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Evaluation of a community-based program for addressing the mental health treatment gap among forced migrant populations: BRIDGE (Building Resilience through Information, Dialogue, Guidance, and Empowerment) Training

Abstract

Background: In an effort to extend the reach of mental health care to marginalized populations, standardized training and credentialing of non-specialist providers has been increasingly adopted worldwide. Among populations with lived experiences of forced migration, access to traditional mental health services is often constrained by interrelated sets of barriers including: limited knowledge of how to navigate unfamiliar health care systems; generalized fear of immigration-related repercussions if/when seeking help from formal institutions; stigma associated with mental health treatment; financial insecurity; transportation costs; housing instability; and shortages of mental health professionals with expertise in forced migration, trauma-informed and trauma-sensitive practice, and evidence-based interventions tailored to the cultural and contextual realities of migrant communities. Given these combined challenges, training and credentialing community-based advocates (CBAs) offers a promising strategy for expanding access to mental health support. As trusted members of the communities they serve, CBAs can deliver a range of culturally responsive mental health services and supports, while helping forced migrants navigate complex systems and overcome barriers to care.

Method: A community and evidence-driven training program for CBAs targeting skills, knowledge and understanding of common mental health conditions experienced by forced migrants and evidence-based strategies for addressing them (Building Resilience through Information, Dialogue, Guidance, and Empowerment) BRIDGE Training, was developed through a partnership between academic researchers, community organizations serving forced migrants, and individuals with lived experience of forced migration themselves. The training uses a combination of didactic material, practice exercises, and group discussion. It consists of 12-hours of face-to-face training. A total of 34 advocates participated in the training and completed pre- and post-test assessments regarding knowledge, understanding and skills. This prospective study examines the feasibility and preliminary effectiveness of BRIDGE Training.

Results: Findings indicate that BRIDGE training is effective at improving all three domains of focus. Trainees' scores on the Understanding Subscale increased significantly ($p<.05$) from pre-training ($M = 15.79$, $SD = 3.78$) to post-training ($M = 44.85$, $SD = 0.50$). Mean pre-training scores on the Ability Subscale ($M = 12.53$, $SD = 1.48$) increased significantly ($p<.05$) to a post-training mean of 39.91 ($SD = 0.38$). Further, trainee ratings improved significantly ($p<.05$) from pre-training ($M = 10.06$, $SD = 1.41$) to post-training ($M = 34.88$, $SD = 0.48$).

Conclusion: Results of this initial evaluation suggest that CBAs are uniquely positioned to effectively support forced migrants in their community who might otherwise fail to have their mental health concerns addressed. This has significant implications for expanding training and increasing support for CBAs as principal stakeholders in migrant mental health, shifting their role from informal caregivers to certified advocates.

Keywords: forced migration, treatment utilization, trauma-informed practice, training effectiveness, community-based advocates, mental health

Volume 14 Issue 1 - 2026

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Received: May 25, 2026 | **Published:** June 09, 2026

Introduction

Forced migration remains a core global issue in 2026, with close to 136 million forcibly displaced people including refugees, internally displaced persons, stateless persons and asylum seekers who have fled their homes to escape violence, conflict and persecution.[1] In the United States alone, there are there are over 3.8 million total immigration cases pending in U.S. immigration courts.[2] Average wait times for asylum decisions in immigration court have reached approximately 4.3 years, with some cases exceeding six years.[2]. During this waiting period, individuals with lived experience of forced migration are left to struggle with unresolved trauma related to premigration and transit experiences, and significant resettlement challenges further

exacerbating this trauma including, unpredictable legal situations, an ever increasing fear of deportation, and difficulties finding stable employment, obtaining adequate housing, integrating into new communities, developing their sense of self, and finding opportunities to support their sense of self-efficacy.[3]

Given these circumstances, it is not surprising that forced migrants experience elevated rates of depression, anxiety, PTSD, suicidal ideation, untreated chronic illnesses (hypertension, diabetes, cardiovascular disease, kidney disease) as compared to the general community.[3,4] For example, approximately 30% of forcibly displaced individuals are affected by PTSD or depression as compared to up to 18% of the general population.[4] Other research has found forced migrant groups to report PTSD and depression at rates that are 5–10 times higher than the general population.[5] Still other studies demonstrate prevalence rates of depression, anxiety, and PTSD estimated between 20% and 80%.[6]

