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Diagnosing and Addressing Mental Illness Among Vermont Refugees: A Study of Mental Health Screening and Community Resources in Burlington, VT

B.A. Political Science

Zachary Russel Johns

Contents

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I would like to express my gratitude to my thesis advisor, Pablo Bose, for his guidance and insight on this project.

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Chapter I. Introduction

The mental health needs of diverse refugee groups in Burlington, VT yield a wide set of challenges for healthcare providers, mental health clinicians and community outreach workers, and the large demand for services strains the small city's specialty resources. This study is concerned with whether provider networks are capable of addressing and treating mental health problems among resettled refugees, and whether mental health screening techniques are adequate in determining mental health disorders in the Burlington refugee community. Provider perceptions of the Burlington community's approach to mental health diagnosis and treatment among refugees are examined. These insights and analyses stem from interviews with clinicians and organization leaders to assess how community resources affect the spectrum of care provided.

Interviews with clinicians also cover the strengths and weaknesses of the domestic mental health screening process for refugees. Screening issues are especially applicable to certain Vermont refugee communities, like the Bhutanese, which have alarmingly high suicide rates (Ao et al, 2016) and is compounded by a significant risk of mental illness for refugees in general (Vonnahme et al, 2015). In a 2019 study by Afkhami and Gorentz, the authors assert that the psychological health needs of refugees resettled in the United States are insufficiently studied due to lack of assessment, referral and treatment data during the resettlement process. Shortcomings in the standardized approach from the HHS's Office of Refugee Resettlement include the flexibility of CDC recommendations, where providers are encouraged to customize the implementation of its behavioral health guidelines to their own specific limitations in

expertise, time, and language (Afkhami & Gorentz, 2019). Therefore, when organizations have inadequate resources for refugee services, the extent of mental health care may be compromised.

This study is focused on refugees in Chittenden County, Vermont, which encompasses seventeen towns, villages and cities. Of these municipalities, refugees have been resettled in the cities of Burlington, South Burlington, Winooski, Colchester, Essex, Essex Junction and Williston. Refugees in Chittenden County access services primarily located in Burlington, which is the primary location of study throughout the project. Chittenden county has a total population of 162,372 and an area of 619 square miles (United States Census Bureau, 2019). Vermont has resettled 4,406 refugees since 2001; the first year such data is available. The following chart shows the diversity of refugee groups resettled in Chittenden County since 2001 (Refugee Processing Center WRAPS Database, 2019). The large number of refugee groups provides context as to how limitations involving funding, staffing and cultural barriers may affect mental health screening and diagnosis for specific refugee groups.

Table 1: Refugee Groups Resettled in Chittenden County since 2001

Nationality	**Population**
Afghanistan	10
Azerbaijan	33
Bhutan	2,053
Bosnia and Herzegovina	39
Burma	318
Burundi	123

Central African Republic	5
Congo	24
Croatia	4
Dem. Rep. Congo	438
Congo	1
Eritrea	2
Ethiopia	2
India	1
Iraq	218
Nepal	14
Nigeria	1
Russia	157
Rwanda	18
Serbia	40
Somalia	726
Sri Lanka	7
Sudan	94
Togo	16
Turkey	6
Vietnam	5

Due to the delicate subject matter at hand and the potential translation difficulties and cultural barriers, I elected to interview clinicians rather than refugees themselves. (Westermeter & Janca, 1997) Participants were asked about their perceived strengths and weaknesses of their own organization, and of the provider community at large. This inquiry was supplemented with questions about the specific mental health screening evaluations used by clinicians at each location. Participants' interview responses are then connected with how care may vary due to cultural variance. At the conclusion of the study, community tactics and screening processes that providers view as most effective in identifying mental illness, and providing a full spectrum of care for those at risk, are identified.

Eleven interviews in Burlington, VT, were used to identify common mental health screening questionnaires and generate analysis regarding provider perceptions of Burlington's capabilities. These interviews provide insight on the perceived community strengths and shortcomings through open-ended questions about the strengths, weaknesses and inter-organizational communication. A thematic analysis was generated from these open-ended questions, by which key themes that are consistent across participants were drawn out (Vaismoradi et al, 2013). Interview coding was used to analyze interviews thematically with analysis phrases from Braun & Clarke (2006). I have chosen to pursue qualitative and mixed methods research, which Omidian praises as useful to "uncover a different type of data from that of statistical methodologies, which focus on broader, less contextual issues." (p. 41) A qualitative study offers the holistic perspective necessary for broader understanding.

This project is a case study of Burlington, Vermont but its findings may be generalized across locations and other networks of mental health services. In Feagin, Orum and Sjoberg's

book, “ A Case for the Case Study,” the authors write that case studies, “can permit the researcher to not only examine the complex of life in which people are implicated but also the impact on beliefs and decisions on the complex web of social interaction.” (pg. 9) A case study of Burlington allows this project to illustrate how provider perceptions impact the direction of refugee mental health services. Bringing this study into new contexts is a matter of analytic generalization, which, “for case study evaluations [...] should aim to apply to other concrete situations.” (Yin, 2013) There are many other cities resettling refugees throughout the United States that face similar issues regarding culturally competent mental health screening, barriers of access to mental health services and inadequate community resources that fail to meet demand for refugees of that community.

The discussion and analysis of this project demonstrate that Burlington, VT faces challenges pertaining to the cultural competencies of providers, the number of providers, the cumbersome nature of mental health screening, the provision of emergency psychological care, and interorganizational communication. To improve these shortcomings, Chittenden County’s community resources must exhibit equitable care that can comfortably accommodate refugee patients within institutional frameworks. Otherwise, these challenges may erect further barriers to care-seeking.

Chapter II. Literature Review

The literature surrounding this Burlington case study is diverse and far-reaching. To entrench this paper in the context of refugee mental health literature, I have started by illustrating the link between the refugee experience and mental health disorders, such as PTSD, depression, anxiety and suicidal ideation. This link provides more background about the mental health needs of refugees that are significant to providing robust services. Subsequently, I detail work pertaining to the challenges facing refugees throughout the resettlement process, as well as proposals to mitigate the impact of the challenges that arise. Next, I cite the literature around common mental health screening tools and their validation for New American populations, as well as literature that contests the effectiveness of such tools. Tracing this debate allows this study to situate Burlington providers within this spectrum of ideas regarding their own organization's screening process. Finally, the literature review concludes by outlining barriers to healthcare and psychological care for refugees. This theme is relevant because it demonstrates the need for community outreach and services that are embedded in the community, which was a common refrain from interview participants.

i. Refugees and Mental Health Disorders

Refugees resettled in the U.S. may have prior experiences with torture and associated trauma. A 1998 study measured the impact of torture on Bhutanese refugees in Nepal in terms of their symptomatology regarding PTSD, depression and anxiety, against Bhutanese refugees that

had not experienced torture. The study concluded with a clear link between torture experience and the onset of PTSD, depression and anxiety symptoms among refugees in Nepali camps. Additionally, tortured refugees also "presented more musculoskeletal system– and respiratory system–related complaints." (Shrestha et al, 1998)

In a 2001 study, the authors asserted that tortured Bhutanese refugees in Nepali camps were more likely to exhibit psychiatric disorders such as "lifetime posttraumatic stress disorder, persistent somatoform pain disorder, affective disorder, generalized anxiety disorder, and dissociative (amnesia and conversion) disorders," than their non-tortured counterparts. In this study, women were more likely to report symptoms than men. (Ommeren et al, 2001) In a further study based on these results, Ommeren et al examined the connection between PTSD and the reporting of nonspecific somatic complaints. Participants in the study that did not differ on physical exams and laboratory tests were asked about somatic symptoms, and participants with PTSD reported more somatic complaints than those without, despite having healthy physical condition. (Ommeren et al, 2002) The true number of torture survivors in the Bhutanese population is unclear, as studies have shown that torture exposure may be significantly underreported due to stigma and fear associated with disclosure experience (Ostrander et al, 2017).

