GLOBAL JOURNAL OF
Community Psychology Practice
PROMOTING COMMUNITY PRACTICE FOR SOCIAL BENEFIT

"There was a need in the community": Practitioners' Motivations to Providing Mental Health Services to Forced Migrants

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Keywords*:* forced migrants, refugees, asylees, mental health practitioners, training.

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Colonel in the Air Force Reserves and is the Equal Opportunity Director for the 477th Fighter Group at Joint Base, Elmendorf-Richardson. Liz joined the Center for Alaska Native Health Research and helped establish the Military Health and Readiness Consortium to further understand and address suicide among military service members in Alaska and beyond. Her role at CANHR is to help the consortium develop, implement, and assess an effective suicide prevention program for service members assigned to rural and remote areas. Currently, the consortium is partnering with members of the Alaska Defense Community to develop pilot interventions for leadership to take a primary prevention approach to reduce suicide risk and other harmful behaviors while increasing the unit's ability to perform their primary mission. In addition to her role with the MiHRC, she is in her 4th year of the Clinical Psychology Doctoral Program at Fielding Graduate University. Additionally, she is a Behavioral Health Consultant at Southcentral Foundation where her team integrates culturally congruent behavioral health into primary care, ensuring that customer-owners receive comprehensive care that addresses their mental, physical, emotional and spiritual needs. Liz is grateful to live in Eagle River, Alaska with her husband, Will, and their three daughters. *Samantha Uehlin,* MA, is a Licensed Professional Counselor currently practicing at a group practice in Portland, Oregon. She holds a Master's degree in Clinical Psychology from the University of Alaska Anchorage (UAA). Samantha has three years of experience working in a rural Alaskan community, where she developed a strong understanding of diverse mental health needs. In her current role, she serves a broad range of community members, including first and second generation immigrants, with a focus on providing culturally sensitive and inclusive care. Samantha is dedicated to fostering a welcoming environment for her clients and is passionate about addressing the unique challenges faced by marginalized communities. She is honored to live and work on the ancestral lands of the Multnomah, Wasco, Cowlitz, Kathlamet, Clackamas, Bands of Chinook, Tualatin Kalapuya, and Molalla tribes. Outside of her professional pursuits, Samantha enjoys reading and exploring the beautiful landscapes of the Pacific

Northwest with her two dogs. *Summer Hunt,* is a zealous and passionate provider with over five years of experience providing community mental health services. Currently serving as a Training and Development Specialist at the Arizona Department of Economic Security, Summer crafts and presents a comprehensive training curriculum to enhance employee skills and maximize performance initiatives. Throughout her career, she has specialized in providing comprehensive services in various healthcare settings. Conducting clinical assessments, developing individualized treatment plans, creating informative presentations at conferences, and facilitating therapeutic groups are some services Summer has mastered. Her expertise includes serving diverse populations and collaborating with multidisciplinary teams to ensure the implementation of holistic client-centered care in every setting. As a Research Assistant with Working Alongside Refugees in Mental Health (WARM) at the University of Alaska Anchorage (UAA), Summer contributed to the mission of investigating forced migrants' access to mental health resources and barriers providers face in serving this population. She continues to prioritize her commitment to mental health advocacy by spending her free time volunteering as a Lead Presenter for the Ending the Silence program at the National Alliance on Mental Illness (NAMI.) There, she delivers evidence-based presentations addressing mental health stigma to middle and high school students. Summer has a Bachelor of Science degree in Psychology from UAA, where she was recognized on both the Chancellor's and Dean's lists. Outside of her professional endeavors, she enjoys practicing yoga with her cats and cooking Korean American fusion cuisine with her partner. *Sara Buckingham*, PhD, is an Associate Professor of Psychology and co-director of the Center for Community Engagement and Learning at the University of Alaska Anchorage (UAA), which facilitates community-engaged research, creative activities, teaching, and service through reciprocal partnerships between the university and the communities in which it is embedded. She is core faculty in a Clinical-Community Psychology PhD Program, where she teaches, mentors students, and leads the Crossroads Research Collective, a community-engaged research-action team that

partners with communities to answer critical questions of interest to them to catalyze action. Broadly, our work centers on how communities and their members shape acculturation, resilience, sense of community, and well-being among newcomer and Indigenous community members. Sara is a Licensed Psychologist and has a small private practice through which she provides culturally responsive assessment and intervention services for forced migrant community members, including asylum-seekers and refugees. Nationally, she serves as the Representative of the Society for Community Research and Action to the legislative body of the American Psychological Association and is the Early Career Psychologist on its Council Leadership Team. Sara also serves on the Board of Directors of the Global Alliance for Behavioral Health and Social Justice. Sara is thankful to live on Dena'ina lands in Alaska and when not working, she can most often be found outside playing in the mountains with her husband and dogs.

Recommended Citation: Snyder, J. D., Mangini, E., Uehlin, S., Hunt, S., & Buckingham, S. L. (2025). "There was a need in the community": Practitioners' Motivations to Providing Mental Health Services to Forced Migrants. *Global Journal of Community Psychology Practice, 16(*1), 1 - 21. Retrieved Day/Month/Year, from (https://www.gjcpp.org/).

