Exploring Perceptions and Access to Mental Health Care Among Bhutanese Community Members in Allegheny County

by

Srinidhi Alur

B.S, University of Pittsburgh, 2018

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This thesis was presented

by

Srinidhi Alur

It was defended on

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and approved by

Patricia I. Documet, MD, DrPH, Behavioral and Community Health Sciences

Mary E Rauktis, PhD, School of Social Work

Thesis Advisor: Martha Ann Terry, PhD, Associate Professor and Director of the
Master's Program, Behavioral and Community Health Sciences

Exploring Perceptions and Access to Mental Health Among Bhutanese Community Members in Allegheny County

Srinidhi Alur, MPH

University of Pittsburgh, 2022

Mental health is a pressing concern for Bhutanese refugees, yet mental health services remain underutilized by this population. This paper aims to explore the factors that affect access to mental health services, including telemental health services, among Bhutanese community members in Allegheny County across levels of the Socio-Ecological Model (SEM). Six Bhutanese community members participated in one-on-one qualitative interviews with the researcher over HIPAA-compliant Zoom. Results from these interviews point to many barriers to mental health care across relational, organizational, community, and policy levels. Barriers to care include negative perceptions towards mental illness, impact of stigma towards mental health on relationships, difficulty navigating healthcare settings, and inadequate supportive personnel. Supports for accessing mental health care were primarily organizational, such as community groups. Participants viewed telemental health as a support, such as reducing the transportation barrier, and as a barrier, like lack of access to private technological devices. Participants identified several strategies for improving access to care across levels of the SEM, including implementing mental health trainings and alternatives for the phrase "mental health". Findings support and add to what is seen in the literature and pose future implications for improving access to care for Bhutanese community members. Results from this study underscore the need for obtaining community input to effectively understand the factors affecting access to mental health.

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Preface

  The researcher would like to acknowledge that she is the daughter of South Indian immigrants, born and raised in the US, does not speak Nepali or Hindi, and has a background in Social Work, Public Health, with an interest in mental health. Drawing attention to the distinction between immigrant and refugee is important, as her and her family had the privilege to move to the US on their own volition. Most refugee groups, including Bhutanese refugees, don't get that choice to leave. Often times refugees are forced out of their home country, which can shape the circumstances surrounding their journey and stay in host countries. The researcher also wants to note she is not fluent in Hindi and Nepali, which are the languages the Bhutanese community predominantly speaks.

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1.0 Introduction

The National Institute of Mental Health (NIMH) estimates that in 2020 nearly 52.9 million American adults, or about one in five, live with mental illness (NIMH Mental Illness). As of 2020, the second leading cause of death among people ages 10 to 34 is suicide (National Alliance on Mental Illness [NAMI], 2022) . Despite evident need, only 46.2 percent of Americans with mental illness received mental health treatment in 2020 (NAMI, 2022). Mental health care is noticeably delayed, as one study found that the average time between onset of mental health symptoms and accessing care was 11 years (Wang et al., 2004). Mental illness remains one of the largest health burdens for minority populations, with little progress in reducing disparities in mental health care access among Black and Latinx populations between 2004 and 2012 (Cook et al., 2017).

Mental health is a pressing concern for the Bhutanese refugee population. Bhutanese refugees in the United States (US) are disproportionately affected by suicide, as they reportedly die by suicide at almost two times the rate of the general population (Meyerhoff et al., 2018). In addition, Bhutanese refugees have reported high rates of mental health disorders, including depression, anxiety, and post-traumatic stress disorder (PTSD) (Maleku et al., 2022). Bhutanese refugees are at especially high risk given that suicidal ideation among this population is under-reported, meaning that detection is challenging (Meyerhoff et al., 2018).

Mental health has been particularly impacted during the Coronavirus Disease 2019 (COVID-19) pandemic, as lockdown and isolation have taken a toll on economic, social, and emotional needs (Chen et al., 2021). Along with pandemic-related environmental factors affecting mental health, recent research has shown COVID-19 impacts the central nervous system (CNS) both directly and indirectly (Pandey et al., 2021). Not only has mental health been impacted by the

pandemic, but serious mental illness (SMI) is also recognized as a risk factor for COVID-19, as those with SMI are more likely to contract or die from COVID-19 compared to the general US population (Gordon, 2022).

Given barriers to in-person appointments, COVID-19 has led many providers to resort to providing telehealth services. Telehealth services can have numerous benefits, such as flexible access, along with drawbacks, like limited access to technology or a private/confidential space (Disney et al., 2021). One recent study assessed clinical social workers perceptions towards telemental health usage among Bhutanese refugees (Disney et al., 2021). This study found that while clinical social workers remained flexible in providing care, they faced numerous barriers to providing telemental health care, such as poor Wi-Fi connection and difficulty building rapport (Disney et al., 2021). Despite the need, limited research on perceptions of Bhutanese refugees towards telemental health is lacking. It is important to assess perceptions towards telemental health usage among Bhutanese refugees to improve user experience and access to care.

Pennsylvania (PA) and Pittsburgh are both home to sizeable Bhutanese refugee populations. More than 9,000 refugees from Bhutan were living in PA during 2009-2019, as reported by the PA Department of Human Services (DHS) (DHS). Secondary migration has led to a large influx of Bhutanese refugees into the Pittsburgh area, making it one of the largest refugee groups in the region, with estimates of over 3,000 refugees (Horn et al., 2013). Therefore, exploring barriers to and facilitators of mental health treatment among Bhutanese refugees in the Pittsburgh region is crucial to inform culturally tailored interventions.

This study explores perceptions of Bhutanese refugees living in Pittsburgh towards mental health and telemental health services and barriers to accessing mental health treatments in addition to recommendations for improving access to mental health care. Chapter Two will examine

existing literature on the resettlement history of Bhutanese refugees, along with perceptions towards mental health and barriers to accessing mental health services among immigrant and refugee populations. This chapter will also address background in telemental health use among immigrant and refugee populations and provide context on the theoretical framework guiding this study, the socio-ecological model (SEM). Chapter Three will describe the methodology of the study, such as building rapport with the community, recruitment and data collection, and analysis. Chapter Four covers the findings from data analysis and details the themes found within the data in relation to the SEM. Chapter Five provides an overview of what findings mean and future directions to explore in research based on the results. Chapter Six contains the conclusion, limitations, and explains how findings support the importance of incorporating community voices in research.

1.1 Research Question

The overarching research question is, "What are factors affecting access to mental health and telemental health care among Bhutanese resettled in Allegheny County?" To explore this, one-on-one interviews with community members involved a series of open-ended questions. Questions were developed in English and translated in Nepali for instances where participants were not proficient in English. A certified Nepali translator was contracted for as-needed services in case participants were non-English speakers. See Appendix A for interview guide.

1.2 Theory/Framework

The SEM will serve as a guide to understand community perceptions towards mental health, along with access/barriers to resources. Numerous factors on multiple levels influence perceptions towards mental health. For instance, one study looking at Arab-Americans found that stigma towards mental health operated on multiple levels (Alhomaizi et al., 2018). In that study, stigma encompassed intersectional stigma, associative stigma, community-level stigma, and even universal stigma (Alhomaizi et al., 2018). The socio-ecological framework and its relevance will be explored more in depth in the background.

2.0 Background

Mental health is a broad classification that refers to our emotional, social, and psychological wellbeing (Centers for Disease Control and Prevention [CDC]). Mental health affects how we cope with stressors and how we relate to the world (CDC). An individual's mental health can be affected by a combination of individual-level and broader, societal-level, factors (World Health Organization [WHO], 2022). These socio-ecological factors can be either protective or detrimental to one's mental health, around the risk of developing mental illness (WHO, 2022). Mental illness can include both Any Mental Illness (AMI) or Severe Mental Illness (SMI), and refers to behavioral, emotional, and psychological disorders that impair functioning in varying degrees (NIMH Mental Illness).

To understand the current mental health crisis among the Bhutanese community, it is imperative that we look at the historical context, and how the mental health climate of the Bhutanese community relates to other immigrant and refugee documented experiences. To clarify, immigrants are individuals who voluntarily leave their home country to seek opportunities, reunite with families, or for other reasons. Immigrants do not typically face barriers to returning to their home countries. Refugees are defined as those fleeing persecution or conflict, and often are unable to return to their home countries (Mangrio & Sjögren Forss, 2017). PTSD and depression are increasingly common among refugee groups, given the nature of their forceful eviction from their home countries (Mangrio & Sjögren Forss, 2017). For the purpose of this paper, the author will cover immigrant and refugee documented experiences separately to reflect the unique and varying circumstances each group faces.

2.1 Historical Context

The Bhutanese refugee crisis is a "protracted refugee situation," which is defined as a situation when more than 25,000 refugees from the same ethnic group have been in exile in any asylum country for five or more years (Banki & Phillips, 2017). Being a group that is part of an "protracted refugee situation" can have long-lasting implications, including a sense of loss of dignity (Banki & Phillips, 2017).

A small Himalayan kingdom, Bhutan is often globally recognized as being a place of high "Gross National Happiness," a title that is in stark contrast with the lived experiences of Bhutanese refugees (Banki & Phillips, 2017). Most Bhutanese refugees residing in the United States are descendants of "Lhotshampa," an ethnic group hailing from Nepal (Acharya, 2022). It is important to note that some Bhutanese refugees consider "Lhotshampa" to be a derogatory label, as it was utilized frequently by the Bhutanese government to "other" them (Acharya, 2022; Banki & Phillips, 2017). To acknowledge this, the paper will use these terms: ethnically-Nepali population, Nepali-Bhutanese, and Bhutanese refugees (Banki & Phillips, 2017).

