Promoting Child Mental Health among Somali Bantu and Bhutanese Refugees: Feasibility, Acceptability and Outcomes of a Family-Based Intervention

Kira DiClemente, MPH
Brown University School of Public Health

Immigrant, Refugee, and Transnational Families
PAA 2020

PSTC

BOSTON COLLEGE
SCHOOL OF SOCIAL WORK

BROWN
School of Public Health

Photos Removed for Online Use
Quotes Removed Pending Publication of Results

For more information on this work, see:

Betancourt, T. S., Berent, J. M., Freeman, J., Frounfelker, R. L., Brennan, R. T., Abdi, S., . . . Gautam, B. (2020). Family-Based Mental Health Promotion for Somali Bantu and Bhutanese Refugees: Feasibility and Acceptability Trial. *Journal of Adolescent Health, 66*(3), 336-344.

Betancourt, T. S., Frounfelker, R., Mishra, T., Hussein, A., & Falzarano, R. (2015). Addressing health disparities in the mental health of refugee children and adolescents through community-based participatory research: a study in 2 communities. *American Journal of Public Health, 105*(S3), S475-S482.

Betancourt, T. S., Frounfelker, R., Mishra, T., Hussein, A., & Falzarano, R. (2015). Addressing health disparities in the mental health of refugee children and adolescents through community-based participatory research: a study in 2 communities. *Am J Public Health, 105*(S3), S475-482. doi:10.2105/AJPH.2014.302504.

Betancourt, T. S., Frounfelker, R. L., Berent, J. M., Gautam, B., Abdi, S., Abdi, A., . . . Mishra, T. (2018). Addressing mental health disparities in refugee children through family and community-based prevention. In *Humanitarianism and Mass Migration: Confronting the World Crisis* (pp. 137-164): University of California Press, Oakland, CA.

FOR FURTHER INFORMATION PLEASE CONTACT:

Theresa Betancourt, ScD

Salem Professor in Global Practice

& Director of the Research Program on Children and Adversity

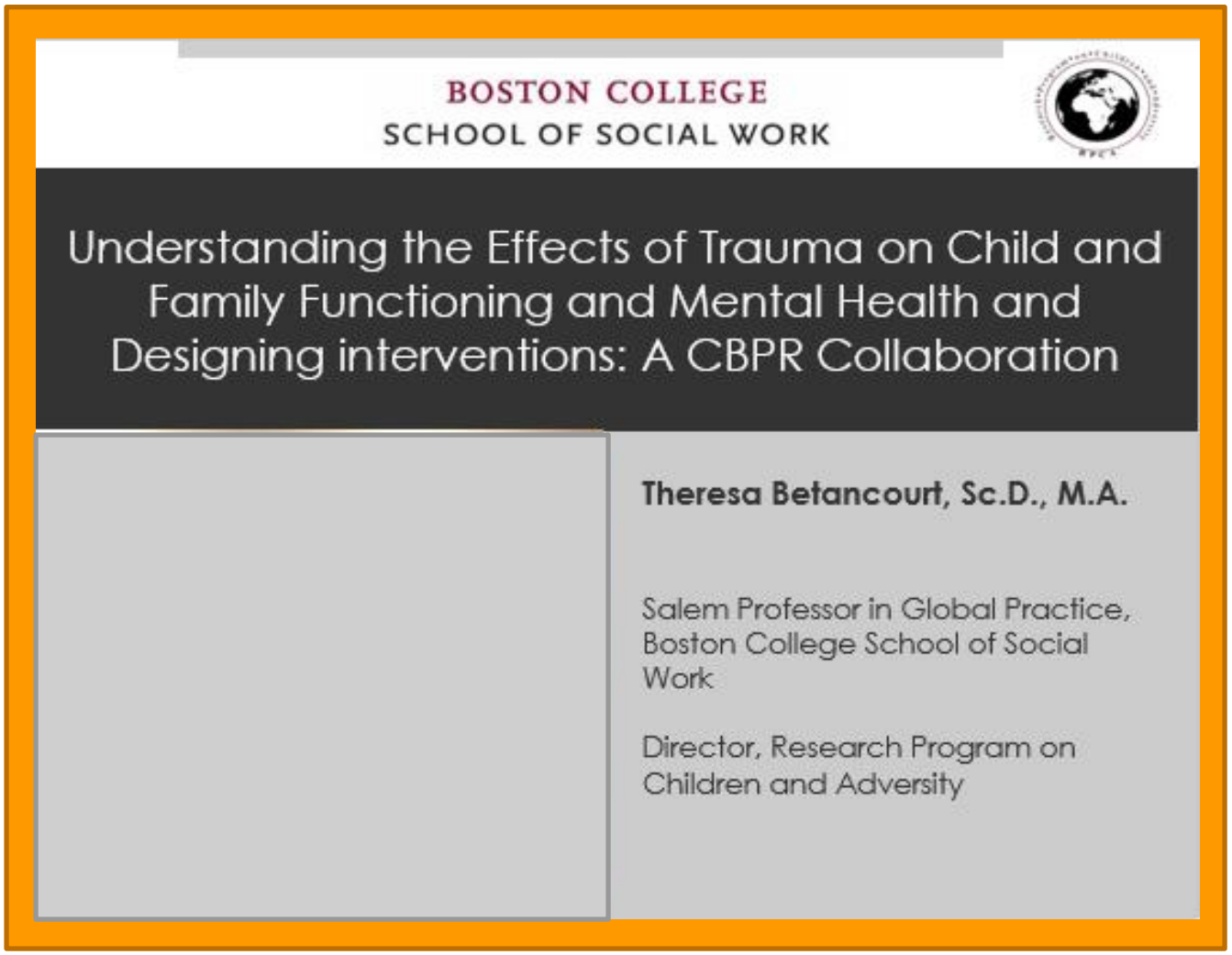
rpcalab_ssw@bc.edu

Kira DiClemente, MPH

Brown University Doctoral Candidate in Behavioral and Social Sciences

kira_diclemente@brown.edu

These slides are adapted from Dr. Theresa Betancourt's Presentation:



