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Addressing the mental health needs of older adult refugees: Perspectives of multi-sector community key informants

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1. Introduction

Since the passage of the Refugee Act in 1980, the United States (U.S.) has admitted more than 3.1 million refugees. The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as "someone who has been forced to flee his or her country because of persecution, war, or violence" (2019). Unlike immigrants, refugees are forcibly displaced to avoid tragic outcomes such as imprisonment or death (Ajrouch et al., 2020). Forced displacement compounded by ongoing stressors, refugees are at significant risk of developing mental health issues, and related morbidity persists beyond the initial resettlement period (Alemi et al., 2014; Hameed et al., 2019; Li et al., 2016). Older adult refugees, in particular, may be at a unique risk but are underrepresented in public health promotion programs or research. When unaddressed, mental health issues can have long-term consequences for morbidity and early mortality among older adult refugees (Kumar et al., 2021; Marshall et al., 2005; Mollica et al., 2001).

2. Background

As the global refugee crisis continues to reach unprecedented numbers, refugees and immigrants, particularly from Afghanistan and the Middle East and North Africa (MENA) region, represent a growing portion of the increasingly diverse and aging population of the U.S. (Cumoletti & Batalova, 2022). In the past decade, approximately 33% of all refugees admitted to the U.S. were Muslims. According to the Migration Policy Institute, virtually all refugees from Afghanistan, Somalia, and Syria were Muslim, with the majority of

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Authors' contribution

Conceptualization (H·S.); Data curation (H.S. & A.E.); Formal analysis (H·S., A.E. & N·K.); Funding acquisition (H·S.); Methodology (M.H., & H·S.); Project administration (H.S. & A.E.); Roles/Writing - original draft (H·S.); Writing - review & editing (H·S., K.A., A.E., N·K., & M.H.).

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refugees from Iraq (67%) (2021). Major waves of migration into the U.S. from Afghanistan and MENA have been primarily driven by political turmoil and economic opportunities outside the region. Since 2010, humanitarian migration from war-torn countries, such as Afghanistan andSyria has been a significant push factor for their resettlement in the U.S. (Cumoletti & Batalova, 2022). The abrupt withdrawal of decades-long U.S. intervention in Afghanistan has also driven an uptick in Afghan arrivals on humanitarian parole (Batalova, 2021). Refugees over 60 make up approximately 4% of the refugee population (UNHCR, 2019). Attention to age provides an opportunity to consider key developmental needs, and identify fundamental principles, tools, and guidelines in mental healthcare and service delivery for this group.

2.1. Refugee mental health

Resettled refugees experience a high prevalence of mental health-related issues, such as depression, psychological distress, anxiety, and post-traumatic stress disorder (PTSD) compared to their native-born counterparts (Alemi et al., 2014; ; Steel et al., 2002; Tinghög et al., 2017). These issues are associated with refugee-related experiences such as traumatic escapes and in-transit experiences, exposure to interpersonal violence, compounded by post-migration stressors (Tinghög et al., 2017). Older refugees may be at increased risk, as forced migration can reduce their social networks and quality of social support, leading to social isolation, grief and mental health challenges (Ekoh, Iwuagwu, George, & Walsh, 2022; Kokou-Kpolou et al., 2020; Yang and Mutchler, 2019). One study finds older refugees in Australia had significantly higher mean scores of trauma events (trauma exposure, loss event, loss of intrapersonal integrity, distress, loss of symbolic self, loss of home, and interpersonal loss) and anxiety, with lower levels of education, higher unemployment rates, and poorer English skills than younger refugees (Li, 2016).

2.2. Mental health care resources in the US

Older adult refugees represent a relevant, distinct, and heterogeneous population with unique needs, that deserve attention. Meeting the mental health needs of older adult refugees in the US requires national and local frameworks and resources. While the Centers for Disease Control and Prevention provide mental health screening recommendations during domestic health examinations, mental health referrals are typically made by primary care providers, and resettled refugees rarely seek specialist services (Guajardo et al., 2016). The Affordable Care Act requires most health insurance plans to cover mental health and substance use disorder services, but coverage varies greatly. Community-based mental health care, such as outpatient care, day treatment, supported employment and housing, case management, and counseling, is available, but little emphasis has been placed on prevention, early screening, treatment, and mental health resources tailored to the needs of the broader refugee population, particularly older adults (Siddiq et al., 2022). The UNHCR's Policy on Older Refugees promotes efforts to ensure the participation and well-being of older refugees, and host governments and the international community can provide resources to meet the unique needs of this population (UNHCR, n. d.). Much of what remains to be done for refugees over the age of 60 can be accomplished with the resources provided by host governments and the international community.

