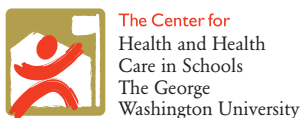# Comparative Case Study of Caring Across Communities

Identifying Essential Components of Comprehensive
School-Linked Mental Health Services
for Refugee and Immigrant Children

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Center *for the* Study *of*
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Comparative Case Study

of

Caring Across Communities

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Executive Summary

Caring Across Communities (CAC) is a three-year initiative of the Robert Wood Johnson (RWJ) Foundation to support the development of school-linked mental health services for immigrant and refugee children. Fifteen grantees, located in eight states, received up to $100,000 a year for three years from 2007 until 2010. The grantees each proposed and implemented a unique strategy to reduce emotional and behavioral health problems among refugee and immigrant children in their community.

In May 2009 the RWJ Foundation and its academic partner that managed the grant, the Center for Health and Health Care in Schools at the George Washington University, awarded a contract to Clea McNeely of the Center for the Study of Youth and Political Violence at the University of Tennessee, Knoxville to conduct an evaluation to determine the key components of comprehensive school-linked mental health services for refugee and immigrant children.

The evaluation addressed three questions:

1. What are the challenges experienced by the children and families the CAC programs serve?

2. What are the necessary components of comprehensive mental health services for refugee and immigrant children?

3. How can partnerships between schools and multiple community agencies work most effectively to implement the necessary components of comprehensive mental health services?

Study Methods

The cross-site evaluation took advantage of the wide variability across program models to identify common elements of culturally-appropriate and accessible mental health services. Notably, this evaluation does not assess whether the programs improved the mental health of immigrant and refugee children and their families.

In-depth interviews were conducted with stakeholders in five CAC sites. The five sites were purposively chosen to maximize variation in the age range of children served, region of the country, and type of children served (refugee, immigrant, or both). The five sites are:

- BieneStar, Duke University, Durham, North Carolina: BieneStar serves immigrant children, almost all from Latin America, in partnership with three elementary schools in Durham, North Carolina.

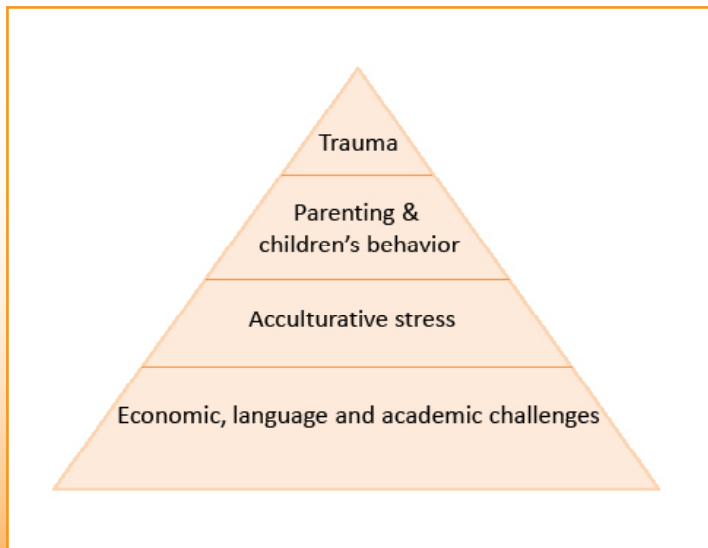- World Relief-Chicago: World Relief-Chicago, a

Figure 1. Challenges facing immigrants and refugees

providers in one site, where individual interviews with the mental health providers were not practical. The interviews and focus group were conducted between October and December 2009. All interviews were recorded, transcribed and translated. Interviews were analyzed qualitatively using the constant comparison method and Atlas.ti 6.1 software.

Study Findings

Question 1. Challenges Experienced by Refugee and Immigrant Children and Families

The immigrants and refugees in the five cities face a multiplicity of challenges. Figure 1 presents the challenges visually as a pyramid.

Daily challenges caused by poverty, language barriers, and not being in sync academically with U.S.-born students are experienced almost universally. The majority of refugee and immigrant children also experience stress from learning to navigate their new culture. A smaller proportion experience challenges related to their children's behavior and how to effectively parent in a new country. At the top of the pyramid are traumatic experiences such as involvement in political violence, witnessing violence, losing a parent, or being the victim of a crime. Participants in this study reported that all four types of challenges caused

refugee resettlement agency, used the CAC grant to provide services in an elementary school (refugee children) and a high school (refugee and Latin American immigrant adolescents).

- Explorer's Program, The Village Family Service Center, Fargo, North Dakota: The Explorer's Program serves refugee children grades K-6 from 14 countries in an elementary and middle school.

- 3Rs Project, Los Angeles Child Guidance Center, Los Angeles: The 3Rs Project provides services to Latin American immigrant parents and children in an elementary school in South Central Los Angeles.

- SHIFA: Boston Children's Hospital, Dorchester, Massachusetts: This program serves Somali children and families. It focuses on a single middle school, although it works with other Somali families as well.

Two-day site visits were made to each of the five sites by a two-person evaluation team. At each site in-depth interviews were conducted with program leaders, staff, school staff, staff from partnering agencies, and parents of students participating in the program. In every site interviews were conducted with the following stakeholders: CAC program directors, CAC mental health providers, other CAC program staff, English language learner (ELL) teachers, school principals or vice principals, and parents of children served by the program. A total 83 interviews were conducted along with one focus group with eight
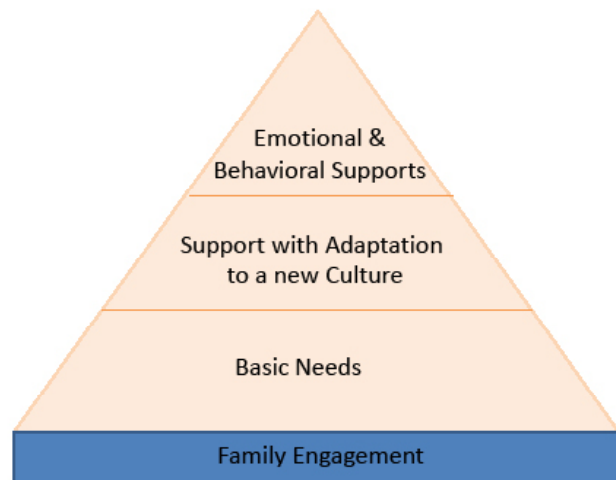

Figure 2. Necessary components of school-linked comprehensive mental health services for immigrant and refugee families

emotional distress. They also reported that the presence of one type of challenge made it more difficult to cope with other challenges.

Question 2. Necessary Components of Comprehensive Mental Health Services

A program component was defined as necessary if 1) in the sites that implemented the component, it was identified by multiple stakeholders as essential to their success; and 2) in the sites that did not implement the component, it was identified by multiple stakeholders as a significant barrier to success. All CAC mental health providers concurred both on the necessity of the following components and on their need to be seamlessly integrated.

All CAC mental health providers also described a hierarchy of need for services. According to the majority of stakeholders, basic needs and assistance with acculturation must be addressed before trauma-informed therapy is appropriate or useful. The pyramid in Figure 2 reflects this prioritization of services.

- **Family engagement.** The base of the pyramid, upon which all services rest and from which all services build, is family engagement. Family engagement was defined by CAC staff and partners as establishing relationships with families and identifying their unique needs and strengths. For this evaluation, our operational definition of whether family engagement occurred was whether, unprompted, parents in the program reported interactions with the CAC staff that were beneficial or helpful. An effective means of gaining recognition and building trust with families is to identify and provide basic needs. Home visits also help to build relationship. Even the simplest things were often named as a means for achieving engagement: being a consistent, helpful, and culturally comfortable presence in the school or community by, for example, greeting children and parents as they dropped their children off at school every day.

- **Basic needs.** This evaluation affirms that comprehensive mental health interventions should start with the provision of basic needs, including academic supports for children, language classes for children and adults, and material support such as a mattress for a child to sleep on or winter clothing for a family. Stakeholders provided two reasons for prioritizing basic needs. First, if a family is worrying about being evicted or a child is worried about failing school , they will not be interested in or capable of addressing other emotional needs. Second, the lack of

basic needs is a primary cause of emotional distress and behavior problems, and helping a family achieve security and academic success may fully address these issues. Addressing basic needs may be an efficient way to resolve mental and emotional distress for many refugee and immigrant families.

- **Support with adaptation to a new culture.** Nearly all refugees and some immigrants need support with adapting to a new culture. According to several stakeholders, assistance with integration into a new culture is facilitated by having cultural brokers who understand the refugees' and immigrants' culture and may even have been an immigrant or refugee themselves. Successful cultural brokers are bilingual and bicultural, know the local refugee or immigrant community, and have the flexibility to spend time with families, conduct home visits, and respond to emergencies. Program staff who are not of the culture can assist with cultural adaptation as well, particularly if they understand the culture and are open to learning from the families about their culture.

- **Emotional and behavioral supports.** At the top of the service pyramid sits emotional and behavioral supports. We use the term emotional and behavioral supports rather than therapy or counseling for two reasons. First, not all stakeholders distinguished counseling or therapy as distinct from social and emotional support. In some sites the mental health models were flexible and included any service that reduced environmental triggers of emotional dysregulation (e.g., paying the rent). Second, therapy and counseling are stigmatized in some cultures and hence their use can inhibit the delivery of effective services. Four of the five programs avoided using the terms "mental health," "counseling," or "therapy," when they first contacted families. The stakeholders reported that a significant minority of children's needs were not addressed with academic, economic and acculturative supports alone. Some children needed intensive emotional and behavioral supports. Acceptance of intensive mental health services was high (in one site, 100%) in settings where emotional and behavioral supports were completely integrated into the pyramid of services. In the sites where the mental health providers were expected to make a cold contact with a family to enlist them in therapy, the mental health providers reported difficulty in quickly gaining parental trust so they could help the child.

A key finding of this evaluation is the importance of seamlessly integrating the four essential components—

family engagement, basic needs, support with functioning in a new culture, and emotional and behavioral support—such that families can turn to a single person to access all services.

A single organizational feature distinguished the programs that successfully engaged parents and integrated all four components from those that did not. *The programs that successfully engaged parents structured their program such that mental health providers worked hand in hand with bicultural family liaisons whom the families trusted and whose specific task it was to help families with navigating a new culture, interpreting a new language, understanding a new academic paradigm, and accessing economic resources.*

Question 3. Effective Partnerships

The Caring Across Communities grantees were required by the Robert Wood Johnson Foundation to form partnerships between local non-profit agencies and school districts. The complexity of the refugees' and immigrants' needs mandated partnerships as well, as no single organization could single-handedly provide comprehensive services. The evaluation identified five actions that maximized effective collaboration between partners.

- **Focus resources**. The sites that served a single school had enough resources from the CAC grant to adequately invest in collaborations and deliver all four components of comprehensive school-linked mental health services. Staff and partners at these sites expressed satisfaction with their work and could point to clear accomplishments. At the sites that spread staff across multiple schools or sites, there was higher staff turnover and staff expressed feelings of inadequacy and being overwhelmed. Although the evaluation did not make a determination on which model had greater impact, it did find that parents served by the CAC programs targeting multiple schools had less contact with the program and, perhaps as a result, perceived many fewer benefits from the program. There is a potential downside to focusing resources, however; the narrow focus of effort may make it harder to build a constituency within the larger school district that is invested in sustaining the program.

- **Share resources.** Partners were more willing to collaborate when they perceived mutual benefit. Teachers who attributed reduced behavior problems in their classrooms to Caring Across Communities were more likely to make referrals and share information about the children's families. Staff from

partner agencies committed more time to CAC activities, whether or not they were paid, when they saw the program helping them achieve their own professional goals. In contrast, a staff person at a partner agency who thought that refugees were inadequately represented among the program staff did not advocate for the CAC program in the community.

- **Develop a shared vision**. The term "shared vision" encompasses several dimensions of successful collaboration, including a shared commitment and belief in the program model, a commitment to constant cultural adaptation and flexibility in the model, respect for each other's point of view, commitment to the team itself, and, most importantly, a commitment to the children and families.

- **Support teachers**. Teachers were identified as essential partners. For many of the immigrant and refugee groups, they are seen as a trusted resource simply by virtue of their role. In addition, they have daily contact with the students and can help or hinder children's adjustment to a new culture and hence their academic progress. Stakeholders, including teachers, identified two ways to support teachers: providing training about immigrant and refugee students, and day-to-day support with discipline, behavior management, and caring for the students.

- **Devote resources to coordination**. Integration of all four components to create a comprehensive service model required more coordination than any of the grantees had anticipated or planned for. Although the logistics were challenging for every site, the three factors listed above—focusing resources, sharing resources, and developing a shared vision—made it possible. The program directors in the sites with the greatest coordination among partners also reported working many more hours than they were compensated for by the grant.

Program Effects

This evaluation was not designed to assess the impact of the CAC programs on immigrant and refugee well-being. Hence we did not ask the study participants their perceptions about impacts of the program. Nonetheless, the participants spoke about observed program effects in sufficient quantity as to be able to posit program effects in three areas.

- **Improved child affect and behavior**. This was the most commonly cited benefit of Caring Across Communities. Parents, teachers, and mental health providers reported that children were better able to focus and learn and were less disruptive in class.

- **Increased access.** Several stakeholders described how the CAC grant had made mental health services more accessible to immigrant and refugee youth.

- **Increased efficacy.** In the sites that worked the most intensively with parents, stakeholders reported an increased ability of parents and children to advocate for themselves. Staff also reported increases in their own efficacy in working with refugees and immigrants. students.

This evaluation confirms and extends three recent sets of recommendations for designing comprehensive mental health services for refugee students (Davies and Webb, 2000; Miller and Rasmussen, 2010; National Child Traumatic Stress Network Refugee Trauma Task Force, 2005). By examining five distinct programs that had been granted the creative freedom to design a program from the ground up, we have been able to distill a set of necessary components for comprehensive mental health services and identify promising strategies for implementing each component.

Introduction

Caring Across Communities (CAC) is a three-year initiative of the Robert Wood Johnson Foundation managed by the Center for Health and Health Care in Schools at the George Washington University.

The goal of Caring Across Communities is to "support the development of school-connected mental health care models to reduce emotional and behavioral health problems among children in low-income, refugee- and/or immigrant-dense communities. ...While services will be available to all students in a selected school, the program will emphasize the importance of developing strategies that meet the unique needs of children from immigrant and refugee families. Funded projects will include approaches that are culturally informed and linguistically accessible to children and families" (RWJ, 2006, p.7).

The Robert Wood Johnson Foundation funded 15 partnerships between school districts and non-profit agencies such as mental health agencies and agencies with expertise serving refugees or immigrants. The 15 sites, located in eight states, received up to $100,000 a year for three years from 2007 until 2010. (A complete list of the programs can be found at http://www.healthinschools. org/Immigrant-and-Refugee Children/Caring-Across-Communities.aspx.) The programs each proposed a unique strategy to achieve the funding goals, although they all shared the following elements as mandated by the funder.

1. At least some of the proposed services are offered in the schools.

2. Families are provided interpretation and translation services.

3. Strategies are adapted to be appropriate for the cultural group(s) being served.

The 15 sites selected for funding varied along the following dimensions: a) whether they served immigrants, refugees or both; b) the number of cultural groups they served; c) the age ranges of the children; d) the mix of services; and e) the number of schools with which they worked.