Thank you to Co-Authors:

Sarah Neville, Jenna Berent, MPH, Jordan Farrar, PhD, Tej Mishra, John Creswell, PhD, William Beardslee, MD, & Theresa Betancourt, ScD

Overview

- Background on RPCA and conceptual drivers
- CBPR experiences with two communities:
  - Somali Bantu
  - Bhutanese
- Mixed methods and cross-cultural mental health
- Family Strengthening Intervention for Refugees
- Qualitative exit interview analysis

Research Program on Children and Adversity (RPCA): Goals

- Identify factors contributing to **risk** and **resilience** in children, families, and communities facing adversity globally
  - Focus on **capacities**, not just deficits

- Contribute to developing an evidence base on intervention strategies:
  - Help **close the implementation gap**
  - Support development of **high quality and effective programs and policies in low resource settings including vulnerable communities in the US**

Modern War and Terrorism: Devastating Consequences for Children & Youth

Globally, at the end of 2018 there were:

- **70.8 million** forcibly displaced people
- **41.3 million** internally displaced people
- **25.9 million** refugees
- **Over half (52%)** were under 18 years old

The number of children living in conflict zones rose by 74% over the last decade.

(UNHCR, 2018; UNICEF, 2019)

Refugee children and mental health: Changing times in the US

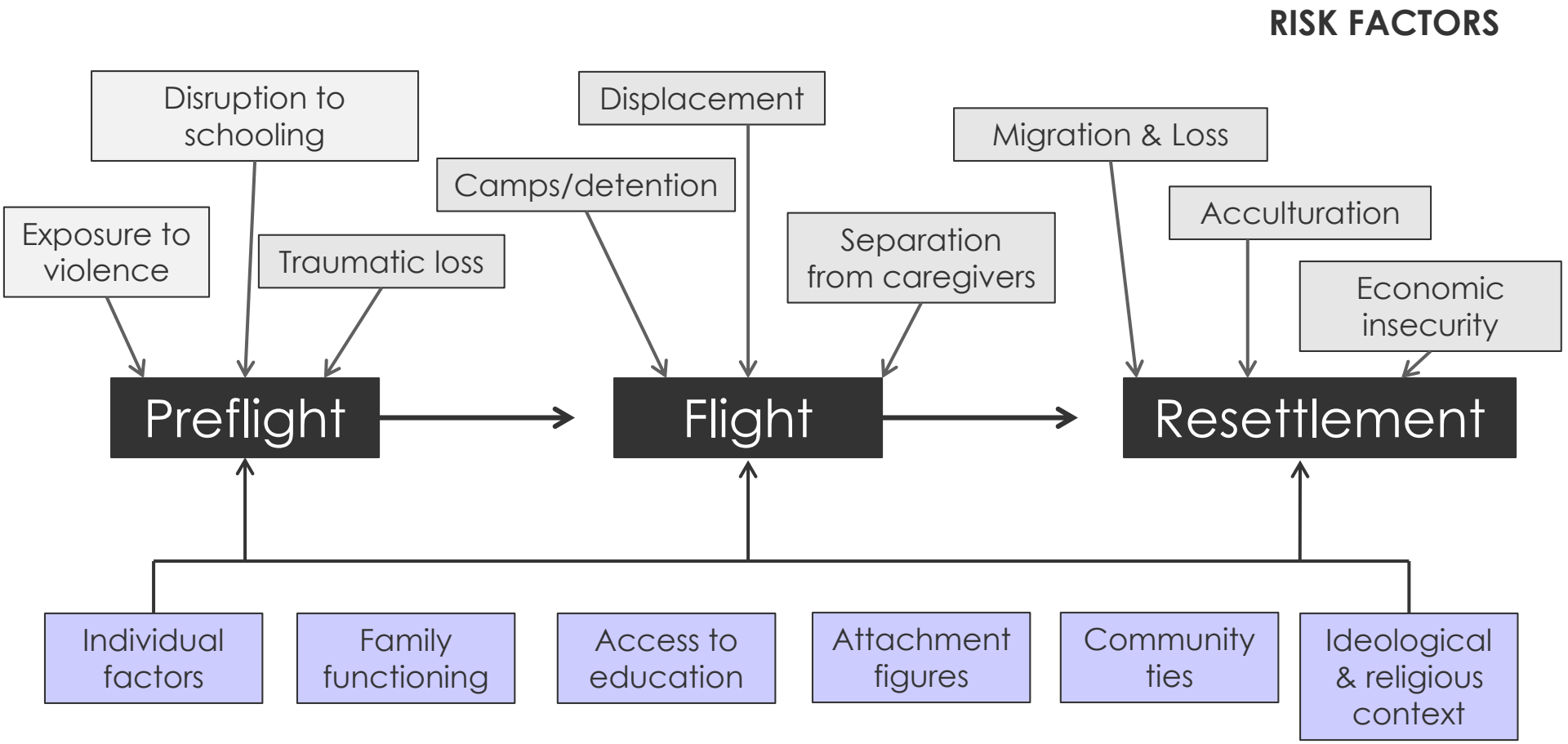
- US traditionally admitted about **70,000 refugees each year.**
- The current ceiling is **30,000 refugees.** As of February 28, 2019, the U.S. has admitted **9,377 refugees** (Refugee Processing Center, 2019).
- Exposed to different factors that increase risk of poor mental health outcomes.
- Depression (10-33%), PTSD (19 to 53%) - compared to 6-9% Depression and 2-9% PTSD in general US population, (Kien et al. 2018; Bronstein and Montgomery, 2011)
- Children in US have poor access to mental health services; situation exacerbated in refugees (Betancourt et al., 2012; de Anstiss et al., 2009)

Refugee barriers to care

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

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

Stages of Displacement



(Lustig et al, 2004)

