



The Mental Health of Refugees during a Pandemic: Striving toward Social Justice through Social Determinants of Health and Human Rights

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Abstract

This paper is the second of two in a series. In our first paper, we presented a social justice framework emerging from an extensive literature review and incorporating core social determinants specific to mental health in the age of COVID-19 and illustrated specific social determinants impacting mental health (SDIMH) of our resettled Bhutanese refugee population during the pandemic. This second paper details specific barriers to the SDIMH detrimental to the basic human rights and social justice of this population during this pandemic. The SDIMH, as described, further informs the need for social justice measures and cultural humility in mental health-care, public health, law, and community engagement. This work concludes with a proposed call to action toward mental health improvement and fair treatment for refugee populations in three core areas: communication and education, social stigma and discrimination, and accessibility and availability of resources.

Keywords Justice · Social determinants · Refugee · Mental health · Pandemic · COVID-19

Introduction

Lawrence Gostin and Madison Powers (2006, 1053), in acknowledging that justice is central to the mission of public health if not its core value, also illustrate that justice alone “cannot determine the ‘correct’ policy or supply an answer to every question regarding the broad direction of public health; neither can any other single organizing principle”. As ethics and legal scholars, this message is critical to our social justice efforts toward refugee mental health in building a framework whereby justice is a driver toward understanding the “multiple causal

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pathways to numerous dimensions of disadvantage” (Gostin and Powers 2006, 1054), and for addressing the social determinants in mental health (SDIMH), while deriving a set of recommendations that recognize individual and collective interests through a cultural humility lens. This paper builds upon our initial work described in our first paper (McGuire et al. 2021), in developing a social justice framework to address the mental health needs of resettled Nepali-speaking Bhutanese refugees, which embraces the central value of justice and contextually described through the language of social determinants of health and human rights. We argue for what Gostin and Powers call a “harmonized engagement” where a system of overlapping and shared responsibility among governments is required; we further argue that this system ought to include not merely federal, state, and local governments, but also essential stakeholders who have the opportunity to make a positive impact on the lives of those who are disadvantaged—in this case, our resettled Bhutanese refugee populations in the age of COVID.

Specifically, public health justice aims to improve the health of a population and provide fair treatment for the disadvantaged. To achieve these ethical goals and address specific SDIMH in the age of COVID-19 (See Fig. 1, which is also described in our first paper, “Impact of a Pandemic on Resettled Bhutanese

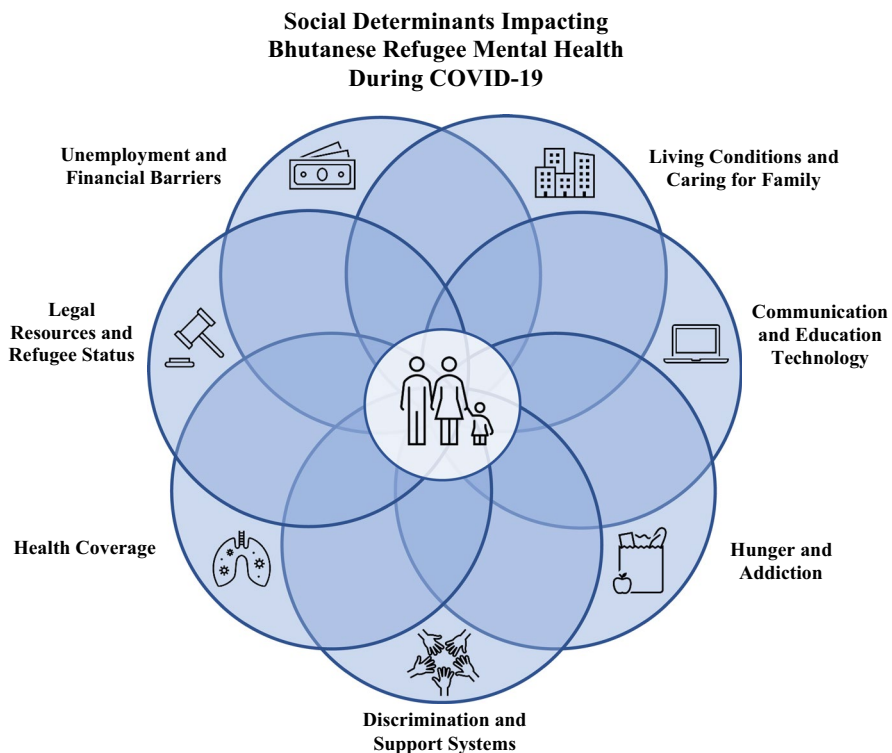


Fig. 1 Social determinants impacting Bhutanese refugee mental health during COVID-19

