Social Work With Migrants and Refugees: Challenges, Best Practices, and Future Directions

Editorial

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This special issue of ***Advances in Social Work*** focuses on current challenges and best practices with migrants and refugees, in an increasingly difficult global context. Over the past decade, forced migration and displacement reached record numbers, while complex geopolitical, economic, and environmental factors contributed to escalating current challenges. International human rights and migration laws provide a framework too narrow and too limited for these recent developments. Political pressure and a growing identity crisis add to the xenophobia and climate of fear, in which security has in some cases become the primary rationale underpinning rapidly changing migration policies. Social work as a profession – in education and practice – has an important (if largely unfulfilled) role to play in advancing the human rights of migrants and refugees. In this commentary, we outline the macro contexts that shape social work practice with migrants and refugees, highlighting the great potential for social work to do much more to advance the rights and interests of those fleeing conflict, economic or natural disasters, or other upheavals.

Setting the Stage: Global Context of a Governance Crisis on Migration and Refugees

Over the past 10 years, the public discourse on migration in general and forced migration in particular was shaped by the ongoing armed conflict in Syria, the postwar volatile situation in Afghanistan and Iraq; famine, increased poverty and armed conflicts in several regions in Africa (e.g., South Sudan, Eritrea, and Yemen); civil unrest, drug wars, and violence in Central and South America; and large magnitude natural disasters throughout the world. These events led to a sharp increase in forced migration, with 68.5 million people being counted as forced migrants at the end of 2017 (United Nations High Commissioner for Refugees [UNHCR], 2017). Of these, a total of 40 million were internally displaced people (IDPs) and afforded limited international protection and 28.5 million had crossed nation-state borders seeking refuge, either as refugees (25.4 million) or as asylum seekers (3.1 million). Political reconfigurations of nationality or citizenship also have contributed to an increased number of stateless people, who are either internally displaced or migrants. They navigate between the interstices of a nation-state system that fails to recognize their rights claims and makes them invisible and extremely vulnerable. One example is the most recent change in the Dominican constitution following the 2010 earthquake in Haiti, and the decision to apply changes retroactively, to 1929, rendering an estimated 250,000 people stateless, or, as Amnesty International report noted, "ghost citizens" (Amnesty International, 2015).

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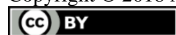
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Within this global migration context, many national governments revised migration policies– but instead of aiming to increase protection for the forced migrants, they added layers of restrictions. Moreover, exclusionary asylum policies have become increasingly shaped by discretionary national political decisions rather than norms of international humanitarian and human rights standards (Greider, 2017). The quotas for resettlements dropped significantly, leading to a 54% drop in resettlement requests by UNHCR in 2017 compared to 2016. Increasingly restrictive immigration policies continue to threaten resettlement programs as an option for refugees. With over half of all the displaced people globally being children, and an increasing number of children traveling alone, the effects of current population movements caused by forced migration carry long-term implications. In 2017 alone 173,800 children were either unaccompanied or separated from adults (UNHCR, 2018).

Two significant larger migration movements, from Syria and other countries in the Middle East and Africa to Europe; and from Central and South America into the United States and Canada have led to increasingly politicized and polarizing national responses in Europe and North America. In 2015, these large movements created what was framed in the political discourse as a "migration crisis" with over 1 million people aiming to find refuge within the European Union (EU). As this is a global crisis of governance, to which nation states either had no appropriate response or responded through ad hoc and often unjust policies, the United Nations became an important forum for attempting to establish a substantive global response. These efforts were symbolically initiated by the New York Summit (September 19, 2016) which aimed to establish forced migration as a global issue and discuss potential global strategies to address it. An immediate product of the summit, the New York Declaration (United Nations, 2016) created a framework for future deliberations. Two distinct strategies were to be developed as part of this framework: one focusing on safe and regular migration and the protection of migrants within specific legal definitions of "regularity" (Global Compact on Safe and Regular Migration), and the second one focusing on refugees and asylum seekers (Global Compact on Refugees) (Hansen, 2018).

Yet, despite the swift response at a global level, several major challenges remain: there is little to no cohesion or agreement between countries on a global response on migration; the New York Declaration has no legally binding power; and these frameworks do not explicitly align with human rights principles, aiming to limit access to protections rather than recognize and protect the rights of *all* migrants.

Anti-Immigrant Attitudes and a Rise in Nationalism and Xenophobia

The main reason for these challenges emanates from national and regional political reactions to large-scale forced migration (Polakow-Suransky, 2017). In 2015, the waves of refugees fleeing the Syrian War and other regional conflicts seeking refuge in Europe elicited a significant commitment to provide refuge in EU member countries. Germany made the boldest political move, by announcing that they would take in 1 million refugees and work to provide relief and safety for incoming migrants. Yet, shortly after Germany's statement, throughout the European Union a new rhetoric emerged, marked by xenophobia and strong anti-immigrant attitudes. This sentiment of "backlash" fed into rising nationalist

movements throughout Europe (Polakaw-Suransky, 2017).

Even the most liberal EU member countries increasingly defined migration policies within a securitization framework. This led to an externalization of borders to ensure control and limit access, not only in Europe, but also in Australia and the United States, pushing immigration control into international territories (Peterie, 2018). Among the European nations, most restrictive immigration policies were pursued by Hungary (infamously closing its borders in 2015 and criminalizing support for asylum seekers and migrants in 2018). These actions in turn triggered similar anti-immigrant responses in Poland and Serbia and were followed by more restrictive border control imposed (temporarily) by Germany and Austria (European Commission, Migration and Home Affairs, 2018), with Italy and other EU countries aiming to follow suit (Deutsche Welle, 2018).

Noteworthy, the closed borders and restrictive policies prevalent throughout Europe, Australia and the United States, has motivated other countries to provide an alternative response and work on sustainable solutions for migrants and refugees. Canada, under the lead of Prime Minister Justin Trudeau, introduced a new strategy on immigration in 2016, aiming to increase support through welcoming refugees and allocating funds for better integration in the Canadian society as well as through regional and local supports in the fight against ISIS and local governmental oppression (Trudeau, 2016). France, through the French Office for the Protection of Refugees and Stateless Persons (OFPRA), and working closely with UNHCR, adopted an innovative approach to preventing smuggling and perilous journeys of forced migrants to and throughout Europe, by vetting asylum seekers on African soil and expediting resettlement into France (Brice, 2018).

In this context, it is important to note that in Europe and the United States, civil society actors are deeply engaged in challenging anti-immigrant sentiments and working with international and local non-governmental organizations (NGOs) to protect migrants. Yet there is a need for better collaboration between the volunteers and the NGOs, and for an increased focus in preparing a qualified workforce to effectively work with asylum seekers. Social workers are not as deeply engaged as they should be in governmental levels of response or within local or international humanitarian non-governmental organizations. This special issue aims to address some of these gaps by increasing awareness among social work educators, scholars, and practitioners of the complex migration issues we face today and pointing to areas of research and practice requiring further attention.

Radical “Restrictionism” in the United States

The United States has long touted its record for resettling refugees and welcoming immigrants through a range of programs (U.S. Department of State, Refugee Admissions, n.d.). Yet that “history” has always been mixed – reflecting moments of heightened xenophobia or opposition to accepting immigrant or refugee groups (Haines, 2010; Zolberg, 2006). Immigration has always been a deeply political process; during the Cold War the United States prioritized accepting refugees who were from the Soviet Union or other Eastern Bloc states. Refugees from Southeast Asia and Iraq, for example, were accepted only in the face of strong political pressure to address the consequences of U.S-

led war (Harding & Libal, 2012).

Throughout U.S. history, immigration and refugee policies have swung between restriction and relative access, reflecting White House and/or Congressional priorities. As guest editors, we recognized as we issued the call for papers in 2017 that opposition to immigration and refugee resettlement had gained a strong ally in President Donald Trump and that support for immigrants and refugees had few visible champions in Congress. While restrictionism is a global phenomenon, its manifestation in the United States under the Trump administration represents one of the most radical shifts; unfortunately the administration's decision to severely limit refugee resettlement encourages other governments to implement exclusionary policies.

As of June 2018, the current administration has moved to effectively close borders, limiting access to immigration and refugee resettlement from several countries including North Korea, Venezuala, Syria, Iran, Libya, Somalia, and Yemen. This restriction systematically refuses to provide timely due process rights to refugees claiming asylum at U.S. borders; enforcing a "zero tolerance" policy that separated parents and guardians from children at the U.S.-Mexico border, and later detained families together; and increasingly criminalizing undocumented migrants and subjecting them to inhumane treatment during detention and deporting migrants without observing laws protecting due process rights (Blitzer, 2018; Pierce, Bolter, & Selee, 2018). The Attorney General, Jeffrey Sessions, has reinterpreted established standards for grounds for asylum in the United States, including gender-based violence and gang violence (Blitzer, 2018). Immigration and Customs Enforcement has ramped up targeting of businesses and communities where undocumented migrants live and work, detaining and deporting record numbers of migrants who have not committed crimes. A new interpretation of the "public charge doctrine" promises to punish immigrants without permanent residence for accessing benefits they have a legal right to use (Shear & Baumgaertner, 2018). And, notably, under the White House leadership, admissions have been cut in the refugee resettlement program to historic lows (International Crisis Group, 2018). These policies must be taken within a broader shift that celebrates "U.S. exceptionalism," including the decision by the Trump administration to withdraw from the Paris Accord, the negotiation of the Global Compacts, and, more recently, its membership in the Human Rights Council at the United Nations.

A core concern that we share with a number of authors in this special issue is how to foster advocacy at local, national, and international levels that advances the human rights of migrants and refugees. The enforcement of "zero tolerance" – whether through policies to separate families as they enter the United States or to incarcerate families for indefinite periods without due process – has become a focus of advocacy and action in social work education and practice. One example of such work is demonstrated by advocacy taken on by Finno-Velasquez and the Center on Immigration and Child Welfare at New Mexico State University. The Center, working with colleagues across the country, has taken a lead role coordinating social work advocacy in the wake of "zero tolerance." Zayas' (2015) engaged scholarship on the experiences of children in mixed status families offers both empirical understanding of the impacts of unjust immigration policies and a model of effective advocacy at state and national levels. Commenting on a case filed by the American Civil Liberties Union, he recently stated "The separation of children from their

parents is universally regarded as one of the most unconscionable and harmful acts that any society or government can commit" (Myers, 2018).

National Association of Social Workers (NASW), in the U.S., issued a strong statement in the wake of ramping up "zero tolerance" and the policy to separate children from their parents or guardians at the U.S.-Mexico border. NASW stated that "The decision to separate children from their parents as soon as the parent crosses the border into the United States is both harmful and inexcusable. More concretely, the policy imperils the health and safety of immigrants. It is wholly un-American to weaponize children as a deterrence against immigration" (NASW, 2018). And, while this statement is an important step in staking a position vis-a-vis this unjust policy, it is time for a renewal of solidarity work in alliance with targeted groups of refugees and migrants in the United States. One place to start – a modest place that is only a first step – is to foster deeper understanding of current social work practice with (im)migrants and refugees.

Overview of the Organization and Contents of the Special Issue

The articles in this special issue address a range of concerns central to social work. As a collective they speak to the importance of integrating exemplars and approaches to social work practice on migration as a matter of advancing social justice and human rights. A majority of articles address social work practice in the United States, though a number of contributions address social work practice in other global contexts, including Sweden, Canada, Thailand, and Greece.

The first set of articles examine rights-based approaches to addressing structural inequalities facing newcomer immigrant communities in the United States. ***Roth, Park and Grace*** tackle the challenges of carrying out policy advocacy in a state that is not "welcoming" to immigrants, examining the indirect tactics of service providers in doing advocacy in the face of increasingly restrictive anti-immigrant policies in South Carolina. ***Carillo and O'Grady*** highlight the importance of community-based work from a structural and rights-based social work lens, focusing on labor rights and access to mental health services in the Chicago area.

The second section of this issue takes up themes of social work practice with children and youth. ***Finno-Velasquez and Dettlaff*** tackle the increasingly punitive U.S. government practice of separating immigrant children from families. They outline the critical role that social workers should play in leading efforts to respond to immigrant families' rights and needs, focusing especially on developing social work expertise; cross systems and cross-disciplinary collaborations; leveraging resources and supports; documentation and collection of data; and targeted advocacy. ***Reynolds and Bacon*** examine the role of schools in supporting integration of refugee children in the United States. Regarding schools as a primary driver of integration, the authors provide insights from a systematic review of literature on school-based programs to support refugee integration. They highlight the importance of successful programs being responsive to the cultural and linguistic backgrounds of refugee subpopulations; informed by the experiences of resettlement, including all stages of the migration process; "embedded in community" and "coordinated across multiple systems." ***Pryce, Kelly, Lawinger, and Wildman*** examine the role of a

Canadian conversation club for refugee youth in three locales in Ontario. Their evaluation demonstrates the promising practice of conversation clubs in increasing participants' sense of hope and belonging. Finally, ***Evans, Diebold and Calvo*** launch a call to action for social workers, in regards to the rights of, and protections provided to unaccompanied minors (UAM) in the United States. In light of the increasing numbers of UAMs, the authors identify available services for children in this category. They also highlight the gaps in services, and provide a list of recommendations for social workers aimed to address the gaps and improve practice.

A third group of articles focuses on health, mental health, and well-being of refugees. Drawing on findings from a larger qualitative study with Cambodian genocide survivors in the United States, ***Berthold, Kong, Ostrander, and Fukuda*** find that isolated elderly Cambodian survivors benefit from efforts to promote social connectedness and support networks. ***Yalim and Kim*** provide a review of the state of scholarship on mental health and psychosocial needs of Syrian refugees, while ***Naseh, Potocky, Burke, and Stuart*** provide the first systematic assessment of poverty and capabilities of Afghan refugees in Iran. In the latter study, the authors point to the limits of measuring poverty by income or monetary levels, given the fact that many Afghan refugees who could not be categorized as "poor" in Iran were still unable to meet basic needs.

While community-based approaches to social work practice with refugees and immigrants is addressed throughout the special issue, the fourth set of articles spotlights a number of different community-based interventions to foster greater social inclusion and well- being among newcomers to the United States. ***Dubus and Davis*** focus on the importance of community health centers in providing services to refugees resettled in the United States. Presenting findings from interviews with 15 mental health workers in six New England states, the authors highlight three crucial elements of best practices with refugees in such centers: client engagement; collaboration with interpreters; cultural competence. ***Deckert, Warren and Britton*** maintain the focus on service providers, writing about the tension between the politics of migration at the state level, the increasing anti-immigrant sentiments, and community engagement in welcoming and supporting migrants. The authors focus on the perspectives of service providers on migrants' vulnerability to exploitation and trafficking, and highlight the need for an expanded definition of trafficking, increased cultural competency among service providers, and the importance of social networks in building communities that will support migrants. ***McCleary and colleagues*** introduce the readers to community-based approaches to dealing with refugee chemical dependency, proposing a framework for sustainable collaborations between refugees and health and social service providers to reduce chemical dependency. Pointing to the prevailing unidirectional practices with resettled refugees, the authors call for participatory practices that will lead to mutual learning and adaptation. The role of community involvement and peer support, and the importance of recognizing and building on refugees' capacity are further highlighted by ***Block, Aizenman, Saad, Harrison, Sloan, Vecchio, and Wilson***. Presenting the findings of a program evaluation of a peer-support program adopted by the Jewish Family and Community Services, the authors talk about the effectiveness of the support group with Iraqi and Buthanese (ethnic Nepali) communities, particularly in increasing the refugees' autonomy and their ability to access

services. This section of articles concludes with ***Frost, Markham and Springer's*** article on creating effective health education programs for refugee communities. Based on a program evaluation of a community-based program for Burmese refugee women in Houston, TX, the authors stress the need for participatory, bottom-up approaches to health education; the engagement of community health workers in health education trainings (with an emphasis on the cultural fit and relevance of such trainings for refugee women); and the importance of incorporating a social work ecological model to frame health-focused interventions for women refugees.

The fifth group of articles spotlights the role of social workers and others working to support refugees and immigrants. Articles in this group provide insight into international work with refugees from Greece, Sweden, and Thailand with the common thread of social work roles and responsibilities in the migration context. ***Guskovict and Potocky*** present a case study of humanitarian staff working with the Danish Refugee Council in Greece. The authors emphasize the importance of training and education on the impact of stress on humanitarian workers, the contribution that social work professionals can make in assessing the impact of secondary trauma, working with humanitarian agencies to develop training on the main stressors and effective self-care techniques, and providing mental health care services to aid workers, normalizing the need for such services, and facilitating access throughout their work. ***Gustaffson and Johansson*** write about social work's ambivalence towards refugees and migrants in Sweden, and the impact of current asylum policies on reception practices. Making the distinction between ability (as affected by shifting migration policies and resources) and willingness (influenced by individual perceptions and biases, as well as personal experiences), the authors propose a shift from providing "minimum standard" services towards a "worthy reception" of asylum seekers and refugees. The article discusses the complexity of the reception structure in Sweden, and identifies three essential barriers to such a shift: the lack of attention to the essential needs of refugees; the lack of gender-sensitive practices (and an overall gender-sensitive framework); and the perception of "worthiness" of refugees amongst service providers. Keeping with the concept of "worthiness" and the tension between security and human rights and social work values, ***Tecle, Byrne, Schmit, Vogel-Ferguson, Mohamed, Mohamed, and Hunter*** write about the absence of a legal framework for asylum seekers and refugees in Thailand, and the lack of protection for urban refugees in Bangkok – particularly women and youth from Pakistan and Somalia. Using both refugee and service providers' voices to reflect on the challenges in accessing and providing services to refugees, the article highlights the need for collaborative work between different stakeholders and the importance of social work-led innovation in improving services.

One critical domain of social work research remains a "new frontier." ***Powers, Schmitz, Nsonwu, and Matthew*** examine climate change as a factor that pushes migrants to leave their homes and communities. They argue for the creation of "transdisciplinary, community-based response systems which are holistic, multi-pronged, and inclusive of migrants' voices and strengths" and point to the importance of storytelling as a methodology to highlight the voices of migrants and advocate for change. The approach suggested by the authors is one that could be heeded for many domains of social work practice, building on *testimonio* and witnessing methodologies being adapted and

pioneered by other practitioner-scholars (Delgado Bernal, Burciaga, & Flores Carmona, 2016).

Overall interest within social work has gained momentum in recent years, as is demonstrated by the number of initial submissions for this special issue and the interest of social work educators in participating in emerging networks working on migration issues. Yet, the current issue reveals several gaps in research focus and interest. Notable is that we received few submissions that addressed the differential and uneven global and local policies governing asylum requests and limited access to services for asylum seekers. Another gap within social work literature concerns examining immigration detention practices and the role of social work in addressing widespread human rights violations occurring in the United States, Australia, and sites throughout Europe and North Africa.

More research is sorely needed on a number of topics within social work practice globally. This includes developing a clearer understanding of where and to what extent trained social workers are contributing to programs within the migration sector, whether in terms of policy advocacy, community organizing, or direct practice as service providers working with immigrants and refugees. Developing new approaches to grappling with ethical dilemmas when participating in the implementation of unjust policies; pioneering responsive methods for social workers to engage in dialogue with varied stakeholders to address xenophobia, nationalism, restrictive migration policies; and promoting innovative practices for the integration of asylum seekers and refugees are all vitally needed.

References

Amnesty International. (2015). *"Ghost citizens" in the Dominican Republic.* Retrieved from https://www.amnesty.org/en/latest/news/2015/11/ghost-citizens-in-the-dominican-republic/

Brice, P. (2018, March 28). This is saving refugee lives. *Washington Post.* Retrieved from https://www.washingtonpost.com/news/theworldpost/wp/2018/03/28/refugee-crisis/?utm_term=.9a72aa86d3b7

Blitzer, J. (2018, June 11). The Trump administration is completely unraveling the U.S. asylum system. *The New Yorker.* Retrieved from https://www.newyorker.com/news/news-desk/the-trump-administration-is-completely-unraveling-the-us-asylum-system

Delgada Bernal, D., Burciaga, R., & Flores Carmona, J. (2016). *Chicana/Latina testimonios as pedagogical, methodological, and activist approaches to social justice.* New York: Routledge.

Deutsche Welle. (2018, April 12). *Germany requests border control extension for Austrian frontier.* Retrieved from https://www.dw.com/en/germany-requests-border-control-extension-for-austrian-frontier/a-43367693

European Commission. (2018). Migration and Home Affairs. Retrieved from https://ec.europa.eu/home-affairs/index_en

Greider, A. (2017, August 1). Outsourcing migration management: The role of the

Western Balkans in the European refugee crisis. Migration Policy Institute. Retrieved from https://www.migrationpolicy.org/article/outsourcing-migration-management-western-balkans-europes-refugee-crisis

Haines, D. W. (2010). *Safe haven? A history of refugees in America.* Boulder, CO: Kumarian Press.

Hansen, R. (2018). A comprehensive refugee response framework: A commentary. *Journal of Refugee Studies*, *31*(2), 131-151. https://doi.org/10.1093/jrs/fey020

Harding, S., & Libal, K. (2012). Iraqi refugees and the humanitarian costs of the Iraq war: What role for social work? *International Journal of Social Welfare, 21*(1), 94-104. https://doi.org/10.1111/j.1468-2397.2011.00780.x

International Crisis Group. (2018, September 12). How to save the U.S. refugee admissions program. New York: ICG. Retrieved from https://d2071andvip0wj.cloudfront.net/002-how-to-save-the-us-refugee-program.pdf

Myers, B. (2018, March 16). Trump's immigration policy shifting children into foster care. Juvenile Justice Information Exchange. Retrieved from https://jjie.org/2018/03/16/trumps-immigration-policy-pushing-children-into-foster-care/

National Association of Social Workers [NASW]. (2018). NASW says plan to separate undocumented immigrant children from their parents is malicious and unconscionable. Retrieved from https://www.socialworkers.org/News/News-Releases/ID/1654/NASW-says-plan-to-separate-undocumented-immigrant-children-from-their-parents-is-malicious-and-unconscionable

Peterie, M. (2018). Deprivation, frustration, and trauma: Immigration detention centres as prisons. *Refugee Studies Quarterly, 37*(3), 279-306. https://doi.org/10.1093/rsq/hdy008

Pierce, S., Bolter, J., & Selee, A. (2018). *Trump's first year on immigration policy: Rhetoric vs. reality.* Washington, DC: Migration Policy Institute. Retrieved from https://www.migrationpolicy.org/research/trump-first-year-immigration-policy-rhetoric-vs-reality

Polakow-Suransky, S. (2017). *Go back where you came from: The backlash against immigration and the fate of Western democracy.* New York: Nation Books.

Shear, M. D., & Baumgaertner, E. (2018, September 22). Trump administration aims to sharply restrict new green cards for those on public aid. *New York Times.* Retrieved from https://www.nytimes.com/2018/09/22/us/politics/immigrants-green-card-public-aid.html

Trudeau, J. (2016, February 8). Prime minister sets new course to address crises in Iraq and Syria and impacts on the region. Retrieved from https://pm.gc.ca/eng/news/2016/02/08/prime-minister-sets-new-course-address-crises-iraq-and-syria-and-impacts-region

United Nations. (2016). New York declaration for refugees and migrants, A/RES/71/1. Retrieved from http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/71/1

United Nations High Commissioner for Refugees [UNHCR]. (2017). Global trends: Forced displacement in 2016. Retrieved from http://www.unhcr.org/globaltrends2016/

UNHCR. (2018). Figures at a glance. Retrieved from http://www.unhcr.org/en-us/figures-at-a-glance.html

U.S. Department of State. (n.d.). Refugee admissions. Retrieved from https://www.state.gov/j/prm/ra/

Zayas, L. H. (2015). *Forgotten citizens: Deportation, children, and the making of American exiles and orphans.* New York: Oxford University Press.

Zolberg, A. R. (2006). *A nation by design: Immigration policy in the fashioning of America*. Cambridge, MA: Harvard University Press.

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We would like to thank each of the authors for their patience and their commitment to raising awareness on migration and forced migration, for conducting research on these topics, and contributing to the existing social work literature, while aiming to improve practice with immigrants and refugees. We would also like to thank all authors who submitted manuscripts, and although not every manuscript could be included in this issue, we hope that such work will continue to be published to raise awareness of the challenges facing migrants and refugees globally. As social work researchers, educators, and practitioners we are called to continue to work on advocacy at local, national, and global levels, to promote safe migration, and introduce best practices that will protect the rights of all migrants.

Advocating for Structural Change? Exploring the Advocacy Activities of Immigrant-Serving Organizations in an Unwelcoming Policy Context

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Abstract: *The growth of the immigrant population in the United States has prompted a recent increase in the number of restrictive immigration policies at the state and local levels. The literature on policy advocacy and social service organizations suggests that these local providers can engage in political activities that challenge the restrictive nature of these contexts. This qualitative study explored how immigrant-serving social service organizations engage in policy advocacy in a state with restrictive, anti-immigrant policies. In-depth interviews with directors of 50 service providers in South Carolina clearly indicate a tension between the need for policy advocacy and the risks associated with engaging in such activities. Fifty percent (50%) of the providers in our sample reported engaging in some form of policy advocacy. However, their policy advocacy activities were often indirect, non-confrontational, and episodic. Most were engaged in coalitions and other forms of indirect advocacy tactics. We discuss implications for the social work profession and recommendations for future research, including the need to further explore the impact of policy advocacy efforts on changing the policy landscape in places that are unwelcoming to immigrants.*

Keywords: *Immigrants; immigration; policy advocacy; social service organizations; immigrant new destinations*

The size of the immigrant population in the United States has grown dramatically in recent decades. For the first time in over a century, U.S. immigrants now represent 13.5% of the total population, including an unprecedented 11 million who are unauthorized (Migration Policy Institute, 2018). These demographic changes have converged with shifts in immigrant settlement patterns such that immigrants are increasingly moving to "new destinations" such as small midwestern towns and the American Southeast, injecting new diversity into places that have not been home to immigrant newcomers in recent memory (Massey, 2008). However, the convergence of these factors has also prompted a flurry of restrictive immigration policies at the state and local levels (Varsanyi, Lewis, Provine, & Decker, 2012). In effect, while federal laws exclusively control the flow of legal immigrants into the United States, a patchwork of state and local policies regulating processes of immigrant *integration* have fundamentally altered the places where immigrants settle—i.e., the local receiving context. These laws include English-only ordinances, agreements between local law enforcement and federal immigration authorities that target unauthorized immigrants, and policies that restrict immigrant access to driver's licenses and higher education.

The assemblage of local anti-immigrant policies and practices form an influential

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aspect of the local receiving context, which shapes whether and to what extent immigrants adapt economically, socially, and culturally to their new home (Portes & Rumbaut, 2006). Just as more "welcoming" contexts can facilitate processes of immigrant integration, places with restrictive anti-immigrant policies can pose an impediment. Local immigrant-serving organizations can provide a buffer against unwelcoming policy environments, offering services and resources that help immigrants with the process of adjusting socially and economically (Cordero-Guzman, 2005). There is some evidence that local immigrant-serving organizations may also engage in policy advocacy to challenge state and local anti-immigrant laws (de Graauw, 2008), but these studies tend to focus on more traditional receiving contexts such as San Francisco (de Graauw, 2008, 2014) or Washington, D.C. (Frasure & Jones-Correa, 2010) where there is a relatively large concentration of such organizations (de Leon, Maronick, De Vita, & Boris, 2009). Limited research has focused on the policy advocacy activities of immigrant-serving organizations in new destination areas that have adopted restrictive anti-immigrant policies.

To address this gap, we explore how immigrant-serving organizations engage in policy advocacy activities in South Carolina, a state with some of the harshest anti-immigrant laws in the country. In keeping with the literature on this topic, we define the term "social service providers" to include local entities that deliver an actual service or program (such as mental health treatment) and "immigrant-serving organizations" to be the subset of social service providers that report delivering services to immigrants (Roth & Allard, 2016; Roth, Gonzales, & Lesniewski, 2015). By "local" we mean that the service delivery model is direct, not through the phone, internet, or mail. Clients must travel to these organizations to access services (or the provider must travel to the community to meet with the client) (see Allard, 2009). We use the terms "social service providers", "immigrant-serving organizations" and "providers" interchangeably throughout this article given that all of the organizations referenced in this study identify as local organizations that deliver services to immigrants.

We aim to address two primary questions: Why do some immigrant-serving organizations engage in policy advocacy activities to advance the rights of immigrants in a harsh immigration policy context, while others do not? And, among those who are active in policy advocacy, what types of actions and strategies do they take? Our framework draws on the literature of immigrant integration (Alba & Nee, 2003; Portes & Rumbaut, 2006) and social service providers as policy advocates (Mellinger, 2014b; Mosley, 2012). This article provides empirical insights into the field of immigrant-serving social service providers engaged in policy advocacy, as well as recommendations for how the field of social work can advance immigrant rights in a restrictive policy environment.

Background

International migration and theories of integration

International migration (or immigration) is the movement of people across nation-state borders (Massey et al., 1994). The literature on immigration spans all aspects of the migratory process, including why immigrants leave, their experience through transit countries, and what happens when they arrive in the destination country (Castles & Miller,

2009). The latter is often referred to as immigrant integration: the process by which immigrants adjust socially, economically, and politically to the places where they settle (Marrow, 2005). Contemporary sociological theories of immigrant integration emphasize that this process unfolds incrementally and at different rates, depending on a range of factors at various levels, whether individual, familial, or institutional (Alba & Nee, 2003; Portes & Zhou, 1993). Importantly, contemporary theories of immigrant integration emphasize that this adaptive process is also impacted by the structural characteristics of the receiving context—the places where immigrants settle. Factors such as racial discrimination, xenophobia, residential segregation, and the uneven quality of public schools all influence the opportunities for integration that are available to immigrants, and they will look different depending on the national context where they settle. Thus, according to Portes and Rumbaut (2006), the social mechanisms that perpetuate exclusion for certain members of a given host society mean that some immigrant groups are able to more easily integrate into different social strata depending on characteristics such as phenotype and human capital, as well as the federal laws governing which immigrants are allowed to enter the country. For instance, the pace of integration and opportunities for social mobility are more constrained for labor migrants and undocumented immigrants than for those who arrive on work visas to fill professional jobs in the tech sector (Portes & Rumbaut, 2006).

Immigrant new destinations

Theories of immigrant integration have traditionally conceptualized the receiving context at the national level, because federal governments are typically responsible for enacting legislation that governs migratory flows (Portes & Rumbaut, 2006). However, with the emergence of immigrant new destinations, a rapidly growing literature has begun to examine how local and state authorities are passing laws that influence immigrant settlement patterns and the process of integration. In contrast to traditional immigrant gateways such as New York and Los Angeles, immigrant new destinations are places that have only recently become home to immigrant newcomers (Massey, 2008; Singer, 2013). Immigrants have moved in growing numbers to suburbs, small towns, rural areas, and regions such as the Midwest and Southeast in search of employment and a lower cost of living (Massey, 2008). The dispersion of immigrant settlement in the 1990s and early 2000s rapidly changed the demographic balance across the United States (Massey, 2008), and their presence stirred a mixture of responses from established residents.

At one extreme were state and local governments that enacted laws and policies meant to deter immigrants from settling permanently (Mitnik & Halpern-Finnerty, 2010; Varsanyi, 2008), a strategy referred to as "attrition through enforcement" (Kobach, 2008). A combination of local government policies (de Graauw, 2014; Mitnik & Halpern-Finnerty, 2010; Ramakrishnan & Wong, 2010; Varsanyi, 2008), anti-immigrant activism (Varsanyi, 2011), and resistance by public bureaucrats (Lewis, Provine, Varsanyi, & Decker, 2013; Marrow, 2009) has come to obstruct immigrant integration in new destinations with a restrictivist response to immigrants. As a result, immigrants in new destinations with harsh anti-immigrant laws experience higher levels of neighborhood segregation than in traditional gateways (Hall, 2013; Lichter, Parisi, Taquino, & Grice,

2010), and face pronounced barriers to services such as healthcare, bilingual education, housing, and English-language classes (Cabell, 2007; Marrow, 2009).

Intermediary organizations as policy advocates

While poverty and legal status create common obstacles to the social and economic inclusion and well-being of immigrants, immigrant-serving organizations can play a significant role in aiding immigrants' lives as they provide immigrants with practical help, represent immigrants for political or cultural purposes, and advocate for them as needed (Cordero-Guzman, 2005). Such organizations provide services related to educational, medical, religious, and other practical needs, but they can also be agents of political incorporation, as they work to shape political agendas and facilitate immigrants' political participation (de Graauw, 2008). Therefore, understanding these local organizations and their impact is critical to how we conceptualize immigrant integration in unwelcoming policy environments, and by extension, how we understand the role of social service organizations in advocating for and protecting immigrant rights.

There is general agreement among scholars about the importance of policy advocacy by "nonprofit organizations" (a broad term that is often used in this literature which includes local social service providers as we defined them) (Berry, 2005; Reid, 2000). Yet, there appears to be less consensus on what policy advocacy actually *is.* Reid (2000) states "there is no agreement on which activities constitute advocacy," but "it broadly describes the influence of groups in shaping social and political outcomes in government and society" (p. 6). Boris and Mosher-Williams (1998) argue that the definition of advocacy is often too narrow, restricted to rights-oriented groups, and limited to legislative advocacy. For example, many organizations assume that policy advocacy is limited to lobbying. Lobbying is one type of policy advocacy, defined by the IRS as direct or indirect appeals to governing bodies in order to influence specific legislation (Mosley, 2013). However, the growing literature on this topic suggests that nonprofit organizations engage in a wider range of activities related to policy advocacy. Although nonprofits cannot engage in certain lobbying activities, such as endorsing specific candidates, they are allowed to advocate for causes, programs, and populations and to lobby elected officials to adopt certain positions on particular policies or issues. While nonprofit organizations are able to hold forums, sponsor debates, host candidates at their offices, register voters, and engage in other nonpartisan activities, these organizations tend to find such rules vague (Mosley, 2013). To avoid any unintentional violations, they tend to steer clear of political advocacy altogether (Berry, 2005). The potential implications of this inaction are significant given that, in our current devolved welfare state, "these are the only organizations that have an incentive to organize, mobilize, and advocate on behalf" of marginalized groups (Berry, 2005, p. 571).

For the purposes of our study, Mosley (2013) adopts a broader definition of policy advocacy among social service organizations as "advocacy that is directed at changing policies or regulations that affect practice or group well-being" (p. 231). This definition of policy advocacy is not necessarily confrontational. Berry and Arons (2003) contend that less aggressive tactics (through partnership with government, for example) are still an effective way to shape policies and programs. Based on Mosley's (2013) definition, then,

policy advocacy might be focused on getting additional funding to serve clients, or on the interests of clients themselves. Policy advocacy may also take place within organizational collaborations, coalitions or associations, particularly for smaller organizations with fewer resources to participate in policy advocacy (see Mellinger, 2014b).

Mosley (2013) identifies three trends in contemporary policy practice that are influencing the way social service providers engage in advocacy and help explain why a growing number are doing so. First, increased reliance on government funding means that these providers are more often interacting with political actors whose decisions impact the clients they serve (Mosley, 2010, 2011). Second, shrinking availability of government funding, especially state and local units, means that the local safety net must increasingly rely on social service providers for assistance and expertise (Allard, 2009; Mosley, 2013). Third, the growth of public agencies working together with private stakeholders is associated with growth in the number of advisory boards, task forces, and other such partnerships (Mosley, 2013). The goal of this type of collaborative governance is to improve transparency, efficiency, and government accountability, but a byproduct is that social service providers have more influence in the policy process.

Based on this broad definition of policy advocacy, many organizations engage in these types of activities. Mosley (2010) found that 57% of social service organizations report some type of advocacy involvement, and qualitative interviews revealed that the majority (93%) were involved in policy advocacy in some way (Mosley, 2013). Similarly, Mellinger (2014a) found that 65% engaged in advocacy. However, the service providers in these studies do not engage in policy advocacy very frequently (Mellinger, 2014a; Mosley, 2013)—a pattern corroborated across the literature (Almog-Bar & Schmid, 2014)—despite its importance for the well-being of the clients they serve.

While important scholarly work has advanced our understanding of policy advocacy and why social service providers engage in it (or not), these studies tend to focus narrowly on specific service domains (such as homelessness) in large cities (Mosley, 2010), or more broadly across organizations in a given region with little consideration for the specific policy context that may be the focus of their advocacy efforts (Mellinger, 2014a). We are unaware of research that has examined the policy advocacy activities of local immigrant-serving organizations in restrictive policy contexts, how they interpret the particular local and national challenges they face, or how they integrate advocacy into their array of organizational activities.

South Carolina context

South Carolina is a new immigrant destination that has adopted restrictive, anti-immigrant policies in response to rapid growth of its immigrant population. The number of immigrants in South Carolina doubled from 2000 – 2015. This was nearly three times the national rate during this period (39%), and five times the rate of the state's native-born population (20%) (See Table 1; Migration Policy Institute, 2018). Nearly one in five immigrants in South Carolina (18%) has arrived since 2010; 61% are non-citizens, and an estimated 42% are unauthorized. Immigrants in the state are more likely than their native-born neighbors to be poor, and 37% do not have health insurance. While the data for

unauthorized immigrants is not available, the disadvantages are even greater for immigrants who are non-citizens (Marrow, 2013; Yoshikawa & Kalil, 2013).

Table 1. *South Carolina Immigrant Demographics, 2015*

	SC		United States	
	#	%	#	%
Demographics				
Immigrant (foreign born)	232,749	5%	43,290,372	14%
Non-citizen	140,748	61%	22,593,269	52%
Unauthorized	98,000	42%	11,009,000	25%
Immigrant % change 2000 - 2015		101%		39%
Native born % change 2000 - 2015		20%		11%
Region of Birth				
Africa	8,771	4%	2,062,257	5%
Asia	58,362	25%	13,249,179	31%
Latin America	118,663	51%	22,111,409	51%
Period of Entry				
2000 – 2009	81,288	35%	12,069,227	28%
Since 2010	42,100	18%	6,746,822	16%
Poverty rate				
Foreign born		21%		17%
Foreign born - non-citizen		28%		23%
Native born		17%		14%

Source: Migration Policy Institute, 2018

In response to the rapid growth of the immigrant population and in the wake of federal inaction on comprehensive immigration reform, South Carolina enacted the Illegal Immigration Reform Act in 2008 and Senate Bill 20 in 2011. The first law restricts undocumented immigrants from public benefits and bars them from public higher education (Illegal Immigration Reform Act, 2008). The second law is fashioned after Arizona Senate Bill 1070, and includes a “papers please” provision which requires police to report individuals who do not have identification indicating they are in the country legally (National Immigration Law Center, 2014). The law also includes a provision for a statewide immigration enforcement unit—the only one of its kind in the U.S. (Largen, 2012). In 2014 a civil rights coalition successfully challenged Senate Bill 20, permanently blocking key provisions that criminalized interactions with unauthorized immigrants (National Immigration Law Center, 2014). However, other aspects of the law were not overturned, and both laws remain. In sum, South Carolina provides a useful empirical window into the policy advocacy activities of immigrant-serving social service providers because it has one of the fastest-growing immigrant populations in the country and some of the most hostile anti-immigrant policies of any state in the nation.

Data and Methods

Data for this analysis comes from the Immigrant Access Project (IAP), a mixed methods study of social service providers conducted by the authors in 2015. The

quantitative portion of the project was an on-line survey of immigrant-serving organizations across South Carolina. We then conducted in-depth interviews with executive directors and program coordinators from a purposive sub-sample of 50 immigrant-serving organizations. This paper is based on analyses from the qualitative portion of the study.

Sample

It can be difficult to identify immigrant-serving organizations (Gleeson & Bloemraad, 2012), in part because so few identify as such when reporting to the IRS (Hung, 2007). This is also the case in South Carolina because there is no comprehensive database of immigrant-serving organizations in the state. Therefore, we used a range of data sources to identify immigrant-serving organizations (Allard & Roth, 2010), which we defined functionally as direct service providers that serve immigrant clients (Cordero-Guzman, 2005; Martin, 2012). This definition includes both ethnic and immigrant organizations (Hung, 2007), as well as mainstream providers (Roth & Allard, 2016). Sources for building our sample included IRS 990 data that identified immigrant and ethnic organizations; regional and state resource guides that listed organizations that serve immigrants; and the referral database of a statewide immigrant-serving organization. This yielded a database of 599 service providers comprised primarily of nonprofits (both secular and faith-based), as well as a small number of public agencies (such as county food pantries) and for-profit entities. We then narrowed the sample to 319 entities by eliminating organizations that did not provide direct services in South Carolina, or for which no current contact information was available. We emailed executive directors of these 319 entities with an invitation to participate in the on-line survey. In all, 183 providers responded, for a response rate of 57%. Data for this study came from in-depth interviews with a purposive sample of 50 survey respondents which we selected based on organization type, size, and primary service focus (e.g., anti-poverty, education, legal services, etc.) to maximize variation (Table 2).

Table 2. *Sample Characteristics of Organizations in Qualitative Phase (n=50)*

	#	%
Type of organization		
Public	11	22%
Secular non-profit	31	62%
Faith based non-profit	6	12%
For-profit	2	4%
Type of service provider		
Health (health, mental health and substance abuse)	10	20%
Anti-poverty (housing, employment, cash assistance, food, general referral)	14	28%
Education (GED, afterschool, parenting classes, early childhood, ESL)	16	32%
Legal services	4	8%
Child and family welfare (youth programs, domestic violence, etc.)	6	12%
Organization size		
Small (fewer than 5 full-time employees)	20	40%
Medium (between 5 - 20 full-time employees)	19	38%
Large (more than 20 full-time employees)	11	22%

Data collection and analysis

We conducted in-depth interviews with executive directors, program administrators, and other leaders at these organizations. All interviews were conducted by phone. Interviews ranged in length from 30–60 minutes and were audio-recorded and transcribed. Interview questions addressed organizational history and mission; capacity (budget, revenues, and number of clients served); and details about general services. We also explored the nature and scope of their services for immigrants, and how these programs had evolved. Finally, and most relevant to this analysis, we asked questions about their view of South Carolina as a receiving context for new immigrants, their involvement with policy advocacy, and their involvement with coalitions that address immigrant rights concerns.

All transcripts were coded by the authors and analyzed using NVivo11, a qualitative data analysis software. Our codebook was informed by theories of immigrant integration (Portes & Rumbaut, 2006) and social service organizations as intermediaries (Mosley, 2013). Codes included "advocacy," "barriers," "mediating role," "strategies," and "organizational partnerships." Analysis focused on text where respondents discussed their view of South Carolina as an immigrant-receiving context and policy advocacy broadly defined (Mosley, 2013). This included respondents' answers to questions such as "How would you describe South Carolina and the welcome that it gives to immigrants?," as well as several questions about advocacy, including "Have you ever participated in organizational activities or conversations related to immigrant rights in South Carolina?" and "Do you think advocating for immigrant rights differs from advocacy for other issues or populations in South Carolina?" These broad questions were followed by a series of probes that asked respondents to describe the nature of these activities, their motivation for participating in them (or not), and their perceptions of the effectiveness these efforts.

Looking across code domains we constructed a series of matrices to identify themes and patterns that guided subsequent analyses (Miles & Huberman, 1994). Themes emerged using the constant comparative approach (Glaser, 1965) which involved comparing data from different respondents to identify common indicators. We structured our findings section based on the themes that emerged from this analysis. Themes include structural barriers to advocacy that are conditioned by the restrictive context of South Carolina, as well as the strategies organizations take in response to these barriers, including indirect advocacy through coalitions and networks.

All three authors were intimately involved with each stage of the data collection and analysis phases. The first two authors were primarily responsible for the coding process. This included weekly meetings to discuss the development of the theory-informed codebook and inconsistencies in how each author applied it to the data. Regular meetings during all phases of the project addressed code book development, the coding process, and interpretation, ultimately enhancing the confirmability of the research findings (Lietz & Zayas, 2010).

Findings

We have organized our findings based on the key themes that emerged from our data.

In this section, therefore, we begin by providing insights into the context of South Carolina from the perspective of the social service providers in our study. This provides an important backdrop for understanding whether they engage in advocacy activities. We then summarize the types of advocacy activities they identify, as well as the barriers they perceive to engaging in advocacy on behalf of immigrants. The final theme addresses their strategies for overcoming these barriers.

South Carolina: A context for immigrant advocacy

There was general agreement among the providers in our study that South Carolina is an unwelcoming receiving context for immigrants. Some respondents said the receiving context is nuanced rather than monolithic, describing South Carolina as a place that, while primarily unwelcoming, has—as one respondent stated—"pockets of welcome." These providers tended to describe parts of their respective city as more receptive to discussing immigration and immigrant rights. However, the majority of our respondents were more sweepingly negative in their assessment. For example, the Executive Director of an anti-poverty organization explained that the climate towards immigrants is "hostile" in South Carolina so you need to "tread lightly" before even broaching the topic. Because tension over the issue "involves everything from religion to politics," he explains, "sometimes you feel like your hands are tied or your mouth is taped closed." The Director of a small health clinic stated that the unwelcoming nature of the state context means that "people don't fight for immigrant rights as much as they do for other people's rights." Respondents repeatedly emphasized that the biases against immigrants are pervasive. The Executive Director of a child welfare agency stated the predominant perspective in South Carolina is that "all immigrants are from Mexico [and] they think all immigrants are illegal…so it's just the fact that we have so much to teach."

Advocating for immigrants

We asked respondents "Have you ever participated in organizational activities or conversations related to immigrant rights?" We probed for more information, asking about the nature of their involvement and why they got involved, or why they have not gotten involved. We also asked whether they are involved with any coalitions that engage in advocacy for immigrants, followed by a similar series of probes. Consistent with other studies of social service providers and policy advocacy activities (MacIndoe & Whalen, 2013; Mellinger, 2014b; Mosley, 2012), 50% of the providers in our sample reported engaging in some form of policy advocacy (Table 3). We organized these activities into "independent" and "coalition" based on whether organizations were engaged in policy advocacy on their own or in collaboration with other entities. Some organizations reported both types of activities, but certain types of organizations were more likely to report involvement in at least one type. Among faith-based providers, for example, 67% reported engaging in at least some type of policy advocacy, and anti-poverty and legal service providers were more likely than some other provider types to report involvement in policy advocacy. Some organizations stated that they were involved in immigrant rights coalitions, while others stated their organization independently engaged in advocacy efforts to address immigrant rights. Still other participants reported engaging in both

independent activities and coalition-based activities.

Table 3. *Types of Immigrant-Serving Organizations and Their Advocacy Activities*

	n	Engaged in Policy Advocacy Activities	
		#	%
Type of organization			
Public	11	3	27%
Secular non-profit	31	18	58%
Faith based non-profit	6	4	67%
For-profit	2	0	0%
Type of service provider			
Health	10	5	50%
Anti-poverty	14	8	57%
Education	16	6	38%
Legal services	4	4	100%
Child and family welfare	6	2	33%
Organization size			
Small	20	8	40%
Medium	19	12	63%
Large	11	5	45%
Total	**50**	**25**	**50%**

*Percentages represent the share of organizations of a given type that reported at least one type of advocacy activity (independent, coalition, or both).

However, while half of the immigrant-serving providers in our sample reported engaging in some form of policy advocacy, many qualified the nature or extent of their involvement. Therefore, in the sections that follow we explore first why more providers do not participate in policy advocacy. We then take up the case of those organizations in our sample that engage in advocacy to better understand the types of advocacy activities they engage in, and how they are able to avoid common barriers to advocacy.

Why some providers do not engage in policy advocacy

If there is general agreement among the organizations in our sample that immigrant rights in South Carolina are particularly vulnerable, why do half of the providers report that they do not engage in policy advocacy to address these structural concerns? The most common reason was a lack of resources. The Executive Director of a small child welfare organization said that she is aware of some current anti-immigrant legislation but has not stayed abreast of the larger question of policy advocacy and immigrant rights. She has "not had the time, [and has] chosen not to be stressed out by it," even though she views that these policies are problematic. Her view is that they "are written by people who have no idea" of the reality experienced by immigrants. Another respondent stated more bluntly that her organization does not have the resources: "I really think that an agency like ours should be involved in advocacy, but you need support for that and you need time to do that and you need to dedicate a staff person to that." She is the Executive Director of an

organization that addresses the basic needs of immigrants and other clients, but has only three full-time staff members.

Consistent with other studies (Mellinger, 2014a; Mosley, 2010), larger providers in our sample were more likely to engage in some form of policy advocacy (see Table 3), but the rationale for noninvolvement among these organizations was similar—even for involvement on local coalitions focused on immigrants and immigrant rights. According to the Director of a literacy center, he refuses to join a coalition if he cannot be actively involved. Contributing in this way would demand time that he currently does not have: "Right now I work about 60 hours a week and, you know, just stepping into another group is hard."

Several organizations stated that it would be politically risky for them to speak out about immigrant rights, inconsistent with their organizational mission, or potentially problematic for (some) members of their board. This was the case for the program manager for an organization that provides ESL services for immigrants. She pointed out that immigration is "controversial" at the state and federal levels and "that's why we're not involved." Another Executive Director stated that some organizations in her city plan advocacy events, but, from her perspective, "there is some fear about doing that and how that is going to end up representing the organization."

Engaging in policy advocacy can also be perceived as risky for the organization, especially if it is a departure from what has been done in the past or outside the scope of the organization's mission. In South Carolina's relatively small cities and towns, an organization's activities are noticed. Advocating for immigrant rights has implications for how the community in general—and potential clients, in particular—view one's organization and who it serves. The literacy center Director introduced above stated, "It's not a spoken rule here, but the previous director didn't want us branching into [advocacy] because we had such a public relations problem about being viewed as a, you know, an immigrant-only resource." Another respondent avoids policy advocacy because immigration is controversial, particularly because much of the debate concerns legal status. Taking a position on this issue can be problematic, she explains. By advocating for immigrant rights, she is concerned she might be "advocating for unlawful behavior" of unauthorized immigrants, with the implication that the community will view her and her organization as morally inconsistent. Another respondent balked when asked if she is aware of state or local policies that affect immigrants in South Carolina. She answered that she knows of these policies but "would rather not comment." She is concerned that answering that question would affect the reputation of her organization as "neutral" and "impartial."

Similarly, other reasons for noninvolvement in policy advocacy boil down to a calculation of risk rather than ignorance of need. For example, a school social worker stated "I'm working for a school district—I could get in trouble." Another respondent explained "as a state employee sometimes it's not—sometimes it can be very uncool to be politically active. And not necessarily dangerous for you as an individual, but dangerous for your institution." A few respondents said that policy advocacy activities were outside of their role or their organization's mission. A medium-sized health services organization had been involved with statewide coalitions in the past, but was too busy at the time of our interview

to be involved. The Executive Director sees the topic of immigration "as controversial right now with some of the dialogues going on at the state level and national level," but his organization does not engage "in the justice stuff" because "we don't really see that as our focus." He explains that the controversy itself is not the reason why his organization chose not to engage in policy advocacy. Rather, "we're trying to focus on our mission." Until the board decides that this is an issue which falls within their organization's purview, the organization will not pursue it. Another Director clarified that advocating for immigrant rights requires an understanding of "the legacy of the politics of oppression here [in South Carolina], and the stereotypes and how people are pretty comfortable with the stereotypes." Miscalculating these politics can be risky for an organization.

One program manager stated that she has not participated in organizational activities or conversations related to immigrant rights because her role is to "teach and manage the English as a second language program," not engage in advocacy. Like many respondents who are not involved with coalitions, she knows about a local coalition and her organization has a relationship with them but is not involved. In other instances of non-involvement, however, respondents stated that they had not been "invited" to join, or had not even heard of any such coalitions. Although these organizations serve immigrants, respondents were unaware of efforts in their area or across the state to coordinate services, build network connections, and address structural factors impeding immigrant access to support. These organizations may still be reluctant to join, for some of the same reasons described above. A manager of a local food pantry explained that their organization might be open to attending a future event aimed at helping the immigrant community, but not at the cost of prioritizing one client group over another. As an organization, they are "concerned with making sure everybody gets food," not just immigrants. Similar to the concerns articulated earlier about misrepresenting an organization's mission, allocating time and resources to join a coalition focused on immigrant rights might signal that a provider is more invested in this demographic than other groups they serve. In sum, there are important stakes these organizations take into consideration when it comes to policy advocacy: capacity of an organization, political and organizational risks involved in political activities in the immigrant-restrictive context, and recognition of their roles in a limited manner.

Overcoming barriers to advocacy

Immigrant-serving organizations in South Carolina that participate in policy advocacy also acknowledge that there are barriers to this form of work, but they tend to find ways around these obstacles, or identify the extra steps required to addressing them. The Director of a legal advocacy organization explained that policy advocacy efforts in South Carolina require challenging the perception that civil rights belong only to citizens: "When we're advocating for the civil rights of the undocumented community we have to have that extra step of explaining that the reason that these are rights is that they're human rights." For others, explaining why they engage in advocacy is less about additional steps, and more a shift in tactics. For example, the lead case manager at one organization generally adopts a "positive perspective" to the possibility of changing the larger structures that impede immigrant integration. Her perspective is guided by the belief that individuals who are

opposed to immigrants and immigration may reconsider their views. However, she admits "I can't just be positive all the time. There are times when we have to fight for our clients' rights."

Among the 50% of organizations in our sample that participate in policy advocacy activities, the majority take an indirect approach to influencing policy. If insider tactics aim to change policy through direct contact with policymakers, indirect tactics represent a category of policy advocacy activities that aim to raise awareness about a policy issue and to help shape a possible solution through means such as public education, writing letters to the editor, and joining advocacy coalitions (Mosley, 2011). This indirect approach is not uncommon among organizations in other service sectors. For example, Mosley (2011) finds in her study of homelessness service providers that 84% participated in coalitions for the purposes of influencing public policy, and 58% provided public education on policy issues.

Coalitions and public education were most common forms of policy advocacy among immigrant-serving providers in our study. The organizations who have been engaged with advocacy state that they have reaped numerous benefits from these partnerships, including information sharing, knowledge building, efficient labor division, organizational growth, and bringing about more structural changes. For example, a nonprofit organization that primarily serves children and families reported working closely with the local police department to raise awareness about immigrant rights. They also organize outreach events and information sessions to improve community relations with immigrants, started a local group aimed at promoting higher education among immigrant youth, and held a week-long conference on the topic.

Coalitions can provide networking opportunities that facilitate other forms of indirect advocacy. This can be particularly useful for small organizations that lack the resources to engage in advocacy, or providers that may perceive policy advocacy as risky, outside their organization's mission, or both. Among these organizations are those that were able to engage in advocacy because they partnered with other coalition members that were more outspoken about immigrant rights. One organization that provides educational services explained this indirect approach offers some "cover" given that advocacy is not strictly part of her organization's mission:

> *It's tricky because our organization—we're not an advocacy organization, so those conversations [about policy advocacy] don't really take place here. But I have definitely had those kinds of conversations with other organizations and other community partners. It's interesting the way that [my organization] is moving. We can't directly advocate, but one thing that I'm very excited about that we're doing is in conjunction with [another local provider]. We're hosting a community forum…that is geared towards business leaders…[to] educate those business leaders about the economic contributions of a Latino community—which is not advocacy, per se, but at least it is a kind of awareness-building for people who may not be very knowledgeable about the [immigrant] community.*

As this Project Coordinator notes, she did not view her collaborative efforts to raise awareness about the immigrant community as "advocacy" per se. However, her more

narrow definition of advocacy also allows her to justify that this indirect tactic is still within (or at least not in contradiction with) her organization's mission.

Similarly, many of the respondents that reported participating in indirect forms of advocacy explained that more direct forms of advocacy were out of reach, or did not view their coalition work as advocacy. For example, a medium-sized provider that works with children and families participates in a local provider networking meeting aimed at serving Latino immigrants. However, the organization is wary of more direct forms of policy advocacy, or of even describing their coalition work as a form of policy advocacy at all. The Executive Director explained that they have to "answer to a board" and advocating more publicly for immigrant rights would be politically contentious. Doing so would "probably hurt my organization from a private funding perspective…and then, ultimately, that would hurt the families that I'm trying to serve." As a result, their organization does not "take a stance on immigrant rights." Indeed, this rationale is an echo of why the non-involved organizations (described above) do not engage in advocacy at all.

To overcome this barrier to joining coalitions focused on immigrant services and immigrant rights, some respondents who joined coalitions sometimes did so personally rather than as representatives of their organization. The Executive Director of a medium-sized nonprofit was hesitant to engage in advocacy because his organization is affiliated with the county. This fact, combined with the problem that there were no existing coalitions in his county that addressed the policy advocacy concerns of immigrants, prompted him to personally start his own coalition. He was careful to explain that this effort was unrelated to his capacity as Executive Director: "Actually, I shouldn't mention the [name of his organization]—it's just something that I'm doing on my own as a private citizen." His strategy is to work with the Latino community rather than other organizational partnerships:

> *I have a 9 to 5 job like everyone else. I'm passionate about the [immigrant] community, but things change. People go, positions change, organizations come and go. But if we could ignite that passion for advocacy in our clientele…I think we are leaving the community better off.*

He views this grassroots approach to coalition-building as a way to give immigrants "voice" so they can "rise up and take ownership of the situation." His grassroots approach might also help avoid the possibility that coalitions, however well-meaning, may erroneously assume that they rightfully speak on behalf of the interests of immigrants (Mosley, 2013). However, his primary motivation for starting his own coalition is because the organization with which he is formally affiliated would be unwilling to let him do so.

Respondents in our sample were organizations involved with local coalitions do not even attend monthly meetings regularly. At times, limited involvement was attributable to organizational capacity, but others stated that the coalitions themselves were inconsistently active or ineffective. Coalitions are not always able to keep member organizations engaged and involved. One program manager stated that she is interested in working with a statewide coalition on policy advocacy, "but since I signed up probably a year and half ago I have not heard anything. I don't know if there's a glitch with that or if they haven't done anything." A number of providers stated that they had been involved with local or state-

wide coalitions in the past, but no new information had been shared about coalition activities, so they were not sure where things stood. For others, the added burden of coalition-related tasks is untenable. The court liaison for an organization that addresses domestic violence explained that she feels inspired when she attends statewide coalition meetings, and finds the conversation productive. However, upon returning to her office the weight of other demands makes it difficult for her—and other coalition members—to carry that momentum out: "I've gone there [to coalition meetings] and really gotten excited about some new ideas, and then just come back and been so overwhelmed that I can't concentrate any of my time on it." Others admit that they have dropped out of some coalitions, especially if they do not seem to be "really moving forward on things." An attorney at a nonprofit legal justice organization admits that this is a difficult bar for many policy advocacy coalitions in the state to meet, but this particularly true in the case of immigration rights. Her organization helped to found a statewide coalition in response to the anti-immigrant legislation that was passed in South Carolina in 2011. The coalition was successful because there was a clear target, but when the threat of this policy subsided the coalition lost momentum:

> *It [the coalition] was very effective because we had something going on. We had something tangible for people to do…I do think that when people have something to do, when there is something big going on, they will pull together. But it's that down time where people have a hard time getting together.*

As a result, several organizations in our study that have a history of involvement with coalitions express an openness to future collaborations even if they are not currently engaged in policy advocacy. For example, the Director of a large health services organization said he is familiar with the work of some local coalitions engaged in political advocacy on behalf of immigrants and has partnered with some members of a local coalition in the past. However, his organization was not formally involved in the coalition at the time of the interview. He stated that he would be willing to *host* a community event related to immigrant rights advocacy, but another organization would need to initiate the event and plan the details. That is, like other organizations in our sample, their involvement in policy advocacy is only periodic. This could change, however, if the issue of policy advocacy becomes more salient in the future. The same Director reflected that his organization joined a statewide advocacy effort when South Carolina enacted anti-immigrant state policies: "And so it [immigration] seemed to be more of a divisive issue, and we continued to treat people and to work with them as we had before, but the conversation and all things changed." Policy shifts in the future may trigger more coalition involvement because there is a clearly-defined issue around which coalition members can rally.

Discussion and Conclusion

In this paper, we explored the policy advocacy involvement of immigrant-serving organizations in South Carolina, a state with restrictive immigration legislation. The process of immigrant integration can be difficult and destabilizing for immigrant newcomers no matter where they settle, but those who live in receiving contexts with harsh, anti-immigrant laws such as South Carolina may be in even greater need of support. Our

study is premised on the notion that local organizations that engage in political activities can influence public policy (Marwell, 2004; Mosley, 2012). To the extent that this is the case, these organizations can function as intermediaries between vulnerable groups and restrictive policy structures (Reid, 2000)—minimizing this barrier to immigrant integration.

Consistent with the literature on social service organizations as intermediaries, we find that immigrant-serving social service providers in our study are positioned to mediate between immigrants and the restrictive policy context. However, not all organizations engage in advocacy activities to advance the rights of immigrants in South Carolina. We find that organizations that engage in advocacy adopt a variety of tactics, but most respondents reported that their advocacy approach was indirect and non-confrontational. Coalition membership was one of the most common forms of advocacy, but even this was limited. Consistent with other studies, we find that involvement depends on factors such as organizational size, funding sources, the willingness of organizational leaders, and their willingness to collaborate (Mosley, 2010, 2013). We also find that while some local social service providers may engage in policy advocacy, others engage in advocacy efforts focused only on the needs of the clients they serve rather than the larger community of which their clients are a part—a common pattern among service providers in other contexts (Garrow & Hasenfeld, 2014). Still other providers in our study do not engage in policy advocacy at all, despite their acknowledgement of harsh anti-immigrant laws in South Carolina.

The limitations of our study prevent us from generalizing these findings to immigrant-serving organizations across the entire state. Our sample of immigrant-serving organizations is not representative, and the self-report nature of the data introduces the possibility of response bias. In addition, our study does not measure the impact of these policy advocacy activities on the laws and other structures that impact immigrant integration in South Carolina. However, other studies suggest that participation in coalitions can be an effective indirect form of policy advocacy (Fyall, 2016), particularly when individual organizations see more independent forms of advocacy to be risky. Indeed, these types of collaborative practices have increased within the field of policy advocacy (Mosely, 2013), and this is common practice for many organizations in our sample. However, because of data limitations in this study, it is unclear the extent to which these coalitions are actively pursuing a social justice agenda to advance immigrant rights in the state. Rather than engaging in serious policy advocacy activities, it is possible that these coalitions merely provide opportunities for sharing information about resources and discussing case-specific problems concerning immigrant clients. Yet, given that many organizations in this study report episodic involvement in policy advocacy, it is possible that the coalitions are similarly responsive to changes in the policy environment. For this reason, staying involved with coalitions when there is a "lull" may lead to more policy advocacy activities in the future if and when the coalition is compelled to take up a policy advocacy cause. Likewise, organizations that are not currently active in coalitions may rejoin when the coalition rallies around a pressing need for policy advocacy. For these reasons, coalition meetings focused merely on networking may perform an important function in the service of future policy advocacy activities by maintaining organizational

ties and working relationships. Given this possibility, future research should explore the elasticity of policy advocacy activities in response to changes in the policy environment.

Consistent with other studies, we also find that many organizations in our sample do not participate in policy advocacy. Some respondents stated that they do not participate in advocacy at all simply because they do not think advocacy involvement should be central—or even peripheral—to their activities. Other reasons they offered were also consistent with the literature, including a lack of knowledge about policy and the policymaking process, organizational capacity, concern for displeasing an external funder, and fear of violating laws (Bass, Arons, Guinane, Carter, & Rees, 2007; Mosley, 2010; Schneider & Lester, 2001). Recognizing the general trend that advocacy is regarded as a peripheral function of a service provider's operations, future research must continue to assess noninvolvement among immigrant-serving organizations by comparing different receiving contexts. This includes examining differences between new destinations and traditional immigrant gateways, as well as places with active statewide coalitions, such as Illinois and Tennessee, relative to places without a unifying mechanism that can channel resources and strategically address immigrant rights concerns. Finally, research should explore whether there is a tipping point for immigrant-serving organizations—when the balance of cost/benefit considerations prompt a provider to decide to engage in advocacy. If so, what are the factors and conditions that predict this type of organizational behavior?

It is critical for the social work profession to pursue these questions in light of current immigration trends and policy. Social workers uphold social justice as a defining feature of professional practice, yet social service organizations are only modestly engaged in policy advocacy vis-à-vis immigrant rights. Through their daily work, social workers often directly witness or hear about the injustices immigrants face and are well-situated to explain these injustices to the broader society. Consequently, social workers and the administrators of social service organizations should be actively engaged in coalitions that advocate for immigrant rights. This is particularly important in places such as South Carolina with restrictive anti-immigrant laws. Providers should also continue to expand their policy advocacy actions to more directly address policy inequalities facing immigrants. For some organizations that assume certain types of advocacy activities are impermissible, this might require that they begin by reviewing what types of direct and indirect actions are allowed within the laws which govern what is defined as "lobbying" by the IRS.

Given the importance of policy advocacy to challenging and improving the structural conditions for immigrant integration, it is critical that social workers bridge the gap between what we profess to be important and what we prioritize in practice. This yawning gap is particularly noticeable in the face of immigrant rights. Social work practitioners need to raise awareness about policy advocacy and encourage their organizations to engage in advocacy practice that protects and enforces these rights.

References

Alba, R., & Nee, V. (2003). *Remaking the American mainstream: Assimilation and contemporary immigration*. Cambridge: Harvard University Press. doi: https://doi.org/10.4159/9780674020115

Allard, S. (2009). *Out of reach: Place, poverty, and the new American welfare state*. New Haven: Yale University Press.

Allard, S., & Roth, B. J. (2010). *Suburbs in need: Rising suburban poverty and challenges for the safety net*. Washington, D.C.: Brookings Institution.

Almog-Bar, M., & Schmid, H. (2014). Advocacy activities of nonprofit human service organizations: A critical review. *Nonprofit and Voluntary Sector Quarterly*, *43*(1), 11-35. doi: https://doi.org/10.1177/0899764013483212

Bass, G. D., Arons, D. F., Guinane, K., Carter, M. F., & Rees, S. (2007). Seen but not heard: Strengthening nonprofit advocacy. Washington, DC: The Aspen Institute.

Berry, J. M. (2005). Nonprofits and civic engagement. *Public Administration Review*, *65*(5), 568-578. doi: https://doi.org/10.1111/j.1540-6210.2005.00484.x

Berry, J. M., & Arons, D. F. (2003). *A voice for nonprofits*. Washington, D.C.: Brookings Institution Press.

Boris, E., & Mosher-Williams, R. (1998). Nonprofit advocacy organizations: Assessing the definitions, classifications, and data. *Nonprofit and Voluntary Sector Quarterly*, *27*(4), 488-506. doi: https://doi.org/10.1177/0899764098274006

Cabell, M. G. (2007). *Mexican immigrant integration in the U.S. southeast: Institutional approaches to immigrant integration in Owensboro, Kentucky*. Retrieved from The Center for Comparative Immigration Studies website https://ccis.ucsd.edu/_files/wp153.pdf

Castles, S., & Miller, M. J. (2009). *The age of migration: International population movements in the modern world* (4th ed.). New York, NY: The Guilford Press.

Cordero-Guzman, H. R. (2005). Community-based organisations and migration in New York City. *Journal of Ethnic and Migration Studies*, *31*(5), 889-909. doi: https://doi.org/10.1080/13691830500177743

de Graauw, E. (2008). Nonprofit organizations: Agents of immigrant political incorporation in urban America. In S. K. Ramakrishnan & I. Bloemraad (Eds.), *Civic hopes and political realities: Immigrants, community organizations, and political engagement* (pp. 323-350). New York: Russell Sage Foundation.

de Graauw, E. (2014). Municipal ID cards for undocumented immigrants: Local bureaucratic membership in a federal system. *Politics & Society*, *42*(3), 309-330. doi: https://doi.org/10.1177/0032329214543256

de Leon, E., Maronick, M., De Vita, C. J., & Boris, E. T. (2009). *Community-based organizations and immigrant integration in the Washington, D.C metropolitan area*. Washington, D.C.: The Urban Institute. doi: https://doi.org/10.1037/e726282011-001

Frasure, L. A., & Jones-Correa, M. (2010). The logic of institutional interdependency: The case of day laborer policy in suburbia. *Urban Affairs Review*, *45*, 451-482. doi: https://doi.org/10.1177/1078087409355640

Fyall, R. (2016). The power of nonprofits: Mechanisms for nonprofit policy influence. *Public Administration Review*, *76*(6), 938-948. doi: https://doi.org/10.1111/puar.12550

Garrow, E. E., & Hasenfeld, Y. (2014). Institutional logics, moral frames, and advocacy: Explaining the purpose of advocacy among nonprofit human-service organizations. *Nonprofit and Voluntary Sector Quarterly*, *43*(1), 80-98. doi: https://doi.org/10.1177/0899764012468061

Glaser, B. G. (1965). The constant comparative method of qualitative analysis. *Social Problems*, *12*(4), 436-445. doi: https://doi.org/10.2307/798843

Gleeson, S., & Bloemraad, I. (2012). Assessing the scope of immigrant organizations: Official undercounts and actual underrepresentation. *Nonprofit and Voluntary Sector Quarterly*, *42*(2), 346-370. doi: https://doi.org/10.1177/0899764011436105

Hall, M. (2013). Residential integration on the new frontier: Immigrant segregation in established and new destinations. *Demography*, *50*(5), 1873-1896. doi: https://doi.org/10.1007/s13524-012-0177-x

Hung, C.-K. R. (2007). Immigrant nonprofit organizations in U.S. metropolitan areas. *Nonprofit and Voluntary Sector Quarterly*, *36*, 707-729. doi: https://doi.org/10.1177/0899764006298962

Illegal Immigration Reform Act, H. 4400, 117th Leg. 2nd Sess. (2008).

Kobach, K. W. (2008). Attrition through enforcement: A rational approach to illegal immigration. *Tulsa Journal of Comparative & International Law*, *15*, 155-163.

Largen, S. (2012, October 12). New S.C. law unit arresting illegals. *Post and Courier*. Retrieved from https://www.postandcourier.com/archives/new-s-c-law-unit-arresting-illegals/article_39331aae-5ca5-5126-8bd0-32aec5240346.html

Lewis, P. G., Provine, D. M., Varsanyi, M. W., & Decker, S. H. (2013). Why do (some) city police departments enforce federal immigration law? Political, demographic, and organizational influences on local choices. *Journal of Public Administration Research and Theory*, *23*(1), 1-25. doi: https://doi.org/10.1093/jopart/mus045

Lichter, D., Parisi, D., Taquino, M., & Grice, S. M. (2010). Residential segregation in new Hispanic destinations: Cities, suburbs, and rural communities compared. *Social Science Research*, *39*, 215-230. doi: https://doi.org/10.1016/j.ssresearch.2009.08.006

Lietz, C. A., & Zayas, L. E. (2010). Evaluating qualitative research for social work practitioners. *Advances in Social Work*, *11*(2), 188-202.

MacIndoe, H., & Whalen, R. (2013). Specialists, generalists, and policy advocacy by charitable nonprofit organizations. *Journal of Sociology and Social Welfare*, *40*(2), 119-149.

Marrow, H. B. (2005). New destinations and immigration incorporation. *Perspectives on Politics*, *3*, 781-799. doi: https://doi.org/10.1017/S1537592705050449

Marrow, H. B. (2009). Immigrant bureaucratic incorporation: The dual roles of professional missions and government policies. *American Sociological Review*, *74*, 756-776. doi: https://doi.org/10.1177/000312240907400504

Marrow, H. B. (2013). Assimilation in new destinations. *Daedalus*, *142*(3), 107-122. doi: https://doi.org/10.1162/DAED_a_00222

Martin, N. (2012). “There is abuse everywhere”: Migrant nonprofit organizations and the problem of precarious work. *Urban Affairs Review*, *48*(3), 389-416. doi: https://doi.org/10.1177/1078087411428799

Marwell, N. P. (2004). Privatizing the welfare state: Nonprofit community-based organizations as political actors. *American Sociological Review*, *69*, 265-291. doi: https://doi.org/10.1177/000312240406900206

Massey, D. S. (2008). *New faces in new places: The changing geography of American immigration*. New York: Russell Sage Foundation.

Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A., & Taylor, J. E. (1994). An evaluation of international migration theory: The North American case. *Population and Development Review*, *20*(4), 699–751. doi: https://doi.org/10.2307/2137660

Mellinger, M. S. (2014a). Beyond legislative advocacy: Exploring agency, legal, and community advocacy. *Journal of Policy Practice*, *13*(1), 45-58. doi: https://doi.org/10.1080/15588742.2013.855887

Mellinger, M. S. (2014b). Do nonprofit organizations have room for advocacy in their structure? An exploratory study. *Human Services Organizations Management, Leadership & Governance*, *38*(2), 158-168. doi: https://doi.org/10.1080/03643107.2013.859197

Migration Policy Institute. (2018). State Immigration Data Profiles. Tabulations from the U.S. Census Bureau’s American Community Survey (ACS), 2015. Retrieved from http://www.migrationpolicy.org/programs/data-hub/us-immigration-trends#history

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. Thousand Oaks: Sage.

Mitnik, P. A., & Halpern-Finnerty, J. (2010). Immigration and local governments: Inclusionary local policies in the era of state rescaling. In M. W. Varsanyi (Ed.), *Taking local control: Immigration policy activism in U.S. cities and states* (pp. 51-72). Stanford, CA: Stanford University Press.

Mosley, J. (2013). Recognizing new opportunities: Reconceptualizing policy advocacy in everyday organizational practice. *Social Work*, *58*(3), 231-239. doi: https://doi.org/10.1093/sw/swt020

Mosley, J. E. (2010). Organizational resources and environmental incentives: Understanding the policy advocacy involvement of human service nonprofits. *Social Service Review*, *84*(1), 57-76. doi: https://doi.org/10.1086/652681

Mosley, J. E. (2011). Institutionalization, privatization, and political opportunity: What tactical choices reveal about the policy advocacy of human service nonprofits. *Nonprofit and Voluntary Sector Quarterly*, *40*(3), 435-457. doi: https://doi.org/10.1177/0899764009346335

Mosley, J. E. (2012). Keeping the lights on: How government funding concerns drive the advocacy agendas of nonprofit homeless service providers. *Journal of Public Administration Research and Theory*, *22*(4), 841-866. doi: https://doi.org/10.1093/jopart/mus003

Mosley, J. (2013). Recognizing New Opportunities: Reconceptualizing Policy Advocacy in Everyday Organizational Practice. *Social Work*, *58*(3), 231–239. doi: https://doi.org/10.1093/sw/swt020

National Immigration Law Center. (2014). Civil Rights Coalition achieves important protections against South Carolina's anti-immigrant law. Retrieved from https://www.nilc.org/2014/03/03/nr030314/

Portes, A., & Rumbaut, R. (2006). *Immigrant America: A portrait* (3rd ed.). Berkeley: University of California Press.

Portes, A., & Zhou, M. (1993). The new second generation: Segmented assimilation and its variants. *The Annals of the American Academy of Political & Social Science*, *530*, 74-96. doi: https://doi.org/10.1177/0002716293530001006

Ramakrishnan, S. K., & Wong, T. (2010). Partisanship, not Spanish: Explaining municipal ordinances affecting undocumented immigrants. In M. W. Varsanyi (Ed.), *Taking local control: Immigration policy activism in U.S. cities and states* (pp. 73–96). Stanford, CA: Stanford University Press.

Reid, E. J. (2000). Nonprofit advocacy and political participation. In E. T. Boris & C. E. Steuerle (Eds.), *Nonprofits and government: Collaboration and conflict* (pp, 291-325). Washington, DC: Urban Institute.

Roth, B. J., & Allard, S. W. (2016). (Re)defining access to Latino immigrant-serving organizations: Evidence from Los Angeles, Chicago, and Washington, DC. *Journal of the Society for Social Work and Research*, *7*(4), 729-753. doi: https://doi.org/10.1086/689358

Roth, B. J., Gonzales, R. G., & Lesniewski, J. (2015). Building a stronger safety net: Local organizations and the challenges of serving immigrants in the suburbs. *Human Service Organizations: Management, Leadership & Governance*, *39*(4), 348-361. doi: https://doi.org/10.1080/23303131.2015.1050143

Schneider, R. L., & Lester, L. (2001). *Social work advocacy: A new framework for action*. Pacific Grove, CA: Brooks/Cole.

Singer, A. (2013). Contemporary immigrant gateways in historical perspective. *Daedalus*, *142*, 76-91. doi: https://doi.org/10.1162/DAED_a_00220

Varsanyi, M. W. (2008). Immigration policing through the backdoor: City ordinances, the

"Right to the City," and the exclusion of undocumented day laborers. *Urban Geography*, *29*, 29-52. doi: https://doi.org/10.2747/0272-3638.29.1.29

Varsanyi, M. W. (2011). Neoliberalism and nativism: Local anti-immigrant policy activism and an emerging politics of scale. *International Journal of Urban and Regional Research*, *35*, 295-311.

Varsanyi, M. W., Lewis, P. G., Provine, D., & Decker, S. (2012). A multilayered jurisdictional patchwork: Immigration federalism in the United States. *Law & Policy*, *34*(2), 138-158. doi: https://doi.org/10.1111/j.1467-9930.2011.00356.x

Yoshikawa, H., & Kalil, A. (2013). The effects of parental undocumented status on the developmental contexts of young children in immigrant families. *Child Development Perspectives*, *5*, 291-297.

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Using Structural Social Work Theory to Drive Anti-Oppressive Practice With Latino Immigrants

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Abstract: *Social work practice with marginalized populations not only requires intervention to address individuals' immediate service needs, but also requires intervention to address the larger structural context that impacts well-being. Critical theoretical frameworks, such as Structural Social Work (SSW) theory, are essential in helping social workers to develop a comprehensive understanding of the manner in which social systems are intentionally designed to oppress marginalized populations, including immigrant and refugee communities. SSW serves to both understand how society's structure causes social problems and to identify how these structures must be changed in order to alleviate harm. Focusing specifically on Latino immigrants, this article presents an overview of SSW theory and discusses its relevance to social work practitioners. This SSW framework will then be applied to analyze two U.S. social systems, the labor regulatory and mental health systems, that are integrally connected to Latino immigrant well-being. Finally, drawing from two case examples of research conducted in Chicago, alternative models of practice in the realms of labor and mental health are presented. Findings from these case examples illustrate how social workers can engage in anti-oppressive practice when they implement interventions that promote personal healing while simultaneously challenging oppressive elements of social systems.*

Keywords: *Structural social work theory; labor; mental health; Latino immigrants; anti-oppressive practice*

> Hide nothing from the masses of our people. Tell no lies. Expose lies whenever they are told. Mask no difficulties, mistakes, failures. Claim no easy victories… (Cabral, 1970, p. 89)

These words of Amilcar Cabral (1970) remind us of the necessity to engage in a genuine way with those with whom we seek to work. As social workers, if we are truly to work for the emancipation and empowerment of those we serve, we must be cognizant of the challenges we are faced with in practice, including both the realities of the "client" and that of the profession. In the same way that Amilcar Cabral used his professional training to support the struggle for liberation of the people of Bissau-Guinean and Cape Verde from the colonization of Portugal, as social workers we are positioned to engage in the complex and at times turbulent work of anti-oppressive practice. Anti-oppressive practice requires that we recognize how individual well-being is integrally connected to larger social institutions. Considering that social institutions in the U.S. perpetuate systems of power, privilege, unequal access, and oppression, anti-oppressive practice intends to alleviate the negative impacts of oppressive social systems on individuals while simultaneously transforming these social structures that perpetuate oppression (Mullaly, 2007). As

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Amilcar Cabral pushes us to understand through his words, we must be honest in the complexities of engaging in anti-oppressive practice and must not claim easy victories that fall short of structural transformation.

Social work with immigrants and refugees presents an important space to engage in anti-oppressive practice. Immigrants and refugees enter a U.S. sociopolitical context where nativist sentiment and rhetoric is pervasive (Ayón, 2014; Collinson & Diamond, 2016; Salas, Ayón, & Gurrola, 2013). Members of these populations commonly experience multiple forms of oppression, including exploitation, marginalization, exclusion from social and civic spaces (i.e., powerlessness), pressure to assimilate to dominant cultural norms (i.e., cultural imperialism), and violence (Young, 2013). These experiences of oppression are manifested in both their interactions with U.S. social structures and in their daily interpersonal interactions (Aguilar-Gaxiola et al., 2012; Garcini et al., 2016; Raymond-Flesch, Siemons, Pourat, Jacobs, & Brindis, 2014). The labeling of the immigrant population in reference to categories of *legality* and *illegality* is used to legitimize oppressive acts (Menjívar, 2016). Considering that experiences of oppression are central to the experiences of immigrants and refugees in the U.S., it is essential that social workers are prepared to assess the impact of oppressive structural contexts on well-being and to challenge oppressive social structures in their daily practice.

Focusing specifically on Latino immigrants, this article will introduce Structural Social Work, a critical social work theory. Following this theoretical overview, we will use a Structural Social Work lens to analyze the U.S. labor regulatory and mental health systems, two systems that are integrally connected to the well-being of this population. As part of this analysis, we will discuss how these systems are intentionally designed to perpetuate oppression. Finally, drawing from two case examples of research that the authors conducted in Chicago (Carrillo, 2017; O'Grady, 2017), we will discuss how social workers can practice outside of oppressive systems. Recognizing how oppressive interactions with social systems negatively impact well-being, the highlighted practice models in the realms of mental health and labor organizing are intentionally designed to promote alternative patterns of interaction. These spaces serve as refuges where community members are supported in reframing their understanding of themselves and their environments, with the aim of empowering them to advocate for structural change in their communities. After highlighting how these alternative practice models both promote personal healing and cultivate spaces of resistance, we will discuss the implications of these local level practices for the social work profession.

Structural Social Work Theory and the Role of Critical Frameworks in Practice

Critical theoretical frameworks provide an important foundation for guiding social work practice grounded in principles of social justice. Critical theoretical frameworks assist social workers in developing a comprehensive understanding of the structural context that impacts the immigrant population and provide a lens for identifying practice solutions that challenge this context. Attending to the larger structural context ensures that individuals, families, and communities are not pathologized for the challenges that they experience. A

Structural Social Work (SSW) critical theoretical framework is of particular relevance for informing anti-oppressive practice with the Latino immigrant population. First, SSW theory provides a descriptive understanding of how oppressive dominant ideologies inform political, economic, and social systems and patterns of interpersonal interactions. Second, SSW offers a prescriptive approach for supporting individuals who have been harmed by social systems and challenging these oppressive social systems and underlying ideologies that cause harm (Mullaly, 2007). While we recognize the breadth of scholars contributing to the body of critical social work literature, we focus primarily on Mullaly's (2007) work in our overview due to the fact that Mullaly's (2007) bridge model of society is central to our subsequent analysis of both the U.S. labor regulatory and mental health systems and the presented alternative practice models.

Structural Social Work Theory

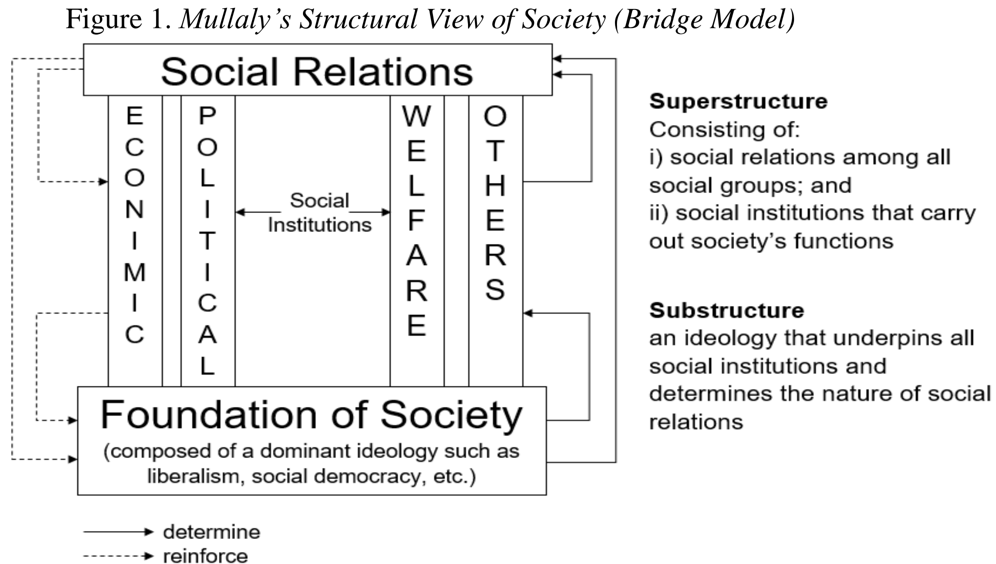
SSW, as first postulated by Maurice Moreau in Canada in 1979, was created in reaction to the "medical and disease model" which seeks to work with people in a dependent position, emphasizing change at the individual rather than the sociopolitical level. SSW seeks to focus the intervention on the direct interactions between individuals and social, political, and economic systems (Moreau, 1979). Stemming from Radical Social Work, which is grounded in socialist ideologies, SSW criticizes conventional social work for a lack of critical self-awareness and pathologizing the oppressed by opting for individual diagnosis at the expense of addressing large social problems (Mullaly, 2007). Even with the attention given to societal level concepts, SSW is meant to be a generalist model of practice for social work with individuals, families, groups, and communities, while not losing sight of the interaction between the personal and larger cultural and political forces (Mullaly, 2007).

As conceptualized by SSW, society is envisioned as a bridge structure, whereby the bedrock, or substructure, on which the bridge is erected is the ideology that underpins society. The foundation of a bridge is not visible, yet it is essential to support the structure on which it is built. The ideologies of society provide a similar foundation. The pillars holding up the bridge platform are the various social institutions created to manage society's primary functions, including but not limited to economic, political, social welfare, labor regulatory, educational, and health systems. The platform of the bridge on which the general population exists and interacts is largely defined by the lower portions of the structure. As Mullaly (2007) explains, "the substructures or foundation of society consists of a dominant ideology, which is transmitted to all members of society through the process of socialization and determines the nature of a society's institutions and the relations among its people" (p. 245). To achieve social transformation, change must happen at all levels and social workers must be ready to navigate throughout the three levels as outlined by the SSW model. Mullaly's (2007) bridge model is displayed below.

At its core, SSW is meant to be both descriptive and prescriptive. The model serves to both understand how society's structure causes social problems and to identify how these structures must be changed in order to alleviate harm. To achieve this goal, an immediate focus on relief must also be accompanied by a long-term focus on structural and institutional change. Utilizing a dialectical understanding, SSW understands that social

welfare and social work contain opposing forces of social care and social control. Given this understanding, the focus of practice is meant to "maximize the emancipatory potential of social welfare and social work and to neutralize or minimize the repressive elements" (Mullaly, 2007, p. 238).

Figure 1. *Mullaly's Structural View of Society (Bridge Model)*



Reproduced with permission from Mullaly (2007, p. 246)

Recognizing that critical analysis of social systems is central to SSW, in the following section we will analyze two U.S. social systems through a structural lens. In particular, we will analyze both the U.S. labor regulatory and mental health systems. Based on our synthesis of the literature, we contend that not only does the Latino immigrant population have unmet needs in the realms of labor and mental health, but also that these systems are designed to perpetuate structural oppression rather than to address unmet needs.

U.S. Social Systems Through A Structural Lens

U.S. Labor Regulatory System

The labor regulatory system falls within the economic system of our society. It is intended to be the mechanism that checks the detrimental impacts of exploitation on workers by employers in their pursuit of profit and efficiency within the capitalist economic system. The labor regulatory system encompasses laws and policies that regulate workplace standards, the state and federal worker protection agencies established to enforce workplace policies (including among others, the Department of Labor, Equal Employment Opportunity Commission), and collective bargaining agreements set by labor unions. In order to understand the structural causes of the workplace exploitation on low-wage immigrant workers, an analysis of the U.S. labor system must be contextualized in relation to both the U.S. labor regulatory system and the immigration system.

The immigration system and labor regulatory system: The connection between "illegality" and substandard working conditions. The literature has long emphasized the role of immigration policy in regulating the flow of foreign labor into the United States (Borjas, 1989; De Genova, 2005; Gomberg-Muñoz, 2011; Massey, Durand, & Malone, 2002; Sassen-Koob, 1981). Decades of increasingly restrictive U.S. immigration policy, culminating with the passage of the Immigration Reform and Control Act of 1986, established a present day political reality in which 11.1 million people live in the United States without legal status (Passel & Cohn, 2016). The political creation of "illegality" establishes a vulnerable and "temporary" population that is often exploited in the workplace and made to live in fear within their communities (Gleeson, 2010). The Mexican migrant community has for generations served as a continued and expendable pool of labor for the United States (De Genova, 2004). By creating a system of deportation targeting undocumented workers, the nation creates what is essentially a disposable commodity (De Genova, 2002).

Even though undocumented immigrant workers maintain many of the same legal protections as documented workers in the workplace, their undocumented status places them in a relatively powerless position. Various studies have identified that undocumented workers face a higher likelihood of experiencing wage theft (Bernhardt et al., 2009; Fussell, 2011), wage disparities (Hall, Greenman, & Farkas, 2010; Rivera-Batiz, 1999), unsafe workplace conditions (Mehta, Theodore, Mora, & Wade, 2002), and workplace injuries and fatalities (Orrenius & Zavodny, 2009; Sanchez, Delgado, & Saavedra, 2011). Substandard wages and workplace conditions plague entire industries and communities that employ a high percentage of immigrant workers (Bernhardt et al., 2009; Levin & Ginsburg, 2000).

Among the most pervasive experiences of immigrant workers is the loss of owed wages. Violations of wage and hourly laws are commonly referred to as wage theft (Bobo, 2009). It occurs through various forms including: failure to pay minimum wage, failure to pay overtime (i.e., paid less than 1.5 times the regular rate of pay for all hours over 40 per week), "off-the-clock violations" (i.e., work not compensated before or after regular shift), meal break violations (i.e., work during break without compensation), or illegal deductions taken from workers' pay. A study by Bernhardt et al. (2009) of 4,387 workers in the three largest cities in the U.S., New York, Chicago, and Los Angeles, identified the industries with the highest rates of wage theft, as measured solely by minimum wage violations. These industries included apparel and textile manufacturing (42.6% violation rate), personal and repair services (42.3%), private households (41.5%), retail and drug stores (25.7%), grocery stores (23.5%), security, building and ground service (22.3%), food and furniture manufacturing, transportation and warehousing (18.5%), restaurants and hotels (18.2%), residential construction (12.7%), home health care (12.4%), and social assistance and education (11.8%). The same analysis of minimum wage violations by demographics identifies undocumented immigrants as reporting the highest percentage of wage violations. Within this demographic, there is a marked difference by gender; nearly half (47%) of undocumented female respondents reported minimum wage violations compared to 30% of undocumented men, by far the highest rate among workers interviewed.

The need for and limitations of federal and state labor enforcement agencies. The relatively powerless position of vulnerable workers makes them less likely to report substandard work conditions (Fussell, 2011). As a result, there is a considerable role for federal and state regulatory agencies to ensure compliance of wage and hourly laws for all workers, including undocumented workers. At the federal level, the Department of Labor is tasked with, among other responsibilities, regulating workplace conditions. Specifically, the Wage and Hourly Division (WHD) "enforces Federal minimum wage, overtime pay, recordkeeping, and child labor requirements of the Fair Labor Standards Act" (U.S. Department of Labor, n.d.). However, analysis of the WHD has shown continued reductions in the investigative staff since its inception. In 1941 when it was first created, the WHD employed 1,769 investigators, compared to 1,544 in 1962 and 750 in 2007. Investigators have decreased despite the fact that the number of businesses covered by the WHD has seen a dramatic increase from 360,000 to 1.1 million to 7 million in the respective years (Bobo, 2009). Separate analyses demonstrate similar findings; between the years of 1975 and 2004 the number of investigators decreased by 14% from 921 to 788, while the number of workers covered increased by 55% and the number of businesses covered increased by 112% (Bernhardt & McGrath, 2005). The limited availability of investigators has led the WHD to be a worker-initiated complaint driven agency instead of one designed to conduct proactive investigations (Weil, 2008). Beyond the federal labor regulatory agencies, states can establish their own labor protection agencies in order to increase the level of protections for workers. However, the enforcement capacity and role of each state agency varies widely throughout the country (Meyer & Greenleaf, 2011).

The absence of labor unions. The erosion of union density in the private sector over the last 50 years is striking (Bui, 2015). This has had a marked impact on working standards within the United States labor market. Without union representation, workers lose the ability to use collective bargaining to increase wages, benefits, and improve working conditions. As a result, in a 44 year span the share of the nation's income taken home by the middle class has declined, with the aggregate household income having shifted from middle-income households, 62% in 1970 to 43% in 2014, to upper-income households, 29% in 1970 compared to 49% in 2014 (Pew Research Center, 2015). The decline in union membership accounts for 35% of the falling share of workers within the middle class and explains nearly half when adding in the union equality effect (Freeman, Han, Madland & Duke, 2015). It has also played a role in limiting upward mobility among low-income children, especially when parents are low-skilled workers (Freeman, Han, Duke, & Madland, 2016).

Within the current labor regulatory system, various factors make it unfeasible for labor unions to organize low-wage workers. Mehta and Theodore (2005) identify the obstacles that employees and organizers commonly experience during their efforts to organize labor unions. Findings from their analysis of 25 union organizing campaigns indicated that companies engaged in a variety of legal and illegal tactics to discourage union organizing (Mehta & Theodore, 2005). While legislative solutions such as the Employee Free Choice Act would serve to lower the hurdles for workers to unionize and would increase opportunities for collective bargaining in more workplaces, more and more states adapt "Right to Work" legislation, which purpose is to weaken union membership by making

union dues optional by union members and prohibits union membership as a condition of employment. The limited support that unions are able to offer to low-wage immigrant workers, coupled with the shortcomings of federal and state labor regulatory agencies, point to the ineffectiveness of the U.S. labor regulatory system in protecting immigrant low-wage workers from workplace exploitation.

The psychological harm of the labor regulatory system's failings. Not only do immigrant workers have unmet needs in the realm of labor protections, but experiences of workplace exploitation have also been found to negatively impact emotional well-being. Lesniewski and Drucker (2017) conducted a mixed-methods research project that explored the psychosocial impact of wage theft on low-wage immigrant workers. Findings revealed that two-thirds of respondents were likely or highly likely to suffer from depression. Immigrant workers who took part in this study reported that they often had to take on additional jobs to compensate for lost wages and experienced psychological distress, family conflict, and nutrition and health issues as a result of working long hours and coping with financial hardships and housing instability (Lesniewski & Drucker, 2017). Synthesizing the literature on the labor regulatory system, it is not only evident that the system fails to address the needs of immigrant workers coping with workplace exploitation, but it is also evident that the system intentionally creates an expendable workforce who is vulnerable to exploitation. Furthermore, these experiences of workplace exploitation negatively impact immigrant workers' mental health.

U.S. Mental Health System

The negative impact of workplace exploitation on emotional well-being is part of a growing body of literature exploring the effects of structural oppression on the mental health of Latino immigrants. For example, research has attributed living in a hostile, anti-immigrant political climate to mental health challenges including depression, anxiety, and chronic trauma among Mexican immigrant adults and their children in Arizona (Salas et al., 2013). Similarly, Flores et al. (2008) found that experiences of interpersonal discrimination were associated with depression among Mexican immigrant adults in California. Evidence also indicates that the experience of being undocumented in the oppressive structural context of the U.S. negatively impacts mental health. Research cites specific examples of experiences that are associated with mental health symptoms, including limited access to employment, education, healthcare, and social services; living in constant fear of deportation; and exposure to negative stereotypes about undocumented immigrants (Garcini et al., 2016; Raymond-Flesch et al., 2014).

A structural analysis of the U.S. mental health system not only indicates that oppressive social systems and discriminatory patterns of interpersonal interactions negatively impact mental health, but also that the system is intentionally designed to limit access to mental health services and inadequately address the mental health needs of Latino immigrants. In accordance with Mullaly's (2007) bridge model of society, underlying capitalist ideologies inform the development of a mental health system that ignores the impact of structural oppression on well-being and limits access to services based on an individual's ability to pay. First, the limited attention paid to the impact of structural oppression on well-being is reflected in the dominance of what Saleebey (2005) describes as the "medical-

psychiatric/pharmaceutical/insurance cartel” (p. 23) model of mental health. Saleebey (2005) defines this model as one in which “a group of institutions…control a particular market or social sector through a melding of their interests and exercising of their social power” (p. 23). By framing mental health in relation to biochemical responses, illness, deficits, and pathology, this biomedical model of mental health service delivery advances the interests of psychopharmaceutical companies while failing to address the structural context that impacts well-being (Saleebey, 2005). Second, according to Rylko-Bauer and Farmer (2002), the mental health system is part of the larger

> …market-based [healthcare] system shaped by forces of competition, commercialization, and corporatization...The orientation is increasingly one of selling ‘product’ rather than providing care, to ‘consumers’ and ‘clients’ rather than to patients, with a reliance on competition to control costs and encourage ‘efficiencies’. (pp. 478-479)

For underinsured and uninsured individuals who are unable to pay out of pocket for mental health services, treatment options are limited.