DESIGNING STRENGTHS-BASED INTERVENTIONS WITH REFUGEE COMMUNITIES

Refugee Program Team & Collaborators

Boston College
Theresa Betancourt
Robert Brennan
Jenna Berent
Jordan Farrar

Funding Support
NIMHHD

Academic Collaborators
John Creswell
William Beardslee
Heidi Ellis
Brandon Khort

Community Consultants
Tej Mishra
Bhuwan Gautam

Chelsea Collaborative
Abdi Abdirahman
Maryan Hassan

Jewish Family Service
Saad Abduljabbar
Kevin Darjee
Prasad Dulal
Manju Gurung
Reeta Rana
Durga Giri
Chanda Acharya

MEIRS
Rilwan Osman
Abdikadir Negeye
Fatuma Mohamed
Nadifo Mohamed
Jama Mohamed
Khasin Saban

RIAC
Maka Osman
Saida Abdi
Ali Maalim
Mani Biswa

Community Based Participatory Research (CBPR)

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

WK Kellogg Foundation Community Health Scholars Program

Community-Based Participatory Research (CBPR)

- Engages researchers and community members in equitable partnership; **deconstruct power differentials** (Minkler, 2010; Leung et al., 2004)

- **Community members engaged in all stages**/aspects of research (Wallerstein & Duran, 2006)

- Shared access to study data and tools; **all team members become representatives of the research**

CBPR and mental health

- Limited application so far in mental health, particularly with refugees
- Promising approach, given **stigma** around mental health
- **Understanding local context and language** (i.e. around mental health problems) can improve community **engagement** and **inform intervention development** (Betancourt et al, 2010)

Our CBPR Approach

- Hire CHWs and research assistants from the communities --train non-specialists
  - **"By Refugees for Refugees"**
- Community outreach events to engage community members
- Reliance on *Community Advisory Boards* at every step:
  - Monthly meetings
  - Liaison between us and the community
  - Advise on needs, culture, etc

SOMALI BANTU REFUGEE COMMUNITY

Somalia

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

Kenya – Refugee Camps

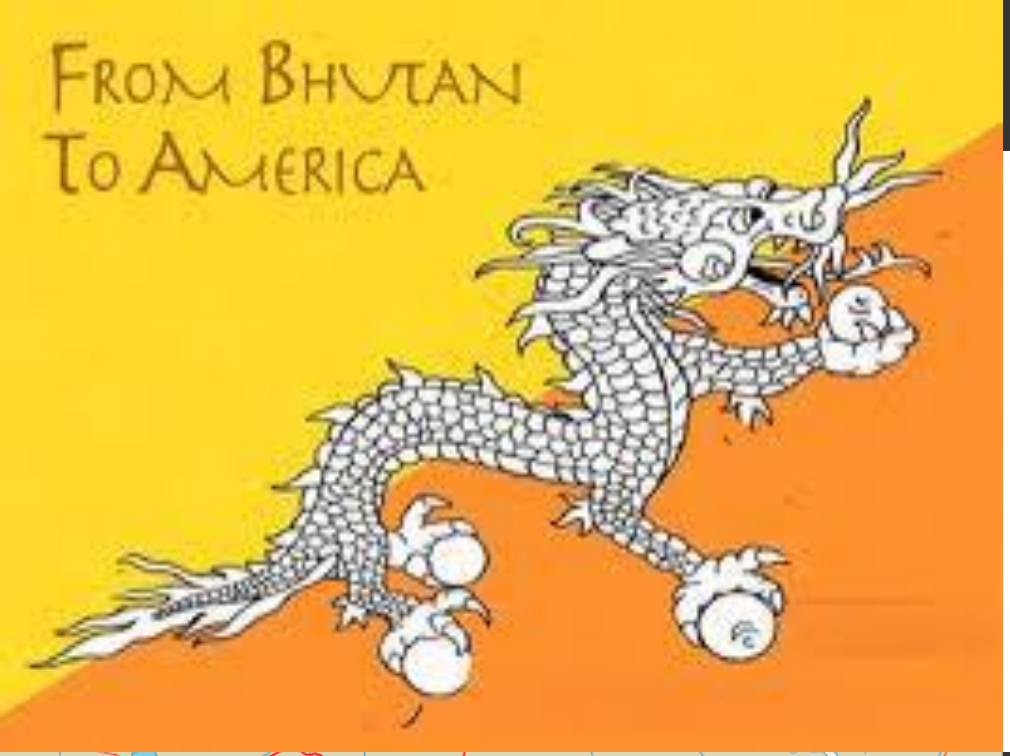
- Massive population displacement; Dependence on UNHCR rations
- Somali Bantu in very insecure areas of the camps; Lootings from across the border at night
- No access to Kenyan society, citizenship, jobs, limited education; slow resettlement of both Somali Majority and Somali Bantu to host countries

Somali Bantu Refugees in the US

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

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

BHUTANESE REFUGEE COMMUNITY



Bhutan

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

Nepal – Refugee Camps

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

Bhutanese Refugees in the US

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

- **Alarming rate of suicide among resettled Bhutanese** in the US (21.5 per 100,000); higher than national average (12 per 100,000) (CDC, 2013)

- Suicide may be connected with experiences of family withdrawal and separation, integration difficulties (especially unemployment), and perceived lack of care, resettlement services, and social support (Hagaman et al, 2016)

Research Partnership

- History
  - 2004, Lynn, MA Public Schools
  - Work on how to better support Somali Bantu refugee children in public schools
  - Evolving community partnership took time
- Result
  - Distinct collaboration to meet both community and research goals

