Clinical Issues in Mental Health Service Delivery to Refugees

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Serious limitations exist in the delivery of mental health services to refugees throughout the resettlement process. Having survived harrowing physical and psychological traumas prior to reaching refugee camps, many refugees encounter mental health services in overseas camps that are characterized by fragmentation, instability, language barriers, and severe staff shortages. Refugees requiring mental health intervention after resettlement in the United States confront additional barriers, including frequent misdiagnosis, inappropriate use of interpreters and paraprofessionals, and culturally inappropriate treatment methods. Suggestions for improving mental health services for refugee populations emphasize modifying diagnostic assumptions and treatment approaches, recognizing potential problems associated with using interpreters and paraprofessionals, and examining the role of consultation, prevention, and outreach services in addressing refugee mental health concerns.

In keeping with the humanitarian concerns of the United States and in response to political unrest in many parts of the world, 1.2 million refugees entered the United States between July 1974 and September 1988 (Report to Congress, 1989).

The traumatic circumstances of the decision to leave one's home because of a well-founded fear of persecution are important to note in understanding the deep distress that is often observed in refugees. Demands on a refugee's coping skills begin in the home country when conditions become intolerable to the point of deciding to leave. Most refugees do not wish to leave their country, family, and friends. Once the decision is made, the process of leaving is often fraught with danger because many countries' restrictions include force and barriers designed to prevent unlawful departure. The actual experience of leaving may endanger the life of the individual.

The departure (or escape) must include a plan and arrangements for travel, which in itself may be life-threatening. For example, people leaving Vietnam typically travel by boat across either the Gulf of Thailand to Thailand or the South China Sea to Malaysia or Indonesia. Since 1975, 505,740 people have reached the aforementioned countries via boat; Hong Kong has received 183,468 individuals, and Thailand alone has received 745,978 refugees from Cambodia, Laos, and Vietnam. Smaller numbers arrived in Singapore (35,036), Korea (349), and the Philippines (52,373; "Refugee Reports," 1989). The sea voyage is almost always perilous and replete with life-threatening experiences, all of which may take a significant toll on one's psychological integrity. Common examples of danger are unseaworthy vessels, insufficient stocks of food and water, violent storms, and attack from pirates, resulting in robbery, kidnapping, homicide, rape, and sinking of the vessel. Cannibalism has occurred when food supplies were exhausted.

Although life may be safeguarded upon reaching the country of first asylum, psychological threats continue and may involve (a) coping with the loss of a family member or friend during the voyage, (b) dealing with the aftermath of sexual assault (which typically invites family and community rejection of the victim), (c) primitive living conditions in secured camps, and (d) restricted movement. Furthermore, after arrival in a first asylum country, an individual may or may not be recognized as a refugee by that country. If the individual is accepted by the country of first asylum as a refugee, the person must still meet resettlement criteria, which differ widely among resettlement countries. If qualified for resettlement the individual may still be denied entry to a resettlement country because of a criminal history, drug use, membership in certain groups (e.g., service in a communist army), or diagnosed excludable mental health or health condition (U.S. Immigration and Nationality Act, 1980, p. 32). Diagnosis of one of these conditions renders the individual medically excludable from the United States as a refugee until he or she is symptom free for a period of one year. Medical waivers may be given. In the case of mental retardation, a waiver is routine in order not to delay resettlement to the United States. In cases in which resettlement is denied, the person faces a future of uncertainty.

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and the hopelessness of an open-ended period of camp life or the possibility of involuntary repatriation.

**Mental Health Services in Refugee Camps**

It is apparent that the refugee experience is potentially so devastating that a mental health delivery system in refugee camps is imperative. In Southeast Asia, mental health services are present in camps to a greater or lesser degree. In most cases, services are provided by social workers (not necessarily psychiatric social workers), nurses, and an occasional psychiatrist or psychologist. Programs rely heavily on indigenous paraprofessionals (i.e., refugees who have undergone training to provide mental health assistance). Some of these paraprofessionals have been employed in mental health facilities upon reaching the United States. Mental health personnel may work for one of several refugee camp agencies. Although a spirit of cooperation is invariably present, each mental health provider answers to his or her respective agency; there is seldom a person with overall supervisory or managerial authority for development and operation of a mental health program. This may pose serious problems in service delivery because of lack of leadership, fragmentation, and poor coordination. In other camps, providers from more than one agency may be pooled to a single agency (as in the camp on Pulau Bidong, Malaysia) or a single agency may assume total responsibility for the mental health service delivery system (as in Phanat Nikhom, Thailand, or the Philippine Refugee Processing Center in Bataan). These arrangements allow for a coordinated and directed effort (Cravens & Luoto, 1989; Culp & Cravens, 1988).