Suicide is a major epidemiological problem among Bhutanese refugees resettled in the U.S. An oft-cited study from the CDC addressed the high rate of Bhutanese refugee suicide in the United States between 2009 and 2012. This age-adjusted rate was calculated at 24.4 per 100,000 people among resettled Bhutanese refugees in the U.S. This is greater than the rate for the U.S. general population, at 12.2 per 100,000 and the rate from Bhutanese refugee camps in Nepal,

which was measured as 20.7 per 100,000 people. In the study, investigators were also able to estimate the high prevalence of certain mental health disorders and suicidal ideation among the population. They measured, “depression (21 %), symptoms of anxiety (19 %), post-traumatic stress disorder (4.5 %), and suicidal ideation (3 %).” To compare this to the general U.S. population, 7.1% of U.S. adults have self-reported a depressive episode, 3.6% have a PTSD diagnosis, 2.7% have generalized anxiety according to estimates from the National Institute of Mental Health (2019). Associations between social factors and suicidal ideation include “not being a provider of the family; low social support; having symptoms of anxiety, depression, and psychological distress; and experiencing increased family conflict after resettlement.” (Ao et al, 2016)

ii. Resettlement Challenges and Techniques for Acculturation

Refugee communities face many practical challenges upon resettlement rooted in the lack of translator service availability. Refugees from Northwestern Vermont expressed issues with public transportation and lack of translation services (Arscott et al, 2010). Regarding the US healthcare system, many refugees feared losing insurance and had difficulty understanding insurance coverage and paying bills (Arscott et al, 2010). Other problems encountered during resettlement include community violence, small social networks, lack of formal child care and food related challenges on top of financial and housing stressors (Ostrander et al, 2017).

Additionally, lack of awareness about U.S. healthcare services are prevalent among refugee groups. In a study detailing the perceptions of cervical cancer screening among Bhutanese and Nepali refugees, more than half of participants had never had cervical cancer screening, such as a pap smear, despite that, “cervical cancer is a leading cause of cancer

disparity in this population." In the study, 80% of women had positive perceptions of pap smears, which were predicted by provider/family/friend recommendations, illustrating that introduction to the cervical cancer screening early in the resettlement process is necessary for larger pap smear uptake (Kue et al, 2017). Kue et al's study, illustrates lack of awareness about the scope of health services provided upon resettlement.

There are proposals and techniques to mitigate the complications of resettlement, however. A 2015 study by Ellis et al exclaims that, "Greater availability of language classes, job training and assistance, educational opportunities, or identification of meaningful volunteer roles within the community may provide important avenues for easing the perception of being a burden and increasing one's sense of internal capacity." Peer-led community health workshops have provided a platform for community building and participation, while increasing a sense of community, sense of belonging and unity. The findings demonstrate that a peer-led intervention model provides culturally responsive and effective tools for building social capital and promoting community health in the refugee community (Im and Rosenberg, 2016).

iii. Mental Health Screening

There is an abundance of literature regarding the validation of mental health screening tools for refugees, as well as the shortcomings of mental health screening for refugees. Surprisingly, only half of US states even provide mental health screenings to refugees and less than half asked about war trauma or torture exposure (Ostrander et al, 2017). Issues regarding screening are especially applicable to the Bhutanese population, which has alarmingly high

suicide rates (Ao et al, 2016) that compound with a significant risk of mental illness for refugees in general (Vonnahme et al, 2015).

The most common screening questionnaire is the Harvard Trauma Questionnaire (HTQ). The questions are used to measure trauma and torture while having refugees describe traumatic experiences, trauma symptoms, anxiety symptoms and depression symptoms (Harvard Trauma Questionnaire, 2019). In an assessment of the construct validity of the HTQ, the cross-cultural application of the HTQ trauma symptom scales was called into question as cultural variations were found in both the reliability and validity properties of the scales. Age and gender were also shown to have statistical moderating effects (Darzi, 2017). Another study suggests that suicide risk among Bhutanese may be underestimated due to mental health screenings and questionnaires that fail to adequately account for cultural variance (Meyerhoff, 2019). These shortcomings may result in a failure to adequately address suicide risk.

In clinical settings in Burlington, Vermont, a common screening tool is the Patient Health Questionnaire (PHQ), which is employed during the intake process. The PHQ-9's reliability, validity and brevity makes it a popular tool (Kroenke, 2001). For children, another popular tool is the Strength and Difficulties Questionnaire (SDQ). The SDQ is widely used and validated. It is a questionnaire for key adult informants like parents and teachers to help identify issues with conduct, depression, anxiety and hyperactivity (Goodman et al, 2000). For culturally competent mental health assessment for refugees, clinicians use a Refugee Core Stressors Toolkit from Harvard University to guide their assessment. This toolkit's four-pronged approach assesses the stressors associated with trauma, acculturation, isolation, and resettlement. On trauma, questions are asked pertaining to emotional regulation, social support and the environment. Acculturation

questions focus on family relationships, language learning and cultural learning. Questions about resettlement stressors involve inquiries on basic needs, financial stressors, healthcare and legal needs. Finally, isolation questions focus on discrimation, loneliness and alienation.

iv. Barriers to Care-Seeking

Literature shows that refugees may opt against seeking clinical care due to practical matters like language and confidentiality, as well as stigma and skepticism surrounding mental health resources. In a synthesis of studies regarding refugee perceptions of primary care providers in the European Union, language was a major factor in refugees' willingness to seek care. The author writes, "Language differences, when seeking health care, leads to problems with establishing trust and low level of confidence in oneself and in the system, especially on the side of the receiving end (refugees). Sharing deep secrets even with a doctor seems to be embarrassing; with an interpreter, more difficult and uncomfortable." (Marblow, 2010 pg. 48) This issue of trust and confidentiality is pressing among many refugee groups. While Bhutanese and Nepali refugees' low rate of cervical cancer screening in Kue et al's study was attributed foremostly to lack of recommendation to the service, Hmong Americans reluctance toward cancer screening was attributed to accessibility to healthcare, cancer literacy and healthcare culture in a 2010 study (Yun Lee & Vang, 2010).

While the impact of cancer literacy is comparable with findings from Kue et al, Yun Lee & Vang's study shows that Hmong Americans' spiritual belief in cancer etiology poses a unique challenge in accommodations by western healthcare services. Furthermore, "many Hmong Americans who have public health insurance feel unwelcomed and disrespected at public health

facilities, which could discourage them from utilizing preventive services, such as cancer screenings." This assertion in particular has profound implications on Hmong refugees' willingness to seek medical care, let alone mental health services. While this specific study has not been performed with a focus on other refugee groups, let alone other care-seeking behavior, the crux of its results has strong potential for generalization across both.

On mental health in particular, the psychological barriers to seeking care may be even more prescient. A qualitative study of mental health seeking behavior among Bhutanese refugees resettled in Western Massachusetts found, through focus group discussions, that access to mental health services were often tertiary to seeking family support, and the support of friends and community members. Furthermore, psychological barriers such as "fears of emotions, social norms, beliefs, and self-esteem associated with cultural norms and values influenced seeking mental health support" (Poudel-Tandukar et al, 2019) .

The mitigation of such barriers requires strong programs rooted in research like Poudel-Tandukar et al's 2019 study. A pilot program employing community participatory research focused on approaching mental health issues within Bhutanese and Somali-Bantu refugee families. Family Strength Intervention for refugees (FSI-R) focuses on improving youth mental health and family relationships. In this program, home-visiting mental health counselors delivered preventative intervention to families. This intervention was a success as opposed to the regular care delivery, as participants reported less traumatic stress reactions, reduced depression symptomatology and fewer instances of family arguing (Betancourt et al, 2020).

