiences, four unsuccessful experiences, and six experiences where the participant identified a need for treatment but did not refer. These 16 written descriptions make up the data included in the thematic analysis.

Participant demographics

Of the 15 participants included in this sample, 60% ($n = 9$) were female and 40% ($n = 6$) were male. Five participants (33.3%) had completed a bachelor's degree and five (33.3%) a master's degree. The remaining participants had completed high school ($n = 2$, 13.3%), an associate's degree ($n = 1$, 6.7%), a PhD ($n = 1$, 6.7%), and an MD ($n = 1$, 6.7%). Three (20%) participants identified as mental health providers, 10 (66.7%) reported working for a clinic, agency, or other organization that serves refugees and two (13.3%) identified as mental health providers and working at organizations that serve refugees. Ten participants (66.7%) had more than 10 years' experience working with refugees, three (20%) had 2 to 5 years' experience and two (13.3%) had 5 to 10 years' experience. Eleven participants (73.3%) had received training on refugee mental health in the past year, three (20%) in the past 5 years, and one reported never receiving training (6.7%).

Client and referral characteristics

Participants were asked to describe the person or client at the center of these referrals, including information about age, language, time in United States, country of origin, and reason for referral. This information was not consistently reported across participants but portrays the range of clients these professionals are encountering. Clients were primarily in their thirties and forties, with one client reported as age 16 and one as 50 years. Two clients were female and nine male. Clients were primarily Karen as well as one Bhutanese-Nepali and two Somali. Most clients had alcohol as their substance of choice. Three clients were reported as needing mental health and chemical health treatment. Referrals were made to a wide variety of programs including initial assessments, outpatient treatment, and residential treatment.

Themes

Three themes and two subthemes emerged from the data. These themes are consistent across all three referral groups: successful, unsuccessful and no referral made.

Theme 1: There is a lack of culturally and linguistically informed substance use treatment programs for refugees, which prevents providers from making substance use referrals and clients from successfully accessing treatment— Most of the participants writing about successful and unsuccessful treatment linkage noted that there is a lack of culturally and linguistically informed substance use treatment programs for refugees. Three participants noted that the reason they did not make treatment referrals for clients even when they identified a need is because of this lack of appropriate resources. One participant wrote “many clients feel disconnected from the providers they are referred to.” Another participant wrote, “The Karen community does not have well-developed culturally-appropriate substance abuse services available to them. We need some treatment programs to really take the lead in designing services appropriate for refugee groups and including the use of interpreters.” Two participants wrote that their clients were successful in treatment because they were able to find providers who understood the culture and provided interpreters, though one participant noted, “this happens rarely.”

Subtheme 1: Treatment programs are unable or unwilling to accommodate clients who do not speak English: In two stories of unsuccessful referrals clients were unable to access treatment because of language barriers. These clients did not speak English and treatment programs were unable or unwilling to provide interpretation services. One participant wrote, “We called treatment programs and they said they don’t work with interpreters and don’t provide interpreters. Everyone has to speak English.” Another participant explained:

> I consider this referral unsuccessful even though the client did get some treatment because 10 days for the level of severity of his addiction was not sufficient. My understanding is that he was placed in the 10-day program because it was hospital based and they had interpreters more easily accessible. I was told by the addictions counselor that he could not get him in a halfway house because of the interpreter issue. I have since learned that addictions programs receive a block grant for treatment no matter how much it costs and that unlike therapy services where the interpreters are paid separately, in addictions programs, the interpreter cost is included in the flat rate for treatment and so they lose money when they need to have interpreters available.

Theme 2: Client characteristics such as motivation and trauma history influence success of referrals to substance use assessment and treatment— Individual client characteristics appeared to contribute to the success of referral linkage. Clients who denied having a problem or whose family members requested the referral were unsuccessful in linking with treatment. Conversely, clients who were motivated to change were more successful in completing treatment. Five participants described situations in which they or a client’s spouse identified a need for treatment based on behavior, but the client denied a problem. One participant wrote that she had made a referral to a counselor,

but the client "did not go, he did not want help but wanted to keep drinking. He said he did not do it 'too much.'"

One participant detailed a lengthy process in which she prepared her client for substance use treatment, arranged transportation and child care, and successfully supported her client in progressing through the initial stages of an outpatient treatment program. However, this client dropped out of treatment because of a history of complex trauma that contributed to relapse.

Subtheme 2: Preparing clients for substance use treatment can influence referral success: Two participants indicated that they spent significant time preparing clients prior to making successful referrals. One participant wrote "[I] worked with this client over several months to prepare her to receive this service, checked to see if there was an opening at the facility, made the referral, and took her to the facility to do the intake." One participant noted that it wasn't until the fourth session with a client that he accepted a referral. Both of these participants also wrote that the trust built during this preparation contributed to referral success.

Theme 3: Coordination of care is important to successful referrals—All of the stories of successful linkage with treatment included one common element: each participant wrote that he or she followed through with supporting and coordinating the patient's progress through the referral and treatment process. Participants wrote that they made telephone calls on behalf of clients to set up appointments and arrange interpreters, reminded clients of appointments, arranged or provided transportation to appointments, and followed up after initial appointments. One participant wrote, "[I] had to call the phone number on the back of his [health insurance] card and we had to provide transportation for every appointment." Another participant wrote, "I did not make the direct referral, but rather worked with the hospital to make sure he was referred. I spoke with the hospital social worker repeatedly to make sure that he was sent to treatment rather than sent home." One participant wrote:

> I was sent the referral for the patient to get a CD assessment. I called to register and make an appointment for the patient. I called the interpreter, to give the date and time of the appointment. I will either set up a ride for the patient, or the interpreter will set it up.