Since the sites differed in the activities they implemented, the families they served, their philosophical approach to mental health, and the structure of their school-community partnerships, the program as a whole provided a unique opportunity to compare and contrast approaches. In May 2009, Clea McNeely of the Center for the Study of Youth and Political Violence at the University of Tennessee, Knoxville was awarded a contract to conduct an evaluation to determine the key components of comprehensive school-linked mental health services for refugee and immigrant children.

This is a qualitative evaluation. The data collected are in-depth interviews with stakeholders—parents, CAC staff, school staff, and staff of CAC partner organizations—from multiple CAC sites. Findings from qualitative studies are derived by systematically reading and analyzing interview transcripts to identify themes. Qualitative evidence is presented using representative statements from the interviews. In accordance with this research tradition, the voices of the interviewees provide the evidence in this report. The many quotations in this report are representative of the evidence from which our conclusions are derived.

The Study

A goal of the funders was to identify common attributes of culturally-appropriate and accessible mental health services. To achieve this end, we a conducted a comparative case study of five of the CAC sites. This comparative case study is a process evaluation. Process evaluations are conducted during program implementation to provide information that will strengthen or improve the program being studied. Process evaluations answer questions such as:

- Did the program reach the people it was intended to reach? Why or why not?
- Did the program accomplish the planned activities? Why or why not?
- How well were the program activities implemented?
- How did external factors influence program delivery?

The answers to these questions inform programs about improvements needed to achieve their intended outcomes. Future programs can also benefit from the results of process evaluations of existing programs.

The Caring Across Communities evaluation was guided by three primary questions:

1. What are the challenges experienced by the children and families the CAC programs serve?
2. What are the necessary components of school-linked mental health services for refugee and immigrant children?
3. How can partnerships between schools and multiple community agencies work most effectively to implement the necessary components of comprehensive mental health services?

Process evaluations are not designed to measure program impact; however, we do report evidence of program effects as observed by the program staff, teachers, and parents.

To answer the above research questions, in-depth interviews were conducted with stakeholders in five CAC sites. The five sites were purposively selected as follows. First, the programs that did not deliver comprehensive services (e.g., provided teacher training only or clinical services only) were excluded. Second, any programs that had experienced changes in leadership or difficulties in day-to-day management were excluded so as to not rediscover that frequent changes in leadership makes it difficult to develop effective programming. From the remaining set of programs, five sites were selected to maximize variation in the age range of children served, region of the country, and type of children served (refugee, immigrant, or both). The five sites are described in the next section.

Program Sites

BieneStar (Durham, North Carolina)

The overarching goal of Duke University's BieneStar program is to "create a sustainable continuum of mental health services that are accessible, culturally competent, and integrated into school services with special emphasis on immigrant children and families" (The Center for Health and Health Care in Schools, 2010).

BieneStar is integrated into existing school-based health centers in three elementary schools in Durham, North Carolina. The academic performance of the three schools is similar: between 36 and 44% of Latino students are at or above grade level (Public Schools of North Carolina, 2010). The three schools vary substantially, however, in the availability of non-academic supports. George Watts Elementary is a Montessori magnet school, with a program targeted to academically gifted students. It is located near Duke University and draws students from both affluent and impoverished neighborhoods. It is racially diverse: 44% Latino, 30% Black, and 23% White.

E.K. Powe Elementary School, also located in an affluent neighborhood near Duke University, serves primarily low-income children. Its student body is also racially diverse: 48% Black, 32% Latino, and 19% White. According to the principal, although few neighborhood children attend the school, the local community provides money, volunteer services, and in-kind support. That allows the school to offer its families help with basic needs, such as food and clothing.

Glenn Elementary is a traditional Title I public school. Like the other two schools it is racially diverse (56% African American and 40% Latino). What distinguishes Glenn is overcrowding due to its location in a part of town inhabited by a rapidly growing immigrant and low-income population. Compared to the other schools, class size is substantially larger, space is severely limited, and the school has fewer non-teaching staff per capita and fewer community volunteers.

The Caring Across Communities grant was used to hire a full-time Spanish-speaking mental health therapist and a part-time bilingual family liaison to design and conduct 15-session parenting groups. The two staff persons split their time across the three schools. The mental health provider works with the immigrant students and families at E.K. Powe and George Watts and with all 700 students at Glenn Elementary, where she is the sole mental health provider. The mental health provider primarily works with

students referred by ELL teachers or staff from the school-based clinic. Once she receives a referral, she contacts the student and family to assess the situation and set up a care plan. The therapist is trained in trauma-informed therapy and uses that approach when appropriate. She also connects students and families with other resources to help them to adjust to living in Durham, assistance with basic needs, and medical care.

The family liaison is based at El Centro Hispano, a community-based organization that assists Latino immigrants. She works with the school principals to coordinate the logistics and recruitment strategies for parent groups. At the time of the interview, BieneStar had successfully gained access to two of the schools, E.K. Powe and George Watts, to offer the parenting program.

World Relief-Chicago (Chicago, Illinois)

World Relief-Chicago is a refugee resettlement agency. Its purpose is to help refugees during their first six to eight months in the United States with housing, language classes, paperwork and documentation, employment, and adjustment to a new country and culture. World Relief-Chicago works with refugees from dozens of countries.

Prior to receiving the Caring Across Communities grant, World Relief-Chicago had worked with schools in two ways: first, helping families enroll their students in schools and second, conducting a limited number of trainings on refugees for school personnel. World Relief also provided mental health services at its headquarters. This project represented an opportunity for the agency to become more involved in providing mental health services in schools.

World Relief-Chicago partnered with two schools: Theodore Roosevelt High School and Hibbard Elementary School.

Theodore Roosevelt High School is a large public high school in the Albany Park neighborhood on the north side of Chicago. Only a small proportion of students (20% for reading, 6% for science, and 19% for math) scored at or above the minimum standard on state assessments. The vast majority of students (95%) are low-income, and the majority are Latino (72%). The Chicago School System has no way to identify the refugee or immigrant children in a school, but according to the assistant principal, there are approximately 230 ELL students at Roosevelt. At the high school, World Relief-Chicago collaborates with Alternatives, Inc., an agency with expertise in adolescent mental health services, to fund a part-time licensed clinical

social worker (LCSW) in the school-based clinic. This bilingual and bicultural social worker provides clinical mental health services and also case management to newly arrived immigrant students from Latin America, in particular those who arrive without parents or guardians. She also sits in on the lowest level ELL class once a week to observe students and help the teacher—who does not speak Spanish—problem solve around behavioral or attendance issues.

In addition, the youth services director from World Relief-Chicago works at Roosevelt nine hours (two days) a week to provide individual therapy to approximately eight refugee students. The youth services director also runs an after-school teen club once a week for refugee students. In the past, the social worker in that position supervised up to nine social work interns who also provided mental health services. These interns were no longer in place at the time of the evaluation. In addition, twice a month the youth services director does outreach in the ELL classroom. She explains the after-school program and counseling services and talks to students individually to see if they are interested.

Roosevelt High School has a Refugee Welcome Center that facilitates enrollment and orientation of students to the high school and provides tutoring to refugee students. This center is staffed by a bilingual and bicultural Ethiopian teacher whose time is split between several schools. World Relief-Chicago and the Refugee Welcome Center collaborate on enrolling new students but, at the time of the evaluation visit, did not otherwise coordinate services.

Hibbard Elementary School is located just a few blocks from Roosevelt. In 2009, 72% of all students scored above the minimum standard on the school district's composite exams. This is higher than the City of Chicago School District 299 average of 68%. The school is predominantly Latino (75%). At Hibbard Elementary, World Relief-Chicago uses the Caring Across Communities grant to place a part-time social worker in the school two partial days each week. The social worker, who is from Kenya and speaks Swahili and English, provides clinical and non-clinical services to refugee students. The non-clinical services include serving as a mentor and role model to African children, especially girls; serving as a liaison between parents and teachers; and supporting teachers through individualized assessment and emotional support of students. In addition, the social worker sits in on the ELL class, whenever possible, to assess emotional and behavior issues and to assist the ELL teacher.

The Hibbard social worker also spends one morning each week working with students who have transitioned from Hibbard elementary to the middle school across the street and. In addition, the social worker has responsibilities unrelated to the Caring Across Communities grant, all of which she tries to accomplish in 30 hours per week.

Explorer's Program (Fargo, North Dakota)

The Caring across Community grant was awarded to the Village Family Services Center in Fargo, North Dakota. This was the Center's first experience working with refugee families, and they spent much of the first year planning the program and developing partnerships. The Explorer's Program began serving children of refugees in grades 3-5 in Kennedy Elementary School and, in the second year, expanded to serve grades K-6. The older students are served at Kennedy's sister school, Discovery Middle School. Refugees from 14 countries currently attend the Fargo Schools.

Kennedy Elementary is a relatively new school that is already running out of space due to new housing developments in the area. It is located in an area with a mix of single-family homes, townhomes and apartment buildings, where many of the refugee families live. The school is 82% Caucasian. In any given year, between 8 and 10% of the student body consists of refugees, mainly from African countries. Over 80% of students achieve proficiency on standardized math test scores and over 70% achieve proficiency on reading scores.

The Explorer's Program has three main program components: individual and group counseling with a mental health specialist; skills coaching provided by a male mentor who spends time with the students in the cafeteria during breakfast and lunch, on the playground at recess, and at the after-school program offered by CHARISM, a nonprofit community agency; and home visits by "cultural mentors" of the same culture (when available), the skills coach, and the mental health specialist. In addition, the CAC staff support the multicultural PTA, which consists of parents of refugee children from multiple countries.

Through these multiple strategies, the Explorer's Program has staff available to students and teachers throughout the school day as well as during the after-school program. The individual and group therapy occurs at the school. The focus is on identifying and building children's strengths, and narrative therapy is the therapeutic approach. The narrative approach was chosen, in part, because it takes away the expert stance from the therapy interaction. The child is the expert on how to resolve the problem, and teachers and parents contribute. The groups have covered topics such as appropriate expressions of anger, making and maintaining friendships, overcoming loneliness and isolation, connecting with family members who are living in another country, and strengthening the adaptive skills and qualities in each of the children.

3Rs Project (Los Angeles, California)

The Caring Across Communities grant provided the Los Angeles Child Guidance Center an opportunity to transform its existing partnership with Norwood Elementary School from providing walk-in clinic services for immigrant children two days a week (4 hours each day) to a comprehensive set of services provided by a family advocate and a mental health counselor in coordination with school staff and community partners also co-located at the school.

Norwood Street Elementary School is located in central Los Angeles, in a neighborhood that is a mix of cafes and stores that cater to students at the nearby University of Southern California, and dense single and multi-family homes occupied primarily by Latino families. The school is 96% Latino and, of these students, 98% are eligible for free and reduced lunch and 79% are English language learners. Many of the school staff are bilingual, including all of the staff in the front office.

The paradigm for the Los Angeles program is the "three Rs": relationships, resiliency, and recovery. Relationships form the basis of the therapeutic relationship. Through those relationships, one tries to build skills or competencies that promote resilience. For those who have already been negatively affected by trauma, trauma-informed therapy strategies are used to promote recovery and healing.

To achieve their goal of increased access to culturally competent, trauma-informed mental health services for uninsured immigrant students or children of immigrants, the 3Rs Project has three components. First, they established a walk-in clinic in the school that is staffed by a mental health professional nearly four days a week. The hours are scheduled as much as possible to be accessible to parents. Several modalities of group and individual therapy are used, including cinema therapy, art therapy, and stress-management groups.

Second, the grant monies are used to provide training on mental health issues to the school staff annually, to parents and families through parent education classes several times

per year, and to the lay health promoters (*promotoras*) of Esperanza Community Housing Corporation. Third, the 3Rs Project facilitates a group of parent supporters, which meets on an ad hoc basis. The parent supporters—all mothers—serve as advisors on the content and structure of the program, help publicize the mental health services available at the school, and attend parent education classes, sometimes with their spouses. All activities with parents are conducted in Spanish by a bicultural and bilingual family advocate, hired with the CAC grant.

The family advocate and the therapist work closely with two other programs at the school: Healthy Start and the Parent Center. Healthy Start invited in and now coordinates many services at Norwood Elementary, including the 3R Project, and serves as the project's primary contact with teachers, administrators and other staff at the school. The Parent Center, which is located near the 3Rs Projects's walk-in clinic, is a resource center for immigrant parents. The coordinator, herself an immigrant, provides individualized support to immigrant families, helping them access basic needs, English-language classes, and medical care. In addition, the Parent Center helps parents understand their rights as undocumented immigrants. The Parent Center refers students and families to the walk-in clinic for mental health services, as well as assists families with legal or economic challenges identified by the mental health staff. From the perspective of the families, the staff funded by Healthy Start, the Parent Center, and the Caring Across Communities grant are all from "El Centro de Padres" (the Parent Center). The staff from the three distinct grants described their programs as seamlessly integrated.

SHIFA Program (Boston, Massachusetts)

Caring Across Communities provided a grant to Boston Children's Hospital to integrate into schools the trauma systems therapy approach for Somali families developed by project director Heidi Ellis, PhD. SHIFA works with the families whose children attend Lilla Frederick Pilot Middle School, a Boston public school piloting new strategies to improve urban education. In addition, other Somali families who request to participate are provided as many services as possible.

The Lilla Frederick Pilot Middle School serves a large proportion of the Somali middle school students in Boston. The student population is 57% Black, and 11% of students are English language learners. The vast majority of the English language learners do not achieve proficiency on state assessments of math, language arts, and science.

The SHIFA program has three main components. The aim of the first component is to be a resource to families, with the dual purpose of helping them with daily challenges and inviting them to participate in the mental health components of the project. The SHIFA program partners with the school's Refugee and Immigrant Assistance Center. A Somali staff person from the Assistance Center, who receives partial salary funding from the CAC grant, reaches out to parents and becomes known in the community as someone interested in supporting the success of their children in school. A major mechanism for engaging families is to conduct home visits. In the SHIFA program, staff conduct up to three home visits a week, depending on the needs of the family. This same staff person also coordinates a family advisory board of Somali parents that meets quarterly to advise the program and, hopefully as a result, the parents become more involved in the school.

The second component of SHIFA is a group for students in the ELL classrooms. The group meets once a week, and the goal is both to have fun and to reduce some of the stressors of acculturation.

Through parent outreach and the student groups, teachers and SHIFA staff identify a subset of students who need more intensive mental health services. These students and their families are invited to participate in trauma systems therapy (TST). The goal of TST is twofold: a) to help a child regulate his or her emotional state and b) to identify and address triggers in the child's environment that make emotional regulation difficult. Thus the TST consists of working with the child individually, with the family in the home, and on legal advocacy issues as necessary. The Boston University School of Social Work has granted scholarships for the training and professional development of two Somali social work students who provide mental health services under Project SHIFA, and who partner with additional social work trainees to build cultural understanding among providers.

The SHIFA project holds weekly team meetings to coordinate care for families and to bring multiple partners' expertise to problem solve. These meetings are attended by the project director, members of the research team, all mental health providers, the staff of the Refugee and Immigrant Assistance Center, and staff of community partner agencies.