Despite this disproportionality in mental illness found among forced migrants, mental healthcare services are sorely underutilized.[3]. Prior research has found rates of mental health service utilization as low as 13–21% among forced migrants. Other studies indicate that, in general, immigrants are 40% less likely than US-born individuals to access mental healthcare services, with some finding only 6% of certain migrant groups ever receiving care.[5]

Given the noted underutilization of mental healthcare services by this population combined with the lack of culturally responsive mental health specialists and the significant access and availability related barriers to engaging in formal mental healthcare services, alternative mechanisms for ensuring that supportive mental healthcare services are made available to forced migrants are required. Indeed, prior studies have called for more accessible, collaborative, trauma-informed, and culturally informed mental healthcare approaches to address this treatment gap.[7] One such approach that has proven successful with other at-risk isolated populations with significantly low treatment utilization rates yet high demonstrated need is empowering communities themselves to identify and respond to need (see for example,.[8]).

In close-knit migrant communities, often forced to live together due to shared complexities of migration processes, community members are in contact with vulnerable persons but do not always recognize those struggling with mental health impairment or know how to intervene early to prevent it from escalating and becoming a crisis. Most upstream interventions rely on professional community health workers from varied formal institutions (education, law enforcement, health, religious) to recognize and respond to individuals in need.[9] However, for a population where representatives of formal systems may not be trusted or easily approached (due to, for example, fear legal status repercussions), it is crucial to foster the capacity of community members themselves to take on such positions.

Peer support for mental healthcare, such as that provided by BRIDGE-trained CBAs, emerged in the 1980s and has received increasing attention in mental health research in recent years.[10,11] It has been promoted by the World Health Organization (WHO) as an important approach for increasing well-being and mitigating the negative effects of social isolation and other stressors associated with migration[10,12] and is considered as both an alternative and/or a complement to formal mental healthcare services.[10] Such programs bring together individuals with shared experiences to provide support grounded in trust, mutual respect, and empowerment, while fostering belonging, connectedness, coping skills, resilience, and improved mental health literacy.[10]

This article describes one such peer-based program, BRIDGE (Building Resilience through Information, Dialogue, Guidance, and Empowerment) Training, which was designed through a multi-year community partnership between the academic researchers, forced migrant women, and trusted local community-based organizations providing non-mental health services to this population. BRIDGE training is grounded in the SPACE framework (Strengths and Participation to Accomplish Capacity and Empowerment), a community-driven conceptual model previously developed by the authors to guide rights-based and participatory work with women and communities affected by forced migration.[13] SPACE centers lived experiences and local knowledge, emphasizes participatory engagement across all stages of intervention development and implementation, and seeks to build individual and collective capacity while positioning migrant communities as active agents of support, leadership, and change. Reflecting these principles, BRIDGE Training shifts mental health intervention beyond strictly institution-based models by engaging trusted community members as community-based advocates (CBAs) equipped to recognize, understand, and respond to common mental health challenges experienced within their communities. Through psychoeducation and evidence-based self-care and support strategies, BRIDGE seeks to strengthen local community capacity and create culturally grounded pathways for promoting mental well-being among forced migrant populations.

In a 12-hour, 6-session training program grounded in a Social Determinants of Mental Health framework,[14] participants explore the etiology, signs and symptoms of relevant mental health disorders; myths and stigma related to mental illness and mental health treatment; and key factors related to resilience and self-care. Participants discuss how to best apply this knowledge to support those who are struggling in their communities based on their own experiences with forced migration and cultural contexts. Community members who participate in BRIDGE Training use their personal experiences with migration along with their knowledge of the local community to develop plans for engaging in preventative and supportive actions collectively and/or individually in their communities. Engaging trusted individuals from within the local community and equipping them with evidence-based understanding, knowledge and skills serves to develop a 'bridge' that addresses the mental health treatment gap grounded in best practices.