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2.3. Resources to refugee services in California

While few U.S. states have formalized stakeholder involvement and the coordination of refugee services at the state level, California stands out as a top refugee-receiving state with a strong commitment to stakeholder coordination. The State Advisory Council (SAC) on Refugee Assistance and Services and through local Refugee Forums bring stakeholders together in high-impacted counties to provide input on critical issues affecting refugees and other immigrants and share best practices in developing and providing refugee programs. California has resettled more Iraqis than any other nationality over the past decade and is home to one of the largest Afghan and MENA populations in the U.S., according to the Migration Policy Institute (Capps et al., 2020). Refugee-impacted counties include Alameda, Los Angeles, Orange, Sacramento, San Diego, San Francisco, Santa Clara and Stanislaus, and refugees are resettled in these regions based on the concentration of available services, existing family ties, and refugee communities, and other factors like housing availability (California Department of Social Services, 2023). Refugee programs and services are administered by a County Refugee Coordinator, who contracts with local service providers, and refugee resettlement agencies work with the UNHCR to identify and coordinate the receipt of refugees. However, resettled refugees are only eligible to receive specific services, including housing and healthcare, for a limited time (Siddiq & Rosenberg, 2021).

2.4. A developmental perspective on refugee trauma

Those seeking refuge are often at a risk of displacement trauma. Displacement is a disruptive event that threatens psychosocial development. Ajrouch et al. (2020) introduced a developmental theoretical framework for trauma, positing that displacement trauma is a multi-systemic and multilevel phenomenon. This theoretical framework identifies the key concepts to guide this study. First, it highlights the need to recognize the importance of timing, or the age at which an event happens. Specifically, age is proposed to significantly shape and mold a person's resources, abilities, and weaknesses in responding to threats to their well-being. In this study, we focused on older adults over the age of 60, recognizing this age group is often underrepresented in research on refugee health. Second, the context of displacement is highlighted. Triggering events and the environment of the host society or community influence how older adults react to a traumatic event. We consider not only the contexts that initiated the need to seek refuge but also situations in which refugees enter after arriving in the US. This theoretical perspective was applied in the present study to expand upon prior literature to describe how community service providers across multiple sectors may help refugees cope with trauma within the community context (Neuner, 2010). Finally, this theoretical framework recognizes that seeking refuge often disrupts daily life, affecting health outcomes on multiple levels (Ajrouch et al., 2020). Following the tenets described above, we considered ecological disruptions to the mental health of older refugees (Miller & Rasmussen, 2010).

In light of the literature outlined above and the limited studies focused on the mental health needs of older adult refugees resettled in high-income countries, this study sought to examine community leaders' and key informants' perspectives of mental health service utilization of older refugees, specifically from Afghanistan and the MENA region.

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Community leaders and key informants, such as faith leaders, social service providers, counselors, and healthcare providers a unique community-level lens on these issues.

3. Methods

3.1. Design

A Community-Based Collaborative Action Research (CBCAR) approach (Pavlish & Pharris, 2012) was used to conduct semi-structured interviews with community key informants and leaders with experience working with resettled refugee communities, particularly from Afghanistan and Arabic-speaking countries. The decision to focus on those from Afghanistan and MENA countries was made prior to data collection, as these countries represent the largest refugee-producing countries in the world (Budiman, 2022). The first author secured pilot funding and established a collaborative partnership with a refugee-serving organization in Southern California, which provided one of the only locally available culturally tailored services for older adults from the MENA region. The research team comprised of the primary researcher (with a refugee background), three academic research mentors, one research assistant (with a refugee background who identified as MENA), and three community stakeholder partners (including two individuals with refugee backgrounds who identified as MENA). The first author developed the study and obtained funding for the research project, and community stakeholder partners provided input on the interview guide and interpretation of the findings. The community-academic partnership collaborated on other projects, including a community needs assessment to inform the development of a mental health intervention and will be published elsewhere.

3.1.1. Data collection—Faith leaders, refugee-serving social service providers, and mental health care workers over the age of 18 with experience working with resettled refugees, particularly from Afghanistan and the MENA region, was purposefully sampled within the Southern California. A community research assistant (CRA) assisted with recruitment. Community key informants were invited through personal contact and letter invitations using networks with refugee-serving organizations and Islamic faith-based institutions. The interviews lasted from 30 to 60 min and were scheduled at a time and place of the participant's preference. The interview questions (Table 1) included probes for specific responses related to older adults in refugee communities. The participants were offered a $25 gift card to a local store to appreciate their participation. All interviews were conducted by the first author, an experienced qualitative researcher, and with a health service research background. The study was conducted from January to May 2020 in Southern California and was approved by the University of California, Los Angeles Institutional Review Board (IRB).

3.1.2. Data analysis—The qualitative analysis approach used a stepwise thematic analysis method (Braun and Clarke, 2021) and incorporated Grounded Theory principles (Charmaz, 2008). The analysis uses an inductive 'bottom up' approach and semantic coding to identify explicitly stated ideas, concepts, and experiences. In the first phase, the first author reviewed and re-read the interview transcripts for data familiarization. In the second phase, initial codes were generated using line-by-line coding (Charmaz, 2008) on all

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transcripts in Word and then uploaded them into Atlas. ti to conduct more thematic coding (Braun and Clarke, 2021). In the third phase, initial codes were collapsed or clustered to ensure a good fit with the data. After reviewing and clustering the codes, 21 initial themes were identified. In the fourth phase, the initial themes were reviewed between the first author and senior author. The 21 proposed themes were either condensed or removed to form three overarching themes. The themes were further refined to capture the most salient patterns in the data. To enhance credibility, community stakeholder representatives from the research advisory group reviewed and provided feedback about the themes and provided alternative explanations and implications of the key elements of each theme. In the fifth phase, the themes were refined and defined. The sixth phase involved a write up of the report. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was used to report the study findings (Tong et al., 2007).