On the provider end, there are challenges surrounding adequate provision of care and mitigating these barriers. Successful care coordination is seen as a necessity in managing a

refugee's health needs. This includes, "ongoing communication between providers, scheduling initial appointments directly, access to emergency mental health services, and case management provided by health plan staff" (Shannon et al, 2018). An important aspect of continuing care beyond the resettlement process is the dialogue between a refugee and his or her physician. While some physicians are trained in cross-cultural medicine, almost none are trained in refugee evaluations. Rhema et al writes that refugee and routine patient evaluations differ because, "1) Refugees are new immigrants from countries where the disease epidemiology is different from the U.S.; 2) Certain infectious disease processes need to be ruled out upon arrival to prevent the spread of communicable diseases; 3) The prevalence of mental health disorders in refugees is higher than the local population; 4) The medical and psychiatric health problems of refugees are often caused or affected by their past experience with trauma and their current acculturation difficulties; and 5) Significant cultural barriers can arise in the accurate evaluation and treatment of these refugees." If physicians are unable to adapt to refugee specifications, the quality of care provided is undoubtedly compromised. Provider education is important for ensuring cultural competence among clinicians. A 2019 study asserts that "Current models of cultural competence are primarily centered on the personal capabilities of professionals and on organizational standards, overlooking their interdependence with community contexts."

Education for the refugee community on mental health is essential for encouraging refugees and immigrants to seek clinical care. A 2015 study measured the results of Mental Health First Aid (MHFA) training on Bhutanese refugee community leaders across the United States. MHFA seeks to educate community members on the signs and symptoms of mental health issues "and decrease negative attitudes towards people with mental illness." Scores on

participants' recognition of mental health issues like depression before and after the course were compared, showing "significant improvement in the recognition of symptoms of depression and expressed beliefs about treatment that became more concordant with those of mental health professionals." (Subedi et al, 2015) MHFA, however, failed to reduce stigmatization of participants toward people with mental health issues in this study, clearly exhibiting the need to incorporate cultural variance within the MHFA course.

Chapter III. Methodology

This project involved semi-structured interviews with mental health clinicians that work with refugees, and community organization leaders. Their responses were used to qualitatively assess the mental health screening process and strength of community assets through the provider lens. Data collection involved eleven interviews at five different locations in Burlington, VT with the goal of garnering insight on the perceived community strengths and shortcomings for the provision of care in Burlington through open-ended questions about the strengths, weaknesses and interoperability in the organization and community at large. The responses to open-ended questions led to a thematic analysis which distilled key themes consistent across all locations (Vaismoradi et al, 2013). Qualitative and mixed methods research, which Omidian praises as useful to "uncover a different type of data from that of statistical methodologies, which focus on broader, less contextual issues," offered the holistic perspective necessary for broader understanding. (p. 41)

i. Interviews

Face-to-face in-depth interviews are essential strategies in collecting qualitative data. While epidemiological studies often employ structured and questionnaire-based interviews, the utilization of the open-format, semi-structured interview "explores meaning and perceptions to gain a better understanding and/or generate hypotheses." (DiCicco-Bloom & Crabtree, 2006) The semi-structured interview is congruent with the goals of my research project, which implored

providers to generate their own meanings from the prompted questions. In accordance with the conceptual framework of this interview style, the questions aimed to "encourage the interviewee to share rich descriptions of phenomena while leaving the interpretation or analysis to the investigators." Furthermore, semi-structured interviews, "co−create meaning with interviewees by reconstructing perceptions of events and experiences related to health and health care delivery;" another consistency with project goals. (DiCicco-Bloom & Crabtree, 2006)

ii. Choosing Participants

As mentioned in the description section, delicate topics, potential translation difficulties and cultural barriers have prompted me to elect to interview clinicians rather than refugees (Westermeter & Janca, 1997). Participants were chosen that work specifically with refugee clients/patients and have distinct knowledge of challenges facing refugee populations in Vermont. The individuals chosen represented organizations that have strong connections with refugee communities in Burlington.

The first of these organizations is the Association of Africans Living in Vermont (AALV). AALV provides integration services for refugees and immigrants that helps new Americans successfully transition to life and work in Vermont upon resettlement. Interpreter and translation services, legal services, case management, workforce development, youth development and behavioral health outreach are rolled into AALV programming. The organization's multidisciplinary approach to integration makes its employees uniquely qualified to comment on the strengths and weaknesses of the Burlington community in providing mental health resources.

Next, the UVM Pediatric New Americans Clinic (PNAC) is a pediatric primary care affiliate of the University of Vermont Medical Center. Their clinic sees pediatric patients with a focus on refugees and immigrants. In addition to specializing in refugee care, the PNAC provides refugee outreach through its 'Safety Day' at Winooski and Burlington public schools. The clinic has also embedded a family wellness clinic within the refugee community called the Building Strong Families Clinic at the Family Room in Burlington, which offers programs for parents and children. These healthcare providers' knowledge of the social determinants of health facing refugee communities is crucial to the assessment of community assets and weaknesses in Burlington. Additionally, their use of mental health screening tools gives insight into the provider conceptions about the effectiveness of such tools.

Interviewees also represented the University of Vermont's Connecting Cultures Program. Connecting Cultures is a specialty psychological service that works with refugees and immigrants to provide mental health interventions such as therapy and counseling. It is an affiliate of the New England Survivors of Torture and Trauma (NESTT). Their services include direct mental health services, outreach services, training of external care providers in the Burlington community and research for the University of Vermont. While providing direct care is an important part of their mission, Connecting Cultures is an even greater asset to the community due to their ability to train up more providers around cultural competency and increase the number of culturally sensitive workers in the Burlington area. Clinicians from this organization have insight into community strengths and weaknesses through their interdisciplinary scope. They use comprehensive mental health screening tools for their diagnostic intake process and have strong insights about their strengths and weaknesses as well.

The University of Vermont Medical Center was a necessary site due to their ubiquity in the Burlington community. While not working with refugees on a specialty basis, the Medical Center sees refugee patients in all departments. Pertaining to mental health care, the emergency department at UVMMC is a common destination for patients having acute psychological emergencies, such as heightened suicidal ideation. Additionally, the psychiatry department sees these same patients if there is availability. Providing the Medical Center with representation in this project was imperative in illustrating a complete view of the mental health provider landscape in Burlington.

Finally, interviewees also represented the Vermont Leadership Education in Neurodevelopmental Disabilities Program (VT LEND). This program prepares leaders across health disciplines in maternal and child health to provide care for patients and families with outstanding health needs. Interviewees from this program had insight into Burlington's mental health resources from the refugee community lens as well as the provider lens. Their participation led to valuable anecdotes regarding the attitude of Burlington's clinicians toward refugee patients.

By choosing representatives and participants from these five organizations, I was able to develop a holistic and complete perspective about Burlington's refugee mental health services. While there were only eleven participants, there was plenty of overlap in sentiments which made coding for thematic content analysis possible and clear. That this multidisciplinary group developed consistent insights with each other, demonstrates that their responses can be indicative of Burlington clinicians' responses on the aggregate.

iii. Multi-Site Challenges

These five organizations were chosen as key informant locations because each is an integral community actor in providing care for refugees in Vermont. To address this project's goals, it was necessary to hear from a diverse group of individuals representing a multitude of backgrounds. This undertaking posed challenges to the project in developing rapport with multiple interview locations. According to Spadley (1979), the first stage of rapport is apprehension. If interviewing in only one location, developing rapport would have been a cumulative process, with interviewees developing preemptive trust through their colleagues' connections with the interviewer, mitigating the initial apprehension in the interview process. Through my involvement in different sites, I often did not have this luxury and worked deliberately to develop "a safe and comfortable environment for sharing the interviewee's personal experiences and attitudes." (DiCicco-Bloom & Crabtree, 2006) This was a consideration in all interviews, but more so for those which were one-and-done at a particular site.

Additionally, this multi-site project posed practical challenges. While a handful of sites were conveniently located on the University of Vermont campus, some, such as the AALV, were embedded in the Burlington community creating small but discernible issues regarding transportation. Finally, setting up interviews at five different locations created challenges around coordination. Communication often involved emailing different informants at once without a true methodological approach to the interviews' scheduling, due to the close proximity of each location. This approach was ultimately successful but could have been more streamlined.

iv. Questions

The questions posed to interviewees were designed to prompt open-ended responses regarding their opinions and experiences with the mental health screening processes employed by their own organizations, if applicable. Some participants' organizations did not use mental health screening and, therefore, were only asked to contribute their educated opinion. Such responses were not used in the qualitative analysis. All participants were asked about their assessment of the strengths and weaknesses of Burlington's community resources, as all were well qualified to discuss. While questions were tailored to the specific role and capabilities of various organizations and clinicians, interviews stemmed from the following template.