Community/Research Coalition CBPR Approach

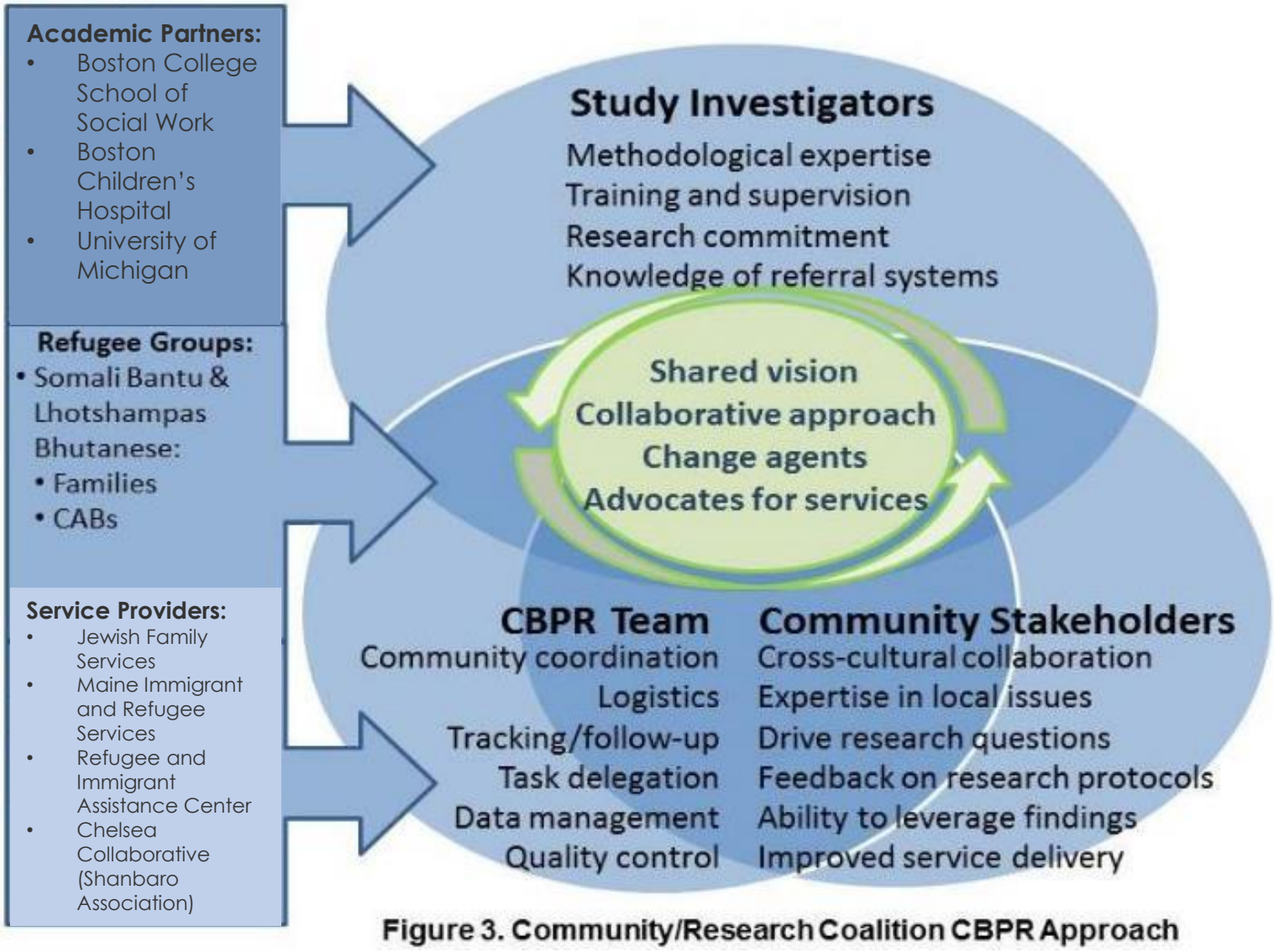


Figure 3. Community/Research Coalition CBPR Approach

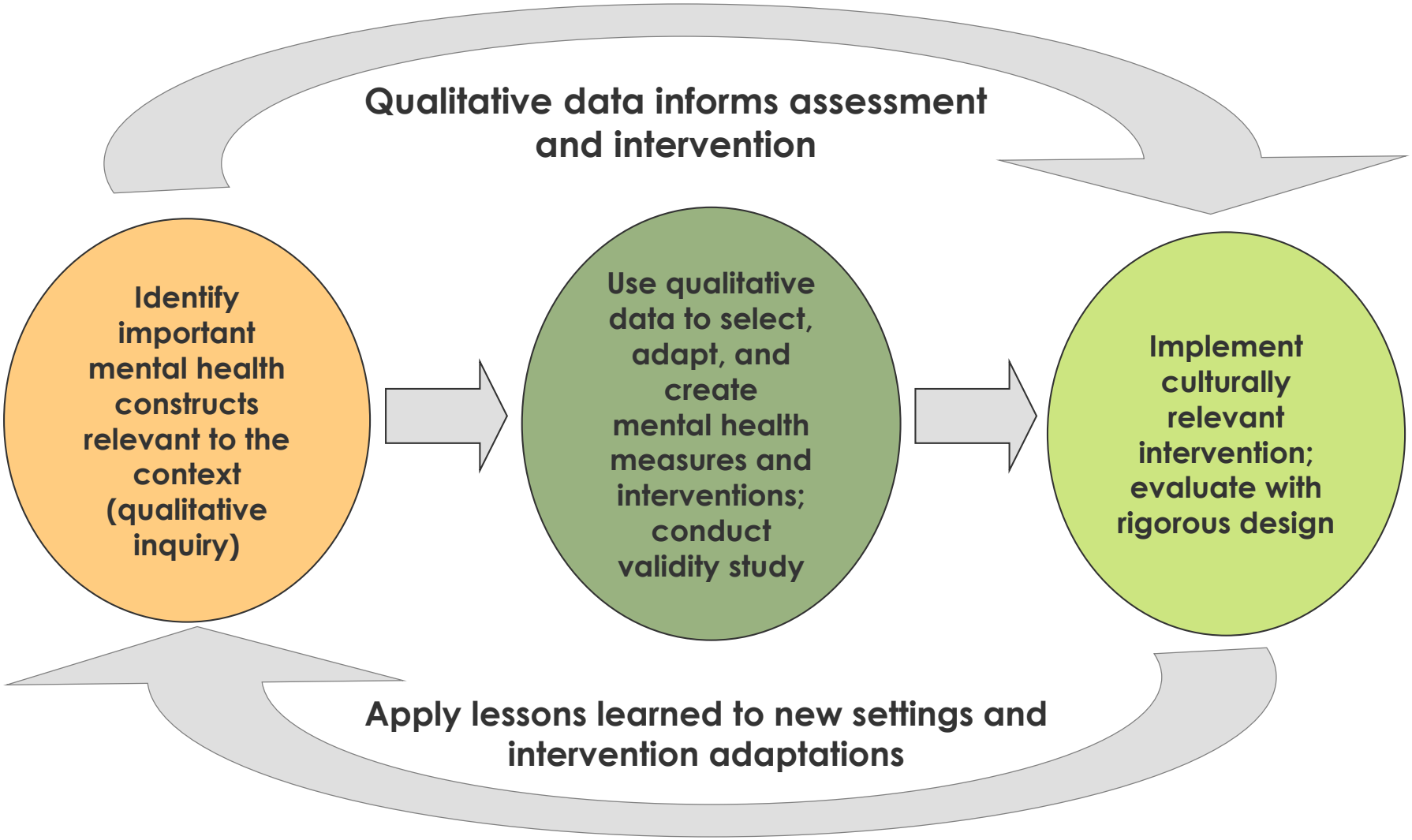
MIXED METHODS AND CROSS CULTURAL MENTAL HEALTH

Culture in Assessment/Measurement and Intervention Development

"Ethnographic studies demonstrate convincingly that concepts of emotions, self, and body, and general illness categories differ so significantly in different cultures that it can be said that each culture's beliefs about normal and abnormal behavior are distinctive"