4. Results

Interviews were conducted with community key informants (N = 20), and included case managers (n = 7), Muslim faith leaders (n = 7), counselors/licensed social workers (n 4), and healthcare providers (n = 2), representing multiple sectors (health, social services, and faith-based settings). This study reports three overarching themes: 1) community key informants' concerns regarding social isolation, stigma, and silence around mental health; 2) challenges with referrals and fragmented pathways to community-based mental health services; and 3) leveraging and de-stigmatizing community-based mental health services for older adult refugees. Only limited community-based programs specifically tailored for older adults from the MENA region were identified, but there is a tremendous desire to address mental health-related issues within the community. Community key informants provided insights on the challenges and recommendations on how older refugees can be better supported in their new environments. See Table 2.

4.1. Theme 1: concerns regarding social isolation, stigma, and silence around mental health

This theme referred to community key informants' concerns about social isolation and increased vulnerability among older adults in relation to factors that contribute to poor mental health. In particular, two subthemes were identified: 1) suffering in silence and dealing with social isolation and 2) cultural barriers to voicing mental health concerns. This theme focuses on the unique challenges faced by older adult refugees from Afghanistan and the MENA region in adapting to a new country, which differs significantly from the experiences of their younger counterparts. One critical aspect of a key factor influencing poor mental health is their experience of suffering in silence and dealing with social isolation. Community key informants identified cultural barriers to voicing mental health concerns among older adult refugees.

4.1.1. Subtheme: suffering in silence and dealing with social isolation—The most prominent mental-health related issues affecting older adult refugees were described by community key informants as primarily social (isolation, and loneliness) and emotional issues (commonly identified as depression, post-traumatic stress disorder, and distress)

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related to the difficult migration experiences, integration in a new country, and the unmanaged trauma of forced displacement. Some community key informants who had mental health training, cautioned on the emphasis on naming specific mental health diagnoses when interacting with older adult refugees. This suggests the importance of using a broader psychosocial lens when addressing this population's mental health needs.

Older refugees faced the need to adapt to a new country where their social lives were much different from those of their homeland. They faced social isolation because of diminished family and social support, and may have less ability to socialize and develop new social networks due to transportation and language barriers. A case manager illustrates, "*People cannot cope with the society in this country, especially immigrants who come at a later age and then they see that their environment here is totally different and they don't have the same family* support *like people do … in their home country*." Older refugees struggle with societal differences in their new country compared to their homeland, particularly if they are displaced at an older age. The experience of losing loved ones and social connections was perceived to be 'harder' for older adults and exacerbated feelings of isolation in a new country. They saw older adult refugees as lacking a feeling of connection to others and struggling to adapt to a new country where social life is much different. A case manager illustrates, "*When you come here, you feel isolated … You don't have enough people to talk to, or other people you know, that you recognize, which is a problem*." Social isolation can manifest in various ways and may stem from reduced social support throughout the refugee migration journey, which can exacerbate the impact of traumatic experiences associated with forced displacement.

Community key informants also acknowledged the diversity within the resettled refugee community, noting that individual migration experiences can differ from one person to another. For instance, forcibly displaced individuals may come from countries such as Afghanistan, Iraq, Somalia, and Syria, among others. They highlighted a 'limbo state' where they may have resided in a country of asylum, refugee camp for many years prior to arriving in the US. Factors such as living in a country of asylum before entering the US, or residing in refugee camps, may further contribute to unstable social networks. Additionally, community key informants who were interviewed during the COVID-19 pandemic described physical social isolation as an additional stressor for older adults with limited social support that contributes to loneliness and overall mental health. A case manager described how she transitioned from home visits to phone calls with seniors during the lockdown. The older adults she interacted with experienced were worried about the pandemic but appreciative of the check-ins even by phone call.

4.1.2. Sub-theme: cultural barriers to voicing mental health concerns—

Participants revealed that older adult refugees typically do not discuss their mental health due to cultural barriers and beliefs about mental illness. A participant states, "*First of all, they [older adults] just hold it in themselves*." Stigma, cultural values, religiosity, not wanting to burden the family, and mental health not emphasized in their home countries contributed to their silence. This stigma towards mental health was particularly heightened among men. A licensed social worker illustrated, "*I saw this a lot amongst the older male adults. They would say, 'We don't talk about distressful things. We don't talk about the*

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past." The belief that men need to be emotionally strong may hinder voicing mental health issues. Thus, they felt that older refugees, particularly males, suffered in silence, and may be unwilling to talk about distressing events or past trauma with family or close friends.