In the 17th century, it is said that the Bhutanese government employed several ethnically-Nepali members as farmers (McGuire et al., 2021). This population set roots in Bhutan for several generations, while maintaining their own distinct ethnic and cultural practices from other Bhutanese citizens (McGuire et al., 2021). From the 1980s to the 1990s, Bhutan's "One Nation, One People policy" spurred widespread efforts by the Royal Government of Bhutan to remove this group from Bhutan (McGuire et al., 2021). The Bhutan monarchy, an ethnically Buddhist group, was threatened by the distinct cultural practices and feared the loss of political power (McGuire et al., 2021). Originally, the Bhutanese monarchy's crackdown began with the enforcement of strict dress and language codes, directly targeting the cultural practices of the ethnically-Nepali

population and eventually leading to the Bhutanese government stripping away their citizenship rights (Banki & Phillips, 2017) When the ethnically-Nepali population pushed back against these rules and advocated for more political representation, the Bhutanese government responded with increased violence and force, culminating in Bhutan exiling almost a sixth of its population (Banki & Phillips, 2017). This group was driven to seek asylum and ultimately resettled in seven refugee camps across Nepal (Banki & Phillips, 2017).

For close to two decades, nearly the entire Bhutanese refugee population remained in Nepali refugee camps. Despite leaving the torture in Bhutan, Bhutanese refugees faced another set of stressors in the Nepali refugee camps, such as discrimination and lack of resources (McGuire et al., 2021). Around 2008, escalating pressure led to the widespread resettlement of Bhutanese refugees in many European and North American countries, including the United States. As of 2019, approximately 24,000 Bhutanese former refugees were residing in the United States (Budiman, 2019).

2.2 Perceptions towards Mental Health among Immigrant Communities

Mounting evidence has shown that mental illness is viewed unfavorably among immigrant communities. For instance, one study found that psychiatric conditions are rarely acknowledged by Somali immigrants and that typical interventions for psychiatric conditions are ineffective for this population (Wolf et al., 2016). Despite mental health being a pressing concern for Somali immigrants, it is often considered "taboo" to talk about. Many Somali immigrants also view taking medications as unnecessary unless severe symptoms are present, which can also limit the type of mental health care this population is willing to receive (Wolf et al., 2016).

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Mental health services are often underutilized by immigrant populations. One study found that while the Latinx immigrant population in the United States experienced lower rates of depression compared to white Americans, they were also less likely to use mental health services (Tyson et al., 2016). Underutilization of mental health services among immigrant populations extends to adolescent and young adult children of immigrants. A recent study exploring utilization of school-based mental health services among Asian adolescents found that they use mental health services less both in school and community settings (Wang et al., 2019). Access to care and perceptions towards care can be heavily influenced by those of the caregivers (Wang et al., 2019). This can be a potential barrier to care as negative perceptions of mental health by caregivers can impact the care adolescents can receive (Wang et al., 2019). For example, only 32% of Asian American immigrant parents view antidepressants as helpful with managing depression (Wang et al., 2019). Addressing perceptions towards mental health care among immigrant populations is needed to improve access to care not only for immigrant adults, but for their children as well.

2.3 Perceptions towards Mental Health Among Refugee Communities

Similar to immigrant populations, considerable research exists on unfavorable perceptions towards mental illness among refugee populations. One qualitative study involving interviews with community leaders found that Karen refugees from Burma often view poor mental health as a result of karma or sin (Kim et al., 2021). The term "mental health" itself when used to describe mental illness can carry a lot of taboo and shame, with many believing that "mental health" is reserved for "crazy people" (Kim et al., 2021). In a similar vein, a focus group study found that Syrian refugees view "mental health" as a punishment from God or even as a supernatural

phenomenon, connected to possession by evil spirits known as Jinn (al Laham et al., 2020). Many refugee groups, such as Rwandan refugees, view spiritual healing and faith-based support as the preferred method for improving emotional wellbeing (Tonui, 2022).

2.4 Barriers to Accessing Mental Health Care Among Immigrant Communities

Despite growing need, much research has found that immigrant populations are less likely access to mental health services. A systematic review found that most common barriers to mental health care for immigrant populations can be categorized as cultural and structural (Derr, 2016). Cultural barriers included stigma and perceptions, while structural barriers included lack of insurance and access to transportation (Derr, 2016). While sharing generally similar barriers, what was considered the most prominent barrier to mental health care for each immigrant group varied (Derr, 2016). Immigrant populations turn to informal support for mental health, including friends, family, and religious leaders (Derr, 2016). Seeking spiritual healing for mental health concerns is common among African immigrant populations (Derr, 2016). Several studies have examined the impact of seeking informal methods for mental health support on seeking formal supports, with mixed results (Derr, 2016).

One study classified four domains of barriers to mental health care for Asian immigrants: knowledge, attitudinal, structural and practical, and relational barriers (Wang et al., 2019). Limited familiarity with mental health services or difficulty identifying mental health symptoms, lack of culturally competent providers, and stigma were three of the most reported factors in this study (Wang et al., 2019). One study showed that 26.3% of Asian-American immigrants struggled to identify mental illness symptoms as they were not as noticeable as physical symptoms (Wang et

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al., 2019). Perceived importance and effectiveness of mental health care are seen as additional barriers to mental health care among Asian-American immigrants, as some respondents reported that "mental health" is viewed as unimportant and typical mental health care as ineffective (Arora & Khoo, 2020).

2.5 Barriers to Accessing Mental Health Care Among Refugee Communities

Refugees often endure combined trauma associated with being forcibly removed from their home country and the resettlement process, added to the difficulties of immigrating to a new country, such as potential language barriers, navigating a new health care system, and culture shock. These additional hardships pose a unique set of needs and challenges for refugee communities when accessing mental health care. Refugees may face multiple forms of trauma throughout the forced migration process, such as war terror, and it is difficult to identify what combination of risk factors exacerbate mental illness for these populations (Cratsley et al., 2021). In addition, where refugees are resettled, either temporarily or long term in their host countries, has its fair share of stressors (Cratsley et al., 2021). Some of these include social isolation, discrimination, and financial hardships (Cratsley et al., 2021). In addition, linguistic barriers are commonly cited since western mental health terminology often does not translate in native languages spoken by many refugee populations. While the WHO has created a global initiative to prioritize mental health care for refugee populations, limited progress has been made toward these goals (Cratsley et al., 2021).

2.6 Perceptions Towards Mental Health and Access to Care Among Bhutanese Refugees

Recent research has focused on perceptions towards mental health care and access to mental health care among Bhutanese refugees to address the imminent need. One study that looked at perceptions towards suicide among Bhutanese refugees in Massachusetts found that while death by suicide was prevalent, many community members were hesitant to talk about it (Brown et al., 2019). Another study that conducted a community health needs assessment in Ohio found that Bhutanese community perceptions toward mental health care were overall negative (MacDowell et al., 2019). The study found that 71% of participants reported that seeking a counselor was viewed unfavorably among the Bhutanese community (MacDowell et al., 2019).

Several factors impact access to healthcare for the Bhutanese community. According to the CDC, federal resettlement benefits end after eight months, limiting access to healthcare (CDC, 2021). Bhutanese refugees resettled in America also experience difficulties navigating the American healthcare setting. Despite the use of Nepali translators during medical appointments, many noted that the dialect used by translators differed greatly from the Nepali that Bhutanese refugees spoke (Salinas et al., 2021). Some report difficulties with having their needs translated adequately and experiencing discrimination from Nepali translators (Salinas et al., 2021). Others, especially elders, express frustration with short appointments and limited time to properly discuss their needs (Salinas et al., 2021). American healthcare providers may also be dismissive of Bhutanese refugees' culture-based healthcare beliefs, including the use of home remedies (CDC, 2021). Coupled with set gender roles, females may vocalize their children's or spouses' health concerns while being less likely to indicate their own personal health matters (CDC, 2021).

Several macro level factors affect access to services for Bhutanese refugees, including poverty, discrimination, language barrier, and housing. Bhutanese refugees experience higher

poverty rates at 33% compared to the general US poverty rate of 15% (Zhang et al., 2021). COVID-19 has likely exacerbated financial stress, which in turn affects access to basic needs such as housing and food (Zhang et al., 2021). Those who experience poverty may be less likely to pursue mental health services, as cost of services and demanding work schedules can serve as barriers to care (Zhang et al., 2021). Bhutanese refugees come to Pittsburgh for accessible job prospects that do not require English proficiency (Dague, 2021). However, options are limited, and those available are underpaid with few to no benefits (Moore, 2018). Ultimately this forces many to take entry-level positions despite holding degrees (Moore, 2018). As one Bhutanese community member in Pittsburgh expressed to a local newspaper, the *Pittsburgh Post-Gazette*, "We know that USA stands for You Start Again" (Moore, 2018, p.2). Bhutanese refugees experience discrimination, and many have trouble reporting harassment due to limited English proficiency (Zhang et al., 2021).

Affordable housing also drew many to Pittsburgh, yet the threat of poor housing conditions remains. In 2015, a report was released about a local slumlord David Gartley renting over-priced properties with no water or sewage services to Bhutanese refugees (WTAE, 2016). While mental health remains a critical issue, much stigma surrounds mental health and can act as a barrier to receiving services or expressing need (Zhang et al., 2021). To address this, Mental Health First Aid (MHFA) trainings run by former Bhutanese refugees have been disseminated to Bhutanese refugee community groups in both Nepali and English across the country (Gurung et al., 2020). An evaluation of these trainings found a decrease in stigmatizing beliefs among those who participated in the bilingual orientation compared to those who did not (Gurung et al., 2020). Follow-up is needed to examine sustained benefits from these trainings.

