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## Experiences of Bhutanese Refugees Receiving Services from Outpatient Mental Healthcare Centers in the United States

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# Walden University

College of Health Sciences and Public Policy

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Kul B. Dahal

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Walden University  
2025

Abstract

Experiences of Bhutanese Refugees Receiving Services from Outpatient Mental

Healthcare Centers in the United States

by

Kul B. Dahal

MHSA, Marywood University, 2021

BS, Keystone College, 2019

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

April 2025

## Abstract

Refugees coming to the United States may encounter difficulties when receiving mental healthcare services from outpatient mental healthcare centers because of lack of awareness about services. The purpose of this phenomenological study was to explore experiences of Bhutanese refugees involving receiving services from outpatient mental healthcare centers in the United States. The health belief model was used as a conceptual framework to provide insights regarding Bhutanese refugees' perceived benefits and barriers to increase awareness. Using convenience sampling, 10 Bhutanese refugees aged 18 or above who received outpatient mental healthcare services currently or in the past and lived in the midwestern United States were selected to participate in this study. Semi-structured interviews using open-ended questions were used via face-to-face. Interviews were conducted in Nepali. Data were transcribed and translated and analyzed using thematic analysis, which revealed six overarching themes supported by current literature: complex scheduling system challenges involving receiving services on a timely basis, unavailability in terms of access to provider delays when receiving mental health services, poor connections between providers and refugees which reduce treatment adherence, communication gap between providers and refugee which impede receiving services, lack of culturally-sensitive care and awareness programs which reduce quality services, and the importance of patient advocates to bridge aforementioned barriers. Results of this study promote social change, awareness, and providing mental healthcare services to Bhutanese refugee populations.

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## Dedication

I dedicate this dissertation to my lovely mom, Bhagi Rathi Dahal, for her phenomenal and unconditional support throughout my Ph.D. program. I also dedicate this dissertation to my sister Hari Maya Basnet and her husband, who supported in my difficulties; to my friend Buddha Shankar, who has provided technical support throughout my study; to my nephew Amin Dahal, who believed in me. Lastly, I dedicate this to all my relatives and friends who never stopped believing me.

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## Chapter 1: Introduction to the Study

The United States has been welcoming refugees from different countries who have painful and tragic histories. In 2022, over 25,000 refugees resettled in the United States (Migration Policy Institute [MPI], 2024). Refugees who are forced to be displaced from their home countries may experience psychological distress before, during, and after travel (Hess et al., 2022). Compared to general populations, refugees are vulnerable and likely to experience higher rates of mental disorders (Frounfelker et al., 2022; Grasser, 2022).

Many Bhutanese refugees have experienced torture, forced displacement, family separation, and resettlement (Maleku et al., 2022). These past experiences may put refugees at risk of developing fear, depression, anxiety, and post-traumatic stress disorder (PTSD) (MacDowell et al., 2020). Most Bhutanese refugees rely on home remedies as a traditional approach to medical treatment, which impacts treatment they need (Grasser, 2022). Refugees have their own norms, values, and beliefs that influence and impact their understanding of mental health (Soukenik et al., 2022; Vaishnav & Blackstock, 2020).

Lack of information about outpatient mental health services and proper use of available services also challenge refugees' ability to obtain needed services (Gurung et al., 2020). There are significant barriers to receiving mental healthcare for refugees and asylum seekers in the United States. Although many studies have been conducted on refugees involving mental health and the need for mental health services, there was no literature on Bhutanese refugees' experiences when receiving services from outpatient mental healthcare centers in the United States.

To address this gap, a phenomenological study was used to understand Bhutanese refugees' experiences and perspectives in when receiving mental health services and how services in outpatient mental healthcare centers impact their overall health outcomes. Understanding mental health problems among Bhutanese refugees may assist in creating strategies for receiving mental health services. Appropriate mental health strategies could reduce the number of people with mental health issues by enhancing culturally appropriate, accessible, and affordable mental health services for refugees.

Outpatient health care providers and primary care settings have responsibilities and opportunities to provide Bhutanese refugees with mental health services and treatment through accurate diagnosis, effective treatment, and appropriate follow-up (MacDowell et al., 2020). Many Bhutanese refugees in the United States are unaware of the need for mental health services as well as use, availability, accessibility, and perceived efficacy of health services (Gurung et al., 2020). Understanding Bhutanese refugees' perspectives and lived experiences regarding receiving mental health services and providing proper treatment can lead to promoting mental health of these populations.

Chapter 1 includes an overview of background information, problem statement, purpose of research, and research questions. Also, I discuss the HBM, the nature of the study, definitions of terms, and assumptions. Finally, this chapter concludes with assumptions, delimitations, limitations, significance of the study, and a summary.

## **Background**

Receiving mental healthcare is necessary to improve mental health conditions in refugees (MacDowell et al., 2020; Soukenik et al., 2022). Several strategies can be used

to provide adequate delivery of care to patients, such as offering support through implementation of effective Mental Health First Aid (MHFA) training in resettled Bhutanese refugee communities (Gurung et al., 2020). MHFA is a skills-based form of training that teaches participants to recognize and respond to mental health issues for themselves or others else in their communities (Dzemaili et al., 2023; Forthal et al., 2022). Training methods include small group activities that are used to provide information on panic attacks. Bhutanese refugees who attained MHFA training have more ability to recognize mental health symptoms (Gurung et al., 2020).

Healing-Centered Engagement (HCE) is a holistic approach where different resource orientations are used to promote mental well-being and provide hope and collective healing in communities (Soto-Aponte, 2021). HCE helped young Bhutanese refugee women increase their positive mental well-being outcomes. However, I also found that a lack of cultural sensitivity and cultural conflict challenged service use and delivery among Bhutanese refugees in the United States.

Bhutanese refugees in the United States may not clearly understand mental health or consider mental health illnesses, which could lead to them not wanting to express their issues (Gurung et al., 2020; Maleku et al., 2022). Lack of mental health knowledge and awareness contributes to refugees receiving inadequate services from outpatient health care. Although researchers have investigated mental health issues in Bhutanese refugees, no literature has explained outpatient healthcare centers that provide adequate services to refugees in order to improve their mental health conditions. Currently, a gap exists in

literature regarding refugees' experience with receiving services from outpatient mental healthcare centers.

This study involved Bhutanese refugees expressing their beliefs, attitudes, perceptions, and experiences related to services from outpatient mental healthcare centers. I intended to use findings for a better understanding of mental health conditions of Bhutanese refugees through their experiences. Additionally, my focus was to help deliver safe and quality services to refugees within local community outpatient mental healthcare facilities and provide guidance to outpatient mental health care providers and administrators. This will improve mental health conditions of Bhutanese refugees by understanding their experiences, preferences, and needs.

### **Problem Statement**

The problem is Bhutanese refugees in the United States have experienced challenges with receiving services from outpatient mental healthcare centers. Refugees who relocate and resettle in the United States receive limited attention from aid organizations and service providers (Frounfelker et al., 2022). Bhutanese refugees often encounter difficulties in terms of obtaining services because of a lack of information about mental health care that prevents or deter refugees from diagnosis and treatment (MacDowell et al., 2020). Since 2006, more than 86,000 Nepali-speaking Bhutanese refugees have been resettled in states, such as Pennsylvania, Ohio, Georgia, New York, Vermont, Iowa, and Colorado (Pew Research Center, 2023). Many Bhutanese refugee family members were separated while fleeing the country, which could lead to experiencing some mental health stigma (Frounfelker et al., 2022; Hess et al., 2022). Post

resettlement in the United States also added fear and uncertainty to refugees resulting from barriers that limit their ability to receiving mental health care (Miller et al., 2022).

Mental health care services access and use are disproportionate in the United States in terms of race, ethnicity, sex, gender, and age (Graves et al., 2024; Soukenik et al., 2022). Many health and human services organizations are constantly working to provide culturally-responsive services to refugees who experience challenges in order to improve access, use, and delivery (Soukenik et al., 2022). These challenges make it difficult for Bhutanese refugees to obtain services from outpatient mental healthcare centers in the United States (MacDowell et al., 2020).

Although, outpatient mental health care centers are providing mental health counseling and various types of training to Bhutanese refugees, it is still unknown whether these services that are provided by outpatient mental healthcare centers fulfill their needs. While completing literature reviews, there was no research about experiences of the Bhutanese refugees who received services from outpatient mental healthcare centers. There is a lack of information about how Bhutanese refugees experience receiving outpatient mental healthcare services in the United States.

### **Purpose of the Study**

The purpose of this qualitative phenomenological study was to explore perspectives of Bhutanese refugees about their experiences when receiving services at outpatient mental healthcare centers in the mid-western region of the United States. Qualitative studies involve information about participants' experiences, perceptions, attitudes, and behaviors (Burkholder et al., 2020; Ravitch & Carl, 2021). The qualitative

approach was suitable to understand mental health problems according to Bhutanese refugees in natural settings where the problem was experienced. The study can guide outpatient mental health care providers to provide better services to refugees, focusing on lived experiences in relation to the identified phenomenon. Moreover, the qualitative approach was used to explore experiences to determine whether outpatient mental health care services are helpful as well as service changes that need to be addressed.

### **Research Question**

The following research question was used for this qualitative study:

RQ1: What are lived experiences of Bhutanese refugees involving receiving services from outpatient mental healthcare centers in the United States?

Two sub-questions were used to further explore this question. The two sub questions are:

SQ1: What are Bhutanese refugees' perceived barriers to receiving mental health care?

SQ2: What are Bhutanese refugees' perceived facilitators that aide in receiving mental health care?

### **Conceptual Framework for the Study**

The conceptual framework for this research was the HBM. The HBM is a used researched model of health behaviors that involves predicting health-related behaviors and belief patterns (McKellar & Sillence, 2020). The HBM has been used broadly to help understand ways people respond to perceived health risks and guide health promotion and disease prevention programs (Lilly et al., 2020). The HBM includes three main categories

that encourage dealing with health behaviors, which are individual perceptions, modifying factors, and likelihood of action. Individual perceptions influence perceptions of illness and its importance to individuals, perceived susceptibility, and perceived severity (McKellar & Sillence, 2020). Modifying factors include demographic variables, perceived threats, and cues to action. Likelihood of action includes perceived benefits and barriers to taking recommended health action (McKellar & Sillence, 2020). The HBM is used to explore and analyze specific levels of influence and components of outpatient mental healthcare services.

The HBM can be used to explore the influence of mental health services on access to outpatient mental healthcare within local areas. Perceptions of personal health behavior threats of individuals are influenced by general health values and specific health beliefs (McKellar & Sillence, 2020). When a patient perceives a threat, the patient's perception of barriers would be higher than perceptions of benefits, which might affect personal experiences. Participants in this study were asked about their experiences with receiving mental health services, barriers, and contributing factors to obtaining services from outpatient mental healthcare centers.

Bhutanese refugees' mental health problems are associated with resettlement stressors and lack of mental health knowledge (Gurung et al., 2020). The HBM helped to facilitate an increased understanding of experienced and perceptions of outpatient mental health care services in the United States.

### **Nature of the Study**

I used a qualitative research method with a phenomenological approach to address the research question. Phenomenology was chosen rather than ethnography or narrative research for this study. Ethnography is a type of study that involves behaviors of cultural groups in relation to phenomena (Burkholder et al., 2020). Moreover, in ethnographic research, researchers should live and participate in the culture of participants rather than observe their behavior to collect information, which may take several years (Burkholder et al., 2020). The purpose of narrative research is to describe individual experiences, biography, life history, oral history, autoethnography, and autobiography, rather than individual lived experiences in relation to a phenomenon (Parks, 2023).

Phenomenological studies involve understanding individuals who share common experiences. Many adult Bhutanese refugees experience negative perceptions of mental health illness (Frounfelker et al., 2022; MacDowell et al., 2020; Maleku et al., 2022). A phenomenological design was used to understand Bhutanese refugees' mental health problems by exploring their views and perceptions. Moreover, I attempted to gain deeper insights about how they understood those experiences.

Interviews were used as a primary data collection instrument. I used open-ended and semi-structured research questions and one-on-one interviews with participants. Convenience sampling was used for the study. The convenience sampling technique consumes less time for researchers' samples from target populations are readily accessible (Golzar et al., 2022; Stratton, 2021). Researchers can reach target populations compared to other non-random sampling techniques (Golzar et al., 2022; Stratton, 2021).

The phenomenological approach was appropriate to understand Bhutanese refugees' experiences, perspectives, beliefs, and opinions about mental health services in outpatient mental healthcare centers. Structured interviews were transcribed using a thematic analysis. I used following Saldana's descriptive coding process and first and second-cycle coding.

Ten participants were selected for the study. Participants were Bhutanese refugees living in the midwestern region of the United States for at least 1 year. Participants were both male and female and 18 or older, and they were required to have received mental health services from outpatient mental health care centers at least once. Only 10 participants were selected for the study.

### **Definitions**

Key terms that were used throughout this study are defined as follows:

*Bhutanese refugees*: People who were forcibly displaced from Bhutan and resettled in the United States due to persecution, conflict, violence, or human rights violations.

*Mental health*: State of mental well-being that enables people to cope with stresses and realize their abilities to contribute to their communities (World Health Organization, 2022).

*Mental health services*: Services which include diagnosis, treatment, or counseling provided in an inpatient or outpatient settings in private or public healthcare centers to improve mental, emotional, and nervous disorders in individual and group contexts (Latoo et al., 2022).

*Outpatient Service:* Kind of service that provides care and treatment to patients who are not hospitalized (Rinne et al., 2022).

*Refugees:* People who forcibly displaced from their country of origin for reasons including persecution, conflict, violence, and human rights violations (Frounfelker et al., 2022).

### **Assumptions**

Several assumptions were made in this qualitative research study. One assumption was participants were interested and openly shared responses regarding their perspectives and experiences with receiving mental health services for this study. However, some refugees were not willing to share these problems with a person whom they did not know personally and was not a medical provider. Providing a safe environment for one-on-one interviews was useful and appropriate. I assumed participants responded honestly and accurately to interviews. I also assumed interviews were culturally sensitive and appropriate. Interview protocols were applied to reduce the potential risk of bias and ensure the trustworthiness of research. All assumptions were crucial in the context of this study.

### **Scope and Delimitations**

The research problem was many Bhutanese refugees who are forced to leave their home country and resettle in the United States experience challenges with receiving and using outpatient mental health care services compared to general populations. Participants were resettled Nepali-speaking Bhutanese refugees with mental health problems who used outpatient mental health care services and resided in the midwestern

region of the United States for at least 1 year. In the study, young adult and older adult participants were included because they were the population who observed and experienced more barriers to obtaining mental health services. No underage participants were included in this study. Participants discussed only their personal experiences, so there might have potential transferability. In general, experiences of participants did not represent experiences of all refugees who live in the United States. However, this study might be useful and applied to other immigrants and minorities in order to understand their own experiences.

### **Limitations**

This study involved only U.S. outpatient mental health care services. Other countries were not included in this study. Some participants become emotional, fearful, hesitant, and refused to participate in discussing their experiences with an unknown person. This led to more challenges in terms of recruiting participants; however, the study was completed within the limited time. Participants provided different interpretations of their experiences based on their feelings during interviews and described their social and cultural backgrounds.

Participants were provided with \$20 gift cards for their time and engagement in research. Providing gift cards may lead to participants skewing their answers to be regarded as good participants. Compensation to participants is a limitation of this study. Participants answered all interview questions. Also, I ensured a clear separation of my role in Bhutanese refugee communities from my role as researcher. Despite limitations,

maintenance of ethical practices and protocols made the study valid, transferable, and meaningful.

### **Significance**

This study was significant because it will lead to positive social change in terms of mental health care and service among Bhutanese refugees. Findings from research may include new information that could help provide a better understanding of experiences of Bhutanese refugees with receiving outpatient mental healthcare services. Understanding Bhutanese refugees' behaviors, perceptions, and experiences related to accessing and obtaining mental health care will lead to better plans and promoting and providing mental health care services in this population.

