



Practitioners' Perspectives on Barriers and Benefits of Telemental Health Services: The Unique Impact of COVID-19 on Resettled U.S. Refugees and Asylees

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Abstract

The COVID-19 pandemic and associated sequelae have disproportionately exacerbated refugee mental health due to health disparities, poverty, and unique risk factors. In response to the pandemic, most mental health providers have shifted to virtual platforms. Given the high need for services in this population, it is essential to understand the effectiveness and potential barriers to serving refugees via telehealth. This study is one of the first to examine the extent that socio-cultural and structural barriers impact telemental health services received by resettled refugees during the COVID-19 pandemic. This study also addresses the potential benefits of telemental health service delivery to refugees. We surveyed 85 providers serving refugee and non-refugee clients in the United States. Statistical analyses revealed that more significant socio-cultural and structural barriers, including access to technology, linguistic challenges, and privacy limitations, exist for refugees compared to non-refugee clients. Potential benefits of telemental health for refugees during the pandemic included fewer cancellations, fewer transportation concerns, and better access to childcare. These results highlight the need to address the disparity in telemental health service delivery to refugees to limit inequities for this population.

Keywords COVID-19 · Telemental health · Refugees · Social determinants of health

Introduction

In May 2022, the United Nations reported an unprecedented global crisis, estimating that 100 million individuals are displaced due to war, persecution, and unstable political infrastructure (UNHCR, 2022). Although refugees and asylees (hereafter referred to as refugees) exhibit remarkable

resilience, the majority have experienced trauma and humanitarian atrocities, placing them at high risk for developing mental health challenges, including anxiety, depression, and post-traumatic stress (Bogic et al., 2015; Campbell, 2007; Ghumman et al., 2016; Marshall et al., 2005; Steel et al., 2009). Furthermore, post-migration living difficulties such as racial discrimination, poor medical and counseling access, worries about family back home, and poverty are consistently related to more significant refugee mental health symptoms (Miller & Rasmussen, 2010; Schick et al., 2018; Schweitzer et al., 2006; Teodorescu et al., 2012). Emerging evidence demonstrates that the unexpected post-migration challenge of the COVID-19 pandemic has disproportionately impacted refugees, further exacerbating mental health challenges in this population (Alemi et al., 2020; Greenaway et al., 2021; Rees & Fisher, 2020; World Health Organization, 2020). In response to the pandemic, refugee mental health providers have recognized the urgent need for expanded telemental health services and have transitioned

¹ Throughout the manuscript we refer to refugees and asylees as “refugees” for simplicity. Refugees and asylees both have a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group. The difference between groups is where this determination is made. Refugees apply for status outside the United States through UNHCR and are chosen for resettlement whereas asylees apply for asylum at the border or

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within the United States. They endure similar horrific traumatic experiences in their journey and in their search for safety.

to technological platforms (Pierce et al., 2021; Wosik et al., 2020). This study is among the first to explore barriers and potential benefits of providing telemental health services to resettled U.S. refugees during the COVID-19 pandemic and to assess the differential impact on refugee and non-refugee clients. This knowledge will assist in promoting equity in the delivery of refugee mental health services.

Impact of COVID-19 on Refugee Mental Health

Due to the recency of the COVID-19 pandemic, only a few studies exist examining the impact of the pandemic on resettled refugees. One study found that 51.95% of practitioners reported the pandemic led to an increase in refugees requesting mental health support, and 48.05% of practitioners indicated greater tension within refugee family relationships (Benjamen et al., 2021). Given the high rates of post-traumatic stress experienced by refugees, Rees and Fisher (2020) offer anecdotal evidence of the pandemic's impact on refugee mental health conditions through the triggering of past trauma. First, the pandemic may lead to intensified fears of illness and death for self and family members, especially those remaining in dangerous, high-conflict and low-resource countries. Additionally, the pandemic has produced government restrictions and mandates (i.e., stay-at-home orders), which might mimic past traumatic experiences of forced isolation or detainment during times of violence and war conflict (Benjamen et al., 2021; Mattar et al., 2020; Rees & Fisher, 2020). Given that refugees often originate from collectivist societies (Simich & Andermann, 2014) where family and community needs have higher priority over individual needs, the pandemic may seriously reduce these personal connections that are strong predictors of recovery from traumatic events (Schweitzer et al., 2006). Moreover, refugees may associate food shortages or scarcity of items with war conflict. For example, the media displayed empty shelves during the pandemic due to hoarding toilet tissue and cleaning supplies. The triggering of past trauma can lead to increased fear and anxiety, negatively impacting sleep and compounding emotional distress (Lies et al., 2020).

In addition to triggering past trauma and exacerbating mental health difficulties, COVID-19 is associated with various job-related stressors that may disproportionately impact resettled refugees (e.g., job loss or increased exposure due to type of job). U.S. refugees experience significant underemployment (Baran et al., 2018) and tend to be employed in service-sector jobs (Clarke et al., 2021). Numerous individuals working in the service industry lost employment during the pandemic which can increase risk of financial insecurity and subsequent mental health challenges (Berry et al., 2020). Furthermore, for those who continued

in their service jobs, these high personal contact occupations can lead to more significant pandemic-related illness and mental health concerns (Berry et al., 2020; Greenaway et al., 2021), especially in the resettled refugee population with pre-existing risks for health conditions and underlying diseases (Greenaway et al., 2021; Kumar et al., 2021). For example, in a recent extensive review of physical health outcomes of resettled U.S. refugees, it was found that refugee adults had up to two times the risk of having a chronic medical condition compared to non-refugee immigrant adults, and increased risk for diabetes and hypertension compared with U.S. born controls (Kumar et al., 2021). Furthermore, these outcomes may reciprocally impact the mental health functioning of refugees, their families, and communities as chronic health conditions have been linked to an increase in mental health challenges. While the economic stress of job loss may negatively impact resettled refugees and their families, remaining in high contact employment during COVID-19 will likely lead to increased illness and death among refugees (Berry et al., 2020).

General Barriers to Refugee Mental Health Services

Although the need for refugee mental health services is high, some general barriers to refugees accessing and utilizing services before the pandemic have been identified. In their systematic review, Byrow and colleagues (2020) reviewed 62 studies addressing perceived barriers to receiving mental health services among refugees. Using thematic analytic techniques, they found the most significant barriers were cultural (e.g., mental health stigma) and structural (e.g., financial strain, language proficiency). They also identified barriers specific to the refugee experience, such as lack of trust in authority figures (Byrow et al., 2020). Other researchers also recognized similar barriers, often dichotomizing barriers as either structural or socio-cultural (Ayers et al., 2018; Kiselev et al., 2020). Structural barriers relate to institutional systems and socioeconomic status, including linguistic challenges, long waiting lists for specialized services, and general logistical challenges faced by refugees (Kiselev et al., 2020). These structural barriers stem from disparities in social determinants of health, including poverty, limited English proficiency, discrimination/marginalization, and high-density housing (Hynie, 2018). Together, these disparities in social determinants of health contribute to greater difficulty in disseminating mental health services to refugees. Understanding logistical challenges confronted by refugees is necessary for comprehending potential structural barriers.