2.7 Telemental Health

According to the American Psychological Association (APA), telemental health is "the provision of behavioral and/or mental health care services using technological modalities in lieu of, or in addition to, traditional face-to-face methods" (Appleton et al., 2021). These modalities include video-conferencing platforms, telephone calls, texting, and email (Appleton et al., 2021). Mental health care in this case can include psychotherapy, evaluations, and medication management (Whaibeh et al., 2020). Telemental health use dramatically rose during the COVID-19 pandemic, with data suggesting use of telemental health services during visits rising from 1% pre-pandemic to close to 80% during March to April 2020, the initial peak of the pandemic (Karimi et al., 2022). The intended goal with telemental health is to serve as a cost-effective method to reach underserved populations and those affected by isolation and quarantine by reducing the barrier of transportation (Whaibeh et al., 2020).

Telemental health has some reported benefits for refugee populations as it can be used to provide urgent care rapidly (Yıldız Nielsen et al., 2022). Recent correspondence to the editor of *Nature Human Behavior* expanded on the benefits telemental health has offered to refugee populations (Yıldız Nielsen et al., 2022). Some of these included less withdrawal from daily life activities and increased solidarity for Syrian women refugees resettled in California (Yıldız Nielsen et al., 2022). Telemental health in the form of skill-building workshops for Afghan newcomers to the US reduced anxiety and stress for attendees (Yıldız Nielsen et al., 2022). However, a study with mental health providers who serve Bhutanese refugees found multiple barriers to providing care, including technology barriers and difficulty noticing non-verbal cues (Disney et al., 2021). Therefore, it is important to understand perceptions of Bhutanese community

members towards telemental health care as a means of informing future telemental health interventions.

2.8 Socio-Ecological Model

The Socio-Ecological Model (SEM) is a framework that explores the relationships between factors that affect health across varying levels including individual, relationship, community, and societal (Hawkins et al., 2021). Examining these levels allows us to understand the interconnectedness of factors that affect a person's health and well-being beyond the individual scope (Hawkins et al., 2021). The SEM can guide interventions by providing a framework organizing the factors that affect a person's health in a population (Hawkins et al., 2021).The University of Minnesota School of Public Health has developed a preliminary Mental Health and Well-Ecological Model of Mental Health to reflect the variety of factors that specifically influence mental health in a community (Mental Health and Well-Being Ecological Model | Leadership Education in Maternal & Child Public Health.). This model is particularly significant given that it specifically focuses on mental health factors and promotion, as opposed to overall health, across the different levels of the SEM. Different mental health factors addressed in this model include relationship level factors like harsh parenting and policy level factors such as government investment in resources for mental health management (University of Minnesota [UMN], 2021). The intended goal of the model is to reflect a public health approach to mental health and identify the range of mental health promotion strategies available ((Mental Health and Well-Being Ecological Model | Leadership Education in Maternal & Child Public Health).

Many studies have explored factors affecting mental health and access to mental health care through the lens of the SEM. For instance, a qualitative study in Nepal identified several barriers to accessing mental health care across the levels of the SEM, including at the policy and health organizational levels (Devkota et al., 2021).

Another study utilized the SEM to examine factors that contribute to emotional distress among Sierra Leon residents (Horn et al., 2021). Conceptualizing findings using the SEM allowed the researchers to identify societal and community level factors, such as poverty and harmful gender norms, that contribute to emotional distress and identified priority needs to address (Horn et al., 2021). The researchers acknowledged that these factors across levels are interconnected and targeting one level of the SEM, such as promoting income-generating opportunities, can affect factors on other levels of the SEM (Horn et al., 2021).

Some studies have used the SEM as a lens to conceptualize solutions in improving access to care. A Canadian study examined Bangladeshi immigrant experiences with accessing primary healthcare through focus group discussions and used the SEM as a framework to present possible solutions to improving access (Turin et al., 2021). These approaches included individual-level approaches, such as increasing self-awareness, community level approaches, like hosting health education workshops, and service-provider level approaches (Turin et al., 2021).

3.0 Methodology

South Hills neighborhoods such as Carrick, Mount Oliver, Castle Shannon, Whitehall, and Baldwin were primary focuses as many Bhutanese refugees reside in these neighborhoods (Horn et al., 2013). The target sample for this study was Bhutanese refugees 18 years and older resettled in Pittsburgh who are Allegheny County residents.

3.1 Interview Guide Development

The interview guide was developed using the SEM. Probes were added under questions to elicit responses on barriers and supports to mental health care across different levels, including across relational, organizational, and policy levels. Using the socio-ecological model allowed for a more holistic view. Examples of questions included in the interview guide are "Tell me more about how your community views mental health and mental health care?", "What are some potential barriers/obstacles to accessing mental health services like therapy?", and "What are some ways in which we can improve access to mental health care for Bhutanese refugees?" Examples of probes include "What are some potential barriers/obstacles to accessing mental health services on a community level? How about at a structural level (local government, policies, etc.)?" See Interview Guide in the appendix for the complete interview guide.

3.2 Building Rapport and Establishing Community Links

To build rapport and establish community links, the researcher volunteered with Zoom Citizenship classes hosted by Bhutanese Community Association of Pittsburgh (BCAP) from early 2021. Being involved with the classes allowed the researcher to form connections with some community members and to troubleshoot Zoom navigation challenges. The researcher also assisted with tabling for BCAP at various cultural events. The cultural events allowed the researcher to observe community gatherings and a glimpse at cultural practices. The researcher visited the community neighborhoods and small businesses, such as shops and restaurants owned by local community members.

3.3 Recruitment and Data Collection

Data collection involved one-on-one interviews and occurred at one point in time. After conferring with knowledgeable individuals within the population, snowball sampling and convenience sampling were identified as the most feasible and appropriate methods for recruitment. Local community leaders advised that allowing community members to voluntarily share study information within their social circles was the most culturally sensitive strategy. Convenience sampling took place in the form of known connections within the community expressing interest in participating. Snowball sampling occurred as participants recommended the study to other community members.

Recruitment utilized a multi-pronged approach. One aspect of recruitment included posting flyers at the BCAP community center and other organizations that serve Bhutanese refugees, such

as Jewish Family and Community Services (JFCS), Acculturation for Justice, Access, and Peace Outreach (AJAPO), and ARYSE. Flyers in both English and Nepali were also posted in community gathering spots such as shops, libraries, and restaurants, if the owners allowed it/provided permission.

Community leaders in these organizations also recommended participants for the study. This occurred when representatives provided brief information about the study to residents along with the researcher's contact information and recruitment materials.

Recruitment occurred in a virtual setting through email and social media platforms. Emails were sent through an email listserv after being approved by the email listserv organizer (e.g. BCAP mailing list). Recruitment advertisements were posted on social media pages, such as Facebook and Instagram, after the approval of the page owner. Only IRB approved recruitment materials were presented and all recruitment materials were translated in Nepali.

Interested community members were also encouraged to share the study recruitment flyer with those in the community who may be interested. In addition, interested participants could reach out to the researcher voluntarily for more information using the contact information included in recruitment materials.

Once participants indicated they were interested in participating (whether via email, phone call, or in person), an invitation-only Qualtrics survey link was disseminated. Individuals could also access the survey via QR code on the recruitment flyers. The survey included a written copy of the introduction script, an option to indicate if they were interested in participating, eligibility questions, and then fields to enter relevant contact information. Contact information could be entered only if they indicate yes for 'interested in participating'. The Qualtrics survey was available in both English and Nepali and had to be taken before participating in the study.

Interviews occurred over HIPAA-compliant Zoom between June 2022-July 2022 and all files were stored on university approved secure servers. Interviews lasted approximately 60 minutes and all participants were compensated with a $30 Giant Eagle gift card. The compensation amount was decided upon after consulting with local community leaders.

3.4 Analysis

Interviews were audio and video recorded to ensure accuracy. In addition, the researcher took handwritten memo notes during each interview to reference during analysis. These notes included context, initial codes, and illustrative quotes. All online data were stored on IRB approved servers and handwritten data was stored in a private locked storage drawer that only the researcher had access to. Data were analyzed using NVivo 12 software. The researcher performed coding for all data using the SEF as a guide in developing themes. Thematic analysis was chosen as the most appropriate approach to understanding the data as to allow flexibility for emergent codes. Data coding was an iterative process, where the researcher first immersed themselves in the content of the data by watching recorded interviews and rereading transcripts. This occurred multiple times to increase familiarity with data and note emerging patterns. Once the researcher established familiarity with the data, they reviewed content for themes and patterns. Themes were loosely grouped according to the SEF framework and interview questions, with broad themes consisting of barriers, supports, and ways to improve access to care. As coding continued, the researcher divided broader themes into subthemes to reflect patterns in the data and included emergent codes that drew upon words used by participants. The researcher then reviewed and revised themes to

ensure each theme was distinct and contained sufficient data. Some themes were merged or removed as overarching themes during this process.

4.0 Results

The researcher interviewed six participants (n=6) for this study, of which three were male and three were female. Half of participants were 31 + and half were between age of 18-30. Of the male participants, two were aged 31+ and one male participant was between the age of 18-30. Among the female participants, one female was age 31+, and two were between the ages 18-30. All participants were residents of Allegheny County, spoke English, and identify as part of the Bhutanese community. The data were analyzed by the researcher. Results fell into the following themes: history and trauma, perceptions, barriers, supports, strategies to improve access to care, and telemental health. Themes are interfaced with the SEM, and factors fall across the individual, relational, organizational, community, and policy levels. Figures are included to illustrate themes in relation to the SEM levels for both factors affecting access to care and strategies to improve access to care. Quotes are cited in the following format, (interview number in chronological order, gender, and age range). For example, a quote from the second interview conducted, with a male participant, and between the ages of 18 to 30 would be cited as (2, M, 18-30).