Study Methods

Two-day site visits were made to each of the five sites by a two-person evaluation team. At each site, in-depth interviews were conducted with program leaders, staff, school staff, staff from partnering agencies, and parents of students participating in the program. The specific persons to be interviewed were determined in conversations with each site's program director. The priority was to interview stakeholders who were staff or key partners in the delivery of school-linked mental health services. At every site interviews were conducted with the following stakeholders: CAC program directors, CAC mental health providers, other CAC program staff (e.g., family liaisons or family advocates), ELL teachers, school principals or vice principals, and parents of children served by the program. A total 83 interviews were conducted along with one focus group with eight providers in one site, where individual interviews with the mental health providers were not practical.

The interviews were conducted between October and

The questions were piloted with program directors and program staff at the annual CAC conference in April 2009 and modified as necessary. A separate interview protocol was developed for parents (see Appendix A). Informed consent was obtained from all interview participants and they were given $25 to thank them for the gift of their information. In the cases where the respondent could not accept money due to his or her workplace policy, the $25 was donated to buy supplies for the children. All research protocols were approved by the UTK Institutional Review Board.

All interviews were tape recorded and transcribed. The interviews with parents were conducted with an interpreter. The interviews were transcribed verbatim and the original language was translated to ensure accuracy of the interpretation. The interpreters were provided by the sites. In about half the cases, the interpreters were professional translators unknown to the parents. In the remaining cases, the interpreters were bilingual program

Table 1. Stakeholders interviewed in the evaluation							
Program Directors	School Principals & Teachers	Immigrant Parents	Refugee Parents	Other CAC Staff	Staff from Partnering Organizations	CAC Mental Health Providers	Total
6	13	13	12	14	22	12	91

December, 2009. Each interview was conducted in a private location by a trained researcher from the University of Tennessee, Knoxville (UTK). Three of the researchers (the study authors) visited between two and four sites each. A fourth researcher, an assistant professor in multicultural education at UTK, visted a single site. All interviewers are female and Caucasian.

The parent interviews were conducted in the parent's home or at the school, whichever location the parent preferred. About half of the parents elected to come to the school for the interview. The interviews with other respondents were conducted in a private room at the school or in their place of work. Table 1 shows the number of interviews conducted with each type of stakeholder.

The interview guide was developed by a collaborative effort between the UTK research team and the program management team at the George Washington University.

staff or the interpreters that typically worked with the CAC staff and were known to the respondents as representatives of the CAC program. Parent interviews were conducted with parents from Mexico (Spanish), Burundi (Kirundi), Liberia (English), Iraq (Arabic) and Somalia (Somali, Somali Bantu and Maay Maay). One Somali interview was conducted in Swahili because a Somali translator could not be found an d the respondent spoke Swahili. All but one of the refugee parents we interviewed were from Africa.

The interviews w ere coded in Atlas.ti 6.1 (Muhr, 2010) using an adapted constant comparison method (CCM) (Strauss 1987). Prior to coding, we identified four broad domains we knew we needed to document to answer the evaluation questions: *challenges* faced by refugee and immigrant children and families, *services* provided, and aspects of *partnerships* that promoted or inhibited the work.

The first step in CCM is to start with a single interview, study every passage to determine what exactly has been said, and label each passage with an adequate code (Boeije, 2002). Four researchers (the three authors plus one undergraduate research assistant) initially read and coded four interviews each (for a total of 12 interviews) using the open codes facility in Atlas.ti. The three authors are Caucasian females, all with substantial experience working with immigrant or refugee children. The research assistant is a white male, with two years experience working with refugees in Uganda. None of the research team is bicultural or has been a refugee or immigrant himself or herself. In open coding, the researcher does not start with a predefined list of codes but rather creates codes specific to the data she or he is coding. As much as possible we chose code labels using the respondent's own words to describe the topic or theme being discussed. The aim of this first step is to label passages consistently throughout the interview to develop the most appropriate labels for the codes.

The second step in CCM is to compare across interviews the codes that have been developed to be internally consistent within (Boeije, 2002) and develop. The authors held four consecutive meetings, called "the interpretive zone" (Wasser and Bresler, 1996), to create a unified coding scheme from the open codes each had developed. We discussed exemplar quotations for each code and definitions of the code. There was considerable overlap between the codes developed by the four coders. We settled on a preliminary coding scheme with 151 unique codes. In a fifth meeting, the research team consolidated the 151 codes to 48 codes by combining codes into broader categories to make coding and analysis feasible. For example, the codes

"challenges-economic-poverty," "challenges-economic-unemployment," "challenges-economic-working multiple jobs," "challenges-economic-transportation" were combined into a single code: "challenges-economic-poverty."

In addition to the three predefined domains--challenges, services, and partnerships--we identified two additional domains: program effects and family/self efficacy. Within these five major categories we created 14 sub-domains and a total of 47 codes distributed across those subdomains. Table 2 presents the five domains and the 17 sub-domains. The numbers in parenthesis indicated the number of codes created for each domain or sub-domain. The full list of codes is presented in Appendix B.

This coding scheme was tested on an additional 12 interviews, and code adaptations and additions made as necessary. Memos were used liberally during the coding process to document initial interpretations of the data or suggest new or adapted codes. The validity of the coding process was regularly checked by having all four coders code the same interview, comparing results, and clarifying the coding scheme as necessary. Although the use of multiple coders to work on the data is more time consuming, the contribution of multiple perspectives to the interpretation process increases the credibility of the findings (Wasser and Bresler 1996).

The third and final step in the adapted contant comparison method was to compare interviews across groups. We made comparisons across sites, between refugees and immigrants and across categories of key informants, specifically parents, school staff, mental health providers, and cultural brokers (regardless of formal role).

Study Findings

Evaluation Question 1

What are the challenges experienced by the children and families the CAC programs serve?

We organize the findings around the evaluation questions. The purpose of this first question, beyond documenting the challenges facing immigrant and refugee families, was to ascertain whether there was agreement on the primary challenges among the various stakeholders; whether the

challenges are similar across cities and between immigrants and refugees; and, to be discussed later, whether the services delivered by communities are targeted at alleviating the most pressing challenges.

It is important to note that in addition to challenges, the interviews provided many examples of strengths and resources to meet those challenges. These will be discussed later in the report.

Several categories of challenges were discussed by all stakeholders in all sites: economic, academic, language, children's behavior, and emotional challenges. Figure 1 presents the relative frequency of the six categories of

Table 2. Descriptions of coding domains (see Appendix B for all codes)		
Domain (# codes)		**Description**
Challenges	Academic (4)*	References to academic challenges such as being placed at the wrong academic level, not having prior education in one's own language, or trouble learning.
	Adjustment to a new culture (2)	References to stresses of adjusting to a new culture, geography, climate, school setting, legal system, etc.
	Child behavior (2)	References to behavioral challenges such as bullying, fighting, being picked on, trouble fitting in, not appropriate behaviors in U.S. schools, being too withdrawn or too rambunctious, or trouble concentrating.
	Economic (6)	References to economic challenges such as poverty, lack of transportation, lack of well-paid employment, and lack of food, clothing and housing.
	Emotional (2)	References to emotional distress of either parents or children, including identified causes of emotional distress such as family dynamics, criminal victimization, and acculturative stress.
	Language barriers (1)	References to not knowing English as a challenge for either parents or children.
	Parenting (3)	References to challenges parenting, such as different expectations regarding discipline and role of parents in schools.
Family/Self Efficacy (1)	————————	References to displays of efficacy or desire for efficacy by parents or children.
Partnerships (1)	————————	References to aspects of partnerships that facilitate the work or make the work more difficult.
Services	Academic supports (3)	References to academic supports for refugee and immigrant children such as ELL training, tutoring, and explaining how things work in the new school.
	Basic needs (1)	References to help with basic needs such as housing, food and clothing, and getting access to public services.
	Behavioral & emotional supports (5)	References to services designed to support children and families with behavioral and emotional challenges.
	How accessed (3)	References to how children and families are connected to and start to access CAC services.
	Language (3)	References to help with language barriers for families, including translation and language training.
	Parenting (1)	References to services designed to help parents effectively parent their children in the new culture.
	Role of staff (4)	References to role of CAC and partner-agency staff in provision of services, including the role and characteristics of cultural brokers.
	Suppport teachers (2)	References to actions that support teachers in the school.
Program Effects (4)	————————	References to positive program outcomes.

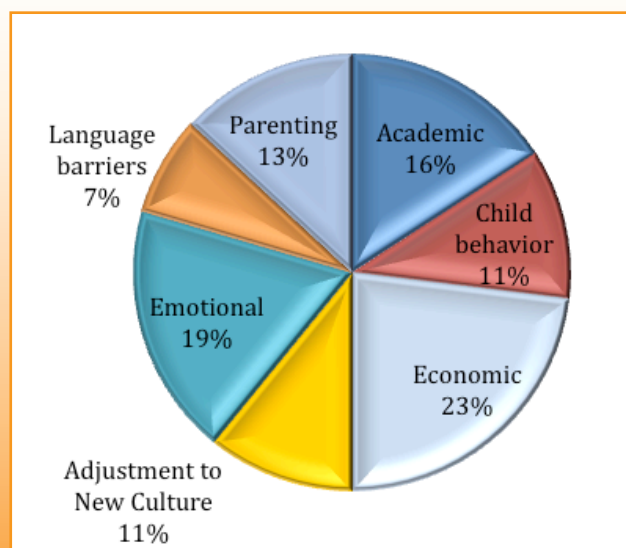*Note: The numbers in parenthesis indicated the number of codes created for each domain or sub-domain.

Figure 1.   Relative frequency with which stakeholders mentioned domains of challenges

food and transportation, buy clothes, and take care of other basic necessities. The refugees also need to pay back the US government for their airfare and travel expenses to the United States.

The immigrants in this study faced economic challenges even more severe than the refugees. Most of the immigrant parents interviewed reported that one or both parents were unemployed due to the economic crisis. Although we did not question the immigrants about their legal status, many of the parents did reveal to us that they could not access services eligible to legal residents or citizens, including emergency housing, medical care, TANF, and food stamps. In North Carolina, where the state had recently passed a law that one had to show proof of residency or citizenship to get a driver's license, the immigrants were not able to drive to find work or get to work once their license expired. Many of the immigrants also arrive indebted, owing money for the trip to the US.

challenges. As is apparent from the pie chart, economic challenges were identified, or named most frequently by participants (23% of all mentions), followed by emotional challenges (19%), academic challenges (16%), parenting challenges (13%), challenges adjusting to a new culture (11%), child behaviors (11%), and language barriers (7%). We discuss each category of challenges in turn.

We identified six prevalent categories of economic challenges that were nominated in every site by a majority of stakeholders: general economic challenges related to poverty (49%), basic needs not being met (21%), legal status as a cause of economic challenges (11%; only nominated by immigrants), living in a poor neighborhood or attending a poor school (11%), and identifications of poverty as a cause of emotional distress. The relative frequency of the various economic codes is presented in Figure 2.

Economic challenges

Before presenting the economic challenges as described by the study participants, it is helpful to understand the policies that affect the economic well-being of refugees and immigrants. Upon their arrival in the US, refugees are assigned to a resettlement agency. Until September 2009, the resettlement agency received $900 for each refugee from the federal Office of Refugee Resettlement. The current per capita grant is $1800. This grant is to be used within the first three months of resettlement as follows: $700 can be used by the agency and $1100 is given to the refugee in three monthly installments. The agency is required to secure and furnish a home; assist with health screening, job training and job search; enroll children in school; and help the refugee access language training, income supports, Medicaid, and other benefits. The refugee, in turn, must begin to build a life with $1100 for the first four months, out of which they typically have to pay rent, purchase
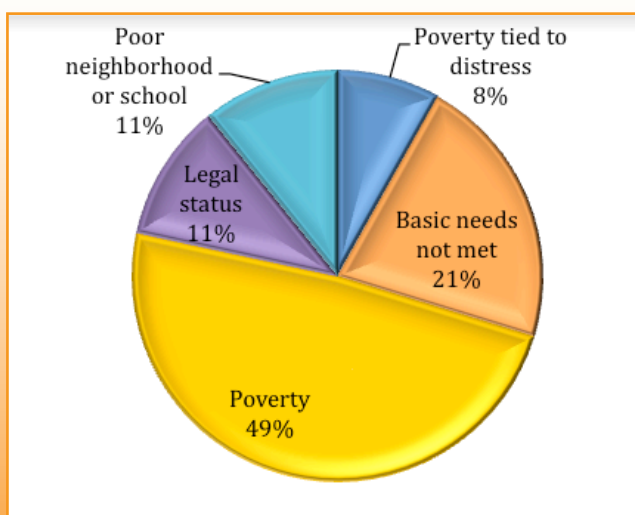

Figure 2.   Economic challenges identified by stakeholders

The following quotes describe the difficulty that the immigrant and refugee families have with poverty and with even fulfilling basic needs such as food, clothing and housing.

Mental health provider for immigrant children:
I think right now the big thing that's going on is housing. There's a big need for housing. … And then just work right now. Everybody is running out of work. The economy is not that great, so people are really, really struggling right now for food and financially. And that's like the biggest stressor right now that I'm hearing.

Teacher of refugee students:
You know, right now it's winter and most of them don't have the clothing. But you know just things like that the family can't afford or get access to.

Refugee parent:
The second problem common to families who are new is transportation. Like going to medical appointment and going to the grocery store and not being able to get there.

Immigrant parents, teachers, mental health providers and other staff identified poverty as a cause of emotional distress or behavior problems in the classroom. Although the refugee parents discussed poverty as a challenge, they did not draw a direct connection between poverty and emotional well-being for themselves.

Mental health provider for immigrant children:
This one boy is usually very animated, and when I saw him the next two times… he was very, very tired. And I found out, well, the temperature had changed and he had been sleeping on the hard floor and didn't have enough blankets.

Teacher of immigrant children:
That's the biggest problem: facing the poverty. And like I said, poverty then disseminates to other areas and causes other problems—you know, domestic violence. Because there's no money, you know, frustration, depression, the child acting out because of the situation; the parents don't know how to handle it, they don't know how to parent because they're used to other situations. And now they're confined to one little space.

A common theme was the barrier that language posed to fulfilling basic needs. Language was mentioned as an economic barrier more frequently for refugees than for immigrants.

Teacher of refugee children:
One of my families has, there was concerns for employment. You know he was let go from his job, and he doesn't know much English. You know he's trying to learn, but you may have seven kids and you have to work, and it just doesn't come easily. And finding a job has been hard for him…without English, you know, he can only get a minimum wage job, and even that's been hard for him to find.

Coordinator of refugee and immigrant welcome center:
We have a student who dropped out… And I think he's only a sophomore. He had to drop out because his parents can't speak English. You know, somebody had to go out and work. You know, they're, they're trying. I think the child moved to another place where he found a job.

Interpreter for Iraqi refugees:
Someone who used to manage an office or used to be a teacher and now mostly they are expected to do labor jobs, because this is what I have available for someone who doesn't speak much English… So it takes a while for them to kind of digest the reality and that this is the situation that at first you have to do these hard jobs, and then you can move into your long term goal.

Many of the families can afford housing only in poor, dangerous neighborhoods with poor-quality schools. This was particularly true in the sites with expensive housing markets: Boston, Chicago and Los Angeles.

Immigrant parent:
You feel trapped, not free to go everywhere. You can go, but there are always dangers everywhere you go because the area where I came to live in first was very dangerous.