The structure of the mental health system results in disparate rates of mental health service access and lower quality services for Latino immigrants. There is a well-established body of literature identifying cost and lack of insurance coverage as barriers to service access (Bridges, Andrews, & Deen, 2012; Cabassa, Lester, & Zayas, 2007; Santiago-Rivera et al., 2011). These access barriers translate to lower rates of service utilization among Latino immigrants in comparison to both non-Latino Whites and U.S.-born Latinos (Cabassa, Zayas, & Hansen, 2006). In addition, evidence indicates that immigrant and U.S.-born Latinos are less likely than non-Latino Whites to receive depression treatment in accordance with established care guidelines, thus pointing to disparities in treatment quality (Lagomasino et al., 2005). Horton (2006) further illustrates the negative impact of the market-based care system on service quality in her case study of a mental health clinic serving primarily uninsured and Medicaid insured Latino immigrants in the northwestern U.S. Because the mental health clinic’s parent hospital was facing budget difficulties due to limited reimbursement for the provision of charity care to the uninsured, the hospital placed increased demands on clinician “productivity” (i.e., meeting specified billable hours quota). In order to meet these demands, clinicians were pressured to implement practices including shortening appointment times, limiting or denying services to uninsured individuals, double booking appointments, and stopping service provision to program participants who “no showed” three appointments, meaning that they missed appointments without providing 24-hour notice (Horton, 2006). Clinicians identified these practices as conflicting with their beliefs about high quality service provision (Horton, 2006).

Within the city of Chicago, the site of the case studies highlighted in this article, research has documented similar disparities in mental health service access and quality for Latino immigrants. Over the past decade, there has been a disinvestment in publicly funded mental health services throughout the city. While there were 12 free mental health clinics operated by the Chicago Department of Public Health (CDPH) in the year 2011 (at one point 19), the number has been reduced to five currently operating clinics (Coalition to Save Our Mental Health, n.d; Lowe, 2015; Spielman, 2017). The only two bilingual

English and Spanish CDPH clinics were among those that closed (Fecile, 2012). Furthermore, a mixed methods study surveying 2,859 primarily Latino community residents on Chicago's southwest side found that 57% of respondents identified cost, 38% identified lack of insurance coverage, and 34% identified a lack of services in close geographic proximity as posing service access barriers. Stigma, by comparison, was reported by only 11% of those surveyed (Collaborative for Community Wellness, 2018). In addition, qualitative data from this same study indicated that when service providers do not consider the impact of structural context on well-being, they are limited in the extent to which they can truly address community residents' mental health needs (Collaborative for Community Wellness, 2018). At both the national and local levels, the mental health system contributes to and reinforces Latino immigrants' experiences of structural oppression by systematically denying access to high quality services.

Challenging Structural Oppression in Practice: Empirical Case Examples

SSW not only emphasizes the importance of assessing social systems from a critical perspective, but it also highlights the importance of challenging structural oppression. The following section will present two empirical examples of practice approaches that challenge oppressive structural contexts based on the authors' research in Chicago. The section will begin with a description of Carrillo's (2017) empirical analysis of innovative practice approaches in the labor realm and a summary of key findings from this analysis. The section will then provide an overview of O'Grady's (2017) case study of a mental health program and highlight findings pertaining to the program's anti-oppressive practice approach.

Alternative Practice Model: Labor

The emergence of the worker center movement has served as a novel approach to organizing workers in the low-wage labor sector who are largely excluded by organized labor. It is in this space that innovative strategies have developed to organize the "unorganizable."

Study methodology. The study by Carrillo (2017) was conducted as research for a doctoral dissertation, with IRB approval. The research focused on the following two research questions: 1) How are the various factors present in the lives of low-wage immigrant workers, excluded workers, and the excluded workforce, in particular, elements of personal, cultural, and structural oppression understood by the worker center organizers? 2) How does this understanding shape and determine the interventions of the worker center organizer and the maturing worker center movement in the Chicagoland area at the three different levels of society; superstructure (interpersonal), structural (social institutions) and substructural (ideologies) in support of this vulnerable workforce? Carrillo (2017) contributes to the literature by examining and developing a conceptual understanding of this organizing process through in-depth, semi-structured interviews with 18 worker center organizers at eight worker centers in the Chicago metropolitan area. Data were analyzed by the author using a modified grounded theory approach to understand the dimensions, properties, context, actions and their consequences related to the process of organizing

vulnerable workers across a variety of low-wage industries and throughout distinct communities in the Chicagoland region.

Study findings. Interviews with the organizers provided space for an examination of the structural elements that are perceived as oppressive in the lives of the workers. The following structures are listed in the order of mentions received within the interviews: labor regulatory (governmental regulatory and enforcement agencies, labor unions, labor policy), immigration (lack of immigration reform, threat of deportation), economic (neoliberal capitalism, the fissured workplace, temp staffing agencies, the informal economy), criminal justice (incarceration, lack of rights for ex-offenders), housing (lack of housing assistance, limited affordable housing options), political (established political parties), educational (school system), welfare (social safety net programs), and health care (access to health care). Many of these structural elements were not only understood through their interconnections, which increase vulnerability to exploitation, but also added to contentious relationships of workers often along racial lines. One respondent captured this notion in the following way:

> *Latino workers, immigrant undocumented workers, are the preferred group for many of these factory owners. They do not… and if you think about why right. It is not knowing regulations, it is not knowing laws, it is like a very obedient workforce that does not cause problems for the boss. People do what they are told right. And it because a fear of retaliation right, fear of deportation, a fear of, if you lose your job you do not have a safety net. You cannot file for unemployment right. So, on the other end, native-born people, if they lose if they are at a place for you know a certain amount of days then they can file for unemployment right. And then the unemployment insurance goes up for the temp agency right. And then you get the factory owners and just say I don't want any Black people I want Mexicans, you know.*

Although each worker center organization is unique, common features exist. Worker centers are often hybrid organizations that take on various functions, including service provisions, advocacy, organizing and formation. The organizations do not exclusively focus on workers from only one company but instead are place-based and work with employees from different employers. These are often democratic organizations, rooted in Latin American liberation movements, which employ elements of popular education. Worker centers often employ a broad agenda that involves causes outside of labor, such as education, tenant rights, and immigration-related issues, among others. They may also involve international issues and transnational work. The centers often have a small but dedicated membership that supports different functions of the organization (Fine, 2006).

Even though worker centers may be varied in their origin and function, they all are grounded in the need to organize alternative local solutions where little else exists in an effort to address the challenges faced by low-wage workers. As a result, organizers have developed strategies to address the issue of workplace exploitation throughout entire sectors of the labor market and within specific communities. These organizers employ a variety of approaches, including direct action, legal action, policy initiatives, partnerships

with state enforcement agencies, collaborations with ally organizations, and promotion of higher workplace standards among the business community.

Understanding the function of the worker center through a structural social work lens proved to be a fruitful endeavor. As a tool to examine oppression in the lives of low-wage workers and prescriptive functions of assessing opportunities for intervention, the model resonated with the worker center organizers in this study. The findings allowed for a detailed understanding of the function that the worker center served as a space for supporting individual workers, organizing for structural change, and engaging in the ideological realm. Worker centers serve as a focal point of activity by workers who seek support on workplace related injustice. However, for workers engaging with the worker center, it also gives them access to many other types of support and possibilities for development.

Worker center organizers shared their understanding of the work through the various roles and functions they serve. At an interpersonal level, the function of the worker center is not only to provide support and attempt to offer relief for the worker, but to also conduct an assessment of other issues present in their lives so that the worker can be connected with other resources and understand how their personal experience is linked to structural oppression. The following respondent highlights an example of the understanding of structural violence as the compounding effect of various oppressive systems:

> *So, I know a worker who has cancer and obviously can't get Obamacare because he is undocumented, and we worked really hard to figure out what to do with him and how to get him what he needed. Before Obamacare even existed, it was more of a question of language access and like if he was trying to get special treatment, could he find the clinic to go to… all of that sort of stuff. So, I think one area of that, is access to services. Another is, and super prevalent one, is contact with the criminal justice system. Whether that is the DUI and in Chicago DUI checkpoints are almost all in black and brown neighborhoods. Whether that is the ways that individual crises mix with poverty to create criminalized communities. You know, like I grew up in an alcoholic household and I also grew up in the suburbs, so you did not see police on a regular basis. So, the ways individual crises and class intersect often leads to calls to the police because there is a fight or DUIs or drinking in public, all of that sort of stuff. Not to mention the direct attack on the workers and the direct racialized policing and that sort of stuff that you know… you are on your way home and a cop forces you up against a wall just for no reason. You know with day laborers a lot of them were living in homeless shelters and a lot of those shelters were getting closed down too.*

Understanding the ties between the personal and the structural, the worker center organizer can engage with the worker in active capacity building and leadership development. The constant presence of the worker center within the marginalized communities they serve also provides the worker center with an opportunity to become the content experts on worker exploitation, and together with the worker engage in developing solutions.

Engaging in the process of structural reform was at the heart of the worker center model, in spite of every challenge present in this undertaking. It is clear however that seeking structural reform requires the development of power. The respondents were all aware of the necessity to develop worker power and would activate their membership base in order to challenge employers and labor regulatory institutions and to reshape policy in favor of the vulnerable worker. Worker center organizers attempt to navigate three essential elements of power: social, economic, and political.

For us [in the Mexican labor movement] it was important [to understand] organizing socially, the economically, and the politically, if you handle all three, you move where you want, and you have power. If you do not handle all three you will not have power as an organization. And here [in the American labor movement] there is no power. The unions have the economic power but not political or social because in the political they are dominated. In the social, they do not do work, they do not care.

Even though challenges and limitations exist in the three areas, respondents were optimistic of the potential for a recently established coalition of worker centers to increase their organizational capacity, as well as to amplify their ability to engage in structural reform. Utilizing the popular organizing axiom, "understanding the world as it is and working towards the world as it should be," worker center organizers must be innovative, creative, resourceful, and above all, not lose sight of what is possible in order to actively support the vulnerable workers. One excellent example of this is the development of the worker cooperative as an alternative economic model, that places people before capital.

Although this study was not meant to be a thorough exploration of all the ideological elements influencing the experiences of the vulnerable worker, capitalism and/or a critique of capitalism was found to be a central ideology in the findings. As this respondent articulates:

I view my goal is developing politically conscious working class leaders and that really only happens through struggle and through struggle in a particular way that is democratic, that is where workers own the struggle and they have to kind of come to grips with the consequences of their actions, they have to come to grips with the strategy themselves and through that process become aware and conscious of capitalism, of racism of the forms of oppression that they are facing and develop leadership over time.

Furthermore, some respondents were keen to understand the dangers of organizing without a deep ideological grounding, as referenced in their critique of Alinsky-style organizing and the U.S. labor movement. Quotes from two different respondents capture this understanding:

So many problems with Alinsky in terms of race and gender and stuff like that. But the biggest critique I have is the whole like leave your ideology at the door and I think, when you do leave your ideology your values your beliefs at the door you get into a situation where, what happened with Alinsky where you organized a bunch of people to like discriminate against another set of minorities. Which you

> *know, the organizing he did in the Back of the Yards, basically he does organizing to exclude black people from the area.*

> *[The] U.S. labor movement because it has no explicit ideology, you know gets led down all these paths and that is part of the reason why we are where we are.*

Although the respondents understood the necessity of grounding their organizing efforts in the ideological space of what a different world could look like, they presented a list of challenges to doing so. Challenges notwithstanding, both the potential and desire to develop an articulation of the ideological grounding exists within the worker center movement in Chicago.

Alternative Practice Model: Mental Health

O'Grady (2017) used a case study design to explore a branch of Saint Anthony Hospital's Community Wellness Program (CWP), located in Chicago, that offers mental health services exclusively to uninsured Latino immigrant adults. Operating under the purview of a community hospital and funded through the hospital's operating budget, the CWP offers mental health services in community-based satellite locations. Mental health services are offered in conjunction with a range of supportive services including family support, health education, and public benefits assistance. The branch of the CWP that was examined is located in a neighborhood with a predominantly Mexican immigrant population, and its unique focus on mental health service delivery with uninsured Latino immigrants provides an important opportunity to explore how the structural context impacting this population is addressed in practice.

Study methodology. O'Grady (2017) conducted a case study of the aforementioned branch of the CWP for her doctoral dissertation research. This case study was informed by the following research questions: 1) How do service providers and service participants describe the services that are delivered at the CWP? 2) How do service providers and service participants experience service delivery at the CWP? and 3) How does the program address the mental health needs of community residents? Using a transcendental phenomenological qualitative approach, O'Grady (2017) conducted 21 semi-structured individual interviews with service providers and mental health program participants; observed routine program activities; and collected 17 agency documents. O'Grady (2017) analyzed all data independently using an inductive open coding process to identify salient themes. Of the 10 interviews conducted with service providers, nine were conducted in English and one was conducted in Spanish, while all 11 interviews with program participants were conducted in Spanish. IRB approval was received prior to beginning research activities. Findings from this case study led to the development of a new empirical model for conceptualizing culturally competent service delivery (O'Grady, 2017). The section below will present data demonstrating how the CWP addresses community members' mental health needs through its anti-oppressive practice strategies, which is one element of the larger empirical model. Due to space limitations, only the English translation is presented for quotes from Spanish-language interviews with program participants. The second author translated all quotes from Spanish to English.

Study findings. Data indicated that at both the level of the organization and the level of individual providers, mental health practice at the CWP challenges the oppressive structural context in which Latino immigrants are situated. At the organizational level, the CWP is intentionally designed to create an alternative space outside of the biomedical model of mental health service delivery. Within this alternative space, mental health services are free and time-unlimited; program participants may start, stop, and reinitiate services without penalty; and program participants are not assigned a DSM-V diagnosis. Service providers explicitly describe their alternative practice model as challenging structural oppression. Services are free and time-unlimited because community members have traditionally been denied access to long-term mental health services when they are unable to pay the out of pocket cost. Similarly, recognizing that program participants have commonly experienced multiple traumas that they may not be ready to explore immediately upon initiating services, the CWP's model provides the flexibility for program participants to process past trauma at a pace that feels comfortable without facing penalties for "no showing" appointments. Service providers also intentionally do not assign DSM-V diagnoses to avoid pathologizing program participants. As one service provider stated:

> *When you're dealing with communities that have been oppressed, marginalized, a lot of this internalized oppression, you know, going to a clinical setting that then reinforces that by giving them diagnoses and reinforcing that yes, they need to be treated for whatever they're dealing with is very, very reinforcing of this oppressive nature.*

Another service provider described that, by framing mental health challenges in the context of environmental conditions rather than in the context of symptomology, this alternative model conveys that: "We are products of our environments, not just products of our pathology."

The alternative practice model at the CWP offers service providers the flexibility to deliver services in a manner that aligns with their ideals about what high quality mental health service delivery entails:

> *We can meet our clients as we see absolutely fit. That means absolutely minimal paperwork. It's just a true devotion to the work being almost entirely relational, not planned out and boxed in and meeting milestones and meeting have you met your goals yet. No. That to me stands out.*

As this quote illustrates, the alternative space that has been created at the CWP is largely defined by alternative patterns of interaction that challenge both traditional service interactions within the biomedical model and patterns of discriminatory interpersonal interactions within society at large. Through these alternative patterns of interaction, service providers dismantle power differentials in the therapeutic relationship; affirm individuals' strengths and provide a space where they may reclaim their self-worth; and collaboratively work with program participants to reframe the meaning attributed to past traumatic experiences.

Service providers described the practice of dismantling power differentials as one in which they convey that program participants enter the therapeutic space with a set of

strengths and expertise. This practice of dismantling power differentials is thus integrally connected to the practice of affirming individuals' strengths and providing a space to reclaim one's self-worth. In accordance with this practice of affirming individuals' strengths, one service provider stated:

> *I am like the mirror. I'm just reflecting back to you what–who you are, and sometimes I might shift the mirror a little to the side, and have you see a different perspective of something, but it's still you, and that strength and that wisdom that you have within yourself that's coming through.*

Recognizing that program participants are systematically denied access to social spaces, service providers described their role as offering a space where individuals can find the answers within themselves, and in so doing can reclaim their voice and self-worth that are silenced and denied within society at large. As program participants feel safe and empowered within the therapeutic space, they explore and reframe past traumatic experiences in collaboration with service providers. Central to this process is contextualizing traumatic experiences in relation to oppressive environmental conditions:

> *What it looks like is… starting to slowly, respectfully, question those narratives with curiosity, not defiantly, but sort of really start to explore the validity of those narratives and see if there are spaces in it where rather than taking a sort of oppression bound take on things that you can sort of insert strengths instead and say well is it that you are truly just a useless person who can't take matters into her own hands. Is that really true? Or is it that that has been imposed on you over the course of your entire life? How much of a choice did you really have in that matter and how much of a choice do you have now to start pushing back?...Then saying maybe then you didn't have a choice to push back, but maybe now you do.*

Mental health program participants described the CWP's alternative practice model, and the alternative patterns of interaction that took place within that space, as promoting positive mental health outcomes. Program participants who had prior experiences with mental health services described the CWP as being different from other places where they had sought services:

> *So, my experience here in the program is that I first entered, and it wasn't like the others. They let me talk, or it was what I was looking for. So that caught my attention, it wasn't like the others where they say, and why did you come? No, they listened to me, they said, well, what can we talk about? Or rather they didn't demand that I talk about certain things, or about why I'm depressed, or something like that. No, with them, what do you want to begin talking about?*

Within the context of this space where they felt the safety and freedom to explore the answers within themselves and process past traumatic experiences, program participants felt an enhanced sense of self-worth:

> *…it has helped me a lot, it is helping me a lot, because before I was, why are these things happening to me? And I didn't know why. But now I am understanding, seeing, that I had always blamed myself, that it must be something that I am doing*

> *wrong, or something like that. But with the passage of time…they are helping me to understand that things happen for some reason and that it is not always my fault.*

Program participants also explained that as they processed past traumatic experiences and redefined how they viewed themselves, they became increasingly aware of the need to advocate for their rights within other social systems:

> *So, the program hasn't told me you have to do this, right, but rather in the way that they go about orienting you, you realize as a parent and as a member of the community what rights you have and what rights you don't have. So, I have learned so much. I have learned so much about everything, that I have rights, what I am able to do. And there are many parents that don't know that.*

Lastly, program participants described how their personal transformation and their desire to affect change in their communities led to their involvement in community organizing initiatives. One service participant described how they became involved in community level efforts to increase Latino immigrants' access to mental health services:

> *…I have seen a radical change that has happened in my life, so radical. So, I said that I could continue with these steps and involve myself with helping people so that they become acquainted with [these services], so that they go and can solve their problems without having a big disruption or having more serious problems… if I saw this change in myself, I think that a thousand people are going to make this change that they so desire.*

Program participants thus identified that as they integrated new understandings of themselves and their environments, this growing sense of critical consciousness empowered them to advocate for structural change in their communities.

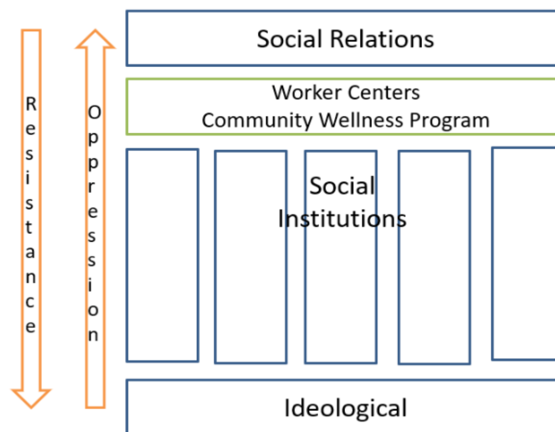
Implications

Implications for Social Work Practice

From a SSW perspective, the examples of the Chicago worker centers and the CWP are illustrative of practice models that are situated between and span across the systemic and relational elements of Mullaly's (2007) bridge model (see Figure 2 below). Both practice models are informed by an understanding of how oppressive systemic and interpersonal interactions negatively impact the well-being of Latino immigrants in Chicago. In addition, both models have created alternative spaces that promote personal and structural transformation. At the personal level, the alternative patterns of interaction promoted within these spaces lead community members to integrate new understandings of themselves and their environments, which ultimately allows them to reclaim their self-worth. In the context of worker centers, immigrant workers are provided with a space to assert their rights in their place of employment, which in turn allows them to recover a sense of self-worth that was challenged as a result of workplace exploitation. Similarly, as program participants at the CWP engage in therapeutic encounters where their strengths and expertise are affirmed and where traumatic experiences are understood in the context of structural oppression, they redefine how they see themselves.

This personal transformation is connected to social justice movement work focused on transforming structural contexts. At worker centers, personal healing is connected to efforts to improve workplace conditions and advocate for labor system regulatory changes through changes in policy. At the CWP, new understandings of how individuals view themselves in relation to their environment inform new ways of interacting with their communities and social systems. As community residents advocate for their rights and become involved in community organizing initiatives, these new patterns of interaction are linked to structural transformation. Not only do immigrant workers and CWP program participants become involved in structural change efforts, but the organizations themselves also challenge oppressive social systems through the infrastructure that they have developed to implement these alternative models.

Figure 2. *The Bridge Model as Applied to Worker Centers and the CWP*



Adapted from Mullaly (2007, p. 246)

While the case examples highlighted in this article demonstrate the potential for alternative practice models to simultaneously promote personal and structural transformation, this is not to say that these models are free of challenges. Worker center organizers are aware of the enormity of the task, given the size of their organizations compared to the industries that they are looking to challenge. The largest worker center in Chicago at the time of the study only employed six organizers. Their limited organizing capacity does not allow worker centers to build the economic power necessary to effectively challenge the labor sectors they are targeting. In addition, at the CWP, the mental health program has a waiting list of approximately eight months, demonstrating that the program cannot keep pace with the demand for services. Although it is important to acknowledge these challenges, they should not be viewed as deterrents for creating alternative practice models. Recognizing that resource limitations pose challenges to the

scope of the intervention in each of the case examples, increased investment in the creation of alternative spaces at the local level is critical for far-reaching structural transformation. Social work practitioners can play an invaluable role in advocating for the creation of these alternative spaces. Furthermore, across organizational contexts, social workers can promote personal and structural transformation by integrating into their practice an understanding of the impact of the structural context on well-being and interacting with program participants in a manner that challenges oppressive systemic and interpersonal interactions.

Implications for Social Work Research

The presented case examples highlight the importance of conducting research with marginalized populations, including the Latino immigrant population, from a SSW perspective. For the Latino immigrant population in particular, there is a growing body of literature documenting the ways in which Latino immigrants experience oppression within U.S. society. Research that fails to take into account the oppressive structural context in which Latino immigrants are situated runs the risk of pathologizing individuals, families, and communities for the challenges that they experience. In addition, research that explores how programs and organizations engage with and push back against oppressive structural contexts allows for the identification of innovative practices across realms connected to well-being. Engaging in anti-oppressive practice that promotes personal and structural transformation requires research highlighting innovative strategies for achieving this aim.

Conclusion

In this article, we have discussed the relevance of a SSW framework for understanding Latino immigrants' experiences of structural oppression. We have additionally used a SSW lens to examine how dominant ideologies inform the development of social systems that intentionally perpetuate structural oppression. Finally, we presented alternative models of practice in the realms of labor and mental health that connect interventions at the personal and structural levels. These spaces contribute to personal healing by promoting alternative patterns of interaction that support Latino immigrants in redefining how they see themselves and reclaiming their self-worth. At the same time, these interventions at the personal level empower community residents to become involved in advocacy and community organizing initiatives, which in turn promotes structural transformation. Findings suggest that when social workers are intentional in implementing interventions that both promote personal healing and challenge oppressive social systems and underlying ideologies, their efforts to change local community contexts can cumulatively translate to more far-reaching structural transformation.

References

Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, & Nakamoto, J. (2012). *Community-defined solutions for Latino mental health care disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup population report*. Sacramento, CA: UC Davis.

Ayón, C. (2014). Service needs among Latino immigrant families: Implications for social work practice. *Social Work*, *59*(1), 13-23. doi: https://doi.org/10.1093/sw/swt031

Bernhardt, A., Milkman, R., Theodore, N., Heckathron, D., Auer, M., DeFilippis, J., Gonzalez, A., Narro, V., Perelshteyn, J., Polson, D., & Spiller, M. (2009). Broken laws-Unprotected workers: Violation of employment and labor laws in America's cities. Chicago, IL: Center for Urban Economic Development.

Bernhardt, A., & McGrath S. (2005). Trends in wage and hour enforcement by the U.S. Department of Labor, 1975-2004, New York: Brennan Center for Justice.

Bobo, K. (2009). Wage theft in America: Why millions of working Americans are not getting paid-and what we can do about it. New York: The New Press.

Borjas, G. (1989). Economic theory and international migration. *International Migration Review*, *23*(3), 457-485. doi: https://doi.org/10.1177/019791838902300304

Bridges, A. J., Andrews, A. R., & Deen, T. L. (2012). Mental health needs and service utilization by Hispanic immigrants residing in mid-Southern United States. *Journal of Transcultural Nursing*, *23*(4), 359-368. doi: https://doi.org/10.1177/1043659612451259

Bui, Q. (2015, February 23). 50 years of shrinking union membership, in one map. *National Public Radio: Planet Money.* Retrieved from https://www.npr.org/sections/money/2015/02/23/385843576/50-years-of-shrinking-union-membership-in-one-map

Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). "It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant Health*, *9*, 1-16.

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(3), 316-330. doi: https://doi.org/10.1007/s10488-006-0040-8

Cabral, A., & Handyside, R. (1970). *Revolution in Guinea: Selected texts*. London: Monthly Review Press.

Carrillo, A. (2017). *Chicago's worker center movement: A structural analysis* (Doctoral dissertation). University of Illinois at Chicago, Chicago, IL.

Coalition to Save our Mental Health. (n.d.). Mission and history. Retrieved from http://saveourmentalhealth.org/mission--history.html

Collaborative for Community Wellness. (2018). *Uplifting voices to create new alternatives: Documenting the mental health crisis for adults on Chicago's southwest side.* Chicago, IL: Saint Anthony Hospital -Center for Community Wellness.

Collinson, S., & Diamond, J. (2016, September 1). Trump on immigration: No amnesty, no pivot. *CNN*. Retrieved from http://www.cnn.com/2016/08/31/politics/donald-trump-immigration-speech/

De Genova, N. (2002). Migrant "illegality" and deportability in everyday life. *Annu. Review Anthropol*, 31, 419-447. doi: https://doi.org/10.1146/annurev.anthro.31.040402.085432

De Genova, N. (2004). The legal production of Mexican/migrant "Illegality". *Latino Studies*, *2*, 160-185. https://doi.org/10.1057/palgrave.lst.8600085

De Genova, N. (2005). Working the boundaries: Race, space, and "illegality" in Mexican Chicago. Durham, NC: Duke University Press. doi: https://doi.org/10.1215/9780822387091

Fecile, J. (2012, May 9). With mental health clinic closures imminent, protesters take to the streets. *HuffPost*. Retrieved from https://m.huffpost.com/us/entry/1333498

Fine, J. (2006). *Worker centers: Organizing communities at the edge of the dream*. Ithaca, NY: ILR Press.

Flores, E., Tschann, J. M., Dimas, J. M., Bachen, E. A., Pasch, L. A., & de Groat, C. L. (2008). Perceived discrimination, perceived stress, and mental and physical health among Mexican-origin adults. *Hispanic Journal of Behavioral Sciences*, *30*(4), 401-424. doi: https://doi.org/10.1177/0739986308323056

Freeman, R., Han, E., Madland D., & Duke, B. (2015). *Bargaining for the American dream: What unions do for mobility.* Center for American Progress. Retrieved from https://cdn.americanprogress.org/wp-content/uploads/2015/09/08130545/UnionsMobility-report-9.9.pdf

Freeman, R., Han, E., Duke, B., & Madland D. (2016). *What do unions do for the middle class?* Center for American Progress. Retrieved from https://cdn.americanprogress.org/wp-content/uploads/2016/01/11102501/UnionsMiddleClass-report.pdf

Fussell, E. (2011). The deportation threat dynamic and victimization of Latino migrants: Wage theft and robbery. *The Sociological Quarterly*, *52*(4), 593-615. doi: https://doi.org/10.1111/j.1533-8525.2011.01221.x

Garcini, L. M., Murray, K. E., Zhou, A., Klonoff, E. A., Myers, M. G., & Elder, J. P. (2016). Mental health of undocumented immigrant adults in the United States: A systematic review of methodology and findings. *Journal of Immigrant & Refugee Studies*, *14*(1), 1-25. doi: https://doi.org/10.1080/15562948.2014.998849

Gleeson, S. (2010). Labor rights for all? The role of undocumented immigrant status for worker claims making. *Law & Social Inquiry*, *35*(3), 561-602. doi: https://doi.org/10.1111/j.1747-4469.2010.01196.x

Gomberg-Muñoz, R. (2011). Labor and legality: An ethnography of a Mexican immigrant network. New York: Oxford University Press.

Hall, M., Greenman, E., & Farkas, G. (2010). Legal status and wage disparities for Mexican immigrants. *Social Forces*, *89*(2), 491-513. doi: https://doi.org/10.1353/sof.2010.0082

Horton, S. (2006). The double burden on safety net providers: Placing health disparities in the context of the privatization of health care in the U.S. *Social Science & Medicine*, *63*, 2702-2714. doi: https://doi.org/10.1016/j.socscimed.2006.07.003

Lagomasino, I. T., Dwight-Johnson, M., Miranda, J., Zhang, L., Liao, D., Duan, N., & Wells, K. B. (2005). Disparities in depression treatment for Latinos and site of care. *Psychiatric Services*, 56, 1517-1523. doi: https://doi.org/10.1176/appi.ps.56.12.1517

Lesniewski, J., & Drucker, J. (2017). *Economic impact and lived experience of wage theft* [PowerPoint slides]. Proceedings from Urban Affairs Association 2017. Minneapolis, MN.

Levin, R., & Ginsburg, R. (2000). *Sweatshops in Chicago: A survey of working conditions in low-income immigrant communities*. Chicago, IL: Center for Impact Research. Retrieved from https://www.issuelab.org/resources/364/364.pdf

Lowe, F. H. (2015, March 30). The closing of the Woodlawn Mental Health Center disrupted the lives of the Black men it served. *Social Justice News Nexus*. Retrieved from http://sjnnchicago.medill.northwestern.edu/blog/2015/03/30/the-closing-of-the-woodlawn-mental-health-center-disrupted-the-lives-of-the-black-men-it-served/

Massey, D. S., Durand, J., & Malone N. J. (2002). *Beyond smoke & mirrors: Mexican immigration in an era of economic integration.* New York: Russell Sage Foundation.

Mehta, C., & Theodore, N. (2005). *Undermining the right to organize: Employer behavior during union representation campaigns*. University of Illinois at Chicago: Center for Urban Economic Development.

Mehta, C., Theodore, N., Mora, I., & Wade, J. (2002). *Chicago's undocumented immigrants: An analysis of wages, working conditions, and economic contributions*. University of Illinois at Chicago: Center for Urban Economic Development.

Menjívar, C. (2016). Immigrant criminalization in law and the media: Effects on Latino immigrant workers' identities in Arizona. *American Behavioral Scientist*, *60*(5-6), 597-616. doi: https://doi.org/10.1177/0002764216632836

Meyer J., & Greenleaf, R. (2011). *Enforcement of state wage and hour laws: A survey of state regulators.* New York: Columbia Law School-National State Attorneys General Program.

Moreau, M. J. (1979). A structural approach to social work practice. *Canadian Journal of Social Work Education*, *5*(1), 78-94.

Mullaly, B. (2007). *The new structural social work* (3rd ed.). Don Mills, Ont.: Oxford University Press.

O'Grady, C. L. (2017). *Culturally competent mental health practice: A case study of an organization serving Latino immigrants* (doctoral dissertation). University of Illinois at Chicago, Chicago, IL.

Orrenius, P. M., & Zavodny, M. (2009). Do immigrant work in riskier jobs? *Demography*, *46*(3), 535-551. doi: https://doi.org/10.1353/dem.0.0064

Passel, J. S., & Cohn, D. (2016). *Overall number of U.S. unauthorized immigrants holds steady since 2009*. Pew Research Center. Retrieved from http://www.pewhispanic.org/files/2016/09/PH_2016.09.20_Unauthorized_FINAL.pdf

Raymond-Flesch, M., Siemons, R., Pourat, N., Jacobs, K., & Brindis, C. D. (2014). "There is no help out there, and if there is, it's really hard to find": A qualitative study of the health concerns and health care access of Latino "DREAMers". *Journal of Adolescent Health*, *55*, 323-328. doi: https://doi.org/10.1016/j.jadohealth.2014.05.012

Rivera-Batiz, F. L. (1999). Undocumented workers in the labor market: An analysis of the earnings of legal and illegal Mexican immigrants in the United States. *Journal of Population Economics*, *12*(1), 91-116. doi: https://doi.org/10.1007/s001480050092

Rylko-Bauer, B., & Farmer, P. (2002). Managed care or managed inequality? A call for critiques of market-based medicine. *Medical Anthropology Quarterly*, *16*(4), 476-502. doi: https://doi.org/10.1525/maq.2002.16.4.476

Salas, L. M., Ayón, C., & Gurrola, M. (2013). Estamos traumados: The effect of anti-immigrant sentiment and policies on the mental health of Mexican immigrant families. *Journal of Community Psychology*, *41*(8), 1005-1020. doi: https://doi.org/10.1002/jcop.21589

Saleebey, D. (2005). Balancing act: Assessing strengths in mental health practice. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives* (pp. 23-44). New York, NY: Columbia University Press.

Sanchez, H. E., Delgado, A. L., & Saavedra, R. G. (2011). *Latino workers in the United States 2011 Report.* Labor Council for Latin American Advancement. Retrieved from http://latinosforasecureretirement.org/resources/LCLAA_Report.pdf

Santiago-Rivera, A. L., Kanter, J. W., Busch, A. M., Rusch, L. C., Reyes, W…Runge, M. (2011). Latino immigrants with depression: An initial examination of treatment issues at a community clinic. *Journal of Immigrant and Minority Health*, *13*, 772-779. doi: https://doi.org/10.1007/s10903-010-9380-2

Sassen-Koob, S. (1981). Towards a conceptualization of immigrant labor. *Social Problems*, *29*(1), 65-85. doi: https://doi.org/10.2307/800079

Spielman, F. (2017, October 31). Health commissioner defends smaller network of mental health clinics. *Chicago Sun Times*. Retrieved from https://chicago.suntimes.com/chicago-politics/health-commissioner-defends-smaller-network-of-mental-health-clinics/

U.S. Department of Labor. (n.d.). Wage and Hour Division Mission Statement. Retrieved from https://www.dol.gov/whd/about/mission/whdmiss.htm

Weil, D. (2008). A strategic approach to labour inspection. *International Labour Review*, *147*(4), 349-375. doi: https://doi.org/10.1111/j.1564-913X.2008.00040.x

Young, I. M. (2013). Five faces of oppression. In M. Adams, W. J. Blumenfield, C. Castañeda, H. W. Hackman, M. L. Peters, & X. Zúñiga (Eds.), *Readings for diversity and social justice* (3rd ed., pp. 35-44). New York, NY: Routledge.

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Challenges to Family Unity and Opportunities for Promoting Child Welfare in an Increasingly Punitive Immigration Landscape

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Abstract: *This paper describes specific challenges to family unity and child welfare among children in immigrant families resulting from immigration enforcement. Surges in immigration activity over the past decade have resulted in family economic hardship, psychological trauma to children, and difficulty accessing social services. Children whose parents are detained/deported are at risk of unnecessarily entering the child welfare system, and encounter significant barriers to family reunification. In recent months, the scope of enforcement priorities that previously safeguarded many parents now target a much larger group of immigrants for deportation, increasingly disregarding the needs of children. Immigration raids have terrorized communities across the country, and repercussions are being felt by the child welfare system and social service providers. Within an anti-immigrant political climate, there is a desperate need for social workers to lead initiatives to respond to immigrants' needs. Strategies include: (1) development of social work expertise in working with immigrants; (2) cross-systems and cross-disciplinary collaborations; (3) leveraging existing resources and supports; (4) documentation/collection of data; and (5) focused advocacy efforts.*

Keywords: *Children of immigrants; child welfare; social work*

The number of children in immigrant families in the U.S. has risen for the past several decades. By 2015, a full quarter of children in the U.S. were from immigrant families (Clarke, Turner, & Guzman, 2017). Numbers of unaccompanied children arriving to the U.S. have also spiked in recent years (Rosenblum & Ball, 2016). In 2016 alone, nearly 250,000 immigrants were deported (U.S. Immigration and Customs Enforcement, 2016). Thousands of unaccompanied children were placed in federal foster care or released to sponsors while awaiting asylum claims. Surges in immigration activity have resulted in family economic hardship, psychological trauma to children, and difficulty accessing social services. Children whose parents have been detained or deported have been at risk of unnecessarily entering the child welfare system, and encounter significant barriers to reunification with their parents. Unprecedented numbers of unaccompanied migrant children arriving to the U.S. in recent years have posed significant challenges for the child welfare system. Once children in immigrant families come to the attention of the child welfare system, they face considerable barriers to achieving positive outcomes.

During the Obama administration, some efforts were made to reduce the risk of collateral consequences of immigration on children. For example, the 2013 ICE Parental Interests Directive protects immigrants' parental rights and responsibilities by increasing detained parent's ability to be involved in child welfare proceedings and arrangement of

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care for their children (U.S. Immigration and Customs Enforcement [ICE], 2013). In recent months, however, the scope of enforcement priorities that previously safeguarded many parents now target a much larger group of immigrants for deportation, increasingly disregarding the needs of children. Immigration raids have terrorized communities across the country, and repercussions are being felt by the child welfare system and social service providers throughout the country.

This article describes specific challenges to family unity and child well-being among immigrant children or U.S. citizen children in immigrant families resulting from immigration policy and enforcement activities. Within an anti-immigrant political climate, this paper identifies opportunities for social workers to lead initiatives to respond to this problem, with strategies that include: (1) development of social work expertise in working with immigrants; (2) cross-systems and cross-disciplinary collaborations; (3) leveraging existing resources and supports; (4) documentation/collection of data; and (5) focused advocacy efforts.

Children of Immigrants in the U.S.

Changes in immigration patterns and trends over the past two decades have considerably shifted the demographic profile of the United States (Grieco et al., 2012). The number of foreign-born immigrants living in the United States has increased, and the proportion of children in the U.S. living in immigrant families has been rising for the past several decades. In 1990, just 8.3% of children in the U.S were in immigrant families, but by 2015, a full quarter of children were from immigrant families (Annie E. Casey Foundation, 2018).

Approximately 20 percent of children with two parents live with two foreign-born parents, and 10 percent of children live in families of mixed-status parents, or families with one foreign-born and one native-born parent (U.S. Census Bureau, 2017). Almost a third (30%) of children of immigrants have at least one undocumented parent (Capps, Fix, & Zong, 2016), while 90% of children in immigrant families are themselves U.S. citizens (Annie E. Casey Foundation, 2017). More than half (55%) of immigrant children are of Hispanic origin, followed by sixteen percent non-Hispanic white, seventeen percent non-Hispanic Asian, and nine percent non-Hispanic black (Child Trends Data Book, 2014). Although children of immigrants reside throughout the country, half of children in immigrant families live in 4 states: California, Texas, New York, and Florida Annie E. Casey Foundation, 2017). Rates of children in immigrant families vary widely by state, ranging from 3% in West Virginia to 48% in California .

The numbers of unaccompanied children arriving to the U.S. have also spiked in recent years, peaking in 2014 and rising again in 2016 with nearly 60,000 arrivals that year (U.S. Customs and Border Protection, 2016). The greatest numbers of children encountered by U.S. Customs and Border Patrol are arriving from Guatemala, Honduras, and El Salvador, known as the Northern Triangle region of Central America (Chishti & Hipsman, 2016). The vast majority of unaccompanied children released to approved sponsors are in California, Texas, New York, and Florida.

Challenges to Family Unity & Child Well-Being

Immigration Enforcement and Child Well-being. Immigration enforcement activities conducted by Immigration and Customs Enforcement (ICE) have resulted in an unprecedented number of deportations over the past decade. The period between 2005 and 2008 was characterized by a large increase in enforcement efforts, most notably with several highly publicized worksite enforcement operations (Dettlaff & Finno-Velasquez, 2013). Major worksite enforcement operations were mostly halted in 2008 with a changing administration and harsh criticism by child advocates. As a result of the attention generated by these raids, ICE developed a set of humanitarian guidelines that applied to enforcement actions involving more than 150 arrests, which was later reduced to actions involving more than 25 arrests (Dettlaff, 2012). Those guidelines encouraged the identification of individuals who are the sole caregivers of minor children or who have other humanitarian concerns, including individuals with serious medical conditions, nursing mothers, pregnant women, or caregivers of spouses or relatives with serious medical conditions. Evidence suggests that when administered appropriately, those guidelines have been effective in preventing or minimizing parent-child separations (Chaudry et al., 2010). The limitation is that those guidelines do not apply to enforcement actions targeting individuals or small groups, including home raids and other small criminal justice operations.

Although worksite raids were suspended under the Obama administration, the Obama administration oversaw the highest number of deportations in recent history. Between 2009 and 2013, almost half a million parents were deported from the United States (American Immigration Council, 2017). In fiscal year 2016 alone, almost a quarter million immigrants were deported (López & Bialik, 2017). The leading countries of origin for deportations were Mexico, Honduras, Guatemala, and El Salvador (Batalova & Lesser, 2017). Documented impacts of worksite raids include family economic hardship, psychological trauma to children, difficulty accessing social services because of language barriers, difficulty documenting eligibility, mistrust and fear, and family separation (Campetella et al., 2015).

There are several reasons for this increase in detention and deportation, all of which are associated with interior enforcement operations, such as fugitive operations, small worksite raids, Customs and Border Patrol traffic stops, and increased cooperation between local law enforcement and the Department of Homeland Security (DHS). In 2007, a strategy was adopted to prioritize the apprehension of immigrants who have committed criminal offenses, which resulted in the merging of several programs under the ICE Agreements of Cooperation in Communities to Enhance Safety and Security (ACCESS) initiative. One of the most well-known of these is the 287(g) program, which established collaborations between ICE and local officials that allow local police to be deputized to enforce immigration laws. Currently ICE has 287(g) agreements with 60 law enforcement agencies in 18 states, and ICE officers have certified more than 1,800 local officers to enforce immigration law (U.S. Department of Homeland Security, 2017). A related program, Secure Communities, uses local jails to identify immigrants for deportation by forwarding fingerprint data from the FBI to ICE, which determines the arrested person's immigration status. If the arrested person is identified as a non-citizen, ICE can request that

local authorities detain that person until ICE moves him or her to an immigration detention center.

Although the stated goal of these programs is the removal of individuals who pose a threat to national security and public safety by prioritizing those with an aggravated felony conviction or multiple felonies, Secure Communities has resulted in the deportation of thousands of immigrants who do not have criminal convictions at all, or whose only crimes are simple misdemeanors such as driving without a license (American Immigration Lawyers Association [AILA], 2011). Secure Communities operates as a partnership between local law enforcement and ICE and is still implemented throughout the country.

In addition to these federal enforcement programs, a number of state and local immigration enforcement initiatives have been fueld by anti-immigrant sentiment, such Arizona's Senate Bill 1070 and other copycat laws. Arizona Senate Bill 1070 (Support our Law Enforcement and Safe Neighbors Act, 2010) imposed penalties on immigrants who failed to provide immigration documentation and allowed law enforcement to ask suspected undocumented immigrants about their immigration legal status. Following the adoption of Arizona's law, many other states considered copycat laws while Utah, Georgia, Indiana, Alabama, and South Carolina passed SB1070-style legislation (Lacayo, 2011). However, Arizona's SB1070 (and others) have since been challenged in court. In 2012 the Supreme Court blocked three of four provisions in the bill as well as in other copycat laws (Liptak, 2012).

Despite the ramping up of enforcement during the Obama administration, some efforts were made to reduce the risk of collateral consequences on children. Advocacy by immigrant rights and child protection groups led to an increased use of prosecutorial discretion to release parents in deportation cases. This resulted in a decrease in removals of parents of children legally present in the U.S. (Trevizo, 2016). In 2011, ICE created policy that directs ICE personnel to avoid arresting individuals at certain “sensitive locations” including churches, schools, and childcare programs (Morton, 2011). Arguably, the largest win for children during the Obama administration was ICE’s 2013 Parental Interests Directive, created with the aim of helping ICE balance the enforcement of immigration laws with respect for a parent's/guardian's rights and responsibilities. The Parental Interests Directive contains specific guidelines for the handling of cases involving primary caretakers, parents or legal guardians of minor children, and particularly those involved in family court or child welfare proceedings. It promotes better tracking of immigration cases involving parents, legal guardians, and primary caretakers of minor children. This directive encourages taking children into account when determining detention placement locations, needs for court participation, and allowing for parent-child visitation. As a result, it also increased the ability of detained parents to make decisions for the care of their children and participate in child welfare proceedings. With the implementation of the Parental Interests Directive, while families continued to be separated by immigration enforcement, the chances that a family would become involved with the child welfare system as a result of immigration enforcement decreased.

However, harsh enforcement strategies were again elevated along the border in 2014 when unaccompanied immigrant children began to flee to the United States in large

numbers to escape violence and persecution in their countries of origin (Kandel, 2017). As a result, the Obama administration publicly committed to an aggressive deterrence strategy which resulted in increased apprehensions of children and individuals seeking asylum from Mexico and other Central American countries (The White House, Office of the Press Secretary [WH OPS], 2014). This surge resulted in an expansion of immigrant detention, including the detention of children and mothers, and increases in the separation of children from their parents when crossing the border (Detention Watch Network, n.d.). Through the Office of Refugee Resettlement, many thousand unaccompanied children are released to parents or relatives willing to sponsor the children while they are waiting for decisions in their immigration cases. As currently funded, the ORR licensing and monitoring process for unaccompanied minor sponsor cases is generally less stringent than the regulation and oversight of state foster care licensing. In most cases, federal protective jurisdiction of unaccompanied children ends after a short home study and release to sponsors. Once released to sponsors, these placements are not subject to any oversight or monitoring, and the children do not have access to health insurance, public assistance, or any health or support services normally afforded to children in state foster care, leaving the placements at risk of disruption, exploitation, and maltreatment.

Impact of Immigration Enforcement on Children and Families. Research documenting the impact of immigration enforcement activities over the past decade suggests that parental detention and deportation results in child trauma and mental health problems, increased family instability, and heightened risk that a family will become involved with the state child welfare system, especially when parents lose their parental rights (Koball et al., 2015). U.S.-citizen children of detained and deported parents experience a greater amount of psychological distress, trauma, and PTSD symptoms than their counterparts with parents who have not been impacted by immigration enforcement (Rojas-Flores, Clements, Koo, & London, 2017). Children affected by parental detention and deporation also demonstrate higher levels of depression and anxiety, lower academic performance, and greater behavioral problems (Rojas-Flores et al., 2017). Furthermore, Dreby (2012) found that children in Latino immigrant families experience significant negative outcomes not only due to the fear of immigration enforcement, but also because of ethnic identity challenges and stigma and conflation of ICE with law enforcement.

Not only does immigration enforcement negatively affect children, but it also affects the entire family system. In one study, spouses and partners reported increased feelings of depression and social isolation, which is associated with negative cognitive and behavioral outcomes in children (Koball et al., 2015). The loss of income from a detained or deported family member contributes to family financial insecurity, housing and related food insecurity, and lack of access to social services due to fear of interacting with government officials (Brabeck, Sibley, & Lykes, 2016; Dreby, 2012). The many burdens of immigration enforcement including financial distress, stressful events, and social isolation, are factors associated with child maltreatment and involvement with the child welfare system (Dettlaff & Finno-Velasquez, 2013).

The Current Climate. The concerns for children resulting from family separation and immigration enforcement have escalated since the 2016 presidential election. In recent months, the scope of enforcement priorities that previously safeguarded many parents now

target a much larger group of immigrants for deportation, increasingly disregarding the needs of children. Shortly after taking office, the Trump administration issued two executive orders that authorized a new list of immigration enforcement priorities expanding removability to include anyone who has committed an act constituting a chargeable offense, such as entering the country illegally, which placed nearly 11 million undocumented individuals and many legal permanent residents at risk of deportation (WH OPS, 2017). Since that time, the nation has seen ramped up activity by ICE in communities across the country.

In 2017, the Trump administration proposed a new deterrence strategy that included systematically separating children crossing borders from their parents and placing them into foster care (Ainsely, 2017). Public outcry put a stop to this border deterrence initiative, but the impacts of ramped up enforcement are still felt (Foley & Planas, 2017). In fact, although it has not received much press, the separation of children and parents at the border has occurred to some degree since the Obama administration (AILA, 2016). With very limited options for family detention, parents and children are often held in separate facilities (Barrick, 2016). Reports have also surfaced of pregnant women seeking asylum being held in detention with risks to their unborn children's health, in violation of ICE's own policy (Bogado, 2014). Asylum claims by people fleeing violence and persecution in Mexico and other Central American countries are no longer being granted (Dickerson & Jordan, 2017). Reports of suicidal ideation and attempt among detained women and their children have emerged.

In July of 2017, the Trump administration also announced that it will begin arresting and deporting undocumented parents, guardians, and relative sponsors of unaccompanied children (Burke, 2017). The effects of this policy exacerbate the chances that unaccompanied children will be placed in state child welfare custody. Not only does this policy punish individuals who have in good faith come forward to care for unaccompanied children, but it will also leave children with fewer relative and kin options for sponsors, placing them at higher risk of disruption in placement and increased risk for entry into state foster care.

Immigration Enforcement and Risk for Child Welfare Involvement. Although an emerging body of research has begun to shed some light on the involvement of immigrant children and families in the child welfare system, the extent to which immigration enforcement activities have contributed to child welfare system involvement remains unknown. One study estimated that in 2011 as many 5,100 children currently in foster care have parents who have been either detained or deported (Wessler, 2011). Although that study could not determine whether these children entered foster care as a direct result of their parents' detention or deportation, anecdotal information suggests that this problem is likely to grow as a result of recent changes to immigration enforcement policies.

Although the exact number of children who become involved in the child welfare system as a result of immigration enforcement is unknown, it is clear that children have been impacted by these efforts. Statistics made available from DHS in late 2012 showed that between July 1, 2010, and September 30, 2012, DHS removed 204,816 parents of U.S. citizen children from the United States (U.S. Department of Homeland Security, 2012) In

2013, ICE conducted 72,410 removals of parents with at least one U.S. citizen child (Foley, 2014). No data have been made public on the whereabouts of the children from these families or the consequences they faced as a result of their parents' deportation.

The challenges of cases involving children who enter the child welfare system due solely to an immigrant parent's arrest or apprehension are far-reaching. Although courts that handle child welfare cases operate under statutes requiring that children's best interests be considered in decisions regarding their custody and placement (Child Welfare Information Gateway, 2010), there are wide variations across juvenile courts in what is interpreted to be in children's best interest when parents are deported. Immigration law does not recognize children's interests as a valid factor in the immigration decisions concerning their parents, which can lead to profound implications for families with mixed immigration statuses. Children may remain in the United States and be permanently separated from their parents – or they can leave their home and all they have known to move to an unfamiliar country to remain with their family. Although this has been described as a "choiceless choice" for immigrant parents (Thronson, 2006), best practice calls for deported parents' decisions regarding their children to be honored when maltreatment is absent. However, the extent to which parents' and children's voices are heard in juvenile court decisions remains unknown.

Parents detained in immigration facilities may be prevented from meaningfully participating in a court plan for reunification. In some cases, child welfare staff are unable to locate parents, reducing their chances of participation in decisions concerning their children, including court proceedings related to their children's care and custody. Deportation proceedings and decisions often last longer than the timeframes under which child welfare agencies must make decisions about children's permanency, further complicating the agencies' ability to act in children's best interests (Cervantes & Lincroft, 2010).

Child Welfare System Challenges. Regardless of how or when children of immigrants come into contact with the child welfare system, social workers face complex challenges to responding to their needs and facilitating positive outcomes related to their safety, permanence, and well-being. Research has shown that children with immigrant parents who become involved with child welfare systems have lower access to mental health services than children with U.S. citizen parents (Dettlaff & Cardoso, 2010; Finno-Velasquez, Cardoso, Dettlaff & Hulburt, 2015). Immigrant parents who become involved with the child welfare system also have less access than non-immigrant parents to needed substance abuse services and concrete supports that can prevent entry of their children into foster care (Finno-Velasquez, 2013; Finno-Velasquez, Seay & He, 2016).

Once children enter foster care, immigration status can create additional delays or barriers to reunification, as non-citizen parents may be unable to obtain employment or participate in certain mandated services or supportive services that could facilitate reunification (Dettlaff & Fong, 2016). Language barriers can result in miscommunication and misunderstandings, and delays in service delivery, which can affect parents' abilities to complete required services and place them at risk for termination of parental rights due

to the timeframes mandated by the Adoption and Safe Families Act (ASFA) of 1997 (Ayón, 2009; Committee for Hispanic Children and Families, 2003).

Child welfare workers may also encounter challenges in the placement of children of immigrants. In many states, undocumented immigrant family members do not qualify to serve as foster parents for children because of their legal status (Ayón, Aisenberg, & Cimino, 2013; Wessler, 2011). Child welfare workers must also attempt to locate relatives residing in other countries to notify and screen for potential placement. Sometimes, when parents reside in other countries, reunification plans must cross transnational borders, requiring coordination of home studies and services with foreign governments (Lincroft & Borelli, 2009; Reed & Karpilow, 2009). Many children and their family members involved with child welfare agencies also qualify for some form of immigration relief, and their ability to obtain legal status depends on the child welfare system's capacity to adequately screen for eligibility and navigate the immigration system, ideally in collaboration with immigration experts (Finno & Bearzi, 2010). Some child welfare agencies across the country have solid partnerships and policies in place to provide those assessments and ensure that immigrant children and families receive due process, but many still do not (Lincroft, 2013).

Another challenge is the lack of expertise within the child welfare workforce about the unique needs of immigrant families that result from their experiences with immigration and acculturation. Achieving reunification with parents largely depends on the child welfare system's ability to provide family services that effectively address the issues that led to this placement, as well as the parents' participation and engagement in these services (Dettlaff & Fong, 2016). Given these barriers, immigrant families may be at a disadvantage in meeting case requirements and reunifying children with family members, thus placing them at greater risk for termination of parental rights.

Since the beginning of the Trump administration, immigration policy has taken a strikingly different direction, with almost unilateral disregard for the well-being of children. The scope of enforcement priorities that previously safeguarded many parents and long-time residents whose only violation was living in the country without documentation now target a much larger group of immigrants for deportation. Immigration raids have taken place in communities across the country, and its consequences are being felt by social workers and their immigrant clients throughout the country. The impact of enforcement activities on child welfare systems is not yet known, but it is widely feared that children's well-being and stability continue to be compromised.

Directions for Social Work

The following are approaches that the profession of social work can take to respond to immigrants' needs: (1) development of social work expertise in working with immigrants; (2) cross-systems and cross-disciplinary collaborations; (3) leveraging existing resources and supports; (4) documentation/collection of data; and (5) focused advocacy efforts.

Development of social work expertise in immigration. First, the profession of social work must develop specific expertise in practice with immigrants. In addition to competence in working with ethnically and culturally diverse groups, as professionals who

work across disciplines, various aspects of the immigration system and immigration law that affect families' lives should be seamlessly integrated into required social work training curricula. Training is needed that provides information to social workers, especially those working in the child welfare field, on the experiences of immigrant children and families to improve cultural responsiveness and reduce the potential for bias. To conduct adequate assessments and provide interventions that respond to their needs, child welfare professionals need to understand the effects of immigration and acculturation on immigrant family systems. Once children in immigrant families become involved in the child welfare system, social workers need to be familiar with resources and programs available for immigrant children and families to provide comprehensive services that meet their needs. Practitioners also need to be familiar with federal and state policies that affect immigrant and refugee children and families and understand how those policies may affect service delivery. Within child welfare systems especially, it is important to develop, recruit, and train social workers who are bilingual and bicultural in order to respond more appropriately to children and families from diverse cultures. Bridging Refugee Youth and Children's Services (BRYCS) offers a number of training tools and webinars on their website that can assist social workers working wtih refugee families, and specifically, refugee children and adolescents, on a number of issues (i.e., trauma, accessing resources, navigating the legal system, etc.). The website for the Immigration Legal Resource Center offers multiple trainings relevant to social workers that are specific to immigration laws. The NASW California chapter offers multiple low-cost courses on their website, including one specific to immigration and child welfare issues. Both courses are designed to provide social workers with information about current U.S. immigration laws and the impact of immigration enforcement on children and families. Improved understanding of immigration policy and culture can lead to improved engagement, more thorough assessments, and more effective service delivery.

Cross systems and cross-disciplinary collaborations. Effective social work practice with immigrant children and families cannot be achieved in isolation. Many immigrant families are likely to intersect with multiple systems, and a coordinated community response is necessary to promote their overall well-being. Within the current environment over the past several months, many grass-roots initiatives have begun in various states and localities around the country to protect immigrant children and families. These include rapid response teams and networks in many states including California, Colorado, Massachusetts, and Virginia that are composed of social workers, attorneys, advocates, and community organizers who offer support particularly in the wake of immigration raids, which often leave children behind (Spivack, 2017). Social workers are the ideal professionals to engage with various systems and ensure all key stakeholders have a place at the table, as issues around immigration and child welfare are complicated, and if successful, will have multiple layers to any response. Collaborations should include foreign consulates and child welfare agencies, legal professionals, public policy and child development experts, courts, schools, health and mental health systems, along with natural supports like churches and faith groups, and academics/research scientists.

Given concerns resulting from ongoing immigration enforcement efforts, social work professionals, and child welfare agencies in particular, need to develop and strengthen

relationships within immigrant communities to create a climate where families feel safe accessing services and the reporting of maltreatment can take place without fear of deportation or other negative consequences to families. Child welfare agencies in particular should develop collaborations with community-based social service providers in immigrant communities to facilitate education about cultural norms related to maltreatment and to dispel fears about reporting.

Leverage existing resources and supports. For social work professionals and agencies struggling with how to respond, many resources already exist. Advocacy groups around the country have been quick to respond in creating toolkits and legal guides, such as family safety planning and trauma response resources, in response to immigration policy changes. Many such resources are highlighted and can be accessed on the webpage of the Center on Immigration and Child Welfare (2017). Two timely and relevant resources include Appleseed's (2017) updated *Protecting Assets and Child Custody in the Face of Deportation: A Guide for Practitioners Assisting Immigrant Families* and the Institute for Women in Migration's (IMUMI; 2017) *A Brief Guide for Families, Organizations, and Public Officials: Resources To Inform, Support, And Prepare Families for a Possible Return to Mexico.* For social workers working in macro settings, energy should focus on translating and disseminating the newest and most relevant research and resources into practice settings, and developing tools and workshops for front-line workers requesting guidance on working with immigrant children and families in the current climate. Plans should focus on using existing training opportunities to increase capacity and skill in working on immigration issues, such as Title IV-E training for child welfare workers, creating a natural platform for disseminating current knowledge into relevant practice.

Documentation and collection of data. In the modern era of data-driven decision-making, one of the greatest challenges to proposing solutions is that there is no accurate data on the number of immigrant children and families impacted by deportation and at risk for child welfare system involvement. Nativity and citizenship status has never been uniformly collected across child welfare systems in the U.S., and the Department of Homeland Security does not collect (or publicly release) information on the children of immigrants who are detained and deported. Congressional members have demanded that Homeland Security begin to release this information (Gillibrand et al., 2017). Social workers should continue to push this issue with legislators to continue this pressure. Immigration information is not required for national child abuse and neglect data collection and reporting, and is thus not collected in a consistent manner across the country. There are rightly confidentiality concerns and apprehension about how such information would be used by federal agencies if it were required. However, without a requirement for collecting immigration information, child welfare agencies do not have a way to ensure that immigrant children and families receive the services they need. With no guidance on how to track children in immigrant families, child welfare agencies also grapple with the most sensitive ways to retrieve and record that information from families. Clear protocols should be developed to dictate how to collect sensitive identifying information from immigrants while ensuring the utmost confidentiality of that information for use within the child protection system only. As it currently stands, without official data identifying immigrant families impacted by deportation and involved with the child welfare system,

efforts to document immigrant family experiences and needs through rigorous research, data collection, community needs assessments, and service evaluations are sorely lacking.

Much additional research is also needed to facilitate the provision of culturally responsive child welfare services. Although some research has begun to identify the presence of immigrant children and families in the child welfare system (Wessler, 2011), specific studies are needed that provide information on interventions that facilitate positive outcomes of safety, permanency, and well-being for immigrant children and families. Interventions that have historically been used with non-immigrant populations may not be effective with immigrant children and families due to their cultural differences, as well as differences in the underlying issues that brought them to the attention of this system. In order to facilitate positive outcomes, interventions need to consider the cultural influences and experiences in immigrant families and how these influences affect service delivery.

Focused Advocacy Efforts. Advocacy is a primary skill of social work practitioners, but now more than ever, all social workers who work with immigrant families, whether in clinical settings, in legal or policy settings, or in research, must include advocacy as part of their responsibilities. Advocacy efforts should focus on electing candidates who support pro-immigrant integration policies, in contrast to restrictive immigration policies, and may include forming local coalitions to respond to community-specific needs and issues. Social workers have an ethical responsibility to understand current policy and report cases of non-compliance with immigration policies to appropriate authorities. Immigrants involved in legal immigration proceedings do not have the right to an attorney, and if they do not have representation, the court will likely not rule in their favor. As part of these advocacy efforts, social workers can help obtain legal representation for immigrant. Multidisciplinary rapid response teams and networks can help provide coordinated and comprehensive responses to immigration raids and other emergency immigration situations (National Immigration Law Center, 2007). Safety and contingency planning resources and trainings in relevant languages are also crucial for immigrant families in order to make practical and legal arrangements in the case of parental detention or deportation (Immigrant Legal Resource Center, 2017). In the current political climate where comprehensive immigration reform remains unlikely, state and local level policy change presents greater promise. Several effective models already exist, such as California's SB 1064 and other collaborative efforts along with border region involving agencies on the U.S. and Mexico sides of the border (Finno & Bearzi, 2010; Lincroft, 2013). Finally, the narrative around immigration and immigrants in this country has always ebbed and flowed around dominant U.S. values, morals, and who is considered to be deserving and undeserving. As professional social workers, we must use our voices to contribute to framing the public narrative around immigration enforcement as a humanitarian crisis characterized by egregious violations to women's and children's rights.

Conclusion

With the scope of immigration policy placing the well-being of our children at an unprecedented crossroads, social workers have an ethical obligation to step up and do everything within their power to mitigate or alleviate the traumatic threats and potentially irreparable damage to child well-being imposed by our immigration system. Efforts to

increase the capacity of social workers to address the unique needs of this population, as well as cross-systems collaborations, and focused advocacy efforts are essential components of this response to facilitate positive outcomes of safety, permanency, and well-being. Specific training on immigration policy and culturally informed, trauma-sensitive practice with immigrants needs to be prioritized in social work curricula. Field placements for social workers in unconventional settings such as immigration legal clinics and faith-based non-profits that serve immigrants should be developed. In sum, the social work field must improve our ability to meet the needs of immigrant children and families of the modern day U.S.

References

Ainsely, J. E. (2017, March 3). Exclusive: Trump administration considering separating women, children at Mexico border. Retrieved from Reuters website http://www.reuters.com/article/us-usa-immigration-children/exclusive-trump-administration-considering-separating-women-children-at-mexico-border-idUSKBN16A2ES?feedType=RSS&feedName=topNews&utm_source=twitter&utm_medium=Social

American Immigration Council. (2017, May 28). *U.S. citizen children impacted by Immigration Enforcement*. Retrieved from https://www.americanimmigrationcouncil.org/research/us-citizen-children-impacted-immigration-enforcement

American Immigration Lawyers Association [AILA]. (2011). *Immigration enforcement off target: Minor offenses with major consequences* (Report No. 11081609). Retrieved from https://www.aila.org/File/Related/11081609.pdf

AILA. (2016, October 12). *Featured issue: Family detention.* Retrieved from http://www.aila.org/advo-media/issues/enforcement/detention.

Annie E. Casey Foundation. (2018). *KIDS COUNT data center*: *Children in immigrant Families.* Retrieved from http://datacenter.kidscount.org/data/tables/115-children-in-immigrant-families?loc=1&loct=1#detailed/1/any/false/870,573,869,36,868/any/445,446

Appleseed. (2017). *Protecting assets and child custody in the face of deportation: A guide for practitioners assisting immigrant families.* Retrieved http://www.appleseednetwork.org/wp-content/uploads/2015/10/Protecting-Assets-And-child-Custody-In-The-Face-Of-Deportation-A-Guide-for-Practitioners-Assisting-Immigrant-Families-2012.pdf

Ayón, C. (2009). Shorter time-lines, yet higher hurdles: Mexican families' access to child welfare mandated services. C*hildren and Youth Services Review, 31,* 609-616. doi: https://doi.org/10.1016/j.childyouth.2008.11.004

Ayón, C., Aisenberg, E., & Cimino, A. (2013). Latino families in the nexus of child welfare, welfare reform, and immigration policies: Is kinship care a lost opportunity? *Social Work, 58*(1), 91-94. doi: https://doi.org/10.1093/sw/sws014

Barrick, L. (2016, August 31). *Special report: Adivided by detention: Asylum-seeking families' experiences of Separation.* Washington, D.C.: American Immigration Council. Retrieved from https://www.americanimmigrationcouncil.org/research/divided-by-detention-asylum-seeking-families-experience-of-separation

Batalova, J., & Lesser, G. (2017, April 5). *Central American immigrants in the United States*. Washington, D.C.: Migration Policy Institute. Retrieved from http://www.migrationpolicy.org/article/central-american-immigrants-united-states

Bogado, A. (2014, July 28). ICE detains pregnant women against its own policy. Retrieved from *Colorlines website* http://www.colorlines.com/articles/ice-detains-pregnant-women-against-its-own-policy

Brabeck, K. M., Sibley, E., & Lykes, M. B. (2016). Authorized and unauthorized immigrant parents: The impact of legal vulnerability on family contexts. *Hispanic Journal of Behavioral Sciences*, *38*, 3-30. doi: https://doi.org/10.1177/0739986315621741

Burke, G. (2017, June 30). Feds will now target relatives who smuggled in children. Retrieved from *The Associated Press website* https://apnews.com/291d565801984005886f5a22c800fee6/Feds-will-now-target-re

Campetella, A., Capps, R., Hooker, S., Koball, H., Pedroza, J. M., & Perreira, K. (2015). *Research report: Implications of immigration enforcement activities for the well-being of children in immigrant families.* Washington, D.C.: Migration Policy Institute and Urban Institute. Retrieved from https://www.urban.org/sites/default/files/alfresco/publication-exhibits/2000405/2000405-Implications-of-Immigration-Enforcement-Activities-for-the-Well-Being-of-Children-in-Immigrant-Families.pdf

Capps, R., Fix, M., & Zong, J. (2016, January). *Fact sheet: A profile of U.S. children with unauthorized immigrant parents*. Retrieved from the Migration Policy Institute website https://www.migrationpolicy.org/research/profile-us-children-unauthorized-immigrant-parents

Center on Immigration and Child Welfare. (2017). *Resources for social workers*. Retrieved from http://cimmcw.org/resources/practice/social-workers/

Cervantes, W., & Lincroft, Y. (2010). *The impact of immigration enforcement on child welfare.* Washington, DC: First Focus. Retrieved from https://firstfocus.org/wp-content/uploads/2010/04/Caught-Between-Systems-Enforcement.pdf

Child Welfare Information Gateway. (2010). *Determining the best interests of the child: Summary of state statutes*. Retrieved from http://www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.cfm

Child Trends Data Book. (2014). *Immigrant children: Indicator of child and youth well-being*. Retrieved from https://www.childtrends.org/?indicators=immigrant-children

Chishti, M., & Hipsman, F. (2016). *Increased Central American migration to the United States may prove an enduring phenomenon.* Washington, D.C.: Migration Policy Institute. Retrieved from https://www.migrationpolicy.org/article/increased-central-american-migration-united-states-may-prove-enduring-phenomenon

Chaudry, A., Capps, R., Pedroza, J. M., Castaneda, R. M., Santos, R., & Scott, M. M. (2010). *Facing our future: Children in the aftermath of immigration enforcement*. Washington, DC: Urban Institute. Retrieved from http://www.urban.org/publications/412020.html

Clarke, W., Turner, K., & Guzman, L. (2017). One quarter of Hispanic children in the United States have an unauthorized immigrant parent. *National Research Center on Hispanic Children & Families* (No. 2017-28). Retrieved from http://www.hispanicresearchcenter.org/publications/one-quarter-of-hispanic-children-in-the-united-states-have-an-unauthorized-immigrant-parent/

Committee for Hispanic Children and Families. (2003). *Creating a Latino child welfare agenda: A strategic framework for change*. New York: Author. Retrieved form http://www.chcfinc.org/wp-content/uploads/2014/04/8.-CHCF-Creating-a-Latino-Child-Welfare-Agenda-A-Strategic-Framework-for-Change-July-15-2003.pdf

Detention Watch Network. (n.d.) *Family detention: The unjust policy of locking up immigrant mothers with their children*. Retrieved from https://www.detentionwatchnetwork.org/issues/family-detention

Detlaff, A. (2012). Immigrant children and families and the public welfare system: Considerations for legal systems. *Juvenile & Family Court Journal*, *63*(1), 19-30. doi: https://doi.org/10.1111/j.1755-6988.2011.01069.x

Dettlaff, A. J., & Cardoso, J. B. (2010). Mental health need and service use among Latino children of immigrants in the child welfare system. *Children and Youth Services Review*, 32, 1373-1379. doi: https://doi.org/10.1016/j.childyouth.2010.06.005

Dettlaff, A. J., & Finno-Velasquez, M. (2013). Child maltreatment and immigration enforcement: Considerations for child welfare and legal systems working with immigrant families. *Children's Legal Rights Journal, 33*(1), 37-63.

Dettlaff, A. J., & Fong, R. (2016). Practice with immigrant and refugee children and families in the child welfare system. In A. J. Detlaff & R. Fong (Eds.), *Immigrant and refugee children and families: Culturally responsive practice* (pp. 285-317). New York, NY: Columbia University Press. doi: https://doi.org/10.7312/dett17284

Dickerson, C., & Jordan, M. (2017, May 3). 'No asylum here': Some say U.S. border agents rejected them. Retrieved from *The New York Times* website https://www.nytimes.com/2017/05/03/us/asylum-border-customs.html?&hp&action=click&pgtype=Homepage&clickSource=story-heading&module=second-column-region®ion=top-news&WT.nav=top-news&_r=0

Dreby, J. (2012). The burden of deportation on children in Mexican immigrant families. *Journal of Marriage and Family, 74,* 829-845. DOI:10.1111/j.17413737.2012.00989.x

Finno, M., & Bearzi, M. (2010). Child welfare and immigration in New Mexico: Challenges, achievements, and the future. *Journal of Public Child Welfare*, *4*(3), 306-324. doi: https://doi.org/10.1080/15548732.2010.496079

Finno-Velasquez, M. (2013). The relationship between parent immigration status and concrete support service use among Latinos in child welfare: Findings using the National Survey of Child and Adolescent Well-being (NSCAWII). *Children and Youth Services Review, 35*(12), 2118-2127. doi: https://doi.org/10.1016/j.childyouth.2013.10.013

Finno-Velasquez, M., Cardoso, J. B., Dettlaff, A. J., & Hulburt, M. S. (2015). Effects of parent immigration status on mental health service use among Latino children referred to child welfare. *Psychiatric Services*, *67*(2), 192-198. doi: https://doi.org/10.1176/appi.ps.201400444

Finno-Velasquez, M., Seay, K. D., & He, A. S. (2016). A national probability study of problematic substance use and treatment receipt among Latino caregivers involved with child welfare: The influence of nativity and legal status. *Children and Youth Services Review*, *71,* 61-67. doi: https://doi.org/10.1016/j.childyouth.2016.10.035

Foley, E. (2014, June 26). Deportation separated thousands of U.S.-born children from parents in 2013. Retrieved from *HuffPost* website https://www.huffingtonpost.com/2014/06/25/parents-deportation_n_5531552.html

Foley, E., & Planas, R. (2017, April 5). Trump administration won't routinely separate families at the border after all. Retrieved from http://www.huffingtonpost.com/entry/dhs-separating-familiesborder us 58e50d4fe4b0f4a923b448b7

Gillibrand, K., Carper, T. R., Coons, C. A., Franken, A., Shaheen, J., Merkley, J. A.... Harris, K. D. (2017, April 3). *Letter to Secretary Kelly and Secretary Price*. Washington, D.C.: United States Senate. Retrieved from https://www.gillibrand.senate.gov/news/press/release/2017/04/04/gillibrand-leads-15-senators-in-letter-to-trump-administration-requesting-information-on-children-separated-from-deported-parents-as-a-result-of-uptick-in-immigration-enforcement-1

Grieco, E. M., Acosta, Y. D., De La Cruz, G. P., Gambino, C., Gryn, T., Larsen, L. J., Trevelyan, E. N., & Walters, N.P. (2012). *The foreign born population in the United States: 2010: American community survey reports.* Washington, D.C.: U.S. Census Bureau. Retrieved from https://www.census.gov/prod/2012pubs/acs-19.pdf

Immigrant Legal Resource Center. (2017). *Family preparedness planning.* Retrieved from https://www.ilrc.org/family-preparedness-plan

Institute for Women in Migration. (2017). *A brief guide for families, organizations, and public officials: Resources to inform, support, and prepare families for a possible return to Mexico.* Retrieved from http://impactodemedidas.imumi.org/ingles/

Kandel, W. A. (2017, January 18). *Unaccompanied alien children: An overview.* Retrieved from https://fas.org/sgp/crs/homesec/R43599.pdf

Koball, H., Capps, R., Hooker, S., Perreira, K., Campetella, A., Pedroza, J. M., Monson, W., & Huerta, S. (2015). *Health and social service needs of U.S. citizen children with detained or deported immigrant parents.* Washington, D.C.: Migration Policy Institute. Retrieved from http://www.migrationpolicy.org/research/health-and-social-service-needs-us-citizen-children-detained-or-deported-immigrant-parents

Lacayo, E. (2011). One year later: A look at SB 1070 and copycat legislation. *National Council of La Raza*. Retrieved from http://publications.unidosus.org/handle/123456789/666

Lincroft, Y. (2013). *The Reuniting Immigrant Families Act: A case study on California's Senate Bill 1064.* Retrieved from http://cssr.berkeley.edu/cwscmsreports/LatinoPracticeAdvisory/LEGAL_State/The%20reuniting%20immigrant%20families%20act_A%20case%20study.pdf

Lincroft, Y., & Borelli, K. (2009). *A social worker's toolkit for working with immigrant families: A child welfare flowchart.* Retrieved from https://ncwwi.org/files/A_SWers_Tool_Kit_for_Working_with_Immigrant_Families.pdf

Liptak, A. (2012, June 25). Blocking parts of Arizona law, justices allow its centerpiece. Retreived from the *New York Times* website https://www.nytimes.com/2012/06/26/us/supreme-court-rejects-part-of-arizona-immigration-law.html

López, G., & Bialik, K. (2017, May 3). *Key findings about U.S. immigrants.* Retrieved from Pew Research Center website http://www.pewresearch.org/fact-tank/2017/05/03/key-findings-about-u-s-immigrants/

Morton, J. (2011, Oct 24). *Enforcement actions at or focused on sensitive locations* [Memorandum]. Washington, D.C.: U.S. Customs and Immigration Enforcement. Retrieved from https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf

National Immigration Law Center [NILC]. (2007). *How to be prepared for an immigration raid.* Retrieved from https://www.nilc.org/get-involved/community-education-resources/know-your-rights/immraidsprep_2007-02-27/

Reed, D., & Karpilow, K. (2009). *Understanding the child welfare system in California: A primer for service providers and policymakers* (2nd ed.). Retrieved from http://www.phi.org/uploads/application/files/h31ef4xly0mtt9oa4lsv07oko48r6kg19g6fisdm62qmymwbs5.pdf

Rojas-Flores, L., Clements, M. L., Hwang Koo, J., & London, J. (2017). Trauma and psychological distress in Latino citizen children following parental detention and

deportation. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(3), 352-361. doi: http://dx.doi.org/10.1037/tra0000177

Rosenblum, M. R., & Ball, I. (2016). *Trends in unaccompanied child and family migration from Central America.* Retrieved from the Migration Policy Institute website https://www.migrationpolicy.org/research/trends-unaccompanied-child-and-family-migration-central-america

Spivack, M. (2017, December 10). Rapid response training programs are aiming to document ICE activities. Retrieved from https://www.usatoday.com/story/news/2017/12/10/rapid-responders-aim-document-ice-activities/939416001/

Support our Law Enforcement and Safe Neighbors Act, Arizona S. 1070, 49th Leg. (2010). Retrieved from https://www.azleg.gov/legtext/49leg/2r/bills/sb1070s.pdf

Thronson, D. B. (2006). Choiceless choices: Deportation and the parent–child relationship. *Nevada Law Journal*, 6, 1165-1214.

Trevizo, P. (2016, January 2). Fewer parents of US-citizen kids being deported. *Arizona Daily Star.* Retrieved from http://tucson.com/news/fewer-parents-of-us-citizen-kids-being-deported/article_e45be3ba-b66e-5017-ab9c-9e0905b35c87.html

U.S. Census Bureau. (2017). *2016 American Community Survey*. Available at https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_B05009&prodType=table

U.S. Customs and Border Protection. (2016, October 18). *United States Border Patrol Southwest Family Unit Subject and Unaccompanied Alien Children Apprehensions Fiscal Year 2016.* Retrieved from https://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children/fy-2016.

U.S. Department of Homeland Security. (2012). U.S. Immigration and Customs Enforcment. *Secure communities: Monthly Statistics through August 21, 2012 IDENT/IAFIS Interoperability*. Retrieved from https://www.ice.gov/doclib/foia/sc-stats/nationwide_interop_stats-fy2012-to-date.pdf

U.S. Department of Homeland Security. (2017, September 27). *Delegation of Immigration Authority Section 287(g) Immigration and Nationality Ac*t. Retrieved from https://www.ice.gov/287g

U.S. Immigration and Customs Enforcement. (2013, August 23). *Facilitating Parental Interests in the Course of Civil Immigration Enforcement Activities* (No. 11064.1). Retrieved from https://cis.org/sites/default/files/Parental_Interest_Directive_8-23-13.pdf

U.S. Immigration and Customs Enforcement. (2016). *Fiscal year 2016 ICE enforcement and removal operations report.* Retrieved from https://www.ice.gov/sites/default/files/documents/Report/2016/removal-stats-2016.pdf

Wessler, S. F. (2011). *Shattered families: The perilous intersection of immigration enforcement and the child welfare system*. Applied Research Center. Retrieved from file:///C:/Users/vdecker/Downloads/ARC_Report_Shattered_Families_FULL_REPORT_Nov2011Release.pdf

White House, Office of the Press Secretary [WH OPS]. (2017, January 25). *Executive order: Enhancing public safety in the interior of the United States* [Press release]. Retrieved from https://www.whitehouse.gov/the-press-office/2017/01/25/presidential-executive-order-enhancing-public-safety-interior-united

WH OPS. (2014). *Letter from the President -- Efforts to address the humanitarian situation in the Rio Grande Valley areas of our nation's Southwest border* [Press release]. Retrieved from https://obamawhitehouse.archives.gov/the-press-office/2014/06/30/letter-president-efforts-address-humanitarian-situation-rio-grande-valle

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Interventions Supporting the Social Integration of Refugee Children and Youth in School Communities: A Review of the Literature

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Abstract: *Schools function as a primary driver of integration and as a link to resources and assets that promote healthy development. Nevertheless, most research studies on school-based programs are conducted on mainstream students, and school professionals looking to deliver interventions serving refugee students are forced to choose between evidence-based programs designed for the mainstream and developing new programs in the cultural framework of their students. The purpose of this literature review is to provide a summary of recent research on successful, evidence-based programs as well as promising interventions and practice recommendations in five core practice areas in schools: school leadership and culture, teaching, mental health, after-school programming, and school-parent-community partnerships. These findings are presented drawing from theoretical frameworks of ecological systems, social capital, segmented assimilation, resilience, and trauma, and describe how such theories may be used to inform programs serving refugee children and youth. Additionally, this review describes the core components of successful programs across these practice areas to inform researchers and practitioners as they select and develop programs in their own school communities. Finally, this review concludes with a discussion of human rights in the education of refugee children and youth.*

Keywords: *Migration; refugees; children and youth; prevention*

At the end of 2016, the number of forcibly displaced individuals worldwide reached a record high of 65.6 million people, 22.5 million of whom were formally recognized as refugees. Just over half of this worldwide refugee population is made up of children below 18 years of age (UNHCR, 2016). When refugee children flee their home countries, the lengthy process of displacement and resettlement can cause protracted periods of disruption, particularly in their education (Block, Cross, Riggs, & Gibbs, 2014; McBrien, 2005; Naidoo, 2009; Nelson, Price, & Zubrzycki, 2014). In schools, refugee students encounter academic and social challenges that may hinder processes of integration and healthy development (Bal & Arzubiaga, 2014; Berthold, 2000; Kanu, 2008; Kia-Keating & Ellis, 2007; Roy & Roxas, 2011).

Schools function as a primary driver of integration and as a link to resources and assets that could promote the healthy development of refugee children. Nevertheless, most research on school-based programs are conducted on mainstream students, and school professionals looking to deliver interventions serving refugee students are forced to choose between evidence-based programs designed for the mainstream and developing new programs in the cultural framework of their students (Rousseau & Guzder, 2008). As the number of refugees across the globe has reached historic highs and has been met with a

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new wave of nativism and xenophobia among far-right movements (Minkenburg, 2013), there is a great need for evidence-based prevention programs in school communities that promote tolerance, encourage social integration, and enhance the health and well-being of refugee children. The purpose of this paper is (1) to provide a review of theoretical frameworks informing social work practice with refugee children in schools, (2) to examine existing evidence-based prevention programs in schools, (3) to identify core components of successful programs, and (4) to offer implications for social work research and practice with refugee children with an emphasis on education as a human right.

Refugee Children

Many refugee children have experienced violence or trauma prior to fleeing their countries of origin. Compared with adults, refugee children are at heightened risk for symptoms of posttraumatic stress disorder (PTSD), anxiety and depression, maladaptive grief, social withdrawal, and behavioral and academic difficulties (Halcon et al., 2004; Layne et al., 2008; Masten & Narayan, 2012; Sullivan & Simonson, 2016). Further, they must adjust to a completely new culture that includes new customs, a new language, and a new education system (Kia-Keating & Ellis, 2007).

Once resettled, refugee children begin the challenging process of navigating a new educational environment. Many refugee students encounter academic, economic, and psychosocial challenges that include separation from family, cultural dissonance, acculturation stress, limited English proficiency, gaps in schooling, distrust or fear of school personnel, conflicting expectations between families and school faculty, and limited financial resources (Bal & Arzubiaga, 2014; Berthold, 2000; Kanu, 2008; Kia-Keating & Ellis, 2007; Roy & Roxas, 2011). As a result, refugee youth are at higher risk for school dropout. In one longitudinal study, fewer than 2 in 3 refugee youth graduated high school, with age of arrival and experiences of discrimination as factors associated with dropout (Correa-Velez, Gifford, McMichael, Sampson, 2017).

Because school attendance is associated with developed fluency, many refugee children use these skills to function as cultural and lingusitic brokers for their families (McBrien, 2005). Students take on roles and responsibilities beyond their years and are burdened with leading their families in navigating the resettlement process. It is often students who are helping their parents build cross-cultural community and social networks, who serve as their interpreters, and who translate documents and correspondence for parents (Uptin, Wright, & Harwood, 2013). These barriers and responsibilities may adversely affect refugee students' abilities to adjust and integrate successfully into a new schooling environment (Block et al., 2014).

There are a number of theoretical frameworks that can be used to understand the process of refugee resettlement and integration in school communities for refugee children and their families. Five theories are reviewed: ecological systems, social capital, segmented assimilation, resilience, and theories of trauma.

Ecological Systems Theory

In the context of the resettlement of refugee children, ecological systems theory emphasizes the necessity of understanding the circumstances surrounding and affecting the resettlement and integration process. Ecological systems theory asserts that human development and behavior is a product of enduring forms of reciprocal interactions – called *proximal processes* – between individuals and their environments over time (Bronfenbrenner & Morris, 2006). This ecological lens acknowledges that the traumatic and rapidly shifting events that occur before, during, and after flight from one's home country would disrupt and protract these very proximal processes necessary for a healthy course of development (Brenner & Kia-Keating, 2017; McBrien, 2011; Rousseau & Guzder, 2008). Difficulties surrounding the causes, processes, and effects of forced migration that occur in one area of an ecological system (e.g., the family) have consequences on other systems (e.g., the individual). Relationships may also be disrupted as a result of the varied reactions children have to the adversity they experience in forced migration. For example, youth exposed to war and violence commonly experience reactions that can burden their development, including symptoms of PTSD, anxiety, depression, grief, social withdrawal, externalizing behavior, separation anxiety, and age-inappropriate dependence on their caregivers (Berthold, 2000; Layne et al., 2008). These reactions to adverse experiences can disrupt the structures in the environments of children exposed to violence, persecution, and forced migration (Brenner & Kia-Keating, 2017).

Social Capital Theory

Because forced migration fundamentally restructures social relationships for refugee children and families, the resettlement process also reduces access to the value and resources that come from relationships with others. Social capital theory argues that social relationships have value. For youth, social capital in the family, community, and school facilitate the development of new skills and capabilities, and may open doors to new opportunities and relationships (Coleman, 1988). However, individuals who are willfully or unintentionally excluded from these networks may not have access to the benefits that these relationships bring (Putnam, 1995). A social capital lens acknowledges the losses in access to resources and opportunities that refugee children experience as a result of forced migration, but also views rebuilding and fostering new positive relationships in order to recreate those resources and opportunities in the host country as a central goal of the resettlement process.

Schools are institutions that have the capacity to help foster the recreation of social capital for refugee children (Naidoo, 2009). As institutional agents, school personnel play a large role in both constructing and breaking down barriers to successful integration for refugee students (Stanton-Salazar, 2011). For refugee children to gain social capital and thrive, they need both social and institutional support from within the networks in which they interact, develop, and learn (Stanton-Salazar, 2011).

Segmented Assimilation Theory

As refugee communities resettle in their host countries and adapt to a new culture, they may experience different pathways and outcomes of integration - one toward successful integration into the social and economic mainstream, and the other "downward assimilation" into a social underclass marked by deviance and reactive ethnicity subcultures (Haller, Portes, & Lynch, 2011; Portes & Zhou, 1993). Segmented assimilation theory argues that three factors – family structure, modes of incorporation, and access to human capital –determine the paths of mobility and integration for refugee communities, from the first to second and third generations and beyond. Given the numerous and complex challenges that are likely to occur throughout the resettlement and integration process, it is probable that resettled children will experience varying paths of acculturation that represent the range between successful integration and downward assimilation (McBrien, 2005). Disparities occurring in the three integration pathway determinants for refugee newcomers form into patterned difference over time. For example, factors such as low parental social and economic capital, hostile modes of incorporation in the receiving community, and weak co-ethnic communities, may lead to a particular path of downward assimilation for refugee children (Haller et al., 2011; Kanu, 2008). School systems may help buffer against these potential risks, or conversely form and reinforce negative pathway determinants for refugee children (Kanu, 2008). For example, discriminatory housing practices that disproportionately place refugee families in low-resource school communities may place refugee children in environments more reflective of Portes and Zhou's (1993) downward assimilation than successful integration into the middle class.

Resilience Theory

Nevertheless, refugee children are not entirely at the mercy of their circumstances. Resilience theory refers to the capacity of individuals to adapt to adversity and withstand or recover from challenges to one's development or security (Masten & Narayan, 2012). Refugee children are part of a population the resilience literature identifies as "high-risk" due to the prevalence of adverse, stressful, and violent circumstances many of them endure prior to and throughout the resettlement process (Werner, 1995). Despite these detrimental experiences, there are multiple predictors for resilience in children, largely based on protective factors in individuals that can help moderate a person's response to adversity (Werner, 1995). Such protective factors can make a more profound impact on the lives of refugee children in comparison to their exposure risk factors and adverse life events (Werner, 1995).

Longitudinal studies on resilience have shown that during childhood and adolescence, factors such as social and problem-solving skills, a sense of autonomy, self-efficacy, a sense of purpose, creative interests, and religious beliefs may all promote positive adaptation to adversity (Benard, 2004). Protective factors in an individual's community may include family relationships as well as trusting relationships with teachers, neighbors, peers, and other positive role models (Werner, 1995). Schools play an important role in fostering resilience for refugee youth. For example, many refugee students possess high educational aspirations, which is a significant individual protective factor, and schools and

their faculty can serve as protective agents at relational and environmental levels (Brenner & Kia-Keating, 2017; Roy & Roxas, 2011).

Understanding Trauma

Trauma, defined as an inescapable event that overwhelms an individual's existing coping mechanisms, is a common part of life experience for refugee populations (UNHCR, 2016). Trauma often follows in the wake of persecution, violence, conflict, and human rights violations in refugees' countries of origin. Experiences of trauma occur in multiple forms and are not limited to circumstances in refugees' countries of origin; trauma experiences can occur across pre-migration, migration, and resettlement periods (Weaver, 2016). Examples of pre-migration and migration trauma common to refugee experiences include lack of food or clean water, being displaced, lack of shelter, ill health without access to proper medical care, murder of a family member or other loved one, being detained or beaten, and witnessing war or violence (Sullivan & Simonson, 2016; Weaver, 2016). Once refugee families are resettled in a country of origin, they may also experience psychological distress resulting from the difficulties of integrating into a new culture. The arduous process of acculturation is rife with potentially adverse circumstances, involving learning a new language, new customs, and navigating new social, financial, and educational systems (Sullivan & Simonson, 2016).

The experience of trauma in the lives of refugee children can have lasting effects. Common child and adolescent responses to trauma may include fear, anger, irritability, sadness, apathy, inattention, anxiety, disrupted sleep, struggling in school, and somatic complaints, such as stomachaches and headaches (Sullivan & Simonson, 2016). In a study conducted with Tamil refugees, most respondents reported that effects of their trauma experiences lingering after migration and resettlement included dwelling at length on their experiences, feeling hopeless, having recurring nightmares, and experiencing retraumatization as a result of triggers (Weaver, 2016). These responses reflect long-term behavioral and emotional effects of experiencing trauma, and they also reflect the brain's responses to trauma, even long after the traumatic event has actually occurred (Van der Kolk, 2014). When one experiences a traumatic event, the limbic system and brainstem in the lower parts of the brain respond to threat by triggering automatic reactions that may help a person reach safety (Nelson et al., 2014). These triggered bodily responses to trauma provide an adaptive and protective function at the time of the traumatic event; however, once these responses have become highly sensitive, similar reactions can be triggered again in situations that may seem similar but are not actually threatening. As a result, circumstances that recurrently trigger a response to distress can disrupt a person's day-to-day functioning (Nelson et al., 2014; Weaver, 2016).

In seeking to understand trauma among refugee children, it is important to exercise cultural sensitivity and recognize the many and diverse understandings of trauma. In Western countries, trauma is largely understood within a biomedical framework, which may be limited in its capacity to understand refugees as whole, diverse people who live lives that go far beyond the illness boundaries of the biomedical approach (Brough, Gorman, Ramirez, & Westoby, 2003). A number of researchers argue that incorporating social factors and the recognition of self-healing capacities can help provide a lens of

cultural humility and empowerment for refugee children who have experienced trauma (Brough et al., 2003; Evers, Van der Brug, Van Wesel, & Krabbendam, 2016; Sullivan & Simonson, 2016).

Key Practice Areas in School-Based Interventions

In light of these theoretical frameworks, the following section describes school-based interventions and recommended practices in five areas: school leadership and culture, teaching, mental health, after-school programs, and family and community partnerships.

School leadership and culture

School leadership and culture is a critical practice area for integration of refugee youth. School leaders have the capacity to create more culturally and linguistically responsive learning environments that promote the sociocultural integration of refugee youth. In a review of literature on school leadership, Khalifa, Gooden, and Davis (2016) identify four culturally responsive school leadership behaviors: developing critical self-awareness, supporting teachers in becoming more culturally responsive, creating culturally inclusive environments, and engaging parents and communities.

School leaders have the capacity to transform school environments to make them more inclusive and more responsive to the needs of refugee students. Scanlan and López (2014) argue that school leaders have three primary tasks in creating culturally and linguistically responsive schools: promote sociocultural integration, cultivate language proficiency, and ensure academic achievement. These goals are achieved by creating a learning architecture that creates and facilitates design for learning, which occurs in the context of communities of practice. By using the term *learning architecture*, Scanlan and Lopez (2014) argue that learning cannot be designed directly; rather school leaders are tasked to design *for* learning through the creation of processes and products that facilatate it. For educators looking to make their schools more responsive for refugee youth, the focus on learning architecture shifts the emphasis from what is "taught" to the structures in place within a school that facilitate cultural and lingusitic learning and exchange – both for teachers and students. For example, if a school leader wanted help their teachers develop culturally and linguistically reponsive teaching practices, the leader should focus not just on what is taught – e.g. a professional development training – but also on creating structures to faciltiate learning in an ongoing manner. Scanlan and Lopez (2014) argue that supportive teacher learning communities where teachers engage in regular and ongoing conversations about topics of pedagogy and cultural and linguistic difference provide an example of learning architecture in practice. The authors also argue that the practical elements of a learning architecture throughout a school community take form via integrated service delivery, which encompasses ensuring equal access to educational opportunities through high-quality teaching, resource allocation, and school policy.

Given the complexity of school leadership and the challenge of conducting randomized controlled trials at the school level, there are few evidence-based examples of school leadership practices that facilitate the integration of refugee youth beyond correlational or single case studies. One study across 44 schools in Melbourne, Australia used a mixed

methods study that combined organizational ethnography, qualitative interviews, and quantitative tracking of refugee outcomes over time to evaluate an intervention called the School Support Programme for refugee youth (Block et al., 2014). The program involves creating a refugee action team at the school, comprised of teachers and members of the leadership and administration team. Each school completes a Refugee Readiness Audit, and in turn develops actions plans to address areas of need. Online resources and professional development opportunities are also included. Findings across the schools indicate promising results - many of the schools developed action plans and put them into action, changed school policies to make them more culturally responsive to refugee youth, and raised awareness among school teachers and staff about the challenges faced by refugees in the school system.

Two case-study examples also provide evidence of strategies that schools might use to create responsive communities for refugee students. In a study of four Australian schools, Taylor and Sidhu (2012) identify the importance of taking an advocacy role in school leadership through supporting students (particularly those unauthorized) through legal processes of immigration, accompanying families through the refugee review tribunal, and community advocacy efforts through newsletters and public statements in support of refugee well-being - even in some cases in response to less receptive language from politicians. The latter emphasizes the need to make the commitment to social justice for refugees explicit through school mission statements, values, and messaging. The authors acknowledge that systemic support via government-sponsored programs is critical to support these efforts. Additionally, a case-study of a South Australian primary schools emphasized the need for teacher trainings, curricular adjustments, and strategic decisions around integrating mainstream and newly arriving students by reducing tracking practices in classrooms and school activities (Pugh, Every, & Hattam, 2012). More research is needed, however, to examine these practices at the district level in order to identify specific school leadership practices that help to effectively integrate refugee youth.

