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Service Providers' Perceptions of Refugees' Needs, Services and Service Delivery Barriers in Burlington, Vermont

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**Service Providers' Perceptions of Refugees' Needs,
Services and Service Delivery Barriers in Burlington,
Vermont**

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Submitted in partial fulfillment of College Honors

Department of Global Studies

College of Arts & Sciences

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Thank you to my advisor, Professor Jeanne Shea, for helping me to design this honors thesis project and for assisting me through the IRB and writing process.

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Finally, thank you to all of the local coffee shops who allowed me to sit for hours on end and drink cup after cup of coffee.

Acronyms and Abbreviations

AALV	Association of Africans Living in Vermont
AHS	Agency of Human Services
BHA	Burlington Housing Authority
CCTA	Chittenden County Transport Authority
CHCB	Community Health Centers of Burlington
CODTP	Co-Occurring Disorders Treatment Program
CTS	Chronic Traumatic Stress
CVOEO	Champlain Valley Office of Economic Opportunity
DCF	Department of Children and Family Services
ELL	English Language Learning
ESL	English as a Second Language
GED	General Education Development Test
LMHC	Licensed Mental Health Counselor
NESST	New England Survivors of Torture and Trauma
NFNA	New Farms for New Americans
PTSD	Post Traumatic Stress Disorder
SBCA	Somali Bantu Community Association
TOEFL	Test of English as a Foreign Language
USCIS	United States Citizenship and Immigration Services
USCRI	U.S. Committee for Refugees and Immigrants

UVMMC

University of Vermont Medical Center

VITS

Vermont Interpreting and Translating Services

VRRP

Vermont Refugee Resettlement Program

Interviewee Biographies

Pablo Bose

Pablo is a professor of Geography at the University of Vermont who has done research on refugees and transportation at the University of Vermont. He is also affiliated with the New Farms for New Americans program, and serves on the boards of the Chittenden County Transport Association and the Burlington Housing Authority. While not a direct service provider, Pablo has a great deal of interaction with the refugee community; he knows many service providers, attends the RISPNet meetings, and does a lot to support the needs of the refugee community in the Burlington area.

Tina Lancaster

Tina is a licensed mental health counselor and social worker. She has been affiliated with Vermont Refugee Resettlement Program as a volunteer for many years and is an advisor for the Diversity Rocks group. She is intimately involved in the Somali Bantu community in Burlington.

George Weber

George is an English language learning teacher at the Somali Bantu Community Association. He teaches English as a second language to many Somali Bantu refugees and other refugees or immigrants in the Burlington area. He also works in the Community Association in whatever capacity they need help with and it will be shown in this thesis that he often provides services in other capacities as well.

Cathy Kelley

Cathy is a licensed social worker who works as a clinician and as the Care Coordinator at Connecting Cultures. Cathy also works as the Care Coordinator at the Pediatric Outpatient New American Clinic at the University of Vermont Medical Center. She has been working with refugees for over 20 years.

Dr. Sandy Steingard

Dr. Steingard is a psychiatrist and also the Medical Director of the Howard Center. She sees many patients who are refugees and who also suffer from persistent mental health issues. In her time at the Howard Center, she has served refugees from many different countries and cultures.

Abstract

This thesis investigates the behavioral, mental health, and social service needs of the refugee community in the Burlington area, and the services available for them. I explore what these services entail and how the various providers who work with the refugee community in the Burlington area provide these services based on the provider's perceptions of the community's behavioral, mental health, and social service needs. My research focused on seeking an understanding of how local service providers determine what services to provide to support the refugee community's needs, as well as how providers think the refugee community perceives and uses these services. This thesis examines what the providers believe works or does not work well to meet the refugees' needs, as well as perceived barriers to and gaps in meeting these needs. Based on data I collected through ethnographic research, participant observation and interviews, I also describe similarities and differences among the providers. In conclusion, I identify potential strategies for overcoming the perceived barriers and gaps.

Chapter I: Introduction

Background Information

In the last couple of decades, research on refugee and immigrant mental health has greatly expanded. This expansion of research is important to refugee populations' health and well-being. Given the trauma many refugees have faced, the subsequent mental health issues they may struggle with further complicate the inevitable stress of adapting to a new country, culture and customs. As a result, research on refugee resettlement and refugee services has many implications for the fields of global studies, global health, medical anthropology, social work, psychology, nursing, and education. Given that refugees come from all over the world, from many different cultures, and from many different experiences, global studies would take a particular interest, as an interdisciplinary academic field, in the intersection of these many different cultures. Global health and medical anthropology also deal with the intersectionality of health and culture, which are key aspects of the refugee resettlement experience. Social work, psychology, nursing, and education are also of importance in this study in that these are the fields that many refugee service providers have training in.

My research investigates the services available to refugees in the Burlington area that aim to alleviate such stressors and support their emotional health and social service needs. As a result, my research provides a unique opportunity to expand knowledge on global mental health. Doing this research in Burlington, Vermont, and focusing analysis on refugee services supporting emotional health and wellbeing offers a niche-perspective on global mental health. Little research has

been done, however, on the efficacy of refugee resettlement programs and related social and emotional health services for refugees or on providers' self-perceptions about the services they provide, especially in Vermont. Additionally, while many studies have focused on refugee mental health, most have been conducted solely in a clinical setting, meaning that the studies focus on refugees who already have a demonstrated mental health issue (Balgopal 2000: 210).

Every year, massive numbers of people seek asylum and refuge in a new country. Numerous cultures and people worldwide historically have sought, and continue to seek refuge in the United States in particular. According to Baird (2011), approximately 320 refugees from all over the world settle in Burlington, Vermont, a Federal Refugee Resettlement District, every year. Like refugees everywhere, they deal daily with mental health and other health-related issues. Since 1989, approximately 6,300 refugees have been resettled in Vermont via the Vermont Refugee Resettlement Program. Men, women, and children who have resettled in Vermont over these past 25 years originate from Bosnia, Bhutan, Burundi, Congo, Rwanda, Somalia, Sudan, Vietnam, and Iraq, among other countries. Of these refugees or new Americans, the largest ethnic groups come from Bosnia, Bhutan, and African countries such as Burundi, Congo, Rwanda, Somalia and Sudan. Approximately 1,705 of these refugees are Bosnian, many of whom are Muslim; approximately 1,437 are Bhutanese, many of whom were exiled to Nepal and speak Nepali; and approximately 1,000 are Africans who escaped from horrific violence in the African countries listed previously (Kelley 2014). Vermont has one of the smallest state populations in the United States and also is one of the least diverse

racially. Vermont's comparatively large refugee population is largely responsible for the minimal diversity in the state.

Given the trauma many refugees experience, and the often long and tumultuous journey they take to reach a resettlement country, many services (social, behavioral and mental health) are needed to help alleviate their stress and other emotions and barriers related to the trauma they experienced in their home country and in transit. Additionally, starting over and resettling in a new country, no matter previous experiences, can be overwhelming. This is why services of different kinds are necessary to support the varied needs of refugee communities.

Many different organizations in the Burlington area are available to provide a variety of different social and emotional services and support to the surrounding refugee community. For example, the Howard Center, which uses different strategies to serve the unique needs of the culturally diverse refugee community, employs 3 refugees from Bhutan. As Program Managers, these individuals serve not only the diverse needs of the broader refugee community, but also more specifically Bhutanese refugees, many of whom have intellectual disabilities. Other examples include the Developmental Services Department, which in 2013 approved services for 71 new clients, including many refugees who presented a high demand for services (Marjoros 2013). The Community Health Center of Burlington (CHCB), another service provider, considers itself the first medical "home" for adult refugees in the Burlington area (Community Health Center Burlington 2014). These examples are just a few of the many organizations serving refugees in the Burlington area. Other organizations, such as the Vermont Refugee Resettlement Organization, tend

to work with refugees mostly when they first are resettling into life in Vermont.

By observing the services that local, state, national, and international organizations provide, one can see what service providers perceive to be refugees' needs, as well as the possible barriers to service provision. According to Eugenia Hsu (2004: 194) in *Clinical Psychology Review*,

“Since refugees are typically pushed out of their homelands, they are often unprepared for circumstances ahead of them that may result in feelings that they have little or no control. Refugees, therefore, feel they are losing control...of their future during the migration process.”

Eugenia Hsu argues that many perceived needs, especially those related to emotional or mental health, are due to stress related to migration, acculturation, and assimilation. Loretta Kuliawat Denhart (2005: 64) states based on her research, “By the very nature of their circumstances, refugees find themselves in a position to need and receive help.” Additionally, many social service needs seemingly result from these emotional or behavioral and mental health needs because “Mental health issues stemming from refugees' experiences also complicate the process of obtaining stable employment...” (88).

As service providers indicate, refugees need help in various ways. These include establishing new homes with proper items for life in the United States, with transportation, skills to conduct themselves in American life and American systems, cultural training, job development, interpretation, and more, all of which are supportive services social agencies provide (Denhart 2005: 91). Refugee needs can be as specific as not understanding the “paper chase that we have here in America, like disputes over telephone and utility bills or troubleshooting when Medicaid or food stamps are stopped and the refugee does not know why,” or figuring out how

to get marriage or driver's licenses without a birth certificate (96). These examples highlight just a few of refugees' needs from the perspective of service providers.

Also of important note is the fact that the needs of refugees change over time in the resettlement process and, frequently, a system of service providers must work together to deliver the various services refugees need at different times. This system of service providers is a common practice in refugee resettlement model states, such as Minnesota. For example, in the first three months of resettlement, voluntary agencies, commonly known as "VOLAGS," work with refugees to serve their immediate needs and connect them to other organizations and emotional health and social services they may need to use in the future (Minnesota Department of Human Services 2014). Organizations like the Department of Health and the Department of Human Services are a huge resource in connecting this system of services in Minnesota (Minnesota Department of Health 2014).

Despite these networked services, providers still face barriers to meeting refugees' needs. Denhart's (2005) research of service providers showed that resettlement workers "consistently pointed out" barriers that "fall into three categories: English language proficiency, adaptation to culturally specific practices in the workplace, and having transferable skills" (130). These barriers, interestingly, are some of the same issues providers already identified as refugee needs. In her research, Denhart noted that providers identified refugees' preconceived ideas about how American society functions and how systems and services work, as barriers to asking for help or understanding how to use services.

Thesis Statement

In order to guide my research, I sought to answer the following research questions: What are the local emotional and/or mental health services and social services available to the refugee community in the Burlington area? What do these different services provide and how do they provide it to the refugee community? What do the local service providers perceive to be the refugee community's emotional health needs and social service needs? How do these service providers determine what services and support the refugee community needs? (How do they do needs assessments?) How do these service providers perceive that their services are being received by and used by the refugee community? What do the providers generally think is working well in terms of meeting these needs? What do they generally think isn't working well? What do service providers' perceive as being in the way of meeting these needs? What are some strategies for overcoming the barriers and gaps in meeting the perceived needs of the refugee community? What are the similarities and differences across the perceptions of the service providers?

Through my research, I encountered a number of social and mental or behavioral health services that serve refugees in the Burlington area. Service organizations in and around Burlington include the State Refugee Office, the Vermont Refugee Resettlement Program (VRRP), the Association of Africans Living in Vermont (AALV), the Somali Bantu Community Organization (SBCA), the University of Vermont Medical Center (UVMMC), Community Health Centers of Burlington (CHCB), Connecting Cultures, and the Howard Center. All of these organizations have different criteria for whom they serve and how they provide services.

Based on my ethnographic research, in this thesis I argue that local service providers perceive that the refugee community of Burlington has many different needs and issues. Service providers perceive there to be a basic need for things like clothing, shelter and food, in addition to social service needs and mental or behavioral health needs. The perceived social service needs of the refugee community of Burlington include issues of citizenship, employment, English language learning, literacy, education, transportation and transit, healthcare, housing, access to services, understanding the system, communication, making doctor's appointments, knowing what services are available and how to access them, filling out forms, and coordinating family life and childcare. Perceived mental or behavioral health needs and issues include Post Traumatic Stress Disorder (PTSD) or trauma related stress, stress, familial relationships, substance abuse and gendered/domestic violence, and feeling emotionally unhealthy.

Local service providers assess need and determine what services to provide by listening to refugees, using methods of observation and experience-based decision making, and prioritization. Some service providers felt like there may be a difference in how they perceive services and how refugees may view these services. Service providers had varying opinions about how refugees perceive local services. A couple of providers felt like they couldn't speak for refugees about how refugees feel about local services.

Most service providers however, feel like service agencies do a good job of supporting the needs of the refugee community, and at the same time, many of them feel like there are many aspects of service provision and of service agencies that

could be improved upon. Service providers also discussed aspects of service provision that they are struggling with due to various barriers that prevent them from delivering services and that prevent refugees from accessing services. Many of the strategies that service providers use to bridge the gap in service provision are the same aspects of their services that they feel are working well.

In chapter one of this honors thesis project, I describe the various social and mental or behavioral health organizations that serve the refugee community of Burlington, Vermont. In chapter two, I present what local service providers perceive to be the basic social service and mental or behavioral health needs for the local refugee community. I also examine how local service providers assess the refugee community's needs and determine services to provide to support and alleviate these needs.

In chapter three, I analyze how providers think the local refugee community views the services offered. I also discuss providers' self-perception of these services and services other organizations provide in terms of what is working, what isn't working, and the challenges they face. The analysis also considers the barriers providers feel prevent them from providing effective services and the barriers they believe prevent refugees from fully accessing these services. In conclusion, I discuss potential strategies for overcoming these barriers.

Research Methodology

My initially approved (by the College Honors Committee) thesis research project on refugee mental health in Burlington unfortunately ran into some

insurmountable barriers, which prompted revision of my methodology. Originally, I planned to interview refugees, mental health service providers, and experts, and focus on refugees' views of their mental health needs and preferences for services and support. However, in the course of writing my proposal for the University of Vermont IRB and some initial research, information regarding feelings among the refugee community that they are extremely over-researched came to light. As a result, I turned my focus to examine refugee services, service providers' perceptions of local refugee social, and mental and behavioral health services. More specifically, I interviewed providers regarding what services they offer refugees, what they believe the refugee community's needs entail, how they determine what services to provide, what barriers to service delivery providers face and how effectively they think the services they provide are working.

This senior honors thesis project was researched under exempt review from the IRB and under the advisement of Professor of Anthropology, Dr. Jeanne Shea. Over the course of my yearlong project, I used ethnographic methods to conduct five semi-structured interviews with local social and mental and behavioral health service providers. I have directly credited some providers interviewed for their contributions; others requested I use a pseudonym to protect their anonymity for all or part of the information they shared with me. All providers interviewed contribute services to refugees in the Burlington area in different capacities. I interviewed two social workers: Tina Lancaster, who is affiliated with the Vermont Refugee Resettlement Program (VRRP), and Cathy Kelley, who works as the Care Coordinator at Connecting Cultures and the University of Vermont New American

Outpatient Pediatric Clinic; one English language learning teacher: George Weber, who works at the Somali Bantu Community Association (SBCA); a Professor of Geography: Pablo Bose, who has done research on refugees and transportation and is affiliated with the New Farms for New Americans program; and a psychiatrist: Dr. Sandy Steingard, who is the Medical Director of the Howard Center. Each hour-long interview was recorded using a digital recorder and transcribed in full using the interview guide below.

Sample Interview Guide

Your Organization:

- What cultural or ethnic groups of refugees do you work with?
- What are the main differences or similarities in the service needs of the different cultural groups that you and your organization work with? For social services? For emotional services?
- How do you assess need in the refugee community?
- What do you see as the local refugee community's emotional health and social service needs?
- How did you determine which services you will provide and prioritize?
- Have the services you provide changed over time? If so, how and why?
- Is there a limit to how many refugees or the kinds of refugees you can serve? If so what and on what is that limit based?
- What things would you say your organization is particularly good at and what are some things that you are struggling with or don't even try to do in terms of meeting perceived refugee needs?
- Is there anything that prevents you from meeting these perceived needs? If so what and how?
 - What do you notice as barriers to meeting these perceived needs? Are there gaps in meeting these needs?
- What do you notice as barriers for refugees in accessing services?
- What are some strategies for overcoming these barriers and bridging these gaps for the refugee community?
- What strategies do you employ for overcoming these barriers?
- In terms of quality or relevance, do you think there is a difference between how you perceive your services and how the refugees perceive them? If so, how so? If not, why not?

- How do you think your services are working for the refugee community? How do you think your services are being received?
- How is the refugee community utilizing your services?
 - What services are most used? Least used?
- What do you think is working well in terms of meeting the refugee community's needs? What do you think isn't working well?

Refugee Services More Broadly:

- What other main local services for refugees are you aware of? And what do you see as their relative strong suits and limitations?
- How do you work with or communicate with other local service providers in the area? Local services? Federal services in the local area?
- If you don't provide a service that a refugee might need, where do you refer them or how do you assist them to find the help or service that they need?
- Do you think that other social service organizations that work with the local refugee community are struggling with the same barriers that your organization is? If so how? If not, why not?
- How do you think other services are doing in terms of meeting what you think are the refugee communities needs?
- What do you think they are doing well? What do you think they aren't doing well?

I also used participant observation methodology in my research by attending a meeting of a network of local service providers, the Refugee Immigrant Service Provider Network (RISPNet), and a lecture given by Pablo Bose on refugee resettlement in Vermont. These methodologies supported answering my research questions.

To analyze my ethnographic data, I synthesized and coded all interviews and observations. I also examined the various service organizations' websites for additional primary data. To supplement my ethnographic and web archival findings, I also researched scholarly resources from various disciplines, including

anthropology, medical anthropology, social work, education, psychology, nursing,
and sociology.

Chapter II: Local Social and Mental or Behavioral Health Services for Refugees

To help identify local services available to refugees in the Burlington area, I connected with professors and friends who have worked with the local refugee community or conducted research in the community. After identifying some organizations, I reviewed their websites to assess their services (what services and how they are provided). I then began contacting people at these organizations to request interviews. Some of the organizations serve the refugee population specifically, while some serve the community as a whole and others follow different criteria (require qualifications) for whom they serve and why. The only organizations that solely serve refugees are the State Refugee Office and the Vermont Refugee Resettlement Program (VRRP). The Association of Africans Living in Vermont (AALV) and the Somali Bantu Community Association (SBCA) serve mostly refugees, however they serve immigrants as well. Organizations that serve refugees and the community as a whole include the University of Vermont Medical Center and Community Health Centers of Burlington, to name a few. Other organizations that provide services based on qualifying factors include Connecting Cultures (the part of New England Survivors of Torture and Trauma (NESTT) that provides mental health services), which serves refugees, asylum seekers, and immigrants—basically anyone who is a survivor of torture or trauma, whether official refugee or not. The Howard Center, likewise serves anyone who suffers from specific mental health issues.

Programs specifically for refugees

The State Refugee Office

The State Refugee Office at the Vermont Agency of Human Services (AHS) coordinates the RISPNet meeting, which convenes every four to six weeks throughout the year at the Fletcher Free Library in Burlington. These meetings bring together service providers from all the various local organizations that serve refugees, immigrants and new Americans in Chittenden and Washington counties (State of Vermont Agency of Human Services 2014). Each two-hour meeting has an agenda, but often when an organization raises an issue, and other providers identify similar issues or recommend suggestions, the discussion does not always strictly adhere to the agenda. The meetings offer service providers an opportunity to learn about other organizations and provide a space for service providers to network with colleges in order to develop connections for client referral.

Denise Lamoureux, State Refugee Coordinator, chairs and coordinates these RISPNet meetings. She kindly included me in the meeting on January 22nd, 2015. As State Refugee Coordinator and chair of RISPNet meetings, Denise Lamoureux works to “increase collaboration, foster the sharing of information, and maximize resources for the resettlement and successful integration of the refugees into Vermont.” As the State Refugee Coordinator, she also “implements the State Plan for Refugee Resettlement, oversees federal grants for refugee services, including refugee medical assistance, refugee social services and refugee children school impact grants.” Lamoureux also chairs the Agency of Human Services’ (AHS) Limited English Proficiency Committee. Her work involves collaboration with all state

departments and agencies, along with other national and community partners (State of Vermont Agency of Human Services 2014). The State Office of Refugee Resettlement works most closely with VRRP, however, as they are two of the larger refugee-specific organizations, that serve only refugees.

