Barriers and Facilitators of Mental Health Service Utilisation among Bhutanese Refugees in the USA: Findings from a Mixed-Methods Study

Eliza Soukenik¹, Hanna Haran¹, Jaclyn Kirsch¹, Sudarshan Pyakurel² and Arati Maleku ¹,*

¹College of Social Work, Ohio State University, Columbus, OH, 43210, USA
²Bhutanese Community of Central Ohio, Columbus, OH, 43229, USA

*Correspondence to Assistant Professor Arati Maleku, PhD, Ohio State University, College of Social Work, 1947 College Road, Columbus, Ohio 43210, USA. E-mail: maleku.1@osu.edu

Abstract

Although discussions regarding the need to develop culturally responsive mental health services for resettled refugee populations in the USA have been burgeoning, efforts to comprehensively understand the unique barriers and facilitators of mental health services across refugee subpopulations remain fragmented. Our study explored the barriers and facilitators of mental health services experienced by the resettled Bhutanese refugee population in a Midwestern city in the USA using a two-phased sequential explanatory mixed-methods study (N = 46). Study findings draw much needed attention to culturally grounded solutions generated by the community to reduce barriers and increase facilitators of mental health engagement. Building on community-generated solutions and expanding the capacity of local community-based ethnic organisations will be the first step in providing services that are truly responsive to the cultural needs of the Bhutanese refugee population. Recognition of refugee communities’ unique collective strengths will be much needed to holistically collaborate with these new members of the society to promote mental well-being and foster a sense of inclusion and belonging, especially in the post-coronavirus pandemic context. Our study also contributes to emerging knowledge on methodological rigor in research amongst understudied, hard-to-reach populations.

Keywords: Bhutanese refugees, community-based ethnic organisation, culturally responsive services, mental health services, mixed methods

Accepted: May 2021
The world is currently witnessing the largest refugee crisis in human history, with 70.8 million people forcibly displaced by the end of 2018, the highest number ever recorded by United Nations High Commissioner for Refugees (UNHCR, 2019). The USA has historically resettled more refugees than any other country since the enactment of the Refugee Act of 1980. However, despite the largest global refugee crisis, refugee resettlement declined sharply during the Trump administration, with only 11,814 refugees resettled in 2020 (National Immigration Forum, 2020). Although third-country resettlement provides stability in many ways, this road is often complex with multifaceted barriers (Pumariega et al., 2005). The cumulative migration stressors before and after migration make refugees more vulnerable to emotional and behavioural health risks (Derr, 2016). Despite the increased susceptibility to mental health risks, however, refugee populations are less likely to access and utilise mental health services than the general US population, despite eligibility for services (Perreira et al., 2012; Burger, 2014). Underutilisation of mental health services has been found to be influenced by social, linguistic and economic challenges; clinical severity; cultural differences in symptom presentation; health system structure and systemic discrimination (van der Boor and White, 2020). Particularly, cultural conflict between the refugees’ cultural norms and mental health service provision and delivery has been suggested as a major contributing factor to underutilisation of mental health services in resettlement locations (Mills, 2008). Furthermore, given the refugee subpopulation diversity, one-size-fits-all approaches to mental health services and interventions do not address the diverse needs and capacities of refugee subpopulations. Our study focused on barriers and facilitators of mental health services experienced by the resettled Bhutanese refugee population in the USA, a refugee population that has been the subject of considerable mental health discussion.

Bhutanese refugees

Bhutanese refugees, called Lhotshampas, are an ethnically and linguistically Nepali minority group forced to flee Bhutan in the early 1990s, when the Bhutan government enacted a one-nation policy that denationalised ethnic Bhutanese-Nepali minorities (Evans, 2010). Once displaced from Bhutan, most Bhutanese people settled in refugee camps in Nepal for more than twenty years, where despite cultural and historical ties to the country, they never received citizenship (Chase and Sapkota, 2017). In 2006, the UNHCR launched one of the largest third-country resettlement campaign, resettling almost 110,000 Bhutanese refugees in Europe,
North America, New Zealand and Australia (Shrestha, 2015). Since 2006, more than 86,000 Bhutanese refugees have resettled in the USA (US Department of State, 2017). The Midwestern US region, where this study occurred, is home to approximately 23,500 Bhutanese refugees (Adhikari et al., 2015). Once resettled, Bhutanese refugees face countless hardships: adjusting to a new environment, lack of employment and reliable social services, language barriers, identity concerns and other psycho-social stressors (Ellis et al., 2016). The Bhutanese community has experienced high rates of depression, anxiety, PTSD, alarming rates of suicide (Ao et al., 2016) and lower utilisation of mental health services (Adhikari et al., 2015). Although local human service organisations attempt to provide culturally responsive services, there are persistent gaps in service accessibility, provision and delivery (Maleku et al., 2020). We begin with a review of the role of human services and mental health service utilisation amongst refugees with a specific focus on Bhutanese refugees in the USA.

**Human services and utilisation of mental health services amongst refugees**

Human services organisations—such as schools, hospitals, social services agencies and community-based ethnic organisations (CBEOS)—play crucial roles in mediating migration transitions faced by immigrant and refugee populations (Maleku et al., 2020). In addition to providing services such as language access, education, health, legal and financial services that enhance, maintain and protect the well-being of communities, these organisations address many distinct needs of local refugee populations, including but not limited to acculturation stress and mental health (Maleku et al., 2020). When it comes to mental health services (MHS), literature posit that refugees face many barriers such as mental health stigma, service provision and delivery (Byrow et al., 2020).

Cultural factors are embedded in preconceived notions of mental health and how symptoms are portrayed, creating internalised and silenced symptoms due to shame (van der Boor and White, 2020). The fear of speaking out and being viewed as ‘crazy’ often keeps refugees from expressing themselves (Shannon et al., 2015). Unfavourable views of individuals who seek MHS and negative perceptions towards psychological services are prevalent amongst Bhutanese refugees (MacDowell et al., 2020). Stigma and privacy concerns surrounding mental health, family pressures and gender hierarchy stem from cultural barriers, which create fear of seeking services (van der Boor and White, 2020). Furthermore, confidentiality concerns—the fear that if services are accessed and confidentiality is not kept—may lead to stigmatisation (van der Boor and White, 2020).
Service utilisation amongst foreign-born population is associated with culturally and linguistically appropriate programmes (Yu et al., 2009). Language barriers were identified as one of the biggest stressors amongst older Bhutanese refugees limiting service access (Poudel-Tandukar et al., 2019). The belief that providers will not understand their culture often keeps refugees from seeking services (de Anstiss et al., 2009). Even with specific effort to provide MHS to refugees, there are significant gaps in providers’ understanding of cultural belief systems (Maleku et al., 2020). Bhutanese refugees often view the health care system as logistically complex and difficult to navigate (Yun et al., 2016). The gap between need and utilisation may be associated with availability, accessibility and perceived efficacy of services (Hagaman et al., 2016). Furthermore, attitudes and perceived discrimination by providers can lead to feelings of rejection, whereby refugees perceive their concerns as often disregarded (van der Boor and White, 2020). Although interpreters used to translate services can be helpful, they can also create concerns surrounding confidentiality; inaccurate interpretation, like omitting material; impeding interpersonal dynamics; passing judgement; or sharing unsolicited personal attitudes and advice (van der Boor and White, 2020).