This study presents the program and the first evaluation of BRIDGE Training effectiveness. We hypothesized that BRIDGE training would improve community-based advocates': a) understanding of the nature and causes of mental illness; b) knowledge of common mental health conditions experienced by forced migrants (i.e., signs, symptoms, common treatments); and (c) mental health skills self-efficacy, defined as self-perceived competence in delivering evidence-based self-care strategies for decreasing mental health distress and promoting well-being.

Methods

Sample

In accordance with and following approval from the appropriate Institutional Review Board, women asylum seekers living in New York City who were members of a local non-mental health community organization served as the sample for this study. Recruitment was conducted through a community-based organization with whom the study PIs collaborate on a large project aimed at increasing access to health and mental healthcare and knowledge of rights and resources among women forced migrants in NYC (Her Migrant Hub; see hermigranthub.org for details). Convenience sampling was used. The partner organizations facilitated access to members of their

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DOI: 10.15406/mojwh.2026.14.00335

asylum-seeker serving community either via direct introductions or allowing members of the research team access to meetings at their organizations attended by asylum seekers. The study team then followed up with individual asylum seekers and all who agreed were invited to participate in the training. A total of 34 women participated in the training series, completing all modules.

BRIDGE training program

BRIDGE training follows a manualized curriculum consisting of a core 12-hour, in-person, group-based training. The program was developed by a team of academic researchers, women asylum seekers, and service providers from community-based organizations serving migrant communities who collaborated over a two-year period to develop and pilot the training program for new community-based advocates. The core content is grounded in a Social Determinants of Mental Health framework and targets three broad areas: understanding of the nature and causes of mental illness; knowledge about common mental health conditions among forced migrants, and skills for implementing evidence-based strategies for reducing mental health distress and increasing well-being. During 6 bi-weekly 2-hour training sessions conducted by the study PIs, consisting of didactics, practice exercises, and group discussions, BRIDGE Facilitators cover six modules grounded in evidence and best practices designed to give trainees the understanding, knowledge and skills to effectively identify, engage and intervene with forced migrants experiencing mental health distress including one focus group to assess needs and 5 content-oriented modules. The entire training is contextualized based on the impact of forced migration as a social determinant of mental health.

Session 1 consists of a focus group in which the trainees discuss their prior experience with mental health treatment, their beliefs regarding the key challenges related to mental health help-seeking in their community, and their experiences with individuals in their community who are experiencing mental health distress. Information from this focus group is then incorporated into the remaining training sessions to ensure relevance of the material.

Session 2 covers myths and stigma related to mental illness and mental health treatment. This module aims to address common stereotypes and culturally held beliefs that impede help-seeking and influence communications of mental health distress. Participants learn to distinguish between mental health disorders, and migration-related responses, normalizing heightened stress, anxiety, and fear, in this context. It also provides basic psychoeducation regarding the nature and causes of mental illness to break through strongly held beliefs regarding mental illness.

Session 3 focuses on mood and anxiety disorders. This module covers common signs and symptoms of depression, panic disorder, generalized anxiety disorder, and social anxiety. It reviews signs and symptoms of these illness as well as common treatments. Key evidence-based strategies for decreasing distressing symptoms associated with these disorders are also presented.

Session 4 focuses on grief, loss, trauma and PTSD. The differences between these concepts are reviewed. Participants learn about the difference between ongoing traumatic experiences often associated with forced migration, and the framing of most PTSD interventions within under the assumption of a post-traumatic state. Symptoms of PTSD and strategies for addressing them are also presented.

Session 5 focuses on trauma-informed and trauma-sensitive care and vicarious trauma. The purpose and impact of these approaches are reviewed as well as how they can inform a lay-helper role. Lastly, vicarious trauma is presented. Psychoeducation and strategies are provided around how to manage one's role as a helper to avoid burnout and compassion fatigue. Session 6 focuses on post-traumatic growth and resilience, compassion satisfaction, and self-care. These concepts are defined and discussed. Strategies for supporting oneself as a helper as well as self-care strategies to support those experiencing mental health distress are provided.

