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# Burmese Community Behavioral Health Survey Final Report

Overview of the Study Findings

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## Overview of the Study Findings

This report provides final descriptive results from the Burmese Community Behavioral Health Survey (BCBHS). The BCBHS study had been conducted in collaborative partnerships with several community-based agencies, including the Burmese Community Support Center, the Burmese Community Services, and Karen Society of Buffalo, as a community-based research project. The final results reported here are based on 256 surveys collected between March 2015 and October 2016. Key findings from the study include:

- **People from Burma are recent arrivals to Buffalo.** Almost all of study participants (93.7%) have arrived within the past 10 years.
- **Burmese<sup>1</sup> community consists of diverse subgroups.** The community is made up of at least eight different ethnic groups. The study participants reported speaking various different languages, primarily related to their ethnocultural background. Recognizing and understanding this diversity is crucial when working with the Burmese community.
- **Average household income is below poverty guidelines.** About 80 percent of the households surveyed reported making less than \$2000 per month. Average number of people in a household was 4.1 (SD=1.9), which makes their average household income 100 percent below 2015 poverty guidelines set by the U.S. Department of Health and Human Services for a family of four (U.S. Department of Health and Human Services, 2015).
- **Majority have spent multiple years in refugee camps.** One hundred eighty-four (71.9%) participants have spent at least a year in a refugee camp and some for over 20 years. Many of those who did not stay in refugee camps have been undocumented immigrants in Malaysia or Thailand for years as well.
- **Concerns about their behavioral health are real.** While the majority of the participants reported having good/excellent physical (69.6%) and mental (73.7%) health statuses, the results of the study also highlight areas where further interventions may be warranted:
  - One hundred twenty-nine (50.4%) participants reported enough trauma-related symptoms (based on RHS-15) that warrant specialized mental health referrals.
  - Fifty-three (20.7%) participants reported enough anxiety symptoms (based on HSCL) that warrant further mental health evaluation.

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<sup>1</sup> The term “Burmese” is used to reference all people from Burma (i.e., their original nationality) for the purpose of this study. There are eight major ethnic groups officially recognized by the Burmese government: Burman (Bamar), Chin, Kachin, Kayin (Karen), Kayah (Karenni), Mon, Rakhine, and Shan. Rohingyas, who are one of the most oppressed ethnic and religious minority groups in Burma, are considered as illegal immigrants from Bangladesh, and are not recognized by the Burmese government as one of the 135 ethnic groups.

- Fifty-seven (22.3%) participants reported enough depressive symptoms (based on HSCL) that warrant further mental health evaluation
- Forty-three (16.8%) participants reported both anxiety and depression symptoms (based on HSCL) that warrant further mental health evaluation.
- Twenty-three (9.0%) participants were identified as having alcohol related problems (based on AUDIT) who could benefit from addiction specialist referrals.
- Four (1.6%) participants were identified as having problem gambling; thirteen (5.1%) participants as having moderate gambling problem; Thirty-three (12.9%) participants as having low gambling problem (based on PGSI).
- **Many are not satisfied with their primary care doctors or clinic.** About one in five (18.1%) participants were either *not at all* or *not very* satisfied with the medical care they received from their primary doctor/clinic in the past 12 months. Given high prevalence rates of trauma and other behavioral health symptoms found in this study, physicians, nurses, dentists, and other healthcare professionals must learn ways to develop trusting relationships with Burmese patients. Doing so will help to recognize behavioral health symptoms that need regular monitoring and, if deemed helpful, a referral for specialty care.

## Background

The city of Buffalo is home to estimated 8,000 and 10,000 refugees from Burma. The Burmese community has been a critical component in Buffalo's revitalization, including the increase in city population for the first time in several decades. Burmese people have resettled in Western New York after escaping a decades of political turmoil in Burma, which has resulted in massive displacement of Burmese people within as well as outside the country. More than half a million people were reported to have lived in designated refugee camps along the western Thailand border at some point (Barron et al., 2007). Of those, approximately 121,100 refugees from Burma entered the United States between 2002 and 2013 (Office of Refugee Resettlement, 2012; Refugee Processing Center, 2014), making them the largest refugee group resettled in the United States since 2000.

As they were continuously resettled in the United States throughout the last decade, Burmese community have begun to raise concerns about the overall status of their community's well-being. In particular, there exists little to no empirical data regarding behavioral health conditions on this important and growing segment of Buffalo residents. Behavioral health problems refer to mental and emotional concerns and/or choices and actions that affect individuals' overall well-being (Substance Abuse and Mental Health Services Administration, 2012). Symptoms of mental illnesses, substance misuses, intimate partner violence, and gambling problems are examples of behavioral health concerns that might impact community members' overall sense of well-being. This information can be instrumental to develop tailored interventions and essential elements of grant application to support much needed community-based services. The BCBHS study was proposed to narrow the knowledge gap in these problem

areas by gathering data through interviewing adult Burmese community residents in Buffalo. It is the first systematic effort to collect empirical data in trying to understand behavioral health conditions among the Burmese community in Buffalo, NY.

This study employs the social determinants of health (SDH) framework, which indicates that the current structural, sociocultural, and individual circumstances altogether shape and influence physical and psychosocial adjustment patterns of people in a society (Commission on Social Determinants of Health, 2008; Galea & Steenland, 2011; Solar & Irwin, 2007). This is especially true for refugees resettled in the United States, who are trying to adjust to a new cultural and built environment while not knowing the language. The SDH framework provides a useful platform in examining sociocultural dimensions, such as language and minority status, as critical factors in shaping long-term behavioral health outcomes among refugee populations in the United States (Kim & Kim, 2014). CSDH set priority for undoing social injustices that create differential physical and mental health statuses for underserved populations. This also includes responding to various behavioral health needs of refugees resettling in a geographically, culturally, and linguistically foreign environment.

## Study Participants

Using a convenience sampling method, community interviewers have been recruiting participants at community-based agencies, religious institutions, and through various community networks. The eligibility criteria to participate in this pilot study are as follows: (a) be a refugee from Burma; (b) be at least 18 years old; and (c) be a resident of Erie County, which includes the city of Buffalo.

Final sample consisted of 256 Burmese community members. A little over half (57.4%) of the participants were female. Their age ranges from 18 to 87, with an average age of 40.7 (SD=12.8). The majority (68.4%) of the participants are married or in a domestic partnership. Four in five participants (80.5%) have less than a high school education. Almost all of the participants are able to speak and understand their native language well, but a smaller majority (73.4%) have reported reading/writing “well” in their native language.

## Data Collection Procedures

Considering a high rate of illiteracy in the population, face-to-face interviews were conducted by the trained bilingual community interviewers using the survey questionnaires, which were translated in Burmese language. In addition, due to logistic & financial limitations of translating the entire survey into Karen languages, interviewers who are proficient in both Karen and Burmese languages were recruited and trained to conduct interviews with participants who can only communicate in Karen. Informed consent was obtained, which explained their basic rights regarding interview participation, including the right to refuse and withdraw at free will at any time during the interview.