Structural barriers, such as economic stressors related to accessing services, paying for services, ability to take time off work and lack of childcare, can exacerbate low utilisation of services (Derr, 2016). Economic stressors can determine the choice and use of services (van der Boor and White, 2020). Though the Affordable Care Act did increase insurance access for many refugees, the system’s complexities still cause lower service use amongst refugee groups. The lack of understanding of the formal health care system limits refugees’ access to services (Byrow et al., 2020). Lack of insurance, cost of services, accessibility and transportation are significant barriers to accessing services (M’zah et al., 2019). Furthermore, the medical facility’s location, transportation issues, scheduling time off work for appointments and finding care for children are compounding barriers to MHS (van der Boor and White, 2020).

Study purpose

As demographic shifts occur across urban regions, understanding the barriers and facilitators of mental health services amongst refugee subpopulations needs more exploration. As part of a larger mixed-methods study that explored mental health from the Bhutanese refugee perspective, we examined community-grounded perceptions of barriers and facilitators of MHS utilisation in the midwestern USA.
Conceptual framework

We used the behavioural model of health care utilisation (Andersen, 1995) and critical bifocality lens (Weis and Fine, 2012) as the guiding framework. Andersen’s (1995) model postulates that an individual’s access to health services is a function of predisposing, enabling and need factors. Predisposing factors include individual sociocultural attributes: demographics (age and gender), social structure (education, occupation, ethnicity, social network, culture) and health beliefs (attitudes, values, knowledge). Enabling factors include resources available to obtain care (personal, family, community factors, genetic and psychological characteristics). Community factors refer to the provision of mental health services, and need factors are the health issues that generate the need for health services, how people view health and health services, and their experience of health problems. Evaluated need refers to professional judgement about people’s health status and the need for medical care. The relationship between service users and providers’ knowledge, attitude and beliefs in delivering mental health services becomes pertinent. Because health care utilisation is strongly dependent on health care systems and structures (Babitsch et al., 2012), it is crucial to situate refugee experiences in the context of systems of power, social policies, history and large socio-political formations (Weis and Fine, 2012). The human services environment continually interacts with the social, cultural, economic and political environments in which organisations, care providers and refugee populations navigate services, which directly or indirectly affects MHS utilisation.

Methods

Research design

We used a two-phased explanatory sequential mixed-methods design (Creswell, 2015), which provides an opportunity to gather a general understanding of a problem using quantitative data and then bolster the quantitative results by exploring in-depth perspectives (Ivankova et al., 2006; Figure 1). We collected data from February through April 2020. The Institutional Review Board provided ethical approval for the study. Prior to data collection, we obtained written informed consent from survey participants and virtual informed consent from focus group participants.

Study sample and data collection

The study sample was recruited through a local CBEO serving the Bhutanese community. The convenience sampling through CBEO
partnership provided access to an otherwise hard-to-reach group (Bonevski et al., 2014). We used parallel sampling (Onwuegbuzie and Collins, 2007) strategy, where the samples for quantitative and qualitative components are different, but drawn from the same population. Parallel sampling was crucial due to our study’s descriptive nature and an attempt to seek convergent and divergent themes by purposefully centring diverse community voices to promote interpretive consistency of quantitative and qualitative data (Collins et al., 2007). Data collection occurred in two phases.

Quantitative data collection \((n = 40)\) consisted of a thirty-item self-administered survey instrument including an open-ended question that focused on mental health understanding, mental health experiences, access and utilisation of MHS. The survey was administered in-person in English and Nepali, depending on participants’ preference and English proficiency. Interpreters were used for survey assistance. Survey participants received a $10 gift card incentive. Following preliminary analysis of the survey data, we conducted a ninety-min virtual focus group discussion (FGD; \(n = 6\)) using the Zoom platform due to Coronavirus Disease 2019 (COVID-19) limitations. Broad questions centred on mental health, cultural beliefs, coping mechanisms and barriers and facilitators of MHS utilisation were used to facilitate the conversation. Unscripted prompts were used to elaborate pertinent topics. The two-person research team conducting the FGD were adept at both Nepali and English. The FGD was video recorded and transcribed verbatim. Participants received a $25 e-gift card incentive.

Demographic characteristics of the study sample are presented in Table 1. The survey sample represented 55 per cent male and 45 per
### Table 1: Demographic characteristics of study participants (N = 46)