In contrast to structural barriers, socio-cultural barriers comprise a dissonance between the country of origin's cultural systems and the host country, such as stigma,

diverging mental health explanations, and cultural mismatches (Kiselev et al., 2020). Regarding diverging mental health explanations, very few studies have examined local conceptual frameworks of diagnoses and trauma treatment in non-Western contexts compared to the numerous epidemiological studies of post-traumatic stress disorder (PTSD; Kohrt & Hruschka 2010). Interestingly, Slewa-Younan and colleagues (2014) conducted interviews with 225 resettled Iraqi refugees and found that after respondents read a vignette of a refugee with symptoms meeting criteria for Western-diagnosed PTSD, only 14.2% identified PTSD as the problem. When respondents were asked what would help the refugee in the vignette, 84.9% of respondents indicated a psychiatrist, and 79.2% reported reading the Koran or Bible would be helpful. Bettmann and colleagues (2015) conducted interviews with Somali and Somali Bantu refugees and found that worry, loss of family members, spiritual possession, and God were some of the explanations given for the cause of mental illness. Nepali-Bhutanese refugees report that trauma impacts the heart-mind connection and that past life sins are responsible for traumatic events (Kohrt & Hruschka, 2010). Connections with the spiritual world and one's ancestral deities were also described as causal factors in mental health conditions for Nepali-Bhutanese refugees. The stigma associated with unfamiliarity with U.S. mental health services is another socio-cultural barrier that has been identified (Clement et al., 2015; Gong-Guy et al., 1991; Satinsky et al., 2019). For instance, refugees from Southeast Asian countries may associate mental health treatments solely with institutionalization and significant mental illness. Therefore, appreciating local conceptual views of mental health is essential to understanding and ultimately addressing socio-cultural barriers for refugees.

Barriers to Refugee Telemental Health: Structural and Socio-Cultural

Due to the COVID-19 pandemic, stay-at-home orders were commonplace across the United States by March 2020 (Disney et al., 2021; Wosik et al., 2020). Mental health providers were mandated to halt in-person services and quickly began delivering services through telemental health platforms to uphold continuity of care (Disney et al., 2021). Although telemental health platforms have been gaining popularity in the last few years, most mental health services were conducted in-person before the pandemic (Benjamen et al., 2021). Estimates indicate the percentage of psychologists utilizing telemental health platforms increased from 7% before the pandemic to 85% during the pandemic (Pierce et al., 2021). Due to the low utilization rates of telemental health before the pandemic, research examining the feasibility and effectiveness of telemental health in this population

is limited (Ashfaq et al., 2020). The few studies that have examined telemental health use during the pandemic have demonstrated the emergence of inequities and barriers unique to refugees (Benjamen et al., 2021; Bose, 2021; Disney et al., 2021). In one study, Disney and colleagues (2021) conducted an online survey of findings from 17 U.S. mental health practitioners of resettled refugees during COVID-19. Through thematic analysis, they discussed various themes related to telemental health barriers such as low technology literacy, lack of resources, client hesitancy, and language issues (Disney et al., 2021). In another study, Benjamen and colleagues (2021) surveyed 77 Canadian primary care clinicians who provided services to refugees residing in Canada during the first six months of the pandemic. Eleven of these clinicians participated in 60-minute qualitative interviews exploring access to care, mental health care, and virtual mental health care during COVID-19. Through qualitative content analysis they identified barriers of virtual care including technological concerns, interpreting challenges, challenges connecting emotionally with clients, and privacy concerns. In their survey, Benjamen and colleagues (2021) found that 68.42% of Canadian refugee clinicians reported a lower rate of access to care during COVID-19 compared to pre-COVID-19.

When refugees are receptive to telemental health services, structural and socio-cultural barriers may impede the delivery of virtual mental health services. Structural barriers to technological platforms include lack of access to technological devices (e.g., computers, tablets), internet connectivity issues, interpreters' availability, privacy, and linguistic differences between client and provider (Benjamen et al., 2021; Kiselev et al., 2020). While it is common for refugees to use telephones, they may be less likely to have access to computers or tablets, which are more likely to have video capability (Bose, 2021). Moreover, older refugee clients may have more significant challenges with using these devices, creating additional age-related disparities. Internet connectivity may be especially challenging for refugee clients due to lack of internet availability and the added difficulty of connecting three individuals (client, interpreter, and provider; Benjamen et al., 2021; Disney et al., 2021). Additionally, given that refugees often reside in high-density homes with multiple families, the privacy necessary to receive telehealth services may be hindered (Mattar et al., 2020; Volkin, 2020). Thus, there appear to be additional structural barriers when using technological platforms compared to in-person services. Given that no studies have compared the structural barriers encountered by providers of refugee clients to non-refugee clients, it is unclear whether these barriers have a disproportionately greater impact on refugee clients.

Although socio-cultural barriers encountered during telemental health services may be similar to those identified for

in-person services, they are likely intensified. For instance, when utilizing telemental health services in their homes, refugee clients may be more concerned about the stigma of mental health treatment if they receive queries from household members (Clement et al., 2015; Satinsky et al., 2019). This stigma may contribute to findings indicating that refugees may not be receptive to telemental health services. For example, one study conducted pre-COVID-19 showed that only 45% of Syrian refugees who experienced post-traumatic stress symptoms were open to telepsychiatry (Jefee-Bahloul et al., 2014). Although socio-cultural barriers to receiving telemental health services likely exist, no study to date has compared the differences between refugee mental health stigma associated with in-person versus telemental health services. Importantly, socio-cultural and structural barriers are not mutually exclusive when considering barriers such as privacy. Privacy issues may be structural in that finding a quiet place may be problematic when having a telemental health session and multiple generations reside at home, while privacy issues may also be related to the socio-cultural barrier of stigma. To better understand barriers such as privacy, we specified in our study whether issues with privacy were due to stigma or residing in large households.

Potential Benefits of Telemental Health

Despite the barriers to providing telemental health with refugee clients, it is worth noting that some research suggests that technology-assisted psychotherapy can be an effective way to deliver mental health services to refugees (e.g., Benjamin et al., 2021). Specifically, telemental health services may mitigate certain barriers to receiving in-person services that may be particularly prevalent for refugee clients, including lack of transportation and access to interpreters in the area (Hassan & Sharif, 2019). Benjamin and colleagues reported that 65% of surveyed practitioners reported that technology assisted psychotherapy is feasible and 67% indicated it could increase health equity for their patients. Additionally, in interviews with 11 respondents, Benjamin and colleagues (2021) asked if practitioners saw virtual mental health approaches as useful for refugees in the future. Open-ended responses included greater access to care, fewer challenges with transportation and childcare, decreased wait times, and the ability to connect with more providers (Benjamin et al., 2021). Although Disney and colleagues (2021) did not specifically ask respondents about potential benefits of virtual care, they commented that telemental health may address disparities in refugee communities via access to practitioners who speak the same language. In the current study, we also examined the potential benefits of telemental health to refugees and how telemental health may be an appropriate alternative approach for some individuals.