Muslim faith leaders observed a silence around mental health, that mental health and treatment available was not well understood in the community, and often brushed aside. A participant, an Imam (Muslim faith leader), stated, "*mental health is not well understood in our community … out of fear, stigma, and other socioeconomic factors*." Other Muslim faith leaders also pointed out, "*in our communities, there's not much talk about mental health because most people tend to brush it under the table … They [refugees] would just say 'emotional pain.' That somebody will get over it*." As a result, older refugee may experience avoidance, denial, or delays in seeking help for mental health concerns. Help-seeking was typically limited to consulting family, friends, or faith leaders rather than professionals, and often occurred when the situation was dire. Barriers include shame, lack of support, or limited awareness of the treatment available for emotional problems. Community key informants described consequences of heightened mental health stigma in the community. A faith leader stated, *They come to us, Imams when it's really bad. Because until then, they just kind of keep overlooking and denying it themselves*." Other silences around the mental health-related needs of older adults concerned concerns about violence or abuse that were not openly discussed in the community. Referring to elder abuse, one participant, a mosque director, stated, "*There's also [elder] abuse. We see that quite a bit, which is not spoken about too much*." Upholding family cohesion or keeping family issues private within the family may prevent elders from speaking out or seeking professional help for fear of being judged or stigmatized in the community.

Overall, community key informants expressed concerns about the mental health needs of older adult refugees. Older adults face social isolation and may suffer in silence due to diminished family and social support in their new country and various cultural factors. They often suffered in silence and did not voice their mental health concerns due to stigma, cultural value for keeping family issues within the family, religiosity, not wanting to burden their family, and mental health not being emphasized in their home countries. Stigma towards mental health was particularly heightened among men. Muslim faith leaders noted that mental health was not well understood or emphasized in their communities and was often brushed under the table. This leads to avoidance, denial, or delay in seeking help for mental health-related concerns. Help-seeking was also limited to consulting with family, friends, or faith leaders but not mental health professionals, often when it was too late. Family cohesion or a desire to keep emotional issues private may prevent elders from seeking professional help for fear of being judged or stigmatized in the community.

4.2. Theme 2: challenges with referrals and fragmented pathways to community-based mental health services

Addressing the mental health needs of older adult refugees is challenging due to the limited availability of culturally tailored mental health services. Participants mentioned their efforts to address mental health needs through referrals to appropriate professionals but encountered disjointed pathways in initiating referrals to community-based mental health services. Some

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community key informants also questioned the appropriateness of traditional US-based mental health care. Three sub-themes illustrated these fragmented pathways: 1) the need for practical mental health training, 2) limited awareness of culturally appropriate mental health resources, and 3) limited capacity to address basic social needs and practical barriers.

4.2.1. Subtheme: needing more practical mental health training—Participants reported varying levels of comfort in recognizing clients' mental health-related needs, stressing the importance of mental health training or education to make appropriate referrals. Across multiple sectors, social services providers, faith leaders, and mental health workers, acknowledge the need for mental health training to refer refugees to appropriate services. They acknowledged that although their roles as social service providers or faith leaders did not include primary counseling or mental health care, but they often worked with clients in need. A case manager stated, "*if you have people who care but are overworked and don't have the right training, there's not much we can offer*." Another case manager illustrates, "*I may not have a definition for mental health, but I see it*." Managing emotions with clients who have experienced displacement or trauma was difficult, as one case manager illustrated, "*we were dealing with many Muslim immigrants and refugees. Our role was to help them gain self-sufficiency … We realized that wasn't enough for them … they needed more attention …"* Some participants reported having had Mental Health First Aid training or some background in mental health through workshops or classes but found that it was not enough and that more efficient training was needed. Service providers recognize that their clients may have unmet mental health needs and desired training to refer to culturally appropriate programs in the region. For example, a Muslim faith leader stated: "*There needs to be very in-depth training for Imams, but it needs to be efficient because Imams are already way overworked … It should be well developed by a person who has researched and knows how to interface between two fields [Islam and psychiatry]."* Participants also recommended that this training for service providers should include what culturally tailored resources are even available locally to refer older refugees, that this training should be tailored to the type or background of the service provider, and be flexible to their schedule.

4.2.2. Subtheme: limited awareness of local resources—Community key informants reported having little knowledge of locally available, culturally appropriate services, and mental health resources. They expressed frustration in identifying specific community-based resources that matched their clients' backgrounds and language. When considering referrals to available community-based resources or services, providers sought congruent Arabic or Farsi-speaking counselors. A case manager illustrated their approach and stated, "*I try to find those places [mental health services] for them, and that's where I've had the worst time, trying to find people places to go or even making referrals*." The participants emphasized the need for community-based services. As another case manager stated: "*There's not many, but there's a lot of services [in the community]. Anything beyond that, I don't think most people are open to going to a psychologist or psychiatrist*." While only limited available local mental health resources were identified across interviews, case managers from two different refugee-serving organizations that had integrated mental health department described that one-on-one counseling as being more acceptable with younger age groups. Similarly, a Muslim faith leader described the challenges of an integrated

counseling program with a Muslim therapist at the mosque setting was perceived to be under-utilized by older adults. Healthcare providers also described how referrals to mental health care were limited to specialist services, mainly due to lack of awareness of the process of referrals to community-based mental health services and knowledge of existing programs.