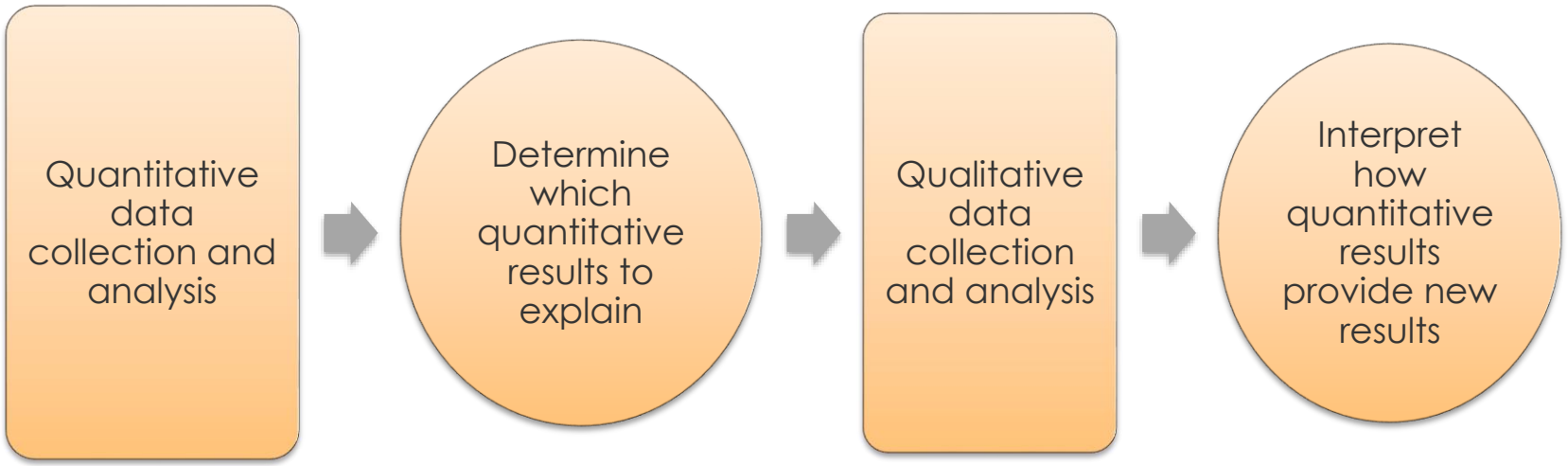
(Kleinman 1988, p.49)

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



Betancourt, T.S. (2015). Using Mixed Methods to Plan and Evaluate Mental Health Programs for War-Affected Children in Sub-Saharan Africa. Chapter 13, Culture of Mental Illness and Psychiatric Practice in Africa. Eds. Emmanuel Akyeampong, Allan G. Hill, Arthur Kleinman. Indiana University Press. ISBN-10: 0253012937