Refugees' Mental Health" (McGuire et al. 2021)), requires improved coordination or "harmonized engagement" among our healthcare professionals and organizations, public health and community agencies, community leaders and advocates, and the Bhutanese refugee community. Such coordination allows for the harmonization of federal, state, and local policies and laws and the strategic delivery of resources and support to address clear barriers as understood through SDIMH.

Addressing Barriers to Social Justice

The following section describes the stakeholders and groups who can begin to work together to tackle these barriers and establish a more just approach in serving the needs of Bhutanese refugees. While we recognize strategic and coordinated efforts throughout the USA to welcome resettled refugees into growing communities, grassroots organizations and community agencies bear the weight of these efforts, and they need a wider net of support to address SDIMH. And while it is unreasonable to address all the aforementioned determinants contributing to injustices and mental health disparities among these key stakeholders, provided is a list of barriers, key themes, and recommendations briefly outlined in Table 1.

This will serve as a frame for those coordinated efforts needed to fulfill basic human needs, to promote awareness of mental and public health within the Bhutanese community, and to practice respect and cultural humility during and following this unprecedented pandemic. These barriers as identified through a close examination of the SDIMH and the aligned goals toward social justice include (1) communication and education (goal: awareness); (2) social stigma and discrimination (goal: respect and cultural humility), and (3) access and availability of resources (goal: fulfilling need). These three themes emerged from our extensive literature review and anecdotal evidence in working with our resettled refugee population.

Communication and Education toward Awareness

Refugee resettlement agencies and public health profit and nonprofit organizations are making great strides in providing essential mental and COVID-19 health information, including where to access health services for testing and care. One such example is refugee response, an organization that has paired up with catholic charities in Cleveland, Ohio, to deliver animated videos about COVID-19 in 12 different languages. These videos are accessible on multiple devices and social media websites and have been viewed by nearly 60,000 persons in 9 countries, and an additional 34,000 individuals in refugee camps, despite this being a local effort targeting the resettled refugees in Northeast Ohio (Refugee Response 2021). Refugee response is also working on videos to alert members of the community about scams and misinformation regarding COVID-19. Similarly, Boston College School of Social Work and the nonprofit Bhutanese Society of Western Massachusetts have produced videos in Nepali to teach Bhutanese refugees about COVID-19, recognizing that many individuals in the Bhutanese population are illiterate in their

Table 1 Recommendations for addressing barriers to mental health in the age of COVID

Barrier to mental health in the age of COVID	Goal	Healthcare and legal systems and professionals	Community health and public health agencies	Community leaders and advocates	Resettled refugee leaders
Communication and education	Awareness	Invest in translators/translated resources Communicate frequency and types of mental healthcare needs Utilize technologies for improving public and mental health communication Develop refugee partnerships with cultural humility Communicate and connect refugees to resources beyond the health system Communicate accurate COVID-19 information Improve medical and legal education Be aware of federal guidelines; practice with evidence based medicine and cultural humility	Invest in translators Communicate all available public/mental health information Develop refugee partnerships with cultural humility Collaborate and address language barriers that have an impact on (mental) health Assist in addressing benefits and burdens of communication technologies for improving public and mental health Communicate and connect refugees to resources Communicate accurate COVID-19 information directly using social media and through refugee leaders Be innovative; develop clear educational strategies inclusive of Bhutanese community Assess educational programs and strategies	Develop refugee partnerships with cultural humility Identify and address determinants Be leaders to provide reliable mental and public health information to the community Support the voices of refugee community members Improve access to education technologies (e.g., laptops) into the homes of refugee families Provide legal and financial assistance programs (unemployment, stimulus pay, other opportunities)	Identify translators and educators for community engagement Hold honest discussions about community mental health and social determinants Develop partnerships with community and public health agencies and community leaders Encourage the community to engage and establish relationships with healthcare professionals and other care providers