Results of this study may result in better ideas and information that help mental health care providers, public health practitioners, and social workers better assist Bhutanese refugees in provision of mental health and social services. Findings can encourage health professionals to devote more understanding and compassion to the Bhutanese and other refugees and situations they experience. This study will lead to insights for public health researchers to prepare and engage in future research on mental health issues of Bhutanese refugees and many other refugees and immigrants in the United States. Any improvement in mental health conditions of Bhutanese refugees they have experienced will contribute to positive social change.

### **Summary**

Chapter 1 include the background, problem statement, purpose of the study, research question, nature of the study definitions, assumptions, scope and delimitations,

limitations, and significance. I explained the need to conduct this study along with the conceptual framework. I aim to enhance mental health of resettled Bhutanese refugees by exploring their experiences with outpatient mental healthcare centers that provide services.

Chapter 2 includes a review of available current literature regarding this topic. It includes the literature review, literature search strategy, conceptual framework, and summary and conclusions. I explain reasons for using semi-structured open-ended interview questions, how interviews were conducted to collect data, and the phenomenological design. Additionally, I address studies related to outpatient mental health care services, which provided a foundation for this study.

## Chapter 2: Literature Review

Chapter 2 includes a brief synopsis of the foundation for this research. Following the introduction is an overview of the literature research strategy and key search terms. I describe the conceptual framework, review literature, and related key concepts to support the study. This is followed by a summary discussing main points in literature.

Many Bhutanese refugees in the United States experience some kind of mental health distress (Frounfelker et al., 2022; Grasser, 2022; Maleku et al., 2022). The main problem that prompted the initial literature search is challenges with receiving mental health services for Bhutanese refugees in outpatient mental healthcare centers. Bhutanese refugees have faced more challenges and obstacles in terms of accessing and receiving mental health services compared to general populations (Frounfelker et al., 2022; Soukenik et al., 2022). Challenges in terms of receiving mental healthcare services led to mental health problems and attempted and complete suicide rates among Bhutanese refugees in the United States compared to the general population (Adhikari et al., 2021).

The annual suicide ideation rates among Bhutanese refugees are high. Between 2009 and 2012, the rate was 20.3 per 100,000 among Bhutanese refugees, whereas general population suicide ideation rate was 12.4 per 100,000 in the United States (Hess et al., 2022). Maleku et al. (2022) stated prevalence of mental health risk is higher among Bhutanese refugees; however, use rates of mental health services are lower among them. Direct and indirect barriers, such as stigma associated with mental health diagnoses and treatment, lack of mental health services information, and cultural practices have prevented refugees from obtaining proper mental health services (MacDowell et al.,

2020). Understanding the need for mental health services in Bhutanese refugee communities is crucial when trying to reduce disparities and barriers. In this chapter, I review existing literature before proceeding to the next chapter.

### **Literature Search Strategy**

Sources were published between 2020 and 2025. The Walden University Library was used to access the following databases: Walden University Library Health Science discipline subject research tool, Academic Search Complete, ProQuest Medical Library, SAGE Journals Online, Google Scholar, CINAHL and MEDLINE Combined Search, PubMed Central, and SAGE Research Methods. Boolean operators, such as AND, OR, and NOT were used to gather accurate and relevant information. I used the following key search terms: *Bhutanese refugee, mental health, mental health disorder, mental illness, psychiatric ill, health care, mental health services, outpatient services, barriers, mental health rate, mental health risk, medication, experiences, perceptions, influence, opinion, initiatives, interventions, health belief model, morbidity, mortality, qualitative, and social change*. Several articles on Bhutanese refugees were found, but many studies are broadly applicable, containing information on other health conditions and sociocultural problems. Information that was relevant to this subject was included to support this research. Via qualitative, quantitative, and mixed methods studies, 231 results were found. All sources were peer-reviewed literature on mental health, mental health services, mental health care, mental health policy, mental health interventions, mental health experience, mental health perceptions and opinions, behavior, and the HBM. I primarily focused on mental health and delivery of mental health services in outpatient mental healthcare centers.

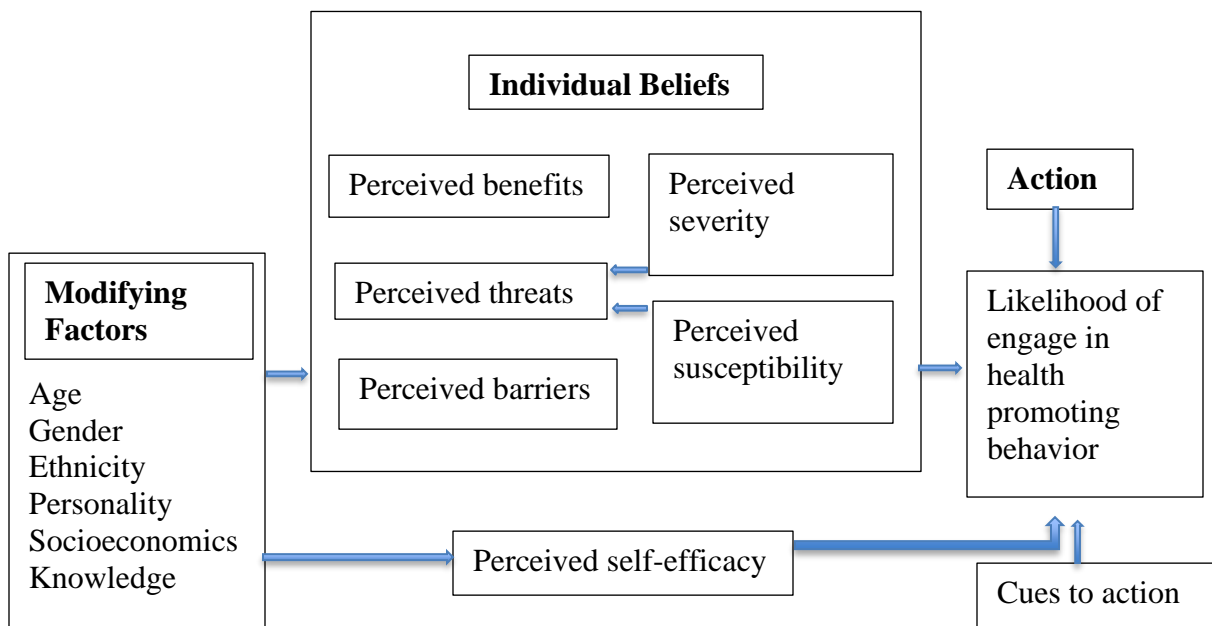
## Conceptual Framework

The HBM was the conceptual framework for this research. It was used to inform research questions and general structure of the study. It is a psychological health behavior change model that was developed to explain and predict health-related behavior, particularly in terms of uptake of health services (Ghorbani-Dehbalaei et al., 2021). The model was developed by social psychologists Godfrey Hochbaum, Irwin Rosenstock, Rosenstock, and Kirscht in the 1950s at the United States.

The HBM can be used by outpatient mental health care providers to understand mental health beliefs and improve mental health in Bhutanese refugees who receive outpatient mental health care services. The framework consists of three main variables: modifying factors, individual beliefs, and likelihood of actions (Ghorbani-Dehbalaei et al., 2021; McKellar & Sillence, 2020). These three factors are necessary for outpatient mental health care providers to understand Bhutanese refugees' attitudes and perceptions towards mental health problems and encourage and achieve healthy behavior changes (see Figure 1)

### **Figure 1**

*HBM*



*Note:* Adapted from Ghorbani-Dehbalaei et al., (2021). The role of health beliefs and health literacy in women's health promoting behaviors based on the health belief model: A descriptive study. *BMC Women's Health*, 21(1), 1-9. <https://doi.org/10.1186/s12905-021-01564-2>

### **Phase 1: Modifying Factors**

The first step is for outpatient mental health care providers to identify modifying factors that may influence Bhutanese refugees' experiences and perceptions towards mental health and obtaining outpatient mental health care services. Modifying factors include age, gender, ethnicity, personality, socioeconomics, and knowledge (Ghorbani-Dehbalaei et al., 2021). Mental health care providers must conduct health assessment of the Bhutanese community to collect information about these modifying factors. For

conducting a health assessment, it is necessary to identify a clear understanding of the target population.

After identifying the target population, mental health providers will identify and engage with community partners, such as Bhutanese community leaders, supporting groups, and refugee organizations. Community partners can provide technical assistance and guidance, facilitating community input through meetings and events, and collecting data (Saleh et al., 2022). Collected information can help providers understand Bhutanese refugees' health knowledge, health behavior, and risk factors that contribute to mental health. Identifying modifying variables can help providers understand Bhutanese refugees' health-related behaviors that directly or indirectly impact their individual beliefs. Moreover, these modifying variables can be useful for mental healthcare providers identifying decision-making points that influence health behavior in Bhutanese refugees.

## **Phase 2: Individual Beliefs**

Once modifying variables are identified, the second step is understanding individual beliefs involving perceived seriousness, susceptibility, benefits, barriers, and self-efficacy. Modifying factors influence individual beliefs. After identifying and understanding individual traits or behaviors, it can be helpful for mental healthcare providers to define Bhutanese refugees' mental health risk, risk levels, and how they are perceived. MacDowell et al. (2020) stated many Bhutanese refugees feel reluctant to talk about mental health problems because of negative perceptions of mental health illness. Understanding target populations' perceived susceptibility and severity of mental health

conditions is essential for mental health care providers to provide essential steps to recommend appropriate actions and benefits of actions to enhance likelihood of successful behavior change.

### **Phase 3: Action**

After identifying modifying factors and understanding individual beliefs, cues to action are necessary to encourage Bhutanese refugees who are receiving outpatient mental care services to engage in health-promoting behaviors. Mental health care providers can demonstrate actions through mental health awareness and training programs, such as healing-center engagement activities and Mental Health First Aid (MHFA) (Gurung et al., 2020; Maleku et al., 2022). These awareness and training programs could enhance self-efficacy and the likelihood of behavior changes (Gurung et al., 2020). When mental healthcare providers enhance necessary services in outpatient mental health care centers for Bhutanese refugees, it may help change their mental health behaviors and result in positive changes in mental health outcomes.

## **Literature Review Related to Key Concepts**

### **Bhutanese Refugees**

Lhotshampas are ethnically and linguistically Nepali speaking minority group in Bhutan (Maleku et al., 2022). At the end of the 19th century, Nepalese farmers migrated to Bhutan and resettled in the southern belt of the country (Karan & Norbu, 2023; MacDowell et al., 2020). In the early 1990s, the Bhutanese government enacted policies to exclude and denationalize Nepali-speaking ethnic and religious minority populations, and they were forced to flee genocide, torture, and other rights violations (Salinas &

Salinas, 2021). Many Nepali-speaking populations fled to Nepal as refugees to save their lives (MacDowell et al., 2020). Since 2008, many Bhutanese refugees have resettled in the different regions of the United States (MacDowell et al., 2020).

Most of the Bhutanese refugees experienced a long and painful historical of collective trauma from war, forced displacement, and loss of citizenship while they were in refugee camps in Nepal prior to their migration to the United States in the 2000s and 2010s (Case Western Reserve University, 2020; Chapadia et al., 2023; Hess et al., 2022). Currently, more than 86000 have been resettled in different states in the United States through the program coordinated by the United Nations High Commissioner for Refugee (UNHCR) (Case Western Reserve University, 2020; Hess et al., 2022; MacDowell et al., 2020). Thousands of refugees resettled in other countries, including Canada, the United Kingdom, Denmark, the Netherlands, Norway, Australia, and New Zealand (Meyerhoff et al., 2021; Neikirk & Nickson, 2024).

Studies have focused on and explained particularly mental health problems and conditions (Chapadia et al., 2023; Maleku et al., 2022; Salinas & Salinas, 2021). However, literature reviews have failed to explain Bhutanese refugees' experiences with mental health services in outpatient healthcare settings in the United States, which is necessary to improve and enhance their mental health conditions and wellness.

### **Bhutanese Refugees in Ohio and Summit County**

About 30,000 Bhutanese refugees primarily resettled in central Ohio, with sizable populations resettled in other cities including Cincinnati, Cleveland, and Akron (Chapadia et al., 2023). Local organizations estimated more than 5,000 Bhutanese

refugees have been resettled in Akron (Karmacharya et al., 2025). Between 4,000 and 5,000 Bhutanese refugees are estimated to have resettled in Summit County, Ohio (Case Western Reserve University, 2020). The resettlement of refugees in Summit County is categorized into two groups. The first group is primarily refugees, who directly come to the county from refugee camps or temporary housing, whereas the second group is secondary refugees, who move into the county from other states or counties of the United States (International Institute of Akron, n. d.). As many Bhutanese refugees established successful enclaves in Akron's North Hills neighborhood, many refugees from other counties moved into Summit County. As a result, Northeast Ohio has become one of the largest refugees resettled regions (Case Western Reserve University, 2020). A long and painful history of collective historical trauma, as well as post-resettlement challenges, caused Bhutanese refugees to suffer from poor mental health outcomes in Ohio and other states of the United States (Chapadia et al., 2023; Maleku et al., 2022). The establishment of appropriate mental health services in outpatient mental health care delivery may lead to better resilience against poor mental health outcomes among the Bhutanese community in Summit County and throughout the country.

### **Outpatient Mental Health Services**

Outpatient mental health services are referred to as general hospitals and community mental health centers where clients receive less-than-24-hour mental health treatment in outpatient settings (National Mental Health Services Survey [NMHSS], 2020). This helps to diagnose and treat patients with mental health conditions, such as anxiety disorders, depression, post-traumatic stress disorder, and other behavioral and

emotional disorders (NMHSS, 2020; Samartzis & Talias, 2020). Outpatient mental health care services include diagnosis and treatment or procedures where patients are not required to be hospitalized (Samartzis & Talias, 2020). In recent years, there has been a high prevalence rate of mental health problems among the general population in the U. S, and it is estimated that about 64.1% of adults with severe mental illness receive mental health services (Presskreischer et al., 2021; Sabado et al., 2022; Sinha et al., 2023). Outpatient mental health care services are crucial to maintain, improve, and restore the mental health of the population. Nowadays, outpatient mental facilities in the U. S. provide a range of specialized mental health services and support to patients based on the type and level of need in a community and the availability of resources (Hung et al., 2020).

According to the NMHSS (2020) report, the number of outpatient mental health facilities differs by state. For instance, South Carolina and Alabama have more than 90% of all mental health treatment facilities are inpatient, and less than 10% are outpatient mental health facilities. Some states, such as Wisconsin, Delaware, and Idaho, have more than 70% of all mental health facilities are outpatient treatment facilities. In the report of NMHSS (2020), in the United States, 23 States have 40% or more of all mental health treatment facilities are outpatient mental health facilities and 27 states have less than 40% of all mental health treatment facilities are outpatient mental health facilities. Between 2015 and 2020, outpatient mental health treatment facilities have decreased from 5,019 to 4,870, or a decrease of 3% across the United States (Utter et al., 2023). Nonprofit organizations owned 61.84% of the outpatient facilities, 16% by public agencies and rest

are integrated primary care (Utter et al., 2023). These data have shown that outpatient mental health services and support are uneven throughout the country in which it may impact mental health services delivery as needed.

The use of outpatient mental health care services has been rapidly increasing in recent years. According to the study conducted by Germack et al. (2020), outpatient mental health visits increased from 7.1% to 8.2% between two periods, 2008 and 2011, and 2012 and 2015 respectively. The majority of mental health patients visit with other providers, including another physician specialist, physician assistants, licensed practical nurses, and nurse practitioners, rather than specialty mental health providers (SMHPs) and primary care physicians (PCPs) (Chen et al., 2022; Germack et al., 2020). The overall utilization of outpatient mental health services in the United States has increased. However, there still exist differences in service utilization between rural and urban regions, and racial and ethnic minorities and White populations (Chen et al., 2022; Lu et al., 2021; Olfson et al., 2023).

There is a difference in receiving outpatient mental health services between racial and ethnic minorities and White populations. White individuals receive more outpatient mental health care, including therapy, counseling, and psychopharmacological services, compared to non-Hispanic Black and Hispanic individuals (Lu et al., 2021; Olfson et al., 2023). Olfson et al. (2023) found that in an annual rate per 100 persons, 25.3 uses outpatient mental health services whereas only 12.2 and 11.4 are used by Black and Hispanic, respectively. Among the racial and ethnic minority groups, there is uneven use of mental health services (Lu et al., 2021). There is an outpatient mental health services

disparities in rural-urban among adults in the United States (Chen et al., 2022). About 28% of mental health patients in rural areas depend on primary care settings for their outpatient visits, whereas only 14% of urban patients are used in primary care settings (Chen et al., 2022). Urban mental health patients have many options for outpatient visits; hence, they often visit specialists compared to rural area patients (Chen et al., 2022).