Vermont Refugee Resettlement Program (VRRP)

VRRP is the organization that provides the first resettlement support to refugees coming into Vermont. Technically, they have “a mandate to work with people...for 8 months,” said Tina Lancaster, local social worker and licensed mental health counselor. VRRP resettles “. . . anywhere between 300 to 400 refugees a year. . . usually around 325,” said Pablo Bose. At the RISPNet meeting in January, the director of VRRP, Amila Merdzanovic, noted that in the previous month (December 2014), the number of arrivals was unusually low, only 15 refugees. In January 2015, however, 22 refugees arrived, including nine Bhutanese, three Iraqis and nine Somali. In February 2015, VRRP expected 25 refugees, including four Iraqis, 18 Bhutanese and three Burmese.

When these refugees arrive, VRRP assists as can with resettlement and addresses acute needs. Alice Clark, a licensed social worker who works with refugees said,

“ . . . you know, when refugees come in particular, they are brought here by Vermont Refugee Resettlement Program, which is tasked with meeting their basic needs when they get here; setting them up in housing and getting them connected to education, social services, benefits, making sure that they have, you know, basic needs met; that they’re set up with health care. So, generally those connections are made...”

Essentially, according to Alice Clark, “if someone is a new arrival, they should be getting most of their needs met from Vermont Refugee Resettlement Program.”

Volunteers, whom the service organization assigns to each family and/or individual, help support a huge part of the resettlement process. Tina Lancaster, a licensed mental health counselor (LMHC) and long-time volunteer with VRRP, describes the volunteers as the people who help refugees integrate. She said that “at the beginning, it’s somebody [a volunteer] who drives you grocery shopping, and takes you to doctors appointments, and fills out paperwork for you, and is a friend to you, and that takes people out of the realm of being terrified . . .” These volunteers, according to the VRRP website, are categorized as Family Friends, Job Search Coaches, and English Tutors (USCRI VRRP 2014). When Tina Lancaster first started volunteering with VRRP, she was a “Family Friend;” her role soon evolved beyond, as she put it, helping “newly arrived families adjust to life in Vermont.”

VRRP’s Job Search Coaches assist refugees with creating résumés and practicing for interviews. English Language Tutors assist refugees in acquiring English language skills (USCRI VRRP 2014). As a volunteer, Tina Lancaster would often gather “a great, big, giant bag to take to the airport in the winter so that they [Somali Bantu refugees] could put on coats and hats before they left [the airport].” Before a VRRP volunteer goes to the airport to meet his or her assigned family, the VRRP director will call a few days in advance with the “names, ages, genders and sizes” of the refugees to meet. VRRP often gathers large amounts of clothing in all sizes. Volunteers can then also “go to their [refugees’] houses with bags of clothes.” Even if, as in the case of Tina Lancaster’s refugee family, they “...couldn’t speak English” and she “couldn’t speak Mai Mai,” as Tina Lancaster describes, together they “sort through clothes and figure it out and laugh, and we made it work.”

VRRP also helps with other acute needs, such as getting a family a cell phone. As Tina Lancaster commented, “You have to get them a phone. What happens if a kid falls and cuts their head open? They’re not gonna know how to get help!” According to the service providers I interviewed, VRRP also connects refugees with other local services and service providers by partnering with other local organizations, such as ReCycle North (Resource), Ohavi Zedek Synagogue, The Possibility shop, Bike Recycle Vermont, or The O’Brien Community Center, to provide services to refugees (USCRI VRRP 2014).

One of VRRP’s primary services is interpretation and translation through its program Vermont Interpreting and Translating Services (VITS). Much information on the program can be found at the VRRP website, which says that VITS is “the state’s premier interpreting service.” According to the VRRP website, their “well-trained interpreters are able to express ideas, words, and concepts that may have no equivalent in the target language and can also integrate the different world views they represent, while respecting the autonomy of all parties present.” VITS interpreters are trained in various types of interpretation services, including “medical, legal, professional, and basic areas, and many are certified medical ‘Bridging the Gap’ interpreters.” The VITS program offers interpretation and translation in

“Arabic, Armenian, Bengali, Bosnian (Serbo-Croatian), Burmese, Cantonese, Chinese, Dinka, Dzongkha, French, Georgian, German, Gujarati, Hindi, Japanese, Karen, Kinyarwanda, Kirundi, Kizigua, Kurdish, Lao, Lingala, Mai Mai, Mandarin, Nepali, Portuguese, Punjabi, Romanian, Russian, Sharshokpa, Somali, Spanish, Swahili, Taishanese, Thai, Tibetan, and Vietnamese” (USCRI Vermont Refugee Resettlement Program 2014).

VRRP also has the English Language Learning (ELL) Department, which is the staff-run English language instruction program. ELL offers classes in English language learning to refugees between 17 and 65 years old. All instructors are professionals who receive training in how to be an ELL instructor from the ELL coordinator at VRRP and have backgrounds in “education, linguistics or speech/language pathology.” ELL provides language instruction to over 500 refugees and teaches both spoken and written English language instruction as well as “spoken language comprehension and expression, literacy, cultural awareness, social language, local community orientation and awareness, health and safety, United States history and geography, and English for the workplace” (USCRI VRRP 2014).

ELL classes are offered at different organizations, businesses and private homes in Burlington, Winooski and Colchester, among other locations in Vermont. The classes are organized into seven curricular levels with varying levels of English language skills at each level. At every curricular level, except for the very first level, “students are expected to purchase program workbooks, to complete home assignments and must pass level assessments in order to advance to the next level.” The Newcomer level, for example, is described as “Little to no spoken and/or written English experience,” while the Intro level is described as “Advanced Beginner: Emerging spoken and written English Skills,” and Level 1 is described as “Early Intermediate: functional spoken and written English skills.” After a student passes all seven levels VRRP encourages him or her to continue English studies

through “employer based training, technical colleges, or college-level programs” (USCRI VRRP 2014).

VRRP also offers employment services. As George Weber, an ELL teacher said to me during an interview, “VRRP might be a better place to go for employment resources, because they are specifically hired to help people get jobs.” VRRP has three employment counselors who work with refugees and local organizations and businesses to find refugees employment. VRRP even has Web page directed to local businesses to explain the benefits of hiring refugees and why they make good employees (USCRI VRRP 2014).

Organizations that serve mostly refugees

The Association of Africans Living in Vermont (AALV)

Organizations like the Association of Africans Living in Vermont (AALV) and the Somali Bantu Community Association were created by former refugees in response to feeling that their needs were not being adequately met by other local organizations that are tasked with serving the refugee population. As George Weber, a service provider at the Somali Bantu Community Association said, “There’s this experience of [refugees] getting burned by working with...” other organizations and so these organizations emerged “...out of [refugees’] needs not being met” by these other organizations. According to the AALV website, it was originally founded as a way for the African community in Vermont at that time to gather socially and “discuss the challenges of being in America.” After over seven years of growth in the community and as an organization, AALV is now a small agency that provides social

services to African refugees and immigrants living in Vermont. As of 2009, AALV began to serve the refugee community as a whole and not just Africans (AALV, Inc. 2014).

In serving the refugee community at large, there are a number of different services that they offer. AALV specializes “in ensuring linguistically and culturally appropriate access and utilization of social services” like childcare, healthcare, and housing, among other things. The case managers at AALV work to help refugees and immigrants transition to life in America and to American culture. As a testament how much work AALV does with the refugee community, its “case managers assist several hundred clients through 4,000 service interventions and roughly 2,000 referrals annually” (AALV, Inc. 2014).

According to Cathy Kelley, a licensed social worker, “AALV has case managers who can assist clients with paper work and things like that. They have legal resources there, so if someone is wanting to apply for citizenship or...for their green card we can send them there.” Additionally, AALV has been holding meetings in partnership with the United States Citizenship and Immigration Services (USCIS) to answer questions about residency, travel documents, medical waivers and the citizenship process. According to the AALV representative at the RISPNet meeting, USCIS has been helpful in answering these questions and correcting misinformation for the refugee community. This same AALV representative said that about 20-35 people come to these meetings, and while AALV was started by and for Africans, recently attendees have mostly been Bhutanese refugees. According to the AALV website, other services they provide include interpretation services. These

interpreters work in many different capacities and with other local “social services providers including health care facilities and courthouse.” Their interpreters work with over 17 different languages and translate from English to these languages or vice versa (AALV, Inc. 2014).

AALV also has two personal and behavioral health programs. One program is education and assistance surrounding domestic violence and the second program provides services for HIV prevention for youth. According to the AALV website, “Both projects are supported with funds from the State of Vermont, and both projects involves the dissemination of linguistically and culturally appropriate information through flyers, home visits, and workshops.” AALV also coordinates their domestic violence project efforts with other local, mainstream service providers who specialize in domestic violence. These efforts often include invention assistance (AALV, Inc. 2014).

AALV offers other programs in workforce development, in coordination with the New Farms for New Americans (NFNA) project, and “job skills training for refugees and immigrants interested in becoming Home Health Aids and Licensed Nurses Assistants (LNAs)” (Association of Africans Living in Vermont, Inc. 2014). NFNA helps “refugees and immigrants continue to practice their agrarian traditions through the production of culturally significant crops.” NFNA teaches and shares their agricultural practices with Vermont farmers and agriculturalists so as to contribute to a cross-cultural agrarian practice in Vermont. NFNA works with well over 90 refugee and immigrant households, mostly with people from Africa and Asia, and partners with nonprofits, the Intervale Center and the Winooski Valley

Park District, to further their mission. Both of these workforce development projects include training, technical assistance, English language assistance, certification preparation and job placement assistance (AALV, Inc. 2014).

AALV is also continuing to innovate. At the RISPNet meeting, AALV announced that they will be partnering with Connecting Cultures to hold a parenting class and a childcare training program. Additionally, AALV is revamping its medical interpreter-training program to include role-play and videos. These trainings will also focus specifically on mental health interpretation, rather than just medical interpretation.

The Somali Bantu Community Association

The Somali Bantu Community Association is another local social service organization that works with refugees and that grew out of a need to address refugee needs in Chittenden County. According to their website, the Somali Bantu Community Association “represents this community’s first opportunity for self-advocacy,” and “its programs, goals and mission are a direct result of community input and leadership.” The Community Association was created in reaction to the resettlement of over 600 Somali Bantu individuals in Chittenden County since 2003. The Community Association offers many different services to the Somali Bantu community and to other refugees living in Vermont (SBCAV, Inc. 2014).

Many Somali Bantu are illiterate in both English and Mai Mai, their native language. In fact, 95% of the Somali Bantu in Chittenden County are illiterate in English and 90% are illiterate in Mai Mai; therefore adult literacy is one of their primary programs. The Vital Information Service Project works in correlation with

SBCA's literacy program. Due to the fact that many Somali Bantu are illiterate, they are often relegated to customer service positions. Even if they are employed, many are left "with little to no opportunity for upward mobility." The Vital Information Service Project provides case management and helps refugees to develop job skills through workshops that "aid individuals in overcoming barriers to employment, educational opportunities, or human services aid" (SBCAV, Inc. 2014).

SBCA also runs a program called the New Father Initiative, which helps fathers in the refugee community by "giving them support and resources they need to continue being strong and positive role models for their children." This program holds weekly meetings to help refugee fathers to adjust to life and parenting in America. By exploring any questions or problems that they are dealing with, refugee fathers are supported emotionally and educationally during this adjustment period (SBCAV, Inc. 2014).

SBCA has a women's committee that has created many different programs within the organization, some of which are orientated toward social networking. One of these programs is known as the Knitting Group Project. SBCA's Women's Committee developed the Knitting Group Project to help refugee women meet, create friendship with other refugees and to bond over shared experiences and circumstances while making traditional crafts. Another program overseen by the Women's Committee is the Tabar Women's Leadership Program, which "is devoted to the needs and concerns of refugee women," specifically. This program focuses on support meetings regarding challenges that mothers face in the U.S., English literacy

classes, and career support through mentor relationships with professionals in the Burlington community (SBCAV, Inc. 2014).

SBCA also sponsors recreational programming. SBCA sponsors three soccer teams for men and women ages 16 to 26 as part of their youth recreational program (SBCAV, Inc. 2014). According to George Weber, a volunteer and ESL teacher at SBCA, this soccer club is of particular importance to the Somali Bantu community “...because that’s where they release and where they have fun and where they enjoy themselves.”

SBCA, much like AALV, has programs regarding legal issues as well. The Somali Bantu Community Reparative Probation Project provides legal referrals and counseling support to low-level offenders and their families. The Emergency and Relief Committee and the Problem Solving Committee, within SBCA, support the Somali Bantu Community Reparative Probation Project. Both of these committees work to address issues of crime and conflict within the Somali Bantu community and Somali Bantu families. Both committees are “devoted to helping those in need through cultural/traditional and religion-based, as well as modern counseling.” The Problem Solving Committee, however, is made up of members who all have training from the United National High Commissioners for Refugees. Each of these committees and the Community Reparative Probation Project are “devoted to helping those in need through cultural/traditional and religion-based as well as modern counseling.” Another legal service that the Community Association provides is the Somali Bantu Citizenship Class. USCIS helps to provide citizenship test study materials and SBCA utilizes volunteers to teach classes in partnership with USCIS

officials. USCIS officials also hold Naturalization & Citizenship Information Sessions “about the naturalization process, the naturalization test and the right and responsibilities of U.S. Citizenship” (SBCAV, Inc. 2014).

Additionally, SBCA provides many administrative services. According to George Weber,

“...you can get assistance with your Department of Health and Human Services forms; so food stamps, Medicaid, that kind of stuff...They’ll come into the office...and they’ll fill out the forms with the interpreter, myself sometimes,...or whoever is there that day. Also people come in to get assistance with filing for unemployment or assistance in job searches...”

The Community Support Program provides many of these administrative services that George Weber mentions, in addition to providing “translation and interpretive services, referrals, transportation services, and...a free computer lab for community use.” The Community Support Program also supports the Direct Services Program in which volunteers help service users “fill out human services paperwork, study for the General Education Development Test (GED), Test of English as a Foreign Language Test (TOEFL), and Citizenship exams, fill out college applications, and work on summer school homework” (SBCAV, Inc. 2014).

The Community Association has its own Community Farming Project that helps refugees find gardening spaces so that they can “grow and harvest their own food” to supplement their “often income-restricted and nutritionally deficient diets.” The Community Farming Project also allows refugees and new Americans to bond over cultural and traditional lifestyles (SBCAV, Inc. 2014).

What is also important to recognize about SBCA is that many of the volunteers and staffers often provide services beyond the programs officially

offered. George Weber would often go with clients to talk with landlords or help them when dealing with Economic Services, a division of the Department for Children and Families at AHS, which “helps Vermonters meet their basic needs by providing public benefits” (Vermont Government 2015). SBCA also helps to address acute needs like getting refugees warm blankets and clothing in the winter, said George Weber.

Mainstream organizations that serve refugees, among other clients

The University of Vermont Medical Center (UVMMC)

Other local service providers like the University of Vermont Medical Center (UVMMC) and the Community Health Centers of Burlington (CHCB), among others, are mainstream organizations that also provide services to a significant number of refugees in the Burlington area. The newly re-named University of Vermont Medical Center (UVMMC) serves many community members each year. In addition to serving the community at large, the UVMMC also sees many refugees, especially through its outpatient clinics. There is, however, a specific clinic within UVMMC’s Outpatient Pediatrics program, which serves “...all new Americans. So anyone who is, who has come here; so refugees, asylum seekers or immigrants,” said Cathy Kelley, the Social Work Care Coordinator at the Pediatric New American Clinic within UVMMC formerly known as “University Pediatrics.” According to Cathy Kelley, there are many “...other agencies that serve refugees in a less public way or you know, their client-base is much broader but they also do work with refugees and new Americans,” and UVMMC is one of these organizations.

Although the New American Pediatric clinic's primary focus is to provide primary care medical services to pediatric patients, they also do a significant amount of care coordination in order to make sure that these new Americans have their needs met all around. Cathy Kelley reported that as the social work care coordinator she makes sure that she is "really looking at...who is already helping that individual" or family in order to ensure that they are "...not duplicating...but also looking for where are the gaps..." The New American Clinic coordinates with many of the local service agencies outlined in this thesis, however, in Cathy Kelley's role specifically she looks at who each patient and their family is working with and coordinates between school representatives and other medical providers etc., to make certain that all providers involved are on the same page. At the New American Clinic the providers work to provide "...holistic care and not just physical health," while also "thinking about mental health and behavioral health..." as well, said Cathy Kelley. Cathy Kelley also reports that their providers treat all their patients "as individuals" by "...getting to know a little bit of their language, greeting them in culturally sensitive ways," and "talking about cultural foods and practices." The New American Clinic is very "receptive to new Americans" and is "culturally sensitive," said Cathy Kelley, in order to provide care to such a diverse population.

The Community Health Center of Burlington (CHCB)

The Community Health Center of Burlington (CHCB) is one of the mainstream organizations that serves many people within the refugee community. CHCB states on its website that it is dedicated to being "a community leader in culturally competent care." CHCB considers itself the first medical "home" for adult refugees

living in the Burlington area. CHCB also offers interpretation services free of charge both in person and over the phone, for all its patients who do not speak English or who speak limited English. Throughout the year, CHCB employs providers who speak 22 different languages in order to better understand their service users. CHCB also offers classes on medical orientation and education for New Americans, as well as other specialized and individualized support services for all its patients.

According to their website, CHCB has many providers, both medical providers and social workers, who specialize in health care and supporting the New American community in Burlington (CHCB 2014). Dr. Steingard, who coordinates between Howard Center and CHCB a lot, said that CHCB is “the primary care provider in town that sort of has a focus on those groups [refugees].”

CHCB also focuses on the mental and behavioral health of its patients, especially because in recent years “CHCB’s gotten a lot more money...to provide what’s called behavioral health care” said Dr. Steingard. For example, Dr. Steingard said that

“So they’re [CHCB] gonna be seeing people who might not need the community support program where I am, but it’s a lot more people...You know...people with depression, people with sort of post-traumatic stress disorders that doesn’t include psychosis. And they’re [CHCB] probably the largest service provider in Burlington.”

According to CHCB’s website, “the Behavioral Health staff” are “an integral part of the health care management.” On staff, CHCB has “eight Licensed Clinical Social Workers who are also licensed as Alcohol and Drug Counselors and a psychiatric nurse practitioner and psychiatrist...” CHCB has clinical social workers available during patients’ medical appointments in order to “help assess your mental health

condition or addictive illness.” Not only do these social workers serve as consultants during a medical visit but they also help get patients into other substance abuse programs. Through their behavioral health program CHCB also provides Cognitive Behavioral therapy for a variety of mental health issues such as “depression, anxiety, stress reduction, addiction, coping skills,” among other issues (Community Health Center Burlington 2014).

Beyond the above, CHCB also has group therapy, through which patients receive support with “Managing Chronic Pain, Clinical Stress Reduction, Insomnia, and Co-Occurring Recovery Support” (CHCB 2014). Additionally, CHCB’s psychiatric staff will work with its patients to find the resources, program, medications and other recommendations that are specific to a patient’s mental health condition. Although CHCB works with the mainstream community in a variety of ways and capacities, from medical appointments, support groups, same day sick clinics, dental health, etc., they tend to see a lot of the refugee community simply because they are one of the largest service providers in Burlington (CHCB 2014).

Service Organizations that have other determining factors for client entry

Connecting Cultures and New England Survivors of Torture & Trauma (NESTT)

Connecting Cultures is an organization in Burlington that provides services based on specific criteria. Much of the RISPNet meeting in January focused on Connecting Cultures and what they do as an organization, which is where most of this data comes from. Connecting Cultures provides services to any survivor of torture or trauma, including refugees and new Americans. Connecting Cultures

works with refugees from over 25 different countries, however, the Somali Bantu and the Bhutanese are their largest clinical populations. Additionally, Connecting Cultures tries to do as much as they can across different groups, especially across the lifecycle and with different ages.

According to Cathy Kelley, Connecting Cultures is really a specialty service, and “it’s the first place people look to in terms of meeting the mental health needs of refugees.” Cathy Kelley is the Social Work Coordinator and Clinician at Connecting Cultures (in addition to her position as the Care Coordinator at the Pediatric New American Clinic), who explained that “Connecting Cultures is the mental health part of the larger project and grant” called New England Survivors of Torture and Trauma, or NESTT¹. Connecting Cultures uses methods of psychology and social work to enact the four components of its program, which are Community Outreach, Direct Clinical Service, Clinical Research, and Training (Mazulla 2015). The key to the success of their program, said Dr. Emily Mazzulla, the Associate Director of NESTT, is having their social workers and psychologists work together.

Connecting Cultures employs about 10 to 12 clinicians, including psychologists and social workers, in order to combine direct clinical service with psychological services. Many of these providers are doctoral students, interns, or social work students. All of the mental health providers, both social workers and psychologists call themselves “Talking Doctors,” said Dr. Emily Mazzulla.