Table 1 (continued)

Barrier to mental health in the age of COVID	Goal	Healthcare and legal systems and professionals	Community health and public health agencies	Community leaders and advocates	Resettled refugee leaders
Social stigma and discrimination	Cultural humility	<p>Recognize social stigma of mental health and of COVID-19 infection</p> <p>Identify impact of racism on refugee health</p> <p>Address racial disparities and biases among professionals in healthcare systems</p> <p>Establish anti-discrimination policies in the treatment of COVID-19</p> <p>Practice with cultural humility</p> <p>Establish respectful therapeutic relationships with refugee patients</p> <p>Use clinical experience and research evidence to advocate for social change</p>	<p>Recognize the stigma of mental health and of COVID-19 infection</p> <p>Provide public health information about social stigma</p> <p>Keep informed and participate in research to identify relevant information about effects of stigma</p> <p>Recognize discrimination and racism and its impact on mental and physical health among refugees (prior to and following resettlement)</p> <p>Address racial disparities and biases among community and public health leaders and members</p> <p>Use public health experience and evidence to advocate for change</p> <p>Develop public health policies and processes for addressing racism</p>	<p>Enforce safety protections and zero-tolerance policies on racist behaviors among enforcement and other public servants of the community</p> <p>Formulate plans to prevent discrimination in the community</p> <p>Enforce anti-discrimination laws</p> <p>Provide resources and assist the healthcare sector to meet healthcare needs of victims of hate crimes</p> <p>Address power imbalances among community leaders and develop accountability measures</p>	<p>Describe refugee perspectives of mental illness and infectious disease (COVID-19) for healthcare providers and others</p> <p>Report hate crimes and discrimination in the community</p> <p>Identify leaders and advocates to empower the community and dismantle the power imbalances</p> <p>Seek out healthcare and legal services if a victim of a hate crime or experienced discrimination</p>

Table 1 (continued)

Barrier to mental health in the age of COVID	Goal	Healthcare and legal systems and professionals	Community health and public health agencies	Community leaders and advocates	Resettled refugee leaders
Accessibility and availability of resources	Serving needs	<p>Secure resources for mental health technologies (e.g., telepsychiatry)</p> <p>Secure resources for COVID-19 testing and treatment</p> <p>Address shortages of mental health resources</p> <p>Expand health coverage, including health insurance, provider access, and translation support</p> <p>Develop and implement fair policies and procedures for limited resource allocation</p>	<p>Provide support to healthcare organizations by detailing community needs and monitoring existing and potential public resource inventory</p> <p>Develop and implement preparedness plans, local and state policies, and advise public policies</p>	<p>Be cognizant of SDIMH and the impact during a pandemic on refugees</p> <p>Spread awareness and promote cultural humility, advocacy, and humanitarian aid</p> <p>Address disparities in healthcare and public health and create opportunities to access available resources, (e.g., walkable testing sites without required transportation)</p>	<p>Be open about community needs, barriers, and goals</p> <p>Empower community members to value their mental and physical health</p> <p>Work with community leaders, healthcare experts, and others to develop policies and processes for addressing resource shortages and alternative ways to help the refugee community</p>

own language. The videos were created after recruiting teachers, epidemiologists, and public health experts in the Bhutanese community and are a project that builds on the Research Program on Children and Adversity in the School of Social Work. Unfortunately, not every person in a resettled community has access to social media websites due to a lack of internet or supporting devices in their home (e.g., mobile phones) and thus rely on neighbors and others with additional inherent risks if safety measures are unknown or ignored.

SDIMH may also be effectively addressed through community mental health education. This may include Mental Health First Aid (MHFA) training (Subedi et al. 2015) which assisted Nepali communities in Massachusetts to better recognize depression and improve mental health literacy (Gurung et al. 2020). San Diego's City Heights Wellness Center provided similar community education by joining local hospitals to offer multilingual cooking classes tailored to the unique needs of the culturally diverse community to combat diabetes and obesity (Sullivan 2019). Community education, specifically using peer-led community health workshops, is a culturally responsive way of promoting community health and social capital in Bhutanese refugee communities (Im and Rosenberg 2016). This form of community education could be the first step in overcoming the strong stigma surrounding mental health and begin to build trust between Nepali-speaking communities and public health and nonprofit agencies.