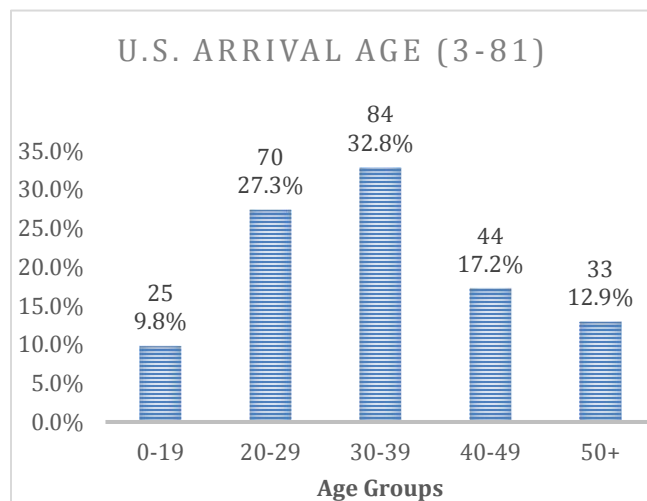
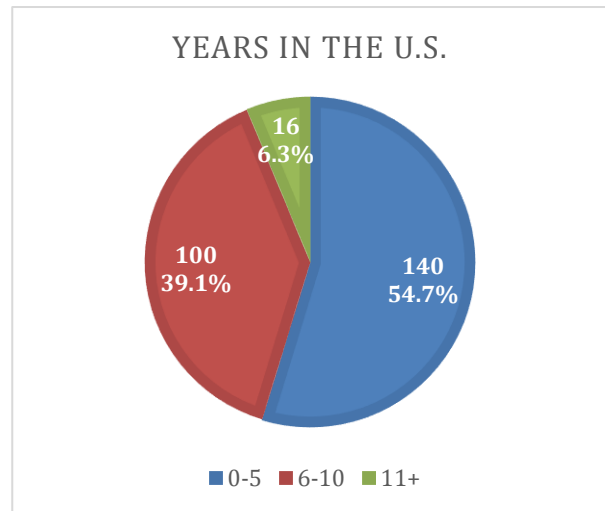
## Selected Study Findings

### Demographic information

One hundred forty-seven (57.4%) of the study participants were females. The mean age of the study sample was 40.7 years old (SD=12.8), with nearly 60 percent of the participants between ages of 30 and 49. The participants' age ranged from 18 to 87 years old at the time of the survey. Two in three participants were either married or in domestic partnership; 19.1 percent were never married; 5.1 percent were either divorced or separated; and 7.4 percent were widowed. In terms of years of education, nearly 80 percent of the participants had fewer than 12 years of education; 5.6 percent have reported completing high school or equivalent level of education; and about 15 percent received beyond high school education.

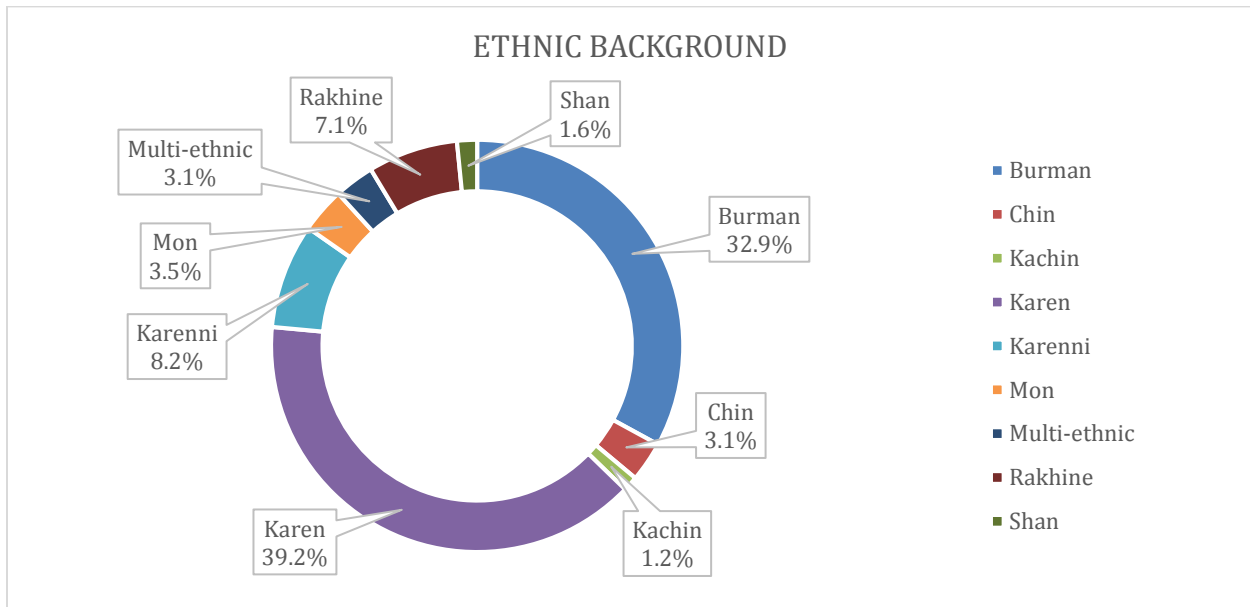
### Years in the United States

Burmese refugee resettlement is a newly emerging development in Buffalo. 93.7 percent of the participants surveyed reported arriving in the United States within the past 10 years. Over half of these participants have been in the United States for less than 5 years. Sixteen (6.3%) participants reported living longer than 11 years in the United States. With these recent arrivals, finding better ways to understand their various needs are still the top priority.



The mean age of the participants was 34.8 (SD=12.7) years old at the time of U.S. arrival. Majority of the participants have arrived before the age of 40. About one third of study participants reported arriving after the age of forty, while nearly one tenth have come to the United States before the age of nineteen. Given that this study only surveyed Burmese adults older than 18 years old, there would be significantly more people who have arrived as children and adolescents in the community.

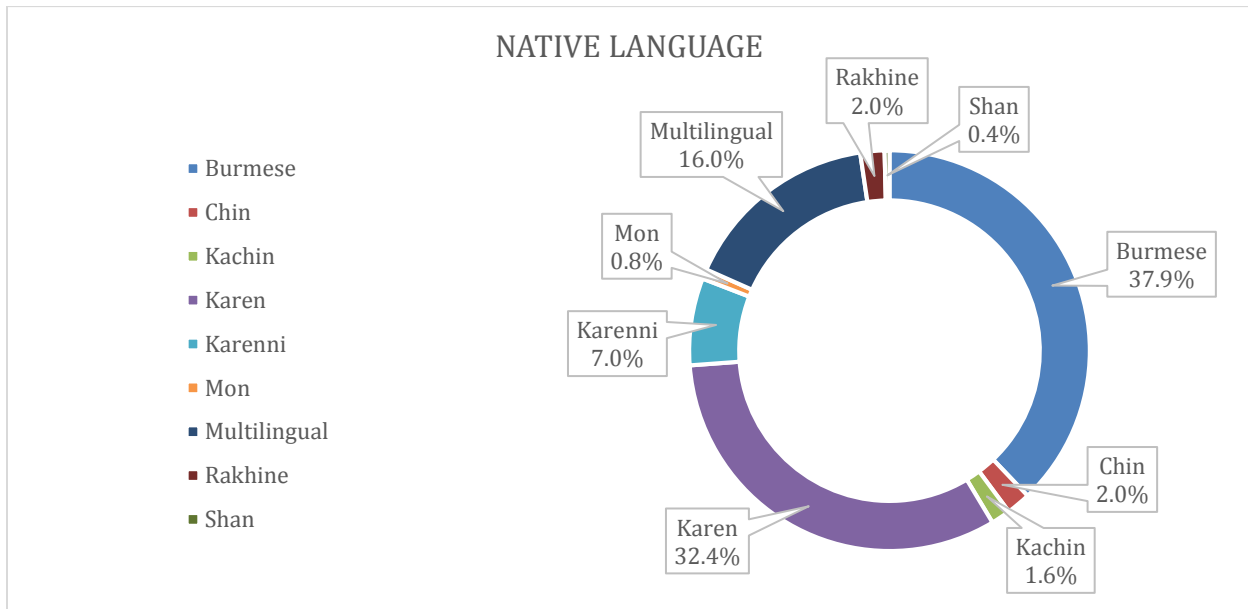
## Diverse ethnic backgrounds



The participants in this study were comprised of several different ethnic groups. One hundred (39.2%) participants were of Karen ethnicity; Eighty-four (32.9%) were Burman; followed by twenty-one (8.2%) Karenni; eighteen (7.1%) Rakhine; eight (3.1%) Chin; nine (3.5%) Mon; four (1.6%) Shan; and three (1.2%) Kachin participants. In addition, there were also eight (3.1%) participants reporting multiple ethnic backgrounds.