4.1 Community: History and Trauma

Figure 1 shown below depict the various factors that affect access to mental health care for Bhutanese refugees in Allegheny County in relation to the SEM. Factors listed in red are classified as barriers to accessing mental health services while factors listed in blue are supports to accessing mental health services.
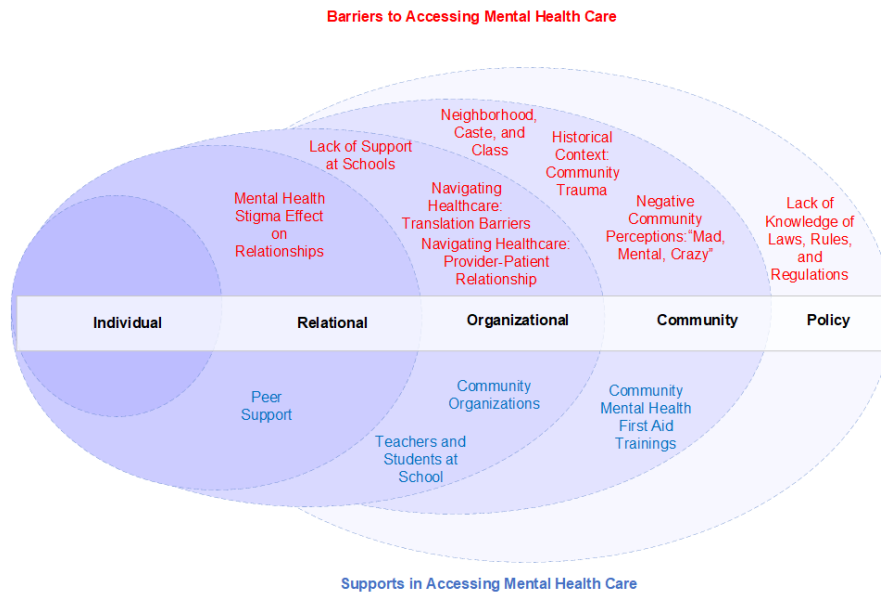
Figure 1. Factors affecting access to care across the SEM

Almost all participants acknowledged resettlement history of Bhutanese community members before arriving in Allegheny County. These experiences centered mostly around time in Bhutan or as refugees in refugee camps in Nepal, and the negative impact these events had on mental health in the community. Some included their own personal experiences in the refugee camps, while others shared stories that were passed down from parents or grandparents.

> Like what nearly doesn't get talked about enough is like. In the community, like people went through like genocide, you know, like in Bhutan before they moved like people lived through like terror campaigns and it's like that's not the way it's classified. Because I think like Bhutan now is rebranding itself as a nation, that uses happiness as its GDP measure and all this. But like at the end of the day that is built on the expulsion of nearly a quarter million people simply for asking for political representation (2, M, 18-30).

Participants acknowledged that in addition to losses endured while leaving Bhutan, such as property, items, and family, community members also lost ties to culture, religion, and food by coming to the US. Many stated that the community has endured much trauma that often is not acknowledged, as one participant expressed, they have not heard their community mention PTSD.

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We left the countries so our parents they left all their value and the property. So once we leave all those things then and then from Nepal we moved to the US, when we moved to US we left culture, the religion, might be the food, kind of those attachment. So we are traumatized. In other way, we are at least stressed out. So all those stress…little things those are all the mental health. (3, M, 31+).

…It's just you're either fine or you're crazy. And if you're not fine, then you've gone crazy…but especially in this community like trying to make sure that people see that like it's not that people have gone crazy it's that… like it's a miracle that not everyone has like gone crazy… People went through real trauma and like it's really worth talking about …I don't think I've ever even heard anyone like mention that like people have PTSD….It's not that like people have gone crazy. People have PTSD from living through genocide and then displacement and then being a country that was going through war. and also in Nepal, you know, like integration was pretty hard. The locals were not that receptive, you know? (2, M, 18-30)

In addition to the difficulties with resettling, some participants expanded on the lack of access to healthcare in refugee camps and how hospital visits were reserved for more severe, or "sick sick" cases.

…But even though I was little, I still remember living in a refugee camp there. We did not have any resources of like most of the healthcare thing. It was only if you're sick. You go to the hospital you didn't… like you didn't used to like make appointments or let's go let's go for a checkup. It wasn't anything like that. If you're sick sick, then you go to the hospital and see the doctor. Otherwise, you do not go to the hospital at all. There was no dental, no anything so there, so there's no like any mental health doesn't come anywhere here like no therapy also. (4, F, 18-30).

4.2 Community: Perceptions towards "Mental Health"

Perceptions were categorized by how the Bhutanese community perceives mental illness and mental health care. Findings show that perceptions included various words and phrases to describe "mental health", such as mad, mental, and crazy.

4.2.1 Mad, Mental, and Crazy

Participants in these interviews used several terms for mental illness and "mental health" that carry a negative connotation within the Bhutanese community. The terms that appeared more frequently were mad, mental, pagal, and crazy. Pagal was described as the Hindi term for crazy. "Mental" was often used synonymously with "crazy" or mad.

> But the people in our community didn't think there is a mental health. … people they think you are pagal…this is the same one in Hindi .So they say pagal when someone says that you have mental health, OK? So pagal, you are crazy. (3, M, 31+)

Some participants even differentiated between different levels of "mental" depending on the severity of the mental health condition. "Mental mental" or "fully mental" was used to describe those with limited consciousness or awareness and in need of assistance from family members with daily living tasks. "Mental mental" or "fully mental" was characterized separately from depression, as depression can be seen as less severe or not acknowledged as an issue. Some mentioned that now community members can recognize when someone is "fully mental" but are unable to identify when someone is depressed.

> Like you know how you are like, mental mental, like you're not conscious of anything…like not someone who's going through a depression… but like some people who are like fully like who are mental mental…they're not aware of what they're doing. They, like family, have to take care of them…Not like someone who can take care of themselves all that and going through something depression or something or wanting to isolate them. Not someone like that, but someone who's like whose like families taking care of like because he's in that stage. She is in that state.(4, F, 18-30)

Even being associated with mental health treatment like a "mental hospital" may be seen as "proving them right", or rather proving to community members that they are "mental".

> People are already insensitive…Mad is a normal thing for people to speak up when they see unusual behavior… Even when people do crazy things, it's a normal trend for anyone to say you'll end up in the mental hospital … And then if they end up going there, they are only proving them so, but yeah. (1, F, 31+)

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One participant mentioned that there are terms used within the community that different levels of mental health that carry negative connotations. One such Nepali term is, "phuskeko," which means "the bolts are loose", synonymous with "screws" being "loose" in the brain. Another saying used to describe mental health is "C by two", which roughly means "consciousness is just half".

> … like it's simply saying, like you know, somebody is having mental health problem in the level as if…their head is the bolt… which is like, it's good that they screwed. You know nuts and bolts, so all those nuts and bolts are gone. We say that in Nepali we call it as…one word called phuskeko, which means, like the bolts are loose and you know… So there are lots of words actually like you know they also call C by two, which means you know C as in Charlie. By two, which means which I believe is like the consciousness is just half. You know, like 1/2 times consciousness… and there's also another word, pagal, which is really, really derogatory word for crazy. (5, M, 31 +)

4.3 Barriers

Barriers were defined as perceived barriers the Bhutanese community faces with accessing mental health care, or what may prevent community members from reaching out for support. Barriers were identified across the levels of the SEM and included stigma towards mental health within relationships, neighborhood location, organizational level factors, such as navigating healthcare and schools, and policy level factors, like insurance challenges.

4.3.1 Relational: Stigma Impact on Relationships

Mental health carries much stigma within the community. Participants acknowledged that being associated with mental health issues can impact relations with community members, including marital prospects. Some participants mentioned that once someone is seen as crazy, they

will always be seen that way, or their whole family will be labeled as "mental", and therefore viewed as an unsuitable marriage alliance.

> Yes, that can affect their marriage too. Yeah, because nobody liked to marry crazy women for their son or daughter and vice versa. And they thought that once that person is diagnosed with the mental health, then they thought he's going to be crazy for the rest of them. (3, M, 31+)

> …let's say one of your siblings have some that's anxiety problems and then your brother would be labeled as if family members are having mental health problems. So it would be really, really difficult for your brother to have a girl from the same community who would be, you know, match for marriage. (5, M, 31 +)

Similarly, another participant stated that many in the community do not have anyone that they can talk to about things that are bothering them and that even husbands and wives do not feel comfortable, or even scared of, sharing this personal information with each other. Relationships, both in familial and in partnerships, could possibly prevent individuals from seeking out therapy. One participant mentioned that if you do feel comfortable telling family or partner about going to see a therapist, they may say that they don't need to go because "I'm here" and "we'll get through this".

> … In my community there are like I think so many people like that do not have anyone to talk to or like they don't have a go to person, like who they can just go to and talk to them, even in like husband, wife relationships.… like husbands or wives are like scared to tell each other like what they want to say. It's not like here… in some families like husbands can't say what they want to do and wives can't say what they want to like to husband. Even though they are husband and wife they don't know what's going on in each other's life if it's like a depression or like something that's bothering them... (4, F, 18-30)

> …I feel like if you if a husband or if your wife talks to their partner about going somewhere and…like going to a therapist, and having them talk to them… most of the time I think it's the partner who like probably stops them saying "I'm here with you like you don't need to go to a therapy like I'll be there for you, we'll, we'll work it out".
> But most of the time it's not about working out it's about what's going on inside you... like I think parents or brother or sister if you share they're like that, and in marriage or like relationship like husband and wife… that's what stops most of the people from going to a therapist because you are thinking that "yes, someone is with me" but like internally you're still disturbed and you need, you're needing a therapist or someone who you can go and treat yourself like somehow (4, F, 18-30)

4.3.2 Organizational: Lack of Support in Schools

A participant indicated school as a potential barrier to accessing care. Compared to Pittsburgh Public Schools (PPS), school districts like in Baldwin may not provide adequate support for refugee and immigrant students.