This study is among the first to specifically address structural and socio-cultural barriers and potential benefits to refugee telemental health treatment with a sample of providers serving U.S. resettled refugees during the COVID-19 pandemic. In addition, it is the only study to date that compared barriers encountered by refugee and non-refugee clients to better understand if these barriers disproportionately impact refugee clients. We predicted that providers would report multiple barriers and unique benefits of telehealth when serving refugees. We also predicted telehealth services would present greater challenges for U.S. resettled refugee clients and their providers than in-person services. Notably, a study conducted in 2020 found that psychologists estimated that after the pandemic, they would continue to perform approximately 35% of their clinical services via telepsychology (Pierce et al., 2021). As such, for refugees to gain access to telemental health services now and in the future, further clarification of barriers to telemental health services is essential.

Method

Procedure

A cross-sectional exploratory design was utilized for this study, allowing for a comprehensive understanding of the barriers encountered by clients through providers' perspectives. All procedures were approved by the Institutional Review Board at the University of Vermont. Data were collected anonymously from mental health providers across the U.S. using Qualtrics Online Survey Software (Qualtrics, 2020) in August 2020. The survey was disseminated via email (in the English language) to listservs associated with two national organizations: The National Consortium of Torture Treatment Programs (NCTTP) and the Association of Psychological Training Clinics (APTC). These national organizations were specifically chosen for their emphasis on mental health services for refugee versus non-refugee clients (NCTTP and APTC respectively). Approximately 34 member organizations of the NCTTP network provide mental health services specifically to refugee and asylees who are survivors of torture. On the other hand, the APTC network includes over 200 doctoral training clinics that provide services to primarily non-refugee clients. Organizations that serve refugees need to have gained trust from refugee communities, have access to interpreter services, and funds to pay for these services. These complicating factors make it less likely for the mental health agencies associated with APTC providers to serve refugees, unless they are designed specifically for this purpose. Additionally, given the training nature of APTC clinics, refugees are not typically

Table 1 Descriptive statistics of barriers and independent samples t-tests comparing refugee and non-refugees on barriers

Barriers	Refugees		Non-Refugees		Independent Samples T Test		
	M	SD	M	SD	df	t value	Sig (two-tailed)
Access to Technology							
Computer	35.86	26.62	87	18.57	83	10.43***	<0.001
Phone	92.06	13.05	98.46	3.89	60.83	3.27***	<0.001
Tablet	21.49	21.23	41.66	33.41	54.56	3.12**	0.003
Telemental Health Platform							
Computer	19.63	25.36	73.11	29.06	82	8.96***	<0.001
Phone	80.66	27.21	39.94	36.04	59.92	-5.65***	<0.001
Tablet	9.49	17.76	18.37	24.96	58.33	1.79*	0.039
Structural and Socio-cultural Barriers							
Access to a technological device	2.98	0.95	1.76	0.82	81	-6.07***	<0.001
Technology challenges	3.42	0.81	2.47	0.86	82	-5.14***	<0.001
Internet connectivity	3.37	0.78	2.59	.82	81	-4.37***	<0.001
Language barriers	2.88	0.91	1.33	0.65	79	-8.90***	<0.001
Cost of treatment	1.67	1.12	1.85	1.06	73	0.71	0.48
Privacy (stigma)	2.65	0.90	2.17	0.76	70	-2.36*	<0.05
Privacy (environment)	3.22	0.90	2.37	0.77	73	-4.27***	<0.001
Provider Barriers							
Contacting/setting up appointments	2.61	0.86	1.84	0.81	79	-4.02***	<0.001
Billing	1.78	1.13	2.10	1.06	65	1.17	0.25
Cancellations	2.31	1.00	2.28	0.81	79	-0.12	0.91
In-Person vs. Telemental Health Barriers							
Number of cancellations	2.30	0.69	2.22	0.71	77	-0.50	0.62
Concerns of privacy	1.34	0.52	1.30	0.47	78	-0.33	0.74
Language barriers	1.78	0.47	1.87	0.35	59	0.64	0.53
Cost of treatment	2.08	0.28	1.89	0.32	50	-2.29*	0.03
Access to childcare	2.00	0.85	2.04	0.74	69	0.18	0.86
Transportation access	2.52	0.77	2.76	0.52	63.82	1.49	0.14

provided mental health services in this setting. Participants were encouraged to invite eligible colleagues who were also members of the above organizations to complete the survey. Participants were considered eligible if they have provided telemental health treatment or are direct supervisors of those who have provided telemental health treatment to refugee or non-refugee clients in the U.S. during the COVID-19 pandemic. All participants provided informed consent. A total of 85 participants completed the survey. Participants were assigned to one of two groups based on the majority of clients they serve: “refugee clients,” which included clients who were refugees or asylees ($N=50$) or “non-refugee clients” ($N=35$).

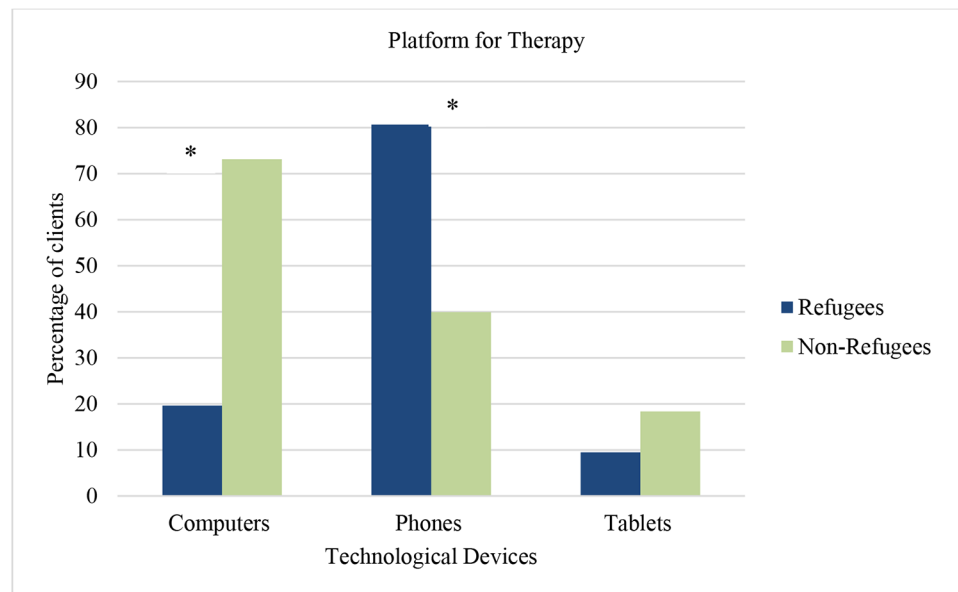
Measure (Survey)

The survey was developed in two stages. First, a pilot study was conducted in which an initial draft of the survey was disseminated to 10 clinicians providing services to refugee and non-refugee clients. The providers were asked to give feedback on the clarity of the survey and if they had encountered additional barriers not considered. Feedback was used

to refine the survey content and create the final version of the survey used for this study.