Mental health provider for immigrant children:
I know that we have had children who have been referred to [name of program] who have been victims of, victims of violent crime in their home, and I don't mean child abuse, I mean intruders.

Academic Challenges

A second area of concern is academic challenges. This was more of a concern for program and school staff than it was

for the parents. Although we did not interview children, stakeholders mentioned that academic challenges were a major challenge for the children as well. This challenge was particularly severe for children who arrived at older ages. We identified two themes within the domain of academic challenges. First, many immigrant and refugee children were below grade level; some had no prior education even in their own language.

Assistant principal of school with refugee and immigrant students:
So, yeah, it's challenging to really help these kids, you know, to expect them to come into a high school after not having an education and just to be able to finish up in four years. It's not going to happen.

Principal of school with refugee students:
Many of them have never gone to school before in their own language. They've never learned to read or write in their own language.

Mental health provider for immigrant and refugee students:
We had kids that didn't know what school was about, were never in a school before. They were older children.

Refugee parent:
Yes, they were placed in grades that did not work… were more than their base of knowledge.

CAC staff person serving refugee students:
Every year we have kids that just came in with no schooling ever before that. The child is eleven years old so, the kid, the parent say, well they have book and pen and they're in school. Why aren't they doing well?

A few parents expressed the opposite concern, that their children were not adequately challenged academically. The same mental health provider quoted above also reported, "Our Arabic population right now, they had a difficult time because the kids are older and we placed them according to birth dates, and they felt their kids should be at a much higher grade."

The second theme within academic challenges is the clear link that respondents drew between academic success and emotional well-being. The respondents described a bidirectional relationship between academics and emotional distress. Some reported emotional distress as the cause of academic problems.

Mental health provider for immigrant children:
He had kind of been doing well academically and after this happened [his brother was murdered in gang violence], he started declining. He was a very angry, irritable child. He was just, you know, angry at the world for what had happened to his brother… Well, you can have great teachers, but if the kid is not emotionally there, you know, it's all kind of going to go to waste. So we need to meet those emotional needs first. And then they can actually learn.

Others reported academic experiences as causing emotional distress.

Mental health provider for refugee children:
So, it's almost feeling like, OK, I'm working with the children in terms of their social/emotional well-being, but their social/emotional well-being is tied into the academic success or the child feeling like they are being able to do what is required of them as a student. And if they are failing that area or not getting, you know, the feedback—the positive feedback, or getting poor grades… then it's the realization, "I'm doing badly."

Language Barriers

Language barriers were a challenge in every domain of the refugees' and immigrants' lives. The sections above provide evidence of how language barriers impede economic and academic success. Language barriers also pose a challenge to the schools and the Caring Across Communities sites, particularly those who served refugees or immigrants from multiple countries.

Social worker for refugee and immigrant students:
Many of them come speaking three, four, five dialects, but maybe have never written, so how do you communicate effectively with parents when you pay translators line by line, and its very expensive getting interpreters in a timely fashion. They work really hard on that but it's not always possible.

Social worker for refugee students:
With parents, we initially had tried to make a parent group… there was a Somali, there was a Sudanese, and there was a Liberian. So the Liberian was ok in terms of language, but then the groups feel almost disorganized if you have too many people translating. So when you're translating for one, it means the other group is just sitting…

Principal of school serving refugees:
We want parents and children to work on them [class projects] together and often times the parents aren't literate. They don't speak the language to serve in that role even as much as they may want to.

Immigrant parent:
My oldest daughter didn't speak English and it was difficult for her to get used to the language because at home only Spanish was spoken.

Challenges of Adjusting to a New Culture

Often called acculturative stress in the research literature, the stress of adjusting to a new culture, food, geography, social system and labor market is a well-documented phenomenon (for a review, see National Child Traumatic Stress Network, Refugee Trauma Task Force, 2003). All stakeholders provided specific examples of how adjustment to a new culture was challenging.

Refugee parent:
The bus took the children so I did not go. I was afraid they would not return, so I left the house around eight and come back around three all the time looking to find the school.

Immigrant parent:
I feel very lonely, because even if we know other people that come from the same town, you still feel lonely.

Mental health provider for serving immigrants:
Considering that there's a lot of pride for their country because, you know, they do miss their country. That's really important to them. And when you're not in your country and you don't know a language, I think you feel immensely more idiotic. You do!

Mental health provider for refugee and immigrant students:
And then coming to school and not always knowing what classroom norms are—what the expectation is for a student in terms of behavior in the classroom. I think that a lot of the times not only are they trying to figure out how to act in school, how to take notes, that you are even supposed to take notes.

Refugee parent:
All the things that are out there. There are so many great things out there, but even understanding what

they are, what kind of food they are, it is a challenge. And I will give you a personal example. When we first came, we had so many cans in the kitchen, but I did not understand anything. So I boxed everything and returned it back to someone else. And today, if I had those cans I will not know what to do without. And I wouldn't even share [laughs].

Challenges adjusting to a new culture were more varied and, on the whole, more stressful for refugees than immigrants. The immigrants in the two sites in this study arrived to communities (Durham and Los Angeles) with large immigrant populations who shared their language and culture. They also had come from a Western culture and had a better understanding of what to expect, at least culturally, in the US. In addition, the immigrant parents interviewed had been in the United States longer, on average, than the refugee families we interviewed. The adjustment stressors most challenging for the immigrant parents were language barriers and fear and uncertainty related to their legal status. The refugees, in contrast, often had few members of their own community in the area and no access to basic elements of their culture, including food, a place of worship, neighbors they could talk to, or people who spoke their language in positions to help them (e.g., schools, government offices, bus drivers, retail clerks).

The challenges of adjusting to a new culture were described by teachers and CAC staff as a cause of challenging behaviors in the classroom. Acculturative stress was cited more frequently as a cause of behavior problems, emotional distress and shyness in children than was the experience of traumatic events.

Refugee parent:
I have seen at [name of after-school program] that kids do similar activities but also, I have seen also that some kids don't feel comfortable doing it. …I can see that some children are still shy. And I have also seen that at school when our children first come here, they feel different and they tend to pull away from others.

Principal of school serving refugee children:
And many times the kids are struggling to make friends, to fit in.

Child Behavior Challenges

Another area of challenges concerns children's behaviors. Behavior problems emerged as a concern at every site.

Some behaviors that are completely appropriate in the students' own cultures are considered problem behaviors in US schools.

Assistant principal of school serving refugee and immigrant students [reporting on a concern brought to her by a teacher]:
I have a student who just arrived who is in my PE class and this child doesn't speak any English and has poor hygiene. What am I going to do? The kids don't want to sit near him or her and I'm trying to give them instructions and they just don't seem to understand what I'm saying.

Principal of school serving refugee children:
I think in some communities there is a different appreciation for genders, those things that exist where they came from are often still part of their culture here, which is understandable, but that also gets brought into the school setting at times.

Mental health provider for refugee students:
…there are behaviors or tendencies they have that when they are in school are behaviors that are considered inappropriate…. The need becomes, OK, almost socializing children into the school culture, you know…"What I should I eat, I shouldn't touch, … I should do my homework." But I guess they haven't internalized it yet. So it's just doing things that help them begin to learn to be able to do those things.

Bullying and fighting were of particular concern. Even among elementary students the bullying between students can have a racial and ethnic dimension.

Mental health provider for elementary immigrant students:
One of the problems here is racist, racist aggression or ethnic aggression between Blacks, Latinos. And this African boy is being picked on for being African. He's black. And he's really being the brunt of bullying… But certainly, certainly African Americans and Latinos are not getting along well. This one African boy is just one of ---we're a school of six to seven hundred – so it's just one case, but it's going on for two years. And this boy has special needs by now.

Mental health provider for high school immigrant students:
There was a lot of tension between the refugee group and the newly arrived [immigrants]. And so what was

happening was they would be saying stuff to each other like: "Oh you need to go back to where you're from." It got kind of hostile.

Other behavior challenges are not necessarily due to the child's refugee or immigrant status.

Immigrant parent:
Sometimes children are too violent, so the other children do not [want to] be with them, because they are having that problem. Sometimes children are very quiet, they don't talk to other children and, as parents, this worries us. My oldest daughter is very shy, she also gets upset very quickly and she cannot control her anger.

Mental health provider for immigrant students [referring to some high-school aged immigrant students]:
They're not paying attention, they're acting up with the teacher, kind of antagonizing behaviors, and just not being able to kind of sit there and focus on what they are supposed to be doing. Not all students, but some of them that have these problems are really not paying attention. Or they come in and sometimes it's not even that they act up. They just sit there and maybe put their head down and just check out. You know, they'll go to sleep or just really not participate. Worst case scenario is that they get themselves thrown out of the classroom, because their behaviors are so distracting that the teacher can't continue to teach the class.

Parenting Challenges

We identified two prevalent sub-domains of parenting challenges: *parent–school interactions* and *cultural differences in parenting strategies*, particularly discipline strategies. There were marked differences in perspectives between parents themselves and the adults in the schools and CAC programs. There were also marked differences between immigrant and refugee parents. The staff working in schools and for the CAC programs focused on barriers to parental involvement in school and in their children's education as the major parenting challenge.

Program director [In response to a question about challenges the community faces]:
Not understanding what the system…what the school system does. Um, and I think it really does take cultural mentors to go out there and help them get

into the school and get involved and be part of their kids' lives.

Health care provider for immigrant and refugee students:
Well, first of all, if you're talking about doing work in a school and you want to get the family involved, school's only open until, you know, whatever time. It's not ideal. You know, when parents are working and you want to get people together. Unless you're doing home visits, which I don't believe that they were doing.

Principal, school serving refugee students:
Communication with the parents and their communication to us is a barrier.

Parents understood that American schools had different requirements for parental involvement but were not always clear on the expectations, and did not always find those expectations comfortable. This was particularly challenging for the refugees from Africa who came from a system in which parents turn over full responsibility and authority for their children's education to the schools.

Refugee parent:
I would tell them children in Africa [are] not like children in America here. Because there if I send my son to school, the teacher there is the one that is responsible for that child. He can beat him, do everything. ... If my child becomes sick in the school, it is the teacher there. He will take care of the child there, but here they will call you up (laughs) and tell you your child is sick and to take them to the doctor. But there is different. Teacher is the one who can take responsibility, to take care of child, ... and then they will take child back home to you. Here is a big difference .

Family liaison for refugee students:
There's no connection between the parents and the teachers because we came from a community that has never been involved with any school system. The school has to do their job, the parents have to do their jobs, so never been that connection. Letters sending and the parents read and they call the teachers—all of that is not there, so you have to be the bridge between the parents and the teacher.

Social worker for refugee students:
I think the stuff I mentioned before about the concept

of the involvement between home and school being so different for them, they struggle with that in different ways, and once they understand kind of where the school actions are coming out of, it helps. But it doesn't always solve things.

The second area of parenting challenges is cultural differences in expectations for parenting, especially parenting in the relatively liberal social context of the United States. Refugees in particular mentioned this challenge and, in some cases, did so quite emotionally. The quotes below illustrate how raising children in a system with more liberal norms challenges the parents' sense of efficacy.

Refugee parent:
When the children are here in America, the children are kind of vocal, you know. They ask, there is no problem with them expressing themselves. But back home it is kind of different. Children don't. Children are not kind of vocal and they don't really [express themselves] because of the respect, you know, for the parent and for older person. ... But here, children can say anything they want to say. Yeah. And that is something, too, that parent need to kind of learn how to get used to when they come over here.

Refugee parent:
I think one of the social workers asked my son, want to know how I discipline, which type of discipline technique I used at home. And my son, he just came here, he doesn't know what he's saying, and then he mentioned to the student who was doing his internship that when I, when I discipline, I have to put it in the hot water, which is not really true. That I, you know, put him in the hot water to discipline him. And this person that is working with my son... right away call DCFS [child protection services] against [me]. And DCFS came with, went to do the investigation and they found out that the story was not really true, you know, that it was not really true. So that really didn't, that really didn't make me happy.

This parent made the recommendation that social work interns receive more training if they are to work with refugees. The bicultural staff and partners who served as cultural brokers—defined in this study as persons who are bicultural and serve as explainers of one culture to another—had great empathy for the refugee parents in regard to parenting in a new culture.

Interpreter for Iraqi refugees:

One of the biggest issues they face is, "I'm used to a certain way of, you know, raising my kid. And they're my own culture, you know, the sort of things that I do with my kid." And they felt that all of a sudden when they came to the US that they lost that control. That their sons and daughters are not listening to them… We come in and say you have to be careful, you know. … And some are not able to deal with that, like, "How am I not… you mean I can't even yell? You mean, I can't even tell them like, 'hey, you cannot… cannot go off… you can't be on your bike all day long. You have to have better grades.'"

Social worker for refugee students:

Many of them are just dismayed that we're not controlling what the kids wear. They're coming from homogeneous populations where religion was government and government was religion, and so they managed whether the girls were wearing the veil or not, how long was their hair, were they touching boys or not touching boys, you know all of that. And so I would say that a big adjustment piece for them is that they come just really feeling at a disadvantage with kids getting all these powers and rights in the United States, and as parents we feel at a loss.

Emotional Challenges

The challenges presented above—economic, academic, adjustment to a new culture, children's behavior, and parenting—cause emotional distress for some refugee and immigrant children and their families. We identified two additional sources of emotional distress among refugee and immigrant children: *poor family functioning* and the experience of *traumatic or tragic events*. We place these two domains under the heading "emotional challenges" because they are traditional areas of focus among psychologists and mental health providers in the West.

A major source of emotional distress among the refugee and immigrant children was problems with family functioning: family violence, substance abuse, divorce and separation, power dynamics within the marital relationship, and emotional abuse. The family's refugee or immigrant status was not seen as a cause of poor family functioning, but problems in the marital relationship or with substance use were seen as being aggravated or magnified by all of the other challenges that are caused by the refugee or immigrant experience, such as navigating a new culture and dealing with profound poverty.

Social worker for refugee students [Referring to a problem in the family]:

It's just the dynamics, and really realizing that when people are at a level of depletion that it's not a measurement of moral character how they respond. They need to get to a level of where they feel not all worn out and are ready to respond like they normally would, and to find those strengths and how to use them here.

Program director:

There's a family who, there's domestic violence going on in the home. … And when the mother got a restraining order on the father, which coming from my culture made a lot of sense, she was ostracized from the community because, you know, that was just not acceptable and there were other channels she was supposed to go through with elders.

A second category of emotional challenges is the experience of traumatic and/or tragic events. Some of these events occurred before arrival in the US and were related to political conflict; others occurred during the trip to the US, particularly for undocumented immigrants; and other tragic and traumatic events occurred in the US after arrival.

Health care provider for immigrant and refugee children:

Because we do the GAPS [adolescent screening tool], we can identify so many kinds of problems. And a lot of that is problems with flashbacks or trauma or even if it's not, you know, all the classic symptoms, there is a lot that has to do with previous abuse or not feeling safe and whatnot.

Mental health provider for immigrants:

During the crossing, yeah. They were held up at gun point in the desert and they didn't get robbed specifically, but they took stuff from other people. So they were lucky. And the student just talked to me about how he and his mom had walked for like eight days just nonstop. And he was just really tired and he was really scared.

The majority of events mentioned occurred post-settlement.