Teaching

Teachers play a primary role in the education and integration of refugee youth, yet research is mixed about the teacher's perceptions of refugee youth and the practices they use to work with this unique student population. A series of studies have examined teacher perceptions and beliefs about refugee children, each in unique social and political contexts. In a survey of 139 teachers in a large urban school district in the US Pacific Northwest, Kurbegovic (2016) found that teachers reported feeling confident and culturally competent to teach refugee students; however, many of these teachers did not believe that the needs and circumstances of these students were unique from those of mainstream students. Because of the significant barriers that culture, language, trauma, and migration play on refugee youth, teacher reports of confidence alongside a lack of acknowledgement of the needs of refugee students suggests a disconnect whereby teachers may be overconfident about their capacity to serve all of their students. This disconnect was also documented by Roy and Roxas (2011), who found that there was a strong disconnect between Somali Bantu families' goals and what their teachers thought their goals actually were, highlighting the ways in which teachers may have overemphasized the deficits of refugee

families and played down or missed their strengths. In other research, teachers have been more direct about the need for additional supports. In a study of Norwegian teachers, Pastoor (2015) found that most teachers had neither sufficient knowledge nor competence to adequately account for the psychological problems that were presented by their refugee students, and expressed a need for more adequate teaching resources and supports. Similar sentiments are echoed in a study of teachers on Prince Edward Island who confirmed the need for additional professional development resources, particularly in the area of teaching in the context of trauma. One teacher described the process of teaching refugee students without adequate preparation as "like feeling your way around in the dark" (MacNevin, 2012).

Additionally, research has highlighted the work that teachers are doing in the classroom to reach refugee students. Windle and Miller (2012) used a survey research design to examine the extent to which teachers used commonly accepted language and literacy teaching pedagogies with refugee students, including practices such as scaffolding learners, using direct and explicit teaching of language, activating prior knowledge, modeling metacognitive skills, and focusing on critical and creative skills. Study findings indicate that over half of the practices they identified were used routinely by a majority of teachers. In light of research on teacher perceptions and beliefs about refugee students, such research suggests that overall teachers are using commonly accepted pedagogical strategies but that there is a knowledge and practice gap with respect to specific, tailored strategies for working with refugee students. One strategy for engaging refugee students can be to make more explicit the connection between students' lived experiences and classroom materials through the incorporation of "funds of knowledge" (Moll, Amanti, Neff, & Gonzalez, 1992). Central to this approach is the understanding that households have cultural and cognitive resources useful for the classroom, and that teachers can use research strategies to engage with parents and households to qualitatively identify funds of knowledge at home that can then be used to augment teaching practices in the classroom. Szente, Hoot, and Taylor (2006) have also developed a series of recommendations for teachers in elementary settings working with refugee youth. These recommendations include: focusing on nonverbal social-emotional interventions, using peer learning strategies when possible, teaching mainstream youth about refugee experiences, and connecting to external resources.

Mental and behavioral health

Though refugee children are at heightened risk for a variety of mental and behavioral health problems (Halcon et al., 2004; Layne et al., 2008; Masten & Narayan, 2012; Sullivan & Simonson, 2016), they are also less likely to seek out mental health treatment to address these challenges (de Anstiss, Ziaian, Procter, Warland, & Bachurst, 2009; Ellis, Miller, Baldwin, & Abdi, 2011). In one study in the Netherlands, 57.8% of refugee children were identified as in need of mental health services in comparison to only 8.2% of their native mainstream Dutch peers, and of these 57.8% only 12.7% actually accessed mental health services. Research has identified financial challenges, language and cultural concerns, parental health literacy, distrust of authority, differences in health care systems from the country of origin, and mental health stigma as factors preventing access to services for

refugee children and families (Cardoso & Lane, 2016; Ellis et al., 2011). Because children spend extensive time in school settings, schools may be a primary mechanism to identify and provide services for refugee youth in need of mental health services and may be a means through which psychoeducation and other strategies to raise awareness among refugee communities of the importance of seeking mental health services. Two reviews of prevention-based mental health programs exist (Rousseau & Guzder, 2008; Tyrer & Fazel, 2014), which identify cultural challenges and the heterogeneity of refugee populations and ethnicities as difficult challenges in this work, and also find evidence that interventions in which participants engage in verbal processing of prior experiences showed great promise. These reviews emphasize the heterogeneity of refugee experiences and gaps between school and family marked by language and culture, and note that clinical interventions for refugee mental health that include verbal processing of prior experiences had strong promise while significant changes in symptomatology are also observed for a number of creative arts interventions.

Some approaches to school-based mental health support use a multi-tiered systems of support (MTSS) framework. MTSS is a practice whereby teachers and school professionals match services according to a student's individual need according to three tiers (Winfrey Avant & Lindsey, 2015). Tier 1 refers to universal services that all children receive, and often refers to school-wide programming and curricula. Tier 2 refers to more specialized services for a subset of students who need additional support, and finally tier 3 is associated with intensive services for students with high needs. Layne et al. (2008) conducted a randomized controlled trial of an integrative mental health program that used an MTSS framework in a school setting for war-exposed youth in Bosnia. The program included psychoeducation and coping skills for all children (tier 1), specialized trauma- and grief-focused intervention for youth with more severe needs and higher exposure to trauma (tier 2), and making referrals to community-based mental health providers outside the school for youth with acute levels of risk (tier 3). Reductions in PTSD and depression symptoms were observed for both the treatment (tier 1 + 2 intervention) and the comparison (tier 1) groups and reductions in maladaptive grief were observed in the treatment group. Studies like these provide helpful guidance and offer examples of how schools might approach the mental health needs of war-exposed and refugee children through an MTSS approach, providing services to children based on their specific level of need. A similar study has also demonstrated that working with teachers to identify and refer students with specialized needs to external mental health providers can be a helpful model for addressing the mental health needs of refugee students (Fazel, Doll, & Stein, 2009).

Cognitive behavioral therapeutic approaches have received some support in the literature as an intervention approach for refugee children with exposure to trauma (for a review, see Murray, Cohen, Ellis, & Mannarino, 2008). A body of research examines how these approaches may be used in school-based mental health settings. One example is the "Children and War: Teaching Recovery Techniques" cognitive-behavioral psychosocial educational program, which is a manualized program that educates students about the symptoms of PTSD and teaches coping strategies to manage these symptoms. A recent randomized controlled trial of the intervention found clinically modest reductions in PTSD, behavioral problems, and challenging emotional symptoms, though these gains were not

sustained at two-month follow-up (Ehntholt, Smith, & Yule, 2015). Another school-based clinical trial in Sri Lanka also found that CBT coupled with creative arts activities helped reduce symptoms for boys and younger children, and children experiencing lower levels of war-related stressors, though the authors cautioned that the intervention may have disrupted natural processes of grieving for other children (Tol et al., 2012). Other research has examined the use of trauma-focused cognitive behavioral therapy (TF-CBT), an evidence-based treatment program for children and adolescents affected by trauma, with refugee populations. Unterhitzenberger Eberle-sejari, Rassenhofer, Sukale, and Rosner (2015) found promising findings in the use of TF-CBT in reducing post-traumatic stress with unaccompanied refugee minors in Germany, though the intervention was not conducted in a school setting. Another controlled trial compared TF-CBT with child-centered play therapy (CCPT) in 31 children in the US Northwest, finding that both intervention approaches reduced trauma symptoms (Schottelkorb, Doumas, & Garcia, 2012). Other research suggests that TF-CBT can be modified slightly for work with refugee youth, including such practice strategies as providing a longer coping skills phase and allowing for adequate treatment closure phase for purposes of trust and safety (Cohen, Mannarino, Kliethermes, & Murray, 2012).

Most school-based mental health interventions are delivered by mental health specialists (social workers, psychologists, counselors, or other support staff). However, one study developed a group-based cognitive-behavioral therapy intervention to be delivered by teachers to war-traumatized Syrian refugee children living in Istanbul, Turkey (Gormez et al., 2017). Due to a lack of resources and the challenges of recruiting Arabic-speaking mental health professionals in Turkey, the research team opted to train existing teachers to deliver an eight-week (70-90 minutes per session) group CBT intervention. Findings demonstrated reductions in anxiety and in intrusive and arousal symptoms of PTSD and provide promise for the capacity of school communities to train teachers to deliver mental health interventions.

Other approaches have also garnered attention in the literature, including narrative exposure therapy (Ruf et al., 2010), motivational interviewing (Potocky 2017), occupational therapy (Copley, Turpin, Gordon, & Mclaren, 2011), and arts-based approaches (Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005; Yohani, 2008). In a clinical trial on the KIDNET narrative therapy for 7-16 year old refugee children with trauma backgrounds, researchers found clinical improvements in PTSD symptoms that were stable at 12-months follow-up, though this particular intervention did not take place in a school setting (Ruf et al., 2010). Narrative exposure therapy differs from other therapeutic approaches by encouraging the client to construct a narrative of their life’s experiences while the clinician focuses on traumatic events within that narrative. In a recent practice brief, Potocky (2017) outlined strategies for using motivational interviewing with refugee youth, emphasizing the importance of a working alliance between practitioner and client that emphasizes collaboration, evocation, and autonomy, though future research is needed to examine the effectiveness of this practice with this population. Occupational therapy has also been used in school-based settings to assist in social and emotional skill development for refugee children, in which the occupational therapist works closely with the student's teacher to develop social skills - seeing occupational tasks as a means to skill

development rather than as an end (Copley et al., 2011). Finally, a team of researchers in Canada have used arts-based approaches to assist refugee students, including the use of drama/theatre, visual arts and photography (Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005; Yohani, 2008). One of the advantages of such an approach is the non-stigmatizing, preventative nature of arts-based activities that allow for creative expression and affirmation of youth identities.

After-school programs

After-school programs (ASPs) have gained renewed attention as a mechanism for supporting students at-risk, in particular due to a recent meta-analysis that demonstrated the capacity of such programs to promote academic, personal, and social skills in children and adolescents (Durlak, Weissberg, & Pachan, 2010). The authors of this study argue that while ASPs demonstrate great promise, effects are highest among programs with the following four criteria: sequenced, active, focused, and explicit ("SAFE"). Sequenced refers to having a clearly defined set of activities oriented toward a particular measurable outcome, active refers to the inclusion of active forms of learning, focused requires that programs have at least one component focused on personal/social skills, and finally explicit means that outcomes are specific and targeted.

Most research on ASPs focuses on mainstream children, and those that examine ASPs and migration in the United States have focused on immigrant, English-learning, and Latino/a groups, but not refugees specifically (Greenberg, 2013; McDonald et al., 2006; Park, Lin, Liu, & Tabb, 2015). A set of studies have examined afterschool programming efforts for Hmong students including an arts-based theatre program (Ngo, 2017), a community-based program (Lee & Hawkins, 2008), and a program developed through a school-community leadership model (Rah, 2013). Such programs provide examples of how schools and community-based organizations have the potential to build cultural bridges that may increase the participation in and success of afterschool programming for specific cultural groups. Additionally, Simpkins, Riggs, Ngo, Vest Ettekal, and Okamoto (2017) have developed specific culturally-responsive practice recommendations for youth programs in light of the growing cultural and linguistic diversity of children in the United States. Example recommendations include crafting explicit policies and procedures regarding inclusivity, creating leadership opportunities for all children regardless of background, structuring activities to foster community and avoid marginalization, and working with staff on areas of cultural responsiveness, awareness, and reduction of bias.

Still, the evidence of afterschool programming specifically for refugee youth remains scant. Some research in this area has used ethnographic or case-study approaches (Naidoo, 2009), describing how such programming may provide access to social and cultural capital and facilitate processes of inclusion. However, there is no research currently examining the effectiveness of such programs. In response to this gap in the literature, the authors are currently working with a local community agency to develop and evaluate an after-school program for refugee children.

School-family and school-community partnerships

Connections between schools, parents, and communities play an important role in children's success in school, yet for families and children from refugee backgrounds these connections tend to be more tenuous, characterized by cultural misunderstanding and difference. Hornby and Lafaele (2011) have identified four primary barriers to parental involvement: parent and family factors (e.g., parent's perceptions beliefs about their involvement, life contexts), parent-teacher factors (differing goals, language differences), child factors, and societal factors. Research on refugee families specifically highlight similar themes, including differing expectations, perceptions, beliefs, and roles about parent involvement; language barriers; deference to authority in schools; and challenges associated with the process of resettlement (Georgis, Gokiert, Ford, & Ali, 2014; McBrien, 2011; Rah, Choi, & Nguyen, 2009; Roy & Roxas, 2011).

Research on interventions to address these issues tend to be case studies with practice recommendations rather than clinical trials. This is generally due to the difficulty in conducting clinical trials with the school/program as the unit of analysis and the unique contexts that this subpopulation brings. In a recent paper, Georgis et al. (2014) recommend the inclusion of cultural brokers between schools and refugee parents, the development of reciprocal opportunities for involvement defined by both the school and parent communities, the fostering of trust and relationships, and being responsive to community needs as four strategies to consider when working with refugee parents. In interviews with school personnel working with Hmong migrants and refugees in Wisconsin, Rah et al. (2009) identified three concrete recommendations from the interviews: 1) creating a bilingual liaison position, 2) partnering with community organizations, and 3) parent education programs focused on issues related to their child's schooling in the United States. Themes of cultural brokerage, community partnership, and advocacy for parents were also present in other research in this area (McBrien, 2011; Taylor & Sidhu, 2012).

Core Components of Effective Programs

While the approaches used by school professionals to improve the well-being of refugee students in this paper differ, there are common core components of successful programs and interventions across all five practice areas. Broadly, programs that include the presence of four recommended practices (sequenced, active, focused, and explicit) are likely to yield positive outcomes for youth from all backgrounds (Durlak et al., 2010). Yet there were other consistent characteristics of programs across practice areas unique to the experiences of refugee children and families. In general, programs were 1) tailored to the contexts of the program, and often to the specific cultural and linguistic backgrounds of a particular refugee subpopulation, 2) informed by the resettlement experience, in particular taking into consideration pre-migration, migration, and post-migration factors in designing program activities and intervention approaches, 3) embedded in community with strong linkages between parents, school leaders and community organizations, and 4) coordinated across multiple systems, whereby parent, school, and community leaders sought to use leadership and coordination strategies to draw upon the strength and expertise of multiple stakeholders to address challenges faced by refugee students. In most cases, programs

opted to either adapt existing evidence-based programs for work with refugee students or develop their own program in light of best practices and research in this area.

Education as a Human Right

The U.N. Convention on the Rights of the Child has affirmed that education is a right and that this right is linked to equal opportunity and inclusion for all children regardless of background. While refugee children face the challenges of a difficult resettlement process, a host of cultural and linguistic barriers, social stigma, and exposure to trauma, it is important to recognize that these difficulties should not be used as an excuse for differential treatment or unequal access to learning opportunities. Social workers - in collaboration with government, schools, teachers, students, and parents, play a key role in ensuring that this right is protected and ensured for refugee children (Thomas, 2016). This is particularly important for social workers practicing in the United States, which has not ratified the U.N. Convention on the Rights of the Child – and where a recent court ruling affirmed that access to literacy is not a constitutionally protected right (Fortin, 2018). Ensuring this right not only works to advance the well-being of children on the margins, but works to serve the democratic goals of education oriented toward building a more just, inclusive, and equal society, consistent with the fourth Sustainable Development Goal of ensuring quality education for all.

What is less clear is how to ensure these rights are carried out at the school level. In contrast to what are called first-generation rights – typically civic and political rights such as the right to free speech – rights related to education are understood as second generation rights, which refer to the social, cultural, and economic rights that require positive action to be ensured by states (Willems & Vernimmen, 2017). In many cases the historical and current political, cultural, and social realities of each state play an important role in the manner in which these rights are ensured (Willems & Vernimmen, 2017). In Europe, for example, questions as to whether refugee students can be assessed additional fees, have a right to education in their native language, or can/should be placed in a separate learning environment provide examples of how the securing of second generation rights on the ground remain topics of social, cultural, and legal debate (Willems & Vernimmen, 2017).

A second issue emerging with human rights and education relates to how the use of such rights are justified and implemented at the school level. McCowan demonstrates (2012) that the ways in which human rights are justified has important implications for both how human rights inform practice in school communities as well as the sustainability of those rights. For McCown, the inclusion of both status-based (deontological) and instrumental (consequential) justifications for supporting human rights provide learning opportunities where rights are upheld not solely for either their intrinsic value nor their instrumental effects, but both. Schools should promote human rights because they are of value in themselves, while also recognizing that the very justification of human rights provides an instrumental opportunity for learning that may make their incorporation in a school community more sustainable. Social workers might consider how the very act of supporting a school community in adopting a rights-respecting framework may in itself be an opportunity for learning.

Implications for Social Work Practice

In offering a review of theory, evidence-based practice, and human rights, this review aims to provide insight as to how to approach social work practice with refugee students in school communities. While broad in scope, current research and practice efforts in these three areas have important implications for social work practice. In light of these efforts, the following recommendations are offered as potential starting points for working to ensure the welfare of refugee children and families in school communities.

1. Support teachers in providing knowledge about the refugee experience and the need for tailoring teaching practices to meet students where they are. Teachers need not develop entirely new teaching strategies, but should focus on incorporating knowledge of refugee children's experiences into their teaching practice. For example, teachers should support refugee students through home-school communication, drawing on refugee family funds of knowledge (Moll, Amanti, Neff, & Gonzalez, 1992), and engaging in goal-sharing strategies rooted in refugee family experiences.
2. Use an MTSS framework to develop a schoolwide plan for addressing the mental and behavioral health needs of all students, but in particular refugee students. At the first tier, this could involve psychoeducation programs as well as arts-based and other non-stigmatizing forms of school-based programming that affirm the cultures and identities of refugee students. At tiers 2 and 3, this could involve developing community relationships with mental and behavioral health providers, or conversely building a school-based mental health program with licensed clinicians who are experienced in working with children exposed to trauma.
3. Continue to develop new therapeutic approaches for working with refugee children, and build upon promising practice-based research on the effectiveness of trauma-focused cognitive behavioral approaches, play therapy, and narrative therapy.
4. Ensure that after-school programs are sequenced, active, focused, and explicit ("SAFE"). This may involve adapting or writing new curricula to help refugee students develop the social, emotional, and academic skills that will help them be successful in school.
5. Appoint bilingual liaisons and cultural brokers and support them financially when possible.
6. Develop community partnerships that foster mutual trust and provide access to resources to support refugee children in schools.
7. Continue to support a culture of research and evaluation in resettlement agencies and programs. In the United States, community-university partnerships may help develop this capacity at the local level and be particularly beneficial for small resettlement nonprofits with limited resources and expertise in research and evaluation.

8. Make more effective use of administrative data systems. One key area is to advocate for the collection of refugee status (as distinct from immigration status or race/ethnicity) by local school districts, who can then use this information to provide aggregate data and reporting on the progress of refugee children in their district.
9. Continue to use evidence-based prevention programs designed for mainstream students across school communities, but tailor them when possible to meet the unique needs of refugee students without compromising program fidelity.
10. Avoid overemphasizing the need for more randomized controlled trials of culturally-tailored interventions, as they are often not reasonable and unrealistic. One strategy to address current research gaps would be to explicitly collect data on refugee status in conventional RCTs of mainstream interventions and use post-hoc tests to see if program outcomes are similar for refugee youth in comparison to their mainstream peers.
11. Advocate for the protection of funding for resettlement programs at the national level, and work with state agencies to ensure that funding supports for refugee children and families remains in the years following resettlement.
12. Work with district administrators and school principals to create a culture that maintains and promotes human rights at the district and school level. This work involes not only communicating human rights and making those rights explicit in district and school communities, but also the educational work of teaching human rights and providing avenues for "deep rooting" (McCowan, 2012, p. 78) and motivation for working to ensure these rights are correspondingly matched by practice and teaching efforts on the ground.

These recommendations are hardly exhaustive, but offer starting points for social workers and allied professionals in school communities to begin and continue the work of supporting the learning of refugee students.

One of the challenges of working to ensure second generation human rights like the right to education is that they require active promotion and support. Education systems need the appropriate funding and resources to carry out this work and ensure that human rights for all are realized. Another ethical document that may inform this work for social workers is the National Association of Social Workers Code of Ethics (2017). In particular, the document calls for social workers to take an active role in advocacy efforts:

> Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people. (NASW, 2017, 6.04c)

It is hoped that this review and the practice recommendations therein offer some guidance for practitioners looking to support the refugee children and families of their school communities.

References

Bal, A., & Arzubiaga, A. E. (2014). Ahiska refugee families' configuration of resettlement and academic success in U.S. schools. *Urban Education, 49*(6), 635-665. doi: https://doi.org/10.1177/0042085913481363

Benard, B. (2004). *Resiliency: What we have learned*. San Francisco, CA: WestEd.

Berthold, S. M. (2000). War traumas and community violence: Psychological, behavioral, and academic outcomes among Khmer refugee adolescents. *Journal of Multicultural Social Work, 8*(1,2), 15-46. doi: https://doi.org/10.1300/J285v08n01_02

Block, K., Cross, S., Riggs, E., & Gibbs, L. (2014). Supporting schools to create an inclusive environment for refugee students. *International Journal of Inclusive Education, 18*(12), 1337-1355. doi: https://doi.org/10.1080/13603116.2014.899636

Brenner, M. E., & Kia-Keating, M. (2017). Psychosocial and academic adjustment among resettled refugee youth. *International Perspectives on Education and Society, 30,* 221-249. doi: https://doi.org/10.1108/S1479-367920160000030016

Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon & R. Lerner (Eds.), *Handbook of child psychology* (pp. 793-828). New York: John Wiley & Sons, Inc.

Brough, M., Gorman, D., Ramirez, E., & Westoby, P. (2003). Young refugees talk about well-being: A qualitative analysis of refugee youth mental health from three states. *Australian Journal of Social Issues, 38*(2), 193-208. doi: https://doi.org/10.1002/j.1839-4655.2003.tb01142.x

Cardoso, J., & Lane, L. (2016). Practice with immigrant and refugee children and families in the mental health system. In A. Dettlaff & R. Fong (Eds.), *Immigrant and refugee children and families: Culturally responsive practice* (pp. 392-427). New York: Columbia University Press.

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect*, *36*(6), 528-541. doi: https://doi.org/10.1016/j.chiabu.2012.03.007

Coleman, J. S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94,* S95-S120. doi: https://doi.org/10.1086/228943

Copley, J., Turpin, M., Gordon, S., & Mclaren, C. (2011). Development and evaluation of an occupational therapy program for refugee high school students. *Austrailian Occupational Therapy, 58*(4), 310-316. doi: https://doi.org/10.1111/j.1440-1630.2011.00933.x

Correa-Velez, I., Gifford, S. M., McMichael, C., & Sampson, R. (2017). Predictors of secondary school completion among refugee youth 8 to 9 years after resettlement in

Melbourne, Australia. *International Journal of Migration & Integration*, *18*, 791-805. doi: http://doi.org/10.1007/s12134-016-0503-z

de Anstiss, H., Ziaian, T., Procter, N., Warland, J., & Bachurst, P. (2009). Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research. *Transcultural Psychiatry*, *46*(4), 584-607. doi: https://doi.org/10.1177/1363461509351363

Durlak, J. A., Weissberg, R. P., & Pachan, M. (2010). A meta-analysis of after-school programs that seek to promote personal and social skills in children and adolescents. *American Journal of Community Psychology*, *45*(3-4), 294-309. doi: https://doi.org/10.1007/s10464-010-9300-6

Ehntholt, K., Smith, P. A., & Yule, W. (2015). School-based cognitive-behavioral therapy group intervention for refugee children who have experienced war-related trauma. *Clinical Child Psychology and Psychiatry*, *10*(2), 235-250. doi: https://doi.org/10.1177/1359104505051214

Ellis, B. H., Miller, A. B., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child & Adolescent Trauma*, *4*, 69-85. doi: https://doi.org/10.1080/19361521.2011.545047

Evers, S., Van der Brug, M., Van Wesel, F., & Kbrabbendam, L. (2016). Mending the levee: How supernaturally anchored conceptions of the person impact on trauma perception and healing among children (cases from Madagascar and Nepal). *Children & Society, 30,* 423-433. doi: https://doi.org/10.1111/chso.12153

Fazel, M., Doll, H., & Stein, A. (2009). A school-based mental health intervention for refugee children: An exploratory study. *Clinical Child Psychology and Psychiatry*, *14*(2), 297-309. doi: https://doi.org/10.1177/1359104508100128

Fortin, J. (2018, July 4). 'Access to literacy' is not a constitutional right, Judge in Detroit rules. *New York Times* (p. A11). Retreived from https://www.nytimes.com/2018/07/04/education/detroit-public-schools-education.html

Georgis, R., Gokiert, R., Ford, D., & Ali, M. (2014). Creating inclusive parent engagement practices: Lessons learned from a school community collaborative supporting newcomer refugee families. *Creating Inclusive Parent Engagement*, *Spring/Sum*, 23-28.

Gormez, V., Kılıç, H. N., Orengul, A. C., Nursoy, M., Mert, E. B., Makhlouta, B., … Semerci, B. (2017). Evaluation of a school-based, teacher-delivered psychological intervention group program for trauma-affected Syrian refugee children in Istanbul, Turkey. *Psychiatry and Clinical Psychopharmacology*, *27*(2), 125-131. doi: https://doi.org/10.1080/24750573.2017.1304748

Greenberg, J. P. (2013). Determinants of after-school programming for school-age immigrant children. *Children and Schools*, *35*(2), 101-111. doi: https://doi.org/10.1093/cs/cdt002

Halcon, L. L., Robertson, C. L., Savik, K., Johnson, D. R., Spring, M. A., Butcher, J. N.,...Jaranson, J. M. (2004). Trauma and coping in Somali and Oromo refugee youth. *Journal of Adolescent Health, 35,* 17-25. doi: https://doi.org/10.1016/j.jadohealth.2003.08.005

Haller, W., Portes, A., & Lynch, S. M. (2011). Dreams fulfilled, dreams shattered: Determinants of segmented assimilation in the second generation. *Social Forces, 89*(3), 733-762. doi: https://doi.org/10.1353/sof.2011.0003

Hornby, G., & Lafaele, R. (2011). Barriers to parental involvement in education: An explanatory model. *Educational Review*, *63*(1), 37-52. doi: https://doi.org/10.1080/00131911.2010.488049

Kanu, Y. (2008). Educational needs and barriers for African refugee students in Manitoba. *Canadian Journal of Education, 31*(4), 915-940.

Khalifa, M. A., Gooden, M. A., & Davis, J. E. (2016). Culturally responsive school leadership: A synthesis of the literature. *Review of Educational Research*, *86*(4), 1272-1311. doi: https://doi.org/10.3102/0034654316630383

Kia-Keating, M., & Ellis B. H. (2007). Belonging and connection to school in resettlement: Young refugees, school belonging, and psychosocial adjustment. *Clinical Child Psychology and Psychiatry, 12*(29), 29-43. doi: https://doi.org/10.1177/1359104507071052

Kurbegovic, D. (2016). *A survey study examining teachers' perceptions in teaching refugee and immigrant students*. University of Washington. Retrieved from https://digital.lib.washington.edu/researchworks/handle/1773/36592

Layne, C. M., Saltzman, W. R., Poppleton, L., Burlingame, G. M., Pasalic, A., Durakovic, E.,...Pynoos, R. S. (2008). Effectiveness of a school-based group psychotherapy program for war-exposed adolescents: A randomized controlled trial. *Journal of American Academy of Child and Adolescent Psychiatry, 47*(9), 1048-1062. doi: https://doi.org/10.1097/CHI.0b013e31817eecae

Lee, S. J., & Hawkins, M. R. (2008). "Family is here": Learning in community-based after-school programs. *Theory Into Practice, 47*(1), 51-58. doi: https://doi.org/10.1080/00405840701764763

MacNevin, J. (2012). Learning the way: Teaching and learning with and for youth from refugee backgrounds on Prince Edward Island. *Canadian Journal of Education*, *35*(3), 48-63.

Masten, A. S., & Narayan, A. J. (2012). Child development in the context of disaster, war, and terrorism: Pathways of risk and resilience. *Annual Review of Psychology*, *63*(1), 227-257. doi: https://doi.org/10.1146/annurev-psych-120710-100356

McBrien, J. L. (2005). Educational needs and barriers for refugee students in the United States: A review of the literature. *Review of Educational Research*, *75*(3), 329-364. doi: https://doi.org/10.3102/00346543075003329

McBrien, J. L. (2011). The importance of context: Vietnamese, Somali, and Iranian refugee mothers discuss their resettled lives and involvement in their children's schools. *Compare: A Journal of Comparative and International Education*, *41*(1), 75-90. doi: https://doi.org/10.1080/03057925.2010.523168

McCowan, T. (2012). Human rights within education: Assessing the justifications. *Cambridge Journal of Education*, *42*(1), 67-81. doi: https://doi.org/10.1080/0305764X.2011.651204

McDonald, L., Moberg, D. P., Brown, R., Rodriguez-Espiricueta, I., Flores, N. I., Burke, M. P., & Coover, G. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools*, *28*(1), 25-34. doi: https://doi.org/10.1093/cs/28.1.25

Minkenberg, M. (2013). The European radical right and xenophobia in West and East: Trends, patterns and challenges. In R. Melzer & S. Serafin (Eds.), *right-wing extremism in Europe: Country analyses, counter-strategies and labor-market-oriented exit strategies* (pp. 9-34). Retrieved from http://library.fes.de/pdf-files/dialog/10031.pdf

Moll, L. C., Amanti, C., Neff, D., & Gonzalez, N. (1992). Funds of knowledge for teaching: Using a qualitative approach to connect homes and classrooms. *Theory Into Practice*, *31*(2), 132-141. doi: https://doi.org/10.1080/00405849209543534

Murray, L. K., Cohen, J. A., Ellis, B. H., & Mannarino, A. (2008). Cognitive behavioral therapy for symptoms of trauma and traumatic grief in refugee youth. *Child Adolescent Psychiatric Clinics of North America*, *17*, 585-604. doi: https://doi.org/10.1016/j.chc.2008.02.003

Naidoo, L. (2009). Developing social inclusion through after-school homework tutoring: A study of African refugee students in Greater Western Sydney. *British Journal of Sociology of Education*, *30*(3), 261-273. doi: https://doi.org/10.1080/01425690902812547

National Association of Social Workers. (2017). Code of ethics of the National Association of Social Workers. NASW Press. Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Nelson, D., Price, E., & Zubrzycki, J. (2014). Integrating human rights and trauma frameworks in social work with people from refugee backgrounds. *Australian Social Work, 67*(4), 567-581. doi: https://doi.org/10.1080/0312407X.2013.777968

Ngo, B. (2017). Naming their world in a culturally responsive space. *Journal of Adolescent Research*, *32*(1), 37-63. doi: https://doi.org/10.1177/0743558416675233

Park, H., Lin, C. H., Liu, C., & Tabb, K. M. (2015). The relationships between after-school programs, academic outcomes, and behavioral developmental outcomes of Latino children from immigrant families: Findings from the 2005 national household education surveys program. *Children Services Review*, *53*, 77-83. doi: https://doi.org/10.1016/j.childyouth.2015.03.019

Pastoor, L. D. W. (2015). The mediational role of schools in supporting psychosocial transitions among unaccompanied young refugees upon resettlement in Norway. *International Journal of Educational Development*, *41*, 245-254. doi: https://doi.org/10.1016/j.ijedudev.2014.10.009

Portes, A., & Zhou, M. (1993). The new second generation: Segmented assimilation and its variants. *Annals of the American Academy of Political and Social Science, 530*, 74-96. doi: https://doi.org/10.1177/0002716293530001006

Potocky, M. (2017). Motivational interviewing: A promising practice for refugee resettlement. *Journal of Ethnic & Cultural Diversity in Social Work*, *25*(3), 247-252. doi: https://doi.org/10.1080/15313204.2015.1028121

Pugh, K., Every, D., & Hattam, R. (2012). Inclusive education for students with refugee experience: Whole school reform in a South Australian primary school. *Australian Educational Researcher*, *39*, 125-141. doi: https://doi.org/10.1007/s13384-011-0048-2

Putnam, R. D. (1995). Bowling alone: America's declining social capital. *Journal of Democracy, 6*(1), [online only]. doi: https://doi.org/10.1353/jod.1995.0002

Rah, Y. (2013). Leadership stretched over school and community for refugee newcomers. *Journal of Cases in Educational Leadership*, *16*(3), 62-76. doi: https://doi.org/10.1177/1555458913498479

Rah, Y., Choi, S., & Nguyen, T. S. T. (2009). Building bridges between refugee parents and schools. *International Journal of Leadership in Education*, *12*(4), 347-365. doi: https://doi.org/10.1080/13603120802609867

Rousseau, C., & Guzder, J. (2008). School-based prevention programs for refugee children. *Child and Adolescent Psychiatric Clinics of North America*, *17*(3), 533-549. doi: https://doi.org/10.1016/j.chc.2008.02.002

Rousseau, C., Drapeau, A., Lacroix, L., Bagilishya, D., & Heusch, N. (2005). Evaluation of a classroom program of creative expression workshops for refugee and immigrant children. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *46*(2), 180-185. doi: https://doi.org/10.1111/j.1469-7610.2004.00344.x

Roy, L., & Roxas, K. C. (2011). Whose deficit is this anyhow? Exploring counter-stories of Somali Bantu refugees' experiences in "doing school." *Harvard Educational Review*, *81*(3), 521-541. doi: https://doi.org/10.17763/haer.81.3.w441553876k24413

Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7-to 16-year-olds: A randomized controlled trial with traumatized refugee children. *Journal of Traumatic Stress*, *23*(4), 437-445. doi: https://doi.org/10.1002/jts.20548

Scanlan, M., & López, F. (2014). *Leadership for culturally and linguistically responsive schools*. New York: Routledge.

Schottelkorb, A. A., Doumas, D. M., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy*, *21*(2), 57-73. doi: https://doi.org/10.1037/a0027430

Simpkins, S. D., Riggs, N. R., Ngo, B., Vest Ettekal, A., & Okamoto, D. (2017). Designing culturally responsive organized after-school activities. *Journal of Adolescent Research*, *32*(1), 11-36. doi: https://doi.org/10.1177/0743558416666169

Stanton-Salazar, R. D. (2011). A social capital framework for the study of institutional agents and their role in the empowerment of low-status students and youth. *Youth & Society, 43*(3), 1066-1109. doi: https://doi.org/10.1177/0044118X10382877

Sullivan, A. L., & Simonson, G. R. (2016). A systematic review of school-based social-emotional interventions for refugee and war-traumatized youth. *Review of Educational Research*, *86*(2), 503-530. doi: https://doi.org/10.3102/0034654315609419

Szente, J., Hoot, J., & Taylor, D. (2006). Responding to the special needs of refugee children: Practical ideas for teachers. *Early Childhood Education Journal*, *34*(1), 15-20. doi: https://doi.org/10.1007/s10643-006-0082-2

Taylor, S., & Sidhu, R. K. (2012). Supporting refugee students in schools: What constitutes inclusive education? *International Journal of Inclusive Education*, *16*(1), 39-56. doi: https://doi.org/10.1080/13603110903560085

Thomas, R. L. (2016). The right to quality education for refugee children through social inclusion. *Journal of Human Rights and Social Work, 1*(4), 193-201. doi: https://doi.org/10.1007/s41134-016-0022-z

Tol, W. A., Komproe, I. H., Jordans, M. J., Vallipuram, A., Sipsma, H., Sivayokan, S., … de Jong, J. T. (2012). Outcomes and moderators of a preventive school-based mental health intervention for children affected by war in Sri Lanka: A cluster randomized trial. *World Psychiatry*, *11*(2), 114-122. doi: https://doi.org/10.1016/j.wpsyc.2012.05.008

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: A systematic review. *PLoS ONE*, *9*(2), 1-12. doi: https://doi.org/10.1371/journal.pone.0089359

UNHCR. (2016). Global trends: Forced displacement in 2016. *UNHCR: The UN Refugee Agency.* Retrieved from http://www.unhcr.org/globaltrends2016/

Unterhitzenberger, J., Eberle-sejari, R., Rassenhofer, M., Sukale, T., & Rosner, R. (2015). Trauma-focused cognitive behavioral therapy with unaccompanied refugee minors: A case series. *BMC Psychiatry*, *15,* 1-9. doi: https://doi.org/10.1186/s12888-015-0645-0

Uptin, J., Wright, J., & Harwood, V. (2013). 'It felt like I was a black dot on white paper': Examining young former refugees' experience of entering Australian high schools. *Australian Educational Researcher, 40,* 125-137. doi: https://doi.org/10.1007/s13384-012-0082-8

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* New York: Penguin Group.

Weaver, H. N. (2016). Between a rock and a hard place: A trauma-informed approach to documenting the traumatic experiences of Tamil refugees. *Journal of Human Rights and Social Work, 1,* 120-130. doi: https://doi.org/10.1007/s41134-016-0013-0

Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science, 4*(3), 81-85. doi: https://doi.org/10.1111/1467-8721.ep10772327

Willems, K., & Vernimmen, J. (2017). The fundamental human right to education for refugees: Some legal remarks. *European Educational Research Journal*, *17*(2), 1-14.

Windle, J., & Miller, J. (2012). Approaches to teaching low literacy refugee-background students. *Australian Journal of Language and Literacy*, *35*(3), 317-333.

Winfrey Avant, D., & Lindsey, B. C. (2015). School social workers response to intervention change champions. *Advances in Social Work, 16*(2), 276-291. doi: https://doi.org/10.18060/16428

Yohani, S. C. (2008). Creating an ecology of hope: Arts-based interventions with refugee children. *Child and Adolescent Social Work Journal*, *25*(4), 309-323. doi: https://doi.org/10.1007/s10560-008-0129-x

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Conversation Club: A Promising Practice in Youth Mentoring of Migrants and Refugees

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Abstract: *This paper evaluates Conversation Club, a Canadian after-school group mentoring intervention focusing on the expansion of the program across three separate regions of Ontario. The authors use a multiple methods design, including questionnaires (n=101), post-session process data, and qualitative interviews (n=18), to evaluate how Conversation Club impacts members' feelings of hope, belonging, sense of ethnic identity, and social support. A focus group (n = 7) with program facilitators was also conducted to explore the process of dissemination of the Club across regions. Findings suggest that Conversation Club holds promise for newcomer youth across settings. Quantitative data showed significant change (p <.01) in levels of hope and sense of belonging. Interviews revealed an increased sense of belonging, possibility, and social support, as well as improved confidence in communicating with others. Insights regarding use of the Club manual suggest the importance of integrating Conversation Club values with flexibility in facilitation to incorporate the strengths and opportunities of context across regions. Study limitations, as well as implications for further social work research and dissemination of best practices in services for migrant and refugee youth, are discussed.*

Keywords: *Migrant and refugee youth, group mentoring, adolescents*

Addressing the international flow of immigrants and refugees is a major concern for governments around the world. In recent years, instability in the Middle East and Northern Africa has caused a migration crisis (Metcalfe-Hough, 2015), with many people fleeing their native countries to avoid violence, as well as to seek improved economic opportunities. In 2015, there were 244 million international migrants, over 16 million of whom were refugees (Migration Policy Institute, 2015).

Canada in particular has emerged as a country willing to accept immigrants and refugees while striving to provide resources to ease the cultural shock and isolation that can often accompany migration (Kantor & Einhorn, 2016; Vieira, 2015). One in five people living in Canada is foreign-born, and in 2018, Canada plans to receive 310,000 additional immigrants (Government of Canada, 2017; Statistics Canada, 2011). In 2016, people from Syria were the third largest source of immigrants to Canada, making up 11.8% of the total immigrant population (Government of Canada, 2016; The Canadian Magazine of Immigration, 2017). Immigrants moving from India to Canada, the second largest group, increased by 1% from 2015 to 2016 (Government of Canada, 2016; The Canadian Magazine of Immigration, 2017). Migrants coming from Democratic Republic of Congo,

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Egypt, Nigeria, Pakistan, and Iran represent 0.9 to 3.8% of the Canadian immigration population respectively (Government of Canada, 2016; The Canadian Magazine of Immigration, 2017). Of this foreign-born population, nearly 20% are newcomer youth (Government of Canada, 2016). Although there is no single official definition, newcomer youth are typically defined as people between the ages of 12 and 24 who have been in Canada for fewer than five years (Affiliation of Multicultural Societies and Service Agencies of BC, 2016; Gouin, 2016; Ontario Council of Agencies Serving Immigrants, n.d.).

In contrast to native-born youth, newcomer youth in Canada (and throughout the world) face the challenges of behavioral and linguistic acculturation in their new country (Birman & Morland, 2014; Bridging Refugee Youth & Children's Services [BRYCS], 2010; MENTOR, 2009; Oberoi, 2016). Many immigrants (dubbed "newcomers" in this Canadian context) struggle with a new language, a new school system, and potentially new social norms (Birman & Morland, 2014; BRYCS, 2010; MENTOR, 2009). Newcomer youth often undergo a process of acculturation that is very different from that of their parents, as they feel more pressure from peers to let go of their foreign identity and embrace an identity rooted in Canadian culture (Birman & Morland, 2014; Oberoi, 2016). Additionally, many newcomer youth experience parent/child role reversals due to their superior understanding of the local language and need to help their parents in many of the daily tasks required to successfully navigate a new community (MENTOR, 2009; Oberoi, 2016).

These new pressures of acculturation and familial needs and expectations can cause significant stress and feelings of isolation among newcomer youth, resulting in increased difficulty relating to Canadian-born peers (Birman & Morland, 2014; MENTOR, 2009), an increased risk of emotional distress in comparison to their peers (Hilario, Vo, Johnson, & Saewyc, 2014), and specific stress related to exclusion, poverty, separation, and in some cases, trauma (MENTOR, 2009). Interventions focused on the unique needs of newcomer youth are critical in addressing the challenges and increased risks they face, and in supporting these youth in a healthy process of integration into their new communities.

Conversation Club: A Group Mentoring Intervention for Canadian Newcomer Youth

For Canadian newcomer youth, access to community services can serve as a protective factor in their migration and acculturation process (Canadian Pediatric Society, 2016). These community services can include: after-school programs, leadership development trainings, basic health trainings and advocacy, mental health services, dating violence advocacy programs, substance use treatment, employment resources, crime prevention resources, and summer camps. "Conversation Club" (also referred to here as "the Club") is a school-based group mentoring program developed by Big Brothers Big Sisters (BBBS) of Peel Province in response to the needs of diverse youth in the community. The program began in 2009 in partnership with local settlement organizations and libraries. The Club was quickly expanded to local schools and is now implemented in 14 sites, including high schools, libraries, community centers, and settlement agencies across Ontario.

Group Mentoring With Youth

Group mentoring is defined by Kuperminc and Thomason (2014) as “natural or programmatic mentoring contexts in which one or more mentors work with at least two” mentees (p. 274). Mentees in group settings are free to try out new behaviors and to observe and learn from others’ behaviors (Kuperminc & Thomason, 2014). Additionally, group mentoring can allow for more culturally attuned work, as some individuals, particularly ethnic minority groups, prefer working with peers with similar experiences versus with a one-on-one mentor from another culture (Herrera, Vang, & Gale, 2002; Kuperminc & Thomason, 2014; Lindsay-Dennis, Cummings, & McClendon, 2011; Utsey, Howard, & Williams, 2003).

Group facilitators are expected to create an atmosphere of collaboration, introduce and maintain direction, promote positive change, and keep the focus of the group (Emelo, 2011; Kuperminc & Thomason, 2014). Conversation Club facilitators, above all else, aim to meet the newcomer youth where they are and work to implement lessons that properly address the needs reported by youth in the program. This sense of collaboration is intended to fuel passion in the newcomer youth and empower them to maintain their ethnic identity while exploring Canadian culture and making new friends.

Group mentoring is one way to broadly address youth’s needs by helping them connect with other newcomers, learn the new language and culture of Canada, and create their own sense of belonging and hope in their new environment. In order to do this, facilitators hear the experiences, hopes, and challenges of youth (MENTOR, 2009); create safe spaces of inclusion and belonging (MENTOR, 2009; Patton, Deutsch, & Das, 2016); provide training in cultural competency (BRYCS, 2010; Oberoi, 2016) and conflict resolution (Deutsch, Wiggins, Henneberger, & Lawrence, 2012); and involve youth with the program planning and shaping (BRYCS, 2010).

Due to their specific struggles, immigrants and refugees can experience significant benefits from mentoring (DuBois, Holloway, Valentine, & Cooper, 2002; Rhodes, 1994). Specifically, group mentoring can provide a foundation for newcomer youth to relate to peers their age (Birman & Morland, 2014; BRYCS, 2010; Cawood & Wood, 2014; Crul & Schneider, 2014; Deutsch, Reitz-Krueger, Henneberger, Ehrlich, & Lawrence, 2016; Hilario et al., 2014; Schmidt, Morland, & Rose, 2009) and receive peer and adult support through their adjustment process (Birman & Morland, 2014). Mentees have a space to promote their bicultural identities (Morland, 2007) and find and foster positive relationships in their new environment (Birman & Morland, 2014; Cawood & Wood, 2014; Hilario et al., 2014; Oberoi, 2016; Schmidt et al., 2009).

The core tenets of group mentoring among youth are fostering connection, cohesion, and mutual support (Kuperminc & Thomason, 2014). For these tenets to be achieved, safe spaces need to be formed in which culturally appropriate practices—including life skills, pro-social behaviors, critical thinking, and emotional coping—are promoted in alignment with specific cultural norms and expectations regarding adolescent development (Oberoi, 2016; Washington, Barnes, & Watts, 2014). Especially among minority adolescents, group mentoring can create a sense of belonging (Cawood & Wood, 2014) that might not be experienced in individualized mentorships. This solidarity with other students not only

allows adolescents to relate with others going through similar experiences (i.e., adjusting to a new country), but provides them the opportunity to support one another and give advice to peers in times of distress (Jagendorf & Malekoff, 2006). Creating these sincere connections with others helps to solidify youth's feelings of hope and belonging.

Expansion and Dissemination of Youth Programs

Although the value of group mentoring in the field is well established, there are many challenges which need to be addressed when disseminating and scaling up group mentoring programs for youth (Durlak & DuPre, 2008; McIsaac, Read, Veugelers, & Kirk, 2017). A common pitfall encountered in the dissemination process is that programs may be too complex for systems and providers to properly implement, which "may reduce adoption and diffusion of the program into systems" (Ozdemir & Giannotta, 2014, p. 112). Researchers must focus on identifying the key elements of a program that make it effective in order to provide clear and simple guidelines for program facilitators that can be realistically implemented in provider settings (DuBois, Portillo, Rhodes, Silverthorn, & Valentine, 2011; Rajan & Basch, 2012). More quotidian factors such as inclement weather, school holidays, and lack of suitable locations can also have a potentially negative impact on the implementation of group mentoring programs for youth (Iachini, Beets, Ball, & Lohman, 2014).

In order to implement beneficial group mentoring interventions with newcomer youth in Canada, there needs to be a clear purpose, an understanding of and planning for structural details (i.e., time and space), proper identification and/or creation of content that is appropriate and relevant for group goals, and, in many cases, support from schools and parents of the youth (BRYCS, 2010; Jagendorf & Malekoff, 2006; Kurland, 1978; Malekoff, 1997). For adult and peer facilitators alike, it is essential for them to pay attention to the process, structure, and boundaries of the group, form alliances with parents, teachers, and school administrators, stress confidentiality and trust among group members and leaders, and make a demand for work (Jagendorf & Malekoff, 2006). Efforts such as these, as reflected in this paper, help to contribute to impactful programming throughout expansion to new contexts and agencies.

The Current Study

Based on the program evaluation data from year one, we found that Conversation Club showed promise in addressing many of the important needs of its Canadian newcomers (Pryce, Kelly, & Lawinger, 2018). Findings suggested improvement among participants, relative to a comparison group, on important metrics such as community belonging, ethnic and cultural identities, and hope for the future (Pryce et al., 2018). Despite the early promise of this intervention, the potential benefits of transferring these outcomes to newcomers in other settings had not been explored. Based on the initial findings, the Conversation Club creators sought to expand the Club to three sites in Ontario (i.e., Peel Region, York, and Ottawa), looking at this expansion from multiple methodological perspectives.

In this mixed methods study, we sought to replicate our initial quantitative findings showing Conversation Club's promise as an intervention to positively impact newcomer youth's sense of belonging and hope. We also explored qualitatively how Conversation Club youth viewed their experience in the club intervention and in Canada more broadly. Finally, because this study focuses on Years Two and Three of the program evaluation, we report on focus group data with Conversation Club program staff regarding the utility of the Club's program manual and how to best scale the program up further.

Procedures

Survey Data

During the Fall semesters of two school years, (2014-15 and 2015-16), we worked with Conversation Club facilitators to secure consent from Conversation Club youth and families to conduct the study (total n=149). Based on the logic model developed with the Conversation Club program team, a questionnaire was developed to look at how the Conversation Club impacted newcomer youth's sense of hope and sense of belonging in their new country. These youth completed a questionnaire that asked for demographic data (age, gender, race/ethnicity, time already in Conversation Club, immigrant status) and also asked the youth about their sense of belonging in the Club and in Canada via the Perceived Cohesion Scale (PCS) (Cronbach's α=.96; Bollen & Hoyle, 1990) and overall sense of hope for the future via the Children's Hope Scale (CHS) (Cronbach's α=.83; Snyder et al., 1997). These scales were part of the initial program evaluation year, as the dimensions of hope and belonging were identified by program staff as meaningful in considering the impact of the program on youth participants. Findings from Year One indicated that Conversation Club youth (n=67) had statistically significant changes on belonging and hope as compared to the comparison group (n=25). The team elected to incorporate these measures into the program evaluation and expansion for Years Two and Three, reported here.

Data were collected by the Conversation Club team and support staff in each site, and transferred by post to the program evaluation team, who then entered the quantitative and demographic data into SPSS for later analysis.

Interview and Focus Group Data

Inclusion of qualitative methods reflects the effort, through this program evaluation, to understand the experience of the Conversation Club program from multiple perspectives. This mixed methods study employed methods sequentially (Creswell, 2013), which allows methods to be used as follow up from lessons learned from a prior method. In this case, the core research question was focused on the impact of Conversation Club participation on hope and belonging across multiple sites. The qualitative data collection allowed us to better understand what aspects of the Club facilitated belonging, and the process through which engagement in the Club takes place. While we assumed that the two methods would hold equal weight in the design, challenges to quantitative data collection, and the richness of the interview data generated, resulted in the qualitative data assuming more dominance in the study, a process noted often by experts in mixed methods (Creswell, 2013).

At the conclusion of these two years, 18 interviews were conducted with a subset of Conversation Club participants across the three sites using a convenience sample. Eight of the interviewees were female and ten were male. The use of qualitative methods offered the flexibility to look at the experience of Club involvement from multiple viewpoints, taking into account environment and social context, while valuing the voice of participants across program levels (Malson, 2010).

These interviews were conducted by members of the Conversation Club team who were not facilitators of the youth's specific Club, so as to avoid any sense of coercion toward the interviewee. Interviewers were initially trained by a research team member on skills important to qualitative interviewing. This training involved several didactic sessions, as well as role plays using the interview protocol, and group feedback to the interviewer. Interviewers were then supervised by this same research team member through weekly group meetings focused on identifying challenges and uncertainties presented through the interview process. Interviewees were invited by program staff to participate in an interview, and a separate consent was obtained from parents for this piece of the research. Once consent was obtained, interviews took place in a private room separate from the Conversation Club during the same time as Club sessions. Interviews were audio recorded and transcribed for accuracy.

The analyses for this study were carried out in a team environment in which members engaged collaboratively to both challenge and validate emergent themes (Boyatzis, 1998; Lyons, 2007). An open coding method was first used by two of the paper's co-authors to capture initial themes. Following this initial coding, two of four co-authors individually reviewed all of the interview transcripts, using open coding to organize content into conceptual categories (Padgett, 2008) that reflected patterns and themes. These themes were organized into a larger outline that was elaborated on and challenged until consensus was reached. Finally, the two coders returned to the transcripts with a coding book and coded all transcripts.

Also, at the conclusion of Year Two, the two lead authors on the project co-facilitated a focus group with seven Conversation Club staff from three sites (three veteran staff with several experiences implementing Conversation Club, and four staff representing two of the new agencies adopting the program, who each had one year of experience implementing the Club). This focus group took place by phone and lasted 90 minutes. Content focused on the challenges and opportunities encountered by staff in their use of the Conversation Club manual and was based on a set of questions developed in collaboration by the lead authors and veteran program facilitators. As a structure for co-facilitation, one lead author asked the questions while the other kept notes and transcribed verbatim key insights offered by the focus group participants. Following the focus group, the two lead authors reviewed the notes and reflections together to identify themes around the manual and scaling up the intervention that are addressed later in this article.

Findings

Demographics

Of the 149 Conversation Club members, 72 (48.5%) were male and 76 (51%) were female, and one student chose not to identify gender. While the group age ranged from 12 to 19, the average age was 15, and the average time the Conversation Club youth had been in Canada was 31.6 months. 85% of the Conversation Club group members had Permanent Resident status in Canada, and the average time of involvement in the Club for this group was 10.25 months (this reflects the differences between the 2 new groups in York and Ottawa, and the long-standing Conversation Club groups in Peel). The Club members described themselves as coming from 33 different countries, including China, Syria, Egypt, Pakistan, the Philippines, & India, making this the most diverse group of Conversation Club youth to date.

Table 1. *Demographic distribution of Conversation Club participants*

Demographics	**Participants**
Male n (%)	72 (48.5%)
Female n (%)	76 (51%)
Age Range	12-19 years
Average Age	15 years
Avg. Months in Canada	31.6 months
% Permanent Residents	85%

Findings noted in Table 2 reflect a within-group t-test performed with usable data from 2014-2016. Though the sample started with a total of 149 participants, several factors impacted study attrition, mostly due to students missing on the day of post-test, and some changing schools and leaving the group before the end of the program Thus, the sample was reduced to 105 and 114 for the two scales. Data from the within-group t-tests indicate that Conversation Club youth reported statistically significant change on their PCS scores (for both subscales of belonging and morale) and CHS scores (showing increased hope on both subscales in terms of both agency and pathways).

Table 2. *Results of within-group t-tests for the treatment (Conversation Club) in Peel, York, and Ottawa 2014-2016*

		Pre-Test			Post-Test			
Subscale	Measure	n	Mean	St. Dev	n	Mean	St. Dev	t-test
PCS	Belonging	105	24.84	5.76	105	26.32	4.72	2.506*
	Morale	105	17.50	5.88	105	25.64	4.43	9.326*
CHS	Agency	114	13.88	2.8	114	14.94	2.57	3.794*
	Pathways	114	13.61	2.61	114	14.13	3.02	2.521*

Note. * = $p < .025$ (Bonferroni Adjustment for each scale) df = 104 for PCS and df= 113 for CHS, based on usable pre-/post-tests.

This data builds on data collected from Year One of this pilot evaluation, which also reflected significant improvement in sense of belonging and experience of hope among the program group relative to the comparison group (Pryce et al., 2018).

Process Evaluation Data

Participants in those two programs who were newly adopting Conversation Club were also asked to complete brief evaluations of their group sessions for the purpose of process evaluation. This involved rating the session on a scale of 1 (*very bad*) to 4 (*very good*; see Table 3), and responding to an open-ended query requesting the rationale for their rating, their favorite part of the session, and what could have been done to improve the session. Out of a total of 101 ratings by Conversation Club youth from October 2015-June 2016, a very strong picture emerged of the strengths of the Conversation Club program. 79.2% of the responses rated the Club sessions as 4 ("very good") and 12.9% of the remaining responses were in the "good" category, meaning that for these new sites, 92% of the sessions were rated positively by the youth involved.

Table 3. *Global ratings of program quality across sessions across new Conversation Club programs.*

Rating	# of Responses	%
3 or 4 (Good or Very Good)	94	92.1%
1 or 2 (Very Bad or Bad)	7	7.9%
Total	101	100.0%

When asked why they gave the session the rating they chose, the Conversation Club youth reported "I had fun" (48.5%), "I liked playing games" (27.3%), and "it made me feel good or happy" (8.9%). The games the Club youth cited that involved using English and conversing with each other were frequently cited in their narrative descriptions, followed by the activities where they were encouraged to talk about their country of origin. Almost 50% of participants said a version of "nothing would make it better, it's great already," but there was a smaller group (30.9%) who provided constructive feedback, stating that they wished for more active gym-based games, like volleyball and basketball, or more field trips.

Qualitative Findings

Across the eighteen interviews conducted with Conversation Club participants at the end of the program year, several themes emerged that assist in unpacking and illuminating the increased sense of belonging indicated by the quantitative data. The section below highlights some the most prominent themes. Of note, pseudonyms are used to protect the confidentiality of participants.

Developing English Language Skills Increases Belonging

Increased agility in speaking English, and related confidence and sense of belonging, emerged as the strongest themes in the interviews focused on the impact of Conversation

Club. Daniel, an older adolescent from the Democratic Republic of the Congo, highlights some of this process in his reflection as associated with greater facility in speaking English, and related increased belonging and connection in relationships:

> *There's a lot of changes that I've seen and, I would say that one would be, uh, how to talk to people. Yeah. 'Cause for me, like, my first time here, I never talk to anyone. […] So when I come, I join this group, they start teaching me good stuff which helps me, which gives me the word of discovering friends, of knowing how to be, ya know, nice to people. Yeah. So. I would say the key for me to talk to people, it was Conversation Club, because that's where I began.*

Daniel's poignant reflection, which includes a reference to his anxieties as he navigates a new culture and environment, speaks powerfully of the "start" that Conversation Club gives him in "discovering friends" and "knowing how to be nice to people." This facilitated communication helped Daniel have an increased sense of belonging in Canada. Daniel's reflection is echoed by a large proportion of those interviewed; as comfort with English increased, so too did a perceived sense of connection, belonging, and confidence. As an example, Christine, from China, shares:

> *I think I might be more confident, because I was thinking, like, I am the English speaking not good. And now, I found someone is the same with me and everyone is the same. Everyone use the less greater words to talk about things. It make me feel better.*

Samantha, a student from Jamaica, also reflects on the contribution of the Club to her ability to communicate and interact with others, sharing:

> *Now, it's like practicing how to talk to people and so when I go out into big society or bigger group, I can talk better each day and I can do my English more better. Because talking to you guys, it's like, I have to talk proper English, so it teaches me how to become better person and talk in proper English.*

Aliyah expands again on this by linking this communication with self-improvement and connection with others. She states,

> *When you hear people talking in the language that you're not really familiar with, you start to learn. And you take chances, you start to talk to people, even though you're not perfect, but you get perfect. That's what I learned from Conversation Club.*

This increased confidence with English supports Club participants not only in their sense of belonging in relationships, but in their feelings of competence in other spheres of life, such as classwork. Danny, an eighth grader who moved to Canada from Pakistan, outlines this clearly when she shares how building confidence through Conversation Club assisted in her school experience:

> *Conversation Club helped me bring up my confidence a little […] I can talk in front of people about something I know, but, like, when you need to present, like, a presentation or anything and when it's all planned, that's when I start messing things up. Now it helped me when I'm presenting in class because in class I used*

> *to, like, my voice used to go down. I didn't even notice about that, my teachers are like, "Oh, yeah. That's getting better than it used to be."*

Emmanuel, a second year high school student from India, continues this theme, affirming the impact of Conversation Club on his confidence, stating, "I learned that if you want to express yourself, you don't need to fear what others are thinking of yourself. Be confident and just say what you want to say. I have become more confident by joining this club."

Club Participation Increases Belonging

One of the strongest themes that emerged from the interviews was in regards to the sense of belonging, and in turn, possibility that was associated with membership in Conversation Club. The majority of respondents discussed an initial sense of isolation and disorientation associated with relocation to Canada, and the important way that involvement in Conversation Club assisted them in having a sense of community. Emmanuel clearly expresses this experience of the Club:

> *This club is very nice; there is no discrimination. People don't judge you on the basis of your looks or your caste or your background. […] Everyone is just, has this experience to share how they feel and they're encouraged to, like, express themselves, don't feel left out.*

Jake, also a student from India, echoes this experience, sharing his sense of belonging as something that is "taught" through the Club, stating, "They talk equally. They always give us, like, a nice talk. They always teach us how to be, uh, how to be part in this group, and they always, uh, take care of us."

A core aspect of this experience of belonging comes from the inclusion demonstrated by the Club. As mentioned by Emmanuel above, some of this inclusion is experienced by a lack of focus on "looks…caste, or your background". Rachel, an older adolescent student from the Democratic Republic of Congo, aptly describes this experience in her interview, stating, "When I joined Conversation Club, I feel like I'm not the only one, ya know. There are others and everyone is maybe interested in what I will say that or words or mistake, everyone like, people are interested in meaning, not mistakes." This openness and lack of judgment can facilitate language, sharing, and, in turn, belonging. Christine, from China, takes this sense of acceptance and belonging even further, stating, "I felt this, like, a big family, and everyone is talking, and everyone is happy, and everyone is friendly and kind, and that is it." Aliyah highlights this sense of family as beyond her daily experience of a traditional classroom, sharing:

> *In the classroom, it's like each and every individual, they just come to class with themselves and leave. Conversation Club is like a family. Everyone has a responsibility for others, everyone has some kind of connection with others, they respect each other. That is the best thing, that's the thing I love the most.*

Here, Aliyah touches on the fact that many Conversation Club participants come from countries where the dominant culture is more collectivistic than that in Canada. Migration from a collectivistic to an individualistic culture poses difficulties for immigrants, particularly for youth who must navigate between the cultures of their parents and their

new home (Schwartz et al., 2015). Although immigrant youth typically undergo significant acculturation, some research indicates that underlying values, such as collectivism, do not change significantly with the acculturation process (Rosenthal, Bell, Demetriou, & Efklides, 1989). Conversation Club provides participants with an opportunity to learn about and engage with Canadian culture in a close-knit group setting which promotes feelings of familiarity and comfort.

Beyond feeling a sense of belonging to a group, many interviewees expressed a sense that such a belonging translates to feeling a part of the society as a whole. Marva, who came to Canada from India, makes this connection beautifully, stating, "It's made me feel like I'm no different than the others and that I don't have to change to fit into society and stuff." Joe, from Pakistan, expands this further, linking his participation in the Club with a greater sense of being a part of Canada. He states, "It is a community, right, and community is a part of Canada. So, like in Canada, there is a lot of people from other countries, so, but we stick together. We feel like we are in Canada." Manish and others echo this sentiment, stating, "Of course, I feel Canadian. 'Cause when I came here, I was feeling something away from the people here. But Conversation Club and other my friends, everyone, made me to be connected to Canada. Now I feel like a Canadian." Many Conversation Club members appear to experience this increased sense of belonging through Conversation Club as an integral part of their development of identity as newcomers and Canadians.

Interpersonal Support Increases Belonging

Participants shared that the sense of belonging also comes from the increased social support and connection that all interviewed youth shared when reflecting on the impact of the Club. This support was provided through connection to peers, as well as Club facilitators and volunteer mentors. Below is one of many examples, as articulated by Daniel, of the experience of friendship and connection cultivated through the Club:

> *Like right now, I can't count how many friends I have because there are many. So Conversation Club helped me know how to talk to people, how to know people. Whenever I walk in the hallway, I talk to them even though I don't know them.*

The abundance of connections that Daniel references is in stark contrast to the initial isolation experienced by many Conversation Club participants as expressed earlier in this section.

Connection extends beyond that with peers to program staff and mentors in the group, as expressed by students in referencing the role of program facilitators and mentors in the experience of building relationships through the program. The participants' words exemplify the importance of these relationships in helping them feel included and empowered in the Club. As James shares,

> *They'll just talk and help you, they'll ask about school, they'll talk more about their experience when they were at school. And then, ya know, they'll just relate it and try to help you and give you advice and stuff.*

Laura connects this experienced "friendliness" with an increase in energy that she has each day the Club is scheduled. In referencing her experience of Conversation Club mentors, she shares:

> *They're friendly. They won't be like, "I don't want to help you." They help us. Like, like a sister or a brother, like that. So I never skip the Conversation Club. […] When it's Thursday, I feel, like, an energy. When it's 3:30, "Oh! Conversation Club! I need to go!" Then I take every step and go fast. And if I see them, I feel happy.*

Laura shares the support that she receives, "like a sister or a brother." She translates that support to her enthusiasm for Conversation Club and making sure she attends as much as possible. This suggests that Conversation Club has the potential to overcome the common challenge of adolescent participation in after school activities by providing social support that participants do not find elsewhere.

Manish also articulates the unique support provided by facilitators and mentors, and the evolving role that they serve in his life. Manish reflects,

> *At first I joined Conversation Club, [staff] was like a teacher to me. But now, she's more than a teacher, she's a friend to me. She just tells what is good and what is bad. And it's [Conversation Club] better than other organizations because my mentor, like, she is really good, she never yells at us. So it makes other students to feel comfortable and better.*

For Manish, the friendly, accepting, advising support offered by Conversation Club facilitators and mentors set the program apart from other after school opportunities. The increased sense of belonging and safety from these adults translates to an increased investment in Conversation Club, as well as well-being and support.

Focus Group Data

To further inform our understanding of what works within Conversation Club, and what needs to be adjusted or changed in order to further support its dissemination, we were able to complement our mixed method data by facilitating a focus group with Club staff (n = 7; all female). This conversation was largely focused on challenges faced by staff in making use of the Conversation Club manual, a tool that had been developed for their use in the early phases of program dissemination. Anecdotally, we were aware that staff were making minimal use of the manual (i.e., "I found the manual gives a few suggested ideas for activities and things to do during the club, but it's more of almost a background before you even get to the Club"), and yet that the larger mentoring organization was hoping to build off of this tool for further dissemination. However, our understanding was limited as to what was needed to make this manual more usable.

Through our focus group conversation, we were able to develop greater understanding in this area. First, we explored manual use to date more systematically. Conversation Club leaders reported using the manual mostly to orient themselves to the general goals and scope of the program, and to develop initial start-up activities (e.g., "I used the manual at the beginning of the session, but then as I got going, I didn't really refer to it from there on

out"). They all reported that as written, the Conversation Club manual was not useful as an ongoing resource for regular consultation or for guidance in confronting challenges.

Next, our focus group addressed these limitations. Participants were asked how additional programs within Canada could adopt Conversation Club in a way that is faithful to its original mission, as well as being likely to promote the benefits that have been documented. According to the professionals participating in the focus group, the manual needed to be divided into broad phases that reflected the natural ebbs and flows of the Club, including the initial phase (i.e., first month), middle phase, and culminating phase (i.e., last two months). They thought that these phases should be outlined and structured within a revised manual, using specific examples and suggestions from the sites currently implementing Conversation Club. According to focus group participants, these phases reflected the development of the group, from introduction, development, engagement, and the development of co-leadership with the Conversation Club youth (Forsyth, 2018; Northern & Kurland, 2001; Yalom, 1995).

Within each phase, participants proposed having a checklist that would help new Conversation Club groups implement the Club with fidelity. This checklist needed to not only highlight important pieces, but also reflect practice wisdom developed through the pilot of Conversation Club across three regions. This needed to be sequential and structured in such a way that new facilitators are incentivized, at least structurally, to revisit the checklist within each phase.

In addition to structural changes, participants highlighted the importance of "shared authorship" as a core value in working with Conversation Club youth, and one that needs to be outlined up front in a manual, as well as woven throughout suggested exercises and foci. According to participants, newcomer youth must have a voice in co-creating a program such as Conversation Club. As an example, one participant said, "They [youth] would see you as the leader, but there is that understanding that the mentors and the youths themselves are able to bring forward their own ideas and the direction of where they want their program and activities to go." Lessons learned over the last year confirm how important it is to both call for and demonstrate examples of how newcomer youth shared authorship works within Conversation Club, and how essential it is to the success of the program.

Finally, as is well supported in evidence-based work on the dissemination of programs (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Kelly, Raines, Stone, & Frey 2010; Taussig et al., 2015), it is critically important to identify how and where new Conversation Club groups can tailor their work to their specific contexts as they adopt this exciting program. One participant summarized this by saying, "I tried to go along with activities [per the manual], but I found a lot of the youth were not really enjoying that…so informing a new staff member to remain flexible and just get the input of the youth would be very important." The work on Conversation Club to date shows that having a basic structure for the phases of the program, with myriad opportunities for Conversation Club group mentor leaders to tailor the specific activities in each phase to the specific cultural contexts of the participating Club youth, appears to have found a balance between keeping program fidelity while still allowing for adaptability and "shared voice" with Conversation

Club youth. Conversation Club group leaders can add their own unique contributions, particularly by including youth voice in the creation and implementation of the Club tasks and activities. Our focus group data indicates that Conversation Club facilitators say they need some guidance in order to balance the important Conversation Club program components that will assure program fidelity with their own creative ideas in engaging youth voice.

Discussion and Implications for Research and Social Work Practice

This paper reinforces findings from our initial study (Pryce et al., 2018) and further situates Conversation Club within the group mentoring literature as a promising intervention that merits further investigation, particularly for immigrant youth and adolescents (Birman & Morland, 2014). With its focus on creating a consistent, safe, and interactive space for newcomer youth, Conversation Club appears to support immigrant youth who often find themselves in a critical and risky transition. Based on the quantitative and qualitative data described here, Conversation Club demonstrates strong potential as an intervention that can build newcomer youth's sense of hope and sense of belonging to their new home. It is also of note that these outcomes, which were embedded in the initial logic model for this evaluation, were informed largely by the practice wisdom and expertise of the Conversation Club group leaders themselves and their creative application of the core ideas of Conversation Club within their specific contexts.

The findings noted above have significant implications for social work practice. Research in the area of program dissemination indicates that programs facilitated by social workers need to be flexible and adaptable (Ozdemir & Giannotta, 2014) to allow facilitators "to modify a program to make it more effective in a specific context" (Durlak & DuPre, 2008, p. 341). In order to achieve this, researchers must "identify critical program elements" (DuBois et al., 2011, p. 79) so that energy can be devoted to ensuring that those elements are maintained, while offering facilitators clear guidelines as to where adaptation of the curriculum is and is not desirable. This also speaks to the importance of training social work practitioners and implementers of interventions such as Conversation Club in how to adhere to a manual for an intervention while remaining flexible in addressing the specific needs of individual participants. Specific to Conversation Club, moving forward with the dissemination, it will be critical to utilize facilitator feedback in continuing to revise the manual to maximize program flexibility and fidelity.

Newcomers often face social, emotional, academic, and personal challenges as they seek to adjust to a new culture and language (Gouin, 2016; Hilario et al., 2014; Oberoi, 2016). Particularly given the unique relational needs of adolescents, the results of this intervention suggest the Conversation Club is offering much that these young people report to seek and value, particularly as they build on the adolescent's need to find productive connections and engage in "shared voice" activities. It is important to note that this study indicates that group mentoring programs may be more effective for newcomer youth than would be individual mentoring programs. This possibility warrants further exploration in both research and practice settings.

Results from this phase of dissemination of this promising program are encouraging for several reasons. In these two years, we saw significant and similar gains from pre- to post-test for all 3 regions on both the Hope Scale and Perceived Cohesion Scale. Significantly, this experience of hope and belonging appears to be manifest across youth migrants of 33 different countries, some of which represent nation states that maintain ongoing and persistent tensions (e.g., India/Pakistan, Syria/Egypt). Strikingly, Conversation Club appears to be a place where that tension is absent. In its place is the clear formation of a new community and one that appears to be able to celebrate ethnic differences while also emphasizing the newcomer youth's transition to becoming part of Canada.

In summary, it is clear that the Conversation Club program has significant promise in impacting key adolescent outcomes of belonging and hope across 3 different regions of Ontario. This initial data focused on dissemination suggests that Conversation Club is a program that can be disseminated to additional mentoring settings. Conversation Club appears to be able to engage and build on the strengths of young adolescents as well as young adult mentors preparing in engaging in supportive, collaborative relationships that enhance identity and development. These connections, between peers, mentors, and even to their homeland, offer a powerful sense of belonging and membership for these adolescents. As Conversation Club seeks to expand further in Canada, and as others work to address the myriad needs and strengths of migrant and refugee adolescents, is it critical to maintain attention to the adaptability and flexibility of the Conversation Club program that has made it successful for many diverse young people.

Limitations

While this study shows some positive outcomes, there are, as always, important limitations to bear in mind in interpreting results. The sampling plan represented a convenience sample of the youth that agreed to participate across three regions and does not include any comparison groups that could more fully show the impact of Conversation Club on its participants. From the quantitative component of the study, there was missing data (i.e., roughly 30-40 youth out of a total of 149 had missing data for some questions at post-test), and that missing data requires that the quantitative findings be interpreted with much caution; while not uncommon for a front-line program attempting to do an independent program evaluation in collaboration with our research team, this is still important to note. Additionally, a significant limitation for the entire study (and indeed, the Conversation Club intervention overall) is the informal nature of how English language comprehension is evaluated. Although this project took place in close partnership with program developers and staff, all of whom had history implementing the Club with young people in their communities, all referrals for the program were made by schools and teachers in the English Language Learner (ELL) classroom. Researchers and the Conversation Club team relied on that assessment to establish how much English the participants had and their capacity to engage in the program and research protocol. Future research needs to formally include a measure of English proficiency to enhance the strength of potential outcome findings. Additional research is needed more broadly on Conversation

Club, as well, both in terms of a larger sample in the Club groups as well as having a comparison group, preferably one that is randomly assigned to a control condition.

Although this project benefits from qualitative data from two perspectives, including Conversation Club participants and facilitators, voluntary interviews at one time point provide a limited view into the experience of the Club. Further, given that this project served as an evaluation of the program and an exploration of considerations for dissemination, the focus of the interview and focus groups, while building on one another, do not serve to deepen the qualitative knowledge provided through this project. More depth in qualitative inquiry, perhaps using phenomenology or case study method, is merited in order to more deeply understand the meaning and experience available to immigrant and migrant youth through group-based mentoring programs. Ensuring additional rigor through interpretation or other means (such as assessment of inter-rater reliability between coders) could also enhance this work.

Conclusion

This mixed-method program evaluation continues to reveal encouraging findings that invite additional investigation into the potential scope and reach of Conversation Club to other areas of Canada. This work represents strong collaboration from a dedicated set of practitioners and researchers and continues to spring from a "shared authorship" approach built on the wisdom of many years of building this innovative effort to incorporate mentoring into services for migrant and refugee adolescents. Future work would do well to further investigate the ways by which Conversation Club can be feasibly and effectively translated to additional regions and settings, as well as ways by which membership in the Club may impact more broadly the adjustment of newcomer Canadian adolescents across this critically important developmental stage.

References

Affiliation of Multicultural Societies and Service Agencies of BC [AMSSA]. (2016). *Newcomer youth: Challenges and strengths.* Retrieved from http://www.amssa.org/resources/migrationmatters-info-sheet-series/

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, *40*(4), 361-368. doi: https://doi.org/10.1037/a0016401

Birman, D., & Morland, L. (2014). Immigrant and refugee youth. In D. L DuBois & M. J. Karcher (Eds.), *Handbook of Youth Mentoring* (pp. 273-289). Los Angeles: Sage. doi: https://doi.org/10.4135/9781412996907.n24

Bollen, K. A., & Hoyle, R. H. (1990). Perceived cohesion: A conceptual and empirical examination. *Social Forces, 69*(2), 479-504. doi: https://doi.org/10.1093/sf/69.2.479

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Los Angeles: Sage Publications.

Bridging Refugee Youth & Children's Services [BRYCS]. (2010). *New directions in mentoring refugee youth.* Retrieved from http://www.brycs.org/documents/upload/BRYCS-BRIEF-Mentoring-Summer-2010.pdf

Canadian Pediatric Society. (2016). *Community resources for immigrant and refugee youth.* Retrieved from https://www.kidsnewtocanada.ca/health-promotion/youth-resources

Cawood, N. D., & Wood, J. M. (2014). Group mentoring: The experience of adolescent mentees on probation. *Social Work with Groups*, *37*(3), 213-229. doi: https://doi.org/10.1080/01609513.2013.862895

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks: Sage Publications.

Crul, M., & Schneider, J. (2014). Mentoring: What can support projects achieve that schools cannot? Retrieved from *SIRIUS Network Policy Briefs series* [Issue 2] http://www.sirius-migrationeducation.org/wp-content/uploads/2015/02/SIRIUS_Mentoring_FINAL.pdf

Deutsch, N. L., Reitz-Krueger, C. L., Henneberger, A. K., Ehrlich, V. A. F., & Lawrence, E. C. (2016). "It gave me ways to solve problems and ways to talk to people." Outcomes from a combined group and one-on-one mentoring program for early adolescent girls. *Journal of Adolescent Research*, *32*(3), 291-322. doi: https://doi.org/10.1177/0743558416630813

Deutsch, N. L., Wiggins, A. Y., Henneberger, A. K., & Lawrence, E. C. (2012). Combining mentoring with structured group activities: A potential after-school context for fostering relationships between girls and mentors. *The Journal of Early Adolescence*, *33*(1), 44-76. doi: https://doi.org/10.1177/0272431612458037

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology*, *30*(2), 157-197. doi: https://doi.org/10.1023/A:1014628810714

DuBois, D. L., Portillo, N., Rhodes, J. E., Silverthorn, N., & Valentine, J. C. (2011). How effective are mentoring programs for youth? A systematic assessment of the evidence. *Psychological Science in the Public Interest, 12*(2), 57-91. doi: https://doi.org/10.1177/1529100611414806

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41,* 327-350. doi: https://doi.org/10.1007/s10464-008-9165-0

Emelo, R. (2011). Group mentoring best practices. *Industrial and Commercial Training*, *43*(4), 221-227. doi: https://doi.org/10.1108/00197851111137898

Forsyth, D. R. (2018). *Group dynamics*. Boston, MA: Cengage Learning.

Gouin, R. (2016). *Facilitating the integration of newcomer children and youth: Study on the government's initiative to resettle Syrian refugees to Canada.* Retrieved from https://www.bgccan.com/wp-content/uploads/sites/3/2017/03/BGCC-brief-Citizenship andImmigration-2016.pdf

Government of Canada. (2016). *#WelcomeRefugees: Key figures.* Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/key-figures.html

Government of Canada. (2017). *Supplementary information 2018-2020 immigration levels plan.* Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/news/notices/supplementary-immigration-levels-2018.html

Herrera, C., Vang, Z., & Gale, L. Y. (2002). Group mentoring: A study of mentoring groups in three programs [Report]. Retrieved from https://files.eric.ed.gov/fulltext/ED467570.pdf

Hilario, C. T., Vo, D. X., Johnson, J. L., & Saewyc, E. M. (2014). Acculturation, gender, and mental health of Southeast Asian immigrant youth in Canada. *Journal of Immigrant and Minority Health*, *16*(6), 1121-1129. doi: https://doi.org/10.1007/s10903-014-9978-x

Iachini, A. L., Beets, M. W., Ball, A., & Lohman, M. (2014). Process evaluation of "Girls on the Run": Exploring implementation in a physical activity-based positive youth development program. *Evaluation and Program Planning, 46,* 1-9. doi: https://doi.org/10.1016/j.evalprogplan.2014.05.001

Jagendorf, J., & Malekoff, A. (2006). Groups-on-the-go: Spontaneously formed mutual aid groups for adolescents in distress. *Social Work with Groups*, *28*(3-4), 229-246. doi: https://doi.org/10.1300/J009v28n03_15

Kantor, J., & Einhorn, C. (2016). Refugees encounter a foreign word: Welcome. *The New York Times.* Retrieved from http://www.nytimes.com/2016/07/01/world/americas/canada-syrian refugees.html

Kelly, M. S., Raines, J. C., Stone, S., & Frey, A. (2010). *School social work: An evidence-informed framework for practice*. Oxford, UK: Oxford University Press. doi: https://doi.org/10.1093/acprof:oso/9780195373905.001.0001

Kuperminc, G. P., & Thomason, J. D. (2014). Group mentoring. In D. L DuBois & M. J. Karcher (Eds.), *Handbook of Youth Mentoring* (pp. 273-289). Los Angeles: Sage. doi: https://doi.org/10.4135/9781412996907.n18

Kurland, R. (1978). The neglected component of group development. *Social Work with Groups*, *1*(2), 173-178. doi: https://doi.org/10.1300/J009v01n02_06

Lindsay-Dennis, L., Cummings, L., & McClendon, S. C. (2011). Mentors' reflections on developing a culturally responsive mentoring initiative for urban African American girls. *Black Women, Gender & Families*, *5*(2), 66-92. doi: https://doi.org/10.5406/blacwomegendfami.5.2.0066

Lyons, E. (2007). Analysing qualitative data: Comparative reflections. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 158-173). London, U.K: Sage Publications Ltd. doi: https://doi.org/10.4135/9781446207536

Malekoff, A. (1997). Planning in group work: Where we begin. *Group Work with Adolescents: Principles and Practice* (pp. 53-80). New York: The Guilford Press.

Malson, H. (2010). Qualitative methods from psychology. In I. Bourgeault, R. Dingwall, & R. de Vries (Eds.), *The Sage Handbook of Qualitative Methods in Health Research* (pp. 193-211). Los Angeles: Sage. doi: https://doi.org/10.4135/9781446268247.n11

McIsaac, J. D., Read, K., Veugelers, P. J., & Kirk, S. F. (2017). Culture matters: A case of school health promotion in Canada. *Health Promotion International, 32,* 207-217. doi: https://doi.org/10.1093/heapro/dat055

Metcalfe-Hough, V. (2015). *The migration crisis? Facts, challenges and possible solutions*. Retrieved from https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9913.pdf

MENTOR. (2009). *Mentoring immigrant & refugee youth: A toolkit for program coordinators.* Retrieved from https://files.eric.ed.gov/fulltext/ED522073.pdf

Migration Policy Institute. (2015). *International migration statistics.* Retrieved from http://www.migrationpolicy.org/programs/data-hub/international-migration-statistics

Morland, L. (2007). Promising practices in positive youth development with immigrants and refugees. *The Prevention Researcher*, *14*(4), 18-21.

Northen, H., & Kurland, R. (2001). *Social work with groups*. NY: Columbia University Press.

Oberoi, A. (2016). Mentoring for first-generation immigrant and refugee youth. *National Mentoring Resource Center.* Retrieved from http://nationalmentoringresourcecenter.org/images/PDF/ImmigrantRefugeeYouth_Population_Review.pdf

Ontario Council of Agencies Serving Immigrants. (n.d.). *Who is an immigrant, refugee, newcomer, & undocumented person?* Retrieved from http://www.newyouth.ca/immigration/settlement-services/what-immigrant-refugee-newcomer-undocumented-person

Ozdemir, M., & Giannotta, F. (2014). Improving dissemination of evidence-based programs through researcher-practitioner collaboration. *New Directions for Child and Adolescent Development, 141,* 107-116. doi: https://doi.org/10.1002/yd.20090

Padget, D. (2008). *Qualitative methods in social work research.* Thousand Oaks, California: Sage Publications, Inc.

Patton, C. L., Deutsch, N. L., & Das, A. (2016). Coordination, competition, and neutrality autonomy and relatedness patterns in girls' interactions with mentors and peers. *The*

Journal of Early Adolescence, *36*(1), 29-53. doi: https://doi.org/10.1177/0272431614556349

Pryce, J. M., Kelly, M. S., & Lawinger, M. (2018). Conversation Club: A Group Mentoring Model for Immigrant Youth. *Youth & Society, 00*(0), 1-21 [online first]. doi: https://doi.org/10.1177/0044118X18780526

Rajan, S., & Basch, C. E. (2012). Fidelity of after-school program implementation targeting adolescent youth: Identifying successful curricular and programmatic characteristics. *Journal of School Health, 82,* 159-165. doi: https://doi.org/10.1111/j.1746-1561.2011.00681.x

Rhodes, J. E. (1994). Older and wiser: Mentoring relationships in childhood and adolescence. *Journal of Primary Prevention*, *14*(3), 187-196. doi: https://doi.org/10.1007/BF01324592

Rosenthal, D. A., Bell, R., Demetriou, A., & Efklides, A. (1989). From collectivism to individualism? The acculturation of Greek immigrants in Australia. *International Journal of Psychology, 24,* 57-71. doi: https://doi.org/10.1080/00207594.1989.10600032

Schmidt, S., Morland, L., & Rose, J. (2009). *Growing up in a new country: A positive youth development toolkit for working with refugees and immigrants*. Retrieved from the BRYCS website http://www.brycs.org/documents/upload/GrowingUpInANewCountry-Web.pdf

Schwartz, S. J., Zamboanga, B. L., Mason, C. A., Baezconde-Garbanati, L., Des Rosiers, S. E., Villamar, J. A., … Szapocznik, J. (2015). Developmental trajectories of acculturation: Links with family functioning and mental health in recent-immigrant Hispanic adolescents. *Child Development, 86*(3), 726-748. doi: https://doi.org/10.1111/cdev.12341

Snyder, C. R., Hoza, B., Pelham, W. E., Rapoff, M., Ware, L., Danovsky, M., ... & Stahl, K. J. (1997). The development and validation of the Children's Hope Scale. *Journal of Pediatric Psychology*, *22*(3), 399-421. doi: https://doi.org/10.1093/jpepsy/22.3.399

Statistics Canada. (2011). *National household survey profile, 2011.* Retrieved from https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

Taussig, H., Weiler, L., Rhodes, T., Hambrick, E., Wertheimer, R., Fireman, O., & Combs, M. (2015). Fostering healthy futures for teens: Adaptation of an evidence-based program. *Journal of the Society for Social Work and Research*, *6*(4), 617-642. doi: https://doi.org/10.1086/684021

The Canadian Magazine of Immigration. (2017). *Canada: Immigrants by source country-2016.* Retrieved from http://canadaimmigrants.com/canada-immigrants-by-source-country-2016/

Utsey, S. O., Howard, A., & Williams III, O. (2003). Therapeutic group mentoring with African American male adolescents. *Journal of Mental Health Counseling*, *25*(2), 126-139. doi: https://doi.org/10.17744/mehc.25.2.q3wda06r0ul0x97c

Vieira, P. (2015, November 24). Canada outlines plans to bring in 25,000 Syrian refugees; Ottawa will bring in Syrians in two groups, even as other nations express concerns about accepting refugees. Retrieved from Wall Street Journal [Online] website https://www.wsj.com/articles/canada-outlines-plans-to-bring-in-25-000-syrian-refugees-1448402154

Washington, G., Barnes, D., & Watts, R. J. (2014). Reducing risk for youth violence by promoting healthy development with pyramid mentoring: A proposal for a culturally centered group mentoring. *Human Behavior in Social Environment*, *24*(6), 646-657. doi: https://doi.org/10.1080/10911359.2014.922789

Yalom, I. D. (1995). *The theory and practice of group psychotherapy*. NY: Basic Books (AZ).

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A Call to Action: Reimagining Social Work Practice With Unaccompanied Minors

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Abstract: *In the decade leading up to 2012, approximately 8,000 Unaccompanied Minors (UAM) arrived annually at the Southwestern border of the United States. Since then, the number of arrivals has drastically increased, surpassing 14,000 between October 1, 2017 and January 31, 2018 alone. The needs of UAM concerning mental health, education, social, and legal counseling often differ from the needs of other Latinx and immigrant populations. However, recent instability in the protections and services tailored to UAM are channeling these youth and their families into mainstream agencies. This article is a call to action for social workers who may now encounter UAM for the first time in their practice. Drawing from almost twelve years of practice experience working with UAM and their families, as family case managers, community liaisons, program managers, grant administrators, and training facilitators, we review needs, services, and promising practices for social work practice with UAM. Recommendations include providing education to parents and caregivers about UAM's rights, U.S. laws and regulations, and service availability; building trust and rapport with families; creating welcoming schools; practicing cultural openness; hiring diverse staff; and fostering partnerships with local service providers.*

Keywords: *Migrant; unaccompanied minor; unaccompanied child; promising practices; Central America; northern triangle, family reunification*

Unaccompanied minors (UAM) (also known as Unaccompanied Children (UC) and Unaccompanied Alien Children (UAC)) are a growing population in the United States (U.S.). Although they hold membership in both the Latinx and the undocumented communities, UAM come to the U.S. with a specific history that sets them apart from other Latinx and undocumented persons. Their pre-migration circumstances, migration journey, integration into life in the U.S., and legal status, lead unaccompanied children to struggle with acculturative stress, social isolation, discrimination, and criminalization (De Genova & Peutz, 2010; Perreira & Ornelas, 2011). These circumstances make youth vulnerable to depression, anxiety, low self-esteem, irritability, aggression, and post-traumatic stress disorder (Carlson, Cacciatore, & Klimek, 2012; Perreira & Ornelas, 2011).

The presence of UAM in the U.S. is increasing, but funding for services specifically tailored for this population fluctuates significantly annually. For instance, the President's Fiscal Year (FY) 2019 Budget requests $1,148 million for the UAM program, an increase of $206 million above the FY18 Continuing Resolution, but $267 million below the FY17

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budget (Department of Health and Human Services [HHS], 2018). The FY19 funding request for similar programs and services for refugees was decreased to $515 million, approximately 25% lower than the FY18 Continuing Resolution (HHS, 2018). Given funding uncertainties and proposed rollbacks to UAM protections and services, UAM youth and their families are being channeled into mainstream services. Consequently, social workers should be prepared to work with this population regardless of their role or specialty.

The article proceeds as follows, first we provide a brief overview of UAM including who they are, where they come from, and the federal programs tailored to address UAM needs post-arrival. Then, we discuss how these services meet the needs of UAM, as well as the gaps in service, followed by a review of UAM outcomes. We conclude with a call to reimagine social work with UAM where we provide recommendations and promising practices for social workers in a variety of settings, such as community health care centers, schools, and the child welfare system; and about a number of topics such as the importance of education regarding U.S. laws, culturally and linguistically appropriate service delivery, and strengthening community partnerships.

Unaccompanied Minors: Who Are They, Where Do They Come From, and What Happens after Their Arrival in the U.S.?

The Homeland Security Act of 2002 Public Law 107–296, 6 U.S.C. § defines UAM as individuals under the age of eighteen who arrive at the U.S. border without lawful immigration status or a parent or legal guardian to provide care and physical custody. Most of these children come to the U.S. from the Central American countries of El Salvador, Guatemala, and Honduras, collectively known as the Northern Triangle (Administration for Children and Families [ACF], 2017a). Many UAM are apprehended by the Department of Homeland Security upon arrival at the U.S. border. Children from the contiguous countries of Mexico and Canada who do not demonstrate signs of trafficking or fear of persecution (about six percent annually) are repatriated back to their country of origin, as required under the William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008 Public Law 110-457 (Ramirez, McKenna, & Somers, 2015; United States Conference of Catholic Bishops [USCCB], 2012). The remaining 94 percent are placed under the care and custody of the U.S. Department of Health and Human Services, Office of Refugee Resettlement (ORR), and are subject to removal.

In the decade leading up to 2012, the average number of UAM arriving at the U.S. border annually ranged from 7,000 to 8,000 (ACF, 2016). Escalating persecution, economic hardship, and violence in the Northern Triangle caused the number to increase drastically between 2012 and 2016 (Customs and Border Protection [CBP], 2016; ACF, 2017b). While the number of arrivals tapered off in FY2017, there has been a steady increase since the start of FY2018, with 14,444 UAM arriving between October 1, 2017 and January 31, 2018 (CBP, 2018). See Table 1 for a breakdown of UAM arrival statistics between FY2012 and FY2017, as complete 2018 data is not yet available.

Table 1. *UAM Arrival Information FY2012-FY2017*

Fiscal Year	SW Border Apprehensions	Gender*		Age*	
		Male	Female	0-14y	15-17y
FY2012	24,403[a]	77%	23%	22%	77%
FY2013	38,759[a]	73%	27%	27%	74%
FY2014	68,541[a]	66%	34%	37%	63%
FY2015	39,970[a]	68%	32%	31%	68%
FY2016	59,692[b]	67%	33%	32%	68%
FY2017	41,435[b]	68%	32%	30%	69%

Note: Gender and Age Columns represent youth referred to the ORR
(Text in this table is adapted from: *ACF, 2017b; [a]CBP, 2016, [b]2017

While reasons for fleeing are complex and unique for each child, most youth seek protection from various forms of persecution, abuse, deteriorating social and economic conditions, as well as gang and generalized violence in their home countries (Crea, Hasson, Evans, Berger Cardoso, & Underwood, 2017a; Piwowarczyk, 2006; United Nations High Commissioner for Refugees [UNHCR], 2014). The long and dangerous journey to the U.S. adds to the risk of traumatic outcomes for UAM (Pine & Drachman, 2005). Many UAM are victims or witnesses to sexual or physical violence, go without food or water for days at a time, walk and take trains under harsh conditions, and are forced to negotiate with smugglers (Griffin, Son, & Shapleigh, 2014; UNHCR, 2014). Upon arrival in the U.S., UAM require specialized interventions and services to overcome their trauma and work towards positive life outcomes.

Legal status and legal relief. The U.S. government is not mandated to appoint attorneys to UAM who are in removal proceedings. Due to financial and time constraints, only about half of the UAM who face deportation secure legal representation (Kids in Need of Defense [KIND], 2016). When navigating the complex U.S. immigration system, UAM who have an attorney are much more likely to be granted some form of protection than children without representation (KIND, 2016). Seventy-eight percent of UAM who attend their scheduled hearings receive some form of relief and remain in the U.S. undocumented (Migration Policy Institute [MPI], 2015). The most common form is administrative case closure, a status that means the child is no longer in active removal proceedings (MPI, 2015). Less than five percent of UAM are granted legal status through one of the following forms of immigration relief for which they may be eligible: Asylum, Special Immigrant Juvenile Status (SIJS), U Nonimmigrant Visas, and T Nonimmigrant Visas (MPI, 2015).

Federally Mandated Services for UAM

The ORR provides shelter care, post-release services (PRS), and foster care to UAM who are apprehended at the southern border. These federally funded services are mandated by the Flores Settlement Agreement of 1997 Case No. CV 85-4544-RJK (C.D. CA, 1997), the Homeland Security Act of 2002, and the Trafficking Victims Protection Reauthorization Act of 2008 (USCCB, 2012).

Shelter care. Upon arrival to the U.S., apprehended youth are transferred to the custody of the ORR and placed into shelters that are funded by the ORR and operated by child welfare agencies licensed by the state in which they are located. These shelters provide children with access to education, health care, mental health services, legal screenings, and case management, as well as assistance with family finding and reunification services (ACF, 2017a). Most UAM stay in shelter care for an average of 34 days (ACF, 2017b), after which, around 90 percent of children are reunified with an adult relative or caregiver in the U.S., referred to as a sponsor (ACF, 2017c). Approximately one percent of UAM meet eligibility for the Long-Term Foster Care (LTFC) program. The remaining UAM, around ten percent, are returned to their home country through voluntary departure or removal (USCCB, 2012).

Post-Release Services (PRS). Approximately 20 percent of children who are reunified with a sponsor receive PRS to help with the transition into their new home and community (ACF, 2017b). These services, which include case management and linkages to education, health care including mental health, and legal representation, are coordinated by social workers who help address the unique needs of reunified UAM (Roth & Grace, 2015). UAM qualify for PRS according to their assessment of needs, their relationship to the sponsor, and the motivation and ability of the sponsor to adequately care for the child (USCCB & Lutheran Immigration and Refugee Service, n.d.). Services generally last for 90 days, but on some occasions are provided for the duration of the child's removal proceedings, or until the child turns eighteen years old.

Foster Care. The Long-Term Foster Care (LTFC) program consists of a network of local agencies that provide culturally sensitive foster care and group home services to less than three percent% of UAM, those who do not have a qualified and appropriate sponsor to care for them and who have been identified as eligible for immigration relief (ACF, 2015a). In most instances, UAM who qualify for LTFC were abused, abandoned, or neglected by one or both parents in their home country, have an asylum claim, or are victims of human trafficking (USCCB, 2012).

To aid in the integration process, the agency providing care must ensure that UAM are placed in a licensed foster home or group home, enrolled in school, and have access to medical care, counseling, recreation, and legal representation (ACF, 2015a). Children are eligible to remain in LTFC until a viable reunification option becomes available, they turn eighteen, or until they are granted legal relief and transition into the Unaccompanied Refugee Minor (URM) program. The URM foster care program is uniquely tailored for foreign-born youth and is subject to the child welfare laws and guidelines in the state in which it is located. As such, it is designed to help unaccompanied migrant and refugee children develop the skills to become self-sufficient and successfully transition into adulthood (ACF, 2015b).