¹ NESTT has been around since about 2007 and as a larger organization NESTT also provides physical health and legal services. Services provided under the health branch include psychiatric, pediatric and physical therapy services. NESTT provides legal services through the Vermont Law School.

Community Outreach is a key component of Connecting Cultures mission and program goals. According to the descriptions Dr. Emily Mazzulla provided at the RISPNet meeting in January, through Community Outreach, “Clinicians visit the refugee and new American communities, disseminate best practices to service providers and partner with community organizations, like AALV, to provide services in a community setting” (Mazulla 2015). Mazulla said the outreach component of Connecting Cultures came out of people not being able to access the mental health services available because of different barriers like cultural incongruity and stigma, among other barriers. Once Connecting Cultures identified these issues, they began to do massive community outreach by using interpreters and cultural brokers and starting with smaller communities. Dr. Mazzulla said that Connecting Cultures’ strategy for outreach is a process of snowballing personal contacts.

Direct Clinical Services the second component of Connecting Cultures’ programmatic endeavors. Through Direct Clinical Services, “Connecting Cultures addresses the psychological and social work needs of refugee children, adolescents, families and adults” (Mazulla 2015). In Direct Clinical Services the providers use individual therapy, group therapy and psychological evaluation. Providers often use pictorial language, especially because many people haven’t received formal education or don’t have strong English language skills. Connecting Cultures provides individual therapy for “children, adolescents, families and adults” in order to treat “a range of clinical concerns, such as symptoms of chronic traumatic stress, posttraumatic stress, depression and anxiety” (Mazulla 2015). Group therapy has been typically for adults, however, Connecting Cultures is beginning to do groups

with adolescents in both the Winooski and Burlington high schools. Group therapy is typically for “adult survivors of torture” and addresses issues such as “adjustment concerns and parenting skills,” whereas the adolescent or youth groups focus on “adolescent social, emotional and behavioral skills and regulation” in combination with projects and cultural discussions (Mazulla 2015). These groups try to “...teach skills that people can take away with them and also maybe even teach to other members of their family so coping skills, mindfulness techniques, relaxation techniques...” as well, said Cathy Kelley. The adjustment groups facilitate discussion regarding adjusting to life in America and a new culture. In these groups, many issues surrounding basic needs or not having a ride to get to the groups come up, so social workers tend to address a lot of basic needs in these groups and even provide a van that drives around to pick people up for the groups each week. One of Connecting Cultures’ newer groups in their Infant/Parent Program works with infants who struggle with disassociation or who aren’t developmentally on track and parents who struggle to be present due to traumatization. Connecting Cultures also does psychological evaluations for torture survivors seeking asylum status in Vermont and implements evidence-based interventions (Mazulla 2015).

In addition to doing Community Outreach and Direct Clinical Services, Connecting Cultures is also dedicated to Clinical Research because as an organization, they are a part of the Behavior Therapy and Psychotherapy Center at UVM and therefore they have additional academic and research responsibilities. Connecting Cultures’ clinical “research goal is to improve our understanding of significant issues, such as how to identify and treat mental health symptoms among

refugees and torture survivors” (Mazulla 2015). Through their research, Connecting Cultures has “developed a psychological intervention using a chronic traumatic stress framework to treat survivors of torture and trauma” (Mazulla 2015). Through research, Connecting Culture collects data in order to see how they’re doing as an organization and to disseminate their results. The benefit of being a research organization as well is that they are able to provide more services because they have grants, which provide them with more resources for more services (Mazulla 2015).

Beyond the other three programmatic components, Connecting Cultures also engages in Training. By providing “trainings and consultation to other mental health agencies regarding working with refugees, new Americans and survivors of torture and trauma” Connecting Cultures helps organizations to create cultural adaptations to specific interventions (Mazulla 2015). Connecting Cultures has a variety of different training topics, however, some examples of them are the following:

“Cultural adaptations for mental health interventions; working with interpreters in a mental health setting; applying a Chronic Traumatic Stress (CTS) framework for working with refugees and torture survivors; coordinating care when working with schools, educators and families; adapting exposure techniques to be culturally relevant using a lifeline exercise” (Mazulla 2015).

Connecting Cultures also does a lot of provider education, trainings and presentations and they work with interpreters to try and support the needs of their interpreters as well, not just their service users. Connecting Cultures is in the process of writing a grant to become a national training entity. As Cathy Kelley, their social work coordinator said, “There really is no end to the training you can get.”

Additionally, Connecting Cultures coordinates with and refers a lot of service users to the New American Clinic at UVMMC, to the Howard Center, to the CHCB and

Economic Services, among other agencies, in order to connect with as many other service providers as possible and to try not to duplicate services. The social workers do what they call social work triage so that they can map who that refugee is working with in the community. In addition to all of these services, Connecting Cultures does a lot of work to combat stigma.

The Howard Center

The Howard Center is another mainstream organization that provides services to refugees based on specific criteria. The Howard Center is a community mental health center that serves all of Chittenden County, said Dr. Sandy Steingard, the medical director of the Howard Center. According to Dr. Steingard, who has been working as a psychiatrist at the Howard Center for over 20 years, “We [the Howard Center] have agreements with the state to provide certain services and one of those agreements is to provide services to adults with what is called serious and persistent mental illness...” One service that the Howard Center provides is their crisis service, which is a “...state-funded program...that works with anyone in Chittenden County who sort of has an acute psychiatric emergency.” The crisis service is also available 24/7 through outreach.

Another program the Howard Center runs is the Community Support Program, which includes a variety of different support programs. Initially, when someone comes in, said Dr. Steingard, they will have an intake session to determine the history and needs of the person to “assess if the person meets the criteria of the program and then we [service providers] describe to them what we [the Howard Center] have.” The Community Support program includes a variety of different

services including “case management, residential, counseling, vocational services, and medication supports” according to the Howard Center’s website. In the vocational service program called Career Connections, the Howard Center has something called “supportive employment” (Howard Center 2014). The “supportive employment” aspect of the vocation program according to Dr. Steingard is

“...based on research on what is an effective way to get people employed and it used to be much more of like a shelter workshop model and now you know its very much geared to sort of getting people competitive employment. Find out what the person wants and help [them] to find a job that matches their skills and their interests.”

The Howard Center also has some unique residential programs. Dr. Steingard described one of these residential programs by saying “You know, we have what’s called a shelter for people with mental illness but its really not a shelter in the traditional sense in that people have their own rooms, they don’t have to be out during the day.” Another residential program is called the Westview House, which is a “psychosocial and recovery clubhouse located in Burlington serving adults (ages 18 and older) in Chittenden County who have been diagnosed with a major mental illness” (Howard Center 2014). According to Dr. Steingard the Howard Center has “had a lot of our refugee community people go through that [residential program] at different points in their kind of coming into town and getting connected with us.” Additionally, the Howard Center has a “wide range of residential and housing options with varied levels of supervision and staffing, based on an individual’s needs” and to support clients who need assistance to live independently.

The final service that is a part of the Community Support Program is the Co-Occurring Disorders Treatment Program (CODTP). CODTP “is an outpatient

program that provides” services and “fully integrated treatment to individuals...who are at high risk for relapse” and who struggle with “persistent mental illness, substance use disorders, and” who have “past or present correctional involvement” (Howard Center 2014). Given that the Howard Center is a mainstream service provider, it is important to recognize that these services aren’t “specific to the refugee community. The services that we [the Howard Center] offer are the services that we offer to everyone,” said Dr. Steingard. A significant portion of the refugee community uses many of these services, however, they are not currently culturally tailored.

Conclusion

There are many different social and health services for refugees in the Burlington area, ranging in size from small community organizations to larger social service agencies. Beyond those organizations already discussed in the chapter, there are a variety of other organizations, agencies and groups that provide services to refugees in the Burlington area, some of which the providers I interviewed mentioned. These organizations or groups include, but are not limited to: the Chittenden County Transit Authority (CCTA), the Burlington Housing Authority (BHA), the Burlington and Winooski School Districts, Champlain Valley Office of Economic Opportunity (CVOEO), Champlain Valley Head Start, Diversity Rocks, a Nepali community group, a Bhutanese community group, the Boys and Girls Club, King Street, Spectrum, Victims Advocate Service, Sarah Holbrooke Community Center, the Fletcher Free Library, Vermont Law, the Free Legal Clinic, the

Department for Children and Families, and Economic Services. All of these groups and organizations provide services in some way or form to the local community as well as new Americans.

As we can see, a broad and complex range of services, some tailored to refugees and their cultures, and others not, are available for mental, physical, social, and economic services that refugees can access in Chittenden County. Many of these services work together, whether directly or indirectly, to help serve the refugee community. Sometimes this is through care coordination and other times it is through referrals to other service organizations or by helping a client access these other services. In the next chapter, I analyze what the service providers who serve the refugee community perceive to be refugees' social service and mental or behavioral health needs, in addition to how providers assess need and determine what services they will provide to the refugee community.

Chapter III: Perceived Refugee Needs, Assessing Need and How

Providers Determine what Services to Provide

This chapter seeks to answer the following research questions surrounding refugees' needs as identified and perceived by the service providers interviewed and how service providers assess need and determine what services to provide. What do the local service providers perceive to be the refugee community's emotional/behavioral health needs and social service needs? How do these service providers determine what services and support the refugee community needs? That is, how do they do needs assessments? This chapter is of great significance to the fields of social work, psychology, nursing, and education because many of the service providers interviewed who discuss these perceived refugee needs have training from these fields. As a result, analyzing how providers from these fields perceive needs, assess need, and determine what services to provide could offer insight and recommendations for service providers in these fields.

Perceived Basic Needs and Issues

In talking with several local services providers who provide services in numerous different capacities, I distinguished a variety of mental health or behavioral health and social service needs that these local providers perceive to be issues for the Burlington refugee community. What will be discussed in this chapter is what providers think refugees are dealing with and/or struggling with, in addition to things that providers think refugees need help with or services they think refugees need. According to the service providers I interviewed, many refugees in

the Burlington area struggle with having their basic needs met. Often these basic needs overlap with their social service and behavioral health needs and seem to be a reason for needing many behavioral health services or social services. According to Abraham Maslow, who developed a conceptual model of human motivation in 1954, human behavior is goal directed. Maslow's hierarchy of needs, as his model is named, states that

“At the most basic level are needs related to the survival instinct (need for food, shelter, clothing, etc.); then come the need for safety and security, social needs such as family and other social support systems, then what Maslow and others describe as self-actualization needs, i.e., achieving full potential as a person and thus satisfying self-esteem” (Last 2007).

Service providers in Burlington perceive that refugees' needs are extensive and many of these needs are what Maslow, and these providers, would classify as the most basic needs. According to the service providers interviewed, there is a huge need for clothing, shelter and food.

Clothing

Most refugees arriving in Vermont do not have sufficient clothing. Pablo Bose stated many of these refugees come from warmer climates where they don't experience winter in the way that we do here in Burlington. Many refugees arrive in Burlington during the winter months and for most of them, when they land here, it is the first time they have ever seen snow or experienced such cold weather. Therefore, when they arrive, they do not have the proper clothing to survive the brutal Burlington winter. This is why many refugees have a great need not just for clothing, but also for weather-appropriate, warm clothing, said Tina Lancaster. So

when volunteers meet refugees at the airport, they will bring newcomers winter coats, hats and gloves.

Housing

The housing situation in Burlington is particularly problematic according to majority of service providers interviewed and it can be one of the more difficult needs to meet. Like George Weber, a service provider at the Somali Bantu Community Association (SBCA) said, “people deserve housing and they don’t have it. You know what I mean?” George Weber gave an example of this when he said “...a family [of refugees] just arrived from Maine, and they’re living in their car in the middle of January, and the only thing we can really do for them is give them blankets and help them through their experience of living in the car. There’s really nothing else we can do.” This family of refugees was moving from Maine to Vermont, said Weber, in hopes of finding an easier life in Vermont. Unfortunately, due to the housing situation when they arrived, there was not much that Weber, or that other service providers could do for them in that moment, he said.

The problem with meeting the basic need of housing for refugees goes beyond simply finding them a home, but finding them housing in appropriately sized apartments with adequate space and rooms for the often large refugee families that resettle in the Burlington area. Additionally, the housing market is very expensive, and renters often pay a lot for very small, dilapidated homes. Moreover, there simply isn’t enough housing, let alone housing that meets the size and rooms needed for families of this size, especially because college students rent many of the larger homes with more rooms, as reported by both Tina Lancaster, a licensed social

worker affiliated with the Vermont Refugee Resettlement Program (VRRP) and George Weber. Pablo Bose also echoed this sentiment when he said, “you know, we have a very tight housing situation and there simply isn’t much available, and it’s very expensive.”

Food

Another basic need that many of the service providers interviewed perceive as a struggle for refugees in the Burlington area is food. According to these providers, many of them spend a lot of their time helping refugees make sure they get food stamps so that they can feed themselves and their families because the cost of food in Burlington is quite expensive. Because meeting basic needs is perceived as a problem by these service providers, many of the social service needs that refugees in Burlington have, derive from needing other things or services in order to simply be able to meet some of these more basic needs. Additionally, the stress of finding ways to meet these needs is often a huge source of behavioral and mental health needs for refugees.

Perceived Social Service Needs and Issues

If we are to follow Maslow’s hierarchy, social service needs are slightly higher on the pyramid than the most basic needs that service providers perceive that refugees in Burlington are dealing with. The social service needs of refugees in the Burlington area cover a wide range of categories and deal with issues of citizenship, employment, English language learning, literacy, education,

transportation and transit, healthcare, childcare, housing, access to services, understanding the system and communication.

Citizenship and the citizenship process

A social service need that nearly every service provider mentioned was the issue of citizenship and the citizenship process. As suggested in the interviews, refugees have significant misunderstanding about and questions regarding the citizenship process. At the RISPNet meeting, Cathy Kelley talked about how many families need and ask for help in understanding and going through the process of getting other family members and children to the United States. During the RISPNet meeting, providers from various organizations talked about how questions regarding citizenship come up a lot, even in contexts unrelated to citizenship, because it is such a concern and so confusing for so many refugees. There is a lot of need surrounding this issue not only because there are so many questions regarding residency, travel documents, medical waivers and the process itself, but also because it can be very expensive to apply for citizenship and applying for a waiver is pretty difficult, said the State Refugee Coordinator. There are other confusing and difficult aspects about the citizenship process, said Pablo Bose at a lecture he gave on Refugee Resettlement in Vermont in the fall of 2014. For example, for the first five years you are in the United States as a refugee you can't apply for citizenship, but by year seven, you have to. The cut off of seven years seems arbitrary and confusing to refugees flooded with concerns of everyday survival. This, Pablo Bose said, begs the question "What are your rights as a refugee then if you break the law?"

Employment

Another significant need that nearly every provider interviewed discussed was the issue of employment. Pablo Bose discussed how he thought that employment is probably the number one issue facing refugees. Pablo Bose said that employment is an issue “...partly because the U.S. refugee system is built entirely around the notion of self-sufficiency and economic self-sufficiency, which means getting a job, but getting a job, versus getting a job that has advancement is obviously a big, big challenge.” Pablo Bose also talked about how refugees are often “sort of pushed toward low-end jobs” and even though

“Vermont has been traditionally a pretty good employer, and I think that’s because the refugee resettlement program very smartly in the early years set up long-term relationships with institutional employers like UVM, Fletcher Allen, the Howard Center, ya know, the big people around here...but the question still is, is it something that is like an entry-level position? Is there any chance for advancement? Those are some of the challenges I definitely hear being talked about.”

Many of the other providers also talked about employment needs. George Weber, among others, talked about how refugees often need assistance doing job searches as well. While some refugees are illiterate or semi-literate, some had high skilled, high status jobs in their countries of origin, and those skills are often under-tapped in the Vermont labor market, which tends to see refugees as primarily suited for blue collar work.

Language

Another perceived social service need that service providers think is significant is language. Many providers talked about language being an overwhelmingly big issue. “People have difficulties with English or acquiring

English,” said Pablo Bose. Tina Lancaster talked about other aspects of the English language learning process in that many refugees “don’t have a mentor or family friend who is a native-born English speaker, who increases their vocabulary;” which means that “the only time they [refugees] are hearing a broad English vocabulary, like educated English, is in school.” Tina Lancaster also talked about how she does some after-school tutoring with refugees who are in high school and the first thing she finds out “about perfectly intelligent 16 and 17 year olds, is how many words in the first paragraph they don’t know” when reading history, or other textbooks. Dr. Steingard talked about how, at least with the refugee patients she sees, “they [refugees] really need help learning English.” George Weber and Cathy Kelley also talked about how “language is a big deal” and how it often contributes to and creates other needs, like in accessing services or in education.

Therefore, there is a great need for interpretation and translation services then when refugees try to access various parts of the system in Burlington whether when they are trying to fill out forms, go to a doctor’s appointment or get something in their house fixed. Additionally, there is a need for accurate translation and interpretation that really communicates across cultures. George Weber discussed an issue he learned of from the refugees he works with when a female refugee he knew called Victims’ Advocate Services because she was experiencing domestic violence from her husband. Victims’ Advocate Services utilized an interpreter from this woman’s own refugee community. This interpreter was a man and in order to protect her husband and because of the cultural responsibility he has for men in his community, he misrepresented what the woman was trying to explain to the service

providers. George Weber said that this “translator was intentionally misinterpreting language to protect the husband.” In this instance, this particular woman was not able to get the help she needed and wanted, even though she had an interpreter. So the need then is no longer just for interpretation and translation services, but for accurate translation and interpretation services in which both the translator/interpreter and the refugee service user are protected and comfortable, and cultural boundaries and needs are respected. This woman’s right to accurate translation and interpretation services however, is supposed to be guaranteed through the “National Standards for Culturally and Linguistically Appropriate Services in Health Care” created by the U.S. Department of Health and Human Services’ Office of Minority Health (Office of Minority Health 2001).

Education

According to most of the service providers interviewed, there is considerable need in terms of education as well. While the majority of refugee children do attend school, the educational service they receive are lacking, said George Weber and Tina Lancaster, who both reported that they think that the schools are failing refugee kids academically. Tina Lancaster commented that she thinks, “the elementary schools are pretty good but for the older kids, high school is not doing well.” As Tina Lancaster said, “I think we need serious addressing of problems in the educational system, especially at the high school levels, it’s terrible, terrible for English-as-a-second-language kids. It’s failing them dramatically.”

Both George Weber and Tina Lancaster felt that there are many ways in which the schools are failing refugee kids, but the most substantial way in which

they feel refugee students are being failed by the educational system, is that refugee students are placed in remedial classes across the board instead of having their actual skill and ability level in each subject tested. This is a problem, according to these service providers, because it is not that they are stupid, incapable or bad students, but that they don't know English well and so they are often viewed as not being capable or smart enough for mainstream classes. George Weber, who has experience with many of these students in his ELL classes, has seen this first hand from both refugee parents and their children. George Weber helped out in in some of the discussions about this issue a few years back. He remembered talking about how if "their ELL language permits them to, they should be in the class" but if "their math and science is at a different level, they're also put in the remedial math and science classes. They're not put in the appropriate classes across the spectrum." Instead, "they're put in the remedial classes throughout the entire educational system and that's a huge issue." Tina Lancaster considered this "an American kind of racism that assumes that if you don't speak good English and come from a non-technological life, you're not as intelligent—which really isn't true." Tina Lancaster saw this with the people she calls "her families," who are two refugee families that she has mentored, with whom she has been worked in solidarity and been friends since they arrived in Vermont. Tina Lancaster said, for example, that

"...families that came, for example from Nepal...and came having already learned calculus in the schools there, they're like, they're thinking American schools are so easy but because they don't speak English they are put in elementary math and they're like, 'What?' And it doesn't have anything to do with ability or talent or that they've already completed calculus in their own school system."

Both George Weber and Tina Lancaster see significant need on the part of these refugee students to receive proper schooling and education in the Winooski and Burlington schools in particular, which is where many refugees settle.

Furthermore, these service providers complain that there is a need for more ELL spots in the schools because if the students were to receive better and/or more opportunity for ELL, they might succeed more in school and have more opportunity to be placed in the correct course levels. Pablo Bose touched on this a bit when he talked about the impact of refugee resettlement within Chittenden County. Pablo Bose talked about how the capacity and capability of the schools and how there simply might not be enough providers to support the need of the refugee students.