Mental health provider, immigrants:

An older brother, sixteen years old, was shot in our community.

Mental health provider:

A lot of teachers will, when they make referrals, they

may say this is a student who's lost a parent or has a parent who's terminally ill or something like that.

Immigrant parent:
Five blacks came in here [referring to her home].They came with guns and they tied us up. They beat up my husband. They tied up my daughters and me and they held us here for about an hour. And now, you know, we are living here, but now we are afraid. We sleep in the living room because we are afraid. That's the way we are living now. During the day it seems to be ok, but at night we are afraid.

Evaluation Question 2

What are the necessary components of comprehensive mental health services for refugee and immigrant children?

All stakeholders were asked what, in their opinion, were the necessary components of comprehensive mental health services for refugee and immigrant children. Based on the answers to this question, as well as answers to other questions during the interview, we identified four components necessary to support the emotional well-being of refugee and immigrant children and their families:

1. Engage families
2. Assist with basic needs
3. Assist with integration into a new culture
4. Provide emotional and behavioral supports.

The inclusion of five unique programs in the evaluation enabled us to compare and contrast different program components. A program component was defined as necessary if 1) in the sites that implemented the component, it was identified by the majority of stakeholders as essential to their success; and 2) in the sites that did *not* implement the component, it was identified by multiple stakeholders as a significant barrier to success. *All CAC mental health providers concurred both on the necessity of the four components and on their need to be seamlessly integrated.*

Component 1. **Engage Families**

Family engagement was defined by CAC staff and partners as establishing relationships with families and identifying their unique needs and strengths. The rationale for engaging

with families was articulated by a program director: "Part one is some effective community and family engagement approach. We have a couple levels of what we're doing, but you have to deal with engagement first or the services you're providing are gonna reach this teeny, teeny, tiny subset of people."

Placing services in the schools was deemed by all stakeholders as extremely helpful to engaging families. Several stakeholders reported that schools helped normalize getting help and that when families become comfortable with a trusted person at the school, they tend to turn to that person for help.

ELL teacher of immigrant students:
The parents come to the school for help; they come to ESL teachers particularly for help. So it's wonderful to be able to say, "I have someone who could work with you on that." The parents really trust the school and trust the teachers.

Principal of school serving refugee students [referring to CAC in-school mentors]:
I think their contact with families and the families learning that there is somebody at the school that I can really trust, who isn't responsible for grading my child, who isn't sending home homework, who isn't asking of me things I'm not able or not comfortable doing. So I think building those relationships with the families has been really important.

Program director:
Maybe I should put that into, kind of, "what are the essential components?" Work with a family before a problem emerges and then you're a logical person to come to when a problem does come up. But having as your starting point, your child is having trouble, is not, you know, is not gonna be as effective I think in engaging families.

One strategy to engage families is to be highly visible to parents and initiate interactions with them at the school. When the CAC program did not provide a formal structure for engaging families, the CAC staff invented their own strategies.

Program director:
So [name] who was the LCSW at the time when we launched the program and, really the first two years of the program, she was just visible. I mean, when she first got started, she'd be out as the buses were dropping kids off and parents were dropping kids off

and coming to the front of the schools, she'd be out there just talking with teachers and chatting with parents and not necessarily, but just real visible at times. So I think folks began to see her as a consistent presence, and teachers did too. And it's something that we strive for with … all of our practitioners, is that, we talk about it in terms of being part of the fabric of the school and part of the fabric of the environment that children and families exist in.

Mental health provider for immigrant students:
She's a teacher's aide for special education. I'll see… sometimes she just sits out in the front of the school and kind of greets parents as they're coming in. And she really goes above and beyond her role. And so she became my best friend, because I wanted also to outreach parents in case I missed any of the kids myself…that these parents at least knew who I was, why I was here. And so I started attending those meetings, making contact with parents, and I've been actually able to get some referrals that way as well.

A second strategy for engaging parents is home visits.

Program director:
I think one of the challenges of school-based work is how do you engage the families? The kids are there, you've got them, a captive audience, that's a start, but we felt like we couldn't do this work without families really being involved, so our home-based team sometimes goes three times a week to visit the family, depending on, again, the level of need…

ELL teacher of refugee students [referring to CAC]:
They do home visits. They can kind of communicate with me if they see something at home that we can talk about, "Oh, is there something we should be concerned about, or is there something the family might need, or is this why they are acting up."

Mental health provider for immigrant students:
I try to meet with the parents as much as I can in the homes. Lots of parents want to do that. Sometimes it's actually better so I can see what's going on in the homes too.

One CAC family liaison described how she engages families in every sphere.

Family liaison for refugee students:
It's unconventional how I do it [laughs]. It's for me

it's always the community and I'm not outside of the community, I'm inside the community. So, I don't work nine to five. I work seven days a week. How? The mosque need organizing event, I'm part of organizers. If there's a wedding happening, I'm part of organizing that wedding. If there's a small party, we have that. Also, we have a monthly tea party that I hold in my office. The women just gather because they don't know where to go. They don't have a place to go, so I am in that place. So, if there is a store, new store opening, I'll be there. So for me to be there where the community [is] at, not sitting in my office and waiting for the clients to come to me. I go [to] the community where the community is. And it's worked well for me. It's worked well.

We counted the program as successful at engaging parents if, when asked how the school had helped them, the majority of parents interviewed at the site named specific ways in which they had interacted with the CAC program and found it helpful. Given that we specifically asked to interview parents who had participated in the CAC program and the parents were chosen by the program leadership, this measure of successful engagement is not overly rigorous.

A single organizational feature distinguished the programs that successfully engaged parents from those that did not. *The CAC programs that successfully engaged parents structured their program such that mental health providers worked hand in hand with family liaisons whom the families trusted and whose specific task it was to help families with navigating a new culture, interpretation, and getting academic supports and employment.* The presence in the school or in the agency receiving the CAC grant of persons who provided these two sets of services—mental health and support with daily stressors—was not enough. The two sets of services had to be fully integrated.

Teacher of immigrant students:
We have a parent center. And they are also advocates because they help. They give the knowledge to the parents to know what their rights are, what their needs are, and where those needs can be met. Um, they, you know, they fight for them in a way. So that's how they advocate. But they advise, too. They are advisory. And we're lucky we have a parent center, you know, with the person that runs the parent center that is there all day. I mean from eight to three, you know, the school hours, giving information and dealing with parents.

Immigrant parent:
I found out about the program through the Parent Center.

Project director:
We have our treatment model, trauma systems therapy, and then we have this adaptation of sort of what we've added in terms of engaging families… At the broadest level, we do parent outreach and psycho-education, and we have, um, I think you're gonna talk with [family liaison's name] from the Refugee and Immigrant Assistance Center. So she takes the lead on parent outreach and does an incredible job. And the goal there is really to be known in the community before there's a problem with the kids and to really also get a conversation going in the community so that what we're calling mental health needs are seen as part of their child's success in school.

Mental health providers who did not work closely with a colleague whose job it was to establish relationships with families and support them with economic and acculturative stressors commented on how difficult it was to engage families to address mental health needs.

Mental health provider, immigrant students:
I would say I was with one family that's really high needs that was referred from DSS [Department of Social Services]…. It took a year to break down that barrier finally, and we've been in school for over a year, and it took that long to break down that barrier. So that's hard. Maybe it would have broken down faster if it, I mean, I don't know, I don't know that for sure. But maybe it would have been easier taking care of physical needs as well as emotional needs.

We also found that active and respectful solicitation of parental input into program priorities or design did not, by itself, lead to successful family engagement. Four of the five CAC program had some mechanism to garner parent ideas, viewpoints, and input into program activities, such as giving their ideas for the topics of a parenting class. In three of the four sites that engaged families in this way, these activities occurred at key points in program planning and not on an on-going bases. None of the parents interviewed in these three sites talked about the real or potential value to them of helping to plan or design the program. Instead, they spoke about specific relationships with specific, trusted individuals at the school who helped them.

Immigrant parent:
My son arrives and tells me, "Teacher Aguilar told me that it wasn't good to do this." He told my son he shouldn't do that because it wasn't good. Little things like that, maybe they are simple things, but yes, they help the children.

Interviewer:
Mr. Aguilar is a teacher?

Immigrant parent:
The truth is I don't know if he is [a teacher or] the interpreter, because he is the translator I turn to regularly.

The fourth site adopted a strategy of fostering consistent, ongoing, supportive relationships with members of the parent advisory board. These types of relationships helped to recruit parents to serve in meaningful advisory roles because they created an environment of trust in which the parents felt comfortable expressing their opinions. In this site the parents reported their participation as deeply meaningful and as life-changing.

Component 2. **Assist with Basic Needs**

As described above, a common theme among study participants was the link between emotional distress and worry about meeting basic needs of food, housing, language acquisition, and transportation. All of the CAC mental health providers recognized the importance of addressing basic needs. Some saw it as integral to mental health services.

Program Director:
I think you need to recognize and deal with the fact that some very concrete stressors that sometimes are tripped over in the case management territory are part of the treatment. I mean, if you take care of some of those things, then the problems are gonna go away, and so we really need to integrate. Just, as a field, we need to own it, you know. Getting food on the table is related to the functioning of the child, and so we need to be working on those things, so concrete needs are real, and also part of that engagement process. If you don't do that, then why, if you're not someone the family can go to when they have a concrete need like, "My kid needs shoes," why are you someone they would go to for a really high-level, personal need, like, "My child is breaking down at night and I'm worried about them killing

themselves." It's just, it doesn't make sense that you wouldn't be a helper at the different levels. You've gotta do that.

Mental health provider for immigrant students:
I think, for myself —and not that I put myself on a high horse for being a therapist and I only do clinical work—but of kind of looking at it as, "Let's meet basic needs first." And so a lot of the time it's not even doing therapy, honestly. It's about addressing needs such as food. I had a child who said he'd been sleeping on the floor a year and finally got a mattress. I'm working on getting him another one because, apparently, there's been bugs, and he doesn't want to throw it out because then he'd have to go back to sleeping on the floor. So, um, basic needs being met first. And then working on any kind of therapy I do, if it gets to that point. Sometimes it doesn't [laughs]. And that's as far as it goes. … But that's kind of like I've had to rethink coming into this project, like "OK, what am I really here to do?" And so, I'm here to help and do whatever I can to help these families.

Whereas some mental health providers saw providing for basic needs as central to the mission of mental health services, others perceived this task as taking time away from mental health services. This latter group tended to feel overwhelmed and frustrated if there were not structural components in the model (e.g., a parent center, family outreach worker, or case manager) to handle these duties.

Mental health provider for immigrant students:
I wish there was a service…something that could work with the families more. You know, I get overwhelmed sometimes with the things that I see are going on at home. Just even needs that aren't being met.

Mental health provider for immigrant students:
Maybe having a separate building or something where they can have the community needs met. And I might be able to be the contact person for that, to organize that part if there's a family in need, like they need clothing, or their house just burned down, or whatever. Try to meet some immediate needs so that I can go ahead with mental health, because I really think that sometimes it's like, "I, I don't really care about this because my bigger stress is that I have to pay rent or I'm gonna be evicted."

Two of the sites partnered with agencies or programs in the school that helped families with basic needs such as food, clothing, housing, negotiating government systems, and transportation. Staff, teachers, and parents in these sites identified this type of a partnership as a strength of their model and as a primary way to engage families, as described above.

Mental health provider:
[I]f I do a home visit and I'm like, you know, "They only had one bed. What can you guys do to help them?" Then they can do a home visit themselves and kind of do a case management assessment. And then that will also help the family aside from the mental health component. Like what other case management needs they had. So … um, it's really like a collaboration in helping the families.

Teachers and school personnel identified academic support as another basic need of refugee and immigrant children. Many teachers pointed to successes the CAC program had achieved with behavioral problems in their classrooms and how the presence of the program allowed them to dedicate more time to teaching (discussed below).

In addition, the teachers and school personnel wished for academic supports. The two most commonly mentioned wish-list items were 1) trainings for teachers on how to work with different immigrant and refugee populations, and 2) academic tutoring for specific students. Some of the five CAC sites participating in this evaluation had provided trainings for teachers in the first two years of the grant period at the partner schools, but none were doing it in the final year. Two teachers remarked on the need for yearly trainings due to high turnover in school staff and to changes from one year to the next in the refugee groups arriving. Although none of the teachers and school staff we interviewed expected the CAC programs to provide tutoring, we include academic supports here because of the bidirectional link between academic success and emotional well-being, described above.

Staff of refugee welcome center:
So teachers scream that they need help, more help. Some teachers are blunt, tell me: "I don't know what to do with that child." So we do support them with a tutor... I know that grant runs out this year [not the CAC grant]. And I don't know what we will do next year, to tell you the truth, as support for tutors. So we'll have to look at other ways basically to support students.

Health care provider for refugee and immigrant students:

I think something that's also really useful is having education for teachers who work with these students because teachers get overwhelmed with all kinds of things, and I think it would certainly benefit all the students who are coming in who are recent immigrants, who are recent refugees, to have teachers who have a better understanding or, for it even to be on their mind to be thinking about cultural competency and to be thinking about the experiences of others.

School district staff:

So it's really important for the school leadership, the school administration to make sure that those teachers, those general ed teachers have some strategies on how to work with ELL students. Doesn't matter if they're refugee or immigrant. Whatever.

Component 3. **Assist with Adjustment to a New Culture**

The third essential component of comprehensive mental health services is assisting immigrants and refugees to adjust to a new culture. Many parents and staff spoke about the desire among immigrants and refugees to "know how things work" and to acquire the necessary skills to be successful in mainstream American culture. In addition to helping refugees and immigrants access needed services, as described above, the two most common strategies for helping refugees and immigrants with acculturative stress were *groups for students and parents* and *informal one-on-one support*. Staff at sites that did not have groups to assist with acculturative stress expressed the desire for such groups. The groups for children were described as follows.

Program director:

The next level up [after addressing basic needs] I would say is working in the schools, so we have groups for kids. Again, these are not stigmatized groups, they are not mental health groups, they're groups for all the [refugee] kids in the English language learner classrooms. We run them once a week, and it's very supportive and fun and we target some of the stressors that we know are risk factors, like acculturative stress, things like that, really helping kids.

Mental health provider for immigrant students:

If I had been in this program earlier, I think what

I would like to have done was to have a group for newly immigrated, just to, you know, what are some of your concerns for acculturation, not using those words, but, you know, what are some things you run into or things that you miss, a group on adjustment to a whole new system. So if I get to do this next year, that's what I would like to do, is have that right away, have that group right away.

Recommendations for content of the parenting classes from parents, CAC staff and school staff included disciplining children in America, expectations for parental involvement in US schools, financial planning, and computer skills. Recommendations from immigrant parents also included coping with stress and family relationships.

Relatively few parents were reached with parenting classes, due to low attendance at some classes, particularly in the first year of funding, and because relatively few classes could be offered due to limited resources.

According to several stakeholders, assistance with integration into a new culture was facilitated by having service providers who were bicultural and who were immigrants or refugees themselves. Some of the stakeholders identified people in this role as "cultural brokers." The quotes below from staff in the role of cultural brokers describe how having a shared culture can help recently arrived immigrants and refugees adjust to life in the US.