| Demographic characteristics | Survey (n = 40), n (%) | Focus group (n = 6), n (%) or M (SD) |
|-----------------------------|-----------------------|--------------------------------------|
| **Age, years**              |                       |                                      |
| 20–30                       | 23 (57.5)             |                                      |
| 31–40                       | 7 (17.5)              |                                      |
| 41–50                       | 8 (20)                |                                      |
| 51–60                       | 2 (5)                 |                                      |
| **Gender**                  |                       |                                      |
| Male                        | 22 (55)               | 3 (50)                               |
| Female                      | 18 (45)               | 3 (50)                               |
| **Religion**                |                       |                                      |
| Hinduism                    | 26 (65)               |                                      |
| Christianity                | 8 (20)                |                                      |
| Buddhism                    | 1 (2.5)               |                                      |
| Other                       | 5 (12.5)              |                                      |
| **Marital status**          |                       |                                      |
| Single                      | 23 (57.5)             |                                      |
| Married                     | 13 (32.5)             |                                      |
| Separated                   | 1 (2.5)               |                                      |
| Divorced                    | 2 (5)                 |                                      |
| Missing                     | 1 (2.5)               |                                      |
| **Employment status**       |                       |                                      |
| Employed                    | 21 (52.5)             |                                      |
| Unemployed                  | 18 (45)               |                                      |
| Missing                     | 1 (2.5)               |                                      |
| **Annual Family income**    |                       |                                      |
| <$10,000                    | 7 (17.5)              |                                      |
| $10,000–20,000              | 2 (5)                 |                                      |
| $21,000–30,000              | 3 (7.5)               |                                      |
| $31,000–40,000              | 11 (27.5)             |                                      |
| $41,000–50,000              | 4 (10)                |                                      |
| $51,000–60,000              | 4 (10)                |                                      |
| $>61,000                    | 4 (10)                |                                      |
| Missing                     | 5 (12.5)              |                                      |
| **Place of birth**          |                       |                                      |
| Bhutan                      | 24 (60)               | 3 (50)                               |
| Nepal                       | 15 (37.5)             | 3 (50)                               |
| Other                       | 1 (2.5)               |                                      |
| **Education**               |                       |                                      |
| High school diploma         | 13 (32.5)             | 2 (33.3)                             |
| Some college, but no degree | 6 (15)                |                                      |
| Associate’s degree          | 3 (7.5)               |                                      |
| Bachelor’s degree           | 9 (22.5)              | 2 (33.3)                             |
| Master’s degree             | 3 (7.5)               | 2 (33.3)                             |
| Never attended school       | 1 (2.5)               |                                      |
| Missing                     | 5 (12.5)              |                                      |
| **Length of stay in the USA** |                    | 10 (0.816)                       |
| Between 1 and 3 years       | 2 (5)                 |                                      |
| Between 3 and 5 years       | 1 (2.5)               |                                      |
| Between 5 and 7 years       | 4 (10)                |                                      |
| Between 7 and 9 years       | 9 (22.5)              |                                      |
| ≥10 years                   | 24 (60)               |                                      |
cent female, with 57.5 per cent of the sample between twenty and thirty years old. The median annual family income was between $31,000 and $40,000. Survey participants overwhelmingly reported practicing Hindu religion (65 per cent), were more likely to be single (57.5 per cent) and unemployed (45 per cent), and had at least a high-school diploma (32.5 per cent). Participants reported a medium level of speaking (\(M = 3.80, \ SD = 1.32\)), listening (\(M = 3.93, \ SD = 1.22\)), reading (\(M = 3.90, \ SD = 1.30\)) and writing (\(M = 3.88, \ SD = 1.30\)) English skills. FGD participants were between twenty and fifty years old.

Methodological rigor

Scholars contend that data collection procedures and sample size vary based on population accessibility and study area (Crosby et al., 2010). Therefore, the practicality of procuring a hard-to-reach population sample should not preclude expectations of methodological rigor, usually developed with more accessible populations and socially acceptable topics (Crosby et al., 2010). The Bhutanese refugees are a systematically hard-to-reach population based on myriad social disadvantages (Shaghaghi et al., 2011). The sensitive topic of mental health compounds research challenges with this population. Because research grounded in community perspectives aims to identify unique experiences of hard-to-reach populations (Bonevski et al., 2014), even with a relatively smaller sample size, these voices address the paucity of knowledge and should not be excluded (Crosby et al., 2010). In addition to the survey sample (\(n = 40\)), we purposefully used qualitative data (\(n = 6\)) to corroborate survey findings to generate crucial meta-inference (Creamer, 2018). Whilst FGD sample size can vary from three to twelve (Padgett, 2017), for sensitive issues like mental health, a smaller sample is recommended to garner in-depth discussions and honour privacy (Padgett, 2017). We included six FGD participants across demographic strata—age, gender and education level—to generate diverse perspectives and increase qualitative research rigor (Hennink et al., 2019). Additionally, our partnership with the CBEO facilitated instrument translation, member checking and community consultation for data accuracy and interpretation (Hacker, 2013).

Data analysis

We analysed the quantitative and qualitative data separately, and then integrated the findings. Univariate analyses helped find patterns in the quantitative data. Qualitative data were analysed using a two-step approach. First, the rigorous and accelerated data reduction technique, which systematically organises and reduces data (Watkins, 2017), was
used to consolidate the transcribed focus group data into a spreadsheet. Thematic analysis followed a three-step coding process: open coding, wherein we coded sections of data into multiple categories; axial coding, wherein we sorted the data by categories based on the relationship between the codes; and selective coding, wherein we synthesised the categories into overarching themes (Saldana, 2016). The first and second authors coded the data independently. The corresponding author evaluated data analysis and resolved any disagreements through an interactive team approach. All authors unanimously agreed on the study's overarching themes and finalised the translation of themes table (Table 2).

Results

Based on the qualitative data analysis, we identified five salient overarching themes. Given the richness of qualitative data, we established qualitative themes as a priority and used a weaving technique to merge quantitative and qualitative data on a theme-by-theme basis (Fetters et al., 2013). We highlighted convergent and divergent themes, crucial to building meta-inference in a mixed-methods study (Fetters et al., 2013).

Theme 1: Cultural barriers to mental health service utilisation

Survey participants overwhelmingly (82.5 per cent) noted that cultural barriers hampered utilisation of MHS (Figure 2). FGD corroborated that cultural stigma centred heavily on the notion that the larger community would label or exclude individuals who received such care. The fear of being labelled as ‘crazy’ or ‘mad’ by the community precluded refugees from engaging in MHS. These concerns are particularly salient in the post-migration context, when social ties are essential to remain connected to one’s cultural identity when integrating into new spaces.