4.2.3. Subtheme: limited capacity to address basic Needs and practical barriers—

Community key informants highlighted limitations that inhibited their ability to facilitate referrals to community-based mental health services, such as language, transportation needs, and cost barriers. They discussed their limited capacity to prioritize mental health because of competing needs. Service providers face challenges in addressing the barriers their clients experienced, including needing transportation, language-concordant counselors, and financial support for the cost of mental health care. As a case manager states, "*the language barrier and other barriers, like transportation, you know you're talking about the older community … the transportation is a very, very big barrier. People have a hard time getting to the people for help."* Participants also identified how refugees' lack of awareness of U.S. privacy laws concerning health information is a critical barrier to mental health care that may be addressed through education and awareness. All of these efforts take time, and service providers often have a limited capacity to navigate and coordinate such care. For example, a mosque director described, "*we're just [providing] referrals, and anything beyond that is not within our capacity to follow up with*." Similarly, other service providers echoed the sentiment that community-based organizations providing social services were already "stretched thin" to expand into mental health services outside their expertise or scope of practice. The limited availability of Farsi- or Arabic-speaking counselors, lack of transportation, and service costs were some of the challenges alogn the referal pathways to community-based mental health care.

Overall, community key informants perceived referrals to community-based mental health services may be a way to address older refugees' mental health needs, however, this process is challenging due to various factors. First, community key informants emphasized the importance of mental health training to make appropriate referrals and recognized the need for training to be tailored to the type or background of the service provider. Second, service providers faced limitations in addressing practical barriers to accessing these services, including language, transportation needs, and cost barriers. They also reported having little knowledge of locally available, culturally appropriate services and mental health resources, and struggled to find places for referrals. They also questioned whether existing community-based services are culturally appropriate for older refugees. Significant challenges have been raised, including the need for mental health training for multisector service providers, limited capacity to implement effective referral systems at community-based organizations, and limited available community-based mental health resources specifically tailored for older adult refugees.

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4.3. Theme 3: leveraging and de-stigmatizing community-based mental health services for older adult refugees

Facilitators include de-stigmatization efforts by building trusting relationships with older adult refugee clients, community outreach, and raising mental health awareness in faith-based settings. Service providers also emphasized leveraging existing efforts to address issues around training, outreach and social-based programs for older adult refugees. A program manager identifies limited available mental health resources for the refugee community, but describes how integrated mental health care within their refugee-serving community-based organization facilitated the ease of delivery of mental health care. She stated, "*A lot of them [older adults] don't know we have mental health services. I get referrals from case managers because our staff will let them know we have a mental health program. They notice they might be struggling or having challenges with mental health, and they will call me in, and then I do a quick assessment*." The integrated mental health care program appeared to be a way to destigmatize formal mental health care when delivered in a community setting.

De-stigmatization efforts through mental health outreach and education have been recognized as priority needs. Community key informants described their process of building trust and drawing from shared backgrounds, language, and even religion, were important for providers in building relationships to help facilitate the use of limited available counseling services. Some also described their approach of normalizing mental health struggles related to forced displacement. Relatability and drawing from shared backgrounds, lived experiences, religion, and language are important for providers in building trust with refugees. For example, faith leaders emphasized their priority in addressing the spiritual needs of their congregants, and they emphasized the importance of building trust with clients. Building trust seemed to facilitate the use of counseling services. To illustrate this, a participant stated,*"for me, it's very important that I build a relationship enough to make a recommendation to see a [counselor]."*

While the roles of community key informants varied, a salient goal in addressing the mental health needs of older adult refugees was to promote social connections and mental health awareness. They referred older adults as being more reluctant to seek help for mental-health related issues, highlighting the crucial role of social gatherings and activities that target psychosocial needs. With limited available programs, some participants identified that social-based activities and social support therapy programs that center on building social connectedness may be a means to promote mental health among older adult refugees. For some providers, social activities were perceived as a more acceptable way to address unmet mental health needs, particularly for men. Examples such as field trips to local events, potlucks, gardening, and other social gatherings addressed social isolation but may also help to promote social connections with others and de-stigmatize the concept of mental health care for older adults. A program manager illustrates how a social support group was developed at their community-based organization and states,*"We started a group therapy [for older adults], and the majority of the clients are all refugees … they talked about dealing with challenges and coming from a different country. It was a very emotional group. It brought back a lot of memories and things they're dealing with … some of them were from*

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Syria and talked about their homes, how they saw their home destroyed." Although this was only one program, it provided an opportunity for older adults to share their experiences and lean on each other for support. Muslim faith leaders also highlight the need for culturally tailored mental health services that incorporates Islamic principles when considering the needs of older adult refugees who identify as Muslim.

Community key informants envisioned greater community collaboration and connections to mental health resources and highlighted the importance of collaborative efforts in addressing the unmet mental health needs of older adult refugees. Community key informants described how older adults from countries experiencing war or ongoing political instability may have arrived in the U.S. under family reunification and may not be connected with resettlement agencies. Therefore, there is a need to raise awareness of the broader community across settings so that family members may become aware of local resources. Community key informants also recognize that faith leaders and service providers may have a role in promoting referrals to community-based mental health services, but would require training and support. A counselor stated, "*Some of them [older adults] will go there [the mosque] and either ask the Imam, and they [Imams] send them to us. Because it's out of their scope that they don't have services, but they will link them to us*." While referrals from faith-based institutions were welcomed, some Muslim faith leaders preferred not to send people to 'just anyone' and expressed the need for services that also incorporate Islamic principles. For example, an Imam illustrated "*we also need therapists who are Muslim, and know how Islam and mental health counseling really actually complement each other*." They also emphasized the need for collaboration with multisector services to facilitate a supportive referral system for community-based mental health services. A faith leader stated, "*They [refugee-serving organizations] need to work closely with others. Also, engage the religious community. There is tremendous volunteer capacity, and there is a tremendous desire*." Other participants described the importance of the mosque setting to promote mental health. One case manager illustrates, "*I think bringing it [mental health outreach] more to the mosque because that's where most people congregate*."