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Global Journal of Community Psychology Practice

Volume 16, Issue 1 May 2025

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Abstract

Millions of individuals around the globe have been displaced from their countries due to disasters, including persecution, war, disease, famine, and weather events. Many forced migrants (FMs) experience mental health concerns that warrant treatment but often face significant barriers to care, including a limited pool of mental health practitioners (MHPs) who are competent, willing, and able to serve them. In Alaska, the Working Alongside Refugees in Mental Health (WARM) program was developed to address this need. After conducting the first WARM workshop, our team sought to understand how MHPs in Alaska are recruited and retained in working with forced migrants to further develop and maintain our program. We examined MHPs' motivations to work with FMs through 13 qualitative semi-structured interviews with MHPs who engage in such work. Experiences with FMs and awareness of FMs in their communities, competence, and connections with other practitioners increased MHPs' motivation and led to service delivery. Community psychology is well positioned to enhance services for FMs through both practitioner-level interventions and systemic interventions. Strategies for increasing and sustaining MHPs' motivations to work with FMs include: forming connections with other MHPs and trusted individuals and organizations, increasing competence to work with FMs via specialized training networks, integrating experiences working with FMs into training programs, and engaging in advocacy to address systems-level barriers to care.

In 2018, a group of researchers, students, and practitioners came together to form Working Alongside Refugees in Mental Health (WARM). Via an innovative practitioner network, WARM seeks to increase the availability of linguistically appropriate, culturally sensitive, and evidence-based mental healthcare for forced migrants across the state of Alaska (Snyder et al., 2019). WARM began through a community-academic partnership between Refugee Assistance and Immigration Services (RAIS) and the University of Alaska Anchorage. While forced migration had been continuously growing in Alaska for decades and is associated with a myriad of mental health ramifications (Alaska Office for Refugees, 2024; Blackmore et al., 2020), there was a dearth of quality mental health services for forced migrants (FMs; Robinson, 2015). Mental health practitioners (MHPs) in the area had previously reported not feeling competent and confident in their ability to serve FMs (Robinson, 2015).

Forced Migration and Mental Health

FMs are people who have been forced to flee their countries due to human-caused and natural disasters (United Nations High Commissioner for Refugees [UNHCR], 2021). In 2020, approximately 34.4 million people were externally displaced from their countries. Among these, 26.4 million were refugees while another 4.1 million are

asylum-seekers (UNHCR, 2021). Often, war is a cause of forced migration. Since February 2022, over 6 million individuals have fled Ukraine to other places in Europe, some of whom who have been admitted to the United States (U.S.; UNHCR, 2022). Since 1980, the U.S. has resettled between 11,411 and 207,116 refugees each year and has received hundreds of thousands of applications for asylum (UNHCR, 2021).

FMs are exposed to many stressors before, during, and after migration, including war, persecution, lack of basic necessities, daily stressors, and post-migration living challenges (Bogic et al., 2015; Chen et al., 2017; Li et al., 2016). FMs also demonstrate considerable resilience, often rooted in cultural assets (e.g., religious beliefs and practices, traditional food and medicine, and sharing and interconnectedness; Lightfoot et al., 2016). However, the stressors FMs face are related to higher rates of adverse mental health outcomes, including posttraumatic stress, depression, anxiety, and somatic disorders (Blackmore et al., 2020; Bogic et al., 2015; Chen et al., 2017; Li et al., 2016). To address these mental health needs, FMs need access to high quality evidence-based mental healthcare.

Despite the need for mental healthcare, FMs face many barriers to quality care, including practical, structural, cultural, social, linguistic, and psychological barriers (Asgary & Segar, 2011; Bartolomei et al., 2016; Byrow et al., 2020; Colucci et al., 2015; Priebe et al., 2011; Sandhu et al., 2013; Satinsky et al., 2019). Two of the more common barriers to quality mental healthcare include language barriers (e.g., MHPs don't speak language of FM or there are not adequate interpretation services available; Asgary & Segar, 2011; Byrow et al., 2020; Colucci et al., 2015; Sandhu et al., 2013) and cultural barriers (e.g., MHPs don't understand cultural background of FM, different views of mental health due to culture; Asgary & Segar, 2011; Byrow et al., 2020; Colucci et al., 2015; Sandhu et al., 2013). Additionally, MHPs also report significant barriers to *providing* services, such as administrative, agency, and personal difficulties, along with limited training and supervision (Colucci et al., 2015). Likely as a result of these barriers, far too few MHPs provide mental healthcare to FMs around the United States, including in Alaska (American Psychological Association, 2010; Robinson, 2015). To increase the availability of culturally congruent, linguistically appropriate, and evidence-based mental healthcare to FMs, WARM was developed, modeled after a number of referral networks that serve FMs across the United States (e.g., Intercultural Counseling Connection). In its first iteration, WARM consisted of psychoeducation and skill-building workshops (e.g., understanding the resettlement process, working with interpreters, fundamentals of mental healthcare with FMs), practical resources (e.g., funding for interpretation services), and psychosocial and community supports for MHPs (e.g., a practitioner network).