“It’s a big number when you consider that they’re not spread throughout Vermont. They’re really in Chittenden County and within Chittenden County they’re really in Burlington and Winooski. So within these...communities...you’re having a very, you know, kind of disproportionally large impact and so some of the service providers raise the question of the number of ELL spots, how many home school liaisons there are, what’s the capacity to absorb them [refugees]?”

Tina Lancaster touched on another problem in the educational system dealing with refugee teenagers. Tina Lancaster said that right now she’s “kind of obsessed with the fact that...a lot of the children or teenagers who are acting out right now or are in trouble with the law, I think all of them are failing academically.” She talked about what might be considered an emotional need, as well as a social service need, when she discussed this issue.

“I think they are humiliated about it [failing] and as a result of being humiliated about it [failing], they’ve stopped trying because they don’t want to write a paper or do homework and have it pointed out that their handwriting looks like a second grader or that their knowledge base is poor. They can’t write well, so they get a chip on their shoulder and they start to act like they don’t care and then they follow that identity and they’re pals

with other kids in that situation and so they're disaffected youth; disconnected, disaffected youth. I think that's a huge problem and I have been screaming about it for ten years because those kids need tutors, early intervention and they need one to one consistent tutoring."

Tina Lancaster touched on a number of needs here in terms of the educational system. In this part of the interview she alluded to the trouble that some refugee teens are starting to get into with the law due to being disconnected and disaffected youth and the drug problem that some of these refugee teens have. Here she also discussed the need for the further support of these refugee students in high schools in the Burlington area. Additionally, she clearly identified the need not only for tutors but for one-on-one, consistent tutoring, because even though "they have after school things in high school where you can come" it's just "random college students...or people who will help you, but it's kind of embarrassing. It's not always the same one; you're in a big group; it's not consistent; it's not a personal relationship..." Tina Lancaster also recognized the need for earlier interventions that happen before the problem gets "this bad" for these refugee students. Tina Lancaster's solution is that "they [refugee teens] need a non-embarrassing situation and that's one to one, in a private home, a long-term relationship I think. That's my theory."

There are a multitude of other needs within the educational system, some of which deal more with refugee parents whose children are in the public school system in the Burlington area. Many refugees who resettle in the Burlington area, if they were educated formally, were not educated through a Westernized educational system so as Tina Lancaster put it, "...in all families where the parents did not have the chance to go to school and are therefore illiterate and are not educated in a

Western form of education, regardless of how smart they may be, their children need a lot more educational support.” These children then need more educational assistance because their parents cannot be the source of at-home support that they might need. This is because these parents don’t have an understanding of Western education and may not be able to read or write, and so they can’t help their children learn those skills. So the question then becomes, where do these children get the support they need?

Furthermore, because many of these refugee parents don’t speak English and are illiterate, there is a disconnect and struggle in communicating these issues and resolving them. There is little to no communication between the schools and the refugee parents, mostly because the schools continue to send home written notices to refugee parents in English. This is a problem for many reasons, one being that many of these refugee parents don’t read at all, let alone read English. Secondly, when the schools have tried to send home written notices in languages other than English, they send them in languages that these refugees don’t even speak. As Tina Lancaster reported to me, she thinks “the community is a little thick about Somali Bantu people because...they send the papers home written in the Somali language, which isn’t their language to begin with, but they [also] can’t read or write...” The reality is that these refugee parents need to be communicated with, just like any other parent of a child at school needs to be communicated with, but in a way that works and actually is communicative for them. As Tina Lancaster said “...someone has to be informing them and accompanying them and inviting them and making them feel like they have a real flow of being able to communicate what’s going on.”

These parents, according to Tina Lancaster, “are very caring and they’d like to be more involved...” but “they need help and mentoring going to parent-teacher conferences and things like that.” Additionally, refugee parents feel very discouraged said George Weber, because their children are being stuck in classes that don’t suit them. George Weber said to me that this all “affects the parents...the parents feel incredibly frustrated, because they can’t adequately get their...they feel like their concerns aren’t being brought, the school board’s not taking them seriously” because they can’t communicate how they feel with school representatives.

Other issues and needs for refugees within the educational system in the Burlington area, relate to accreditation and opportunity. Pablo Bose talked about how accreditation can be a big problem for refugees when they come here. If refugees were educated and held degrees in a certain field from their native country, often times it can be difficult to get that degree recognized in the United States and/or it might not hold the same value here as it did in their native country. George Weber also talked about issues regarding higher education and opportunities for refugee students in the Burlington area.

Refugee students often suffer later in life because they were stuck in remedial classes throughout their childhood educational experiences. George Weber discussed how refugee students really “pay the price” for having been stuck in remedial classes throughout the school system because when they graduate there is even less opportunity for them to move on to higher education. George Weber

talked about this especially in terms of UVM when he said that “...there’s not a place for students like them [refugees]” at UVM. He continued to say that

“...it’s hard enough for me to find an in-state place like UVM. I mean...the administration it isn’t really reaching out or helping in participating [in finding] a solution to these problems because they complain about enrollment, of low enrollment of Vermont students, [but] there are always the people of color being admitted to the university, and yet they’re really not doing anything to reach out to this population that is in-state students and people of color and refugees. Those relationships are lacking.”

Essentially, there really isn’t much opportunity for refugees to continue their education post high school, because on their transcripts they might not appear to be “good enough students” and because universities and colleges, like UVM, aren’t reaching out to them and offering them opportunities to continue their education, said George Weber. They are not perceived as sources of tuition revenue or high test score metrics in the recent corporate turn in American higher education.

Social service needs that the average citizen might not struggle with to the extent that refugees do

Many of the other social service needs that refugees in the Burlington area struggle with are things that the average Burlingtonian might not have as hard a time with. These struggles include transportation and getting around town, making doctor’s appointments, the health care system, knowing what services are available, how to access them and how the system works, filling out forms, and coordinating family life and childcare, among many other issues.

Transportation

Transportation and getting around the Burlington area, especially to jobs, is perceived to be a significant need for the refugee population in this area. In the groups that service providers at Connecting Cultures run, many refugees bring up the issue of getting around town. According to these providers, many refugees talk about how even if they think they might have a ride, there is often the stress and possibility of losing or not having the ride. Therefore, there is a need for reliable transportation. Pablo Bose talked about the issue of transit for refugees a lot, especially because he enacted his own research on refugees and transportation in Chittenden County. In a lecture Pablo Bose (2014) gave on refugee resettlement, he talked about how there are many jobs, especially for refugees, in St. Albans, that refugees then have to find a way to get to. Pablo Bose also talked about how many refugees have expressed that “getting a car is an important part of becoming an American.” So not only is there a perceived need for cars within the refugee community, there is also a huge want for cars, however, the expense of driver’s education and owning a vehicle deter this from becoming a reality for many refugees.

Navigating the healthcare system

Other things as seemingly simple as making a doctor’s appointment or navigating the healthcare system are a challenge for refugees in the Burlington area, said the service providers interviewed. Making a doctor’s appointment can be exceedingly difficult because a refugee might need a translator or interpreter just to call and make an appointment at a clinic. This need for translation and

interpretation to simply make a doctor's appointment causes a lot of stress for refugees said the service providers at Connecting Cultures. Health care can be a difficulty for refugees because even though they have "access to all kinds of healthcare...people have to try to adjust to a very different kind of healthcare system" said Pablo Bose. As many people know, the healthcare system in the United States is a very complicated one, even more so for people who don't come from an experience of Western, biomedical health provision. Cathy Kelley also talked about how there is a lack of understanding about "...how the mental health and health systems work in the U.S." This lack of understanding can come from not having the English language skills to know how to navigate finding providers or understand the intricacies of insurance or filing for Medicaid to help pay for the expense of health care visits.

Services: What's available? How to access them? How does the system work?

A perceived need that a couple of providers talked about is knowing what services are available, how to access them and how the system works. According to Cathy Kelley, there is a lot of misunderstanding and misinformation about how systems and services work in the Burlington area. Cathy Kelley also said, "access is such a huge issue [and that includes the language piece]." Additionally, there is a disconnect between providers and refugee service users in that many service providers assume that refugees understand the system and know what they're supposed to do. Cathy Kelley said, "There's still a lot of providers out there who don't recognize their need to adapt and expect people [refugees] to just come in and

understand what they're supposed to do or expect them to bring an interpreter with them."

Cathy Kelley thinks there is a huge need for education about how the social service and health care systems work. An example is how the housing system works and the amount of frustration and lack of understanding about how it works, said Cathy Kelley. Cathy Kelley told me that they

"...have some homeless clients [homeless refugees] who we've worked...we've really struggled to try to figure out a way to get them housed; housing is a huge issue in our area for everyone. So we get a lot of requests for assistance with that and we really can't do much. People are on lists and then there are misconceptions, some of them based on cultural beliefs and practices, about how you move up on the list. I think for some individuals coming from cultures where you know maybe a bribe would help you get services, they think that that's the way the system works...but we have to do a lot of education around how does the system work? What are some things you can do to try to make it move faster? Which is basically being on all the different housing lists and going through different programs that have you know some stringent requirements but that might get you there faster but its an avenue that's open to everyone. Um, so, that's just an example of how complicated it can be I think."

This is just one example of a complicated system that is hard to explain, especially when translation is involved and when people come from different cultural experiences. Cathy Kelley further discussed how difficult understanding the system can be when you start to have problems. For example, refugees are generally set up with connections to health care, education, and housing

"...but a lot of times again there's a lack of understanding of how to access some pieces of that or for instance if someone is placed in housing that they are not happy with, what do they do next? Um, or if they're placed in a job that is not working for them, uh, sometimes needs arise out of that."

Assistance with forms

Other perceived social service needs include assistance filling out forms and coordinating family life and childcare. These are some final examples of the social service needs that the service providers I interviewed perceive to be needs of the refugee community in the Burlington area. Many refugees, according to the service providers interviewed, need a lot of assistance when it comes to filling out and filing forms. For example, George Weber talked about how many “...people [refugees] come in to get assistance with filing for unemployment...” or to get “assistance with your department of health and human services forms, so food stamps, Medicaid, that kind of stuff.”

Coordinating family life and childcare

Managing and coordinating family life in a large family can be difficult enough as it is, but when factors like being a refugee in a foreign place are included, other problems arise. This comes out of other needs as well, like needing reliable and consistent transportation to get your family around or to attend to all of your children’s different needs. Tina Lancaster, for example, helped out a refugee family by bringing all six of their kids to the dentist while the mother and father both go to work. Tina Lancaster also discussed with me the challenges of being a single parent and a refugee, and being a single parent as a refugee can exacerbate the level of difficulty of coordinating family life (among other needs).

Because many refugee families are large with many children, finding childcare can be difficult. Pablo Bose talked about how childcare can be a major issue for refugee families in Burlington. This could be for many reasons, one being that childcare is an extremely costly expense, but also because many refugees have

different cultural ideas about how children should be raised or how they should interact with each other, which often don't fit with typical American ideas about childcare and childrearing. Tina Lancaster also discussed the issue of childcare. For example, in many of the summer programs that refugee children could go to, girls and boys go swimming together, which many Somali Bantu families might not be comfortable with due to feeling that the genders should be separated for such activities.

While extensive, these are only the social service needs that the service providers interviewed discussed with me. Refugees themselves may report different or similar things that they deem to be their social service needs. Although in some instances, what was reported to me by these service providers are complaints and thoughts from refugees themselves to these service providers, there is always room for errors in communication or understanding. If we are to continue to think about need in terms of Maslow's hierarchy, the next set of needs higher up on the pyramid would be emotional needs or what I will call behavioral or mental health needs.

Perceived Mental and Behavioral Health Needs and Issues

According to the service providers interviewed and the service providers at the RISPNet meeting, there are many perceived behavioral or mental health needs and issues that refugees in the Burlington area deal with including Post Traumatic Stress Disorder (PTSD) or trauma-related stress, stress, substance abuse, familial relationships, substance abuse and gendered violence/domestic violence, and feeling emotionally unhealthy. Some issues regarding behavioral or mental health

needs are hard to categorize, especially because often there are different cultural understandings and meanings for what someone is going through. These behavioral or mental health needs and issues are either issues that these service providers perceive to be prevalent for the refugee community, are needs they have dealt with directly or are things that refugees have told them that they are struggling with.

Post Traumatic Stress Disorder

The service providers interviewed identified Post Traumatic Stress Disorder (PTSD) or trauma-related stress as a significant behavioral or mental health need or issue for the refugee community of Burlington. Service providers at Connecting Cultures actually think that the term Chronic Traumatic Stress, rather than PTSD, might be a better name for what symptoms refugees experience as a result of traumatic experiences (Mazulla 2015). There are many different mental and behavioral health needs related to trauma and the stress or continued stress of these traumatic experiences. Many of the providers interviewed, especially the providers at Connecting Cultures, discussed how many refugees who have experienced trauma feel a serious inability to be present in their lives, because of the reoccurrence of trauma playing through their minds and the inability to focus on what is currently happening. Because so many service providers at Connecting Cultures began to see this as a recurring complaint among their clients, they began a group for refugee women surrounding that issue and identified need. This mental health need is particularly difficult for refugee parents, because they find that they are so traumatized that they struggle to act as parents and be present for their children, said the service providers at Connecting Cultures. The idea of being

present has several layers of meaning. What the providers mean when they talk about refugee parents struggling to be present is that providers find that these traumatized parents relive certain moments of their trauma in the moment where they should be/could be feeding their baby or spending time with their child. Another layer of this inability to be present is that traumatized refugees could be dealing with anxiety or depression that is overwhelming and prevents them from fulfilling their duties as parents and therefore keeps them from physically being present in the lives of their children.

The many different kinds of trauma lead to different mental or behavioral health responses and needs from each individual refugee. There is obviously the initial trauma that, for many refugees, was the instigating event for leaving their country of origin. Additionally, the trauma of being in a refugee camp for 10 or 15 years, said Pablo Bose, can also lead to many mental or behavioral health problems.

Pablo Bose and George Weber also discussed with me the emotional effects and current mental or behavioral health needs related to the sexual violence that many refugee women experience in the resettlement process, often in their country of origin or in the refugee camps. These traumatic and sexually violent experiences are often difficult to overcome and often result in feelings of guilt or shame. These feelings, on top of dealing with the actual trauma, can be a serious mental health struggle and need for many refugee women, even long after the trauma has passed.

Dr. Sandy Steingard talked with me about refugees who experience the more severe effects of PTSD and trauma-related mental health needs. Many of these refugees suffer from psychotic experiences triggered by the traumatic experiences

they have had. As a result, there is a need for some refugees to use psychotherapeutic medications to help alleviate and treat the great suffering they experience related to trauma.

Mental or behavioral health needs can also be related to an experience of being marginalized or discriminated against, either in their country of origin, or in the resettlement country, said many of the service providers interviewed. Tina Lancaster and George Weber talked about the Somali Bantu experience and how some of their trauma related mental health needs or behavioral health needs in general, are related to the discriminatory experiences they had in Somalia with the Somali Somalis who are viewed as ethnically superior. There is also, however, trauma related to the American racial hierarchy and systems of oppression that create experiences of trauma and stress for refugees. Oftentimes refugees are people of color and are therefore subject to the unfortunate racism that is all too prevalent in the United States, which can lead to detrimental health and mental health effects. There is also great stress for refugees in figuring out how to navigate the United States' complicated racial hierarchy and trying to understand how it works and affects them.

Non-Trauma Related Stress

Although providers identify mental health needs related to traumatic experiences as a significant need in the refugee community, many providers also discussed how refugees often talk about stress related to other issues, as being more pressing. A view that the majority of the providers interviewed shared with me is a feeling that many refugees have expressed to them. Many providers talked about

how refugees will say things to them like “I know I have PTSD but I don’t have anywhere to sleep tonight!” or “I don’t have time to worry about going to UVM if I can’t feed myself and I’m not housed!” In this example then, even identified mental health needs feel almost unimportant in the face of other more pressing needs like finding adequate housing or food, which in turn leads to the mental health issue of stress. Service providers at Connecting Cultures, both psychologists and social workers, discussed how this issue presents itself in their group sessions and ends up getting in the way of having the intended discussions (about mental health issues) that these groups are based on. These service providers mentioned how the stress of finding a ride, making doctor’s appointments, and other related types of worries or concerns become the focus of these groups. What can be concluded then, is that “more significant” mental health issues, like PTSD, might not always feel as prevalent or as pressing of a need as the day-to-day stresses of adjustment, acculturation and living in the United States as a refugee. The problem here is that these providers are so focused on plying their own trade and focal expertise that they are missing the forest for trees. As Maslow argued, basic needs must be met before other needs can feel like a priority.

As a result, the service providers interviewed perceive stress, in many different forms, to be a significant mental or behavioral health need for refugees in the Burlington area. At first this stress can stem from “the initial stress and trauma of immigration and integration,” said Pablo Bose. “There is this initial trauma of displacement and the harassment that has caused the displacement” which leads to issues of its own. Then the stress of immigration and of trying to integrate into a

new society presents a huge amount of stress for refugees during resettlement.

Pablo Bose said that these kinds of stresses are hard to compare to “bigger” mental health challenges like PTSD, but really one of the biggest mental health challenges are these daily stressors like “...getting a job right now or...trying to deal with money here.”

The stress of employment takes a huge toll on refugee mental health. The process of job searching, being unemployed or even being employed, present a huge amount of stress for refugees resettling in Burlington. For one, refugees aren't able to prioritize their “bigger” mental health needs because there are more pressing issues like getting a job. Secondly, there is the stress of feeling like they are being pushed into lower end jobs that have little to no opportunity, said Pablo Bose. And third, they stress about feeling inadequate because their educational achievements and previous schooling are not recognized in the U.S., especially because of their English language abilities. As Tina Lancaster told me, many refugees feel great stress knowing that their children are depending on them to survive in this new country, and it's hard for them to not be home with their kids, because they have to work outside the home, and because they don't know the language well. This type of stress then leads to feeling completely overwhelmed, said Tina Lancaster, especially for single refugee mothers.

Familial Relationships

An issue that creates emotional, behavioral and mental health needs for refugees is the emotional strain of familial relationships, particularly those relationships between parents and their children, said many of the providers

interviewed. Adjusting to American culture can be hard enough for refugees during the resettlement process, but what many service providers recognize is that refugee parents and children seem to be adjusting at different rates and to different extents, which can create turmoil between parents and children.

From what the service providers I interviewed have noticed, it seems that refugee adolescents are adapting more completely to American culture and becoming more American than their parents by adopting American practices more quickly and fully. This then exacerbates the often already tense relationship that adolescents have with parents during their teenage years. As Tina Lancaster said,

“I think there’s a vast range of people, families, that are not very healthy where the gap, one of the biggest gaps, biggest problems, is the gap between parents who were raised in a country with one religion, you know, one culture, one language, who are now here, and their kids are gone from them most of the day. And their kids are not identified with where they came from. Somali Bantu kids, if you will find, will not say they’re from Somalia. They will never say that. They never were in Somalia. They were born in refugee camps, in Kenya. They’ll say they’re from Kenya. Their identification is not Somali. So there’s confusion for the parents I think and the kids in how to stay connected...Kids are chafing at the restrictions and the controls in those families...The families where that bond got broken, kids are sometimes staying away from home for three or four days; they’re getting in trouble with the law. They’re, they can’t talk to their parents. There’s not that tradition of intimate adolescent conversations about life so, you know, maybe the parent yells with their distress and the kid just shuts down and they don’t come home for a week or something you know? So there’s a break in the bond that’s, I think that, you will see that. Right now we’re seeing that as a crisis. It’s not happening with a majority of families, but it’s happening with a high enough percentage that it’s scary.”

Tina Lancaster pointed out a lot of key problems in the relationships between refugee parents and their children. One key issue here, that a lot of the emotional, behavioral, mental health needs stem from, is the clash in cultures. There is great confusion for the parents and their kids in figuring out how to relate to each

other when they feel that they are from completely different cultures. For the parents, this also feels very upsetting and sad because they feel in some way that they are losing their kids to America. For the children, they feel like they have no one to talk to and no one who can understand this problem, said Tina Lancaster. Then, when they all try to deal with the issues at hand, they end up fighting with each other, which feels unproductive and often times, scary. Cathy Kelley also talked about this issue of

“...families really struggling with their adolescents and that generation gap where the kids were born in refugee camps, or here [the United States], and they have a much, much different experience than their parents did, who often times were getting married at their age and having kids and perhaps weren't able to get an education let alone go to college and have options. So, a real gap there in trying to think about ways to bridge that.”

Cathy Kelley said that these issues can make parent-child relationships “really tricky!”