Cultural mistrust was both internal and external to the Bhutanese community. More than a third (37.5 per cent; Figure 2) of survey participants reported a lack of trust in service providers that impeded their engagement with services. Although distrust was external and people would feel comfortable receiving mental health care if providers were from the community or embedded in the Bhutanese culture, FGD participants expressed concerns that confidentiality breaches amongst local interpreters, often from the Bhutanese community, dissuaded community members from accessing MHS. Given the cultural stigma surrounding mental health, the fear of confidentiality breaches by local interpreters and subsequent negative ramifications from the Bhutanese
| Extracted original thematic codes | Categories                                                                 | Subthemes                                                                 | Overarching themes                      |
|---------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------|
| More education; cultural mistrust; fear of breaches; confidentiality; cultural mistrust internal and external to community; historical experience of counselling as punishment; difficult to change counselling concept into a health service; service challenges due to providers not being aware of cultural factors; fear of cultural stigma; fear of administration; fear of past trauma | Lack of confidentiality; stigma; cultural mistrust internal external; fear; language; income; historical experiences; fear of authority | - Cultural mistrust  
- Fear of authority | Theme 1: Cultural barriers to mental health service utilization |
| Lack of culturally responsive counsellors, services; lack of understanding from counsellor; language barrier; lack of transportation; lack of health insurance; low income; lack of in-person interpreter services; lack of knowledge on available resources; lack of agency outreach; unaware of counselling; lack of Nepali counsellors; misinterpretation from interpreter; lack of relevant screening tools | Lack of culturally responsive services; language and income barriers; lack of bicultural workers; lack of knowledge on available resources and services; lack of agency outreach | - Lack of diverse mental health workforce  
- Lack of linguistically appropriate services  
- Lack of culturally responsive services | Theme 2: Provider-level barriers to mental health services |
| Case management; holistic services; post-migration stressors; employment; transportation; no health insurance; service unawareness | Case management approaches | Case management approach | Theme 3: Case management approach to holistic mental health services |
| Increase in services, ensure confidentiality; culturally competent agencies; CBOE, community-academic partnership; language issues; providers not aware of culture; disaggregated services; need more mental health practitioners; bi-cultural workers; younger generation; increased leadership; culture changed and adapted; increase in community-based services | Increase in culturally competent services; collaboration with community; increase bicultural workers; community–academic partnerships; culturally appropriate strategies; data disaggregation; community-based services expansion | - Community collaboration  
- Community–academic partnership  
- CBOE partnership and capacity | Theme 4: Multi-sector collaboration for culturally responsive mental health services |
| Normalise mental health; leadership discussing mental health; more education; understand root causes of problems; interventions—culturally grounded; culturally appropriate services; based on experience of a refugee; create long-term approaches; gaps in current modalities; age-wise appropriate material; translated materials; diverse modes of outreach | Culturally appropriate community-level education; culturally appropriate strategies; targeted age-appropriate programmes | Culturally appropriate strategies to address mental health | Theme 5: Community-grounded culturally responsive mental health solutions |
community should they learn about seeking MHS was prevalent in the community:

When someone is being referred for counselling, they would hesitate to go. They think if I start going [to] counselling sessions, the local interpreters might share it with my husband or wife. If my wife knows about it—I’m done. I’ll be labelled as mad, crazy person throughout my life (FGD).

It is imperative to situate post-migration challenges in a historical understanding of refugee experiences. FGD participants highlighted discordance in mental health-related language. In refugee camps, the term ‘counsellor’ was associated with an authority figure who monitored camp behaviour and contacted people only when they engaged in untoward actions. These past experiences proved challenging for Bhutanese refugees to reconcile in the USA, where the term reference mental health professionals. Participants highlighted the incongruence between seeing a mental health professional and being punished by authority:

If I go to counselling in refugee camp, it means I made some mistake—I might have been using [a] benefit illegally or treating people badly, and [that’s why] I’ve been brought to counselling session. So, to our people, when you say “counselling” that doesn’t make sense in terms of health services. [To them], it literally means somebody’s going to advise me on my character or behaviour—because that’s how counselling was set up in refugee camps. So, that concept is still there (FGD).

This perceived unequal power structure incited past feelings regarding authority figures rather than a helping relationship. FGD participants explained that cultural mistrust of mental health providers included challenges related to Western cultural norms of professional appearance and demeanour. The professional nature and formal relationship between a counsellor and patients were viewed as authoritarian. Engaging with clients to facilitate a sense of trust also entailed a culturally appropriate physical appearance and body language, which could promote a mutually beneficial working relationship:

I also think there’s a fear of administration, authority figure, a person with buttoned-up shirt [who] asks you all these questions. They feel very intimidated, scared to talk about their personal life because they feel they might get into trouble (FGD).

Theme 2: Provider-level barriers to mental health services

The lack of a diverse mental health workforce negatively contributed to MHS utilisation. Survey participants expressed that providers not speaking the Nepali language (57.5 per cent), providers not understanding the Bhutanese culture (55 per cent) and a lack of trust in MHS (37.5 per
Figure 2: Barriers to access and utilization of mental health services.
cent) contributed to lower utilisation of MHS. FGD participants corroborated that the dearth of Nepali-speaking providers is a prominent barrier, further stigmatising the service use. Although many MHS in the area claim to provide culturally appropriate services, they use word-by-word or phone translation that focuses on language as a mere communication medium, missing to recognise the cultural nuances and meanings. Because organisations do not have bicultural workers, they often fail to recognise cultural attributes expressed through language. This gap in cultural recognition leads to inadequate dialogue between service users and providers, which further discourages utilisation of already stigmatised MHS:

There are so many agencies saying they’re providing mental health services, but they don’t have culturally appropriate services; they keep claiming they speak Nepali like they have Nepali-speaking staff. But those staff only do certain work—they are there to represent the community, but they are not counsellors. The counselling part is done by a foreign language speaker. That is dangerous, especially in mental health. If you have an interpreter over the phone, that is also not a way of counselling (FGD).

Survey participants highlighted the ‘need for language and translation’ and that ‘more culturally grounded mental health services are needed’. They stated that ‘services need to be provided based on need, and providers should focus on service quality’. Survey participants highlighted the unavailability of culturally responsive services in the local region and noted gaps in service quality:

There are few providers around. Many claims they provide services, but these agencies are not doing enough (Survey).

Survey participants reiterated that ‘providers need more training’. They stated that ‘there is a need for more Nepali-speaking mental health workers’ FGD participants echoed the need to diversify the mental health workforce to ensure providers’ cultural and linguistic backgrounds mirror that of the Bhutanese community and that they truly understand the cultural meanings of symptoms and expressions:

Not having culturally responsive counsellors is a big barrier. A lot of our population, they don’t speak English very well to express themselves fully. So, mostly what we’re doing is using translators or interpreters to help communicate. Important things get left behind, like the emotional factor—that really creates, a distrust, a lack of understanding between the counsellor and the client, that fear they won’t get the right diagnosis or get the right treatment plan (FGD).

Participants expressed that providers should understand the cultural and historic experiences of the Bhutanese community to engage in culturally responsive services. A FGD participant provided examples of
how service providers engage in culturally inappropriate dialogues and approach personal subjects that are deemed culturally unfit:

She’s [service provider] asking if I’m happy with my wife. What is the point [of that] for [my] mental health? I’m happy with my wife, I can’t say I’m not happy. So culturally inappropriate things—like a woman says she’s pregnant and the counsellor asks, “Are you married?” In our culture, you cannot become pregnant without being married. So, those are culturally different. She was probably required to ask as screening tool, but those things are not very relevant to the culture (FGD).