Forced Migration in Alaska

Alaska presents a unique context for mental healthcare due to its large land mass, few urban centers, and many remote rural communities that can only be accessed by air or boat. MHPs are often located in urban centers, although some travel to rural communities to provide services. The experiences of Alaska's FM population are likely unique, as – at the time this project was developed – the state's sole refugee resettlement agency was located in Anchorage, the largest city (population of roughly 300,000), but resettled refugees all over the state, including in smaller rural

communities. With the war in Ukraine and uptick in populations served by the federal refugee public-private partnership, refugee resettlement in Alaska has since grown.

In its first 20 years, Catholic Social Services Refugee Assistance and Immigration Services (RAIS), had resettled over 1,400 refugees to Alaska from over 18 countries (Refugee Processing Center, 2022). Moreover, people have fled their countries, often but not always from Mexico and Central America, to seek asylum in Alaska. Approximately 7.8% of the Alaska residents were born in another country, and many meet the definition of FMs (United States Census Bureau, 2021). In 2015, community-based researchers partnered with RAIS and conducted a needs assessment with informants from community-based organizations and refugees (Robinson, 2015). Robinson (2015) identified specific barriers to mental health care in Alaska included MHPs lack of training to work with refugees, to work cross-culturally, and to work with interpreters.

Building from a foundation of community partnership and empowering settings (Dalton & Wolfe, 2012), the WARM project sought to support MHPs in their work with FMs. Specifically, we developed and implemented programming (e.g., workshops) and practical and psychosocial resources (e.g., interpretation services, a practitioner network) to increase the availability of culturally congruent, linguistically appropriate, and evidenced based mental health care for FMs in Alaska. A 'foundations' workshop covering the fundamentals of the refugee process (and the process as it pertains to Alaska) as well as fundamentals of mental healthcare for refugees was held in January 2019, with MHPs from all over the state in attendance. Attendees ranged from graduate students to seasoned professionals across fields, including psychology, counseling, and social work. After this first workshop, MHPs reported more competence, interest, and confidence in working with forced migrants (Snyder et al., 2019). Despite these positive outcomes, we did not know how MHPs were recruited and retained in working with forced migrants in spite of the barriers they faced. Previous literature reported many possible motivating factors for MHPs working with forced migrants. Some studies had noted that *personal experiences* with migration and/or FMs are important motivating influences for MHPs work (Baranowski et al., 2018; Baranowski & Smith, 2018; Mishori et al., 2016; Schonholz et al., 2020). *Personal motivations*, include interactions that are personally meaningful (Mishori et al., 2016), inspiring (Schonholz et al., 2020), or value- consistent, also appeared to sustain MHPs' work (Baranowski et al., 2018). Finally, past studies illustrated that MHPs also report doing this work due to *prosocial motivations,* including wanting to serve victims of human rights abuses (Baranowski et al., 2018) or a duty to serve others (Mishori et al., 2016; Schonholz et al., 2020). U.S.-based work has focused on students (Dussán et al., 2009; Schonholz et al., 2020), or practitioners providing evaluations to asylum seekers (Baranowski et al., 2018; Mishori et al., 2016) and undocumented immigrants (Baranowski & Smith, 2018). As such, we sought to understand how MHPs in Alaska were recruited and retained in working with FMs to inform how we could best develop and sustain WARM.

Current Study

To better understand how MHPs are recruited and retained in this work, this study sought to understand MHPs'

motivations to work with FMs in Alaska. Alaska-based MHPs likely have distinct experiences compared to those in other states and countries, given that the U.S. does not have a national healthcare system, many MHPs deliver services through private practices, and the geography of Alaska (i.e., most MHPs are in urban centers while FMs can be found throughout Alaska, including in smaller rural communities; Hamp et al., 2016). Our qualitative study sought to answer the question: *What motivates MHPs to initially seek to provide mental healthcare to FMs and what sustains them in this work?*

Method

An email invitation was sent to mental health listservs in Alaska asking for interested individuals to contact the first author. To participate in this study, MHPs needed to meet the following inclusion criteria: 1) self-identify as an MHP, 2) be over age 18, 3) be proficient in English, and 4) have experience providing mental healthcare to at least one FM. Thirteen MHPs participated (see Table 1). Of these, 77% (*n*=10) were female, 77% (*n*=10) were White, and 92% (*n*= 12) had a least a master's degree. Only 58% (*n*=7) of participants disclosed their age; of these, the average age was 36.1 years (*SD* = 7.5 years). MHPs reported serving between one and over 200 FMs throughout their careers; the median number of refugees served by MHPs was 40. The semi-structured interviews each lasted 25 to 40 minutes (*M* = 34.62 minutes, *SD* =7.78 minutes) and were completed during June and July of 2019 via Zoom. Interviewers obtained informed consent, discussed incentives (a $25 gift card), and answered questions MHPs had before beginning the interview. MHPs chose pseudonyms for confidentiality. Interviews were audio recorded, transcribed verbatim, and checked for accuracy. Identifying information was removed. This study was deemed exempt from review by the University of Alaska Anchorage Institutional Review Board.