From public service announcements to healthy lifestyle initiatives (e.g., online stay-at-home exercises, social media connections with families and others), it is essential to include the Bhutanese community. Having to quarantine oneself and one's family leads to a greater propensity for poorer lifestyle choices (e.g., less healthy foods, smoking, alcohol consumption) and a lack of safe environments to exercise while social distancing. Good nutrition, exercise, and the ability to connect with others impact mental health within the Bhutanese community. Furthermore, due to some doctors, dentists, veterinarians, and other healthcare workers reducing or stopping "non-essential" services, a disruption in basic care (e.g., dental care) can lead to a general apathy about one's health or ignite fear and reluctance to seek help.

Addressing Social Stigma and Discrimination through Respect and Cultural Humility

Educating and informing current and future medical and legal professionals about SDIMH among the Nepali-speaking refugees is imperative, and particular attention needs to be given to cultural humility to reduce social stigma of mental health and COVID-19 and combat discrimination and racism within the Bhutanese community. In addressing SDIMH among refugees, medical and legal professionals need to develop cultural humility that becomes habitual with every patient and client. This cultural humility emphasizes self-awareness of personal biases and beliefs, recognizing and appreciating individual cultural experiences and perspectives, and being willing to sensitively listen and learn from others through a lifelong process (Tervalon and Murray-Garcia 1998; Yeager and Bauer-Wu 2013; Foronda et al. 2016). Many lack this ability to recognize and address the cultural and racial barriers within

patient populations that directly contribute to SDIMH. Each Bhutanese refugee and family are unique; when professionals understand the cultural SDIMH among the Bhutanese community and appreciate their individual stories and experiences, culturally sensitive treatment for mental health can be effective and valued despite its stigma. Habitual practicing of cultural humility also leads to better recognition of SDIMH among patients and more frequent and pertinent referrals for mental health needs and social support.

Cultural humility also utilizes cultural perspectives to effectively screen for SDIMH and suicide risk. This includes recognizing the stigma of mental health and rephrasing questions for cultural understanding. For example, a sample of Bhutanese refugees in Vermont only reported 6.7% with suicidal ideation, while 48.3% reported some desire to be dead according to the wish to be dead scale (Meyerhoff and Rohan 2020). Changing the wording of questions surrounding suicidal ideation to be culturally sensitive better identified hidden feelings of depression and suicidal ideation among Bhutanese refugees (Meyerhoff and Rohan 2020). Published mental health screenings must be adapted to each patient in regards to stigma, culture, understanding, etc., and current research shows that healthcare providers practicing cultural humility are key to providing optimal care to culturally diverse populations (Peterson et al. 2020).

Practicing cultural humility while working alongside resettled refugees also leads to greater mutual respect and trust, and it provides a better foundation to address SDIMH. Conversely, not recognizing implicit bias in the form of poor word choice and culturally insensitive responses leads to mistrust and negative health outcomes. Deeply rooted and intolerable xenophobia, discrimination, and racism contaminate our communities during the COVID-19 pandemic alongside the SARS-COV-2 virus. This novel coronavirus, inappropriately dubbed the “Wuhan virus” or “China virus,” has led to increased violence and hate crimes particularly toward resettled Bhutanese refugees of Asian ethnicity. For example, a local resettled Nepali-speaking Bhutanese elderly man was walking down the sidewalk, coming back from an Asian food store in a city in Northeast Ohio, and he was violently struck on the head with a glass beer bottle by an individual who yelled racist comments (“go back to your country (expletive)!”; “you are killing *real* Americans”). This example among several illustrate how resettled Bhutanese refugees have been direct victims of xenophobia because of their Asian ethnicity, and thus proactively fostering respect and trust during this pandemic is a prerequisite to addressing SDIMH and empowering the mental health of resettled Bhutanese refugees.

Access and Availability of Resources: Fulfilling Essential Human Needs

With the heightened impact of SDIMH among the Nepali-speaking refugee community during this unprecedented time, addressing SDIMH at the level of healthcare systems and professionals will assure access to basic human needs and support their mental health. Lack of accessibility and availability of resources is a significant barrier to the mental health of Bhutanese refugees in the age of COVID-19, and

providing greater accessibility and availability of mental health screenings, covid-19 screenings, and health coverage need to be prioritized.