Do Services Meet the Needs of UAM?

Services rendered by the PRS and LTFC programs are mandated by federal legislation (Flores Settlement Agreement, Homeland Security Act, and TVPRA), but are contingent upon funding availability, and the current situation leaves thousands of UAM underserved

every year. Historically, eligible UAM and their families were offered assistance through the PRS program for at least six months. However, for most UAM and their families, this period of assistance was reduced to three months during 2016. The shorted eligibility time frame has led to many unresolved needs at the end of services, and to increased risks for UAM for poor educational outcomes, ongoing mental health concerns, and immigration issues (Roth & Grace, 2015).

A concern with the LTFC program is that there are not enough funded slots for the youth who meet the eligibility criteria. Additionally, as with domestic foster care, there are not enough families willing to take and be trained to serve culturally diverse youth (DiNitto, 2011). For UAM this is compounded by people's preconceived notions of helping an undocumented child, hate, fear, and the perceived challenges of housing a child who speaks a different language (American Federation of Teachers, n.d.). Eligible UAM who are unable to access the LTFC program remain in shelters long-term, which violates the child welfare best practice of placing children in the least restrictive setting.

The lack of services tailored to meet the needs of UAM has channeled these youth and their families into social welfare programs and community-based services. Roth and Grace (2015) note that UAM encounter many service providers and that social workers in schools, hospitals, legal clinics, and elsewhere "need to develop a broader recognition of the unique challenges that varying immigration statuses pose for children and their families" (p. 251). For mixed immigration status families with children born in the U.S., the natural citizens may be eligible for programs such as Medicare, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families (Haider, Schoeni, Bao, & Danielson, 2004). However, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 bars undocumented immigrants from receiving federal welfare benefits, and even UAM who obtain legal relief must wait five years before they are eligible to apply for benefits (Haider et al., 2004). As a result, many UAM and their families rely on the support of family and local nonprofit services not aimed at the UAM population.

UAM in the U.S.

Literature suggests that negative experiences of children prior to migration influence their behavior after arrival (Crea, Lopez, Taylor, & Underwood, 2017b). However, there is little systematic research that specifically discusses the needs, or the long-term outcomes of UAM who do not receive services tailored to their needs. This lack of information is compounded by a lack of indicators and instruments for caseworkers to both assess mental health concerns and make appropriate referrals (Cardoso et al., in press; Crea et al., 2017b). The discussion below summarizes the limited research on these topics.

Health and Mental Health

Children who have experienced forced migration are particularly vulnerable to mental health concerns (Kennedy, 2013; Piwowarczyk, 2006). Most UAM enter the U.S. with pre-flight trauma, and fewer than 20 percent had access to health care in their home country (Kennedy, 2013). A study of pre-flight trauma among UAM showed that almost half of participants were displaced by drug cartel or gang related violence, or by government

actors. Almost a quarter of UAM were victims of abuse and violence within their family, and ten percent of participants were exploited by smugglers (UNHCR, 2014).

Untreated historical trauma, combined with the trauma suffered during migration and the difficult adjustment post-arrival, places UAM at risk for undesired mental health outcomes if the trauma is unaddressed (Kennedy, 2013; Pine & Drachman, 2005). Accessibility of treatment is a significant challenge for this population due to language barriers, lack of transportation, lack of health insurance, cost, and cultural norms around seeking professional mental health services (Hacker, Anies, Folb, & Zallman, 2015). Utilization of medical services such as blood transfusion, organ transplant, and immunizations also vary for people of some religious and cultural backgrounds (Blood Weekly, 2016; Grabenstein, 2013). Finding culturally competent organizations that offer no-cost and low-cost health services for uninsured, undocumented immigrants can be problematic; long wait times, complex paperwork, and fear of discrimination and deportation often reinforce the barriers that prevent access (Hacker et al., 2015; Redden, 2017; Roth & Grace, 2015).

Education

Equal access to opportunities for advancement is key for the integration of immigrants. Education is at the forefront of such opportunities (Calvo, Teasley, Goldbach, McRoy, & Padilla, 2018; Waters & Pineau, 2015). All children in the U.S. have a right to attend public schools regardless of country of birth (U.S. Department of Education [U.S. DOE], 2014). However, UAM are often denied enrollment, diverted to alternative schools, or face delays in the enrollment process when they lack the required documentation (i.e., birth certificate, proof of residence, immunization records, and transcripts (Booi et al., 2016; Bridging Refugee Youth and Children's Services, 2016). Unfortunately, the circumstances which force most UAM to leave their countries also prevent these youth from obtaining important documentation and personal records prior to migration (UNHCR, 2016).

These experiences with the school system heighten the risk of experiencing discrimination and social isolation, which in turn may influence academic outcomes (Oxman-Martinez & Choi, 2014). Additionally, immigrant children with little or no formal education have unique academic needs for which schools and educators across the country are sometimes unprepared (Booi et al., 2016). These factors widen the achievement gap between UAM and their English-speaking peers (López & Radford, 2017). Permanent legal status has been found to increase graduation rates for UAM in high school (Crea et al., 2017a; Kohli, 2011).

Child Welfare

The ORR has a federal foster care program that serves a small percentage of UAM annually, but UAM and their families may also interact with the state-based child welfare system through investigations, family preservation services, foster care, or adoption. For youth who are released from the ORR care into the community, the prolonged family separation (Roth & Grace, 2015), *adultification* (Trickett, Jones, & Nagayama, 2007), and adjustment to a new community, can result in family breakdown and involvement with the

child welfare system. Additionally, many UAM enter the child welfare system when their parents are either detained or deported (Applied Research Center, 2011).

Cultural norms of immigrant families may alter social worker's ability to accurately identify problems or conflict (Patil, Mcgown, Nahayo, & Hadley, 2010). Relatedly, permanency and family finding can be slightly different for UAM in the foster care system because their family may not speak English, may not have legal status in the U.S., or may not reside in the U.S. (Socha, 2014). As with any other child in the foster care system, when reunification is not possible, adoption may be considered as an option for UC even if they entered the country without authorization as legal immigration status is not required to be eligible for adoption in the U.S. (Department of State, 2017). However, the largest challenge in pursuing adoption for UAM is that they often have a biological parent in home country with whom they maintain contact so termination of parental rights may not be feasible, and/or in the child's best interest. Proving the death of a parent can also be a challenge in countries where formal death certificates are not kept, the cost of paperwork is prohibitive, or if the death happened in transit when fleeing the home country (International Human Rights Clinic, 2015).

U.S. Laws and Regulations

Laws are stringent and better enforced in the U.S. than in some Central American countries (USCCB, 2013a), and violation of any U.S. law by an undocumented person can have harsh implications, including deportation (Catholic Legal Immigration Network, 2016). It is not uncommon for immigrant families to be unfamiliar with U.S. laws, especially among recent arrivals. Important laws that can be a source of concern include activities such as driving without a license; alcohol consumption under the age of 21; purchasing tobacco products under the age of eighteen; and illicit drug use (USCCB, 2013a). In addition, using physical harm to discipline a child and using physical aggression towards a spouse or partner is prohibited in the U.S., and school attendance is mandatory in most states for children between the ages six to sixteen (USCCB, 2013a).

A Call for Action

UAM are now more likely than ever to interact with mainstream social services. The authors of this manuscript draw from their direct practice experience with UAM, as well as from their experience administering programs that serve UAM, to prepare all social workers for work with this population. At the direct practice level, the authors have experience in case management for the PRS program where support was given to families to ensure their connection to local community services at the time of reunification. Additional direct practice experience included partnership-building with community organizations and schools to increase awareness and service availability for UAM. At the macro level, the authors' experience has been gained via employment for the ORR-contracted agencies that provide oversight for federally mandated UAM programs across the U.S. In this role, the authors engaged in program development, program management, training facilitation for direct care staff, and quality assurance of case management, and foster care services specifically for UAM youth. A thorough understanding of UAM programming requirements, child welfare best practices, and the unique needs of UAM

was acquired over almost 12 years of combined social work practice with UAM. Given the current shift in funding and priorities for UAM, the authors worked together to reflect upon their experiences and draw out the most salient themes as advice for other social workers.

Recommendations for Social Workers

Based on the gaps identified above, and on many years of social work practice experience with UAM held by the authors, the following sections outline promising practices to improve social work practice with UAM for mainstream service providers. We focus on: (1) access to health and mental health services, (2) navigating the educational system, (3) involvement with the child welfare system, (4) understanding U.S. laws and regulations, (5) ensuring culturally relevant service delivery, and (6) building community partnerships.

Health and Mental Health Services

When working with undocumented families without healthcare coverage, we recommend utilizing no-cost and low-cost health services whenever they do not require proof of residency (Ciaccia & John, 2016). In communities where low-cost mental health options are scarce, we suggest utilizing alternative services such as mentoring programs and church support groups and activities as these were found to be successful for unaccompanied minors from Eritrea (Socha, Mullooly, & Jackson, 2016). In emergency situations, hospital services are always available to families without insurance. However, we recommend that social work agencies build partnerships with local medical providers so they may be more willing to serve populations outside of their typical clientele. Social workers may also be instrumental in advocating for healthcare expansion within their own communities and at the national level by making a case for benefits to be extended to undocumented individuals.

The Educational System

We recommend that social workers advocate for the enrollment of UAM to ensure that all youth are given the opportunity to learn and grow. This can be done through the flexibility of the McKinney-Vento Act of 2001 to overcome residency requirements (U.S. DOE, 2004), and use of the ORR's case documents for evidence of immunizations, age, and to explain the absence of a legal guardian in the U.S. (Evans, Perez-Aponte, McRoy, in press). Case documents can be also used to inform the system about the educational systems in the countries of origin, and thus, to overcome transcript requirements. Social workers also play a vital role in ensuring that UAM are properly assessed upon entering school and are provided with the appropriate English Language Learner (ELL) supports as required under the Equal Educational Opportunities Act of 1974, and Every Student Succeeds Act of 2015 (U.S. DOE, 2016; Equal Educational Opportunities Act of 1974) when parents/caregivers are unfamiliar with local resources. Booi et al. (2016) discussed the nuances of disability testing and Individual Education Plans (IEP) for undocumented youth.

After enrollment, social workers should provide, or work with community organizations to provide teachers and administrators with training on the background of UAM, cultural norms in Central American countries, and the impact of childhood trauma (Morland, Duncan, Hoebing, Kirschke, & Schmidt, 2005; Evans, Perez-Aponte, &McRoy, in press). When schools adopt a welcoming environment and staff understand the ways in which UAM are similar to and different from other refugee and immigrant children, they may be better equipped to meet their needs (Barillas, 2010). School personnel should engage parents and caregivers of UAM early to build trust and create a culture of support in integrating immigrant children because school is often the first place that UAM interact with community members outside of their ethnic or cultural group. Encouraging the use of the co-teaching model in schools with high numbers of UAM and other ELLs enables one teacher to "determine the learning target, pacing of content, and alignment to standards" while the other facilitates learning, enabling non-English speakers to better learn (Beninghof & Leensvaart, 2016). Lastly, social workers must play a role in the detection and consequences of discriminatory behaviors in the school setting and in the community at large.

The Child Welfare System

When social workers encounter UAM and their families in the child welfare system, we recommend that they be responsive to sociocultural background (Pottie et al., 2011), and avoid stereotyping, especially during child welfare investigations. Dettlaff and Rycraft (2010) describe best practices for working with Latino families in the child welfare system that honors the cultural values and differences. We recommend that workers be cognizant of cultural differences and family constraints; making assumptions can be dangerous. Whenever possible, researching the culture of the family before a home visit can enable the caseworker to be more confident and allow for a deeper conversation with the family regarding how behaviors or norms are different in the U.S. versus in the family's home country. Morland et al. (2005) also recommend working alongside ethnic leaders and cultural brokers to gain trust. For example, methods of discipline vary widely around the world and caregivers may lack skills for behavior modification, as deemed appropriate in the U.S., without assistance. It is also not uncommon for immigrant families to live in what may appear to be crowded, multi-generational households (Booi et al., 2016; Halpern, 2008). Lack of space should always be carefully weighed with the benefits of living with family prior to removing a child from a home. We recommend using an ecological systems theory to help the family expand their network, mobilize support and increase coping skills (Paat, 2013). This can also be done through actions such as providing referrals for all family members to services such as English classes, community activities, family mentoring, internet safety courses, and mock court sessions.

For UAM who enter foster care, social workers should persist in attempting to locate family members to provide care for them. Social workers should ask for extensions in the standard family finding process and repeat the search process every couple of months, being creative in their approach each time. Family tracing should be ongoing because UAM may have new family members who arrive to the U.S. over time. Similarly, using the cultural definition of "family" can extend the potential caregiver pool to include fictive kin,

neighbors, godparents, and the like (Socha, 2014). When searching for family in other countries and assessing them as potential caregivers, conducting online searches, (i.e., through social media platforms), or using the services of agencies such as The International Committee of the Red Cross (ICRC) Restoring Family Links Program or International Social Service's family tracing services can be invaluable (ICRC, n.d.; International Social Service, 2017). Language barriers, poor conditions in home country, and legal status are not appropriate reasons to overlook family in the search or assessment process. When considering adoption for a UAM youth, we recommend carefully weighing all the options and ensuring that family reunification options both in the U.S. and abroad have thoroughly been explored. If UAM are being considered for adoption in the U.S. or to return to family in home country, social workers should encourage appointment of a child advocate to conduct a best interest determination (BID) which can help to examine the advantages and disadvantages to living in each country (Evenhuis, 2013).

U.S. Laws and Regulations

We recommend that social workers provide education to UAM and their families regarding ways that American laws and customs differ from those in their home country. In many communities, social workers can refer clients to existing classes that provide this information to new community members. In other cases, they can create classes and resources, or provide ad hoc education. The Refugee Cultural Orientation program is a resource that could be used as a model in developing a training plan (Cultural Orientation Resource Center, 2018). Always keep in mind that it is better to be proactive in providing information on U.S. laws rather than reactive.

Culturally Relevant Service Delivery

To ensure effective service delivery for UAM, mainstream service providers and social workers should obtain training about the specific needs of this population, so services can be adapted. More specifically we saw that service providers enjoyed training specific to this population (USCCB, 2013b) and therefore recommend training on trauma-informed care, cultural competency, and human trafficking for staff that interact with UAM (Morland et al., 2005).

Additionally, we recommend that agencies hire culturally diverse staff who can relate to UAM to ease the adjustment process. This could include Latinxs, Spanish speakers, adults who came to the U.S. as a UAM, people who have lived and worked abroad, or family members of UAM. We often found that service delivery is most effective when culturally-relatable paraprofessional staff work alongside trained social workers to provide complementary aspects of holistic care (Linsk, 2014), so that the UAM have different people from whom they can seek guidance.

Client satisfaction surveys can be an excellent way to assess the perspectives of UAM and their caregivers on their experience with the agency. It is important to note that these surveys should be made available in multiple languages, and administered verbally rather than in written form when necessary to better gauge each UAM's experience and feedback.

Community Partnerships

Both managers and frontline staff play an important role in the development of formal and informal community partnerships. These relationships are crucial to ensure access to services for UAM clients. A social worker's ability to facilitate referrals to services for UAM improves when there are pre-existing relationships between the social worker, their agency of employment, and external organizations. We recommend building and maintaining partnerships with community organizations such as legal providers, mental health clinics, health clinics, food banks, schools, and adult learning programs. Additionally, churches can provide a wealth of assistance including financial support, volunteers, temporary housing assistance, child care, clothing, and food. Morland et al. (2005) recommend partnerships with refugee service agencies and hosting "cross-service training" events that facilitate interagency communication, resource sharing, and coordination between local agencies.

When a gap in resources or services is identified, seeking new opportunities for collaboration can ensure the need is met. This might mean reaching out to an existing organization to extend services to UAM. In exchange for increased referrals, request that staff at the partnering organization partake in UAM-related training and offer assistance with interpretation services for the child during appointments. These can be very fruitful partnerships as they create opportunities to develop new programming crafted to the specific needs of UAM. For example, an agency that provides legal services to UAM released from federal custody recently started to contract social workers after realizing that their UAM clients need more than just legal help. This partnership has enabled UAM and their families to connect with local services and resources in the community. While many UAM encounter legal service providers, very few receive post-release services, so having a social worker on staff makes a significant impact.

General Recommendations

In addition to specific recommendations linked to particular social work areas above, there are other recommendations that span all practice settings. For instance, all social workers should build trust and rapport with UAM and their families so that they feel comfortable asking for help and referrals to the services they need (Roth & Grace, 2015). Establishing a relationship requires that social workers are familiar with their client's culture (Aggarwal et al., 2016), respect their right to self-determination (NASW, 1996), and work with the client to resolve issues. Additionally, social workers can educate families on their rights, dispel myths, and assist families in finding safe ways to engage with the community they live in.

Social workers and case managers should also help UAM and their families to increase their knowledge of local resources and where to seek help in the community. Social workers should first connect UAM and their families to agencies that focus on services for Latinxs, as these service providers will be best equipped to meet their cultural and linguistic needs. However, practitioners should not hesitate to refer families to mainstream services when a need cannot otherwise be met. When using mainstream providers, social workers should advocate that the agency (such as doctor's offices, courts, and schools)provide

interpretation for families who may need it. However, it is important to ask the family about their preferred language first because while Spanish is the first language of many UAM, some arrive with little or no familiarity with Spanish and instead speak an indigenous dialect such as K'iche' or Mam (Crea et al., 2017a). Refer to the Civil Rights Act of 1964, the Affordable Care Act of 2010, and the Court Interpreters Act, 28 U.S.C. §1827 to make providers aware of their obligation to provide interpretation (Administrative Office of the U.S. Courts, n.d.; CME Learning, 2017). If this is unsuccessful, social workers can connect UAM to pro-bono language services such as college interns studying languages, community volunteers, telephonic interpretation, or web-based applications as needed. It is important to ensure that these individuals have received the required training to comply with the confidentiality regulations of interpreters.

Discussion

Grounded in years of experience working with UAM across a variety of settings, this manuscript reimagines social work practice with these youth, highlights lessons learned, and proposes promising practices for social workers who may encounter UAM in their daily practice. Because UAM are a relatively recent population, professional social workers who have been practicing for a while may not have learned about UAM during their social work education. With the appropriate training, we can adapt mainstream service delivery to guarantee that the needs of UAM are successfully addressed.

It takes a community to provide UAM with the full range of services that they may require. Our recommendation to build community partnerships with other agencies is consistent with other areas of social work practice. For example, Alter (2009) found that the sustainability of human service organizations today is highly dependent on the extent of their partnerships within the local community. Moreover, few organizations that attempt to operate completely independently can function long-term. Collaboration plays a critical role in strengthening the services available, meeting previously unmet needs, and achieving positive long-term outcomes (Alter, 2009; Shore, Hammond, & Celep, 2013). Establishing relationships with places of worship for various religions is also highly recommended, as connecting unaccompanied minors with the appropriate faith-based institution can help them cope with their new surroundings and prevent feelings of isolation (Raghallaigh, 2011).

Ensuring effective service delivery falls to supervisors, program managers, and macro social workers in most agencies. Hiring both bilingual/bicultural paraprofessional staff (Roth & Grace, 2015; Linsk, 2014) as well as trained social workers plays an important role in service delivery. Similarly, Earner (2005) recommends that specialists in child welfare and refugee and immigrant serving agencies be cross-trained to ensure that they are aware of the nuances of serving this population (Morland et al., 2005); the advice for cross-training can span beyond child welfare. When thinking about adapting services to UAM we also need to be cognizant of the differences among UAM themselves. For example, a study found that UAM from Guatemala were eight times more likely to only achieve a K-12 education by time they discharged from foster care than youth from other

countries (Crea et al., 2017a), suggesting that cultural and linguistic differences have an impact on UAM educational attainment.

Considering what we know about UAM education, the ideas of prompt enrollment in local schools and welcoming school environments is key to their educational success. Research shows that racism, xenophobia, acculturative stress, and behaviors of cultural discrimination can hinder immigrant students' ability to succeed in the classroom (Kumi-Yeboah & Smith, 2017). However, when placed in positive school environments with supportive teachers, these students show incredible resiliency to succeed (Kumi-Yeboah & Smith, 2017). Furthermore, a study found that UAM and other ELLs experience increased educational outcomes when they are integrated into classrooms with native English-speaking students, rather than isolated into classrooms for newcomers for an extended period of time (Beninghof & Leensvaart, 2016; Pardini, 2006).

Conclusion

The number of Central American UAM in the U.S. has increased considerably since the early 2000s. These children flee their home countries for various reasons, including community violence, persecution, and economic hardship. Their home situation and journey to the U.S. often includes traumatic experiences such as abuse, abandonment, violence, and involvement with smugglers. Some services such as shelter care, post-release services, and long-term foster care are mandated by federal legislation and are designed to help UAM when they arrive to the U.S. However, these services are limited in funding and scope, and therefore mainstream service providers need the knowledge and tools to appropriately adapt their services to meet the needs of UAM. All social workers have a vital role to play in helping UAM to process, overcome, and thrive in their new communities.

References

Administration for Children and Families [ACF]. (2015a). *Children entering the United States unaccompanied*. Retrieved from https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied

ACF. (2015b). *About unaccompanied refugee minors*. Retrieved from https://www.acf.hhs.gov/orr/programs/urm/about

ACF. (2016). *Fact sheet*. Retrieved from https://www.acf.hhs.gov/sites/default/files/orr/orr_fact_sheet_on_unaccompanied_alien_childrens_services_0.pdf

ACF. (2017a). *About unaccompanied alien children's services*. Retrieved from https://www.acf.hhs.gov/orr/programs/ucs/about

ACF. (2017b). *Facts and data*. Retrieved from https://www.acf.hhs.gov/orr/about/ucs/facts-and-data

ACF. (2017c). *Unaccompanied alien children released to sponsors by state*. Retrieved https://www.acf.hhs.gov/orr/resource/unaccompanied-alien-children-released-to-sponsors-by-state

Administrative Office of the U.S. Courts. (n.d.). *Federal court interpreters*. Retrieved from http://www.uscourts.gov/services-forms/federal-court-interpreters

Aggarwal, N. K., Farias, P. J., Becker, A. E., Like, R., Lu, F., Oryema, N., & Lewis-Fernández, R. (2016). The role of cultural psychiatry in improving the policy response to Central America's unaccompanied minors at the American border: Local and global implications. *International Journal of Cultural Mental Health 9*(4), 381-386. doi: https://doi.org/10.1080/17542863.2016.1225110

American Federation of Teachers. (n.d.). *National & local refugee relief efforts for unaccompanied children*. Retrieved from https://www.aft.org/national-local-refugee-relief-efforts-unaccompanied-children

Alter, C. (2009). Building community partnerships and networks. In R. Patti (Ed.), *The handbook of human services management* (2nd ed., pp. 435-454). Thousand Oaks, CA: Sage Publications.

Applied Research Center. (2011). *Shattered families: The perilous intersection of immigration enforcement and the child welfare system*. Retrieved from https://www.raceforward.org/research/reports/shattered-families

Barillas-Chón, D. (2010). Oaxaqueño/a students' (un)welcoming high school experiences. *Journal of Latinos and Education, 9*(4), 303-320. doi: https://doi.org/10.1080/15348431.2010.491043

Beninghof, A., & Leensvaart, M. (2016). Co-teaching to support ELLs. *Educational Leadership, 73*(5), 70-73.

Blood Weekly. (2016). Studies from medical university yield new data on organ transplants. *Blood Weekly*, 30.

Booi, Z., Callahan, C., Fugere, G., Harris, M., Hughes, A., Kramarczuk, A., Kurtz, C., Reyes, R….Swaminatha, S. (2016). *Ensuring every undocumented student succeeds: A report on access to public education for undocumented children.* Retrieved from Georgetown Law Human Rights Institute website https://www.law.georgetown.edu/human-rights-institute/our-work/fact-finding-project/ensuring-every-undocumented-student-succeeds-a-report/ Bridging Refugee Youth and Children's Services. (2016). Schools. Retrieved from http://www.brycs.org/schools.cfm

Calvo, R., Teasley, M. Goldbach, J., McRoy, R., & Padilla, Y. (2018). Achieve equal opportunity and justice. In R. Fong, J. E. Lubben, & R. P. Barth (Eds.), *Grand Challenges for Social Work and Society* (pp. 248-264). NY, New York: Oxford University Press.

Cardoso, J. B., Brabeck, K., Stinchcomb, D., Heidbrink, L., Price, O. A., Gilgarci A, O., Crea, T. M., & Zayas, L. H. (in press). Challenges to integration for unaccompanied

migrant youth in the post-release U.S. context: A call for research. *Journal of Ethnic and Migration Studies.*

Carlson, B., Cacciatore, J., & Klimek, B. (2012). Risk and resilience perspective on unaccompanied refugee minors. *Social Work, 57*(3), 259-269. doi: https://doi.org/10.1093/sw/sws003

Catholic Legal Immigration Network. (2016). *Interior enforcement executive order and DHS memo*. Retrieved from https://cliniclegal.org/resources/interior-enforcement-executive-order-and-dhs-memo-faqs

CME Learning. (2017). *New 2016 ACA rules significantly affect the law of language access*. Retrieved from https://www.cmelearning.com/new-2016-aca-rules-significantly-affect-the-law-of-language-access/

Court Interpreters Act. (1978). Public Law 95-539, 28 U.S.C. §1827

Crea, T. M., Hasson, R. G., Evans, K., Berger Cardoso, J., & Underwood, D. (2017a). Moving forward: Educational outcomes for existing unaccompanied refugee minors (URM) foster care in the United States. *Journal of Refugee Studies*. doi: https://doi.org/10.1093/jrs/fex020

Crea, T. M., Lopez, A., Taylor, T., & Underwood, D. (2017b). Unaccompanied migrant children in the United States: Predictors of placement stability in long term foster care. *Children and Youth Services Review, 73,* 93-99. doi: https://doi.org/10.1016/j.childyouth.2016.12.009

Cultural Orientation Resource Center. (2018). *About cultural and community orientation*. Retrieved from http://www.culturalorientation.net/providing-orientation/about

Customs and Border Protection [CBP]. (2016). *United States Border Patrol Southwest family unit subject and unaccompanied alien children apprehensions Fiscal Year 2016*. Retrieved from https://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children/fy-2016

CBP. (2017). *U.S. Border Patrol Southwest border apprehensions by sector FY2017*. Retrieved from https://www.cbp.gov/newsroom/stats/usbp-sw-border-apprehensions-fy2017#

CBP. (2018). *Southwest border migration FY2018*. Retrieved from https://www.cbp.gov/newsroom/stats/sw-border-migration

De Genova, N., & N. Peutz (Eds.). (2010). *The deportation regime: Sovereignty, space, and the freedom of movement*. Durham: Duke University Press. doi: https://doi.org/10.1215/9780822391340

Department of Health and Human Services [HHS]. (2018). *Putting America's health first: FY2019 President's Budget for HHS*. Retrieved from https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

Dettlaff, A. J., & Cardoso, J. B. (2010). Mental health needs and service use among Latino children of immigrants in the child welfare system. *Children and Youth*

Services Review, 32, 1373-1379. doi: https://doi.org/10.1016/j.childyouth.2010.06.005

DiNitto, D. M. (2011). *Social welfare: Politics and public policy* (7th ed.). Boston, MA: Allyn & Bacon.

Earner, I. (2005). Immigrant children and youth in the child welfare system: Immigration status and special needs in permanency planning. In G. Mallon & P. Hess (Eds.), *Child welfare for the 21st century* (pp. 655- 665). New York, NY: Columbia University Press.

Equal Educational Opportunities Act of 1974 [EEOA]. (1974). Public Law 93-380. 20 USC Sec. 1701-1758

Evenhuis, M. (2013). Child-proofing asylum: Separated children and refugee decision making in Australia. *International Journal of Refugee Law, 25*(3), 535-573. doi: https://doi.org/10.1093/ijrl/eet037

Evans, K., Perez-Aponte, J., & McRoy, R. (in press). Without a paddle: Barriers to school enrollment procedures for immigrant students and families. *Education and Urban Society.*

Flores v. Reno, Case No. CV 85-4544-RJK (C.D. CA, 1997)

Grabenstein, J. (2013). What the world's religions teach, applied to vaccines and immune globulins. *Vaccine, 31*(16), 2011-2023. doi: https://doi.org/10.1016/j.vaccine.2013.02.026

Griffin, M., Son, M., & Shapleigh, E. (2014). Children's lives on the border. *Pediatrics, 133*(5), e1118-e1120. doi: https://doi.org/10.1542/peds.2013-2813

Hacker, K., Anies, M., Folb, B., & Zallman, L. (2015). Barriers to healthcare for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy, 2015*(8), 175-183. doi: https://doi.org/10.2147/RMHP.S70173

Haider, S. J., Schoeni, R. F., Bao, Y., & Danielson, C. (2004). Immigrants, welfare reform, and economy. *Journal of Policy Analysis & Management, 23*(4), 745-764. doi: https://doi.org/10.1002/pam.20045

Halpern, P. (2008). *Refugee economic self-sufficiency: An exploratory study of approaches used in Office of Refugee Resettlement programs*. Report retrieved from the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation https://aspe.hhs.gov/system/files/pdf/75561/report.pdf

Homeland Security Act of 2002. (2002). Public Law 107–296, 6 U.S.C. § 279

International Committee of the Red Cross [ICRC]. (n.d.). Restoring family links. Retrieved from https://familylinks.icrc.org/en/Pages/home.aspx

International Human Rights Clinic. (2015). *Registering rights: Syrian refugees and the documentation of births, marriages, and deaths in Jordan*. Retrieved from

http://hrp.law.harvard.edu/wp-content/uploads/2015/11/Registering-rights-report-NRC-IHRC-October20151.pdf

International Social Service-USA Branch. (2017). Services for children. Retrieved from http://www.iss-usa.org/services/services-for-children

Kennedy, E. G. (2013). Unnecessary suffering: Potential unmet mental health needs of unaccompanied alien children. *JAMA Pediatrics*, *167*(4), 319-320. doi: https://doi.org/10.1001/jamapediatrics.2013.1382

Kids in Need of Defense [KIND]. (2016). Improving protection and fair treatment of unaccompanied children. Retrieved from https://supportkind.org/wp-content/uploads/2016/09/KIND-Protection-and-Fair-Treatment-Report_September-2016-FINAL.pdf

Kohli, R. K. S. (2011) Working to ensure safety, belonging and success for unaccompanied asylum-seeking children. *Child Abuse Review, 20*(5), 311-323. doi: https://doi.org/10.1002/car.1182

Kumi-Yeboah, A., & Smith, P. (2017). Cross-cultural educational experiences and academic achievement of Ghanaian immigrant youth in urban public schools. *Education and Urban Society, 49*(2), 434-455. doi: https://doi.org/10.1177/0013124516643764

Linsk, N. (2014). *Strengthening families through para professionals in the social service workforce*. Presentation for Global Social Service Workforce Alliance Symposium. Retrieved from http://www.socialserviceworkforce.org/system/files/resource/files/Strengthening%20Families%20through%20Para%20Professionals%20in%20the%20SSW%20-%20Alliance%20April%202014%20Symposium.pdf

López, G., & Radford, J. (2017). Facts on U.S. Immigrants, 2015: Statistical portrait of the foreign-born population in the United States. Retrieved from the PEW Research Center website: http://www.pewhispanic.org/2017/05/03/facts-on-u-s-immigrants-current-data/

Migration Policy Institute [MPI]. (2015). *Unaccompanied child migrants in U.S. communities, immigration court, and schools*. Retrieved from http://www.migrationpolicy.org/research/unaccompanied-child-migrants-us-communities-immigration-court-and-schools

Morland, L., Duncan, J., Hoebing, J., Kirschke, J., & Schmidt, L. (2005). Bridging refugee youth and children's services: A case study of cross-service training. *Child Welfare, 84*(5), 791-812.

National Association of Social Workers [NASW]. (1996). *Code of ethics*. Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Oxman-Martinez, J., & Choi, Y. R. (2014). Newcomer children: experiences of inclusion and exclusion, and their outcomes. *Social Inclusion, 2*(4), 23-37. doi: https://doi.org/10.17645/si.v2i4.133

Pardini, P. (2006). In one voice: Mainstream and ELL teachers work side-by-side in the classroom, teaching language through content. *The Journal of Staff Development, 27*(4), 20-25.

Paat, Y. (2013). Working with immigrant children and their families: An application of Bronfenbrenner's Ecological Systems Theory. *Journal of Human Behavior in the Social Environment 23,* 954-966. doi: https://doi.org/10.1080/10911359.2013.800007

Patil, C. L., Mcgown, M., Nahayo, P. D., & Hadley, C. (2010). Forced migration: complexities in food and health for refugees resettled in the United States. *NAPA Bulletin, 34*(1), 141-160. doi: https://doi.org/10.1111/j.1556-4797.2010.01056.x

Perreira, K. M., & Ornelas, I. J. (2011). The physical and psychological well-being of immigrant children. *Future of Children, 21*(1), 195-218. doi: https://doi.org/10.1353/foc.2011.0002

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. (1996). Public Law 104–193

Pine, B. A., & Drachman, D. (2005). Effective child welfare practice with immigrant and refugee children and their families. *Child Welfare, 84*(5), 537-562.

Piwowarczyk, L. A. (2006). Our responsibility to unaccompanied and separated children in the United States: A helping hand. *Boston University Public Interest Law Journal*, *15*(2), 263-296.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M…Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. *CMAJ: Canadian Medical Association Journal,183*(12), E824-925. doi: https://doi.org/10.1503/cmaj.090313

Raghallaigh, M. (2011). Religion in the lives of unaccompanied minors: An available and compelling coping resource. *The British Journal of Social Work, 41*(3), 539-556. doi: https://doi.org/10.1093/bjsw/bcq136

Ramirez, W., McKenna, M., & Somers, A. (2015). Repatriation and reintegration of migrant children. In K. Musalo, L. Frydman, & P. C. Cernados (Eds.), Childhood and migration in Central and North America: Causes, policies, practices and challenges (pp. 455-480). San Francisco, CA: Center for Gender and Refugee Studies.

Redden, M. (2017). Undocumented immigrants avoid vital nutrition services for fear of deportation. Retrieved from https://www.theguardian.com/us-news/2017/may/09/undocumented-immigrants-wic-nutrition-services-deportation

Roth, B. J., & Grace, B. L. (2015). Falling through the cracks: The paradox of post-release services for unaccompanied child migrants. *Children and Youth Services Review, 58,* 244-252. doi: https://doi.org/10.1016/j.childyouth.2015.10.007

Shore, B., Hammond, D., & Celep A. (2013). When good is not good enough. *Stanford Social Innovation Review, Fall 2013*, 40-47.

Socha, K. (2014). Challenges and solutions to family reunification efforts with undocumented or foreign-born youth. *Focus, 20*(3), 16-18.

Socha, K., Mullooly, A. and Jackson, J. (2016). Experiences resettling Eritrean youth through the US unaccompanied refugee minor program. *Journal of Human Rights and Social Work 1*(2), 96-106.

Trickett, E., Jones, C., & Nagayama Hall, G. G. (2007). Adolescent culture brokering and family functioning: A study of families from Vietnam. *Cultural Diversity and Ethnic Minority Psychology, 13*(2), 143-150. doi: https://doi.org/10.1037/1099-9809.13.2.143

United Nations High Commissioner for Refugees [UNHCR]. (2014). *Children on the run: Unaccompanied children leaving Central America and Mexico and the need for international protection*. Retrieved from http://www.unhcr.org/en-us/about-us/%20background/56fc266f4/%20children-on-the-run-full-report.html

UNHCR. (2016). *Global trends*. Retrieved from http://www.unhcr.org/en-us/global-trends-2016-media.html?query=Global%20trends

United States Conference of Catholic Bishops [USCCB]. (2012*). Improving access: Immigration relief for children in federal foster care before and after the Trafficking Victims Protection Reauthorization Act of 2008*. Retrieved from http://www.usccb.org/about/children-and-migration/unaccompanied-refugee-minor-program/upload/Immigration-Relief-for-Children-in-Federal-Foster-Care-Before-and-After-TVPRA-2008_USCCB-December-2012.pdf

USCCB. (2013a). *Mission to Central America: The flight of unaccompanied children to the United States*. Retrieved from http://www.usccb.org/about/migration-policy/upload/Mission-To-Central-America-FINAL-2.pdf

USCCB. (2013b). The United States unaccompanied refugee minor program: Guiding principles and promising practices. Retrieved from http://www.usccb.org/about/children-and-migration/unaccompanied-refugee-minor-program/upload/united-states-unaccompanied-refugee-minor-program-guiding-principles-and-promising-practices.pdf

USCCB & Lutheran Immigration and Refugee Service (n.d.). *Post-Release Services: Family preservation services for immigrant children released from federal custody*. Retrieved from http://www.usccb.org/about/children-and-migration/upload/LIRS-and-USCCB-Post-Release-Services-FAQs-Final.pdf

U.S. Department of Education [US DOE]. (2004). *Laws & guidance: Part c- Homeless education*. Retrieved from http://www2.ed.gov/policy/elsec/leg/esea02/pg116.html

US DOE. (2014). *Educational services for immigrant children and those recently arrived to the United States*. Retrieved from http://www2.ed.gov/policy/rights/guid/unaccompanied-children.html

US DOE. (2016). *Non-regulatory guidance: English Learners and Title III of the Elementary and Secondary Education Act (ESEA), as amended by the Every Student*

Succeeds Act (ESSA). Retrieved from https://www2.ed.gov/policy/elsec/leg/essa/essatitleiiiguidenglishlearners92016.pdf

U.S. Department of State. (2017). Intercountry adoption: Who can be adopted. Retrieved from https://travel.state.gov/content/adoptionsabroad/en/adoption-process/how-to-adopt/who-can-be-adopted.html

Waters, M. C., & Pineau, M. G. (Eds.). (2015). *The integration of immigrants into American society*. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/21746

William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008. (2008). Public Law 110-457, 8 U.S.C. § 1232

Young Center for Immigrant Children's Rights. (n.d.). Child advocate program. Retrieved from https://www.theyoungcenter.org/child-advocate-program-young-center/

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Socially Isolated Cambodians in the US: Recommendations for Health Promotion

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Abstract: *Community organizations in the United States are severely challenged to serve Cambodian refugees who experience health disparities associated with their traumatic experiences. Community leaders have identified a sub-set of community members of particular concern: those at either end of the age spectrum (elders and young people) who are socially isolated. As part of a larger community-based participatory research project, we conducted a focus group with seven Cambodian community leaders from six cities. The study sought to better understand the phenomenon of social isolation of Cambodian elders and young people in order to inform health promotion efforts. Cambodian leaders expressed keen concern for those community members who rarely seem to leave their homes or interact with the Cambodian community. Prominent themes identified by leaders related to isolation were: a generational pattern; benefits of extended family; health concerns; cultural influences and language; impact of stigma; fear and safety concerns; and lack of sufficient resources. In addition, leaders identified several possible solutions to address the phenomenon of social isolation in their communities. Health promotion efforts with this population should identify isolated individuals and enhance their social connectedness and support networks as part of a larger integrated effort.*

Keywords: *Cambodian; genocide; social isolation; community leaders; community-based health promotion*

Concerned about socially isolated elders and adolescents in their families, Cambodians in the United States have reached out to community leaders for help. The impact of exposure to trauma experienced in Cambodia, during migration and in refugee camps, and/or in the United States, along with other factors such as social determinants, may interact to contribute to the problem of social isolation among some Cambodian Americans (Wagner, Berthold, Buckley, Kuoch, & Scully, 2015).

The elders are survivors of the genocide in Cambodia, when an estimated 1.7 million Cambodians were killed during the 1975 to 1979 reign of the Khmer Rouge (approximately 21% of the total population; Kiernan, 2004). Article II of the United Nations' Convention on the Prevention and Punishment of the Crime of Genocide defines genocide as "any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: (a) Killing members of the group; (b) Causing serious bodily or mental harm to members of the group; (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; (d)

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Imposing measures intended to prevent births within the group; (e) Forcibly transferring children of the group to another group" (UN General Assembly, 1948, pp. 1-2).

An epidemiological study of a representative sample of Cambodian refugees (aged 35 to 75, n=490) living in Long Beach, California (the largest community of Cambodians in the United States) who survived the Cambodian genocide documented an average of 15 different types of major traumas from the Cambodian civil war and genocide experienced before their arrival in the United States (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Such traumas include: exposure to bombings and combat; slave labor; starvation; separation from family members and kidnapping; brain-washing; being terrorized, including living under a constant threat of death; witnessing atrocities; murder of family members and friends; and other forms of torture. Those with exposure to a greater number of types of trauma were more likely to have posttraumatic stress disorder (PTSD; Marshall et al., 2005).

Despite their significant exposure to multiple severe traumas and consistent with findings across refugee populations (Simich & Andermann, 2014; Wagner et al., 2015), Cambodian refugees in the United States exhibit enormous strengths and resilience (Grigg-Saito, Och, Liang, Toof, & Silka, 2008). Many have demonstrated creative and successful mechanisms of coping, strategies for survival, and adaptive abilities to respond to intergenerational conflict (Lewis, 2010). Some community initiatives support intergenerational bonding through engagement activities meant to develop and nurture senior-youth relationships (Yoshida, Henkin, & Lehrman, 2013).

Cambodian refugee elders have documented health and mental health disparities with higher rates of depression, PTSD, diabetes, hypertension, and cardiovascular disease than found in the general U.S. population (Kinzie et al., 2008; Marshall et al., 2005, 2016). Among Cambodian refugees (who arrived in the United States prior to 1995) and Cambodian immigrants (arriving 1995 and later) seeking medical care, those who were refugees reported poorer health-related quality of life, overall health, and health status across all physical health conditions measured (Sharif et al., 2018). Cambodians who came as refugees to the United States as young children or adolescents experienced high rates of PTSD and depression associated with their experiences during the Khmer Rouge regime, in refugee camps, and exposure to community violence in the United States (Sack et al., 1994). Racial discrimination in the United States is also associated with PTSD and depression in Cambodian adolescents (Sangalang & Gee, 2015).

Now in their mid-thirties to forties, some Cambodian survivors who came to the United States as children or adolescents have become parents themselves. Research with families of U.S. military veterans, Holocaust survivors, and Cambodian mothers in the United States with PTSD have found support for the intergenerational effects of trauma (Bowers & Yehuda, 2016; Dekel & Goldblatt, 2008; Field, Muong, & Sochanvimean, 2013). Specifically, role-reversing parenting (i.e., when a parent seeks to get their own emotional needs met by their child) mediated the intergenerational transmission of anxiety symptoms from Cambodian mothers who had survived the genocide and were seeking treatment for PTSD in the United States (Field et al., 2013).

The American Academy of Social Work and Social Welfare and AARP have identified social isolation as one of the Grand Challenges that must be addressed (Lubben, Gironda, Sabbath, Kong, & Johnson, 2015). Reports of poorly functioning, traumatized, and depressed Cambodian adolescents, young adults, and elders who isolate themselves in their homes are deeply concerning for a number of communities (Berthold et al., 2018; M. Scully, personal communication, May 18, 2016). Cambodian American leaders have struggled with how to understand and address the isolation of their elders and youth. Some of these isolated individuals have died by suicide. The Centers for Disease Control and Prevention (2013) has called for increased training in refugee communities to expand awareness of suicide and increase the identification of those at high risk.

Social isolation is a prevalent and potentially modifiable risk factor that affects the health and mortality of elders (Cornwell & Waite, 2009; Cudjoe et al., 2018; Holt-Lunstad, 2018; Lubben, 2018; Miyawaki, 2015; Steptoe, Shankar, Demakakos, & Wardle, 2013). Socially isolated elders experience mental health issues such as depression (Dorfman et al., 1995) and suicidal ideation (Vanderhorst & McLaren, 2005). Their social isolation can be exacerbated not only by personal factors but also by a variety of structural factors, such as living in a high-crime neighborhood (Portacolone, Perissinotto, Yeh, & Greysen, 2018).

There is a growing body of research on adolescent internet usage, although few studies have focused on internet usage as a socially isolating factor among Cambodian American youth. For more than a decade, surveys of U.S. households have reported adolescents spending greater amounts of time on the internet and socially isolating themselves from their families and peers (Gross, 2004). Turow (1999) reported that 60% of families in the United States expressed concern that their children were going to become socially isolated because of their internet usage. No statistically significant relationship was found between social isolation and well-being (i.e., loneliness, social anxiety, depression) in one study with a White, middle-to-upper class population (Gross, 2004). Many contemporary youths have unprecedented access to the internet and are “growing up wired” (Spies Shapiro & Margolin, 2014, p. 1), using social networking sites (SNS) as a primary means of establishing social connections and relating with peers (Ellison & Boyd, 2013). Systematic reviews document mixed findings regarding the association between the use of the internet and SNS and adolescent well-being and mental health (Seabrook, Kern, & Rickard, 2016). Some studies report that the social connectedness promoted by the use of SNS may protect youth from mental health problems (Ellison & Boyd, 2013), while others find that problems with communication and managing expectations contribute to increased experiences of isolation (Baek, Bae, & Jang, 2013; Best, Manktelow, & Taylor, 2014). Positive influences of SNS on adolescent well-being may include more chances to associate with and enhance relationships with peers, including with those who may generally be less accessible, and more opportunity to self-disclose (Spies Shapiro, & Margolin, 2014). These same authors identified potential risks associated with the use of SNS, however, such as receiving negative feedback and pressure to self-disclose, as well as experiencing harmful social comparisons. In a U.S. nationally-representative sample aged 19-32, young adults with higher social media use reported feeling more socially isolated than those who used social media less (Primack et al., 2017). The characteristics of social media use by young adults rather than the amount of time spent using social media may be what has the most impact

on their mental health. Problematic social media use of an addictive nature was found to be independently and strongly associated with greater depressive symptoms in young adults in a U.S. nationally-representative sample (Shensa et al., 2017).

Humans are social beings and most belong to complex and intricate webs of social networks that allow for support, engagement and interpersonal contact. Social supports have been shown to have positive health benefits (Hurtado-de-Mendoza, Gonzales, Serrano, & Kaltman, 2014) and social attachments appear to be potentially beneficial in managing adversity and trauma (Bryant, 2016). Several theoretical frameworks including Social Ecological Theory (Bronfenbrenner, 1979), Conservation of Resources Theory (COR; Hobfoll, 2001), Network Individual Resource (NIR) model (Johnson et al., 2010), and the Network Episode Model (NEM; Pescosolido, 2006) all posit that networks are instrumental to stress responses and to coping with stressors. Social Ecological Theory is often cited in social work literature (Rotabi, 2007) and serves as a holistic theoretical approach to help understand the interconnectedness between Cambodian refugees and their socio-political environments. Bronfenbrenner (1979) separates the different levels of the environment into five nested subsystems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. This framework helps social workers to better understand Cambodian refugees' experiences, such as language difficulties, unemployment, family dynamics, community violence, and poor health outcomes (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010). Various deleterious effects are experienced by adults who have been exposed to childhood trauma in the absence of effective social supports (Norman, Hawkley, Ball, Berntson, & Cacioppo, 2013). Without social networks to create and establish social supports, social isolation may result (Cacioppo & Hawkley, 2003). Social disconnectedness is also associated with damaging neuroendocrine effects (Cacioppo, Cacioppo, Capitanio, & Cole, 2015). Social isolation, similar to more traditional clinical risk factors, has been found to predict mortality in a nationally representative U.S. sample (Pantell et al., 2013). When considering the impact of social isolation, it is important to recognize the potential effect of cultural context. Compared to the more individually-based culture predominant in the United States, Cambodian refugees come from a group-based culture. As such, it is possible that the impact of social isolation may be intensified for Cambodians.

Social isolation has both subjective and objective components (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Subjective social isolation (self-report of loneliness and isolation) has been independently linked to mortality (Luo, Hawkley, Waite, & Cacioppo, 2012) and depression (Vanhalst, Goossens, Luyckx, Scholte, & Engels, 2013). Objective social isolation is seen in those who are socially disconnected from others, as measured by living alone, having a small social network, being unmarried, lack of regular participation in social activities, and limited contact with family and friends (Holt-Lunstad et al., 2015). Southeast Asian elders living in Philadelphia were found to be socially disconnected and at risk for depression (Kim et al., 2015). In this sample, those Cambodians who were younger at the time that they immigrated had less depression than those who were older at immigration. Social disconnectedness and co-occurring health conditions were found at high rates in a sample of Cambodians in Connecticut (Berthold

et al., 2018). Lack of community and religious engagement were associated with their poor health outcomes.

The living situation of Cambodians in the United States is often quite different from their traditional life in Cambodia (Smith-Hefner, 1999). In stark contrast to their experiences of residing in relatively small close-knit communities in Cambodia prior to the Khmer Rouge regime, life in the United States is often difficult and isolating for Cambodian elders (Wagner et al., 2015). Their communities in the United States are more dispersed, making it a challenge to access their social networks and socialize with friends without using a car or bus. Elders are frequently dependent for transportation on their adult children who have busy lives and may not live with them. Persistent isolation faced by these elders may exacerbate the adverse mental and physical health outcomes experienced from their exposure to trauma and torture in their home country, exposure to toxic stress (i.e., joblessness, poverty, gang violence) in the United States, and intergenerational role conflicts between traditional and acculturated values (Dinh, Weinstein, Kim, & Ho, 2008; Smith-Hefner, 1999).

To date, health promotion efforts in Cambodian American communities have been limited, in part due to lack of resources (Kuoch, Scully, Tan, Rajan, & Wagner, 2014; Sharif et al., 2018). Existing efforts have largely been targeted at the chronic health of elders, including group treatment and health education programs for diabetes (Berkson, Tor, Mollica, Lavelle, & Cosenza, 2014; Wagner et al., 2015), integrated interdisciplinary models that attend to the whole person (Grigg-Saito et al., 2010; Wagner et al., 2015), and preventive health measures (Grigg-Saito et al., 2008; Nguyen, Tanjasiri, Kagawa-Singer, Tran, & Foo, 2008). The use of traditional, complementary, and alternative medicine, including spiritual practices, is common in Cambodia for treating chronic conditions (Peltzer, Pengpid, Puckpinyo, Yi, & Anh, 2016) and was integrated with Western healthcare in Cambodian refugee and displaced persons' camps in Thailand (French, 1994). While Cambodian Americans continue to use complementary and alternative medicine in the United States, its use is often not integrated with Western health and mental health care, with some notable exceptions such as the practices of the Metta Health Center in Lowell, Massachusetts (Grigg-Saito et al., 2010).

Limited research has focused on factors associated with health behaviors and health outcomes in resettled Cambodians (Nelson-Peterman, Toof, Liang, & Grigg-Saito, 2015) and understanding psychosocial factors related to exercise (Coronado, Sos, Talbot, Do, & Taylor, 2011). Little attention has been given to deepening the understanding of social isolation among members of the Cambodian American community or to specifically targeting isolated individuals in health promotion efforts.

This article reports findings from the final phase of a community-based participatory research (CBPR) study conducted collaboratively between Cambodian leaders from six states in the United States, university researchers, and Khmer Health Advocates (a Cambodian non-profit organization). The purpose of the larger study was to build Cambodian community capacity to design and conduct research related to the health of the estimated 327,719 members of the Cambodian community in the United States (U.S. Census Bureau, 2016). A community survey was conducted in the initial phase of this study

and concerns about socially isolated community members were reported by all study sites. We share the findings of a focus group of leaders from the six Cambodian communities that sought, in part, to better understand the phenomenon of social isolation of Cambodian elders and young people in order to inform health promotion efforts.

Methods

Design and Participants. A single focus group was conducted to gain perspectives from community leaders regarding social isolation and other challenges and strengths of their communities. Seven Cambodian community leaders from the six study sites (two from Connecticut) participated. This included 6 females and 1 male, aged 45 to 66, who were in leadership positions (i.e., directors or senior staff members) at Cambodian non-profits in six cities or states in the United States: Long Beach, California; the State of Connecticut; Lowell, Massachusetts; Minneapolis, Minnesota; Portland, Oregon; and Philadelphia, Pennsylvania. The leaders were highly educated (possessing at least some college to masters' degrees), bilingual in English and Khmer, and from the middle-class. All but one of the focus group participants were ethnically Cambodian genocide survivors who came to the United States as refugees. The remaining participant was White and had worked in Cambodian communities in the United States for approximately three decades. The leaders had extensive experience working with Cambodian refugees and served small-to-large Cambodian communities in the east, mid-west and west of the United States where approximately one-third of all Cambodians in the United States resided.

Procedures. Participants engaged in a 90-minute conference-call focus group discussing their community's key health concerns. The focus group was conducted in spoken English and facilitated by the PI, Co-Investigator, and a graduate research assistant. Semi-structured questions were asked of participants relating to their understanding of the health of the Cambodian American community and concern about homebound members of the community. Questions included, in part: "As a leader, how do you see the health of your community?"; "What do you perceive to be the most common health problems of Cambodian American adults in your community?"; [after social isolation and homebound community members was raised by focus group members] "How much do you view members of your community being homebound as a problem? People who are isolated, who don't leave their homes much - is that a big problem in your community?"; and "What are your perceptions about how important community health workers are or aren't to the health of your community?". The focus group was audiotaped and transcribed verbatim, yielding twenty single-spaced pages of transcript. An informed written consent process was used, and the University Partner's IRB provided oversight of this study.

Data Analysis. The transcript was entered into NVivo for coding and data analysis. Holistic coding was employed to identify underlying themes by "lumping" the narrative according to stories or broad topics (Saldana, 2013). The PI, Co-Investigator, and a graduate research assistant coded the focus group transcript separately and met to discuss their coding decisions. This process continued until coding consensus was achieved. At the conclusion of each debriefing, memos were created to help document the team's decision-making during the various phases of the research project and how these changes impacted the study. These steps increased the rigor of the study by helping to control for the

researchers' biases and positionality (Padgett, 2008). Once all the transcripts were holistically coded, the research team thematically analyzed the codes and condensed them into 13 broad constructs (Padgett, 2008; Saldana, 2013). This article reports on an in-depth analysis of the social isolation-related themes.

Results

Cambodian leaders expressed keen concern for those community members who rarely seem to leave their homes or interact with the Cambodian community. Prominent themes identified by leaders related to isolation were: a generational pattern; benefits of extended family; health concerns; cultural influences and language; the impact of stigma; fear and safety concerns; and lack of sufficient resources (see Table 1). In addition, leaders identified several possible partial solutions to address the phenomenon of social isolation in their communities.

Table 1. *Social Isolation Themes*
1. Generational pattern
2. Benefits of extended family
3. Health concerns
4. Cultural influences and language
5. Impact of stigma
6. Fear and safety concerns
7. Lack of sufficient resources
8. Possible partial solutions

Generational pattern of isolation. Community leaders saw social isolation as a particular problem for two groups in the community: elders (variously defined as older than 50 and over aged 60 or 65 by others) and the younger generation (teenagers and young adults). Leaders identified elders as particularly at risk of isolation if they were unemployed, lacked transportation, and were depressed. With respect to isolated youth, one leader remarked, "We hear about young people. Usually they're males and they're in their 20's, who never come out of their room." Other leaders indicated that this was the case in their communities as well, and that the problem extended to teenagers.

Benefits of extended family. Among the key benefits of extended family discussed were the practical benefits of intergenerational aid provided by those in the younger generation to their elders. This aid included assisting elders to socialize outside of their home, encouraging them to be more physically active, and driving elders to their health appointments (occasionally interpreting for them at their appointments). One leader described intergenerational Cambodian living arrangements, "We're scattered, and a lot of parents live with their adult children that take good care of them already. So they provide transportation, have their own medical insurance for the parents." Elder grandparents may also provide valuable assistance for the younger generation. For example, they may provide care to grandchildren that in turn reduces their own social isolation.

Health concerns. A number of health concerns were seen as linked to isolation, either as a perceived cause of isolation and/or believed to result in isolation over time. Youth and elders alike were known to be depressed and isolating themselves in their bedrooms or

homes. Leaders shared similar stories about the youth isolating themselves in their bedrooms. One leader explained that youth,

> *age between 18, 19, 20, 22, some of them lock themselves in their room. What I learned, some of them, their parents didn't want them to get out, so what they do, they lock themselves in their room and then they have Internet, and they would spend hours and hours at night on Internet or playing games, and they become a challenge for their parents to get them out, because they just lock themselves in. They become isolated and when their parents become concerned, sometimes it's too late to get them out.*

Leaders expressed concern about suicide being a problem among younger Cambodians who were extremely socially isolated. One leader shared an example of a youth suicide and reflected that suicide in the younger generation was a problem in his community,

> *Just Saturday, I went to the temple. This woman said her grandson just hanged himself or killed himself, he's 21 years old. There must be something going on that we don't know about in this age group. So that is depressing and it's . . . an issue of concern for the family and for us as a community. So they [are] kind of hidden, but it's also an issue for us to look into.*

One leader highlighted that some elders were isolated "because they still live in the past," affected by symptoms of PTSD such as traumatic memories of their experiences during the genocide. Those secluded in their homes were known to get less than adequate physical exercise that was believed to lead to worse physical health. Several of the leaders asserted that less activity led to more smoking for some. Closely related to their concerns about social isolation, the health of elders was seen as at risk for being compromised when they depended on others, such as children or other extended family members, for transportation to the doctor or for other daily necessities. A leader from the northeast stated that,

> *children grow up, have family of their own and move out, and they come to visit their parents once or twice a week at the most. If parents feel like they can drive or they can go out on their own, they can get out and socialize among their peers, especially in the summer, but in the winter it's hard for them to get out. So they are homebound and they are more depressed and they don't do much physical activity, which puts more stress on their health as well, on their physical health.*

The inability to get out of the home to buy fresh vegetables was seen as contributing to elders eating larger quantities of salty fish paste and processed foods, which in turn was believed to lead to increased problems with high blood pressure, a condition the leaders knew was prevalent among genocide survivors in their communities.

Of keen concern to the leaders was that many in their communities relied on going to the emergency room for routine health problems, in part due to their isolation and difficulty getting to regular doctor visits. As one leader remarked,

> *…we have new programs, it's called ER diversion, because why, because they use a lot of ER or use emergency visit … for health care, for doctor visit.… they wait until they have problem, and they don't have a primary care doctor. They just go*

> *to ER...when they are sick, they just take themselves or take their children to the ER and use that as their [laughs] their primary care doctor. So now we have a plan called ER diversion, try to convert that system back to a primary care visit.*

Cultural influences and language. The dynamics between parents, adolescents, and elders were described as having a strong cultural dimension, which appeared to interact with the problem of social isolation. Some members of the older generation have limited or no English fluency and the younger ones frequently have limited fluency in Khmer. Language barriers between the generations may also contribute to the communication challenges experienced. As one leader put it,

> *But the teenager, they also face that problem, why? Because I heard somebody brought up about that they hide themselves in their room playing games, and they don't understand how to explain, how to communicate with the parents, how to explain their feelings.*

The communication barrier between parents who lived through the genocide and their children who did not may make it difficult to understand each other's experiences and needs. This is particularly challenging when it can be impossible to fully or accurately express the experience of genocide in words in any language. Another leader commented that the barrier to communication related to the poor mental health of the parents.

> *I see isolation mostly with the elderly, 55 and up, and the younger ones, the first generation that were born in Cambodia then they came here. . . . [The children] cannot talk or express feelings to the parents. Parents [are] depressed, so the children go their own way.*

The leaders were concerned that depressed and otherwise poorly functioning parents may be compromised in their ability to supervise their children.

Leaders also noted the influence of culture among Cambodian elders who report their health as good or bad. The leaders explained that a negative complaint (i.e., that their health is not good) means (culturally) they are blaming their children for not taking good enough care of them. In keeping with Cambodian culture, even under circumstances when they are isolated and their children and/or other family members are not providing them with sufficient assistance (including transportation to get them out of the home), elders are not supposed to complain. One participant commented,

> *Also another thing is that look at the Cambodian culture. So we supposed not to complain. Because nobody takes care of you besides yourself. The parent cannot say, not good, because otherwise, they say that the children not good to take care of you.*

Another participant acknowledged that context (including whether they are asked when they are alone or in the presence of others) might influence the response of elders to being asked about their health.

> *My mom for example, my mom cannot [laughs], if somebody ask her, she probably look around first, if her children [laughs]. If she say that she is not good, so it mean she blames her children, too.*

Impact of stigma. Stigma was another theme identified by the leaders that contributed to the isolation of elders in the home. The loss of employment was one identified source of stigma. The experience of loss of social status and stigma associated with loss of employment by Cambodian elders is a phenomenon shared by older adults in the general population as well. The Cambodian leaders explained that Cambodians in the United States value being able to buy a house and car, and they do not want to be seen as unemployed or receiving unemployment benefits or other government assistance. One leader remarked that

> *The parents are, what we learn is that people who are losing their jobs, if they are 50 years old to 60 years old, they don't want to get out because they lose the job. They sometimes did not feel comfortable and the most people whom have a problem, the most of the seniors.*

It became apparent from the leaders that people felt others looked at them differently if they were not employed. A fairly common question asked when meeting others in the community is, "Where do you work?" This question would be difficult and stigmatizing to answer for those unemployed, contributing to their preference to stay home to avoid such questioning. Older Cambodian men might find being unemployed particularly troubling, as culturally they are used to being the ones to financially support their families.

Fear and safety concerns. Fear and concern for safety was another key factor identified as contributing to elders staying at home and parents keeping their children inside in the evenings. There were regional differences, however, with several of the communities being particularly noted for higher rates of community violence, including Cambodian and non-Cambodian gang violence. One of the leaders linked the low rates of high school completion and college attendance, and the high unemployment of youth, with involvement in crime, a problem the leader's agency was insufficiently resourced to address.

> *…it's very, very limited to hire people, especially in [NAME OF CITY]. About five hundred plus [CAMBODIAN] youth in [THE CITY], and 46% graduated from high school, only about 10% go to college. So you can see the issue. If ten shootings in [THIS CITY], probably six, seven of them are by Cambodian youth.*

Leaders made a link between fear and safety concerns among their community members and the phenomenon of social isolation.

Lack of sufficient resources. Cambodian leaders saw community health workers—or other staff members conducting outreach— as invaluable because they could check on homebound community members, assist them in leaving their homes, and connect them with activities. None, however, had the resources to afford robust outreach programs. Most were working with small or bare-bones staff and could not meet the need in the community.

> *I think we do need some kind of outreach, but also have to be the combination of socialization, sport activity, especially in wintertime. And also probably, just to bring the seniors as well as the youth and adults out of the home. So it mean[s] that the role of social services is very important here, because [MY ORGANIZATION] is the only [CAMBODIAN] social / human services in [THE STATE].*

Possible partial solutions. In the face of such challenges related to social isolation in their communities, leaders identified possible strategies and partial solutions. One leader spoke about having vans and staff members for driving elders to temples to socialize and get religious/spiritual support, and to take them to health appointments:

> *. . . the most people whom have a problem, the most of the seniors. But we have five vans provide transportation to them every week. So that resolve[s] some issue[s] with the people who live in [NAME OF CITY]. However, people living in another area, especially in [ANOTHER CITY] area, it's about 90 miles from us. Those people don't have [any] place to go.*

Other leaders noted how they wished they had such resources in their communities, but they lacked sufficient funding. In addition, all leaders agreed that another critical resource was community health workers (CHWs) who are bilingual in Khmer and English.

> *Yeah, very, very important to have a community health worker, because translator come when needed, but a community worker be there to advocate and to also bridge the cultural gap . . . that's what we need, because the community health workers have built a relationship with the community on an on-going basis, and also have built a relationship with the provider on an on-going basis.*

In relation to the problem of adolescents isolating themselves in their rooms, one leader had recommended to some parents to disconnect the internet and try to take their adolescent out and spend more time with the adolescent.

Discussion

Cambodian community leaders in this study identified two very socially isolated groups within their communities: elders and young people (teens and young adults). Although the Cambodian leaders represented six separate Cambodian communities across the United States, most were experiencing similar challenges with these isolated groups. All but one of the leaders were themselves ethnically Cambodian genocide survivors who came to the United States as refugees in the 1980s and had lived and worked in their Cambodian community in the United States ever since. These community leaders provided contextual insights into some of the factors that may be contributing to social isolation. The Cambodian leaders themselves had experienced many of the same or similar circumstances and losses that elders in their community faced. These shared experiences may have made them particularly attuned to the losses of the elders and to the challenges parents faced with teenagers isolating themselves.

A shift in family culture, particularly given the younger generations' more engaged participation in a new culture in the United States, and limited communication between family members due to language barriers, appeared to be pervasive factors affecting the Cambodian communities. Cambodian leaders explained that older generations possess limited English fluency and younger generations lack fluency in their native Cambodian language of Khmer. Although intergenerational aid is often a significant benefit of an extended family (e.g., teens or young adults providing elders with transportation to medical appointments, the temple, and to visit friends; and with young people learning about their

culture and heritage), many Cambodian Americans are severely limited in their verbal interactions across generations due to language barriers.

Further amplifying the social isolation of elders and adolescents are their fears and safety concerns within their own neighborhoods and communities. Many elders report a fear of leaving their homes and parents keep their children at home because of community violence—specifically, Cambodian and non-Cambodian gang violence—which has been associated with adverse mental health outcomes (Green, Gilbertson, & Grimsley, 2002).

The barriers discussed above were perceived by the community leaders in this study and also supported in the literature (D'Anna et al., 2017; Wagner et al., 2015) as contributing to increased health concerns for these two isolated populations, impeding them from engaging in adequate physical exercise, purchasing healthy fresh fruits and vegetables, and accessing preventative health services. These circumstances make reducing negative health outcomes and implementing health promotion activities more challenging.

It may seem surprising to some social workers that grief and loss were not mentioned by the community leaders as a theme in the focus group related to social isolation, given the history of genocide that they and their community members experienced. Grief and loss are universal in the Cambodian community, however, culturally it is not common for people to talk about this as a theme. The majority of Cambodians are Buddhists who focus on acceptance and maintaining a relationship with those who have died through traditional ceremonies that occur in community. There continues to be a give-and-take between the dead and the living as the living pray for guidance and blessing and the spirits of the dead offer comfort and protection. Social isolation is therefore seen as a serious problem because those who are isolated have not only diminished contact with the living but also with the dead.

Given the association of social isolation with poor outcomes, including increased mortality and adverse mental health outcomes (Cudjoe et al., 2018; Holt-Lunstad et al., 2015; Lubben, 2018; Pantell et al., 2013; Steptoe, Shankar, Demakakos, & Wardle, 2013; Vanderhorst & McLaren, 2005), health promotion efforts should be directed to socially isolated elders and young Cambodian Americans. Their communities, however, have severe resource constraints (Kuoch, Scully, Tan, Rajan, & Wagner, 2014). Cambodian community-based organizations in the United States have been pushed to the brink of financial collapse during this economically challenging time (T. Kuoch and M. Scully, personal communication, May 10, 2018). Since this study concluded, one of the participating community-based agencies has closed. New and creative partnerships need to be developed to improve health outcomes for Cambodian American elders and young people. Social workers should partner with Cambodian community-based agencies and community healthcare systems to aid in reducing unnecessary emergency room visits and provide necessary language services. One of the vital resources helping to bridge barriers to health promotion efforts is the excellent work being conducted by Cambodian CHWs. Unfortunately, most are working as volunteers and are not able to engage with all the Cambodian Americans who need their support. Cambodian CHWs are bilingual and possess the required skills to provide federally mandated Title VI translation services for

social workers and other health personnel, which would reduce the unethical reliance on family members and nonprofessional interpreters (Berthold & Fischman, 2014). The CHWs have the skill set (language, cultural and ethnic expertise, and advocacy) and trust of the community to help increase long-term health outcomes and improve access to publicly funded community care (Lu, D'Angelo, Kuoch, & Scully, 2018; Zahn, Matos, Findley, & Hicks, 2012).

Implications for Social Work Practice

Social workers play a critical role in providing quality services to refugees both in direct care positions and within interdisciplinary teams and should partner with CHWs to become trusted members of this community. The National Association of Social Workers' (NASW's) (2016) *Standards for Social Work Practice in Health Care Settings* recommends that assessments are customized for vulnerable populations, such as refugees. Social workers must ensure that all facets of the refugee's life are taken into consideration when conducting an assessment and fully appreciate the interconnectedness and depth of the refugee's life journeys. This includes past experiences of trauma in their country of origin, during migration, and when resettling. Further, social workers must understand and appreciate the link between trauma exposure and health risks for refugees, and culturally appropriate systems of care (Ostrander, Melville, & Berthold, 2017). CHWs play an important role in ensuring that health care is culturally appropriate for Cambodian Americans.

Social workers should advocate to legislators for a significant investment of resources to support CHWs, which would ensure that the right to access health care for some of the most vulnerable and marginalized Americans is realized, that the health care they receive is culturally appropriate, and that they receive preventive care services (Nguyen et al., 2008; Renfrew et al., 2013; Taylor et al., 2013). Employing CHWs would also ensure that health providers are in compliance with Title VI (Berthold & Fischman, 2014; Wagner et al., 2013). Compared to the cost of medications and other treatment, the cost of funding CHWs would be modest. One study found a cost-savings and reduction in potentially dangerous medication errors when Cambodian CHWs partnered with pharmacists using telemedicine to deliver medication therapy management (Center for Technology and Aging, 2011).

Cambodian community organizations can also utilize bilingual CHWs to create, organize, and run online groups to support elders and young Cambodians struggling with limited transportation, fears about community violence, and social isolation. Cambodians have been early adopters of technology since they first came into the United States. They relied on videotapes for entertainment and information as soon as videotapes became available on a commercial level in the early 1980s. Over the ensuing years, Cambodian Americans have been among the first to use the Internet for communications with family across the United States and in Cambodia. Skyping and the use of Facebook-Messenger is common in Cambodian communities in the United States and technology serves as a link between the young and the old (T. Kuoch, personal communication, May 10, 2018). Employing an online peer support model, Cambodian elders and adolescents could develop quality peer relationships, enlarge their social networks, and decrease a sense of loneliness

and social isolation. One study of online peer support groups with children aged 7 to 11 from predominantly White, middle to upper-class populations across Canada suffering from asthma and their parents reported growth in supportive relationships with family and friends, increased self-confidence, and decreased loneliness and social isolation (Stewart, Letourneau, Masuda, Anderson, & McGhan, 2013).

Through the use of strategic and critical partnerships, CHWs, social workers, and their interdisciplinary colleagues could implement necessary trainings for health providers and non-profit agencies who work with Cambodian communities. Such trainings could focus on raising awareness and enhancing services for Cambodian Americans in the short term and increasing advocacy for health promotion resources in the long term. Following the example of organizations in communities with high concentrations of Cambodians such as Lowell and Lynn Massachusetts, Cambodian elders' physical, mental, and social needs may be met through participation in social day care or adult day health centers (Dubus, 2017). One possible model that could be considered is the development of a social enterprise for-profit arm of a community-based organization that has potential to generate additional revenue while combating social isolation in community members.

Rather than focusing efforts solely on the consequences of social isolation for individuals, promoting health requires addressing the root causes, such as structural factors contributing to the problem of social isolation. Metzl and Hansen (2014) define structural competence as "the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases…also represent decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures" (p. 128). Social workers must not overlook how an individual Cambodian's lived experiences are shaped and constrained by structural factors that impact Cambodian refugees every day, such as insurance companies dictating how long and what type of services they will cover, the effect that racism has on cortisol levels, the impact of community violence, the lack of culturally appropriate services and goods, and insufficient public transportation for daily living activities.

Limitations

The non-probability purposive sampling employed in this study was a key limitation. The leaders in the focus group represented six large Cambodian communities in the United States. Thus, our findings may not be representative of the opinions or experiences of other Cambodian community leaders or reflective of the situation of other Cambodian communities in the United States, including regions where there are no Cambodian agencies. Further, the participants may have opened up more or given different descriptions if the focus group had been conducted in Khmer. In addition, the findings came from only one focus group and were not meant to be generalized. The focus group explored multiple topics, therefore, we did not have time to probe further about social isolation. It is important to note that adolescents may not view themselves as socially isolated because they have access to vast social networks through the use of the internet. This study did not examine the nature of these networks or the type of support received by these adolescents via social media and the impact on adolescent well-being.

The fact that the focus group occurred as a conference call could be seen as a limitation, in that it did not allow for face-to-face non-verbal communication. If the participants had been strangers, the remote nature of the focus group may have also complicated the development of trust and open discussion. In our case, all participants were well known to each other, having met in person previously on multiple occasions to work on various research and community projects. Holding the focus group over the telephone allowed us to include leaders from around the United States, inviting a range of community experiences to be shared and accounted for.

Implications for Social Work Research

Future research that examines the problem of social isolation with additional focus groups and key informant interviews involving more community leaders, as well as elders and youth would be valuable. One pressing concern expressed by the focus group participants was of adolescents isolating themselves in their bedrooms and spending significant time on the Internet and playing video games. The leaders perceived that this was negatively affecting the adolescents' well-being. Given the relative lack of study of this phenomenon in Cambodian youth and the mixed findings in the literature regarding internet usage and well-being (Baek et al., 2013; Best et al., 2014; Ellison & Boyd, 2013; Seabrook et al., 2016), further study is needed to understand the prevalence and impact of isolating behavior by Cambodian American teens. Social workers should partner with Cambodian community agencies to better study this phenomenon and to understand the adolescents' perspectives and experiences. Research regarding the risk factors for suicide in Cambodian American community members, particularly in the young people, and on effective suicide prevention strategies is also a pressing need. In addition, outcomes research on interventions aimed at reducing the prevalence of social isolation in vulnerable Cambodian elders and adolescents and its negative effects should be undertaken.

Several of the observations and insights expressed by community leaders in this study based on their experiences living in and serving their communities for many years are not well-documented in the literature and would warrant further study. For example, the literature has identified the impact of sociocultural factors and smoking in Cambodian Americans (e.g., smoking to cope with stress, combat hunger during the Khmer Rouge genocide period, and as part of Buddhist religious ceremonies (Friis et al., 2012)) but no literature was found documenting that less activity leads to smoking by some Cambodian Americans. In addition, previous research has found that lower acculturation and education as well as a history of severe and prolonged food deprivation/insecurity during the Khmer Rouge regime is associated with greater consumption of high-sodium Asian sauces, lower consumption of vegetables and fruits, and other less healthy food behavior in Cambodian refugee women in Lowell, Massachusetts (Peterman, Silka, Bermudez, Wilde, & Rogers, 2011; Peterman et al., 2010). Further study is needed to determine if the inability to get out of the home noted by leaders in our study is related to eating behavior and health among isolated Cambodian Americans.

Research with non-Cambodian mothers has found a strong association between postpartum depression and impaired parenting (Muzik et al., 2017) and negative effects on child development (Brummelte & Galea, 2016). In a study of active child protective service

cases in Cambodian families in Los Angeles, maternal depression and/or PTSD was associated with poor parenting outcomes and neglect (Chang, Rhee, & Berthold, 2008). Further study is needed to examine whether there is a relationship between Cambodian American parents' mental health problems and poor functioning and their ability to supervise their adolescent children, a concern expressed by our study participants that they perceived to contribute to the adolescents isolating themselves in their rooms.

Further research is also needed regarding the leaders' expressed concerns about the factors leading some Cambodian youth to become criminally involved and the leaders' perception that social isolation in their community members is associated with fear and safety concerns. Findings from such research may contribute to the prevention of community violence and provide insights into strategies to reduce social isolation among vulnerable individuals. Researchers and clinicians have long known that long-term social isolation can lead to damaging psychological effects in humans. Recent research with mice has found that a brain chemical that causes stress, fear, hypersensitivity to threats, and aggression is overproduced in the context of chronic social isolation and that blocking the chemical can remove these negative effects of isolation (Zelikowsky et al., 2018). Possible therapeutic applications of these findings may yield benefits for socially isolated humans in years to come. Regardless of possible clinical and pharmacological advances in the future, efforts to target the structural factors that contribute to creating social isolation are fundamentally needed (Ostrander et al., 2017).

Conclusions

Cambodian leaders have explicitly identified social isolation as a major concern that must be addressed for cultural reasons and to reduce the risk of behavior-dependent chronic disease, such as Type II diabetes. Anecdotal reports of suicide attempts of isolated Cambodian youth in the United States are also particularly troubling to Cambodian CHWs and leaders. Health promotion efforts in this population should directly work to identify isolated individuals and enhance their social connectedness and support networks as part of a larger integrated effort. Programs should consider working closely with public schools if possible, in order to share resources and information to better prevent, identify, and address youth social isolation.

Further, the social isolation of Cambodians in the United States is a chronic community problem that requires a community solution (Ostrander et al., 2017). The problem of social isolation is related to cultural and language isolation (i.e., lack of a common language between the generations). Community-based organizations (CBOs) and Cambodian community members tend to be financially resource-poor. Adequate funding is necessary to develop needed programming and infrastructure, and to undertake and evaluate long-term interventions that address broader structural factors and social determinants associated with the chronic health conditions and isolation that are prevalent in this community.

Despite their financial limitations, Cambodian communities and CBOs have other relevant cultural resources and expertise. Many Cambodian communities have CHWs with interpreting skills, cultural understanding, and knowledge of the traumas experienced by

members that are necessary for effective interventions. Community-based organizations can also mobilize key stakeholders in the community such as Buddhist monks, elders, and youth organizations to educate its members about important issues like social isolation and work collaboratively to generate solutions. Working together, Cambodian communities have great potential for successfully combating social isolation.

References

Baek, Y. M., Bae, Y., & Jang, H. (2013). Social and parasocial relationships on social network sites and their differential relationships with users' psychological well-being. *Cyberpsychology, Behavior, Social Networking, 16*(7), 512-517. doi: https://doi.org/10.1089/cyber.2012.0510

Berkson, S. Y., Tor, S., Mollica, R., Lavelle, J., & Cosenza, C. (2014). An innovative model of culturally tailored health promotion groups for Cambodian survivors of torture. *Torture, 24*(1), 1-16.

Berthold, S. M., & Fischman, Y. (2014). Social work with trauma survivors: Collaboration with interpreters. *Social Work, 59*(2), 103-110. doi: https://doi.org/10.1093/sw/swu011

Berthold, S. M., Loomis, A. M., Kuoch, T., Scully, M., Hin-McCormick, M. M., Casavant, B., & Buckley, T. (2018). Social disconnection as a risk factor for health among Cambodian refugees and their offspring in the United States. *Journal of Immigrant and Minority Health.* Published online May 23, 2018. doi: https://doi.org/10.1007/s10903-018-0760-3

Best, P., Manktelow, R., & Taylor, B. (2014). Online communication, social media and adolescent well-being: A systematic narrative review. *Children and Youth Services Review, 41*, 27-36. doi: https://doi.org/10.1016/j.childyouth.2014.03.001

Bowers, M. E., & Yehuda, R. (2016). Intergenerational transmission of stress in humans. *Neuropsychopharmacology Reviews, 41,* 232-244. doi: https://doi.org/10.1038/npp.2015.247

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Brummelte, S., & Galea, L. A. (2016). Postpartum depression: Etiology, treatment and consequences for maternal care. *Hormones and Behavior, 77,* 153-166. doi: https://doi.org/10.1016/j.yhbeh.2015.08.008

Bryant, R. A. (2016). Social attachments and traumatic stress. *European Journal of Psychotraumatology, 7*, 1-7. doi: https://doi.org/10.3402/ejpt.v7.29065

Cacioppo, J. T., Cacioppo, S., Capitanio, J. P., & Cole, S. W. (2015). The neuroendocrinology of social isolation. *Annual Review of Psychology, 66*(1), 733-767. doi: https://doi.org/10.1146/annurev-psych-010814-015240

Cacioppo, J. T., & Hawkley, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine, 46*(3), S39-

S52. doi: https://doi.org/10.1146/annurev-psych-010814-015240

Centers for Disease Control and Prevention. (2013). Suicide and suicidal ideation among Bhutanese refugees - United States, 2009-2012. *Morbidity and Mortality Weekly Report*, *62*(26), 533-536. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6226a2.htm

Center for Technology and Aging. (2011). Eliminating barriers to care: Using technology to provide medication therapy management to the underserved—A Center for Technology and Aging Grant Program. Retrieved from http://www.techandaging.org/eMTM_Connecticut_Pharmacists_Foundation_Case_Study.pdf

Chang, J., Rhee, S., & Berthold, S. M. (2008). Child abuse and neglect in Cambodian refugee families: Characteristics and implications for practice. *Child Welfare, 87*(1), 141-160.

Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior*, *50*, 31-48. doi: https://doi.org/10.1177/002214650905000103

Coronado, G., Sos, C., Talbot, J., Do, H., & Taylor, V. (2011). To be healthy and to live long, we have to exercise: Psychosocial factors related to physical activity among Cambodian Americans. *Journal of Community Health, 36*(3), 381-388. doi: https://doi.org/10.1007/s10900-010-9319-5

Cudjoe, T. K. M., Roth, D. L., Szanton, S. L., Wolff, J. L., Boyd, C. M., & Thorpe, R. J. (2018). The epidemiology of social isolation: National Health and Aging Trends Study, *The Journals of Gerontology: Series B*, gby037. doi: https://doi.org/10.1093/geronb/gby037

D'Anna, L. H., Peong, V., Sabado, P., Valdez-Dadia, A., Hansen, M. C., Canjura, C., & Hong, M. (2017, November). Barriers to physical and mental health: Understanding the intersecting needs of Cambodian and Latino residents in urban communities. *Journal of Immigrant and Minority Health , 2017,* 1-18 [Published online first]. doi: https://doi.org/10.1007/s10903-017-0677-2

Dekel, R., & Goldblatt, H. (2008). Is there intergenerational transmission of trauma? The case of combat veterans' children. *American Journal of Orthopsychiatry, 78*(3), 281-289. doi: https://doi.org/10.1037/a0013955

Dinh, K., Weinstein, T. L., Kim, S. Y., & Ho, I. K. (2008). Acculturative and psychosocial predictors of academic-related outcomes among Cambodian American high school students. *Journal of Southeast Asian American Education and Advancement, 3*, 1-23. http://dx.doi.org/10.7771/2153-8999.1102

Dorfman, R. A., Lubben, J. E., Mayer-Oakes, A., Atchison, K., Schweitzer, S. O., De Jong, F. J., & Matthias, R. E. (1995). Screening for depression among a well elderly population. *Social Work, 40*(3), 295-304.

Dubus, N. (2017). A qualitative study of older adults and staff at an adult day center in a

Cambodian community in the United States. *Journal of Applied Gerontology, 36*(6), 733-750. doi: https://doi.org/10.1177/0733464815586060

Ellison, N. B., & Boyd, D. M. (2013). Sociality through social network sites. In W. H. Dutton (Ed.), *The Oxford handbook of internet studies* (pp. 151-172). Oxford: Oxford University Press.

Field, N. P., Muong, S., & Sochanvimean, V. (2013). Parental styles in the intergenerational transmission of trauma stemming from the Khmer Rouge regime in Cambodia. *American Journal of Orthopsychiatry, 83*(4), 483-494. doi: https://doi.org/10.1111/ajop.12057

French, L. C. (1994). *Enduring Holocaust, surviving history: Displaced Cambodians on the Thai-Cambodian border, 1989-1991.* (Order No. 9514851). Available from ProQuest Dissertations & Theses Global. (304117734)

Friis, R. H., Garrido-Ortega, C., Safer, A. M., Wankie, C., Griego, P. A., Forouzesh, M.,.. Kuoch, K. (2012). Socioepidemiology of cigarette smoking among Cambodian Americans in Long Beach, California. *Journal of Immigrant and Minority Health, 14,* 272-280. doi: https://doi.org/10.1007/s10903-011-9478-1

Green, G., Gilbertson, J. M., & Grimsley, M. F. J. (2002). Fear of crime and health in residential tower blocks. A case study in Liverpool, UK. *European Journal of Public Health, 12*(1), 10-15. https://doi.org/10.1093/eurpub/12.1.10

Grigg-Saito, D., Och, S., Liang, S., Toof, R., & Silka, L. (2008). Building on the strengths of a Cambodian refugee community through community-based outreach. *Health Promotion Practice, 9*(4), 415-425. https://doi.org/10.1177/1524839906292176

Grigg-Saito, D., Toof, R., Silka, L., Liang, S., Sou, L., Najarian, L., . . . Och, S. (2010). Long-term development of a "whole community" best practice model to address health disparities in the Cambodian refugee and immigrant community of Lowell, Massachusetts. *American Journal of Public Health, 100*(11), 2026-2029. doi: https://doi.org/10.2105/AJPH.2009.177030

Gross, E. F. (2004). Adolescent Internet use: What we expect, what teens report. *Applied Developmental Psychology, 25,* 633-649. doi: https://doi.org/10.1016/j.appdev.2004.09.005

Hepworth, D., Rooney, R., Rooney, G., Strom-Gottfried, K., & Larsen, J. (2010). *Direct social work practice: Theory and skills* (8th ed.). Belmont, CA: Brooks/Cole.

Hobfoll, S. E. (2001). The influence of culture, community, and the nested-self in the stress process: Advancing conservation of resources theory. *Applied Psychology, 50*(3), 337-421. doi: https://doi.org/10.1111/1464-0597.00062

Holt-Lunstad, J. (2018). The potential public health relevance of social isolation and loneliness: Prevalence, epidemiology, and risk factors. *Public Policy & Aging Report*, *27*(4), 127-130. doi: https://doi.org/10.1093/ppar/prx030

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10*(2), 227-237. doi: https://doi.org/10.1177/1745691614568352

Hurtado-de-Mendoza, A., Gonzales, F. A., Serrano, A., & Kaltman, S. (2014). Social isolation and perceived barriers to establishing social networks among Latina immigrants. *American Journal of Community Psychology, 53*(1), 73-82. doi: https://doi.org/10.1007/s10464-013-9619-x

Johnson, B. T., Redding, C. A., DiClemente, R. J., Mustanski, B. S., Dodge, B., Sheeran, P., . . . Fishbein, M. (2010). A network-individual-resource model for HIV prevention. *AIDS and Behavior, 14*(2), 204-221. doi: https://doi.org/10.1007/s10461-010-9803-z

Kiernan, B. (2004). The Cambodian genocide, 1975-1979. In S. Totten, W. S. Parson, & I. W. Charny (Eds.), *Century of genocide : Critical essays and eyewitness accounts* (2nd ed., pp. 339-374). New York: Routledge.

Kim, T., Nguyen, E. T., Yuen, E. J., Nguyen, T., Sorn, R., & Nguyen, G. T. (2015). Differential role of social connectedness in geriatric depression among Southeast Asian ethnic groups. *Progress in Community Health Partnerships: Research, Education, and Action, 9*(4), 467-468. doi: https://doi.org/10.1353/cpr.2015.0084

Kinzie, D. J., Riley, D. C., McFarland, D. B., Hayes, D. M., Boehnlein, D. J., Leung, D. P., & Adams, D. G. (2008). High prevalence rates of diabetes and hypertension among refugee psychiatric patients. *The Journal of Nervous and Mental Disease, 196*(2), 108-112. doi: https://doi.org/10.1097/NMD.0b013e318162aa51

Kuoch, T., Scully, M., Tan, H. K., Rajan, T. V., & Wagner, J. (2014). The National Cambodian American Town Hall Meeting: A community dialogue on “Eat, Walk, Sleep” for health. *Progress in Community Health Partnerships: Research, Education, and Action, 8*(4), 541-547. doi: https://doi.org/10.1353/cpr.2014.0068

Lewis, D. (2010). Cambodian refugee families in the United States: “Bending the tree” to fit the environment. *Journal of Intergenerational Relationships, 8*(1), 5-20. doi: https://doi.org/10.1080/15350770903520635

Lu, J. J., D’Angelo, K. A., Kuoch, T., & Scully, M. (2018). Honouring the role of *community* in community health work with Cambodian Americans. *Health and Social Care in the Community, 00*, 1-9. doi: https://doi.org/10.1111/hsc.12612

Lubben, J. (2018). Addressing social isolation as a potent killer! *Public Policy & Aging Report*, *27*(4), *136-138.* doi: https://doi.org/10.1093/ppar/prx026

Lubben, J., Gironda, M., Sabbath, E., Kong, J., & Johnson, C. (2015). *Social isolation presents a grand challenge for social work.* Baltimore, MD: American Academy of Social Work and Social Welfare. Retrieved from http://aaswsw.org/wp-content/uploads/2015/03/Social-Isolation-3.24.15.pdf

Luo, Y., Hawkley, L. C., Waite, L. J., & Cacioppo, J. T. (2012). Loneliness, health, and

mortality in old age: A national longitudinal study. *Social Science & Medicine, 74*(6), 907-914. doi: http://dx.doi.org/10.1016/j.socscimed.2011.11.028

Marshall, G.N., Schell, T.L., Elliott, M.N., Berthold, S.M., & Chun, C-A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *JAMA, 294*(5), 571-579. https://doi.org/10.1001/jama.294.5.571

Marshall, G. N., Schell, T. L., Wong, E., Berthold, S. M., Hambarsoomian, K., Elliott, M. N., Bardenheier, B. H., & Gregg, E. W. (2016). Diabetes and cardiovascular disease risk in Cambodian refugees. *Journal of Immigrant and Minority Health, 18*(1), 110-117. doi: https://doi.org/10.1007/s10903-014-0142-4

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133. doi: http://dx.doi.org/10.1016/j.socscimed.2013.06.032

Miyawaki, C. E. (2015). Association of social isolation and health across different racial and ethnic groups of older Americans. *Ageing & Society, 35*(10), 2201-2228. doi: https://doi.org/10.1017/S0144686X14000890

Muzik, M., Morelen, D., Hruschak, J., Rosenblum, K. L., Bocknek, E., & Beeghly, M. (2017). Psychopathology and parenting: An examination of perceived and observed parenting in mothers with depression and PTSD. *Journal of Affective Disorders, 207,* 242-250. doi: https://doi.org/10.1016/j.jad.2016.08.035

National Association of Social Workers [NASW]. (2016). *NASW Standards for Social Work Practice in Health Care Settings.* Retrieved from https://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf

Nelson-Peterman, J. L., Toof, R., Liang, S. L., & Grigg-Saito, D. C. (2015). Long-term refugee health: Health behaviors and outcomes of Cambodian refugee and immigrant women. *Health Education & Behavior, 42*(6), 814-823. doi: https://doi.org/10.1177/1090198115590779

Nguyen, T.-U., Tanjasiri, S. P., Kagawa-Singer, M., Tran, J. H., & Foo, M. A. (2008). Community health navigators for breast- and cervical-cancer screening among Cambodian and Laotian women: Intervention strategies and relationship-building processes. *Health Promotion Practice, 9*(4), 356-367. doi: https://doi.org/10.1177/1524839906290251

Norman, G. J., Hawkley, L., Ball, A., Berntson, G. G., & Cacioppo, J. T. (2013). Perceived social isolation moderates the relationship between early childhood trauma and pulse pressure in older adults. *International Journal of Psychophysiology, 88*(3), 334-338. doi: http://dx.doi.org/10.1016/j.ijpsycho.2012.12.008

Ostrander, J., Melville, A., & Berthold, S. M. (2017). Working with refugees in the United States: Trauma-informed and structurally competent social work approaches [Special Issue]. *Advances in Social Work, 18*(1), 66-79. doi: https://doi.org/10.18060/21282

Padgett, D. K. (2008). *Qualitative methods in social work research* (2nd ed.). Thousand

Oaks, CA: Sage.

Pantell, M., Rehkopf, D., Jutte, D., Syme, S. L., Balmes, J., & Adler, N. (2013). Social isolation: A predictor of mortality comparable to traditional clinical risk factors. *American Journal of Public Health, 103*(11), 2056-2062. doi: https://doi.org/10.2105/AJPH.2013.301261

Peltzer, K., Pengpid, S., Puckpinyo, A., Yi, S., & Anh, le V. (2016). The utilization of traditional, complementary and alternative medicine for non-communicable diseases and mental disorders in health care patients in Cambodia, Thailand and Vietnam. *BMC Complement Altern Med, 16,* 92. doi: https://doi.org/10.1186/s12906-016-1078-0

Pescosolido, B. A. (2006). Of pride and prejudice: The role of sociology and social networks in integrating the health sciences. *Journal of Health and Social Behavior, 47*(3), 189-208. doi: https://doi.org/10.1177/002214650604700301

Peterman, J. N., Silka, L., Bermudez, O. I., Wilde, P. E., & Rogers, B. L. (2011). Acculturation, education, nutrition education, and household composition are related to dietary practices among Cambodian refugee women in Lowell, MA. *Journal of the American Dietetic Association, 111*(9), 1369-1374. doi: https://doi.org/10.1016/j.jada.2011.06.005

Peterman, J. N., Wilde, P. E., Liang, S., Bermudez, O. I., Silka, L., & Rogers, B. L. (2010). Relationship between past food deprivation and current dietary practices and weight status among Cambodian refugee women in Lowell, MA. *American Journal of Public Health, 100*(10), 1930-1937. doi: https://doi.org/10.2105/AJPH.2009.175869

Portacolone, E., Perissinotto, C., Yeh, J. C., & Greysen, S. R. (2018). "I feel trapped": The tension between personal and structural factors of social isolation and the desire for social integration among older residents of a high-crime neighborhood. *Gerontologist, 58*(1), 79-88. doi: https://doi.org/10.1093/geront/gnw268

Primack, B. A., Shensa, A., Sidani, J. E., Whaite, E. O., Lin, L. Y., Rosen, D., . . . Miller, E. (2017). Social media use and perceived social isolation among young adults in the U.S. *American Journal of Preventive Medicine, 53*(1), 1-8 [E-pub]. doi: https://doi.org/10.1016/j.amepre.2017.01.010

Renfrew, M. R., Taing, E., Cohen, M. J., Betancourt, J. R., Pasinski, R., & Green, A. R. (2013). Barriers to care for Cambodian patients with diabetes: Results from a qualitative study. *Journal of Health Care for the Poor and Underserved, 24*(2), 633. doi: https://doi.org/10.1353/hpu.2013.0065

Rotabi, K. (2007). Ecological theory origin from natural to social science or vice versa? A brief conceptual history for social work. *Advances in Social Work, 8*(1), 113-129.

Sack, H. W., McSharry, N. S., Clarke, N. G., Kinney, N. R., Seeley, N. J., & Lewinsohn, N. P. (1994). The Khmer adolescent project: Epidemiologic findings in two generations of Cambodian refugees. *The Journal of Nervous and Mental Disease,*

182(7), 387-395. doi: https://doi.org/10.1097/00005053-199407000-00004

Saldana, J. (2013). *The coding manual for qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Sangalang, C. C., & Gee, G. C. (2015). Racial discrimination and depressive symptoms among Cambodian American adolescents: The role of gender. *Journal of Community Psychology, 43*(4), 447-465. doi: https://doi.org/10.1002/jcop.21696

Seabrook, E. M., Kern, M. L., & Rickard, N. S. (2016). Social networking sites, depression, and anxiety: A systematic review. *JMIR Mental Health, 3*(4), e50. Published online first. doi: https://doi.org/10.2196/mental.5842

Sharif, M. Z., Biegler, K., Mollica, R., Sim, S. E., Nicholas, E., Chandler, M., . . . Sorkin, D. H. (2018). A health profile and overview of healthcare experiences of Cambodian American refugees and immigrants residing in Southern California. *Journal of Immigrant and Minority Health.* Published online first April 28, 2018. doi: https://doi.org/10.1007/s10903-018-0736-3

Shensa, A., Escobar-Viera, C. G., Sidani, J. E., Bowman, N. D., Marshal, M. P., & Primack, B. A. (2017). Problematic social media use and depressive symptoms among U.S. young adults: A nationally-representative study. *Social Science & Medicine, 182,* 150-157 [Published online first]. doi: https://doi.org/10.1016/j.socscimed.2017.03.061

Simich, L., & Andermann, L. (Eds.). (2014). *Refuge and resilience: Promoting resilience and mental health among resettled refugees and forced migrants.* NY: Springer Science + Business Media. doi: https://doi.org/10.1007/978-94-007-7923-5

Smith-Hefner, N. J. (1999). *Khmer American: Identity and moral education in a diasporic community*. Berkeley, CA: University of California Press.