Theme 3: Case management approach to holistic mental health services

Securing housing and employment, accessing social services and working with underdeveloped social networks and language barriers during resettlement are seldom straightforward. Lack of awareness of services (67.5 per cent), transportation challenges (65 per cent) and lack of health insurance (45 per cent) prevented Bhutanese community members from accessing MHS (Figure 2). Participants discussed that these post-migration challenges are compounded by gaps in holistic services, which exacerbate mental health symptoms:

There are other barriers like transportation, health insurance, money, income—in addition to not having culturally responsive counsellors (FGD).

In the light of these post-migration stressors, participants expressed that holistic case management services have the potential to address the many facets of resettlement challenges and facilitate reduction in mental health symptoms in tandem. Although formal MHS and trained professionals are vital to treating and managing mental health symptoms, reducing the stressors that may contribute to mental distress in the first place would be crucial:

Case management plays a big role because a lot of our folks are struggling with their day-to-day lives. They’re struggling to read mail, they’re struggling to call their doctor, they’re struggling to schedule an appointment. So, when that happens, there’s an additional layer of all these problems that they have to deal with. A lot of times, our clients that come, they don’t come here for mental health issues. They come for case management because that is making their lives easier. So, sitting in a room talking about their problems is not going to really help them because they have so many other problems that they’re dealing with (FGD).

Theme 4: Multisectoral collaboration for culturally responsive MHSs

FGD participants emphasised that to curate a larger breadth of culturally responsive mental health services, community collaboration across
sectors is needed. Community collaboration was discussed in terms of strengthening partnerships outside the Bhutanese community, leveraging the knowledge and skills of the Bhutanese CBEO, and encouraging the younger generation to seek careers that would diversify the mental health workforce. Respondents identified that to expand service capacity in the region and produce more culturally responsive services, academic institutions, larger human services agencies and other private sector agencies should work with the CBEO, which has cultural expertise and community knowledge:

More services, more centres, more providers with enough infrastructure who can work with the community, is what I say. I’m not against any agency, they claim to serve Bhutanese community, but they’re not serving our community. They’re just making up their numbers for grants and getting next cycle of the grant approved, but they are not actually focusing on what service the clients need. So, maybe agencies can partner with our CBEO on how they can better serve will be helpful (FGD).

There should be more mental health centres where people could go in and have trusted confidential information (Survey).

The Bhutanese community highly regarded the local CBEO. Survey respondents (47.5 per cent) reported that they turn to their community rather than outside providers when experiencing mental health challenges. FGD participants corroborated that leveraging the services of the CBEO would help build trust and promote service utilisation in the region. This partnership with the CBEO could have far-reaching implications to overcome negative views of mental health stigma and MHS and expand community-based programmes targeted to the Bhutanese community:

I think circumstance has to force the community to find a breakthrough and expand their comfort zone and horizon. Sharing that message because things are doable, even if it is a cultural barrier—if I go against my culture, I will be outcasted, it cannot happen. It could change the whole process of what we do religiously and culturally when time forces us to. Another thing is with the work I do, the Bhutanese CBEO is always such fallback support because if [the organization where I work] cannot provide services, we say, please go to the CBEO (FGD).

More than half of the survey participants (62.5 per cent) said that having more Bhutanese workers would facilitate the utilisation of MHS (Figure 2). To increase Bhutanese service providers, FGD participants discussed the importance of community–academic partnership that would not only build the capacity of the CBEO, but also encourage the younger generation to pursue careers in social work. FGD participants reminisced about relationships with a faculty member affiliated with a local academic institution and how this relationship had facilitated social work degree pathways for Bhutanese youth.
I think without [the academic partner], our program or any other program that we are operating at [CBEO] would not have come to this success, even getting many students to the university. She has played such a vital role to encourage people. She is always encouraging me—saying that you [should] apply for this, apply for social work, go to school. So, I think we need inspiring people like her—this mentorship will help create a generation of future social workers or future counsellors (FGD).

Participants reiterated that youth leadership was crucial to dismantling barriers between the Bhutanese community and MHS engagement, which would be accomplished by helping Bhutanese youth engage in higher education. Participants encouraged younger participants in the focus group to seek careers in mental health fields:

The opportunity of having these youngsters in this conversation, I would challenge them to seek careers in the mental health field. Because that's where the trust comes—because you come from the community, you speak the language, you understand the culture, you will play key roles (FGD).

Theme 5: Community-grounded culturally responsive MHSs

Survey findings (Figure 3) show that the availability of Nepali-speaking providers (80 per cent), providers who understand Bhutanese culture (72.5 per cent) and MHS provided by the Bhutanese community (70 per cent) would be the most significant facilitators of MHS. Furthermore, participants said better understanding of mental health issues in the Bhutanese community (62.5 per cent) and increased access to services (55 per cent) would increase utilisation. Half of the survey participants stated that MHS are easily accessible (50 per cent) in their community. The other half (50 per cent) said services were not easily accessible.

FGD participants corroborated survey findings and proposed community-grounded solutions to increase access and utilisation of MHS. Participants expressed the importance of normalising discussions around mental health and creating an open dialogue around historical and present experiences that contribute to mental health symptoms. Particularly, sharing personal experiences of mental health challenges by community leaders and key figures would create a sense of collective experience, dismantling the inherent stigma and negative cultural views around mental health and help-seeking behaviour. These shared stories would normalise mental health support and encourage participants to share community experiences and use needed services:

I think we should also start normalizing the mental health idea. We should start talking about this more in our personal level because if they see leaders talking about their mental health experiences, it will
Figure 3: Facilitators to mental health service utilization ($N = 40$).
encourage folks who are dealing with similar situations—they will feel like it is not only them who are experiencing these things. So, when they see someone who’s managing their life pretty well, who’s still achieving everything else and talking about their mental health issues, it will definitely encourage them to seek help [or] to even start talking about this with their families and friends. If we start holding sessions where we bring a lot of people and talk about mental health issues, I feel like that will create normalcy. The whole idea is to normalize it as much as possible (FGD).