Mental health crises can range from rapid mood swings, abusive behavior, and paranoia to the risk of suicide. When people have mental health crises, there are several ways to receive services. Suppose the patient feels or is experiencing a mental health crisis and needs an immediate response. In that case, there are crisis helplines such as 911 for self-harm that seems imminent, the National Suicide Prevention Lifeline, Crisis Text Line, and Hotlines for each county (Commonwealth of Pennsylvania, n. d.). General hospitals and community mental health centers can improve outpatient mental health services to refugees and ethnic minorities by providing service through the efficiency of health professionals, safety for patients and professionals, accessibility of patients to services, continuity of services over time, and suitability of services (Samartzis & Talias, 2020). Providing better services to refugees and ethnic minorities can help hospitals and mental health centers improve their quality of outpatient mental health services.

### **Services Among Refugees**

Outpatient mental health care services are necessary for refugees to improve their mental health and wellbeing. According to Mattar et al. (2023), mental health providers require specialized knowledge and skills, including trauma-informed clinical skills, acculturation knowledge, and resettlement and historically embedded information to

engage in refugee mental health care. Occasionally, some mental health awareness programs are conducted, such as mental health first aid training (Gurung et al., 2020), healing-centered engagement (Maleku et al., 2022), and interventions that may help patients understand and promote their mental health conditions (Mattar et al., 2023). There are some healthcare programs that focus on refugees and asylum seekers and provide holistic healthcare coordinated with social and legal aid. For instance, using an innovative mode of outpatient care, the Boston Center for Refugee Health and Human Rights (BCRHHR) provides mental health services to refugees (Boston Medical Center, n. d.). The BCRHHR also provides training to professionals and conducts research to understand the need, promote health, and improve the quality of life for refugees (Boston Medical Center, n. d.).

The San Francisco Department of Public Health (2021), Zuckerberg San Francisco General Hospital and Trauma Center has a newcomers health program that provides services to refugees and asylees. The newcomer health program includes mental health screenings, physical exams, lab tests, vaccines, and treatments. It refers newcomers to specialists if they have complicated health conditions. In addition, it provides culturally and linguistically appropriate health assessments to newly arrived refugees. American Psychiatric Association (APA, 2020) has stated that systems of care for the mental health of refugees need to focus on various factors, including social, cultural, and family support. Higher resilience is associated with refugees, in which the need of support for mental health services needs to be increased (United Nations High Commissioner for Refugees ([UNHCR], 2022). In the United States, refugees are

provided with mental health and support benefits and services by the Office of Refugee Resettlement program (Office of Refugee Resettlement [ORR], 2023). The ORR collaborates with local health departments, resettlement agencies, and community-based and non-governmental organizations to provide services to refugees and eligible populations (ORR, 2023).

### **Services Among Bhutanese Refugees in Ohio**

Culturally and linguistically appropriate mental health services are delivered to racial and ethnic minorities in Ohio (Ohio Department of Mental Health and Addition Services [OhioDMHAS], n. d.). A study has found that social support programs and services contribute to better resilience against poor mental health outcomes in the Bhutanese community in Ohio (Chapadia et al., 2023). The gap between the mental health service delivery and utilization of services becomes a significant factor of mental health concern in Bhutanese refugees in the state of Ohio (Ohio State University, 2022) and across the U. S. (Maleku et al., 2022). Many local health departments are working under the OhioDMHAS to fulfill the mental health requirements of refugees and minorities (OhioDMHAS, n. d.). Lack of knowledge to navigate health resources and fear of communicating with service providers become barriers to Bhutanese utilizing mental health resources in Ohio and other states where refugees resettled (Maleku et al., 2022).

### **Barriers**

Each year, thousands of refugees come to the United States. The 2024 report from the Department of Homeland Security showed that a total of 60, 050 people come to the United States as a refugee during 2023, including both principal and derivative

accompanying refugees (Office of Homeland Security Statistics, 2024). Many refugees who come to the United States speak their own language and do not speak or understand English proficiently. For instance, the majority of the Bhutanese refugees do not understand English; as a result, it is difficult for them to get information on mental health care services and support as needed (Gurung et al., 2020; Maleku et al., 2022). Language barriers can pose challenges to health providers in providing high-quality services and maintaining patient safety (Al Shamsi et al., 2020). Systemic discrimination and social and cultural differences are linked to the Bhutanese community's low rate of mental health services utilization (Maleku et al., 2022).

Lack of social networks, discrimination of fear from providers and staff members, and hesitation to seek available services from within their locality create challenges for mental health professionals to provide care to Bhutanese refugees (Maleku et al., 2022). Sabado et al. (2022), ethnic and racial minorities are less likely to utilize available health care resources compared to their White counterparts in the United States Social stigma, cultural mistrust, limited transportation, lack of insurance coverage, inadequate availability of mental health providers in their area, and language proficiency are the significant factors that deter ethnic and racial minorities from proper utilization of mental health services and other support resources (Sabado et al., 2022; Sinha et al., 2023).

At the provider level, lack of cultural competence and available providers (Hynie et al., 2023; Maleku et al., 2022), and at the interventional level, equity in the efficacy of intervention across groups (Hynie et al., 2023) are the significant barriers refugees faced and encountered in mental health services utilization. In recent years, the COVID-19

pandemic has challenged the delivery of outpatient mental health services across the United States (Zhu et al., 2022). It is still unclear to what extent COVID-19 impacted mental health services. However, many in-person mental health services visits are reduced by half every month (Zhu et al., 2022). As a result, the use of telehealth uptake has increased (Zhu et al., 2022). The adoption of telehealth may have challenges for racial and ethnic minorities, including refugees who are not familiar with using recent technologies.

### **Disparities in Refugees**

Refugees are diverse groups of populations who need different types of physical and mental health care services and support (World Health Organization, 2021). Moreover, they have experienced trauma from war or displacement and post-migration difficulties, putting them at higher risk for mental health disorders (MacDowell et al., 2020; Maleku et al., 2022), where enhancement of mental health care delivery is necessary. Healthcare is expensive in the United States (The Commonwealth Fund, 2023), and the lack of health insurance often makes it impossible for refugees to seek and receive necessary health care and support (Feinberg et al., 2021). Research studies have shown that many refugees often seek healthcare services only in emergency situations (Hess et al., 2022; Maleku et al., 2022), which may require more complicated methods of treatment and more expensive procedures. Refugees often rely on the traditional approach to healthcare rather than medical treatment unless the condition is serious or unresolved (Hess et al., 2022), which impacts providing an equal level of services as provided to the general population (Hess et al., 2022; Maleku et al., 2022).

**Benefits**

Outpatient mental health care services have many benefits. For instance, outpatient behavioral health treatment is the most effective way to treat behavioral health conditions (Bellon et al., 2022). Patients are not required to stay in the hospital overnight in outpatient services, which helps reduce the cost of treatment for those who do not have full coverage insurance (Chew et al., 2022; National Alliance on Mental Illness, 2020). According to the Pew Research Center (2023), currently, the volume of mental health patients is rapidly increasing across the United States. However, mental health services are not sufficient in the United States despite high demand (National Council for Mental Wellbeing, 2024). Mental health crisis in the United States is associated with limited options for treatment, and access to and attitude towards mental health services (National Council for Mental Wellbeing, 2024). In this case, outpatient mental health services would be the better option to provide treatment for as many patients as possible without hospitalization.

Outpatient treatment can help patients learn to cope with stressors and manage their mental health (American Addiction Centers [AAC], 2024). Moreover, outpatient treatment has therapeutic interventions and support services, including group and individual counseling, family therapy, education sessions, occupational or recreational therapy, psychotherapy, family therapy, medication for addiction treatment, and other treatment services (AAC, 2024). Other benefits of outpatient treatment include greater flexibility in scheduling without disrupting patients' regular or normal responsibilities and the opportunity to apply the skills learned in treatment in patient's homes or another

living environment (AAC, 2024). These various ways of treatment can help fulfill the specific needs of an individual as well as communities.

### **Ways to Enhance Mental Health Services**

Past studies have discussed Bhutanese refugees with mental health problems, focusing on ways to promote and increase mental health services and awareness to them (Gurung et al., 2020; MacDowell et al., 2020; Maleku et al., 2022). Some of the researchers have explored highlighting specific factors in their studies. For instance, Maleku et al. (2022) found that improvement in utilization of available health resources and social network support can be effective for Bhutanese refugees for mental health improvement. Another study found that social support can play a crucial role in increasing better resilience against poor mental health outcomes in refugees (Chapadia et al., 2023). The study conducted by MacDowell et al. (2020) found that many Bhutanese refugees resettled in the United States have negative perceptions of mental illness, where psychological support is necessary to cope with and improve mental health conditions.

Bjorlykhaug et al. (2022) and Chapadia et al. (2023) found that there are various associations between social support and mental health services use. When refugees are informed about health information, access to outpatient mental health services, and provide mental health training, these can help improve in receiving and utilization of outpatient health services. Furthermore, mental health facilities with social support-oriented mental health services can help mental health recovery (Bjorlykhaug et al., 2022). Mental health services and support linkage can reduce fragmentation and improve efficiency and effectiveness in service delivery (Bjorlykhaug et al., 2022). Mental health

problems can be reduced by effective health promotional efforts, such as health education and assistance that can help heighten awareness about mental illness and improve the quality of life (Salinas & Salinas, 2021). Mental health services are sensitive and responsive to racial, ethnic, religious, and gender differences (Gurung et al., 2020; Maleku et al., 2022). Culturally appropriate orientation and programs influence and establish a positive impact on seeking mental health support and expanding the use of health services among Bhutanese refugees (Gurung et al., 2020; Maleku et al., 2022).

### **Mental Health Care Acts**

Mental health care acts are crucial to implementing health plans effectively for individuals with mental and substance use conditions. In the past, there was no recognition that mental health and substance use disorders are as important as other medical and surgical care (U.S. Department of Health and Human Services [DHSS], 2023). Several healthcare acts are established and implemented in the United States for the benefit of mental health patients. Some of the health acts are the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 are federal laws (Baumgartner et al., 2020; Xie et al., 2023). They required health insurers and large-group health plans that offer health and substance use disorder to provide the same level of benefits for mental and substance use treatment and services that they do for medical and surgical care (Baumgartner et al., 2020; Xie et al., 2023). The MHPA and MHPAEA were established with the aim that there should not be greater cost-sharing or other limitations for mental health services. Having said that, MHPAEA did not apply to individual and small-group plans, resulting in limitations on

the benefits provided for mental health care than for general health care (Baumgartner et al., 2020; Xie et al., 2023).

The Affordable Act (ACA) of 2010 is more beneficial for most individuals as well as to small employer health insurance plans to offer plans through the health insurance marketplace (Baumgartner et al., 2020; Xie et al., 2023). The ACA has established a better policy environment for people with various mental health problems and substance use disorder services (Xie et al., 2023). For instance, every insurance plan must provide mental health treatment coverage and preventive services to every individual who requires it at no cost. The ACA addressed the MHPAEA's problem by improving coverage expansions with mental health services (Baumgartner et al., 2020). Expanded plans included young people staying on parents' plans until age 26, expanding the Medicaid program, guaranteed access to mental health services within individual and small groups, and mandating 10 essential health benefits that include mental health and prescription drugs (Baumgartner et al., 2020).

### **Rationale for Selection of the Variables and Study Approach**

The variables for this study are Bhutanese refugees' experiences with receiving services and outpatient mental health care services. I selected these variables since the lack of services in outpatient mental health care facilities negatively impacts mental health outcomes in patients. Several scientific studies have been conducted on Bhutanese refugees, focusing on the causes of mental problems and ways to reduce the problem. However, no literature exists on how Bhutanese refugees experience receiving services in outpatient mental healthcare centers. This study can help current and future mental health

practitioners understand Bhutanese refugees' mental health problems by exploring their views, perspectives, and experiences. The findings from the study can help identify what impact outpatient mental health care services have on Bhutanese refugees' mental health experiences and how these experiences can be considered when designing health promotion initiatives.

### **Summary and Conclusions**

Chapter 2 included currently available academic literature about outpatient mental health care facilities and how those facilities are working to provide services. Several databases and the Walden Library were used to search most of recent studies on mental health problems in Bhutanese refugees, and how they experienced receiving services in outpatient healthcare centers for their problems in the United States. For the literature search strategy, several terminologies that contributed more knowledge on the topic were used. Although several studies have been conducted on this population concerning receiving mental health services, it is still unknown how available services provided to them in outpatient health care services impact their positive mental health outcomes. Considering that the Bhutanese refugee population is increasing rapidly, more studies need to be conducted to understand mental health needs and also provide necessary outpatient mental health services.

Lack of proper and unsuitable outpatient mental health services delivery based on refugees' needs led to poorer quality of care in Bhutanese communities. This qualitative study was useful to explore and understand how Bhutanese refugees experience receiving services in outpatient mental healthcare centers to fulfill their needs in the United States.

Moreover, the qualitative approach helped facilitate in-depth dialogues between participants and myself. Analyzing responses of patients helped me to understand their experiences better.

Chapter 3 includes a review of the research design and qualitative methodology. I address the research design and rationale, my role as the researcher, methodology, issues of trustworthiness, and ethical procedures.

### Chapter 3: Research Method

The aim of this study was to explore participants beliefs, opinions, perspectives, and experiences regarding services in outpatient mental healthcare centers, where Bhutanese refugees interact with doctors, nurses, and other health care professionals. In qualitative studies, researchers try to understand individuals, groups, and phenomena in contextualized ways in order to express how people make meaning and interpret their perspectives, experiences, and beliefs (Ravitch & Carl, 2021). Moreover, in qualitative studies, researchers study social phenomena in natural settings through natural observations, descriptions, and thematic analysis of participants' behaviors and perspectives that lead to better understanding of the phenomenon (Burkholder et al., 2020). The qualitative approach was suitable for understanding perspectives of Bhutanese refugees about receiving services from outpatient mental healthcare centers in the United States. Outpatient mental health providers and professionals can deliver better services to refugees by understanding their opinions, perspectives, and experiences regarding barriers to receiving care.

Lack of understanding of mental health and lack of information about outpatient mental healthcare centers within local areas often leads to challenges in terms of receiving proper mental healthcare services that impact treatment of Bhutanese refugees (Gurung et al., 2020; Maleku et al., 2022). Current literature involves understanding mental problems of Bhutanese refugees and finding strategic ways to control them. I aimed to close the research gap in existing literature and answer the research question.

Chapter 3 includes an explanation of qualitative methods along with the descriptive phenomenology approach, research design and rationale, my role as the researcher, methodology for participant selection, instrumentation, procedures for recruitment, interview process, procedures for data collection, issues of trustworthiness, ethical procedures, and a summary of the chapter.

### **Research Design and Rationale**

Qualitative research is used to better understand peoples' perceptions, opinions, experiences, and motivations for behaviors (Bazen et al., 2021). It involves broadly stated questions using 'how' and 'why' questions to produce rich and descriptive data about human experiences and realities with individuals in their natural setting in order to help researchers understand those experiences (Renjith et al., 2021). The qualitative research method was a suitable option for this study to understand Bhutanese refugees' perceptions regarding mental health problems that they experienced involving mental health service delivery in the United States. A phenomenological design was selected in order to meet and fulfill my purpose and implement the plan for the study.

Phenomenology studies involve exploring what individuals experience and focusing on their lived experiences in connection with identified phenomena (Burkholder et al., 2020), which helps in terms of understanding participants experience and meanings of those experiences (Alhazmi & Kaufmann, 2022). Participants can openly talk about different experiences related to the phenomenon of the study. A phenomenological approach was more suitable for analyzing Bhutanese refugees' experiences with mental health services in outpatient mental healthcare centers. Husserl's phenomenological

method was used to capture and describe important aspect of Bhutanese refugees' experiences and understand the experiences they encountered in outpatient mental health care context.