Because of the fragmented and limited mental health staff resources, it is vital that the refugee camp population be identified and divided into priority groups (i.e., those judged to be most at-risk, such as victims of violence, unaccompanied minors, single young women and men, and elderly persons). When decompensation occurs, the person is given immediate attention to the extent possible. More recently, two new at-risk groups are being seen: Amerasians (Amerasian Homecoming Act, 1987) and re-education camp detainees (political prisoners).

Mental health services are provided in refugee camps in a variety of work settings that range from the most primitive (outside without benefit of an office or private space as in some camps in Hong Kong) to quite attractive space that meets Western criteria (as in Bataan). In the former situation the noise level from the camp population is high, privacy is totally lacking, and the discomfort provided by the elements is disconcerting. Services in the camps generally include social history taking, limited counseling, psychotropic medication, and use of traditional healers as found in Khao I Dang and Phanat Nikhom, Thailand, and in the Philippine Refugee Processing Center (Bataan). Traditional healing includes prescribed rituals, incantations, steam baths, massage, herbs, and other organic materials that are used with apparent effectiveness. In addition, a great variety of group activities led by a mental health provider or indigenous paraprofessional are used extensively. Group psychotherapy, as known in the United States, is a rarity. Group work focuses on immediate problem solving, developing English language skills, anticipating the assimilation process, understanding Western gender roles, parenting, learning to recognize stress, and accessing the Western mental health system. The focus is on the present, on problem-solving and coping skills, strategies that are foreign to many Southeast Asians.

Medication compliance is achieved by a professional observing the individual at the clinic or by an indigenous paraprofessional monitoring patients in the camp. Inpatient service is provided in a primitive structure set aside and staffed on a 24-hour basis by an indigenous nonprofessional. In some cases, such as in Hong Kong or Bangkok, access to a psychiatric hospital in a metropolitan area is possible but not routine. In all cases, the goal of the provider is either to serve the priority groups and bring about symptom relief or to stabilize the person for a period of one year in order to meet the U.S. waiver requirements and enable the individual to resettle.

Although situations vary from camp to camp, a number of consistent problems are found in refugee camp mental health services. These include frequent worker turnover, fragmentation of services, lack of on-site leadership, language barriers, poor working conditions, isolation (camps are typically a great distance from population centers), staff burnout, an unending high demand for service, and huge case loads. Perhaps the most unfortunate problem is that after entry into the United States there is no mechanism for individual follow-up of refugees (for either clinical or research purposes) who have received mental health services in an overseas camp.

**Services in the United States**

Although the services available prior to resettlement are far from ideal, many refugees encounter difficulty obtaining services after resettlement. The delivery of mental health services to refugees in the United States is a process troubled by difficulties unimagined by U.S. clinicians working with other populations.

The vast majority of refugees seeking mental health services in the United States encounter barriers that preclude easy access to such services. A 1987 survey of services accessible to Southeast Asian refugees in California revealed surprising gaps in service delivery, even in areas with relatively large refugee populations (Gong-Guy, 1987). Only the two largest counties in the state included programs covering the full range of mental health services, including inpatient, residential and day treatment, outpatient, and outreach services. Existing outpatient services were characterized by long delays (3 to 12 months for some refugee groups) and by availability of services only through interpreters. A severe shortage of adequately trained bilingual–bicultural mental health personnel was apparent throughout the state, and cross-cultural training for others serving refugees was virtually nonexistent. The shortcomings of the mental health service delivery system

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for refugees were particularly striking considering the size of the refugee population (then approaching 300,000) and the estimated risk within this population. Although California’s refugee population is the largest, compared with other states, the shortage of accessible mental health services for refugees is mirrored throughout the nation.