Many refugee adolescents are dealing with learning social, emotional, and behavioral skills, which is typical of most adolescents, however, their experiences as refugees and being a part of a refugee family intensifies the learning process. As a result, many refugee adolescents are struggling with emotional regulation, according to the service providers at Connecting Cultures and Tina Lancaster. Tina Lancaster talked about how refugee adolescents are becoming “disaffected and disconnected” due to their struggles at home with their parents and feeling inadequate and stupid at school. This has also led to the worsening problem of refugee adolescents getting in trouble with the law, particularly for drug and alcohol use and abuse, and for skipping school.

Substance Abuse and Domestic Violence

According to the majority of service providers, there is huge concern about substance abuse in the refugee community, particularly among men and adolescents. The topic of substance use and abuse became a huge focus during the RISPNet meeting that I attended and was also mentioned in many of the individual interviews conducted. At the RISPNet meeting, the State Coordinator Denise Lamoureux brought up the issue of substance abuse in the refugee community and how it seems to be quite different from the substance abuse problem among the general, mainstream population of Vermont. The service providers in attendance said that this is because the refugee population is seen using different drugs and substances than the general population. Furthermore, refugees are using in different environments. Two of the main substances that seem to be a problem among the refugee community are Khat and alcohol.

Service providers also noted during the meeting that substance abuse seems to be connected to issues of domestic violence or gendered violence, which has a huge effect on families. Pablo Bose talked about how the prevalence of gendered violence or domestic violence in refugee or immigrant communities

“might have more to do with the fact that women end up being a double symbol, not only of kind of gender norms but also sort of cultural traditions. So they become a vessel of cultural traditions so it’s seen as doubly transgressive if they are not doing, doing something.”

In this sense, Pablo Bose thought that domestic violence might have more to do with the fact that women have to take on double roles in their families when they resettle because they have to maintain their cultural traditions but also help provide for the

family. Men sometimes see this dual role that their wives hold as threatening to their role as the family provider. Pablo Bose said that often people talk about issues of domestic violence among immigrant communities “as though it’s about tradition and culture,” but really, “it’s a combination of both the actual stress of immigration and integration” and the stress of women occupying two cultural roles. What Pablo Bose meant by this is that women not only occupy the traditional role of mother or wife but also occupy the role that men traditionally hold of being the provider for the family. Because many refugee women also have to work in order for their families to survive in America due to the high cost of living, it seems that many men feel threatened by their traditional role being occupied by a woman and they don’t know how to deal with that stress and/or feelings of inadequacy.

Service providers stated that many refugees are scared to talk about issues of substance abuse and domestic violence, because they are scared that they personally will get in trouble, even if they aren’t the ones using or abusing, which leads to feelings of guilt, despair and hopelessness. According to the service providers, men don’t really open up or talk about these issues, even though women and children are beginning to. What’s interesting as well is that service providers said that refugees will talk about how other refugees have these problems, but they won’t talk about themselves. Service providers said that this seems to be an issue and represent an inability to talk about personal emotional feelings or personal mental or behavioral health struggles. As occurs with domestic violence in non-refugees as well. There is often a very real risk that telling outsiders who then

intervene may come back to bite women and children when their extended families find out.

Feeling Emotionally Unhealthy

Many of the service providers discussed how refugees often display and talk about feelings of being emotionally unhealthy. Tina Lancaster talked about this a lot in that many people in the Somali Bantu community seem really emotionally unhealthy, especially the adolescents and the single mothers. The providers at Connecting Cultures talked a lot about how many refugees, particularly refugee women, struggle with feelings of loneliness and struggle with connecting to people and community. These providers also talked about how these women struggle with finding coping mechanisms, building relationships, and even just leaving the house. Many providers recognize these as symptoms of depression or anxiety, which they say many of their refugee clients exhibit. A lot of refugees who receive services at Connecting Cultures want to continue going to support groups long after their initial adjustment or trauma groups, because they feel that they have continuing mental or behavioral health needs that they are struggling with. Again, the magic cutoff dates make little sense in terms of refugees' lived experience.

Assessing Need and How Providers Determine What Services to Provide

While it is important to understand the needs of the refugee community of Burlington, it is also imperative to identify *how* local service providers determine what need is. It is essential then, to understand how service providers assess need, as well as how they decide what services to provide in order to meet and alleviate

the needs of the refugee community. Each service provider seems to have their own nuanced way of assessing need, but ultimately it boils down to listening to what each refugee has to say and what they feel their needs or struggles are. Service providers also use methods of observation, experience-based decision making and prioritization as ways of determining and assessing need in the refugee community. Often, assessing “need” is a combination of what refugees express, what providers see as standard for a decent life, locally available diagnostic and social welfare categories, and what resources happen to be available through various programs.

Listening to Refugees

Many of the service providers interviewed stated that their first step in assessing need and in deciding what services to provide is to listen to what a refugee has to say about what they are experiencing, what they are struggling with and/or what they say their need is. At Connecting Cultures the service providers said, “It is really up to the patient to discuss symptomology” and then they go on from there in the treatment process. Cathy Kelly, who works at Connecting Cultures, said that they really look at whether or not a person wants to get assistance with their mental or behavioral health needs. She said it’s important to acknowledge if

“the person is wanting to get some assistance with that [mental or behavioral health need/issue], because some people that’s not, even though they’ve been through really horrible things, they’re focused on getting a job or they’re focused on parenting, you know, it [wanting help] really has to come from them, what they wanna work on. We’re not gonna force them into anything. If they are interested in working on emotional or behavioral issues, coming up with a plan around that...or a referral to somewhere else if that’s more appropriate then you know, making sure that happens.”

Cathy Kelley said that what she tries to do, and tries “to encourage our students to do, is really think about when someone comes in, what are they asking

for? What are, you know, the most significant needs?" This is what the service providers at Connecting Cultures call "social work triage," in which they map, based mainly on "what that refugee" they are working with says about who they are "working with in the community, what is working, and what they would like service-wise." In his own research, Pablo Bose surveys the refugee community and asks them directly what their needs are in order to assess the level of need within their community. Tina Lancaster also primarily determines need based on what people tell her. As she said, "I pretty much go by what people tell me. I listen to them" For example,

"At this point, people talk to me, so if somebody is having a baby and anyone knows that they don't have clothing for the baby, someone will call me and tell me, or even stop me on the street. They also tell me if something is urgent."

Tina Lancaster also said "some teenagers are starting to ask me if there's a way that I can get them some counseling."

George Weber talked about how he listens to his refugee clients in order to figure out what they need and how he can help. He described his process in that he is "a very solutions oriented person." He said,

"The first thing that I try to do is I assess what is the underlying cause of the problem. So that's the first thing. I mean, as soon as the first word is spoken, or the first action is taken, that's immediately where my mind goes. Um, and so then the next step is language, what people are talking about you know... So it's just a matter of taking the time to pay attention to what's being said and respect what's being said."

Therefore, it is important to him that he takes the time to listen to what they are actually saying in order to know what they are feeling and experiencing so that he

can figure out exactly what the problem is and what services he can provide to help them.

Dr. Sandy Steingard also assesses need based on what a refugee client, or any client, has to say as well. She said, “The core component of psychiatry, really social services, is clinical interviews.” Dr. Steingard said that at the Howard Center they “meet with the individual” and they

“try to meet with the family...and just try to get as much information as you can about you know what the person is experiencing, what the family is observing, what the sort of general level of functioning is.”

Dr. Steingard also discussed the importance of listening to what a patient has to say about what they are experiencing because

“... unlike other areas of medicine where you may have certain screenings and assessments...like, you know, a blood test, or a CAT scan, or an imaging study, Psychiatric evaluation is based entirely on language.”

Additionally, Dr. Steingard said that their treatment plans are really “a collaborative effort” between the patient and their case manager, especially in the Community Support Program at Howard Center. Through this collaborative effort, providers ask, “What do you need? What are your goals? How do you define goals?” and everything “comes out of you know, this kind of conversation that we’re having” she said. Dr. Steingard said, “We find out what the person wants and help...” them find what matches their interests.

Methods of Observation

The majority of service providers interviewed also use methods of observation to assess need and determine what services to provide and what support refugees in Burlington need. At Connecting Cultures, many of the service

providers ultimately observe what mental health symptoms the survivors of torture and trauma exhibit, and then they do evidence-based interventions based on what symptoms they have observed. These providers are systematic in how they identify symptoms, especially ones that are historically representative of PTSD, like flashbacks or disconnection. The service providers at Connecting Cultures also observe within the different groups that they run because people will bring up their needs, issues and struggles. Based on what is discussed during a group meeting, the providers observe and analyze what themes arise and often will create other groups based these other themes. Cathy Kelley said that “when we do that [create groups], that’s based on identification of more of the shared need.” Tina Lancaster also uses observation as a way to determine what services she will provide to the refugees she serves. For example, Tina Lancaster said:

“I observe and if I look at kids and their pants are that short, I say ‘Oh!’ and I talk to the mom and you know, do you have enough clothes? Do you need help? Do you need help with clothes? So yeah, I both observe and sometimes I can see by the behavior of children that they’re stressed so I’ll check in.”

Occasionally, Tina Lancaster said, she’ll get a call from someone else that has observed problems with in the refugee community. “For example,” she said, “there’s a woman who’s an advisor for Diversity Rocks who works at Spectrum with at-risk youth and a lot of refugee youth and if she knows that, if either of us knows there’s a crisis with somebody, we’ll call each other and tell each other.”

Experience-based decisions

Many of the service providers interviewed determine what services to provide based on their own experience in the field. Connecting Cultures has “developed a psychological intervention using a chronic traumatic stress framework

to treat survivors of torture and trauma” (Mazulla 2015). Connecting Cultures uses this model rather than a PTSD-based model, which is what the literature contends is best, because in their experience, it makes more sense and works better. Based on their experience working with refugees and in combination with their skills and training, the service providers at Connecting Cultures have determined that they don’t want to pathologize as much as the literature suggests they do. From their experience, these service providers find that using a chronic traumatic stress framework is best for providing services to refugees because it is non-pathologizing and strength-based, and because no one is ever really “post” trauma. Many service providers, according to Pablo Bose, have a lot of experience in serving populations through social service “and so what they do is apply their general set of services to this population” based on the experiences they have had in the field. Tina Lancaster also uses her long-term experience to figure out how to provide services to refugees.

As she said,

“...it has been a long time so I kind of have my groove. There are things that I automatically take care of like I make sure kids have shoes, and clothes, and warm clothes, and all that kind of stuff. With my own families, I make sure the parents have all those things too.”

George Weber said that based on experience, providers can always assume that there will be acute needs that will come up and it’s easy to address those first and then move on to more significant or larger issues because “acute needs will always get handled.”

Prioritization

The service providers interviewed often focused on the idea of prioritization as a way of determining what services to provide. Many providers focus on what

feels urgent or significant to address first in order to prioritize and make their services efficient and effective. Tina Lancaster said that she

“goes by what seems the most serious. If someone has a child who’s now in the legal system and is on house arrest, I prioritize that over somebody who says, who has been here ten years, who says ‘my one year old could use some clothes,’ because I feel like I could get them. You can buy them clothes; they can go to the used clothing store; it costs them a couple of bucks to go to the possibility shop; that’s not an urgent need.”

While Tina Lancaster will work to provide services to the best extent that she can, she feels that she needs to do her own assessment and do “what feels more urgent or serious in kids lives” in terms of “safety, health, future;” anything that seems “pretty serious” she said.

Cathy Kelley also talked about the importance of prioritization given that they have limited resources to help people. Cathy Kelley said that “some people come in with a laundry list, and you know, we have to be realistic about that. I also try to be very up front about the fact that there’s some things I can help with and some things I can’t,” meaning that she assesses need based on what is available and what is realistic (i.e. need versus want). She talked about how even though “assessment of needs can be tricky...we’re always trying to be cognizant of the fact that people do have a lot of needs but also that they are involved with other organizations,” so the prioritization piece comes in when they do social work triage.

During social work triage, they find out with whom else a refugee is working so that they don’t duplicate services and can prioritize meeting the needs that aren’t already being met. Cathy Kelley said that “really prioritizing and helping them [refugees] identify and prioritize needs” is extremely important in determining what services to provide them with. Dr. Steingard also talked about the need to determine

what the higher priorities are in order to determine what service to provide. "Often times" these "higher priorities" are

"sort of obvious...you know, shelter, food, that kind of thing. Sometimes, if someone is you know, very horribly psychotic and we can't really interact with them, sort of trying to get a handle on that is, becomes an obvious need. And so you approach that and you know if somebody becomes more stable, we can you know, then we have you know sort of time to take a breath and say 'Okay, where do you wanna go? What are your personal goals?'"

Therefore, prioritization is important in terms of addressing the initial, more urgent needs of shelter, food, or psychosis so that they can eventually have "a shared conversation" to determine future treatment and service plans and goals.

Discussion

Miriam Potocky-Tripodi (2002) discusses the importance of doing needs assessments in social work (124). While many of the service providers interviewed discussed how they use methods of observation and listening to the refugees as ways of determining refugee needs, Potocky-Tripodi discusses the need to do post-service provision needs assessments as well. Potocky-Tripodi thinks that needs assessment at that point in service provision is important, because it helps providers to measure outcomes "in order to determine the extent to which the intervention has been effective" (124). I agree that this is an important step in needs assessment because by doing needs assessment at some point after initial services have been provided, service providers are able to analyze what needs still need to be met. At that point providers can do program and practice evaluation, which Potocky-Tripodi thinks should be done on a daily basis. The benefit of doing needs assessments and evaluations is that the work can be shared among providers who

serve refugees so that providers can better identify need among refugee populations.

One way providers can assess mental health need is by asking refugees to fill out surveys regarding emotions, mental health, stress, and trauma. Bhugra (2010) discusses the importance of surveys and studies in identifying mental health need in refugees and asylum seekers (10). Some of the surveys that he references are similar to the ones that Beiser and Fox and Willis used in their research and case studies of refugee mental health. Bhugra (2010) provides similar data and statistics regarding prevalence of various mental illnesses that tend to be prevalent in refugee populations. What needs to be kept in mind about using surveys to analyze mental health need in refugee communities, is that the answers are not necessarily self-generated because they are asked to select from a series of responses to describe how they are feeling (10). The problem here is that the answers selected may not accurately describe how a refugee is feeling or what they are struggling with, which is why I think that needs assessments that include a direct refugee opinion and involve listening to a refugee client speak about their issues, may work better. Balgopal (2000) discusses how this kind of needs assessment through survey and studies may not be entirely accurate or representative of the population for a number of reasons, with which I agree (210). Balgopal says that “studies concerned with mental health” of refugees “focus only on clinical populations,” which demonstrates from the onset, a certain level of perceived need (210).

This analysis of refugees’ needs is limited in that it is focused on providers’ perceptions of need. A full analysis of the issue would include open-ended

interviews to ask a variety of refugees what their highest priority needs were. However, that is beyond the scope of this study. Most refugee service providers try to take refugees' self-perceived needs and priorities into account, however, this is very challenging due to the wide variety of languages, cultures, individual experiences, communication problems and limited resources. It is important to acknowledge however, that refugees may not always be able to recognize some of their needs, which is why the role of service providers and their expertise, training, and how they do needs assessment is important as well.

In my analysis of how the service providers I interviewed assess need in the local refugee community, it was interesting that none of them mentioned a systematic way in which they do needs assessment. For example, checklists are often a key element of needs assessment and it is noteworthy that none of the providers interviewed discussed using checklists in needs assessment. Although I was able to categorize the ways in which these providers assess need into specific strategies, the majority of these strategies of needs assessment as individualized and personal. What I mean is that these strategies of needs assessment are not necessarily implemented in a formal way by service providers or by service agencies, which could suggest a need to create a formal and strategic form of needs assessment.

Many of the perceived social service needs for refugees that the local service providers interviewed identified, are needs that other service providers and scholarly literature have identified as well. In Denhart's (2005) research, she discovered that many service providers help refugees with what they call "the

paper chase that we have here in America,' like disputes over telephone and utility bills or troubleshooting when Medicaid or food stamps are stopped and the refugee does not know why" (96). Other examples of social service needs which were identified by Denhart include a Bosnian refugee needing help getting a driver's license because he didn't have "any records like birth certificates" or "a Ukrainian couple who wanted to sponsor a relative but did not have a marriage license to prove that they were spouses" or "a refugee who had taken his citizenship test and the paperwork had gotten lost" (96). While some of these examples vary slightly, many of the service providers I interviewed identified a similar social service need for assistance with these types of issues. Denhart also discussed how many refugees rely on the goodwill of volunteers for donations that will help alleviate some of their need for basic items like clothing (98), which is much like what Tina Lancaster reported.

Many refugees suffer from a variety of different mental or behavioral health issues, due to many different reasons, that may present themselves in different ways and at different times throughout the resettlement process and along the timeline of being a refugee, which the service providers I interviewed perceive to be needs of the refugee community they serve. Some of these mental or behavioral health needs include the inability to be present, feeling emotionally unhealthy, or dealing with non-trauma related stress. Often, however, the mental health issues that many refugees suffer from are due to the traumatic experiences that they have been through (these are often the same experiences that forced them to seek refuge in another country). Other mental health issues are related to the resettlement process

and the stress of acculturation, however, in many cases in which a refugee is suffering with mental health needs, these two explanations are intermixed and are both factors in their suffering. As Sujoldžić (2004) says, “Thus in terms of mental health consequences, to the stresses and traumas inflicted on refugees before escape, during flight, and in refugee camps, one must add the difficulties and fears that face the refugees during resettlement and the acculturation process” (146). These resettlement stressors can include concern and feelings of inadequacy due to job role loss, fear of not making it as high as they had hoped in a career, or from performing lower status jobs (Groen 2009). This can additionally be related to “loss of one’s previous social role and social support network” (Sujoldžić 2004: 147). Furthermore, there is a sense of “cultural bereavement,” which many refugees find distressing (Smich 2008: 47). All of these mental health needs are needs that local service providers perceive to be things that the refugee community struggles with.

The literature on refugee mental health needs identifies PTSD, depression, anxiety, and stress as the most common mental health problems faced by refugees, which are many of the perceived mental health needs that the service providers interviewed identified. The statistics of prevalence in refugee populations, however, vary from study to study. In a case study of Dinka and Nuer refugees from Sudan who have resettled in Nebraska, the exact statistics of prevalence of mental health problems such as PTSD, depression and anxiety were fairly low. This is due to the fact that many of these refugees do not label what they feel, as depression. When looking at more specific questions on the questionnaires that these refugees received, you can see, however, that the percentages of “having recurrent thoughts

or memories of the most hurtful or terrifying events and/or avoiding activities that remind them of the traumatic or hurtful events,” “recurring nightmares,” “feeling nervous, tense, or worried,” “complaining that everything feels like an effort,” “being tired all the time,” “feeling lonely or sad” etc. were all very high (Fox and Willis 2009: 168). Which for service providers, indicates that many Sudanese refugees suffer from mental health issues that could be classified as depression or anxiety. All these labeled feelings can be related to my research in that service providers, like Tina Lancaster, identified that many refugees are not “emotionally healthy,” or how providers at Connecting Cultures talked about how they have heard refugees express feelings of loneliness or how they feel unable to be present with their children. These feelings are very much represented by how the refugees in the literature identify how they are feeling.

It is both interesting and important to acknowledge the difference in how refugees and service providers perceive refugees’ needs. For example, often times what western, biomedical psychiatry, and other service providers, would label depression or anxiety, and the feelings and emotions that refugees mention, are often different, even though many of these emotions or feelings are what service providers would identify as key signs of depression, even if that is not what refugees would say they are suffering from. The same symptoms can therefore be understood as different diagnoses, but since western medical professionals are making the diagnosis in the case of refugees, they often perceive refugees’ mental health needs differently than a refugee him or herself might. This is important to recognize in my research since it is the service providers mostly, who determine refugees’ mental or

behavioral health needs. Even though many of the service providers interviewed stated that they assess need based on what refugees tell them, it is important that service providers recognize that what refugees tell them and how they describe their experience, might need to be interpreted and diagnosed differently. This can be related to Arthur Kleinman's article *What is a Psychiatric Diagnosis? (1988)* in that not all cultures recognize PTSD, depression or anxiety as diagnostic categories.