Phenomenological studies involve understanding experiences of people who share common experiences regarding a particular phenomenon (Burkholder et al., 2020). With phenomenological qualitative methods, descriptive attitudes involve what researchers hear, read, and perceive when describing participants' experience, while interpretive attitudes are used to approach data and discover structure and meaning of participants' experiences during the data analysis process (Alhazmi & Kaufmann, 2022). Both forms of phenomenological methodologies were used to understand Bhutanese refugees' experiences with mental health service in outpatient health care delivery in the United States.

Interviews between myself and participants was necessary for data collection, where bias may distort accurate results. Both respondent and researcher biases are highly detrimental, affecting reliability and validity of findings (Florczak, 2022). Bracketing can guide and direct research inquiries to some extent (Alhazmi & Kaufmann, 2022). Husserl (1982) stated phenomenological reduction can liberate researcher biases and assumptions before conducting studies. I used Husserl's phenomenological method, which was useful in terms of studying Bhutanese refugees' experience with mental health services in outpatient mental healthcare settings.

### **Role of the Researcher**

As a researcher, my primary role in this qualitative research was to design the study process, conduct interviews, collect data, and analyze findings among participants (Burkholder et al., 2020). I was responsible for collecting all data using various techniques to record, document, and manage data, including audio recording participants' interviews, note-taking, and transcription or coding notes and sending them to participants to ensure accuracy. Researchers must follow systematic and rigorous approaches to facilitate the data analysis process, which helps strengthen quality and transparency of results (Knott et al., 2022). Researchers are required to use strategies such as reflexivity to ensure validity and reliability of data analysis (Burkholder et al., 2020).

Qualitative studies tend to emphasize interview location should be free from distracting influences (Bjorvik et al., 2023; Burkholder et al., 2020). Researchers must choose appropriate interview locations because they are the fundamental active aspect of the research process (Bjorvik et al., 2023). While conducting interviews with Bhutanese refugees, I adhered to and chose comfortable and distraction-free environments, which helped interviewees feel at ease and comfortable to speak freely. Privacy was another important factor that researchers need to protect and respect participants' rights and dignity. I received approval from the Walden University Institutional Review Board (IRB) to ensure and protect personal information and identity before conducting interviews. Participants were informed about recording of interviews on my cell phone

with an application called NoNotes. I had given more priority to convenient, accessible, and permissible locations and closed-door areas for interview.

For this study, I collaborated with the Bhutanese Community Association of Akron and Greater Akron Hindu Sewa Samittee Inc. to obtain approval to recruit and conduct the study (see Appendix, A). I engaged with a couple of Bhutanese community leader to translate the interview guide, recruitment flyer, and consent form into Nepali and back to English. These individuals did not take part in the study. Moreover, working with community leaders and stakeholders was helpful in terms of promoting community events.

Researchers must consider ethical issues while collecting data (Burkholder et al., 2020). There were no personal or professional relationships between myself and participants that could cause ethical concerns in this study. I bracketed my personal experiences, biases, and perceptions prior to conducting research and throughout the data collection process. Bracketing helps researchers avoid altering participants' responses and analyze phenomena separately from participants (Thomas & Sohn, 2023). I used interview protocols to maintain and support the integrity of research and ensure no threat to reliability. The interview protocol included gathering informed consent forms from participants, arranging interview questions, sharing the interview process in detail, and providing transcripts to participants.

## **Methodology**

### **Participant Selection Logic**

The population of interest for this study were Bhutanese refugee individuals who have lived in Summit County in Ohio for at least a year. Participants aged 18 years or older participated in the study. In addition, they utilized outpatient mental health care services for their mental health-related problems at least once. In this study, 10 participants through the Association of Akron and Greater Akron Hindu Sewa Samittee Inc. were recruited. While recruiting the participants, individuals were asked if they are Bhutanese refugees and if they have previously used outpatient mental health care services. Nepali-speaking Bhutanese refugees who are originally from Bhutan were the target population for this study because interviewing Nepali-speaking Nepalese did not align with the concept of the study.

Convenience sampling, which is the most useful mode for interview-based research, was used in this study. In convenience sampling, a small number of participants can be drawn from a large population. Furthermore, it can be used to collect samples that are conveniently located and available around a location (Stratton, 2021). Research conducted on convenience may not generalize the entire population from which the sample is drawn; however, it can have high internal validity if the findings are trustworthy and the data are properly analyzed (Andrade, 2021). Phenomenology is not about the results in generalizations; it concerns the depth of people's perceptions, and the result lies in their transferability, where a large sample size is not needed to produce insight into the phenomenon (Burkholder et al., 2020). According to Braun and Clarke

(2021), the researcher can gain an in-depth understanding of a phenomenon with a relatively small sample size. Sarfo et al. (2021) suggested that small sample sizes of five to twenty-five participants are adequate for phenomenological studies. Small sample size focuses in understanding individual lived experiences of a phenomenon rather than making generalizations about the general population (Braun & Clarke, 2021; Sarfo et al., 2021).

Using convenience sampling in qualitative research has several advantages, such as no need for a list of all the population elements, little time investment since the sample is readily accessible, and little effort since the researcher is not involved in the complication of utilizing a randomized sample (Simkus, 2023). I posted flyers at the office of each organization with my phone number and name. Interested individuals contacted me through phone calls as well as text messages to get involved in the study. Each participant who completed the interview were provided with a \$ 20 gift card for a total cost of \$ 200.

### **Instrumentation**

Several data collection instruments were used, such as a checklist, digital recorder, cellphone, pen, and notebook. Being fluent in Nepali language, I translated interview questions and participants responses. No google translator or certified Nepali translator was used in the study. A checklist helped ensure everything that is needed in a qualitative interview was ready before conducting an interview in the field. All the interviews were recorded on a digital audio recorder and on a cellphone as a backup recorder. Interviews were scheduled for 45-60 minutes to have enough time to explain the

interview process, conduct an interview, and provide an overview of the collected information. Englander (2020) stated that it is essential to observe and record the behavior of participants because it indicates their feelings about the phenomenon. Behavioral changes, such as sad, happy, or uncomfortable, were observed and recorded in the notebook while participants were telling the story about their experiences.

Semi structured interviews were used for this study. The semi structured interview is a combination of both structured and unstructured interview styles (Ruslin et al., 2022). The researcher used both predetermined as well as unplanned questions while conducting interviews. It allows researchers to acquire more in-depth information from participants in qualitative research (Ruslin et al., 2022). It is more flexible and adaptable and encourages participants to share their stories remaining on the topic and anticipates probes that might be used to explore participants' responses (Burkholder et al., 2020; Ravitch & Carl, 2021; Ruslin et al., 2022). All the interview questions were guided and comprised of two primary research questions.

The list of interview questions that were asked in the interviews were open-ended (Appendix A). In qualitative research, open-ended interview questions are important because they help participants express their perceptions, opinions, beliefs, thoughts, feelings, and experiences in detail. Allowing participants to tell their lived experiences freely and fully without constraints can help the researcher obtain rich and detailed data (Burkholder et al., 2020). Interview questions were focused on Bhutanese refugees' perceptions and experiences with mental health service in outpatient mental health care

settings. Demographic questions were used to make sure that participants are from the target audience.

### **Procedures for Recruitment and Interview Process**

Recruitment was based on research methodology. A proper recruitment plan is necessary to strengthen the trustworthiness and research success in qualitative research (Negrin et al., 2022). Participants were recruited through the Bhutanese Community Association of Akron and the Greater Akron Hindu Sewa Samittee Inc. In collaboration with Bhutanese refugee community leaders, the research recruitment flyers were shared in public places such as bulletin boards and posted in the above-mentioned organizations' lobbies. First, the flyer was developed in English and then translated into Nepali language. Stacks of flyers were printed and made available to each of the organizations, which participants were easily obtaining and take with them.

Participants who were interested in the study could contact me directly through phone calls or text messages to express their interest. During the call, a few questions were asked to make sure that interested participants met screening the inclusion criteria. For interested participants who met the inclusion criteria, I scheduled them for an interview. Before the interview, each participant was provided with a consent form. For participants who were not able to read either Nepali or English, I helped them read the consent in their own language. Once they fully understood the purpose of the study, I told them to sign the form to imply their consent for the study.

Interviews were conducted at the participants residences as per the availability and preferences. The interview room was enclosed to maintain privacy and keep it free

from distracting influences. Conducting interviews in a comfortable and peaceful environment is essential to allow participants to explore perceptions and lived experiences conveniently.

### **Procedures for Data Collection**

In qualitative research, an interview is an essential tool for collecting data. Interviewing is a research method where the researchers talk to those with knowledge or experience on the topic of interest (Dunwoodie et al., 2022; Rubin & Rubin, 2012). I collected data from the participants using the semi structured interviews. Each interview sessions were scheduled for 45-60 minutes; however, each interview did not take more than 30 minutes in average for participants to express their experiences. I spoke in Nepali as per participants choice during the interview to helped simplify and clarify a question. Before starting the interview, each participant was reiterated the importance of consent and confidentiality. Participants were informed that they can stop and leave the interview at any time during the interview if their minds change. Participants were also be informed that their personal information will be kept safely and will not be mentioned anywhere outside of the interview room. After the completion of the interviews, I transcribed and translate, and analyzed the recordings using categories and themes.

### **Issues of Trustworthiness**

#### **Credibility**

Credibility, also known as internal validity, is the researcher's ability to deal with all the complexities and patterns that cannot be easily explained (Rubin & Rubin, 2012). In qualitative research, the researcher must be careful whether the credibility is related to

the research design, instruments, and data (Ahmed, 2024; Rubin & Rubin, 2012). In this study, the alignment of the research problems and other research components, which were the foundation of the study. The credibility of the research represents the honest and transparent report that encountered possible confounders and how they are addressed throughout the study process (Burkholder et al., 2020; Ravitch & Carl, 2021).

Researchers can establish credibility in qualitative research by implementing various strategies such as peer debriefers, triangulation, and external auditors.

### **Transferability**

Transferability, also known as external validity, is the method by which qualitative studies can transfer to a broader context, maintaining context-specific richness (Rubin & Rubin, 2012). It focuses more on sampling factors such as geographical location, number and characteristics of participants, and timeframe of data collection and analysis. Generalizability is not expected in qualitative research, so the transferability of qualitative data assures that study findings are applicable to similar settings or individuals. It can be demonstrated by clear assumptions and contextual inferences of the research setting and participants. In this study, transferability was maintained by providing enough contextual data regarding Bhutanese refugees' experience with receiving services in outpatient mental health care centers and framing for outsiders to be able to contextualize the study's findings fully.

### **Dependability**

In qualitative research, dependability is the stability of the data (Ravitch & Carl, 2021). It describes the reason for choosing a particular research method and whether

methods are relevant to the research questions. Furthermore, dependability explains the challenges the researcher may face in the study and how to proactively address those challenges. To ensure dependability, I reported the research method in detail in such a way that the reader can determine proper research practices that will be followed and enable future researchers to repeat the study. Englander (2020) stated that the researcher must not be careless throughout the study to ensure the dependability of a qualitative study.

### **Confirmability**

Confirmability of qualitative data is confirmed when data are checked thoroughly throughout the data collection and analysis process to ensure results. In other words, it is a foundational premise of qualitative research to ensure that the data and findings are not due to participant and researcher bias (Ahmed, 2024; Rubin & Rubin, 2012). For this reason, the researcher should be careful during interviewing, collecting data, coding, and analyzing processes. Several strategies can be applied for confirmability, such as implementing triangulation, reflexivity processes, and external audits (Ahmed, 2024; Rubin & Rubin, 2012).

### **Ethical Procedures**

In research studies, the researcher's decision is guided by consideration of research ethics in most cases (Burkholder et al., 2020), and it is a continuous process of learning and development in research (Head, 2020). Several ethical procedures must be taken to minimize potential risks that might be encountered in the study, including but not limited to decisions about participant recruitment, instrumentation, data storage, data

analysis, and dissemination. One of the most crucial ethical procedures needed to conduct interviews and collect data was to obtain approval from the Institutional Review Board (IRB) of Walden University. Successful completion of a course called “Human Subjects Protection” through the Collaborative Institutional Training Initiation (CITI) was required to receive the certificate.

The IRB consent form was given to each participant to inform them that their privacy and shared information will be protected. The IRB consent form included all the required information, such as audio or video recorded interviews and how long the interview will last. The participants were informed about the risks and benefits of the study. Also, the participants were made aware of the voluntary nature of the study. In the study, all the participants were Bhutanese refugees, 18 years of age or older, and reside at least one year in the U. S.

The primary focus was not to cause harm to any study participants. The topic’s sensitive nature was disclosed to prepare the participants for the possibility of evoking memories that might cause them to get emotional. Each participant was provided with a consent form with relevant information at the beginning of the interviews. Participants were reminded that they can stop the interview at any time. Participants signed consent form will be collected and kept safely for five years in a file cabinet before destruction. A copy of the consent form was provided to each participant who participated in the study.

### **Member-Checking**

In qualitative research studies, meaningful member-checking, also known as validity, is essential to provide credibility to the data (Lopez-Zeron et al., 2021; McKim,

2023). In member checking, researchers present data transcripts to participants to check for accuracy with their experiences (Lopez-Zeron et al., 2021). Effective member-checking techniques help researchers ensure data accuracy, credibility, and validity by gathering participant feedback (Lopez-Zeron et al., 2021; McKim, 2023). Research must remain vigilant if data are collected from multiple languages with diverse participants to avoid excluding their voices (Lopez-Zeron et al., 2021).

### **Summary**

This chapter included different research method components that are necessary for the study of Bhutanese refugees' experiences receiving services from outpatient mental healthcare centers. I applied a qualitative design, in which a phenomenological approach was used to answer the research question. This approach was used to employ semi structured interviews to collect data. Semi structured interviews are often open-ended and more flexible, allowing participants to talk openly about their different experiences. For the study, I collaborated and partner with Bhutanese refugee community leaders who helped disseminate my study in the Bhutanese community.

Chapter 3 included detailed information about the research method. I detailed the research design and rationale, my role as the researcher, issues of trustworthiness, and ethical procedures to protect identity of participants. Chapter 4 includes the data collection process and research findings and ways to enhance mental health services in outpatient mental health care centers for better mental health outcomes in Bhutanese communities.

## Chapter 4: Results

In this qualitative, phenomenological research study, I addressed Bhutanese refugees' experiences receiving services from outpatient mental healthcare centers. Perceived barriers, perceived severity, perceived benefits, clue to action, and facilitators are reviewed in the context of receiving services. Interviews were conducted with 10 participants over 18 who met study criteria to collect data and understand individual lived experiences in terms of receiving outpatient mental health services. Semi-structured in-person interviews with individual Bhutanese refugees were used for descriptions of their perceptions, thoughts, and feelings for analysis.

RQ1: What are the lived experiences of Bhutanese refugees in receiving services from outpatient mental healthcare centers in the U.S.?

Two subquestions further explore this question. The two sub questions are:

SQ1: What are Bhutanese refugees' perceived barriers to receiving mental health care?

SQ2: What are Bhutanese refugees' perceived facilitators that aide in receiving mental health care?

Chapter 4 begins with a description of the study setting, participants' demographic information and characteristics that were relevant to the study, and data collection and analysis procedures, followed by a discussion of data confidentiality, reliability, and validity of qualitative research. Chapter 4 has included the coding process, themes, overview of data analysis, data findings addressing research questions, and a summary.

### **Setting**

Data collection began after IRB approval notification # 09-23-24-1099081) with an expiration date of September 22, 2025. Participants were provided with options for when and where to conduct interviews. Recruitment of participants was done through the partner organization. Once partner organizations forwarded invitations to volunteers who met inclusion criteria, interested volunteers were contacted through phone calls, texts, and emails. Out of 30 prospective participants, 22 met interview inclusion criteria. Ten participants who responded with specific days and times were interviewed. Twelve participants showed no interest at the last minute, even though interview dates and times were scheduled. As per participants' preferences, in-person interviews were conducted in their own residences in Nepali. In-person interviews led to a deeper understanding of participants' reactions and were relatively easier to observe in terms of behaviors (Lobe et al., 2022). Participants' privacy was maintained while conducting interviews. All participants signed consent forms at the time of interviews. Participants' availability for interviews was 7 days a week because no participants worked or had any jobs; therefore, interviews were completed within 2 weeks. Each interview was audio recorded, and I took field notes. Individual participants were referred to as Participant 1(P1), Participant 2(P2), and so forth to ensure confidentiality.