Because access to language-appropriate inpatient psychiatric care is particularly limited, refugees often receive treatment at inappropriate levels within the mental health system. In California counties in which no inpatient facilities are available for specifically treating refugees, clinics treat these severely disturbed individuals in outpatient settings rather than send them to sit unattended for days or weeks in inpatient facilities without access to interpreters or culturally appropriate treatments. In locations in which only outreach services are available, potential consequences are even more serious.

Given the absence of specially targeted programs, refugees in need of mental health care must depend on the existing service delivery system. Unfortunately, most adult refugees are precluded from using these services because of their lack of English fluency, which compounds other problems typically associated with accessing public services. Simple transactions such as using public transportation may require interpretation services that are rarely available. These and other barriers to the use of mental health services by refugees have led to the documented underutilization of such services (Nguyen, 1985; Sue & McKinney, 1975).

One fundamental barrier is that most refugees are unfamiliar with mental health services as they exist in the United States. For example, refugees from Southeast Asian countries, if they are familiar at all with the concept of mental illness, associate mental health treatment only with severe pathology requiring permanent institutionalization. Thus, all conditions requiring mental health treatment are highly stigmatized, and interventions are shunned. Among other factors contributing to this stigma in refugees from various cultures are the beliefs (a) that mental illness is familial or heritable with serious implications for marriageability of other family members, (b) that illness in one family member is related to past family transgressions and therefore damaging to the family reputation, (c) that the identification of mental illness will lead to deportation or discontinuation of government benefits, or (d) that information will be spread throughout government agencies or within the ethnic community. These and similar beliefs described by others (e.g., Hoang & Erickson, 1985; Ishisaka, Nguyen, & Okimoto 1985; Kinzie, 1985b; K.-M. Lin, Masuda, & Tazuma, 1982; Tung, 1985; Westermeyer, 1985) represent significant barriers to refugees obtaining mental health services. Mental health intervention is seen as a desperate last resort, when family resources, traditional healers, and general medical approaches have proven ineffective (Kinzie, 1985b).

Other barriers to utilization of services by refugees are related to treatment approaches used by mainstream Western mental health care providers. The initial establishment of therapeutic goals with refugee clients can be a formidable stumbling block. Mental health practitioners attach relatively greater significance to psychological and emotional issues than do refugees. Refugees cite as their most pressing problems lack of English skills, family separation, unemployment, limited funds, lack of transportation, and insufficient child care. Depression, anxiety, and other psychological problems are either absent or mentioned less frequently (Moon & Tashima, 1982). Practitioners who focus on addressing emotional issues to the point of excluding pragmatic issues are perceived as unresponsive to the needs of the refugee, and are unlikely to be seen as a relevant resource. There is general agreement among practitioners that effective treatments for Southeast Asian refugees emphasize directive methods and concrete tasks, rather than focus on purely emotional issues (Kinzie, Tran, Breckenridge, & Bloom, 1980; Lum, 1985; Tsui & Schultz, 1985).

Clinicians working with refugees must confront the refugee’s expectations regarding the duration and nature of treatment. Clients unfamiliar with the typical course of therapeutic intervention may interpret the need for repeated visits as an indication that a treatment is ineffective. Failure to provide an explicit treatment framework, including an explanation of the need for regular visits over a specified period, often leads to premature terminations among refugee clients.

Clinicians should similarly provide an explanation of the treatment approach in general because many refugee clients who are familiar only with medical treatment will expect medication to be prescribed during their first visit. Refugees who fail to receive medication may conclude that their needs have been misunderstood or underestimated, and may seek “proper” medical treatment elsewhere (Tung, 1985). Conversely, some treatment approaches rely almost exclusively on psychotropic medications to address refugee clients’ complaints, in response to difficulties involved in conducting psychotherapy through interpreters. The limitations of this approach are well illustrated by the familiar sight of refugees appearing with dozens of bottles of unused medication in response to a clinician’s query regarding previous treatments. This practice has obvious implications for the appropriate utilization of mental health care by an entire segment of the population, and one might expect an eventual erosion of the refugee’s faith in the effectiveness of mental health treatment and potentially adverse reactions to unmonitored multiple medications. Although issues of compliance with medication regimens are prominent in clinics treating refugees (Kemp, 1985; Kinzie, 1985a), settings that provide a balance of medication and other supportive and psychotherapeutic services have reported positive results (Kinzie, 1985b; Mollica & Lavelle, 1988).