To curate a culturally responsive programme that can facilitate mental health awareness and increase service utilisation, participants stated the importance of using culturally appropriate strategies across subpopulation groups. It is important to disaggregate subpopulations and use appropriate strategies based on their needs to help establish the scope of the problem and provide visibility to smaller groups that remain hidden in the larger Bhutanese population. Although mental health challenges have permeated across all demographic subgroups, expanding targeted programmes and using appropriate strategies based on demographic subgroups may reduce cultural mistrust and truncate symptoms due to increased awareness and acceptance of receiving help. In particular, participants highlighted the need for community-based programmes targeted across age groups, gender, and the need to be inclusive of Bhutanese men and older adults, who tend to remain disengaged from mental health discussions. Participants proposed that songs, skits, media platforms and school-based programmes would be beneficial to raise mental health awareness. Participants also reiterated the need for community empowerment and engaging mental health providers at the community level:

More resources are required such as home visits. I believe in empowering community members with language (English) and bringing mental health providers to the community (FGD).

How do we make awareness programs reachable to our population? If we limit to a certain age group, it doesn’t bring impact because we have these spikes of mental health in all age groups—in the younger population, people like my dad’s age and people my age. I think this is [an] epidemic in our community. How do we make culturally age-wise appropriate material? Is a song our best idea, maybe lyrics of songs and sharing through media, or a skit and doing that in school level? How do we play a role? Because I think we need to teach our young generation. So, they will have the concept of mental health and then this dire situation won’t come [up] (FGD).

FGD participants emphasised the need to expand culturally tailored programmes currently implemented through the local CBEO to the larger region. They underscored the need for outside entities to recognise refugees’ unique experiences, honour their cultural differences and
disaggregate refugee subgroup differences. In particular, the Bhutanese refugee experience should be parsed from other refugee sub-populations to explore the deep-rooted historical and collective experiences that have led to this population’s resettlement and how these experiences have affected them differently compared with others. It is crucial to focus on the root causes of mental health issues across refugee groups and not merely use a one-size-fits-all approach to treating symptoms of mental health, which has been the current service modality:

We have a wound; we have a disease that needs surgery. But what we are doing is putting a band-aid on it. It is not going to fix this problem. We really have to come up with a culturally appropriate intervention in every single refugee community. Somali need to come up with theirs based on their experience, we need to come up with one based on our own experience, Iraqi need to come up with theirs. The middle-class American model that hospitals are using is not going to work with minority community. They need to know it clearly and upfront—it is not working. We have to work to create a new approach that works for us in addressing mental health. Otherwise, this is just first-aid only (FGD).

Discussion and implications

Study findings illuminate myriad barriers and facilitators to accessing MHS amongst resettled Bhutanese refugees in the USA. More importantly, results highlight community-generated solutions to mitigate MHS challenges that can inform current service provision and delivery efforts. Consistent with prior studies, findings show that challenges associated with post-migration stressors including social, cultural, linguistic, economic, transportation, health system structure and gaps in provision and delivery of services impede mental health utilisation in the Bhutanese refugee population (van der Boor and White, 2020). Cultural stigma around mental health and fears of being labelled, shamed and isolated from their community contributed to lower MHS utilisation (MacDowell et al., 2020). These concerns are particularly noteworthy amongst Bhutanese refugees, who embody an interdependent collectivist culture and view overall well-being in terms of the larger community (Im and Rosenberg, 2016). Cultural mistrust around MHS was both internal and external to the Bhutanese community. Findings showed concerns surrounding confidentiality when providers engage with local interpreters. If services are accessed and confidentiality is not kept by providers, refugees feared this could lead to stigmatisation by the community (van der Boor and White, 2020). Furthermore, there was distrust around MHS due to the false perception of culturally responsive services. Findings show that cultural and linguistic incongruences between providers and the Bhutanese community appeared to be a major barrier that created
distrust in services and discouraged service utilisation. At the provider level, acknowledging the population’s unique experiences and adjusting standard practices of care are much needed to build trust and culturally sensitive services (Maleku and Aguirre, 2014).

Study findings reiterated the local CBEO as an important community entity. However, the local CBEO experienced structural challenges, wherein small, non-profit organisations become siloed from larger agencies (Maleku et al., 2020). These structural constraints make it challenging to expand services and meet diverse needs. Increasing multi-sectoral collaboration with larger agencies and academic partnerships were identified to offset funding limitations, increase capacity and create a presence in the human services landscape. Study findings emphasise how community-generated strategies such as holistic case management; community-level awareness and empowerment; peer-led information sharing by Bhutanese leaders; building capacity of the local CBEO; diversifying mental health workforce; disaggregating subgroup needs and multi-sectoral collaboration could foster service access and utilisation.

Creating opportunities to heal and engage in meaningful transition may be partly achieved through streamlining case management services. A case management approach providing MHS focused on social and cultural determinants of health may assist refugees in navigating a new environment. Application of the hierarchy of needs such as employment, housing, language support and other social determinants may be useful to providers to first address lower-level needs that could have contributed to mental health stressors in the first place (Lonn and Dantzler, 2017). Understanding the role of case managers in providing holistic MHS to refugee subpopulation has important implications for social work. Furthermore, Western interventions that focus on trauma have been deemed incongruent with Bhutanese cultural perspectives (Pulla, 2016). The social work profession focuses on culturally inclusive practices and provision of holistic care to an increasingly diverse population. Meeting this challenge is exacerbated by larger systemic practices that have led to a predominately White (68.8 per cent) and female (83 per cent) workforce (The George Washington University Health Workforce Institute, 2017). Though cultural competence is enshrined as a standard of the social work profession, minority populations’ adverse experiences in receiving care elucidate the discrepancy between ethical requirements and realities of this human-centred profession (Käkelä, 2020). In lieu of available Bhutanese-Nepali service providers, social workers need to address the power dynamics, historical experiences and structural forces that contribute to poor mental health outcomes. Findings show fear of authority when engaging with mental health workers, highlighting their professional and formal demeanour as a physical representation of unequal power dynamics between providers and clients. Additionally, Western terms for discussing therapeutic services hold different
meanings associated with unpleasant past experiences. Findings highlight the need for providers to be cognizant of the myriad pre- and post-migration experiences that have constrained refugees’ power and abilities to exercise their rights (Käkelä, 2020). Findings call for healing-centred interventions that focus on unique strengths and resilience of the community beyond trauma.