### **Demographics**

Based on inclusion criteria, 10 participants were selected for interviews. All participants self-identified as Bhutanese refugees living in the midwestern region of the United States for at least a year. Participants were both male and female and 18 or older

and must have received outpatient mental healthcare services currently or in the past (see Table 1).

**Table 1**

*Participant Demographics*

Participants	Location	Number of years live in the U.S.	Gender	Race/Ethnicity	Primary Language	Number of years live in Nepal as refugee.
P1	Akron, OH	12	F	Asian	Nepali	18
P2	Akron, OH	12	M	Asian	Nepali	18
P3	Akron, OH	14	M	Asian	Nepali	16
P4	Cuyahoga falls, OH	10	M	Asian	Nepali	20
P5	Parma, OH	14	F	Asian	Nepali	16
P6	Cuyahoga Falls, OH	13	M	Asian	Nepali	17
P7	Cuyahoga Falls, OH	12	M	Asian	Nepali	18
P8	Akron, OH	13	F	Asian	Nepali	17
P9	Cuyahoga Falls, OH	14	M	Asian	Nepali	16
P10	Akron, OH	12	F	Asian	Nepali	18

**Data Collection**

Flyers were used to invite volunteers to contact me by email or phone to volunteer in the study. The partner organizations assisted in forwarding the invitation on behalf of myself to participate in the study who met inclusion criteria. After the proposal was

approved by the Walden University IRB, prospective participants were contacted through phone calls, text messages, and emails to schedule dates and times as per their availability to conduct interviews. Individual interested participants contacted me directly by telephone to participate in the study. Each individual participant was prescreened to determine whether they met criteria to participate in the study before data collection started.

Participants informed me they were available and felt more comfortable at any time in the day between 9 am and 5 pm. Data were collected from a minimum of one participant to a maximum of two participants each day, depending on location distance from one participant to another. In total, 10 participants were included in the study. The data collection process for this study went from October 15, 2024, through October 27, 2024. All interviews were conducted onsite at participants' residences in different cities within Ohio.

Participants were encouraged to schedule specific days and times when no one overhears or sees responses to ensure confidentiality while discussing sensitive information. Initially, each interview session was planned to be 45 to 60 minutes in length. However, no interviews lasted more than 35 minutes. Interviews were conducted in the Nepali language, as per participant's choice. Semi structured interview questions and additional questions to probe for clarity were asked to participants.

All 10 interviews were recorded using Sony - PX series digital voice recorder. My cell phone was also used to record interviews for backup in case the digital voice recorder stopped recording. Once each interview was completed, files were saved on laptops and I

played interviews for each participant to review. Replaying recorded interviews led to participants the opportunity to review accuracy of their shared information. Most participants added additional information they did not or forgot to answer in recording sessions. All additional information was noted in the notebook. After completing the reviewing process, all participants were informed they could add or delete information within a week if they thought or felt information, they provided was not accurate. Also, I thanked each participant for their participation and provided a \$20 gift card for their time. My phone number and/or email were given to each participant to perform member check follow-up calls to ensure accuracy of collected data.

### **Data Analysis**

Data was collected from a semi structured audio interview with ten Bhutanese refugees who met the criteria for the study. All the participants were asked the same scripted open-ended interview questions. Some additional follow-up prompt questions were asked to participants to allow them to express their lived experiences and perspectives in receiving outpatient mental healthcare services within their locality. Throughout the process, confidentiality was maintained by following the IRB-approved format. Data analysis included reviewing demographic information, audio recordings, and transcription several times.

Initially, the interviews were transcribed and translated from Nepali into English into a Word document. NVivo, Microsoft Word, and Excel were used to organize, transcribe, and code the data. The interview transcripts and journal notes were read and re-read several times to review the participants' responses and gain a better understanding

of their experiences with outpatient mental health services. Each audio-recorded interview was listened to multiple times to ensure there was no mistranscription or translation of participants' responses. Some corrections in the transcription were made where necessary when the translation was not clear or accurate.

Codes were developed by identifying and extracting from common words and phrases that arose during the interview. The common words and phrases mentioned repeatedly were interaction inability and family members assistance. Table 2 shows common codes shared from each participant's experience. Several codes reoccurred throughout most of the interviews which indicated saturation of the study was met.

**Table 2**

*Codes from Participants*

Codes	Number of Participants that Mentioned Experienced Code
Appointment scheduling difficulties	7
Appointment cancellation	7
ineffective check-in process/follow up	6
Delay to receive services	7
Long wait in healthcare centers	7
Limited mental health resources	5
Difficulties in interaction	5
Interaction inability	10
Lack of trust with providers	6
Patient-provider relationship	7

Lack of friendliness or openness	5
Overwhelm sharing mental health concerns	6
Misunderstanding with providers	7
Misinformation	4
Unclear instruction	3
Difficult in sharing thoughts and concerns	3
Need yoga and other activities	5
Need mental health awareness program	3
Family members assistance	10
Relatives' assistance	7
Community leaders' assistance	4
Phone interpreter	7
Nepali speaking provider and/or social workers assistance	4

The codes were modified and structured based on the significant statement made during the interview. Themes were developed from the codes based on the data that provided meaningful insights related to the research question for understanding the phenomenon being studied. Data saturation was achieved by collecting data from ten participants, which provided enough information where no new insights or significance was needed for the data analysis process. Table 3 represents a clear picture of codes, categories, and themes of how a researcher can visualize the data. No discrepant data was identified in the study, and participants' responses were relevant to the study's research question.

**Table 3**

*Codes, Categories, and Themes*

Themes	Categories	Codes
Complex scheduling system challenge in receiving services on timely basis	<p>Most common challenges in receiving appropriate services</p> <p>Disruption refugees in continuity of care and treatment</p>	<p>Appointment scheduling</p> <p>Reduce access to timely appointments</p> <p>Check-in process</p> <p>Proactive follow-up</p>
Unavailability and limited access to providers delays in receiving mental services	<p>Impacts on refugees' care and treatment</p> <p>Limited mental healthcare resources</p>	<p>Delay</p> <p>Long wait</p> <p>Provider shortage</p> <p>Limited healthcare centers</p> <p>Appointment cancellation</p>
Poor interconnection between providers and refugees reduces treatment adherence	<p>Impact on accessing necessary care and treatment</p> <p>Reduce refugees' engagement in their own mental healthcare decision</p>	<p>Lack of trust</p> <p>Patient-provider relationship</p> <p>Interaction ability/difficulties</p> <p>Lack of friendliness or openness</p> <p>Overwhelmed sharing mental health concerns</p>
Communication gap with providers impedes refugees in receiving necessary services	<p>Hinder the ability in expressing problems and concerns openly</p> <p>Create barriers to understand treatment plans</p>	<p>Misunderstanding</p> <p>Misinformation</p> <p>Unclear instruction</p> <p>Difficult in sharing mental health issues and concerns</p>
Lack of culturally responsive services and awareness programs reduce quality services	<p>Tailor care based on individual's cultural context</p> <p>Factors to promote quality of services</p>	<p>Yoga and/or spiritual program/</p> <p>Culturally related program</p> <p>Mental health awareness programs</p>

The importance of patient advocates to bridge aforementioned barriers	Provide general information about mental health	Family members Relatives Community leaders Phone interpreter
	Guide and support in receiving services	Nepali speaking social workers
	Assist in translating and expressing mental health concerns	

After completing the coding process six overarching themes were identified as shown in table 4.

**Table 4**

*Six Overarching Themes*

Complex scheduling system challenge in receiving services on a timely basis	Unavailability and access to providers delays in receiving mental health services	Poor interconnection between providers and refugees reduces treatment adherences
Communication gap between providers and refugees impedes in receiving necessary services	Lack of culturally sensitive care and awareness programs reduce quality services	The importance of patient advocates to bridge aforementioned barriers

In qualitative analysis, coding attributes meaning to collected data that would be used later for the purpose of categorization, theme, and other analytic processes (Saldana, 2021). The themes will be discussed further in the results section. The coding process requires evidence of trustworthiness, credibility, and dependability.

### **Evidence of Trustworthiness**

In qualitative research studies, trustworthiness reflects the concept of truth, which necessitates different approaches to support and promote valid findings related to the design of the study (Burkholder et al., 2020). Trustworthiness in qualitative research studies consists of four major components: credibility, dependability, transferability, and confirmability (Ahmed, 2024). In this study, the following constructs describe approaches and measures used to achieve the evidence of trustworthiness.

#### **Credibility**

In a qualitative study, credibility can be achieved by accurately capturing the reality of the participants' experiences and perspectives that reflect the true value of the research data (Burkholder et al., 2020; Ravitch & Carl, 2021). In this study, in-person interviews were conducted to collect data that helped to achieve credibility in the findings. In-person interviews can help the researchers gain a deep understanding of the participant's experiences and perspectives through building rapport and observing body language, such as facial expressions and mirroring (Burkholder et al., 2020). Observation of nonverbal gestures helped me gain greater insight into participants' responses and experiences. During the data collection process, I spent a considerable amount of time with each participant. The participants were encouraged to elaborate on their responses during the interview to gain clarity when the responses were unclear. Repeating responses has helped me to better understand participants' lived experiences and perspectives and ensured the researcher understood their responses. After the completion of each interview, the recorded interview was played for each participant to review.

Feedback was received to validate the collected data further. The participants added some more information about their experiences, which they did not mention during the recording. The participants shared their personal experiences and explained in detail when asked. Every detail shared by participants was recorded and noted for a deeper understanding of their experiences.

### **Dependability**

In a qualitative study, dependability refers to the “stability of the data” (Ravitch & Carl, 2021). To achieve dependability in this study, inclusion criteria were rigorously taken into consideration to ensure that the raw data of the findings have a reasoned argument. In the study, I became careful that the responses provided by the participants were based on the questions asked. While conducting interviews, the participants were asked questions clearly and concisely to ensure they understood the questions very well, which helped them to elaborate on their experiences and perspectives based on the question. The dependability of this study was achieved through detailed documentation, such as recruitment flyers, an open-ended interview guide, and a consent form. Rigorous consideration was taken in the data collection and data analysis processes to ensure the dependability of the study.

### **Transferability**

Transferability is a form of external validity that is used to ensure whether a set of findings from one study can be applied appropriately to another particular situation (Burkholder et al., 2020; Maxwell, 2021). The phenomenological research conducted in this study with Bhutanese refugees who have been receiving services from outpatient

mental healthcare centers in Summit County, Ohio, is likely to be transferable if conducted at other locations with refugees coming from other countries. With regard to transferability, a sufficient and thorough description of the data was provided so that future researchers can make an informed application of the study's findings and judge what does or does not apply to other scenarios. The research context and participants' characteristics were carefully documented, which can enable other researchers to determine to what extent the findings can help them predict values regarding the experiences and perceptions of refugees in other contexts.

### **Confirmability**

Qualitative research may have included biases and prejudices that could distort the findings (Ravitch & Carl, 2021). Confirmability is necessary to verify that no biases or prejudices are involved in the study and ensure that the data and results are validated. In the study, more concentration and caution were taken during the interview, data collection, coding, and analysis stages. Focusing on the researcher's objectivity ensures other readers that the findings are not derived from the researcher's opinion but from the collected data (Burkholder et al., 2020; Ravitch & Carl, 2021). The direct quotes spoken by participants were kept in the reflective journal, and the audit trail was used to prevent personal biases. All these above measures and procedures allowed me to bracket and, support and promote the valid findings related to the design of the study.

### **Results**

The central research question that guided the study was: What are the lived experiences of Bhutanese refugees in receiving services from outpatient mental

healthcare centers in the United States? The central question was divided into two sub questions to better understand the participants' perspectives, opinions, thoughts, beliefs, feelings, and observations that they experienced while receiving services. Two sub questions further explore the main question. The two sub questions were: "What are Bhutanese refugees' perceived barriers to receiving mental health care?" And "What are Bhutanese refugees' perceived facilitators that aide in receiving mental health care?"

Data analysis for these research questions generated six overarching themes. (1) Complex scheduling system challenge in receiving services on a timely basis, (2) Unavailability and access to providers delays in receiving mental health services, (3) Poor interconnection between providers and refugees reduces treatment adherence, (4) Communication gap between providers and refugees impedes in receiving necessary services, (5) Lack of culturally sensitive care and awareness programs reduce quality services, and (6) The importance of patient advocates to bridge aforementioned barriers. Out of six themes, five themes, one to five represent the response of sub-question 1, while theme 6 represents the response of sub-question 2 of the central research question. All these six themes were guided by the research questions, and the results were developed by the theme below.

**Theme1: Complex Scheduling System Challenges Involving Receiving Services on a Timely Basis**

Theme one described the participants' experiences regarding the convenient arrangement for check-ins, follow-ups, and other appointments to receive service on a timely basis. Participants discussed their experiences and expressed concern about some

of the challenges they encountered while scheduling to visit their outpatient mental health providers. Out of ten, seven participants expressed they do not get immediate appointments with providers they regularly visit. Participants' statements are as follows

P1 stated: "I cannot schedule myself. So, I need someone to assist me in rescheduling. When my appointment is canceled, it is quite a challenge for me to reschedule again."

Participant P3 stated: Several months ago, I was not feeling well; I told my son to make an appointment for me."

P4 said: "Scheduling appointments is quite challenging for me. I need assistance. I have to depend totally on someone. I have to depend on my children to schedule appointments, and they remind me when my appointment is."

P5 stated: "Here in the U.S., I cannot visit providers whenever I like to. It is different from Bhutan and refugee camps in Nepal. It's so complex. I have been in the U.S. for more than 10 years. But I still do not know when and how to schedule an appointment whenever I need to."

P6 stated: "Sometimes I do not remember, and also, do not understand when my appointment is."

Participant P7 said: "My sons and daughters help me schedule hospital appointments for me."

P10 stated: "It is difficult getting an appointment with desired specialists. Sometimes, I felt I might not get treatment as I wanted."

Participants stated that not accommodating their requests by providers impacted check-ups and follow-ups, which brought concerns of frustration and disappointment. Six of the participants expressed complex scheduling led to difficulties in the check-in process and proactive follow-up with providers, which adversely affected receiving services for their mental health problems. The following were actual responses:

P3 stated: "For me, complex scheduling affected me for immediate health check-ups and follow-up with mental health providers when needed."

P4 mentioned: "I missed my appointment, and I did not get a treatment. It's not my fault; they (the providers) had to understand me. I would not allow seeing a provider and having a check-up. I suffered a lot."

P5 stated: "When I visit providers on time, sometimes they call in for a check-up sooner, and sometimes I have to wait more than an hour. I do not know how these happen."

P6 stated: "Why do providers not call patients a week prior or after a week once they cancel an appointment? It's ridiculous."

P7 said: "Sometimes I am frustrated and worry if I cannot get an appointment on time, it has impacted my treatment."

P9 stated: "When I went to visit my doctor, I was informed my appointment was canceled. During those times, I felt bad. But this does not happen all the time, only sometimes. It happened to me once or twice in several years."

## **Theme 2: Unavailability and Limited Access to Providers Delays in Receiving Mental Health Services.**

Participants described their perceptions and experiences regarding the availability and access to mental healthcare providers within their community. Seven participants explained that availability and access to providers make a significant difference in receiving services on a timely basis. They reported that they had to wait more than 30 minutes or even longer before being seen by their providers at an outpatient mental healthcare center. Participants expressed long waiting is stressful and potentially delays necessary care and treatment. Each participant's response is noted below:

P1 stated: "The healthcare center called me several days ago and informed me that the doctor would not be available on my appointment day and told me to reschedule. Why do healthcare centers cancel appointments? Why do they not take it seriously?"

P3 said: "Here in the U.S., I need an appointment to visit doctors. I do not get an appointment whenever I need."

P5 said: "I do not know why doctor appointments take so long? Sometimes I have to wait a long time in the doctor's office for a check-up, and sometimes they done faster."