In summary, community key informants described facilitating factors to community-based mental health services through. De-stigmatization efforts, community outreach, and raising mental health awareness in faith-based settings were important facilitators. Service providers emphasized the need to find alternative ways to support the mental health needs of older adult refugees, including services delivered by culturally and linguistically congruent providers, and culturally tailored social-based therapies. They also highlighted the importance of social activities and social support therapy programs to address social isolation and promote mental health. The study also highlighted the need for collaboration and connections to mental health resources and raised awareness of the broader community across settings. Community key informants emphasized the need for multisector services to facilitate a supportive referral system for community-based mental health services.

5. Discussion

This study delves into the mental health needs of older adult refugees from the MENA region, drawing on insights from community key informants such as social services and

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mental health care providers. These findings highlight the challenges faced by older refugees forcibly displaced from their home countries, as they adapt to a new country with different social dynamics and diminished family support. Furthermore, the findings identify the reluctance of older Muslim adults to discuss mental health issues due to cultural stigma and various other factors. Our findings suggest that age, context, and ongoing disruptions in the post-migration setting in the U.S. influence older refugees' mental health, and help-seeking behaviors, corroborating prior literature in other high-income countries (Li, 2016). Refugee service providers representing multiple sectors of the community, including faith-based institutions, social services agencies, and community-based mental health services, offer rich insights into mental health concerns and service use, particularly among older adults from Afghanistan and the MENA region. Refugees' barriers to mental health care are examined, and particularly, the challenges that service providers experience in addressing the mental health needs of refugee clients. Lastly, the importance of integrated mental health care in community settings and future directions for research are discussed.

5.1. Importance of age

Given the state of the global refugee crisis and the aging population in the US, attention to older adult refugees is a significant public health issue. These findings highlight the importance of age as a factor that influences refugees' risk of poor mental health. The age of migration and increased length of stay among foreign-born adults are both factors that contribute to mental health disparities (Castañeda et al., 2015). Additionally, refugees who have resettled in the U.S. since the 1980s are now aging in the U.S. and have a unique need for support to promote successful integration in a new country (Siddiq et al., 2022). Established literature identifies better mental health among foreign-born adults than US-born adults (Alegría et al., 2017). However, this health advantage deteriorates with as immigrants reside in the U.S. for a longer period of time (Bustamante et al., 2021). Refugees may also underutilize mental health services despite having a greater need for services (Blackmore et al., 2020). Therefore, older adult refugees may have increased vulnerability to unmet mental health needs due to age-related risk factors. These findings identified that service providers reported a heightened reluctance to discuss mental health among older adults from the MENA region, and when open to it, older adults' preference for seeking help from their social networks or trusted faith leaders. A key feature of themes pertaining to the importance of age is that older refugees faced the need to adapt to a new country where their social lives were much different from their homeland and where social and family circles are much smaller, making their difficult to adjust to the US. These findings supports the notion that age is a critical factor in shaping trajectories of integration (Strang and Ager, 2010). Community stakeholders also reported limited availability of tailored mental health services particularly for older adult refugees in the Southern California region. This is in contrast with studies in other high-income countries such as Australia, which found that a greater percentage of older refugees perceived that they had received sufficient support from the broader community over younger refugees (Li, 2016).

5.2. Importance of context of migration

In light of these findings, forced displacement as a context of migration, is an important factor in explaining older adult refugees' increased risk of mental health issues, yet only

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limited research focus on their mental health needs (Ekoh et al., 2022; Johnson et al., 2019). These findings also highlight the diverse migration and resettlement experiences of older adult refugees. Many older refugees have experienced multiple traumatic events throughout their lives, including violence, persecution, and loss of family and friends. These experiences can lead to symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), and other mental health issues. Older adult refugees are also at higher risk for social isolation, which can exacerbate mental health problems (Taylor et al., 2018). Additionally, adapting to a new culture and navigating complex healthcare systems can be stressful and challenging for older refugees, leading to increased mental health needs (Siddiq et al., 2023). The cumulative effect of these factors can have long-term consequences for mental health, morbidity and early mortality among older adult refugees. However, limited prevalence data on resettled refugees in the U.S. exists as most datasets do not capture the context of migration. Therefore, there is a need to identify push factors in large population-based datasets when examining health disparities in older adult migrant populations. Examining health disparities among forced migrants in the U.S. answers the call to disaggregate data by the Institute of Medicine (IOM) “Leave No Migrant Behind: The 2030 Agenda and Data Disaggregation.” The IOM report is the first of its kind to address a range of categorization needs related to migrant populations.