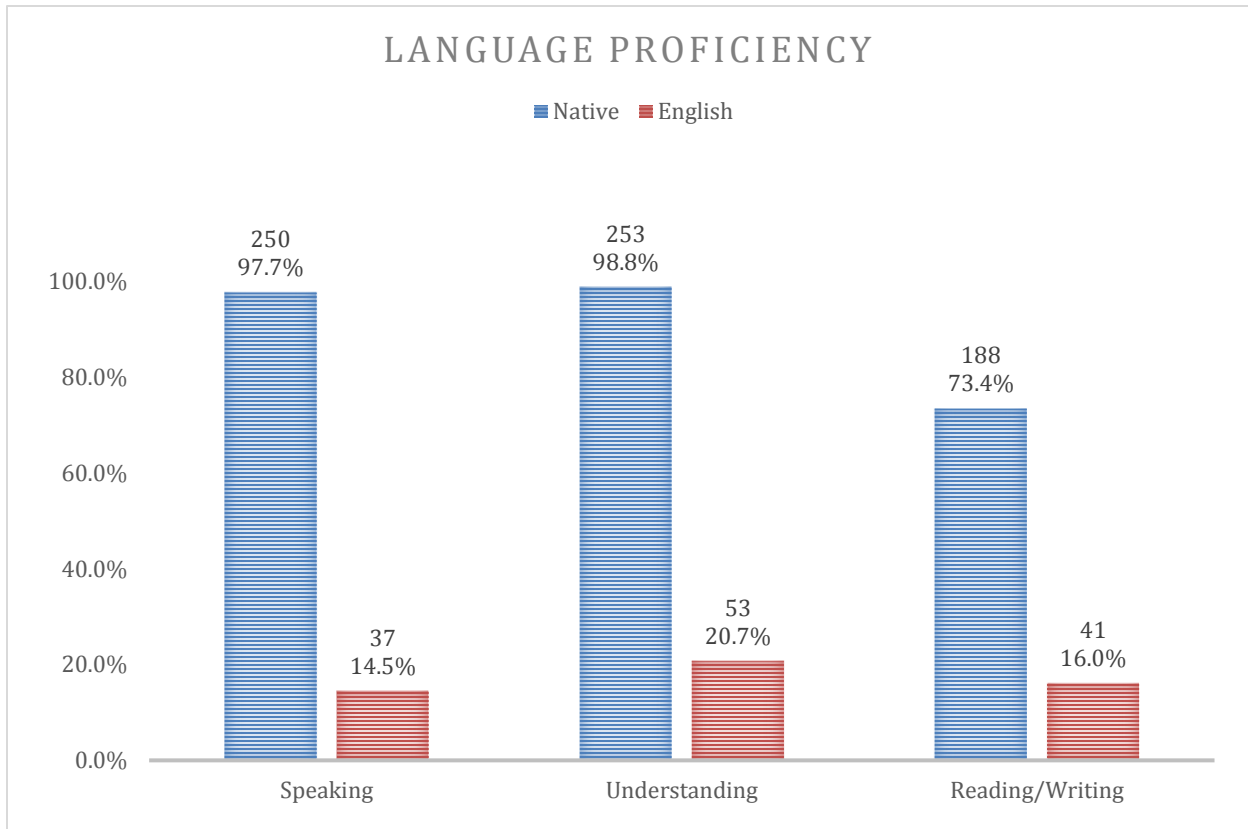
## Diverse ethnic Languages



Overall, the study participants reported speaking at least eight different languages. The most common native language spoken was Burmese<sup>2</sup>, which ninety-seven (37.9%) participants reported speaking as their native language. Eighty-three (32.4%) spoke Karen (either Sgaw or Poe) languages. Eighteen participants (7.0%) reported Karenni as their native language, which was the third most common language spoken among the participants. Forty-one (17.1%) participants reported speaking one or more ethnic languages in addition to Burmese. A few other ethnic languages (Chin, Kachin, Mon, Rakhine, and Shan) were also reported spoken by small, but significant, portion of the study participants. Given this linguistic diversity, providing appropriate interpretation and translation services becomes a crucial part of service delivery. This linguistic diversity also is worth noting when assessing an organization’s level of preparation to effectively serve the Burmese community in Buffalo.

<sup>2</sup> Burmese is designated as the official language of Burma.

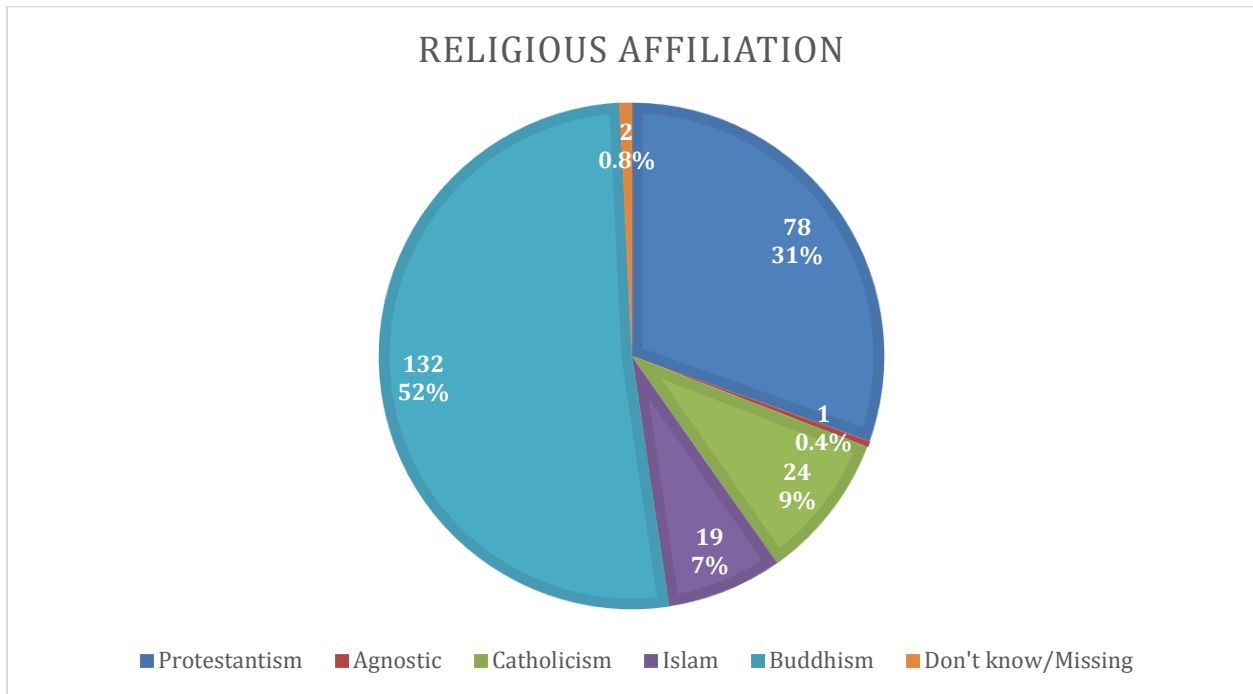
## Limited English proficiency



Overall, almost all study participants reported feeling proficient in speaking and understanding their own native language. However, when it comes to reading and writing their native language, about one in four participants reported not feeling proficient in reading and/or writing their native language. As the Burmese language is instituted as the only official language in Burma, and minimal effort to preserve languages of ethnic minorities, it appears that there is not enough opportunity to regularly use and practice reading and writing these ethnic languages, such as Karen and Karenni.