Measures

Sociodemographics

Sociodemographics were assessed using a self-report measure developed by the study Principal Investigators and included age, marital status, level of education, employment status, years in the US, and country of origin.

Understanding, Knowledge, Skills

Self-assessment of understanding, knowledge, and skills was a measure developed by the study Principal Investigators that they have successfully used in several previous studies. The measure consists of 3 subscales that ask trainees to self-rate their sense of understanding, knowledge, and competency around key material presented in the 5 content-oriented BRIDGE training modules. Each question included in the questionnaire corresponds to specific material in the training. The questions are rated along a five-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Nine (9) items assessed self-perceived understanding. Fourteen (7) items assessed for self-perceived unknowledge. Eight (8) items assessed for self-perceived skills. Sample items include, for example, "I have confidence in my understanding of the factors that contribute to resiliency" (understanding), "I have confidence in my knowledge of the key risk factors for common mental health disorders" (knowledge), and "I have confidence in my ability to implement self-care strategies with others to support well-being" (skill). The items in each subscale are added to represent subscale totals. Additionally, a total score is computed by summing the score of all of the items, with a higher score representing greater increase in understanding, knowledge, and skill. Further, trainees were asked to rate on a 5-point scale ranging from 1 (not at all) to 5 (very) their perception of how critical of an issue mental health is in their community and how available mental health services are in their community.

In addition, questions assessing training effectiveness were included in the post-test. Trainees were asked to rate on a 5-ppint scale ranging from 1 (not at all) to 5 (extremely) how satisfied they were with the training, how helpful the training was, and how much the training me their expectations. Lastly, one open-ended question asked trainees to identify specific learning outcomes: "What are 3 key take-aways you learned from the training? Be specific."

Data analysis

The statistical analyses were performed using IBM SPSS Statistics for Windows, version 27.[15] Descriptive statistics (means, standard deviations, and percentages) were used to describe the sample demographic characteristics. Paired t-tests were conducted to compare pre- and post-training assessments for each of the 3 subscales as well as the total scale. Statistical significance was set at p=.05.

Results

Table 1 reports on the sociodemographic characteristics of the sample. All trainees were identified as female and were on average 38 years old (+10). Seventy percent (70%) of trainees were married. Most trainees were employed (71%) and had at least a high school level of

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DOI: 10.15406/mojwh.2026.14.00335

education (76%). Trainees were in the US for an average of 20 years (+8) and most came from Mexico (53%). Twenty-three (23) of the 34 trainees completed the full 6-module training series. Eleven (11) missed 1 session due to childcare responsibilities (x3) or illness (x8). All participants rated mental health as being an "extremely" critical issue in their community (100%, n=34). Forty-one percent (41%) rated mental health services as "not at all" available (n=14); 44% reported services as being "a little" available (n=15); 11% reported services as "somewhat" available (n=4); and 3% (n=1) reported services as being "very" available.

Table 1 Sociodemographic characteristics of the sample

Sociodemographic Characteristic	n (%)	Mean (SD)
Age (years)		38 (10.11)
Marital Status		
Single/Never Married	24 (71)	
Married	7 (20)	
Divorced/Separated	3 (9)	
Level of Education		
High School Diploma/GED	13 (38)	
Some College/Technical Training	13 (38)	
Bachelor's Degree	5 (15)	
Graduate/Professional Degree	3 (9)	
Employment Status		
Employed	27 (79)	
Unemployed	7 (21)	
Years Living in the United States		20 (7.97)
Country of Origin		
Mexico	18 (53)	
Dominican Republic	10 (29)	
Honduras	3 (9)	
Salvador	2 (6)	
Columbia	1 (3)	

Table 2 reports on the results of the paired-samples t-tests. Findings indicate significant improvements from pre-training to post-training across all 3 domains of understanding, knowledge, and ability, and total score. Across all analyses, post-test scores were substantially higher than pre-test scores, with p-values below.001 and large effect sizes, demonstrating that the training had a very strong impact on trainee outcomes.