On Mental Health Screening:

i. Please provide a description of your mental health screening process i.e. which questionnaires and surveys do you employ?

ii. If a screening reveals a patient who is a possible mental health diagnosis, what steps are in place to ensure the provision of care?

iii. What do you believe are the strengths and weaknesses of your organization's mental health screening process?

iv. If a screening reveals a patient who is at a high statistical risk of PTSD or depression related to past trauma, is there a plan in place to address this risk?

v. If a screening reveals a patient who has suicidal ideation, what steps are in place to ensure the provision of care?

vi. How does mental health screening differ between refugees and the general population?

vii. Does mental health screening differ across refugee groups? If so, how?

viii. What specific challenges accompany mental health screening in the refugee community?

On Community Assets:

i. What are the strengths and weaknesses of your community in providing mental health care for refugees?

ii. Are there initiatives in your area that focus on a strengthening of community among refugees themselves?

iii. Are there initiatives in your area that focus on a strengthening of community between refugees and the broader community?

iv. What institutions in your community play a major role in the provision of healthcare for refugees, both physical and mental?

These questions were crafted to implore clinicians to think critically about their organization's own policies and operations. They gave interviewees the leniency to interpret the questions as they wished, while still serving the project's goals of provider assessment. Participants' responses to these questions were used to create codes for a thematic content analysis. I created a set of codes based on the subject of the participants' responses. Responses fell into the subjects of 'cultural competence,' 'not enough providers,' 'confidentiality,' 'mental health screening,' 'emergency,' and 'communication.' These six codes were broadened and sharpened into the themes discussed in the analysis. The codes for 'not enough providers' and 'confidentiality' were combined to become "Challenges of Community Size." The other four were renamed to better demonstrate their meaning.

Chapter IV. Analysis

i. Introduction and Empirical Analysis

Upon the completion of interviews and data collection, I employed a thematic content analysis to distill the key themes from every interview. In accordance with literature on thematic content analyses, I, "grouped and distilled from the texts a list of common themes in order to give expression to the communality of voices across participants." (Anderson, 2007) After reading through interview transcriptions numerous times, I was able to identify the following themes as the most common and relevant. The following is my attempt to objectively describe the themes barring analytical interpretation.

1. Cultural Nuances

Cultural nuances describes the challenges around the particularities of refugees' perceptions of emotional health and its associated resources. This includes the sentiment that community resources and organizations may not have a complete understanding of the challenges facing refugee communities upon resettlement. It also includes the assertion that mental health issues often present as physical ailments for refugee populations.

2. Challenges of Community Size

This theme describes the interviewee complaint that there are often not enough mental health or psychiatric providers in Burlington to meet demand. Additionally, there were complaints around the even lesser number of culturally competent providers that trusted organizations are comfortable referring to. This theme may also include concerns around confidentiality pertaining to interpreters and providers from the refugee community itself.

3. Screening Challenges

This theme describes the perceived challenges around screening and diagnosis. It includes concerns about the length of intake processes, common screening tools for the general population being invalidated for refugee populations, and screening tools that are inconsiderate of non-English language speakers.

4. Emergency Care

This theme addressed complaints about emergency psychological care and its lack of comprehensiveness. This section includes concerns about the lack of emergency resources, a lack of culturally competent emergency providers and the necessitation of an unproductive and cyclical care plan for people who are contemplating suicide.

5. Interorganizational Communication

This theme addresses the synergy between participants' organizations and other resources in the community. This includes sentiments about the challenges and benefits of inter-organizational communication.

The interview transcriptions were coded for these five themes and the interviewees' responses were used to inform the analysis.. The following figure illustrates the number of interviewees that mentioned each of the coded themes.

Figure 1. Number of Clinicians Contributing to Thematic Content Analysis

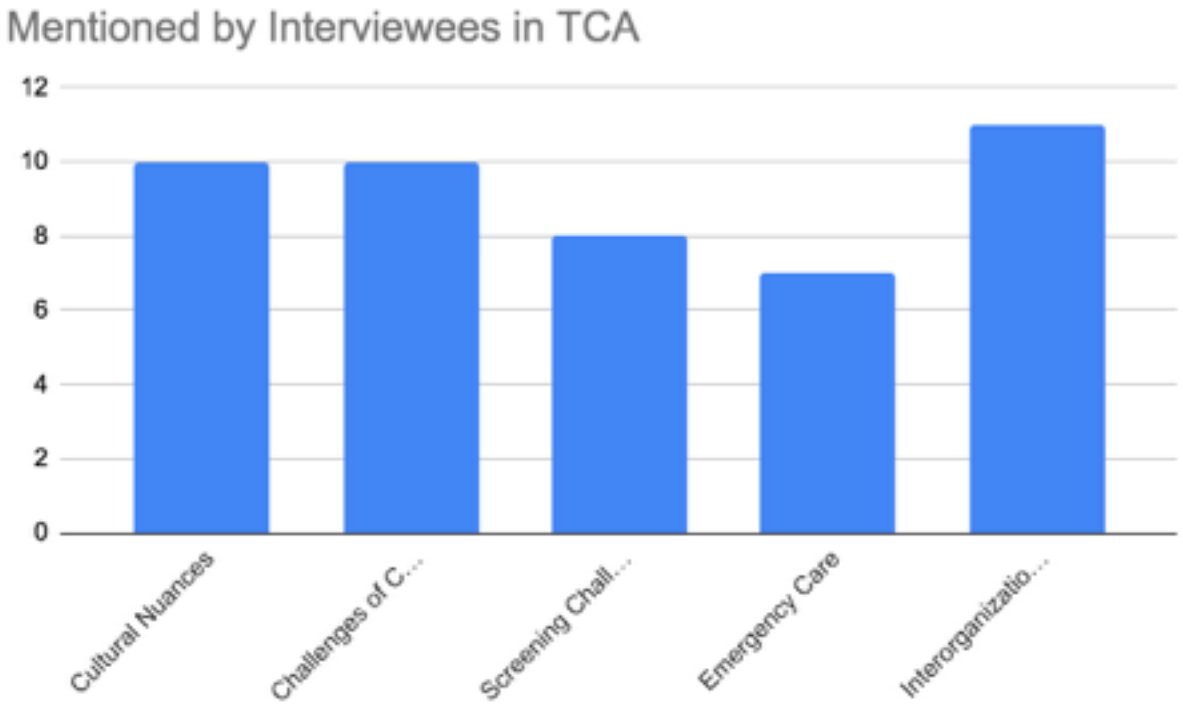

Figure 2 illustrates the average number of times a thematic topic was brought up by the interviewee in our conversation.

Figure 2. Themes Mentioned per Interview

Cultural Nuances	3.36
Challenges of Community Size	2.91
Screening Challenges	2.91
Emergency Care	1.27
Interorganizational Communication	3.72

ii. Qualitative Analysis

1. *Cultural Nuances*

Study participants expressed many challenges around providing mental health services for refugee populations that conceptualize mental health and psychological issues differently than the general Vermont population. For a clinician that has little experience working with

refugees or interpreters, this can be a challenging reality, and it could have profound implications on refugee and immigrants' faith in the healthcare system and, thus, their health-seeking behavior. This is a particular challenge when it involves conceptions around services for mental health. One clinician explained:

> *"There's a lot of confusion and stigma about what mental health services are in the refugee population. More distrust and confusion around what it is. What the constructs are for what we would call a disorder doesn't have a perfect translation."*

A community leader corroborated:

> *"I think with all the refugee populations that we work with, the perception is the same. If you talk about mental health services, they have this conception that if you have to access them, it means you're crazy."*

This baseline sense of distrust towards mental health services mirrors the refugee conception of psychological disorders, which is often incongruent with the western lens. In certain refugee populations, mental health and psychological issues are experienced differently and are often stigmatized and shamed. This is consistent with literature from Ostrander et al (2017) that psychological issues are often underreported due to fear. On the differences of mental health experiences between refugees and the general population, one clinician expressed that:

> *"Identifying issues as mental health versus something else that can be very cultural in nature can be a challenge. A lot of languages don't have terms for depression. Certainly for more specific diagnoses, autism for example, to really try to explain that disorder to parents can be quite challenging."*

These incongruent conceptions of mental health issues with mental health resources are major challenges because resettled refugees have a uniquely high risk of suicidal PTSD, anxiety and depression due their possible exposure to torture and trauma, as well as post-migration stressors. This link is consistent with literature from Ao et al (2016) and Ommeren et al (2001), but it was also viewed by providers as exceptionally clinically relevant in making diagnoses and assessing suicide risk though the screening process. One clinician drew this idea out further, saying:

> *"Inherent in the refugee experience, there are stressors that to almost anyone would trigger some level of mental health challenge. Then there's the adjustment component also. [...] The mental health component in the refugee experience exacerbates all other things and are always there. Even if someone is doing well, there's likely a mental health component."*

This confluence of post-migration stressors, negative conceptions of mental health services, and misunderstandings about Western mental health disorders undoubtedly impacts help-seeking behavior for refugees that may be recommended to access psychological services in Burlington. This was a concern for a variety of providers, who see refugee community members reluctant to access services, or opting out of the city's psychotherapy services when they might be needed. One provider outlined some of the justifications surrounding inaction:

> *"'We take care of it in our family,' can be a huge barrier to seeking treatment. The shame and the stigma is a big barrier to seeking treatment. That children don't have mental problems. That they don't have trauma. They don't have problems. That can be a barrier.*

Getting people into treatment can be very difficult as a result of a lot of those things. A lot of cultural pieces around stigma and shame."

Working around these cultural barriers is a necessity for providers that are committed to improving mental health outcomes in the community. A common thread among participants was the notion of continuous community outreach, and many cited the importance of being familiar in the community to develop a sense of trust and reciprocity. This idea is consistent between community leaders, counselors and healthcare providers. A community leader mused:

"I think in the ideal world, counselors put their faces out there and say, 'we are here to learn from you and to listen. And to impart the knowledge that we think can help you.' Or, 'to learn from you in terms of how you manage stress and how to do so, using the information that we know.' It's a collaboration."

Another added:

"I think it's important to do continuous outreach. It's not a one time thing. It's a never-ending process. If you write a grant, think about the sustainability of that actively. Do not only limit it to the grant time period. How can you continue that so people think it is a support? Otherwise, it's for the grant. The grant ends and they are making us their puppet. They feel like they are being used for the grant."

The continuity of mental health outreach is an important distinction and it is necessary in increasing the perceived accessibility of health services to refugees. While there are many challenges involving the cultural nuances of working with the refugee population in Burlington, community outreach and education initiatives are seen as a necessary prerequisite to developing

trust in the community for providers and organizations. Challenges surrounding skepticism of services will continue to exist in the Vermont refugee population, but organizations can help improve this sentiment over time by demonstrating a continuous and visible flow of outreach and support.

Sites that participated in this study have attempted continuous outreach in various ways that align with their organizational missions. In the healthcare sphere, the UVM Pediatric New American Clinic has implemented a new 'Building Strong Families Clinic' geared toward supporting parental wellness and providing information about parenting in a different country. Additionally, the Association of Africans Living in Vermont has a myriad of services catered to promoting both autonomy and community for refugees. The New Farms for New Americans program is designed to give New Americans access to gardens and plots of farmland to be used at their discretion. The AALV also sponsors "community cafes," where New American women meet to process their experiences and support each other. If more organizations employed programs like these, the level of trust toward mental health services would likely rise.

1. *Challenges of Community Size*

Burlington, Vermont is a small city with a small New American community. Due to this small population, there is not an overwhelming demand on psychological and healthcare services to cater to refugee and immigrant patients. Burlington lacks a robust spectrum of mental health resources in general, and finding culturally competent services is an even greater challenge. All participants in this study *do* provide services for refugees, and they repeatedly expressed that Burlington did not have enough providers to meet the mental health needs of New American communities. Furthermore, many were uncomfortable referring out to certain organizations and

clinicians without experience working with refugees. Provider confidentiality was another issue that arose. As refugee community members have now been trained as interpreters or mental health providers themselves, people seeking services may be uneasy about community members having knowledge of their personal psychological diagnoses.

The small community size in Burlington presents challenges with developing particular services for refugees. One healthcare professional explained:

> *"Being small means it's hard to have a lot of specialized resources, so we've got Connecting Cultures, which is amazing to have that in a setting like this. There's not otherwise a lot of services directly focused on the refugee population because it's a small place and it's not that big of a population to carve out a lot of specific things."*

With the small number of organizations available to refugees comes a similarly inadequate number of providers to satiate the demand for psychological services. Psychology workers and mental health clinicians themselves recognized the problem of having extensive waitlists for their services due to a small number of providers elsewhere in the community. When asked about his or her organization's weaknesses in providing care, one clinician said:

> *"Some of our weaknesses are that we have this waitlist. It's too long*. [...] *I think a general problem in Burlington is there are not enough providers to meet the need. People are always on a waitlist."*

One healthcare professional commented that the availability of specialty providers is even more limited by seasonal operations that coincide with the University of Vermont.

"*Providers are full. Connecting Cultures have had some people that have stayed for a while but often they have just September through June. So if you're referring somebody in May, there might not be a clinician that can carry on with them for a while."*

While there are not enough mental health providers for refugees to meet demand, another problem is that culturally trained providers feel uncomfortable referring out to resources that are inexperienced with New Americans and non-English language speakers. A provider commented:

"*There are a few providers we refer to in the area but that's been a challenge recently that, compared to the number of people on the waiting list, we don't have the capacity to take people as quickly as we want to. We don't always feel like we have enough providers who we know really well that we feel comfortable referring out."*

Another added:

"Directing people to culturally sensitive providers can be challenging. Even some of the larger providers of mental health are not necessarily culturally sensitive."

One provider expressed that the lack of culturally sensitivity greatly impacted help-seeking behavior and skepticism in the healthcare system. Providers who are not sensitive make refugee patients and clients feel like their problems are not being taken seriously. This provider said of untrained professionals:

"It's if they already have implicit bias, in that immigrants do not know anything or do not deserve respect. They think they are superior; body language, the way they speak. I think everybody needs more education and practical training to culturally and linguistically appropriate services."

While an inadequate number of providers coupled with a lack of training in cultural sensitivity is a major problem for professionals, community size generates issues for help seekers as well. While interpreters and mental health providers from the refugee community have been trained to respect confidentiality, providers expressed that there is an overwhelming uneasiness in clients who need to use providers from their own ethnic community. Even seeing other refugees from their community in waiting rooms can be a major source of anxiety, according to many study participants. One healthcare professional communicated both of these issues:

> *"Having places that you go that aren't labeled or where you don't see other refugees you know in the waiting room, that can be a problem in our small community. We have problems with interpreters in a small community, where they don't want to use an interpreter because they see them in other settings and they'll know what happened to them. We have problems with interpreters also being traumatized and hearing about trauma revisits their own trauma. A lot of vicarious trauma and secondary trauma.*"

A community leader expressed:

> *"Because interpreters are so embedded in the community, someone may run into another person and assume, 'now you know my problems. Maybe you are talking to the community about my problems.' That can be challenging for interpreters."*

This anxiety about confidentiality is undoubtedly linked to the cultural nuances of surrounding stigma and shame in refugee communities discussed in Section A of the analysis, as well as the literature review. The stigmatization of mental health resources and skepticism

around them is also applicable inwardly, to the refugee community itself. The following quote draws out the link between the stigma and anxiety surrounding community providers. When speaking on the Bhutanese refugee community in particular, a mental health clinician explained:

> *"That's one community that there seems to be a lot of conversation amongst community members. I've had clients talk about being wary that their community members know that they're coming here for services. Their perception is that if they're coming here, it's because they're crazy. It certainly speaks to a strength in the clients that they're still willing to come. That's a barrier to even getting in the door. Even when someone is engaged in therapy, I hear a lot about other people in the community that say people know what's going on in my life or with my husband, and DCF, with my kids being taken away from home. It's my impression that it gets a little messy with, maybe interpreters, but also community providers. Because now that the Bhutanese population has been here for a while, a lot of those folks are starting to become providers in the community. That gets complicated, being in the provider role and a representative of the community. I think clients sometimes worry about those boundaries for the providers. For that reason, some clients have very strong preferences."*

In light of all these challenges, a small community size can also be considered a strength due to the relative ease at which resources are coordinated and care is provided across different organizations and disciplines. Over time, different organizations have formed strong relationships with other organizations in Burlington, making their work easier through trusted partnerships. A pediatric healthcare provider explained:

"It's fairly easy to reach out and build relationships with people who are able to help them in the school setting and parents. Communication is relatively easy, which is important because there's a lot of barriers to mental health communication."