P6 stated: "I have difficulties reaching to my providers and miss the appointment."

P2 stated: "I cannot go to the healthcare centers by myself; I need someone to take me to my appointments. Sometimes, I have to wait a longer time than expected. If I get proper treatment, it would be worth it for me to wait a long time. But sometimes, if it did not work, I was disappointed. I am worried about my health."

P8 stated: "Several times, I had to wait for more than 30-40 minutes to see the providers even when I reached out to the healthcare center on time. I feel bored and frustrated waiting too long."

P9 said: "I have been seen by one of the doctors. In case he is absent, my appointment gets canceled."

Five participants mentioned that limited healthcare centers and a shortage of mental healthcare providers contribute to delays and challenges in receiving proper services for them on time. They expressed it is difficult to get services with limited resources, which affects their treatment and ultimately deteriorates their overall health outcomes. Some of the statements from the respondents are as follows:

P1 stated: "I think availability and convenient access to providers is good for better treatment to me. A couple of times, several years ago, my appointments were canceled."

P7 stated: "If providers do not have enough time to check up patients, they should refer patients to other healthcare centers."

P9 said: "I do not think there are several outpatient mental healthcare centers in this area. I have been seen by one of the providers. In my area, it is a challenge to find mental healthcare providers. I plan to change my healthcare center so that a new provider may provide better services as needed. I am bored going to the same healthcare center repeatedly and taking the same medication."

P3 stated: "Providers might be busy or have few providers in mental healthcare centers, so it is challenging to get timely services."

P5 said: "Some say there are few numbers of mental healthcare providers. Is that right? I do not understand."

### **Theme 3: Poor Interconnection Between Providers and Refugees Which Reduces Treatment Adherence**

One of the significant factors that might help outpatient mental health care providers to provide necessary services is good interconnection with patients. Without a good connection between providers and patients, neither providers can offer better services, nor can patients receive the services they need. All ten participants described their interaction difficulties with mental health providers that impact receiving necessary services for their mental health care and treatment. Each participant's statements are listed below:

P1 said: "I feel discomfort in telling my story in detail."

P2 said: "I know there should be a good relationship between provider and patient to receive better services. But I do not have any way to connect with the provider."

P3 stated: "From the provider's side, they try to provide me comfortable and excellent care. But still, I feel we do not have a mutual understanding, which might impact my services."

P4 said: "I do not know where to go and whom to contact."

P5 stated: "Well, I do not know anything, but my children interact with my providers whenever necessary."

P6 said: "I do not have interaction ability."

P7 stated: "It is challenging to interact with providers. I think a good relationship with providers could also enhance the diagnosis and treatment process."

P8 stated: "I came from a different country, different culture, different background. All these factors make it difficult for me to deal with providers."

P9 stated: "I think I need to seek assistance from someone who can help me. Otherwise, my illness would not be cured."

P10 said: "I hope in the coming day; I can have better interaction with the provider so that I can share my concerns in better ways."

Five participants stated they do not have trust in their mental health providers. They believed their providers did not prescribe medication and provide care and treatment as they needed. Each participant's responses are noted below:

P1 stated: "Maybe I am from different social and cultural background, and it might be challenging to build a trustful relationship with my providers. I do not know, but I feel it might impact the ability to receive services as needed."

P2 said: "I think it would be better if providers could understand what I need. I also need to understand them; otherwise, no good relation exists."

P5 said: "I trust my children's decision, and they manage whatever I need. However, I do not have direct interaction with any providers."

P8 said: "I cannot share my opinions, thoughts, and views with my providers."

P10 stated: "I think providers need to understand patients so that patients can trust and express what they want to share with providers."

There should be a good relationship between patients and mental healthcare providers to build trust where providers can provide services, and patients can receive necessary services. Four participants did not feel there was a good relationship with their providers. As a result, participants said they did not receive services as expected.

Statements are as follows:

P2 stated: "Until now, I have not been able to build good relationships with my providers. It's ridiculous."

P4 stated: "I do not feel I have a good relationship with my providers."

P7 stated: "I think a good relationship with providers could also enhance the diagnosis and treatment process."

P9 stated: "I do not have a good relationship with my provider. Many times, I told my provider to change my medication, but he still did not change. My medication works only sometimes. I need better medication."

Five participants felt a sense of detachment from what was going on in mental healthcare treatment and available mental healthcare services provided within their community. Thus, the hardship of connecting with providers and utilizing available resources became a challenge to them. Quotations are as follows:

P2 stated: "When I feel sick and when I need to ask medication-related concerns or questions, there is no way to contact providers."

P4 stated: "I do not know where to go and whom to contact."

P5 stated: "I am worried and feel lonely when I cannot do anything by myself without others' assistance."

P7 stated: "When I have any concerns or health issues, I should directly contact my providers. But I could not; that made me frustrated and worried."

P8 stated: "I think not being connected with providers could impact decision-making, which is very important for providing as well as receiving necessary services."

#### **Theme 4: The Communication Gap with Providers Impeding Refugees from Receiving Necessary Services**

Most participants described the communication gap with their outpatient mental healthcare providers as a significant factor impacting receiving appropriate services. Participants explained that it is challenging to communicate and share their mental health issues and concerns with their providers because of the language differences. Eight participants responded communication gap led to misunderstanding, which they believed it yield to failure in obtaining a proper service from outpatient mental healthcare centers. Participants responses are as follows:

P2 stated: "I speak Nepali, and my providers speak English. So, I have difficulty communicating with my provider. I am worried about miscommunication or failure to communicate with my providers."

P3 stated: "I have tried to talk with my providers a couple of times but ended up with miscommunication and misunderstanding. It's challenging."

P4 stated: "If I could communicate with my healthcare providers, I would not have to encounter difficulties like misunderstanding."

P5 mentioned: "I heard some people got mistreated because of misunderstanding with the provider. I worry and feel lonely when I cannot do anything alone without others' assistance."

P6 said: "I cannot communicate with my healthcare providers because I do not understand English well. But when someone speaks for me, I am not 100 percent sure if I communicate myself to providers. There could also be misunderstandings with others."

P8 stated: "If there is a misunderstanding between provider and patient, how can I be ensured I am getting the right services?"

P9 stated: "When I do not understand what my providers say, I feel frustrated, helpless, and annoyed. I tried to speak myself with providers, but I am worried of misunderstanding that could lead to mistreatment."

P10 stated: "Once I reached one of the healthcare centers, but it was difficult to reach the specific provider; I tried to ask one of the receptionists at the front desk. She did not understand me, and I didn't understand what she said. So, I was so frustrated."

Four participants described that misinformation due to poor communication with outpatient mental health providers resulted in incorrect medication, missed follow-up, and misdiagnoses. Responses are noted below:

P3 said: "Nepali interpreters are provided in mental healthcare centers, I think, sometimes I get wrong information. If I speak and understand English well, I do not have to encounter any challenges while interacting with health providers."

P4 stated: "Failure to communicate with providers also leads to misinformation."

P7 mentioned: "Several times I have missed my appointments due to misinformation. I think it has impacted my care and treatment procedure."

P8 stated: "Sometimes providers prescribe different medication than what I wanted. Maybe it is due to misinformation between providers and patients, but I don't know."

Four participants described that failure to communicate with the provider properly deterred them from understanding clear instructions about mental health conditions and treatment options. Participants' statements are noted below:

P1 said: "I am illiterate. It is challenging for me to follow all the instructions given by providers. Like which medication to take, what to do and when to refill medication, when to go for follow up and such."

P4 stated: "I have been receiving services from outpatient mental healthcare centers. However, I expect better communication to lead to a better understanding of follow-up instruction and easier-to-understand health information."

P5 said: "I do not know why those medications do not work for me. Maybe I am not following the proper instructions for taking medication or taking it incorrectly. I do not understand medical terminology and instructions given by my providers. I am worried about my health."

P8 mentioned: "Mental health providers provide mental health information and instructions. But it is difficult to understand all the information and instructions. Otherwise, my health would be better than now."

Five participants described they experienced difficulty in sharing mental health issues and concerns with their providers because of the failure to communicate with mental health providers. Quotation as follows:

P3 stated: "Language barrier makes it difficult to communicate with my providers and express my feelings."

P6 stated: "See, you and I communicate confidently, right? It's not like that when I have to communicate with my providers. If I could communicate with healthcare providers, I could discuss whatever I want and get better services than what I am getting currently."

P7 stated: "If I have any concerns or health issues, I would directly contact my providers. But I could not; that made me frustrated and worried."

P9 stated: "There are several concerns and health issues that I want to discuss with my providers openly. For that, I should talk openly, and if I discuss using a translator, my privacy will be disclosed. It seems impossible for me."

P10 stated: "I want every healthcare center should have at least one Nepali-speaking provider so that people like me can easily reach that provider and express what is needed."

### **Theme 5: Lack of Culturally Responsive Services and Awareness Programs Effects on Refugees**

Several participants mentioned that there is no culturally sensitive care services are included in outpatient mental healthcare centers in the midwestern region of the U.S. Participants said due to lack of culturally sensitive programs, outpatient mental healthcare

centers do not actively incorporate and respect their beliefs, norms, and values that can help tailoring better mental health treatment approaches. Six participants stated that culturally sensitive care can reduce the stigma associated with mental health, improve access to care, and enhance treatment outcomes. In addition, it could enhance the effectiveness of services in outpatient mental healthcare centers. Participants statement are as follows:

P1 stated: "I do not think culturally sensitive care is available currently. People like me who have faith on my cultural values and traditions need such services that can help free from mental stress."

P3 stated: "I need some culturally based care and treatment because I believe in my traditions and customs that my ancestors have followed for a long time."

P5 stated: "I feel weak nowadays even though I take medication every day. I think traditional ways of treatment would be better for me."

P6 stated: "If mental health providers can understand my background, where I came from, what is my cultural context? I think it would be convenient for health providers to provide necessary services based on cultural context. I think the way of thinking also varies depending on beliefs and traditions."

P7 stated: "If outpatient mental health centers can adopt some of the traditional ways of treatment, I would be happy. I practice yoga at home and it helps me better than medication from healthcare centers."

P10 stated: "I have my own beliefs, values, communicating styles, and many more. Health providers should understand the cultural nuances of patient population. So

that they can provide according to patients' needs, and patients like me can also receive better quality services."

Three participants described that culturally sensitive practices in outpatient mental healthcare centers can help address their unique needs. They thought that a culturally based awareness program could help them engage and reduce the stigma associated with mental health issues and concerns. Participants stated mental healthcare services provided to them from outpatient mental healthcare centers did not align with cultural beliefs and practices. The responses are below:

P2 stated: "Here, most of the time, I have to stay inside home. I think it make me sicker. I want healthcare centers to organize some Nepali cultural programs, yoga classes, and spiritual practices where I can be engaged. It would help me free from loneliness, frustration, and anxiety."

P3 stated: "I think if outpatient mental healthcare centers include stress management and psychotherapy programs based on health problems, it would be better. The cultural program could help people like me and me to engage. If it is not possible daily, at least twice a month."

P7 stated: "Health centers can include yoga and mental health awareness programs for people like me."

P10 stated: "Outpatient mental healthcare centers should organize some culturally sensitive care related mental health programs that help to understand the need of refugees better and facilitate access to care and treatment."

**Theme 6: The Importance of Patient Advocates to Bridge Aforementioned Barriers**

Most participants depend on family members, relatives, community leaders, phone interpreters, and Nepali-speaking social workers to receive mental health services provided in mental healthcare centers in their community. These facilitators provide guidance and support for refugees in various ways, such as navigating to mental healthcare centers, facilitating communication between refugees and mental healthcare providers, and connecting with appropriate mental health resources available within their community. All ten participants described family members as a voice for them to connect to mental healthcare centers and relevant health resources when necessary. Seven participants stated that along with the family members, relatives also assisted them in facilitating the provision of mental health services. Four participants stated that family members, relatives, community leaders, Nepali-speaking social workers, and volunteers help them to guide, support, and connect with mental health resources. Each participant's statements are noted below:

P1 stated: "My children and relatives assist me. Whenever I go to outpatient mental healthcare centers, I go with someone from within my family member."

P2 stated: "I discuss with my family, my relatives, and some of the community leaders who know about the mental health services provided in this area."

P3 stated: "With my children and relative. Sometimes, I talk to community leaders who also help me with what to do and where to go regarding mental health concerns and health issues."

P4 stated: "I have conversations with my family and relatives daily. I have connections with some of the community leaders."

P5 stated: "Most of the time, I communicate with my son and daughter-in-law. Sometimes, I communicate with my daughters. Sometimes, relatives come to my house, and I communicate with them. All these people help me to understand mental health services, and also, they encourage me to get treatment."

P6 stated: "I am lucky to have sons, daughters, daughters-in-law, son-in-law, and relatives. Everyone is near to my house. Whenever I do not feel well, they come to my house. I tell them what happened to me. They take me to healthcare centers where I get proper treatment."

P7 stated: "Families, friends, relatives, community leaders, and health providers. I am illiterate, so I have to depend on those people. I communicate in Nepali with my family, friends, and relatives."

P8 stated: "with my family members, relatives, and some of the people from the Bhutanese community. Without their help, it would be impossible for me to get medication and treatment."

P9 stated: "Who else do I communicate with? I communicate with my family members and someone whom I knew."

P10 stated: "I communicate with my family members and some relatives."

The majority of the participants encountered challenges in receiving mental healthcare services using virtual or phone interpreters as a medium to communicate with their providers. Eight participants revealed that most outpatient mental healthcare centers

provided phone interpreters while communicating with their health providers. However, they were not satisfied with the phone interpreter and did not fully trust them. They encountered confusion, unclear translations, and worried about mistranslations and misconstrue. Some participants preferred an in-person interpreter rather than a phone interpreter. Participants were anxious and concerned that improper translation could impact their ability to receive the appropriate services they needed. Participants responses are given below:

P1 stated: "Healthcare centers provide phone interpreters; it is difficult to understand via phone call. It isn't easy to hear what the phone interpreter says. I think it would help a lot if healthcare centers had in-person interpreters. Several years ago, I was provided with a phone interpreter, but it was unclear; it confused me."

P2 mentioned: "Phone interpreters tell me to use short phrases, so how can I share my concerns using short phrases? It will take a long time, and I forget what I plan to say by pausing and continuing again."

P5 stated: "There are chances of misinterpretation, and if it happens, the consequences will be destructive."

P6 said: "It is difficult to understand a phone interpreter; I want an in-person interpreter so that I can understand clearly."

P7 stated: "When I communicate with providers, I need an interpreter. Sometimes, my children help me to interpret; sometimes, phone interpreters help me. But I prefer my children to translate. I do not trust much on phone interpreter."

P8 said: "I do not believe translation is done correctly. I feel that mistranslation and misconstrue can impact receiving proper treatment. Sometimes providers prescribe me different medication than what I wanted."

P9 stated: "Most of the time, a phone interpreter assists me in communication with providers. However, I feel uncomfortable. There are several concerns and health issues that I want to discuss with my providers openly. For that, I should talk openly, and if I discuss using a translator, my privacy will be disclosed."

P10 stated: "Phone interpreters are provided only during the time of check-up. I am not satisfied with that only."

### **Summary**

This qualitative, phenomenological study involved to understanding lived experiences of Bhutanese refugees receiving services from outpatient mental healthcare centers within the Midwestern region of the United States. I focused on Bhutanese refugees' perceived barriers to receiving mental health care and perceived facilitators that aid in receiving mental health care. Analysis of interview data collected from the 10 participants yielded the six themes. Bhutanese refugees experienced challenges involving scheduling on a timely basis and access to specific providers whenever needed. Participants stated it was difficult to interact and communicate with providers. Even when outpatient mental health providers provided phone interpreter services, participants did not feel virtual interpreter services worked perfectly for them. Most Bhutanese refugees want culturally sensitive care based on their cultural backgrounds and beliefs

when providing treatment. Bhutanese refugees perceived these factors as barriers to receiving quality care.

In Chapter 5, interpretations of findings were presented. I also discussed limitations of the study, recommendations, and implications for positive social change, and overall significance of the study.