The refined survey consisted of five sections of questions. Refer to Table 1 for a comprehensive list of the questions on the survey. All respondents completed the first section, which included demographic questions of the providers and their clientele (i.e., role in clinic/organization, ages served, percentage of refugee and non-refugee clients served). Providers were then presented with either questions about their refugee clients, non-refugee clients, or both, depending on their clientele. The second section included items about clients’ access to and use of various common technological devices. The third section inquired about how much of a problem each barrier (e.g., challenges with technology, cost of treatment) presents to clients and providers. Participants rated these questions on a 4-point Likert scale (1–4) from “not at all” to “a lot.” The fourth section asked providers to compare their experience of telemental health with in-person services for several different areas (e.g., concerns of privacy, language barriers). Providers were asked to indicate if these barriers were “worse/much worse,” “same,” or “better/much better” for their clients when receiving telemental health services compared to in-person services. The fifth

Fig. 1 Providers' perspectives on refugee and non-refugee client access to technological devices. $*p < 0.001$



and final section consisted of two open-ended questions, probing additional barriers or benefits providers may have experienced while providing telemental health services. Specifically, providers were asked: (1) what are additional barriers that you have experienced when working with clients through telemental health? (2) have you encountered any benefits of telemental health, as compared to face-to-face services?

Results

Overview of Analyses

The Statistical Program for the Social Sciences software program (SPSS) was used to analyze the survey results. Participant demographic and characteristics of their clientele were examined using descriptive statistics and frequencies. A series of t-tests were used to compare the means of survey items for refugee and non-refugee clients. Open ended questions were analyzed in NVivo 11 (QSR International Pty Ltd, 2020) using thematic analysis to identify common themes across participants. Guided by the six phases of thematic analysis described by Braun and Clark (2006), authors coded responses using inductive and deductive approaches.

Description of Participants

Eighty-five mental health providers self-identified as eligible for the survey. Providers primarily identified as clinicians (54.12%) and supervisors (49.41%), with a small percentage identifying as student therapists (7.06%). Of

note, these categories are not mutually exclusive, as some supervisors also identified as clinicians. Providers served a range of age groups, with almost all indicating they worked with adults (97.65%). Approximately half (45.88%) of providers worked with children, 59.82% worked with adolescents, and 60.0% worked with older adults over the age of 65. Over half of the providers reported that the majority of their clientele were refugees (58.82%), with the remaining providers reporting that the majority of their clientele consisted of non-refugees (41.18%).

Overview

Providers shared that they have encountered both benefits and challenges while providing telemental health services to their clients. Results are separated into common themes that emerged from the survey and/or the open-ended responses from the providers surveyed. Quotes from the open-ended portion of the survey are included throughout the themes to provide additional context.

Access To and Use of Technological Devices

In general, providers indicated that a high percentage of their refugee clients (92.06%) and non-refugee clients (98.46%) had access to telephones. Providers reported that refugee clients had significantly less access to computers (35.86%) compared to non-refugee clients (87%; $t(83)=10.43$, $p < .001$). Refugee clients were also significantly less likely to have tablets (21.49%) than non-refugee clients (41.39%; $t(60.83)=3.11$, $p < .001$). The devices used for telemental health services also differed based on refugee status (Fig. 1).

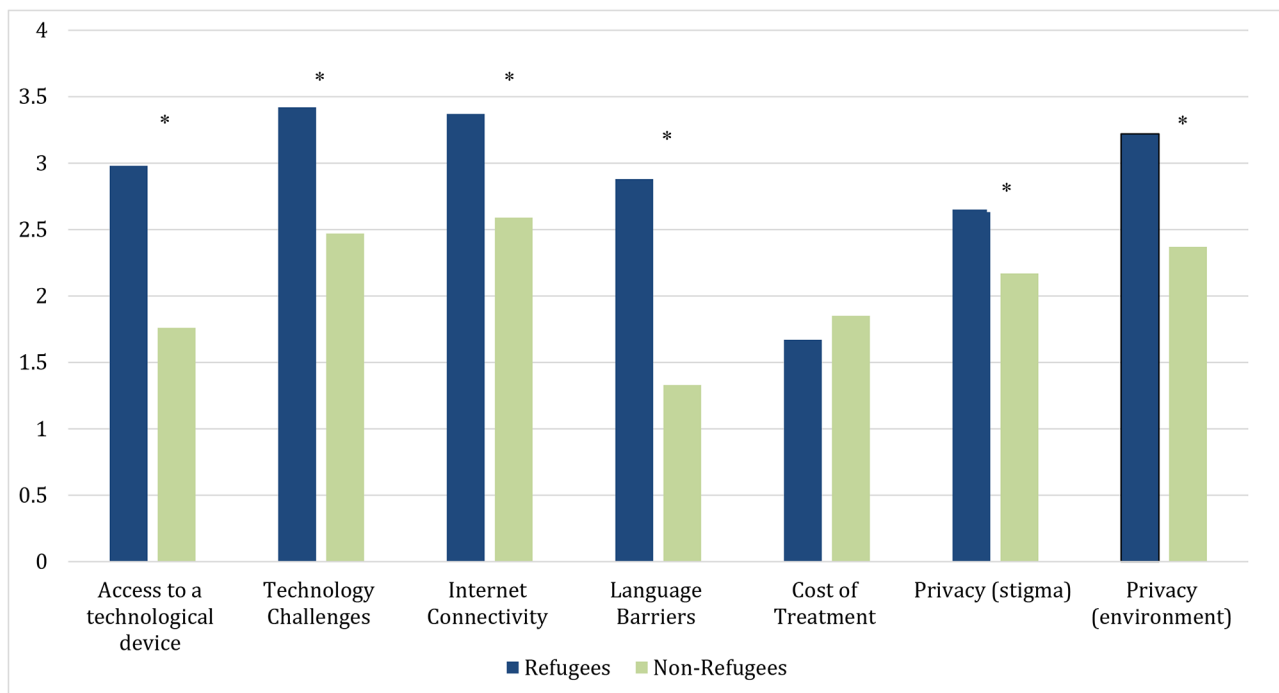


Fig. 2 Providers' perspectives on barriers encountered by refugee and non-refugee clients during telemental health services. * $p < 0.05$

Refugees were more likely to use phones to access services (80.66%) than non-refugee clients (39.94%; $t(59.92) = -5.65, p < .001$) and less likely to use computers (19.63%) compared to non-refugee clients (73.11%; $t(60.83) = 3.27, p < .001$). Few refugee or non-refugee clients were reported to use tablets to access services (9.49% and 18.37%, respectively) and use of tablets did not significantly differ by refugee status. The majority of providers (67.35%) perceived refugee clients' access to a technological device as either "somewhat" or "a lot" of a problem. Additionally, access to a technological device was significantly more problematic for refugee clients compared to non-refugee clients, $t(81) = -6.07, p < .001$.