On the other hand, majority of the participants reported limited English proficiency in speaking, understanding, and reading/writing English. Most of the participants have lived in the United States for a short length of time, so the low level of English proficiency is to be expected. Since this study did not survey those younger than 18 years old, we cannot ascertain the level of English language proficiency among those who had opportunity to receive and take advantage of formal education since their arrival in the United States.

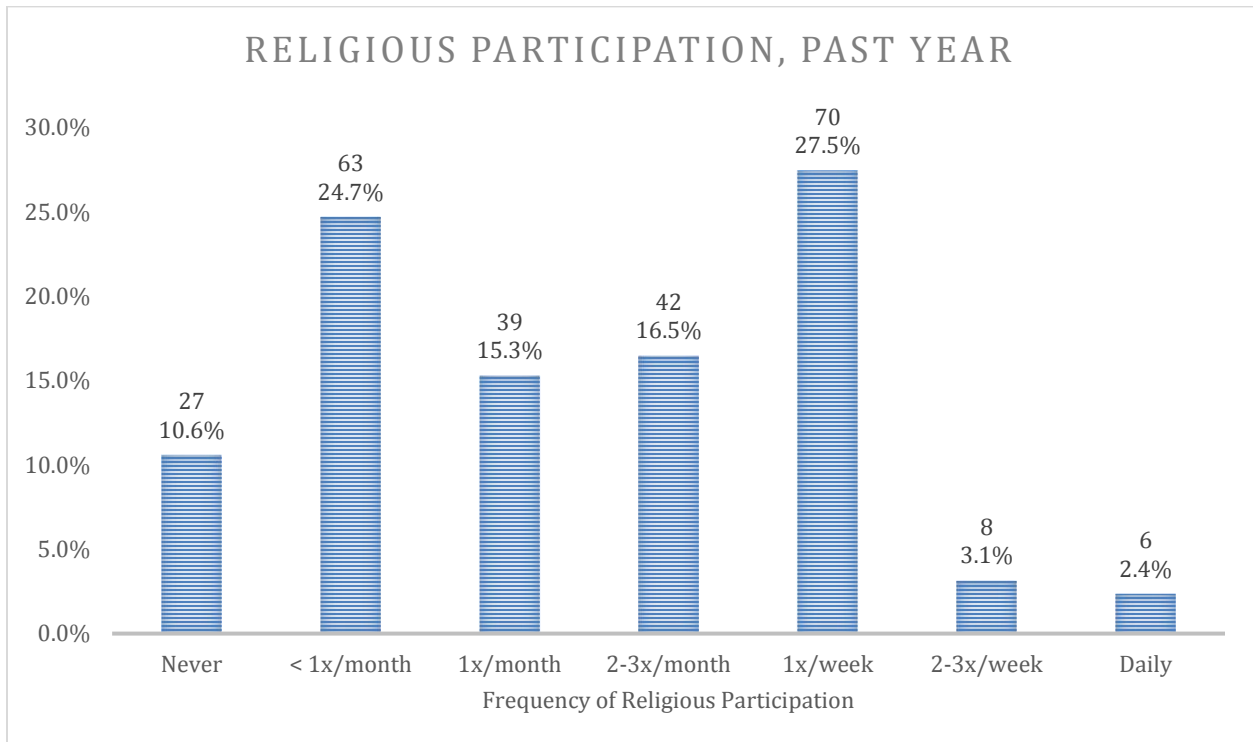
## Religious affiliation



Among the participants of this study, 132 (51.6%) participants identified their religion as Buddhism. Seventy-eight (30.5%) participants identified themselves as protestants; 24 (9.4%) Catholic; and 19 (7.4%) Muslim. One participant reported being an agnostic and two participants reported either “don’t know” or left the question unanswered. Buddhism in Burma represents 90 percent of their population (U.S. Department of State, 2014), and many ethnic minorities in Burma are also religious minorities. Among the two major ethnic groups represented in this study, 60.6 percent of Karens identified as protestants/Christians, while 78.2 percent of Burmans identified as Buddhists. About one in five Burman participants identified as Muslim<sup>3</sup>. None of Burmans in the study identified with Protestantism, while no Karen participant identified with Islam.

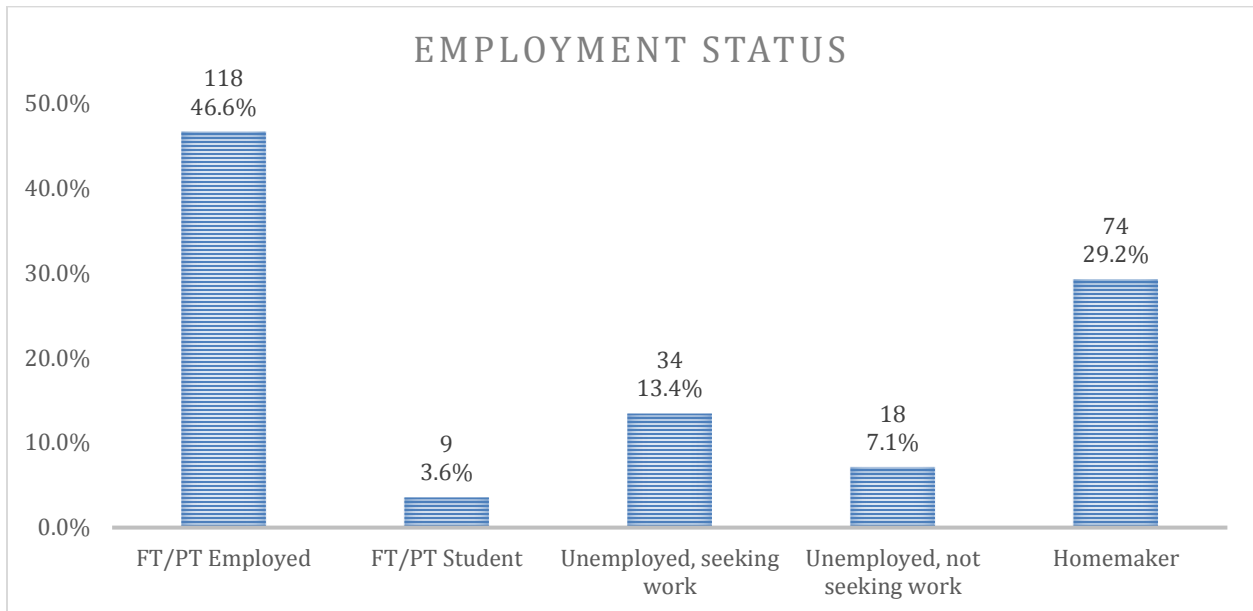
<sup>3</sup> They are Burmese Muslims, not Rohingya. Initial discussion with community research collaborators recommended not including Rohingya as one of the options in the ethnic background question.