## Chapter 5: Discussion, Conclusions, and Recommendations

In this phenomenological qualitative study, a gap in literature was addressed regarding lived experiences of Bhutanese refugees in the context of receiving services from outpatient mental healthcare centers in the midwestern region of the United States. The problem was many Bhutanese refugees often encounter challenges in terms of obtaining necessary mental healthcare services within their communities. With the aim of gaining a deeper understanding of the problem, invitations via phone calls, text messages, and email were sent to Bhutanese refugees in the midwestern region, particularly Ohio, where a higher number of refugee populations resettled. Ten individuals who met study criteria participated in interviews with their consent. All individuals were interviewed using preplanned interview questions. These 10 individuals described and shared their experiences in terms of receiving services from outpatient mental healthcare centers and how it impacted their overall mental health outcomes.

Six main themes emerged through these interviews: complex scheduling system challenge in terms of receiving services on timely basis, unavailability and access to providers delays, poor interconnection between providers and refugees which reduces treatment adherence, communication gap between providers and refugees which impedes receiving necessary services, lack of culturally-sensitive care and awareness programs which reduce quality services, and the importance of patient advocates to bridge aforementioned barriers. These themes are discussed in detail in this chapter in the context of current peer-reviewed literature which was described in Chapter 2. In this

chapter, interpretations of findings, limitations of the study, recommendations, and implications are presented, followed by a conclusion.

### **Interpretation of the Findings**

Findings include six main themes that emerged from this research. Each of these themes was necessary to answering how Bhutanese refugees perceived barriers they encountered and how they perceived facilitators' aid in terms of receiving appropriate services from outpatient mental healthcare centers. Considering the HBM as a conceptual framework, I revealed these six elements come into play in terms of Bhutanese refugees' perceived barriers and facilitators which aid in obtaining mental health services.

#### **Complex Scheduling System Challenges in Terms of Receiving Services on a Timely Basis**

Findings showed Bhutanese refugees encountered several difficulties in terms of scheduling appointments for receiving mental healthcare services from outpatient mental healthcare centers. Bhutanese refugees in the United States. are first-generation immigrants. Most asylums and refugees do not have a clue what hospital or healthcare centers provide specific mental healthcare services (van der Boor & White, 2020). After resettling in the United States, Bhutanese refugees have to adopt new appointment scheduling systems to receive mental health services, which they were unfamiliar with while they were in refugee camps in Nepal and their home country in Bhutan (Soukenik et al., 2022).

MacDowell et al. (2020) stated Bhutanese refugees often encounter challenges that prevent them from receiving care due to seeking mental health services that are not

perceived as normal in their country of origin. Many Bhutanese refugees often consider U.S. healthcare systems to be logistically complex and difficult to access (Soukenik et al., 2022). Lack of availability and accessibility of mental health services within Bhutanese communities added complexity to scheduling appointments to receive services on a timely basis. Two categories were revealed in the complex scheduling system: most common challenges in receiving appropriate services and disruptions in continuity of care and treatment.

### **Most Common Challenges in Receiving Appropriate Services**

Results showed many participants reported unfamiliarity with the healthcare system deterred them from obtaining appropriate services. One of the significant barriers Bhutanese refugees perceived was complicated scheduling appointments in the United States, which hinders refugees from visiting providers whenever needed. During this study, participants revealed they had to depend on family members or someone from within communities to schedule appointments to visit providers. Westernized approaches to mental health care limit Bhutanese refugees in terms of receiving and use of necessary services (Maleku et al., 2022).

Most refugees do not understand formal health care systems of host countries, which limits access to services. Complexities of the healthcare system cause challenges to refugees in terms of accessing services and lower use of appropriate services (Byrow et al., 2020). There is a pressing need for comprehensive efforts to meet Bhutanese refugees' unique needs for appropriate mental health services from outpatient mental healthcare centers to improve their long-term mental health outcomes. Through

developing appropriate strategies or education materials and programs targeting refugee populations, mental health providers need to address those challenges experienced by Bhutanese refugees.

### **Disruptions in Continuity of Care and Treatment**

Findings of the study showed unfamiliar or complicated scheduling systems impeded Bhutanese refugees from continuity of care and treatment on a timely basis. In order to receive desired mental healthcare services regularly and on a timely basis, patients must maintain consistent appointment schedules. Many Bhutanese refugees failed to schedule appointments on time or missed scheduled appointments. Bhutanese refugees often perceive healthcare systems as complex, and they do not know how to make contact or schedule appropriate services (Soukenik et al., 2022; van der Boor & White, 2020), which contributes to disruptions in continuity of care and treatment for them.

Furthermore, results showed there is a need to provide customized services to meet specific needs of refugees in terms of scheduling appointments more conveniently. Use of healthcare depends on healthcare systems and structure in the United States (Soukenik et al., 2022). Complex healthcare systems and structure impact refugees in term of receiving and using mental health services. Proper scheduling systems may not only help mental health patients enhance continuity of care and treatment on time but also help mental health providers efficiently use available resources for needy patients and maximize patient visits within a given timeframe.

### **Unavailability and Limited Access to Providers Delays in Receiving Services**

Findings of this study showed unavailability and limited access to providers are challenging for Bhutanese refugees living in the midwestern region of the United States. Mental health services are highly specialized; they often have waiting lists and rely on providers who want services (Bunn et al., 2023). Some participants said due to lack of mental healthcare providers within local communities, they often waited longer times and were sometimes forced to travel long distances for mental healthcare and treatment. Limited resources make referrals difficult to address mental health conditions in refugees (Bunn et al., 2023). Unavailability and limited access to provider delays in terms of receiving mental health services were developed from two categories: Limited mental healthcare resources and impacts on refugees' care and treatment.

### **Limited Mental Healthcare Resources**

Use of mental health services is low among Bhutanese refugees compared to the general population in the United States (Maleku et al., 2022). Most participants revealed there are limited mental healthcare resources in areas where they can easily access them. Study findings showed most Bhutanese refugees are likely to seek help from mental healthcare resources. Some participants reported there were limited mental healthcare resources in their communities, and some were unaware of the availability of resources, while some encountered challenges in terms of accessing these resources.

Results showed that a limited number of mental healthcare providers in their community is also one of the hindrances Bhutanese refugees encountered to receiving better mental health services they needed. Limited mental healthcare resources can

reinforce the stigma associated with mental health issues that can lead to mental health patients' negative perceptions towards seeking mental health services (Ahad et al., 2023). Many Bhutanese refugees wanted to change their providers so that they could access them more conveniently. However, it was difficult for them to seek and find providers due to limited providers.

### **Impacts on Refugees' Care and Treatment**

Findings showed concerns surrounding the negative impact on refugees' care and treatment. Bhutanese refugees were worried and frustrated, knowing their appointment was canceled and needed to be rescheduled. Moreover, limited mental healthcare centers and providers shortage causes longer waiting times or follow-up appointments for refugees. This can lead to delays in the diagnosis and treatment of patients, which can worsen their health condition. When refugees need increasing efforts to screen and identify mental health conditions, it is challenging to get immediate referrals due to resource limitations in available services (Magwood et al., 2022). In some cases, refugee mental health patients were forced to visit the emergency room (ER). However, it might be challenging to receive the same care and treatment from the ER as they receive from their regular provider.

In the United States, outpatient mental health facilities are available in various locations. However, refugee communities encounter barriers to accessing community-based prevention and specialized treatment services due to linguistic accessibility, medical facility's location, and transportation (Bunn et al., 2023). Furthermore, many mental health programs are highly specialized, and they often provide services to trauma-

focused psychotherapy to individual refugees. Refugees often rely on providers who may not be familiar with their mental health conditions. Sometimes, refugees often have waiting lists for referrals to receive services (Bunn et al., 2023). Bhutanese refugees perceived unavailability and limited access to providers and delays in receiving services, which impacted their overall mental health outcomes.

### **Poor Interconnections Between Providers and Refugees Which Reduces Treatment Adherence**

Health providers and patients must have a good connection to obtain appropriate mental health services from outpatient healthcare centers. The majority of the Bhutanese refugees encountered difficulty interacting with mental health providers face-to-face or via phone calls without the assistance of others. Refugees perceived that poor interconnection with their providers contributed to a lack of trust and challenge to share mental health concerns that reduced treatment adherence. Lack of social network support (Maleku et al., 2022) and belief in mental health problems and their insight on the need for psychological support (MacDowell et al., 2020) have developed poor connection of Bhutanese refugees with their mental health providers in the United States. Poor interconnection with providers impacted on accessing and obtaining appropriate care and treatment, and reduced engagement in mental healthcare decision in the Bhutanese refugees.

### **Impact on Accessing Necessary Care and Treatment**

Many Bhutanese refugee mental health patients, it was difficult to connect with their mental health providers. Refugees had to depend on their children, relatives, or

someone within their Bhutanese community to interact with providers (Byrow et al., 2020; Maleku et al., 2022). Without the assistance of others, it seems difficult for refugees whenever a patient needs necessary care and treatment (Bunn et al., 2023). Bhutanese refugees often struggle with navigating or accessing to find appropriate specialists for their mental health care and treatment. Attitudes and perceived discrimination by providers often lead refugees to concerns (Soukenik et al., 2022). Poor interconnection between providers and refugees further hinders treatment adherence. Consistent with prior studies, findings show mental health providers need to build trustful relationships with refugees to better understand their needs and address challenges to accessing care and treatment.

### **Reduction of Refugees' Engagement in their own Mental Healthcare Decisions**

Without a good connection between patients and providers, neither providers get a better opportunity to understand patients' needs, nor do patients share their mental health concerns with providers. Results of the study revealed lack of interaction of Bhutanese refugees with their providers builds up a lack of trust that reduces engagement in their own mental healthcare decisions. The help-seeking behavior of refugees relates to perceptions of mental health and mental health treatment, which impact refugees' engagement in their own mental healthcare decisions (Byrow et al., 2020).

Furthermore, findings revealed a lack of friendliness or openness of Bhutanese refugees with providers, which impacted the sharing of their mental health concerns. Lack of trust in mental health services in Bhutanese refugees has contributed to lower utilization of Mental health services, which is linked with discrimination based on race,

language, legal status, and discordant cultural beliefs (Soukenik et al., 2022). Mental health providers need to build a positive provider-patient relationship through open communication that builds trust, active listening that allows the patient to express their mental health concerns freely, using clear, understandable terms, and providing patients with treatment options by discussing benefits and risks. This could help Bhutanese refugees engage in their own mental healthcare decisions.

### **Communication Gaps with Providers Which Impede Refugees in Receiving Services**

A communication gap with providers is one of the significant factors that prevent Bhutanese refugees from receiving mental health services from outpatient mental healthcare centers in the midwestern region of the U.S. Majority of the Bhutanese refugees perceived communication gap led to misunderstanding, misinformation, unclear instruction, and challenging in sharing mental health issues and concerns. This led to more frustration and disappointment in Bhutanese refugees, which ultimately resulted in negative impacts on them. Refugees perceive their mental health condition as often disregarded because of attitudes and perceived discrimination by providers (van der Boor & White, 2020). The lack of bicultural health workers in mental healthcare centers fails to recognize cultural attributes and language spoken by service users. The gap in cultural recognition leads to insufficient communication between service users and providers, which impedes refugees from receiving and utilizing necessary services (Soukenik et al., 2022).

Consistent with prior studies, results show that refugees' low literacy rate, cultural and linguistic differences, the belief that talking will not help, and hesitation to a

discussion about mental health expand the communication gap with mental health providers (Maleku et al., 2022). The communication gap with providers was developed from two categories: hindered ability to express problems and concerns openly and created barriers to understanding treatment plans.

### **Issues with Expressing Problems and Concerns Openly**

Maleku et al. (2022) stated that the Nepali language is limited in terminologies to describe mental health, and also differences in expressing emotional distress are limited by their ethnic and cultural language. Consistent with prior studies, findings show that limited terminologies in Nepali and cultural language build a communication gap between mental health providers and Bhutanese refugees that impedes the provision and receiving of appropriate mental health services. Results showed most Bhutanese refugees encountered difficulties in communicating with providers and sharing their mental health issues because of language differences. Migrants and refugees experience difficulties in accessing and receiving mental health services due to linguistic and cultural discordance between them and healthcare professionals (Krystallidou et al., 2024). Bhutanese refugees perceived language as a barrier to effectively communicating with their providers. Findings show that outpatient mental healthcare providers need to consider written material or cultural sensitivity to provide services to Bhutanese refugees when possible.

### **Barriers to Understand Treatment Plans**

When patients do not effectively communicate with their providers, it might create a barrier to fully understanding treatment plans, follow-up appointments, proper

usage of medication, and proper utilization of services available within their community. In the United States, many Bhutanese refugees do not utilize mental health services and support due to language barriers and negative perceptions towards mental health treatment (Gurung et al., 2020; Maleku et al., 2022). Findings showed that many Bhutanese refugees do not understand their treatment plans because of a lack of communication with their providers. Communication gaps not only created difficulties for refugees to get information on mental health care services but also posed challenges to mental health care providers to understand patient needs, provide high-quality services, and maintain patient safety (Al Shamsi et al., 2020).

### **Lack of Culturally Responsive Services and Awareness Programs Which Reduce Quality of Services**

Most Bhutanese refugees were not satisfied with services provided by outpatient mental healthcare centers because they did not include culturally sensitive care in their services. Refugees believed culturally responsive services, such as yoga and culturally related spiritual programs, would help them relieve their mental stresses. Cultural competence in mental health care is vital because not addressing cultural concerns may lead to unnecessary or incorrect treatment modalities (Ogundare, 2020).

Furthermore, cultural misunderstanding between providers and patients might lead to mistrust between them. This can lead providers to provide inadequate mental health services to refugee patients and address their unique needs, which can lead to poor care and treatment. Use of mental health services in refugees is associated with culturally and linguistically appropriate programs (Soukenik et al., 2022). Bhutanese refugees

perceived outpatient mental healthcare centers do not have enough community-based ethnic mental health programs in their community; as a result, they are deprived of receiving information on mental health resources. Two categories: tailor care based on the individual's cultural context and factors to promote quality of services combined used to develop the theme- Lack of culturally responsive services and insufficient awareness programs reduce quality services.

### **Tailored Care Based on Individual Cultural Contexts**

With a lack of culturally sensitive programs, outpatient mental healthcare centers do not actively incorporate and respect many Bhutanese refugees' beliefs, norms, and values that can help to tailor better mental health treatment approaches. Maleku et al. (2022) stated mental health professionals need to develop culturally responsive interventions to understand mental health of Bhutanese refugees and effectively address their mental health needs. Findings showed that refugees wanted outpatient mental healthcare providers to understand the cultural nuances of the patient population. Refugees are unlikely to engage in mental health care and treatment where referrals are made without attention to cultural understandings of the symptoms (Bunn et al., 2023). Bhutanese refugees believe understanding the patients' cultural background can help providers understand the need for care and treatment based on cultural context.

### **Factors to Promote Quality of Services**

Culturally responsive care is essential due to refugees' challenges and numerous barriers to receiving care (Mattar & Gellatly, 2022). Results showed Bhutanese refugees strongly believed that stress management, psychotherapy, Nepali cultural programs, yoga

classes, and spiritual practices could help them to engage and be free from loneliness, frustration, and anxiety. Furthermore, the results showed that if outpatient mental healthcare centers adopt culturally based programs, it will not only help Bhutanese refugees to engage and reduce the stigma associated with mental health issues and concerns but also improve and promote the quality of mental healthcare services. Gurung et al. (2020) and Maleku et al. (2022) emphasized that culturally appropriate orientation and programs positively impact seeking mental health needs and expand the use of mental health services among Bhutanese refugees in the United States.

### **The Importance of Patient Advocates to Bridge Aforementioned Barriers**

Another interesting finding was that family members, relatives, community leaders, and Nepali-speaking social workers were the facilitators for Bhutanese who aided in receiving mental healthcare services provided in their community. Identifying and addressing barriers and facilitators is necessary to influence refugee mental health and to provide better care and services (DeSa et al., 2020). The findings also revealed that most of the outpatient mental healthcare centers provided phone interpreters to patients; however, Bhutanese refugees are not satisfied with phone interpreters, and they do not trust them. Bhutanese refugees feel more comfortable seeking help from friends and family than professionals (Maleku et al., 2022; Soukenik et al., 2022). Facilitators that aid in receiving mental healthcare services are composed of three categories: Provide general information about mental health resources, guide and support in receiving services, and assist in translating and expressing mental health concerns, which are discussed below.