Discussion

This study explored referrals to substance use treatment for refugees to better understand what supports and prevents refugees from connecting with services. Three themes emerged that contribute to current knowledge of refugee linkage with treatment services as well as to development of emerging theories about engaging refugees with health and mental health care in resettlement (Williams & Thompson, 2011).

First, the lack of culturally and linguistically relevant services, as well as a policy environment that makes provision of interpreters difficult, creates a barrier to successful linkage with treatment. In fact, these barriers may prevent professionals from making needed

referrals in the first place. This finding is consistent with literature about barriers to mental health treatment for refugees (Wong et al., 2006). Yu and colleagues (2009) found that providing culturally relevant treatment options for Asian American/Pacific Islanders in New York City significantly increased participation rates. As awareness of the need for substance use treatment for refugees grows, there will need to be corresponding attention paid to developing culturally and linguistically informed treatment models.

Participants also reported an agency-level policy environment that creates language barriers for refugees needing treatment. Although agencies that receive federal funding are required to provide interpretation services (Chen, Youdelman, & Brooks, 2007), participants reported being unable to place clients in treatment because of agency policies limiting interpretation availability. In the state of Minnesota, block grants cover substance use treatment costs for clients receiving medical assistance (Minn. Stat. § 254B.04, 2015). This may make hiring interpreters too costly for agencies that must also draw program fees from the same block grant, particularly for inpatient or halfway house programs. Participants who reported success in connecting refugees to services with interpretation noted that this is a rare occurrence and that refusal of services is the norm. Until culturally and linguistically informed treatment options exist, policies at mainstream treatment agencies and at the county and state level need to be adapted to reflect the needs of refugees.

Second, individual characteristics such as untreated trauma histories and motivation for treatment may prevent refugees from accessing treatment. This finding is consistent with extensive literature about the co-occurrence of trauma and substance use in mainstream populations (Jacobsen, Southwick, & Kosten, 2001). Recent research on dual diagnosis suggests that concurrent treatment is most effective for clients who have co-occurring PTSD or trauma symptoms and substance use disorders (Horsfall, Cleary, Hunt, & Walter, 2009).

Some participants found that working with refugees over time to prepare for referral to treatment helped ensure success. Cultural beliefs about drinking and drug use may contribute to refugees' willingness to engage with Western treatment modalities. Compounding this, refugees often struggle with navigating a complex health care and social service system (Ngo-Metzger et al., 2003; Pavlish, Noor, & Brandt, 2010). Newly arriving refugees encounter a legal system in the United States that may define drinking and drug use differently than their home countries or countries of refuge. Professionals working with refugees may need to incorporate education about substance use disorders, the U.S. legal system as it pertains to drug and alcohol use, and treatment models into their work with refugees prior to initiating a referral.

Although not noted by participants, it is also possible that providers themselves lack training in assessment of substance use problems and engaging clients with assessment and treatment. It is notable that only 15 out of 64 participants reported experiences with referring for substance use. There are several possible explanations for this, but it is possible that lack of training in recognition of substance use issues could prevent providers from assessing or referring for treatment. In a study of barriers to mental health screening for refugees, Shannon and colleagues (2012) found that whether states screen for mental health in newly arriving refugees was at least partially related to education and knowledge about the

psychological impact of war trauma. This is consistent with literature that defines *substance use* as an area where social service providers are frequently under prepared (Bina et al., 2008).

Third, initial case management preparation and ongoing coordination of care clearly contributed to referral success. All participants who wrote about successful referral experiences indicated that they conducted significant groundwork to connect their refugee client with care. Most participants contributed successful linkage with care to this initial work. This case management did not stop with the referral but continued with ongoing coordination of care including checking in with clients and providers, reminding clients of additional appointments and working with clients to address ongoing barriers to care. Consistent with literature on refugee mental health care, case management and ongoing coordination of care appear quite important to ensuring successful linkage with and completion of treatment (Priebe et al., 2012).

Together, these themes contribute to emerging ideas about connecting refugees to health and mental health care. Community-based, culturally derived models of care that locate services within refugee communities may be more successful than continued efforts to connect refugees to mainstream services that are culturally, linguistically, and geographically inaccessible. Additionally, service models that integrate behavioral health and primary care may improve care for refugees who are not effectively engaged through referrals (Unutzer, Schoenbaum, Druss, & Katon, 2006). The World Health Organization (2008) promotes integration of health and mental health services through incorporating mental health into health policies and coordinated networks of services at multiple levels.

These findings may be limited by the qualitative methodology and the small sample size. Both of these factors limit generalizability. Anecdotally, it appears that many refugees enter substance use treatment through the legal system. This remains an unexplored area, and professionals within the legal system were not included in this study, which presents a limitation to the scope of the findings. We did not interview refugee consumers about their experiences with mental health referrals, which would be a fruitful direction for future research. Survey responses provided brief stories and not in-depth interviews, which may have yielded deeper knowledge of referral experiences. As our goal was to collect numerous experiences, we were unable to conduct such in-depth interviews.

Implications

To our knowledge, this is the first study to explore what makes substance use referrals for refugees successful or unsuccessful. Scholarship about refugee substance use is limited, and this study makes some contributions to a new and growing field. Our findings indicate that there is a need not only for culturally relevant treatment for refugees, but also for an examination of barriers created by agency, county, and state policies, such as those governing interpretation. Additionally, some refugees may have trauma histories that need to be addressed in conjunction with substance use treatment. Finally, it appears that good case management and coordination of care are essential to successful treatment. These findings

also contribute to the development of theory about engaging refugees in mental health and substance use treatment by supporting ongoing efforts to develop integrated systems of care.

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