## Religious participation

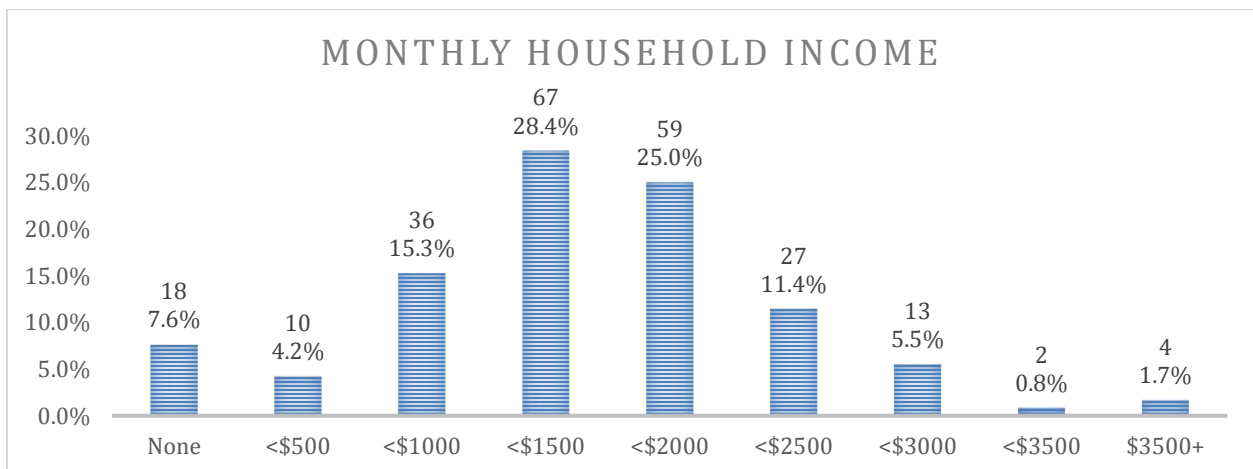


Majority of the participants said they have participated in religious activities at least once in the past 12 months. Sixty-three (24.7%) participated less than monthly; 39 (15.3%) participated monthly; 42 (16.5%) 2-3 times a month; 70 (27.5%) weekly; 8 (3.1%) 2-3 times a week; and 6 (2.4%) participated in daily religious activities. Twenty-seven (10.6%) participants have never participated in any religious activity in the past 12 months.

## Employment & income

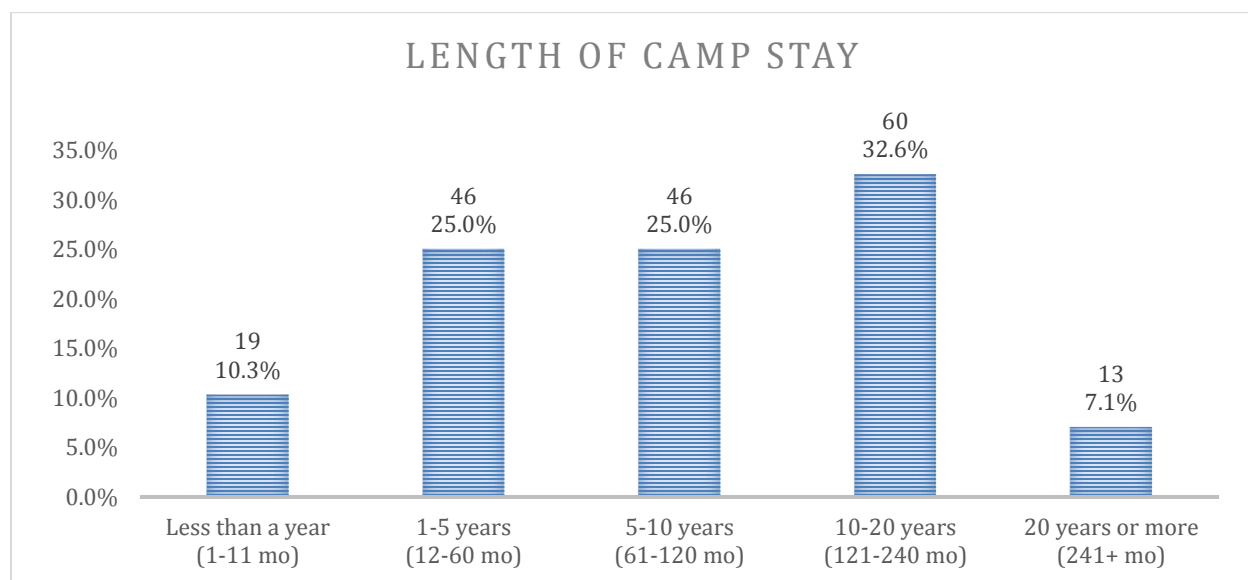


The unemployment rate of the study participants who are actively seeking work was 13.4 percent. This was significantly higher than the unemployment rate in the Buffalo-Niagara Metro area as a whole, which was 5.6 percent in 2015 (New York State Department of Labor, 2016). Indeed, the average monthly household income reported was less than \$2000 per month; a little over half of the participants (53.4%) reported having household incomes between \$1000 and \$2000 per month. The average number of people in a household was 4.1 (SD=1.9) persons. The 2015 poverty guidelines for the family of four was \$2020.83 per month (U.S. Department of Health and Human Services, 2015). Aside from language barriers, educational, vocational, or professional degrees earned in Burma are not accepted as equivalent degrees in the U.S. job market, which may contribute to underemployment and limit their earning potential. A fair number of participants (29.2%) were also homemakers, which limits the number of workers per household and thus the total household income.



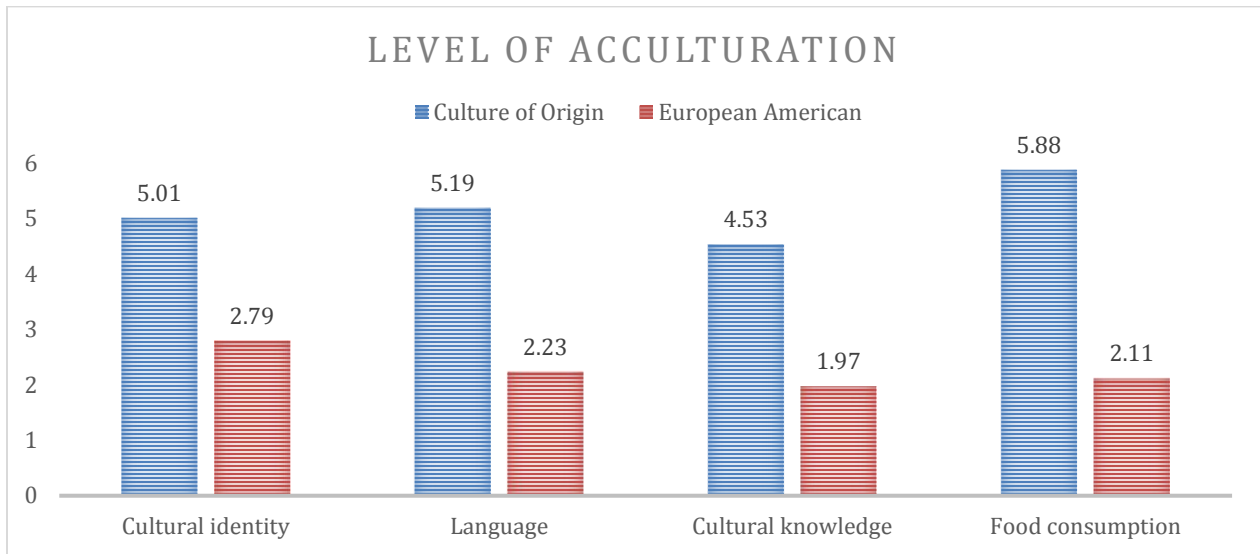
## Refugee camp stay

One hundred eighty-four (71.9%) participants in the study reported spending at least some time in a refugee camp. Of those who stayed in refugee camps, 165 (88.7%) participants have spent more than a year; seventy-three (39.7%) participants reported spending over a decade. The mean length of stay in a refugee camp was 9 years and 6 months. While living in camps, refugees are limited in their ability to move freely outside of the camps and resources can sometimes be scarce inside the camps (Capps et al., 2015). Protracted stay, along with safety and security problems, in the camps can add additional stress to refugees who have escaped violence and persecution in their country of origin. In addition, lack of food and sanitation in the camps contribute to developing various medical problems and exacerbating pre-existing medical conditions. Finally, uncertainty surrounding their fate while surviving in the camps can further worsen their already tenuous emotional and psychological status.