Findings reveal a persistent lack of trust in MHS that has contributed to lower utilisation of MHS in the Bhutanese community. The lack of trust with service systems is linked with discrimination based on race, language, legal status, language and discordant cultural beliefs (Perreira et al., 2012). The realities of establishing life in new spaces as a visible minority cannot be overlooked. Discrimination at the individual, social and structural levels is a prominent barrier for refugees when engaging in MHS (van der Boor and White, 2020). Service providers should think beyond diagnoses and symptom reduction to holistically serve this population and recognise the interwoven dynamics that may be exacerbating mental health challenges and hindering service utilisation. Additionally, honouring lived experiences, being receptive to different ways of knowing and recognising community strengths are paramount to adequately engaging with these new members of society (Steimel and Alvares, 2016). Furthermore, disaggregating within-group differences based on socio-demographic characteristics, needs and capacities will provide visibility to hidden groups (Kim et al., 2021). Future studies exploring within-group differences by socio-demographic characteristics such as age, gender and income as they relate to mental health utilisation in Bhutanese subpopulation groups will provide important insights for targeted service responses. Increasing the visibility of minority groups is a social justice imperative, fundamental to social workers.

Findings should be generalised with caution due to small sample size that limited the breadth of statistical inferences. The use of a virtual platform could have excluded members with lack of digital technology access. Completing the survey in the presence of others may have led to respondent bias. The use of interpreters may have led to biases or a loss of meaning during translation. Despite these limitations, findings on community-generated solutions are best positioned to enhance programmes and services that not only empower the Bhutanese community, but also inform mental health service provision, delivery, access and utilisation for the overall well-being of refugee communities.

Conclusion

Mental health care barriers in the Bhutanese community stem from a lack of culturally and linguistically responsive care, incongruencies in service provision, lack of a diverse workforce and cultural and historical
views of mental health that hinder engagement with the Western modalities of mental health services. Findings draw attention to the community-generated solutions to reduce barriers and increase facilitators for mental health engagement. Building on community-generated solutions and expanding the capacity of local community-based initiatives will be a first step to providing culturally responsive services. Recognition of unique community assets will be much more important in the post-COVID-19 context. Research and practice foci on collective strengths of refugee communities are much needed to holistically collaborate with these new members of society to promote mental well-being and foster a sense of inclusion and belonging.

Acknowledgements

The authors would like to thank the Bhutanese Community of Central Ohio and Jennie Babcock, BSW Director at the College of Social Work at The Ohio State University for all their assistance with the study.

Funding

Funding for this study was provided by The Ohio State University Honors & Scholars Undergraduate Research Scholarship funds. Its contents are solely the responsibility of the authors.

Conflict of interest statement. None declared.

References

Adhikari, S. B., Yotebieng, K., Acharya, J. N. and Kirsch, J. (2015) Epidemiology of Mental Health, Suicide and Post-Traumatic Stress Disorder among Bhutanese Refugees in Ohio, 2014, Columbus, OH, Ohio Department of Mental Health and Addiction Services, Community Refugee and Immigration Services.
Andersen, R. M. (1995) ‘Revisiting the behavioral model and access to medical care: Does it matter?’, Journal of Health and Social Behavior, 36(1), pp. 1–10.
Ao, T., Shetty, S., Sivilli, T., Blanton, C., Ellis, H., Geltman, P. L., Cochran, J., Taylor, E., Lankau, E. W. and Cardozo, B. L. (2016) ‘Suicidal ideation and mental health of Bhutanese refugees in the United States’, Journal of Immigrant and Minority Health, 18(4), pp. 828–35.
Babitsch, B., Gohl, D. and Von Lengerke, T. (2012) ‘Re-revisiting Andersen’s behavioral model of health services use: A systematic review of studies from 1998–2011’, Psycho-Social Medicine, 9, 11.
Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I. and Hughes, C. (2014) ‘Reaching the hard-to-reach: A systematic review of strategies for improving health and medical research with socially disadvantaged groups’, Medical Research Methodology, 14(42), 1–29.
Burger, W. R. (2014) *Human Services in Contemporary America* 9th edn, Belmont, CA, Brooks/Cole.

Byrow, Y., Pajak, R., Specker, P. and Nickerson, A. (2020) ‘Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review’, *Clinical Psychology Review*, 75, 101812.

Chase, L. and Sapkota, R. P. (2017) ‘“In our community, a friend is a psychologist”: An ethnographic study of informal care in two Bhutanese refugee communities’, *Transcultural Psychiatry*, 54(3), pp. 400–22.

Creamer, E. (2018) *An Introduction to Fully Integrated Mixed Methods Research*, Sage.

Collins, K.M.T., Onwuegbuzie, A.J. and Jiao, Q.G. (2007) ‘A mixed methods investigation of mixed methods sampling designs in social and health science research’, *Journal of Mixed Methods Research*, 1(3), 267–94.

Creswell, J. W. (2015) *A Concise Introduction to Mixed Methods Research*, Los Angeles, Sage.

Crosby, Salazar R.A., DiClemente L.F., R.J. and Lang, D.L. (2010) ‘Balancing rigor against the inherent limitations of investigating hard-to-reach populations’, *Health Education Research*, 25(1), 1–5.

de Anstiss, H., Ziaian, T., Procter, N., Warland, J. and Baghurst, P. (2009) ‘Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research’, *Transcultural Psychiatry*, 46(4), pp. 584–607.

Derr, A. S. (2016) ‘Mental health service use among immigrants in the United States: A systematic review’, *Psychiatric Services* (Washington, D.C.), 67(3), pp. 265–74.

Ellis, B. H., Hulland, E. N., Miller, A. B., Bixby, C. B., Cardozo, B. L. and Betancourt, T. S. (2016) *Mental Health Risks and Resilience among Somali and Bhutanese Refugee Parents*, Washington, DC, Migration Policy Institute.

Evans, R. (2010) ‘The perils of being a borderland people: On the Lhotshampas of Bhutan’, *Contemporary South Asia*, 18(1), pp. 25–42.

Fetters, M. D., Curry, L. A. and Creswell, J. W. (2013) ‘Achieving integration and mixed methods designs—Principles and practices’, *Health Services Research*, 6(2), pp. 2134–56.

Hagaman, A. K., Sivilli, T. I., Ao, T., Blanton, C., Ellis, H., Cardozo, B. L. and Shetty, S. (2016) ‘An investigation into suicides among Bhutanese refugees resettled in the United States between 2008 and 2011’, *Journal of Immigrant and Minority Health*, 18(4), pp. 819–27.

Hacker, K. (2013) *Community-Based Participatory Research*, Sage Publications Inc.

Hennink, M.M., Kaiser, B.N. and Weber, M.B. (2019) ‘What influences saturation? Estimating sample sizes in focus group research’, *Qualitative Health Research*, 29(10), 1483–96.