Mental health screenings should be strongly encouraged, if not mandatory, to better support the Bhutanese refugees and their vulnerability to mental health challenges. The CDC currently recommends health screenings when resources are available (Kobau et al. 2012); however, other responsibilities of healthcare providers often take precedence. This leads to underutilization of mental health assessments despite the increasingly high prevalence of mental illness during COVID-19. Due to Health Resources and Services Administration (HRSA) quality care measures, many federally qualified health centers (FQHCs) prior to the pandemic began the initiative to incorporate mental health screenings as part of every patient visit. Initial mental health screenings include the two question PHQ-2 survey which is typically given by a medical assistant. If a positive response is elicited, a follow-up Patient Health Questionnaire-9 may be given with additional assessments such as the Harvard Trauma Questionnaire (HTQ), the Vietnamese Depression Scale (VDS), the Comprehensive Trauma Inventory-104 (CTI-104), the New Mexico Refugee Symptom checklist-121 (NMRSL-121), and the Refugee Health Screener-15 (RHS-15).

Overwhelming healthcare demands during the pandemic, however, have forced already overburdened FQHCs to reprioritize healthcare worker's responsibilities to COVID-19 testing, telehealth calls, and assuring that patient safety and previous progress in implementing health screenings were reduced and often discontinued. Despite patients being told mental health counselors are available, stigma and concealed mental health needs prevent them from asking for help. Healthcare professionals need to be aware and well-trained to perform these mental health assessments, and healthcare centers must prioritize the utilization of screenings during patient visits in clinics and via telehealth. Additionally, increasing mental health assessment research will improve upon the validity, reliability, effectiveness, and quality of these assessments while also ensuring proper privacy and confidentiality. These improvements to mental health screenings may benefit all patient populations, including resettled refugee populations, during the COVID-19 pandemic. Resettled Bhutanese refugees, however, will particularly benefit from such implementations as SDIMH and anti-Asian racism and hate crimes intensify among their communities.

Mental health screenings should also be embedded in other healthcare screenings and made widely available, especially if and when this population might have access to COVID-19 testing. There is increased discrimination and stigma that patients experience during infectious disease outbreaks, especially among our resettled Bhutanese refugees. While the rates of depression during COVID-19 are still uncertain, past outbreaks (e.g., Ebola outbreak in West Africa) showed symptoms of depression and anxiety among 48% of the population (Jalloh et al. 2018). Srivatsa and Stewart (2020) attribute these extremely high rates of mental illness to the minimal mental health training to clinicians treating patients with infectious diseases, as well as general mistrust due to heightened political instability, mistrust of government, and the spread of misinformation. Similar rates of mental illness may be expected during the COVID-19 pandemic where mental health training is minimal, misinformation is generating greater mistrust, and extreme political climate is resulting in heightened stress in the USA. Greater access and availability to mental health

screening needs to be provided in the form of mental health training for all physicians and patients, and referral pathways and support services need to be established (Srivatsa and Stewart 2020). Additionally, Srivatsa and Stewart (2020) recommend that follow-up mental healthcare should always be provided as needed during and after treatment for infectious disease. Equal opportunity for COVID-19 screenings, treatment, and economic support also need to be made easily accessible and available. Although many free COVID-19 drive-thru testing sites are available throughout the USA, without a car or transportation, these locations are often too far for Nepali-speaking refugees to access. Closer testing sites or mobile testing clinics could significantly help overcome barriers to testing.

A Call for Comprehensive and Coordinated Clinical and Public Healthcare

Greater health coverage also needs to be made available to this population, especially during the pandemic. This includes help receiving healthcare insurance, provider access, and translation support to assure access to mental health and COVID-19 treatment. Refugees in the USA are initially given 8 months of Medicaid (Hauck et al. 2014), but the majority no longer have this health coverage, and any employee health coverage has been cut as jobs have been lost. Health insurance coverage like Medicaid needs to be extended to provide equal opportunity to be treated during the pandemic. As legal scholars and public health experts have pointed out, increasing access to medical services—via Medicaid and other federally funded programs—is actually likely to decrease the nation’s overall healthcare spending because preventative treatments are typically cheaper than emergency services (Bart-Plange 2014). Many uninsured immigrants are forced to rely upon expensive emergency room treatments. However, if Medicaid were expanded, more immigrants could obtain cheaper, preventative treatments before their ailments become too serious. Overall, this would have a positive impact on the cost of US healthcare and substantially benefit refugee populations. Additionally, Nepali-speaking professional interpreters and migrant health workers in hospitals and clinics are infrequently available to address cultural and linguistic needs, and referral social services usually do not have any Nepali language services to help address additional needs contributing to SDIMH during COVID-19.