Table 2 Pre- and Post-Training Self-Rated Assessment of Understanding, Knowledge, and Skills

Outcome measure	Pre-Test mean (SD)	Post-Test mean (SD)	Mean difference	t(df)	p	95% CI for Difference	Cohen's d
Understanding	15.79 (3.78)	44.85 (0.50)	-29.06	-44.34 (33)	< .001	[-30.39, -27.73]	-7.60
Ability	12.53 (1.48)	39.91 (0.38)	-27.38	-100.06 (33)	< .001	[-27.94, -26.83]	-17.16
Knowledge	10.06 (1.41)	34.88 (0.48)	-24.82	-92.42 (33)	< .001	[-25.37, -24.28]	-15.85
Total Score	38.38 (4.49)	119.65 (0.88)	-81.26	-103.13 (33)	< .001	[-82.87, -79.66]	-17.69

Understanding

Trainees' scores on the Understanding Subscale increased dramatically from pre-training (M = 15.79, SD = 3.78) to post-training (M = 44.85, SD = 0.50). The results of the paired t-test showed this difference was statistically significant, t(33) = -44.34, p <.001. The average increase in understanding was 28.83 points (95% CI=[27.73,30.39]). The effect size was large (Cohen's d = -7.60), indicating that the training produced a considerable improvement in trainees understanding.

Ability

Participants also demonstrated significant improvement in perceived ability. Mean pre-training scores on the Ability Subscale (M = 12.53, SD = 1.48) increased to a post-training mean of 39.91 (SD = 0.38). The results of the paired t-test showed this difference was statistically significant, t(33) = -100.06, p <.001. The average increase was 27.38 points (95% CI[26.83, 27.94]). The effect size was large (Cohen's d = -17.16), again demonstrating that the training had a substantial effect on participants' ability.

Knowledge

Scores on the Knowledge Subscale demonstrated similar results. Trainee ratings improved from pre-training (M = 10.06, SD = 1.41) to post-training (M = 34.88, SD = 0.48). The paired t-test indicated this increase was statistically significant, t(33) = -92.42, p <.001. Participants improved by an average of 24.82 points (CI=[24.28, 25.37]). The effect size was large (Cohen's d = -15.85), supporting extensive gains in knowledge following the training.

Total score

Finally, overall total scores increased from a pre-training mean of 38.38 (SD = 4.49) to a post-training mean of 119.65 (SD = 0.88). The results of the paired t-test indicated that this difference was statistically significant, t(33) = -103.13, p <.001. The mean increase was 81.26 points (95% CI[79.66, 82.87]). The effect size was large (Cohen's d = -17.69), reflecting ample and important overall improvement from the training.

All participants rated being "extremely" satisfied with the training (100%, n=34). In terms of helpfulness, 97% (n=33) rated the training as "extremely" helpful and 3% (n=1) rated the training as "Very" helpful. Lastly, in regard to whether their expectations for the training were met, 97% (n=33) responded as "extremely" and 3% (n=1) responded as "very".

Discussion

This study is the first to examine the effectiveness of a community-driven, evidence-based mental health training program, co-developed by women asylum seekers and designed to support the forced migrant population. BRIDGE training was developed specifically to increase access to and utilization of mental healthcare services for communities in which the treatment gap is high by positioning trusted community-based advocates to identify and respond to need. Results indicate that BRIDGE Training significantly increased both self-perceived understanding of and knowledge about the nature of mental illness and factors impacting help-seeking (i.e., stigma); the signs and symptoms of common mental health disorders experienced by forced migrant communities; and evidence-based strategies for

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decreasing mental health distress and supporting well-being. Findings demonstrate that the training also positively influenced trainees' skill level at implementing evidence-based strategies to address their own needs as well as for supporting the well-being of others. The consistency of the findings across all domains of understanding, knowledge and skill, together with the substantially large effect sizes suggests that trainees experienced meaningful and extensive gains from pre- to post-assessment.

Our findings are consistent with the broader literature demonstrating peer support models as effective and scalable approaches to addressing mental health disparities, particularly among populations that may experience barriers to traditional care. This research indicates that peer-based approaches are particularly valuable in communities where mistrust of formal systems, stigma, language barriers, discrimination, and/or cultural incongruence limit access to formal mental healthcare services.[16,17] and are effective at improving quality of life, health consequences and behaviors, psychosocial adjustment, and social inclusion, and perceived social support.[10,18] In such communities, peer-delivered interventions may be particularly effective because peers often share lived experiences, cultural identities, and/or community contexts that facilitate trust and relational credibility, creating accessible, culturally grounded pathways to mental health services that 'bridge' the gap in care.

