

Addressing Differential Impacts of COVID-19 in NYS: A Symposium and Edited Volume  
Chapter Submission

*Narrowing the gap: Using telemental health during COVID-19 to address disparities for resettled  
refugees*

Lindsey Disney

## Narrowing the gap: Using telemental health during COVID-19 to address disparities for resettled refugees

### **Mental Health Needs and Challenges of US Resettled Refugee Population**

This chapter presents telemental health as a means of service delivery with resettled refugee populations in the context of a global pandemic. There is little known about resettled refugee mental health needs, effective treatment, or treatment preferences, and even less about the specific impact of COVID-19 on the refugee population. Consequently, a review of limited empirical studies and experiential knowledge from a refugee-focused practitioner is used to identify policy and practice recommendations. These recommendations will address resettled refugees' needs, ultimately aiming to mitigate the mental health disparities that would otherwise occur among this overlooked group.

A refugee is a person who has fled their country of origin as a result of violence or persecution. In 2020, the number of globally displaced persons reached an all-time high of 80 million (UNHCR 2021), as did the number of individuals seeking refugee status (20,650,304; UNHCR 2021). There have been approximately 3 million refugees resettled in the US since the United States Refugee Act of 1980 (Connor 2017). New York has been among the states resettling the largest number of refugees, with only California and Texas resettling more. By definition, a refugee has resided in a second (or third or fourth) country, which is termed the "asylum" country, prior to being permanently resettled in the "resettlement" country. For example, a Syrian refugee might seek temporarily asylum in a camp in Lebanon, ultimately hoping for resettlement in Germany. Refugees often live in camp settings while in the asylum country, and asylum countries are often neighboring to their country of origin (Bonney 2013). Asylum countries are overwhelming in the Global South, and resettlement countries are typically Western nations (Bonney 2013). Less than 1% of refugees waiting in an asylum country will ever be permanently resettled in a resettlement country (UNHCR USA).

The refugee experience is nuanced and largely dependent on individual context. While an Eritrean refugee fleeing violence in Ethiopia's Tigray region might share few similarities with a Central American teenager escaping gang-perpetrated persecution, there are certain commonalities, such as cumulative trauma and extreme stress, that may be conceptualized as hallmarks of the refugee experience. Against a societal backdrop of war and violence, refugees often experienced human rights violations, including persecution, family separation, torture, and rape (Disney and McPherson 2020). Exposure to trauma is often ongoing, as opposed to a single moment of upheaval or loss. As a result, refugees are at high risk of trauma-related mental health issues (Javanbakht et. al. 2019), with an estimated thirty percent of refugees experiencing PTSD or major depression (Shannon et. al. 2015). In addition to significant mental health implications, exposure to trauma before, during, and after resettlement can also wreak havoc on refugee well-being, and may be exacerbated by acculturative stress due to racism, xenophobia and other forms of discrimination (Sangalang et. al. 2019). Additionally, such exposure to trauma may be compounded by secondary effects of forced migration, including the daily stress of acculturation and the concurrent losses of employment, financial status, family support, identity, and social status (Ehnholt and Yule 2006; Disney and McPherson 2020).

The mental health field is poised to play a crucial role in promoting healing in this historically underserved population. A growing body of empirical work highlights the discrepancies between refugees' needs for mental health services and the accessibility and cultural appropriateness of such services. Refugees are less likely to seek mental health support due to systemic barriers to treatment and cultural stigma and dissonance (Lamkaddem et. al. 2014; Satinsky et. al. 2018). Systemic barriers to effective mental health care may include lack of transportation, reliable childcare, linguistically appropriate clinical services or services with qualified interpreters, available services in an individual's area, and insurance or financial means to pay for services (Stewart et al. 2017).

Refugees may feel a sense of mistrust toward service providers, particularly if seen as authority figures, as well as general discomfort when sharing personal information given past experiences of exploitation, repression, and persecution. Refugees may struggle to find specialized clinicians who are proficient in the refugee's unique culture and context as well as sensitive to power dynamics as manifested in the clinical relationship. Finally, cultural norms related to mental health and wellness may create a sense of stigma around seeking and accepting support; however, the presence of such stigma is not universal, nor should it be conflated with lack of knowledge about mental health issues (Shannon et. al. 2015).