Spies Shapiro, L. A., & Margolin, G. (2014). Growing up wired: Social networking sites and adolescent psychosocial development. *Clinical Child and Family Psychology Review, 17* (1), 1-18. doi: https://doi.org/10.1007/s10567-013-0135-1

Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America*, 110, 5797-5801. doi: https://doi.org/10.1073/pnas.1219686110

Stewart, M., Letourneau, N., Masuda, J. R., Anderson, S., & McGhan, S. (2013). Impacts of online peer support for children with asthma and allergies: "It just helps you every time you can't breathe well." *Journal of Pediatric Nursing, 28*(5), 439-452. doi: http://dx.doi.org/10.1016/j.pedn.2013.01.003

Taylor, V., Bastani, R., Burke, N., Talbot, J., Sos, C., Liu, Q., . . . Yasui, Y. (2013). Evaluation of a Hepatitis B lay health worker intervention for Cambodian Americans. *Journal of Community Health, 38*(3), 546-553. doi: https://doi.org/10.1007/s10900-012-9649-6

Turow, J. (1999). *The Internet and the family: The view from the family, the view from the press*. Retrieved from The Annenberg Public Policy Center of the University of Pennsylvania: http://www.appcpenn.org/Internet/family/rep27.pdf

UN General Assembly. (1948, December 9). *Convention on the Prevention and Punishment of the Crime of Genocide* [United Nations, Treaty Series, vol. 78, p. 277]. Retrieved from http://www.refworld.org/docid/3ae6b3ac0.html

U.S. Census Bureau. (2016). 2016 American Community Survey 1-Year Estimates: Cambodian alone or in any combination by selected population profile in the United States. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S0201&prodType=table

Vanderhorst, R. K., & McLaren, S. (2005). Social relationships as predictors of depression and suicidal ideation in older adults. *Aging & Mental Health, 9*(6), 517-525. doi: https://doi.org/10.1080/13607860500193062

Vanhalst, J., Goossens, L., Luyckx, K., Scholte, R. H. J., & Engels, R. C. M. E. (2013). The development of loneliness from mid- to late adolescence: Trajectory classes, personality traits, and psychosocial functioning. *Journal of Adolescence, 36*(6), 1305-1312. doi: http://dx.doi.org/10.1016/j.adolescence.2012.04.002

Wagner, J., Berthold, S. M., Buckley, T. E., Kuoch, T., & Scully, M. (2015). Diabetes among refugee populations: What newly arriving refugees can learn from resettled Cambodian Americans. *Current Diabetes Reports, 15*(8), 56-71. doi: https://doi.org/10.1007/s11892-015-0618-1

Wagner, J., Burke, G., Kuoch, T., Scully, M., Armeli, S., & Rajan, T. V. (2013). Trauma, healthcare access, and health outcomes among Southeast Asian refugees in Connecticut. *Journal of Immigrant and Minority Health, 15*(6), 1065-1072. doi: https://doi.org/10.1007/s10903-012-9715-2

Wagner, J., Kong, S., Kuoch, T., Scully, M. F., Tan, H. K., & Bermudez-Millan, A. (2015). Patient reported outcomes of 'eat, walk, sleep': A cardiometabolic lifestyle program for Cambodian Americans delivered by community health workers. *Journal of Health Care for the Poor and Underserved, 26*(2), 441-452. doi: https://doi.org/10.1353/hpu.2015.0029

Yoshida, H., Henkin, N., & Lehrman, P. (2013). *Strengthening intergenerational bonds in immigrant and refugee communities.* Philadelphia, PA: The Intergenerational Center at Temple University. Retrieved from http://education.temple.edu/sites/education/files/uploads/misc/metlife1112_web.pdf

Zahn, D., Matos, S., Findley, S., & Hicks, A. (2012). *Making the connection: The role of community health workers in health homes.* Retrieved from New York State Health Foundation: http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf

Zelikowsky, M., Hui, M., Karigo, T., Choe, A., Yang, B., Blanco, M. R., . . . Anderson,

D. J. (2018). The neuropeptide Tac2 controls a distributed brain state induced by chronic social isolation stress. *Cell, 173*(5), 1265-1279. doi: https://doi.org/10.1016/j.cell.2018.03.037

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Mental Health and Psychosocial Needs of Syrian Refugees: A Literature Review and Future Directions

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Abstract: *Since 2011, the Syrian refugee crisis has resulted in a massive displacement of Syrians, inside and outside of Syria. The enormous psychosocial needs of displaced Syrians have been documented by various reports and studies. With expected arrivals of Syrian refugees resettling in the United States in the near future, the intensity of the challenges for both resettlement agencies and the Syrian refugees themselves are expected to increase. A literature review was conducted for publications produced between March 2011 and January 2017. Academic and grey literature were explored to provide an overview of the psychosocial well-being and cultural characteristics of Syrians. Additionally, current models were analyzed to identify future directions for social work practice. It is vital to understand the Syrian refugee crisis through a multidisciplinary lens. Responding to the challenges found among Syrians requires deliberate consideration for sociocultural, historical, and political issues that uniquely describe them and their contexts. Identifying psychosocial needs may facilitate other aspects of resettlement outcomes, such as employment, education, and social integration. Incorporating a holistic model that reflects trauma-informed and human rights perspectives into clinical as well as policy practices is critical for better overall resettlement outcomes for Syrian refugees, and refugee populations in general.*

Keywords: *Syrian refugees; refugee mental health; refugee crisis; refugee resettlement; psychosocial wellbeing*

As of May 2017, over 13.5 million displaced Syrians were in need of humanitarian assistance (USAID, 2017). On average, 3,300 Syrians arrived in neighboring countries every day in 2014 (e.g., Turkey, Jordan, Lebanon, Iraq, and Egypt), creating a large burden on the host countries (Zetter & Ruaudel, 2014). Not all Syrians who have crossed into neighboring countries are registered refugees. Even though nearly half of the Syrian population has been displaced since the crisis began in 2011, only 5.2 million are formally registered as refugees (United Nations High Commissioner for Refugees [UNHCR], 2017). Thus, the majority still do not have refugee status as recognized by the international community. The government of Turkey, alone, has registered almost 3 million Syrians (UNHCR, 2017). The large number of refugee arrivals has begun to exact severe negative social and economic tolls on the region (Zetter & Ruaudel, 2014). Given the host countries' own political and societal challenges, they are having a difficult time meeting even the basic needs of the refugees, and lack sufficient capacity to cope with the vast influx.

Addressing the Syrian Refugee Crisis

Refugee flows are the result of regional and international conflicts, contributing to social and political instability in neighboring countries (Newman & Selm, 2003). Over the

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past 50 years, the globalization of technology and communication has popularized images of refugees. Thus, there is a constant reminder of what is assumed to be a "flood" of refugees from "Non-Western" countries to the "West" (Gale, 2004, p. 336). The images of the refugees attempting to cross from Turkey to Greece, and then to other European countries, have been intensified by traditional news and social media outlets. These visual images are often used by governments or media to create political rhetoric around national security in resettlement countries that undermine efforts to provide safety for refugees and their families (Gabiam, 2016; United States Congress House, 2015). Therefore, countries like the United States acknowledge that they would actually prefer these refugees to stay in the region, closer to their home country, and deliver humanitarian assistance through neighboring countries. In 2015, the U.S. government announced that nearly $419 million would be provided for those affected by the war in Syria (U.S. Department of State, 2015). The monetary aid allows international aid agencies to work in collaboration with host countries to provide shelter, food, water, healthcare, education and employment for Syrian refugees (UNHCR, 2014a). Providing financial support to the neighboring host countries could prevent Syrians from seeking assistance abroad. However, the large numbers of people in need make it extremely difficult for humanitarian organizations to manage even the basic needs of refugees; despite receiving aid from the international community, only about 54% of the money is spent on the direct care of Syrian refugees (Center for Middle Eastern Strategic Studies, 2014). Although keeping refugees in the region may have seemed like a good idea at first, providing financial aid to neighboring host countries may not be a long-term solution to meet refugees' health and psychosocial needs. Countries with more stable political, social, and economic environments can afford to provide better health care services, social services, education for children of refugee families, employment, job-training opportunities, and housing options for displaced populations like the Syrians.

The lack of appropriate services in neighboring host countries to meet the basic needs of refugees, such as food, housing, and safety, has meant that addressing mental health services has not been a priority for refugees in the region. It is nearly impossible for humanitarian organizations to follow up on the healthcare needs of refugees because of refugees' relocation patterns in neighboring countries. For instance, Turkey has an unconditional "open door policy" that allows Syrian refugees to move freely within the country's border. Only about 10% of the Syrian refugees live in camps throughout Turkey, while the rest of them live either in cities along the Turkey-Syrian border, or are dispersed throughout the country (Ferris & Kirişci, 2015). Thus, humanitarian organizations are only able to reach a small percentage of Syrians in need, and are unable to follow-up on their physical and mental health needs. Even in refugee camps, many mental health issues and psychosocial needs are not being addressed because of limited monitoring capacity (Aziz, Hutchinson, & Maltby, 2014). Mental health and psychosocial services barely exist for Syrian refugees residing outside of the camps in neighboring host countries, who are colloquially referred to as "urban refugees" (UNHCR, 2015). They live in cities, towns, and rural areas, often in dire circumstances, and are not easily reachable by humanitarian aid organizations (Cultural Orientation Resource Center, 2014). These logistical barriers make it challenging for academic researchers to carry out studies beyond basic needs assessments on Syrian refugees' mental health status (Jefee-Bahloul & Khoshnood, 2014).

The neighboring host countries lack long-term refugee policies, resulting in their seeking ways to resettle Syrian refugees in countries that have established resettlement policies. Even though these countries, such as the United States and Canada, have limited mental-health-related services tailored to refugees, they have other policies that can lead to improvements in providing these services to the Syrian refugees. For instance, the United States has the Office of Refugee Resettlement incorporated into the Department of Health and Human Services, which provides assistance for accessing health care, housing, and employment services (Office of Refugee Resettlement, 2016; Pace, Al-Obaydi, Nourian, & Kamimura, 2015). With these basic necessities secured, there is a greater possibility of identifying psychosocial needs and connecting refugees to the appropriate services.

However, the executive order banning travel from seven Muslim countries, which initially went into effect on January 27, 2017, has begun to have a significant impact on individuals and families from these countries, including Syria. It has reignited the debate about whether to further restrict existing refugee processing and security screening protocols. The resettlement program will be capped at 50,000 refugees for the 2017 fiscal year, down from the 110,000-person ceiling instituted in the previous year (Migration Policy Institute, 2017; The White House, 2017). The order has limited the capacity of governmental and non-governmental organizations to respond to the needs of refugees, and created ambiguity globally (Spiegel & Rubenstein, 2017). It is now even more important to create awareness about the needs and challenges of incoming and resettled Syrian refugees, and refugees in general. Thus, this paper aims to provide a review of the current literature addressing the mental health and psychosocial needs of Syrian refugees, and to inform social work practitioners and scholars about the experiences and cultural characteristics of upcoming and/or resettled Syrian refugees in the resettlement countries.

Methods

The literature on refugee studies encompasses a wide variety of academic disciplines, including international relations, law, anthropology, sociology, economics, social work, geography, medicine, psychology, and history (Skran & Daughtry, 2007). The area of refugee studies lacks standard textbooks, a theoretical structure, and a systematic body of data. Researchers must be prepared to incorporate and modify ideas, concepts, and theories from multiple disciplines (Stein, 1986). Some academic journals have devoted certain issues to humanitarian crises; however, this does not guarantee that the information will be delivered to the target audience, such as humanitarian organizations workers, social services workers, and policy makers. Combining the academic and humanitarian platforms can allow professionals to share experiences, interact, and collaborate on needed mental health research areas (Jefee-Bahloul & Khoshnood, 2014).

Recognizing risk and protective factors for the psychological wellbeing of the refugees is a prerequisite for establishing a knowledge base for effective services (Beiser, 2006). To identify factors that play a role in the mental health of Syrian refugees, the literature review focused on articles and reports published between March 2011 and January 2017. Peer-reviewed journal articles were searched through academic and public databases, including PsychINFO, Social Work Abstracts, Academic Search Complete, Journals@Ovid Full Text, ProQuest, Google Scholar, and Medline. A combination of the following key terms

was used: Syrian refugees, Syria, refugee mental health, psychosocial wellbeing, mental health, refugee resettlement, PTSD, and trauma. Additionally, reports from various government agencies and non-governmental organizations were identified via their official websites, including The United Nations Refugee Agency and the World Health Organization (WHO). Grey literature from published chronicles and dissertations were also used to identify relevant literature for this study. Both academic and grey literature were searched using the following inclusion criteria: 1) Studies that examine only the mental health needs and psychosocial wellbeing of adult Syrian refugees, or 2) studies that examine both the mental health/psychosocial wellbeing and physical health needs of adult Syrian refugees. Studies about Syrians' mental health before 2011, when the Syrian conflict began, were not included in this review. Sixteen peer-reviewed journal articles and ten publications from the grey literature met the inclusion criteria. In this paper, the needs of displaced Syrians are reviewed and discussed according to this literature. Additionally, cultural/religious considerations and gender-specific issues emerged as sub-categories based on the review.

Results

Mental Health and Psychosocial Needs of Syrian Refugees

Many displaced Syrians experience a variety of mental health problems, including distress, sadness, fear, anger, nervousness, disinterest and hopelessness (UNHCR, 2014b). Severe emotional disorders, including depression and anxiety, are the most common mental health problems (54%) the refugees experience (Hijazi & Weissbecker, 2015), with the reported problems causing disruptions in their daily functioning. The stressors faced by Syrians can be classified into three major categories. The first stressor category contains concerns regarding security and protection, such as difficulties obtaining legal status and protection in the host countries, and worries about protecting children. The second category is about limited access to health services, especially for those who require continued care and follow up. The third category is about dealing with misconceptions that often paint Syrian refugees as exploiting their refugee status and diverting resources away from local residents, all of which contribute to increasing group tensions that already existed (Hijazi & Weissbecker, 2015).

Since the Syrian Crisis began in 2011, only a handful of studies have been published examining the mental health and psychosocial needs of Syrian refugees. Almost all of these studies were conducted in either refugee camps or in clinics in one of the neighboring host countries. Barriers to conducting academic research in the region hinder the ability to identify and meet the support and treatment needs of Syrians (Jefee-Bahloul & Khoshnood, 2014). The number of Syrians in need is expected to increase due to the lack of mental health care and professionals in the region. Approximately 600.000 Syrians are estimated to need treatment for severe mental illness, and another 4 million may be suffering from mild or moderate mental health problems (WHO, 2015). The large number of people in need makes it difficult to assess the impact of displacement on the mental health of the population, and to deliver the appropriate services and treatments. In addition, the stigma attached to individuals with a mental illness, and their families, may make it even more

difficult to deliver mental health services to Syrian refugees. For instance, 354 Syrian refugees in a refugee camp in Turkey were asked about their openness to a referral for psychiatry and tele-mental health, which is the use of technology to offer treatment options and accessibility for people with mental illness (Jefee-Bahloul, Moustafa, Shebl, & Barkil-Oteo, 2014; Nelson, 2008). Even though 41.8% of the sample met the criteria for posttraumatic stress disorder (PTSD), only 34% reported the need to see a psychiatrist. Of those, only 45% were open to mental health services via technology. Their reported reasons for declining tele-mental health services were privacy, distortions in the doctor–patient relationship, and unfamiliarity with the technology (Jefee-Bahloul et al., 2014). According to Hassan et al. (2015), many Syrians were also skeptical about psychology, psychiatry and utilizing mental health services in the past, which created a negative perception of mental illness, along with the fear of being stigmatized. Before the crisis, most Syrians viewed mental illness as something that brought shame to the family, and Syrians with mental health needs were usually reluctant to seek professional help. Today, however, with such a large increase in the level of psychological distress among Syrian refugees, they might be more open to seeking professional help for mental health and psychosocial support (Cultural Orientation Resource Center, 2014; Hassan et al., 2015).

El Chammay, Kheir, and Alaouie (2013) conducted an assessment in Lebanon's different districts to gather detailed information about the quality and coverage of services for Syrian refugees. The study illustrated four levels of activities based on the assessment: basic services and safety (Level 1); strengthening community and family support (Level 2); focused non-specialized psychosocial support (Level 3); and specialized or clinical services (Level 4). Focused non-specialized psychosocial support accounted for 52.4% of all activities, while 37.3% of service activities concentrated on strengthening community and family support. This assessment points out the importance of non-specialized psychosocial support services and community programs, which can facilitate improved responses to the present problems of Syrian refugees, and reduce the stigma attached to mental health treatment among Syrians.

Recognition of the Syrians' experiences is critical to evaluating their mental health. Hassan et al. (2015) stressed the need to consider the following conditions for delivering appropriate services: 1) manifestations of pre-existing mental disorders; 2) conflict-related violence and displacement; and 3) the post-emergency context, such as those related to living conditions in the host countries. Almost no data is available regarding pre-existing mental disorders of Syrians before the war. However, the number of Syrians with severe mental disorder symptoms might have increased given risk factors such as potentially traumatic events, forced displacement and loss of social support (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). Additionally, the largest psychiatric hospital in Lebanon reported increased admissions of Syrians after the crisis started (Lama, François, Marwan, & Sami, 2015). Both internally and externally displaced Syrians have faced war-related violence, including massacres, murder, torture, hostage-taking, enforced disappearance, rape and sexual violence (Hassan et al., 2015); these potentially traumatic events increase the possibility of mental health concerns among displaced Syrians. Aside from the impact of pre-resettlement conditions on mental health, Syrians who flee Syria and arrive in a host or a resettlement country may experience further difficulties due to

poverty, loss of livelihood, unemployment, and limited access to housing, health care, and education (Hassan et al., 2015). These conditions do not necessarily result in mental disorders but it is important to differentiate pre- and post-resettlement contexts when helping Syrian refugees. This type of approach to assessment may reduce the propensity to simply label refugees with mental illnesses and allow service providers to deliver more appropriate services.

The approaches that national and international organizations have adopted toward the mental health care of refugees have been criticized for their focus on Western psychiatric categories, as these approaches pay little attention to the social, political and economic factors that play a vital role in refugees' lives (Jeon, Yoshioka, & Mollica, 2001). An overemphasis on traditional counseling models and individualistic theoretical approaches may also devalue some of the refugees' cultures that are more collectivistic (Brown, Jones, Nilsson, Russell, & Klevens, 2006). Although post-emergency, context-related studies are almost non-existent, most studies in the developing literature on the mental health of Syrian refugees still focus on psychiatric diagnosis and treatments (Acarturk et al., 2016; Alpak et al., 2015; Lama et al., 2015). Trauma-focused models highlighting pathologies may not always be helpful for refugees whose immediate needs are social and economic (Hutchinson & Dorsett, 2012). Institutional and treatment services that pay more attention to refugees' own perceptions and expressions of their needs can be a more appropriate approach for delivering services. It is critical that intervention studies with Syrians and other refugee populations take cultural and sociopolitical context into consideration, to bridge between research and practice with refugees.

Cultural and Religious Considerations

It is important to understand and distinguish among the cultural and religious value systems of Syrians when exploring the perspectives of families and individuals, and when evaluating the psychological and social problems they face. Hassan et al. (2015) underlined the wide diversity of socioeconomic, ethnic and religious backgrounds found within the Syrian population, which influence the dynamics and relationships among members of the Syrian communities and families. These varied backgrounds may have some common religious and cultural characteristics but providers should take care not to overgeneralize these characteristics when delivering services.

As noted by Moustafa (2015), it is difficult to develop a single, generalized Arab or Muslim view on the concept of mental health. Nonetheless, there are several common themes that are unique to Middle Eastern cultures. For instance, the concept of *majnoon,* which roughly translates to "crazy person," "mad," or "insane," is often used to describe individuals who need psychiatric attention. "The symptoms/behaviors associated with majnoon overlap with those of psychotic disorders, such as schizophrenia, but not with common mental disorders such as depression, anxiety or posttraumatic stress disorder" (Hassan et al., 2015, p. 24).

It is common to experience and interpret psychological symptoms physically rather than emotionally (i.e., psychosomatic symptoms) in non-Western cultures (Bou Khalil, 2013; Dwairy, 2006). Arabic and Syrian idioms describe distress with both somatic

complaints and psychological symptoms (Hassan et al., 2015). Similarly, a Syrian in need of psychological help may use metaphors, expressions, or proverbs to express distress. The somatic symptoms can be expressed in the Syrian context as heaviness in the heart, cramps in the guts, burden or weight on the chest, or having the feeling of ants crawling over the skin (Hassan et al., 2015). Understanding these cultural expressions of mental health symptoms may allow mental health providers to properly interpret psychological and physical complaints.

Syrian refugees struggle with their sudden loss of autonomy, sense of control over their lives, and loss of their family members and homelands (Hassan et al., 2015; Moustafa, 2015). The idea of carrying on a new life in foreign places causes anxiety, fear, uncertainty, frustration, and emotional disturbances. These experiences influence social functioning and/or result in specific symptoms that may be the criterion for the diagnosis of a mental disorder. Thus, it is important not to over-diagnose Syrian refugees with clinical disorders, since their experiences cannot be described strictly using Western-based, evidence-driven medicine (Bou Khalil, 2013; Hassan et al., 2015). Daily concerns about their safety and difficult life circumstances may exacerbate their mental health conditions, which might contribute to developing mental disorders, but will also contribute to a feeling of demoralization and hopelessness. Improving their circumstances and delivering appropriate services can significantly improve their mental health, which may not then require any psychiatric interventions.

Gender-Specific Considerations

In Syria and neighboring countries, women and girls are strongly affected by the recent conflict. Meeting their basic rights, such as safety, health, and education, are immensely important because women are essential stakeholders in a post-conflict reconstruction and recovery process (Sami et al., 2014).

In the Syrian culture, although men have historically been perceived as protectors of the family, this perception has now dramatically changed. Women continue to take care of the family; their workloads have increased while men's workloads have decreased overall because legal restrictions make it difficult for Syrian men to find employment in the host countries. Thus, they experience boredom, disempowerment, and low self-esteem. Lower self-esteem may lead refugee men to express their masculinity negatively. For example, these feelings are used as excuses to act violently against family members. This has contributed to an increase in gender-based violence among Syrians (Anani, 2013; Charles & Denman, 2013). Syrian refugee men reported that they are physically aggressive toward their spouses and children (UNHCR, 2014b).

The lack of employment among Syrian refugees has also disproportionately affected women and youth. Child labor and survival sex among young girls have increased, with refugee households succumbing to impoverishment, and issues of their immediate well-being rising (El Chammay et al., 2013; Zetter & Ruaudel, 2014). Girls as young as 10 years old have been used for prostitution. The number of early marriages has increased, because families want to "protect their daughters from being raped and ensure that they are under the protection of a man" (Anani, 2013, p. 76). Many families also arrange marriages for

their young daughters in order to alleviate financial burdens. They believe that girls can be protected if they are married into a more financially secure family (Charles & Denman, 2013). However, this results in marriages happening at a very early age for these girls. Some families even resort to selling their daughters to older men in order to decrease their overall family expenses. According to aid workers in Lebanon, young girls and women also consider prostitution in order to provide money and food for their families (UNHCR, 2013). This issue is not restricted to Lebanon; in some camps in Turkey, women have been sold under the guise of "temporary marriage." Two women refugees, who act as companions to male customers at a bar in Turkey, explained that women between the ages of 15 and 50 have been sold for up to 5,000 Turkish Lira (about $1700 US Dollar) in the camps (Acarer, 2015). These arrangements are not only made by families; there are also many organized illegal groups involved in this issue. Government controls in the camps are inadequate for preventing Syrian women and girls from facing these challenges.

Sami et al. (2014) underlined the fact that these risks to refugee women and children are significant, and that gender-based violence (GBV) might worsen as the conflict in Syria continues. The lack of adequate shelter caused by overcrowded camps and high rent in urban areas increases the risks for women, particularly those in female-headed households. In Jordan, nearly half of households headed by females have no monthly income, and mainly survive on donations. Additionally, women and girls are exposed to harassment, including offers for sex and marriage in the community (CARE, 2013).

Syrian parents and other family members also end up demonstrating poor parenting skills due to distress borne out of their refugee-related experiences (James, Sovcik, Garoff, & Abbas, 2014). Refugee household members spend time at home, and rarely socialize due to safety and security concerns for women and children. Males who are the heads of households feel depressed, anxious, and useless since they are unable to adequately provide economic and psychological safety for their families. Fathers are also ashamed that their children are unable to continue their education, and that some male children are working at low-paying and harsh jobs to help support their families (CARE, 2013).

Some researchers looked into the psychosocial needs of Syrian refugee women through studies that included women's health conditions. A needs assessment conducted in Lebanon indicated a significant relationship between violence and reproductive health among displaced Syrian women. Thus, better reproductive health services in refugee settings, along with referrals to psychosocial services, are immediate needs for refugee women (Masterson, Usta, Gupta, & Ettinger 2014). According to the UN Population Fund, about 1.7 million women need access to reproductive health services (as cited in Sami et al., 2014). However, many women are unaware of reproductive and psychosocial services provided by humanitarian organizations and NGOs available to them (Al-Qdah & Lacroix, 2017; Charles & Denman, 2013). In the long term, the loss of education about, and access to, reproductive health may contribute to negative effects on their well-being in terms of fertility, health of offspring, and maternal care (Charles & Denman, 2013).

Another important issue for Syrian refugee girls is their inability to continue their education due to the conflict. These girls are at risk of survival sex and early marriage. Furthermore, school-aged children without access to education severely compromise their

chances to lead a stable life in the future, as they are more likely to suffer from prolonged psychological stress (Charles & Denman, 2013). Access to education at all ages is one of the priorities in supporting children's mental health and well-being (Patton et al., 2016). Promoting schooling in each neighboring country could directly affect children's future. However, in some cases, refugee children are the family breadwinners because it is easier for them to find paid work in host countries like Turkey (Human Rights Watch, 2015). Not being able to provide for their families and witnessing their kids' vulnerability due to financial and social struggles may additionally contribute to parents' sense of powerlessness and psychological distress (Dejong et al., 2017). Access to education for refugee children may reduce child labor, deter early marriage and recruitment by armed groups, foster their mental health and resilience, strengthen social cohesion, and raise hope for an entire generation (Human Rights Watch, 2015; UNICEF, 2014). Securing education for children can be done through advocacy by establishing minimal accreditation standards, assessing and monitoring children's vulnerability, strengthening institutional mechanisms and referral systems; fostering awareness among parents about available educational options in host countries, and addressing gender-based violence and specific needs of girls (MSYD, 2017; UNICEF, 2014).

Practice and Policy Recommendations

There have not been any studies published that look into resettlement outcomes of Syrian refugees in the United States. Among the reasons for the lack of studies are the disputes over resettling Syrians in the United States, with strict screening processes and only a relatively small number of resettled Syrian refugees to date. In addition, Syrian refugees resettled in the United States have mostly been assigned to places where they have personal or family connections (Welsh, 2015). Thus, Syrians are not usually placed together in the same towns or cities, but are scattered throughout the United States, which makes it difficult to conduct a viable study.

The expected arrivals of Syrian refugees in the near future means that the number and intensity of challenges for both the resettlement agencies and the Syrian refugees themselves are also expected to increase. The following intervention and policy recommendations are made to deliver better services for Syrian refugees—those who are already resettled and those who will be resettling in the United States in the future.

Elements of Effective Interventions with Syrian Refugees

With the number Syrian refugees ever-increasing, it is crucial that refugee mental health models respond to the needs of the population in relevant and appropriate ways. Multi-layered models that are used by UNHCR programs in the pre-resettlement context have been helpful for Syrian refugees in camps and urban settings (Budosan, Benner, Abras, & Aziz, 2016; Hassan et al., 2015). These models can be adapted to refugees' post-resettlement settings. The programs include four layers: 1) Basic services and security; 2) community and family support; 3) focused psychosocial or non-clinical support; and 4) clinical/psychiatric services (Hassan et al., 2015). Security is an important aspect because most persons with early posttraumatic symptoms are expected to recover if conditions of safety are re-established (Jefee-Bahloul, Barkil-Oteo, Pless-Mulloli, & Fouad, 2015).

Thus, a basic needs assessment along with a mental health screening can be helpful during the first months of resettlement. Providing this type of assessment is critical within the first three months so that appropriate referrals can be made while refugees still have access to intensive case management. Some elements beyond basic and safety needs can be added to the second and third layers of the models for the Syrian population in the post-resettlement context. Efforts should support individuals to restore relationships and build healthy patterns of interaction. This can be accomplished through creativity-based programs using the arts (e.g., theatre, singing, drawing, or poetry) and community activities designed to attract people with social events, educational workshops, cultural shows, or community dialogues (Jefee-Bahloul et al., 2015; Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014).

A few psychosocial and community-based interventions were tested with Syrian refugees in Turkey and Jordan. Budosan et al. (2016) implemented a three-component model with urban Syrian refugees at an outpatient health center and a community center. First, a mental health team received comprehensive training to become familiar with intervention, and with issues among displaced Syrians. The second component consisted of non-intrusive care and support through assessing the needs and concerns of refugees. The last component included educational activities (English, Turkish language, computer classes, etc.), vocational activities (cooking, journal & media design, graphic design, a beauty course), and recreational activities (children's activities, cinema, music, etc.). These activities aimed to restore social cohesion, and to rebuild trust and capacity. According to the results, there were improvements in resilience and general well-being measurements. The model seems to meet the increased demand for context-sensitive, multi-level, and community-based interventions. Another study was undertaken at the Zaatari refugee camp in Jordan. It was based on a vocational program with women refugees (Jabbar & Zaza, 2016). The results indicated that women's confidence, self-esteem, and skills improved; the program helped women to generate income to build a better life, and gave them hope after experiencing conflict-related traumas. One last intervention study with Syrian refugees was conducted at an urban area in Jordan. It was designed to help refugees rediscover their basic psychological needs, learn how to satisfy them in small but meaningful ways that are achievable within their circumstances, and promote well-being within their new way of life (Weinstein, Khabbaz, & Legate, 2016). The intervention aimed to enhance need satisfaction through encouraging small acts that facilitate closeness and reconnection with family or loved ones, instill a sense of achievement and engagement in interesting acts, and encourage self-congruent decision-making. This intervention reduced need frustration, symptoms of depression, and general stress. Although these studies were conducted in host countries, the findings offer ideas about what might work for Syrian refugees in the United States, or in any other resettlement country. Utilizing a similar integrated approach with multilayered services can be helpful to improve the psychosocial wellbeing of Syrians.

Some Syrian refugees may need a social space where they can share their challenges and deal with their past experiences. This element does not usually require clinical treatment; rather, it is a psychosocial support group that re-creates social networks and facilitates engaging in meaningful daily activities (Hassan et al., 2015). Community

members from refugee groups can be good candidates for a role in peer-to-peer support. Prominent individuals in communities (e.g., imams, leaders, and women with strong social networks) need to be consulted on traditional ways of healing and the appropriateness of the model. Mental health professionals can play an instrumental and supportive role in this type of intervention but not a lead role in facilitating pathways of natural recovery from stress (Silove, 2004).

Psychosocial but non-clinical groups can also be developed with Syrians, using a strength-based perspective. According to Boswall and Al Akash (2015), stigma and isolation are common among Syrian women in Jordan due to limited resources and a lack of networks. An intervention that targets this and similar populations may create contexts in which silent and isolated people can be reached (Fitzsimons & Fuller, 2002). Facilitating groups at smaller, local facilities can be helpful for increasing participation in activities in both pre- and post-resettlement contexts. Thus, there should be creative solutions to increase participation by isolated people, and decrease the stigma about mental health.

A further area of study into the mental health of refugees should also consider the circumstances in resettlement countries. Studies of refugees' mental health have a tendency to emphasize the impact of past traumatic events, particularly in the country of origin and/or in the process of flight (Kim, 2016). Scant attention is paid to the impact of post-resettlement experiences on mental health. Competently designed and implemented interventions that focus on long-term benefits and on sustainability are what refugees need once the resettlement agencies have departed the scene (Williams & Thompson, 2011).

Resettlement Policy

Addressing mental health services may not become a priority even after refugees resettle in the United States because the U.S. refugee resettlement policy focuses heavily on refugees becoming self-sufficient in a short time (i.e., 6-8 months; Beiser, 2006; Pace, et al., 2015). This policy offers overseas and domestic medical screening guidelines for every refugee who resettles in the U.S. (Centers for Disease Control and Prevention, 2013). The guidelines are designed to ensure that refugees' health problems do not become obstacles to employment, and the focus is primarily on screening for communicable diseases. However, this may mean that significant opportunities to protect the refugees' mental health are being missed through the narrow focus on their employability based purely on physical health status.

Even for the U.S. population in general, navigating the complex U.S. healthcare system and getting access to mental health services are challenging because of stigma, cost, and a shortage of mental health care professionals (Bushak, 2016). Difficulties in understanding the U.S. health care system limit accessibility to services for refugees as well. In 2015, the Office of Refugee Resettlement implemented the Refugee Health Promotion Program to increase health literacy among refugees (Office of Refugee Resettlement, 2016). This program relies on self-sufficiency in navigating the complex U.S. healthcare system (Pace, et al., 2015). Given the difficulties refugees face in trying to be self-sufficient in such a short time, language and structural barriers, it is critical to implement policies and programs that provide easier pathways for refugees to access care services, as well as comprehensive

health education programs (Beiser, 2006; Pace et al., 2015).

Improving ways to detect mental health needs early in the resettlement process may facilitate a better adjustment by the refugees overall, which would have a subsequent positive impact on other aspects of resettlement outcomes, such as employment, education, and social integration. For instance, poor mental health outcomes are associated with unemployment and social isolation among resettled refugees (Blight, Ekblad, Persson, & Ekberg, 2006; Hollander, 2013). Paying more attention to psychosocial needs through a mandatory mental health assessment in the early stages of resettlement might improve daily functioning and long-term adjustment to the host country.

Taking intersectional characteristics of refugees into account—particularly for Syrian refugees—should be a prerequisite for policymakers. Being a refugee coming from an Arabic-speaking country may result in experiences of discrimination and xenophobia against Syrians. Despite a lack of evidence, Syrian refugees are considered a threat to U.S. national security (The White House, 2017). Political discourse about needing to implement stricter security measures in refugee screening and banning Syrian and other refugees from Muslim countries from entering the United States can normalize the enforcement of discrimination and exclusion. This rhetoric increases confusion and misunderstandings among local communities. The risks of everyday discrimination and micro-aggression attached to the political discourse can lead to psychological distress among those who are perceived to have minority characteristics such as gender, race, or religion (Seng, Lopez, Sperlich, Hamama, & Reed Meldrum, 2012). Initiating programs that bring social harmony, and changing the political rhetoric are critical for successful overall refugee resettlement, which would help to reduce misconceptions about the refugees. Implementing community-based protection strategies that include promoting refugee rights, creating public awareness on refugee issues, and preventing abuses may reduce negativity and hostility towards refugees in host countries (Al-Makhamreh, Spaneas, & Neocleous, 2012; Zetter, & Ruaudel, 2014). Having refugees take on advocacy roles may also protect and empower those who resettle in another country. Activities such as information dissemination, collective decision-making with consideration for sociocultural norms, and cooperating with agencies whose are responsible for serving the refugees can help transform policies and services at local, national, and global levels.

Bowen and Murshid (2016) suggest a conceptual framework in which trauma-informed care (TIC) can guide social policy and advocacy efforts to address social problems related to trauma. Of the five TIC principles (safety, trustworthiness and transparency, collaboration and peer support, empowerment, choice, and intersectionality of identity characteristics), the principles of safety and trustworthiness may be the most critical when instituting a policy for Syrian refugees, and for refugees in general. Policymakers should ensure that policies clearly articulate the importance of providing a basic safety net for refugees while guaranteeing that refugees are treated with dignity and respect. Identifying issues that arise due to the lack of trust between institutions and refugees may also facilitate the successful integration of refugees. A refugee policy with TIC principles can create new pathways for psychological safety among refugees because of TIC's commitment to preventing re-traumatization.

Finally, the role of social workers is to some extent ambiguous in host countries (e.g., Jordan) and academic programs lack staff with a degree in social work or experience (Al-Makhamreh et al., 2012). Internationally, there has been a lack of social work involvement in policy development, service provision and advocacy related to refugee issues (Harding & Libal, 2012). In host and resettlement countries, social workers should be acknowledged as key players in refugee policy decisions and delivery of psychosocial services. The international alliances between educators, practitioners, researchers from professional associations and social work educational institutions need to be built to address needs of today's refugees (Al-Makhamreh et al., 2012). Social work as a profession must advocate on behalf of displaced people and have a more activist role to promote social justice and human rights in *all contexts*; not only in Global North (Harding & Libal, 2012).

Conclusion

Addressing the mental health and psychosocial needs of Syrian refugees requires deliberate considerations of sociocultural and historical issues that uniquely describe Syrian refugees and the contexts that result in their refugee status. In addition to physical and mental health problems, the cultural, historical and political aspects of the Syrian refugee experience should be reflected in social work research, practice, and policy. Therefore, promoting research that is based on multidisciplinary perspectives incorporating various viewpoints about Syrian refugees' mental health may be vital. An understanding of unique issues involved in working with Syrian refugees would allow social work practitioners and scholars to deliver the most effective interventions, and improve policies to better serve Syrian refugees.

Several vulnerable and marginalized Syrian refugee groups (e.g., LGBTQ refugees, elderly group, and refugees with specific needs due to disability, injuries or chronic disease) could not be included in this review since the needs of these groups have not been addressed in the literature including social work. The risks these groups face due to limited services and discrimination escalate their psychological stress and contribute to their feelings of powerlessness. The needs of vulnerable and marginalized refugees must get more attention and be a part of humanitarian practice conversations to assist them to restore control over their lives (Al-Qdah & Lacroix, 2017; Hassan et al., 2015). These groups might be better identified through innovative methodologies such as participatory rapid appraisal or transformative mixed-methods (see Al-Qdah & Lacroix, 2017 and Mertens, 2012).

Other groups whose needs do not get adequate attention in the literature is older school-aged refugees such as high school- and university-aged Syrians. The official language in almost all neighboring countries is Arabic except Turkey; the country has hosted the largest Syrian refugee population. Turkish proficiency is the core challenge for especially older school-aged Syrian refugees (Karipek, 2017). The Lebanese curriculum also includes French and English depending on the school (Dejong et al., 2017). Lack of language proficiency results in low self-confidence and socialization, and feelings of inadequacy, insecurity, hopelessness and worthless in the host country. (Human Rights Watch, 2015; Karipek, 2017). Almost 50% of Syrians in Lebanon ages between 15 and 24 reported having thoughts about committing suicide (UNFPA, 2014). The mental health and

psychosocial needs of these individuals are evident. As the conflict in Syria enters its seventh year, the literature regarding these groups is still scant. There should be more local and global endeavors to make the needs of these groups more visible. Additionally, there is a need for a more concerted effort in developing social work scholarship on refugee mental health and wellbeing so that the role of social work as a profession and a discipline on these issues can globally and locally be recognized.

The length of the conflict and its effect on the displaced Syrian population will determine the future of refugees' migration patterns and needs (Dewachi et al., 2014). Organizations must ensure that their work strengthens the local systems in the region. The international arena needs to consider today's refugees as more than just a displaced group, but also as individuals on their way to becoming citizens of the future (Mollica & McDonald, 2002). Services that strengthen psychological well-being and prevent re-traumatization need to be adopted by international, national and local efforts. The impact of the conflict may well last a lifetime for Syrian refugees. Delivering services with a more holistic model for understanding refugee experiences, and adopting a human rights perspective and trauma-informed care to clinical and policy practices are critical to responding to the psychosocial needs of the Syrian refugee population and other refugee populations in a more effective and meaningful manner.

References

Acarer, E. (2015, January 17). Kamplardaki Kadin ticareti. *Cumhuriyet* [Women trafficking in refugee camps]. Retrieved from http://www.cumhuriyet.com.tr/haber/turkiye/188373/Kamplardaki_kadin_ticareti.html

Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Gulen, B., & Cuijpers, P. (2016). The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: Results of a randomized controlled trial. *Psychological Medicine, 46*, 2583-2593. doi: https://doi.org/10.1017/S0033291716001070

Al-Makhamreh, S., Spaneas, S., & Neocleous, G. (2012). The need for political competence social work practice: Lessons learned from a collaborative project on Iraqi refugees-the case of Jordan. *British Journal of Social Work, 42,* 1074-1092. doi: https://doi.org/10.1093/bjsw/bcs087

Al-Qdah, T., & Lacroix, M. (2017). Syrian refugees in Jordan: Social workers use a participatory rapid appraisal (PRA) methodology for needs assessment, human rights and community development. *International Social Work, 60,* 614-627. doi: https://doi.org/10.1177/0020872816673889

Alpak, G., Unal, A., Bulbul, F., Sagaltici, E., Bez, Y., Altindag, A., . . . Savas, H. A. (2015). Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. *International Journal of Psychiatry in Clinical Practice, 19,* 45-50. doi: https://doi.org/10.3109/13651501.2014.961930

Anani, G. (2013). Dimensions of gender-based violence against Syrian refugees in Lebanon. *Forced Migration Review, 44,* 75-78.

Aziz, I. A., Hutchinson, C. V., & Maltby, J. (2014). Quality of life of Syrian refugees living in camps in the Kurdistan region of Iraq. *PeerJ, 2,* e670. doi: https://doi.org/10.7717/peerj.670

Beiser, M. (2006). Longitudinal research to promote effective refugee resettlement. *Transcultural Psychiatry, 43,* 56-71. doi: https://doi.org/10.1177/1363461506061757

Blight, K. J., Ekblad, S., Persson, J., & Ekberg, J. (2006). Mental health, employment and gender. cross-sectional evidence in a sample of refugees from Bosnia-Herzegovina living in two Swedish regions. *Social Science & Medicine, 62*, 1697-1709. doi: https://doi.org/10.1016/j.socscimed.2005.08.019

Boswall, K., & Al Akash, R. (2015). Personal perspectives of protracted displacement: An ethnographic insight into the isolation and coping mechanisms of Syrian women and girls living as urban refugees in northern Jordan. *Intervention, 13,* 203-215. doi: https://doi.org/10.1097/WTF.0000000000000097

Bou Khalil, R. (2013). Where all and nothing is about mental health: Beyond posttraumatic stress disorder for Displaced Syrians. *American Journal of Psychiatry, 170,* 1396-1397. doi: https://doi.org/10.1176/appi.ajp.2013.13091249

Bowen, E. A., & Murshid, N. S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health*, *106*, 223–229. doi: https://doi.org/10.2105/AJPH.2015.302970

Brown, K. S., Jones, L. N., Nilsson, J. E., Russell, E. B., & Klevens C. L. (2006). The empowerment program: An application of an outreach program for refugee and immigrant women. *Journal of Mental Health Counseling, 28,* 38-47. doi: https://doi.org/10.17744/mehc.28.1.fmc2j3jw5xx1cvbf

Budosan, B., Benner, M. T., Abras, B., & Aziz, S. (2016). Evaluation of one mental health/psychosocial intervention for Syrian refugees in Turkey. *International NGO Journal, 11,* 12-19. Retrieved form http://www.academicjournals.org/journal/INGOJ/article-full-text-pdf/727C48058926

Bushak, L. (2016). *Refugees in America's healthcare system: How refugee families get the care they need to build new live.* Retrieved from http://www.medicaldaily.com/refugee-healthcare-371676

CARE. (2013). *Syrian refugees in urban Jordan*. Retrieved from http://www.care.org/syrian-refugees-urban-jordan

Centers for Disease Control and Prevention. (2013). *Immigrant and refugee health.* Retrieved from http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html

Center for Middle Eastern Strategic Studies. (2014). The situation of Syrian refugees in the neighboring countries: Findings, conclusions and recommendations. Retrieved from http://www.orsam.org.tr/files/Raporlar/rapor189/189eng.pdf

Charles, L., & Denman, K. (2013). Syrian and Palestinian Syrian refugees in Lebanon: The plight of women and children. *Journal of International Women's Studies, 14*, 96-111.

Cultural Orientation Resource Center. (2014, November). *Refugees from Syria.* Retrieved from http://www.culturalorientation.net/library/publications

DeJong, J., Sbeity, F., Schlecht, J., Harfouche, M., Yamout, R., Fouad, F., . . . Robinson, C. (2017). Young lives disrupted: Gender and well-being among adolescent Syrian refugees in Lebanon. *Conflict and Health, 11*, 25-34. doi: https://doi.org/10.1186/s13031-017-0128-7

Dewachi, O., Skelton, M., Nguyen, V. K., Fouad, F. M., Sitta, G. A., Maasri, Z., & Giacaman, R. (2014). Changing therapeutic geographies of the Iraqi and Syrian wars. *The Lancet, 383,* 449-457. doi: https://doi.org/10.1016/S0140-6736(13)62299-0

Dwairy, M. (2006). *Counseling and Psychotherapy with Arabs and Muslims: A Culturally Sensitive Approach.* Teachers College Press, New York: NY.

El Chammay, R. E., Kheir, W., & Alaouie, H. (2013). *Assessment of mental health and psychosocial support services for Syrian refugees in Lebanon.* Retrieved from http://data.unhcr.org/syrianrefugees/download.php?id=4575

Ferris, E., & Kirişci, K. (2015). *What Turkey's open-door policy means for Syrian refugees.* Retrieved from http://www.brookings.edu/blogs/order-from-chaos/posts/2015/07/08-turkey-syrian-refugees-kirisci-ferris

Fitzsimons, S., & Fuller, R. (2002). Empowerment and its implications for clinical practice in mental health: A review. *Journal of Mental Health, 11,* 481-499. doi: https://doi.org/10.1080/09638230020023

Gale, P. (2004). The refugee crisis and fear: populist politics and media discourse. *Journal of Sociology*, *40*, 321-340. doi: https://doi.org/10.1177/1440783304048378

Gabiam, N. (2016). Humanitarianism, development, and security in the 21st century: Lessons from the Syrian refugee crisis. *International Journal of Middle East Studies, 48*, 382-386. doi: https://doi.org/10.1017/S0020743816000131

Harding, S., & Libal, K. (2012). Iraqi refugees and the humanitarian costs of the Iraq war: What role for social work?: Iraqi refugees and the humanitarian costs of the Iraq war. *International Journal of Social Welfare, 21,* 94-104. doi: https://doi.org/10.1111/j.1468-2397.2011.00780.x

Hassan, G., Kirmayer, L. J., Mekki- Berrada, A., Quosh, C., El Chammay, R., Deville-Stoetzel, J. B.,…Ventevogel, P. (2015). *Culture, context and the mental health and psychosocial wellbeing of Syrians: A review for mental health and psychosocial support staff working with Syrians affected by armed conflict*. Retrieved from http://www.unhcr.org/55f6b90f9.pdf

Hassan, G., Ventevogel, P., Jefee-Bahloul, H., Barkil-Oteo, A., & Kirmayer, L. J. (2016). Mental health and psychosocial wellbeing of Syrians affected by armed conflict.

Epidemiology and Psychiatric Sciences, 25, 129-141. doi: https://doi.org/10.1017/S2045796016000044

Hijazi, Z., & Weissbecker, I. (2015). *Syria Crisis: Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis.* Retrieved from http://internationalmedicalcorps.org/document.doc?id=526

Hollander, A. (2013). Social inequalities in mental health and mortality among refugees and other immigrants to Sweden-epidemiological studies of register data. *Global Health Action, 6,* 1-11. doi: https://doi.org/10.3402/gha.v6i0.21059

Human Rights Watch. (2015). *"When I picture my future, I see nothing": Barriers to education for Syrian refugee children in Turkey.* Retrieved from https://www.hrw.org/report/2015/11/08/when-i-picture-my-future-i-see-nothing/barriers-education-syrian-refugee-children

Hutchinson, M., & Dorsett, P. (2012). What does the literature say about resilience in refugee people? Implications for practice. *Journal of Social Inclusion, 3*, 55-78.

Jabbar, S. A., & Zaza, H. I. (2016). Evaluating a vocational training programme for women refugees at the Zaatari camp in Jordan: Women empowerment: A journey and not an output. *International Journal of Adolescence and Youth, 21*, 304-319. doi: https://doi.org/10.1080/02673843.2015.1077716

James, L., Sovcik, A., Garoff, F., & Abbasi, R. (2014). The mental health of Syrian refugee children and adolescents. *Forced Migration Review*, *47,* 42-44.

Jefee-Bahloul, H., & Khoshnood, K. (2014). Mental health research in the Syrian humanitarian crisis. *Frontiers in Public Health, 44*, 1-2. doi: https://doi.org/10.3389/fpubh.2014.00044

Jefee-Bahloul, H., Moustafa, M., Shebl, F. M., & Barkil-Oteo, A. (2014). Pilot assessment and survey of Syrian refugees' psychological stress and openness to referral for telepsychiatry (PASSPORT Study). *Telemed and E-Health*, *20,* 977-979. doi: https://doi.org/10.1089/tmj.2013.0373

Jefee-Bahloul, H., Barkil-Oteo, A., Pless-Mulloli, T., & Fouad, F. M. (2015). Mental health in the Syrian crisis: Beyond immediate relief. *The Lancet, 386,* 1531. doi: https://doi.org/10.1016/S0140-6736(15)00482-1

Jeon, W., Yoshioka, M., & Mollica, R. F. (2001). *Science of Refugee Mental Health: New Concepts and Methods.* Retrieved from http://hprt-cambridge.org/wp-content/uploads/2011/01/ScienceofRefugeeMentalHealth.pdf

Karipek, Y. Z. (2017). Asylum-seekers experience and acculturation: A study of Syrian-university students in Turkey. *Turkish Journal of Middle Eastern Studies, Special Issue,* 105-133.

Kim, I. (2016). Beyond trauma: Post-resettlement factors and mental health outcomes among Latino and Asian refugees in the United States. *Journal of Immigrant and Minority Health, 18,* 740-748. doi: https://doi.org/10.1007/s10903-015-0251-8

Lama, S., François, K., Marwan, Z., & Sami, R. (2016). Impact of the Syrian crisis on the hospitalization of Syrians in a psychiatric setting. *Community Mental Health Journal,52*, 84-93. doi: https://doi.org/10.1007/s10597-015-9891-3

Masterson, A. R., Usta, J., Gupta, J., & Ettinger, A. (2014). Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Women's Health, 14*, 1-8. doi: https://doi.org/10.1186/1472-6874-14-25

Mertens, D. M. (2012). Transformative mixed methods: Addressing inequities. American *Behavioral Scientist, 56,* 802-813. doi: https://doi.org/10.1177/0002764211433797

Migration Policy Institute. (2017). *Trump Executive Order on Refugees and Travel Ban: A Brief Review.* Retrieved from http://www.migrationpolicy.org/research/trump-executive-order-refugees-and-travel-ban-brief-review

Mollica, R., & McDonald, L. (2002). Refugees and mental health: Old stereotypes, new realities. *UN Chronicle, 39,* 29-30.

Moustafa, M. (2015). Telepsychiatry and mental health care for Syrian refugees in Turkey (Order No. 3717905). Available from ProQuest Dissertations & Theses Global (1711728428). Retrieved from https://elischolar.library.yale.edu/cgi/viewcontent.cgi?article=2002&context=ymtdl

MSYD. (2017). *Geçici koruma altındaki yabancıların eğitim hizmetlerine erişimleri önündeki engeller ve bunların okullaşma oranlarına yansımaları(Ankara örneği)* [Educational access for children in Ankara Syrian school]. Retrieved from http://msyd.org/2017/12/14/ankara-suriyeli-okul-cagindaki-cocuklarin-egitim-erisimi/

Nazzal, K. H., Forghany, M., Geevarughese, M. C., Mahmoodi, V., & Wong, J. (2014). An innovative community-oriented approach to prevention and early intervention with refugees in the United States. *Psychological Services, 11,* 477-485. doi: https://doi.org/10.1037/a0037964

Nelson, J. A. (2008). Tele-mental health: Advancements and opportunities. *Home Health Care Management & Practice, 21*, 70-71. doi: https://doi.org/10.1177/1084822308322285

Newman, E., & Selm, J. V. (2003). *Refugees and forced displacement: International security, human vulnerability, and the state.* Tokyo, Japan: United Nations University Press.

Office of Refugee Resettlement. (2016). *Office of Refugee Settlement.* Retrieved from http://www.acf.hhs.gov/programs/orr/

Pace, M., Al-Obaydi, S., Nourian, M. M., & Kamimura, A. (2015). Health services for refugees in the United States: Policies and recommendations. *Public Policy and Administrative Research, 5*, 63-68.

Patton, G., Sawyer, S., Santelli, J., Ross, D., Afifi, R., Allen, N., . . . Viner, R. (2016). Our future: A lancet commission on adolescent health and wellbeing. *Lancet, 387,* 2423-2478. doi: https://doi.org/10.1016/S0140-6736(16)00579-1

Sami, S., Williams, H. A., Krause, S., Onyango, M. A., Burton, A., & Tomczyk, B. (2014). Responding to the Syrian crisis: The needs of women and girls. *Lancet, 383,* 1179-1181. doi: https://doi.org/10.1016/S0140-6736(13)62034-6

Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Reed Meldrum, C. D. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science and Medicine, 75,* 2437-2445. doi: https://doi.org/10.1016/j.socscimed.2012.09.023

Silove, D. (2004). The challenges facing mental health programs for post-conflict and refugee communities. *Prehospital and Disaster Medicine, 19,* 90-96. doi: https://doi.org/10.1017/S1049023X00001539

Skran, C., & Daughtry C. N. (2007). The study of refugees before "refugee studies". *Refugee Survey Quarterly, 26,* 15-35. doi: https://doi.org/10.1093/rsq/hdi0240

Spiegel, P., & Rubenstein, L. (2017). The academic case for repealing trump's refugee and travel ban. *The Lancet, 389*, 679-680. doi: https://doi.org/10.1016/S0140-6736(17)30332-X

Stein, B. N. (1986). The experience of being a refugee: Insights from the research literature. In C. L. Williams & J. Westermeyer (Eds.), *The series in clinical and community psychology. Refugee mental health in resettlement countries* (pp. 5-23). Washington, DC, US: Hemisphere Publishing Corp.

The White House. (2017). *Executive Order: Protecting the nation from foreign terrorist entry into The United States.* Retrieved from https://www.whitehouse.gov/presidential-actions/executive-order-protecting-nation-foreign-terrorist-entry-united-states/

United States Congress House. (2015). *Admitting Syrian refugees: The intelligence void and the emerging homeland security threat.* Retrieved from https://www.gpo.gov/fdsys/pkg/CHRG-114hhrg96168/pdf/CHRG-114hhrg96168.pdf

U.S. Department of State. (2015). *New U.S. Humanitarian Assistance to Respond to Syria Crisis.* Retrieved from http://www.state.gov/r/pa/prs/ps/2015/09/247115.htm

UNFPA. (2014). *Situation analysis of youth in Lebanon affected by the Syrian crisis.* Retrieved from http://www.unfpa.org.lb/Documents/Situation-Analysis-of-the-Youth-in-Lebanon-Affecte.aspx

United Nations High Commissioner for Refugees [UNHCR]. (2013). *In Lebanon, Syrian refugees resort to 'survival sex'*. Retrieved from http://www.unhcr.org/cgi-bin/texis/vtx/refdaily?pass=52fc6fbd5&id=51f8a31a5

UNHCR. (2014a). *Asylum Trends, First half 2014*. Retrieved from http://www.unhcr.org/5423f9699.html

UNHCR. (2014b). *Assessment of mental health and psychosocial support needs of displaced Syrian in Jordan.* Retrieved from https://data.unhcr.org/syrianrefugees/download.php?id=6650

UNHCR. (2015). *2015 UNHCR country operations profile – Turkey.* Retrieved from http://www.unhcr.org/pages/49e48e0fa7f.html

UNHCR. (2017). *Syria regional refugee response.* Retrieved from http://data.unhcr.org/syrianrefugees/regional.php

UNICEF. (2014). *No lost generation: Protecting the futures of children affected by the crisis in Syria.* Retrieved from https://www.unicef.org/appeals/files/No_Lost_Generation_Strategic_Overview__January_2014.pdf

USAID. (2017). *Syria complex emergency – Fact sheet #5.* Retrieved from https://www.usaid.gov/crisis/syria/fy17/fs05

Weinstein, N., Khabbaz, F., & Legate, N. (2016). Enhancing need satisfaction to reduce psychological distress in Syrian refugees. *Journal of Consulting and Clinical Psychology, 84,* 645-650. doi: https://doi.org/10.1037/ccp0000095

Welsh, T. (2015, November 20). 8 facts about the U.S. program to resettle Syrian refugees. *The U.S. News.* Retrieved from http://www.usnews.com/news/articles/2015/11/20/8-facts-about-the-us-program-to-resettle-syrian-refugees

WHO. (2015). *World Health Organization Syrian Arab Republic.* Retrieved from http://applications.emro.who.int/dsaf/EMROPUB_2015_EN_1876.pdf?ua=1

Williams, M. E., & Thompson, S. C. (2011). The use of community-based interventions in reducing morbidity from the psychological impact of conflict-related trauma among refugee populations: A systematic review of the literature. *Journal of Immigrant and Minority Health, 13,* 780-794. doi: https://doi.org/10.1007/s10903-010-9417-6

Zetter, R., & Ruaudel, H. (2014). Development and protection challenges of the Syrian refugee crisis. *Forced Migration Review*, *47,* 6-10.

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Assessing Refugee Poverty Using Capabilities Versus Commodities: The Case of Afghans in Iran

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Abstract: *This study is among the first to calculate poverty among one of the world's largest refugee populations, Afghans in Iran. More importantly, it is one of the first to use capability and monetary approaches to provide a comprehensive perspective on Afghan refugees' poverty. We estimated poverty using data collected from a sample of 2,034 refugee households in 2011 in Iran. We utilized basic needs poverty lines and the World Bank's absolute international poverty line for our monetary poverty analyses and the global Multidimensional Poverty Index (MPI) for our capability analyses of poverty. Findings show that nearly half of the Afghan households were income-poor, approximately two percent of the households had less than USD 1.25 per person per day, and about 28% of the surveyed households were multidimensionally deprived. Results suggest that 60% of the income-poor households were not deprived from minimal education, health, and standards of living based on the MPI criteria, and about 32% of the multidimensionally deprived households were not income-poor. These findings call for more attention to poverty measurement methods, specifically for social workers and policy makers in the field, to gain a more realistic understanding about refugees' wellbeing.*

Keywords: *Refugee, multidimensional poverty, absolute poverty, income poverty*

According to the United States Council on Foreign Relations (2017), currently 28 conflicts are ongoing around the world, none of which are being resolved. These ongoing and unresolved conflicts are one of the main reasons that the population of forcibly displaced individuals rose to the record high number of 65.6 million in 2016 (United Nations High Commissioner for Refugees [UNHCR], 2017a). This means that one in every 113 people on the planet was either an internally displaced person (IDP), an asylum seeker, or a refugee by the end of 2016 (UNHCR, 2017a).

Refugees are forcibly displaced people who have crossed an international border based on a well-founded fear of persecution and sought protection in another country (UNHCR, 2010). For this population, leaving home countries is usually abrupt and unplanned, as the majority flee war or conflict-affected areas (UNHCR, 2017a). This abrupt and unplanned departure frequently leaves refugees with limited social and physical assets and places them at high risk of poverty (Jacobsen, 2005). Adding to this risk, most refugees can only afford to escape to neighboring countries (Jacobsen, 2005); consequently, an overwhelming majority (84%) live in developing countries with limited resources (UNHCR, 2017a). The combined lack of physical and social assets and limited resources in host countries puts refugees in vulnerable positions and prone to experience multiple

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deprivations. While studies on refugees' poverty are scarce, they affirm high rates of poverty among some groups of refugees (Alloush, Gonzalez, Gupta, Rojas, & Taylor, 2016; Chaaban, Seyfert, Salti, & El Makkaoui, 2013; Hejoj, 2007; Khawaja, 2003).

This study aims to measure poverty and deprivation among one of the world's largest refugee populations, Afghans in Iran. More specifically, this study aims to answer two research questions:

1. What are the poverty rates of Afghan refugees in Iran?
2. How do these poverty rates vary by the households' demographic characteristics?

To provide a comprehensive answer to the first question, this study utilizes both the capability and monetary approaches in poverty measurement. The study utilizes basic needs poverty lines and the World Bank's absolute international poverty line for the monetary poverty analyses and the global Multidimensional Poverty Index for the capability analyses of poverty. To answer the second question, this study assesses poverty rates by age, gender, and occupational status of the head of Afghan refugee households and by households' refugee status and dwelling types in Iran.

State of Knowledge on Refugee Poverty

Limited studies have been conducted on refugee poverty, particularly in developing countries. Among the published studies in this field, the monetary approach to poverty is more common and studies with the capability approach are scarce. The literature on refugee poverty in general will be presented first, followed by the literature on poverty among Afghan refugees in Iran. Moreover, since the focus of this study is on Afghan refugees who live in Iran as a temporary host country, only literature relevant to refugee poverty in temporary host countries will be reviewed. The countries that refugees first arrive to in search of safety and protection are known as temporary host countries. Refugees in these countries generally receive temporary protection until they find a durable solution for their displacement. According to the UNHCR, and based on the 1951 Convention Relating to the Status of Refugees, three categories of durable solutions exist: 1) voluntary repatriation to the country of origin, 2) local integration in the temporary host country, and 3) resettlement in a new country (UNHCR, 2010, 2017b).

Among the studies that we retrieved on refugee poverty in temporary host countries is a study by Khawaja (2003) in Jordan. In this study, 60% of the refugees who were surveyed in 12 refugee camps said they did not have enough money to make ends meet. Approximately 27% of the respondents to the same survey reported income that was below 50% of the income they said they needed. Also in Jordan, another study found that 41.8% of surveyed Palestinian refugees in two camps lived below a poverty line set at 50% of the median self-reported needed income (Hejoj, 2007). Chaaban and colleagues (2013) found that 27% of refugees in Lebanon were poor based on basic needs poverty lines, and 40% were multidimensionally poor based on the capability approach and the authors' index capturing refugees' health, food security, adequate education, access to stable employment, decent housing, and possession of essential household assets. Income poverty rates for Syrian refugees were 90% in Jordan and 70% in Lebanon based on the respective national

poverty lines (UNHCR, 2016). In a study among 545 households in three Congolese refugee camps in Rwanda, income poverty ranged between 73% and 76% and multidimensional poverty, based on the global Multidimensional Poverty Index, ranged between 22% and 47% (Alloush et al., 2016).

The above-identified studies associated refugees' poverty with place of residence, years of residence in host countries, household sizes, age groups, education levels, and employment of the head of the households. Lower poverty rates were reported for refugees living in urban and rural areas (Alloush et al., 2016; Jacobsen, 2005), longer periods of residency in host countries (Khawaja, 2003), higher levels of education (Hejoj, 2007; Khawaja, 2003), and households with an employed household head (Hejoj, 2007). Reported poverty rates were higher among refugees aged 60 and older (Hejoj, 2007), those in retirement ages (Khawaja, 2003), those living in refugee camps or settlements (Alloush et al., 2016), and households with six or more children (Hejoj, 2007).

Despite the large population of Afghan refugees in Iran, we found no previous study on Afghan refugees' poverty in this country. According to the UNHCR latest global trend report, one in every nine refugees worldwide is from Afghanistan and around 40% of this population resides in Iran (UNHCR, 2017a). Lack of information and the political sensitivity of the topic for the Iranian government could be among the reasons for the absence of studies in this field (Tober, 2007). While lack of information is a major problem, the limited available reports and studies on Afghan refugees indicate the existence of deprivation in different aspects of refugees' lives, specifically in health and education. Among the reported health concerns for Afghan refugees in Iran are high child mortality rates and malnourishment. A study on Afghan refugees who lived on the border of Iran, Afghanistan, and Pakistan reported a 50% death rate for children under the age of five (Poureslami, MacLean, Spiegel, & Yassi, 2013). Another study on Afghan refugees in the Pakdasht area in Iran indicated that 11% of the Afghan children under the age of five were underweight and 8.5% were stunted in physical growth (Abdollahi et al., 2015). A more recent study on Afghan refugees in Tehran and Mashhad cities showed that over 60% of the surveyed households suffered from moderate to severe food insecurity (Omidvar, Ghazi-Tabatabie, Sadeghi, Mohammadi, & Abbasi-Shavazi, 2013). Moreover, studies on Afghan refugees in Iran indicated low levels of education among this population. Adelkhah and Olszewska (2007) reported that only 33% of the school-aged Afghan children were enrolled in schools in 1998 and Garakani (2009) reported that only 55% of the newly-arrived adult Afghans in Iran were literate in 2002.

The preceding review on the state of knowledge on refugee poverty has demonstrated high rates of poverty among surveyed refugee groups, which calls for further investigations and poverty research among understudied refugee populations, like Afghans in Iran. Moreover, these studies showed that different poverty measurement methods may yield different poverty rates among the same population, which highlights the need for more comprehensive approaches in poverty assessments.

Conceptual Frameworks

The conceptual models of the study are grounded in the monetary and capability approaches to poverty and deprivation. These two approaches underlie the definition of the outcome variable of the study, poverty rates.

Monetary Approach to Poverty

The monetary approach to poverty is the most commonly used method for poverty calculations (Laderchi, Saith, & Stewart, 2003). In this approach, a specific amount of money, the poverty line, separates poor from non-poor individuals or groups (Laderchi et al., 2003). This approach was introduced by pioneers like Booth (1887) and Rowntree (1901) in the 19th and early 20th centuries and has remained the most convenient method for researchers, as it relies on widely available data on households' or individuals' expenditures or income (Laderchi et al., 2003).

In the monetary approach, different techniques are used to construct poverty lines. The most commonly used approach is *the cost of basic needs* (Haughton & Khandker, 2009). In this approach, the poverty line is set at the estimated cost of acquiring adequate nutrition and essentials of living, such as clothing and shelter (Haughton & Khandker, 2009). Another widely used technique to define a poverty line with this approach is asking people what is the minimum amount of income needed to make ends meet? The answer defines a *subjective poverty line* (Haughton & Khandker, 2009). The third commonly used poverty line in this approach is the *absolute international poverty line* calculated by the World Bank based on the minimum cost of essentials of living, which allows a cross-country comparison of poverty (Haughton & Khandker, 2009). In this study, we use the cost of basic needs poverty lines and the World Bank absolute international poverty line for our monetary poverty analyses.

Although the monetary approach to poverty is the most commonly used method for poverty calculations, it has at least two major limitations associated with using money as a proxy to quantify deprivation. One of the main limitations is the flawed assumption of constant purchasing power of money over time and in different locations (Abu-Ismail, El-Laithy, Armanious, Ramadan, & Khawaja, 2015). Defined monetary poverty lines are not constantly adjusted to take account of fluctuating exchange rates and inflation rates. Another important limitation of the monetary approach to poverty is the assumption that a specific amount of money necessarily equals fulfillment of specific needs. For instance, a household that can afford primary schooling for children, but neglects it, or a household that has enough money for health care, but does not have access to it, is not identified as poor or deprived using the monetary approach to poverty. However, children of the first household are deprived of education and members of the second are deprived of primary health care.

Capability Approach to Poverty

In the 1980s, the capability approach to poverty was introduced as a response to the above-discussed gaps in the monetary approach (Laderchi et al., 2003). The capability approach was first presented in its modern context by the Nobel Prize winner in economics,

Amartya Sen (Robeyns, 2005). Sen (Sen & Honderich, 1985; Sen, 1988, 1999, 2000) pioneered the capability approach and his work was further advanced later by Martha Nussbaum (Nussbaum, 1992, 2000, 2003). The capability approach explores the ability of individuals or groups to do what they want to and be what they want (functioning), based on their available opportunities and freedom instead of their amount of assets (income) owned (Robeyns, 2005). This approach argues that wellbeing is about opportunities that individuals or groups have to live the lives that they have reasons to value (Robeyns, 2005). Such opportunities could vary among different people in different societies and could be affected by social values, cultural factors, social class, societal conventions, and customs (Clark, 2005). Therefore, this approach fits well with the prominent person-in-environment framework in the social work profession. Like the capability approach, the person-in-environment perspective highlights the importance of understanding individuals and their behaviors in relation with their environment and discusses that people's lives are shaped and have meaning within their social structures (Cornell, 2006).

The capability framework as defined by Sen is flexible, without a fixed list of capabilities (Clark, 2005). However, during the past decades, several researchers have tried to define a list of capabilities for this approach to create an index (Laderchi et al., 2003). Among the more popular indices based on this approach is the Human Development Index (HDI, Robeyns, 2005). The HDI measures life expectancy at birth, adult literacy, educational enrollment, and per capita income (Robeyns, 2005). The United Nations Development Programme (UNDP) has utilized the HDI in its annual human development reports to assess welfare in different countries since 1990 (Robeyns, 2005). However, since 2010, the HDI has been replaced in the annual human development reports with the global Multidimensional Poverty Index (MPI) as a more comprehensive index (UNDP, n.d.). The MPI was designed by Alkire and Santos (2010) at the Oxford Poverty and Human Development Initiative (OPHI) with the financial support of the UNDP (OPHI, n.d.). This index measures deprivation in three dimensions: education, health, and standard of living through 10 indicators (Table 1). Table 1 summarizes this index based on the UNDP technical notes on MPI (Jahan et al., 2015). In this study, we use the MPI for our poverty analyses based on the capability approach.

Variables

Poverty is the outcome variable of the study, and, as discussed, it is defined by the capability and the monetary approaches. Besides estimating the average poverty rates based on these two approaches, this study explores how poverty rates vary based on age, sex, and occupational status of the head of the households and households' refugee status and dwelling types. In this study the outcome variables, poverty rates, are continuous (ranging from 0% to 100%), and households' socioeconomic and demographic characteristics, as independent variables, are categorical.

Age, as the first independent variable of the study, has four age categories of household heads: adolescent (under the age of 18), young adult (ages 18-35), middle-aged adult (ages 36-59), and older adult (ages 60 and over). Biological sex of the heads of the households, as the second independent variable of this study, has two categories, female-headed and male-headed. Occupational status, as the next independent variable of the study,

categorizes heads of households into two categories: employed with a paid job and unemployed (including unemployed individuals who are looking for a job, students, housewives, and those who listed their occupation status as others). Refugee status of the households, as the fourth independent variable in this study, classifies households into two categories: documented and undocumented. Refugees in Iran are documented if they hold valid documentation issued by the Iranian government and they are undocumented if they don't have such a document (Koepke, 2011). If the household head is documented it usually means that all the household members are documented, as refugee documentation cards are issued for a household as a unit in Iran. Dwelling type is the last independent variable in this study and classifies households into four categories: households living in urban areas, rural areas, settlements, and colonies. Settlements are government-run camps, which are usually located in remote areas and far from main cities. Refugees in settlements have access to some humanitarian assistance like free sanitary materials and food items, but usually have limited access to livelihood opportunities due to the remoteness of the camp locations. Colonies usually consist of extended Afghan family members or tribal members who live together in the form of a group. Colonies are usually located on the outskirts of refugee-populated cities.

Table 1. *Dimensions, Indicators, Deprivation Thresholds and Weights of the MPI*

Dimension	Indicator	Deprived if…	Relative Weight
Education	School attainment	No household member has completed at least six years of schooling	16.7%
	School attendance	A school-age child (up to grade 8) is not attending school[1]	16.7%
Health	Nutrition	A household member (for whom there is nutrition information) is malnourished, as measured by the body mass index for adults (women ages 15-49 in most of the surveys) and by the height-for-age z-score calculated based on World Health Organization standards for children under age of five	16.7%
	Child mortality	A child has died in the household within the five years prior to the survey[2]	16.7%
Standard of living	Electricity	Not having access to electricity	5.6%
	Drinking water	Not having access to clean drinking water or having access to clean drinking water through a source that is located 30 minutes away or more by walking	5.6%
	Sanitation	Not having access to improved sanitation facilities or having access only to shared improved sanitation facilities[3]	5.6%
	Cooking fuel	Using "dirty" cooking fuel (dung, wood or charcoal)	5.6%
	Flooring	Having a home with dirt, sand or dung floor	5.6%
	Assets	Not having at least one asset related to access to information[4] and not having at least one asset related to mobility[5] or at least one asset related to livelihood[6]	5.6%

[1] In order to avoid a mismatch between age of the child and beginning of the school year, a late enrollment for a period of up to 12 months was allowed.
[2] In case that a survey fails to track time of death of a child, any death reported by mother (age 35 and younger) is considered.
[3] Definitions for drinking water and improved sanitation are extracted from the Millennium Development Goals.
[4] Including radio, television or telephone (both landline and mobile telephones).
[5] Including bike, motorbike, car, truck, animal cart or motorboat.
[6] Including refrigerator, any size of land usable for agriculture, or livestock comprising of a horse, a head of cattle, two goats, two sheep or 10 chickens

Source: Jahan et al. (2015).

Data Analyses

Afghan refugee households' poverty rates based on the monetary approach were calculated using the cost of basic needs poverty lines and the World Bank absolute international poverty line. In this study, we refer to the former as the income poverty rate and the latter as the absolute poverty rate. Income poverty rates were calculated by comparing Afghan refugee households' monthly income with the related cost of basic needs poverty lines in Iran. Refugee households' monthly income was calculated based on the sum of the households' monthly expenditures on food, clothing, health, education, tobacco, transportation, communication, housing, and energy, plus monthly savings. This calculated income was compared with the basic needs poverty lines that are adjusted for inflation from Ghaedi's (2010) study. A household was categorized as income-poor if the calculated monthly income was less than the basic needs poverty line for its household size.

Afghan refugees' absolute poverty rate was calculated based on a comparison of daily individual incomes with the World Bank absolute international poverty line, which was USD 1.25 per day per person at 2011 purchasing power parity (Haughton & Khandker, 2009). Daily individual incomes were calculated by dividing households' monthly income by the number of household members and an average of 30 days in one month.

Afghan refugee households' poverty based on the capability approach was calculated using the global Multidimensional Poverty Index (MPI). In this study, we refer to the poverty rate calculated based on this method as the multidimensional poverty rate. As noted earlier, the MPI consists of three dimensions and ten indicators. According to this index, a household is deprived in the first dimension, education, if none of the members have completed at least six years of schooling, or if any school-aged child (up to eighth grade) is out of school (Jahan et al., 2015). In the second dimension of MPI, health, a household is deprived if any child has died within the five years prior to the survey, or any member is malnourished (Jahan et al., 2015). In the present study, data on child deaths were collected for the year prior to the survey. The MPI measures malnutrition based on the body mass index for adults aged between 15 to 49 and the z score for height to age for children below the age of five (Jahan et al., 2015). However, due to limitations of the dataset in this study, malnutrition was calculated based on the minimum food expenditure required for purchasing adequate monthly calories per adult (ages 15 and above). Food acquisition and amount of money spent to purchase food could be a proxy indicator for nutrition (Thorne-Lyman et al., 2009; Pinstrup-Andersen, & Herforth, 2008; Zezza, Carletto, Fiedler, Gennari, & Jolliffe, 2017).

Minimum required food expenditures were extracted from Khodadad-Kashi and Heidari's (2009) study. Those researchers calculated minimum monthly required food expenditures in urban and rural areas for 2,179 calories per day, which represents an average Iranian diet according to Pajouyan's study (as cited in Khodadad-Kashi & Heidari, 2009). For the present study, these estimated minimum required food expenditures were adjusted with the Central Bank of Iran's (n.d.) reported inflation rates for food and beverages in 2009 (30.2%), 2010 (9.9%), and 2011 (16.6%), resulting in minimum required food expenditures of IRR 641,605 in urban areas and IRR 530,018 in rural areas. Per capita

food expenditures were compared with these two numbers. To calculate the per capita food expenditures, households' spending on food was divided by a weighted number of adults in the family (score 1 for members aged 15 or above, score 0.5 for members between the ages of 2 and 15, and score .25 for members under the age of 2). Households living in settlements were excluded from malnutrition analyses as they receive food baskets from the World Food Programme in Iran (World Food Programme, 2017).

A household is deprived in the third dimension of the MPI, standard of living, if it does not have access to electricity, clean drinking water, improved sanitation, if it has "dirty" cooking fuel, a home with a dirt floor, or lacks assets (Jahan et al., 2015). Households' assets in this method are related to access of information (radio, TV, land line telephone or mobile phone), mobility (bike, motorbike, car, truck, animal cart, motorboat), livelihood (refrigerator, any size arable land), or livestock (a horse, two goats, a head of cattle, two sheep, or 10 chickens) (Jahan et al., 2015).

According to the MPI definition, access to clean drinking water means water is available at the home or the source of clean drinking water is accessible within 30 minutes by walking (Jahan et al., 2015). Due to limitations of the dataset utilized, access to clean drinking water in this study was calculated based on the households' access to piped water at home. Moreover, according to MPI definition, unimproved sanitation includes using public or shared toilets or use of unacceptable privacy types (United Nations, n.d.). Since information about quality of facilities was not available in the selected dataset for this study, only households who shared a toilet or latrine were considered as deprived in this area. Furthermore, due to limitations of the dataset and lack of information about house flooring, this indicator of the MPI (home with a dirt floor) was excluded from calculation.

Using Stata version 14 (StataCorp, 2015), for each household in the dataset, a score of 1 was assigned to each of the MPI indicators if that household was deprived in that area, and 0 was assigned if that household was not deprived in that area. For instance, if none of the members of a household had completed at least six years of schooling, a score of 1 was assigned to the first indicator of the MPI in the education dimension and if at least one member of a household had completed at least six years of schooling, a score of 0 was assigned to this indicator.

In accordance with the MPI definition, the three dimensions of education, health, and standard of living were equally weighted as 1/3 or 0.33. All indicators within each dimension were also equally weighted. This means that each one of the two indicators in the first and the second dimensions were weighted as 1/6 (1/3 ÷ 2) or 16.7%. For the third dimension (standard of living), only five out of the six indicators were weighted, as information about house flooring was not available in the utilized dataset. Therefore, each one of the five indicators was weighted equally as 1/15 (1/3 ÷ 5) or 6.7%. For each household, the deprivation score was calculated by summing the weighted indicators. In accordance with the MPI definition, a household was categorized as multidimensionally poor if the calculated deprivation score was 33.3% or greater.

Results

Demographic Characteristics

The demographic characteristics of the head of the households are shown in Table 2. As seen, the vast majority of households were headed by young (ages 18-35) or middle-aged adults (ages 36-59). Female-headed households constituted a small portion of the sample, seven percent (142 households). Similarly, households with unemployed or undocumented heads had a smaller representation in the sample. Furthermore, nearly one-half of the households resided in urban areas, more than one-third resided in rural areas, and much smaller percentages lived in colonies and settlements.

Table 2. *Poverty Percentages by Demographic Characteristics of Head of Households*

Demographic Characteristic	Sample % (n)	Income Poverty	Absolute Poverty	Multidimensional Poverty
Age				
16-17	0.1% (2)	0% (0)	0% (0)	100% (2)
18-35	34.3% (697)	46.6% (325)	1.7% (12)	31.1% (217)
36-59	51.8% (1,054)	47.8% (506)	2.7% (28)	24.6% (261)
60+	13.8% (281)	44.1% (124)	2.1% (6)	30.6% (86)
Biological sex				
Male	93.0% (1,892)	46.0% (880)	2.1% (40)	27.2% (514)
Female	7.0% (142)	52.8% (75)	4.2% (6)	36.6% (52)
Occupational Status				
Employed	81.1% (1,649)	46.8% (771)	2.2% (36)	27.5% (454)
Unemployed	18.9% (385)	47.8% (184)	2.6% (10)	29.1% (112)
Refugee Status				
Documented	84.3% (1,715)	48.5% (832)	2.2% (37)	25.5% (437)
Undocumented	15.7% (319)	38.5% (123)	2.8% (9)	40.4% (129)
Dwelling Type				
Urban	46.0% (936)	71.8% (672)	1.6% (15)	36.0% (337)
Rural	36.9% (751)	20.5% (154)	2.4% (18)	20.2% (152)
Colony	9.5% (194)	13.9% (27)	0.5% (1)	26.8% (52)
Settlement	7.5% (153)	66.7% (102)	7.8% (12)	16.3% (25)

Research Question 1: Poverty Rates

The three different types of household poverty rates are shown in Table 3. As seen, nearly half of the surveyed households were income-poor, meaning they lived with an average monthly income level less than the basic needs poverty lines. However, only about two percent of the surveyed Afghan refugee households were living in absolute poverty, meaning living with less than USD 1.25 per day. Finally, about one-fourth of the surveyed households were multidimensionally poor, meaning they had a total deprivation score of 33% or higher.

Table 3. *Household Poverty Rates (n=2,034)*

Poverty Type	% (n)
Income poverty	47.0% (955)
Absolute poverty	2.3% (46)
Multidimensional poverty	27.8% (566)

Table 4 shows the percentage of households that were deprived on different indicators of the MPI broken down by the demographic characteristics of the head of the households. Access to electricity, the first indicator in standards of living, was not displayed in the table since in this study, 100% coverage and zero deprivation was considered for this indicator. As demonstrated in Table 4, the greatest deprivations were in the areas of nutrition and school attainment; over one-half of the households were at risk of malnutrition, and nearly half had no member (aged above 13) with at least six years of schooling. Nearly one-fifth of households did not have access to private bathrooms. The remaining indicators showed much less deprivation. Around 10% of the surveyed households had at least one school-aged child out of school; did not have access to clean cooking fuel; and/or did not have at least one of the assets relevant to access to information, mobility, livelihood, or livestock. Less than two percent of the households lacked access to piped water. Four households reported a death under the age of five within the year prior to the survey.

Among the different age groups, households headed by an adolescent or an older adult had the highest rates of deprivation across different indicators of the MPI. Households headed by an adolescent had the highest rates of deprivation in school attendance for children and access to sanitation, clean cooking fuel, and assets. Households headed by an older adult had the highest rates of malnutrition and child mortality, and the lowest rate of access to clean drinking water. Moreover, households headed by a female and an undocumented Afghan had the highest rates of deprivation in all, except one of the indicators, access to clean drinking water. Among the surveyed households, those headed by an unemployed individual had higher rates of deprivation in health dimension and standards of living. Furthermore, the highest rates of deprivation in the two indicators of education were observed among Afghans residing in colonies, the highest rates of deprivation in the two indicators of health were observed among Afghans residing in urban areas, and the highest rates of deprivation in the four indicators of standards of living (excluding electricity) were observed among Afghans residing in settlements.

There were substantial disparities within households across the three poverty measures. Around 60% (571) of the income-poor households were not multidimensionally poor. This percentage signifies that more than half of the households who had a monthly income below the income poverty lines in Iran had access to minimum education, health, or standards of living; in other words, their combined deprivation score in the three dimensions of MPI was higher than the multidimensional poverty threshold. Conversely, 32% (182) of the multidimensionally poor households were not income-poor. In other words, around one in every three households who were deprived from minimum education, health, and standards of living according to the MPI definition, had an income level higher than the income poverty lines in Iran. Moreover, 54% (25) of the refugee households who were in absolute poverty were not multidimensionally poor. This number demonstrates that over half of the refugees who did not have a minimum of USD 1.25 per day had access to minimum education, health, and standards of living according to the MPI definition. Furthermore, 27% (545) of the multidimensionally poor refugees were not in absolute poverty. Members of more than one in every four households, who were deprived from minimum education, health, and standards of living according to the MPI definition, had more than USD 1.25 per day.

Table 4. *Percentage of Households Deprived on MPI Indicators and Demographic Characteristics of Head of Households*

Demographic Characteristic	All % (n)	Edu 1[1] % (n)	Edu 2[2] % (n)	H 1[3] % (n)	H 2[4] % (n)	SR 2[5] % (n)	SR 3[6] % (n)	SR 4[7] % (n)	SR 5[8] % (n)
Age									
16-17	0.1% (2)	50% (1)	50% (1)	50% (1)	0% (0)	0% (0)	100% (2)	50% (1)	50% (1)
18-35	34.3% (697)	61% (424)	8.8% (61)	45% (310)	3% (2)	1.3% (9)	24% (165)	12% (80)	1.4% (10)
36-59	51.8% (1,054)	34% (354)	11% (114)	63% (659)	0.1% (1)	1.6% (17)	12% (131)	8.3% (87)	0.9% (10)
60+	13.8% (281)	42% (117)	8.9% (25)	64% (180)	0.4% (1)	2.1% (6)	21% (60)	14% (40)	4.3% (12)
Biological Sex									
Male	93.0% (1,892)	44% (826)	10% (183)	56% (1,064)	0.2% (3)	1.7% (32)	17% (318)	10% (187)	1.2% (23)
Female	7.0% (142)	49% (70)	13% (18)	61% (86)	0.7% (1)	0% (0)	28% (40)	15% (21)	7.0% (10)
Occupational Status									
Employed	81.1% (1,649)	45% (745)	11% (175)	55% (902)	0.2% (3)	1.9% (31)	17% (284)	10% (160)	1.3% (22)
Unemployed	18.9% (385)	39% (151)	6.7% (26)	64% (248)	0.3% (1)	0.3% (1)	19% (74)	13% (48)	2.8% (11)
Refugee Status									
Documented	84.3% (1,715)	40% (692)	9.0% (155)	56% (962)	0.1% (2)	1.5% (25)	17% (284)	11% (193)	1.6% (27)
Undocumented	15.7% (319)	64% (204)	14% (46)	59% (188)	0.6% (2)	2.2% (7)	23% (74)	4.7% (15)	1.9% (6)
Dwelling Type									
Urban	46.0% (936)	49% (456)	14% (126)	68% (635)	0.3% (3)	0.3% (4)	13% (117)	3.4% (32)	1.2% (11)
Rural	36.9% (751)	34% (254)	4.1% (31)	60% (451)	0.1% (1)	1.9% (14)	12% (87)	4.5% (34)	0.8% (6)
Colony	9.5% (194)	63% (122)	14% (28)	33% (64)	0% (0)	2.6% (5)	20% (39)	9.3% (18)	1.0% (2)
Settlement	7.5% (153)	42% (64)	11% (16)	0% (0)	0% (0)	6.5% (10)	75% (115)	81% (124)	9.2% (14)
Total % (n)	**100% (2,034)**	**44.1% (896)**	**9.9% (201)**	**57% (1,150)**	**0.2% (4)**	**1.6% (32)**	**17.6% (358)**	**10.2% (208)**	**1.62% (33)**

[1] School attainment: no household member has completed at least six years of schooling
[2] School attendance: a school-age child (up to grade 8) is not attending school
[3] Nutrition: household does not make minimum food expenditure required for purchasing adequate calories per person per day
[4] Child mortality: a child has died in the household within the year prior to the survey
[5] Drinking water: not having access to piped water
[6] Sanitation: not having access to a toilet or having access only to a shared toilet
[7] Cooking fuel: using a household energy source other than electricity, gas, or gasoline
[8] Assets: not having at least one asset related to access to information (telephone or desktop computer) or having at least one asset related to information but not having at least one asset related to mobility (motorbike, personal vehicle) or at least one asset related to livelihood (refrigerator)

More specifically, in regard to the MPI indicators, around 48% (432) of the households without a member with at least six years of schooling, around 33% (67) of the households with at least one out-of-school child, around 39% (446) of the households at risk of malnutrition, 25% (1) of the households with child mortality, about 34% (11) of the households without access to piped water, around 38% (137) of the households without access to a private toilet, 25% (51) of the households without access to clean cooking fuel, and 21% (7) of the households without access to adequate assets for living were not income-poor. These percentages underscore that, despite facing deprivations in the mentioned indicators of the MPI, these households held income levels above the income poverty lines in Iran. Additionally, less than 15% of the households deprived in any of the 10 indicators of the MPI were in absolute poverty, meaning that their members had less than USD 1.25 per day.

Research Question 2: Poverty Rates by Demographic Characteristics

The three poverty measures broken down by the previously-identified demographic characteristics are shown in Table 4. Income poverty and absolute poverty rates were highest among households headed by middle-aged (36-59) adults. In contrast, multidimensional poverty was somewhat lower among households with middle-aged heads, affecting about one-fourth of these households, compared to nearly one-third of the 18-35 and 60+ age groups. Among the youngest age group (consisting of only two households), neither was income- or absolute-poor, though both were multidimensionally poor.

Income poverty, absolute poverty, and multidimensional poverty rates were considerably higher among female-headed households compared to male-headed households. Households with employed and unemployed heads had similar rates of poverty on all three measures. Income poverty was ten percentage points lower among undocumented than documented refugees. Yet, the reverse was true for multidimensional poverty, being 15 percentage points higher among undocumented than documented refugees. The absolute poverty rate was similar for these two groups, around 2-3%.

Income poverty was far higher among households living in urban areas and settlements, compared to those in rural areas and colonies. Absolute poverty was much higher among those in settlements compared to the other three dwelling types, yet the reverse was true for multidimensional poverty, which was much lower among those in settlements than the other three dwelling types. Income and absolute poverty rates were the lowest among refugees living in colonies.

Discussion

Overall poverty rates were high among the surveyed Afghan refugee households in Iran. Around half of these households were income-poor and more than one-fourth were multidimensionally deprived. The absolute poverty rate was low (around 2.3%), yet this rate was considerably higher than reported absolute poverty rates in Iran of 0.3% in 2010 and 0.1% in 2013 (The World Bank, 2017). These high rates of poverty highlight the need

for further attention to poverty reduction strategies including humanitarian assistance in the short-term and investment in Afghan refugees' self-sufficiency in the long-term in Iran.

Findings show that income and absolute poverty rates were higher among households headed by middle-aged adults. One reason for this result in our sample could be the larger average family size of this group (mean= 6.2). Average family size among households headed by a middle-aged adult was more than twice the average family size of the two households headed by 16- and 17-year-old Afghans, 1.6 times larger than the households headed by young adults, and 1.1 times larger than the households headed by older adults. Although the basic needs poverty lines are higher for larger households, the per capita income levels could be lower as the total income is divided by a larger number of household members. Unlike income and absolute poverty rates, multidimensional poverty was the lowest among households headed by middle-aged adults, meaning that members of these households were less likely to be deprived in health, education, and standard of living.

All poverty rates were considerably higher in female-headed households compared to male-headed households, which demonstrates vulnerability of this group. Higher rates of poverty among female-headed households could be due to restrictions on access to the job market for female refugees in Iran. Refugees should apply for and purchase temporary work permits to be able to work in Iran (Giles, 2010; Koepke, 2011). Refugee men between the ages of 16 and 60 are eligible to apply for work permits through the Ministry of Labor in Iran (Koepke, 2011). Some refugee women (e.g. female household heads) can also apply for work permits, but the mainstream of Afghan women lack access to this document (Giles, 2010). Moreover, refugees in Iran can only work in specific fields, which are mainly menial occupations that are enumerated periodically by the Iranian Ministry of Labor (Barr & Sanei, 2013; Rajaee, 2000). These labor-intensive occupations automatically exclude female refugees from access to the legal job market in Iran.

In our survey, only 28% of the female household heads were working compared to 85% of the male household heads. Moreover, most Afghan women who had a job at the time of the interview (about 63%) had some level of skill and could be categorized as skilled workers such as nurse, teacher, tailor, and hairdresser. However, most of the employed men (about 54%) were unskilled workers, for instance, construction worker, guard, brick factory worker, greenhouse worker, animal husbandry worker, well digger, daily worker, and garbage collector. It seems that for women, having a skill made it more likely to find a job. A similar situation has been reported among repatriated refugees in Afghanistan (Nurani et al., 2006).

Households with employed and unemployed heads had similar poverty rates. Low-paying legal fields for refugees and lack of job security in Iran may explain this finding. Most of the legal fields of work for refugees in Iran are low-paid menial jobs. Additionally, refugees must pay for costly temporary work permits to be able to work in these low-paid menial fields. According to Koepke (2011), in March 2009, the average cost for a temporary work permit renewal was around USD 300 to USD 500. The high cost of temporary work permits forces a considerable number of refugees to turn to the informal job market in Iran, with lower pay and higher risks of job insecurity. Anecdotal data show that Afghans earn 12% to 20% less than Iranian workers in similar fields, despite working

an average of 10% longer hours per day (Abbasi-Shavazi, Glazebrook, Jamshidiha, Mahmoudian, & Sadeghi, 2008). Moreover, according to Abbasi-Shavazi and colleagues (2008), less than three percent of the Afghans who work in Iran have a written contract with their employer. In our sample, refugees were mainly involved in day labor jobs (28%), which are usually low-paying and labor-intensive with no job security.

Findings show that the multidimensional poverty rate was higher among undocumented than documented refugees (40.4% versus 25.5%). Undocumented Afghan refugees in Iran are subjected to arrest and deportation to Afghanistan (Koepke, 2011); consequently, they live in fear and might lack access to health, education, and standards of living due to their limited rights in the country. Despite this disadvantage, undocumented refugees in our sample had lower levels of income poverty. This could be explained by a younger average age of the heads of the undocumented households (39 years) compared to documented households (44 years). Younger refugees might be more successful in sustaining long hours of labor-intensive jobs. This could be one of the reasons that the average monthly income level was higher among undocumented refugees (approximately USD 635) compared to documented refugees (approximately USD 619) in our sample. Additionally, average household size was lower among undocumented refugees (about 4.9) compared to documented Afghan households (around 5.4) in our sample.

Income and absolute poverty rates were the lowest among refugees living in colonies. As discussed earlier, refugees who belong to one tribe usually live in colonies with close and extended family members and high levels of bonding (Koepke, 2011). The lower rates of poverty among Afghans living in colonies could be an indication that family and social support could help refugees find better livelihood opportunities and sustain income levels higher than the monetary poverty lines. Moreover, the multidimensional poverty rate was lowest among refugees who resided in settlements. This could be the result of access to food baskets in settlements that makes risk of malnourishment minimal among refugees in these settings in Iran. Despite low rates of multidimensional poverty, income and absolute poverty rates were high among refugees in settlements. As discussed, settlements in Iran are in remote areas; therefore, settlement residences have limited access to livelihood opportunities.

More than half of the income-poor households were not multidimensionally deprived, meaning that although they earned less than the required income for basic needs, they were able to fulfill minimum living requirements. Refugees' minimum living standard could be fulfilled despite low levels of income through humanitarian assistance, social support, and unofficial community credit systems. For instance, in our survey 82% of the income-poor refugees in settlements were not multidimensionally poor, which means that they had access to minimal standards of living despite low levels of income. As discussed earlier, refugees in settlements have access to some humanitarian assistance.

Findings also demonstrate that around one-third of the multidimensionally poor households were not income poor, meaning that members of these households were deprived from basic education, health, or standard of living despite reporting adequate income to meet their needs. Lack of access to education, health, or standards of living could be related to lack of information or structural barriers instead of lack of money. For

instance, in our sample refugees in colonies had the least amount of monetary poverty rates, yet more than half of the households had no adult member with at least six years of schooling and they had the highest rate of out-of-school children. As discussed earlier, colonies are usually located on the outskirts of cities, where access to schooling is limited. Moreover, colony refugees are less integrated within the Iranian society and might tend to place less value on education.

Limitations

The dataset for this study was collected in 2011, and the findings may not represent the current situation of Afghan refugees in Iran. However, to the extent of our knowledge this dataset is the largest and most current research-based dataset on Afghan refugees in Iran. Additionally, the utilized dataset in this study was collected by interviewers who were paid for completed questionnaires. Potential related ethical challenges associated with payment to interviewers for completed questionnaires were minimal, for the interviewers were selected from an elite group of Afghan refugees in order to ensure successful data collection. Moreover, all interviewers were informed that the collected data will be cross checked. The utilized dataset in this study was collected by interviewers who were both Afghan students and recipients of the Albert Einstein German Academic Refugee Initiative (DAFI) for pursuing university-level education in Iran. Furthermore, our crossed checked data, through 20 random phone call interviews with refugees who provided their contact information (close to 10% of the sample), showed no major discrepancies and affirmed acceptability of the collected data. Nevertheless, bias was observed in selection of Afghan communities by the interviewers, in that they mainly selected communities they were familiar with.

Furthermore, due to limitations of the dataset, child deaths were measured for the prior year instead of the prior five years; a proxy indicator was utilized to quantify malnutrition; and one indicator of the MPI, house flooring, was excluded. These modifications enabled the authors to calculate multidimensional poverty, but the computed rates might not be an exact representation of the official MPI. Moreover, we estimated the minimum food costs based on the adjusted findings of the study by Khodadad-Kashi and Heidari (2009) with inflation rates. Although this adjustment enabled us to calculate malnutrition among the surveyed households, adjusted costs with inflation rates might not be exactly representative of minimum food costs in 2011.