> Like PPS has, like counselors and stuff and they have people… that like know what they're doing and have been doing that work for years. Baldwin has like upwards of… they had like nearly 100 students that were refugees and it wasn't just Nepali refugees…but there was no help. (2, M, 18-30)

They mentioned experiencing racism and disregard for cultural traditions and holidays by the school staff, like all the Bhutanese students getting unexcused absences when they were out of school for Nepali holidays.

> In fact, the teachers were actively racist, so like that's like that's fun. So it's like there was no training on how to do cultural competency at all…. Like whenever there were like Nepali festivals and stuff like on days you know like religious days or whatever. No one was there and yet everyone got like an like unexcused absence on their record. Meanwhile PPS has public holidays that you just like are off, you know, so it's like they don't think about the fact that there is like a quite a big contingent of people that need that help and are here and are going to your schools and are possibly going to be going there for a long time. (2, M, 18-30)

Another barrier seen at schools was lack of appropriate support staff for refugee and immigrant students to access. .This participant mentioned that lack of support for navigating post-graduation may have contributed to negative mental health and the increase in suicides seen in the community several years ago.

> …People graduate high school and like they'll either go into nursing or whatever… But a lot of people and end up like entering the job field and not knowing what to do and like they don't, you know, they are feeling lost in life as you tend to do after you graduate from school, and there's really like no support structure. You know because you can't talk to like a therapist through it because like it's a different issue… and that's where like a lot of different other like intersectional lot of toxic masculinity stuff come into play. And it's like that is where we saw a lot of like suicides. You know? (2, M, 18-30)

4.3.3 Organizational: Navigating Healthcare

Provider-patient relationships can be a barrier. Participants sometimes feel like their concerns are not being listened to by their providers, or rather there is a disconnect, which can affect their trust in them. Not feeling heard could be a result of very brief appointments and feeling like providers are rushed. Long wait times were cited as an additional barrier with accessing healthcare, especially during COVID.

> So when you try to set up appointment, you will get a appointment for after six months or one year…I know the doctor don't have time so their time is allocated maybe 15 minutes for uh, for general checkup and maybe annual checkup, maybe 30 minutes. (3, M, 31+)

Some noted differences in type of care received from their time in other US cities versus in Pittsburgh. They said that it could be that in the city they previously lived in, doctors were used to working or "flowing with" more diverse clientele compared to those in Pittsburgh. A participant also acknowledged the difficulty in restarting care in a new city like Pittsburgh and having to start from the beginning with treatments they know don't work for them. When some have pushed back against these medical decisions, they felt that were labeled as "difficult patients" and dropped as patients for unrelated reasons.

> … and I have to fight. I have to fight with them. I have to fight with them then the doctor tell me I cannot see you anymore. I know I fight them, I know because they see me first time, after two days I have next appointment, on the next appointment they say that we cannot take your insurance anymore. Without any information. So, I know they are lying to me, but they didn't want to see me because I'm just constantly fighting them. Maybe I'm a difficult person. or maybe I look different, or maybe it's my skin tone whatever. (3, M, 31 +)

A participant indicated that these struggles and "disconnect" were difficult, as often in their culture doctors are viewed as a God.

> I go through all those things and I always try to tell them my feeling, but they don't like to listen to me. See those are disconnected, yeah? So it's not only disconnected, it's a trust with your doctors because in our culture the doctor is a God. (3, M, 31 +).

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4.3.4 Organizational: Translation Challenges

When prompted with barriers to receiving support, several participants indicated challenges with accurate interpretation services, specifically interpreters not knowing western mental health terminology.

> Interpreters are also not familiar with the words. They can like… they have to go word by word, which might not make sense to people who are seeking help. We have to go by meaning sometimes… If we are not getting into the message that we are supposed to, the intended message because of what different reason like translate, translation, accuracy and all of that. (1, F, 31+)

Some also mentioned that interpreters chosen by providers can be from their own community, so they fear that information shared during appointments will not remain private. One participant expressed that providers rarely hire a new interpreter in response to patients possibly knowing the hired interpreter. They explained that individuals may worry that they cannot say personal things in front of interpreter, especially if they know the interpreter is from their community.

> …than that someone who speaks their language might or might not keep that thing like within him. We may follow or may not follow the protocol, it's up to his or her <translator> ethic. We never know even the providers so. (1, F, 31+)

> And then sometimes for the convenient based reason when they have already, when the provider have already hired the interpreter, they will not hire someone else. (1, F, 31 +)

4.3.5 Community: Neighborhood, Caste, and Class

One participant mentioned that community is separated geographically based on neighborhood, which ties in to the caste and class relations of community members. Specifically, there are differences in demographics between the Brownsville corridor, Carrick, and Mount Oliver communities compared to the Baldwin and Whitehall communities. For example,

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community members who are upper class were more likely to be homeowners in areas like Baldwin and Whitehall and were more likely to have higher income and have more access to resources. Those who did not experience much upward mobility were more often associated with lower caste. Neighborhood location, caste, and class all affect access to mental health services, as those who are higher caste, and consequentially higher income, may have more time and resources to pursue mental health resources.

> There was like a pretty big community out in Mount Oliver and Carrick for a while and then sometime in like the two, the mid 20 tens people started looking at houses and… so like large groups of people started buying suburban houses like in Whitehall, Brentwood and Baldwin especially… But in that a lot of people also got sort of left behind, and that upward mobility…So you have to like seek it out and as we mentioned, like it's very hard to seek it out if you don't already have that foundation of like of like someone in the family can speak English. (2, M, 18-30)

> A lot of the community is still working class to poor, especially the folks that are like more on the Brownsville corridor. So there's like a class aspect to it, where it's like it's easier to get access to care if you're in the South Hills more than if you're really like out in the city … So in the suburban neighborhoods you have people that are more well off, and… if you're well off because you're not having to worry about the basic necessities of life, and therefore you can start taking care of your like mental health needs. (2, M, 18-30)

The participants mentioned that the role caste can play in access to care is not often acknowledged within the community. Given the differences in needs across neighborhoods, the types of supports required may differ as well.

> It's like class and caste, especially caste really play a big role in it….I don't think the community nearly talks about how caste has played into class in America (2, M, 18-30)

> … so it's like some people have made that transition. But a lot of people have been unable to do that. And when you talk to like BCAP, they I think will also like talk about the divide between like the Carrick and Mount Oliver communities versus like the Whitehall and Brentwood one…I think it's like those are two different communities with very different needs. And so like we need to like start tackling them differently because they've sort of like drifted off a little bit. (2, M, 18-30)

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4.3.6 Policy: Insurance and Cost

Barriers to accessing mental health services exist at the policy level, as policy, rules, and regulations can impact the quality of life of community members. Participants indicated that cost of therapy and lack of insurance coverage could be another barrier to seeking therapy, as they would not want to spend money on those services and would be worried about the amount on bills.

> Yeah, because as of like, uh, as of like resources and stuff, I think there is a lot of like stopping from going to a therapist thinking that they're expensive, like expenses, also, like if they like if they go visit for one hour, they might take this much like the bill will be. that can also be a barrier…Yeah….So but the cost, yeah. (4, F, 18-30)

Some pointed to specifically having Medicaid or UPMC for You presenting a barrier to therapy services, with many providers not accepting that insurance, and the burden of responsibility placed on people to have to seek out services on their own.

> Once the receptionist hears that you have UPMC for You and not UPMC, it's like it's over. You're not getting any appointments… but like even me personally, like I literally am seeking a therapist and I can't get it because Medicaid and they won't even like entertain the thought you know. Like they'll be like "oh, I'll call you back", they never call back so it's like me trying to explain to them on the phone, you know, without a language barrier, that's already hard enough because of like the perceptions of poverty and then… everything on top and it's like well now I can't even imagine how hard it is for other people. Putting the onus on them to have to seek out those services. (2, M, 18-30)

4.4 Supports

Supports was defined as existing supports for accessing mental health care within the Bhutanese community. Codes primarily fell within peer support and organizational support, with community organizations being the most commonly cited support available.

4.4.1 Relational: Peer Support

A participant stated existing supports can differ depending on each generation, as younger generations could rely more on schools or peer support, while older generations could benefit from organizations like BCAP. Schools could provide support in the form of teachers that students can talk to. Peer support was emphasized as a valuable asset since younger generations may trust their peers more in keeping their mental health information private or that their peers would be more accepting and understanding. One participant even mentioned that younger generations may feel more comfortable talking to a peer, even if they are strangers, given this collective understanding that talking about mental health is more accepted in their generation.

> … And the younger generation like me or like younger than me, they can always get help from schools or like they can come to someone who's my age also like anyone from my age.... so yeah they can get access. like younger generations now are like will have much easier than us because we came here from Nepal, and the younger generation have us, and we had no one, like our parents and grandparents didn't know anything whenever we came here. So we know a lot more than them, of course. But like for younger generation, it will be easier to like access those kind of stuff well, like from through us. (4, F, 18-30)

4.4.2 Organizational: Community Groups

Supports were mainly identified on the organizational level. Community groups were identified as a key support for mental health, specifically BCAP. Participants viewed these groups as beneficial even if they do not offer specific mental health services, as these groups are able to connect them with existing mental health services.