Among forced migrants, in particular, research has found that peer interventions effectively address many of the challenges faced by this population, including community integration, acculturation, and psychological distress.[17] This research notes that interventions co-developed with forced migrants are even more effective at addressing culturally specific needs and facilitating engagement.[17]

Our findings also align current evidence demonstrating that peer training programs enhance trainees' confidence and competence in providing emotional and practical support.[18,19] Trained peer supporters also have been found to report increased confidence at work; increased self-esteem; improved social networks; greater connectedness; increased hope and optimism about the future; stronger sense of meaning in life; greater use of self-care behaviors; improved clinical status; and, better mental illness management and improved general health resulting from their own increased understanding and awareness of mental health issues.[10, 20–24]

One particularly noteworthy finding of the current study is the extremely low variability in post-test scores, indicating that trainees reported very similar post-training ratings. This pattern could suggest a ceiling effect; however, it may also indicate that the training successfully delivered core competencies across participants. This is promising for non-mental health specialist workforce development initiatives as they suggest that brief or targeted training programs are sufficient and effective at producing consistent gains in foundational mental health support competencies. This finding may also reflect the fact that BRIDGE Training incorporates experiential learning, practical application, and a relational approach which can accelerate self-efficacy and skill acquisition.[10,25] Lastly, our trainees may have experienced such extensive benefits from BRIDGE Training as it validated their own lived experience and reduced stigma related to mental health discussions, allowing them to explore their own culturally held beliefs around mental illness and increase their mental health literacy.

Implications for research and practice

Research on peer-based models of mental health support for forced migrant populations is quite limited, despite the evidence that suggests that such programs have the potential to be highly effective with marginalized populations and at addressing the significant challenges that exist in accessing traditional mental healthcare. Our study shows that training CBAs as peer supporters is not only feasible but effective at improving mental health understanding, knowledge and skills. Expanding the reach and impact of BRIDGE training is a promising path towards reducing the mental health treatment gap experienced by forced migrants, particularly as immigration policies continue to limit access to basic services for this population, while simultaneously increasing existing stressors and creating new ones. This then begs the question, what is necessary to further support the expansion and legitimization of the program?

We offer several recommendations to support the expansion, adaptation, and long-term sustainability of BRIDGE Training to address the access and utilization gaps experienced by various forced migrant communities:

1. Formalizing a recognized certification pathway

Establishing a structured certification program with recognized credentials is a critical step in legitimizing the role of community-based advocates (CBAs), promoting ethical practice, and ensuring consistent standards of competence. Formal credentialing can strengthen the professional identity of CBAs, increase confidence among service providers and funders, and create clearer pathways for workforce integration and career advancement.

2. Developing organizational readiness to integrate CBAs into the workforce

Organizations should be encouraged to systematically assess their mission, policies, practices, attitudes, and beliefs about psychosocial treatment in order to evaluate and address their readiness to integrate CBAs into the workforce. Integrating BRIDGE-trained CBAs has the potential to address shortages of culturally responsive providers, reduce extensive waitlists that often delay care, and transform organizations from being perceived as foreign or inaccessible institutions to trusted entities that reflect and are grounded in the communities they serve.

3. Create and expand sustainable reimbursement mechanisms

Reimbursement for peer-based support is another critical aspect of expansion. Medicaid is increasingly becoming a funding source for peer support services, especially within mental health services. However, to date, it is not universal. Expanding the ability to bill Medicaid and other public and private insurers for services provided by CBAs, together with enforcement of mental health parity requirements, could substantially improve the financial viability and scalability of programs such as BRIDGE Training.