Conclusion and Implications

In the absence of a prior published study on Afghan refugees' poverty and potential deprivation in Iran, this study provides a baseline for future research and some basic information for policy makers and service providers. Knowledge regarding Afghan refugees' poverty rates can help social workers, who are front-line service providers for refugees, to advocate properly and mobilize required support for better service provision for this group. Moreover, findings in this study in addition to future research on refugees' welfare and poverty could be influential for social workers involved in advocacy and policy making. Such data can help plan short-term and long-term poverty reduction strategies. For instance, in case of lack of education and skills, long-term planning could influence human

capital, or in case of malnutrition among children, food assistance programs in schools or communities can prevent future health problems.

Additional studies, specifically longitudinal research, are needed; meanwhile, our findings demonstrate high rates of poverty among Afghan refugees in Iran. The income poverty rates show a need for further attention to Afghans' self-sufficiency and livelihood opportunities in Iran. Furthermore, high rates of deprivation in educational attainment indicate a need for awareness-raising on the importance of education among Afghans and call for further attention to structural barriers in access to education for this group. For this study, we calculated the malnutrition through a proxy indicator, but our findings demonstrate a need for further investigation in this field. Social workers can contribute to the body of literature in this field by data collection and more importantly through field-level research with Afghan refugees. They can also promote education among their Afghan refugee clients and advocate for refugees' access to livelihood opportunities, education, and health in Iran.

Findings in this study highlight higher rates of poverty and deprivations among female headed households, calling for further attention to this group. Female-headed households constitute a small percentage of our sample, showing that they could be hard to reach. Both aspects, vulnerability and being hard to reach, should be considered in resource allocation and service provision by social workers. Therefore, priority should be given to female headed households in direct service provision and outreach programs.

Moreover, findings in this study illustrate high rates of poverty and deprivation even among households with an employed head. Social workers should advocate for refugees' rights in the Iranian labor market, specifically for their access to job security and minimum wage. Refugees could secure more sustainable jobs with higher incomes if they are provided free trainings in skills required in the Iranian labor market. A secure job and access to minimum wage could also enhance refugees' access to health and education.

More importantly, our findings highlight some of the shortcomings of monetary poverty assessments in capturing deprivations that Afghan refugee households might experience. Despite income levels higher than the basic needs poverty lines or the absolute poverty line, a considerable number of Afghan refugee households in our sample were not able to fulfill minimum education, nutrition, and standards of living for their members. For instance, undocumented refugees in our sample were less likely than documented refugees to be income poor, but they were experiencing considerably higher rates of multidimensional poverty. Monetary methods could overlook deprivations experienced by the most vulnerable groups, as income and absolute poverty measures failed to capture multiple deprivations of the undocumented Afghans in this study. Considering the popularity of monetary poverty assessment methods, service providers, specifically, social workers, should be more careful in interpreting poverty rates. Lack of poverty based on monetary poverty methods only shows income levels above the set poverty lines and should not be interpreted as lack of deprivations. For deprivation analyses and more comprehensive poverty assessments, service providers should listen to refugees and consider the deprivations identified by their clients, and more comprehensive indices like the MPI should also be utilized.

References

Abbasi-Shavazi, M., Glazebrook, D., Jamshidiha, G., Mahmoudian, H., & Sadeghi, R. (2008). *Second-generation Afghans in Iran: Integration, identity and return*. Kabul, Afghanistan: Afghanistan Research and Evaluation Unit. Retrieved from https://areu.org.af/wp-content/uploads/2016/01/823E-Second-Generation-Afghans-in-Iran-CS-2008.pdf

Abdollahi, M., Abdollahi, Z., Sheikholeslam, R., Kalantari, N., Kavehi, Z., & Neyestani, T. R. (2015). High occurrence of food insecurity among urban Afghan refugees in Pakdasht, Iran 2008: A cross-sectional study. *Ecology of Food and Nutrition, 54*(3), 187-199. doi: https://doi.org/10.1080/03670244.2013.834819

Abu-Ismail, K., El-Laithy, H., Armanious, D., Ramadan, M., & Khawaja, M. (2015). *Multidimensional poverty index for middle income countries.* New York, NY: United Nations. Retrieved from https://www.un.org/development/desa/dspd/wp-content/uploads/sites/22/2017/04/multidimensional-poverty-index-jordan-iraq-morocco-en.pdf

Adelkhah, F., & Olszewska, Z. (2007). The Iranian Afghans. *Iranian Studies, 40*(2), 137-165. doi: https://doi.org/10.1080/00210860701269519

Ahmadinejad, M. (2011). *Multidimensional poverty and inequality among Afghan refugees: The case of Afghan refugees residing in selected areas of Iran* (Unpublished master's thesis). Alzahra University, Tehran, Iran.

Alkire, S., & Santos, M. E. (2010). Acute multidimensional poverty: A new index for developing countries. *Oxford Poverty & Human Development Initiative (OPHI) Working Paper No. 38*, University of Oxford. Retrieved from http://www.ophi.org.uk/acute-multidimensional-poverty-a-new-index-for-developing-countries/

Alloush, M., Gonzalez, E., Gupta, A., Rojas, I. R., & Taylor, J. E. (2016). *Economic life in a refugee camp.* Retrieved from http://migrationcluster.ucdavis.edu/events/seminars_2015-2016/alloush/paper_alloush.pdf

Barr, H., & Sanei, F. (2013). In P. Kine, C. Baldwin, J. Saunders, B. Frelick, G. Simpson, A. Farmer, . . . B. Adams (Eds.), *Unwelcome guests: Iran's violation of Afghan refugee and migrant rights* (pp. 1-124). New York, NY: Human Rights Watch. Retrieved from https://www.hrw.org/report/2013/11/20/unwelcome-guests/irans-violation-afghan-refugee-and-migrant-rights

Booth, C. (1887). The inhabitants of Tower Hamlets (School Board Division): Their condition and occupations. *Journal of the Royal Statistical Society, 50*, 326-340. doi: https://doi.org/10.2307/2340191

Central Bank of Iran. (n.d.). *Consumer price index for goods and services.* Retrieved from http://www.cbi.ir/simplelist/1611.aspx

Chaaban, J., Seyfert, K., Salti, N. I., & El Makkaoui, G. S. (2013). Poverty and livelihoods among UNHCR registered refugees in Lebanon. *Refugee Survey Quarterly, 32*(1), 24-49. doi: https://doi.org/10.1093/rsq/hds022

Clark, D. A. (2005). *The capability approach: Its development, critiques and recent advances*. Retrieved from http://www.gprg.org/pubs/workingpapers/default.htm

Cornell, K. L. (2006). Person-in-situation: History, theory, and new directions for social work practice. *Praxis, 6*, 50-57.

Council on Foreign Relations. (2017). Global conflict tracker. Retrieved from http://www.cfr.org/global/global-conflict-tracker/p32137#!/

Garakani, T. (2009). *Place-making in the margins: A case study of Afghan refugees in Iran (1980-2001)* (Unpublished doctoral dissertation). Columbia University, New York, NY. doi:9781109299717

Ghaedi, Z. (2010). *Calculating the national poverty line in Iran* (Unpublished master's thesis). Alzahra University, Tehran, Iran.

Giles, W. (2010). Livelihood and Afghan refugee workers in Iran. In W. Lem, & P. G. Barber (Eds.), *Class, contention, and a world in motion* (pp. 23-40). New York, NY: Berghahn Books.

Haughton, J., & Khandker, S. R. (2009). *Handbook on poverty and inequality*. Washington, DC: World Bank. Retrieved from http://documents.worldbank.org/curated/en/488081468157174849/Handbook-on-poverty-and-inequality

Hejoj, I. (2007). A profile of poverty for Palestinian refugees in Jordan: The case of Zarqa and Sukhneh camps. *Journal of Refugee Studies, 20*(1), 120-145. doi: https://doi.org/10.1093/jrs/fel025

Jacobsen, K. (2005). *The economic life of refugees*. Bloomfield, CT: Kumarian Press.

Jahan, S., Jespersen, E., Mukherjee, S., Kovacevic, M., Bonini, A., Calderon, C., . . . Zampino, S. (2015). *Technical notes: Human development report 2015, Work for human development* (No. 978-92-1-126398-5). New York, NY: UNDP. Retrieved from http://hdr.undp.org/sites/default/files/hdr2015_technical_notes.pdf

Khawaja, M. (2003). Migration and the reproduction of poverty: The refugee camps in Jordan. *International Migration, 41*(2), 27-57. doi: https://doi.org/10.1111/1468-2435.00234

Khodadad-Kashi, F., & Heidari, K. (2009). Measuring poverty index based on Iranian households' nutrition. Retrieved from http://joer.atu.ac.ir/article_2892_afdb880b4763a0c724625ed6bdec75c0.pdf

Koepke, B. (2011). The situation of Afghans in the Islamic Republic of Iran nine years after the overthrow of the Taliban regime in Afghanistan. *Middle East Institute: Refugee Cooperation, 4*, 1-13.

Laderchi, C. R., Saith, R., & Stewart, F. (2003). Does it matter that we do not agree on the definition of poverty? A comparison of four approaches. *Oxford Development Studies, 31*(3), 243-274. doi: https://doi.org/10.1080/1360081032000111698

Nurani, J., Saboor, A., Kamran, M., Saify, Z., Ibrahimi, A., Shikaib, A., . . . Torabi, Y. (2006). *Integration of returnees in the Afghan labor market*. Kabul, Afghanistan: International Labour Office and UNHCR. Retrieved from http://www.unhcr.org/en-us/subsites/afghancrisis/45333f202/integration-returnees-afghan-labour-market-full-report-altai-consulting.html

Nussbaum, M. (1992). Human functioning and social justice: In defense of Aristotelian essentialism. *Political Theory, 20*(2), 202-246. doi: https://doi.org/10.1177/0090591792020002002

Nussbaum, M. (2000). *Women and human development: A study in human capabilities*. Cambridge, UK: Cambridge University Press. doi: https://doi.org/10.1017/CBO9780511841286

Nussbaum, M. (2003). Capabilities as fundamental entitlements: Sen and social justice. *Feminist Economics, 9*(2-3), 33-59. doi: https://doi.org/10.1080/1354570022000077926

Omidvar, N., Ghazi-Tabatabie, M., Sadeghi, R., Mohammadi, F., & Abbasi-Shavazi, M. (2013). Food insecurity and its sociodemographic correlates among Afghan immigrants in Iran. *Journal of Health, Population and Nutrition, 31*(3), 356-366. doi: https://doi.org/10.3329/jhpn.v31i3.16828

Oxford Poverty and Human Development Initiative. (n.d.). *Background to the MPI*. Retrieved from http://www.ophi.org.uk/background-to-the-mpi/

Pinstrup-Andersen, P., & Herforth, A. (2008). Food security: achieving the potential. *Environment: Science and Policy for Sustainable Development*, *50*(5), 48-61. doi: https://doi.org/10.3200/ENVT.50.5.48-61

Poureslami, I. M., MacLean, D. R., Spiegel, J., & Yassi, A. (2013). Socio-cultural, environmental and health challenges facing women and children living near the borders between Afghanistan, Iran and Pakistan (AIP region). *Journal of International Women's Studies, 6*(1), 20-33.

Rajaee, B. (2000). The politics of refugee policy in post-revolutionary Iran. *The Middle East Journal, 54*(1), 44-63.

Robeyns, I. (2005). The capability approach: A theoretical survey. *Journal of Human Development, 6*(1), 93-117. doi: https://doi.org/10.1080/146498805200034266

Rowntree, B. S. (1901). *Poverty: A study of town life*. London, UK: MacMillan and Co.

Sen, A. (1988). *The standard of living*. Cambridge, UK: Cambridge University Press.

Sen, A. (1999). *Commodities and capabilities*. New York, NY: Oxford University Pres.

Sen, A. (2000). *Social exclusion: Concept, application, and scrutiny.* Manila: Asian Development Bank. Retrieved from https://think-asia.org/bitstream/handle/11540/2339/social-exclusion.pdf?sequence=1

Sen, A., & Honderich, T. (1985). Rights and capabilities. *Morality and Objectivity, 6* (2), 151-166.

StataCorp, L. P. (2015). STATA 12 [Computer software]. *College Station, TX: StataCorp LP*.

Statistical Center of Iran. (2010). *Expenditure and Income Questionnaire.* Tehran, Iran: Statistical Center of Iran.

The World Bank. (2017). *Country dashboard, Iran, Islamic Rep*. Retrieved from http://povertydata.worldbank.org/poverty/country/IRN

Thorne-Lyman, A. L., Valpiani, N., Sun, K., Semba, R. D., Klotz, C. L., Kraemer, K., ... Bloem, M. W. (2009). Household dietary diversity and food expenditures are closely linked in rural bangladesh, increasing the risk of malnutrition due to the financial crisis. *The Journal of Nutrition, 140*(1), 182S-188S. doi: https://doi.org/10.3945/jn.109.110809

Tober, D. (2007). "My body is broken like my country": Identity, nation, and repatriation among Afghan refugees in Iran. *Iranian Studies, 40*(2), 263-285. doi: https://doi.org/10.1080/00210860701269584

United Nations. (n.d.). *Millennium development goals indicators: The official United Nations site for the MDG indicators*. Retrieved from https://mdgs.un.org/unsd/mdg/Metadata.aspx?IndicatorId=31

United Nations Development Programme. (n.d.). *Multidimensional poverty index (MPI)*. Retrieved from http://hdr.undp.org/en/content/multidimensional-poverty-index-mpi

United Nations High Commissioner for Refugees [UNHCR]. (2010). *Convention and protocol relating to the status of refugees.* Retrieved from http://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html

UNHCR. (2016). *3RP Regional Refugee & Resilience Plan 2016-2017 in response to the Syria Crisis, Mid-Year Report.* Retrieved from http://www.3rpsyriacrisis.org/wp-content/uploads/2016/09/3RP-Mid-year-Report-Final.pdf

UNHCR. (2017a). *Global trends: Forced displacement in 2016.* Retrieved from http://www.unhcr.org/5943e8a34

UNHCR. (2017b). Chapter 7: Solutions for Refugees. In UNHCR (Eds.), *The 10 point plan in action* (pp. 183-206). Geneva, Switzerland: Author. Retrieved from http://www.unhcr.org/50a4c17f9.pdf

World Food Programme. (2017). *Islamic Republic of Iran.* Retrieved from http://www1.wfp.org/countries/iran-islamic-republic

Zezza, A., Carletto, C., Fiedler, J. L., Gennari, P., & Jolliffe, D. (2017). Food counts. Measuring food consumption and expenditures in household consumption and expenditure surveys (HCES). Introduction to the special issue. *Food Policy*, 72, 1-6. doi: https://doi.org/10.1016/j.foodpol.2017.08.007

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Culturally Effective Practice With Refugees in Community Health Centers: An Exploratory Study

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Abstract: *The global refugee crisis requires providers of health and behavioral health services to develop culturally-effective practices that can meet the needs of the ever-changing demographics of those being resettled. Community health centers in the United States are often asked to provide services during the first year of resettlement for refugees. Social workers are among those professionals who provide the behavioral health services in the community health centers. To better understand the challenges for these providers, this qualitative study examines the experiences of 15 providers of refugee behavioral health services at community health centers in the northeast of the United States. The participants were interviewed, and those transcribed interviews were analyzed for themes. Findings revealed three main themes: client engagement as crucial; collaboration with interpreters; and cultural competence is an imperative but ill-defined. Important implications focus on the need for cultural competence and the challenge to obtain this competence given the resources and demands in community health centers.*

Keywords*: Refugee; community health center; cultural competence*

Currently, there are over 65 million forced migrants throughout the world (United Nations High Commissioner for Refugees [UNHCR], 2017). Forced migrants are individuals that are required to relocate due to internal conflicts, persecution, or unsustainable environments due to social/economic factors or climate changes. Of the 65 million forced migrants, over 23 million are United Nations designated refugees. The current refugee crisis is the largest in history and is not abating. In fact, by all statistics it is increasing and rapidly changing (UNHCR, 2017). With the effects of climate changes accelerating, one can expect forced migrations due to climate changes to increase (Campbell, 2014; Farbotko, Stratford, & Lazrus, 2016; Yoosun, 2008), adding to our current refugee crisis.

While the legal term "refugee" has been in use since 1951, the United States, and many other countries, have been receiving refugees for centuries (Matera, Stefanile, & Brown, 2015). Throughout much of the history of the United States, social workers have in some form or other been providing direct services to refugees (Healy, 2008). Our long history of working with refugees continues today. Each year the president determines the number of refugees allowed to enter the United States (UNHCR, 2017). In 2016, under President Obama, the United States, accepted nearly 85,000 refugees (Krogstad & Radford, 2017). In 2017, President Trump set the cap to 45,000 refugees, and in 2018, the cap was placed at 21,292 refugees to be accepted into the United States (UNHCR, 2017). While at the time of this writing, the numbers of new refugee arrivals have been restricted, the global crisis has not abated, and the needs of refugees will continue to be a dynamic and demanding

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concern for social workers well beyond any current presidential administration.

In the United States, community health centers are on the front lines of working with refugees. A community health center is a nonprofit comprehensive primary care facility that is federally mandated to provide services to underserved areas (Taylor, 2004). Through the assistance of local agencies, the UN-designated refugee is connected to a local community health center that provides health and behavioral health care services (Bruno, 2015; Morland & Levine, 2016). Refugees have often survived traumatic events, leaving many with symptoms of depression, anxiety, and post-traumatic stress disorder. All refugees need housing, support entering into the labor field, and many need assistance learning English (Esses, Hamilton, & Gaucher, 2017; Moulton, 2016). In addition, individuals and families may enter the United States with pre-existing health and mental health conditions that can complicate their resettlement (Burnett, 2016; Bustamante, Leclerc, Mari, & Brietzke, 2016; Ellis, Murray, & Barrett, 2014; Hansen & Huston, 2016; Moulton, 2016). Social workers are among the healthcare professionals who serve refugees in community health centers and must help them navigate an under-resourced system to meet their needs (Adams, Gardiner, & Assefi, 2004; Al-Husban & Adams, 2016; Ay, Arcos González, & Castro Delgado, 2016; Barghadouch et al., 2016; Bozorgmehr, Szecsenyi, Stock, & Razum, 2016; Burnett, 2016; Esses et al., 2017).

Challenges in Cross-Cultural Social Work Interventions

This study examines in particular the cultural challenges of providing effective interventions. In this section we introduce some of the major cultural challenges that other studies have researched. Refugees may come from situations and cultures not accustomed to seeking mental health services. Providing culturally-effective services to this group may also involve addressing possible stigma the individual, family or community may experience when seeking mental health services (Al-Makhamreh, Spaneas & Neocleous, 2012). Additionally, some cultures may be more family-centric than the United States, and therefore may expect to involve family members in their care (Weaver, 2005; Weine, Kuc, Dzudza, Razzano, & Pavkovic, 2001). For social workers, this can create ethical issues regarding privacy and confidentiality. Service delivery may need to be modified to be culturally-effective. Weaver (2005) posits that group-based interventions grounded in cultural competency and spirituality could more effectively provide support to refugees. In a meta-analysis of refugee programs, Sossou, Craig, Ogren, and Schnak (2008) found that some recipients of refugee services were more responsive to a “contact perspective approach”, a cross-cultural approach that involves an exchange of ideas, negotiation, and interaction among refugees, their families, and professionals.

UN designated refugees are provided Medicaid to cover health expenses their first year of resettlement. However, many are prevented from receiving care because of communication and transportation barriers (Fike & Androff, 2016). Social workers are crucial players in knitting together services and supporting refugee communities. In addition to collaboration, outreach, and culturally-sensitive practice, work with refugees requires language services and experience in working with interpreters as cultural brokers (Decola, 2011; Fondacaro & Harder, 2014; Hsieh & Kramer, 2012; Njeru et al., 2016). The issues involved in working with refugees are complex. Social workers in community health

centers are on the front lines of managing the needs of newly arrived refugees. It is important to understand more about these challenges. Our current refugee crisis provides a painful and critical moment to learn best-practices, and to share those practices with others in the field. This study is timely and important in expanding the field's knowledge on the best practices in working with refugees in community health centers.

Purpose of the Study

This study sought to understand how community health centers are responsive to differing refugee populations. Understanding the experiences of community health center social workers working with refugees, may provide helpful information on best practices and current challenges. This article reports on a descriptive study of how social workers in community health centers perceive their provision of services to refugees across cultural and linguistic barriers. This study examines community health centers (n=15) in six northeastern states in the United States to gain a deeper understanding of the challenges for centers. For example, how do the centers address the needs of refugees? What do providers see as important components of culturally-effective services? What have they found to be successful approaches in bridging the cultural and linguistic challenges of providing services to an ever-changing refugee population?

Method

Participants

This purposive sample consisted of 15 mental-health workers in community health centers in all six New England states, including 12 social workers, 1 psychologist, 1 psychiatrist, and 1 program manager. These community centers are located in large and small cities where refugees are resettled in the largest numbers. The researchers contacted each center to invite the social worker—or, in the absence of a staff social worker, another professional in a similar role—to participate in the study. The sample consisted of 9 women, 6 men; three of the men had been refugees from countries in Southeast Asia or Africa. The participants worked in interdisciplinary teams with medical and behavioral health providers, and often held multiple roles: administrator, clinician, case manager, and program manager.

Procedure

The Institutional Review Board reviewed and approved the study. After having participants sign an informed consent, the researchers conducted one-time interviews held at each participant's health center. A semi-structured interview schedule was used, and the topics explored included: characteristics of the health center (e.g., services provided, funding sources), refugee populations served, training for practice with refugees, and approaches for addressing linguistic and cultural barriers. The interviews lasted between 60-90 minutes, and were digitally recorded and transcribed by a research assistant.

Data Analysis

The interview transcriptions were uploaded to Dedoose, a qualitative data analysis application. Two research assistants were trained in the process of inductive qualitative data analysis from the Grounded Theory tradition (Bryant & Charmaz, 2007). Both researchers and research assistants independently open-coded one interview; by comparing our respective coding decisions, we came to agreement on concepts that would be used by the research assistants to analyze the subsequent interviews. After coding the remaining transcripts, the researchers reviewed their data analysis, and together, we discussed their decisions and resolved any discrepancies. The research assistants were not involved in conducting the interviews, and thus, provided fresh perspectives on the data during the analysis. This team approach increased the trustworthiness and credibility of the analysis by allowing for greater fidelity in the coding decisions (Denzin & Lincoln, 2011). In the next stage of analysis, the researchers expanded or collapsed concepts to ensure accuracy, and considered relationships across the concepts. Finally, exemplars were identified to reflect the concepts surfaced through the coding process.

Findings

In describing their work with refugee populations, three main themes arose across all interviews: client engagement as crucial; collaboration with interpreters; and cultural competence is an imperative but ill-defined. This last theme, cultural competence is an imperative but ill- defined, is an overarching theme that is woven throughout the other two. Client engagement as crucial seems to be a component of effective service delivery that the participants subjectively used as an assessment of their own cultural competency. Working with interpreters seemed to be a resource participants used as they tried to provide culturally competent services. The participants also acknowledged on-going challenges with being culturally competent, both on an individual level for the provider and on a systemic level throughout the center.

The participants identified the countries where their refugee populations originated from, including: Bhutan, Bosnia, Burundi, Burma, Cambodia, Congo, Djibouti, Eritrea, Iraq, Nepal, Somalia, and Sudan. New groups of refugees from new countries continue to arrive for services. Each community health center reported that the populations were ever-changing, and most centers had no more than two weeks' notice of the new arrivals. This created a shared challenge among the participants as they felt ignorant of the historical and cultural experiences of the new arrivals, and ill-prepared to tailor services to them. Each theme will be described below with exemplars from the participants.

Client Engagement as Crucial

Participants reflected on the process of engagement with the client, and seemed to subjectively use their feelings of engagement with the client as an indicator of their own ability to bridge the cultural differences between themselves and the client. Participants understood that the journey for the refugees had been stressful. They also understood that many of the refugees felt mistrustful. The participants stated that engaging the client in each session was a crucial component to effective interventions. Many health centers

received a couple of weeks' notification that new refugees would arrive, rarely with any medical or behavioral health history. One participant explained: "We have a general sense in terms of numbers. Every few months we get an update from the [Office for Refugees and Immigrants] to get an idea of what to be ready for." This "general sense" seemed insufficient to fully anticipate and prepare for engagement with new refugee populations.

Client engagement often involved providing practical help to improve access and utilization of the health center's services. One participant explained, "The health center spends half a million dollars a year on what are called enabling services: interpretation and transportation." While resettlement agencies meet many of the refugees' concrete and immediate needs, the health centers tended to supplement these efforts with onsite assistance (e.g., a food pantry) and community referrals (e.g., English classes). A participant linked the provision of these services to their clients' clinical presentation and goals. At this center, social workers helped refugees obtain work experiences to help individuals feel more competent. "Whether volunteering or internships, it helps with mental health, gets people out of the house, helps get references, and maybe builds connections towards a job."

Participants spoke about the complexity of work, and thus, the need for collaboration with other providers. One participant described, "These are very time-consuming cases, and so if that team—everybody who is touching the case—doesn't have a forum to meet, then the case doesn't work." Another participant noted that social workers often are particularly skillful at client engagement, which can be modeled for a physician if they are both present. She explained the benefit of an integrated model that paired a clinician with a primary care team, "Very often the doctor will say, 'Oh, okay you go into room so and so.' Then that doctor doesn't see what that mental health person does. It's good for them to see what [the clinician] asks the person."

With effective client engagement, participants noticed that refugees knew they could turn to the health center for assistance. A participant described, "Our friends and colleagues in the Cambodian community said, 'There's a mental health crisis. Would you go over and take a look?'" Refugees likely know the needs of the community more quickly than the clinicians. When a rapport has been established, refugees could partner with the center to meet their needs. For example, one participant described: "Most of our interpreters have approached us because they see the need that is in their own communities."

Collaboration With Interpreters

The theme of engagement was often interwoven with the participants' experiences with using interpreters in sessions with clients. Most of the participants were English-speaking and required interpreter services when working with clients. Health centers had different resources available for meeting this need, including bilingual staff who were trained as interpreters but also served other functions, part-time or per-diem professional medical interpreters, or telephone interpreters. Some centers had a combination of these options, depending on the needed language, availability of interpreters, and cost. A participant explained that his administrators favored phone interpretation for cost-savings: "Per-diem is expensive if there's a no-show or for just a few hours. They have to have a certain number

of patients willing to be seen in order to justify a full-time interpreter."

Participants believed how the interpretation services were offered affected the quality of their interactions with the clients. This participant expressed the conflict between what the community health center could provide, versus what she believed enhanced client/provider engagement, "I get that the phone is cheaper, but I wish we could choose an interpretation service based on what is most helpful to establishing trust."

The participants varied in how they perceived the experience of in-person versus telephonic interpretation. For some, telephonic interpretation services were efficient and convenient, and allowed them to provide services for clients who spoke nearly any language. They also felt that it made the client feel safer than working with an in-person interpreter. Since many of the refugees fled due to internal conflicts, having someone from their culture and who lived in their current community, might feel unsafe, especially if the interpreter and client came from different sides of the conflict. One participant described, "We've found, most especially for our Iraqi patients, that they don't want an Arabic-speaking face-to-face interpreter. They prefer telephonic because that feels more protective and private." Another participant echoed this concern and described that patients sometimes insist keeping matters within their family unit:

> *Some of the cultures are a very close-knit group and they don't want this person to know their personal business, like our Nepali interpreter knows a lot of our Nepali patients, so they don't want him to know their business. They want their family member [to interpret].*

For participants who favored telephone interpretation, they encouraged a greater engagement between the provider and client without an interpreter present. In these discussions, the participants returned to issues regarding engagement of the client, and how the use of an interpreter enhanced or impeded engagement. One participant reported that many of his colleagues felt interpreters were "in the way," and another wished that she could speak another language so as "not to have that third-party in the room." Others, however, experienced phone interpretation as a barrier to the therapeutic relationship because there can be difficulty hearing exactly what it being said, a lack of body language, and a lot of repetition. Another participant described the impact on client and provider engagement of using phone interpretation: "You sit there and you're really both looking at the phone, rather than interacting with each other. [The phone] is this plastic thing."

For the participants who preferred in-person interpretation, they believed the third person in the room enhanced engagement and made the visits go "smoother." Participants described several different roles that the interpreter played. Oftentimes, the interpreter shared cultural similarities to the client, and thus provided a sense of comfort and trust. In this sense, the interpreter "becomes part of the treatment team." All three parties—clinician, client, and interpreter—negotiate to find the most helpful balance between being a verbatim translator, a cultural broker, and a "clarifier when the terminology or jargon is too high." One participant described the process she engages in to determine if the arrangement is working: "It's always been a dialogue, and I always check in with the interpreter and the client to see what's going on, if I need more clarification or if they need clarification." Another participant echoed that it is helpful for the client and interpreter to

"develop a rapport between them." Sometimes as the client feels more comfortable a shift can happen, and the client can engage with the clinician as well as the interpreter. A participant described:

> *Oftentimes because of the work we're doing, because of the trauma history, one of the shifts I'll notice is when the client starts to trust you. In the beginning they would just talk to the interpreter, and the interpreter talks back to me, but it's so cool to see that trust shifting, because then the person starts looking at me directly when they talk. It's that moment I know that the trust is building because it's awkward to talk to someone when they don't understand what you're saying, but that begins shift.*

In this sense, the interpreter appears to meet needs of the client and the clinician, and assists with effective client engagement. Community health centers had difficulty finding qualified interpreters who also knew the community. Health center employees who spoke multiple languages were tapped to add interpretation work to their existing jobs on an ad-hoc basis, although this could be an imposition, may or may not be compensated work, or create a dual relationship. The participants were aware of the burden this can be on a staff worker, as this quote demonstrates,

> *Our front staff worker often is asked to interpret on-the-fly. It means that when she is called to interpret, either we have no one at the front desk, or we have to pull someone else in. And, you know, she doesn't get paid more for doing two jobs [interpreting and front desk]."*

Another participant explained:

> *One of our case managers does [interpretation], but again, our case manager is very much in the community and has functions as a case manager here. We rarely use her as an interpreter for anything, because that complicates her life trying to do her actual job in terms of what she knows about their psychosocial needs, like food and housing.*

Cultural Competence is an Imperative but Ill-Defined

While the participants reflected on the importance of engagement with the clients, and the challenges in using interpreters, these themes were parts of a larger theme: the need to be culturally competent yet with no clear definition or guidance on what constitutes cultural competence. The participants each expressed a need for cultural competence when working with refugees. In their assessments and interventions, participants found that some things were culturally unacceptable to inquire about, particularly mental health issues. A participant explained, "I did have one interpreter who said we don't ask about coping [coping is not a concept in the culture]. I tried to figure out another way to ask the same question." Another participant noted that the hesitancy goes beyond privacy concerns: "Sometimes people don't feel comfortable talking [about mental health], even if they don't know the interpreter." Participants also noted that health beliefs are culturally determined:

> *You could explain to them simple diabetes stuff, and diabetes is non-existent in some parts of Somalia. It's a challenge trying to convince them that there is*

> *treatment and medications for it, and people have lived with the disease 15, 20, 30 years, so [it seems like] nothing to worry about.*

Cultural competence related to effective client engagement. Knowing the cultural norms for cross-gender encounters helped one female participant navigate seating arrangements:

> *I let the people choose whether they want to sit. If a male doesn't feel comfortable being in here with me alone, I often have a male interpreter. There is one man I keep the door half-open with because he doesn't feel comfortable being in here by himself.*

The community health centers worked with refugees from several countries and experienced little training or information on the clients' needs, culture, or history. In addition, each client came to the center with multiple needs that reached beyond the services the centers could provide. This added stress to the participants who often felt ineffectual in bringing about changes the refugees needed most to feel less anxious and depressed: housing or work.

Services would be improved if there were more trainings, education, and preparation for working with each group of refugees. While the participants assumed most of the refugees experienced some form of trauma prior to arriving, there were few other common characteristics among the different refugee populations. Participants stated that culture, language, and geographical differences made service delivery challenging as one approach was not universally effective. Knowing more about the specific group would enable the providers to know what questions to ask, what to look for in assessing trauma, and to better engage.

Participants saw themselves as responsible for becoming culturally competent in their work with refugee clients, especially as the countries of origin were regularly changing. One participant described learning from missteps early on. For example, she described, "When we got a new population, we were just looking around for somebody in the community who spoke Arabic, not realizing there's going to be all these different cultural issues." She learned from her clients and the interpreters in the community that the regional, ethnic, and religious differences needed to be considered in order to meet the clients' needs. One participant described that she could not tailor her work to a particular cultural group because they work with so many different, ever-changing groups. "I tend to use the same approach with everyone. I use cognitive behavioral therapy with my clients. I don't have the time to individualize, especially when we don't even speak the same language." While another participant believed that services needed to be targeted to each culture and felt limited by lack of time and training.

> *We're not familiar with any of our cultures. When I first came on board, I would spend an unbelievable amount of time before I met with a family researching that culture, but there's so many cultures that we work with that it's one of those things were I probably do less.*

Some health centers had developed the cultural knowledge and skill set for working with a particular population, and while others had to constantly adapt to refugees from different countries of origin.

Sometimes, demonstrating cultural competence meant changing aspects of how the center managed services. For example, one center set up blocks of time during the week when clients could drop-in as needed. This was initiated when refugees from some countries had a difficult time understanding the concept of “appointment time”. Instead of having repeated no-shows from these clients, the clinic changed their concept of appointment. Providers aimed to engage refugee clients in a culturally effective manner, but at times encountered systemic issues that needed to be addressed for centers to be responsive and strategic with their limited funding.

Discussion

This study examined the views of 15 social service providers from 15 community health centers that serve refugees. The participants discussed challenges in providing culturally- effective care to a clientele that is ever-changing. The voices of the participants echo what many in community health centers and those who work with refugees know: the needs of this population are great, and the services few. Community health centers and other agencies that serve refugees and forced migrants are required to be culturally adept, flexible in the services provided and even in the structure of their agencies. These findings also highlight the need for more support to providers of refugee services.

There was a range of how each center described or demonstrated cultural competence. The range included, on one end, wall posters that presented ethnically diverse populations to, the other end, décor that reflected diverse cultures as well as bi-cultural staff, information posted in multiple languages, and in-person interpreters or bilingual staff. Some participants stated that they took extra measures to learn about the history of the refugee population. These participants wanted to know why the individual or family had to flee, which camps they were in while waiting for resettlement, and what their cultural beliefs were about health and well-being.

These differences in the participants’ understanding of cultural competence was also evident in the interventions the participants used. For some participants, they felt that most of the refugees experienced depression and/or anxiety and would benefit from cognitive behavioral therapy (CBT). For these participants, CBT was effective across cultural differences. Those participants that believed culture differences affect the efficacy of an intervention, stated that they tried to understand the refugee’s cultural beliefs about the presenting symptoms. These participants might use CBT and mindfulness practice, as well as draw from the refugee’s own beliefs regarding healing and encourage the refugee to incorporate his/her own cultural remedies (i.e., coining, cupping).

Limitations of the Study

This study interviewed one primary provider in each of the 15 community health centers in this study. Interviewing more staff at each center might provide additional information and alternate voices than those captured in this study. This study did not interview interpreters or clients. Such interviews might offer important insights into how each member of the interventions (client, interpreter, social worker) experienced the quality and effectiveness of the services provided. The scope of this study was focused on the

providers. Future studies should include recipients of refugee services. Studies that examined the satisfaction the recipients of the services experienced alongside the providers' perceptions of the effectiveness of the services might reveal interesting findings. In addition, the experiences and ability of multiple systems to provide culturally-effective services (providers, interpreters, governments, resettling agencies, communities) involved in providing for refugees should also be examined. Through such studies, a larger understanding of the challenges, opportunities, and current barriers to providing culturally-effective services can be examined through a multi-systems and dynamic perspective that acknowledges the complexity of this global crisis

Implications

An important finding in this study is the acknowledged need by the participants that cultural competency is imperative to provide effective services, and the shared frustration among the respondents that that competency is difficult to define and harder to reach when working with multi-need clients from populations that are ever-changing. The participants from the 15 community health centers in this one region of the United States individually reported a similar challenge that service providers for refugees world-wide face: how to define cultural-competence and what do providers need to be competent. In this study, the participants focused on engagement as a critical component in cultural competency, and the use of interpreters as both a challenge and a conduit in developing engagement.

There are a number of on-going multi-system factors that complicate service provision to refugees. Community health centers and other agencies charged with providing services to refugees are often under-resourced and expected to be prepared with little to no advance notice or training. The global refugee crisis we face shows no signs of lessening. Agencies are asked to meet the needs of an ever-changing demographic without the resources, training, and combined applied knowledge that each center/agency requires. Current and future political conflicts and the increasing climate changes point toward a chronic refugee crisis. Social workers will continue to be called on to serve individuals and families who are forced to flee their homelands. It is imperative that social workers are prepared to meet this demand. Being prepared means better coordination of the involved systems (involved governments, resettlement agencies, communities), and embracing the practice of cultural competence within health and behavioral health teams. We do not need to acquire these skills in isolation from other agencies who provide for refugees. Sharing of experiences, such as in this study, can enhance our understanding of culturally-effective practice, and lessen the burden of learning new practices each time the population changes. It is hoped that this study widens the literature and that future studies will seek answers to questions such as: How does a profession learn to be culturally competent with as little as two-week notice of a new group's arrival? What are the most culturally effective ways of working with interpreters? What are the best approaches to engagement? Which interventions are most useful? The participants of this study offer us a window into these ongoing challenges, and deepen our understanding of cultural competence as an ethical imperative in addressing the needs of forced migrants.

References

Adams, K. M., Gardiner, L. D., & Assefi, N. (2004). Healthcare challenges from the developing world: Post-immigration refugee medicine. *British Medical Journal*, *328*(7455), 1548-1552. doi: https://doi.org/10.1136/bmj.328.7455.1548

Al-Husban, M., & Adams, C. (2016). Sustainable refugee migration: a rethink towards a positive capability approach. *Sustainability*, *8*(5), 1-10. doi: https://doi.org/10.3390/su8050451

Al-Makhamreh, S., Spaneas, S., & Neocleous, G. (2012). The need for political competence social work practice: Lessons learned from a collaborative project on Iraqi refugees—The case of Jordan. *British Journal of Social Work*, *42*(6), 1074-1092. doi: https://doi.org/10.1093/bjsw/bcs087

Ay, M., Arcos González, P., & Castro Delgado, R. (2016). The perceived barriers of access to health care among a group of non-camp Syrian refugees in Jordan. *International Journal of Health Services*, *46*(3), 566-589. doi: https://doi.org/10.1177/0020731416636831

Barghadouch, A., Kristiansen, M., Jervelund, S. S., Hjern, A., Montgomery, E., & Norredam, M. (2016). Refugee children have fewer contacts to psychiatric healthcare services: An analysis of a subset of refugee children compared to Danish-born peers. *Social Psychiatry and Psychiatric Epidemiology*, *51*(8), 1125-1136. doi: https://doi.org/10.1007/s00127-016-1260-1

Bozorgmehr, K., Szecsenyi, J., Stock, C., & Razum, O. (2016). Europe's response to the refugee crisis: Why relocation quotas will fail to achieve "fairness" from a health perspective. *The European Journal of Public Health*, *26*(1), 5-6. doi: https://doi.org/10.1093/eurpub/ckv246

Bruno, A. (2015). Refugee admissions and resettlement policy. *Current Politics and Economics of the United States, Canada and Mexico, 17*(3), 485-501.

Bryant, A., & Charmaz, K. (Eds.). (2007). *The Sage handbook of grounded theory*. Thousand Oaks, CA: Sage. doi: https://doi.org/10.4135/9781848607941

Burnett, A., & Peel, M. (2001). Health needs of asylum seekers and refugees. *British Medical Journal, 322,* 544-547. doi: https://doi.org/10.1136/bmj.322.7285.544

Bustamante, L. H. U., Leclerc, E., Mari, J. D. J., & Brietzke, E. (2016). It is time to prepare mental health services to attend to migrants and refugees. *Revista Brasileira de Psiquiatria*, *38*(3), 263-264. doi: https://doi.org/10.1590/1516-4446-2015-1883

Campbell, J. R. (2014). Climate-change migration in the Pacific. *The Contemporary Pacific*, *26*(1), 1-28. doi: https://doi.org/10.1353/cp.2014.0023

DeCola, A. (2011). Making language access to health care meaningful: The need for a federal health care interpreters' statute. *Journal of Law & Health, 24*(1), 151-182.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative*

research. Thousand Oaks, CA: Sage.

Ellis, B. H., Murray, K., & Barrett, C. (2014). Understanding the mental health of refugees: Trauma, stress, and the cultural context. In R. Parekh (Ed.), *The Massachusetts General Hospital textbook on diversity and cultural sensitivity in mental health* (pp. 165-187). New York: Springer. doi: https://doi.org/10.1007/978-1-4614-8918-4_7

Esses, V. M., Hamilton, L. K., & Gaucher, D. (2017). The global refugee crisis: Empirical evidence and policy implications for improving public attitudes and facilitating refugee resettlement. *Social Issues and Policy Review*, *11*(1), 78-123. doi: https://doi.org/10.1111/sipr.12028

Farbotko, C., Stratford, E., & Lazrus, H. (2016). Climate migrants and new identities? The geopolitics of embracing or rejecting mobility. *Social & Cultural Geography*, *17*(4), 533-552. doi: https://doi.org/10.1080/14649365.2015.1089589

Fike, D. C., & Androff, D. K. (2016). “The pain of exile”: What social workers need to know about Burmese refugees. *Social Work*, *61*(2), 127-135. doi: https://doi.org/10.1093/sw/sww005

Fondacaro, K. M., & Harder, V. S. (2014). Connecting cultures: A training model promoting evidence-based psychological services for refugees. *Training and Education in Professional Psychology*, *8*(4), 320-327. doi: https://doi.org/10.1037/tep0000071

Hansen, L., & Huston, P. (2016). Health considerations in the Syrian refugee resettlement process in Canada. *Canada Communicable Disease Report*, *42*(S2), S3-S7. doi: https://doi.org/10.14745/ccdr.v42is2a02

Healy, L. M. (2008). Exploring the history of social work as a human rights profession. *International Social Work, 51*(6), 735-748. doi: https://doi.org/10.1177/0020872808095247

Hsieh, E., & Kramer, E. M. (2012). Medical interpreters as tools: Dangers and challenges in the utilitarian approach to interpreters’ roles and functions. *Patient education and counseling*, *89*(1), 158-162. doi: https://doi.org/10.1177/0020872808095247

Krogstad, J., & Radford, J. (2017, January 30). *Key facts about refugees to the U.S.* Retrieved from http://www.pewresearch.org/fact-tank/2017/01/30/key-facts-about-refugees-to-the-u-s/

Matera, C., Stefanile, C., & Brown, R. (2015). Majority–minority acculturation preferences concordance as an antecedent of attitudes towards immigrants: The mediating role of perceived symbolic threat and metastereotypes. *International Journal of Intercultural Relations, 45*, 96-103. doi: https://doi.org/10.1016/j.ijintrel.2015.02.001

Morland, L., & Levine, T. (2016). Collaborating with refugee resettlement organizations: Providing a head start to young refugees. *Young Children, 71*(4), 69-75.

Moulton, D. (2016). Refugee health clinics grapple with demand. *Canadian Medical Association Journal, 188*(11), E240-E240. doi: https://doi.org/10.1503/cmaj.109-5288

Njeru, J. W., DeJesus, R. S., Sauver, J. S., Rutten, L. J., Jacobson, D. J., Wilson, P., & Wieland, M. L. (2016). Utilization of a mental health collaborative care model among patients who require interpreter services. *International Journal of Mental Health Systems*, *10*(1), 15. 1-6. doi: https://doi.org/10.1186/s13033-016-0044-z

Sossou, M. A., Craig, C. D., Ogren, H., & Schnak, M. (2008). A qualitative study of resilience factors of Bosnian refugee women resettled in the southern United States. *Journal of Ethnic & Cultural Diversity in Social Work*, *17*(4), 365-385. doi: https://doi.org/10.1080/15313200802467908

Taylor, J. (2004). The fundamentals of community health centers. Retrieved from https://www.nhpf.org/library/background-papers/BP_CHC_08-31-04.pdf

United Nations High Commissioner for Refugees. (2017). *Figures at a glance*. Retrieved from http://www.unhcr.org/en-us/figures-at-a-glance.html

Weaver, H. N. (2005). Reexamining what we think we know: A lesson learned from Tamil refugees. *Affilia*, *20*(2), 238-245. doi: https://doi.org/10.1177/0886109905274546

Weine, S. M., Kuc, G., Dzudza, E., Razzano, L., & Pavkovic, I. (2001). PTSD among Bosnian refugees: A survey of providers' knowledge, attitudes and service patterns. *Community Mental Health Journal*, *37*(3), 261-271. doi: https://doi.org/10.1023/A:1017533214935

Yoosun, P. (2008). Making refugees: A historical discourse analysis of the construction of the 'refugee' in US social work, 1900-1957. *British Journal of Social Work, 38*(4), 771-787. doi: https://doi.org/10.1093/bjsw/bcn015

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Midwestern Service Provider Narratives of Migrant Experiences: Legibility, Vulnerability, and Exploitation in Human Trafficking

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Abstract: *This exploratory study examined the vulnerability and exploitation of migrants from the perspective of service providers who work in social service organizations. Researchers conducted 16 interviews and 1 focus group with service providers whose clientele had direct experience with migration. These service providers indicated that there is incongruence, even tension, between a welcoming local response to migrant populations and the state-level political rhetoric and policy initiatives, which are predominantly anti-immigration. This study demonstrates that there are contradictions and tensions related especially to exploitation in Midwest migrant populations. Service providers acknowledged complexity in the problems related to migrant vulnerability and exploitation and were interested in change. Findings of this study highlight particular vulnerabilities of migrant populations, a lack of legibility of human trafficking in social service organizations, and a difference between political rhetoric and local responses to migrant populations. Policies and practices in social service delivery need to reflect the subtleties of risk for exploitation and offer broad preventive support for migrant populations through education and advocacy.*

Keywords: *Service providers; human trafficking; vulnerability; migrants; labor exploitation*

Globalization and human mobility influence social service organizations across the world. In the United States of America and elsewhere, social workers interact with migrant populations soon, if not immediately, after their arrival. Whether their role is directly or indirectly related to cultural adjustment and negotiation, social workers have the potential to play critical roles in migration. Their "frontline" (Lipsky, 2010) work intersects with migrants when they are looking for employment, enrolling in school, establishing a home, learning a new language or culture, and understanding new systems of social welfare (Balgopal, 2000; Chang-Muy & Congress, 2008; Dominelli, 2010; Furman, Ackerman, Loya, Jones, & Negi, 2012; Nash, Wong, & Trlin, 2006; Valtonen, 2001). Increases in global migration influence many areas of society, including racial and ethnic diversity, religious diversity, family dynamics/inter-marriage, and public policy (National Academy of Sciences, 2015). These social workers and service providers can play an important role in the prevention of and identification of exploitation as they interact with migrant populations.

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As political, social, and economic forces shift over time, the terrain of social service delivery also shifts. Contemporary social workers who work with migrant populations face many new and difficult challenges (Ayón & Becerra, 2013; Chappell Deckert, 2016; Valtonen, 2001), and they have broadened their practice to focus not only on settlement but more keenly on integration and belonging (Ben-David, 1995) as well as preventing the heightened risk for exploitation. These challenges are complicated by globalization, a rise in nativism (a political position that prioritizes citizens over new residents or migrants), the marginalization of migrants (del Mar Farina, 2013), restrictive policy decisions that impact social welfare institutions (Ayón, 2016; Romero & Williams, 2013), and more flexible and transient patterns of human mobility (Kim, 2009; Sirojudin, 2009).

As awareness of human trafficking improves nationally, social workers become more knowledgeable of the potential exploitation migrants face. Social workers who work with migrant populations learn about human trafficking issues through changes in policy, interactions with clients, and public awareness campaigns. However, most of the information designed for social workers' use in this area of practice has a bias toward sex trafficking and has neglected other areas of potential exploitation (Alvarez & Alessi, 2012).

The goal of this research was to understand characteristics and behaviors associated with vulnerabilities to labor exploitation and human trafficking as expressed by Midwestern service providers. Using interviews and focus group methods, a research team from the University of Kansas worked with regional service providers from a variety of perspectives and public forums to find answers to the over-arching question: How do Midwestern service providers perceive migrant experiences related to vulnerability and exploitation? Answering this question fills a gap in the literature on human trafficking risks and vulnerabilities, and, as we learned, raised awareness of signs of trafficking among area service providers likely to come into contact with trafficked persons.

For the purposes of this paper, service providers include people who work or volunteer in positions that directly interact with clients by providing some kind of social service, including (but not limited to) education, healthcare and mental health services, occupational assistance/jobs/employment, legal services, social welfare, financial assistance, or community organization and advocacy. Social workers are employed in many of these social service organizations, but they are not the only ones who provide direct service to people seeking their services (Salett, 2006). Therefore, the focus of this inquiry includes social workers and other service providers who are in direct contact with migrant populations while delivering some sort of social service. In these positions, they hear stories directly from clients who describe the risks of living in a precarious condition. The perspectives of service providers in mental health, education, medical care, housing, and employment in this study helped address the gaps in the scholarship around this precarity. Their ability to work alongside clients through different challenges gives them unique knowledge that can assist researchers in understanding the potential for improved identification and response to risk (Hodge & Lietz, 2007; Kelleher & McGilloway, 2009). Including service providers from varied sectors of social service (more than just social work) provided us with a richer and more descriptive understanding of the experiences of vulnerable migrants.

Literature Review

There is much more scholarship related to vulnerability and exploitation of migrants in sex trafficking than there is in labor trafficking. This inquiry sought to understand this phenomenon through the perspective of service providers and the knowledge or assumptions they have surrounding trafficking. In order to do this, the research team considered the Midwestern context, values, and politics, definitions of trafficking and the scope of the problem, and social service provision for exploited and marginalized populations as they pertain to trafficking awareness and intervention.

Midwestern Context, Values, and Politics

With the goal of stimulating economic growth, many Midwestern states have recently embraced tax reduction policies in an effort to create smaller government and to become more "business-friendly." Consequently, many of our interview participants indicated that social service provisions have been significantly cut, resulting in higher caseloads and reduced resources for many of these institutions. This causes stress for the service providers in addition to reducing quality of services for clients (Lipsky, 2010). Privatization, a common means to reduce state-provided social services, leads to fewer social service programs overall and reduces states' ability to track trafficking operations (Peksen, Blanton, & Blanton, 2017).

The geography and economy of the Midwest make many areas prime locations for trafficking or exploitation to occur, and scholars have recently started to examine the Midwest as a potential site for trafficking (Heil & Nichols, 2015; Moser, 2015; Williamson & Prior, 2009). According to Gleason et al. (2016), regional characteristics may increase human trafficking, including a high number of military bases, areas with large immigrant communities, and direct routes for interstate travel, all of which describe the Midwestern context within this study. Additionally, farming and meat-packing industries attract migrants to these states for employment (Artz, 2012; Martin, 2012). The agricultural base lends itself to keeping people in isolation, a tactic O'Neill Richard (1999) describes as both logistically savvy and emotionally cruel.

Defining Trafficking and Understanding the Scope of the Problem

The U.S. defines severe forms of trafficking as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age" (U.S. Department of State, 2017, p. 3). It also includes "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery" (Victims of Trafficking and Violence Protection Act of 2000, 2000) While both the Victims of Trafficking and Violence Protection Act of 2000 (2000) and the Palermo Protocols (United Nations Office on Drugs and Crime, 2000) have a clear definition of labor trafficking in its many forms, global media attention, victim identification protocols, and survivor intervention services continue broadly to focus on sex trafficking.

According to the U.S. Department of State (2017), 66,520 survivors of sex trafficking and 17,465 labor trafficking survivors were identified in 2016 globally. Of those identified, there were 14,897 prosecutions for sex trafficking, and only 1,038 prosecutions for labor trafficking cases. Only 9,071 of the total number of cases led to convictions, and only 518 of those were labor trafficking. There were only 439 federal convictions of traffickers, and only an additional 387 cases at the state and local level (U.S. Department of State, 2017). In this inquiry, exploitation includes the misuse and abuse of a person for economic gain. Exploitation is broader in scope than these formal definitions of trafficking, and it may or may not lead to trafficking.

Since so much of the problem remains unidentified and hidden, the illicit nature of human trafficking presents countless methodological problems for researchers (Brennan, 2005; Weitzer, 2012, 2014; Zhang, 2012). There is widespread belief that the scope of human trafficking is much larger than reflected in government reports. Many trafficked persons are wary to come forward because they fear arrest, deportation, or retribution by traffickers on themselves or their families (Schwarz & Britton, 2015; Zhang, Spiller, Finch, & Qin, 2014). They may not even see themselves as trafficked (Brennan, 2008; Hoyle, Bosworth, & Dempsey, 2011; Musto, 2013).

Similarly, law enforcement agencies may not have training or protocols in place to identify and assist trafficked persons (Farrell, McDevitt, & Fahy, 2010) or conflate it with other forms of criminalized labor, such as sex work (Musto, 2016). This is especially pronounced in labor trafficking cases, where there are competing understandings of what constitutes labor exploitation, illegal immigration, human smuggling, and labor trafficking. When issues of labor trafficking become conflated with smuggling, law enforcement may fail to identify or intervene in human trafficking cases, so much so that researchers have called for stand-alone training and research on labor trafficking to increase understanding and identification of the crime (Barrick, Lattimore, Pitts, & Zhang, 2014).

In addition, much of the anti-trafficking discourse and rhetoric focuses on notions of an ideal victim, one who bears no culpability in their exploitation and who is deserving of protection and assistance (Chapkis, 2003; Hill, 2016; Hoyle et al., 2011; Musto, 2009; Sassen, 2002; Schwarz et al., 2016; Schwarz & Britton, 2015; Srikantiah, 2007; Stienstra, 1996). These narratives have real, material consequences for trafficking survivors and lead to missed opportunities to identify the broad range of exploited and vulnerable populations that may be trafficked. The construct of trafficking that solely involves passive women of color from the economically-struggling Global South who are victims that need to be saved by a white, Western legislative hero is one that enforces racism (Baker, 2013; Bromfield & Capous-Desyllas, 2012; Capous-Desyllas, 2007; Jones, Engstrom, Hilliard & Diaz, 2007; Lutnick, 2016; Mapp, 2016), diminishes individual agency, and limits prevention efforts that are concerned with trafficking outside of the realm of sex. As Srikantiah (2007) writes,

> Iconic victims originate from cultures in Asia, Latin America, or Africa stereotyped as suppressing the individuality of women and girls and rendering them simple prey for manipulation by clever traffickers. The iconic victim concept

> is thus consistent with stereotypes of foreign women and women of color as meek, helpless, and belonging to repressive male dominant cultures. (pp. 201-202)

This stereotypical narrative of iconic victimhood perpetuates larger tropes about women of color and restricts the potential to identify and assist survivors whose identities complicate or resist this construction.

Social Services for Exploited and Marginalized Population

Globalization has contributed to increasingly complex issues in social service delivery including labor migration, new forms of labor exploitation, and new platforms that increase risk (i.e. digital) (Agbényiga & Huang, 2012; Jones et al., 2007; Salett, 2006). Paired with free market models that encourage government downsizing through privatization, the demand for cheap or free labor is increasing dramatically (Peksen et al., 2017).

According to the *Trafficking in Persons Report* (U.S. Department of State, 2017), the global focus of investigations has been on sex trafficking, even while non-governmental organizations report serving higher numbers of labor trafficking survivors. Unlike sex trafficking, labor trafficking has not been prioritized or widely recognized by law enforcement or social service agencies (Barrick et al., 2014; Owens et al., 2014). Kaufka Walts (2017) identifies three reasons for this gap, including minimal research on labor trafficking, lack of attention to labor trafficking in legislative or policy efforts, and the lack of training for service providers (p. 62). While the risk factors are often similar for both labor and sex trafficking, such as sexual assault and mental health concerns, labor trafficking is less frequently identified by service providers (Schwarz, 2017). Similarly, many of the risk factors identified in trafficking research (poverty, housing instability, health concerns, strict gender roles with male dominance, and lack of legal status) are also evident in the broader migrant populations. Therefore, perspectives from service providers who attend to migrant populations can provide a window into the ways in which migrant vulnerability can lead to exploitation and trafficking.

Certainly, there is a need to expand conversations and research trends in human trafficking to include a deeper examination of labor trafficking and other forms of labor abuse, including the understanding that exploitation is the foundation of the abuse (Hayes & Unwin, 2016). This exploitation or result thereof may lead to some form of interaction with a social worker or other service provider in health care, child welfare, emergency shelters, or advocacy organizations (Jones et al., 2007). Still, social workers and other service providers are generally not trained to assess or intervene in the area of labor exploitation (Alvarez & Alessi, 2012; Capous-Desyllas, 2007).

The National Association of Social Workers (NASW) does promote materials about trafficking that include both forced labor and exploitation (Abdus-Shakur, 2016; NASW, 2015b; Salett, 2006). However, the majority of materials that exist for social workers connected to human trafficking are related to sex. This is true in social work research as well (Okech, Choi, Elkins, & Burns, 2017). Alvarez and Alessi (2012) suggest social work adopt a broader definition of trafficking: “Human trafficking encompasses the transportation and subjugation of persons for financial gain” (p. 142), which would include both labor and sex trafficking. We refine this definition further, since human trafficking

does not have to include transportation, movement, or crossing borders. Both international standards and US law agree that trafficking can, but does not have to, include such transportation. Research suggests several indicators of trafficking that should be noted by social workers including debt bondage, unstable or overcrowded living spaces, hesitation to speak or seek services, lack of possession of key documents, inability or fear of moving, and poverty (Salett, 2006). Considering the Midwestern context, politics, demand for labor, and increasingly restrictive social welfare policies, this study sought to better understand the issues from the perspectives of direct service providers who are on the frontlines of receiving and attending to people at risk by asking the following research question: How do Midwestern service providers perceive migrant experiences related to vulnerability and exploitation?

Methods

For this study, all interviews were conducted with the approval of the University of Kansas's Institutional Review Board, and all the participants provided informed consent. In the Spring of 2016, seven graduate student researchers conducted interviews with service providers in Midwestern states whose clientele had direct experience with migrants. These organizations provided services in mental health, education, medical care, housing, and employment. Interviews were chosen for inclusion based on the connection they had to the provision of social services. The sixteen (out of 19) interviews chosen for inclusion for this study capture a range of sectors: legal officials, state legislators, educators, and immigration advocates. Additionally, they represented urban, rural, and suburban areas. Three interviews were not included due to the peripheral nature of the role of the respondent.

The research team worked collaboratively to develop interview protocols for different service providers including legal, advocacy, and social services. Questions for each of the protocols were consistent thematically, but they also permitted adjustment based on the different disciplinary or organizational perspectives. This guide included key questions with follow-up prompts and allowed for flexibility during the interview process. Interviews were designed to last approximately one hour. Interviews ranged from 30 minutes to two hours, depending on the participants' interest in the project and their time constraints. Interviews were conducted in English by members of the research team, either individually or in pairs.

In addition to these individual interviews, the same research team conducted a focus group with social work graduate students who had practicum placements in local social service agencies. The focus group was meant to provide additional information regarding perceptions of trafficking risk from a broader audience. Some of these students were working explicitly with migrant populations. However, all of the clientele they served had direct experience with vulnerability through poverty, mental health issues, or lack of employment or housing. The focus group lasted for approximately one hour and was conducted in English.

The individual interviews and focus group were digitally recorded and transcribed by the research team. These transcriptions were carefully de-identified and uploaded to a

secure network drive, only accessible by approved researchers for analysis. Transcriptions were uploaded into a qualitative analysis software program (ATLAS.ti), and they were read/analyzed for general themes using inductive strategies rooted in grounded theory (Glaser & Strauss, 1967). In two separate working sessions, the research team collaboratively discussed the themes and developed a general coding scheme. From there, they designated team members to explore particular themes in all of the interview and focus group data. A second round of analysis included more focused coding related to each particular theme.

Findings

Through this project, contradictions and tensions related to labor trafficking in the Midwest region became clear in three areas: migrant vulnerability to exploitation, legibility of human trafficking, and political rhetoric versus local response. The first two areas illustrated by this study are well established in the literature. However, they warrant inclusion because the emphasis of this research was to highlight perspectives from an understudied region and to illustrate the perspectives of service providers. The first area highlighted specific vulnerabilities to exploitation among migrant service-users from the perspective of service providers (See Table 1). The second area highlighted a theme that human trafficking may not be legible from the perspective of service providers. The third area, which reflects a potentially novel contribution to the research, manifests the theme that state and national level political rhetoric about immigration is shaping policy decisions that do not necessarily align with local, organizational responses.

Migrant Vulnerability to Exploitation

The first theme identified by service providers in this inquiry emphasized the importance of social support and social networks in reducing vulnerability of migrant populations. Social networks serve as a cushion in an otherwise hostile environment.

Structural issues such as limited healthcare, transportation, housing, secure employment, and lack of community supports were all identified as barriers to helping migrant populations gain stability and reduce vulnerability to social ills. Participants recognized these vulnerabilities but did not always make the clear connection to trafficking and exploitation. Table 1 briefly introduces the themes of vulnerabilities that were identified by the service providers in our inquiry (in alphabetical order) and is followed by some descriptive examples from the data.

Table 1. *Vulnerability to Exploitation of Migrants as Perceived by Service Providers*

Vulnerability	Description
Documents withheld	Clients' documents have been withheld by trafficker to limit power or ability to leave
Employment or income precarity	Income withheld by intimate partner or trafficker, or access denied
English-only services	Not enough multilingual service providers and/or access to interpreters
Gender	Women are more vulnerable to trafficking
History of trauma or abuse	Participants refer to migrants' increased vulnerabilities due to generalized trauma, sexual and/or intimate partner violence, or substance abuse
Housing Instability	Migrants experience instability in housing due to legal status, financial resources, or because it is provided by employer.
Immigration Status	Whether the client has legal status to be in the United States
Isolation, physical and social	Being physically, culturally, or linguistically removed from social supports or networks.
Lack of Supervision	Minors left without adult supervision
Migrants' lack of understanding of English language and/or American culture	Inability to communicate in the dominant language and/or lack of familiarity with systems and institutions of the migrants' new culture

Documents withheld. One common method of disempowering the persons being trafficked is to hinder their ability to move freely by withholding their documentation that identifies who they are and indicates their status as migrants. While some workers are sponsored into the USA on H-1B visas and feel beholden to the sponsor of the visa, those visa holders may work for multinational companies that provide them with a support network and resources to learn their surroundings. In contrast, some workers find themselves dwelling in inhumane conditions with their co-workers, allowed out only to go to work where they are supervised constantly in low-wage positions. They are powerless to leave because their identification documents are being kept from them, and they are terrified to report to authorities because they are unaware of their rights. One participant said of their interaction with this vulnerability:

> *Some labor recruiter went to India and told them they could get them green cards if they each spent about $20,000 to come to the United States and work in a ship yard. Some of them borrowed money, some of them mortgaged houses, some of them had savings, so this whole group of people came, and the real hope was that if they got green cards they could then bring their families. So they are immediately locked up, and they are actually given H-2B visas, guest worker visas and forced to work under pretty deplorable, unhealthy conditions, living in unhealthy conditions. Their passports were collected. They couldn't leave. And if they didn't keep working, they would lose the money, they would lose their houses, their fathers' houses, whatever they had done to get the money together.*

Employment or income precarity. Not only are workers vulnerable to having their "documents, their driver's licenses, their visas, their passports, whatever they might have with them" taken by their trafficker, as was indicated by yet another service provider, lack of access to their income also entraps vulnerable migrants and impedes their leaving. Illegal, unethical, exploitative employment arrangements often mean very little income even though the migrant worker has fulfilled their work obligation. A participant reported:

> *They are brought in by... gang leaders ... as a gang of workers and the patrons, the leader is the one who gets paid, and he decides how much each person in the group makes. It is not a normal employment relationship. It's not a legal one. They just, they are like a subcontractor, and the dress it up by calling it a 'subcontractor,' but it's really a patron system, and if you screw up or piss off that person, you don't get paid.*

English-only services. Providers recognized that their own inability to speak a language other than English as a barrier to serving migrants. Representative of this theme is the following excerpt:

> *We frequently advocate for interpreters at health appointments for our clients. Sometimes we provide that interpretation service. Sometimes we either are not able to for one reason or another or sometimes we just take the opportunity to advocate and say 'the clinic really needs to provide it, and this is why' kind of thing. It is really, sometimes it is very frustrating that this is still such a big barrier. It seems like it should be easier by now.*

Gender. Participants suggested that migrant women are particularly vulnerable to exploitation, which is congruent with the increased susceptibility of women to oppression that is recognized worldwide. Whether it be because of gender roles and associated social norms differing from their home nation and the U. S., or because patriarchal underpinnings create a climate where women are considered subordinate, many women are at an increased disadvantage when they migrate. One service provider described this inequality within the refugee population they served:

> *I think gender plays a huge impact, specifically working with refugees from certain countries. For instance, in Burma the gender roles seem...very...strict and rigid at times. So even when I'm communicating with refugee clients--let's say it's a heterosexual couple--prolonged eye contact, for instance with the wife could suggest a whole number of things that you wouldn't think of. I think that when those strict gender roles carry over into a new culture, I think that can still leave you particularly vulnerable.*

Migrating with one's spouse who is likely from the same cultural milieu has its difficulties, but engaging in a relationship with someone from a different cultural background is also challenging when one person is put at a disadvantage because of perceived dominance or subordination. An example from the data that illustrates this imbalance:

> *I think the final one I would say and again related to sexuality would be some exploitative situations or easily lend themselves to exploitative situations where*

> *you have an undocumented woman generally and an American man, and they enter into some sort of relationship…It so easily lends itself to exploitation.*

Finally, the patriarchal construct of women as property of the male head of household undergirds this participant's statement that "A lot of the women's dads sell them to their husbands."

History of abuse or trauma. The prevalence with which people experience trauma and violence is alarming. Whether it be domestic violence, child abuse, or past exploitation, often at the hands of a loved one, these factors increase vulnerability to further exploitation from the perspectives of many participants. Having a history of trauma was mentioned numerous times, with domestic violence repeatedly identified as a risk factor for exploitation. These experiences were often combined with other risks for vulnerability as identified by a participant, "Typically, there is substance abuse. There is history of trauma; they're undocumented and typically indigenous. Feeling very vulnerable, like they don't have rights." The perception that it is socially acceptable in some cultures, even normal, to experience abuse at the hands of an intimate partner was described by a participant in this way:

> *The second area is domestic abuse and sexual violence, particularly prevalent in my experience…we helped people get visas, U Visas because they're victims of sexual violence and domestic abuse…and in fact I think, maybe not sexual abuse, but domestic violence is culturally accepted in many ways.*

The logistics of migration itself create openings for trauma as well, as voiced by this participant:

> *They're a lot of things that happen before they come here which is why they're here. Or they happen when they were crossing the borders. I worked with a woman who was raped by a coyote.*

Housing instability. One theme that emerged in the conversations with most participants addressed the instability many people face, and the nature of homelessness in the area. Women appear particularly vulnerable when it comes to housing and financial disempowerment. They often have children they are trying to care for and keep safe, as illustrated by this participant:

> *So housing is a huge thing. Because obviously if you don't have rental history, if you don't have proof of income. Like these are thing that are consistently demanded with U.S. housing. So we have established partnerships and relationships with the apartment complexes in [name of county]. … If they just don't have any of these demanded documents or proof then they aren't even considered.*

Immigration status. It comes as no surprise that service providers recognize the stress experienced by migrants without legal documentation. Not only does this status increase the hardship of securing gainful employment, it leads to increased vulnerability to exploitation due to the migrants' perceptions that they have no rights, as indicated here:

> *There is still that underlying fear of not having papers …. I am using their terminology, 'I don't have any papers.' Having no papers and feeling very vulnerable, you have to put up with things that other people don't have to put up with.*

Additional support for this theme came from these participants who stated: "I have heard from my friends in [Urban City 2], it was about 40% of their population is undocumented workers and undocumented kids. And they would be more apt to not report anything that might happen" as well as "Probably helping the families find ways to be here legally without feeling like they have to keep a step ahead of being caught… it's kinda a scary time in our country frankly, with the whole Donald Trump campaign."

Physical and social isolation. The interview data clearly indicated that physical and social isolation increase vulnerabilities to exploitation and should be considered by service providers of migrant populations. Service providers talked about the physical isolation that migrants face, including very limited transportation. They only go where their employers want to take them, and in rural areas often do not have the bus systems they need to get to services.

Social isolation was also identified as an area of vulnerability. For example:

> *I think where you have problems is in places in more rural areas, how you get the networks to reach in those areas is going to be a challenge…I think you know, part of what [Non-Profit Law Firm 2] does…we have a migrant farm workers program that deal…workers who move from state to state or some sort of agricultural crop, and they face a whole variety of issues but their job and where they live is on site, and so if the employer doesn't want someone on the property to talk with those people, you can't get on the property to talk to those people.*

Lack of supervision. Participants identified a distinct difference between the vulnerabilities of migrant adults and minors, although there is a great deal of overlap in the characteristics that increase vulnerability to exploitation. Children experience increased risks of exploitation simply because they rely on others for their care, transportation, and access to most services they would ever need. They are subordinate to (most) adults in that they are generally physically weaker, have less life-wisdom due to inexperience, and as is often the manner of youth, trusting and unaware that their situation puts them at risk. Participants shared their concerns about young people being left unsupervised and the increase in vulnerability because of this: "We are concerned particularly for our teenage girls, particularly if they have a single parent and they are coming from a single parent household and maybe that parent is working second or third shift." Additionally, one indicated that they were

> *…Just worried about supervision, even though the child might be at an age where it is OK that they are home because they are 16 or 17 but just ensuring that they are safe and that they are not victimized.*

Migrants' lack of understanding English language and/or American culture. While one's ethnicity or cultural background do not inherently increase vulnerability, immigrating from another country without a thorough understanding of American culture

and/or English increase the risk of exploitation. Tied directly to this theme is the vulnerability often felt by people who are at the mercy of smugglers when trying to immigrate to the US without going through legal channels to do so. Many immigrants are just not prepared for the intricacies of American culture and the people who are more than happy to prey upon their ignorance. One respondent reflected:

> *I think maybe also just not knowing the culture. For instance, we had one gentleman who found a job on his own and thankfully he continued to talk with his case manager about it, but it was not a positive situation. I mean the manager was quite verbally abusive, the pay was not what it should be, and so thankfully he was in communication with us, and we advised him that he needed to leave that job.*

Another stated:

> *… limited English proficient, coming from different places, not understanding the legal system at all, or people often don't understand what rights they might have…and I think you know, access to quality education, I think affects people too, cause they feel like they don't read or understand well when they're faced with these legal documents that people give them, they just sign them, they don't read them, and then they don't understand what kind of debt they're getting into that, that makes them, it makes it unsurmountable for them – payday loans, that people are frequently signing, they don't understand how it works.*

Legibility of Human Trafficking

A second key theme identified by service providers relates to the legibility of human trafficking. Schwarz and Britton (2015) write,

> The defunding of social services and the welfare state continues to distance the members of society most vulnerable to trafficking from the institutions and structure they most need. In particular, the bodies and lives that are the least legible then become even more separated from the democracy that was intended to include them. (pp. 64-65)

Service providers negotiate the meaning of "human trafficking" in very different ways. Service providers serve migrants who are also survivors of trauma on a daily basis, yet many providers may unintentionally fail to connect the actual lived experiences of their clients to trafficking policies and provisions that protect survivors (Chapkis, 2003). This confusion, paired with anti-immigration rhetoric and restrictive social welfare policies, contributes to a climate in which individuals fail to read themselves into trafficking narratives. They are often not legible within the more common perceptions of what trafficking looks like.

The data from these interviews indicated that there is a gap between what people perceive as trafficking and how it is defined or treated as a result of policy. Most of the awareness campaigns and efforts toward prevention that these service providers discussed specifically highlighted young girls involved in sex trafficking and did not address labor exploitation or other forms of trafficking risk. Additionally, anti-trafficking rhetoric that focuses on kidnapping and abduction ignores the possibilities that people could be coerced

or exploited in other ways. For example, several interview participants initially said they had no experience with trafficking and suggested we interview other people. However, when we explained the definition of trafficking from the Victims of Trafficking and Violence Protection Act of 2000 (2000), they realized that the exploitation many of their clients faced could be identified as, or lead to, labor trafficking. For example, one service provider working with a migrant advocacy organization stated they see similarities in the work they do:

> *…we deal with issues in the global economy that include migration. And while human trafficking isn't going to come up directly, there are so many similarities between the kinds of abuses you find that we call human trafficking and the kinds of working conditions that undocumented people face or people who are brought in—in the labor gangs. To me, the line is very fuzzy, between what's human trafficking and what's just your standard abuse of workers who are undocumented.*

This service provider denied having a connection to trafficking and then, while answering, renegotiated its meaning. Acknowledging a "fuzzy" line between trafficking and various working conditions not only makes identifying trafficking difficult, it means that providers and advocates may be dismissing the possibility that trafficking occurs to their organizations' clients outright.

Another participant who works with refugee resettlement in the United States pushed back on the idea that she was working with trafficked individuals. This social worker initially thought that only her former employment agency addressed trafficking, but she stopped and retracted:

> *I guess I should back up and say that I am sure that we have, if you are talking about folks who have been trafficked prior to them coming to the US, then yes we have served them…So, I mean, it depends what your definition of trafficking is…But we have folks coming from situations where they have paid smugglers or traffickers for safe passage out of their home country or things like that that was not "safe passage."*

Each of these examples considers the relationship individual service providers have with the definition of "human trafficking." Within the interview process itself, several participants became aware of their potential connections or interactions with clients who may be in fact be survivors of human trafficking. This is an interesting finding: that the very process of discussing trafficking with these service organizations helped clarify the ways in which their organization needed to address their work with potentially exploited clients. Conversations within interviews themselves appeared epiphanic and perhaps transformative as indicated by reflections in the data.

Access to services/resources was critically important to these service providers. They expressed a desire to go to where the clients are and to take services to them, especially considering that these are populations that in some cases are hidden: "They are not out looking for social service organizations; they are not out." There was also a desire to build collaborative services in an effort to increase access. Service providers were committed to

both quality and access in their care: "…even people without insurance deserve the best quality that they could get."

The majority of participants expressed that their organizations lacked training in human trafficking, lacked a protocol for identifying human trafficking, and lacked specific procedures for intervening and assisting survivors. Most service organizations represented in the interviews did not have a working definition of trafficking. They were often apologetic about their lack of direct experience in trafficking.

Political Rhetoric Versus Local Response

In addition to the legibility question, a third theme demonstrated that Midwest service provider narratives illustrated a tension between national and state-level political rhetoric and local community responses to migrant populations in the Midwest. Service providers discussed their need to negotiate political and governmental approaches that restrict rights for migrant populations with a Midwestern ethos of generosity and welcome. A service provider working with migrants in the Midwest worried about anti-immigrant sentiment in political and governmental rhetoric:

> *Prior to [the Paris attacks] I would say that families were very much welcomed, and I did not really have concerns about how they were being accepted or what it meant in the wider community. Now, because of where things are at, and some of the thoughts and beliefs we hear about, I have greater concerns about whether the families coming to this area are being fully welcomed.*

The service provider also noted that they have seen an increase in support for the work of the organization:

> *...I see as a silver lining of things, is that I've had a lot more volunteers coming forward and saying 'how can we support your agency?' and what you do. Even one entity used the word--kind of I see this as our congregations' resistance to what we are hearing [in the media]…a lot of people are saying, 'no, we want to be welcoming. How can we get involved?'*

Considering increased political restrictions on refugees and migrants, our research team also asked Midwestern service providers for their perspectives on their motivation to continue to provide services. Their responses reflected both individual and systemic issues that drive vulnerability and exploitation of migrant populations, and many used a specific lens of religion, ethos, and their self-described Midwestern norms that motivated them to action.

First, service providers identified areas of structural oppression and injustice that create difficulties for migrant populations and motivate the service providers to work for change. Specifically, they highlighted poverty, gender inequality, anti-immigrant sentiment, corruption, healthcare access, trauma, and economic forces that contribute to problems of exploitation and vulnerability. These issues can layer one on top of another and create complicated and dense situations of vulnerability.

Second, providers identified ways in which social policies (particularly related to welfare reform and immigration) increase the risk of exploitation. Due to desperation, trauma, and lack of assistance, the people with whom they work are forced into compromising situations of employment. These injustices move service providers to action: “I just felt duty-bound to get involved and try to do something.” Many of them mentioned strong desires for policy shifts and expanded supports and the expansion of social services. Service providers listen to the experiences of migrants in their organizational contexts and try to translate those experiences into a call for social change. One service provider who provided education to migrants stated: “I want it [human slavery] to be disturbing for everyone involved. And to not let things go by the wayside. It *should* bother us.” These findings are reflective of previous research related to structural oppression and the risk of exploitation (Berg, 2015; Gleason et al., 2016; Lutnick, 2016; Schwarz & Britton, 2015; Todres, 2011). However, it highlights that in the midst of staunch political rhetoric that is anti-immigrant, anti-poor, and anti-assistance, there are voices that reflect a Midwestern narrative that is welcoming, generous, and kind.

Finally, service providers encountered various legal and ethical issues in their work, most prominently mentioning issues of legal status and the risks associated when migrants are not authorized or undocumented: “…undocumented workers and undocumented kids…they would be more apt to not report anything that might happen.” The fear of talking and a lack of understanding basic rights inhibit the helping process. Service providers appear to be motivated by a need for more integrated approaches and more legislative reform for protections. One provider stated, “I am really hoping that we can get something done legislatively…I just want to see it get strengthened.” In addition to identifying structures that needed to change, service providers also recognized that they could do more personally: “I feel trapped by my limited language ability,” and “I am sure there are times where we were working with clients, and we did not do a good enough job of explaining what’s going on…” This indicates a feeling of unpreparedness among service providers.

Discussion

This study explored the perspectives of service provides related to the exploitation of migrant populations and their vulnerability to trafficking. Findings indicate three main areas of emphasis which are discussed in the previous section: 1).Vulnerabilities of migrant populations, 2). A lack of legibility of human trafficking in social service organizations, and 3). A difference between political rhetoric and local responses to migrant populations. In order to address the specific vulnerabilities to exploitation identified by our interview respondents, systemic and community issues that affect exploitation must be addressed. This includes access to services, social and economic inequality, citizenship status, transportation, and language, and is reflective in other literature related to trafficking risks as well (Baker, 2013; Berg, 2015; Lutnick, 2016; Okech et al., 2017; Todres, 2011; Warren, 2016). Collaboration between service providers is also important. It was clear from these interviews that there are not enough resources to adequately support migrant populations and/or the motivation to improve these services at the regional level.

The NASW, in the latest version of *Standards and Indicators for Cultural Competence in Social Work Practice* (2015a), has addressed the expectation that services be provided

in the "client's preferred language with the proficiency required," (p. 45) which could mean keeping professional interpreters on staff, certainly for commonly spoken languages represented by the migrant population in the geographic area. Federally-funded entities are required to provide an interpreter, yet many migrants speak indigenous languages for which interpreters are rare.

Related to access and mobilization of resources for clients, social service interventions need to be formed around social networks (Negi, Michalopoulos, Boyas, & Overdorff, 2013). Recognizing the importance of social networks, service providers were motivated to help link their clients into key relationships, connecting them to social networks so they can be a meaningful part of a community. They identified how healthy community and family connections can serve as a buffer against situations of exploitation. There is also a need to increase the knowledge base by educating social workers and other service providers about migration-related policy and trauma-informed care to improve their skills and understanding of vulnerability to exploitation and to expand research related to social networks.

Regarding legibility, social workers and other service providers need to broaden their understanding of trafficking to include narratives of exploitive practices so that they can successfully identify people being trafficked and help survivors navigate systems of assistance. A risk factor for labor exploitation identified by Schwarz (2017) was prior (and unsuccessful) involvement with a social service provider. This indicates that survivors were seeking some sort of assistance, but their vulnerabilities for exploitation went unaddressed. For example, a client who seeks a health assessment may not be asked if they feel socially isolated or fear deportation. A holistic evaluation of individual cases will help identify risks earlier so that interventions are more effective (Barrick et al., 2014; Simmelink & Shannon, 2012). Helping providers understand the full range trafficking policy and intervention tools could help them identify and assist their clients who may be vulnerable to various forms of trafficking. Educational and prevention programs to educate social service organization staff and advocacy groups on labor and trafficking practices as they relate to exploitation must increase in quality and frequency (Hodge & Lietz, 2007; Salett, 2006).

The "fuzzy" lines related to defining trafficking make it difficult for service providers to connect trafficking risks with more commonly understood social problems. When legibility among service providers is evident, that may filter to service-users as well. Schwarz and Britton (2015) argue that trafficking prevention is elusive without shifting structural factors such as gender, class, and sexuality inequalities. Our data aligns with previous research that argues this connection needs to be strengthened.

This study was conducted in a very politically conservative region of the country, where gubernatorial executive orders restrict services to migrant populations. Still, it is important to note that these interviews were conducted in the early months of the 2016 presidential campaign, and since then the social and political divide regarding perceptions of migrants has deepened. Regardless of political restrictions, local communities are stepping in and offering assistance and, in some cases, providing sanctuary for migrant populations. Service providers need training in migration policy and public advocacy in

order to protect themselves, their agencies, and the people they are trying to help from unwelcome attention.

It is also important for social workers and other service providers to pay attention to systemic issues such as lack of affordable housing, which is related to the vulnerability of precarious housing, power, privilege, and oppression (Alvarez & Alessi, 2012; Okech et al., 2017). These systemic narratives are often omitted from interventions for trafficking. However, they are the perfect venues for identifying preventive strategies (Schwarz & Britton, 2015). Migrants and others who live in a state of precarity need access to a safe place to live, sustainable and supportive employment, and quality health care and education. Social workers are professionally positioned to do this work. Increasing the training and support in community social welfare organizations is consistent with other recommendations in social work research (Okech et al., 2017) and echoed across other sectors, such as law enforcement (Farrell et al., 2010; Owens et al., 2014) and medical providers (Becker & Bechtel, 2015; Powell, Dickins, & Stoklosa, 2017). This area can be enhanced in social work practice across social institutions. Social workers can fine tune assessment strategies and expand referral options for quality education, transportation, medical care, and mental health services. They can also advocate for policy changes to support migrant populations and create sustainable migration reform

Participants referred to assisting clients with obtaining U Visas, which are available to survivors of violent crimes (including certain forms of trafficking) who work with law enforcement to investigate or prosecute offenders (Warren, 2016), yet the T Visa is another tool to assist immigrants. The T Visa, which makes it possible for survivors of human trafficking to obtain legal residency if they cooperate with law enforcement to investigate or prosecute their traffickers, can be transformative for clients if social workers understand the procedure and collaborate to develop accessible processes in their communities. The T Nonimmigrant status (T visa) provision was enacted, along with the U Visa, under the Victims of Trafficking and Violence Protection Act of 2000 (2000). The T Visa has the potential to reframe victimization into a more positive opportunity by allowing trafficked survivors, who are in the United States as a result of being trafficked, to eventually gain legal residency, and then U.S. citizenship. As Warren (2016) recommended with regard to the U Visa, in order for the T Visa to be fully realized, Congress must mandate nationwide training to develop consistent procedures to enable clients to access these visas. Social workers and other social service professionals cannot wait for a governmental revision to include the funding required to fill this need. They can fulfill an essential role in working with local and state law enforcement, labor divisions, and organizations that serve migrant populations to utilize both the T Visa's and U Visa's potential to identify and stop human trafficking.

Limitations

While the intent of this study was to understand the perceptions of service providers, one drawback is that there are no direct voices of people with lived experience of migration themselves. This is a broader problem in migration literature, as talking with people who have recently experienced migration must be addressed with sensitivity. A second limitation of this study relates to the interview process for this study. Even though the

research team met together to develop interview questions and discuss interviewing strategies, the actual nuances of the interviews themselves may have varied. Finally, only one interview was conducted with each service provider. Multiple interactions may have provided more depth and detail to the interviews.

Recommendations and Future Research

Social work's ecological perspective acknowledges a need for services across practice levels. Social workers can offer this perspective to other service providers in helping to address trauma and interpersonal issues while simultaneously helping to navigate systemic issues that contribute to exploitation. Social workers are poised to lead in collaboration with others to train community members in recognizing and intervening in suspected trafficking. Their participation with local law enforcement and policy-makers is essential to challenging the structures and practices that enable predatory individuals to take advantage of vulnerable people. Services need to include approaches that are not linear, are flexible/adaptable to client needs, and are interactive and client-driven (Chappell Deckert, 2016). Service providers need to establish trusting relationships so the potential for deeper issues of exploitation to be uncovered readily exists (Hayes & Unwin, 2016). Further inquiry is warranted for a more complete understanding about how conversations about trafficking and exploitation create changes in service provision.

One principle of social work education is to develop professional resourcefulness and alliance with our clients. These skills put social workers in the forefront of the social services, assisting migrants who have left behind everything that they knew with regard to language, culture, and social systems either by choice or by force. As social workers, we are called by our ethical code and values to aid trafficking survivors with competent service that enhances dignity and well-being. This is a justice concern of utmost importance, and we must be prepared to act responsibly and with sensitivity.

This study's qualitative nature did not seek to quantify the increased effects of additional variables of vulnerability on one's susceptibility to exploitation. Knowing how much more vulnerable a person is because of the complexity of their life situation may awaken policy-makers to the needs of vulnerable and marginalized people, but it has failed thus far. More resources are needed in general: to get people to their services, to keep children safe, to teach parents the skills they need to be better parents, to help people feel less isolated and see themselves as worthy members of their communities, and to prosecute those who prey upon the many vulnerable people with whom we create a society.

The three areas highlighted by this study (vulnerabilities of migrant populations, a lack of legibility of human trafficking in social service organizations, and a difference between political rhetoric and local responses to migrant populations) move the profession forward by illustrating key issues from the perspective of those who most directly interact with migrant populations through social services. Addressing the vulnerabilities to exploitation can prevent further marginalization, bring the hidden parts of the problem to the forefront, and build networks of support across community agencies. Responding to structural oppression and advocating for stronger social welfare policies, in addition to clarifying the "fuzzy line" identified by the respondents of what is/is not exploitive will help to improve

legibility and access to services. Finally, understanding the incongruence, or tension of restrictive immigration and social welfare policies against the motivation of grassroots communities to respond in a welcoming and generous manner will help social workers feel empowered and hopeful as they create communities that can support and encourage these vulnerable populations.

References

Abdus-Shakur, A. (2016). Assessing hidden abuse: Human trafficking of children involved in child welfare. *National Association of Social Workers Child Welfare Specialty Practice Section* (Spring/Summer). Retrieved from https://www.socialworkers.org/assets/secured/documents/sections/child_welfare/newsletters/2016%20Child%20Welfare%20Summer%20Issue1.pdf

Agbényiga, D. L., & Huang, L. (2012). Gendered immigration: Implications and impact on social work education. *Advances in Social Work*, *13*(2), 291-305.

Alvarez, M. B., & Alessi, E. J. (2012). Human trafficking is more than sex trafficking and prostitution: Implications for social work. *Affilia: Journal of Women and Social Work, 27*(2) 142-152. doi: https://doi.org/10.1177/0886109912443763

Artz, G. M. (2012). Immigration and meatpacking in the Midwest. *Choices. Quarter 2*. Retrieved from http://www.choicesmagazine.org/choices-magazine/theme-articles/immigration-and-agriculture/immigration-and-meatpacking-in-the-midwest-

Ayón, C. (2016). Talking to Latino children about race, inequality, and discrimination: Raising families in an anti-immigrant political environment. *Journal of the Society for Social Work and Research, 7*(3), 449-477. doi: https://doi.org/10.1086/686929

Ayón, C., & Becerra, D. (2013). Mexican immigrant families under siege: The impact of anti-immigrant policies, discrimination, and the economic crisis. *Advances in Social Work*, *14*(1), 206-228.

Baker, C. N. (2013). Moving beyond ‘slaves, sinners, and saviors’: An intersectional feminist analysis of U.S. sex-trafficking discourses, law and policy. *The Journal of Feminist Scholarship, 4*, 1-23.

Balgopal, P. R. (2000). *Social work practice with immigrants and refugees*. New York, NY: Columbia University Press. doi: https://doi.org/10.7312/balg10856

Barrick, K., Lattimore, P. K., Pitts, W. J., & Zhang, S. X. (2014). When farmworkers and advocates see trafficking but law enforcement does not: Challenges in identifying labor trafficking in North Carolina. *Crime, Law and Social Change*, *61*(2), 205-214. doi: https://doi.org/10.1007/s10611-013-9509-z

Becker, H. J., & Bechtel, K. (2015). Recognizing victims of human trafficking in the pediatric emergency department. *Pediatric Emergency Care, 31*(2), 144-147. doi: https://doi.org/10.1097/PEC.0000000000000357

Ben-David, A. (1995). Family functioning and migration: Considerations for practice. *Journal of Sociology and Social Welfare, 22*(3), 121-137.

Berg, H. (2015). Trafficking policy, meaning making and state violence. *Social Policy & Society, 14*(1), 145-155. doi: https://doi.org/10.1017/S1474746414000414

Brennan, D. (2005). Methodological challenges in research with trafficked persons: Tales from the field. *International Migration, 43*(1-2), 35-54. doi: https://doi.org/10.1111/j.0020-7985.2005.00311.x

Brennan, D. (2008). Competing claims of victimhood? Foreign and domestic victims of trafficking in the United States. *Sexuality Research & Social Policy 5*, 45-61. doi: https://doi.org/10.1525/srsp.2008.5.4.45

Bromfield, N. F., & Capous-Desyllas, M. (2012). Underlying motives, moral agendas and unlikely partnerships: The formulation of the U.S. Trafficking Victims Protection Act through the data and voices of key policy players. *Advances in Social Work*, *13*(2), 243-261.

Capous-Desyllas, M. (2007). A critique of the global trafficking discourse and US policy. *Journal of Sociology & Social Welfare*, *34*, 57-79.

Chang-Muy, F., & Congress, E. P. (2008). *Social work with immigrants and refugees: Legal issues, clinical skills, and advocacy.* New York, NY: Springer.

Chapkis, W. (2003). Trafficking, migration, and the law: Protecting innocents, punishing immigrants. *Gender and Society, 17*(6), 923-937. doi: https://doi.org/10.1177/0891243203257477

Chappell Deckert, J. (2016). Social work, human rights, and the migration of Central American children. *Journal of Ethnic & Cultural Diversity in Social Work*, *25*(1), 20-35. doi: https://doi.org/10.1080/15313204.2015.1121420

del Mar Farina, M. (2013). Failure to mourn "White Nativism": Impact of deportation on Hispanic American–born children and mixed-status families. *Smith College Studies in Social Work, 83*, 139-169. doi: https://doi.org/10.1080/00377317.2013.803362

Dominelli, L. (2010). *Social work in a globalizing world*. Cambridge, UK: Polity Press.

Farrell, A., McDevitt, J., & Fahy, S. (2010). Where are all the victims? Understanding the determinants of official identification of human trafficking incidents. *Criminology and Public Policy, 9*(2), 201-233. doi: https://doi.org/10.1111/j.1745-9133.2010.00621.x

Furman, R., Ackerman, A. R., Loya, M., Jones, S., & Negi, N. (2012). The criminalization of immigration: Value conflicts for the social work profession. *Journal of Sociology and Social Welfare, 39*, 169-185.

Glaser, B., & Strauss, A. (1967). Grounded theory: The discovery of grounded theory. *Sociology the journal of the British sociological association*, *12*, 27-49.

Gleason, K. D., Baker, C., Carangan, A., Espinueva, J., Herrera-Mendoza, A., Lukacinsky, D., & Remis, A. (2016). The importance of considering local context when attempting to address human trafficking: A qualitative study with service providers and advocates in Hawai'i. *Global Journal of Community Psychology Practice*, *7*(3), 1-13. doi: https://doi.org/10.7728/0703201604

Hayes, S., & Unwin, P. (2016). Comparing the cultural factors in the sexual exploitation of young people in the UK and USA: Insights for social workers. *Revista de Asistenta Sociala, 1*, 27-39.

Heil, E. C., & Nichols, A. J. (2015). *Human trafficking in the Midwest: A case study of St. Louis and the bi-state area*. Durham, NC: Carolina Academic Press.

Hill, A. (2016). How to stage a raid: Police, media and the master narrative of trafficking. *Anti-Trafficking Review, 7*, 39-55.

Hodge, D. R., & Lietz, C. A. (2007). The international sexual trafficking of women and children: A review of the literature. *Affilia*, *22*(2), 163-174. doi: https://doi.org/10.1177/0886109907299055

Hoyle, C., Bosworth, M., & Dempsey, M. (2011). Labelling the victims of sex trafficking: Exploring the borderland between rhetoric and reality. *Social & Legal Studies, 20*(3), 313-329. doi: https://doi.org/10.1177/0964663911405394

Jones, L., Engstrom, D. W., Hilliard, T., & Diaz, M. (2007). Globalization and human trafficking. *Journal of Sociology & Social Welfare*, *34*, 107-122.

Kaufka Walts, K. (2017). Child labor trafficking in the United States: A hidden crime. *Social Inclusion, 5*(2), 59-68. doi: https://doi.org/10.17645/si.v5i2.914

Kelleher, C., & McGilloway, S. (2009). 'Nobody ever chooses this...': A qualitative study of service providers working in the sexual violence sector-key issues and challenges. *Health & Social Care in the Community, 17*(3), 295-303. doi: https://doi.org/10.1111/j.1365-2524.2008.00834.x

Kim, M. (2009). The political economy of immigration and the emergence of transnationalism. *Journal of Human Behavior in the Social Environment, 19*, 675-689. doi: https://doi.org/10.1080/10911350902910849

Lipsky, M. (2010). *Street-level bureaucracy, 30th ann. Ed.: Dilemmas of the individual in public service*. New York, NY: Russell Sage Foundation.

Lutnick, A. (2016). *Domestic minor sex trafficking: Beyond victims and villains*. New York, NY: Columbia University Press. doi: https://doi.org/10.7312/lutn16920

Mapp, S. C. (2016). *Domestic minor sex trafficking*. New York, NY: Oxford University Press.

Martin, P. (2012). Hired farm workers. *Choices, 27*(2), 1-7. Retrieved from http://www.choicesmagazine.org/UserFiles/file/cmsarticle_233.pdf

Moser, T. (2015). Trafficking in rural Nebraska. *Nebraska Medicine, 14*(1), 7-11.

Musto, J. L. (2009). What's in a name?: Conflations and contradictions in contemporary U.S. discourses of human trafficking. *Women's Studies International Forum, 32*(4), 281-287. doi: https://doi.org/10.1016/j.wsif.2009.05.016

Musto, J. (2013). Domestic minor sex trafficking and the detention-to-protection pipeline. *Dialectic Anthropology, 37*, 257-276. doi: https://doi.org/10.1007/s10624-013-9295-0

Musto, J. (2016). *Control and protect: Collaboration, carceral protection, and domestic sex trafficking in the United States*. Oakland, CA: University of California Press. doi: https://doi.org/10.1525/california/9780520281950.001.0001

Nash, M., Wong, J., & Trlin, A. (2006). Civic and social integration: A new field of social work practice with immigrants, refugees and asylum seekers. *International Social Work*, *49*(3), 345-363. doi: https://doi.org/10.1177/0020872806063407

National Academy of Sciences. (2015). *The integration of immigrants into American society*. Washington, DC: National Academies Press. doi: https://doi.org/10.17226/21746

National Association of Social Workers [NASW]. (2015a). *Standards and indicators for cultural competence in social work practice*. Washington, DC: NASW Press.

NASW. (2015b). Slavery and human trafficking. In J. Gutin & S. Lowman (Eds.), *Social work speaks* (10th ed., pp. 275-279). Washington, DC: NASW Press.

Negi, N. J., Michalopoulos, L., Boyas, J., & Overdorff, A. (2013). Social networks that promote well-being among Latino migrant day laborers. *Advances in Social Work*, *14*(1), 247-259.