Literature on Afghan refugees provides examples of how they, as refugees, experience mental health issues that are often prevalent needs in refugee populations, much like the perceived needs of Burlington's refugee community. Lipson (1993) reports that the Afghan refugees that she worked with in California "experience depression and psychosomatic symptoms of stress related to family role change and conflict in American society, loneliness and isolation...and culture conflict..." (413). Lipson also notes "Both Afghans and their American health providers perceive numerous mental health problems in the Afghan community, in particular, stress, depression, and numerous 'aches and pains'" (414). Lipson further suggests, "...this community may have considerable posttraumatic stress disorder" (414). Additionally, some mental health problems that presented themselves in this particular refugee community were: appearing to be in a perpetual daze, mutism, recurring nightmares, survivor guilt, "...and the continuing stressors of news of their country and family members who remain there" (419). One Afghan woman, who Lipson interviewed, summarized her experience of being a refugee and dealing with her distress by saying "Living in the United States is no refuge; it is simply moving from one hell to another hell" (420). Tina Lancaster described a similar sentiment

that a refugee man shared with her when he told her “It’s hard to be a refugee in Vermont; it’s hard to be a refugee period.”

The case of Somali refugees is further evidence of the mental health needs that many refugee populations, like the refugee community in Burlington, commonly experience. Groen (2009) spent a great many years researching and recognizing cultural identity in mental health care through establishing a trusting, long-term relationship with an informant who is a Somali refugee. This informant complained “about a lack of concentration and memory, having difficulty falling asleep, anxieties and depressed feeling” all of which pointed to classic symptoms of PTSD (453). Additionally, the Somali refugee also reported nightmares, as well as “faintness, heart pounding, trembling, headache, feeling restless, lack of energy, loss of sexual interest,...and feeling hopeless, lonely and suicidal” (453). Much like the Afghan woman mentioned earlier, this Somali man compared the difficulties in his resettlement country to his previous experience. While the Afghan woman called them both hells, the Somali man said “to be a Somali refugee in the Netherlands is the same as being a Yibir in Somalia” due to the types of discrimination he has faced and the distress he experienced and continues to experience as a result of living as a person of color in a primarily white resettlement country (458). As a Yibir, he faced certain discrimination in Somalia due to ethnic hierarchies and in the Netherlands he faces a similar, yet different kind of discrimination with the resulting effects of stress and upset (459). Many of the local refugee service providers talked about the deep effects that racial hierarchies and discrimination have on refugees who resettle in Vermont, which is also a predominately white state.

These case studies of multiple different refugee communities and cultures during the resettlement process demonstrate some of the mental health needs that refugees suffer with and from as a result of the trauma they fled from, the fleeing process and the resettlement process. Interestingly enough, there have been some studies on how some of these mental health issues differ between male and female refugees. According to Beiser (2009), in a previous study he had conducted he found that “...shortly after the refugees arrived, men had higher rates of depression than women...During the years thereafter, male rates of depression dropped more rapidly than those of women” (551). Beiser contends that this may be related to how male refugees are more likely from female refugees to face acculturative stress shortly after arriving because they were the ones who were more likely to have been in the labor force in their country of origin and may feel the burden of not being able to provide for their family in the way they may have previously been accustomed. Overtime, however, the stresses of acculturation tend to lessen and therefore so too do the rates of depression, however this stress and the changes in roles for men and women can be problematic and create great stress for men (551). Pablo Bose stated that this could be an explanation for what seem to be very high rates of gendered or domestic violence among refugee communities, which seems to make great sense as an explanatory reason.

Chapter IV: Perceptions of Local Services: What's Working and What Isn't & How Barriers and Gaps can be Overcome

This chapter seeks to answer the following research questions surrounding perceptions of the local services available to the refugee community: How do these service providers perceive that their services are being received by and used by the refugee community? What do the providers generally think is working well in terms of meeting these needs? What do providers generally think isn't working well? What do service providers perceive as being in the way of meeting these needs? What are some strategies for overcoming the barriers to and gaps in meeting the perceived needs of the refugee community? First, this chapter looks at how providers think refugees' perceive the local services available to them. This chapter then identifies what service providers feel is working well to meet refugees' social service and mental health service needs. This chapter also analyzes what is not working to meet refugees' need and why. This entails looking at the barriers to service provision and what barriers prevent refugees from accessing services. Finally, this chapter analyzes strategies for overcoming these various barriers. This research on perceptions of how services are doing to meet refugees' needs could be important to many different academic fields in that it presents an analysis of how services and service provision could be improved. If other people within the fields of social work, psychology, nursing, and/or education recognize that they are struggling with similar issues or are presented with new strategies to overcome barriers, it could be beneficial to service providers and refugees in resettlement all over the world.

How refugees perceive local social and mental health services, according to service providers

When service providers were asked about how they think the refugee community perceives their services, these service providers acknowledged that many refugees think local services could be doing things in different or better ways. Two providers felt that their perception is probably different than how refugees' might perceive local services. A couple of the providers interviewed felt that they really couldn't speak to what refugees think about the local social or mental health services available to them. Only one service provider discussed having heard positive feelings from the refugee community about local services. Given that I did not have the opportunity to speak with the refugee community about how they feel about local services, these answers are entirely perception-based. Some service providers told me how they imagine the refugee community perceives local services, while other service providers related to me what members of the refugee community directly told them.

A difference in perception between refugees and providers

Some service providers said they thought there was a difference between providers' and refugees' perceptions of needs and the quality of various services. Cathy Kelley, along with Tina Lancaster, thought, "there certainly could be a difference between how" they "perceive services and how the refugee community perceives the services." Cathy Kelley thought that this different perception of services certainly comes up on occasion, but it can be hard to recognize, and "it'd be easier to think 'Oh, we've been doing this work for a while; we totally understand

peoples' needs and how to meet those.” She did however, think this is a complacent attitude and that there is need for self-assessment on behalf of service providers to figure out how to best serve the refugee community. Tina Lancaster thought there is undoubtedly a disconnect between how providers and refugees perceive local services and refugees' needs.

Tina Lancaster presented an example of this difference in perception of needs and services by telling me a story about a young refugee woman she knows who is 27 and has six kids. Tina Lancaster said “she [the young woman] laughs about it when there are classes in parenting. She said, ‘Like these women who are like, you know, 25 years old and have one baby are gonna teach me how to be a parent?’” Tina Lancaster went on to tell me that when this mother was in the hospital after having given birth, “the breast consultant came in to teach her how to nurse, and she just rolled her eyes and is like, ‘Please. I nursed all my babies and I know how to do it, you know?’” Tina Lancaster could clearly see, especially in that specific situation, how at least this one refugee woman felt about that particular service.

Tina Lancaster has also heard other Somali Bantu mothers make fun of Connecting Cultures for trying to teach parenting skills to them. These mothers find it almost ludicrous, because the issue isn't that they don't know how to parent, it's that they don't know how to parent children who are part of a different culture than the one with which they identify. These women want to learn how to deal with the stress that comes along with that type of parenting struggle, said Tina Lancaster.

According to Tina Lancaster, these women don't want to feel like someone is saying

to them, “I’m gonna teach you, an ignorant person, about how to raise your children.” Instead, they want to “talk together about what’s stressing their family out; what’s working and what’s not” said Tina Lancaster. If these refugees were to be honest with the service providers, said Tina Lancaster, they would tell providers that they “really do want to feel more included in the planning. Like as a receiver of services, they want to be a participant in the process to address some problems.” Tina Lancaster thought, however, that this might just be a feeling of refugees who have been settled in Vermont for a couple of years because “when people first come, they’re not ready for that [participating in service development]...they’re just overwhelmed with adjusting, but at this point, that’s what they want. They want to be a participant in planning what they need.”

A need for improvement in refugee services

The general response to questions asked about refugees’ perceptions of local social and mental or behavioral health services is that there is a huge margin for improvement. Vermont Refugee Resettlement Program (VRRP) is a service agency that has a huge volunteer base to run its different programs and services. As a result of being mainly volunteer-run, it seems that there is a lot of turnover in terms of who is volunteering and/or working there at any given time. Tina Lancaster talked about how many refugees mention to her that they “wish that volunteers who were with them to begin with were still with them” in the way that Tina Lancaster is. Tina Lancaster said, “...people [volunteers] don’t have any idea how much people [refugees] grieve for them [the volunteers]. Some people [refugees] still ask me, ‘What happened? Did they [the volunteer] die?’” Some of this sense of loss can be

interpreted as cultural misunderstanding, because the refugees don't understand this idea of volunteerism and instead perceive these volunteers to be their friends, and in their cultures, friends are not supposed to be short term. The sentiment, however, is that they wish volunteers were more permanent and that relationships would continue beyond initial resettlement because the refugees feel as though they have "made a bond, but the other people [the volunteers] seem to have broken it." This loss of volunteers seems to have a great impact on refugees both socially and emotionally because they don't see these volunteers as just warm bodies; they have a very personal and emotional connection to these volunteers, which even if the volunteers share to some extent, is ripped away when volunteers leave them. There is a great deal of volunteerism in America that is often well-intentioned and extremely helpful, however, it is often short-term and holds different meaning for volunteers than it does for the people they serve.

Tina Lancaster also explained to me the concerns that some refugee parents have about the schools and the boys and girls clubs. Apparently, many refugee parents have "pulled their kids out" of these programs "because, you know, they [refugee kids] were kind of getting too wild." Refugee parents complained to Tina Lancaster that their middle school aged boys were coming home doing "weird things like take pictures of their butts and texting it to people." According to Tina Lancaster, these parents don't want their kids to be going somewhere or using a service that encourages, or at the very least doesn't stop, behavior like this. Another refugee mother that Tina Lancaster knows won't let her son

"...go to any more [school] dances...because she went to pick him up at a dance and went into a room and there were kids grinding in middle school,

and she was like ‘that’s, that’s the end of that.’ And I’m like, what the heck is wrong with the school that they have sixth and seventh graders grinding in a darkened room? Grinding with no adult supervision. Like, I wouldn’t send my kid either.”

Ultimately, these parents don’t understand or approve of the behaviors that they feel these services, or institutions, encourage. Tina Lancaster said that these parents don’t understand why the schools aren’t “having game night with the lights on or something? Or play a lot of vigorous, fun, interactive things instead of pushing them into adult behaviors when they’re 12...” Tina Lancaster said that many of these parents who have pulled their children from these services, or from programs at the Boys and Girls Club or at the schools. This is due to difference in understandings of what is normal. For instance, these refugee parents understand that in the mainstream American culture in Vermont today, it is completely normal for boys and girls to go swimming together, but that the types of behaviors that many of the refugee parents have seen don’t feel normal or appropriate and they don’t like it.

There are other reasons that refugees might feel dissatisfied with their experience as service users in the Burlington area. Cathy Kelley recognized that sometimes refugees might not feel as positively about what they provide at Connecting Cultures, even though the providers feel like they do a good job. Cathy Kelley said that refugees’ might not feel as positively because their “services are more limited, and there is usually a wait. People sometimes get frustrated with that.” She went on to say that sometimes she thinks, “people feel they don’t get what they need or maybe their expectations were different than what actually works out.” Cathy Kelley’s example of this was that sometimes people come in “thinking we’re [the providers at Connecting Cultures] are gonna get them citizenship immediately;

that's not going to happen." She thought that sometimes this leads to "more of a possibility that they're going to be somewhat disappointed." Additionally, she said, "working on these really difficult emotional issues" is an "up and down" process, she said. "For some people, they start to maybe tell their really difficult story and then are very triggered by that; flooded by that, and don't want to continue." For this reason, Cathy Kelley feels like "there are different reason why refugees might felt dissatisfied with" their services at Connecting Cultures, even though they are the only specialized mental health service for survivors of torture and trauma.

Some service providers talked about how refugees don't feel positively about some local services, because they have a lot of fear about and from these services. An example of a service that many refugees fear is the Department of Children and Family Services (DCF). Cathy Kelley explained "there is a lot of fear about DCF within the refugee communities. A lot of fear about their kids being taken for very minor things" and fear about how the system works. So from a refugee standpoint, said Cathy Kelley, "I think they would, you know, say that the agency that was the least" well received and the "worst" at understanding their needs, is DCF. Refugees stay clear of using other services as well, due to fear of being stigmatized or shunned by their community. An example of such a service would be Victims' Advocate Services, which George Weber discussed with me briefly. Refugees won't use those services, because they fear the reactions of their families and friends. These services then no longer feel helpful. Refugees also told George Weber about how they don't use services like Victim's Advocate Services, because they feel like the translation and interpretation is unhelpful and/or not confidential.

Providers who were unable to speak for refugees

Many of the service providers interviewed felt that they couldn't, or wouldn't, speak to how the refugees feel about local services. One provider felt that it wasn't his place to speak for the refugee community about their thoughts, opinions and feelings about local services. Another provider felt like her service agency hadn't really done anything systematically to ask refugees about their perceptions of the services provided. George Weber felt very strongly about not speaking for the refugee community in any context, because he felt like it wasn't his place to say what he thought they might feel. George Weber said he didn't know how to explain it well, but he felt that he didn't "have the right to speak on their [refugees] behalf because it's not up to me to say whether I think their needs are being met or where a solution has been reached. That's for them to reach a conclusion to." George Weber also felt like his own position in American society as a white male would cloud and disguise the truth about the refugee community's perceptions. George Weber felt like his limited capacity to speak for the refugee community was not solely based on race and gender but also on "all these things that limit my capacity to understand their lives." George Weber said he simply doesn't come from a similar experience, and as much as he cares and wants to support and help the refugee community, he can't, and will never, completely understand what they have been through.

Dr. Sandy Steingard also felt like she couldn't really answer questions as to how the refugee community perceives local services. "Truthfully," she said, they were "excellent questions" but "unfortunately, I can't tell you because I haven't really asked them [refugees]." Dr. Steingard did say that at the Howard Center, they

“...do consumer satisfaction surveys annually. They’re sent out anonymously by the state and we get them back and you know, I, I am familiar with that, but it’s not broken down into refugees. So you know, you it probably would be good to have that, but I can’t say honestly that I’ve like posed that directly.”

Dr. Steingard said that due to her training and her specific way of working as a psychiatrist, she always asks people “What would be a good use of your time?” So, she said, she “certainly asks people what their needs are” but she doesn’t know that she has “done that in a systematic enough way to be able to give a meaningful answer” about how refugees perceive the services of the Howard Center.

One service that has a good reputation among refugees

Many of the providers interviewed discussed the problems that refugees have with local social and mental health services; however, one service provider shared with me some positive opinions that refugees have of a local health service. The New American clinic at what used to be called University Pediatrics is a particular service that gets “a very positive response” from the refugee community. Cathy Kelley said that they know that this outpatient clinic has a positive reputation among the refugee community because “people could go elsewhere.” Cathy Kelley said that furthermore, what they “hear over and over is ‘I love Dr. Green. I love Dr. Weinberger;’ um, whoever their primary pediatrician is.” According to Cathy Kelley, refugee families who go to the New American clinic for their children’s health and wellbeing, vocalize that they feel “very satisfied.” Cathy Kelley reported that really, “families tend to stay with us” because they like their experiences at the Pediatric New American Clinic.

How things are going: What is working

In general, most service providers felt like there are a number of things that the organizations they work for, and other service agencies, are doing well to support the needs of the refugee community of Burlington. Service providers thought that some of the things that they are really good at doing include: being culturally sensitive and culturally competent, using the Chronic Traumatic Stress (CTS) Framework for therapy (along with group therapy), being flexible and doing as much as they can with limited resources, and being strategic by coordinating with other providers. These are all actions and services that local service providers self report to be things that they feel like are working well for the refugee community and are helping to alleviate need.

Cultural Sensitivity and Cultural Competence

Cathy Kelley discussed how she feels that both Connecting Cultures and the New American outpatient pediatric clinic at the University of Vermont Medical Center (UVMHC) are really good at being culturally sensitive and culturally competent. Being culturally sensitive, according to Cathy Kelley, helps patients and clients feel comfortable using these services to alleviate their needs. She said at “Connecting Cultures, we are very culturally sensitive. We’ve learned a lot over time about how to work with refugees and other new Americans, especially survivors of torture and trauma” and utilizing culturally competent practices is one of the things they have learned that works well in serving the refugee community. As a result, Connecting Cultures is “the first place people look to in terms of meeting the mental

health needs of refugees.” This practice of cultural sensitivity has also been helpful and works well at the New American Pediatric Clinic. As Cathy Kelley reported,

“I think we’re incredibly good at being receptive to new Americans and being culturally sensitive...the pediatricians that I work with are really good at treating people as individuals, getting to know a little bit of their language, greeting them in culturally sensitive ways, talking about cultural foods and practices...”

All of these little things, like greeting a patient in a way that is culturally relevant to them, are important and make a patient feel comfortable enough to open up and share how they are struggling, with service providers. Because refugees do tend to feel more comfortable and forthcoming as a result of using cultural competence, service providers at Connecting Cultures and at the New American Clinic feel that these culturally sensitive and competent practices work well for them and work well in terms of meeting refugees’ needs.

The Chronic Traumatic Stress (CTS) Framework and Group Therapy

Connecting Cultures, as an organization, feels a great sense of pride in how well their Chronic Traumatic Stress (CTS) framework and group therapy work for the refugee community that they serve. Service providers at Connecting Cultures feel that the CTS framework really works, because it helps patients acknowledge that the horrific events aren’t just in the past, because providers know that many refugees feel the continued stress and impact of these events on their daily life. These service providers feel that this framework works better than a PTSD framework, which only really discusses trauma as a past event. By acknowledging that it is hard to hear the word “refugee” without PTSD, providers are able to push past some of the stereotypes and allow patients to discuss their own symptomology.

Service providers feel like this works well for refugees, because it allows refugees to discuss and open up on their own terms, rather than making them feel as if something is wrong with them. According to the service providers, CTS “increases valued living despite what these refugees have been through” (Mazulla 2015). By using the CTS framework, service providers help patients through the realization that “even though some of their symptoms may never go away, there are skill-based things that they can use in the moment to help them move forward,” said Cathy Kelley. These skills are things like mindfulness and relaxation exercises, among other exercises, that help refugees focus on their strengths rather than their weaknesses. All of these tools and practices are things service providers find work well to alleviate refugees’ needs.

The group work and group therapy that Connecting Cultures does with refugees and torture and trauma survivors seem to be a really worthwhile tool that works well to support refugees’ mental or behavioral health needs. Connecting Cultures recently starting doing some groups with youth and students in the Burlington and Winooski schools. Even though these groups only started a few months ago, many adolescents at these schools want to participate in these groups, which is great, according to service providers, because the need for them is big. The service providers feel that this is proof that the groups are working particularly well for youth and adolescents. Additionally, among the adults who participate in the therapeutic groups for survivors of torture and trauma or for adjustment concerns, there is great desire to continue group meetings long after their original group experience has ended. Many refugee adults want to continue group work because

they want to be able to talk about the continued issues and stressors that they experience, like loneliness or relationships problems. Service providers feel like these groups are beneficial and work well for refugees because refugees are able to share what they are going through with other people who truly understand them in a safe and welcoming environment. As Cathy Kelley said,

“I think that we provide a lot of beneficial services and you know there’s no one else doing this kind of work in this area so that in itself I think speaks well of what we’re doing. And I think especially the groups that we run and...there are lots of individual success stories.

Doing well despite working with limited resources

The majority of service providers interviewed feel like their services are working well for the refugee community, especially given how few resources they have to work with. As Pablo Bose said of other service providers in town, “I think that the service providers do an amazing job. To be perfectly honest, I think that they do an amazing job with very limited resources. And I think that’s something that I see again and again.” Given how few resources many of these service agencies have, Pablo Bose said that he is continually impressed by the “range of different opportunities, different kinds of work, different kinds of training programs” that service providers offer to refugees. Tina Lancaster also spoke to this theme when she talked about the Vermont Refugee Resettlement Program (VRRP), even though she thought that other service providers might not agree with her. Tina Lancaster said “VRRP only has a mandate to work with people and money for eight months. They do continue contact and they never turn anybody away who comes and asks for help” even though “that’s all they’re supposed to do.” Tina Lancaster went on to say that VRRP is “not supposed to work with them [refugees] you know, for years,

and help them to become healthy integrated citizens” but they do. Therefore, Tina Lancaster thinks that “in a lot of ways, they [VRRP] does a good job” especially knowing “exactly what the limitations are.” Tina Lancaster said that VRRP does a really good job of “getting people [refugees] working” and getting them “access to English classes,” which are really important in meeting many of their other needs. Dr. Sandy Steingard also felt that “as far as communal health programs go, we [the Howard Center] are pretty good and pretty flexible.” Dr. Steingard stated that she really felt that at the Howard Center, they do their best and try to be flexible in order to help “get people off the streets, getting them housed and getting them quickly into services” despite having to serve such a wide variety of people with different needs. Dr. Steingard said that they “try hard to meet their [refugees’] need,” even though they serve so many different people and that they “don’t really discriminate” in order to make that happen.