Table 1
Demographic Characteristics (N = 13)

	n (%)
Gender Identity	
Female	10 (76.9%)
Male	3 (23.1%)
Race and/or Ethnicity	
White	10 (76.9%)
Asian/Asian American	1 (7.7%)
Latinx	1 (7.7%)
Mixed Ethnicity	1 (7.7%)
Highest Level of Education Attained	
PhD/PsyD	5 (38.5%)
MA/MS/MFT/MSW	7 (53.8%)
BA/BS/BSW	1 (7.7%)
Occupation	
Psychologist	5 (38.5%)
Therapist	5 (38.5%)
Student	3 (23.1%)

Measure

An interview guide consisting of open-ended questions about MHPs' experiences providing mental health services to FMs was developed by the research team and guided the interviews. Topics included how MHPs had worked with FMs in the past, challenges and successes they experienced in the work, and what practitioners would like from future WARM trainings. For example, MHPs were asked, "What interests you in working clinically with FMs, like refugees, asylees,

and asylum-seekers?" The semi-structured protocol allowed interviewers to ask clarifying questions, probe for more information, and follow up on emerging patterns from previous interviews. Member-checking was conducted during the interviews, with the interviewer stating back what they understood for confirmation or clarification. Participants were asked direct questions about their demographic characteristics at the end of the interview.

Analysis

Data were analyzed via team-based thematic analysis with an inductive research strategy in which themes were identified, analyzed, organized, described, and reported from the data without a priori hypotheses about what may be discovered (Braun & Clarke, 2006; Brodsky et al., 2016; Nowell et al., 2017). The research team conducted open coding to generate thematic categories from the data. Consensus on codes and definitions was built through a team approach and a codebook was generated with names of codes, definitions, and examples of code application. The resulting framework was applied to all transcripts, with focused coding completed by the first and second author independently for each transcript. The last author then reviewed and compared independent coding and determined the appropriate code(s) based on the codebook and in consultation with the coders in the few cases in which coding diverged (Brodsky et al., 2016). Once all transcripts were coded, the research team analyzed the codes to begin to develop themes according to patterns that arose from the data. After broad themes were developed from the data by consensus from the full research team, they were expounded upon by members of the research team through continued analysis of the relevant coded transcripts. Saturation was determined by no new codes arising and when interviews did not extend, modify, or generate new findings. Saturation was reached at the ninth interview and themes were robust across interviews (see Table 2).

Results

Despite barriers they faced to providing quality services and engaging FM clients in treatment, all MHPs described strong motivations to serve FMs. MHPs highlighted the importance of experiences in cultivating awareness of FMs, their needs, and barriers they faced to mental health care as well as knowledge of evidenced-based treatment care healthcare systems. These, in turn, cultivated extrinsic, prosocial, and intrinsic motivations, which appeared to facilitate MHPs' actions to serve FMs. MHPs highlighted the mutual influence of connections with other MHPs and people across disciplines on their experiences as well as on their awareness and knowledge. Finally, their narratives revealed that the more experience they had working with FMs, the more awareness, competence, and motivation they developed. We discuss these themes below.

Table 2
Themes, Subthemes, and Cases

Theme	Subtheme	Cases (N=13)
Connections		**9**
	With other MHPs who serve FMs	9
Experiences		**13**
	Formal training	8
	Community experiences	5
	Lived experiences	3
Awareness		**13**
	of barriers to mental health care for FMs	13

of FM population in community	8
of mental health care needs of FMs	10
Motivations	**13**
Intrinsic	7
Extrinsic	5
Prosocial	8
Competence	**13**
Synchronous education opportunities and trainings	13
Asynchronous knowledge resources	7
Practical experience providing mental health services	13
Supervision	6

Connections

Connections with other MHPs, healthcare professionals, and people in other fields were often explained as the primary context for developing and sustaining motivations to serve FMs. Jenny[3] described how connections with other practitioners led her to experiences and a burgeoning awareness of FMs in her community:

> *"The director of the [refugee resettlement program] ... came into one of my psychology groups and I was just like 'oh, wow,' like, I didn't even realize [refugees] were here. ... [She said] they could use volunteers, so I actually ended up going and volunteering."*

Catherine noted that one such connection drew out her motivation for working with refugees:

> *"About 3 or 4 years into that position [a school counselor], the district created ... a position for a refugee liaison for the school district to work with the resettlement agency... I worked really closely with the former refugee liaison and just got to know the refugee families and so then three years ago when she retired I came into that position."*

A therapist, Alias, described how connections to other MHPs provided a collaborative context that helped MHPs sustain their motivation and resulted in better care for FMs:

> *"[New MHP] is here now and she speaks Spanish, which is just a godsend. But in the past, it wasn't like I could refer to someone else to do the therapy [when I was conducting a psychological evaluation for asylum]. And, that's just a huge shift. It's just great to be able to work with [a client] who is seeing a therapist, so you know [mental health treatment] has been taken care of. You are just having a forensic role."*

Building the connections amongst MHPs not only helped serve FMs more effectively, but also helped MHPs develop awareness and address barriers, as Abby noted:

> *"No one person necessarily holds all the answers. So, I think creating a community ... that can come together and really think about and try to solve some of these issues. ... I am so glad people in our community are curious about [improving mental healthcare access for FMs] and*

[3] This and all names as pseudonyms chosen by the MHPs.