> I think having people to connect or like for example, we have BCAP, although it doesn't deal with mental health, but it does, refer people to get service and just coordinate with other service provider. To make people get the service benefit from the existing services. (1, F, 31+)

So they do have in my community... they do have like… BCAP, they can. I feel like they can go to them and then like ask them if they know anywhere like or anyone or any like hospital that provides therapist where they can go to and like have them have like help get help through them. And in my community, as of now, like I think, BCAP is the only one they can get access... older generations. I don't think they would ever say that I'm mentally ill or depression…but as of like… who are like ages of my moms and dad. They can like ask BCAP people... (4, F, 18-30)

These different community groups, such as Squirrel Hill Health Center, were credited as part of the reason the conversation around mental health has been changing for the better. A participant expanded on different supports available based on geographic location, noting that supports and needs may look different in different neighborhoods.

So like it is like slowly changing because of the work that like that BCAP has done, I feel like that Squirrel Hill Health Clinic has done, just a lot of the nonprofits I think are starting the ball on like having that conversation. I hope we can get to a place in a couple of years where we start to recognize that like a lot of the help that we need is because of these, like deep rooted historical traumas, so I I feel like the conversation is changing…. (2, M, 18-30)

4.5 Ways to Improve Access

Ways to improve access was categorized as strategies, feedback, and suggestions participants provided to improve access to mental health services. Responses ranged from changing the language surrounding mental health, like using a different term that does not carry a negative connotation, to more organizational and community level initiatives, such as conducting mental health education meetings and training community members as mental health nurses. Figure 2 shows suggested strategies for improving access to care across the different levels of the SEM.
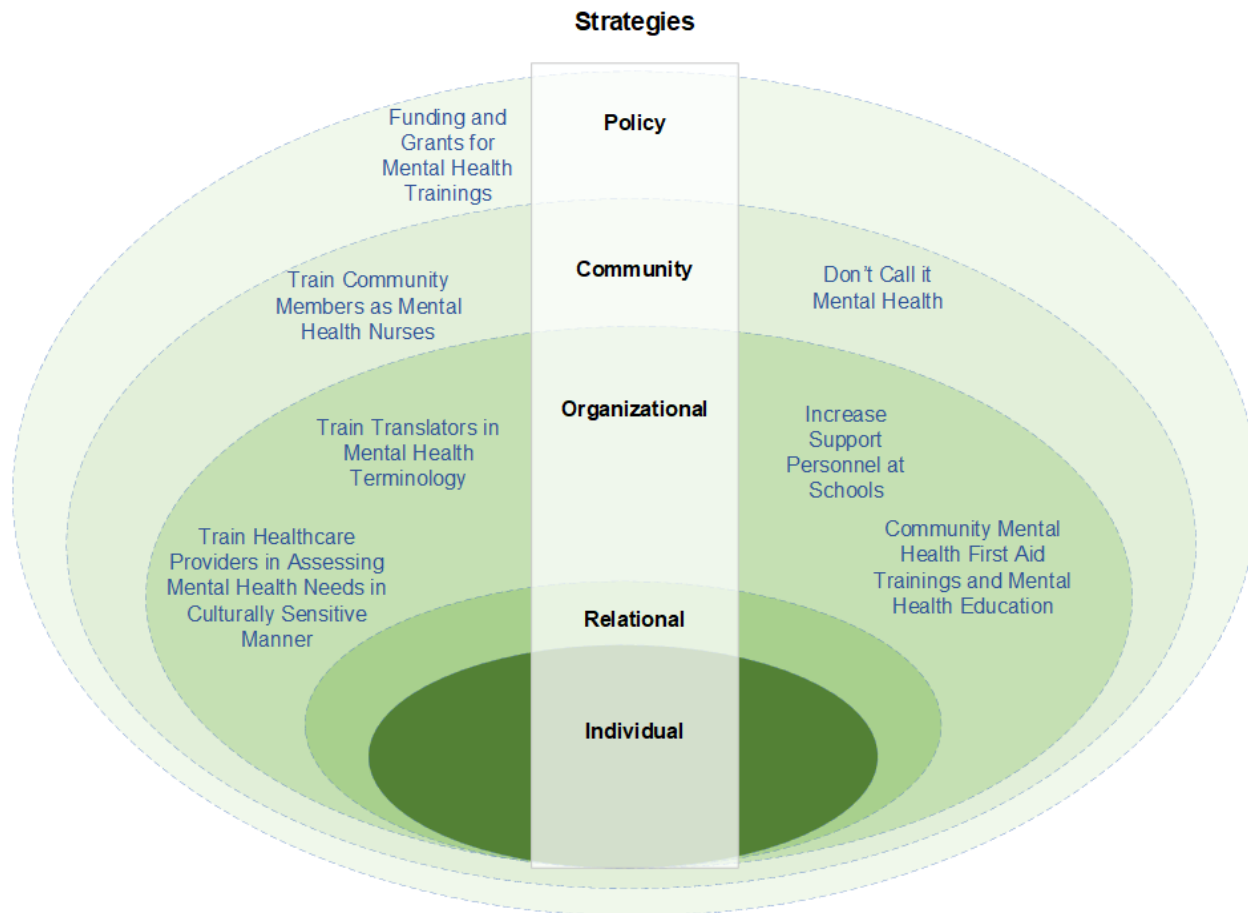
Strategies

Policy — Funding and Grants for Mental Health Trainings

Community — Train Community Members as Mental Health Nurses; Don't Call it Mental Health

Organizational — Train Translators in Mental Health Terminology; Increase Support Personnel at Schools

Train Healthcare Providers in Assessing Mental Health Needs in Culturally Sensitive Manner; Community Mental Health First Aid Trainings and Mental Health Education

Relational

Individual

Figure 2. Strategies to Improve Access to Care Across the SEM

4.5.1 Community: Do Not Call it Mental Health

Participants expressed that the term "mental health" is seen as a negative term in the community. Many participants offered alternative phrases to use instead of mental health when talking about these issues, such as "health and wellness" or even "behavioral health".

> Not saying pagal is better. Not saying mental is better because <they> don't like that word… They know they already know, so before they said that craziness we used the word crazy before or the word mad… when we came here United States, then we talk about mental health. Now the people they know about mental health. "oh mental they oh they are giving me. They're making me. Doctor is making me a crazy doctor is making me a mad. I'm not mad." So now they have to use a different term, terminology. So instead of saying mad, I think the best way is health and wellness. (3, M, 31+)

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…Mental health is not perceived well, you know, in our community. So it's like more kind of stigmatized. So when we talk about mental health, like if we want to treat somebody with mental health problems that I think would better tell like behavioral health issues so we can treat or something. The problem in your head, instead of saying that you have good mental health issues. So this is the way we can address. So that's why even the word mental is not received well in our community. (5, M, 31+)

4.5.2 Community: Normalizing and Talking About It

Another approach offered as a strategy to improve mental health access was normalizing mental health by talking about mental health, feelings, and emotions. Participants said that by just being vocal and expressing you are there to listen, or casually talking about seeking a therapist, can improve access.

I feel like talking about it more like we're like talking about it. More to them ,like I talked to my mom…my family about, not specifically about mental illness and everything, but I do tell them like if you're going through something or if you want or wanting to talk to me about something, just let me know and I will listen to you like....... so I feel like and then to someone who doesn't have that access going to them or gathering them for something and like raising awareness of mental health would really help. And like talking to them would really help. (4, F, 18-30)

But like just even me being like Oh yeah, like I'm currently in the process for like looking for a therapist, we can get it after I get the job, but just like getting that out there, you know because like it, it like normalizes things so. (2, M, 18-30)

Another participant shared that while administering mental health first aid trainings, they openly talked about their own personal experiences with mental health. Whenever they did this, and explained how certain mental health conditions like anxiety and depression can manifest, many community members would approach the trainer and express that they had similar experiences and were unaware that this was all considered mental health. The participant expressed that because there is a lack of mental health education, most community members consider mental health to be solely severe mental illnesses, like schizophrenia and psychosis. Associating mental

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health with this has contributed to the fear of having the label of mental health. Therefore, increased dialogue surrounding mental health and what it is can help dismantle the stigma.

> ... I think it was me who at first said like "you know I have mental health problem" and people are just looking at me and the second thing that I told was like "I have a lot of anxiety." And then like "having anxiety is, you know, it's equally likely that I can have depression , and the person having depression can easily die, and it's mostly the depression that people you know, die by suicide." And I said that and then people started looking at me and they were asking questions, and then it became so interactive…

> And slowly, people started to expose "Oh my gosh, I didn't know that it was mental health problem. I have this problem that I won't be able to sleep... I can't just stop, you know, there's a lot of restlessness"…you know like when they start telling that, I can pursue that. Like how many people have all this mental health problems … because of the lack of as education about mental health really is they only understand schizophrenia and psychosis as the mental health problem and because of that they are really, really scared of all those labelings. (5, M, 31 +)

4.5.3 Organizational: Mental Health Trainings or Educational Community Meetings

Mental health trainings and educational community meetings were identified as ways to improve access to mental health care. These trainings or meetings can help educate members of the community on mental health, mental illness, and how to recognize the signs of worsening mental health.

Some participants that previously attended mental health trainings hosted by trained community members found these trainings to be beneficial and offered mental health trainings for families as a possible avenue to improve access.