A mental health provider’s lack of knowledge or appreciation of culturally sanctioned healing practices within refugee communities can constitute another barrier to effective service delivery. Frequently, refugee clients seek mental health treatment while continuing to practice traditional folk healing at home, or in addition to seeking
advice from healers in the refugee community. Prohibiting the use of these adjunct healing practices or denigrating their value as superstitious may interfere significantly with the client's perception that the clinician is a credible healer. Anecdotal reports of clinicians supporting the use of cultural healing practices while encouraging simultaneous adherence to the clinicians' treatment plan suggest that this practice can lead to a more effective integration of mental health intervention as a valuable healing resource for refugees.

Finally, with regard to the special mental health needs of refugee children, barriers often exist because of the nature of the settings in which difficulties arise (schools, day care facilities, and recreational programs) and the lack of a mental health orientation by teachers and others. Presenting problems include a range of somatic complaints and various school problems such as learning disabilities, depression, and disruptive behavior. In these settings, non-mental-health professionals are presented with the task of helping the child improve his or her functioning without the skills to adequately assess numerous multidetermined problems. A major task for the mental health professional becomes one of determining the most effective way to provide assessment and prevention services to the greatest numbers of refugee children in the settings in which problems are first detected.

Mental health professionals from all disciplines must provide consultation to providers of children's services in public and private agencies under a primary prevention model. Williams and Berry (1991), in the preceding article in this issue, and Brunswick (1969) have identified the elements of this model. In addition, the principles and methodologies of secondary and tertiary treatment must be understood by non-mental-health professionals who are on the front lines of service delivery to refugee youth. For example, Beavers (1986) and Coppolillo (1977) have identified cross-cultural factors in the treatment of child abuse. Lee (1988) presented factors contributing to acculturative stress and related them to life-cycle patterns of adolescent Southeast Asian refugees. Langer, Gersten, and Eisenberg (1974) described specific behavioral patterns among various groups of children living in New York City. General adaptation patterns have been investigated in regard to Indochinese unaccompanied minors (Porte, 1986), Amerasians (Nicassio, LaBarbera, Coburn, & Finley, 1986), and Mariel Cuban adolescents (Rodriguez, Skotko, & Santisteban, 1985). Only with innovative, flexible consultative and training methods can comprehensive primary prevention principles be applied and the barriers between mental health technology and refugee needs be removed.

Limitations Related to Diagnostic Difficulties

The shortage of mental health practitioners available to serve refugees is partly related to the lack of expertise in cross-cultural diagnostic skills. Most clinicians are wary of attempting to assess psychiatric conditions of refugees from unfamiliar cultures, particularly where language differences prohibit direct communication with clients. Despite many similarities to the general population in the clinical picture presented by refugees, frequent misdiagnosis of pathology occurs with refugees. Disorders occurring more frequently among refugees are particularly problematic for practitioners who are unfamiliar with these populations.

Somatic complaints are among the refugee's most frequent presenting problems (E. H. Lin, Carter, & Kleinman, 1985; K.-M. Lin, 1986). Although somatic complaints are more likely for refugees as a consequence of battle, torture, deprivation, or disease associated with the various phases of the refugee experience (Westermeyer, 1986), refugees are typically referred for mental health services by primary care clinics at which medical interventions were deemed inappropriate following extensive evaluations. Somatic presenting complaints only occasionally suggest somatization disorder among refugees, as this diagnosis and hypochondriasis are not frequent among refugees (Garcia-Peltoniemi, 1987). Anecdotal reports of apparent conversion disorders among Cambodian refugees complaining of impaired vision have recently received increasing attention.

Despite their initial focus on physical complaints, most refugee clients readily endorse psychological symptoms when asked (Mollica & Lavelle, 1988), and their initial somatic complaints typically dissipate as they respond to psychiatric treatment (Westermeyer, 1986). The tendency to focus on physical complaints may be related to their traditional backgrounds that discourage the direct expression of feelings, or to traditional holistic views of body and mind (K.-M. Lin, 1986). Refugees experiencing significant psychological distress may lack the direct communication skills necessary to convey these emotions, or may be limited by the use of interpreters with insufficient training. For depression in particular, Mollica and Lavelle reported that refugees presenting with somatic complaints, although acknowledging psychological symptoms, viewed only their somatic complaints as warranting medical attention. Somatic complaints should more generally alert the clinician to a diagnosis of depression, in view of the prevalence of prolonged, debilitating depressive disorders among refugees (Kinzie et al., 1982; Westermeyer, 1986).