Coordinating with other providers

Many service providers feel that something that is working well to meet the refugee community’s service needs is coordinating with other local service providers. Cathy Kelley spoke a lot about how important care coordination is and how it helps to meet refugees’ needs. Care coordination, she said, is really just about “bringing together providers” in order to better support refugee needs. Connecting Culture’s strategy of social work triage seems to be a good method in care coordination. Through social work triage service providers are able to see “what resources someone is connected to” and where the gaps are in order to figure out what services they still need to meet refugees’ needs and so as not to duplicate

services. Cathy Kelley said that they especially do “some work in the schools trying to be more connected to other providers; trying to bring providers together in different ways to really look at who’s the team supporting a certain client or patient.” Additionally, care coordination allows other providers to be connected with other culturally competent providers in order to create a larger network of culturally competent and sensitive providers.

How things are going: What is not working and why

Although many of the service providers interviewed felt that there were some things that they were doing well to meet the needs of the refugee community, there are also some things that providers feel need improvement or that aren’t working well. Sometimes, the service providers interviewed would discuss how they think other service providers are struggling to meet the needs of the refugee community, while other times providers discussed the things that their organization is personally struggling to do. Many of the services that local service providers are struggling to provide or that aren’t working, aren’t working well because of various different barriers that either prevent refugees from accessing services or prevent providers from helping refugees in the way they need. Some of the services that providers feel aren’t working well are: the schools, housing services, and the system of refugee resettlement overall. Other things that service providers are struggling with as barriers to meeting refugees’ needs include: being fully culturally competent or culturally sensitive (despite that also being something they said that they are doing well), language and interpretation, and money and resources. Barriers that

prevent refugees from accessing services include: daily stressors and adjustment issues, language, and stigma and fear. Many of these barriers for refugees are some of their service needs as well.

Services that aren't working well

Some of the services providers interviewed discussed other services that they do not feel are working well. These service providers felt that these services are not meeting the demonstrated needs of the local refugee community. These services include: the schools, housing services, and the system of refugee resettlement overall.

The school system is a service that many providers felt is not meeting refugees' needs. Tina Lancaster, as mentioned in other chapters, felt like the schools are failing kids academically and that the schools are not helping refugee students to succeed. George Weber strongly voiced a similar opinion that the schools are not working well for many refugee kids. He said that there are "a bunch [of refugee kids] that are in the ELL program and they're not students who should be in ELL programs" but "the school district has no real capacity to do anything other than stick them in remedial ELL classes...because they have no plan." George Weber talked a lot about how it seems like the schools don't even care about their refugee students because they aren't taking the time to acknowledge how this system isn't working for the refugee students and they aren't doing anything to increase their capacity to do more for these students.

The housing situation in Burlington is another service that many providers acknowledged is not working well for the refugee community. Although Tina

Lancaster acknowledged that “there’s limited housing in Burlington, some of the apartments are gross, but” the problem is these apartments are “...all there is, you know? And we have to get them [refugees] an apartment right away and so they’re put in a crummy place.” Tina Lancaster additionally discussed how landlords aren’t coming up “with some sort of basic standard” for good housing. The situation has worsened, she said, because there is hardly any more section 8 housing because “there’s no funding for it.” So the problem then becomes, “how does a new family afford an apartment unless they can get into public housing? But Burlington has limited public housing.” The result is that families of eight people, with six children, are placed in 3-bedroom apartments when “they should be in a 5-bedroom apartment, but there aren’t any.” Furthermore, because these refugee families are forced to live in inadequate apartments there are often problems that they need to discuss with their landlords. Landlords, however, often take advantage of them because they don’t speak English. The landlords then get away with “claiming damages” on the part of the refugees “and keep their deposits because they can say that [the refugees damaged property]...and the society protects the landlord” said George Weber.

A significant number of service providers interviewed also brought up issues about how the system of refugee resettlement isn’t working well to support refugees’ needs. For example, as a refugee you are supposed to be guaranteed Medicaid as health insurance; however, the Vermont Health Connect system does not yet recognize refugees, because of a coding issue. Even though refugees should be eligible for this aid, the computer system tells providers that refugees cannot be

recognized as eligible claimants because they have not been immigrants for at least 5 years. This was a problem that service providers brought up at the RISPNet meeting in January. Pablo Bose discussed the larger issue of refugee resettlement in the United States and that it is essentially a privatized system. The problem with this, he said, is

“that you have a number of government agencies, so Homeland Security, Health and Human Services, and the Department of State, who determine who’s coming in; and to some degree, where they’re going to go. But they then outsource the actual resettlement of these people to a group of nine or ten resettlement agencies. And so those resettlement agencies are the ones who are actually doing the resettlement. Whether it’s USCRI, which is the parent of VRRP, or International Rescue Committee, the Lutherans, or the Catholic Charities or whatever it is, it’s them who are doing it.”

The problem with having so many different organizations enacting the resettlement process is that it becomes an “incredibly fragmented system” that “is not really the federal government at all.” “What then makes it very challenging,” Pablo Bose said,

“is you don’t necessarily have a ton of coordination and even at the federal government level you have multiple agencies that are involved in this. And so what it leads to, I think, is a lot of inefficiency; a lot of duplication. And then I think that there’s far too much that is offloaded, not just to the states, but onto the municipalities and on to the local communities.”

The obvious problem is that this process is extremely inefficient and ends up duplicating a lot of its services. Additionally, local governments and local agencies, in areas like Burlington, get overwhelmed and overloaded during the resettlement process. George Weber discussed this impact on “the city of Burlington, Chittenden County, the state of Vermont, and the State Department” in that these government services and agencies “are not adequately addressing the fact that peoples’ basic needs are not being met.”

An additional problem with having such a fragmented system of resettlement is that local service agencies end up competing for grants to fund their services.

George Weber said, “now they’re [local service agencies] all competing for the same grants” because

“AALV and the refugee resettlement program are officially state sponsored programs and they get funding from those sources. So the Somali Bantu Community Organization of Vermont is not one of those programs so they just do not have access to those resources.”

The result is that the Somali Bantu Community Organization of Vermont ends up competing with other local agencies for grants and funding.

George Weber also discussed how many of these resettlement services are offered “predominately by white people and white narrow political structures,” which creates racial hierarchies, cultural misunderstandings, and a lack of cultural competence in the resettlement process. George Weber gave an example of refugees meeting with State Department or Homeland Security officials and the lack of cultural sensitivity they had when helping refugees through the citizenship process.

George Weber said that he knew a Somali refugee very well who said that in his

“... country, you know, you were born during the rainy season or you were born during the dry season. This whole concept of being born on April 14th is, they don’t know how to deal with that. So you know, so when they’re basically being treated by the State Department and told they’re liars or thieves because they don’t know their birthday.”

This creates great fear for refugees in trusting the system and service providers throughout the resettlement process, and beyond.

Service providers’ struggles and barriers to meeting refugees’ needs

The service providers interviewed discussed things that they, and that other service agencies, are struggling with and that are barriers, which prevent them from

meeting refugees' needs. These difficulties include: struggling with being cultural competent, language and interpretation, and money and resources. While some refugee service organizations, like Connecting Cultures or the New American Pediatric Clinic, feel like cultural competence or cultural sensitivity is one of their strong suits, for other organizations, cultural competency is something that they really struggle with.

For example, Tina Lancaster discussed how agencies and schools continue to send home letters when it has been repeatedly been made known that many parents in the refugee community do not read English, or know how to read at all. Cathy Kelley echoed Tina Lancaster's example by saying that many organizations will call "refugees and leave messages in English or send them mail when you know they don't read English or don't read at all." She emphasized this point by saying that if "someone gets a really important letter about their child's welfare that might look the same as a piece of junk mail." George Weber agreed, "There's a real lack of knowledge about the community using service providers." He doesn't think cultural competency is the correct way to describe this lack of knowledge, but ultimately it does describe what he considers to be a lack of understanding on the part of service providers about refugees' cultures and experiences.

Cathy Kelley further expressed her frustration that "some organizations are not very culturally sensitive." She said what's even more frustrating is "when you see an agency repeatedly resisting attempts to get trained in being more culturally sensitive or having a standard practice of using interpreters." Cathy Kelley thinks that ultimately it is a lack of attention being paid to simple things that could be made

to be more culturally sensitive. Additionally, Cathy Kelley thinks that there is “a general sense sometimes, among organizations that it’s too difficult to work with especially non-English speakers...that they should learn English,” because “it creates more work for us.” Cathy Kelley realizes that these issues and “attitudes are difficult to address” but that they really are preventing refugees from getting the services that they need. Furthermore, there are “still a lot of providers out there who don’t recognize their need to adapt and expect people to just come in and understand what they’re supposed to do or expect them to bring an interpreter with them.”

Dr. Sandy Steingard discussed her own struggle to be culturally competent in her practice at the Howard Center, even though she tries and wants to be as culturally sensitive as she can. She said “I think that it is hard being in a small city, with small pockets of refugees from very different places so it’s really tough to develop any kind of like culturally sensitive expertise with one particular group.” Dr. Steingard said that she has “one or two patients from” multiple “different ethnic groups,” and they “have a pair of sisters from Burma and...some guys from different parts of Africa. And Africa’s a big continent. So even sort of jumping in all the Africans as one group is kind of an incredible insult to this remarkable multicultural continent you know?” As a result, Dr. Steingard feels like she has “to sort of watch myself and monitor that,” which can be “a little challenging.” Dr. Steingard explained that she treats so many different people, from so many different ethnic and cultural backgrounds, including other patients from Nepal, Russia and Bosnia and therefore she feels that “it’s just really, really difficult to develop *true* cultural sensitivity for sort of ‘in-house’ expertise with these particular groups.” Dr. Steingard said that it’s

“just an on-going challenge that’s hard because...we’re always just struggling to meet the general need and be sensitive to these individuals who have a particular vulnerability...” Dr. Steingard feels that part of what she struggles with is that the Howard Center is a mainstream organization that does treat people from so many different ethnic groups. “In bigger cities,” she said, “there will just be a whole clinic that’s just geared toward particular ethnic groups and sometimes even sub-clinics. And so you get people who you know, know the leaders of the community.” She feels like maybe having opportunities to work in that kind of environment would make cultural competency more attainable and that as service providers they could then maybe have a greater effect on “a bigger population.”

Cathy Kelley and Dr. Sandy Steingard both talked about struggling with language and interpretation, especially when working with refugees on mental or behavioral health issues. Cathy Kelley discussed how the “interpretation piece is a difficult one, because...there are not a lot of trained interpreters in this area, because we don’t have a huge base of individuals who speak languages other than English.” Dr. Steingard expanded on the struggle of dealing with different languages in mental health work. She said “I always feel like I’m working with one hand tied behind my back” because “...doing psychiatry when you do not share a common language is a challenge.” Dr. Steingard said that this becomes especially difficult when you start to deal with “certain things that just aren’t translatable, you know, nuance, and the idiom and all that stuff.” What has to be kept in mind is that along with the language and interpretation difficulties, is that often times Dr. Steingard is treating patients who are psychotic and have delusions, so these untranslatable items become further

confounded. Ultimately, treating mentally ill patients who do not speak the same language as the provider and come from a different cultural context can be “very daunting and difficult.” Even just to find out “what’s going on and what her problems are, her needs are” can be “almost theatrical” and is “enormously challenging,” said Dr. Steingard.

Another thing that service providers seem to really struggle with is money and resources. Many of the service providers interviewed discussed how difficult it can be to have enough money to fund all of the services they need to provide. Cathy Kelley spoke to the cost of interpreters and how “that’s something that we’ve [Connecting Culture] struggled with over time because we are grant-funded so our resources are not infinite” which is a struggle. The high cost of interpreters and being grant-funded really limits Connecting Cultures’ ability to serve the refugee community. For example, Cathy Kelley explained that they “can’t meet with somebody for three hours because we [Connecting Cultures] just can’t afford to pay the interpreter for all that time.” Cathy Kelley also talked about how money impacts their resources. She said, “We [service providers] could always do more, but that’s if time and money were infinite. Time, money, bodies; that’s the tricky piece of it,” because “it really comes down to resources.” Cathy Kelley explained how at Connecting Cultures, they have had problems with staff going into overtime; overtime creates money strains, but they simply can’t afford “to have more full time, on-going staff” because they “don’t have the funding for that.” Tina Lancaster also discussed how money and understaffing is “the biggest thing” that prevents service agencies from meeting the needs of the refugee community, even though “the good

will is there.” George Weber described how lack of money impacts the Somali Bantu Community Association as well. He said, “There was no money for books. There was no money to pay somebody who actually knew what they were doing” in terms of teaching English as a second language. He said because he “didn’t have any resources to find out what to do,” he would give the most attention to the people with the most need, because that’s all he could do with the resources he had, which left some refugees with their needs unmet.

Barriers for refugees

Refugees also experience many barriers that prevent them from accessing services, said the service providers interviewed. This means that services might not be working well for refugees, because they are struggling to overcome barriers in order to utilize these services. Many of the barriers that prevent refugees from using local services are actually the same as some of their service needs. As Cathy Kelley said, “there are a lot of barriers for folks, so that’s just a huge on-going need.” These barriers include: daily stressors and adjustment issues, language, and stigma and fear.

Daily stressors and adjustment issues are things that many service providers identify as barriers for refugees, which then prevent refugees from accessing services that they provide. Things like family matters, stressing about educational issues, parent/child relationships, legal matters, and housing problems are all things that put a lot of stress on refugees on a daily basis. Some of these issues, along with trying to adjust to a new culture, can be huge barriers in accessing and/or using the

services refugees might need in a more imminent. These daily stressors and adjustment issues can prevent refugees from using services in the way that they might be intended. For example, many service providers at Connecting Cultures talk about how when these types of issues being to overwhelm a refugee they are trying to treat for more significant mental health issues, like trauma, it can make it harder to do what they call “the deeper work.” Therefore, refugees’ stress becomes a barrier, not only to healthy functioning, but also to using the services in a way that will improve and alleviate some of their needs. Cathy Kelley talked about how the stresses of “transportation can be a barrier,” along with the stress of trying to fit something like weekly therapy into a refugee family’s schedule. Say, for instance, that “a child or adolescent is referred for services at Connecting Cultures, their parent isn’t necessarily able to bring them for weekly therapy” and the task of trying to figure out how to get their child there on a weekly basis can be incredibly stressful for them. Cathy Kelley talked about how similarly, “follow up, even around health issues doesn’t always happen” for the same reason, because “there are so many demands on people [refugees].” Cathy Kelley said because service providers work with “a lot of very large families” and they recognize that “logistically, it’s difficult to get your child in for the second in a series of shots because you have to figure out how to get there” and what to “do with the other kids.” Consequently, barriers like these get in the way of refugees being able to use services in the way they might need to.

The service providers interviewed also talked about language as a barrier for refugees. As George Weber said, “English lends itself to having a hard time

overcoming these barriers.” Thus, not knowing English or not having strong English skills, can seriously prevent refugees from having the ability to even access services, let alone understand how a service might work or how it might be able to help them. Cathy Kelley said “...just figuring out how to navigate [being on hold] is difficult when you’re a non-English speaker.” Cathy Kelley also discussed how not having English language ability can lead to a “lack of knowledge about resources” and “sometimes a lack of understanding about how to access” services and know “what’s available”. Cathy Kelley believes that “language is the number one” barrier for refugees. As the care coordinator at the New American Pediatric Clinic, she can’t be in every appointment so a doctor might say to a patient “We have Cathy here; she might be able to help you with that.” The problem then comes when Cathy Kelley tries to connect with these clients by phone, because for her to call them, she has to have a phone interpreter and “some of the languages are not readily available.” She said that on occasion, she’s “tried to call people...but could not even find the correct interpreter in order to do that.” As a result, connecting with people through language can be a real barrier to utilizing services. Many providers also talked about how disheartening and overwhelming learning English can be for refugees, which is only worsened by other issues that they are struggling with, which many refugees know could be more easily dealt with if only they knew English.

Stigma and fear are other barriers, according to local service providers, that prevent refugees from accessing services. Tina Lancaster said “I think that most Somali Bantu people that I’ve talked to are fairly horrified by the idea of mental health care of any kind...they’ve never had anything like that,” and so it scares them.

She said what scares them is that they'd be talking to a complete stranger, and that "they [refugees] have no idea whether they [providers] are actually culturally competent or whether they're racist." Therefore, many Somali Bantu refugees don't access mental health services, because they are terrified of using them. Cathy Kelley said that stigma can also be a huge barrier, "especially for mental health services" because people are scared of what it might mean if they go use those services.

George Weber also talked about the impact of fear on refugees and how it prevents them from accessing services and from participating in advocating for themselves.

George Weber said, "Many people have experiences in refugee camps and going through a civil war. They're very afraid and very intimidated by trying to build relationships with community organizations because they're very afraid of that kind of confrontation." George Weber said that he remembered a time when there was a young refugee woman who had a "protest at the school and parents thought their daughter were gonna be killed or somebody from their family would disappear," because they were "confronting these problems publicly and politically." For that reason, "there is a fear, a legitimate fear" and "real hesitation...about speaking out and building relationships." Moreover, refugees fear being stigmatized and "labeled a rabble rouser or the trouble ones" by people within their own community.

Discussion

Through my research, I discovered that in treating refugees who suffer from mental health issues, there are a variety of problems that can arise, such as language barriers and the types of service providers available. Quite simply put, a huge issue

in treating mental health issues for refugees is the barrier of language. Often, biomedical psychiatrists will not know the language of the refugee that they are treating because western, biomedical doctors are often English speakers and refugees are often not. Additionally, there is the complexity of adding an interpreter and/or a translator into the mix. Although this will bridge the language gap, it can leave room for things to get lost in translation and it could be overwhelming for a refugee to have multiple people listening to them discuss deeply personal emotions and suffering. According to Swartz (2014), problems that can arise due to language barriers are the following: “inability to communicate with service users,” “difficulty in educating service users about their psychiatric diagnoses,” difficulty in translating “the emotionally loaded and culturally nuanced local idioms of distress into a psychiatric diagnosis,” “referral for specialist services” due to the “absence of specialists speaking” the language, and the “discussion of confidential matters” is often “impossible when family members” are the acting interpreters (3). The vast majority of these issues are barriers that service providers discussed with me and that I analyzed to be barriers as well. Furthermore,

“Interpreters may be erroneously assumed to be experts on the cultural and linguistic worlds of their clients, and be asked to make complex judgments about the cultural acceptability of experiences service users may have...Quite apart from the fact that no single person can speak on behalf of a whole cultural group, interpreters may not come from the same social groups as service users even if they are native speakers of the same language – there are vast differences within language groups regarding beliefs about and experiences of distress and healing” (2).

This leads directly into the problems with the types of service providers that exist. A great challenge to culturally competent mental health services is the lack of training and personnel who are educated and knowledgeable of the cultures they are

working with (3). Even if service providers are educated to a small extent, it can be difficult, as Dr. Sandy Steingard mentioned, to be an expert in cultural competency when there are so many different cultural groups that providers serve. Another discussion then regarding cultural competency is who should be teaching it and how? The problem here it seems, is that many providers feel like they need to be experts in cultural competency in order to serve many different cultures. However, as Tervalon and Murray-García (1998: 118) contend, “cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves” which might better be described as cultural humility, instead of cultural competence because it creates cultural competency as an ongoing process, rather than an end-point or an end-goal.

McKinney (2007) discuss the benefits and challenges of having cultural brokers who essentially work as a mediator between the two cultures at hand in order to foster better cultural competency in service provision interactions; often times this cultural broker is a former refugee. Although there may be benefits to having a former refugee act as a sort of cultural broker at service agencies, especially when these sorts of issues arise, there are some difficulties and challenges that arise as well. Often times, these cultural brokers or “bicultural counselors” are not specifically trained as paraprofessionals and although they may be cultural “experts,” their lack of training given some of the diagnoses at hand, particularly if the nature of them is severe or complex, leads to problems (490). Additionally, it can

be emotionally difficult for these former refugees to spend so much time “working with refugees who had suffered traumatic life trajectories similar to their own” (495). Some bicultural counselors expressed “mixed feelings” about their position and feeling like they were “wounded healers” (495). One woman expressed this doubt by saying “I feel like I really haven’t helped myself but now I am helping others” (495). Furthermore, the job of being a bicultural counselor or cultural broker can be difficult in that the refugees they serve can place an inordinate amount of demand on them that “dominant culture” service providers may not necessarily experience, creating a kind of “exhausting dependency” on these former refugees (495). Pablo Bose and Tina Lancaster discussed how the Vermont Refugee Resettlement Program (VRRP) often hires people from the refugee community. Tina Lancaster explained, however, that although many refugees see ways in which they could help improve services for other refugees, they don’t feel like they have the time, or energy, to devote what little free time they have to work in that capacity.