> *working on that and trying to address that need."*

Connections not only often provided MHPs their first experiences with FMs that cultivated their awareness and developed their competence, but also developed and helped sustain their motivation to provide mental health services to FMs.

Experiences

MHPs reported a variety of experiences – formal training, community experiences, and shared life experiences – that contributed to them coming to work with FMs. *Formal training* often served as an entry into working with FMs, as Christine explained, "When I was doing my initial practicum in my program through the university setting, I had the opportunity to work with a refugee family." Such training served as a way to build knowledge and skills for those who were previously interested, as Abby illustrated, "I didn't work with FMs before internship [where I served FMs]. I had interest in working with refugees before coming to Alaska because of everything that was going on in the world." Experiences did not have to be directly related to mental health to foster awareness and motivation; rather, they extended to other *community experiences*. Some MHPs, such as Jenny, worked with FMs in community settings, which fostered motivation to serve FMs as MHPs: "I volunteered [with FMs] so you know, help teach English, and job readiness skills." Other MHPs noted that some type of *lived experience*, be it their own or in their family's history, contributed to their desire to work with FMs. Alias explained, "My parents were FMs, post-World War II. So, that's probably where it starts, where my interest starts, my draw to that particular population." Mickey's shared experiences developed his awareness: "Being [an] immigrant…when I came to United States about 10 years ago, I faced similar challenging when I was trying to assimilate to the American culture."

Awareness

The variety of experiences led to an increased awareness of the presence of FMs in their communities as well as a realization of the barriers to mental healthcare they face. Jenny came to understand barriers to healthcare access through her volunteering:

> *"I was just like calling agencies to ask about [if] they took Medicaid. … to see if they provided interpretation … and there was just not much going on out there. … It was just kind of an experience where I was like holy cow, there is so limited access, like this is a group that could be helped."*

Ultimately, for Jenny this resulted in increased exposure and developing further awareness, "The more … you work with that population, I feel like for me at least, the more you wanted to work with them and help. … There just seemed like there was a need in the community." Developing awareness of the population and needs was a driving force behind MHPs' motivation to serve FMs, such as Christine, "We have a large need for … [working with FMs]. … We are one of the few main resettlement sites. … We have a very diverse population here."

Motivations

MHPs described several types of motivations – intrinsic, extrinsic, and prosocial – that drove them to serve FMs. R explained her *intrinsic motivation*, "[It] made me feel pretty fulfilled. I thought that I was doing a pretty good service to someone

that was going through such a cultural shock, and a lot of other things." Abby similarly commented that she gets personal satisfaction from this work:

> *"I really enjoy this kind of work and I feel like it really resonates with me and my values. It can take a lot of energy, it can take using different parts of your brain, or different cognitive skills. I think that it is really important, and it is work that I definitely enjoy."*

MHPs also reported providing mental healthcare due to *extrinsic motivations*, often related to training requirements. Many students are required to participate in training experiences, and may often see FMs clients through these experiences, as Jenny noted, "When I was [in graduate school] as a masters level student in their clinic, I saw a Congolese refugee there." Supervisors provided a key role in MHPs' extrinsic motivation. R shared:

> *"[My supervisor] was able to help me with just how uncomfortable I was with the interpreter being there, that phone just like sitting there. I was very … anxious the first couple of sessions. … I messed up the first couple of times and [my supervisor] was just very … understanding and really nice about it and encouraging."*

Although MHPs may have been extrinsically motivated at first, working with FMs to meet training requirements, these motivators provided experience that help develop experiences and awareness that set the stage for further motivation. Finally, *prosocial motivation* facilitated work with FMs. Jan explained, "I think it's really important that we care for people in our community and we care for this population in a very thoughtful, kind supportive manner. We work very hard to do that." A psychologist, M, noted, "I had interest in working with refugees before coming to Alaska because of everything that was going on in the world. I saw terrible things going on in the world and wanted to help in some way." In sum, diverse motivations set the stage for MHPs to become involved mental healthcare for FMs.