Post Intervention: Explanatory Sequential Design



Pre-post test quantitative assessment

Exit interview on feasibility and acceptability

APPLYING THE MIXED METHODS PROCESS WITH REFUGEE COMMUNITIES IN BOSTON

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

American Journal of Public Health (AJPH), 2015

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

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

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

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

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

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

FAMILY STRENGTHENING INTERVENTION FOR REFUGEES

Boston College School of Social Work

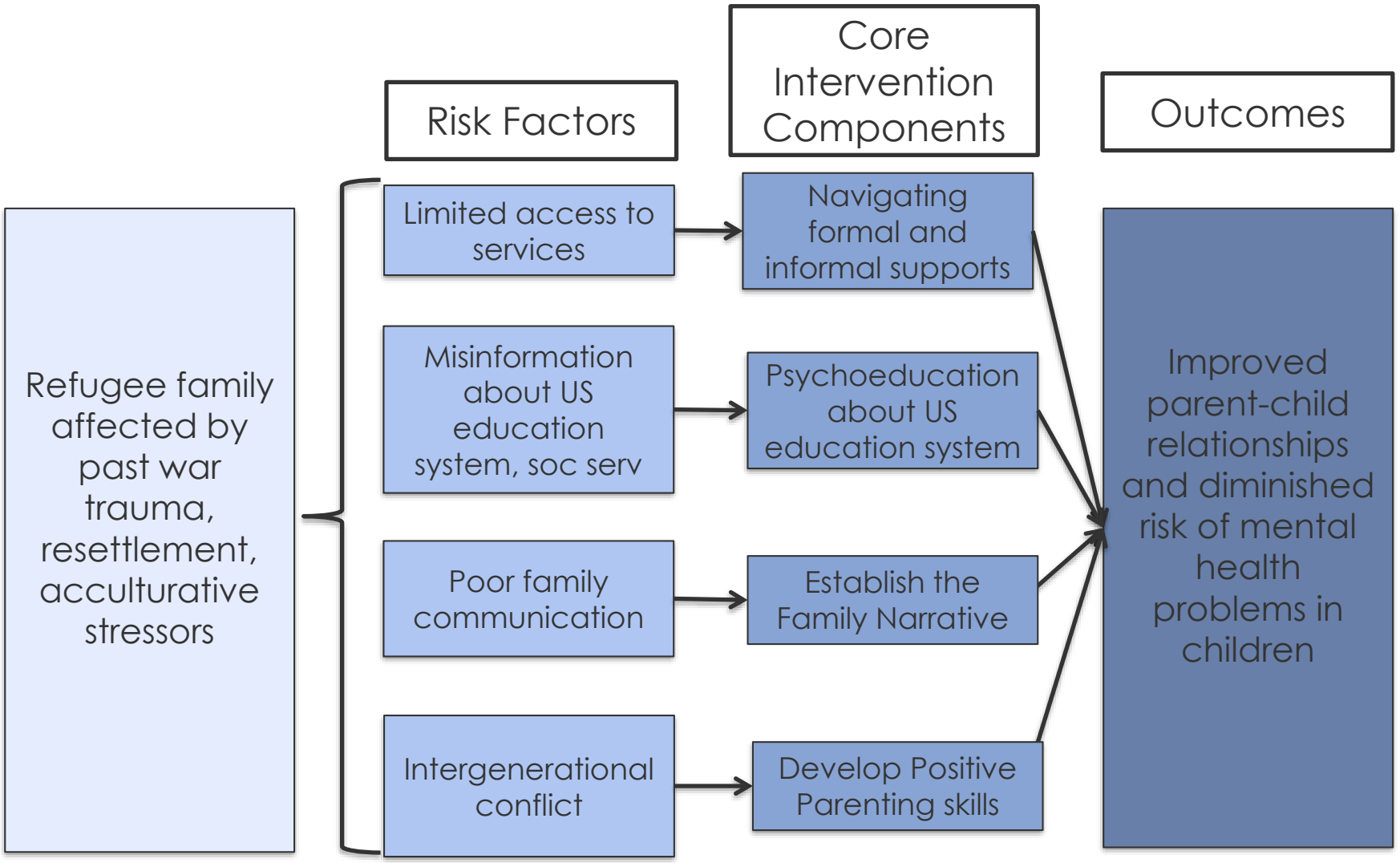
A family-based preventive mental health intervention for use with children and families with a refugee life experience

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

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

FSI Module Characteristics

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



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

Outline of Module Themes

Modules	Theme(s)
1 – 2	Introduction
3	Children and Family Relationships
4	Responsive parenting and caregiving
5	Engagement with the US education system
6	Supplemental module: Promoting Health, Wellbeing, and Safety
7 – 8	Communicating with Children and Caregivers
9	Uniting the Family
10	Bringing It All Together

JOURNAL OF ADOLESCENT HEALTH
Volume 65 : Number 5 : November 2019
ELSEVIER
ISSN 1054-139X
Improving the Lives of Adolescents and Young Adults

(Complete Table of Contents Inside)

OFFICIAL PUBLICATION OF THE
SAHM
SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE
www.jahonline.org

Quantitative Findings from FSI-R Pilot Recently Published:

ELSEVIER
JOURNAL OF ADOLESCENT HEALTH
www.jahonline.org

Original article

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

Theresa S. Betancourt, Sc.D., M.A. [a,*], Jenna M. Berent, M.P.H. [a], Jordan Freeman, M.P.H. [a], Rochelle L. Frounfelker, Sc.D., M.P.H., M.S.S.W. [b], Robert T. Brennan, Ed.D., M.A. [a], Saida Abdi, Ph.D., L.C.S.W., M.S.W., M.A. [c], Ali Maalim [a], Abdirahman Abdi [a], Tej Mishra, M.P.H. [a], Bhuwan Gautam, M.P.A. [a], John W. Creswell, Ph.D. [d,e], and William Beardslee, M.D. [c,f]

[a] *Research Program on Children and Adversity, Boston College School of Social Work, Massachusetts*
[b] *Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, Montreal, Canada*
[c] *Boston Children's Hospital, Boston, Massachusetts*
[d] *Department of Family Medicine, University of Michigan Medical School, St. Ann Arbor, Michigan*
[e] *College of Education and Human Services, University of Nebraska-Lincoln, Lincoln, Nebraska*
[f] *Judge Baker Children's Center, Harvard University, Boston, Massachusetts*

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

ABSTRACT

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

IMPLICATIONS AND CONTRIBUTION

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

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

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

Eligibility Criteria for Family Based Prevention Pilot

- **Eligible families:**
  - Are Somali Bantu or Bhutanese refugees
  - Have at least one school-aged child (between 7-17 years)
  - Have been in the U.S. 3 months or longer

- **Exclusion Criteria:**
  - The family is currently in crisis (i.e. psychosis, suicidality)

Qualitative Data Collection & Analysis

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

Data collection was supported by use of MAX QDA Software

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

Qualitative Data Collection

- Research Questions were:
  1. How acceptable and/or feasible, if at all, is the FSI-R for addressing the challenges facing parenting among refugee families and their children at the individual parent, family, community and societal levels? What, if anything, contributes to the acceptability and feasibility of the intervention?
  2. What kinds of changes, if any, do caregivers and children see in themselves, their families, and their communities after participating in the FSI-R?
  3. What perspectives, if any, do intervention participants offer to improve future impact, acceptability and feasibility of the intervention?
- Analysis carried out using MAXQDA

Qualitative Interviews (N=36)

Somali Bantu
(10 families)

- Caregivers: n=10
  - 8 female, 2 male
  - Mean age=41.6
- Children: n=8
  - 4 female, 4 male
  - Mean age=14.5

Nepali Bhutanese
(11 families)

- Caregivers: n=9
  - 4 female, 5 male
  - Mean age=46.4
- Children: n=9
  - 3 female, 5 male
  - Mean age=15.6

Descriptive Statistics of Interview Sample

Table redacted, unpublished;
See below for entire study population demographic data:

Betancourt, T. S., Berent, J. M., Freeman, J., Frounfelker, R. L., Brennan, R. T., Abdi, S., . . . Gautam, B. (2020). Family-Based Mental Health Promotion for Somali Bantu and Bhutanese Refugees: Feasibility and Acceptability Trial. *Journal of Adolescent Health, 66*(3), 336-344.