> If one or two family members attend any trainings, when to seek help, how do I identify the problem, this kind of might help. (1, F, 31+)

One participant who aided in administering mental health trainings indicated that they started administering mental health trainings given the rising number of deaths by suicide within the community. They administered trainings all over the US once Bhutanese communities across

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the country found out that these services were offered. So many community members showed interest that sometimes the trainings would reach capacity and they would have to limit the number of attendees. However, administering trainings occurred on a voluntary basis and eventually they had to discontinue administering trainings.

> So I did mental health training to quite a many, many locations, like from all the way to Texas, Nebraska, North South Carolina to Vermont… Our community like we are very much…tight knit community and because of that like people know that once we did some mental health training, they heard us and they proposed to us like "You know, my friend told that you did. You guys had some good training. Would you come to our place" and we went and when we went then… we're allowed to put only 30 participants on by National Council for Behavioral Health… but what happened was like people used to come like over 60 participants some time… we were like trying to accommodate and we tried to reduce the numbers… (5, M, 31+)

> the second thing was what was happening in the community was like there a lot of people dying by suicide. So among the all the refugee population, Bhutanese have the highest rate of death by suicide among the resettled refugees, so I just wanted to express you know what I have learned and that's what I tried, and some of them worked…I couldn't continue because it was more kind of voluntary, so now I have stopped. It's just me.

Participants also discussed topics that would be important to include in these educational community meetings, such as how depression can show up in different ways, that it may not always be obvious when someone needs help, and it's okay to talk to someone for help. A few participants also indicated strategies for hosting these educational community meetings and best ways to meaningfully engage community members. One participant stated that including a fun activity, or having something fun to do at the gathering, could help people feel more comfortable and more willing to open up.

> .... someone who doesn't have that access <support>, going to them or gathering them for something and like raising awareness of mental health would really help. And like talking to them would really help... If you're too stressed, like or if you're wanting to isolate yourself. Like if you wanting to sit alone, you don't want to talk to people. That… does not mean you're just angry or you're mad, or you don't… like people... it really means that something is going on with you and you're really, really needing help. You really want someone there for you, but... You're not able to tell the person that you want something, someone to like come help you…That and then also of course if you're too stressed about

something, just have someone talk to you, like if you're going through something that's, like, life happens to everybody. So, if you're going through something…like if you're not in the right position right now….you have someone to talk to… like all these topics are like really good to cover whenever like if gathering like this happens. (4, F, 18-30)

4.5.4 Organizational and Community: Increase Support Personnel

Suggestions include increasing access to support personnel across organizational and community levels of the SEM. Support personnel are broken down into school support staff and training community members in mental health nursing.

4.5.4.1 Organizational: Support Staff in Schools

A participant stated that increasing support staff in schools for refugee kids can help teach students how to ask for help and reinforce that there is someone available to support them. The participant specified that having the support staff available during school hours will make it more accessible for refugee students, as it is less likely for them to seek out such services after school.

> So, like targeting kids in school to like, help them be able to like, ask for help. And like establishing that pattern early on…I feel like the suburban schools have been like lacking in in getting people that can do those works in those schools, even though they have the population to sustain someone who could do that job… even if it is for like only a couple of years, you know it's it's worth investing in it. (2, M, 18-30)

> you need to have someone there at all times because the kids need to be able to like walk by that office, see it and think "not today, but maybe tomorrow." You know what I mean? It's like you have to like start building the small habits of people knowing that like they can go to someone for help with all these problems Because once, it turns out, once you don't and you graduate and you're left in a world with no support structures, trying to navigate a whole bunch of things. It's like that's not really great for mental health. (2, M, 18-30)

4.5.4.2 Community: Train Community Members as Mental Health Nurses

One participant offered incentivizing community members to specialize in mental health nursing as a means of improving access to mental health services in the community. They

explained that there are already high numbers of community members going into nursing, having

them specialize in mental health nursing would help create a support system within the community.

Community members serving as mental health providers would help reduce the stigma

surrounding mental health, decrease the language barrier, and have more existing knowledge about

the culture within the community.

> Another thing I'll say with the mental health is that like a lot of kids they're going into nursing straight out of out of high school. Why not target them for being like mental health counselors?... Why not tell them that like this is a thing and so we have a lot of people in the Community that can speak both in English and in Nepali, so that like later on, it's like 5 years, we can completely just solve the issue… So why not target them to do something that they could come back to the community with and like stay here, be rooted in the community. Be like support center for like a whole bunch of different peoples you know. Because I think that that solves so many other pieces, you know it's someone that looks like you. It's someone that talks in your language, it's just like it's someone that knows the experience (2, M, 18-30)

4.6 Telemental Health

Most participants said they did not know of anyone within the community who has utilized

telemental health services, so were unsure what that experience could be like. Participants

expressed that they could see telemental health services being beneficial to reach those with limited

access to transportation, especially for women, or as a way to privately seek care. services.

> That would be great. Like for people who can't drive because there is a lot of people in my community who can't drive like, especially the ladies. There are a lot of people who like, who are home all day with kids…like they will just they can just go in the room and then just access through and talk to a doctor that would help them a lot. Like for everybody who doesn't want to go physically and meet up in a person and who's not comfortable enough to go and meet in person, if you wanna talk to your doc, but you don't wanna see the doctor and meet the doctor and talk to them.. Then you can do it through your phone or iPad (4, F, 18-30)

> Other participants mentioned that while telemental health services can be helpful, there are

potential barriers associated with it. The main barrier is access to technology and technology literacy. Access to technology could be affected by cost of technological devices, such as expensive laptops, or lack of access to a private device in the home. One example provided was families may have one shared desktop computer situated in a common area of the house, making it difficult to conduct a confidential and private teletherapy session. Technology literacy can also be a barrier for those with limited familiarity with technology associated with telemental health.

> A lot of families still have the one computer, the one main computer…and then like a personal computer. And that's sort of like their information bubble thing. And like we, usually the kids, use the laptop and like the old folks, because you know these are like intergenerational households usually…But like most families usually have like a TV and then a family computer. How are people going to take the family desktop and like go into their rooms and talk about how they're feeling? You know, when, like it's all in the living room, so barrier to access to tech as we know is like one of the biggest things for like using tech to do social justice is that not everyone has the tech to do it. (2, M, 18-30)

4.7 Gender Differences

One participant expanded on gender differences in seeking mental health support. For example, male community members may have easier access to therapy services than female community members. Female community members may be less hesitant to seek therapy services and may show more preference for medications.

> Even if they were tortured by the royal government of Bhutan as a male member? They have benefited… But for a female, if they were abused physically and sexually, they have not come forward and seek support as openly as male. (1, F, 31 +)

> …and for many women the medication is helping rather than the counseling. (1, F, 31+)

4.8 Generational Differences

Many participants highlighted differences in generational perspectives of mental health. Younger generations were seen as being more accepting of mental health as an issue, while older generations still lacked knowledge about mental health or felt shame with discussing mental health. Younger generations specifically seem aware that mental health can be illness or body condition, whereas older generations may be more dismissive of mental health as a condition.

> What it's also because I feel like since I've been here young and I went to school here…I do have that potential of like helping them, and I do believe that… I'm not gonna go like to someone and say "oh he was asking that". I don't think the younger generation would think that too because that's how they're being raised now. Like, even though they are in Nepali family like they most of them like are like in school... So I don't think they would think that "ohh she will go and say something to someone else" like I don't think they would say so as of like me going to school here and like getting raised here. I do have that potential helping whoever's wanting to go.. and even the older, like older people who don't like really care as much. If someone comes to me and asks me, I love to help them. (4, F, 18-30)

The differences in generational perspectives were attributed to younger generation members moving and being raised in the US, and therefore being exposed to these perspectives in US schools. A participant acknowledged that they do not know if they would have been so accepting of mental health as a condition if they still resided in Nepal.

> well, the huge change is of course the country. Because if we were still in Nepal, I don't think that this would be like I don't think I would even talk about. I don't think I would even know what mental like issue is or depression is. I don't think I would even know too.... like the huge difference is that a country change... Also me being raised here and also going to school here learning things from here, adapting all the things from here. That's a major change also. Do that is a change between like older like my parents, and then me... yeah, the transformation from there to here its... it is. (4, F, 18-30)

However, a few participants stated that while younger generations are more accepting, they are still less in population and don't make the decisions in the family.

> For the new folks, let's say who are small kids and who complete their middle school high school here. Their way of thinking things…Because here they know that, "oh, it is all is the condition of your body condition, your mind condition. So

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sometimes your body release those chemicals so they know that our body is like a computer". You know those small things can affect your life, so they know that one and they didn't think all that is manageable so for them is easy, but those new generations they are less in population. And they didn't make decision in the family. (3, M, 31+)

5.0 Discussion

All participants identified a need for access to mental health resources within their community. All participants mentioned trauma related to their history as negatively impacting mental health, such as PTSD from facing violence in Bhutan and staying in refugee camps in Nepal. Some participants also noted the lack of healthcare available when in refugee camps. Other studies have documented the harsh resettlement journeys of Bhutanese refugees and the lasting effects of traumatic experiences and violence from the Royal Government of Bhutan (Acharya, 2022; Banki & Phillips, 2017).

Participants recognized several barriers to mental health care access. These barriers varied across SEM levels and included stigma toward mental health within interpersonal relationships, lack of accurate and perceived confidential translation services, issues navigating healthcare systems, and difficulty understanding laws and policy in a new country. Translation as a barrier to care for Bhutanese refugees has been recorded in the literature, especially with differences in dialect and discrimination from translators (Salinas et al., 2021). Results also support previous research findings on difficulties translating mental health terminology into Nepali (Cratsley et al., 2021). Supports were mostly categorized on the organizational level, with groups like BCAP being the most prominent identified support. Participants acknowledged generational differences in perceptions towards mental health, with older generations viewing mental health more negatively than younger generations. These differences were present in barriers, supports, and strategies to improve access to care, with different needs and supports identified across generations.