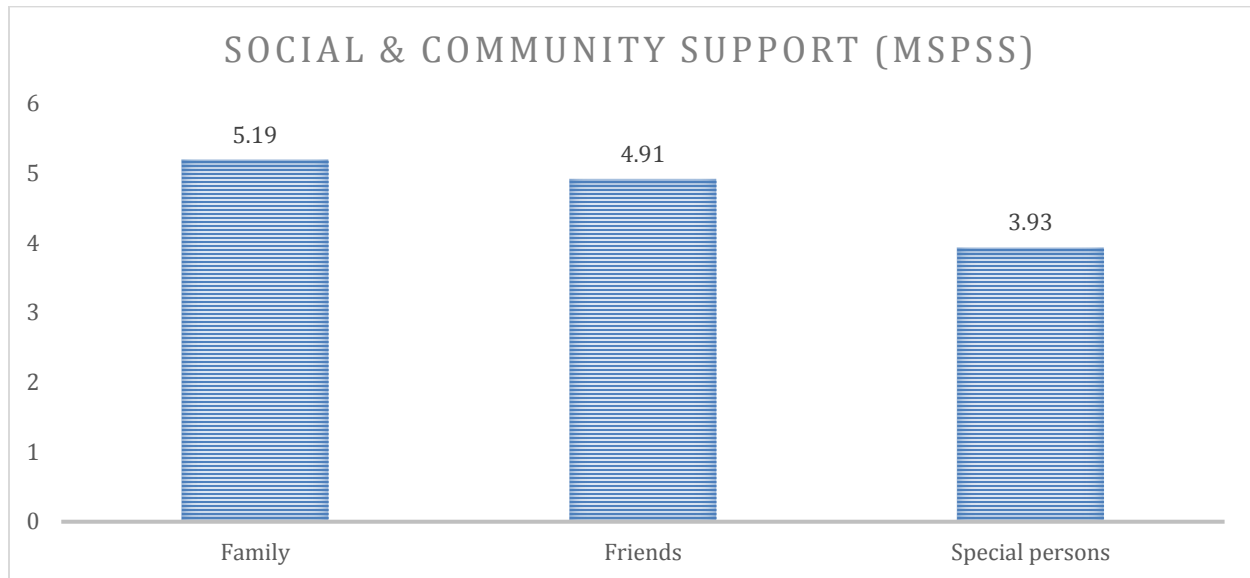
Among those who reportedly had no experience of staying in refugee camp (n=72), forty-two (58.3%) had said that they have spent years as undocumented migrant workers in Malaysia, where they sent back remittance to their family members in Burma. Their average stay in Malaysia was about six years (SD=6.1), which ranged from 1 to 27 years. Without minimal protection for their basic human rights, these participants also reported experiences with local police forces harassing and jailing them.

## Multidimensional acculturation status



Asian American Multidimensional Acculturation Scale (AAMAS; Gim Chung, Kim, & Abreu, 2004) is used to measure four different dimensions as they relate to their culture of origin and European American (i.e., mainstream) culture. Overall, the study participants reported feeling strong connection to their cultural of origin. As expected, their level of comfort and familiarity with European American culture is much lower. Specifically, the biggest disparity comes from food consumption. On average, study participants said that they consume food from their own culture very often, while not often consuming “American” food. Interestingly, the cultural identity dimension was most similar across two cultures, perhaps signaling the early process of acculturation for these new arrivals. In addition, language dimension was also showing some indication for usage of English language, probably out of necessity, despite the limited English proficiency reported.

## Social & community support



Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was used to measure the level of social and community support that Burmese participants perceived among their family, friends, and special persons<sup>4</sup>. As expected, their biggest social and community support comes from family members, followed very closely by friends. Although much lower than family or friends support, participants still assessed the level of support from special friends as somewhat supportive.

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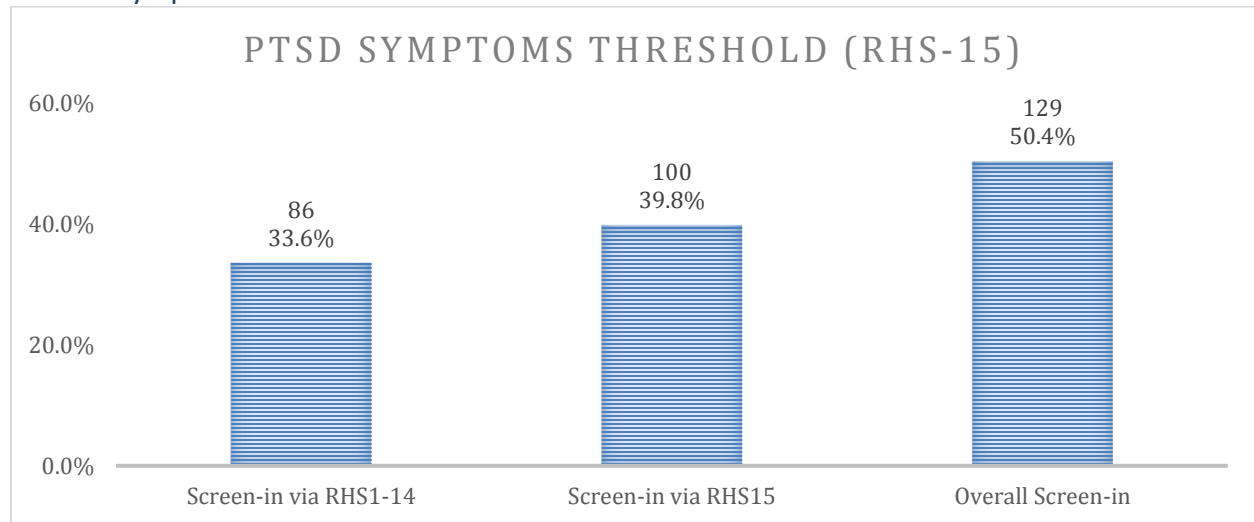
<sup>4</sup> For this study, “special persons” are defined as an acquaintance who is not a family member or close friends, such as their caseworker, neighbor, teacher, etc.



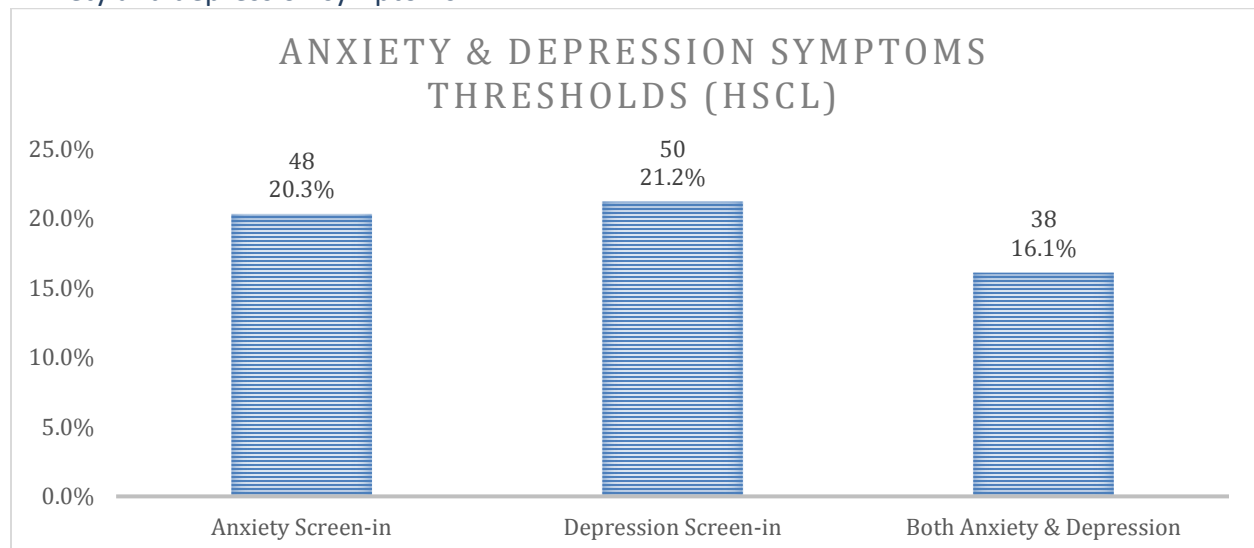
## Behavioral health statuses and concerns