Improving upon the SDIMH and mental healthcare of the Nepali-speaking refugees through a justice framework must also be directly addressed through the coordination of preventative efforts of community health, public health agencies, and nonprofit agencies. To meet the needs of the resettled Bhutanese population, it is essential for healthcare professionals and public health stakeholders to have open and honest dialogue and sharing of information, such as benefits and risks associated with vaccines and other preventive measures, to ensure that it is up-to-date, relevant, and able to guide the delivery of integrated mental and public healthcare. This further includes promoting opportunities in the community for employment, education, professional training, transportation, technology training and access to technology, addiction services, health insurance, and school meal programs, among many other resources. Although some of these services are temporarily provided

upon resettlement, there remains a large disconnect between refugees arriving and becoming self-sufficient. Ninety days of government assistance upon resettlement in the USA is not enough to establish a foundation for self-sufficiency as it takes a long time to learn the English language; secure employment, housing, and transportation; and understand the healthcare and legal systems. Greater access to such services provided by public health and nonprofit agencies needs to be extended with supportive personnel resources (such as legal experts to provide aid and interpreters to provide translation services), and this access must be continually made available upon resettlement and after with integrated financial, political, and legal support from other government and community leaders.

Financial and Legal Aid and Advocacy Needs

Sufficient access to legal tools, resources, and technology for telecommunication is crucial for resettled Bhutanese refugee populations as ongoing cases and hearings are still being conducted in spite of the global pandemic. In the USA, for example, court hearings for certain immigration matters are still being conducted with few protections in place for litigating non-citizens (Loweree et al. 2020). While the UN Refugee Agency continues to help refugees achieve resettlement, the agency has disclosed that it does not technically provide legal advice or direct representation on immigration matters (UNHCR n.d.). Of course, in order to ensure that this support is available, particularly through NGOs and other public health agencies, more funding must be allocated to these programs by federal and state governments. Arguably as important as increasing financial support, there needs to be an increase in political support for the refugee community. Political support for this vulnerable population will not only raise awareness, but also affect substantial change. Via supportive public statements, legislation, and so on, politicians and governmental leaders around the world have a duty to make room for refugee issues.¹

Extensive financial and political support enables refugee-focused nonprofit organizations to continue providing a network of services to resettled persons. One such organization, Asian Services In Action (ASIA), Inc. in Ohio, has had much success in this area. ASIA, Inc. has become a “one-stop shop” for its refugee communities in the northeast Ohio region; from healthcare services to translation services and English classes, ASIA, Inc. maintains a myriad of programs aimed toward assisting the refugee community throughout their resettlement.² Organizations like this must be supported so that our refugee neighbors are given an equal opportunity

¹ Illustrative of this political support is a letter authored by Ohio’s governor, Mike DeWine. In a letter to Mike Pompeo, US Secretary of State, Mike DeWine advocated for continued refugee resettlement in the state of Ohio (ASIA, Inc. 2020). Mike DeWine stated in his letter that, “Ohio has a long and successful history of welcoming and assimilating refugees from all corners of the globe...Ohio also has a well-developed support network to welcome and assimilate refugees”. This letter was prompted by the federal government which now requires each state to consent to the continued resettlement of refugees within its borders.

² See ASIA, Inc.’s website (<http://www.asiaohio.org/>) for more information about the organization, including a full list of its programs and services.

at success. On a broader community level, public health and nonprofit agencies may address SDIMH among the Nepali-speaking refugee community by establishing safe recreational spaces like parks and gardens, community courses in English and mental health, and Nepali translation services provided in all support services, not just the limited translation services provided in some clinics. Community level group workshops for mental health interventions also improve mental health and allow for a more successful transition in refugee resettlement (Peterson et al. 2020). Another way of addressing mental health disparities is by using problem and emotion focused coping strategies, which has reduced stress among some resettled Bhutanese refugees in Massachusetts (Poudel-Tandukar et al. 2020).