One participant also acknowledged gender differences in accessing therapy, as female community members may feel less comfortable compared to male community members and may

prefer medications for mental health needs instead. Gender differences in seeking mental health services among Bhutanese refugees has been reported in the literature, however limited research exists on how Bhutanese refugee women view taking medications as treatment for mental illness (CDC, 2021b). Participants were unaware of community members who had experience with teletherapy and identified potential benefits and drawbacks to using teletherapy. Furthermore, participants provided several opportunities for improving access to mental health care across the SEM levels, including calling it something other than "mental health," hosting community mental health trainings and education meetings, talking about mental health and normalizing it, and increasing support personnel.

Based on findings, there are multiple themes that merit more exploration. Neighborhood, caste, and class, gender differences, generational differences, and schools as a barrier to mental health are all areas that would be benefit from more study. Geographic location in relation to caste and class carries implications for tailoring strategies based on the needs of different neighborhoods. A previous study found that Nepali Dalit community members located in San Francisco experienced caste-based discrimination across multiple domains, including in housing and in the workplace (Pariyar et al., 2022). Still, there is little known about the effects of caste and class on access to mental health care among Bhutanese community members in the US. One participant explicitly mentioned gender differences in accessing care, as women who have experienced abuse may feel less comfortable accessing therapy. While not specifically coded under gender differences, another participant mentioned that teletherapy would be especially beneficial for women community members as many women in the community do not drive and typically stay at home.

Past research has shown that there may be gender differences in accessing mental health care, where Bhutanese women are less likely to seek mental health care (CDC, 2021b). Understanding more in depth what gender differences exist in accessing mental health services can inform more tailored strategies to reaching women in need. Many participants pointed to differences in how the older generation perceives mental illness compared to the younger generation, and that supports and barriers to care can differ across generations. However, while describing these generational differences, one participant who identified as part of the younger generation acknowledged that they were not sure if they would be so willing to discuss "mental health" if they were still living in Nepal. This raises the question of are these differences in factors affecting access to mental health care due to the generational divide, or are differences a result of changing countries. Interestingly, one participant viewed schools as a prominent barrier to accessing mental health care or contributing to negative mental health given their experience with their school district. However, another participant identified schools and teachers as a possible support for younger generation community members to access mental health resources. More exploration may be needed to see what separates schools as barriers versus supports for Bhutanese community member students.

Something to note is that almost all participants seemed to refer to "mental health" as a phrase in a negative connotation. Rather, instead of distinguishing between positive mental health and negative mental health, many would express that "mental health" was a problem in their community. The negative perceptions towards mental illness among immigrant and refugee communities has been well-documented in research (Brown et al., 2019; Kim et al., 2021; Wolf et al., 2016). This specific view of mental health can have implications for tailored mental health education curriculum for the community.

5.1 Future Implications

There are several future implications based on findings from this study. Strategies for improving access to mental health services for Bhutanese community members should be a multi-level approach with specific strategies targeting the different levels of SEM.

5.1.1 Organizational and Community: Increase in Supportive Personnel

Schools should have a support person with experience working with refugee youth to provide guidance post-graduation. These personnel should ideally be available during school hours to maximize accessibility. Schools should practice cultural humility and acknowledge cultural traditions, including holidays, of their student body. This may prevent potential feelings of isolation among refugee youth in schools. In addition, schools should also consider the most effective means of communication for their student body to promote inclusivity.

Existing literature has shown that translation services may be inaccurate or discriminatory (Zhang et al., 2021). Findings from this study expand on this by showcasing the need for improving knowledge of mental health terminology and consequences of using a translator that is known to the patient. Providers should check with patients if they are comfortable with a selected translator and offer alternatives. Translators should work in conjunction with those knowledgeable of Nepali mental health terminology to provide more accurate translation. Medical providers should also have training in broaching mental health in a culturally sensitive manner with the community.

Encouraging community members who have an established interest in nursing to train in mental health nursing can expand the support network available for the Bhutanese community.

Training in mental health nursing can be implemented by establishing a grant or providing funding for members of the community to train in mental health nursing and work within the community for designated period of time. Training community members in mental health nursing equips them with the tools required to identify and administer support for those in need. Having someone from the community in a mental health provider role can also establish more trust in the provider as the provider will have more cultural knowledge to inform their practice. In addition, community members that can speak Nepali as mental health providers can reduce the present language barrier and reduce the need for a translator.

5.1.2 Community: Community Trainings and Mental Health Education

Previous studies have shown the benefits of having mental health trainings administered by community members (Gurung et al., 2020). Findings from this study supported the benefits of community mental health first aid trainings. Continuing to offer support for members of the community to administer large scale mental health first aid trainings can help reduce stigma towards mental health on both the relational and community level. Having members of the community trained to administer these trainings allows for more curated and tailored education, as members of the community may be more familiar with the mental health terminology used within the community. Mental health education for the community can also bolster peer support, as it equips them with helpful knowledge and resources to share with their peers.

5.1.3 Organizational and Policy: Funding Incentives to Support Mental Health Resources

One of the participants indicated that they were unable to continue administering mental health trainings as it was on a voluntary basis. Providing funding or grants to sustain community led mental health first aid trainings could address this barrier. Access to funding is crucial to creating sustainable interventions, as funding supports the tools and individuals required to implement the interventions. Therefore, instating trained community members as MHFA instructors to improve access to mental health services would require funding or grants to maintain the services. This is also true for all types of support personnel, such as support staff in schools and community members trained in mental health nursing.

6.0 Conclusion

Access to mental health care remains a pertinent issue for the Bhutanese resettled refugee community as mental health resources are severely underutilized among this population. This is especially significant given that one of the largest refugee populations in Allegheny County is Bhutanese refugees. To address factors affecting access to mental health services, this paper explored perceptions, barriers, supports, and strategies to improve access to both mental health and telemental health care for Bhutanese community members. Qualitative individual interviews were conducted over HIPAA-compliant Zoom with six participants. Interviews were conducted in English and with members of the Bhutanese community who were 18 years and older.

Findings show that several barriers to accessing mental health care exist across the SEM. Perceptions towards mental illness and "mental health" among the community were overall negative, which negatively impacts access to care. Barriers to care include stigma within relationships, lack of support in schools, difficulty navigating healthcare, translation challenges, and insurance cost. Existing supports to mental health services centered around community organizations and peer support. Participants provided several recommendations for strategies to improve access to mental health services for their community, such as increasing support personnel, like holding Mental Health First Aid Trainings hosted by trained community members, and alternative phrases for the term "mental health."

This study has several limitations. Using snowball and convenience sampling may have inadvertently selected those who were intrinsically motivated to talk about mental health. Convenience sampling involved reaching out to known connections within the community. While Zoom-only interviews carry some benefits, it limits who can be interviewed, as only those who

had access to a technological device or were comfortable using Zoom were feasibly able to participate. Due to limited resources, the researcher was the sole coder and transcriber for the interviews, which could impact the breadth and depth of codes identified. The researcher is not fluent in Nepali or Hindi, which are the primary languages spoken within the community. Given all interviews were conducted with participants fluent in English, this may have limited the pool of eligible Bhutanese community members that could participate. To mitigate this, the researcher had contracted a translator to provide interpretation services in Nepali for participants that required it. However, community members not fluent in English may have felt uncomfortable participating with a translator present, particularly with the sensitive nature of the topic. In addition, the study was conducted only in Allegheny County, which prevents these findings from being generalizable to other Bhutanese communities in the US. Nonetheless, this study is the first to contextualize the experiences of Bhutanese immigrants in the US within the SEM, providing a starting point for deeper analysis beyond Allegheny County.

The state of our mental health is an essential part of our overall wellbeing. Yet communities, such as the Bhutanese community, have limited access to mental health resources while facing growing demand. This study emphasizes the importance of supporting and incorporating community voices when creating tailored mental health interventions. Interventions and strategies implemented in communities without incorporating community feedback run the risk of being ineffective or even detrimental. While sample size for this study was small, each participant provided valuable insight into the factors that affect access to mental health within their community. The findings from this study serve as a launching point in tackling an urgent public health issue affecting Bhutanese refugees in Allegheny County.

Despite existing mental health care resources in Allegheny County, study findings show structural barriers to mental health care access that may be contributing to this urgent public health issue affecting Bhutanese refugees in Allegheny County. Mental health care providers and community advocates can leverage these findings as a starting point to develop personalized strategies to improve access to mental health care for Bhutanese individuals. Given the ineffectiveness of current approaches, decision-makers who wish to effect a real change must consider strategies that thoughtfully consider the needs of the Bhutanese community instead of a one-size-fits-all approach.

Interview Guide

- Tell me more about how your community views mental health and mental health care?

- Has anyone you have known accessed mental health care? If so, what was their experience like? If no, why not?

- What are your impressions of mental health? What are your impressions of therapy?

- What are some potential barriers/obstacles to accessing mental health services like therapy?

    o Probe: What are some potential barriers/obstacles to accessing mental health services on a community level? How about at a structural level (local government, policies, etc.).

- What are some supports the community has to accessing mental health services?

    o Probe: What are some supports to accessing mental health services on a relationship/interpersonal level? How about at the community level? How about at a structural level (local government, policies, etc.).

- What role do you think telemental health will play in accessing mental health services?

- What are some ways in which we can improve access to mental health care for Bhutanese refugees?

    o Probe: Ask about different levels of access and factors, such as among family members or community-wide setting.

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