RESULTS

1. Acceptability and Feasibility

- Three primary themes observed:
  1. ***Scheduling and time as an initial barrier to acceptability and feasibility***
  2. ***Experiences discussing the past***
  3. ***Experiences with the interventionist***

Scheduling and time as an initial barrier to acceptability and feasibility

- Children discussed the intervention meeting times as **conflicting with their after school** or weekend activities, while caregivers and children alike most frequently noted the challenge of scheduling intervention sessions around **caregivers' work schedules**.
- Other barriers to scheduling included coordinating children and caregivers **conflicting schedules**; working around afterschool programs or **peer time** where children may stay late at school; **commitments within the community**; medical **appointments**; time spent caring for family members; and **extended travel to visit family**.

Scheduling and time as an initial barrier to acceptability and feasibility

- Ultimately, scheduling issues were a barrier that **most families were able to overcome in order to participate in the intervention**, assisted by the flexibility of **home visiting**.
- Often, participants shared that the **interventionist played an important role** in ensuring that scheduling did not ultimately affect the ability of families to participate in the intervention.

Quotes Redacted Pending Publication

Experiences discussing the past

- For many children from both communities, the intervention's focus on **creating a family narrative** provided them an opportunity to learn about their **family history.**

Quotes Redacted Pending Publication

Experiences discussing the past

- Though this was an opportunity for children to learn about their family history, the process of **retelling past histories** was **not easy** for all parents, particularly for mothers within the Somali Bantu community where **trauma experiences** had been high.

Quotes Redacted Pending Publication

Experiences with the interventionist

- Overall, participants spoke highly of their interventionists, describing them as respectful, patient, and understanding and viewing them as **a real source of knowledge.**
- When asked about their experiences with the interventionists, members of both communities brought up that their interventionist was **a part of their community**, which contributed to the acceptability of the FSI-R.

Quotes Redacted Pending Publication

2: Impacts on participants

- Three primary themes emerged, which will be addressed separately by community:
  1. Family communication
  2. Spending time together as a family
  3. Relationship between caregivers

Family communication: Bhutanese

- Bhutanese families spoke about how the intervention led children to **share more** with their parents and vice versa.

Quotes Redacted Pending Publication

Family communication: Bhutanese

- Not only did children share more about their daily lives with their parents, but parents also took the **initiative to ask their children** about their lives.

Quotes Redacted Pending Publication

Family communication: Somali Bantu

- Within Somali Bantu families, they spoke about **enjoying more unstructured communication** than before and speaking more **politely** to one another.
- For some participants, the intervention provided an opportunity to **discuss life before coming to the U.S.**

Quotes Redacted Pending Publication

Family communication: Somali Bantu

- In addition, several participants remarked that they enjoyed increased unstructured **discussion time** with their family.

Quotes Redacted Pending Publication

Family communication: Somali Bantu

- For many Somali Bantu families in particular, communication is difficult primarily due to **language barriers.**
- For Somali Bantu parents who speak a native unwritten language (*Maay Maay*), yet their children are actively learning English, the intervention represented an **opportunity to come together** despite this.

Quotes Redacted Pending Publication

Spending time together as a family: Bhutanese

- Just as families enjoyed increased unstructured communication time with one another, they also **enjoyed spending more time together** as a family as a result of the intervention.

Quotes Redacted Pending Publication

Spending time together as a family: Somali Bantu

- Similarly, Somali Bantu families remarked that they enjoyed spending more time together as a family after the intervention, with a particular emphasis on time spent together among **siblings**.

Quotes Redacted Pending Publication

Relationship between caregivers: Somali Bantu

- Very few Somali Bantu mentioned that the intervention affected the relationships **between caregivers.**

Quotes Redacted Pending Publication

Relationship between caregivers: Bhutanese

- On the other hand, Bhutanese participants were more likely to share about how the intervention affected **caregiver relationships**.
- Many commented that their married relationships had **always been positive.**

Quotes Redacted Pending Publication

Relationship between caregivers: Bhutanese

- However, some participants, especially children, talked about **observing changes** in their parents' relationship.

Quotes Redacted Pending Publication

3: Improving the intervention

- Two major themes emerged:
  1. *Seeking tangible skills*
  2. *From family to community*

Seeking tangible skills

- When asked how, if at all, the intervention can be improved for the future, participants across both communities suggested that future iterations of FSI-R include more training in **tangible skills.**

Quotes Redacted Pending Publication

Seeking tangible skills

- Even if the intervention were not to deliver the **services**, themselves, participants hoped to get at least more information about **tangible services.**

Quotes Redacted Pending Publication

From family to community

- When asked how the intervention could improve, **Bhutanese children** in particular suggested altering the intervention setting from the **family unit** to the **community**.

Quotes Redacted Pending Publication

DISCUSSION

Discussion Points

- Overall, these exit interviews reveal that the FSI-R was well received by the Somali Bantu and Bhutanese communities and **led to positive and well-received changes in in family dynamics.**
- The results demonstrate the **value of creating shared narratives** within families and the enhanced communication that can result, especially as it offered families an opportunity to discuss experiences they had not previously discussed in a **protected- yet at-home-setting.**
- The increase in communication with families across both communities as well as an **increase in pleasure in one another's company** at home and during activities is a promising result of this pilot intervention.
- The dynamics that the FSI-R helped to create also provide **targets for future interventions.**
  - *Expansion into the community for youth*
  - *Partnering with language-learning initiatives*

Future steps...