Therefore, the development of effective systems of mental health service delivery tailored to the unique characteristics and needs of the resettled refugee population is of critical importance, particularly in the context of a post-COVID world. While the ripple effects of the pandemic's economic, social, and physical health implications have permeated American society, the refugee community – along with communities of color in general – have faced additional and specific pandemic-related hardships. In the refugee community, these challenges included higher incidences of COVID-19 cases, risk for COVID-19 related financial distress, barriers to accessing medical treatment, lack of reliable information about vaccination, and greater social isolation compounded by lack of access to and knowledge of technology (Sieffien et. al. 2021). Exacerbating these challenges, the pandemic's social distancing measures necessitated a full-scale shift to virtual mental health service provision. Although not a panacea, telemental health, which has been used for service provision in some refugee resettlement camps prior to the emergence of COVID-19, presents unique benefits and challenges for refugee-serving providers and clients.

While the body of empirical work on the effects of the pandemic's forced transition from face-to-face (FTF) services to a phone or video format is growing, less attention has been paid to telemental health best practices with resettled refugees in a post-COVID world. Provided here is a summary of what is known from the literature, and from this author's current research and clinical social work practice experience.

### **Benefits and Challenges for Telemental Health with Resettled Refugee Populations Following COVID-19**

COVID-19 generated large-scale societal changes, one of which was the unplanned cessation of in-person mental health services and the rise of telemental health. Telemental health services increased in the US twelvefold at the beginning of the pandemic, and a year later, 96.5% of psychologists reported using telemental health during the first year of the pandemic (Pierce et al. 2020). Clients and providers reluctantly employed telemental health services as a real-time service option following widescale restriction of non-emergency, FTF

services and stay-at-home orders (Connolly et al. 2021). In short, telemental health became a “best case scenario” when other means of service delivery were severely limited.

The majority of research conducted on the preferences and effectiveness of telemental health with refugees has been in camp settings with Palestinian refugees in Lebanon and Syrian refugees in Jordan, Turkey, and Syria (Jefee-Bahloul 2014; Naal et al. 2021). Telemental health services in camp settings are beneficial because they provide services to people who have extremely limited resources (Jefee-Bahloul 2014). With telemental health, providers can provide services where FTF services likely are not possible, and there is an opportunity for providers to be linguistically and culturally like their clients. Telemental health overcomes many of the challenges that FTF mental health services face, including a lack of providers who speak the same language as the clients, lack of interpreters, and lack of available FTF providers who are willing or permitted to see clients in a resettlement camp setting. Thus, in a population with high prevalence rates of trauma exposure and mental health symptoms, telemental health provides an opportunity for more individuals to receive services than if using the FTF model. Telemental health makes sense for people who are living in an asylum country and camp setting.

However, prior to COVID-19, there is little evidence that telemental health was used for refugees who have been permanently resettled in a Western country. Liem et al. (2021) conducted a rapid, systematic review of digital health interventions with resettled refugees and other immigrants in the U.S. and found only sixteen studies, of which only seven included refugee participants, specifically. Liem et al’s (2021) study highlighted how little is known about effective telemental health interventions with cross-cultural, cross-linguistic populations. Thus, while telemental health has been available for the general U.S. population since the 1960s, there is very scant evidence that telemental health was a deliberate format for resettled refugee populations prior to COVID-19 (Liem et al. 2021).

During the abrupt, mandated transition to telemental health in March 2020, many refugee-serving clinicians were doubtful about the effectiveness of telemental health with refugee clients (Disney et al. 2021). I have worked in refugee mental health for ten years, as a mental health practitioner, clinical supervisor, and researcher. To share my own clinical bias, I was also reluctant to embrace the potential benefits that telemental health might offer for our refugee clients. Would client and clinician be able to connect and build rapport over the phone? Would I be able to pick up on subtle cues and nonverbal communication? Would the telemental health format provide a safe enough space to process trauma? The overarching question was, will we be able to provide services that help our clients? At the start of the pandemic, I wondered if perhaps refugee-serving mental health providers felt that telemental health would only add additional layers of complexity and difficulties to the already difficult challenge of providing effective and relevant services cross-culturally and cross-linguistically.

### **Few Resources**

One of my initial and ongoing concerns with the telemental health format was that clients lacked the resources to successfully engage in telemental health. Many refugee clients share small living spaces with many family members and do not have access to a private and confidential space for a one-hour period. When schools closed early in the pandemic, adult clients frequently lacked childcare resources, and children would often be in the background of therapy sessions, halting the disclosure of sensitive topics and requiring attention throughout

the session. Access to reliable internet and tech devices is also an issue for many refugee clients. Meanwhile, most clinicians do not lack resources in the way that their refugee clients might, highlighting the differences in privilege between client and clinician.