Public health agencies and nonprofit agencies can more fully advocate and support SDIMH of resettled Bhutanese refugees by aligning community resources and collaborating together to identify health-related priorities. Rather than individual agencies focusing only on the services they provide, these agencies must join with other community agencies and leadership to mutually address mental health needs. For our Bhutanese community, this may look like public health and nonprofit agencies working alongside elders and spiritual leaders in the community and aligning community resources to accomplish mental health-related priorities. This cooperation then allows for greater understanding of cultural values and preferences, language considerations, and alternative mediums best suited to reduce the impact of depression and anxiety (Baker et al. 2016). Such cooperation has been illustrated with one of our local agencies that provide legal, health, financial, and social support for our Bhutanese resettled refugees (Asia, Inc.); this agency has been supportive in our own efforts in addressing the needs of this valued population within our community.

Another way of coordinating community resources is through clinical screenings of SDIMH. One example is the federal Accountable Health Communities Model (AHCM) which seeks to reduce clinical spending by addressing social determinants. This prioritizes clinical screenings for unmet social needs and connects different community services to ensure the availability and responsiveness of resettled Bhutanese refugees' needs, which are often unrecognized without established culturally sensitive clinical screenings (Sullivan 2019). Public health and nonprofit agencies, healthcare clinics, and legal services should address community-based issues that expose resettled Bhutanese refugees to mental illness by screening for unmet social needs and providing direct connections to community services and resources.

Conclusion

The fear of getting sick, of being hospitalized, and losing one's own life or the life of a family member during this global health crisis are on the minds of most persons, but for Bhutanese refugees who have been resettled to the USA, these fears, along with unexamined social determinants, contribute to and are exacerbated by untreated mental illness and addiction (e.g., PTSD). The isolative nature of having to quarantine, the inability to connect with healthcare professionals and other

experts in person, and other potentially life-threatening barriers further contribute to this fear. Although refugees sometimes receive a mental health screening during an initial visa medical examination and are referred for psychiatric evaluation, many of the mood, anxiety, psychotic, and substance-related disorders emerge during resettlement and might not be sufficiently screened, let alone treated. When further traumatic events—such as a global pandemic—occur, the mental health needs, along with public health needs, of resettled refugee populations must be met to ensure survivability of their communities embedded in American society, but often omitted from privilege and social status.

The Bhutanese refugee population has lived through multiple types of crises (displacement, physical and sexual violence, loss of loved ones due to illness or violence, living in camps deprived of basic needs, etc.); however, they have a tremendous capacity for resilience, or “the ability to maintain relatively stable, healthy levels of psychological functioning in the face of highly threatening events” (Refugee Health Technical Assistance Center 2011; Bonnano 2005a, 2005b). The Refugee Health Technical Assistance Center (2011) explains that it is “respectful to honor their capacity for resilience and to foster positive adaptation by helping them obtain and protect internal and environmental resources.” So while urgent mental health needs currently escalate among resettled Bhutanese refugees, including a suicide rate more than double the numbers of US born citizens, it is important to recognize that many resettled refugees look to protective factors such as hope and a sense of duty to others as Bhutanese experts are beginning to come together to help their community stay safe. Despite their resilience, however, it is an obligation of healthcare professionals, government leaders, advocates, and others to address the SDIMH, related barriers, and infectious disease protections in the age of COVID-19 for our resettled Bhutanese refugees and all refugees, asylum seekers, and other marginalized, vulnerable populations who have been traumatized in their home countries and in refugee camps, and re-traumatized through challenges in resettlement.

While we have focused our attention on supporting the mental health needs of our Nepali-speaking Bhutanese resettled refugee populations in our local community, may our insights, experiences, and justice-based framework be of value to others who deeply care about the welfare of others and our shared humanity. Harmonized engagement, cultural humility, and advocacy are essential to social justice efforts, and for a deeper understanding of social determinants of (mental) health and the meaning of basic human rights.

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Declarations

Conflict of interest The authors declare no competing interests.

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