O'Neill Richard, A. (1999). *International trafficking in women to the United States: A contemporary manifestation of slavery and organized crime*. Center for the Study of Intelligence. Retrieved from https://www.cia.gov/library/center-for-the-study-of-intelligence/csi-publications/books-and-monographs/trafficking.pdf

Okech, D., Choi, Y. J., Elkins, J., & Burns, A. C. (2017). Seventeen years of human trafficking research in social work: A review of the literature. *Journal of Evidence-Informed Social Work*, 103-122. doi: https://doi.org/10.1080/23761407.2017.1415177

Owens, C., Dank, M., Breaux, J., Banuelos, I., Farrell, A., Pfeffer, R., & McDevitt, J. (2014). *Understanding the organization, operation, and victimization process of labor trafficking in the United States* (Research Report). Washington, DC: Urban Institute. Retrieved from http://www.urban.org/research/publication/understanding-organization-operation-andvictimization-process-labor-trafficking-united-states

Peksen, D., Blanton, S. L., & Blanton, R. G. (2017). Neoliberal policies and human trafficking for labor: Free markets, unfree workers? *Political Research Quarterly*, *70*(3), 673-686. doi: https://doi.org/10.1177/1065912917710339

Powell, C., Dickins, K., & Stoklosa, H. (2017). Training U.S. health care professionals on human trafficking: Where do we go from here? *Medical Education Online, 22*(1), 1267980. doi: https://doi.org/10.1080/10872981.2017.1267980

Romero, S., & Williams, M. R. (2013). The impact of immigration legislations on Latino families: Implications for social work. *Advances in Social Work*, *14*(1), 229-246.

Salett, P. E. (2006, November). *Human trafficking and modern day slavery. Human rights and international affairs: Practice update.* Retrieved from http://www.socialworker.org/diversity/affirmative_action/humanTraffic1206.PDF

Sassen, S. (2002). Women's burden: Counter-geographies of globalization and the feminization of survival. *Nordic Journal of International Law, 71*, 255-274. doi: https://doi.org/10.1163/157181002761931378

Schwarz, C. (2017). Human trafficking in the Midwest: Service providers' perspectives on sex and labor trafficking. University of Kansas Anti-Slavery and Human Trafficking Initiative. Retrieved from https://kuscholarworks.ku.edu/bitstream/handle/1808/23853/ASHTI_ServiceProviderPerspectives_2017.pdf?sequence=1&isAllowed=y

Schwarz, C., & Britton, H. E. (2015). Queering the support for trafficked persons: LGBTQ communities and human trafficking in the Heartland. *Social Inclusion*, *3*(1), 63-75. doi: https://doi.org/10.17645/si.v3i1.172

Schwarz, C., Unruh, E., Cronin, K., Evans-Simpson, S., Britton, H. & Ramaswamy, M. (2016). Human trafficking identification and service provision in the medical and social service sectors. *Health and Human Rights, 18*(1), 181-191.

Simmelink, J. A., & Shannon, P. (2012). Evaluating the mental health training needs of community-based organizations serving refugees. *Advances in Social Work*, *13*(2), 325-339.

Sirojudin, S. (2009). Economic theories of emigration. *Journal of Human Behavior in the Social Environment, 19*, 702-712. doi: https://doi.org/10.1080/10911350902910880

Srikantiah, J. (2007). Perfect victims and real survivors: The iconic victim in domestic human trafficking law. *Boston University Law Review, 87*, 157-211.

Stienstra, D. (1996). Madonna/whore, pimp/protector: International law and organization related to prostitution. *Studies in Political Economy*, *51*, 183-217. doi: https://doi.org/10.1080/19187033.1996.11675333

Todres, J. (2011). Moving upstream: the merits of a public health law approach to human trafficking. *North Carolina Law Review, 89*, 447-506.

U.S. Department of State. (2012). *Trafficking in persons report*. Washington D.C.: U.S. Department of State. Retrieved from https://www.state.gov/documents/organization/192587.pdf

U.S. Department of State. (2017). *Trafficking in persons report*. Washington D.C.: U.S. Department of State. Retrieved from https://www.state.gov/documents/organization/271339.pdf

United Nations Office on Drugs and Crime. (2000). United Nations Convention against Transnational Organized Crime and the protocols thereto. New York, NY: United Nations.

Valtonen, K. (2001). Social work with immigrants and refugees: Developing a participation-based framework for anti-oppressive practice. *British Journal of Social Work, 31*(6), 955-960. doi: https://doi.org/10.1093/bjsw/31.6.955

Victims of Trafficking and Violence Protection Act of 2000, Pub. L. No. 106-386, 114 Stat. 1464. (2000). Retrieved September, 16, 2017 from http://www.state.gov/documents/organization/10492.pdf

Warren, S. (2016). The U Visa for Immigrant Victims of Violent Crime: What social workers need to know. *Journal of Ethnic & Cultural Diversity in Social Work*, *25*(4), 320-324. doi: https://doi.org/10.1080/15313204.2016.1187102

Weitzer, R. (2012). Sex trafficking and the sex industry: The need for evidence-based theory and legislation. *The Journal of Criminal Law & Criminology, 101*(4), 1337-1370.

Weitzer, R. (2014). New directions in research on human trafficking. *The ANNALS of the American Academy of Political and Social Science, 653*, 6-24. doi: https://doi.org/10.1177/0002716214521562

Williamson, C., & Prior, M. (2009). Domestic and minor sex trafficking: A network of underground player in the Midwest. *Journal of Child & Adolescent Trauma, 2,* 46-61. doi: https://doi.org/10.1080/19361520802702191

Zhang, S. X. (2012). Measuring labor trafficking: A research note. *Crime, Law, and Social Change, 58*, 469-482. doi: https://doi.org/10.1007/s10611-012-9393-y

Zhang, S. X., Spiller, M. W., Finch, B. K., & Qin, Y. (2014). Estimating labor trafficking among unauthorized migrant workers in San Diego. *The ANNALS of the American Academy of Political and Social Science, 653*, 65-86. doi: https://doi.org/10.1177/0002716213519237

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The Karen Chemical Dependency Collaboration: Lessons Learned in Using a Collaborative Framework to Promote Refugee Integration

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Abstract: *While refugee integration is defined as a bidirectional process of mutual learning and adaptation, in practice, the U.S. resettlement program continues to emphasize refugees' acculturation processes and places little emphasis on cultural or logistical adaptation of existing services. When adaptation does happen, it is often structured around dominant notions of health and well-being. There is a need to explore bidirectional integration processes and existing systems adaptations to accommodate people with refugee backgrounds at the institutional level. This article details a framework to build a sustainable collaboration between a refugee community and existing health and social service systems to reduce harmful alcohol use. The conceptual framework emphasizes three components: 1) adaptation of refugees' indigenous expertise, networks, systems, and resources; 2) adaptation of existing systems to serve new groups in culturally relevant and effective ways; and 3) the participatory processes through which refugees and existing systems collaborate to achieve mutual goals. This paper describes the application of this framework and concludes with a discussion of lessons to support replication of the framework in other settings. Lessons learned include: equalizing power, paying attention to relationships and roles, engaging in deep cultural adaption of interventions, and building individual and organizational capacity to support partners.*

Keywords: *Refugee resettlement; substance abuse; refugee integration; cultural adaptation*

A note from the authors: Throughout the paper we use the language "people with refugee backgrounds" and "communities with refugee backgrounds" rather than "refugees" or "refugee communities". We believe that overuse of the term "refugee" narrowly defines people according to one life experience, rather than recognizing the intersectional identities that people with refugee backgrounds carry (gender, race, ethnicity, etc.). "People/Communities with refugee backgrounds" recognizes that it is part of life experience, but not the totality of it. Additionally, the term "refugee" often carries with it implications of people who are traumatized, helpless, and victims, which can obscure the strengths and resilience of people who are refugees.

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In 2016, approximately 85,000 people resettled to the United States as legal refugees (U.S. Department of State, 2016). People with refugee backgrounds face a myriad of obstacles to successfully integrating into their new societies (Strang & Ager, 2010). Most have been exposed to numerous life-threatening traumas prior to resettlement. Upon arrival in a resettlement country, they often continue to face difficulty finding meaningful and living wage employment, learning a new language, accessing health care services, and adjusting to a new culture and climate (Fazel, Wheeler, & Danesh, 2005). Pre-and post-migration trauma as well as structural barriers, such as lack of living-wage employment or language barriers, contribute to elevated risk for mental health disorders such as post-traumatic stress disorder and depression, as well as increased substance abuse and family violence (Fazel et al., 2005).

Since 2005, Karen people have been resettling to the United States with refugee status in large numbers. Karen people are an ethnic minority group in Burma (also known as Myanmar). For more than 60 years, since the granting of independence to Burma, Karen people and other ethnic minority groups have been engaged in conflict with the Burmese government for their own autonomy (South, 2012). The Burmese government has perpetuated widespread human rights abuses against Karen people, including kidnapping and forced labor, imprisonment and torture, gender-based violence, and destruction of Karen villages and farmland (Shannon, Vinson, Wieling, Cook, & Letts, 2015). Since the 1980s, more than 200,000 Karen people and other ethnic minority groups have fled Burma (The Border Consortium, 2016). Many have fled to refugee camps in Thailand or live as urban refugees in Malaysia. A large wave of Karen people began resettling to the United States with refugee status in the mid-2000s, and there are an estimated 70,000 Karen people currently living in the U.S. (U.S. Department of State, 2016).

Like all people with refugee status resettling to the U.S., Karen people's resettlement is facilitated by federal and state policies and programs that emphasize integration into existing communities (Darrow, 2015). The concept of refugee integration lacks a standardized definition but can generally be described as both a process and goal of engaging newly resettling communities with existing communities. Newland, Tanaka, and Barker (2007) define integration as "a dynamic, multidirectional process in which newcomers and the receiving communities intentionally work together, based on a shared commitment to tolerance and justice, to create a secure, welcoming, vibrant, and cohesive society" (p. 10). Research on the processes and outcomes of integration has focused heavily on the adaptation processes of people with refugee status, including: language acquisition, employment, social connections, and access to health care (Ager & Strang, 2008). Indicators of successful integration generally focus on economic or social achievements of people with refugee backgrounds (Ager & Strang, 2008; Bakker, Cheung, & Phillimore, 2016). Policies to facilitate integration almost exclusively fund programming that targets the adaptation of people with refugee backgrounds, rather than facilitating adaptation of existing services to meet the needs of new communities (Kirkwood, McKinlay, & McVittie, 2014; Strang & Ager, 2010).

Integration is a broad and complex process and a term with both popular and political usage. Integration takes place on every level of society and in every sector of a community and involves a range of stakeholders such as law enforcement, politicians, employers,

neighbors, and refugees themselves. Research on the processes of refugee integration has explored the impact of social capital on refugees' ability to find employment, housing, and learn a language (Elliott & Yusuf, 2014); on the impact of policies in employment and housing sectors (Mulvey, 2015); and on barriers to integration such as racism and hostility (Dandy & Pe-Pua, 2015). Research on integration has increasingly explored the ways in which institutions and institutional capacity in an existing community influence resettlement experiences. The scholarship suggests that the capacity of sectors such as health, employment, and education to receive refugees and encourage participation with these systems can impact integration (Valtonen, 2004).

In their definitive work on markers of refugee integration, Ager and Strang (2008) identified health outcomes and access to health care as a significant marker of successful integration for communities with refugee backgrounds. Healthy practices such as routine primary care visits and nutrition were closely tied to positive health outcomes in Burmese communities (Lee, Choi, Proulx, & Cornwell, 2015). Lack of health insurance and other barriers to receiving health and behavioral health care for people with refugee backgrounds has also been shown to be associated with higher levels of mental and emotional distress (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Access to health and behavioral health care that is culturally and linguistically relevant has been also shown to have a direct impact on reducing health and mental health problems in communities with refugee backgrounds (Murray, Davidson, & Schweitzer, 2010).

Research and resettlement policies have placed the responsibility for adapting, adjusting, and integrating primarily on communities with refugee backgrounds despite the fact that most definitions of integration indicate that it is a two-way process that requires effort on the part of existing communities to adapt to newcomers (Ager & Strang, 2008; Newland et al., 2007). Adaptation of existing health and social service systems is needed to provide culturally relevant, appropriate, accessible, and effective services. One aspect of systemic adaptation, cultural adaptation of interventions, has received increasing attention over several decades resulting in a host of exemplars of culturally adapted services (Barrera, Castro, Strycker, & Toobert, 2013). Cultural adaptation has been defined as "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodriguez, 2009, p. 362). Cultural adaptation is one way of reducing some of the most significant barriers to accessing health care and social services, including language and differing health beliefs (Healey et al., 2017). While cultural adaptation has received the most scholarly attention, there are other aspects of systems that require adaptation to meet the needs of communities with refugee backgrounds including adaptations to service delivery systems or geographic locations of programs.

Currently, there is sparse research on gold standards of cultural adaptation, and few models of mutual adaptation exist (Epstein, Santo, & Guillemin, 2015; Newland et al., 2007). Furthermore, the processes through which existing systems adapt to accommodate new communities remain unexamined, with the exception of cultural adaptation of social services. There are numerous methods for cultural adaptation of mental health or other social service interventions, but there is no gold standard, and scholars follow a range of

methods (Epstein et al., 2015). Attempts have been made to describe and categorize cultural adaptation processes, which can generally be divided into two categories. First, surface adaptations include the use of culturally relevant images, fonts, and language, and second, deep level adaptations include the integration of cultural knowledge, values, and beliefs (Barrera et al., 2013).

A systematic review of adaptation methods found that out of 31 studies only 14 included consultation with members of the community of interest in the process of cultural adaptation (Healey et al., 2017). Despite this finding, most adaptation frameworks highlight the importance of collaboration or consultation with members of the target community in adaptation procedures (Barrera et al., 2013; Castro & Yasui, 2017; Epstein et al., 2015). One of the authors of this paper has articulated a framework for a collaborative approach to integration (Cook, 2016). This paper describes lessons learned from the application of a framework to promote integration within the health/behavioral health sector by building collaborative relationships between a refugee-background community and existing services.

The Karen Chemical Dependency Collaboration

The purpose of this paper is to describe the application of a conceptual framework for a collaborative approach to integration that was used to build a sustainable and effective partnership between a resettled refugee-background community and existing health and social service systems in St. Paul, Minnesota. One measure of integration is that people with a refugee background are able to access and benefit from health and behavioral health systems in resettlement (Ager & Strang, 2008). Taking a bidirectional view of integration, this should imply that they are able to access services that meet their cultural and linguistic needs and that existing health and behavioral health services have actively reduced access barriers and adapted to meet the needs of the new community. While the surface or primary goal of the Collaboration was to reduce harmful alcohol use in the St. Paul Karen community, the underlying or foundational goal of the Collaboration was to build a network of mutual relationships to promote this kind of bidirectional integration between existing services and communities with a refugee background.

Harmful Alcohol Use in the Karen Community

A small number of studies have identified risk factors that are associated with an increased risk for substance use in groups with refugee backgrounds (Ezard, 2012; Ezard et al., 2011; Miremadi, Ganesan, & McKenna, 2011; Posselt, Galletly, de Crespigny, & Procter, 2014). Only a handful of studies could be identified that looked specifically at substance use with Karen people who were refugees (Ezard et al., 2011; McCleary & Wieling, 2016). One found that Karen people who were refugees were at increased risk for harmful alcohol use because of pre-migration trauma and post-migration stress (McCleary & Wieling, 2016), and another found that Karen people faced significant barriers to accessing culturally and linguistically relevant substance use treatment in resettlement (McCleary, Shannon, & Cook, 2016). There are no comprehensive epidemiological studies of alcohol or substance use in resettled Karen communities, making it difficult to estimate prevalence or scope of substance use and associated health, social, and legal issues in Karen

ethnic groups in the U.S. (Semere, Yun, Ahalt, Williams, & Wang, 2016). However, the Karen Chemical Dependency Collaboration described below emerged as a direct result of Karen community leaders, medical providers, and social service providers identifying harmful drug and alcohol use and related consequences as the most significant problem and unmet need facing the community.

Formation of the Karen Chemical Dependency Collaboration

In 2013, one of the authors of this paper received a fellowship that provided protected time and funding to conduct a needs assessment and build a sustainable response to a significant health need within a community experiencing health disparities. Drawing on previously developed personal and professional relationships within the Karen community, this author worked with Karen leaders and representatives of existing service agencies including health, law enforcement, and behavioral health to conduct a thorough needs assessment that included focus groups, individual interviews, and participant observation. The results of this needs assessment identified harmful alcohol and drug use as one of the most significant health problems facing the Karen community in St. Paul. The needs assessment, as well as other research conducted in partnership with the same community, identified pre- and post-migration risk factors for alcohol use that included exposure to trauma and human rights abuses and resettlement stress (McCleary & Wieling, 2016). Additionally, the needs assessment identified multiple barriers to accessing existing treatment systems including language barriers, difficulty navigating confusing and byzantine treatment requirements such as numerous intake appointments and treatment meetings, difficulty with health insurance, and treatment programs that did not reflect Karen people's cultural and conceptual understandings of alcohol and drug addiction and recovery (McCleary & Wieling, 2016).

In response to an increasing need for culturally and linguistically relevant responses to harmful alcohol use, the authors of this paper formed the Karen Chemical Dependency Collaboration (KCDC; hereafter "the Collaboration"). The mission of the Collaboration is to reduce harmful alcohol use in the Karen community. All authors of this paper are members of the Collaboration and three are its co-directors. The Collaboration is a cross-cultural, cross-professional group of approximately 30 individuals representing a range of organizations from numerous sectors. Members include Karen community leaders, physicians, mental health and substance use providers, law enforcement officers, probation officers, case managers, researchers, Karen interpreters, public health nurses, and social workers. The Collaboration strives to have at least 50% representation of Karen members in every meeting and works to ensure cross-sector representation. The Collaboration has met bi-monthly since 2014 and has developed four intervention areas to comprehensively address harmful alcohol use and associated consequences throughout the community. They include: develop community education, health promotion, and prevention tools; develop culturally and linguistically relevant substance use treatment and community-based recovery support services; increase the capacity of the Karen language and Karen interpreters related to interpreting in mental health and substance use settings; and train faith leaders who are often the first source of support for families. These intervention areas and the resulting strategies were identified by Karen community leaders. One of the

Collaboration members had developed a general framework of collaborative processes to promote refugee integration. In the remainder of this paper we describe the framework and discuss important lessons learned from its implementation with the Collaboration.

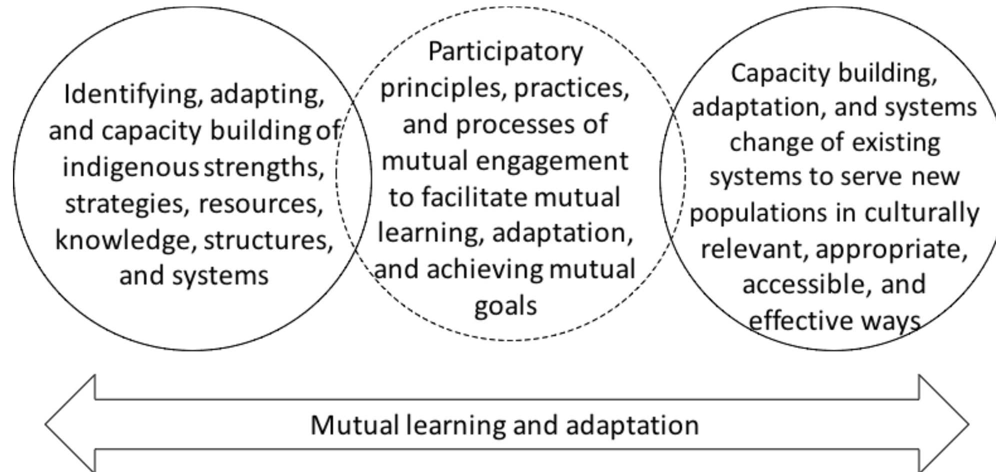
The initial founding of the Collaboration and its first years were financially supported by a fellowship received by one of the authors of this paper. The funding provided protected time in the form of salary offset to the author who acted as the primary organizer of the Collaboration in its initial years as well as ancillary funds for supplies, food for meetings, and other expenses. In the beginning, most of the Collaboration members attended meetings on a voluntary basis or as part of their employment. After this initial support the Collaboration sought and secured foundation funding to support all of the initiatives. One of the founders of the Collaboration is a primary care physician in a major health care system. Many of the initiatives are located within the health care system, which allows for connecting behavioral and primary health care as well as promotes sustainability.

Collaborative Framework to Promote Refugee Integration

One of the authors of this paper developed a general framework that has guided the work of the Collaboration (Cook, 2016). The framework is visually represented in Figure 1. It consists of three components: the first describes the indigenous expertise, networks, socio historical structures and systems, and resources (human, social, cultural) that refugee-background communities bring with them to resettlement and the processes through which they adapt and transform them for use in the resettlement context. The second consists of the resources of existing systems in the resettlement environment and the processes through which these systems adapt to serve new groups in culturally relevant, appropriate, accessible, and effective ways. The third and joining circle consists of the participatory principles, practices, and processes of mutual engagement through which representatives from new refugee-background communities and existing systems collaborate to facilitate mutual learning and adaptation to achieve mutual goals.

This framework is based on a definition of integration as a bi-directional process (Ager & Strang, 2008) that recognizes the value of mutual learning and collaboration. It is a strengths-based, empowerment approach because it recognizes that communities with refugee backgrounds have existing strengths, strategies, and resources and may have significant knowledge and experiences adapting and transforming these resources and support systems in new contexts. The relationship between mainstream providers and representatives and providers from new resettlement communities in this framework is one of allies rather than of provider-client. In the project described in this paper, this framework was used to a guide a community-development approach to improving health, an indicator of integration, for the Karen community.

Figure 1. *A Collaborative Model for Promoting Integration of Existing Systems and New Refugee-Background Communities*



Application of the Framework

The intention of the Collaboration is to reduce harmful alcohol use in the Karen community. Karen community leaders and representatives initially identified four topical areas that warranted attention. Members of the Collaboration then formed smaller working groups over the past four years to create interventions that responded to each of the areas of need, which will be described below. Founding members of the Collaboration recognized that cross sector partnerships of this sort are notoriously difficult to build, maintain, and sustain. Members of the Collaboration also felt that the majority of approaches to refugee integration focused almost entirely on encouraging refugees to adapt and acculturate and promoted only surface level cultural adaptations on the part of existing services. The underlying intention of the Collaboration was to provide space to identify the Karen community's strengths, strategies, and forms of problem solving and to engage existing systems in deeper levels of adaptation and learning and contribute to bidirectional adaptation.

Collaboration members used the framework described above as a guide to build partnerships across sectors, ensure adaptation on the part of both existing systems and Karen people, and to center participatory processes and mutual learning. As such, the lessons described below are not lessons in developing alcohol treatment interventions but rather lessons learned in developing partnerships that promote bidirectional integration. In the following paragraphs we describe some of the ways we applied this framework specifically to relationship building and the development and evaluation of interventions. Then, we focus on general lessons learned that could be applied to this type of collaboration in other sectors and places.

Indigenous Strengths

This framework for bidirectional integration requires that the indigenous expertise, ways of knowing, and problem solving strategies of communities with refugee backgrounds be central to the process of integration. To ensure that refugees' expertise was a central part of decision-making and intervention planning throughout the work of the Collaboration, time was provided at each Collaboration meeting to hear from Karen people. Second, Karen people were placed in central positions within the development of each intervention and their expertise was recognized as equal to that of existing social service providers.

One example of this is the ways in which aspects of addiction, recovery, and well-being were negotiated. In the early days of the Collaboration representatives of existing treatment services focused on getting feedback from Karen people on how to adapt existing treatment modalities to better serve Karen people. For example, providers asked Karen people to advise on things like individual versus group treatment or ideas for relapse prevention. However, a lack of mutual understanding about concepts such as addiction, recovery, treatment, and relapse inhibited effective communication. Mutual adaptation thus depended on mutual learning and developing a shared understanding of these concepts from both dominant and Karen perspectives.

Existing systems

The framework also requires that existing systems engage in adaptation on a number of levels, including adaptation of how existing treatment modalities were delivered and a deeper level of adaptation throughout the entire system. To this end, we intentionally recruited not only providers to be members of the Collaboration, but also engaged with substance use treatment program directors and upper level administrators of health care systems. These members were best positioned to facilitate broader system adaptations that were needed to effectively serve Karen patients. For example, the support of program directors was needed to approve new sites for offering treatment and new processes for securing consistent interpreters.

Building the capacity of organizations and agencies to engage in this kind of deeper level adaptation takes time and resources. Much effort was spent educating both providers and upper level administration on the limitations of existing systems and the need to engage in mutual learning and adaptation to more effectively serve Karen patients. This foundational work was necessary to achieve the Collaboration's objectives.

Mutual learning

The center circle of the framework represents mutual learning and participatory practices. The Collaboration meetings served as a space for Karen community members and existing system representatives to come together and learn from each other. The Collaboration met bi-monthly throughout its existence and many sub groups of the Collaboration met independently outside of these meetings. Meeting face to face with each other was a central aspect of this framework. Two-hour Collaboration meetings were structured to provide half of the time for mutual learning and half of the time for

participatory problem solving. Mutual learning involved Collaboration members presenting to the group and has included information about Karen language and culture related to substance use, explanations of dominant treatment approaches in the United States, and relationship building between law enforcement and the Karen community. This was an opportunity for all members to learn about each other and the sectors represented. It also fostered unique and beneficial partnerships such as between educators and probation officers to engage youth in substance use prevention activities.

The second half of meetings were spent in participatory problem solving. Smaller groups of members from a range of sectors met to discuss specific issues that have arisen in the development and implementation of various interventions. The Collaboration has been most successful when there has been a specific topic to discuss in smaller groups such as adapting existing chemical health assessment tools to be more culturally relevant or engaging newer arrivals with refugee status in substance use education programs. Collaboration members reported that they bring this mutual learning back to their respective agencies and communities and are often able to make immediate small changes to their service delivery.

Resulting Interventions

The Collaboration identified four areas of need: culturally relevant substance use treatment, training for Karen interpreters, capacity building for Karen faith leaders, and culturally relevant prevention education. Working groups have developed a range of programs and interventions in each area. Some recent successes include the development of a manualized, culturally specific, trauma informed outpatient group treatment program for adult Karen men who engage in harmful alcohol use. This program was co-developed by a Karen professional with over 10 years of experience working in substance use treatment in refugee camps in Thailand and other KCDC members with expertise in mental health and substance use treatment. The Collaboration has also written a glossary of mental health and substance use terms that were negotiated, translated and back translated by a group of Karen interpreters and health professionals. The glossary was used to train over 75 professional interpreters in Minnesota. The Collaboration developed several community education tools and offered trainings in the Karen community. Collaboration members have trained existing mental health and substance use professionals, probation officers, and other existing systems on working effectively with the Karen community. Recently, the Collaboration has begun to expand its work into understanding and addressing substance use among Karen youth.

Methods

This paper does not report on a traditional research study but is a conceptual paper that describes the experiences of implementing an approach to supporting collaboration and integration in communities with refugee backgrounds. While it did not employ a traditional research methodology, per se, a systematic approach was used to develop this paper. First, the framework itself was developed out of a separate research project reported elsewhere (Cook, 2016). Approximately two years after its start, several Collaboration members agreed to an internal self-evaluation in the form of individual interviews with founding

members. A core team of Collaboration members developed a semi-structured interview guide and informal interviews were conducted with about 10 members. The interview guide included topics such as reasons for participating in the Collaboration, strengths and challenges of collaborative work, and ideas for enhancing collaborative work. All of the authors of this paper are founding members of the Collaboration. The process of developing the lessons learned had several steps. First, we reviewed the results of the evaluation interviews. Second, we developed a timeline of the Collaboration noting important and formative events. Third, we developed a list of lessons we learned as a result of these formative events. Finally, we synthesized these lessons and summarized them in preparation for writing the paper.

Lessons Learned

Numerous lessons have been learned over the past four years about building and maintaining a sustainable collaboration between representatives from the Karen community and existing systems to respond to the problem of harmful alcohol use in the Karen community. Below are three important lessons are outlined.

Lesson One: Learning How to Share Power

A host of scholarship about building cross-cultural collaborations and community organizing emphasizes the importance of sharing power with community members (Bryson, Crosby, & Stone, 2006; Wallerstein & Duran, 2008). Generally, it is suggested that this be achieved through ensuring community representation in meetings and events. We found, though, that we needed to move beyond representation to consider how patterns and styles of communication both in and outside of formal meetings contributed to power imbalances. We also needed to learn how to develop specific mechanisms and processes for sharing power in practice.

Learning about and being responsive to different communication styles. Karen Collaboration members suggested that it was difficult for them to speak up in meetings that were facilitated in English and in a style that is reflective of dominant culture in America, partly because of cultural norms of respect. Often Karen Collaboration members felt more comfortable communicating in one-on-one, informal settings with trusted members of the Collaboration with whom they had a relationship, rather than in a large group setting. We found that other Collaboration members were more likely to speak up in meetings that were facilitated in Karen with interpretation for non-Karen speakers, rather than the other way around. Additionally, Karen Collaboration members were more likely to speak up in large group meetings if they were able to debrief with Collaboration colleagues who had more experience in dominant modes of meeting and communicating before and after meetings to gain context and insight into nuances of discussions.

Once the Collaboration started being responsive to multiple styles of communication and building the capacity of all members to respect, honor, and seek out multiple ways of communicating, power shifted to be more equalized between Karen and non-Karen members. Part of sharing power in this way meant that non-Karen Collaboration members needed to let go of control and trust Karen co-directors to run meetings in their own style

and language. Lastly, shared decision-making consisted of continuously sharing ideas and being open to new ideas as the work unfolded. While the work of the Collaboration aimed at advancing clearly outlined and agreed upon goals, the process often took a circuitous route, following an iterative, flexible process that incorporated new insights and understandings as they emerged.

Recognizing the cultural context of all knowledge to facilitate listening and learning. Learning to share power also meant that Collaboration members needed to recognize the contextual limits of their expertise and to validate other ways of thinking. A key way that we shared power was in recognizing the importance of context in leveraging power and accessing resources. For example, one of the first tasks the Collaboration undertook was to develop a culturally and linguistically relevant outpatient group alcohol treatment program for adult Karen men. Initially, treatment provider Collaboration members, all of whom were not Karen, positioned themselves as the experts on treatment and addiction and Karen members as experts on culture. The intention was to combine these seemingly separate spheres of knowledge and learn from each other. However, in positioning themselves as experts on addiction, providers failed to recognize the limits of their ways of knowing when applied to a Karen context. We had to work hard to encourage providers to set aside their own paradigms and learn from Karen people's understanding, knowledge, and language related to addiction, substance abuse, and treatment, rather than filtering this knowledge through their own paradigm. For example, we encouraged providers not to assume that there were Western or English equivalents for the things that Karen people shared, but instead to seek to understand them in their own context.

One example of this occurred during a Collaboration meeting when a Karen member described the nuances of saying "no" to an offer in Karen culture. In discussing how to say no when offered alcohol as a form of relapse prevention, one Karen Collaboration member explained that for many Karen people it is culturally taboo to say no to social offers and hospitality. A non-Karen member responded that Karen people needed assertiveness training to develop skills in saying no as a form of self-protection. This member saw reluctance to say no as lack of assertiveness rather than attention to cultural norms and practices.

We also recognized that some non-Karen providers had significant experience working with Karen culture, for example, in mental health settings. However, we encouraged them not to view themselves as experts in Karen culture, but to be perpetually humble about their knowledge and continue to learn from and recognize Karen people as experts in their own culture. Additionally, some Karen Collaboration members had both cultural and professional treatment knowledge. For example, one Karen Collaboration member had extensive professional training and experience in substance use treatment in the refugee camps, though he was not licensed to practice in the U.S.

Rather than placing Collaboration members in silos of either having cultural knowledge or having treatment knowledge, we needed to recognize everyone's multiple and overlapping areas of expertise and experience. One effective way to shift this power balance was to ask non-Karen providers to critically interrogate the dominant assumptions and perceptions inherent in American models of treatment and shift from seeing these

treatments as culturally-neutral to culturally-specific. This shift allowed providers to step back and make space for Karen expertise in both culture and addiction and to recognize the cultural context of all knowledge.

One example of this is illuminated by a lengthy discussion during a Collaboration meeting of the concept of goal setting. In developing the treatment program, some members wanted to include sessions related to setting and achieving goals. Substantial time was spent negotiating a Karen translation for the word “goal”, which included negotiating the meaning of goal as a construct. As part of that conversation a Karen member said that because many Karen people have spent decades in refugee camps without hope of either repatriation or resettlement, they often did not have experience setting goals for the future. An aspect of goal setting is having a sense of autonomy over one’s future and this is limited in a conflict and refugee camp context. The Karen member indicated that while Karen people can and do set and achieve goals, the concept of goal setting needed to be considered within the context of a history of conflict and protracted internment in refugee camps.

Letting go of control and leveraging spheres of influence. One critical way in which power was shared was by actively allowing and trusting multiple leaders to leverage their own spheres of influence. Karen co-directors of the Collaboration had leadership in areas where their knowledge was most influential – most often in meetings with Karen community partners and community members – and the Collaboration followed their lead in these areas. This often meant that non-Karen participants were in meetings held in Karen language and may not know all the nuances and details being discussed. Non-Karen partners had leadership in areas of funding or navigating dominant systems and again others followed their lead in this area. This approach required letting go of control and deeply trusting each other’s intentions, competence, and understanding of what was specifically needed in various situations. The co-directors came to see themselves as standing back-to-back each leveraging their power in their own sphere of influence while standing together to move the program to fruition.

Lesson Two: Recognizing a Variety of Relationships, Roles, and Capacity

Collaboration scholarship emphasizes the importance of building trusting relationships as a foundation for engaging stakeholders (Ball, 2008). Throughout the lifespan of the Collaboration, we came to recognize the importance of paying particular attention to the difference between relationships with individuals and with the organizations those individuals represent as well as recognizing the different roles that Collaboration members have both within the Collaboration and in the greater community. Paying attention to these different roles was essential to building trust.

Building sustainable institutional partnerships. The Collaboration has consisted of a variety of stakeholders. Karen members attended Collaboration meetings as representatives of existing agencies, ethnic community based organizations, Karen churches, or as individual community members. Most, but not all, non-Karen Collaboration members attended meetings as representatives of a particular organization such as a hospital, clinic, university, treatment facility, or social service agency.

One of the founding members of the Collaboration joined as a representative of a major hospital system that provided both in-patient and out-patient substance use treatment. His presence represented an important relationship with an essential institution. As the manager of treatment services within the hospital system, his position provided access to important resources. Unfortunately, within the first two years of the Collaboration, he left his position and the Collaboration no longer had a formal relationship with the hospital system. Over the course of the next year, three other individuals filled his former role, meaning we had to work to rebuild the relationship anew with each person. Ultimately, we learned that we needed to build sustainable relationships with institutions and not just with individual representatives of those institutions. We also came to recognize that while interpersonal relationships were critical to trust building and partnering, the institutional relationships were essential to building sustainable programs.

Building individual and organizational capacity to participate. Many Collaboration members attended Collaboration meetings and worked on Collaboration projects as part of their paid positions. However, several Karen and a few non-Karen Collaboration members attended meetings on their personal time motivated by a personal commitment to the issue. Additionally, some participated as representatives of their organizations, but their organizations did not have capacity to support much time to engage in work with the Collaboration. This created an inequity and challenge to sustaining membership, because not all members were equally compensated for their equally valuable time and work. Additionally, Karen members had less capacity to engage with the Collaboration because they more frequently did not have institutions to support their time involvement.

All of the work of the Collaboration has been dependent on all members having the capacity for mutual engagement. This mutual engagement is dependent on all members being actualized partners in all endeavors. Often, this meant that the Collaboration needed to support individual or institutional capacity building to participate on equal footing. Because we recognized the value of Karen representation in the Collaboration and, in particular, the importance of involving a large, local Karen-led nonprofit organization, we found ways to build the capacity of several partners to participate in the Collaboration and to work on its strategic initiatives. For example, we tried offering gift cards to compensate Collaboration members for their time to attend meetings when they were not supported by an institution.

One significant way that we built institutional capacity for the Collaboration was to secure funding to develop a few part-time, paid staff positions. We also created a shared position between the Collaboration and a Karen ethnic community based organization (ECBO). Before we created this position, the Karen ECBO wanted to be involved in Collaboration work but had very limited staff capacity to contribute. A shared, paid position allowed for the ECBO to play a leadership role in the Collaboration and provided an avenue for increased partnership between the Collaboration and the ECBO in working on several Collaboration initiatives. The person hired for the position was a Karen person who had substantial training and experience with substance use treatment in refugee camps on the Thai-Burma border. Because this person's training was not recognized by U.S. licensing systems, he was prevented from using this knowledge and skill in a formal

setting. A shared position between the Collaboration and the Karen ECBO gave this individual a formalized setting to contribute his skills and training.

Lesson Three: Adapt Interventions at the Paradigm Level in Addition to the Implementation Level

Cultural adaptation is often categorized as surface level – incorporating culturally relevant images, fonts, and language – or deep level – incorporating cultural knowledge, values, and beliefs and involving ethnic social support systems in interventions (Barrera et al., 2013). One of the most successful outputs of the Collaboration has been the culturally–specific outpatient group treatment program for Karen men who engage in harmful alcohol use. The treatment is facilitated through the use of a provider manual (with ethnographic rationale) and participant workbook that were written by members of the Collaboration. A small group of Collaboration members engaged in an intensive process of developing the treatment program over the course of two years.

Often, developing culturally relevant programs involves adaptations that are focused primarily on implementation, such as offering a treatment group in a community center or substituting culturally relevant images. While this is an important aspect of service delivery, we found that significant adaptation was also needed at the paradigm level. We needed to think through not just how to translate words into Karen but how to engage with a Karen paradigm or cognitive framework around the meaning of addiction, treatment, and recovery. For example, we incorporated Karen proverbs, metaphors, and commonly known tales as access points to Karen ways of thinking. This meant that Karen people needed to be present for and engaged with every aspect of the development of the treatment model. It also meant that we needed to privilege Karen ways of thinking whenever possible. This theme is closely related to a previous lesson: recognizing the cultural context of all knowledge to facilitate listening and learning.

Overcoming Challenges

While the Collaboration has been generally successful in relationship building and intervention development, there have been challenges along the way and we foresee several challenges in the future, particularly around replication of this type of collaboration.

Ongoing and deeply entrenched challenges for the Collaboration are anticipated given limitations of existing agency, county, state, and federal policies. In particular, health insurance reimbursement requirements and policies regulating treatment delivery presented barriers that were difficult to overcome and required compromises that pushed against a pure application of the framework. For example, in order for treatment programs to be sustainable, they need to be delivered by a licensed therapist for insurance reimbursement purposes. Because the Karen community in St. Paul is relatively new, at the time the treatment program was developed, there were no Karen people who were licensed to provide reimbursable mental health or substance use treatment services. The program is jointly facilitated by a Karen man with substance use treatment experience who has not been able to re-credential in the U.S. and a non-Karen licensed social worker. Thus,

interpretation services are required, which are an additional barrier as many Karen people would do better working directly in their native language.

As second challenge that we foresee in the future is difficulty with replicating the Collaboration. St. Paul, Minnesota is home to a large, well-organized, and active Karen community with a long-standing Karen community based organization and a robust workforce of Karen interpreters. Several active community leaders are engaged with this project. Additionally, several non-Karen members of the Collaboration have more than ten years of experience working with the Karen community personally and professionally and were able to build on these long-standing relationships in founding the Collaboration. Lastly, the development of the treatment interventions have been spearheaded by a Karen man who resettled to St. Paul after working for many years as a counselor in one of the only drug treatment programs based in the refugee camps along the Thailand-Burma border. These strengths and experiences are unique and difficult to replicate in other geographic locations.

Discussion

Health outcomes and access to health care have been operationalized as markers of integration for communities with refugee backgrounds (Ager & Strang, 2008). Achieving this indicator of integration requires bidirectional adaptation efforts on the parts of both new communities and existing systems. This paper describes the lessons learned over the past four years in applying a general framework for collaboration to reduce harmful alcohol use in the Karen community and to, in turn, facilitate integration between a newly resettled community and existing health and social service systems.

One of the overarching principles that guided the work of the Collaboration was that integration is a bidirectional process (Ager & Strang, 2008; Newland et al., 2007). In other words, the success of this collaboration was dependent on mutual learning, capacity building, and adaption. The guiding framework for collaboration had three components: first, resettlement communities' indigenous expertise, networks, systems, and resources need to be recognized and adapted for use in the resettlement context; second, the resources of existing systems need to be adapted to be culturally relevant and accessible to resettlement communities; and third, integration is facilitated through participatory principles and practices that facilitate mutual learning and adaptation to achieve mutual goals.

The lessons presented in this paper suggest that effective cultural adaptation of existing interventions may need to go beyond surface level adaptations. In this project, significant adaptation was needed at the paradigm level in addition to the implementation level, which included engaging Karen knowledge and meaning around addiction, treatment, and recovery. Additionally, and consistent with findings by Epstein et al. (2015), Castro & Yasui (2017), and Barrera et al. (2013), this project also demonstrated that developing deep collaborative partnerships with the target community was essential for achieving mutual adaptation. It offers several suggestions for facilitating mutual learning and adaptation related to equalizing power, learning about and being responsive to different communication styles, recognizing the cultural context of all knowledge, building

sustainable institutional partnerships, and building individual and organizational capacity to participate toward mutual goals. The experiences of this Collaboration suggest that the collaborative approach to integration framework described in this paper may be a useful model of mutual adaptation, which fills a gap in existing research (Newland et al., 2007).

Implications for Social Work

The framework described in this paper has several implications for social work practice with refugee-background communities. One of the primary functions of the framework is to provide mechanisms for ensuring the inclusion of refugee-background communities' expertise, knowledge, and strategies in the adaptation of health and behavioral health systems. Social workers have an ethical mandate to engage in strengths-based work, to recognize the ways in which traditionally marginalized voices are often obscured and to actively promote inclusivity and equity.

One success of the Collaboration, facilitated by the use of the framework, was engaging representatives across a diverse range of sectors for a sustained period of time. Collaboration members include law enforcement officers, social workers, Karen leaders, Karen interpreters, doctors, researchers, and drug and alcohol counselors. There are limited opportunities for a diverse group of people to work together on community issues, and establishing structured spaces that provide opportunities for mutual learning and capacity building may be one way to enhance cross sector collaborations.

Another implication for social work is in the area of research. The framework described here would benefit from application in other geographic locations, with other communities, and in response to other issues of integration, such as employment or education. Research that tests applications and implications of the framework are needed.

References

Ager, A., & Strang, A. (2008). Understanding integration: A conceptual framework. *Journal of Refugee Studies*, *21*(2), 166-191. doi: https://doi.org/10.1093/jrs/fen016

Bakker, L., Cheung, S. Y., & Phillimore, J. (2016). The Asylum-Integration Paradox: Comparing asylum support systems and refugee integration in The Netherlands and the UK. *International Migration*, *54*(4), 118-132. doi: https://doi.org/10.1111/imig.12251

Ball, C. L. (2008). *Enhancing Community Capacity to Engage and Involve Immigrant and Refugee Families: A Model for Inclusive Collaboration*. Edmonton, Canada: Families First Edmonton.

Barrera Jr, M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of Consulting and Clinical Psychology*, *81*(2), 196-205. doi: https://doi.org/10.1037/a0027085

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based

practice. *Professional Psychology: Research and Practice*, *40*(4), 361-368. doi: https://doi.org/10.1037/a0016401

Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The design and implementation of cross-sector collaborations: Propositions from the literature. *Public Administration Review*, *66*(s1), 44-55. doi: https://doi.org/10.1111/j.1540-6210.2006.00665.x

Castro, F. G., & Yasui, M. (2017). Advances in EBI Development for Diverse Populations: Towards a Science of Intervention Adaptation. *Prevention Science*, *18*(6), 623-629. doi: https://doi.org/10.1007/s11121-017-0809-x

Cook, T. L. (2016, November). "*Rebuilding the village": Indigenous community development strategies of Karen refugees in resettlement*. Paper presented at the Council on Social Work Education. 62nd Annual Program Meeting, Advancing Collaborative Practice Through Social Work Education, Atlanta GA.

Dandy, J., & Pe-Pua, R. (2015). The refugee experience of social cohesion in Australia: Exploring the roles of racism, intercultural contact, and the media. *Journal of Immigrant & Refugee Studies*, *13*(4), 339-357. doi: https://doi.org/10.1080/15562948.2014.974794

Darrow, J. H. (2015). Getting Refugees to Work: A street-level perspective of refugee resettlement policy. *Refugee Survey Quarterly*, *34*(2), 78-106. doi: https://doi.org/10.1093/rsq/hdv002

Elliott, S., & Yusuf, I. (2014). 'Yes, we can; but together': social capital and refugee resettlement. *Kotuitui: New Zealand Journal of Social Sciences Online*, *9*(2), 101-110. doi: https://doi.org/10.1080/1177083X.2014.951662

Epstein, J., Santo, R. M., & Guillemin, F. (2015). A review of guidelines for cross-cultural adaptation of questionnaires could not bring out a consensus. *Journal of Clinical Epidemiology*, *68*(4), 435-441. doi: https://doi.org/10.1016/j.jclinepi.2014.11.021

Ezard, N. (2012). Substance use among populations displaced by conflict: A literature review. *Disasters*, *36*(3), 533-557. doi: https://doi.org/10.1111/j.1467-7717.2011.01261.x

Ezard, N., Oppenheimer, E., Burton, A., Schilperoord, M., Macdonald, D., Adelekan, M., ... & van Ommeren, M. (2011). Six rapid assessments of alcohol and other substance use in populations displaced by conflict. *Conflict and Health*, *5*(1), 1-16. doi: https://doi.org/10.1186/1752-1505-5-1

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, *365*(9467), 1309-1314. doi: https://doi.org/10.1016/S0140-6736(05)61027-6

Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: A systematic review. *BMC Health Services Research, 17*, 1-26. doi: https://doi.org/10.1186/s12913-016-1953-x

Kirkwood, S., McKinlay, A., & McVittie, C. (2014). 'Some people it's very difficult to trust': Attributions of agency and accountability in practitioners' talk about integration. *Journal of Community & Applied Social Psychology*, *24*(5), 376-389. doi: https://doi.org/10.1002/casp.2178

Lee, S., Choi, S., Proulx, L., & Cornwell, J. (2015). Community integration of Burmese refugees in the United States. *Asian American Journal of Psychology*, *6*(4), 333-341. doi: https://doi.org/10.1037/aap0000027

McCleary, J. S., Shannon, P. J., & Cook, T. L. (2016). Connecting refugees to substance use treatment: A qualitative study. *Social work in public health*, *31*(1), 1-8. doi: https://doi.org/10.1080/19371918.2015.1087906

McCleary, J. S., & Wieling, E. (2016). Forced displacement and alcohol use in two Karen refugee communities: A comparative qualitative study. *British Journal of Social Work*, *47*(4), 1186-1204. doi: https://doi.org/10.1093/bjsw/bcw076

Miremadi, S., Ganesan, S., & McKenna, M. (2011). Pilot study of the prevalence of alcohol, substance use and mental disorders in a cohort of Iraqi, Afghani, and Iranian refugees in Vancouver. *Asia-Pacific Psychiatry*, *3*(3), 137-144. doi: https://doi.org/10.1111/j.1758-5872.2011.00136.x

Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health*, *34*(6), 529-538. doi: https://doi.org/10.1007/s10900-009-9175-3

Mulvey, G. (2015). Refugee integration policy: the effects of UK policy-making on refugees in Scotland. *Journal of Social Policy*, *44*(2), 357-375. doi: https://doi.org/10.1017/S004727941500001X

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry*, *80*(4), 576-585. doi: https://doi.org/10.1111/j.1939-0025.2010.01062.x

Newland, K., Tanaka, H., & Barker, L. (2007). *Bridging divides: The role of ethnic community-based organizations in refugee integration.* Washington, DC: Migration Policy Institute.

Posselt, M., Galletly, C., de Crespigny, C., & Procter, N. (2014). Mental health and drug and alcohol comorbidity in young people of refugee background: A review of the literature. *Mental Health and Substance Use*, *7*(1), 19-30. doi: https://doi.org/10.1080/17523281.2013.772914

Semere, W., Yun, K., Ahalt, C., Williams, B., & Wang, E. A. (2016). Challenges in identifying refugees in national health data sets. *American Journal of Public Health*, *106*(7), 1231-1232. doi: https://doi.org/10.2105/AJPH.2016.303201

Shannon, P. J., Vinson, G. A., Wieling, E., Cook, T., & Letts, J. (2015). Torture, war trauma, and mental health symptoms of newly arrived Karen refugees. *Journal of*

Loss and Trauma, *20*(6), 577-590. doi: https://doi.org/10.1080/15325024.2014.965971

South, A. (2012). The politics of protection in Burma: Beyond the humanitarian mainstream. *Critical Asian Studies, 44*(2), 175-204. doi: https://doi.org/10.1080/14672715.2012.672824

Strang, A., & Ager, A. (2010). Refugee integration: Emerging trends and remaining agendas. *Journal of Refugee Studies*, *23*(4), 589-607. doi: https://doi.org/10.1093/jrs/feq046

The Border Consortium. (2016). *Six Month Programme Report*. Bangkok, Thailand: Author. Retrieved from: http://www.theborderconsortium.org/media/80489/2016-annual-report-jan-dec.pdf.

U.S. Department of State. (2016). *Refugee Admissions.* Retrieved from: https://www.state.gov/j/prm/ra/index.htm.

Valtonen, K. (2004). From the margin to the mainstream: conceptualizing refugee settlement processes. *Journal of Refugee Studies*, *17*(1), 70-96. doi: doi: https://doi.org/10.1093/jrs/17.1.70

Wallerstein, N., & Duran, B. (2008). The theoretical, historical, and practice roots of CBPR. *Community-Based Participatory Research for Health: From Process to Outcomes*, *2*, 25-46.

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Peer Support Groups: Evaluating a Culturally Grounded, Strengths-Based Approach for Work With Refugees

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Abstract: *Many refugees will face unique socio-emotional stressors before, during, and after resettling in their new home country. The program presented herein focuses on the use of para-professionals, peer educators, from within refugee communities to build upon the Center for Torture and Trauma Survivors Clubhouse model. Group leaders seek to provide supports that will: 1) decrease feelings of isolation; 2) build community networks and; 3) increase feelings of empowerment within the community. To accurately represent the fluidity of the refugee population in this metropolitan region, background is presented on an established refugee population from Iraq and a more recent influx of refugees of Bhutan (ethnic Nepali). The juxtaposition of the two groups underscores the importance of presenting a dynamic program that is peer-led to provide the supports necessary to acclimate to their new environment. Program evaluation results from groups run in 2016-2017 indicate that the groups have been successful in helping participants make friends, get information, become more independent, and feel better about life in America. Additionally, participants report a significantly higher number of individuals who they can "talk to about problems or worries" and connect to with a sense of trust within their ethnic community. Finally, the utility of other therapeutic and support processes, such as horticultural and expressive arts therapies, are discussed apropos work with refugee populations.*

Keywords: *Refugee; peer support; social work; community; group work*

Background and Significance

According to the United Nations High Commissioner for Refugees (2010), a refugee is someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (p. 3). Refugees come from a variety of locations around the world, and each refugee carries with them a unique set of values, cultural

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identity, and language. Refugees do not choose to relocate themselves but are instead compelled to leave their countries in order to protect their lives and/or their freedom.

Refugees are subject to a variety of stressors both before and after their resettlement. The events leading up to their displacement can be wrought with political violence, war, or related threats (Cole & Blythe, 2010). Many refugees will have been subject to some form of trauma either directly or indirectly. Refugees from collectivistic cultures will often share traumas of oppression, discrimination, and torture through a collective identity (Karcher, Kuperminc, Portwood, Sipe, & Taylor, 2006). However, individuals of a certain nationality may experience persecution or trauma because of their belonging to a certain subgroup. This is prevalent in cases of ethnic and religious persecution.

It is common for researchers and practitioners to focus on the trauma that refugees have endured; therefore, the majority of treatment programs for refugees focus on symptoms of Post-Traumatic Stress Disorder (PTSD, Obradovic, Tirado-Strayer, & Leu, 2013; Watters, 2001). Symptoms of PTSD can include difficulty sleeping, bad dreams, and loss of interest in activities. This can be a major concern for health care providers of refugees as PTSD can be difficult to treat in cultures where psychotherapy is not widely accepted.

Nevertheless, it is important not to label all refugees as suffering from some type of pathology because they are all individuals going through extraordinary circumstances. Health care professionals should be conscious of cultural differences that may arise when interacting with refugees, and to seek strengths-based approaches for work with clients (Congress & Chang-Muy, 2015). Various cultures have differing concepts on time management, family dynamics, and social interactions. Often the circumstances that refugees experience upon resettlement may also be complex and can include poor school systems, poverty, unsafe neighborhoods, and bullying (Cole & Blythe, 2010; MENTOR, 2009; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). Social workers and others working with refugees must consider and acknowledge cultural differences on the pathway to acculturation/assimilation.

After resettlement, a variety of factors can affect refugees: feelings of isolation, depression, and somatization. Research that studied the mental health of refugees and their resettlement found an association between post-displacement conditions and mental health outcomes (Kaslow, 2014; Porter & Haslam, 2005). Therefore, psychopathology among refugees is not necessarily a consequence of posttraumatic wartime stressors but can reflect contextual factors about the displacement process (Kim, 2013). In order to provide adequate care to refugees, it is necessary to realize that the stressors that are a part of their resettlement can have significant impacts on their mental health (Shannon, Vinson, Wieling, Cook, & Letts, 2015). The psychological consequences of displacement cannot simply be labeled the product of acute stressors of trauma but should instead be understood in the context of the economic, social, and cultural conditions from where the refugees are displaced and those in which they are resettled (Shannon, Wieling, Simmelink-McCleary, & Becher, 2015).

This paper presents the results of a program evaluation designed to obtain information about social services desired and utilized in an urban/suburban population of immigrants and refugees engaged in a peer-support group. Agency administrators at a Pittsburgh based

Jewish Family and Community Services (JFCS) chose a strengths-based peer support model for myriad reasons, including, but not limited to: cultural sensitivity, cost-effectiveness and face validity in promoting social integration. Program goals included: 1. Decrease feelings of isolation, 2. Build community networks, and 3. Increase feelings of empowerment within the community.

Literature Review

Group Work with Refugees

JFCS assists refugees in several ways: gaining access to welfare, English as a Second Language Programs (ESL), accessing health services, and assistance in green card applications. Additionally, JFCS provides acculturation workshops to refugees with information about topics such as safety, hygiene, healthcare, U.S. laws, public benefits, employment, banking and budgeting, etc. As it applies to health, these workshops also stress the importance of preventative care as opposed to reactionary health care. However, the needs of the refugee populations extend beyond the confines of an acculturation workshop. Connecting clients with support networks is a critical tool in the broader issue of addressing social and mental health.

A strengths-based group therapy approach to working with refugees addresses the need for community healing of the refugee population (Drozdek & Bolwerk, 2010; Im & Rosenberg, 2016; Kira, Ahmed, Mahmoud, & Wassim, 2010). This strengths-based approach is culturally appropriate, flexible, and tailored to the unique needs of this population. Many clients of JFCS belong to collectivistic cultures in which healing takes place within the community. Individual psychotherapy is often steeped with individualism and western ideals, which may not coincide with the refugees' cultural values. Additionally, because refugees often experience cumulative trauma, challenges to personal identity as well as community and social identity occur. In order for community and social identity to be repaired, a group therapy approach targeting collective self-esteem and rebuilding group identity are essential (Drozdek & Bolwerk, 2010; Kira et al., 2011). Research with this population suggests more positive outcomes for refugees receiving group therapy compared to those receiving individual therapy (Bass et al., 2013).

Peer models have been used successfully in immigrant/refugee acculturation programs throughout the world including peer education programs for communicable illnesses (Broadhead et al., 2002; Thomas, Clarke, & Kroliczak, 2008); whereas support groups have been efficacious in treating numerous populations ranging from addiction to new parent support groups (Yalom, 2005). Research suggests that after social support interventions, refugees reported increased social integration, decreased loneliness, and healthier coping skills (Stewart, Simich, Shizha, Makumbe, & Makwarimba, 2012). A strengths-based support group model embraces concepts like cultural humility and competence as it is rooted in community growth and strength. Researchers have suggested that having others from their homeland as a part of the group welcoming and acclimating them to their new surroundings helps in easing into the transition to a new location (Kaslow, 2014). Therefore, a peer-administered social support group is an excellent fit for the growing refugee communities in Allegheny County as it is grounded in the communities' natural

support system, is a strengths-based approach, and is sustainable as peers learn the tools to empower and continually learn from and support one another.

Additionally, because refugees are less likely to use traditional mental health services, the strengths-based peer support model provides a much-needed outlet for social and emotional healing (Cole & Blythe, 2010). In fact, the use of peer models may have a positive impact on stigma in using mental health services aiming to potentially empower the community in addressing mental health issues from within (Thomas et al., 2008). Evidence suggests that refugees are likely to seek out services based on meeting their hierarchical needs (food and shelter before education) (Geltman, Augustyn, Barnett, Klass, & Groves, 2000). This approach is also economically practical as it has the ability to address the needs of several individuals concurrently, and the cost of staffing is less than that of a traditional mental health group.

Peer Support Models with Refugees

Peer-led interventions start from a point of commonality. In the realm of health outcomes, have been proven to increase positive outcomes in members of their community (Im & Rosenberg, 2016; Webel, Okonsky, Trompeta, & Holzemer, 2010). Extensive research has been done using the Promotores model and it is well-documented that this peer health education model is beneficial to client health outcomes. A recent meta-analysis found that peer groups are especially effective with hard-to-reach and cultural minority populations--further evidence that the peer model is the right fit for the populations and communities in the Pittsburgh region (Webel et al., 2010).

In researching best practices for strengths-based support group work with the refugee population, several "best practice" guidelines were identified. These included: a community-based model focused on present stress first and past trauma second, homogeneity of members, flexible but structured sessions, and community network building (Kira et al., 2011). JFCS has adapted the Center for Torture and Trauma Survivors' (CTTS) clubhouse model for use with the refugee and recent population in Allegheny County. The CTTS clubhouse model follows each "best practice guideline" and was adapted to fit the needs of refugees from numerous cultural backgrounds. It is critical that evidence-based practice (EBP) be the centerpiece of the work with these populations. EBPs include a grounding in empirical evidence coupled with integration of the latest research evidence: a critical combination for effective treatment with clients who may have additionally experienced trauma (Strand, Popescu, Way, & Jones, 2017). The clubhouse model is a culturally sensitive, adaptable, and sustainable model that provides evidence for therapeutic efficacy. Several organizations around the globe have adopted similar support group models including: Freedom from Torture based in the U.K, the Bellevue/NYU program developed by Dr. Hawthorne Smith, the Advocates for Survivors of Torture and Trauma model based in Baltimore, and Nah We Yon, an African women's refugee support group based in New York City. All of these organizations have documented the economic and therapeutic sustainability of their adaptations of this model.

JFCS Peer Support Program

JFCS has adapted the CTTS clubhouse model for use in an eight-week open format support group (sometimes separated by gender depending on the ethnicity). The group follows an open format in that men or women are invited to participate and drop-in attendance is permitted. The concept behind the drop-in attendance is to allow the communities to view the group as being open, and in tune with cultural mores, where attendance does not prevent an individual from participation.

Peer facilitators receive training at JFCS in group dynamics, cultural sensitivity, and recognizing and referring individuals: 1) in need of mental health services, or 2) at risk of harm to self or others, to the appropriate resources. Peer facilitators are encouraged to check in with group members via telephone or email in order to facilitate communication and develop stronger bonds and to acknowledge that pressing questions or concerns cannot always wait until the next meeting (Fischhoff, 1986). Allowing group members to check in with the facilitators or other group members in between sessions serves to strengthen the group's sense of community and build upon community ties that are being built during group sessions. Pre/post group assessments are conducted in the first session (in person) and after the final session (via phone using an interpreter) in order to obtain data on the progress of the group.

Following best practice guidelines, the CTTS clubhouse model combines a variety of therapies into one cohesive strengths-based support group environment. CTTS developed groups for Iraqi men, women, and families, Burmese men, Bhutanese (ethnic Nepali) families, and pan-African women who have survived torture, trauma, and oppression (Kira et al., 2011). Session content includes: emotional exploration, education on topics ranging from building a resume to symptoms of PTSD, traditional healing methods such as dance and movement therapy, art and music therapy, as well as meditation, storytelling, cooking and eating, and bead working have been used depending on the preference of the group.

The emotional exploration provides community building, normalization, support, and acceptance, which can lead to decreased feelings of isolation, depressive symptoms, anxiety, and PTSD symptoms (Kira et al., 2011). Exploration of current life stressors, acculturation issues, religious, and political issues are common. The education involved in the session largely depends on the needs and desires of the clients. Members suggest topics for discussion allowing the concrete, present needs of the individuals to be met. This also allows the clients to feel empowered and strengthened by decision-making and knowledge. Members are able to brainstorm, use problem-solving skills, and learn from one another thus producing community network building, community self-esteem, and a sense of support (Lubin, Loris, Burt, & Johnson, 1998).

JFCS was not able to obtain any formal training curriculum from CTTS. A manual was created based on evidence-based practice with peer-led groups for refugee populations completed by CTTS and described by Kira et al. (2010) and Kira et al. (2011). The manual includes two sections, Part 1: basic instruction and information on group dynamics, group participation styles and how to manage groups effectively; and Part 2, which offers a curriculum that can be tailored to meet the needs of each unique population and provide

the resources needed. The ten different content areas to be covered over the eight weeks (i.e. some weeks may include more than one content area), See Table 1.

Table 1. *CTTS Weekly Content Areas*

Section(s)	Content Area
1	An introduction and overview of group structure and foreshadowing for more distinct content
2	Life in a different culture: which focuses on issues of acculturation
3 & 4	Taking care of yourself: which focuses on tools for self-care and stress management
5	Health care in the United States: which provides group members information on how to seek health care in the United States
6	Building a strong support system: which provides instruction on identifying friends, family members and other resources who they can turn to for support and help
7	Family life in the United States: which helps group members identify the differences between family life in their native countries and give group members an opportunity to discuss challenges they've faced in adapting to family life in the United States
8	Employment: which helps participants to recognize and promote their personal strengths to improve chances of employment
9	Legal immigration and naturalization issues: which provides group members with needed information on legal issues regarding immigration and naturalization
10	Final session: which provides for debriefing, identifying next steps and connecting group members to new resources as necessary

Homogenous groups are generally preferred when working with refugees (Fischman & Ross, 1990). The CTTS clubhouse model also stresses the importance of homogeneity within the groups, including homogeneity by ethnicity, gender and if possible, age. The principles guiding these decisions are that the more similar the experiences among group members, the greater sense of community built between members, collective self-esteem, and greater cohesion leading to better outcomes for each individual. According to Yalom (2005), groups are ideally homogenous for earlier work and heterogeneous, mixed groups may be best for an advanced group setting.

In many cultures, it is taboo for women and men to discuss together many of the social, political, and economic topics that could be content for a support group. Both genders may feel uncomfortable opening up and sharing issues that may prove beneficial and healing when discussed separately. Additionally, women and men may also differ in their level of interest in the topics discussed. For women, themes such as care for family, particularly during war, relationships, and parenting issues commonly occur (Kira et al., 2011). For men, these topics seem less important making a mixed gender discussion on these issues less effective.

According to the CTTS clubhouse model, mono-ethnic groups are also important in creating ethnic-specific expression, greater ethnic identification, and collective self-esteem. These groups seem more effective and practical, as mono-ethnic groups have

shared experiences, language and culture. Age may also be an important factor in separation of groups; however, gender and ethnicity seem to be most important. Nevertheless, because the more similar the experience among group members the better, a 65 year old Iraqi male refugee may have different needs than a 17 year old Iraqi male refugee. At JFCS all of the groups are mono-ethnic while only some of the groups are mono-gender.

Paraprofessional community members facilitate and lead these groups following the model, training and handbook created by JFCS staff. By using leaders within the refugee community JFCS builds on the natural supports already existing within the community. Using a similar argument used as homogeneity of group members, JFCS feels that community members are able to relate and build collective self-esteem better than mental health professionals outside of the community again, due to shared experience, language, and culture. Training and challenges of peer facilitators are discussed in detail later.

Refugee Characteristics

The characteristics of refugees both before and after their displacement can be predictors of mental health. Female refugees tend to have worse mental health outcomes than male refugees (Porter & Haslam, 2005; Ringold, Burke, & Glass, 2005). Older individuals have a more difficult experience with the resettlement process while children and adolescents are less affected by the stresses of displacement (Porter & Haslam, 2005; Ringold et al., 2005). Higher levels of education and socioeconomic status were also found to be predictors of poorer mental health outcomes (Porter & Haslam, 2005; Ringold et al., 2005). Once refugees arrive, they can encounter unstable living environments and a lack of economic opportunity, which can further place them at risk for poor mental health outcomes (Cole & Blythe, 2010). Soon after arrival, children and youth face a unique complication: they often attain language fluency quickly and, as a result are often negotiating the complex role of being an interpreter and culture-broker for parents and elders in their community (Cole & Blythe, 2010). This displacement of power and cultural expectations can make the acculturation process even more burdensome to families. In the following section, critically important history and data about cultural uniqueness will be discussed to underscore the flexibility of the CTTS model to provide services to an established refugee community and to a newer, growing community in the region.

Iraqi Community

Administrators at JFCS chose to root their group in the CTTS model because this model has an evidence base for use within the specific communities prevalent in Pittsburgh, PA. In speaking with Bhavini Solanki-Vasan (personal communication, May 12, 2013), the former clinical director of Family Intervention Specialists at CTTS, “Iraqi refugees seem to be much more focused on obtaining jobs and housing rather than addressing any trauma or current stress they have endured.” She recommends an adaptation of the original model with the inclusion of a solution-focused approach (based on solution-focused therapy) for Iraqi refugees.

Solution-focused therapy involves setting clear, specific, and attainable goals and working in small increments to achieve these goals (Malan, Heath, Bacal, & Balfour, 1975). This type of therapy is used at the Family Center located in Milwaukee with documented success with refugees as well as with other abuse and trauma victims. This strengths-based approach is clearly utilized in work with all clients at JFCS and is incorporative of creating self-sufficient goal setting capability. Peer educators focus on long term goals for clients and utilize group work to share strategies to successfully engage clients in the Pittsburgh services, communities or work forces that will improve life circumstances.

Because of the conservative nature of Iraqi culture, homogeneity of groups by gender is extremely important to the success of the group. Sensitive issues are bound to come up and clients will be more apt to speak openly about these if there is a single gender group. Many individuals who flee their home countries because of changing geo-political factors that result in some aspect of their identity (e.g., being a member of a minority religious sect) putting them at risk of peril often have family still living in their home country (Rosseau, Mekki-Berrada, & Moreau, 2001; Simich, Hamilton, & Baya, 2006; Turner, Bowie, Dunn, Shapo, & Yule, 2003).

A study done with Iraqi Mandaneans, a small pre-Christian sect, prior to the war in 2003 demonstrated high rates of PTSD (29%) and/or prolonged mental health disability (54%) in this minority refugee population (Steel, Silove, Brooks, Momartin, Alzuhairi, & Susljik, 2006). Furthermore, research has found that Iraqi refugees who still have family in Iraq are more likely to experience an increased mental health disability in addition to PTSD and depression (Nickerson, Bryant, Steel, Silove, & Brooks, 2010). Observations done over the past three years of groups in the Iraqi community of JFCS underscore these findings in that support group members speak about trauma related to their experience in Iraq and/or their experience of resettlement in the USA (JFCS, 2016a). The clinical observer for the Iraqi peer support group additionally observed participants developing friendships and community relationships, increasing knowledge about resources in the community, and venting frustrations/identifying solutions with issues regarding their resettlement (JFCS, 2017a).

The group has provided an opportunity for education and networking opportunities for the refugees. Members report that it has been cathartic just to speak about these issues as it alleviates feelings of isolation. Some of the issues the group is currently grappling with include intergenerational conflicts, deaths of family members in Iraq, experience of discrimination from employers and the recognition/conferral of degrees and titles from Iraq in the US (JFCS, 2016b). The Iraqi group maintains cultural traditions, such as the sharing of fruit, tea and pastries at their meetings; group leaders are given a budget to provide snacks or items to facilitate group cohesion (JFCS, 2016a). The three tenets of the CTTS model are followed while tailoring the group approach to the Iraqi population and the unique challenges they face in the Pittsburgh region.

Bhutanese Community

The CTTS clubhouse model has provided group therapy to the Bhutanese, ethnic Nepali (persecuted and forced to flee Bhutan over 20 years ago) community in the past where they incorporated a community representative to lead their groups. A primary goal for the Bhutanese group was to develop a social organization for the Bhutanese community, which in turn would facilitate community healing. Developing social networks can be critical in creating support within the community through mutual sharing of experiences, collective problem solving, and the reduction of feelings of isolation (Miller, 1999).

Currently, the Bhutanese community has a good infrastructure for connecting with its community members. Through the use of the Bhutanese Community Association of Pittsburgh (2016) established in 2012, information is distributed through their weekly community bulletins. These bulletins are done through online video, which makes the information easier to obtain for many Bhutanese due to the high rates of illiteracy within their population.

Sessions have an emphasis on the emotional exploration aspect of the CTTS model as research suggests that the Bhutanese will greatly benefit from exploration through discussion and shared stories. Seminal work done over nearly twenty years underscores the central use of "folk" stories as a way to observe social worlds and to understand the female sense of self in Nepalese (specifically southeastern Tarai culture) (Davis, 2014). Storytelling allows the group members to engage with each other in a manner that allows for collective healing. CTTS uses basic stress coping techniques that could be employed in this model. Such techniques included the use of laughter and humor where group members were encouraged to share humorous events relating to their present situation. The goal was to help normalize issues, deal with stress, and allow for the group members to engage in healthy laughter.

Other group activities used within the Bhutanese community are culturally grounded. These include yoga and meditation, which provide a spiritual approach to the group meetings. The groups being run by and for the Bhutanese community use yoga, breathing techniques, mind/body techniques, music, storytelling, citizenship, active participation from group members and discussions of resources and cultural differences (JFCS, 2016c). Groups ranging in size from 15-40 typically meet early in the day on Saturday. The group often starts with some light physical exercise to get everyone up, moving, and feeling connected to the group (JFCS, 2016d). Next, group members are educated about important issues relevant to their resettlement. This could include the issues of underemployment or unemployment, use of public transportation, understanding different aspects of the public schools and their current emotional status (JFCS, 2016c). Groups always include time for open discussion (topics can include gender roles, cultural beliefs, holidays, school practices) and this can sometimes include a compare/contrast session of how things were in the refugee camps or in their native Bhutan. The time in the camps was very hard, and for some, may result in a diagnosis of PTSD (JFCS, 2015). There is a lot to process in terms of the social, economic and political differences between cultures; the group lends itself naturally to be the host of such conversations.

Program Evaluation Methods

Participants

Participants were adults that participated in a peer support group sponsored by JFCS between August 2016 and August 2017. Two hundred-twenty unique participants participated in at least one group and completed pre-group and/or post-group assessments. Post-group assessments were not completed by a large number of subjects. Additionally, some individuals participated in multiple groups (n = 42). This analysis focuses on the 79 unique individuals who completed both pre- and post-group assessment. When a participant completed multiple sessions, data from the earliest session with both pre- and post-group assessments was included. Note: When considering only first-time group participation, pre- and post-group data was available for 45 participants. The results obtained from that sample were qualitatively similar to those presented below, but not all results reached statistical significance due to reduced power. The majority of participants were Bhutanese (ethnic Nepali) (Bhutanese: n=62; Congolese: n=4; Iraqi: n=10; Korean: n=3; Latina; n=2). These sample sizes did not allow statistical comparison between groups.

Design

Training peer educators presents various challenges for those supervising the group. The model utilized by JFCS stresses the importance of using lay leaders, from the communities they intend to peer educate, as they will be able to create a better dynamic within the group rather than using a professional social worker and interpreter. The layout of the 8-week sessions is described in the aforementioned literature review section. During the course of the sessions a clinical observer with a degree in social work sits in on one meeting (approximately 3 hours) for each group cycle. This individual does not have an interpreter and is there to observe group dynamics and group process; the individual debriefs with the group leader at the end of the session to ensure all content discussed is documented. Yalom (2005) suggests that one supervisory hour per group session is the optimal ratio for leaders-in-training. However, this ratio is a guideline for mental health professionals and can be adjusted accordingly for peer leaders.

Measures

The effectiveness of the support group was measured using an agency-specific pre/post survey that focused on the group goals. Surveys were translated into the languages of the communities served. When clients were not literate, the surveys were interviewer-administered using interpretative services. The questions focused on one’s ability to utilize or obtain public transportation, employment services, health services, school, support networks, employment, food, bill payment, and read mail. Group members are then specifically asked about feelings of hopelessness, size of their support network, group and leader satisfaction levels, likelihood of referring others to the group, and need for additional services or referrals. Members are offered space on the pre and post surveys to write in additional comments as necessary. JFCS collects data on whether the survey was read to the member, or completed by the member independently.

To ensure that accurate feedback is obtained, only individuals who have attended at least four of eight group meetings complete the post-survey. Work, health issues, etc. can affect attendance any given week. JFCS has worked hard to limit the impact of childcare obligations and barriers to transportation by providing bus passes and/or group leaders assist in providing transportation to the groups and baby-sitting. Locations of the groups are carefully determined based on where the participants live.

Results: Paired Samples Analysis

Analyses

McNemar's tests were used to compare the responses between pre- and post-assessments for questions 1 and 2/3, i.e., Are participants' responses consistent or do they change between the pre-assessment and post-assessment? (Note: binomial exact tests were used if cell counts were too low to use McNemar's test). Questions 4, 5, 6 were scored from 0-2 based on a 3 level Likert scale and were examined using non-parametric Wilcoxon signed rank tests.

Due to modifications to the survey instrument and missing data, some items do not have data from all participants. Participants who chose "Does not apply" were treated as missing, as this was not an option on some survey versions. All analyses were completed using SPSS v. 25.

Expectations vs. Outcomes. The majority of participants expected group participation to help them with all four items (making friends, getting information, becoming more independent, feeling better about life in America) and for most participants, these expectations were met (see Table 2). However, there was a significant difference in responses for items "Getting information" and "Feeling better about life in America," indicating that not all participants' expectations were met for these two items (all ps<0.05).

Table 2. *Participants' Expectations of How Group Will Benefit Them vs. Reported Benefit at Post-Assessment (n=78-79)*

		Outcome at Post-Assessment			
Question	Expectation	No	Yes	Total %	*p*
Make friends (n=78)	No	0	2	2.6%	0.687
	Yes	4	72	97.4%	
	Total %	5.1%	94.9%		
Get information (n=79)	No	3	5	10.1%	0.017*
	Yes	17	54	89.9%	
	%	25.3%	74.7%		
Become more independent (n=79)	No	13	14	34.2%	0.286
	Yes	8	44	65.8%	
	Total %	26.6%	73.4%		
Feel better about life in America (n=79)	No	4	2	7.6%	0.007*
	Yes	13	60	92.4%	
	Total %	21.5%	78.5%		

Note. *significant at the p<.05 level

Ability to Access Services. For most items, participants were more likely to report ability to access at completion of the group. This change was significant for accessing transportation, health care, and ethnic community supports (*all binomial exact tests, all ps*<0.001). For example, 10 participants reported not being able to access health care before the group, but were able to do so at the end of the group, while only one participant reported change in the opposite direction. (See Table 3 and Figure 1 below). There was not a significant change for some items, e.g., accessing school and jobs. This may be due to changes in whether the person was in school or employed, which was not assessed.

Table 3. *Participants' Ability to Access Services (n=40-78)*

Question	Pre-group	Post-group No	Post-group Yes	Post-group Total %	p
Transportation (n=77)	No	2	10	15.6%	0.039*
	Yes	2	63	84.4%	
	Total %	5.2%	94.8%		
Health care (n=78)	No	2	10	15.4%	0.012*
	Yes	1	65	84.6%	
	Total %	3.8%	96.2%		
Jobs (n=40)	No	14	13	67.5%	0.167
	Yes	6	7	32.5%	
	Total %	50.0%	50.0%		
School (n=60)	No	3	11	23.3%	1.000
	Yes	10	36	76.7%	
	Total %	21.7%	78.3%		
Ethnic community supports (n=75)	No	2	24	34.7%	<0.001**
	Yes	1	48	65.3%	
	Total %	4.0%	96.0%		
Daily needs (n=74)	No	3	9	16.2%	0.664
	Yes	12	50	83.8%	
	Total %	20.3%	79.7%		

Note. *significant at the p<.05 level, **significant at the p<.001 level

Feelings of Hopelessness/Loneliness, Friends, Trust. Results indicated no significant differences between levels of hopelessness/loneliness before and after group participation. However, participants did report an increase in connection and sense of trust with their ethnic community between pre- and post-group assessment (Z=-2.78, $p = 0.005$; See Table 4 and Figure 2). Specifically, 28 participants showed an increase in this measure between the pre-group assessment and post-assessment, while 11 participants showed a decrease. Additionally, there was a trend for participants to report an increase in the number of people in Pittsburgh that they felt comfortable talking to about their problems or worries ($p= 0.070$).

Figure 1. *Participants' ability to access services before/after grp participation (n=40-78)*

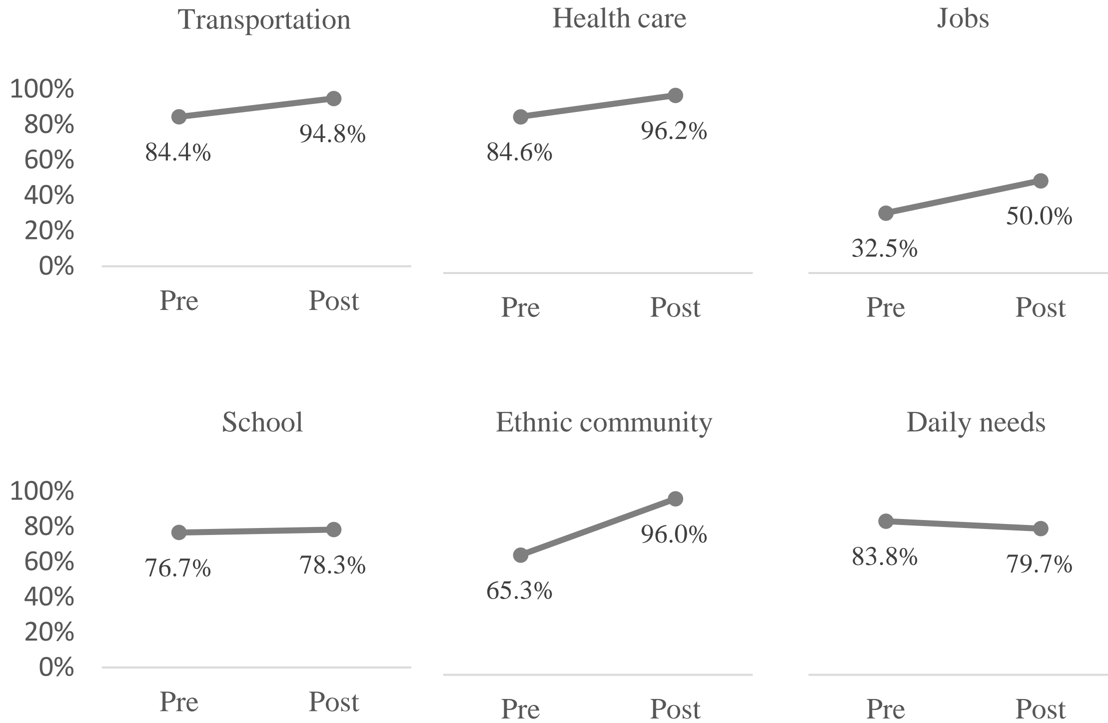
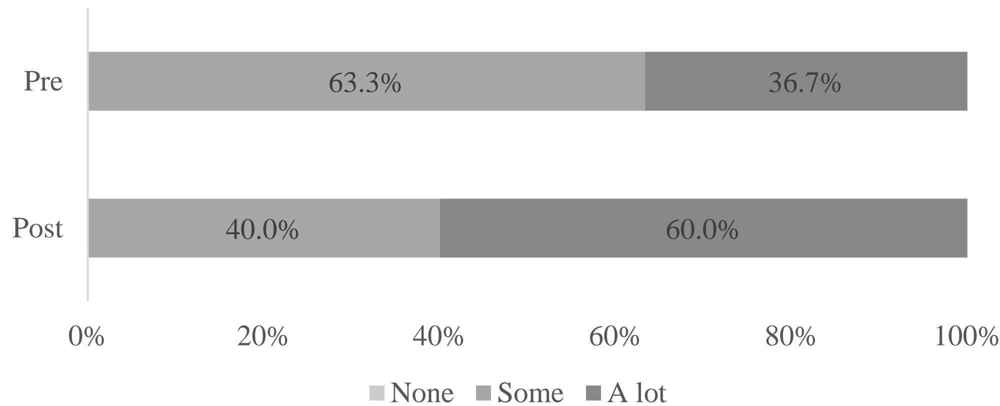


Table 4. *Participants' Feelings About Hopeless/Loneliness, People They Can Talk to, Feelings of Trust in Their Community Before and After Participation. (n= 55-75)*

Question	Pre-group	Post-group				p
		Hardly ever	Sometimes	A lot	%	
In the past 2 months, how often have you felt hopeless? (n=55)	Hardly ever	0	17	6	36.2%	0.244
	Sometimes	11	14	1	53.2%	
	A lot	4	1	1	10.6%	
	%	27.3%	58.2%	14.5%		
How many people in Pittsburgh do you feel comfortable talking to about your problems or worries? (n=74)	Pre-group	None	1-2	3+	%	p
	None	0	0	2	0.0%	0.070
	1-2	2	14	22	57.1%	
	3 or more	0	12	22	42.9%	
	%	2.7%	35.1%	62.2%		
How much do you feel a connection and sense of trust with your ethnic community? (n=75)	Pre-group	None	Some	A lot	%	p
	None	0	0	1	0.0%	0.005*
	Some	0	19	27	63.3%	
	A lot	0	11	17	36.7%	
	%	0.0%	40.0%	60.0%		

Note. *significant at the p<.005 level

Figure 2. *Comparison of "How Much Do You Feel a Connection and Sense of Trust with Your Ethnic Community?" From Pre-Group to Post-Group Assessment*



Discussion

Results indicate that the participants felt significantly more independent and more connected with members of their ethnic community after participation in these groups. This indicates that the groups have been successful in two critical ways that help in the assimilation and acculturation of refugee populations. In general, participants showed an increased ability to access health care, job resources, transportation, school, and their own ethnic community. One surprising finding was that participants' expectations were not met for "Getting information" and "Feeling better about life in America." Possible explanations for this may include the simultaneous ending of case management services, creating a gap in services for those who had not yet fully engaged in services like transportation, food/meals, health care, and employment services. Perhaps feeling more connected to your ethnic community or acculturation may be indicative of the complimentary issue of assimilation to American culture. Many of the individuals who have resettled from Bhutan tend to be older (ages 45+) and research has shown that age is a significant factor in the lengthening the processes of acculturation and assimilation (Cheung, Chudek, & Heine, 2011).

Limitations

An important issue to note is that some individuals participated in these groups two, three, and even four times. The groups are designed for disparate states of assimilation/acculturation within groups. Some individuals may feel they have reaped the benefits from the groups with one session (8 weeks) whereas for others repetition of concepts and supports may be necessary for internalization of key concepts and resources. As stated previously, only the earliest record of participation (pre/post) was used for individuals in which, this occurred. Moreover, the agency may want to consider methods of recruitment for the peer groups so that repetition is less of an issue for future groups. Power for this analysis was greatly reduced by the issue of repetition, and the sample size shrunk from 79 to 45. Even more of an impact was the lack of data from the post surveys.

Future Directions

Organizations around the globe are continuing to develop and test programs for refugees and their families (Ostrander, Melville, & Berthold, 2017). Social work interventions with refugee populations are well equipped to focus on the strengths perspective by incorporating empowerment workshops into curricula for assimilation and acculturation (Carlson, Cacciatore, & Klimek, 2012). Empowerment workshops are another creative treatment being used to heal refugees. Free to Grow (FTG), an organization using a holistic approach to well-being has been employed by organizations such as UNICEF and MultiChoice Africa to provide workshops for refugees and survivors across the globe (Jaranson & Quiroga, 2011). The workshops focus on life skills, interpersonal growth, self-esteem, and the "ownership" of personal growth and development. FTG workshops include 4 sessions spanning 4 days. In the context of family work, the Cultural Context Model aims to make clients aware of the context of power and privilege in their newly adapted culture (environment) and provides them with a family-based intervention that simultaneously seeks to ensure social justice (McDowell, Libal, & Brown, 2012).

Group work is particularly effective with small groups of individuals who have had similar experiences (i.e., siblings, peer groups, or others from refugee backgrounds) to demonstrate shared feelings and show those who feel alienated that they are not alone (McMahon, 2009, p. 75-76). Working with refugee clients from similar backgrounds in a group setting also promotes community-building through cultural education and preservation (A.R.T., 2017). Many refugee populations demonstrate this, such as at the Za'atari refugee camp in Jordan where community artwork represents a variety of cultural themes and issues. Group work allows clients to develop social skills, decreases feelings of isolation through peer support, and increases self-awareness (Coholic, 2010). Research has shown that children and adults alike are able to bond with others, both locally and internationally, through their creativity, empowering them to overcome obstacles and increasing their self-esteem (Ely, Koury, Bennett, Hartinger, Green, & Nochajski, 2017).

The peer support group model provides clients with the social network and grounding in community resources necessary for them to feel a sense of mastery in their new environment. However, it is also limited in scope because the leaders do not have a specific therapeutic mental health and/or clinically therapeutic focus in the work that is being done. Future direction may include utilizing a social worker beyond the training of the peer leaders and instead engaging leaders in a more in-depth social work educational experience; including, but not limited to, taking select social work courses at local community colleges with a focus on ethics, interviewing and engagement skill building.

Currently JFCS offers additional supportive services to refugees including the Immigrant Services & Connections (ISAC) program that connects refugees to existing services in the community. Future directions for work with this population may include additional training for peer leaders in specific trauma-informed care and group mental health strategies and may also include augmenting sessions with a clinician who can provide mental health screenings and referral to individual or family counseling resources.

References

Art for Refugees in Transition [A.R.T.]. (2017). About A.R.T. Retrieved from http://www.artforrefugees.org/about.html

Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., & ... Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, *368*(23), 2182-2191. doi: https://doi.org/10.1056/NEJMoa1211853

Broadhead, R., Heckathorn, D., Altice, P., van Hulsta Y., Carbonec, M., Friedland, G. H., O'Connor, P. G., & Selwynd, P. A. (2002). Increasing drug users' adherence to HIV treatment: Results of a peer-driven intervention feasibility study. *Social Science and Medicine, 55*(2), 235-246. doi: https://doi.org/10.1016/S0277-9536(01)00167-8

Bhutanese Community Association of Pittsburgh. (2016). *Home.* Retrieved from http://www.bcap.us

Carlson, B., Cacciatore, J., & Klimek, B. (2012). A risk and resilience perspective on unaccompanied refugee minors. *Social Work*, *57*(3), 259-269. doi: https://doi.org/10.1093/sw/sws003

Cheung, B., Chudek, M., & Heine, S. (2011). Evidence for a sensitive period for acculturation: Younger immigrants report acculturating at a faster rate. *Psychological Science, 22*(2), 147-152. doi: https://doi.org/10.1177/0956797610394661

Coholic, D. (2010). *Arts activities for children and young people in need: Helping children to develop mindfulness, spiritual awareness and self-esteem*. London and Philadelphia, PA: Jessica Kingsley Publishers.

Cole, A., & Blythe, B. (2010). Mentoring as an alternative to therapy for immigrant and refugee youth. *Revista de Asistenta Sociala*, *9,* 149-156.

Congress, E. P., & Chang-Muy, F. (2015). *Social work with immigrants and refugees: Legal issues, clinical skills, and advocacy* (2nd ed.). New York, NY: Springer.

Davis, C. (2014). *Maithil women's tales: Storytelling on the Nepal–India border*. Urbana: University of Illinois.

Drozdek, B., & Bolwerk, N. (2010). Evaluation of group therapy with traumatized asylum seekers and refugees- the Den Bosch model. *Traumatology, 16*(4), 117-127. doi: https://doi.org/10.1177/1534765610388298

Ely, G., Koury, S., Bennett, K., Hartinger, C., Green, S & Nochajski, T. (2017). "I feel like I am finding peace": Exploring the use of a combined art therapy and adapted seeking safety program with refugee support groups. *Advances in Social Work*, 18, 103-115. doi: https://doi.org/10.18060/21130

Fischhoff, A. (1986). *Birth to three: A self-help program for new parents*. Eugene, OR: Castalina.

Fischman, Y., & Ross, J. (1990). Group treatment of exiled survivors of torture. *American Journal of Orthopsychiatry, 60*, 135-142. doi: https://doi.org/10.1037/h0079191

Geltman, P. L., Augustyn, M., Barnett, E. D., Klass, P.E., & Groves, B. M. (2000). War trauma experience and behavioral screening of Bosnian refugee children resettled in Massachusetts. *Journal of Developmental & Behavioral Pediatrics*, *21*, 255-260. doi: https://doi.org/10.1097/00004703-200008000-00001

Im, H., & Rosenberg, R. (2016). Building social capital through a peer-led community health workshop: A pilot with the Bhutanese refugee community. *Journal of Community Health*, *41*(3), 509-517. doi: https://doi.org/10.1007/s10900-015-0124-z

Jaranson, J. M., & Quiroga, J. (2011). Evaluating the services of torture rehabilitation programmes: History and recommendations. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *21*(2), 98-140.

Karcher, M., Kuperminc, G., Portwood, S., Sipe, C., & Taylor, A. (2006). Mentoring programs: A framework to inform program development, research, and evaluation. *Journal of Community Psychology, 34,* 709-725. doi: https://doi.org/10.1002/jcop.20125

Kaslow, F. (2014). Intervening with immigrant families: An integrative systems perspective. *Journal of Family Psychotherapy*, *25,* 177-191. doi: https://doi.org/10.1080/08975353.2014.910031

Kim, S. (2013). Re-discovering voice: Korean immigrant women in-group music therapy. *The Arts in Psychotherapy*, *40,* 428-435. doi: https://doi.org/10.1016/j.aip.2013.05.005

Kira, I., Ahmed, A., Mahmoud, M., & Wassim F. (2010). Group therapy model for refugee and torture survivors, *Torture, 20*(2), 108-113.

Kira, I., Ahmed, A., Wasim, F., Mahmoud, V., Colrain, J., & Rai, D. (2011). Group therapy for refugees and torture survivors: Treatment model innovations. *International Journal of Group Psychotherapy*, *62*(1), 69-88. doi: https://doi.org/10.1521/ijgp.2012.62.1.69

Lubin, H., Loris, M., Burt, J., & Johnson, D. (1998). Efficacy of psychoeducational group therapy in reducing symptoms of posttraumatic stress disorder among multiply traumatized women. *American Journal of Psychiatry, 155*, 1172-1177. doi: https://doi.org/10.1176/ajp.155.9.1172

Malan, D., Heath, E., Bacal, H., & Balfour, F. (1975). Psychodynamic changes in untreated neurotic patients: II. Apparently genuine improvements. *Archives of General Psychiatry, 32*, 110-126. doi: https://doi.org/10.1001/archpsyc.1975.01760190112013

McDowell, T., Libal, K., & Brown, A. L. (2012). Human rights in the practice of family therapy: Domestic violence, a case in point. *Journal of Feminist Family Therapy*, *24*(1), 1-23. doi: https://doi.org/10.1080/08952833.2012.629129

McMahon, L. (2009). *The handbook of play therapy and therapeutic play*. New York, NY: Routledge.

MENTOR: The National Mentoring Partnership. (2009). *Mentoring immigrant and refugee youth: A toolkit for program coordinators*. Retrieved on June 8, 2010, from https://www.mentoring.org/new-site/wp-content/uploads/2015/09/Mentoring_Immigrant_and_Refugee_Youth-A_Toolkit_for_Program_Coordinators.pdf

Miller, K. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychiatry*, *29*, 283-306.

Nickerson, A., Bryant, R., Steel, Z., Silove, D., & Brooks, R., (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44,* 229-235. doi: https://doi.org/10.1016/j.jpsychires.2009.08.006

Obradovic, J., Tirado-Strayer, N., & Leu, J. (2013). The importance of family and friend relationships for the mental health of Asian immigrant young adults and their nonimmigrant peers. *Research in Human Development, 10*(2), 163-183. doi: https://doi.org/10.1080/15427609.2013.786559

Ostrander, J., Melville, A., & Berthold, S. M. (2017). Working with refugees in the US: Trauma-informed and structurally competent social work approaches. *Advances in Social Work,* 18, 66-79. doi: https://doi.org/10.18060/21282

Porter, M., & Haslam, N. (2005). Predisplacement and post displacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *The Journal of the American Medical* Association, *294*, 602-612. doi: https://doi.org/10.1001/jama.294.5.602

Ringold, S., Burke, A., & Glass, R. M. (2005). Refugee mental health. *The Journal of the American Medical Association*, *294*, 646. doi: https://doi.org/10.1001/jama.294.5.646

Rosseau C., Mekki-Berrada A., & Moreau S. (2001). Trauma and extended separation from family among Latin American and African refugees in Montreal. *Psychiatry: Interpersonal and Biological Processes, 64*, 40-59. doi: https://doi.org/10.1521/psyc.64.1.40.18238

Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry, 45*, 299-307. doi: https://doi.org/10.3109/00048674.2010.543412

Shannon, P. J., Vinson, G. A., Wieling, E., Cook, T., & Letts, J. (2015). Torture, war trauma, and mental health symptoms of newly arrived Karen refugees. *Journal of Loss and Trauma, 20*(6), 577-590. doi: https://doi.org/10.1080/15325024.2014.965971

Shannon, P. J., Wieling, E., Simmelink-McCleary, J., & Becher, E. (2015). Beyond Stigma: Barriers to Discussing Mental Health in Refugee Populations. *Journal of Loss & Trauma*, *20*(3), 281-296. doi: https://doi.org/10.1080/15325024.2014.934629

Simich L., Hamilton, H., & Baya B. (2006). Mental distress, economic hardship and expectations of life in Canada among Sudanese newcomers. *Transcultural Psychiatry*, *43,* 418-444. doi: https://doi.org/10.1177/1363461506066985

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *British Journal of Psychiatry, 188*, 58-64. doi: https://doi.org/10.1192/bjp.bp.104.007864

Stewart, M., Simich, L., Shizha, E., Makumbe, K., & Makwarimba, E. (2012). Supporting African refugees in Canada: Insights from a support intervention. *Health & Social Care in the Community*, *20*(5), 516-527. doi: https://doi.org/10.1111/j.1365-2524.2012.01069.x

Strand, V., Popescu, M., Way, I., & Jones, A. (2017). Building field agencies' capacity to prepare staff and social work students for evidence-based trauma treatments. *Families in Society, 98*(1), 45-56. doi: https://doi.org/10.1606/1044-3894.2017.8

Thomas, L., Clarke, T., & Kroliczak, A. (2008). Implementation of peer support demonstration project for HIV+ Caribbean immigrants: A descriptive paper. *Journal of Immigrant & Refugee Studies*, 6, 526-544. doi: https://doi.org/10.1080/15362940802480407

Turner, S., Bowie, C., Dunn, G., Shapo, L., & Yule, W. (2003). Mental health of Kosovan Albanian refugees in the UK. *British Journal of Psychiatry, 182*, 444-448. doi: https://doi.org/10.1192/bjp.182.5.444

United Nations High Commissioner for Refugees. (2010). *Convention and protocol relating to the status of refugees.* Retrieved from http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf

Watters, C. (2001). Emerging paradigms in the field of mental health care of refugees. *Social Science and Medicine*, *52*, 1709-1718. doi: https://doi.org/10.1016/S0277-9536(00)00284-7

Webel, A., Okonsky, J., Trompeta, J., & Holzemer, W. (2010). A systematic review of the effectiveness of peer-based interventions on health-related behaviors in adults. *American Journal of Public Health*, *100*(2), 247-253. doi: https://doi.org/10.2105/AJPH.2008.149419

Yalom, I. (2005). *The theory and practice of group psychotherapy*. New York City, NY: Basic Books.