Diagnostically misleading suspiciousness and paranoia are prominent across diagnostic groups within most refugee populations (Jack, Nicassio, & West, 1984; K.-M. Lin, Inui, Kleinman, & Womack, 1982; Pederson, 1949; Tyhurst, 1951). Although schizophrenic disorders occur with greater frequency among refugee groups compared with nonrefugee groups (Krupinski, Stoller, & Wallace, 1973), their prevalence is actually quite low. Brief reactive psychoses, particularly those characterized by paranoid reactions and hysterical psychosis, occur with far greater frequency than schizophrenic disorder within refugee groups (K.-M. Lin, 1986). In fact, refugees may remain at heightened risk for paranoid disorders many years following resettlement because of social and linguistic isolation (Hitch & Rack, 1980). However, because of the difficult process of collecting histories through an
interpreter, psychotic and paranoid symptoms are often misdiagnosed as schizophrenia.

Similarly, flashbacks, hallucinations, and dissociative phenomena typical of posttraumatic stress disorders (PTSD) are erroneously interpreted as symptoms of schizophrenia, despite the obvious traumatic histories of many refugees. Both PTSD and isolated symptoms of the disorder, such as recurrent traumatic nightmares, are prevalent among refugees (Eitingon, 1960; Krupinski et al., 1973; Mezey, 1960; Pederson, 1949; Tyhurst, 1977). Clinics providing mental health treatment to refugees report PTSD and associated symptoms lasting many years, although not necessarily accompanied by continuous psychosocial dysfunction (Kinzie, Sack, Angell, Manson, & Rath, 1986; Molica & Lavelle, 1988). Frequently, PTSD accompanies major depressive disorder, a combination suggesting a more serious clinical picture and less favorable outcomes than either disorder occurring alone (Garcia-Peltoniemi, 1987).

Evaluating for organic impairment is another area of confusion among practitioners assessing refugees. The process of determining past and current functional abilities is impeded by the lack of adequately translated, standardized, and normed psychological and neuropsychological tests (Williams & Westermeyer, 1983). Many clinicians who are unfamiliar with the principles of cross-cultural assessment nonetheless attempt to perform psychological testing with refugees. Interpreters are often asked to interpret materials that have been rigorously standardized in English only, a process that can effectively invalidate results. Butcher (1987) has provided general guidelines for the use of psychological tests with refugees, including an annotated listing of assessment instruments available in different languages. Preliminary educational norms for Southeast Asian children and adolescents (Irwin & Madden, 1986) are also useful, although similar norms remain largely unavailable for Southeast Asian adults and refugees of other cultures. Viewing the difficulties of diagnostic assessment in refugee populations, it is not surprising that many clinicians avoid working with these populations.

Administrative Difficulties Impeding Service Delivery

The delivery of mental health services to refugee communities is directly affected by staffing limitations that can compromise standards of mental health care. Mental health agencies search for clinicians with bilingual-bicultural skills because most adult and family services must be provided in languages other than English, but the number of licensed clinicians is extremely limited or virtually nonexistent in some refugee groups. A survey of licensed mental health professionals serving Southeast Asian refugees in public settings in California identified only 18; all were Vietnamese (10 psychiatrists and 8 social workers). The study was unable to locate any professionally trained Cambodians, Laotians, Hmong, or Mien (Gong-Guy, 1987). This shortage is reflected in other refugee groups.