ELL teacher who speaks Arabic and Kurdish:

Well, actually number one, when, when you speak their languages because they feel more confident, you know, they feel more open because, "OK. Somebody's talking my language." So they open.

Mental health provider for immigrant students.

[A]side from me speaking Spanish, I'm an immigrant myself. So I do, um, you know, self disclose when necessary, like any clinician would. And I just feel that when I have disclosed that part when necessary, it just helps to establish the rapport quicker and kids can relate to me. I had a little girl say, "wow, really?" Like I gave her more hope, I think, saying like, "you … you know, you grew up here. When you were two you came like my family came." And she … seemed very hopeful, like you know, "I have a future and … I can go to school."

Family liaison for refugee students:

I was talking about going with some families to

the schools last week and having them meet the teachers. The school said that some of them have never been because they didn't know. I think that of the basic level just having, you know, we all know we have come through war, we all know we brought a lot of things here and found a lot of things here, pain and suffering and trauma, but I think just having the faith and language and culture that understands what that is and going to a space that normally is a scary and big and unknown and having that support. At the basic level we are something that brings them that that comfort, that knowing that when they come here, we are with them that there is a support that family wants.

Mental health provider for refugee students:
If there is a problem with that child and I give a developmental explanation to a teacher, *that* she will connect with and will understand OK. But with a parent, then, … I find I'm not necessarily using my theory or my education. Now I'm using my knowledge of what my culture is, which might, um, be similar to their values and beliefs and customs. And so that is what I then fall back on, and not necessarily, you know, what I've done in school.

Mental health provider for immigrant students:
I think it's also so important to have people look like the people you are serving. I don't know if that's fair or not to say that, because there are plenty of therapists who are very professional, who know their stuff, and they can do the work. But, I think when you have these clients, they're looking—I mean, they look at your physical appearance. They're looking at, "OK, this person has the same color skin I do," or "This person understands where I'm coming from," because they assume that, "OK, well, you know what I mean." And I think it will be great in an ideal world if you have more providers that are also bicultural.

Staff members who served in the role of cultural brokers spoke both to the limits of being bicultural as well as to the ways in which staff who are not bicultural can assist with integration into US culture. The same mental health provider who spoke of the importance of looking like the people she serves said the following:

Mental health provider for immigrant students:
So just because I'm a Spanish-speaking therapist doesn't mean that, you know, I understand every single dynamic of where these kids are coming from…

well, kids from Ecuador are going to refer to things in different ways than the kids from Mexico. So I can't say that I completely understand, and I've had to ask the student, "You know, I'm sorry, I don't understand what you mean by that. Can you explain it to me?" And just, you know, to be culturally competent you'd have to admit that you're not always going to understand where they're coming from. And you have to understand where they're coming from. And in order to understand that, you have to let the client educate you.

Interpreter for Iraqi refugees:
What I like about [name of agency] is the staff, whether its ESL teachers or, you know, immigration or mental health or resettlement… a lot of them either traveled overseas or lived overseas or they were already interested in new refugees or in social services or in conflicts overseas, so it does help a lot when that person understands that there are cultural differences. Uh… what you assume for your family or friends or your sister, whatever, may not apply to this person, and taking that into consideration when you offer something to them or try to share some of your experiences with them…. So I think, sometimes just understanding the culture and making sure that before you initiate with services or ask them for anything, that you understand why would they say "yes" or why they would say "no." Making sure you, um, you educate yourself.

One mental health provider described the value of cultural brokers and people not of the refugee or immigrant's culture working together.

Mental health provider for refugee students [this provider is Caucasian]:
Could I say one thing? I also think, like, it's important to have, at least in our project, I think it's been very important to have Somali and non-Somali together. We've been able to speak to the kids and the parents. But we also have a Somali and non-Somali viewpoint. And we are able to reach kids at different levels, you know. Like I've been able to have very enriching conversations with kids who struggling with acculturation, talking about, you know, what it means for them and their families and stuff in a way that maybe [names of cultural brokers] couldn't, you know. In the same way, they can talk to them in a different way that they can't talk to me.

Component 4. **Provide Emotional and Behavioral Supports**

Emotional and behavioral supports are the fourth essential component for comprehensive mental health services. We use the term "emotional and behavioral supports" rather than therapy or counseling for two reasons. First, not all stakeholders distinguished counseling or therapy from social and emotional support. Second, the terms therapy or counseling can imply a joint understanding between client and therapist that mental health services are being delivered.

A perceived strength of the CAC programs was that mental health programs are delivered in culturally appropriate ways to decrease stigma and improve their effectiveness. Here is one example of how two stakeholders described the same set of services.

> *Refugee parent:*
> **The program had asked me and [staff person's name] comes to my home every week. My son used to fight a lot.**

> *Program director:*
> **The treatment model is about what we call a trauma system, and by that I mean there's two parts to what we need to think about. One is a traumatized child who's unable to regulate their emotional state, and the second is a social environment where a system of care either can't help a child maintain that emotion regulation or is actually triggering the child and leading to them becoming dysregulated. So, most broadly, our approach is to try and work on both sides at once.**

Several types of emotional and behavioral supports were described. This evaluation did not assess their absolute or relative effectiveness and hence we cannot comment on the individual merit of any particular therapeutic strategy. The breadth of strategies is a testament to the dearth of research on effective mental health services for refugee children, the support of the RWJ Foundation for designing and testing innovative strategies, and the creativity of the Caring Across Communities staff.

The range of behavioral and emotional supports includes trauma-informed individual and group therapy, support groups, individual behavior plans, coaching in conflict resolution skills, coaching in relationship skills, mentoring, and non-traditional individual and group therapies such as narrative methods, play therapy, and cinema therapy.

In this evaluation, we describe the programs primarily from the perspectives of stakeholders who are not mental health providers, as this is the perspective least represented in research and evaluation to date. Reports from these stakeholders describe how the services are experienced by school personnel, community partners, parents, and children.

Several teachers reported that having mental health services in the school for refugee and immigrant children made their job easier. The mental health providers, in turn, reported that referrals from teachers were a primary pathway for children and their families to access services.

> *Teacher of immigrant children:*
> **As a teacher I see how these behaviors, how these events, how these tragedies affect the children in the actual classroom. Once the children were serviced and got the counseling and the guidance, I've seen them come around. We've set up a behavior plan for them, we've given the parents and them counseling and like even parent, parental-like guidance - like how to parent your child to the point that now these children are able to focus on learning, which is the purpose of coming to school and being successful.**

> *ELL teacher of refugee children:*
> **If there's any needs that I feel that the students, like emotional needs they can work on with her [referring to mental health provider], or problems that I see that I can't really get to, I often refer them to her, because she works with many of my students. So, for example, last year we had a lot of issues with just the girls getting along, and relationships, and fighting and hitting, and she was able to work with some of the issues that they had.**

> *Teacher of immigrant students:*
> **Because the children are able to get that service here, they don't have to go anywhere else, and it helps that the parent, teacher, and student are in one place, because we can all communicate and get that child better services and quicker services. And it's all structured in a way that all three parties—or even four parties because the counselors involved are communicating consistently or constantly in providing the same reinforcement techniques for the student and help them. So I think that's the biggest piece of the program for us, having the counselors onsite.**

Principal of school serving refugee students:

I really believe that this has made a difference for our children. I don't get many referrals now for behavior problems that are from our English language learner students.

Not all sites established coordination between teachers working with the refugee and immigrant children and CAC mental health services. The conversation below exemplifies one such school; it is drawn from a joint interview conducted with staff of the school's tutoring program for refugees.

Tutor:

They do have mental health interns come and work with them on Fridays.

Supervisor:

Is that here? The ones that are-

Tutor:

It's at the school…. But I don't know who, who these children, the students are. And in a way I would like to know so we know who's getting serviced, but as long as they are getting service…

Supervisor:

Yeah, that's one of the things that we don't get is—we don't get the information, like who's getting mental health services on a regular basis or working on a small group kind of activity on a weekly basis, so that's something that we probably should request that. Just so that for our own sake to see what kind of services that those students are getting in addition to instructional.

Tutor:

Especially if they need special services, then that could help as a backup if it's documented with us.

Although refugee and immigrant parents were sometimes unaware of the specific services their child received, several reported that emotional and behavioral supports implemented by CAC had helped their child.

Refugee parent:

He said that there is the program that can help the children in the school. After that I signed the paper and she worked with my son. It's worked now very good. Because at the time our kid there had played like uh touching, bullying. They caught him bullying. But there in our place no mark for us, but here is a problem. And now my son is ok now. He knows how to join the American kids, to get together with them

but now no problem. Now call from the school all the time and doing good.

Refugee parent:

I went to the community. They then sent a letter in the mail. They helped calm the child down and I did the same; now she does her homework and her learning is good.

Immigrant parent:

She was very shy and even if other children affected on her she would not say anything and thanks to the guidance she came out of her bubble.

At one site approximately half of the parents we interviewed did not volunteer information about CAC services when asked how the school had helped them, despite the fact that their children had received CAC services (a criteria for being interviewed). These parents instead mentioned support with basic needs, a service not provided by the CAC program at this site.

Interviewer:

Now, I'd like to ask you about any people who helped your two sons here at school. Can you tell me who was helpful and what they did that was helpful?

Immigrant parent:

Well, for example, a tutor, they help him in math and reading. This time it wasn't approved, he's on the waiting list. And then when they are sick, sometimes I take them to the clinic that they have here.

Interviewer:

Can you name any people who have been particularly helpful, a person here at the school?

Immigrant parent:

A person that has helped me?

Interviewer:

With your children.

Immigrant parent:

Well, in particular, no. But for me a big help, for example, is that here they also provide them breakfast. … I give them milk but in the house there isn't enough money to buy milk. When there is enough of course one buys it for them. But when there isn't? And so I think it's a help they are giving me.

At the end of this interview, the parent was asked, "Who called you to meet with me today?" and "How do you know [name of the person who called]?" The parent responded

that the mental health provider had called her and that she knew her because she attended weekly parenting classes. The parent, when asked, then went on to report that the class had helped her with disciplining her son and helped her feel less lonely.

This interview is an example of how in some cases addressing basic needs—in this case providing tutoring, health care, and breakfast to her children—relieves an acute emotional stressor that cannot be addressed by traditional mental health services.

Integration of Program Components: Making the Sum More than the Parts

Several quotes above have alluded to the importance of having the four essential components—family engagement, basic needs, support with functioning in a new culture, and emotional and behavioral support—integrated in such a way that families have a single access point for all services. This exemplar quote describes why integration of the components is essential.

> *Focus group participant (role unknown) serving refugee students:*
> **If someone wants to do a mental health service program for kids, they have to understand you are not starting with that. You're starting with this incredible infrastructure that you build and the mental health services can fit inside of that. But if we had just set out to do mental health services for these kids, nobody would have ever come and we wouldn't have had anybody get anything out of it. But we have nine of the most extraordinary outreach workers reaching to the community and getting people talking about this idea. And I think this idea that we're sort of not quite the mental health professionals that they are scared of, we're sort of in-between, this is really, really important. … You have to be in the school, I think, with the kids before there's a problem, checking with the families before there's a problem. Um, and being this other resource, so that when there is a problem, the student will you know … it's a tiny step for them to take. But so much of the funding is targeted toward this little tiny room in the specific mental health services, which in isolation does nothing without that infrastructure.**

How can partnerships between schools and community agencies work most effectively?

The Caring Across Communities initiative funded partnerships between community non-profit agencies and school districts. The intent of the initiative was for the partners to leverage resources to build a comprehensive model of mental health services and to have that model be integrated into the school setting. A key evaluation question, therefore, was to learn how to set up partnerships to maximize the probability of achieving these goals.

In this section we describe the facilitators and barriers to partnership. We present the facilitators to effective partnerships discussed by stakeholders in at least four of the five sites.

Focus Resources

A decision the programs had to make at the outset was how many schools to serve. In this evaluation, three of the sites (Los Angeles, Fargo, and Boston) concentrated all of their resources on a single school, although two of the sites continued to follow the students as they matriculated into another school. The other two sites (Chicago and Durham) provided school-based services in two or three schools.

The sites that served more schools had difficulty implementing all four components deemed necessary for comprehensive mental health services. Neither the program leadership nor the program staff had enough time to form partnerships with school personnel at each school or to engage families by being present, visible and helpful. Some of the CAC staff who worked in multiple schools reported feeling overwhelmed, ineffective, and inefficient.

> *Mental health provider, immigrant students:*
> **You know, if I could focus on one school, then I could put all my energy into that school and say, ok, we'll work on this, this, and this. Which still wouldn't take care of all the problems, but I could put a lot more energy into one specific school.**

Share Resources

A common measure of partnership quality is the extent to which partners share resources, including but not limited

to money. Many of the stakeholders interviewed for this evaluation were keenly aware of equity in the distribution of resources. Stakeholders who perceived that the CAC program made their job easier or truly helped families were more likely to contribute time and energy to the program's success. The following quote is from a mental health provider employed by a partner agency. The CAC grant provided salary coverage that allowed her to expand her work in an area she thought important.

Mental health provider employed by partner agency:
There was a need for immigrant adolescents to receive services specifically Spanish-speaking newly arrived. And so there was a great partnership that was formed with [CAC agency]. [My agency] and [CAC agency] partnered up for this project. Since we had the space here and we are working with [the school], it's like a partnership and we're all kind of working together. And, so what my role specifically is, I provide treatment for newly arrived Spanish-speaking immigrant students.

Family liaison for refugee students:
But we [are] doing it [helping families], thanks to the partnership between [CAC organization] and my organization. So, if this grant doesn't cover what we doing for the parents, my organization, my other hours, it's covering. So if we were doing this program again, I wouldn't change what, how we doing it in my program, but I would suggest that other grantees do the same. To partner with community-based organizations, the population they serve, and in that case, the whole load is not on the CAC grant but the other grants cover the need of the family.

In contrast, stakeholders who perceived others as disproportionately benefitting from the funding were less willing to offer their own resources or social capital (i.e., access to their networks and relationships in the community). One stakeholder, for example, resented the CAC program's decision to hire a US-born person full time when the African refugee serving that same function was hired on a part-time basis (it is important to note that this stakeholder did not necessarily have knowledge of whether the African refugee was offered a full-time position).

Community partner:
I know they … they were thinking to hire some of the community members where they can help or bring the individuals they know in the community and kind of assist. I know one individual was able to work, but

I didn't see anyone else and we were hoping that we can get other people involved with education from back home in the social work and also in the education field, but they were never hired.

The focusing of resources allowed for higher-quality services and stronger partnerships, but it did have a downside. The narrow focus did not naturally create a base of support in the school district, in part because a priority of the school system is equitable distribution of resources.

School district staff person:
…my biggest complaint of her [mental health provider], of that program was I want it everywhere and they say, [school name] was one of our extreme needs schools but I saw it, especially if you're in my position, you know, at especially at our middle schools and a couple of our elementary where the kids, please help those guys too, you know, I can name 300 kids that could use the help.

Because of these equity issues, this district staff person did not feel should could advocate for the school district to contribute to sustaining the program after the CAC grant ended. Thus there is a tension between achieving quality through focusing resources and achieving sustainability by building a larger constituency for the services.