### **General Information about Mental Health Resources**

All participants perceived their family members as crucial facilitators who provided general information about mental health resources. Family members have a deeper and more holistic understanding of patient's needs and assist in providing information on appropriate resources available within their community. Most Bhutanese refugees included in this study were older adults who did not speak or understand English proficiently; therefore, they had to depend on their children who speak and understand English or someone else within the community to get information on available mental health resources. Many Bhutanese refugees speak their own language, which makes it difficult to get information on mental healthcare services and support as needed (Gurung et al., 2020; Maleku et al., 2022). The study results also revealed that, along with the family members, some of the Bhutanese refugee patients get necessary information about mental health resources from their close relatives and trustable community leaders.

### **Guide and Support for Receiving Services**

I was intrigued to learn that family members, relatives, community leaders, and social workers were not only providing general information about mental health resources but also guidance and support in receiving mental health services for refugee mental health patients. These facilitators provide guidance and support in various ways, such as scheduling appointments, taking to appointments or transportation, communicating with providers, reminding appointments, making informed decisions about treatment options, and treatment adherence. The use of the patient's close relatives or friends as interpreters is the best way to facilitate patient-provider communication,

which provides a better opportunity for refugees to receive appropriate mental health services (DeSa et al., 2020; van der Boor & White, 2020). Bhutanese refugees feel more comfortable seeking assistance from within their community, such as their family members, relatives, friends, and community leaders, than professionals (Maleku et al., 2022). Consistent with the prior study, the result revealed that without the guidance and assistance of these facilitators, it is very challenging for Bhutanese refugee mental health patients to receive necessary care and treatment on a timely basis.

### **Translating and Expressing Mental Health Concerns**

Many Bhutanese refugees depend on family members, particularly children, to assist in translating while communicating with their mental health providers. They trusted their children and relatives rather than phone interpreters while communicating with providers. Findings showed that Bhutanese refugees' children not only assist in translating but also ask questions and concerns about the behavior of patients to ensure adherence to treatment plans and options. Support from within the family helps refugee patients receive every possible mental health resource available within the community, ultimately contributing to improving patient mental health outcomes. Results showed that some Bhutanese refugees were unsatisfied with the virtual phone interpreter. Even though interpreters may help overcome communication, the lack of trained interpreters, poor funding for translation services, and lack of availability impact refugees in obtaining quality services (DeSa et al., 2020; Pollard & Howard, 2021).

Many refugees experienced unclear, confusing, and difficult-to-understand via phone calls. They were worried that mistranslation and misconstrue could impact

receiving appropriate care and treatment. Sometimes, Bhutanese refugees are prescribed different medication by providers than what is needed when using a phone interpreter. Many refugees feel uncomfortable and worried about the privacy disclosed (Byrow et al., 2020). Refugees are not able to talk openly with their mental health providers due to confidentiality concerns that may lead to stigmatization (van der Boor & White, 2020). Trained and qualified interpreter services are required in every outpatient mental healthcare center in the United States for Bhutanese refugees to express their mental health concerns and enhance their overall mental health outcomes.

### **Limitations of the Study**

Several limitations are present in the study that require consideration. Many participants were unwilling and hesitant to participate in the study after they were asked to fill out the consent form. They were worried that signing a consent form would appear in the study and might impact their home care services. The data for the study were collected from a target population with a limited sample size since only Bhutanese refugee patients who used services from outpatient mental healthcare centers and lived in Summit County in Ohio could qualify for the study. The small sample size and the use of convenience sampling may limit the generalizability of the study findings to Bhutanese refugees. All participants volunteered to share their lived experiences in receiving mental health services, and they might be unique and not resemble the general Bhutanese refugee population.

The interview guide was first developed in English and translated into Nepali. Since the Nepali language has limited terminologies, some English words do not exist in

the Nepali language. The interview guide was translated into the Nepali language using words that closely match the English words. The consistency between the English and Nepali interview guides was confirmed by back translating the Nepali interview guide to the English language. Both Nepali and English language guides matched in terms of interview questions, flyers, and consent forms. For most of the participants, this was the first time they participated in a research study where their voice was recorded.

Participants seemed a bit nervous, and their responses were brief and to the point.

However, most of the participants responded with the same information, expressed in different ways. Providing the same information was helpful for the credibility of the research findings. Despite these limitations, however, this study captured the voice of Bhutanese refugees to elucidate the conceptualization of receiving mental health services from outpatient mental healthcare centers in the U.S. through the Bhutanese refugees' lens.

### **Recommendations**

While this study was focused on Bhutanese refugees resettled in the midwestern region of the United States, future studies should be conducted in other regions of the United States. Important aspects of mental health services, such as awareness, quality, and accessibility to outpatient mental healthcare centers in midwestern may vary in another region of the United States. There are three recommendations for future research. The first recommendation is availability. Availability of mental health resources may vary depending upon states or region that may influence patients experiences in receiving services. Thus, the study should be repeated in different regions of the United States

using a larger sample size and more in-depth questions to understand their experiences better.

Second recommendation for future research would be to conduct interviews with Bhutanese refugees who understand and speak English well. The findings show that the language barrier is a significant factor that impedes participants from receiving appropriate services and utilizing the resources available within their community. By conducting studies on Bhutanese refugees who have better communication skills in English, future researchers will be able to compare the experiences between participants who understand and speak English and those who do not in terms of utilization and receiving available mental health resources and services.

The third recommendation for future researchers would be to conduct interviews with Bhutanese refugees based on age groups. This will allow future researchers to gain a deeper understanding or insight specific to different life stages and perspectives on mental health issues, utilization of resources, and obtaining services from outpatient mental healthcare centers. When the study is conducted across age groups in Bhutanese refugees, it will allow the researcher to tailor questions and interpretations of each age group's experiences, allowing the researcher to collect more prosperous, more accurate data.

Most of the participants in the study were not satisfied with the phone interpreter services provided in outpatient mental healthcare centers. Thus, future researchers also need to conduct a study on the experiences of Nepali-speaking Bhutanese refugee patients using interpreter services with their providers.

## **Implications**

There are a few implications for mental healthcare providers who seek to address Bhutanese refugees' challenges in obtaining services from outpatient mental healthcare centers. The findings from the study provide new information that helped add knowledge to an existing gap in the literature pertaining to the experiences of the Bhutanese refugees' challenges in receiving outpatient mental health care services. Allowing the Bhutanese refugees to express their voices has provided better ideas and information that can help mental health care providers, public health practitioners, educators, community leaders, and social workers better assist the Bhutanese refugees in the provision of mental health and social services. This is an important step in achieving positive social change.

The results of this study indicated the need for culturally sensitive services in outpatient mental healthcare centers for Bhutanese refugees. Initiating a culturally responsive service will not only help Bhutanese refugees receive culturally based healing practices in mental health care and treatment but also enhance the quality of mental health services. Furthermore, culturally responsive care in mental health programs will actively educate mental health providers to consider and respect the patients' cultural background and help tailor treatment to meet the unique needs based on each patient's cultural context.

Most mental healthcare centers provide virtual phone interpreter services to Bhutanese refugees and other non-English speaking patients. However, it seems that Bhutanese refugees are not satisfied with interpreter services because it is difficult for them to understand jargon Nepali words. Moreover, many older Bhutanese mental health

patients are not able to express their mental health issues adequately without family or relatives' assistance. In this case, the virtual interpreter might not work for them. Thus, the findings of this study provided preliminary information for making better plans and promoting and providing mental healthcare services to the Bhutanese refugee population.

The findings can encourage health professionals to devote more understanding and compassion to the Bhutanese and other refugees and the situations they experience. This study will provide insights to public health researchers to prepare and engage in future research on the mental health issues of the Bhutanese refugees and many other refugees and immigrants in the U.S.

### **Conclusion**

The goal of this study was to understand the experiences of Bhutanese refugees' in obtaining mental health services from outpatient mental healthcare centers, particularly on the barriers they encountered, and assistance received from facilitators. Face-to-face interviews were conducted with ten Bhutanese refugees who have been receiving mental health services to answer the study questions. The HBM was used to develop the research question, and by following the HBM, participants in this study were asked about their experiences of receiving mental health services, barriers, and contributing factors to obtaining services from outpatient mental healthcare centers. Through the interview, it became apparent that Bhutanese refugees face many obstacles in receiving mental health services that impact their overall mental health outcomes.

There were several challenges that Bhutanese refugees faced when trying to receive services for their mental health care and treatment. Some of the challenges that

arise directly relate to outpatient mental healthcare centers' ability to secure services for refugees on a timely basis. The challenges include unavailability and limited mental healthcare providers, a complex appointment scheduling system, a lack of culturally responsive services, and a lack of available mental health resources within the community. Other challenges stem from the inability of refugee patients to interact and communicate with their mental health providers. Though Bhutanese refugees encountered several difficulties in receiving services from outpatient mental healthcare centers, facilitators such as family members, relatives, community leaders, and Nepali social workers provided assistance to them in receiving some of the necessary services.

The result of this study is significant because it provided better ideas and information about Bhutanese refugee' difficulties in receiving services through their experiences. Understanding the Bhutanese refugees' experiences can help outpatient mental healthcare providers and researchers bring positive social change in terms of mental health care and treatment among the resettled Bhutanese refugees in the United States. In fact, any improvement in the mental health conditions of the Bhutanese refugees they have experienced will contribute to positive social change.

Using a phenomenological research design was appropriate to answer the research question. However, data were collected from specific locations with small sample sizes using convenience sampling, which might limit the generalization of the results to Bhutanese refugees living in other regions of the United States. In addition, most of the participants were illiterate adults who volunteered in the study; thus, the findings may not resemble the general Bhutanese refugee population. The result indicated a need for

further study among the Bhutanese refugees based on the education level and age groups for a better understanding of their experiences of accessing and receiving mental health services.

Furthermore, this study pointed to the results of only Bhutanese refugees who live in the midwestern region of the United States. Therefore, more research needs to be conducted in other regions of the United States for better knowledge and understanding of the lived experiences of receiving mental health services from outpatient mental healthcare centers. It is also essential to educate mental healthcare providers and other mental healthcare-related practitioners about the Bhutanese refugee population through disseminating research findings. The results of this research will help mental health professionals provide appropriate mental health services to Bhutanese refugees based on their needs.

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## Appendix A: Interview Questions in English Version

### **QUESTIONS**

There are two sections of questions, demographic questions, and interview questions

**A. Demographic Questions**

1. Name of the county you live in.
2. How long have you been residing to this current county?
3. Sex:
  - a. Male b. Female c. Intersex d. not listed e. Prefer not to answer
4. Race/Ethnicity:
  - a. White b. Black or African American c. Asian d. Hispanic or Latino e. Native Hawaiian or Pacific Islander f. Prefer not to answer
5. What is your primary language spoken at home?
6. How long have you lived in Nepal as a Bhutanese refugee before coming to the U.S.?

**B. Interview Questions**

1. Do you have any questions for me before we begin?
2. What do you know about mental health services provided in outpatient mental healthcare centers in your community?
3. What information does outpatient mental healthcare centers in your community offer to improve your mental health?
4. How do you feel about receiving outpatient mental health services for your mental health-related problems?
5. Who have you had a conversation with within your community regarding mental health services?
6. What do you think about the experience with the mental health providers in outpatient mental healthcare centers?
7. What resources did mental health providers share with you about the ways to receive mental healthcare services in your community?
8. What were some of the challenges you experienced in getting mental health care services from outpatient mental healthcare centers?
9. What were some of the positive experiences you had in getting mental health care services from outpatient mental healthcare centers?
10. What circumstances made you feel like giving up on going to outpatient mental healthcare centers?
11. What are your future expectations in receiving mental health services from outpatient mental healthcare centers?
12. What do you think about outpatient mental health care centers regarding the quality of care and services provided to refugees who receive mental health services? What can they do for you and patients like you?
13. Would you like to share anything else with me about the mental health services that you have been receiving from outpatient mental care centers?

Appendix A (Continued): Interview Questions in Nepali Version

अन्तर्वार्ता प्रश्नहरू

त्यहाँ प्रश्नहरू दुई खण्डहरू छन्, जनसांख्यिकीय प्रश्नहरू, र अन्तर्वार्ता प्रश्नहरू

#### A. जनसांख्यिकीय प्रश्नहरू

1. तपाईं बस्नुहुने काउन्टीको नाम ।
2. तपाईं यस हालको काउन्टीमा कति लामो समयदेखि बस्दै हुनुहुन्छ?
3. सेक्स: a पुरुष b. महिला c. इन्टरसेक्स d. सूचीबद्ध छैन e. जवाफ नदिन रुचाउँछन्
4. जात/जाति: a सेतो b. कालो वा अफ्रिकी अमेरिकी c. एसियाली d. हिस्पैनिक वा ल्याटिनो e. मूल हवाईयन वा प्रशान्त टापुवासी f. जवाफ नदिन रुचाउँछन्
5. तपाईंको घरमा बोलिने प्राथमिक भाषा के हो?
6. अमेरिका आउनुअघि भुटानी शरणार्थीको रूपमा नेपालमा कति समय बस्नु भएको थियो?

#### B. अन्तर्वार्ता प्रश्नहरू

1. हामीले सुरु गर्नु अघि के तपाईंसँग मेरो लागि कुनै प्रश्न छ?
2. तपाईंको समुदायको बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रहरूमा प्रदान गरिने मानसिक स्वास्थ्य सेवाहरूको बारेमा तपाईंलाई के थाहा छ?
3. तपाईंको समुदायमा बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रहरूले तपाईंको मानसिक स्वास्थ्य सुधार गर्न के जानकारी प्रदान गर्दछ? के तिनीहरूले सुझावहरू प्रदान गर्छन्, जस्तै अरूसँग जोडिने, सिक्रे र रचनात्मक बन्ने तरिकाहरू खोज्ने, निद्रामा सुधार गर्ने प्रयास गर्ने, स्वस्थ खाने, र आदि?

4. आफ्नो मानसिक स्वास्थ्य सम्बन्धी समस्याहरूको लागि बाहिरी रोगी मानसिक स्वास्थ्य सेवाहरू प्राप्त गर्दा तपाईंलाई कस्तो लाग्छ?
5. मानसिक स्वास्थ्य सेवाहरूको सन्दर्भमा तपाईंको समुदाय भित्र तपाईंको संरक्षण को संग छ?
6. बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रहरूमा मानसिक स्वास्थ्य प्रदायकहरूसँगको अनुभवको बारेमा तपाईं के सोच्नुहुन्छ? के तिनीहरूले मानसिक स्वास्थ्य सेवाहरू प्राप्त गर्ने तपाईंको निर्णयमा कुनै प्रभाव पारेको छ?
7. तपाईं बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रमा जाँदा मानसिक स्वास्थ्य प्रदायकहरूले तपाईंलाई कसरी मद्दत गरे?
8. मानसिक स्वास्थ्य प्रदायकहरूले तपाईंसँग तपाईंको समुदायमा मानसिक स्वास्थ्य सेवाहरू प्राप्त गर्ने तरिकाहरूको बारेमा के स्रोतहरू साझा गरे?
9. बाहिरी बिरामी मानसिक स्वास्थ्य सेवा केन्द्रहरूबाट मानसिक स्वास्थ्य सेवाहरू प्राप्त गर्न तपाईंले अनुभव गर्नुभएका केही चुनौतीहरू के के थिए?
10. बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रहरूबाट मानसिक स्वास्थ्य सेवाहरू प्राप्त गर्दा तपाईंले पाएका केही सकारात्मक अनुभवहरू के थिए?
11. कुन परिस्थितिले तपाईंलाई बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रहरूमा जान छोड्ने जस्तो महसुस गराउनुभयो?

12. बाहिरी रोगी मानसिक स्वास्थ्य सेवा केन्द्रहरूबाट मानसिक स्वास्थ्य सेवाहरू प्राप्त गर्नमा

तपाईंको भविष्यका अपेक्षाहरू के छन्?