Additionally, the landscape of culturally competent providers is changing and more are being trained up by Burlington organizations like AALV and Connecting Cultures. Many participants expressed that refugee-oriented services have become much more comprehensive within the past decade, and that there is goodwill within Burlington providers to learn and develop culturally appropriate techniques. While there is more work to be done, organizations have done well in mitigating some of the major challenges facing a small community like Burlington.

2. *Screening Barriers*

Study participants who employed mental health screeners used a myriad of tools depending on their organization's focus and goals. Pediatric healthcare providers employed the PHQ-9 for depression and the CRAFFT for substance use in the adolescent population. For young children, they employed the Ages and Stages Questionnaire and the M-CHAT; both for developmental screening. For parents, they use the PHQ-2 and a screener regarding social determinants of health. Specifically for refugees and immigrants who are new arrivals, pediatric providers used the SDQ (Strength and Difficulties Questionnaire) during the first arrival visit, one month after, six months after, and one year after. On arrival, parents are screened with the PHQ-2 and the Edinburgh screener for depression. In the healthcare setting for adults, a physician participant employed the PHQ-2, PHQ-9 and GAD-7. Psychological health clinicians

used a more thorough screening process rolled into a larger assessment termed ‘intake.’ Intake involves an open-format, unstructured interview, and then moves to a packet of questionnaires asking about physical complaints, health issues, chronic pain and mental health symptoms. Screeners throughout this process include the Kessler-6 and the Refugee Health Screener.

While these screening tools and patient intake measures are used because of their relative validity and effectiveness, providers cited a handful of problems and weaknesses of their screening process. These complaints often revolved around the length of the screening, the cultural competence of some screener questions and difficulties of garnering accurate responses, particularly with children.

Mental health clinicians uniformly expressed that their intake process was too comprehensive and cumbersome for refugee clients. One clinician stated, “All of these intake assessments are taxing for people. We have done a number of them, and have decided that it really needs to get cut down.” This was a common sentiment among clinicians, who believed that the length of the screening process impeded on prompt treatment. One interviewee asserted that the intake process could last up to, “at least four sessions, which is a lot for clients to get through especially when they’re wanting help right away. It often feels like a tradeoff where we get a very complete picture of the person, and they have to wait an extra month or so to start treatment.” A strength of the intake process is that it provides a comprehensive diagnosis and, thus, a strong segue into treatment. Providers expressed that sometimes tangential questions are added to the intake to further research projects. While this contributes to lengthening the intake, it may also develop clinically relevant insights to further tweak existing intake questions.

When refugee patients encounter services that are less culturally accommodating, comprehensive packets of information for intake become profoundly more difficult. A healthcare professional explained, "from psychiatric care, med management, it's terrible. You have to fill out a packet of information to even get an appointment. It's cumbersome if you speak English, nearly impossible if you don't. It's really onerous." This is a crucial difference between refugee-specialized intake and general medical intake in Burlington. Specialized services' intake is cumbersome because it is trying to get a complete picture while using the current intake to improve future intake. As one clinician described it, "we're getting research to study the population and the presentation of different problems." In comparison, general services' intake processes are cumbersome because they do not provide space for the cultural nuances of help-seeking behavior.

Furthermore, refugee providers commented on a number of kinks throughout their own screening processes where certain questions contain confusing idioms that are unclear for an English language learner or through interpreter services. A healthcare professional participant explained that some questions used in their organization's screening process are, "totally weird." The interviewee continued that:

> *"The classic one is in the Edinburgh when it asks, 'are things getting on top of you?' This means 'do you cope well?' but it's phrased in the really odd way that is very hard to understand and interpret. There are certain questions on the SDQ that people always seem to answer in a different way than intended."*

Certain screeners in general drew ire from mental health clinicians, as one interviewee disparaged the Cognitive and Affective Mindfulness Scale as, "very confusing for clients. It's

very heady, psychologically-minded and abstract. For example it says, 'it's easy to keep track of my thoughts and feelings,' or 'I can usually describe how I feel at the moment in considerable detail.' This is just confusing, even through an interpreter."

A final challenge within mental health screening for Burlington providers is that responses are often inaccurate, or cultural disconnect prevents answers that are congruent with western prerequisites for a specific diagnosis. A pediatric healthcare professional stated that a common occurrence in working with children is that, "we get a number of false positives. I've also had a lot of kids that answer the screening questions totally normal but then tell me that they're really stressed or depressed or anxious." This, too, is connected with literature from Ostrander et al, regarding the stigmatization of mental health disclosure in refugee communities (2017). One clinician explained that, with a sensitive topic like suicidal ideation, "these are highly stigmatized experiences. When we ask about them, we're not sure we're getting an accurate answer." This idea also pertains to Dalgaard and Montgomery's assertion that, "the process of trauma disclosure is highly culturally embedded," for children and families (2015). Getting clients to open up about their mental health symptoms and experiences requires long-term demonstration of care. One healthcare professional added, "as we build a relationship and see them more, the hope is that, as they feel comfortable, they're able to let us know."

In other situations, screening questionnaires fail to grasp the cultural context of various psychological experiences. Specifically, Bhutanese refugees were shown by research from the University of Vermont to express suicidal ideation abstractly and passively. One of the architects of this study was interviewed and explained that, "This idea of suicidal thoughts is actually very complicated. Many of these folks don't necessarily have suicidal thoughts but a more abstract

desire to go to sleep for a long time, escape, not be here, not stand in death's way, disappear." He maintained that the shortcomings of current screening for suicidal ideation did not grasp this concept. The screening questions for suicidal ideation asked about the topic directly, but did not ask about abstract thoughts such as 'the wish to be dead' or 'the wish to disappear.' This research was able to embed more suicidal ideation warning signs within the screening and intake process.

1. *Critical Care*

Throughout the interview process, I asked participants how emergent psychological episodes were handled within their organizations. While many sites had protocols and plans for an acutely suicidal patient or client, there was often a lack of knowledge about the fate of the patient following the introduction of emergency services. When participants did have this understanding, there was concern that the infrastructure for psychological emergencies in Burlington, and Vermont in general, is inadequate.

Many participants expressed that their organization had a suicide plan for clinicians to follow with their clients. One participant stated that their organization's response, "depends on the level of suicidal risk and intent. It varies from calling First Call to the Howard Center, or taking [the client] to the emergency room." Often, the response for mental health providers included making a safety plan with their client. For one organization, the development of a safety plan is, "most likely what we do, and checking in with the client to schedule more frequent appointments. This might involve a family member doing a welfare check to keep us informed that they're safe."

However, developing a safety plan is not always a viable option for a person in a crisis situation. Often, a patient needs a higher level of care but the lack of providers in Burlington makes care provision a challenge. One provider lamented:

> *"I have colleagues who have been meeting with someone once a week and that person has an increased risk of suicide, or are talking about it more to the point that meeting with a therapist once a week isn't enough. For some reason, that person wasn't fitting nicely into one of the categories in the Howard Center, so they weren't able to take them either. This sometimes results in us holding onto cases which are pretty high risk without feeling like there's a good alternative."*

A healthcare provider expressed circumstantial differences to their response as well, and stated, "usually, if someone is actively suicidal, we send them to the ER. Then they wait for a bed." Participants expressed that when hospitalization is needed, there is an unfortunate lack of beds and resources to meet the need for Burlington's patients with psychiatric problems. There is only one psychiatric floor of the University of Vermont Medical Center with limited beds. Often, this lack of resources results in early discharges from the Emergency Room. A mental health clinician asserted that after admittance to the ER, "the community just doesn't have what people need. They're in the hospital for a couple days and are discharged to [my organization] and we're in the same place that we started."