Develop a Shared Vision

The focus group interview held at one site in lieu of interviews with CAC staff produced a rich discussion about what it means to develop a shared vision between partners. Participants mentioned commitment and *belief in the program model*, *a commitment to constant cultural adaptation*, *respect for each other's point of view, and commitment to the team itself.*

Focus group participant 1:
I went to a conference where people asked the question, "What makes your program work?" and I said it's the shared vision. That there is a common goal, a shared vision. And not in the sense of some kind of an abstract or philosophical way, but in a concrete action way. Where the vision, actually, we want to make the kids better. We want to make sure those kids have what they need to function well…

Focus group participant 2:
I don't know if it is a vision that has evolved over

time, but my understanding of it now is that it is about connection. It's about connecting kids and their families, connecting kids and families and their schools, it's about connecting within the Somali cultures and without the Somali cultures, so that they have models and connections and a comfort level in both worlds. I think the partnership is really why this works. It's, people are invested not because they have an ego at stake, but because they really want this to work for the kids. They want these kids to be OK here …

Focus group participant 1:
Yes you have a vision, but when you bring in another culture, that vision had to sort of be able to meld with that other culture's needs and desires and ways of doing things.

Focus group participant 3:
There is a dual thing, a commitment *and* the ability to stop and sort of make sure that everyone is on the same page. [The program director] would say, "Let's stop. Where are we going? Are we clear what the problem is to solve it?" So that ability to actually bring everyone along to that… So that no one person's vision overtakes. That vision becomes a shared vision.

Focus group participant 4:
… like when you get married the question is no longer is this going to work; it's how do we make this work when a problem comes up. And I feel like that within our partnership that's the attitude everyone has taken. So, it's not easy. We do come from very different backgrounds and missions. I mean there are individually agencies. But when we hit a bump in the road I never feel like it is a question is someone going to walk out and say: "This is it. I'm not in anymore." It is more a question of "OK this is where the work is," this is the real question because both of our viewpoints are valid and if we are hitting or coming at loggerheads, this is the work to figure it out and sticking together.

Support Teachers

Teachers were identified as essential partners. For many of the immigrant and refugee groups, they are seen as a trusted resource simply by virtue of their role. In addition, they have daily contact with the students and can help or

hinder children's adjustment to a new culture and hence their academic progress. As described above, stakeholders, including teachers, identified two ways to support teachers: providing training about immigrant and refugee students, and day-to-day support as issues or questions arise.

ELL teachers lauded as especially helpful the day-to-day support with discipline, behavior management, and caring for the students. The first quote below is from a teacher at a school in which the CAC program provides day-to-day support for teachers. The second quote is from a school in which the CAC program provides little interactions with students outside of individual or group therapy.

ELL Teacher of refugee students:
[The staff person] is there on recess, recess duty, playing with them, teaching them sports, and teaching them how to get along on the playground. And he's there in the morning. I just think it's great for our kids, and whenever they see him in the hallways, they're excited to have someone else that they know.

ELL Teacher of immigrant students:
I would like to see it [additional money] spent on more time given to counselors here on our campus so that they are able to stay after hours later on into the evening so parents can come in. And, um, having somebody being able to help with, like I said, the discipline that happens at the school … the discipline problems that happen at the school. And just the recess and lunches and being able to help us coordinate and just be like a second set of eyes, you know.

Coordinate—Lots and Lots of Logistics

Stakeholders who believed they had effective partnerships at their sites commented on the necessity for frequent interactions between partners. This posed a challenge for all sites since partners were often working on multiple projects and were not co-located.

Program Director:
I think the biggest challenges are logistic in nature, but that doesn't mean that they're not significant, because we're all coming from different locations, and nobody is on this grant more than like a teeny, tiny fraction of their time, and most of the senior partners really are not funded at all. It's a partnership built out of shared ideals, which makes it really

strong, but it also means getting everyone together for a meeting is asking favors. …. A lot of it's just good will.

Despite the challenges, stakeholders did report successful coordination of services, particularly in the sites operating in a single school. All six program directors commented that logistical support took substantially more time than they had expected or were compensated for.

A factor identified as promoting coordination was flexible and supportive school leadership. A mental health provider working in multiple schools contrasts the differences between not having and having a principal's support.

Mental health provider for immigrant students:
But then I have the other issue of there's only one school where I have room. The other two schools, I'm always getting kicked out of the room I'm being in, and then they give me a space, and then I open the door and somebody else is meeting in there, you know. … And, and I don't know how much; I'm not a teacher, so how much room do I have to say to the principal, "I need room"?

[School name] as far as partnerships, they have been really good about just saying, you know, "What do you need? What is that we can help you?" They're the ones that have provided space for us to meet. … And they have been very, like, instrumental, like the principal and sometimes even the vice-principal will show up at parent meetings so that parents can see that they're connected, that they care. Have offered to, if we have a message, they'll put it on the automatic calling from the school. Making referrals and even just following up as far as, you know, checking, "How is that going? Is there anything that I need to do?" And so on. I think that [school name] has been especially good at that.

Perceived Program Effects

This evaluation was not designed to assess the impact of the CAC programs on immigrant and refugee well-being. Hence we did not ask the study participants their perceptions of program impacts. Nonetheless, the participants spoke about observed program effects in sufficient quantity as to be able to summarize them here. These perceptions may not be representative of the stakeholders since we did not specifically ask participants for their views on the program's successes or failures.

Increased Access

Several stakeholders described how the Caring Across Communites grant had made mental health services more accessible to immigrant and refugee students.

Mental health provider for immigrant students:
We were trying to increase access. So by being here at the school, just increasing the access for mental health services. Um, we were also trying to reach that population that would otherwise not be able to receive therapy. We had kids who were uninsured who came through our program. And I think if it weren't for the [name of program] they would not have received services.

Refugee parent:
The community is important, and the community agencies together are more important, they help us navigate or they interpret for us.

Increased Efficacy

In the sites that worked the most intensely with parents, stakeholders reported an increased sense of efficacy on the part of both parents and children and an increased ability of both parents and children to advocate for themselves.

Mental health provider for immigrant students:
I think that mom that I said participated in the program … she's just like an advocate now. I'm really proud of her. I saw her from this really quiet woman, just kind of in the back, to now, you know, telling teachers what her kids need.

Immigrant parent [referring to her child]:
She also defends herself and says to other people what other children do to her. If she has a conflict in her classroom and I tell her that I'm coming to help her with the conflict, she says, "No, I will take care of myself."

Improved Child Affect and Behavior

Several of the quotes above illustrated stakeholders' perceptions of improvements in individual children's emotional states, behaviors, and ability to learn. This was the most commonly cited benefit of the Caring Across Communities   program, particularly by the mental health providers and the parents.

Immigrant parent:

Ever since she receives the services she even surprised me that she even washes her face by herself and she is not as stiff as she used to be.

Refugee parent:

The children grew up us refugees and they were even jumping on the table at first, so she helped us with the kids by talking to them about how to respect teachers and the school.

ELL teacher of refugee students:

…now we don't have as many behavior issues.

Refugee parent:

My daughter started going against me and [family liaison] gave me support and I calmed her down and thanks to God, she is in the right path now.

Discussion and Summary

Discussion

The goal of this evaluation was to answer the following questions.

1. What are the challenges experienced by the children and families the CAC programs serve?

2. What are the necessary components of comprehensive mental health services for refugee and immigrant children?

3. How can partnerships between schools and multiple community agencies work most effectively to deliver the necessary components of comprehensive mental health services?

Evaluation Question 1

Challenges

The immigrants and refugees in the five cities—Boston, Chicago, Durham, Fargo, and Los Angeles—faced a multiplicity of challenges, and in many cases the challenges exacerbated each other to compound their difficulties. Some of the refugee families arrived in the United States after experiencing terrible losses and traumatic events. Once the refugees and immigrants arrived, the challenges of resettling in a foreign culture were universally stressful, oftentimes more stressful than earlier trauma. These challenges are compounded by poverty and social isolation. In this study, poverty was more severe among the immigrant families, most of whom had no work and no access to benefits.

Figure 3 presents the challenges visually as a pyramid. Daily challenges caused by poverty, language barriers, and not being in sync academically with U.S.-born students are experienced almost universally. The majority of refugee and immigrant children and families also experience stress from learning to navigate their new culture. A smaller proportion of parents experience challenges related to their children's behavior and how to effectively parent in a new country. At the top of the pyramid are traumatic experiences such as involvement in political violence, witnessing violence, losing a parent, or being the victim of a crime. Although much of the research literature on trauma-informed therapy among immigrant and refugee children focuses on pre-migration trauma or trauma during migration (for a review see Miller and Rasmussen, 2009), stakeholders in this evaluation identified post-migration traumatic experiences as well.

Participants in this study reported that all types of challenges caused emotional distress. They also reported that the presence of one type of challenge made it more difficult to cope with other challenges.

Evaluation Question 2

Necessary Components of Comprehensive Mental Health Services

A program component was defined as necessary if 1) in the sites that implemented the component, it was identified by multiple stakeholders as essential to their success; and 2) in the sites that did not implement the component, it was identified by multiple stakeholders as a significant barrier to success. All CAC mental health providers concurred both on the necessity of the following four components and on their need to be seamlessly integrated.

All CAC mental health providers also described a hierarchy of need for services. According to the majority of stakeholders, basic needs and assistance with acculturation must be addressed before trauma-informed therapy is appropriate or useful. The pyramid in Figure 4 reflects this prioritization of services.
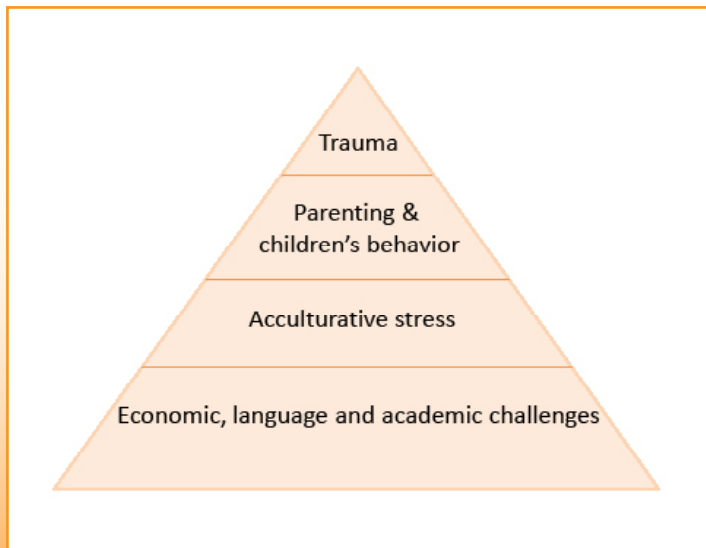
Figure 3. Challenges facing immigrants and refugees

- **Family engagement.** The base of the pyramid, upon which all services rest and from which all services build, is family engagement. Family engagement was defined by CAC staff and partners as establishing relationships with families and identifying their unique needs and strengths. For this evaluation, our operational definition of whether family engagement occurred was whether, unprompted, parents in the program reported interactions with the CAC staff that were beneficial or helpful. An effective means of gaining recognition and building trust with families is to identify and provide basic needs. Home visits also help to build relationship. Even the simplest things were often named as a means for achieving engagement: being a consistent, helpful, and culturally comfortable presence in the school or community by, for example, greeting children and parents as they dropped their children off at school every day.

- **Basic needs.** This evaluation affirms that comprehensive mental health interventions should start with the provision of basic needs, including academic supports for children, language classes for children and adults, and material support such as a mattress for a child to sleep on or winter clothing for a family. Stakeholders provided two reasons for prioritizing basic needs. First, if a family is worrying about being evicted or a child is worried about failing school , they will not

be interested in or capable of addressing other emotional needs. Second, the lack of basic needs is a primary cause of emotional distress and behavior problems, and helping a family achieve security and academic success may fully address these issues. Addressing basic needs may be an efficient way to resolve mental and emotional distress for many refugee and immigrant families.

- **Support with adaptation to a new culture.** Nearly all refugees and some immigrants need support with adapting to a new culture. According to several stakeholders, assistance with integration into a new culture is facilitated by having cultural brokers who understand the refugees' and immigrants' culture and may even have been an immigrant or refugee themselves. Successful cultural brokers are bilingual and bicultural, know the local refugee or immigrant community, and have the flexibility to spend time with families, conduct home visits, and respond to emergencies. Program staff who are not of the culture can assist with cultural adaptation as well, particularly if they understand the culture and are open to learning from the families about their culture.

- **Emotional and behavioral supports.** At the top of the service pyramid sits emotional and behavioral supports. We use the term emotional and behavioral supports rather than therapy or counseling for two
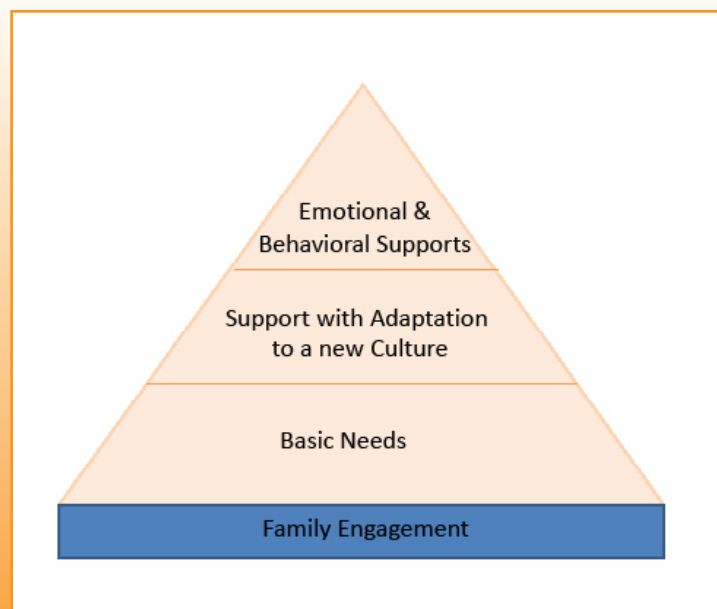

Figure 4. Necessary components of school-linked comprehensive mental health services for immigrant and refugee families

reasons. First, not all stakeholders distinguished counseling or therapy as distinct from social and emotional support. In some sites the mental health models were flexible and included any service that reduced environmental triggers of emotional dysregulation (e.g., paying the rent). Second, therapy and counseling are stigmatized in some cultures and hence their use can inhibit the delivery of effective services. Four of the five programs avoided using the terms "mental health," "counseling," or "therapy," when they first contacted families. The stakeholders reported that a significant minority of children's needs were not addressed with academic, economic and acculturative supports alone. Some children needed intensive emotional and behavioral supports. Acceptance of intensive mental health services was high (in one site, 100%) in settings where emotional and behavioral supports were completely integrated into the pyramid of services. In the sites where the mental health providers were expected to make a cold contact with a family to enlist them in therapy, the mental health providers reported difficulty in quickly gaining parental trust so they could help the child.

> *All CAC mental health providers described a hierarchy of need for services. According to the majority of stakeholders, basic needs and assistance with acculturation must be addressed before trauma-informed therapy is appropriate or useful.*

Integration of Program Components

A key finding of this evaluation is the importance of seamlessly integrating the four essential components—family engagement, basic needs, support with functioning in a new culture, and emotional and behavioral support—such that families can turn to a single person to access all services.