Access to technology was also a common theme identified in the open-ended question pertaining to barriers. Providers frequently discussed clients' lack of access to computers or video-capable devices and the associated difficulties they have encountered. Challenges noted were that sessions were less productive and focused, and that there were limitations to the types of interventions that were feasible. For example, one provider indicated specific aspects of interventions that are limited without video: "For refugee clients who only use the phone, it is difficult to show them things or walk through processes. For example, interactive interventions that incorporate photos or modeling, and trauma interventions like narrative exposure feel impossible to do over the phone."

Structural and Socio-Cultural Barriers

Technology-Related Barriers

Providers frequently identified that barriers extend beyond lack of access to technology, indicating that even if clients have access to devices, they may encounter additional technology-related barriers, including navigating their devices and inconsistent internet or phone service. Specifically, a high percentage of refugee providers reported that challenges with technology (92.0%), and internet connectivity (89.80%) were either "somewhat" or "a lot" of a problem for their refugee clients (Fig. 2). Technology-related structural barriers were a prevailing theme throughout providers' open-ended responses as well. One provider wrote, "Not having internet access is the greatest barrier for clients as well as not having the training to use technology." Additionally, how problematic challenges with technology and internet connectivity have been differed by client status, with refugee clients experiencing greater problems $t(82) = -5.14, p < .001$ and $t(81) = -4.37, p < .001$ respectively (Table 1). Providers identified that the exacerbation of technology-related barriers for their refugee clients is partly because, "internet service providers are not attentive to language barriers" and that refugee clients, especially older clients, more often lack technological literacy.

Table 2 Providers' perspectives on barriers experienced by refugee clients over telemental health services compared to in-person services

Barrier	<i>N</i>	Worse/Much Worse <i>N (%)</i>	Same <i>N (%)</i>	Better/ Much Better <i>N (%)</i>
Number of Cancellations	47	6 (12.77%)	21 (44.68%)	20 (42.55%)
Interpreting Services	46	9 (19.57%)	35 (76.09%)	2 (4.35%)
Concerns of Privacy	47	32 (68.09%)	14 (29.79%)	1 (2.13%)
Language Barriers	46	11 (23.91%)	34 (73.91%)	1 (2.17%)
Cost of Treatment	25	0 (0%)	23 (92.0%)	2 (8.0%)
Access to Child Care	43	15 (34.88%)	13 (30.23%)	15 (34.88%)
Transportation Access	42	7 (16.67%)	6 (14.29%)	29 (69.05%)

Language Barriers

Providers shared that language was a significant barrier to providing telemental health services to refugee clients. Language barriers were significantly more of a barrier for refugee clients, $t(78.92) = -8.90$, $p < .001$; approximately 64.58% of providers reported that language barriers were “somewhat” or “a lot” of a problem for their refugee clients, compared with 3.03% of non-refugee providers. Providers frequently discussed challenges related to language unique to telemental health, with 23.91% of refugee providers reporting that language barriers were “worse” or “much worse” over telemental health, and only 2.17% indicating that language barriers were “better” with telemental health services. Refugee providers indicated that they have had an especially difficult time successfully integrating interpreting services into their telemental health practice, with approximately 19.57% of refugee providers indicating that interpreting services were “worse” or “much worse” over telemental health compared to in-person services, with only 4.35% reporting that they were “better (Table 2).” Furthermore, many providers noted that challenges accessing and incorporating interpreting services have impacted their refugee clients' therapy experiences. Providers shared that, “Some video platforms don't have access to interpreter integration,” likely due to limitation on the number of participants permitted at one time, limiting the number of clients that can utilize video platforms. When platforms do support interpreters, many providers remarked that connecting to interpreters can be difficult, which can increase interpretation time and thus decrease the time spent engaging in therapeutic intervention.

Privacy

Privacy due to lack of space or the number of people in the home was another barrier that providers reported was significantly more prevalent for their refugee clients, $t(73) = -4.27$, $p < .001$. Almost half of the refugee providers reported privacy due to lack of space or the number of people in the home as “a lot” of a problem, compared to less than 6.67% of non-refugee providers. When compared to in-person services, a high percentage (68.09%) of refugee providers indicated that their clients' privacy concerns were “worse” or “much worse” over telemental health, with only 2.13% indicating that privacy concerns were “better” over telemental health. Consistent with survey findings, concerns with privacy were frequently reported in the open-ended question regarding barriers with many providers highlighting, “Difficulty with interruptions because of family members coming into their room where session is taking place.” The open-ended responses also elucidated some additional concerns with privacy not specified in the survey. Multiple providers discussed concerns with the portability of devices leading to clients receiving services outside of their home. One provider explained, “Clients out in the community when it is time for their call has been a main concern.” The portability of devices has also introduced additional considerations including those of safety, such as “clients driving a vehicle while engaging in telehealth.”

Privacy related to mental health stigma, a socio-cultural barrier, also significantly differed based on refugee status, $t(70) = -2.36$, $p < .05$. Specifically, the majority of refugee providers indicated that privacy-related mental health stigma was “somewhat” or “a lot” of a problem for their clients, while the majority of providers of non-refugee clients reported that this barrier was either “not at all” or “a little” problematic. One provider explained, “For some clients, confidentiality and their ability to share deep thoughts is affected by who is around.”

Scheduling Appointments and Attendance

Contacting clients and setting up appointments significantly differed by refugee status $t(79) = -4.02$, $p < .001$, with providers reporting these barriers as more significant with refugee clients than non-refugee clients. Although cancellations as a barrier did not differ by refugee status, when asked to compare their experience of cancellations with in-person services, the majority of providers of refugee clients indicated that cancellations were either the “same” or “better” with telemental health services. As 42.55% of refugee providers reported that the number of cancellations was “better” for telemental health, and 12.77% reported that they were “worse,” providers frequently emphasized the benefits

of telemental health regarding a decrease in cancellations, no-show appointments, and late attendance. Some providers mentioned the unique difficulties that refugee clients experienced regarding scheduling for telehealth including, “People who don’t speak English aren’t getting language appropriate reminders for their appointments, so they forget.”

Transportation

The majority of providers emphasized transportation barriers (i.e., reliable transportation, long commutes, lack of driver’s license, travel costs) as, “among the biggest barriers to in-person office visits” and therefore not requiring transportation as one of the greatest benefits of telemental health. Consistent with this finding, approximately 69.05% of refugee providers indicated that transportation access was “better” or “much better” for telemental health than in-person services. One provider explained the impact that telemental health services had in reducing transportation barriers, and ultimately increasing client access: “Clients are very pleased that they need not travel and incur the costs of transportation to attend their sessions. This in some cases make clients able to attend sessions more frequently.”

Access to Childcare

Interestingly, providers had mixed responses regarding the impact telemental health has had on access to childcare. For instance, approximately 34.88% of providers reported that access to childcare was “worse” or “much worse” compared to in-person services, while another 34.88% of providers reported that access to childcare was “better” or “much better.” One provider shared their experience with both the drawbacks and benefits of telemental health regarding childcare: “For clients who have children, caring for them during the session has more options from home than in the office, though the distractions remain.” Overall providers shared that on the one hand clients do not have to find childcare, which can be a barrier with in-person services, however, having children at home during sessions can increase distractions that were not present for in-person appointments.