4. Strengthen research on outcomes and implementation

Further research is needed to evaluate the effectiveness, implementation, and cost-efficiency of BRIDGE Training and related interventions. Future studies should assess outcomes such as changes in mental health symptoms, access to and utilization of services, participant empowerment, and community capacity. Implementation research should also examine fidelity, adaptation across diverse settings, and the organizational factors that facilitate successful integration of CBAs. Demonstrating robust evidence of effectiveness will be critical to securing funding, influencing policy, and supporting broader dissemination.

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5. Center migrant communities in curriculum adaptation and evaluation

Migrant communities should be engaged as equal partners in the ongoing assessment, refinement, and adaptation of the training curriculum. Drawing on participatory and community-based research approaches, individuals with lived experiences of forced migration can help identify culturally specific expressions of distress, barriers to care, and locally relevant support strategies. Their engagement ensures that the curriculum remains responsive to community priorities, culturally grounded, and aligned with principles of dignity, participation, and self-determination.

6. Promote context-specific and culturally responsive adaptations

Although BRIDGE Training provides a structured framework, its content should be continuously adapted to reflect the legal, social, linguistic, and cultural realities of the communities and contexts in which it is implemented. Collaboration among researchers, practitioners, and community members can help tailor the curriculum to address varying migration trajectories, trauma experiences, and service systems, thereby enhancing both its relevance and effectiveness.

7. Engage in policy advocacy, to promote the inclusion of community-based advocates in the mental health workforce

Policymakers and professional organizations should recognize CBAs as a vital component of the mental health workforce, particularly in under-resourced and displacement-affected settings. Advocacy efforts should focus on developing credentialing standards, expanding reimbursement policies, and incorporating community-based models into broader strategies to reduce mental health disparities and improve access to care for migrant populations.

Strengths and limitations

This pilot study has several methodological limitations worth noting. First, the reliance on self-report of changes in understanding, knowledge and skills is a limitation of this study as social desirability and recall issues are potential concerns. Participants may also overestimate their level of understanding, knowledge, and skill. Future studies based on a rigorous experimental design are needed. Second, this study does not allow us to assess for the impact of the training over time. Post-training long-term follow-up will be important to provide valuable information about the implementation of the training and sustainability of the training effects over time. Third, this study did not collect information about CBA characteristics that might influence their work with forced migrants or their response to training. For example, we did not formally assess for the trainees' personal experiences with migration and mental health distress which might influence their beliefs about and understanding of training materials. However, their own experiences were raised throughout the training and used to shape the discussions. Fourth, this sample included only undocumented migrants that resided in the United States for longer periods of time than other migrant populations and formed a community that was strengthened over time, which might not be the reality of other migrant groups, such as asylum seekers, refugees, or people under other forms of temporary protection. Providing the BRIDGE training to participants for multiple migrant communities would allow us to measure its effectiveness beyond this community.

Despite these limitations, this study also has a number of strengths. To begin, this is one of the first studies to examine an evidence-based training program of community-based advocates co-developed by women with lived experience of forced migration for women forced migrants. This study establishes BRIDGE training as aligned with community driven priorities, responsive to cultural beliefs and expectations, and effective at increasing mental health understanding, knowledge, and skill. Further, we centered the voices of women with lived experience of forced migration. In doing so, rather than entering marginalized communities as the experts and thereby increasing reliance on outsiders, we were able to position communities to care for themselves. In addition, we were able to ground BRIDGE training material in the needs, values and beliefs of the community from the outset rather than having to modify an existing formalized program to be relevant to the community.

Conclusion

Despite noted limitations, the results are encouraging and point to the need for replication using larger samples, experimental design, more rigorous assessment measures, and longitudinal follow-up. As the forced migrant population in the United States to continues to grow, the mental health treatment gap is sure to increase, negatively contributing to the mental health distress experienced by this population. The impact of unaddressed mental health needs has significant implications not just for individuals but for the larger community and society as a whole in terms of decreased social cohesion and reduced economic productivity. Leveraging trusted peers and empowering them to provide mental health support within their community has the potential to significantly reduce the treatment gap among forced migrants and increase access to greatly need mental health support.

Acknowledgements

None.

Conflicts of interest

The authors declare that there are no conflicts of interest.

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DOI: 10.15406/mojwh.2026.14.00335