A very few participants (21; 8.3%) reported any concerns regarding their mental health. A few more participants (29; 11.4%) shared that other people expressed concerned about their mental health conditions. The majority of the participants reported having good/excellent physical (69.6%) and mental (73.7%) health, results of behavioral health related measures reveal a number of behavioral health concerns where further intervention maybe warranted. A significant portion of the participants in the study reported many trauma-related symptoms (RHS-15), anxiety and depression (HSCL), and alcohol related problems (AUDIT). More than seven percent of the participants were also identified as having moderate to severe problem gambling (PGSI). As a newly arrived group, early behavioral health intervention is key to ensuring the continuing well-being of the community.

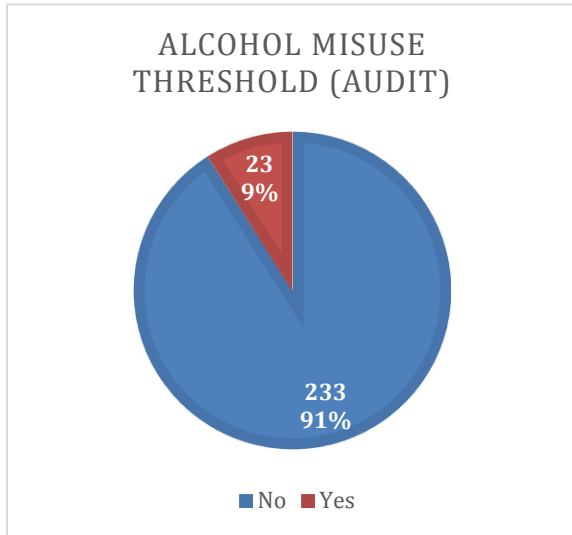
### Trauma symptoms



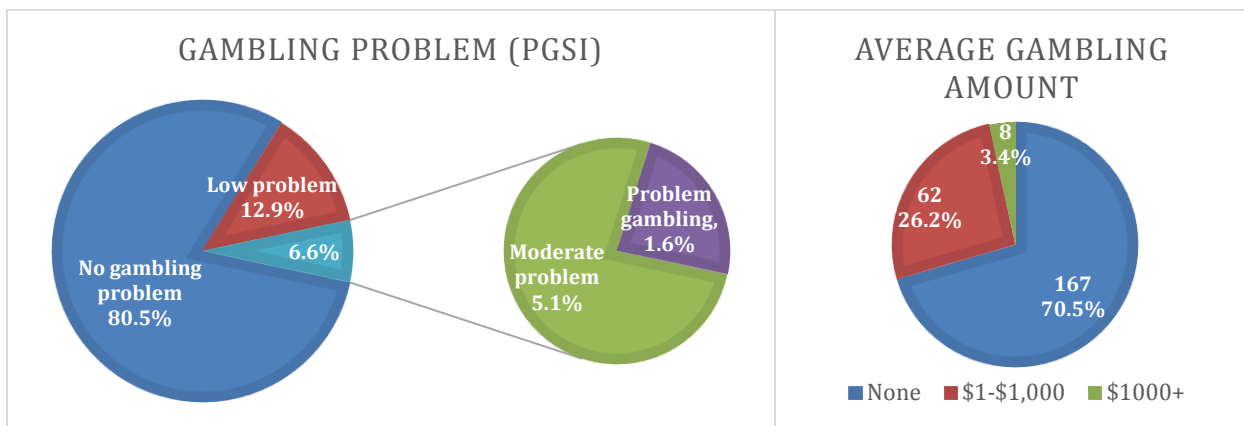
### Anxiety and depression symptoms



Alcohol & gambling issues and concerns

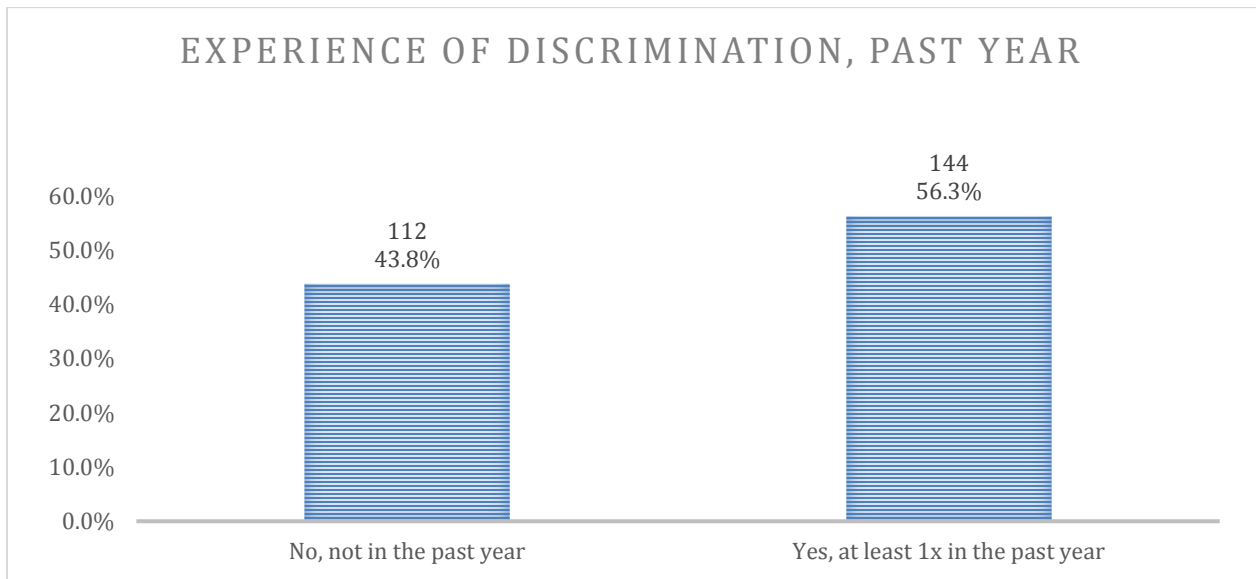


The Alcohol Use Disorder Identification Test (AUDIT) is used to identify individuals with potentially serious and harmful patterns of alcohol use (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Alcohol use disorder (AUD) includes abusing as well as dependence on alcohol. The 9.2 percent identification rate among the study participants is higher than among the U.S. adult population, which was estimated at 6.8 percent in 2014 (National Institute on Alcohol Abuse and Alcoholism, 2016). Given that minimizing and underreporting is not uncommon, it is likely that the rate may be higher among the Burmese community in Buffalo in general.