Im, H. and Rosenberg, R. (2016) ‘Building social capital through a peer-led community health workshop: A pilot with the Bhutanese refugee community’, *Journal of Community Health*, 41(3), pp. 509–17.

Ivankova, N. V., Creswell, J. W. and Stick, S. L. (2006) ‘Using mixed-methods sequential explanatory design: From theory to practice’, *Field Methods*, 18(1), 3–20.

Käkelä, E. (2020) ‘Narratives of power and powerlessness: Cultural competence in social work with asylum seekers and refugees’, *European Journal of Social Work*, 23(3), pp. 425–36.
Kim, Y.K., Maleku, A., Lim Y., Kagotho, N, Scott, J. and Ketchum, M. (2021) ‘Financial challenges and capacity among African refugees in the southern United States: A study of sociodemographic differences’, The British Journal of Social Work. First published online on February 5, 2021. 10.1093/bjsw/bcab008.

Lonn, M.R. and Dantzler, J.Z. (2017) ‘A practical approach to counseling refugees: Applying Maslow’s hierarchy of needs’, Journal of Counselor Practice, 8(2), 61–82.

MacDowell, H., Pyakurel, S., Acharya, J., Morrison-Beedy, D. and Kue, J. (2020) ‘Perceptions toward mental illness and seeking psychological help among Bhutanese refugees resettled in the U.S’, Issues in Mental Health Nursing, 41(3), pp. 243–50.

Maleku, A. and Aguirre, R. T. (2014) ‘Culturally competent health care from the immigrant lens: a qualitative interpretive meta-synthesis (QIMS)’, Social Work in Public Health, 29(6), pp. 561–80.

Maleku, A., Kagotho, N., Baaklini, V., Filbrun, C., Karandikar, S. and Mengo, C. (2020) ‘The human service landscape in the midwestern USA: A mixed methods study of human service equity among the new American population’, The British Journal of Social Work, 50(1), pp. 195–221.

Mills, E., Singh, S., Roach, B. and Chong, S. (2008) ‘Prevalence of mental disorders and torture among Bhutanese refugees in Nepal: A systemic review and its policy implications’, Medicine, Conflict and Survival, 24(1), pp. 5–15.

M’zah, S., Lopes Cardozo, B. and Evans, D. P. (2019) ‘Mental health status and service assessment for adult Syrian refugees resettled in metropolitan Atlanta: a cross-sectional survey’, Journal of Immigrant and Minority Health, 21(5), pp. 1019–25.

National Immigration Forum (2020) Fact Sheet: U.S. Refugee Resettlement, Available https://immigrationforum.org/article/fact-sheet-u-s-refugee-resettlement/ (accessed March 19, 2021).

Onwuegbuzie, A. J. and Collins, K. M. (2007) ‘A typology of mixed methods sampling designs in social science research’, The Qualitative Report, 12(2), 281–316.

Padgett, D.K. (2017) Qualitative Methods in Social Work Research. 3rd Edition. Sage Publications Inc.

Perreira, K. M., Crosnoe, R., Fortuny, K., Pedroza, J., Ulvestad, K., Weiland, C. and Chaudry, A. (2012) Barriers to Immigrants’ Access to Health and Human Services Programs. ASPE Issue Brief, Washington, DC, Office of the Assistant Secretary for Planning and Evaluation.

Poudel-Tandukar, K., Jacelon, C. S., Chandler, G. E., Gautam, B. and Palmer, P. H. (2019) ‘Sociocultural perceptions and enablers to seeking mental health support among Bhutanese refugees in Western Massachusetts’, International Quarterly of Community Health Education, 39(3), pp. 135–45.

Pulla, V. (Ed.). (2016) The Lhotsampa people of Bhutan: Resilience and Survival, New York: Palgrave Macmillan.

Pumariaga, A. J., Rothe, E. and Pumariaga, J. B. (2005) ‘Mental health of immigrants and refugees’, Community Mental Health Journal, 41(5), pp. 581–97.

Saldana, J. (2016) The Coding Manual for Qualitative Researchers. London, Sage.

Shaghaghi, A., Bhopal, R. S. and Sheikh, A. (2011) ‘Approaches to recruiting “hard-to-reach”populations into research: A review of the literature’, Health Promotion Perspectives, 1(2), 86–94.
Shannon, P. J., Wieling, E., Simmelink-McCleary, J. and Becher, E. (2015) ‘Beyond stigma: Barriers to discussing mental health in refugee populations’, *Journal of Loss and Trauma*, **20**(3), pp. 281–96.

Shrestha, D. D. (2015) ‘Resettlement of Bhutanese refugees surpasses 100,000 mark’, http://www.unhcr.org/en-us/news/latest/2015/11/564dded46/resettlement-bhutanese-refugees-surpasses-100000-mark.html (accessed February 19, 2021).

Steimel, S. and Alvares, C. (2016) ‘Negotiating knowledge and expertise in refugee resettlement organizations’, *Cogent Social Sciences*, **2**(1), pp. 1162990.

United Nations High Commissioner for Refugees (2017) ‘Global trends on forced displacement in 2016’, http://www.unhcr.org/en-us/statistics/unherstats/5943e8a34/global-trends-forced-displacement-2016.html (accessed March 19, 2021).

van der Boor, C. F. and White, R. (2020) ‘Barriers to accessing and negotiating mental health services in asylum seeking and refugee populations: The application of the candidacy framework’, *Journal of Immigrant and Minority Health*, **22**(1), pp. 156–74.

Watkins, D. C. (2017) ‘Rapid and rigorous qualitative data analysis: The RADaR technique for applied research’, *International Journal of Qualitative Methods*, **16**(1), pp. 160940691771213.

Washington University Health Workforce Institute (2017) *Profile of the Social Work Workforce*, Available. https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SWWorkforce-Book-FINAL-11-08-2017.aspx

Weis, L. and Fine, M. (2012) ‘Critical bifocality and circuits of privilege: Expanding critical ethnographic theory and design’, *Harvard Educational Review*, **82**(2), pp. 173–201.

Yu, J., Clark, L. P., Chandra, L., Dias, A. and Lai, T. F. M. (2009) ‘Reducing cultural barriers to substance abuse treatment among Asian Americans: A case study in New York City’, *Journal of Substance Abuse Treatment*, **37**(4), 398–406.

Yun, K., Paul, P., Subedi, P., Kuikel, L., Nguyen, G. T. and Barg, F. K. (2016) ‘Help-seeking behavior and health care navigation by Bhutanese refugees’, *Journal of Community Health*, **41**(3), pp. 526–34.