Even when patients can get access to psychiatric beds, they often are taken to Brattleboro; a two-hour drive away from Burlington. One healthcare provider expressed profound frustrations with the psychiatric hospital in Southern Vermont; the Brattleboro Retreat. In addition to the logistical challenges of being admitted to a hospital where family is kept at a

two hour distance, this participant continued that, "they don't use interpreters [...] They don't communicate with their family. They don't call the family to let them know what's going on. We've had a lot of challenges. It's been really difficult. And they are not always culturally sensitive." This is not an ideal situation for patients or providers.

During the hospitalization phase of psychological crisis, there is importance in maintaining continual involvement and patient advocacy. One clinician expressed the tension within families regarding a plan for adolescent suicidal ideation:

"We have had situations that have come up where the parents haven't agreed that [our plan] was needed or the best plan." This patient advocacy boils down to "being part of the process. [...] Getting [an emergency bed] set up and monitoring them while they're there. Being involved in discharge planning. We're always thinking about the level of care that's needed and actively being part of that planning."

Having an understanding of the emergency process and advocating for vulnerable patients is tantamount to providing a full spectrum of care.

2. *Inter-organizational Communication*

In the section, Challenges of Community Size, clinicians talked about the advantages of having a small community that is able to coordinate care across different organizations and disciplines. This is a feature of care that I term interoperability, and it comes with a distinct set of challenges involving basic communication and coordination. In healthcare, psychological service, and social service settings, providing a full spectrum of care requires that organizations refer to different resources that may ameliorate patients' negative circumstances contributing to health and wellbeing. Inter-organizational connections may take place at a local or national scale.

Participants expressed that, after years of working with other organizations in Burlington, strong inter-organizational relationships are formed. A pediatric healthcare provider explained, "we see a bulk of refugee kinds and the bulk of their parents are seen at the Community Health Center. And the bulk of kids go to a handful of school districts [...] It's fairly easy to reach out and build relationships with people who are able to help in the school setting and parents." These relationships are helpful in the referral process, when providers know an organization or clinician is culturally sensitive. Often some multidisciplinary resources are embedded in-house. For example, the UVM Pediatric Clinic for New Americans has a psychologist and a social worker in the clinic. Connecting Cultures has its own physical therapy program. The AALV has Connecting Cultures clinicians embedded in its office as well.

However, there are a handful of challenges that accompany inter-organizational coordination. Often, study participants cited basic communication issues and sought better relations with other organizations. A clinician stated, "I don't know if we coordinate well enough with other agencies and other agencies might not coordinate well enough with us. I think there could be better referral relationships." Another added, "Some of the basic communication issues come up. People not getting back to you. Miscommunication. The language barrier certainly comes into play, where I might feel really comfortable reaching out to a family but other people don't." This sentiment connects with the aforementioned theme that there are not enough culturally sensitive providers in Burlington to meet demand.

Furthermore, some referral resources are more reliable than others. A mental health clinician explained, "it's hard to get in touch with referral sources." One clinician explained that their organization's referral process was not detailed enough to demonstrate client needs prior to

the first visit, saying, “An issue with our referral process right now is we often don’t get a comprehensive picture of someone and they might have a mental health problem and also they need social work and also could benefit from other things we do.” This problem that risks redundancy for the patient within care coordination.

While communication is important on the local level, it is also necessary nationally so that providers can use the most universally-optimal protocols for their patients. One healthcare professional asserted, “there’s a fairly good deal of sharing ideas across communities. We’re all doing some of the same stuff. There’s a big association of refugee healthcare providers in North America.” This is important for the communication of insights across communities, however sometimes state or national guidelines are incongruent with providers’ discretion. In an explanation of their organization’s screening process, one health provider complained,

> *“The SWYC is nice because it does ask about some temperament questions, which in the young kids, we don’t really ask mental health questions. But those questions were helpful but I wasn’t allowed to use it anymore because it wasn’t the standard that the state was using. So we stopped using it, which is too bad.”*

Refugee providers in Burlington have developed creative ways to enhance interoperability for clinicians in the area. The most comprehensive of which are Refugee Immigrant Service Provider Network (RISPNet) meetings that allow for refugee providers to share their thoughts and resources across disciplines and organizations. The meetings are, “a rare opportunity to get everyone who’s involved in this work in the same room together and get updates on what everyone else is doing.” Building trust in the provider community is often contingent upon the willingness to communicate with others, and attending RISPNet meetings

seem to be an avenue to build this social capital. One participant expressed that who culturally competent providers trust ,“has to do with who is showing up at these RISPNet meetings, who is putting in the extra work.”

Chapter V. Discussion and Conclusion

i. Equitable Care and Policy Prescriptions

When asked how care differs between refugees and the general population, one healthcare provider said, "We try to provide the exact same level of care and that often means that we put more resources into [refugee-specific care]." This statement exemplifies the need for an equitable framework to provide a full spectrum of care for refugees and immigrants. To provide care on a baseline level requires more inputs, more provider knowledge, and ultimately, more time and energy than working with Vermont natives. The previous analysis highlights many of the disparities between providing mental health resources for New Americans against the general population. Each of the themes discussed in the previous analysis section is relevant to the improvement of care; not only in Burlington, but with any small city that faces similar challenges around provider availability and confidentiality. In the context of the themes raised by interviewees, the provision of equitable care can be realized by Burlington's providers. However, it is clear that Burlington's resources, in the aggregate, do not always yield a level of care that can be considered equitable.

In the *Cultural Nuances* section of analysis, providers expressed the differences between refugees and the general population in the presentation of mental health issues. Disorders like PTSD, anxiety and depression often were somaticized in physical ailments and experienced abstractly. There was an overwhelming concern among interviewees that many providers in healthcare or traditional mental health services were unaware that disorders could be presented this way. In Burlington, organizations like Connecting Cultures offer training for providers on

cultural competence, however, there is a need to improve understanding and sensitivity, especially among healthcare workers. For effective training, there must be internal drivers within a particular organization to reach a higher level of cultural competency among staff. Staff members should understand why this education is important, as they should understand the clinical ramifications of their training. To address the need for equity in mental healthcare as concrete policy, healthcare organizations and institutions must start by providing cultural competency education and training for all employees. This should include practical training, such as working with interpreters. It should also include training that demonstrates how mental health's cultural nuances lead to unfamiliar presentation of mental illness.

One interviewee postulated that this training should be expanded not only to clinicians, but anyone who makes contact with refugees and immigrants in a care setting, saying, "everybody needs more education and practical training to culturally and linguistically appropriate services. It's important to train people right from the front desk, because they are the ones who receive people, people from diverse communities." Fortunately, training regarding chronic traumatic stress, cultural mental health perspectives, working with interpreters, and trauma-informed systems of care is available in the Burlington community through Connecting Cultures. Larger healthcare institutions within Vermont, and throughout the country, need to make a deliberate effort to learn from the providers that do have experience with New Americans, so they don't unknowingly create a negative experience that further fuels refugee skepticism in mental health resources and healthcare. Receiving cultural training, while time intensive, is a prerequisite to equitable care.

Interviewees expressed barriers to access being a major problem for refugee communities. As illustrated by the general skepticism and stigma around mental health resources among refugee communities, these barriers are often social and are strong enough to prevent patients from even walking in the door. To address refugees' concerns about confidentiality in direct mental health services, organizations might consider offering more robust online services for clients. A telemedicine approach could work around many of these concerns and allow clients to be in control of their environment if entering a waiting room in public is an anxiety-inducing concern.

Additionally, equitable care means that resources must be embedded in the community and must be subject to continuous outreach. High visibility for mental health resources is a step towards destigmatization and reducing the associated barriers to care. Organizations could increase visibility by participating in local events, hosting their own events, speakers or seminars on topics of interest, and create partnerships with other community organizations.