A single organizational feature distinguished the programs that successfully engaged parents and integrated all four components from those that did not. *The programs that successfully engaged parents structured their program such that mental health providers worked hand in hand with bicultural family liaisons whom the families trusted and whose specific task it was to help families with navigating a new culture, interpreting a new language, understanding a new academic paradigm, and accessing economic resources.*

Evaluation Question 3

Effective Partnerships

The Caring Across Communities grantees were required by the Robert Wood Johnson Foundation to form partnerships between local non-profit agencies and school districts. The complexity of the refugees' and immigrants' needs mandated partnerships as well, as no single organization could single-handedly provide comprehensive services.

The evaluation identified five actions that maximized effective collaboration between partners.

- **Focus resources**. The sites that served a single school had enough resources from the CAC grant to adequately invest in collaborations and deliver all four components of comprehensive school-linked mental health services. Staff and partners at these sites expressed satisfaction with their work and could point to clear accomplishments. At the sites that spread staff across multiple schools or sites, there was higher staff turnover and staff expressed feelings of inadequacy and being overwhelmed. Although the evaluation did not make a determination on which model had greater impact, it did find that parents served by the CAC programs targeting multiple schools had less contact with the program and, perhaps as a result, perceived many fewer benefits from the program. There is a potential downside to focusing resources, however; the narrow focus of effort may make it harder to build a constituency within the larger school district that is invested in sustaining the program.

- **Share resources.** Partners were more willing to collaborate when they perceived mutual benefit. Teachers who attributed reduced behavior problems in their classrooms to Caring Across Communities were more likely to make referrals and share information about the children's families. Staff from partner agencies committed more time to CAC activities, whether or not they were paid, when they saw the program helping them achieve their own professional goals. In contrast, a staff person at a partner agency who thought that refugees were inadequately represented among the program

staff did not advocate for the CAC program in the community.

- **Develop a shared vision**. The term "shared vision" encompasses several dimensions of successful collaboration, including a shared commitment and belief in the program model, a commitment to constant cultural adaptation and flexibility in the model, respect for each other's point of view, commitment to the team itself, and, most importantly, a commitment to the children and families.

- **Support teachers**. Teachers were identified as essential partners. For many of the immigrant and refugee groups, they are seen as a trusted resource simply by virtue of their role. In addition, they have daily contact with the students and can help or hinder children's adjustment to a new culture and hence their academic progress. Stakeholders, including teachers, identified two ways to support teachers: providing training about immigrant and refugee students, and day-to-day support with discipline, behavior management, and caring for the students.

- **Devote resources to coordination**. Integration of all four components to create a comprehensive service model required more coordination than any of the grantees had anticipated or planned for. Although the logistics were challenging for every site, the three factors listed above—focusing resources, sharing resources, and developing a shared vision—made it possible. The program directors in the sites with the greatest coordination among partners also reported working many more hours than they were compensated for by the grant.nts.

> *The programs that successfully engaged parents structured their program such that mental health providers worked hand in hand with bicultural family liaisons whom the families trusted and whose specific task it was to help families with navigating a new culture, interpreting a new language, understanding a new academic paradigm, and accessing economic resources.*

Perceived Program Effects

This evaluation was not designed to assess the impact of the CAC programs on immigrant and refugee well-being. Hence we did not ask the study participants about their perceived impacts of the program. Nonetheless, the participants spoke about observed program effects in sufficient quantity as to be able to posit program effects.

Increased access. Several stakeholders described how the CAC grant had made mental health services more accessible to immigrant and refugee youth.

- **Improved child affect and behavior**. This was the most commonly cited benefit of Caring Across Communities. Parents, teachers, and mental health providers reported that children were better able to focus and learn and were less disruptive in class.

- **Increased efficacy.** In the sites that worked the most intensely with parents, stakeholders reported an increased ability of parents and children to advocate for themselves. Staff also reported increased efficacy in working with refugee and immigrant students.

Summary

This evaluation confirms and extends three recent sets of recommendations for designing comprehensive mental health services for refugee students (Davies and Webb, 2000; Miller and Rasmussen, 2010; National Child Traumatic Stress Network Refugee Trauma Task Force, 2005). By examining five distinct programs that benefited from the creative freedom offered by the RWJ Foundation, we have been able to distill a set of necessary components for comprehensive mental health services and identify promising strategies for implementing each component.

We end with a representative quote taken from responses to the last question in the interview with parents.

> *Interviewer:*
> **Is there anything else you would like to tell us about the program or anything that you think we should know?**
>
> *Immigrant parent:*
> **My only suggestion is please do not remove the program ... to continue, because we are going to end up with nothing and we really need it. We need it a lot. Another thing, not only here, but everywhere, that the program is really needed, because it brings the families up. Strengthens them. And I think the results are great.**

References

The Center for Health and Health Care in Schools (2009) Caring Across Communities: Addressing the Mental Health Needs of Children and Refugees. Grantee Descriptions. Retrieved April 28, 2010 from http://www.healthinschools.org/Immigrant-and-Refugee-Children/Caring-Across-Communities/Duke-Bienestar.aspx.

Boeije, H. (2002) A purposeful approach to the constant comparison method in the analysis of qualitative interviews. Quality & Quantity, 36:391-409.

Miller, K.E. and 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, 70:7-16.

Muhr, T. (2010) Atlas-Ti: The Knowledge Workbench. Version 6.1.1 [Computer software]. Berlin, Germany: GmbH

National Child Traumatic Stress Network, Refugee Trauma Task Force (2003) Mental Health Interventions for Refugee Children in Resettlement: White paper II. Boston, Massachusetts: National Child Traumatic Stress Network.

National Child Traumatic Stress Network, Refugee Trauma Task Force (2003) Review of child and adolescent refugee mental health: White paper. Boston, Massachusetts: National Child Traumatic Stress Network.

Public Schools of North Carolina (2010) North Carolina School Report Cards. Retrieved May 14, 2010 from http://www.ncreportcards.org/src/.

Robert Wood Johnson Foundation (2006) Current calls for proprosals. Retreived March 19, 2010 from http://www.rwjf.org/applications/solicited/cfp.jsp?ID=19607.

Strauss, A. L. (1987) Qualitative Analysis for Social Scientists. Cambridge: Cambridge University Press.

Wasser, J.D. and Bressler L. (1996) Working in the Interpretive Zone: Conceptualizing Collaboration in Qualitative Research Teams. *Educational Researcher*, 25(5): 5 -15.

Appendices

Appendix A. Interview Guides for Evaluation of Caring Across Communities

Interview Questions for Staff and Partners

1. Please tell me your role in the CAC program.
   a. What are your responsibilities outside of the Caring Across Communities grant?
   b. Approximately how much time do you spend on CAC activities?

2. How would you describe the community(ies) that the CAC program serves?
   a. What kinds of experiences have you seen among the children and families?
   b. What needs or concerns have community members presented, either directly (sought for themselves/yourselves) or indirectly (were identified by others)?
   c. What needs or concerns have school staff presented, either directly (sought for themselves/yourselves) or indirectly (were identified by others)?
   d. Have there been cases of diversity within the community that called for varied approaches and services?
   e. What are the specific cultural considerations you have encountered during the service period?

3. How does your CAC program address community needs?
   a. How would you describe your program's operational model?
   b. Suppose a new refugee or immigrant family moves

to your community and enrolls their child in the school you serve. Can you describe for me how that child or family would come into contact with your program?

c. What is your program's guiding philosophy (or philosophies)? [What are your program's mission, vision, goals, objectives…?] (Interviewer probe: get specifics of universal prevention, targeted prevention, and interventions. Our goal is to create a flowchart of children through the program).

4. How do you define culturally relevant services?

   a. How does cultural relevance relate to:

      i. The specific community(ies) you serve?

      ii. The services you provide?

      iii. The ways in which you implement the services?

5. What are necessary components of comprehensive mental health services for the refugee and immigrant children you serve?

   a. What would be ideal program circumstances, components and methods?

   b. What barriers exist to implementing these ideal components?

   c. What facilitating resources or circumstances exist to support implementation of your program?

6. The RWJ Foundation has stressed partnership in the CAC initiative. How do you define partnership?

   a. Who are some of your partners?

   b. I'd like to ask you about a few of these partners [interviewer: pick a few partnerships]

      i. Please tell me how you work with this partner. (Interviewer prompts: agreed-upon ways to communicate or informal, communication; shared power and authority; sharing of resources.).

   c. How have relationships with this community partner complicated your work?

   d. Enhanced or benefited the work?

7. How are immigrant and refugee families involved in your program?

   a. What facilitates engagement?

   b. What are barriers to family engagement?

   c. Do you have any examples that demonstrate ways in which family engagement has strengthened

the program? (Interviewer prompts if needed: document which of following roles families occupy: clients themselves; relied on to make kids available as clients (e.g., consent, transportation, etc.); program leadership/partnership; cultural brokers – translate community to program, program to community, or both)

8. Now I would like to ask you a hypothetical question. If a local foundation were to give this RWJ project an additional $20,000, how would the decision be made about how to spend it?

   a. If the decision were entirely up to you, how would you spend the additional $20,000?

Interview Questions for Parents

1. What are some of the challenges children and families in your community face?

2. Tell us about your experiences when you started your child(ren) in school?

   a. What was it like for you and your children to adjust to a new culture?

   b. Did you find the school welcoming?

3. What would you tell a friend who has just arrived to this community to do if their child was having difficulty to their new school?

4. If the school [or agency] asked you for your advice, what would you tell them about the best way to help children from _____ be successful at [name of school]?

5. Have there been any times when someone at the school [or agency] asked you to advise them on how they could best help children from families like yours? If so, please tell me about it.

6. Now I'd like to ask you about any people who have helped your children at school. What did they do that was helpful?

Appendix B. Coding Hierarchy and Definition of Codes

Domain	Sub-Domains	Codes	Description
Challenges	Academic	Academic-general	All references to academic challenges that do not fit in the specific academic codes
		Academic-prior education	All references to level of prior education placing kid at different level than U.S. kids of same age (e.g., no prior education, need to teach at different levels, etc.)
		Academic-success tied to emotional stress	All references to parents or kids experiencing stress or distress because of academic performance.
		Academic-value of education	All references to parents or children not valuing education or expecting too much of education.
	Adjustment to a new culture	Stress of adjustment	References to stresses of adjusting to a new culture, geography, climate, school setting, legal system, etc.
		Stress of adjustment greater than trauma	Any reference to how the stresses of new language, not know how things work, poverty, social isolation, etc. are more stressful for refugees & immigrants than specific traumatic events pre-migration or during migration.
	Child behavior	Child behavior-general	References to behavioral challenges such trouble fitting in, not appropriate behaviors in U.S. schools, being too withdrawn or too rambunctious, or trouble concentrating.
		Child behavior-fighting/ bullying	Any reference to child initiating or being victim of fighting or bullying.
	Economic	Poverty	Any references to economic challenges that does not fit into a specific economic category.
		Basic needs not met	Any reference to individual family's lack of housing, lack of transportation, or lack of food & clothing.
		Language causes economic challenges	Any reference to link between not speaking English and poverty. Also code these references as C-language barrier.
		Poor neighborhoods & schools	Any reference to living in a poor/dangerous neighborhood or attending low-income schools.
		Legal status tied to economic challenges	Any reference to link between legal status and economic challenges.
		Poverty tied to emotional distress	Any reference to how lack of basic needs causes emotional strain, isolation, feeling trapped or distress.

Domain	Sub-Domains	Codes	Description
Challenges (continued)	Emotional	Emotional-general	Any reference to emotional distress or emotionally challenging situations that does not fit into specific code categories.
		Tragic/traumatic events	Any reference to a tragedy or trauma such as losing a child, being robbed, traumatic involvement with political conflict.
	Language barrier	Language barrier	Any references to child or parents having trouble because of English skills
	Parenting	Parenting-general	Code references to parenting that do not fit in more specific parenting codes.
		Different style of parenting/discipline	Any reference to how ways of parenting, including discipline and value of education, are different in the U.S. and how that causes challenges for the school, parents, or children
		Parent-school interactions	Any reference to challenges with parent involvement, parent-school communications, getting paperwork returned, parents understanding schools' expectations, etc.
Family/Self Efficacy		Family/Self efficacy	Any reference to individual or family's desire (or lack of desire) for efficacy to help their child, to participate in education, to learn to survive in the U.S., to ask for help, to advocate for self or child.
Partnerships		Partnerships	References to aspects of partnerships that facilitate the work or make the work more difficult.
Services	Academic supports	Academic support-general	All references to academic-related services that do not fit into specific code for types of services.
		Academic support-individual or small-group help	Any reference to tutoring, individual or small group help in-school or with homework
		Language training	Any reference to English language classes, tutoring, coaching, or support
	Basic needs	Basic needs	All references to basic needs such as blankets, beds, clothing, food, housing, healthcare, transportation or other necessities for life in the U.S.

Domain	Sub-Domains	Codes	Description
Services (continued)	Behavioral & emotional supports	Behavioral & emotional support-general	References to services designed to support children and families with behavioral and emotional that do not fit in specific coding categories.
		Conflict resolution/ relationships	Any reference to helping children with resolving conflict, making friendships, dealing with bullying, etc.
		Counseling/therapy	Any reference to individual counseling or therapy or behavior plan for parents, kids, or families
		Groups	Any reference to group therapy or social-emotional supports provided in a group for kids
		Nontraditional modalities	Any reference to modalities other than talk therapy, e.g. cinema, drawing, writing, play, narrative
	How services accessed	How accessed-general	Any reference to how CAC services are accessed by children and parents not identified by specific codes.
		Foster relationship with parents	Any reference to getting to know parents, recruiting parents, making parents feel comfortable or familiar with the program. This may include home visits.
		Referral from staff	Any reference to referral from teachers or staff in school, even if not employed by the school (e.g., nurse, Healthy Start staff)
	Language services	Language services-general	References to help with language barriers not covered by specific S-language codes.
		Bilingual staff	References to help with language barriers for families, including translation and language training.
		Language instruction	Any reference to language classes, tutoring, instructional methods, etc.
	Parenting	Parenting	Any reference to parental guidance, parenting classes, helping parents get involved in child's education, etc.

Domain	Sub-Domains	Codes	Description
Services (continued)	Role of staff	Role of staff-general	Any reference to role played by program or school staff that supports or undermines efforts not coded for specific roles.
		Cultural broker-personal characteristics	Any reference to personal characteristics of person in cultural broker role (e.g., knowledge of culture, ability to relate to experiences, understand school system, etc.)
		Cultural broker role	Any reference to what cultural broker does to help children & families, e.g., explain things, bridge cultures, provide emotional support, make referrals, case management, interpreter, etc.
		Role of school staff	Any reference to school staff or principal providing (or wishing they would provide) support, case management, referrals, information, etc.
	Support teachers	Support teachers-general	Any reference to efforts/strategies to support teachers not identified by a specific code.
		Educate about refugees/immigrants	Any reference to training, coaching, or guiding teachers re refugee & immigrant experiences, including trauma, cultural norms, and therapies used.
Program Effects	(No sub-domains)	Academic effects	Any reference to improved attendance, grades, graduation, learning
		Advocates for self/family	Any reference to parent or child learning to advocate for themselves
		Access to services	Any reference to easier access to services for children and families
		Child affect/coping/behaviors	Any reference to positive change in child's disposition, capacity to cope, temper, and behaviors
		Program effects-general	Any reference to program effects not captured by other codes.