5.3. Importance of the post-migration setting

The stressors experienced in the post-migration setting may have an even more impact on overall mental health outcomes than pre-migration experiences. Traumatic experiences such as forced displacement may be compounded by cascading layers of stress throughout the migration journey (Giacco, 2020; Johnson et al., 2021). For example, the combination of in-transit phase experiences such as residing in refugee camps, the stressful asylum seeking process, breakdown of family and social ties, declining health status as a result of increased length of stay in the US, the stress of social isolation experienced in resettlement countries, may contribute to older adult refugees’ vulnerability to poorer mental health outcomes (Frost et al., 2019; Virgincar et al., 2016; C et al., 2019). Service providers also raised concerns not related to the migration journey, but post-migration stressors like financial difficulties, housing instability, and elder abuse that contributes to the increased vulnerability of older adult refugees for poor mental health that warrant further research. These findings illustrate the need to incorporate social determinants of health when considering older adult refugees’ mental health.

Service providers identify the insidiousness of social isolation in the post-migration setting due to diminished family and social support. Social isolation in the post-migration context is an important mental-health-related issue, which is corroborated in limited literature (Ajrouch, 2008; Tonui et al., 2022). Social support has been found to buffer against post-migration stress in some studies on refugee populations, though the evidence on this is mixed. Some studies point to the potential of community navigators in addressing social isolation among people with anxiety or depression and may be useful for refugee populations (Lloyd-Evans et al., 2017, Lloyd-Evans et al., 2020; Yun et al., 2016). Our findings also suggest that integrated mental health services within the community through faith-based institutions or community-based organizations that offer social based activities

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should be prioritized. Furthermore, community key informants highlighted the importance of social outlets beyond the family for older adults' mental health, offering opportunities to address mental health challenges stemming from past traumas, current stressors, and social isolation. Social connections that refugees build outside of the family that share their experiences may be an important social-based tool for addressing displacement-related trauma and promoting mental health (Russo et al., 2021).

5.4. Barriers to referring older adult refugees to mental health care

While previous studies highlighted pervasive barriers to mental health care among resettled refugees (Jamuna & Dell, 2020; Kiselev et al., 2020), these findings identified the barriers that multisector service providers have in referring elder refugee clients to community-based mental health resources. Of central concern is the challenges of discussing the topic of mental health due to older adult refugees' reluctance to talk about mental health needs. Stigma towards mental health remains a significant barrier for many, and overcoming stigma is a slow process that requires trust and relationship building. However, the limited capacity of mosques and other social service organizations inhibits the ability of faith leaders and service providers to identify, initiate, and complete referrals to the minimal available community-based mental health services. Promoting pathways to mental health care requires a collaborative effort across sectors of the community. It is important to consider the centrality of religion, particularly Islam, as an integral factor in addressing mental health needs of older adult refugees from Afghanistan and MENA region, yet limited research or public health programs rarely partner with faith-based communities or mosque settings. There growing research in understanding Muslims' unique needs pertaining to mental health and the Islamic faith (Ali, 2016; Awaad et al., 2017; Awaad et al., 2022). Our study represents an important step in community and academic efforts in promoting mental health awareness across Muslim and Arab communities in tackling the stigma towards seeking mental health services through community-based research (Awaad et al., 2022).

5.5. Future research and recommendations

Integrating mental health care across multi-sector community settings has the potential to address issues such as stigma, access, transportation, and language barriers, which are particularly paramount for older adult refugees. There is growing recognition that service providers in community settings may play an essential role in addressing older adult refuges' mental health needs (Kohrt et al., 2018; Syed et al., 2020). Multisector service providers may be the first line in recognizing and initiating referrals for possible mental health needs. Encouragement from faith leaders, trusted service providers, or even the family and loved ones of older adults may be especially valuable in facilitating the use of mental health services (Ali, 2016; Meran and Mason, 2019). One study finds refugees were more likely to accept referrals to community-based mental health services were referred by non-clinic sources (Ballard-Kang et al., 2018). However, the acceptability of a referral to mental health services may not always be welcomed, and discussions about mental health should be culturally sensitive and carefully considered (Shannon, 2014). Therefore, psychoeducation, gentle conversations, and referrals to social-based activities may be acceptable approaches to destigmatize mental health and increase access to care (Shannon, 2014).

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This study recommends developing culturally appropriate programs and services, as well as providing training to service providers to help destigmatize the mental health of refugees and immigrants, particularly among older adults from Afghanistan and the MENA region. There is a need to consider multi-sector community collaborations and incorporate social-based therapies into mental health services while training and supporting providers. Social-based activities such as horticulture, gardening (Clatworthy et al., 2013; Hartwig & Mason, 2016), and art therapy (Schouten et al., 2015) have been shown to improve low to moderate levels of depression and anxiety and may be an appropriate approach for promoting mental health in older adult refugees. A recent review of the literature finds that social-based interventions improve mental health outcomes in resettled refugees in the US from Muslim-majority countries, however, limited targeted interventions have focused on older adults (Siddiq et al., 2023). Other research also identifies mobile technologies to improve screening for refugee populations (Hashemi et al., 2017).