Therapeutic Rapport

In the open-ended responses, providers repeatedly discussed the impact of telemental health on their relationship with their clients. Some providers noted, “Delays to the establishment of the therapeutic alliance with telehealth” due to the distance that telehealth services create and the increased home-distractions. One provider wrote, “More aspects of psychosocial and mental health services get ‘lost in translation’ via a virtual platform. We depend so much on

the emotional ‘feel’ of working with someone in person.” Interestingly many other providers shared that clients have enjoyed welcoming them into their homes and that, “Some clients have benefited from the slight distance created by remote care in engaging in the therapeutic process.” Specifically, one provider shared, “Not being in the physical presence of the therapist can at times allow them to reveal more vulnerable aspects of their experience which they may feel more ashamed about when meeting in person.” Furthermore, providers commented on their increased understanding of their clients’ context due to “a first-hand view of stressors.” With this better understanding of home environment, providers discussed that “clients can practice in the moment at home” and “discuss what thoughts/feelings are coming up in real-time.”

Discussion

According to mental health practitioners across the U.S., the COVID-19 pandemic and increased telemental health service utilization have introduced additional barriers as well as potential benefits to refugee clients. To our knowledge, this is the first national study conducted during the COVID-19 pandemic comparing providers’ perspectives on the structural and socio-cultural barriers to utilizing telemental health services between refugee and non-refugee clients in the U.S. Based on the data collected from mental health providers, our findings revealed multiple structural and socio-cultural barriers that affect refugees more significantly than non-refugees. Some of these barriers are unique to telemental health services, while others exist across therapy platforms (i.e., in-person or telemental health). We also found that providers reported some benefits of telemental health when working with refugee and non-refugee clients. This study contributes to our understanding of the specific telemental health barriers as well as benefits that refugees encounter through providers’ perspectives, and highlights target areas for increasing telemental health utilization during and beyond the COVID-19 pandemic.

Barriers

Providers reported a number of barriers to telemental health services that uniquely and significantly impact refugee clients. Our findings demonstrated how these barriers disproportionately impact refugee clients in comparison to non-refugee clients noted by the quantitative data (*t*-score comparisons) as well as by the providers’ open-ended responses.

Regarding access to technological devices, providers indicated that overall access to technology was more

problematic for refugee clients. Specifically, providers noted that refugee clients were much less likely to own computers and tablets, and thus, they were more likely to use telephones to access services than non-refugee clients. Our findings are consistent with other studies that found that refugees tend to have poorer access to computers than telephones compared to their non-refugee counterparts, likely due to a lack of financial resources (Bose, 2021; Disney et al., 2021). There are several benefits to having access to computers rather than telephones for telemental health services. For example, computer screens are usually larger than telephone screens making it easier for providers and clients to see one another more clearly for rapport building and providing visual instructions (e.g., modeling mindfulness, coping skills). Additionally, it is important to consider that some telephones do not have video cameras (e.g., flip phones), which providers in this study indicated was a great disadvantage to clients. Without visual interactions, providers miss visual cues, facial expressions, and body gestures necessary for psychological assessment and some treatment techniques requiring modeling (e.g., showing deep breathing, progressive muscle relaxation, etc.).

Given the greater portability of telephones, they may also pose greater challenges to confidentiality as providers may be less likely to ensure their clients are in a private space, a concern that participants frequently discussed. Even more concerning is the case of a therapeutic emergency such as a threat of imminent suicide. If a provider needed to call a crisis number or 911, not knowing the client's exact location using a portable telephone could lead to a dangerous situation. Providers also indicated that privacy due to lack of space or the number of people in the home was significantly more of a problem for refugee clients than non-refugee clients. Based on this finding, when refugee clients utilize phones, it may be beneficial for providers to explicitly state the limits of confidentiality in public spaces and give clear expectations about the importance of knowing a client's location during sessions.

In addition to limited access to certain technological devices, providers of refugee clients also endorsed several technology-related structural barriers. Specifically, we found that technology and internet connectivity challenges were significantly more of a problem for refugee clients than non-refugee clients. Difficulties with internet connectivity is likely a result of multiple factors, including strained Wi-Fi, lack of data stemming from financial constraints, and high-density households. Additionally, low technological literacy might be especially prominent in this population due to the lack of technology usage in their country of origin. As expected, language barriers were significantly more problematic for refugees than non-refugees, as non-refugee clients are more likely to be native English speakers and

technological barriers are often exacerbated due to language challenges. For example, navigating telemental health platforms often require basic English proficiency (e.g., for creating passwords), which may not be realistic for all refugee clients. Furthermore, to provide interpretation services, client, provider, and interpreter all require reliable technology and internet connectivity, which can pose additional challenges.

Providers also indicated that interpreter challenges were a main barrier for refugee clients, which is consistent with previous research highlighting that interpreter-related issues are common barriers preventing refugees from successfully utilizing in-person mental health resources (Kiselev, Morina, et al., 2020; Shannon et al., 2015). Our study found that these barriers extend to telemental health services and may be magnified over telehealth due to the cost, accessibility, and availability of interpreting services. Issues with inconsistent access to interpreters may lead to the interruption of consistent treatment for refugee clients. Providers indicated that contacting clients and setting up appointments is also a more significant barrier for refugee clients than non-refugee clients. Language barriers likely play an important role when providers try to contact and schedule with their refugee clients, as an interpreter is often needed for these interactions. Refugees who are not proficient in English also cannot receive appointment reminders and may more easily forget their appointments. Therefore, providers are encouraged to utilize interpreting services, including multilingual appointment reminder services to promote consistent attendance.

Another goal of this study was to understand the socio-cultural barriers that providers described when delivering telemental health services to refugee clients. Although past studies have highlighted the need to examine socio-cultural barriers, such as stigma surrounding mental health (Kiselev, Pfaltz, et al., 2020), this is the first study to examine stigma related to refugees and telemental health during the COVID-19 pandemic. Specifically, we asked providers how much of a problem privacy-related stigma has been for their refugee clients during the pandemic. Providers noted that refugee clients may be less likely to have a private space in their home compared to non-refugee clients, due to higher-density homes. Privacy concerns are likely exacerbated over telemental health since stay-at-home orders at the beginning of the pandemic may have increased the density of homes to an even greater extent. This lack of privacy, related to mental health stigma may negatively impact refugee clients' therapy experience as providers discussed they may be less willing to share their deeper thoughts and emotions given that the session can be interrupted by a family member. Thus, concerns with privacy is a barrier that can

be considered both structural (environmental) as well as a socio-cultural barrier for refugee clients.

Taken together, when determining if telemental is a feasible option for refugee clients, providers should consider potential barriers summarized above which include not only structural and technological barriers but also socio-cultural barriers, including stigma that may limit the effectiveness of telemental health services.