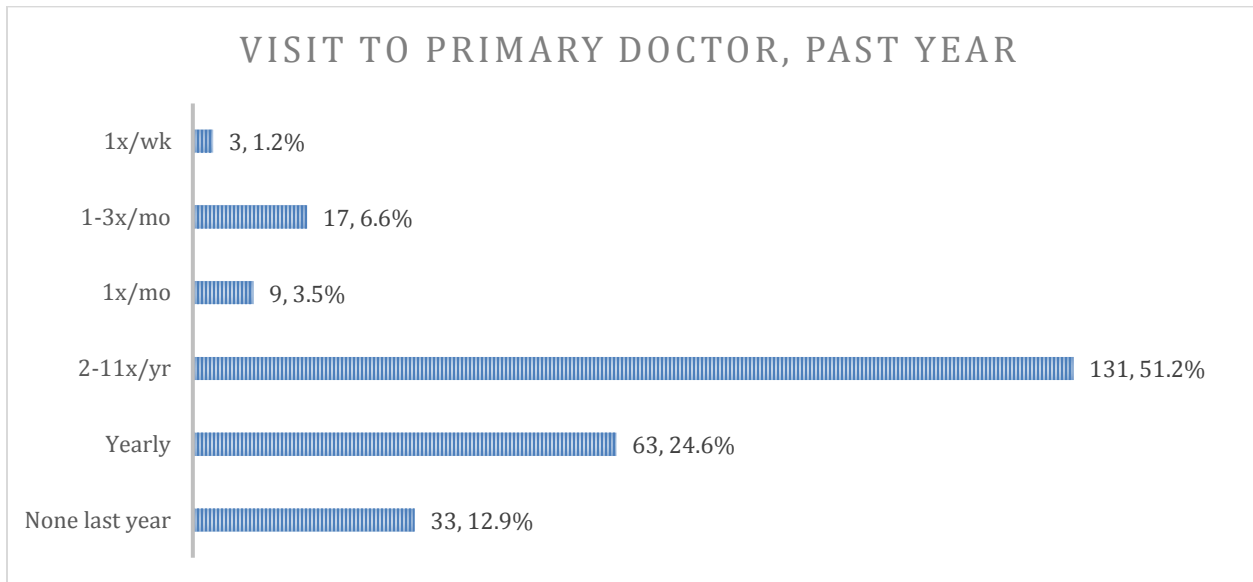
Problem Gambling Severity Index (PGSI) identifies potential gambling-related problems and consequences (Ferris & Wynne, 2001). The prevalence rate of problem gambling for this participants was 1.6 percent, which was lower than the U.S. prevalence rate of 2.2 percent in 2012 (R. J. Williams, Volberg, & Stevens, 2012). While the number of individuals with problem gambling is very few, those who turn to gambling may be at higher risk for other comorbid mental health conditions, including post-traumatic stress disorder (Kessler et al., 2008). Considering high mental health concerns among the Burmese community in general, monitoring potential problems related to gambling activities may be important.

### Everyday discrimination experience

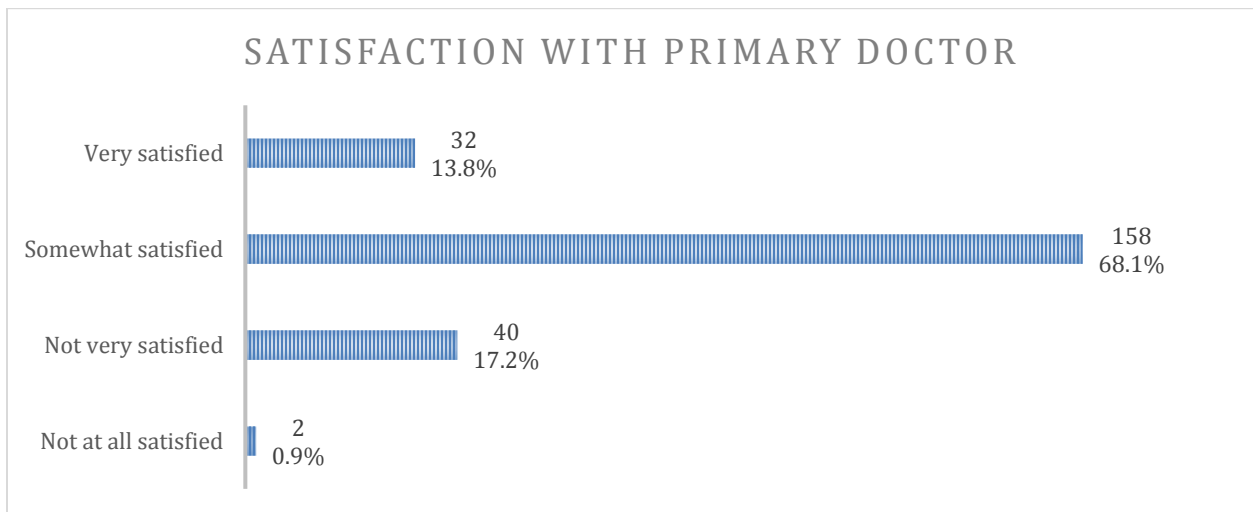


Everyday discrimination measure (D. R. Williams, Yu, Jackson, & Anderson, 1997) is designed to compile a series of discriminatory experiences that the respondents have encountered during the past 12 months. These “everyday” discriminations can be based on any aspect of their sociocultural identity, including ancestry or national origin, race, ethnicity, gender, sexual orientation, age, religion, physical features, and education or income status. One hundred forty-four (56.3%) study participants reported experiencing at least one discriminatory encounters in the past 12 months. Not surprisingly, of those who listed the potential reasons for experiencing these discrimination, the majority were related to their language (difficulty), skin color, and tribal association. Given the ethnic linguistic and ethnic diversity of the study participants, we may need to further evaluate the details of these discriminatory encounters, such as where and in what contexts these discrimination encounters are happening.

### Satisfaction with primary care



More than 80 percent of the participants went to see their primary care doctor in the past 12 months. About one in five participants (18.1%) indicated that they are either not very or not at all satisfied with their primary care physician. Past literature suggests that Asian Americans in general have relatively lower satisfaction with the primary care (Murray-Garcia, Selby, Schmittiel, Grumbach, & Quesenberry, 2000; Ngo-Metzger, Legedza, & Phillips, 2004). What we do not yet know clearly is the rate of physician satisfaction among refugees generally, and with Burmese community members in particular. This level of dissatisfaction with their physicians may contribute to refugees' decisions not to seek services from their primary care physician. Thirty-three (12.9%) participants in the study did not visit their primary care physician in the past year, in spite of having health insurance coverage for basic preventive care.



## Conclusion & the Next Step

This final report highlights main descriptive findings from the BCBHS study. The study findings begin to confirm many of the real concerns aired by the Burmese community, such as trauma, anxiety, depression, and alcohol problems, which have propelled this study in the first place. On the other hand, the findings so far failed to confirm community members' other concerns, such as domestic violence incidences. The next phase of the study is to present the results to the community members through a number of community forums. We hope to receive important feedback from the Burmese community about their thoughts on the study results, as well as any suggestions for how to best respond to behavioral health conditions identified in the study.

## Acknowledgement

The BCBHS project has been generously funded by the University at Buffalo Civic Engagement & Public Policy Research Fellowship and the UB School of Social Work Les Brun Research Endowment Fund Pilot Program. We want to thank the staff of Burmese Community Support Center, the Burmese Community Services, Inc., and the Karen Society of Buffalo for stepping up to conduct interviews despite their busy schedule. We also want to thank a number of key community representatives, for their continuing partnership and support for this project. Finally, we thank the countless number of individuals from the Burmese community who graciously agreed to participate in this survey.

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