Also, clinicians must make efforts to reduce barriers in-house. On the topic of mental health screening, questionnaires are often arduous and confusing. Reducing the length of screening would require prioritizing clarity and concision for clients over research projects or institutional goals. This may be a necessary move in building up client trust in the process, and contributing toward a positive initial experience that may positively impact the provider-patient relationship.

Interorganizational relationships play a role in providing equitable care because there are a large number of social determinants of both physical and mental health. Resolving mental health issues should invoke a multi-pronged response that incorporates resources from a number

of domains. Organizations like AALV offer a wide array of resources in-house, spanning youth development, legal aid, workforce development and health, among others. According to Ao, et al (2016), "not being a provider of the family; low social support; having symptoms of anxiety, depression, and psychological distress; and experiencing increased family conflict after resettlement," are all factors that contribute to a high level of suicidal ideation among refugee populations. This wide range of predictive factors illustrates that limiting mental health care to traditional psychological services does not provide a full spectrum of care. More resources, time, and energy are needed to develop the social support necessary to see New Americans succeed in the context of American culture.

One of the more striking shortcomings of Burlington's resources lies in the inadequacy of emergency psychological care. While organizations have plans in place to involve the proper resources for getting an acutely suicidal person to a hospital, the discharge procedure and continuation of care is more nebulous. The lack of psychiatric beds at University of Vermont Medical Center and the Brattleboro Retreat, in Brattleboro, VT, leads to hasty discharges from the UVMMC Emergency Department and puts these patients back into the care of organizations that enacted crisis resources initially. This is cyclical and counterproductive. While there are resources at the Howard Center that involve full-day care for people with acute psychological disorders, this level of intensity is sometimes not enough. When psychiatric beds do open at UVMMC, there is not enough to satiate demand. When a bed opens at the Brattleboro Retreat, patients may be moved many miles from their families. This is a problem for all patients with acute psychological disorders. It is even more of a struggle for refugees who face a lack of interpreter resources in Brattleboro; a blatant example of equal treatment, yet inequitable care for

refugees. More opportunities for long-term psychiatric care is necessary to better outcomes for refugee patients. The UVM Medical Center should allocate more beds to psychiatric care to increase capacity, if possible. The Brattleboro Retreat should incorporate cultural competence into their organization's mission and framework.

ii. Limitations

While this project made every effort to involve major refugee care actors in Burlington, the analysis may have benefited from insight to more local organizations: namely, the Howard Center and the Community Health Center of Burlington. The Howard Center is involved heavily with clients in crisis. Their services involve developmental health, mental health and substance use and recovery. They would have been especially valuable to speak about emergency care because of their 'First Call' program which provides intervention for people in crisis with phone support, intervention and assessment, referrals, and connections to follow-up care. The reason they are not represented among interviewees is that the size of the organization made individuals relatively inaccessible. Many attempts at connecting with the organization were left without a response.

The Community Health Center of Burlington may have been another worthy inclusion. This organization provides primary care for a large number of Burlington's refugee adults. In addition to medical care, they provide psychiatric services, behavioral health services and interpreter services. Many of the Pediatric Clinic for New Americans' patients' parents are seen there and they have a strong referral relationship with Connecting Cultures.

While assessing the strengths and weaknesses of community resources and mental health screening through the provider lens is a valuable practice, more research focused on the refugee

community itself would be needed to generate holistic insights and perspectives. Often the questions posed could have been better answered by refugees. During one interview, a participant was asked about specific challenges for the Bhutanese community and explained, "I should say, while I have done some of this research, I am not a community member myself, and the best folks to talk to are people in the community." A fundamental dilemma with provider-oriented research on services that target a specific demographic is that the target population is bypassed in the analysis. Obviously, there are clear practical obstacles to incorporating refugees into research participation, as outlined in the methodology chapter. However, further research would effectively combine the provider lens and the refugee community lens to develop a more complete assessment of mental health services for refugees, and give refugees the voice that they are entitled to.

iii. Transplantation of the Research

While this project is a case study that focuses specifically on mental health resources in Burlington, Vermont, it is relevant to other small cities that are undoubtedly facing similar challenges. In healthcare settings throughout the United States, clinicians are working with the same refugee populations with the same cultural specificities of mental health presentation as in Burlington. Of resettled refugees, studies show a link between mental health disorders like PTSD and somatic complaints (Ommeren et al, 2002). This is a nuance that is not specific to Vermont: it holds clinical relevance throughout the western world.

Burlington's shortage of mental health providers and, specifically, culturally competent mental health providers, is likely similar to other small cities that lack a large number of

specialized resources. A number of interviewees expressed that it was surprising that a city like Burlington even had specialized psychological services like Connecting Cultures. Therefore, the need for training of providers to increase the supply of culturally competent providers may be even more pressing in other cities where refugees are resettled. Additionally, the close-knit refugee communities of small cities will likely pose the same challenges surrounding confidentiality among providers from the community itself. The fear that one's personal problems will be circulated through their social connections is a significant point of apprehension for clients and can result in barriers to access.

The only way to ameliorate these insecurities is through strong patient-provider trust, which is built through the display of cultural education as proof that providers are acting in the best interest of their patient or client. This should be a common goal nationwide. Challenges pertaining to emergency care and inter-organizational communication are all relevant to other locations throughout the country as well. There should be an expectation that patients seeking acute, emergent psychological care should have access to that, without having to wait for a bed or return to the care of organizations that are unequipped to handle such a patient or client. The lessons from these interviews will maintain their relevance both within and outside the sphere of Bulington, Vermont.

Coda: Thesis of a Pandemic

As of Spring, 2020, COVID-19 has infected over one million Americans and killed over 80,000; numbers that are sure to grow. It's striking to witness a circumstance that illuminates health disparities so nakedly. Older people and people with preexisting conditions like lung disease, asthma, diabetes, chronic kidney disease, heart disease and conditions causing a person to be immunocompromised, are at a high risk of severe illness and death. But stopping at this distinction is, frankly, fraught. Such preexisting conditions are experienced disproportionately by communities of color and low-income communities, which has materialized in recent statistics on COVID-19 deaths, as white people account for only 51.9% of COVID-19 deaths, despite comprising 60.4% of the U.S. population (CDC, 2020; U.S. Census Bureau, 2019). This disproportionate distribution starkly illustrates the social determinants of health at play in the United States, where the aforementioned communities are statistically less inclined to favorable health outcomes.

According to the CDC, the five key determinants are economic stability, education, social and community context, health and health care, and neighborhood and built environment. In the context of this project, these themes are highly relevant. As referenced in the literature review, trying economic circumstances, lack of education like language classes and job training, and barriers pertaining to care-seeking, are unfortunate realities facing refugee communities nationwide. These challenges are being exacerbated by the COVID-19 pandemic, which has worsened economic conditions, living conditions and health conditions. This pandemic has altered lifestyles for many, but it disproportionately harms vulnerable populations who are both

more susceptible to the virus, and more adversely impacted in the economic and social spheres. The refugee clientele and clinicians discussed throughout this project will find their lives and livelihoods greatly compromised. Dealing with this pandemic will also place a greater burden on mental health services. As economic prospects wane and social life becomes more limited, demand for such services will undoubtedly increase. Clinicians must develop creative solutions to meet this demand.

While the virus itself has illuminated these disparities, our response to the virus illuminates the need for change. Throughout the last two months, we have seen a grossly inadequate federal response that failed to contain and trace the virus, downplayed its severity, and left us well short of the test kits required to move past home isolation orders. Command of the situation was held by a rotating cast of characters in the Trump administration, until these important decisions were fully decentralized to governors, who have tried their best to ameliorate the federal government's waffling. While this failed response may largely be accredited to the current administration, the need for change lies deeper than an election cycle. As hopefully illustrated in this project, the level of care provided for America's people needs to increase. It must become more comprehensive, more robust, and must carry far fewer barriers to entry. To put it bluntly, we owe each other the decency of a healthcare system that works for all Americans; a healthcare system that is free and fair.

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