Competence

Motivation alone was not sufficient for MHPs to serve FMs. Building knowledge and skills helped MHPs feel better prepared to serve FMs. MHPs consistently reported that training was critical, with Christine's sentiment of, "[Serving FMs] aligns with my training," echoed by many. Mickey shared about how training affected his views: "Now, when [I work with FMs], I feel, even though I don't speak the same language, I will feel more confident to use the clinical skills that I came in with the last 10 years, to help, to do the best I can, to offer the best services [I can]." Competence could come from a variety of sources. *Resources* that promoted knowledge were helpful to many MHPs, like R:

> *"[My supervisor] sent me this one website where you could type in the name of a country and it described what was going on in the country at that certain time. … Because that is important to know what is happening there, and their families might still be there. … it is semi helpful going into it knowing what to expect when they talk about things."*

Another critical source of competence was *practical training* and *supervision*, Mickey

explained:

> *"[My supervisor] helped me to find a lot of research [that] talked about, modifying CBT approach to help with this kind of population that comes from different cultural background. As a kind of a newbie, very green in that field, that definitely helped me to be more flexible, helped me to be understand that we should not always follow strictly our DSM-IV-TR, or now the DSM-V, to diagnose their symptoms. Sometimes we need to take into effect their cultural background and how to modify the treatment approach."*

While many MHPs cited competence in knowledge and skills as leading to serving FMs, others explained that they need to further develop their competence to work with FMs. Abby explained, "I am fortunate to have good supervision support around these issues but [I] would love more training for sure." Competence development perpetual for many. Jenny remarked:

> *"I would like to [serve FMs] once I am licensed because that is an area of interest. I would like to help out the community. … But I think I would be lacking the nuts and bolts of some of that stuff. It would be really nice to have [more training]."*

Discussion

MHPs described a rich process that led to working with FMs, consisting of personal experiences that built their awareness and developed their motivations. Echoing past work on practitioners working with FMs due to personal experiences (Baranowski et al., 2018; Baranowski & Smith, 2018; Mishori et al., 2016; Schonholz et al., 2020), MHPs noted that their own experiences, personally and professionally, shaped their awareness of FMs and their unique challenges. Connections with other practitioners facilitated experiences and awareness; such connections have been found to help facilitate medical student involvement in programs that served FMs (Schonholz et al., 2020) and to help facilitate medical practitioner interest in conducting asylum evaluations (Mishori et al., 2016). This web of experiences, connections, and awareness developed motivation for serving FMs. MHPs described several motivations – intrinsic, extrinsic, and prosocial – for working with FMs consistent with extant literature (Baranowski et al., 2018; Baranowski & Smith, 2018; Mishori et al., 2016; Schonholz et al., 2020). Although MHPs may have begun working with FMs because they were required to by their settings, many reported continuing because their experiences were rewarding personally and because they were able to serve others. MHPs frequently spoke to extrinsic motivators present in training but described intrinsic and prosocial motivation sustaining their work. Connections with other practitioners served as the context in which many MHPs developed their experiences, awareness, motivations, and competence to serve FMs. These connections may serve to foster initial experiences with FMs, and they may also be critical to shift practitioners' extrinsic motivations to intrinsic motivations over time while also sustaining MHPs in their work with FM.

Despite this rich process surrounding MHPs' motivations for working with FMs, there remain considerable barriers to FMs receiving linguistically appropriate, culturally congruent, evidence-based mental healthcare. FMs may experience

barriers with individual MHPs (e.g., practitioner cultural incompetence, linguistic barriers), the healthcare system in general (e.g., cost of care, limited options due to care reimbursement, service language and interpretation), stigma, and systemic-level issues such as discrimination or social exclusion (Baranowski et al., 2018; Byrow et al., 2020). MHPs also experience limitations in their abilities to provide services to FMs due to limited training and supervision and limited time to offer reduced-fee or pro-bono care to FMs without insurance (APA, 2010; Byrow et al., 2020). While not this paper's focus, indeed, MHPs in our sample echoed these challenges; intervention in these areas is critical. Understanding MHPs' motivations, including what develops and sustains them, to work with FMs may help to address some of the disparities in FMs' mental healthcare utilization and yet larger systemic changes are likely needed to make services fully accessible.

Implications and Applications

As the competencies for community psychology practice have guided the foundation and implementation of WARM, they are well-suited to guide interventions to increase the availability and utilization of quality mental health care for forced migrants (Dalton & Wolfe, 2012). For instance, this problem is best viewed from an ecological perspective, with multiple levels of analysis (and thus intervention), including individual MHP (e.g., skills, knowledge, and attitudes) and FM levels (e.g., attitudes towards mental health care). Examples of MHP skills and knowledge include knowledge of the various migration pathways and processes, ability to work with interpreters, and skills in culturally adapting evidence-based interventions. MHPs' attitudes include their confidence in abilities to provide services to FMs while individual FM level variables could include distrust towards mental health care systems and knowledge related of mental health care. Another level could be organizational for MHPs (e.g., organizational support for working with forced migrants) and community for FMs (e.g., reception context, resources in the community). For instance, MHPs' organizations could provide requisite infrastructure for working with FMs like interpretation services and administrative support, while the community-level factors for FMs could include discrimination at the community level and availability of community-based support (e.g., school-based mental health programming for FMs). Finally, there are broader systemic issues for both MHPs and FMs which include national and state or provincial policy related to FMs and provision of mental health care (e.g., insurance reimbursement) as well as the broader systemic attitude towards FMs in the host country. Interventions should be targeted towards these multiple levels.