5.6. Policy implications

Our findings implicate several main areas of U.S. policy. First, there is a lack of emphasis on mental health care in community or informal care settings in the U.S. (Kohrt et al., 2018). In places like Europe and other countries that emphasize preventive health, strengthening community-based healthcare has been identified as a valuable strategy for reducing mental and physical health inequalities and improving the integration of migrants and refugees into local communities (Riza et al., 2020). According to the World Health Organization (2004), optimal mental health services should emphasize more mental health care in community settings, where mental health needs are high, and the cost of services is lower. Additionally, mental health screening protocols for refugees arriving in the U.S. have been deemed inadequate in part due to the lack of a standardized national program (Siddiq & Rosenberg, 2021). The Office of Refugee Resettlement (ORR) guidelines require general health screening in the first 90 days; however, there is inadequate procedural or financial support for mental health screening for refugees. Finally, balancing the demand for mental health services and the availability of qualified mental health professionals compels an examination of the opportunities that may exist to promote reimbursement and payer policies that non-licensed and peer counseling services may access. Increasing access to and promoting the sustainability for community-based mental health, care may be crucial to prevention, early intervention, and long-term solutions to the ongoing mental health needs of immigrants and refugees.

6. Conclusion

This study examined the mental health needs of older adult refugees through insights from community key informants. The findings highlight the challenges faced by older adult refugees, including reluctance to discuss mental health issues due to stigma, particularly among older Muslim adults. Age, migration context, and post-resettlement setting significantly influence the mental health and health-related behaviors of older adult refugees, especially those from Afghanistan and the MENA region. To address these challenges, multi-sector collaborations can strengthen community-based mental health care systems and destigmatize mental health issues among immigrants and refugees, particularly

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older adults. Integrated mental healthcare in community settings is crucial, and future research should focus on developing targeted interventions and fostering collaboration among sectors to improve the mental health outcomes and overall well-being of older adult refugees.

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Table 1

Interview guide and question examples.

1	Tell me about your work with the refugee community.
2	People experience lots of different types of mental health issues (PTSD/Dep). What types of mental illness do members of the refugee community experience? What about older adults specifically?
3	What do they [older adult refugees] call this problem?[a]
4	What do they think about their problem? And, what do they tell you about it?[a]
5	Where do they go for help?[a]
6	What do they think about the place where they go for help?[a]
7	Why do they go there? Or, if they do not go anywhere, why not?[a]
8	How do they manage if they are not getting professional care?[a]
9	What are the major barriers around accessing mental health care, information or resources you see in the refugee community?[a]
10	What do you think is needed to help people:[a] • recognize their problem? • access information or resources? • actually, physically come in to get care from a professional?

[a]Probes include: What about older adults?.

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Table 2

Theme overview.

Themes	Subthemes	Quotes
Concerns regarding social isolation, stigma, and silence around mental health	Suffering in silence and dealing with social isolation	"When you come here, you feel isolated … that has an effect. You don't have enough people to talk to, or other people that you know, that you recognize, that is a problem. Definitely, isolation has an effect on mental health. I think that isolation for such a long period, I feel like, is one of the big things." "People cannot cope with the society in this country, especially the migrants who come at a later age and then they see that their environment here is totally different and they don't have the same family support like people do in the Islamic countries … or in their home country."
	Cultural barriers to voicing mental health concerns	"Mental health is really what I think is very not well understood in our community … Our community doesn't want to acknowledge it. It's not that they are not aware of it. They're aware of it, but at the same time they don't want to acknowledge it out of fear, stigma, and other socioeconomic factors." "I saw this a lot amongst the older male adults where they would say, 'We don't talk about things that were distressful. We don't talk about the past'." "They come to us, Imams, when it's really bad. Because until then, they just kind of, they keep overlooking and denying it themselves, really."
Challenges with referrals and fragmented pathways to community-based mental health services	Needing more practical mental health training	"We were dealing with a lot of Muslim [immigrants and refugees]. Our role was to help them gain self-sufficiency, so we would create a plan for them, short-term and long-term goals, and get them back on their feet, hopefully. That was the goal … We realized that wasn't enough for them … they needed more attention. They just didn't have access to a lot of things. A lot of them had language barriers. A lot of them were educated in their country … You're dealing with a lot of emotions, a lot of anger, a lot of sadness. It is extremely difficult."
	Limited capacity to address basic needs and practical barriers	"I think institutions that deal with refugee populations need to collaborate. They need to work together because you're talking about people who have needs on every single level, financial, housing, educational … So on every level, they're in need. And the refugee resettlement agencies, they have limited capacity." "I don't think Imams should be tasked with addressing the mental health issues, this is for the professionals, [Imams] are already overwhelmed with the community needs already"
	Limited awareness of local resources	"A lot of them [older adults] don't know we have mental health services. I get referrals from case managers because our staff will let them know we have a mental health program. They notice they might be struggling or having challenges with mental health, and they will call me in, and then I do a quick assessment; it happens all the time."
Leveraging and de-stigmatizing community-based mental health services for older adult refugees		"A lot of this is building on trust and rapport until you feel that you can make that recommendation [to mental health care], put him in that place where you think they could follow through with your suggestions." "I think bringing it [mental health outreach] more to the mosque because that's where most people congregate. That's the one thing I think about having the tables set up where people know about it. And social media, I think, plays an essential aspect now … Yeah, that would be the best way to reach out to them, but I think the older generation [prefers] tabling." "So having that sort of a connection. There's a lot of elderly folks that have come over from Syria and so providing needs specific to them. So refugee agencies that work with refugees on any level need to be well connected."