Many of the strategies for overcoming the barriers to and gaps in meeting the perceived needs of the refugee community are the same things that service providers feel that they are doing well or that are working well to meet what they perceive to be the refugee community’s needs. An example of this would be the strategy of social work triage that Connecting Cultures employs or the van that they use to bring women to adjustment groups. Things like care coordination, the CTS framework, working with interpreters whenever possible, utilizing culturally competent language and practices, using specific cultural adaptations (especially in mental health interventions), community outreach, surveying refugees about their

needs, teaching people skills they can use at home, and using interpreters are all strategies that service providers use to overcome barriers. Denhart (2005) asserts that care coordination and using networks of service providers, whether “formal or informal, are essential to getting services delivered, to helping refugees build social capital” and to helping them overcome barriers (26). I agree that care coordination seems to be vitally important in refugee service provision, and while service providers told me that they actively coordinate care for individual patients, I think that coordination between service providers could be done in a more concrete and systematic way. It seems to me that beyond coordinating care for individual patients, there is not much direct communication or coordination between the many service providers, which could be a strategy for overcoming some of the many barriers that these service providers say they face.

Beyond using what they think already works to overcome barriers, many of the service providers interviewed had some other ideas about how they could bridge the gap in service delivery. Some service providers think that self-assessment and honesty, doing more trainings, finding a different way to fund the resettlement system, early interventions, mentors, Call-in Circles (to be defined later), and addressing problems on a systemic level are all strategies they could employ to overcome barriers.

Cathy Kelley and Dr. Sandy Steingard both think that self-analysis or self-assessment, in combination with self-honesty, are strategies that could benefit and strengthen service delivery. According to Cathy Kelley, self-assessment could be as simple as asking oneself a list of questions like:

“Is this really the best way? Are we meeting peoples’ needs? Are these the best services? Is this the best way to deliver these services? How can we adjust our services? Have needs shifted? How can we adapt our practices? Where is the best site to hold a group given where people live? How will they get there?”

It would be important to take the time to reflect on these questions and then to also talk about the answers as a team of service providers within an organization, and theoretically at the RISPNet meetings as well. Dr. Steingard contributed a similar idea that it is important to self-reflect and be honest about what your limitations are in order to figure out the best way to provide services.

Providing more training is another strategy that Cathy Kelley thinks could be useful for the community of service providers in order to better provide services overall. These trainings could be trainings for medical interpreters, specifically about how to do interpretation most effectively in a mental health setting. The reasoning behind that specific of a training is “that most interpreters, if they get training, don’t get training in...they’re trained maybe in working in a medical setting or in a legal setting but not in a mental health setting” which “is a little different” said Cathy Kelley. Trainings could also cover topics like “what are clients’ rights in regards to requesting interpreters?” It could be important to do more training surrounding working with interpreters because interpreters are “definitely one way we can try to bridge the gap” said Cathy Kelley. Since Connecting Cultures is a training entity, soon to be a national training entity, it would be important to continue providing cultural competency training to other local refugee service organizations. These cultural competency trainings are important for overcoming barriers in service delivery because they cover how to use greetings “in that

person's language" or how to be "cognizant of things like preferences around touch or eye contact."

Given that many of the service providers interviewed discussed how money and resources are a barrier for them in service delivery, many refugee service providers and experts think that finding a new way to fund refugee social and mental health service organizations would be a good strategy to overcome many of the money problems that these agencies experience. Pablo Bose thinks that one way we can improve the monetary situation in refugee resettlement is by putting "more money into our communities as a federal government." Pablo Bose thinks that in order "to do this [refugee resettlement] properly, we need to put more money, not on a grant, not on an annual grant basis, but really as kind of base-funded programs." Therefore a strategy to overcoming money and resource issues could be completely reconfiguring the entire grant system that is the funding basis for many refugee resettlement and refugee service organizations.

Tina Lancaster thinks that one strategy for overcoming some of the problems within the educational system is to intervene early with refugee students who demonstrate that they are struggling in school, whether it is educationally, socially or behaviorally. One way that Tina Lancaster thinks this is possible is through mentoring and/or "one to one consistent tutoring." She said that in her experience kids who have "any kind of mentoring...tend to be sturdier and have more experiences and have more, more of somebody they can talk to who's in-between their age and their parents age and they can talk about American problems with them."

Another strategy that Tina Lancaster presented to me is the idea of a Call-in Circle. A Call-in Circle is something that she considers to be

“...really culturally compatible with each of our refugee groups.” [A Call-in Circle, she said, means that] “...you bring the kid in and you bring all interested parties in. So the parents are there. The kid is there. The kid can invite who his supports are, his or hers. The teachers who care, the people from school, anybody from their community, friend of the mother. Everybody comes in and everybody talks.”

The idea of these Call-in circles is that anyone can request one and that everyone who is involved with the child can participate, so long as they are “willing to do something to support” the child. Tina Lancaster said “So if I come, I have to be willing to say if you need help with English, come to my house on Tuesday; I’ll help you with questions.” In the Call-in Circle,

“... everybody comes in and everybody talks. They say what they see the kid doing, what’s scaring them. They wanna know why it’s happening. What can we do to support you? What’s the problem? Why are you causing all this trouble in school?”

Maybe the reason for the Call-in Circle is something as simple as the “kid has a hard time sitting still, who knows,” said Tina Lancaster, but the point of the Call-in Circles is that they “are where they [all the people who are involved with the child] are holding the kid accountable but also providing total support.” Tina Lancaster said that they started implementing this strategy in schools in January.

George Weber discussed a strategy that he thought was important for addressing many of the issues and barriers that refugees in the Burlington area face, which is that people should address barriers and need on a systemic and structural level. George Weber thinks that the problem is that we talk about many of these problems “in isolation of each other.” For example, he thought that if you’re talking

about refugees, they aren't "the only community in Burlington or Chittenden County that doesn't have housing and shelter and food needs met." George Weber thought that if "you start talking about only meeting the needs of this one community, alienating everybody, the other groups," you can't solve the overall problem which is that there are many other people, beyond just the refugee community, who struggle with overcoming barriers to meet those same needs. George Weber thought that

"... there needs to be a solution that addresses shelter, not shelter for refugees, not shelter for white people, not shelter for black people, but shelter in general. And so, what are we gonna do about the problem of employment in general, not necessarily refugee employment."

He thought that "the solution isn't based in a solution for refugees," but in a strategy for addressing "the community as a whole," so that "everybody has housing." George Weber thought that in order to find a real solution, you have to use a strategy that "addresses everybody's issues."

In the scholarly literature, Denhart (2005) also contends that looking at "the players in isolation...leads to a disproportionate focus" (10). What Denhart means by this is that this type of isolationist thinking focuses on only one part of the problem. It also then focuses only "on those who lack privilege or position rather than those who exercise it," meaning the people who run the system or create the policies (10). Denhart (2005) also argues that when "people doing resettlement work make a point of differentiating refugees from other immigrants" reinforces the idea that "by the very nature of their circumstances, refugees find themselves in a position to need and receive help" and that the help they need is different than the help that other "deserving poor" need (64).

While I do agree that there are many systemic and structural issues that need to be addressed, I do not agree with what Denhart, as a scholar, and George Weber, a service provider, contend in regard to the kind of help that refugees need. While there are many systemic and structural issues, that if fixed, would greatly improve many refugees' situations in Burlington and bridge many of the gaps that exist, I think there is a great need for service providers to use cultural competence and specific training when addressing refugees' needs specifically. The strategy of implementing culturally competent and sensitive practices is key in helping refugees to overcome some of their fears that prevent them from accessing services.

Using interpreters is another key strategy in overcoming many of the barriers to service delivery. According to Denhart (2005) who argues that interpreter's "language and cultural competencies" are invaluable skills "in bridging language and cultural gaps between refugees and health professionals or government agencies, as well as internally, between clients and case managers or job developers [employment counselors]" (91). Denhart demonstrated the importance of having interpreters in mental health service provision as well, because interpreters are key in helping to explain and interpret things like idiom or nuance (101), which many providers, like Dr. Steingard, need help with. Denhart also supports the strategy of care coordination and having service provider networks because "refugees must be connected into the existing service and social systems" and the only way to do that is to have "multiple people within primary resettlement make those contacts to secondary resettlement and associate service resources" like Connecting Cultures or AALV (92).

Another strategy that Denhart (2005) identifies is that of meeting refugees where they are at. For example, through my research it was identified that many refugees struggle with transportation, so Connecting Cultures contracts someone to drive a van to pick people up and bring them to their group therapy sessions. Denhart discusses a similar strategy that service providers she observed utilized in which they created “a relationship with a mobile unit that does psychiatric assessments at people’s homes” (107). Denhart also discusses the importance of educating refugees on how the systems work and with whom and how “refugees must interact and facilitate exchanges” with the service provision systems (121). This is quite similar it seems, to Cathy Kelley’s concern and desire to educate and help refugees understand how to access services that can help alleviate their needs. Other strategies that the literature contends are “best practices for working with refugees” include “strengths perspectives and empowerment theory” which are much like the strength-based focus of the Chronic Traumatic Stress framework (Fong 2004: 20). Fong also discusses how using frameworks that focus “on contexts and an understanding of the cultural norm, values, and beliefs of their [refugees’] home countries is” important to incorporate into social work practice (42), which is much like how the doctors and social workers at the New American Pediatric Clinic and at Connecting Cultures utilize culturally sensitive greetings and concepts surrounding touch and eye contact. Fong further enforces this when she conveys the anthropological importance of understanding “the culture and environment of...native lands” (49).

Chapter V: Conclusion

This thesis investigated many different aspects of service provision to refugees in the area surrounding Burlington, Vermont. There are a huge variety of services that support the local refugee community in many different ways. These service organizations and agencies provide both social services and mental or behavioral health services to support what they perceive to be the refugee community's needs. Some of these service organizations include the State Refugee Office, the Vermont Refugee Resettlement Program (VRRP), the Association of Africans Living in Vermont (AALV), the Somali Bantu Community Association (SBCA), the Community Health Centers of Burlington (CHCB), the University of Vermont Medical Center (UVMCMC), Connecting Cultures, and the Howard Center, among others. All of these organizations have different reasons and qualifying factors that determine whom they serve and why. Some of these organizations focus solely on serving the refugee community and their needs, while others serve the community at large in addition to serving the refugee community.

For the purpose of my research, I interviewed local service providers to answer research questions regarding what service providers perceive to be the refugee community's needs, and how providers assess need and then decide what services to provide. The service providers interviewed perceive that the local refugee community struggles with many different needs including basic needs, like food, clothing and shelter, social service needs, and mental or behavioral health needs. By coding and analyzing service providers' responses, I determined that they perceived that the refugee community of Burlington struggles with social service

needs and issues of citizenship, employment, English language learning, literacy, education, transportation, healthcare, childcare, housing, access to services, understanding the system, communication, making doctors' appointments, knowing what services are available and how to access them, filling out forms, and coordinating family life. The service providers interviewed perceive mental or behavioral health needs and issues to include Post Traumatic Stress Disorder (PTSD) or trauma related stress, non-trauma related stress, substance abuse, familial relationships, and gendered/domestic violence, and feeling emotionally unhealthy. Local service providers have many different ways in which they assess need and determine what services to provide. Local service providers reported that they assess need by listening to refugees, using methods of observation and experience-based decision making, and prioritization.

When asked whether they felt like there was in a difference between how they perceive services and how refugees perceive their services, local service providers felt like there may be difference in how each community views services. As a result, service providers had varying opinions about how refugees might perceive local services. A couple of providers felt like they couldn't or wouldn't speak for refugees about how they view local services. Most service providers however, felt like service providers and service agencies in general do a good job of supporting the local refugee community's needs. At the same time, however, many providers felt like there are many aspects of service provision that could be improved and that aren't working as well. As a result, there are most certainly some aspects of service provision that local service providers struggle with as barriers,

which prevent them from delivering services. Additionally, service providers mentioned barriers that they felt prevent refugees from accessing local services. Finally, I analyze the strategies that service providers present and use as ways to bridge the various gaps in service provision.

Implications

This research indicates that there are many services in the Burlington area that support the needs of the local refugee community beyond the Vermont Refugee Resettlement Program and the other services that I focused on for the purpose of my research. For example, there are many other mainstream social welfare and social service organizations in Vermont that serve the refugee community, like Economic Services or the Department of Children and Family Services. Although there exists a large variety of services to support the needs of the refugee community of Burlington, the service providers interviewed implied that there are many needs still go unmet. Even though many organizations do what they can to support the refugee community, many basic needs are not met and result in significant stress for many refugees. This thesis exposed many ways in which service providers perceive that the system of refugee resettlement is not working as a result of needs not being met and because of things that they, as service providers, are struggling with. The implication then, is that there is a huge margin for improvement within the field of refugee service provision, even though there are aspects of service provision that are going well. Service providers themselves acknowledged that there is always room for improvement and that there is no end

to the amount of training that providers can receive.

In analyzing local service providers' perceptions about local services that they, and other organizations provide, it is clear that there is a need to support service providers in new and different ways. For example, organizations and service providers should share with each other what they are struggling with and what they have found works, so that providers can not only support each other, but find new and better ways to deal with the aspects of service provision that they are struggling with. Creating more, and new, training opportunities for service organizations could also be important. Additionally, like some of the providers interviewed said, the system of refugee resettlement needs to be restructured in order to facilitate better service provision. Furthermore, changing the way in which organizations are funded could make a huge impact on the capacity service organizations have to support the refugee community. Finally, finding a better way to include refugees' opinions and perceptions about their needs, and ideas about service provision, could create a better system of service provision for all parties involved.

Limitations

There were, however, some limitations to my research. Looking at providers' perceptions of their services in Burlington provides an incomplete analysis of the efficacy of refugee resettlement programs and social and emotional, behavioral and mental health services. Even though finding an objective measure of what needs refugees have would be best, identifying and understanding these needs is highly tempered by distinct cultural, social, and political factors. Analysis based solely on

providers' perceptions leads to a potential disconnect between what providers offer to refugees and what the refugee community actually needs. Additionally, the refugee community may not realize the services provided will meet some needs they in fact have, or they may not accept or pursue the services offered due to stigma surrounding that particular need.

This methodology has, however, provided a unique approach to understanding an important component of refugee services by exploring how service providers view the community they serve and their effectiveness in meeting what they perceive to be refugees' needs. While not interviewing any refugees does pose a limitation in terms of not fully examining the effectiveness of services provided, the role service that providers play in relationships with the refugee community is nonetheless critical to successful resettlement. In addition, refugees often develop new ideas of what they need closer to those of local service providers as they as refugees acculturate to the norms of their adopted country. Focused examination of provider perceptions thus provides a useful perspective on refugee needs.

Availability of service providers also posed some limitation, however. Many local service providers are extremely busy professionals. Securing interviews posed challenging given their schedules and mine as a student who also works part time. I reached out to more than 20 providers from various organizations, but due to scheduling conflicts or lack of response to my inquiry, I was able to interview only five providers. A critically missing perspective is that of a provider from the Vermont Refugee Resettlement Program. The inability to interview any providers

there may be in agreement with other local service providers' perception of VRRP, which is that they are not always responsive.

One other limitation to my research is that my study does not include the direct perspective of someone from the local public school system. I was not able to interview a teacher, a superintendent, a principal, or a homeschool liaison, which would have provided another important perspective to my research as many people in the school system serve a majority of the refugee children. Due to time constraints, access, and availability, I unfortunately could not include this perspective in my research. Another missing perspective is that of a provider from the Association of Africans Living in Vermont (AALV). As one of the most important service providers in the Burlington area it would have been an important perspective to include, unfortunately, the timing did not work out to interview a provider from AALV.

Recommendations for Future Research

Due to the limitations of my own research, it would be interesting to continue this research to include the local refugee community's opinions and perceptions of the services available to them. It would then be interesting to compare the different perceptions and analyze strategies through which service providers could better incorporate the refugee community's self perceptions. Not a lot of research has been done on the efficacy of refugee service providers, so it would be interesting to conduct research in a similar vein of the efficacy of service provision in other resettlement sites and then to compare the case studies. Additionally, while there is

plenty of scholarly literature and research on refugee mental health, there is not a lot of research on service providers' perceptions of what they think refugees struggle with, instead, the literature presents analysis of refugee mental health more as fact. Therefore, it would be interesting to analyze the impact of provider perceptions in the care and services they provide.

Additionally, I think it would be interesting to include an educational perspective in this type of research. Given the amount of issues that providers discuss regarding the educational system and schools for refugee students and their parents, it would be important to analyze the perspective of providers in the school system. It could be interesting to analyze the needs and perceptions related solely to schools for refugees and their families.

Finally, I think it could also be really important and interesting to further analyze the disposition and demographic of the people and providers who do this kind of work with refugee communities. While I touched on this a bit in my research, it is interesting to note that many of the service providers who serve refugee communities are white. Furthermore, when I attended the RISPNet meeting, it was extremely apparent that many of these providers were white women either in their 20s or late 40s/50s. Therefore, I think it would be really interesting to do research on refugee service providers' backgrounds, training, and demographic information, because it is clear that that has an impact on service provision as well.

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Appendix

Research Information Sheet

Title of Study: Service Provider Perceptions of Refugees Needs, Services and Service Delivery Barriers in Burlington, Vermont

Principal Investigator (PI): Samantha Sawyer

Faculty Sponsor: Jeanne Shea, Ph.D., Associate Professor, Department of Anthropology, University of Vermont.

Introduction:

You are being asked to participate in research for an undergraduate student honors thesis project about local social services and mental health/emotional health services for refugees in the Burlington area, in regards to perception of these services. I aim to interview 6 – 10 service providers on this topic.

Purpose:

To identify what providers of local social and emotional services perceive to be the needs of the local refugee community; to identify providers' perceptions of the services they provide; to identify perceptions they have of barriers to delivering these services to the refugee community; and finally to identify any similarities and differences across these perceptions.

Study Procedures:

If you take part in this research, you will be asked to spend about thirty minutes to an hour verbally answering a series of questions about what services you provide to the local refugee community, your knowledge of the community you serve, and your opinions and perceptions about the services you provide. The interviews for this research project will take place in Fall 2014 at a time and place that is convenient for you.

The interviews will be conducted by the PI who has received training in research ethics, interview techniques, and medical anthropology under the advisement of the PI's faculty sponsor, Dr. Jeanne Shea.

Your answers will be audio-recorded, transcribed, and coded. All information collected will be de-identified. When the thesis project has been completed, you will be informed and given a copy of the work.

Benefits

As a participant in this research project, there will be no direct benefit for you;

however, information from this project may benefit other people now or in the future.

Risks or Discomforts

There are no known risks other than the small risk of breach of confidentiality. We will do our utmost to protect the information that we collect from you.

Costs

There will be no costs to you for participation in this research study other than your time.

Compensation

You will not be paid for taking part in this study.

Confidentiality:

All information collected about you during the course of this research project will be kept without any identifiers, unless you chose to be credited for some or all of what you say. Unless you specify otherwise, you will be referred to in the research records by a pseudonym (code name) or case number (serial number) only. There will be no list that links your identity with this code. Research information will be stored in a locked file cabinet and on a secure password-protected personal computer. These materials will be accessible only to the research personnel. Once full and accurate transcription of the contents is confirmed by the PI and her faculty sponsor, the audio recordings will be destroyed.

Voluntary Participation/Withdrawal:

Taking part in this interview is voluntary. You are free to not answer any or all questions or to withdraw at any time. You may choose not to take part in this interview, or if you decide to take part, you can change your mind later and withdraw your interview from the research. If you decide to withdraw from participating, if you wish, we will destroy any interview data that we have already collected from you and not include it in any reports or publications.

Questions:

If you have any questions about this study now or in the future, you may contact Samantha Sawyer PI at the following phone number: 763-258-9245, or by email at smsawyer@uvm.edu. You may also contact her faculty sponsor, Dr. Jeanne Shea at the following phone number: 802-656-3181, or by email at jeanne.shea@uvm.edu. If you have questions or concerns about your rights as a research participant, then you can contact Nancy Stalnaker, Director of the Research Protections Office at (802) 656-5040.

Participation:

You have been given a summary of this research and thesis project. Your participation is voluntary, and you may refuse to participate without penalty or discrimination.

If you understand and agree to take part in this research study, please indicate "yes". This will be considered your verbal permission to take part in this research study.