Findings from this study indicate particular ways in which community psychologists could intervene in their own communities to increase the amount of MHPs able and willing to work with FMs. For instance, community psychologists can work to build diverse coalitions of community members and organizations to empower them in identifying strengths and assets of their own communities (Dalton & Wolfe, 2012). Our findings indicate that connections are critical for recruiting and sustaining MHPs in work with forced migrants. Psychologists and other MHPs play vital roles in creating networks consisting of individuals and organizations across disciplines and roles. For instance, MHPs may be able to develop relationships with other professionals who work with FMs regularly (e.g., individuals working at the local refugee resettlement

agency or state refugee coordinators) to better understand the needs of FMs within their communities.

Psychologists and other MHPs seeking to promote FM mental health can start by identifying which organizations and practitioners within their communities conduct refugee health screenings, as they will find medical professionals who routinely work with FMs. These connections may also serve to develop awareness of issues for FMs and motivation for MHPs to work with FMs clinically. Providing ancillary direct services, such as helping provide transportation for FMs to their medical appointments and addressing other practical barriers to care, are vital – and yet often overlooked – ways of supporting mental health (Baranowski & Smith, 2018). Furthermore, integrating MHPs into networks that work in close collaboration with trusted organizations and individuals (e.g., cultural navigators, refugee resettlement agencies) may serve to boost FMs' trust in MHPs and provide MHPs the connections they need to develop experience and awareness (Baranowski & Smith, 2018).

These diverse coalitions could also engage in program development and resource development within their own communities (Dalton & Wolfe, 2012). For instance, coalitions could provide training programs to MHPs in their own communities (e.g., Snyder et al., 2019). These specialized networks that can provide training to MHPs would also foster connections between MHPs (Baranowski et al., 2018). These coalitions could also partner with MHP graduate training programs to provide initial experiences to more MHPs that can be mental health related (e.g., a clinical practicum) or not directly related to mental health (e.g., helping a FMs acclimate to the community), as our results suggest that motivation from a developing awareness and connections can come from a broad array of experiences (Baranowski et al., 2018; Mishori et al., 2016; Schonholz et al., 2020). For example, one program, Connecting Cultures, offers training and supervision to graduate students in psychology to help them to learn to serve refugees with evidence-based practice and culturally sensitive framework (Fondacaro & Harder, 2015). These training opportunities may also serve the training program in its ability to train a workforce that is competent to work with diverse, multicultural populations (APA, 2010).

Another way in which MHPs may foster connections is by developing ongoing consultation groups in which practitioners can connect with other practitioners, bring complex clinical cases for discussion, and receive peer consultation from practitioners (Baranowski et al., 2018). Such groups could serve to enforce skills and knowledge necessary for MHPs to provide linguistically-appropriate, culturally-congruent, and evidence-based care to FMs. Consultation groups may be especially important for MHPs practicing in isolation (i.e., private practice; Baranowski et al., 2018). Interested practitioners could start by reaching out to their professional colleagues within their community to see if they are interested in forming a group centered around FMs' mental health needs. Practicing psychologists, for example, could also contact practitioners within their state via their local State or Territorial Psychological Association. State or Territorial Psychological Associations could create FMs interest groups that seek to help that specific State or Territorial MHPs address FMs issues.

Many of these approaches may prove

especially beneficial for targeting practitioner or individual-level barriers, but barriers may remain at the organizational or systemic level (e.g., Asgary & Segar, 2011; Baranowski et al., 2018). Systemic barriers include Medicaid eligibility, language and interpretation services, mental healthcare system navigation, financial difficulties, housing issues, lack of transportation (Asgary & Segar, 2011; Baranowski et al., 2018; Baranowski & Smith, 2018; Byrow et al., 2020). All of these barriers were echoed by MHPs in this sample. Intervention at an organizational level could include encouraging public and private entities offering funding to MHPs who see clients who do not have access to insurance to defray the costs involved in providing mental healthcare (Baranowski et al., 2018). Intervening at a broader level may be critical to address these serious barriers that FMs face to care (APA, 2010). Expanding Medicaid and increasing access to affordable housing and job opportunities may all be important areas to target for FMs (Asgary & Segar, 2011). MHPs could also intervene by advocating at the local, state, and national level to influence systems and policies to enable more socially-just practices with forced migrant communities (Baranowski et al., 2018; Baranowski & Smith, 2018; Dalton & Wolfe, 2012).