### **The Digital Divide**

One major obstacle to telemental health services with the refugee population is the “digital divide,” which refers to disparities in access to tech devices and the Internet, and “tech literacy,” which refers to the ability to understand and use technology. Immigrants in the US are disproportionately and negatively impacted by both the digital divide and tech literacy. Financial disparities related to unemployment, underemployment, and low incomes are a key reason for limited access to tech devices and the Internet. Some resettled refugees have never used technological devices in their homelands, although the majority are familiar with speaking on the phone. One small study of refugee-serving mental health providers post-COVID-19 found that the majority of refugee clients used cell phones for telemental health sessions and did not use video (Disney, Mowbray, and Evans 2021). Thus, telemental health for resettled refugees has the potential to overcome challenges related to provider and language availability, but may also exacerbate other challenges, such as digital access and literacy (Grieco-Page 2021).

### **Adapting Clinical Skills for the Telemental Health Format**

The rise of telemental health during COVID-19 has required adaptations and modifications from nearly all clinics and providers. For example, initial needs assessments, screening tools, and clinic procedures needed to be modified to ensure best practices (Mishkind et al. 2021), and many providers required training on engagement strategies and technological strategies to provide effective telemental health services (Sansom-Daly and Bradford 2020). Refugee-serving providers who were working cross-culturally and had been trained in Western therapy approaches already gave significant consideration to the provision of effective and relevant cross-cultural services. For example, in contrast to Western or US-born clients, refugee clients prefer high context communication, more provider self-disclosure to build rapport, and case management as part of treatment. Refugees are generally from cultures that rely more on the physical context or non-verbal communication to understand one another (“high context communication”), rather than the Western cultural preference of explicit verbal language (“low context communication”) (Hall 1989). Without the fuller context provided by being FTF, there is a higher risk of misunderstanding and miscommunication between Western therapist and refugee client. The switch from face-to-face to a virtual format required refugee-serving clinicians to reconsider basic clinical skills such as building rapport, self-disclosure, use of silence, and non-verbal communication in order to provide effective and relevant cross-cultural services.

Clinicians have reported feeling that the process of developing a strong therapeutic alliance is more challenging via the virtual format (Barnett et. al. 2021). More self-disclosure may be needed to build rapport for the telemental health format. For refugee-serving clinicians who held sessions over the phone following COVID-19, the difficulty of perceiving non-verbal cues and communication was significant, given the high-context communication style of refugee clients (Disney, Mowbray, and Evans 2021). Verbally “checking in” on a client’s emotional state throughout the session is one way to compensate for increased difficulty in perceiving non-verbal communication.

Another core clinical skill, the use of silence, required adaptation for phone telemental health sessions. The clinician's use of silence during face-to-face sessions is an intentional active listening skill that gives the client time to process or direct the session. Without the shared physical presence, silence as a clinical skill was undermined by the possibility of *inactive* listening. Was the clinician paying attention at all, or could the clinician be distracted on the other end of the line? One modification that clinicians can utilize is to offer a verbal signal (i.e. "what you shared is profound...") that they are present but not rushing.

While I was able to adapt clinical skills to build rapport and show active listening over the phone, I continued to process how these adaptations intersected with my theoretical orientation. Theoretical orientations that emphasize human connection felt more difficult to utilize than short-term or cognitive interventions. When using the telemental health format with refugees, another adaptation that clinicians may need to consider is whether treatment should focus on PTSD or MDD, the two most prevalent mental health disorders in resettled refugee populations. Interventions aimed at reducing complex PTSD, such as Narrative Exposure Therapy or EMDR, require an emotionally safe physical space and shared presence for clinician to provide containment and emotional co-regulation, none of which is possible via phone telemental health sessions but may be more possible if clients are able to have a private and confidential space and videoconferencing resources. Videoconferencing would allow more opportunities for non-verbal communication, co-regulation, and synchronous, shared experience of changes to privacy, compared to phone sessions.