Benefits

Despite the barriers encountered, we also found unique benefits of telehealth reported by refugee mental health providers. Specifically, compared to in-person services, providers reported that their refugee clients have fewer cancellations, fewer transportation problems, and better access to child-care when receiving telemental health services than in-person services. Through open-ended responses, the providers also highlighted opportunities that telemental health services offer to improve treatment engagement such as clients practicing coping skills in their homes in real time which may contribute to individualized positive outcomes. These findings highlight that telemental health may ameliorate some barriers refugees commonly encounter during in-person services, leading to more equitable access for a historically underserved population. In addition, providers may gain new strategies of improving treatment engagement and rapport building by virtually observing each client's unique needs, strengths, and family circumstances presented in real time and thus, gain clinical insights in improving client-centered and culturally sensitive services. Therefore, despite the barriers mentioned above, it is important to emphasize that telemental health services may be a critical alternative for some refugee clients. Providers may consider utilizing this platform beyond the COVID-19 pandemic by being more aware of both barriers and benefits presented by telemental health services.

Our findings have important clinical and policy implications when serving refugee populations through telemental health services. Regarding clinical implications, refugee service providers should be mindful of the complex and multilayered barriers that this population faces, including technological problems, limitations of privacy, issues of cross-cultural communication and interpreter services. Regarding policy implications, our findings indicate a need to develop policies that ensure equitable access to mental health services for refugee and non-refugee clients. Additionally, policies are essential that ensure a higher level of funding for professional trainings that promote multicultural humility of providers serving refugee client populations. Through these trainings, providers can develop more intentionality in serving clients by learning the unique needs

as well as strengths of each refugee community when delivering telemental health services. Additionally, trainings that include both clinicians and community interpreters and focus on strengthening collaborative relationships between interpreters and clinicians would help to increase successful cross-cultural communication and improve interpreting services. Another area of funding includes addressing the reported lack of access to video-capable devices and frequent technological barriers experienced by refugee clients. Emphasis should be placed on developing ways for refugees to access technological resources at little to no cost, as well as creating spaces (e.g., local community organizations) for refugees to access services privately. Lastly, to address socio-cultural factors, including stigma, funding should also focus on developing culturally-sensitive behavioral health awareness programming for refugee communities with the goal of reducing mental health stigma and increasing willingness to engage in mental health services. By further developing awareness and dialogue regarding the needs as well as strengths of refugee communities, we hope that researchers, clinicians, and policy makers will continue working together to improve telemental health services through the COVID-19 pandemic and beyond.

Limitations

Although our study highlights the barriers and benefits of telemental health services delivered to refugees, it also has some limitations. First, the data were obtained from only providers' perspectives. Directly receiving self-report responses from refugee and non-refugee clients would clarify clients' perceived barriers and benefits of telehealth. Also, although we utilized a standard recruitment method through two national networks of mental health providers, this may impact the generalizability of our findings. Future studies may consider recruiting a broader sample of responses, as well as gathering additional information about the participants, including location, types of agencies, services provided, and issues of focus in treatment. Also, given the heterogeneity of refugees' backgrounds, it may be important to identify potential differences in telemental health access and utilization between refugees of different races, ethnicities, and cultural backgrounds. Lastly, to better understand the root cause of the barriers identified in this study, future studies should include social determinants of health, such as lack of resources, poverty, level of English proficiency, and discrimination.

Conclusion

Our study contributes to the limited literature examining barriers to refugees receiving mental health services and telemental health during the COVID-19 pandemic. Multiple unique barriers impact refugee clients' ability to utilize telemental health services effectively and many of these barriers are more significant for refugees than non-refugees. This study also highlights the potential benefits of telehealth which may increase refugee clients' access to mental health services. Based on the findings of this study, researchers, clinicians, and policymakers must strive together to offer treatment programs that mitigate barriers, reduce harm, and promote effective services when working with refugee communities.

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Data Availability The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Consent to Participate Informed consent was obtained from all individual participants included in the study.

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References

- Alemi, Q., Stempel, C., Siddiq, H., & Kim, E. (2020). Refugees and COVID-19: Achieving a comprehensive public health response. *Bulletin of the World Health Organization*, 98(8), 510–510A. <https://doi.org/10.2471/BLT.20.271080>
- Ashfaq, A., Esmaili, S., Najjar, M., Batool, F., Mukatash, T., Al-Ani, H. A., & Koga, P. M. (2020). Utilization of mobile mental health services among syrian refugees and other vulnerable arab populations—a systematic review. *International Journal of Environmental Research and Public Health*, 17(4), 1–15. <https://doi.org/10.3390/ijerph17041295>
- Ayers, B. L., Purvis, R. S., Bing, W. I., Rubon-Chutaro, J., Hawley, N. L., Delafield, R., Adams, I. K., & McElfish, P. A. (2018). Structural and socio-cultural barriers to prenatal care in a US Marshallese community. *Maternal and Child Health Journal*, 22(7), 1067–1076. <https://doi.org/10.1007/s10995-018-2490-5>
- Baran, B. E., Valcea, S., Porter, T. H., & Gallagher, V. C. (2018). Survival, expectations, and employment: An inquiry of refugees and immigrants to the United States. *Journal of Vocational Behavior*, 105, 102–115. <https://doi.org/10.1016/j.jvb.2017.10.011>
- Benjamin, J., Girard, V., Jamani, S., Magwood, O., Holland, T., Sharfuddin, N., & Pottie, K. (2021). Access to refugee and migrant mental health care services during the first six months of the COVID-19 pandemic: A Canadian refugee clinician survey. *International Journal of Environmental Research and Public Health*, 18(10), 1–11. <https://doi.org/10.3390/ijerph18105266>
- Berry, L. L., Danaher, T. S., Aksoy, L., & Keiningham, T. L. (2020). Service safety in the pandemic age. *Journal of Service Research*, 23(4), 391–395. <https://doi.org/10.1177/1094670520944608>
- Bettmann, J. E., Penney, D., Clarkson Freeman, P., & Lecy, N. (2015). Somali Refugees' Perceptions of Mental Illness. *Social Work in Health Care*, 54(8), 738–757. <https://doi.org/10.1080/00981389.2015.1046578>
- Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, 15(1), <https://doi.org/10.1186/s12914-015-0064-9>
- Bose, P. S. (2021). *Telehealth Experiences and Access Report 2021*
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Psychiatric Quarterly*, 3, 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, 75(December 2019), 101812. <https://doi.org/10.1016/j.cpr.2019.101812>
- Campbell, T. A. (2007). Psychological assessment, diagnosis, and treatment of torture survivors: A review. *Clinical Psychology Review*, 27(5), 628–641. <https://doi.org/10.1016/j.cpr.2007.02.003>
- Clarke, S. K., Kumar, G. S., Sutton, J., Atem, J., Banerji, A., Brindamour, M., Geltman, P., & Zaaed, N. (2021). Potential impact of COVID-19 on recently resettled refugee populations in the United States and Canada: Perspectives of refugee health-care providers. *Journal of Immigrant and Minority Health*, 23(1), 184–189. <https://doi.org/10.1007/s10903-020-01104-4>
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45(1), 11–27. <https://doi.org/10.1017/S0033291714000129>
- Disney, L., Mowbray, O., & Evans, D. (2021). Telemental Health Use and Refugee Mental Health Providers Following COVID-19 Pandemic. *Clinical Social Work Journal*. <https://doi.org/10.1007/s10615-021-00808-w>
- Ghumman, U., McCord, C. E., & Chang, J. E. (2016). Posttraumatic stress disorder in Syrian refugees: A review. *Canadian Psychology*, 57(4), 246–253. <https://doi.org/10.1037/cap0000069>
- Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist*, 46(6), 642–648. <https://doi.org/10.1037/0003-066X.46.6.642>
- Greenaway, C., Hargreaves, S., Barkati, S., Coyle, C. M., Gobbi, F., Veizis, A., & Douglas, P. (2021). COVID-19: Exposing and addressing health disparities among ethnic minorities and migrants. *Journal of Travel Medicine*, 27(7), 1–3. <https://doi.org/10.1093/JTM/TAAA113>
- Hassan, A., & Sharif, K. (2019). Efficacy of telepsychiatry in refugee populations: A systematic review of the evidence. *Cureus*, 11(1), 1–10. <https://doi.org/10.7759/cureus.3984>
- Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *Canadian Journal of Psychiatry*, 63(5), 297–303. <https://doi.org/10.1177/0706743717746666>
- Jefee-Bahloul, H., Moustafa, M. K., Shebl, F. M., & Barkil-Oteo, A. (2014). Pilot assessment and survey of Syrian refugees' psychological stress and openness to referral for telepsychiatry