Limitations

Given the methods employed, this study is not able to determine causality. The responses of MHPs may have been affected by the follow up questions, which varied based upon the specific conversation. However, through our interviews, it seemed as though MHPs were offering their honest feedback. Study personnel backgrounds may have affected data analysis, although a diverse team with unique perspectives conducted analyses to limit this. This study included both professionals and trainees who have differing levels of training. Another limitation of the study is the variability in MHPs training and experience serving FMs, as MHPs who participated had various levels of training which may have resulted in different motivations for working with FMs. MHPs self-selected to participate, and so those who participated may be especially motivated to work with FMs. Our study results may also have some limitations of application due to the uniqueness of the context of Alaska (i.e., MHPs tend to be focused in one urban setting, while FMs tend to be spread out across Alaska, including in smaller rural areas). Finally, the term "forced migrant" encompasses a wide range of cultural groups and experiences, and so future research is needed to understand barriers for specific populations.

Future Directions and Conclusion

In spite of the significant barriers practitioners face providing mental health care to FMs, practitioners make efforts to serve FM clients, citing a diverse set of reasons, motivations, and circumstances that promote and sustain their work. MHPs' experiences appear to bolster their awareness of FMs' mental health issues, which serves to increase motivation to work with FMs. Connections with other practitioners are essential to fostering these experiences and awareness. Further investigation of MHPs' motivations to work with FMs may lead to innovative techniques to continue to develop mental health practitioner networks that can work with FMs. Continued examination of the processes that contribute to motivation in real-time might be considered (e.g., following trainees in their experiences with FMs longitudinally) to examine causality and limit the influence of retrospective recall. Another potential research avenue

could be learning more from MHPs who do not currently serve FMs, and the barriers they see as preventing them from working with FMs. Understanding their perceptions of barriers could prove beneficial in developing interventions so that they work with FMs in the future. Our results are promising, as they suggest that there are diverse ways in which we can develop MHPs' motivations to work with FMs to address the dearth of mental health services for this population. Additionally, since this study focused on the perspectives of MHPs, additional research should look at what FM's perspectives on quality mental health services. Community psychology is a promising approach to address the dearth of MHPs able and willing to provide culturally congruent, linguistically appropriate, and evidence-based mental healthcare to FMs.

WARM can serve as a potential community-based model for training opportunities that capitalize upon the results of this study to address this need. Since the initial workshop and this further assessment, WARM delivered additional in-person workshops and offered sponsorship to national and international online trainings to respond to the opportunities that arose during the pandemic. Specific trainings or workshops that can be valuable to MHPs eager to engage in this space include: fundamentals of the resettlement and immigration process and FM mental health, working with interpreters in mental health, and evidence-based therapies directly developed with and for FMs like Narrative Exposure Therapy (NET). While trainings foster awareness of FM issues and competence in working with FMs, these workshops also serve to facilitate connections between MHPs and other groups working with FMs, which can also be beneficial in recruiting and retaining MHPs in this work. Additionally, WARM has helped to match FMs with qualified MHPs and, via community grant funding, provide interpretation for the duration of services as needed. This serves to help provide MHPs with direct experiences of providing services to FMs. By providing these trainings, connections, and experiences working with FMs, the WARM program also serves to increase MHP motivation to work with FMs.

Recognizing the need for sustaining the work of WARM, the Alaska Office for Refugees created a new full-time position for a State Refugee Mental Health Manager, with the director of WARM serving on its search committee. While all states that participate in refugee resettlement have health coordinators, Alaska is unique in having a position dedicated specifically to mental health, especially given its comparably small population. In 2023-2024, the office held its first ECHO (Extension for Community Healthcare Outcomes), a collaborative tele-mentoring model designed to enhance knowledge sharing and capacity building among practitioners. ECHO follows a hub-and-spoke model where specialists (the hub) provide ongoing guidance, education, and case-based learning with local practitioners (the spokes) through virtual sessions. Six sessions were offered in the Refugee Mental Health ECHO: Refugee 101; Working with Interpreters; Common Problems, Diagnoses, and Impacts of COVID on Refugees; Assessment; Evidence-Based Practices and Psychopharmacological Interventions; and, Completing the N648 and Oath Wavers. As sustaining practitioners is vital – perhaps even more important than bringing new MHPs into the network – from there, the team moved to creating a "Communities of Care" practitioner consultation network in 2024-

2025. This network includes MHPs from the primary clinics that serve FMs in Anchorage (two integrated primary care clinics that provide refugee health screenings and training clinic associated with the psychology graduate programs at the University of Alaska Anchorage). WARM will continue to be guided by the community psychology practice competencies (Dalton & Wolfe, 2012) as it seeks to empower MHPs to provide linguistically appropriate, culturally sensitive, and evidence-based mental healthcare to FMs in Alaska. As needs change and resources shift, WARM can serve as a model for other communities interested in increasing the number of MHPs able to provide linguistically appropriate, culturally sensitive, and evidence-based mental healthcare to FMs by addressing awareness, experiences, competence, motivations, and connections of MHPs.

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Acknowledgments

This research was funded by the University of Alaska Anchorage's Center for Community Engagement and Learning (CCEL) and the College of Arts and Sciences (CAS). We are grateful to the respondents for their willingness to entrust us with their perspectives about working with forced migrants. We hope that the information gleaned from their experiences will help others in serving forced migrants around the world.