Additionally, refugee clients often have expectations about their therapists that are outside the traditional role of the Western-trained therapist. Requests often include case worker needs, such as understanding mail, scheduling a doctor's appointment, or applying for social welfare benefits. Rather than "correcting" or "teaching" what the role of the therapist "should be," refugee-serving clinicians consider whether the request presented can be part of a holistic, flexible, and culturally relevant treatment model, or whether the request is outside ethical and/or legal boundaries. Requests for direct advice are also common, particularly related to US systems, legal questions, or medical concerns. Therapists are often viewed as more knowledgeable due to holding advanced educational degrees, having a strong command of the English language, and/or understanding of US legal, medical, educational, transportation, social welfare, or cultural systems. Therefore, refugee clients may assume that therapists are obligated – as a result of their privileged positions - to provide advice.

During the pandemic, refugee clients may ask their clinicians' recommendations about COVID-19 vaccines. In addition to possibly viewing their therapists as being more educated or informed about COVID-19 vaccines, refugee clients might also ask clinicians this question because refugee clients often have personal and historical experiences of governmental abuse and are seeking answers and confidence in a trusted source, such as a therapist. For therapists, this question could provoke powerful emotions for a clinician who has strong feelings about vaccines. Additionally, this question could prompt a unique ethical dilemma. Should the COVID-19 vaccine question be treated as any other medical question and responded to with deference to the client's medical doctor for advice? Or, given the high context communication style of most refugees, could a lack of clearly stating a pro-vaccine position be (incorrectly) interpreted by clients as an anti-vaccine position?

**Strategies for Telemental Health with Resettled Refugee Populations Following COVID-19**

As conflicts continue in Afghanistan, Syria, Ethiopia, South Sudan, Venezuela, and other parts of the world, and humanitarian crises worsen in part due to the ongoing global pandemic, resettlement countries must prioritize the protection and support of these vulnerable and uniquely resilient populations. There are several key strategies for both improving telemental health with resettled refugee populations following COVID-19 and leveraging the rapid expansion of telemental health services in the U.S. to address mental health disparities.

Overcoming the digital divide is a key aspect of eradicating mental health disparities. Funding is needed to increase internet accessibility, overcome tech illiteracy, and expand telemental health services. For example, all clients should have access not only to reliable WI-FI, but also to Internet with sufficient bandwidth capacity to allow for telemental health services. Funding should be allocated for community programming that increases tech literacy, and mental health clinics, particularly those that are Medicaid-funded, need government investment in telemental health technology. Lastly, mental health clinics might consider reaching out to refugee clients for a face-to-face visit to demonstrate how to use tech devices for telemental health sessions and communication.

Another strategy is to increase the collective telemental health toolkit of the mental health professions. Schools that educate mental health practitioners should revise curriculum to include telemental health best practices. Professional licensing boards and state regulating boards must collaborate about telemental health credentialing requirements and cross-state allowances. As laws and governing agencies cyclically restrict and loosen the non-emergency service options that are available for people seeking mental health services, clinicians must stay abreast of frequent changes while also assessing client need and ability to engage effectively in telemental health.

Lastly, more research is needed to understand how best to decrease the challenges and leverage the benefits of telemental health with refugee clients. Additionally, given the diversity within the resettled refugee population, such as language differences and cultural contexts of their countries of origin, research is needed to tailor telemental health preferences and strategies to particular subgroups of resettled refugees.

Together, these strategies capitalize on the strengths of telemental health for resettled refugees, while also addressing the ways telemental health can exacerbate mental health access inequity. Telemental health has the potential to increase access for resettled refugees who may not be able to receive FTF services due to lack of transportation, childcare, language, or services in one's area. Additionally, the pandemic has shown us that there cannot be a "one size fits all" means to mental health service delivery; there is a need for alternative pathways to treatment aside from FTF. A silver lining of COVID-19 may be that there is now a burst of research aimed at understanding how telemental health can reduce the mental health disparities faced by underserved populations, such as the resettled refugee population in the US.

### **Concluding Remarks**

Historically, collective experiences of national and international hardship have prompted change and innovation, particularly vis a vis economic and social welfare policymaking. Consider, for example, the cataclysmic effects of the Great Depression, followed by the economic watershed of the New Deal. Although far from over, the COVID-19 pandemic may similarly be conceptualized as a long-overdue catalyst for evaluating, adapting, and re-

imagining how mental health services are provided to increasingly diverse client populations. Sub-populations, such as refugees, have unique lived experiences, strengths, challenges, and needs, and such characteristics merit specific consideration in processes of developing culturally responsive and appropriate interventions and services.

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