- (PASSPORT Study). *Telemedicine and E-Health*, 20(10), 977–979. <https://doi.org/10.1089/tmj.2013.0373>
- Kiselev, N., Morina, N., Schick, M., Watzke, B., Schnyder, U., & Pfaltz, M. C. (2020). Barriers to access to outpatient mental health care for refugees and asylum seekers in Switzerland: The therapist's view. *BMC Psychiatry*, 20(1), 1–14. <https://doi.org/10.1186/s12888-020-02783-x>
- Kiselev, N., Pfaltz, M., Haas, F., Schick, M., Kappen, M., Sijbrandij, M., De Graaff, A. M., Bird, M., Hansen, P., Ventevogel, P., Fuhr, D. C., Schnyder, U., & Morina, N. (2020). Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland. *European Journal of Psychotraumatology*, 11(1), <https://doi.org/10.1080/20008198.2020.1717825>
- Kohrt, B., & Hruschka, D. (2010). Nepali concepts of psychological trauma: The role of idioms of distress, ethnopsychology, and ethnophysiology in alleviating suffering and preventing stigma. *Culture Medicine and Psychiatry*, 34(2), <https://doi.org/10.1007/s11013-010-9170-2>
- Kumar, G. S., Beeler, J. A., Seagle, E. E., & Jentes, E. S. (2021). Long-term physical health outcomes of resettled refugee populations in the United States: A scoping review. *Journal of Immigrant and Minority Health*, 23(4), 813–823. <https://doi.org/10.1007/s10903-021-01146-2>
- Lies, J., Drummond, S. P. A., & Jobson, L. (2020). Longitudinal investigation of the relationships between trauma exposure, post-migration stress, sleep disturbance, and mental health in Syrian refugees. *European Journal of Psychotraumatology*, 11(1), <https://doi.org/10.1080/20008198.2020.1825166>
- Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C. A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *Journal of the American Medical Association*, 294(5), 571–579. <https://doi.org/10.1001/jama.294.5.571>
- Mattar, S., Piwowarczyk, L. A., Mattar, S., & Piwowarczyk, L. A. (2020). COVID-19 and U.S.-based refugee populations: Commentary. *Psychological Trauma: Theory, Research, Practice and Policy*, 1–2. <https://doi.org/10.1037/tra0000602>
- Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science and Medicine*, 70(1), 7–16. <https://doi.org/10.1016/j.socscimed.2009.09.029>
- Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. *American Psychologist*, 76(1), 14–25. <https://doi.org/10.1037/amp0000722>
- Qualtrics. (2020). <https://www.qualtrics.com>
- QSR International Pty Ltd (released in March 2020). <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home>
- Rees, S., & Fisher, J. (2020). COVID-19 and the Mental Health of People From Refugee Backgrounds. *International Journal of Health Services*, 50(4), 415–417. <https://doi.org/10.1177/0020731420942475>
- Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*, 123(9), 851–863. <https://doi.org/10.1016/j.healthpol.2019.02.007>
- Schick, M., Morina, N., Mistridis, P., Schnyder, U., Bryant, R. A., & Nickerson, A. (2018). Changes in post-migration living difficulties predict treatment outcome in traumatized refugees. *Frontiers in Psychiatry*, 9(OCT), 1–8. <https://doi.org/10.3389/fpsy.2018.00476>
- Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry*, 40(2), 179–188. <https://doi.org/10.1111/j.1440-1614.2006.01766.x>
- Shannon, P. J., Wieling, E., Simmelink-McCleary, J., & Becher, E. (2015). Beyond stigma: Barriers to discussing mental health in refugee populations. *Journal of Loss and Trauma*, 20(3), 281–296. <https://doi.org/10.1080/15325024.2014.934629>
- Simich, L., & Andermann, L. (2014). *Refuge and resilience: Promoting resilience and mental health among refugees and forced migrants*. Springer US. <https://doi.org/10.1007/978-94-007-7923-5>
- Slewa-Younan, S., Mond, J., Bussion, E., Mohammad, Y., Guajardo, U., Smith, G. G., Milosevic, M., Lujic, D. S., & Jorm, F. F. (2014). Mental health literacy of resettled Iraqi refugees in Australia: Knowledge about posttraumatic stress disorder and beliefs about helpfulness of interventions. *Bmc Psychiatry*, 14(1), 1–8. <https://doi.org/10.1186/s12888-014-0320-x>
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA - Journal of the American Medical Association*, 302(5), 537–549. <https://doi.org/10.1001/jama.2009.1132>
- Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology*, 53(4), 316–332. <https://doi.org/10.1111/j.1467-9450.2012.00954.x>
- UNHCR (2022). Ukraine, other conflicts push forcibly displaced total over 100 million for first time. In *UNHCR*
- Volkin, S. (2020). *How are refugees affected by COVID-19?* Johns Hopkins Magazine. <https://hub.jhu.edu/2020/04/20/covid-19-refugees-asylum-seekers/>
- World Health Organization (2020). *Apart Together Survey: Preliminary overview of refugees and migrants self-reported impact of COVID-19*. <http://apps.who.int/bookorders.%0Ahttps://reliefweb.int/sites/reliefweb.int/files/resources/9789240017924-eng.pdf>
- Wosik, J., Fudim, M., Cameron, B., Gellad, Z. F., Cho, A., Phinney, D., Curtis, S., Roman, M., Poon, E. G., Ferranti, J., Katz, J. N., & Tchong, J. (2020). Telehealth transformation: COVID-19 and the rise of virtual care. *Journal of the American Medical Informatics Association*, 27(6), 957–962. <https://doi.org/10.1093/jamia/ocaa067>

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