Because of the shortage of bilingual-bicultural professionals, most mental health agencies rely on the use of interpreters and paraprofessionals for direct delivery of services. Unfortunately, trained mental health interpreters for refugee populations are even more uncommon than licensed refugee professionals, and the vast majority of interpreters used in mental health have no formal training (Egli, 1987). Moreover, mainstream clinicians rarely receive training on the clinical use of interpreters. Arrangements for interpretation are often made casually, and clinics frequently rely on family members or individuals from the refugee community who have no training in either interpretation or mental health concepts and terminology. Interpretation skills are trivialized and undervalued in many clinical settings, as illustrated by the reports of clerical staff or janitors being asked to interpret during psychiatric evaluations (Marcos, 1979; Westermeyer, 1987). Interpretive distortions occurring in the clinical setting can seriously undermine the clinician's attempts to diagnose and treat refugee clients (Marcos, 1979; Sabin, 1975; Westermeyer, 1987; Williams, 1985). Such distortions arise for a variety of reasons: deficient language skills of the interpreter, lack of psychiatric sophistication, interpreters' attitudes toward either patient or clinician, or attempts by interpreters to deny or make sense of blatantly psychotic or culturally unacceptable material (Marcos, 1979; Price, 1975). When family members or friends are asked to provide interpretation, pathology may be minimized or exaggerated, depending on the interpreter's agenda. Although problems of interpreter distortion may be reduced with appropriate instructions and thorough preinterview briefing (Marcos, 1979; Westermeyer, 1987; Williams, 1985), the clinician working with a casual, untrained, nonprofessional interpreter cannot be assured that the client's confidentiality will be honored, that linguistic skill deficits will not substantially alter the messages to be conveyed, or that the interpreter will not convey his or her own reactions to material to the client in order to "manage" the interview.

Rather than depending on casual contacts with untrained interpreters from the community, many settings employ bilingual-bicultural paraprofessionals (typically also refugees). Paraprofessionals fulfill multiple role demands, including interpreter, translator, counselor, case worker, culture broker, outreach worker, and community advocate (Egli, 1987). These individuals usually receive minimal training to provide needed services, which typically consist of occasional in-service training provided by nonrefugee staff and on-the-job case supervision. Most agencies delivering services to refugees have limited budgets and are unable to financially support additional educational activities. In California, a series of state-sponsored, federally-funded training conferences and workshops in 1987 and 1988 were heavily attended by refugee mental health paraprofessionals, virtually all of whom stated that this was their first exposure to an organized refugee mental health training experience.

Paraprofessionals often serve as the refugee client's only direct contact with the mental health system, despite
the lack of mental health training. These positions are particularly challenging because of the nature and severity of refugee clients’ clinical diagnoses and the complexity of their psychosocial and financial problems. In fact, paraprofessional care may be inappropriate for most severely disturbed refugee clients. Studies focusing on paraprofessional services have suggested only that paraprofessionals can perform effective counseling with non-professionals, although perhaps initially gratifying for them, can also overwhelm them as their responsibilities exceed their expertise.

Because most paraprofessionals are also refugees exposed to war-related trauma, overidentification with clients is common. Paraprofessionals’ reactions to feelings evoked by clients’ recollections of trauma can range from being reluctant to encourage clients to discuss traumatic material to experiencing a resurgence of posttraumatic stress syndrome symptoms associated with their own past traumas (Kinzie, 1985b). These individuals are likely to experience burnout at higher rates than others within the mental health system, because their mobility within the system is limited by their paraprofessional status and inability to serve nonrefugee clients. A number of agencies have attempted to address this problem with additional supervisory and group support for bilingual paraprofessionals, although the results of these efforts have not been evaluated.

Despite these many difficulties, a number of mental health agencies are providing effective services to refugees. Outpatient mental health clinics have been incorporated into broad-based community agencies that offer a variety of educational, primary prevention, or case management programs (Lum, 1985) that allow refugees to avoid some of the stigma attached to mental health clinics. Innovative prevention and outreach services are prominent in many effective treatment programs to diminish resistance to mental health interventions, although permanent funding for such services is rare. One pilot health and mental health promotion program in Fresno, California, presented refugees with relevant health education topics with refugee staff who were trained and supervised by a psychiatric nurse with cross-cultural training. As successful referrals into the mental health system increased, permanent refugee mental health staff positions were created. To reduce the stigma associated with psychiatric services, several clinics in California and Minnesota have incorporated culturally appropriate services such as acupuncture. One California community mental health clinic treating large numbers of Cambodian refugees employs a Buddhist monk, who has now received formal social work training. And finally, in an effort to increase the expertise of mainstream mental health providers, the California Department of Mental Health sponsored a mobile treatment and clinical consultation team that provided on-site services to remote counties.

The problems with mental health service delivery to refugees will remain a challenge for the foreseeable future, as the number and diversity of refugees entering the United States continues to grow. We hope, however, that the barriers experienced by the current generation of clinicians treating refugees both here and in the refugee camps will not be encountered in treating successive generations of refugees.

REFERENCES