- **Policy and political landscape changed** dramatically over the course of the study
- **Pathway to scale up linked to ACA:** provisions for supporting community health workers and prevention services remain at risk (but not gone yet!)
- Focus on **State level policy** in MA and ME
- Undergoing a **300-family** effectiveness trial

Implications

- **Promoting mental health and healthy family dynamics** in refugee children and families is **critical to longer term success**

- **Changing the Narrative to a more strengths-based approach is key**

  - CBPR is a promising approach for **engaging** refugee **communities** in research; process is **iterative** with **continuous integration of lessons learned**

- Working with partners, it is vital to also **attend to primary concerns** of the community

  - **Collaboration** and **mutual exchange** can assist in development of **acceptable**, **feasible** and ultimately more **sustainable** interventions

Thank you!

This work was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health [Grant numbers: R24MD008057, PI: Betancourt, T.S., and R01MD010613, PI: Betancourt, T.S.].

We are grateful to the Population Studies and Training Center at Brown University for funding our PAA participation, which receives funding from the NIH, for training support (T32 HD007338) and for general support (P2C HD041020).

References

Betancourt, T.S., Newnham, E.A., Layne, C.M., Kim, S., Steinberg, A.M., Ellis, H. & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. Journal of Traumatic Stress, 25, 682-690.

Betancourt, T.S., Abdi, S., Ito, B., Lilienthal, G.M., Agalab, N., & Ellis, H. (2015). We Left One War and Came to Another: Resource Loss, Acculturative Stress, and Caregiver-Child Relationships in Somali Refugee Families. *Cultural Diversity & Ethnic Minority Psychology*. 21(1):114-125.

Betancourt, T.S., Frounfelker, R., Mishra, T., Hussein, A., & Falzarano, R. (2015). Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities. *American Journal of Public Health*, 3, s475-s482.

Ellis, B.H., Hulland, E.N., Miller, A.B., Barrett Bixby, C., Lopes Cardozo, B., Betancourt, T.S. (2016). Mental Health Risks and Resilience among Somali and Bhutanese Refugee Parents. *Migration Policy Institute*.

Frounfelker, R., Assefa, M., Smith, E., Abdirahmana, A., & Betancourt, T.S. (2017). "We would never forget who we are": Resettlement Stress, Family Functioning, and Resilience among Somali Bantu Refugee Youth. *European Child and Adolescent Psychiatry,* 26(11),1387-1400

Brown, F., Mishra, T., Frounfelker, R., Prasai, A., Bhargava, E., Betancourt, T.S. (In Preparation). "Hiding their troubles": A qualitative exploration of suicidality in Bhutanese refugees in the USA. *Cultural Diversity & Ethnic Minority Psychology*.

Betancourt,T., Frounfelker,R., Berent,J., Gautam,B., & Abdi, S. (n.d.). Addressing Mental Health Disparities in Refugee Children through Family and Community-based Prevention. In *Catastrophic Migrations of the 21st Century.*

Betancourt, T.S. & Khan, K.T. The mental health of children affected by armed conflict: Protective processes and pathways to resilience. Int Rev Psychiatry. Jun 2008;20(3):317-328.

Minkler M. Linking science and policy through community-based participatory research to study and address health disparities.*American Journal of Public Health*. 2010;100(S1):S81-S87.

Leung MW, Yen, IH, Minkler M. Community based participatory research: a promising approach for increasing epidemiology's relevance in the 21st century. *International journal of epidemiology*. 2004;33(3):499-506.

Wallerstein NB, Duran B. Using community-based participatory research to address health disparities. *Health promotion practice*. 2006;7(3):312-323.

UNHCR, 2012, The state of the world's refugees,

Betancourt, T.S., Newnham, E.A., Layne, C.M., Kim, S., Steinberg, A.M., Ellis, H. & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. Journal of Traumatic Stress, 25, 682-690.

de Anstiss H, Ziaian T, Procter N, Warland, J, Baghurst P. Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research. *Transcultural Psychiatry*. 2009;46(4):584-607.

Fazel M, Reed RV, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*. 2012;379(9812):266-282.

Edberg M, Cleary S, Vyas A. A trajectory model for understanding and assessing health disparities in immigrant/refugee communities. *Journal of Immigrant and Minority Health*. 2011;13(3):576-584.

Lustig, S., Kia-Keating, M., Knight, W.G., Geltman, P., Ellis, H., Kinzie, J.D., Keane, T. & Saxe, G.N. (2004). Review of child and adolescent refugee mental health. Journal of the American Academy of Child and Adolescent Psychiatry, 43(1), 24-36.

Kleinman, Arthur. Rethinking Psychiatry. Simon and Schuster, 2008; pg 49.

Embassy of the United States. US ambassador bids farewell to 90,000th refugee to resettle to the United States. Available at: https://np.usembassy.gov/u-s-ambassador-bids-farewell-90000th-refugee-resettle-united-states/. Accessed February 6, 2019.

Bronstein I, Montgomery P. Psychological distress in refugee children: a systematic review. Clin Child Fam Psych 2011;14(1):44-56. doi: 10.1007/s10567-010-0081-0.

Kien, C., Sommer, I., Faustmann, A. et al. Eur Child Adolesc Psychiatry 2019;28: 1295. https://doi.org/10.1007/s00787-018-1215-z

Betancourt, T.S. (2015). Using Mixed Methods to Plan and Evaluate Mental Health Programs for War-Affected Children in Sub-Saharan Africa. Chapter 13, Culture of Mental Illness and Psychiatric Practice in Africa. Eds. Emmanuel Akyeampong, Allan G. Hill, Arthur Kleinman. Indiana University Press. ISBN-10: 0253012937