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Refugee Health Education: Evaluating a Community-Based Approach to Empowering Refugee Women in Houston, Texas

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Abstract: *Although resettlement agencies in the United States assist refugees by offering a variety of local social and health services, refugees are still less likely to access these services. Few studies have evaluated refugee health education interventions focusing on barriers to accessing healthcare and overcoming negative social determinants of health. This study evaluated the feasibility, acceptability, and perceived impact of a yearlong health education intervention to empower Burmese refugee women living in Houston, Texas. The intervention included workshops, community excursions, question and answer (Q&A) sessions, and home visits. The evaluation was a formative qualitative study including interviews with Burmese refugee women who participated in the intervention and local resettlement agency caseworkers. Qualitative content analysis guided the data analysis and was conducted to identify categories and emergent themes. Key findings indicated that motivation to participate in the intervention was impacted by the women's perceived relevance of health education material to Burmese cultural values and opportunities for hands-on learning to promote self-efficacy. Recommendations for future interventions include the use of community health workers to train refugee health educators, pairing English lessons with health education material to promote development of English language skills, developing teaching materials for refugees with low literacy, establishing bottom-up support from refugee resettlement agencies, and incorporating the social work ecological model to tailor health-focused interventions to the specific needs of the refugee community.*

Keywords: *Refugee health; women's health; health education; program evaluation*

In fiscal year 2015, the United States received approximately 70,000 refugees (United States Department of State, 2015), of whom 7,479 refugees were resettled in Texas. Houston received 39% of the refugees, making it one of the top destinations for refugee resettlement in the U.S. (Montour & Kazmierski, 2013). Burmese refugees make up the second largest refugee group in Texas (Montour & Kazmierski, 2013). In Houston, resettlement agencies assist in connecting refugees to various services including food stamps and health insurance, as well as English as a second language (E.S.L.) classes, job development, and linkage to health clinics. Despite local services offered by resettlement agencies, refugees are less likely to access health and social services due to low health literacy, inability to navigate the healthcare system, scheduling challenges, lack of daycare options, language barriers, differing cultural beliefs, and lack of access to experienced interpreters, all of which lead to an overall decline in health (Murray, Mohamed, &

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Ndunduyenge, 2013; Vermette, Shetgiri, Al Zuheiri, & Flores, 2015).

Key health issues for newly arrived refugees to the U.S. include a high prevalence of musculoskeletal and pain issues, mental health challenges such as depression, anxiety, and posttraumatic stress disorder, and social problems such as isolation, financial challenges, culture shock, and employment difficulties (Eckstein, 2011). For Burmese refugees, infectious diseases such as hepatitis B, HIV and tuberculosis are also prevalent (Montour & Kazmierski, 2013). Medical screenings in Texas reveal that recently arrived Burmese refugees make up 47% of newly diagnosed hepatitis B cases and 24% of newly diagnosed HIV cases among all recently arrived refugees (Montour & Kazmierski, 2013). Also, 44% of newly arrived Burmese refugees settling in Texas were found to have a positive tuberculosis skin test (Montour & Kazmierski, 2013). Poor initial health outcomes for newly arrived refugees often are a result from living in a refugee camp for numerous years before coming to the U.S.

Designed to tackle health disparities within the refugee population, refugee-focused health and social interventions typically center around community capacity-building, developing self-efficacy to navigate the U.S. healthcare system, and encouraging community empowerment (Baird et al., 2015; Glanz, Rimer, & Viswanath, 2008; Im & Rosenberg, 2016; Wieland et al., 2012). Despite an important foundation of public health social work research on refugee health education interventions, few interventions designed specifically for Burmese refugees have been implemented, and little to no program evaluations have been conducted to assess the feasibility and acceptability in delivery of these health education interventions for Burmese refugees living in the U.S. (Hartwig & Mason, 2016; Ornelas et al., 2017; Rowe et al., 2016; Walker, Koh, Wollersheim, & Liamputtong, 2015).

In responding to the public health needs of the local Burmese refugee community in Houston, Texas, a pilot community-based health education intervention, titled Refugee Women's Health Initiative, was developed in partnership with a local refugee resettlement agency and implemented by two students from The University of Texas Health Science Center in Houston (UTHealth). Focusing on Burmese refugee women, the pilot intervention provided health education and life skills coaching. Empowerment was defined as building knowledge, skills and self-efficacy across a range of health topics related to both preventive behaviors and navigation of the healthcare system. The intervention provided health education via a life skills approach. Workshops focused on real-life applications to practice new skills and improve skills needed to navigate life in the U.S. Workshop topics were identified from focus groups with Burmese refugees and case managers at the resettlement agency over a two-month period prior to the implementation of the intervention. Workshops were held weekly for one year and included presentations and discussions on a range of health topics, dissemination of health education materials, question and answer (Q&A) sessions with medical providers, and excursions to promote community exploration. A workshop, excursion, or Q&A session was planned weekly for the duration of one year. The hour-long workshops were held in a classroom space offered by the resettlement agency with a Burmese interpreter to assist with communication. Home visits were completed twice a month by the intervention team to build rapport with the refugee women. Table 1 provides a summary of the intervention activities and workshop

topics identified by the women.

Table 1. *Workshop Topics, Excursions, and Q&A Sessions: April 2014-May 2015*

Workshop Topics	Excursions	Q&A Sessions
• Cultural Adjustment- Life in the U.S. • Navigating the Public School System for Parents • Nutrition • Job Development - Where to Start Job Hunting • Dental Care and Oral Hygiene • Planned Parenthood - Well Woman Exam & Family Planning • Personal Hygiene • Budgeting Skill Building and Financial Advice • Substance Abuse and Domestic Violence • Obesity and Diabetes Prevention • How to Become a Community Health Worker • Photo Voice • Ophthalmology Vision Screening • Self-esteem, Self-care, and Goal-building	• Zumba in park • Grocery store visit • Family trip to beach • Children's museum • Houston Zoo • Health fair • Art museum • Houston Medical Center	• OB/Gynecology • Pediatrician • Psychiatrist

The priority population of the pilot intervention was Burmese-speaking refugee women enrolled in services at the local resettlement agency. Since participation in health education interventions is typically low in minority populations (Mirza et al., 2014; Zanchetta & Pourselami, 2009), and given the pilot nature of this intervention, there were no restrictions on ethnicity. While Burmese refugees from all ethnic backgrounds were invited to participate, due to funding restrictions, only a Burmese-speaking interpreter was available to assist with the focus group, workshops, and all other activities. As such, only women who were comfortable speaking Burmese attended. Burmese refugee women were specifically invited to participate because of their central role in influencing health outcomes of the family. This includes their important role in managing childcare, and making health decisions for their children and families. Likewise, refugee women are an at-risk priority population because they are typically more isolated, have limited English skills, and feel unsure about their future (Walker et al., 2015). Recruitment for the pilot intervention was facilitated through the case managers from the resettlement agency. Case managers contacted all Burmese refugee clients who were enrolled in services at the agency to provide information about the focus group and future workshops. A total of thirty-eight Burmese refugee women participated in the intervention activities from April 2014-May 2015.

This study was a process evaluation of the Refugee Women's Health Initiative that had the following objectives: 1) To assess the feasibility, acceptability, and initial impact on health knowledge and self-efficacy of the refugee women and resettlement agency staff, 2) To understand process-related aspects of the intervention including knowledge, perceived benefits and implementation barriers, 3) To assess feasibility for future implementation of this health education initiative on a larger scale, and 4) To contribute to the growing public

health social work literature on interventions for Burmese refugee communities resettled in the U.S. by providing insights from refugee women and resettlement agency staff on best practices for developing and delivering health education programming for recently resettled refugees.

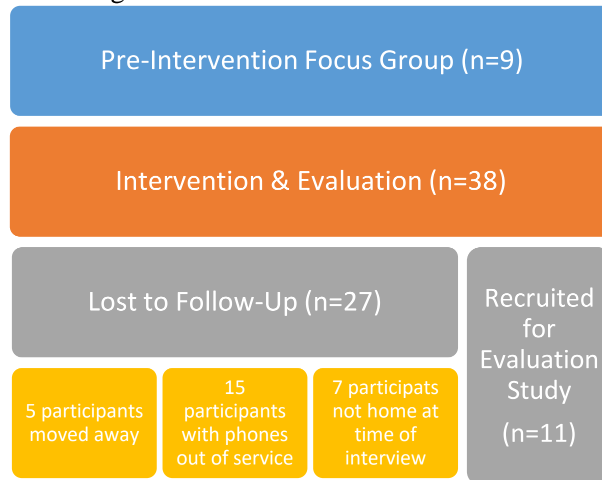
Methods

This evaluation study used an exploratory, post hoc, single-group only research design to better understand the delivery and initial impact of health education and health promotion strategies in the refugee communities upon completion of the intervention. The evaluation was formative and qualitative in nature, relying on semi-structured interviews to capture perspectives of the refugee women and resettlement agency staff. The same graduate student from the University of Texas Health Sciences acted as the evaluator and conducted data collection and data analysis. The study was approved by the University of Texas Health Sciences Committee for the Protection of Human Subjects.

Participants

Only Burmese refugee women who had previously participated in the Refugee Women's Health Initiative intervention were eligible to be part of the evaluation. Participation in the intervention was defined as having attended one or more workshops over the course of the year-long intervention. A total of 38 Burmese refugee women were eligible. With the help of the Burmese interpreter, the evaluator reached out to all eligible participants by phone or home visits to recruit for the evaluation study. A total of 11 Burmese refugee women agreed to participate in the evaluation. Twenty refugee women were lost to follow-up, and seven women were unavailable at the time of the interviews. Of those who were lost to follow-up, five had moved to another state, and 15 had changed cell phone numbers and addresses. Figure 1 provides an outline of the recruitment process.

Figure 1. *Recruitment Cascade*



Because of low literacy in both Burmese and English, verbal consent was considered

most appropriate for the women to fully understand the study and consent process. A scripted consent form was read to the women with the aid of a Burmese interpreter. Participants were informed that participation in the evaluation study would not impact social services received from the refugee resettlement agency. Participants were able to withdraw from the evaluation at any time.

Resettlement agency staff members were selected to participate in the evaluation based on the following criteria: 1) Having worked at the resettlement agency for the past year, and 2) Having had some type of role in the intervention such as acting as the driver in transporting the women to the workshops or providing case management. Permission from the resettlement agency supervisor was obtained for staff to participate in the evaluation. Staff members were provided letters informing them about the study which served as passive consent to participate. Staff were informed that participation would not lead to repercussions in employment status. Confidentiality of information was paramount to protect both the refugee women and staff. Based on the study's criteria for selecting agency staff members, five staff were eligible for interviews and asked to participate.

Data Collection

A semi-structured interview guide was used to guide interviews with the refugee women. The guide included twelve questions focusing on perceived benefits to participating in the intervention, cultural appropriateness of topics, barriers to attending the workshops or excursions, cues to action for participating, and suggestions for improvement. Interviews were conducted by the evaluator and a native Burmese speaker from the University of Texas Health Sciences who served as the interpreter. Interviews were conducted and audio recorded in the homes of the women with the assistance of the interpreter. In accordance with the preference of the women, interviews with the refugee women included a mixture of individual and group. A brief survey was administered at the time of the interview to collect demographic information. Survey data were verbally collected by the interpreter and recorded on paper by the interviewer.

A separate semi-structured interview guide was administered to the resettlement agency staff and comprised of seven questions addressing the role of the intervention within the resettlement agency, staff's knowledge of the intervention, perceived benefits and barriers of the intervention, and general comments or observations about the overall initiative. All staff interviews were conducted face-to-face with the evaluator and were audio-recorded.

All recorded interview data from both refugees and staff were transcribed verbatim and entered into Atlas.ti for coding (Lapan, Quartaroli, & Riemer, 2012). Using a native Burmese speaker as an interpreter, the interview questions were translated from English to Burmese so the refugee women would understand the questions being asked. All responses were interpreted back into English and audio recorded. The interviews were then transcribed and an English transcription was used for data analysis.

Analysis

Interviews were analyzed using conventional qualitative content analysis to generate

categories inductively from the data. Conventional content analysis is often used when there is limited existing research (Hsieh & Shannon, 2005), which was the case with existing research on Burmese refugee women. After transcribing the recordings and translating the interviews to English, open coding was performed to examine smaller units of meaning and repeating patterns (Lapan et al., 2012). Themes and codes were shared with the interpreter and colleagues for further contextualization and confirmation of the findings. A coding manual was developed with code names and definitions for assigning codes. A separate coding manual was created for refugee women and staff. The coding manuals evolved throughout the analysis as part of inductive category development. There was no adoption of coding schemes from previous studies (Zhang & Wildemuth, 2009). Secondary coding established categories to organize key themes, highlight patterns, and make inferences. The interviews with the refugee women were analyzed separately from the interviews with the staff. Quotations from the women were kept in third person to maintain the manner in which the interviews were translated during data collection.

Results

Characteristics of Participants

Of the eleven women who agreed to participate in the interviews, six women were interviewed one-on-one, and five were interviewed in groups of two and three. The average age of the women participating in the evaluation was 34 years. On average, the women had spent almost half of their life in a refugee camp and had lived in the United States an average of 3.25 years. A majority (81%) of the women had a primary school education or less and, of those, 45% of the women had no education.

Interviews with Refugee Women

Interview Themes. Four prominent themes were drawn from the interviews with the refugee women: 1) Perceived benefit of participating, 2) Opportunities to practice English, 3) Community as a cultural value, and 4) Family as a cultural value.

For the women attending the intervention, there was a perceived benefit in learning new information that was relevant and useful to their everyday lives. During an interview with a refugee woman who had attended the workshop hosted by Planned Parenthood and the workshop on personal hygiene, the woman spoke at great lengths about the information she learned from the experience. The interpreter translated, "*She found the discussion on topics of health, and you know, reproductive health, and personal hygiene was a draw [to attend the workshop].*" For this particular woman, there was a perceived benefit in learning about reproductive health and hygiene that attracted her to the workshop. That benefit was a motivator for her to attend. Likewise, the women felt empowered when learning new skills. The interpreter assisted in translating for one woman by stating, "*Because she didn't know about family planning before, and then she learned about it in the workshops. So, that's why she liked it. It was useful for her.*" Empowerment was noted when the women learned a skill that was beneficial in being able to navigate and manage life in the U.S. Some of the women identified the perceived benefit of learning a new skillset as the most important aspect of the intervention, as was noted in the following quote from a woman

who had attended the Houston Medical Center excursion where she learned to ride the city bus. The interpreter explains, "*Her favorite part was the visit to the hospital because she learned how to get there and then how to ask for help at the hospital.*" Knowledge gained on various health topics and the opportunity to practice a new skillset was a strong motivator for the women to attend the workshops and other activities of the intervention. Overall, there was positive reinforcement associated with attending the intervention. When interviewed, one of the women mentioned knowledge gained as a positive reinforcement to attend the workshops. The interpreter summaries for her, "*She said like she didn't know anything about—anything about hygiene, family planning, personal hygiene and family planning or health, but she learned something from this—all these workshops, particularly about the intrauterine device.*" In general, the women felt they had gained something in return for attending the intervention, whether it be knowledge about a relevant topic or the opportunity to practice certain skillsets.

The opportunity for the women to practice English language skills was a big draw for the women to attend the workshops. Hands-on learning opportunities were embedded in the workshops and community excursions, and workshops were perceived as a safe space to practice the health behavior or life skill while using English. As a result of increased opportunities to practice English and learn vocabulary related to life skills, the women felt more confident in their ability to execute certain life skills such as calling the doctor to make appointments or taking the city bus. A group interview with three women denotes this change in confidence. The interpreter translates for the women, "*...now they feel a little bit more confident to call for the appointment or to ask for the appointment [in English].*" Using English in the workshops and activities was a strong motivator for some of the women to attend. This was apparent with one woman's quote which was interpreted as, "*She thinks it really helped to gain knowledge and also to learn English a little bit more, to talk with friends. That's why she also always liked to participate on all these activities.*"

The women developed a unique community identity that was formed from a shared experience of participating in the intervention, and it created a foundation for community development and exchange of knowledge and skills. The social aspect was a significant draw for the women to attend the intervention. As was noted from the workshops, a strong sense of community was an observed shared cultural value among the Burmese women, which the intervention helped to nurture and support. The community of women formed through the intervention provided a communication channel for the health education messages. One participant described to the interpreter how she and others would spread the health messages to others in the Houston Burmese refugee community. The interpreter reported that, *"They discuss the [home] visits and the workshop at home among each other—they also then talk to other people about the workshop."* Relationships were cultivated over the course of the intervention, leading to reciprocal rapport-building among the women. Information was discussed among the women at home and knowledge was passed from woman to woman and from family to family. Health education messages also spread to the larger Burmese refugee community. At one point during an interview, the interpreter stated, *"They are Karen not Karenni. But they met with other Karenni women in the workshop and then they learn about them, too."* Communication channels were not

impacted by ethnicity. Health education messages passed between Karen and Karenni Burmese refugees living in Houston.

Family was another strong cultural value identified by the women. Knowledge and skills gained in the workshops were framed in the context of benefiting the family. One woman emphasized the importance of family in the following quote which was translated as, "*She felt more confident about healthy behaviors after the workshop, not only for her but also her family and especially for her children."* The women wanted their children to become healthier and better adjusted to life in the U.S. The women were more likely to retain information pertaining to the children because of the value placed on family, as was noted in an interview in which the interpreter claimed, "*She remembered it because it was the one [topic] she liked to know and it was useful for her, too, because she has kids going to the school. So that is why she still remember."* The women's information retention was significantly improved for topics that had a perceived benefit and touched on cultural values such as family or community. During the interviews, the women spoke about the information they were best able to retain, which revolved around topics pertaining to their children's health. The interpreter assisted in translating one woman's views on the workshop topics in a statement, *"The most memorable part for her was one of the workshops- a teacher came in and then talked about how to take leave for her children and also how to communicate with the schoolteachers."* Linking the intervention to relevant topics and shared cultural values had significant impact on the women's participation in the intervention. As is consistent with best practices in adult health education (National Committee for Health Education, 2016), motivation for the women to attend the workshops was found to be tied to a perceived benefit of attending, opportunities for hands-on learning, and the inclusion of topics that the women felt were applicable to their everyday lives and culturally relevant.

Interviews with Resettlement Agency Staff

A total of five interviews were conducted with the agency staff. All staff came from the same department within the agency, the long-term case management department. Staff members were in charge of assisting refugee clients who had been in the U.S. for any length of time from three months to five years. None of the staff declined the request for an interview.

Goodness of Fit

Staff interviews revealed the importance placed on the intervention as being a good fit for the agency, as well as a good fit for the refugee community. Goodness of fit was defined by the agency staff as an intervention that: 1) Has flexibility and the ability to mold to the structure or schedule of the agency, 2) Encourages agency and staff involvement, 3) Fills service gaps and addresses client problems that the agency does not have the capacity to handle, and 4) Does not burden the agency for classroom space, time or financial support. In a comment about program scheduling being a good fit for the agency, a staff member stated, "*[Other outside health education programs] kind of have their own kind of timeframe and their own schedule in mind, and they don't really seem to want to work with*

what's best for the entire agency overall, thinking that the only thing we have to do really is like their programming" The emphasis on health education programs being a good fit relates to the work burden placed on case managers at refugee agencies. A case manager who was interviewed reported managing 300 clients who were assigned to his caseload. Refugee case workers oftentimes have extensive caseloads and struggle to provide the in-depth attention to all clients. Those with major medical problems often consume the attention of case workers, leaving limited time for interventions aimed at improving the long-term health outcomes in the refugee population. In one particular instance, a staff member claimed, "*And so I think that that was great as well that you guys needed less space and much of those women didn't need a lot from us, and I think that was helpful to the staff as well who were overwhelmed with a lot of work already*." The need for programs that counter the heavy work load of the case managers is echoed in the following statement, "*It was almost like a breeze honestly compared to others that we've had there, honestly, because—you know—some of the other people we worked with—they really were super kind of needy. Like we had to do all the calling [for program recruitment]. We had to do all the da-da-da—you know. They didn't want to kind of go into the community themselves and do some work. They'd want us to do everything and they would just show up and present."* Agency staff who had worked with previous programs that were organized by groups of volunteers were weary of any new projects that would require extra time.

Disconnect

The heavy work load of the staff at the agency coincided with a certain level of disconnect between the staff and the intervention. The intervention was not fully integrated and adopted into the structure of the resettlement agency. In one interview, a staff member mentioned, "*I don't know [about the workshops] because I'm always outside. We provide them transportation. From outside it looks like it goes well. I don't know inside, because I've never been in [the workshops]."* Staff who were involved in the intervention were not knowledgeable about some aspects of the program or understood the objectives of the project. Staff involvement in the pilot intervention was limited to providing transportation for the women. None of the agency staff attended a workshop or Q&A session. Future implementation of the full-scale intervention would ultimately have to depend on external organizers, either social workers or health educators.

Discussion

This evaluation provides an overview of the feasibility and acceptability of implementing a health education intervention targeted at refugee communities. The findings from the evaluation are consistent with health promotion literature that links peer-to-peer learning with community building, increased community participation, and creating a sense of belonging within the refugee population (Im & Rosenberg, 2016). The strength of the intervention was nesting the health education program within the Burmese refugee community to encourage community members' on-going participation in the development and implementation of the intervention. This was done through an initial focus group with the refugee women to select topics for the workshops, the use of an interpreter from the refugee community, and home visits that allowed an opportunity for

regular, in-person feedback from the women. Community-building was evident in the development of social networks among the women. Community involvement in the design and implementation was critical for the intervention to be successful. Refugee health literature has established that community-based approaches to implementation and evaluation research are more effective with vulnerable populations such as refugees. Models such as the Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) are recommended strategies (Baird et al., 2015; Balcazar, Garcia-Iriarte, & Suarez-Balcazar, 2009; Wieland et al., 2012).

The intervention created a social space for helping refugee women to connect with each other socially and emotionally. Given the multiple health benefits of positive social relationships (Hartwig & Mason, 2016; Im & Rosenberg, 2016; Khawaja, White, Schweitzer, & Greenslade, 2008; Simich, Beiser, Stewart, & Mwakarimba, 2005; Walker et al., 2015) as well as the adverse health consequences of social isolation (Thoits, 2011; Wilkinson & Marmot, 2003), public health social work interventions for refugees should be intentional about creating spaces for their participants to get to know each other and to develop social relationships and support. Connections the refugee women make with each other may be even more important than the specific lifestyle skills the program aims to deliver.

The most significant barrier to implementing the intervention was lack of buy-in from the resettlement agency. Staff interviews highlighted the importance of the organizational compatibility of the intervention. When examining whether an agency will adopt an intervention, compatibility of the intervention with the overall mission statement and goals of the agency is a fundamental component (Roger, 2003). This study demonstrates that compatibility and agency buy-in were two of the most significant barriers to creating a feasible and sustainable intervention. The intervention had agency buy-in from the leaders of the resettlement agency, but not from the ground workers who oversaw the daily running of the organization. There needed to be leadership from the bottom up, including incorporation of frontline staff in planning the intervention, as recommended by health promotion planning frameworks such as Intervention Mapping (Bartholomew et al., 2016).

It is important to note the low participation in this evaluation (n=11 out of possible 38). This is particularly important due to the fact that actual participation in a specific health promotion intervention is traditionally low among ethno-cultural groups. This is due to difficulty accessing health information, language barriers, and a lack of culturally appropriate or tailored health education material (Mirza et al., 2014; Zanchetta & Pourselami, 2009). These low participation rates in the refugee health education programs make it difficult for program planners to fully evaluate outcomes and understand the long term impact of refugee-focused programs. As shown from this evaluation of an intervention for refugees, health educators and social workers working with these populations should focus on developing evaluation strategies that are incorporated into the intervention to overcome problems with low attrition. However, few studies have been done to explore secondary migration of refugees within the first three years after initial resettlement in the U.S. In this study, 18% of the women participating in the intervention had moved away by the time the evaluation activities began. Also, 55% did not have a phone that was working which could also indicate that they had moved out of the area. Innovative approaches are

needed to discover various ways of maintaining communication with a vulnerable population such as the refugee communities so that health care professionals can follow up on healthcare needs, and social workers can provide long-term services to this particular population, and evaluate program outcomes. While it may be difficult to analyze long-term impacts of an intervention with the Burmese refugee population due to attrition, short-term outcomes can be assessed by continuous monitoring and evaluation of the intervention.

The implications for social work point to a need for the ecological approach in better understanding the social determinants of health that impact refugee communities (Ostrander, 2017). Integrating the biopsychosocial, cultural and environmental perspectives is an essential skill for social workers, as recognized by the NASW (NASW, 2016). To utilize the ecological perspective, social workers must be able to move away from the traditional division of micro, mezzo and macro practice in order to view the refugee community in context of the diverse components impacting refugee health (Grise-Owens, 2014). Likewise, social workers are key components in the resettlement process because of their ability to analyze situations from a wholistic approach, build cross-cultural connections with clients (Russell, 2001), connect refugees to resources or services, and provide emotional support during the resettlement process (Agbenyiga, 2012). Social workers are ideally placed in resettlement agencies and have the needed skills to be able to positively impact health education messaging, reduce the high loss to follow up rates when implementing programs, and improve overall agency buy-in for future health education programs.

Research studies on refugee health have not focused enough on discovering effective methods for interviewing refugee women. This study used mixed interview styles by interviewing the women individually and in small groups. A mixed interview style was chosen based on the idea of being culturally appropriate and attuned to the needs of the women who requested that they be interviewed in groups. There is little to no existing evaluation data available for the Burmese refugee population, and little to no data on the best practices for conducting evaluations for resettled Burmese refugees in the U.S. Hence, future public health social work research should focus on developing best practices for qualitative methods that address cultural sensitivity and research standards when working with the refugee population.

Recommendations

Public health social work interventions aimed at improving health outcomes for refugee communities in the U.S. may benefit from the following considerations in regards to designing and implementing health-focused public health social work programs:

1) Incorporate the community health worker (CHW) model as a solution to overcome language and cultural barriers. Language and cultural differences act as significant barriers for refugees attempting to access the healthcare system and negatively impact health outcomes (Clark, Gilbert, Rao, & Kerr, 2014; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Pesata, Pallija, & Webb, 1999; Sheik-Mohammed, Mcintyre, Wood, Leask, & Isaacs, 2006). The CHW model takes into consideration cultural values such as social networks and community identity among communities. Furthermore, peer-to-peer

teaching is an effective approach using cultural values and existing strengths of the community. The CHW model may also act as a method to overcome high attrition rates in refugee-focused interventions by providing the motivation to stay active in a health education intervention. The CHW certification of completion is a tangible goal that in turn can lead to employment in community health clinics. Having tangible goals and motivators such as a certificate of completion for CHW training can prove to be key in the success of refugee participation in future health promotion programs.

2) Pair English language lessons with health education lessons to promote development of language skills in understanding health. English language competency is an essential survival skill for refugees living in the U.S. due to a lack of accessible and available interpreter services. Oftentimes, refugees do not have the medical vocabulary to feel confident interacting with a health provider when describing health concerns or receiving a diagnosis (Murray et al., 2013; Vermette et al., 2015). English lessons intertwined with health education lessons would provide refugees with vocabulary specific to mental, physical, and social health.

3) Develop partnerships with resettlement agencies to establish agency buy-in and support for health education interventions. Participation from the resettlement agencies is crucial to achieve the intended outcomes of any intervention. Development of an intervention for refugees should begin with the staff members and directors of the resettlement agencies acting as stakeholders in planning and implementation which follows best practices of current health promotion program planning models (Bartholomew et al., 2016). The agency can provide significant resources toward the intervention and assist with accessing the refugee population.

4) Incorporate the social work ecological framework in designing future interventions targeted at refugee communities. The use of a multi-dimensional intervention that addresses social determinants of health at each level and works to address those factors has the potential to positively impact health outcomes for refugee communities.

Limitations

Although this study has a small sample size, the purpose of this study was to examine the feasibility and acceptability of conducting a year-long pilot health education program for the Burmese refugee population, and to understand the perceived benefits and barriers in implementing such a program. The participant's views obtained in the evaluation may not necessarily reflect those of the Burmese refugee community located in other geographic areas. However, this study provides a description of a health education program for refugees that may serve to guide the development of other interventions. Other refugee populations may have varying cultural beliefs, practices, and cultural experiences that were not identified by this study. The study also has limited geographic bounds and may not be applicable to other regions of the U.S. where social services and healthcare access differ. The design of this study does not address outcome data that measures changes in health behavior of the refugee women. Furthermore, data collection relied upon self-reported data and may reflect some level of response bias.

Conclusion

The refugee population has often been neglected in health care policies and medical practices. With opportunities in preventive medicine provided by the expansion of the Affordable Care Act, there is a greater need to reach neglected populations to provide preventive care and health education. Unlike other populations, resettled refugees in the U.S. face particular barriers to accessing healthcare or health education programs. Likewise, the refugee population has particular motivation to attend health education programs that must be understood in a larger cultural context. This study provides information on best practices for working alongside refugees in the U.S., and explores various cultural and programmatic components to consider when designing a health education program for refugees who have been resettled in the U.S. Furthermore, the highlighted recommendations in this study demonstrate the need for social workers to consider the cultural context of the target population as it relates to health-focused social work programs, and the specific programmatic needs of the refugee population in the U.S. Recommendations from this evaluation study were drawn from a pilot intervention. The lessons learned can be transferred to a larger more in-depth intervention and expanded to meet the needs of refugees from other cultural and language backgrounds. While few studies have been conducted to evaluate Burmese refugee health education in the U.S. and examine the best practices in refugee health education, this study provides a foundation for public health social workers to explore critical knowledge missing in immigrant and minority health research.

References

Agbenyiga, D. L., Barrie, S., Djelaj, V., & Nawyn, S. J. (2012). Expanding our community: Independent and interdependent factors impacting refugees' successful community resettlement. *Advances in Social Work*, *13*(2), 306-324.

Baird, M. B., Domian, E. W., Mulcahy, E. R., Mabior, R., Jemutai-Tanui, G., & Filipe, M. K. (2015). Creating a bridge of understanding between two worlds: Community-based collaborative-action research with Sudanese refugee women. *Public Health Nursing*, *32,* 388-396. doi: https://doi.org/10.1111/phn.12172

Balcazar, F. E., Garcia-Iriarte, E., & Suarez-Balcazar, Y. (2009). Participatory action research with Colombian immigrants. *Hispanic Journal of Behavioral Sciences*, *31*(1), 112-127. doi: https://doi.org/10.1177/0739986308327080

Bartholomew, K. L., Markham, C. M., Ruiter, R. A. C., Fernandez, M. E., Kok, G., & Parecel, G. S. (2016). *Planning health promotion programs: An intervention mapping approach*. San Francisco, CA: Jossey-Bass.

Clark, A., Gilbert A., Rao, D., & Kerr, L. (2014). 'Excuse me, do any of you ladies speak English?' Perspectives of refugee women living in South Australia: Barriers to accessing primary health care and achieving the Quality Use of Medicines. *Australian Journal of Primary Health*, *20*, 92-97. doi: https://doi.org/10.1071/PY11118

Eckstein, B. (2011). Primary care for refugees. *American Family Physician, 83*(4), 429-

436.

Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behavior and health education, theory, research and practice*. San Francisco, CA: Jossey-Bass.

Grise-Owens, E., Miller, J. J., & Owens, L. (2014). Responding to global shifts: Meta-practice as a relevant social work practice paradigm. *Journal of Teaching in Social Work, 34*(1), 46-59. doi: https://doi.org/10.1080/08841233.2013.866614

Hartwig, K. A., & Mason, M. (2016). Community gardens for refugees and immigrant communities as a means of health promotion. *Journal of Community Health, 41*(6), 1153-1159. doi: https://doi.org/10.1007/s10900-016-0195-5

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi: https://doi.org/10.1177/1049732305276687

Im, H., & Rosenberg, R. (2016). Building social capital through a peer-led community health workshop: A pilot with the Bhutanese refugee community. *Journal of Community Health*, *41*(3), 509-517. doi: https://doi.org/10.1007/s10900-015-0124-z

Khawaja, N. G., White, K. M., Schweitzer, R, & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry*, *45*(3), 489-512. doi: https://doi.org/10.1177/1363461508094678

Lapan, S. D., Quartaroli, M. T., & Riemer, F. J. (2012). *Qualitative research*. San Francisco, CA: Jossey-Bass.

Mirza, M., Luna, R., Mathews, B., Hasnain, R., Hebert, E., Niebauer, A., & Mishra, U. D. (2014). Barriers to healthcare access among refugees with disabilities and chronic health conditions resettled in the US Midwest. *Journal of Immigrant Minority Health, 16*(4), 733-742. doi: https://doi.org/10.1007/s10903-013-9906-5

Montour, J., & Kazmierski, V. (2013). *Texas refugee health program-2014 refugee health report*. Retrieved from https://www.unthsc.edu/texas-college-of-osteopathic-medicine/wp-content/uploads/sites/9/Refugee-Health-Report-2014.pdf

Morris, M. D., Popper, S. T., Rodwell T. C., Brodine S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health, 34,* 529-538. doi: https://doi.org/10.1007/s10900-009-9175-3

Murray, K. E., Davidson, G. R., & Schweitzer R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry, 80*(40), 576-585. doi: https://doi.org/10.1111/j.1939-0025.2010.01062.x

Murray, K., Mohamed, A. S., & Ndunduyenge, G. (2013). Health and prevention among East African women in the U. S. *Journal of Health Care Poor Underserved*, *24*(1), 233-246. doi: https://doi.org/10.1353/hpu.2013.0029

National Association for Social Work [NASW]. (2016). NASW standards for social work practice in health care settings. Retrieved from

https://www.socialworkers.org/LinkClick.aspx?fileticket=fFnsRHX-4HE%3D&portalid=0

National Committee for Health Education. (2016). *The health education specialist: A companion guide for professional excellence* (7th ed.). Whitehall, PA: National Committee for Health Education.

Ornelas, I. J., Ho, K., Jackson, J. C., Moo-Young, J., Le, A. Do, H. H.,…& Taylor, V. M. (2017). Results from a pilot video intervention to increase cervical cancer screening in refugee women. *Health Education Behavior, 0*(0), 1-10. doi: https://doi.org/10.1177/1090198117742153

Ostrander, J., Melville, A., & Berthold, S. M. (2017). Working With Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches. *Advances in Social Work, 18*(1), 66-79. doi: https://doi.org/10.18060/21282

Pesata, V., Pallija, G., & Webb, A. A. (1999). A descriptive study of missed appointments: Families' perceptions of barriers to care. *Journal of Pediatric Health Care, 13,* 178-182. doi: https://doi.org/10.1016/S0891-5245(99)90037-8

Roger, E. M. (2003). *Diffusion of innovations*. London: Free Press.

Rowe, C., Watson-Ormond, R., English, L., Rubesin, H., Marshall, A., Linton, K.,… Eng, E. (2016). Evaluating art therapy to health the effects of trauma among refugee youth: The Burma art therapy program evaluation. *Health Promotion Practice, 18*(1), 26-33. doi: http://journals.sagepub.com/doi/pdf/10.1177/1524839915626413

Russell, M. N., & White, B. (2001). Practice with immigrants and refugees. *Journal of Ethnic and Cultural Diversity in Social Work, 9*(3-4), 73-92. doi: https://doi.org/10.1300/J051v09n03_04

Sheikh-Mohammed, M., Mcintyre, C. R., Wood N. J., Leask J., & Isaacs, D. (2006). Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *Medical Journal of Australia, 185,* 594-597.

Simich, L., Beiser, M., Stewart, M., & Mwakarimba, E. (2005). Providing social support for immigrants and refugees in Canada: Challenges and directions. *Journal of Immigrant and Minority Health, 7*(4), 259-268. doi: https://doi.org/10.1007/s10903-005-5123-1

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, *52*(2), 145-161. doi: https://doi.org/10.1177/0022146510395592

United States Department of State. (2015). *FY15 Refugee Admissions Statistics*. Retrieved from https://2009-2017.state.gov/j/prm/releases/statistics/251285.htm

Vermette, D., Shetgiri, R., Al Zuheiri, H., & Flores, G. (2015). Healthcare access for Iraqi refugee children in Texas: Persistent barriers, potential solutions and policy implications*. Journal of Immigrant Minority Health, 17,* 1526-1536. doi: https://doi.org/10.1007/s10903-014-0110-z

Walker, R., Koh, L., Wollersheim, D., & Liamputtong, P. (2015). Social connectedness and mobile phone use among refugee women in Australia. *Health and Social Care in the Community*, *23*(3), 325-336. doi: https://doi.org/10.1111/hsc.12155

Wieland, M. L., Weis, J. A., Palmer, T., Goodson, M., Loth, S., Omer, F., … Sia, I. G. (2012). Physical activity and nutrition among immigrant and refugee women: A community-based participatory research approach. *Women's Health Issues, 22*(2), e225-232. doi: https://doi.org/10.1016/j.whi.2011.10.002

Wilkinson, R., & Marmot, M. (Eds.). (2003). *The social determinants of health: The solid facts* (2nd ed.). Copenhagen, Denmark: WHO Europe.

Zanchetta, M. S., & Poureslami, I. M. (2009). Health literacy within the reality of immigrants' culture and language. *Canadian Journal of Public Health in Canada 2006, 97*(2), S26-S30.

Zhang, Y., & Wildemuth, B. M. (Ed.). (2009). Qualitative analysis of content. In *Applications of social research methods to questions in Information and Library Science* (pp. 1-12). Santa Barbara, CA: Libraries Unlimited.

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Mitigating Psychological Distress Among Humanitarian Staff Working With Migrants and Refugees: A Case Example

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Abstract: *Ongoing acute stress in humanitarian work leads to psychological distress among humanitarian workers. Stress management within humanitarian agencies requires responses at both the individual staff member and agency levels. Stress management is often conceptualized in four categories: stress that can be accepted; stress that can be altered; stress to which individuals can adapt; and stress that can be avoided. Humanitarian workers accept the stress created by the environment in which they choose to work. They can manage stress by altering their own behaviors through improved communication skills and the implementation of self-care plans. They can adapt, with the help of staff care plans such as counseling and peer support, to the stress created by their own histories of trauma or mental illness. The stress created by the workplace can be avoided. However, without a comprehensive support plan for mitigating psychological distress, both the individual humanitarian worker and the agency overall suffer. This article reviews current literature regarding the impact of avoidable stress and the impact of adaptation programs such as staff care and stress management plans on humanitarian work, and illustrates these impacts with a case example from the Danish Refugee Council, an international non-governmental organization with approximately 300 employees working in Greece.*

Keywords: *Humanitarian workers; refugee; migrant; self-care; stress management; Greece*

Self-care is a core principle of social work (Cox & Steiner, 2013), and is critical for effective work with traumatized populations (Lipsky & Burk, 2009). Refugees are people who are forced to flee their homes because of war or persecution. By definition, a person who is labeled a refugee has experienced trauma. Yet, self-care is not universally practiced within humanitarian agencies serving these vulnerable populations (Porter & Emmens, 2009). People categorized as refugees have experienced the trauma of forced migration and as many as 37% may be suffering from PTSD and 75% may be suffering from depression (Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015). Thus, working with traumatized individuals requires that those providing services understand the unique aspects of stress to which they are exposed.

Humanitarian workers, also referred to as aid workers, are those working with an agency that is responding to a humanitarian crisis. Both humanitarian work and social work are helping professions that seek to protect and promote human dignity. The International Association of Social Workers (IFSW) defines social work as a profession that "promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for diversities are central to social work" (IFSW, 2014, para. 1). Social workers conduct

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professional activities under the guidance of the Code of Ethics, which outlines the core values of the profession as: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (National Association of Social Workers, 2017).

Humanitarian work is defined through the Geneva Conventions. The International Committee of the Red Cross (ICRC) delineated the role, specifically in the 4th Geneva Convention, which outlines the protection of civilians during war. The ICRC (2014) further defines a humanitarian mission as the delivery of necessary assistance that protects the dignity of the person receiving aid. Just as social work activities are guided by a Code of Ethics, humanitarian work is guided by four key principles: humanity, neutrality, impartiality and independence. Together these principles oblige aid workers to provide assistance that protects the rights and vulnerabilities of every person in need (Rysaback-Smith, 2015).

Both social workers and humanitarian workers choose a profession of providing assistance to people in need. However, social workers are more homogenous in their roles, whereas the humanitarian field is made up of people with a variety of backgrounds. Some aid agencies specialize in health care, such as Doctors without Borders or Doctors of the World, and their staff is often made up primarily of health care providers. Other aid agencies, such as the Danish Refugee Council, focus on the needs of the entire refugee community. They set up and manage camps, create shelters, and provide sanitation services. They also provide protection monitoring, ensuring that people entering the camp are screened for special needs. In many ways, humanitarian workers create and administrate a city. Their backgrounds may be in fields such as engineering, to ensure that housing needs are addressed, or international relations, to ensure that they have a macro understanding of the crisis.

Because not all roles require the same type of education, not all aid workers have the type of training that is considered standard among social workers, such as an understanding of human development, trauma, or the importance of clinical supervision. Although these staff come from a variety of disciplines, many work directly with the affected population and very few, outside of those in specialized organizations, have a background in social work or mental health. Similar to social workers, humanitarian workers are often responsible for conducting assessments to identify needs and assist beneficiaries in accessing basic necessities, such as food and shelter. For humanitarian workers, unique stressors are often present in locations that in and of themselves are stressful. Stress management requires responses at both individual and agency levels. A review of stress management and staff care techniques among international aid agencies (Curling & Simmons, 2010) revealed that 74% of staff members felt moderately or extremely stressed.

In the human service sector, it is well-known that burnout, vicarious trauma, and secondary traumatic stress are occupational hazards (Mathieu, 2012). The criteria for burnout are met when a person working in human services experiences emotional exhaustion, depersonalization, and a reduced sense of accomplishment (Maslach, Schaufeli, & Leiter, 2001). Vicarious trauma is the change in worldview that takes place as the result of hearing an accumulation of traumatic stories over time. Arising from the

helper's engagement with the traumatized client, vicarious trauma involves distress, specifically a change in the worker's cognitive schemata (Nimmo & Huggard, 2013). As with Post-Traumatic Stress Disorder, the change in worldview seen with people suffering from vicarious trauma may be a shift from altruism into pessimism. For example, an aid worker may generally see the world as a place with good people trying to help each other, but over time may begin to see it as a place where people torture and harm each other, instead of help each other. The worker may or may not be aware of these effects. Secondary traumatic stress is experienced when the helper begins to display trauma responses similar to those of persons directly exposed to trauma (Pearlman & Saakvintne, 1995). Secondary traumatic stress symptoms are very similar to those of PTSD, such as hypervigilance and intrusive thoughts, except that the exposure to trauma is secondary rather than primary (Bride, Robinson, Yegidis, & Figley, 2004). A worker's secondary traumatic stress reactions may or may not reflect the client's actual responses.

All three of these types of staff stress manifestations impact the quality of care provided to people in need. But for humanitarian aid workers, much like social workers, a significant piece of their sense of purpose and identity is associated with their work, which means the consequences of burnout, vicarious trauma and secondary stress can be very high.

This article will apply the lens of common stress management techniques to a review of the challenges facing humanitarian workers and their agencies as they work to meet the needs of refugees and migrants. The article will further apply this stress management lens to a case example based on the first author's experience providing a psychosocial support program to staff of the Danish Refugee Council delivering humanitarian services to refugees in Greece. The case example will draw upon the author's case notes, records of services provided, and anecdotal observations.

Conceptual Framework

Stress management is often conceptualized in four categories, or four "A's": (1) accepting stress; (2) altering stress; (3) adapting to stress; and (4) avoiding stress (Mayo Clinic, 2016; Robinson, Smith, & Segal, 2017). Humanitarian workers accept the stress created by the environment in which they choose to work. Aid workers can manage stress by altering their own behavior through improved communication skills and the implementation of self-care plans. They can adapt to the stress created by their own histories of trauma or mental illness and the stress created by the workplace with the help of staff care plans such as counseling and peer support (Mayo Clinic, 2016; Robinson et al., 2017). However, when the majority of staff are experiencing psychological distress due to acute stress, without a support plan, the stress reactions can create a toxic environment (Glasø & Vie, 2010). This toxic environment is avoidable through the application of the other "A's" in stress management.

The Four "A's" in Humanitarian Work

Accepting Stress

As in the field of social work, there are some stressors that are an inherent and accepted part of humanitarian work. Accepted stress in the humanitarian workplace can come from many different sources: a worker's own history of trauma or mental illness; ongoing exposure to people who have been traumatized and are suffering; and high-risk work environments. Social workers are taught, throughout their training, to know themselves and the environment that they are entering. By understanding the physical and emotional risks, social workers can recognize their strengths and limitations and learn how to manage challenging work environments. Humanitarian work takes place in similarly stressful environments, both physically and mentally, but the training and support these workers receive while on mission often lacks this fundamental aspect. Although aid workers are aware of the types of environments in which they will work, they are often unaware of the level of emotional distress this type of work can have on them.

Humanitarian aid is provided to people who have experienced manmade and natural disasters. The profession itself requires that aid workers accept stress, including witnessing the impacts that war, violence, and disasters have on people (Curling & Simmons, 2010). Aid workers' own safety may be at risk while deployed in unstable and dangerous situations (Connorton, Perry, Hemenway, & Miller, 2011; Curling & Simmons, 2010; Ehrenreich & Elliot, 2004). In addition, aid workers are continuously exposed to the traumatic experiences of the people they are supporting (Blanchet & Michinov, 2014). However, studies find that stress and burnout are not correlated with higher-risk or higher-stress environments (Cardozo et al., 2012; Eriksson et al., 2009). While being exposed to these stressors, aid workers are often separated from the support of their families and other social networks (Connorton et al., 2011; Ehrenreich & Elliot, 2004).

Aid workers who have experienced personal trauma or mental illness may be unaware that working with traumatized individuals may trigger their own memories of trauma (Cardozo et al., 2005; Ehrenreich & Elliot, 2004). This type of stress can impede judgment and reduce coping skills (Sommers-Flanagan, 2007). It can also increase the risk of depression, anxiety, and burn-out (Cardozo et al., 2012). Aid workers with a history of anxiety and depression are at greater risk of experiencing anxiety, depression and overall emotional exhaustion in the field (Cardozo et al., 2012).

Over the past few years, several surveys have found high rates of stress, along with symptoms of depression, PTSD and anxiety among staff working within the humanitarian sector. In a 2010 study, 74% of aid workers surveyed were found to be moderately or severely stressed (Curling & Simmons, 2010). Severe stress places a person at increased risk of depression. A 2011 study reported that up to 43% of aid workers have experienced PTSD, 20% have experienced depression, and 29% have experienced anxiety (Connorton et al., 2011). A longitudinal study found that rates of anxiety in expatriate aid workers increased from nearly 4% to nearly 12% from pre-deployment to post-deployment, while rates of depression nearly doubled from 10.4% to 19.5% (Cardozo et al., 2012).

Studies often find higher rates of emotional distress among national staff, or staff coming from the host country, in comparison to international staff, or expatriate staff coming from other countries. National staff often face a unique burden. In many crises, they share a similar culture, language, heritage and history as the refugees they are assisting. They themselves may also have experienced forced migration (Cardozo et al., 2012). The burden of accepted stress is higher in these humanitarian staff members. A 2008 study found Sudanese aid workers had higher levels of stress and burnout than their international counterparts (Musa & Hamid, 2008). A 2009 article found that 42% of national staff in Guatemala experienced symptoms of PTSD (Putman et al., 2009). A 2012 study found that 68% of national staff in Uganda had symptoms of depression, while 53% had symptoms of anxiety, 26% had symptoms of PTSD, and 50% had symptoms of burnout (Ager et al., 2012). Notably, each of these studies found that the aid workers as a group had experienced both primary and secondary trauma, corroborating the unique burden of national staff in regard to their frequent exposure to the same traumas as their clients.

The risks of emotional distress are well known and documented, but often aid workers themselves are unaware of the impact that this work could have on their overall wellbeing. A 2009 longitudinal survey of aid workers revealed that 40% of participants stated that the work environment was more stressful than expected (Dahlgren, DeRoo, Avril, Bise, & Loutan, 2009). And, perhaps more importantly, these workers are often unaware of some of the factors that could protect them from emotional distress.

Without knowing these risks, the emotional distress experienced by aid workers often goes untreated, which can have a significant impact on not only the individuals experiencing these symptoms but the quality of the work they provide. For example, in a Sri Lanka study, over half of humanitarian workers experienced traumatic stress symptoms and nearly one-third avoided working with certain clients (Cardozo et al., 2013).

Altering Stress

The types of stress that can be altered are those that individuals have some control over. Self-care strategies along with assertive and open communication skills are ways in which people can alter their experience to decrease stress (Mayo Clinic, 2016; Robinson et al., 2017). Aid workers employ numerous positive and negative coping skills. Positive coping skills can include journal writing, open communication with friends, exercise, the use of mindfulness and meditation, and counseling. Although aid workers are often separated from their families and support networks, a new support network is frequently formed with colleagues, who are often their friends and sometimes their roommates as well. A 2016 study of Serbian medics in the Democratic Republic of the Congo measured the impact that open communication had, in comparison to the use of avoidance, and found that it had a positive correlation with reduced stress levels (Jokovic, Krstic, Strojanovic, & Spiric, 2016). The same study highlighted how connection with work, regular communication with family, and regular exercise can help lower stress levels. In a 2012 study, strong social support was related to lower levels of depression and burnout (Cardozo et al., 2012). The converse has also been found to be true; depression rates were higher among aid workers with lower family and social support (Cardozo et al., 2005). Mindfulness trainings for aid workers are now being successfully introduced into the field (Pigni, 2014).

The impact of psychological distress on the individual may elicit negative coping skills such as emotional dysregulation, cynicism, and self-destructive behaviors. Aid workers often respond to emotional distress with anger, avoidance, or distancing (Connorton et al., 2011; Ehrenreich & Elliot, 2004). One study found that 27% of aid workers engaged in risk-taking behaviors such as speeding, drinking and driving, unprotected sex, frequent change in sex partners, and excess use of alcohol and other drugs as ways of coping (Dahlgren et al., 2009). A similar study found that 16% of aid workers met the criteria for alcohol abuse (Connorton et al., 2011).

The coping skills that people employ to respond to stress can have a significant impact on the quality of work they provide. Negative coping skills can lead to accidents involving injury (Dalhgren et al., 2009). Aid workers rely on their communication skills to assess and respond to the needs of their refugee clients. Emotional avoidance, cynicism and distancing can impact the relationships staff have with their clients, as these defense mechanisms may reduce the amount of information workers receive from their clients.

Avoiding Stress

Some stress can be avoided altogether with advance planning. Within the context of humanitarian work, avoidable stress is that which is caused by the dynamics within an office environment. Stress management is not only the responsibility of the individual; it is also an agency responsibility. Typical signs of agency burnout include high turnover, clique formation, frequent conflicts, scapegoating, lack of initiative, increased sick leave, and lower output (United Nations High Commissioner for Refugees [UNHCR], 2001). One study found that the top five sources of stress within humanitarian work were not associated with related trauma or safety factors; they were all agency-related. The stressors included workload, ability to achieve work goals and objectives, hours, status of contract, and feeling undervalued (Curling & Simmons, 2010). A similar study in Sri Lanka found that when staff members felt supported by their agency they experienced lower levels of depression and anxiety symptoms (Cardozo et al., 2013). Another similar study found that 56% of participants identified the office environment as the most frequent stressor experienced by humanitarian workers (Dahlgren et al., 2009). Likewise, among the various stressors listed in a 2004 study were lack of adequate resources (i.e. personal time or logistical support to meet expectations), excessive bureaucratic demands, lack of leadership and recognition from the employer, and interpersonal conflict among team members (Ehrenreich & Elliot, 2004).

Although aid work is provided in high-stress environments, the agencies themselves do not need to be high-stress. High-stress agency characteristics include unclear boundaries, over-identification with clients, uncoordinated services, lack of clinical supervision and coaching for leaders, workaholism, self-sacrifice and inadequate self-care. Low-stress agencies include care-for-caregiver programs, coaching for leaders, and clear definitions of roles and boundaries (Pross & Schweitzer, 2010). Unsupportive administration, lack of professional challenge, and difficulties in providing client services are predictive of high burnout rates (Bell, Kulkarni, & Dalton, 2003). Low-stress environments, on the other hand, have been identified as having strong boundaries, having good leaders that utilize internal resources and delegate responsibilities to staff according

to their skills and experience, providing opportunities to learn and improve skills, and providing space for reflection to build self-awareness. Clinical supervision, in particular, has frequently been associated with lower agency stress (Bell et al., 2003; Jones, Muller, & Maercker, 2006). Staff members feel valued when they have the opportunity to provide feedback on agency decisions (Brooks et al., 2015; Curling & Simmons, 2010; Halbesleben & Buckley, 2004).

Because aid work is provided in an emergency context, not everything can be planned. Emergency work, which is usually characterized by deadlines and short-term contracts for management staff, may lead to competing procedures and overall frustration in the field (Francis, Galappatti, & van der Veer, 2012). Decisions are made quickly, and roles and expectations are continuously evolving (Blanchet & Michinov, 2014). However, just as aid agencies are able to plan for the setup of a camp and the number of tents needed, they can anticipate and plan for the certain aspects of internal stress. Protective planning can assist with team cohesion, inter-office communication, and sense of efficacy.

An unstable work environment with unclear roles has a direct impact on transactive memory, that is, the memory that allows a team to function successfully (Blanchet & Michinov, 2014). The transactive memory is a shared cognitive process that helps a team know which person to rely on for what task. When staff members change teams or leave, it is difficult for the remaining team members to adjust unless the incoming staff member has the same skill set and strengths. As the transactive memory decreases, so does the degree to which individuals rely on their colleagues, and they become more likely to keep their work to themselves.

Humanitarians are often much more patient with their refugee clients than they are with each other and the way that this cohort of colleagues interact with each other acts as a catalyst to spread stress. Ongoing exposure to trauma can have a cumulative effect; people may not feel the impact of the first or second exposure to trauma but after several experiences they may begin to show symptoms (Curling & Simmons, 2010). As it is cumulative, the overall impact can appear in subtle changes. According to studies, seasoned aid workers are less likely to experience high rates of stress or burnout than more inexperienced workers, but it has been noted that this conclusion may be inaccurate (Eriksson et al., 2009). Surveys assessing rates of burnout and secondary stress use time limits, with questions framed as, “In the last two weeks have you…?” People who have experienced an accumulation of stress may simply have adjusted to the cynicism and depersonalization used in reaction to their stress (Eriksson et al., 2009). Therefore, seasoned workers, now in leadership roles, may have adapted to the depersonalization and the cynicism common in burnout, but the impact of burnout can still be seen in the way they treat their work and their colleagues. Emotional dysregulation and cynicism impact the office environment by leading to outbursts of anger and blame. In addition, work takes longer to complete when someone is dealing with the emotional exhaustion and depersonalization of burnout (Halbesleben & Buckley, 2004). As stress and burnout spread, team cohesion and work effectiveness decrease as much as 50% (McCormack & Joseph, 2012; Nilsson, Sjöberg, Kallenberg, & Larsson, 2011). Burnout is more likely to spread from management to staff than vice versa (Maslach et al., 2001). Eriksson et al.

(2013), in their work on locally recruited staff in Jordan, recognized that managers can be five times more likely than non-managers to experience burnout.

Inexperienced aid workers often develop burnout due to growing recognition of the limited scope of services that humanitarians provide (Cardozo et al., 2012). Aid workers start their careers imagining how they will help people, but the limitations of what can be done to help can create feelings of inadequacy, and if not managed correctly, burnout. Many people who choose humanitarian work are perfectionistic and highly motivated. Humanitarians are people who expect to make a difference in the world through their work (Eriksson et al., 2013). The reality of the work and its limitations can cause cognitive discord when those who thought they would make a difference now feel that none of it matters. They may focus more strongly on the failures of the work than on its successes, and internalize the failures as their own. This often causes feelings of inferiority and shame in humanitarian workers (McCormack & Joseph, 2012). This type of stress can cause serious challenges for the agency. According to studies, it can impede recruitment and retention of good staff (Nilsson et al., 2011). When dysfunction sets in, no matter how hard people work, the quality of services delivered suffers.

One challenge to ensuring that staff feel valued is the way in which programming is evaluated and funded. Funding priorities lead agencies to value service delivery to high numbers of beneficiaries over capacity building within staff. However, staff feel valued when they are given the opportunity to improve their skills and grow within an agency (Halberson & Buckley, 2004). The decrease in sense of value or ability to contribute to the agency impacts the sense of self-efficacy and the overall feeling of burnout. Increased stress causes people to leave rapidly. The dichotomy in agencies' priorities creates a rise in the number of beneficiaries and a simultaneous drop in service quality (Goncalves, 2011).

Adapting to Stress

Adaptation in stress management refers to changing one's expectations or standards. Within this context, humanitarian aid agencies adjust their standards regarding the type of care and support they provide to their staff. People in Aid, an organization founded by humanitarians to improve organizational effectiveness, identifies the objective of staff care to create wellbeing among staff and improve the quality of their work (Goncalves, 2011). In addition, aid agencies have a *Duty to Protect* principle with regard to staff. The *Duty to Protect* often refers to the duty to keep someone safe from physical harm. But given that decreased emotional well-being increases risk of accidents and decreases quality of service, agencies also have a duty to protect staff against burnout, secondary stress, and vicarious trauma. Measures that can be taken by agencies to decrease exposure to these occupational hazards include providing emotional support, physical safety, and a respectful environment (Cripe & Nyssens, 2017).

Study after study recommends that agencies offer access to counseling and/or peer support models. A 2005 study of Kosovar aid workers (Cardozo et al., 2005) found that existing support services provided to staff were characterized as poor by the participants, and recommended staff support to attenuate the emotional distress experienced. Another

study noted that the key to protecting staff from secondary traumatic stress is recognizing it and treating it early through mental health services (Bilal, Rana, Rahim, & Ali, 2007). In a study of Guatemalan aid workers, the authors noted a need for emotional support (Putman et al., 2009). A study in Sri Lanka recommended ongoing training regarding stress along with increased support for staff (Cardozo et al., 2013).

Emotional support programs provided to staff should include two primary aspects: training and ongoing support. Other programmatic initiatives such as counseling and peer support models have also been shown to be helpful (Curling & Simmons, 2010). Studies have identified having someone to talk to, and training regarding the emotional distress that is common in aid work, as essential to protecting staff against severe emotional distress and burnout (Jokovic et al., 2016). Trauma-specific training has been found to decrease the potential for vicarious trauma (Harr, 2013). Curling & Simmons's (2010) study on support programs for aid workers found that 77% of participants identified training on stress and trauma reactions as necessary and 64% of staff saw access to counselors as helpful. Furthermore, a study of International Red Cross delegates found that participants who had someone to talk to, such as a counselor or a peer support person, were 28% less likely to feel emotionally exhausted (Dahlgren et al., 2009).

More and more agencies are recognizing the need to support their staff through onsite or outsourced counseling, emergency assistance programs, and peer support programs. The World Health Organization has developed a promising pilot program called *Problem Management Plus* that utilizes paraprofessional counselors to deliver short-term crisis counseling (Rahman et al., 2016). Although this program is envisioned to provide direct support to beneficiaries, it could also be a promising model for peer support. Through the use of peer support or counseling, agencies have the opportunity to help not only those who seek counseling, but the entire agency. However, it is important to note that programs that respond to the emotional needs of aid workers must take into account the types of individuals they seek to support. Aid workers are often people who would be considered "non-traditional" clients. Many come from cultures and backgrounds for whom counseling carries a heightened sense of stigma, and those coming from western backgrounds often deny a need for counseling and use emotional distancing as a coping mechanism (Brooks et al., 2015).

Case Example: The Greek Context

Greece is a major transit point for Middle Eastern migrants and refugees, particularly those from Syria. Syrian refugees constitute the largest community of displaced people in the world. Over 5 million Syrians have sought safety worldwide (UNHCR, 2017a). Over 1 million refugees crossed through Greece between 2015 and 2016 (European Civil Protection and Humanitarian Aid Operations, 2017). Refugee camps in Greece are now home to over 60,000 people (UNHCR, 2017b). In response to the crisis, the United Nations, the European Union and humanitarian aid organizations, such as the Danish Refugee Council, have established refugee camps and related services throughout Greece. However, in Greece, the normal stressors that are common in refugee crises are exacerbated by the country's economic crisis and lack of government preparedness to respond to the crisis.

The first author provided psychosocial support services to the Danish Refugee Council in Greece starting in 2016, shortly after the agency began operations in that country, through 2017. At the time, the agency had approximately 300 staff in Greece. The psychosocial support program developed for the Danish Refugee Council in Greece included four components: training on burnout, secondary traumatic stress and vicarious trauma; clinical supervision/case consultation; group counseling; and individual counseling. The overall approach was influenced by a trauma-informed self-care framework (Salloum, Kondrat, Johnco, & Olson, 2015).

This case example is based on the initial nine months of the psychosocial support program, from September 2016 through June 2017. The program was developed in response to a high rate of burnout seen among staff and was initially intended to focus on the needs of one area of humanitarian work, protection. Protection staff are responsible for conducting vulnerability assessments with each refugee. Their assessments assist in informing their colleagues about vulnerabilities that an individual refugee may have and that may need to be accounted for with each aspect of the work, from food distribution to medical support to housing accommodations. The psychosocial support program consisted of live programming, delivered during five visits to each of four program sites, and remote support delivered via Skype. In September of 2016, protection staff from four sites across Greece – Athens, Thessaloniki, Larissa and Lesvos – were invited to a multi-day intensive training. Six hours of this training was dedicated to the concepts of trauma, vicarious trauma, and staff care. Following the training, each protection team was provided monthly clinical supervision/case consultation. In addition to the ongoing clinical supervision, each team was provided with the opportunity to participate in an open group session.

During the initial visit to each office, the scope of work expanded from protection staff to all staff in the agency, based on staff requests. Although only protection staff were provided with clinical supervision/case consultation, all staff were invited to participate in trainings, group sessions, and individual sessions. Staff participating in some portion of the psychosocial support program ranged in age from 22 to 60 years old and came from over a dozen countries in Europe, North America, and the Middle East. Staff at each of the four sites mirrored the population make-up of the surrounding refugee camps, to ensure that communication between staff and refugees could be easily facilitated. During the initial nine-month period of the psychosocial support program, 21 training sessions were provided to approximately 120 aid workers (approximately 40% of the agency personnel) on signs and symptoms of mental health crises along with burnout. Each training lasted approximately two hours and introduced the signs and symptoms of PTSD, depression, anxiety, burnout, vicarious trauma, and secondary traumatic stress. Also during this period, 262 individual counseling sessions were provided to approximately 70 people (23% of the staff), and seven counseling groups were held.

Accepting Stress in the Greek Context

As noted earlier, national staff often have higher rates of emotional distress. National staff are often the people to hear the needs of the refugee first hand; they then interpret them to international aid workers. However, in Greece, it is not national staff that play

these roles but international staff. These expatriate staff often come from refugee-producing countries, and some have first-hand refugee experiences.

In Greece, the Danish Refugee Council's staff accepted the stress of working with traumatized individuals, although many were unaware of the impact that may have had on their own personal wellbeing. However, the environment itself is not a war zone. With the exception of working with a disturbed or violent client, these aid workers are physically safe while conducting their work. Nonetheless, the physical safety did not seem to mitigate the level of emotional distress. As described previously, training was provided to the staff on the signs and symptoms of PTSD, depression, anxiety, burnout, vicarious trauma and secondary traumatic stress. This information was new for the vast majority of participants. Even seasoned aid workers were surprised to learn that the emotional distress they were experiencing individually was common among aid workers.

Altering Stress in the Greek Context

Among the staff members who received individual counseling over the nine-month period in Greece, 34%, or 24 people, found themselves becoming avoidant. As noted previously, social support within the aid worker community most often comes from co-worker relationships. This can create a certain level of support, but it can also isolate the workers from other aspects of their social networks. Avoidant behaviors impacted their personal and professional lives.

Within the counseling sessions, one of the questions the therapist (first author) often asked was, "What generally makes you feel better when you're upset?" Staff members frequently responded that talking to their families and their friends outside of aid work was helpful. But as stress increased, the level of engagement with such friends and family decreased. Most had gone weeks or months without talking to anyone outside of their co-workers. Participants often expressed worry about "burdening" their loved ones with their stress, and exhaustion at even the thought of trying to explain how they were feeling. However, the reverse was also true; when participants reached out to their families and friends they often returned to counseling the following week citing a lower level of stress.

In group counseling sessions, each group discussed the challenges of working and socializing together. When socializing together, the groups found that they often talked about work. But this only served to heighten their stress levels. Each group discussed ways in which they could change this pattern of behavior. One group found a creative solution in the decision to create a list of conversation topics and cut them up into little strips of paper and put them in a plastic bag. That way when they were out, they could choose a non-work related topic, from those included in the plastic bag, to discuss.

Avoiding Stress in the Greek Context

Low-stress and high-stress qualities were seen within the Danish Refugee Council in Greece. The agency responded to needs of staff for training regarding topics such as boundaries, active listening, and psychological first aid, providing opportunity for staff to increase their skills. In addition, some staff were invited to participate in case consultations/clinical supervision to allow staff to receive feedback and assess the

successes and challenges of their work. However, the spread of burnout and overall stress had a significant impact on the personal experience of the work. Common conversations during individual counseling sessions included interpersonal experiences with colleagues. Frustration often stemmed from the feeling that colleagues didn't know how hard a person was working, or the strengths that person had. Individuals experiencing conflict within the workplace often felt alone in their work, or as if they could rely on only a few people.

Adapting to Stress in the Greek Context

The author used a flexible approach in designing and delivering a psychosocial support program for the Danish Refugee Council in Greece. Particular attention was paid to the needs of these "non-traditional" clients through activities and trainings that normalized conversations about feelings and challenges. The programmatic approach utilized strategic timing of services offered. The initial introduction to the psychosocial support program was a training using psychosocial and stress-relief activities to highlight the commonality of the feelings of distress individuals often feel. Participants were then invited to participate in psychosocial groups around stress management. Finally, individual counseling was made available. Sessions focused on past experiences of trauma, grief and loss, along with the everyday stressors of humanitarian work. Through programming and training on burnout, the aid workers became more likely to seek services as needed, once familiar with the service provider.

Discussion

The body of research reviewed earlier provides ample evidence that humanitarian work can cause burnout, vicarious trauma, and secondary traumatic stress among aid workers. The environment of the work, the nature of the work, and organizational stressors create barriers to the provision of quality humanitarian services to vulnerable populations. The experience of humanitarians working with the Danish Refugee Council in Greece mirrors the prior research regarding trauma and stress in this field. Viewing the stressors faced by humanitarian workers through the lens of the four "A's" of stress management provides a roadmap to assist agencies and aid workers both in decreasing the emotional distress and the impact it has on beneficiaries.

Implications for Humanitarian Workers and Agencies

Although aid workers accept the inherent stressors of the job, they need training and education about how those stressors may impact them. With information regarding the emotional impact the work will have, aid workers can alter some of their behaviors to increase their overall wellbeing. Aid agencies can avoid the internal stress that the office dynamic creates through planning and developing staff recognition and support programs. Finally, aid agencies can further decrease the rates of burnout, vicarious trauma, and secondary traumatic stress through adaptation programs such as counseling or peer support.

Limitations

This article presented a case example of a psychosocial support program implemented by the Danish Refugee Council in Greece. The description provided was based on the first author's case notes and anecdotal information, thus limiting scientific rigor. Further, a case example based on one agency in one country prohibits generalization. Finally, this program was provided both through in-person and remote support; the relative effectiveness of the two approaches cannot be determined.

Recommendations for Future Research

To further support or refute the observations made in this case example, replications in other humanitarian settings should be conducted. More rigorous quantitative and qualitative evaluations are needed to examine the impact of psychosocial support programming on the stress experienced by humanitarian workers. The authors are presently conceptualizing means to include such evaluations in future research endeavors. Moreover, further research regarding the accumulation of trauma exposure among seasoned aid workers is needed. Often, seasoned aid workers ignore symptoms of psychological distress within themselves, sometimes for years. In these cases, assessment tools may not adequately identify the distress, as the adaptive functioning, including pessimism and acting out behaviors, has become normalized. Finally, further research regarding the efficacy of remote-based psychosocial support for humanitarian workers would be valuable.

Conclusions

This article has highlighted the unique role that social workers can play in supporting humanitarian work. Social workers have the benefit of academic training that provides skills in the areas of interviewing traumatized individuals, boundary-building, and understanding personal triggers. In addition, social workers have the benefit of ongoing clinical supervision to help hone those skills. These social work skills are foundational elements of good self-care and provide support to both the worker and the program beneficiary; however, humanitarian workers often do not have the benefit of these types of training and supervision.

Aid workers often fear the stigma of mental illness, coming from communities where counseling is considered abnormal. They often feel that they took a job that is defined by emotional and physical intensity and that asking for help undermines their self-image of their ability to do the work. The employment cycle of an aid worker is often divided into three phases: pre-deployment, during mission, and post-deployment. Each of these phases offers an opportunity for prevention of burnout, vicarious trauma and secondary traumatic stress (Hearns & Deeny 2007). However, many international non-governmental organizations find themselves responding to instead of preventing burnout, vicarious trauma and secondary traumatic stress. Agency culture, the accumulation of stress that may be present in seasoned aid workers, and stigma all create barriers to creating programs that can prevent and respond to existing psychological distress.

The refugee crisis in Greece, for many aid workers, was envisioned as a light mission. Instead of working in a war zone, they would be working in Europe. However, as the volume of requests for psychological support in this program suggests, working with traumatized people is always strenuous, regardless of the setting.Yet, as demonstrated by this program, when support is made available and seeking support is normalized as a common response to the types of occupational hazards experienced by aid workers, it is often highly utilized and well-received.

References

Ager, A., Pasha, E., Gary, Y., Duke, G., Eriksson, C., & Cardozo, B. (2012). Stress, mental health, and burnout in national humanitarian aid workers in Gulu, Northern Uganda. *Journal of Traumatic Stress, 25*, 713-720. doi: https://doi.org/10.1002/jts.21764

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84,* 463-471. doi: https://doi.org/10.1606/1044-3894.131

Bilal, M., Rana, M., Rahim, S., & Ali, S. (2007). Psychological trauma in a relief worker: A case report from earthquake-struck areas of Northern Pakistan. *Prehospital and Disaster Medicine, 22*, 458-462. doi: https://doi.org/10.1017/S1049023X00005215

Blanchet, C., & Michinov, E. (2014). Relationships between stress, social support and transactive memory among humanitarian aid workers. *International Journal of Emergency Management*, *10,* 259-275. doi: https://doi.org/10.1504/IJEM.2014.066484

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, *14*, 27-35. doi: https://doi.org/10.1177/1049731503254106

Brooks, S., Dunn, R., Sage, C., Amlot, R., Greenberg, N., & Rubin, G. (2015). Risk and resilience factors affecting the psychological wellbeing of individuals deployed in humanitarian relief roles after a disaster. *Journal of Mental Health*, *24*, 385-413. doi: https://doi.org/10.3109/09638237.2015.1057334

Cardozo, B., Crawford, C., Eriksson, C., Zhu, J., Sabin, M., Ager, A.…Simon, W. (2012). Psychological distress, depression, anxiety, and burnout among international aid workers: A longitudinal study. PloS One, *7,* 1-13. doi: https://doi.org/10.1371/journal.pone.0044948

Cardozo, B., Holtz, T., Reinhard, K., Gotway, C., Ghitis, F., Toomey, E., & Salama, P. (2005). The mental health of expatriate and Kosovar Albanian humanitarian aid workers. *Disasters, 29*, 152-170. doi: https://doi.org/10.1111/j.0361-3666.2005.00278.x

Cardozo, B., Silvilli, T., Crawford, C., Scholte, W., Petit, P., Ghitis, F., & Ager, A. (2013). Factors affecting mental health of local staff working in the Vanni region, Sri

Lanka. *Psychological Trauma: Theory, Research, Practice and Policy, 5,* 581-590. doi: https://doi.org/10.1037/a0030969

Connorton, E., Perry, M., Hemenway, D., & Miller, M. (2011). Humanitarian relief workers and trauma-related mental illness. *Epidemiologic Reviews*, *34,* 145-155. doi: https://doi.org/10.1093/epirev/mxr026

Cox, K., & Steiner, S. (2013). *Self-care in social work: A guide for practitioners, supervisors, and administrators.* Washington, DC: NASW Press.

Cripe, L., & Nyssens, O. (2017, August 3). Aid Worker Wellbeing: The Duty of Care. Mental Health and Psychosocial Support Network (MHPSS.net). Video retrieved from www.youtube.com/watch?v=q-pwpv0CoO8

Curling, P., & Simmons, K. (2010). Stress and staff support strategies for international aid work. *Intervention*, *8,* 93-105. doi: https://doi.org/10.1097/WTF.0b013e32833c1e8f

Dahlgren, A., DeRoo, L., Avril, J., Bise, G., & Loutan, L. (2009). Health risks and risk-taking behaviors among International Committee of the Red Cross (ICRC) expatriates returning from humanitarian missions. *Journal of Travel Medicine*, *16*, 382-390. doi: https://doi.org/10.1111/j.1708-8305.2009.00350.x

Ehrenreich, J., & Elliot, T. (2004). Managing stress in humanitarian workers: A survey of humanitarian aid agencies' psychosocial training and staff support. *Peace and Conflict: Journal of Peace Psychology, 10,* 53-66. doi: https://doi.org/10.1207/s15327949pac1001_4

Eriksson, C., Bjork, J., Larson, L., Walling, S., Trice, G., Fawcett, J., Abernethy, A., & Foy, D. (2009). Social support, organizational support and religious support in relation to burnout in expatriate humanitarian aid workers. *Mental Health, Religion & Culture, 12*, 671-686. doi: https://doi.org/10.1080/13674670903029146

Eriksson, C., Kemp, H. V., Gorsuch, R., Hoke, S., & Foy, D. (2001). Trauma exposure and PTSD symptoms in international relief and development personnel. *Journal of Traumatic Stress, 14,* 205-212. doi: https://doi.org/10.1023/A:1007804119319

Eriksson, C., Lopes Cardozo, B., Ghitis, F., Sabin, M., Gotway Crawford, C., Zhu, J., Rijnen, B., & Kaiser, R. (2013). Factors associated with adverse mental health outcomes in locally recruited aid workers assisting refugees in Jordan. *Journal of Aggression, Maltreatment & Trauma, 22*, 660-680. doi: https://doi.org/10.1080/10926771.2013.803506

European Civil Protection and Humanitarian Aid Operations. (2017, July 27). *Greece.* Retrieved from http://ec.europa.eu/echo/where/europe-and-central-asia/greece_en

Francis, F., Galappatti, A., & van der Veer, G. (2012). Developing a responsive model to staff care beyond individual stress management: A case study. *Intervention, 10*, 74-78. doi: https://doi.org/10.1097/WTF.0b013e328351bc4b

Goncalves, P. (2011). Balancing provision of relief and recovery with capacity building in humanitarian operations. *Operations Management Research, 4*, 39-50. doi: https://doi.org/10.1007/s12063-011-0045-7

Glasø, L., & Vie, T. L. (2010). Toxic emotions at work. *Scandinavian Journal of Organizational Psychology*, *2*, 49-54.

Halbesleben, J., & Buckley, M. (2004). Burnout in organizational life. *Journal of Management, 30,* 859-879. doi: https://doi.org/10.1016/j.jm.2004.06.004

Harr, C. (2013). Promoting workplace health by diminishing compassion fatigue and increasing compassion satisfaction. *Social Work and Christianity, 40*, 71-88.

Hearns, A., & Deeny, P. (2007) The value of support for aid workers in complex emergencies: A phenomenological study. *Disaster Management and Response,* 5, 28-35. doi: https://doi.org/10.1016/j.dmr.2007.03.003

International Committee of the Red Cross. (2014). The Geneva conventions of 1949 and their additional protocols. Retrieved from https://www.icrc.org/en/document/geneva-conventions-1949-additional-protocols

International Federation of Social Workers. (2014). *Global definition of social work.* Retrieved from http://ifsw.org/get-involved/global-definition-of-social-work/

Jokovic, D., Krstic, D., Stojanovic, Z., & Spiric, Z. (2016). Experience of the air medical evacuation team of Serbian armed forces in the United Nations mission in the Democratic Republic of the Congo: Deployment stress and psychological adaptation. *Vojnosanitetski Pregled*, *73,* 188-191. doi: https://doi.org/10.2298/VSP140114145J

Jones, B., Muller, J., & Maercker, A. (2006). Trauma and posttraumatic reactions in German development aid workers: Prevalence and relationship to social acknowledgement. *International Journal of Social Psychiatry, 52*, 91-100. doi: https://doi.org/10.1177/0020764006061248

Lipsky, L. V. N., & Burke, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler.

Maslach, C., Schaufeli, W., & Leiter, M (2001). Job burnout. *Annual Review of Psychology*, *52*, 397-422. doi: https://doi.org/10.1146/annurev.psych.52.1.397

Mathieu, F. (2012). *Routledge psychosocial stress series. The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization.* New York, NY, US: Routledge/Taylor & Francis Group.

Mayo Clinic. (2016). *Need stress relief? Try the 4 A's*. Retrieved from http://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress-relief/art-20044476

McCormack, L., & Joseph, S. (2012). Psychological growth in humanitarian aid personnel: Reintegrating with family and community following exposure to war and genocide. *Community, Work, and Family, 16*, 147-163. doi: https://doi.org/10.1080/13668803.2012.735478

Musa, S., & Hamid, A. (2008). Psychological problems among aid workers operating in Darfur. *Social Behavior and Personality, 36*, 407-416. doi: https://doi.org/10.2224/sbp.2008.36.3.407

National Association of Social Workers. (2017). *Code of ethics.* Retrieved from https://www.socialworkers.org/about/ethics

Nilsson, S., Sjöberg, M., Kallenberg, K., & Larsson, G. (2011). Moral stress in international humanitarian aid and rescue operations: A grounded theory study. *Ethics & Behavior*, *21*, 49-68. doi: https://doi.org/10.1080/10508422.2011.537570

Nimmo, A., & Huggard, P. (2013). A systematic review of the measurement of compassion fatigue, vicarious trauma, and secondary traumatic stress in physicians. *Australasian Journal of Disaster and Trauma Studies, 1,* 37-44.

Pearlman, L.A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary stress disorders. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized* (pp. 150-177). London, UK: Brunner-Routledge.

Pigni, A. (2014). Building resilience and preventing burnout among aid workers in Palestine: A personal account of mindfulness based staff care. *Intervention, 12,* 231-239. doi: https://doi.org/10.1097/WTF.0000000000000043

Porter, B., & Emmens, B. (2009). *Approaches to staff care in international NGOs*. Retrieved from http://www.chsalliance.org/files/files/Resources/Articles-and-Research/approaches-to-staff-care-in-international-ngos.pdf

Pross, C., & Schweitzer, S. (2010). The culture of organizations dealing with trauma: Sources of work-related stress and trauma. *Traumatology*, *16,* 97-108. doi: https://doi.org/10.1177/1534765610388301

Putman, K., Lantz, J., Townsend, C. C., Gallegos, A., Potts, A., Roberts, R…Foy, D. (2009). Exposure to violence, support needs, adjustment, and motivators among Guatemalan humanitarian aid workers. *American Journal of Community Psychology, 44,* 109-115. doi: https://doi.org/10.1007/s10464-009-9249-5

Rahman, A., Riaz, N., Dawson, K. S., Usman Hamdani, S., Chiumento, A., Sijbrandij, M.,…Farooq, S. (2016). Problem Management Plus (PM+): Pilot trial of a WHO transdiagnostic psychological intervention in conflict-affected Pakistan. *World Psychiatry, 15*, 182-183. doi: https://doi.org/10.1002/wps.20312

Robinson, L., Smith, M., & Segal, R. (2017). *Stress management: Using self-help techniques for dealing with stress*. Retrieved from https://www.helpguide.org/articles/stress/stress-management.htm?pdf=true

Rysaback-Smith, H. (2015). History and principles of humanitarian action. *Turkish Journal of Emergency Medicine*, *15*, 5-7.

Salloum, A., Kondrat, D., Johnco, C., & Olson, K. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers.

Child and Youth Services Review, 49, 54-61. doi: https://doi.org/10.1016/j.childyouth.2014.12.023

Slewa-Younan, S., Uribe Guajardo, M. G., Heriseanu, A., & Hasan, T. (2015). A systematic review of post-traumatic stress disorder and depression amongst Iraqi refugees located in western countries. *Journal of Immigrant and Minority Health, 17*, 1231-1239. doi: https://doi.org/10.1007/s10903-014-0046-3

Sommers-Flanagan, R. (2007). Ethical considerations in crisis and humanitarian interventions. *Ethics & Behavior, 17*, 187-202. doi: https://doi.org/10.1080/10508420701378123

United Nations High Commissioner for Refugees [UNHCR]. (2001). *Managing the stress of humanitarian emergencies.* Retrieved from https://drc.ngo/media/2113528/unhcr-booklet-on-stress-management.pdf

UNHCR. (2017a, August 6). *Syrian regional refugee response.* Retrieved from http://data.unhcr.org/syrianrefugees/regional.php

UNHCR. (2017b, August 10). *Greece.* Retrieved from https://data2.unhcr.org/en/situations/mediterranean/location/5179

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A Worthy Reception? Ambivalences in Social Work With Refugees and Migrants in Sweden

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Abstract: *The purpose of this article is to analyze how reception practices and the meaning of a "worthy" reception of refugees and migrants are negotiated in encounters between various receiving actors in times of shifting Swedish migration policies. The analysis is grounded in ethnographic methodology and draws on data collected in 2016. The aim of the study was to document experiences of the so-called "refugee crisis" in Europe and Scandinavia from a bottom-up perspective among professionals and volunteers narrated during reference group meetings. The reference groups consisted of representatives from state and municipal agencies, the private sector, and civil society organizations. The actors represented in the mixed reference groups were diverse, but all were involved in reception activities. In the analysis we have combined political philosophy about willingness versus ability to receive refugees and migrants with postcolonial theoretical perspectives on concurrent claims and voices. We identified three themes that are central in the negotiation of the practice and meaning of a "worthy reception": first, the overlooked existential needs of refugees and migrants; second, the lack of gender- and diversity-sensitive reception practices; and third, ambivalences in relation to various refugees groups in times of shifting migration policies. We recommend that in order to promote a worthy reception of refugees and migrants, existential needs must be taken care of and gender- and diversity-sensitive practices must be developed. Another recommendation is to recognize how migration policy limits a society's ability to receive refugees and migrants, but also affects the willingness among those actors who receive.*

Keywords: *Migrants; refugees; reception; social work*

Today, migration policies in liberal democracies are marked by an ambivalence between seemingly contradictory jurisdictions and claims (Andersson, 2014; Gibney, 2004). This ambivalence can be seen in the public debate, with themes such as human rights versus national security and the rights of refugees versus the right to protect national welfare state institutions. In Sweden, such contradictions manifested themselves with the implementation of a new law in 2016 which restricted the possibilities for permanent residency and family reunion for asylum seekers (SFS 2016:752). Political leaders justified the law by referring to the pressure that an increased influx of refugees in 2015 put on migration agencies, social services, schools, health and medical care and so on. The "refugee crisis" of 2015 was thus framed as a crisis for the receiving country rather than a crisis for the people seeking protection (SOU 2017:12).

Thus, the "refugee crisis" was framed and re-framed in similar ways in several European countries. In some countries, like Sweden and Germany, the rhetorical reactions of leading politicians in 2014 and 2015 concerning the increased numbers of arriving asylum seekers were marked by solidarity and empathy. In a speech in the summer of 2014, then Swedish Prime Minister Fredrik Reinfeldt, who lead a center-

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right coalition government, exhorted the Swedish people to "open your hearts" towards asylum seekers fleeing war-torn regions. Furthermore, conservative German Chancellor Angela Merkel commented on the increased numbers of received asylum seekers in Germany in autumn 2015 with the words "wir schaffen das" ("We will make it"), addressing a symbolic message to the German people to have trust in the German society's ability and willingness to receive refugees. In contrast, other countries like Poland, Hungary and Slovakia consistently turned away asylum seekers and refugees. Nevertheless, even in countries like Sweden and Germany, the political atmosphere concerning migration policies changed radically during late autumn 2015 and the following years. New regulations and strict border controls were implemented not only around the external borders of the EU but also (temporarily) between EU countries to limit migration movements. One of the main arguments for these increasingly strict measures in European countries was the fact that there was, and still is in 2018, a split among EU countries. Several Eastern and Central European countries did not want to receive asylum seekers and refugees at all. Others, mainly South European countries close to the Mediterranean Sea where large numbers of migrants first arrived, as well as Germany and Sweden as the largest receiving countries, preferred to establish a redistribution system leading to an obligation of all EU-countries to receive a "fair" share of asylum seekers and refugees migrating to the EU (Gibney, 2015; Regeringens skrivelse, 2016; Svensson, 2017, pp. 20-21).

In Sweden the new law about restrictions on permanent residency and family reunification can be described as a turning point in Swedish migration policy (Johansson, 2005), which has had a significant impact on everyday social work connected to the reception of refugees and migrants. On the one hand, professionals and volunteers have been obliged to act in accordance with the new restrictive legislation. On the other hand, they are endeavoring to provide a welcoming and "worthy" reception in line with professional ethics and the ambitions of a social democratic welfare regime (Esping-Andersen, 1990; International Federation of Social Workers [IFSW], 2012/2004). In this way, the reception of refugees and migrants is practiced and produced on the front line between divergent but concurrent demands in contemporary Sweden. The purpose of this article is to analyze how reception practices and the meaning of a "worthy" reception of refugees and migrants are negotiated in encounters between various receiving actors in times of shifting Swedish migration policies. Our primary research question is: How is the meaning of a "worthy" reception negotiated in personal narratives by different professionals and volunteers?

The study is based on data collected in the fall of 2016 from eight recorded reference group meetings with three mixed groups consisting of both professionals and volunteers involved in the reception of migrants and refugees. In our analysis, we combine political theory about a society's ability and/or the willingness to receive refugees and migrants with postcolonial perspectives on concurrences in cultural encounters.

Research Perspectives on Swedish Refugee and Migrant Reception

This study intersects research in social work, migration studies, and cultural sciences. We employed a broad definition of social work, which includes professionals and civil society volunteers involved in the asylum process and the reception of asylum seekers. Social work has a given function in civil society organizations. Civil society involves individual commitment, which has been clarified in reception activities of

refugees and migrants during the last several years. For instance, civil society volunteers organize a variety of relief efforts, such as serving food, collecting and distributing clothes and arranging temporary housing for refugees and migrants. In Sweden, civil society organizations have sometimes taken the place of state or municipal authorities in providing social services for refugees and migrants when these public actors have failed or ceased to act. Furthermore, professional social workers in public organizations have also cooperated with civil society organizations, sometimes using civil society as an arena to support the public authorities' efforts (Turunen & Weinryb, 2017).

In Scandinavia several studies have been conducted on workers at the Swedish Migration Agency (Brekke, 2004; Hedlund, 2016; Ottosson & Lundberg, 2013; Valenta & Berg, 2010), those who work with newly arrived children in the Swedish school system (Bunar, 2015; Nilsson Folke, 2017), in social services (Montesino & Righard, 2015), within health care services (Safipour, Hadziabdic, Hultsjö, & Bachrach-Lindström, 2017) and at the Swedish Public Employment Agency or the National Social Security Agency (Schierenbeck, 2003; Soydan, 1995). A great deal of previous research has focused on how Swedish receiving sectors deal with integration and issues of promoting resilience, health and identity, as well as how they are marked by racism and structural discrimination (Andersson, Ascher, Björnberg, & Eastmond, 2010; Eliassi, 2015). Although these studies are relevant for the present study, they all focus on the reception measures of one specific welfare sector or authority separately. In order to understand the reception of refugees and migrants as the sum total of many different agents and institutions in the welfare state, a comprehensive and inclusive perspective on reception is necessary (Gustafsson, 2015).

Within the field of migration research there is a growing critique of the tendency to focus on the migrants' backgrounds and experiences rather than the contexts, structures, and actors forming the conditions of migration. In the field of social work, "cultural differences" or "otherness" is often framed as the "problem" explaining migrants' weak structural integration. Migrants' "otherness" is often targeted in specific interventions (Ahmadi, 1998/2003; Hessle, 1988). Such social interventions are often focused on migrants' ability and willingness to adapt to Swedish society instead of the surrounding advantageous or disadvantageous conditions that exist concerning migrant's integration Montesino & Righard, 2015, pp. 11-12). One consequence of such a perspective is that the migrant becomes the "problem," or the one who needs to change in order to integrate. This is known as the "minority model" (Pripp, 2005).

This critique is also present among scholars influenced by postcolonial theories that suggest a shift in focus to the surrounding society in order to understand the conditions for migrants and migration (Andersson, 2014). This suggestion is supported by several studies within the fields of migration studies and social work or social policy that show that the character of social policy and immigration policy regimes strongly influences refugees' and migrants' level of control over their own empowerment, participation, and well-being (Castles & Miller, 2011; Montesino & Righard, 2015; Sainsbury, 2012). In contrast, however, other studies show that reception measures take their point of departure from the needs of the host society, rather than the needs of the migrant. This leads to an ambivalent position of the migrant who is offered reception measures that might be empowering. At the same time, it is not measures that the migrant can choose or suggest themselves. In that sense, the migrant has relatively less

power (Andersson, 2014; Gibney, 2015; Gustafsson, Fioretos, & Norström, 2012; Larsen, 2011). These concerns are central to the perspectives of the present study. The surrounding society, here primarily represented by different welfare state professionals and civil society volunteers, and its reception measures are regarded as central for understanding the challenges of migration and the resettlement of migrants (Castles & Miller, 2011; Johansson, 2008).

Theory and Concepts

Zetterqvist Nelson and Hagström (2016) use the concept of "reception structure" to characterize the Swedish reception of refugees and migrants. According to Zetterqvist Nelson and Hagström (2016), the concept clarifies how Swedish reception involves different sectors and agencies, each of them governed by their own laws and regulations (pp. 11-12). These sectors and agencies operate largely independently of each other rather than in close collaboration. Accordingly, Sweden's reception of refugees and migrants is not a "system" governed by one general law or regulation, but a complex "reception structure" consisting of different sectors and agencies such as the Police, the Migration Agency, municipal institutions such as schools and social services, regional health care, civil society, and private companies. The private sector is part of the reception structure since parts of the public welfare include contracted services from the private sector. Residential care homes for unaccompanied children and accommodations for asylum seeker families are often run by private companies (Zetterqvist Nelson & Hagström, 2016, p. 12).

The concept of "reception" refers to a broad and complex arena of actions surrounding refugees and migrants (Andersson, 2014). As a consequence, many of the actors included are not specialized in reception in the administrative or legal sense, but work as teachers in schools, public officials or social workers and encounter refugees and migrants in their everyday work as a consequence of migration. They all have an impact on the refugees' and migrants' lives, but how they operate and intersect, as well as the joint outcome of their work, is difficult to understand if their agency and professional practices are not analyzed together (Andersson, 2014; Gustafsson, 2015; Zetterqvist Nelson & Hagström, 2016).

Encounters taking place in the reception of refugees and migrants are theoretically framed by the concept of "cultural encounters." This concept is contested, first and foremost, in how it has been used by researchers to describe and evaluate differences between people based on ethnicity and nationality, often in hierarchal, stereotypical and oppressive ways (Hall, 1997; Hastrup, 2010). In present postcolonial research, however, the concept is still used both to understand encounters between colonizers and colonized peoples and to investigate how different knowledge-producing groups give voice to concurrent perspectives and interpretations of the world (Brydon, Forsgren, & Fur, 2017). The concept of "concurrences" refers to simultaneous but contradictory process of meaning-making for example, agreement, competition, entanglement and incompatibility (Fur, 2017, p. 45). Used in research on colonial asymmetries, indigenous people or, as in this case, migration, the concept of concurrences opens up for a respect for pluralism and entanglements rather than singling out dominant perspectives and separate claims and jurisdictions. Fur (2017) notes, "It is not a multiplicity of histories per se that interests me, but the way in which they become entangled, ensnared by their competing jurisdictions" (p. 51). A challenge for researchers is to acknowledge and handle such a plurality of knowledge regimes

and how they are concurrent but also given disparate authority and power to dominate and silence each other (Fur, 2017, p. 42).

Departing from this perspective, we consider the cultural encounter as a fruitful description of the encounters of those involved in the reception. The actors involved work for state and municipal agencies, private enterprises, and civil society organizations. They operate in organizations that have different jurisdictions and mandates depending on their assignment. For example, a social worker or a teacher working at the municipal level is involved in reception work but on different terms than an actor working at the state level for the Swedish Migration Agency or for a civil society organization. We consider the actors involved in reception work as representing different knowledge-producing groups. They work as professionals and volunteers under different jurisdictions and give voice to different claims that sometimes exist in parallel to each other and at other times converge. Taken together, they are involved in processes of negotiation that produce the meaning of a *worthy* reception.

In this study, political philosophy theories about the reception of refugees and justice between states are used in order to analyze the notion of *worthiness*. These theories are explored and advanced by political scientist Gibney (2004, 2015), who writes about the obligation of liberal democracies to receive refugees and offer resettlement. Gibney investigates the need for justice and standards for an equitable division between states of the responsibilities for refugees. In connection to a fair distribution based on statistical data, population, GDP etc., Gibney (2015) also discusses the relation between the ability and the willingness of a state to receive refugees. He suggests that the ability of a state to accept refugees might be influenced by the level of racism amongst the populace, its previous experience of integrating non-citizens and community preferences for particular types of refugees. He concludes that such factors say more about the willingness of a state to take refugees than its actual ability to do so (Gibney, 2015, pp. 456-457).

We use the terms *ability* and *willingness* in the analysis of a worthy reception. *Ability* frames the way participants in the reference groups identify and explain their assignment to receive refugees and migrants. Their assignment is controlled by legislation and limited by their mandate, resources and competence. In these ways, the ability to receive is in certain respects restricted. To fulfill reception work within these limits could be considered as a minimum for a worthy reception. As Gibney (2015) states, the willingness to receive refugees and migrants is restricted by more subjective considerations and non-measurable factors. In a qualitative study such as this one, subjective perspectives and meanings were what we are actually looking for. Although ability and willingness are difficult to quantify, they still have a significant impact on reception. A society's willingness to receive refugees and migrants can be stronger or weaker than its ability to do so. For example, in contemporary Sweden, more and more professionals in social services engage in volunteer work with refugees and migrants in their spare time in order to be able to do everything they want to do, not only what they can do within the framework of their professional work.

Methods

This study is part of a regional project in southern Sweden which documented professional and volunteer experiences from the reception of refugees and migrants in 2015 and 2016. The project was conducted in 2016 as a collaboration between four

scholars in social work and cultural sciences, two curators at regional museums, and two regional public officials. The documentation of professional and volunteer experiences and voices was implemented using reference groups and individual interviews. We divided 15 selected professionals and volunteers into three reference groups who met for three sessions of three hours each during the fall of 2016. The participants represented state agencies: the Public Employment Agency, the Migration Agency and the Police; municipal agencies: social services, schools and group residences for unaccompanied minors; private entrepreneurs running refugee accommodations and civil society organizations: the Red Cross, the Church of Sweden and Fryshuset (the Freezer House). Following the last meeting, eight participants were interviewed individually by students at the university.

Through our method of gathering these representatives in mixed groups, we included different perspectives from various knowledge-producing groups in an open dialogue with each other. In the dialogue, they describe their experiences in narratives, explore their own claims and jurisdictions, and compare and negotiate with the others. Participants explored how their perspectives and functions in the reception of refugees and migrants are entangled and concurrent. Each meeting with the three reference groups was recorded. In total, the data consists of 16 hours of recorded narratives and discussions from reference group meetings and eight individual interviews. In all three groups, the group leaders (the researchers) endeavored to give space for all participants to present themselves, their organization, and their experiences and perspectives on the reception of migrants and refugees from the fall of 2015 to the fall of 2016.

The analytical work of coding and finding central themes in the data started during the period of data collection. After the first meeting with the three reference groups, central themes in the data that could be discussed at the second meeting were isolated. Four themes came forward in the coding of the first meetings: the elusive concept of integration, the overlooked existential needs of refugees and migrants in reception work, the problem of non-gender-sensitive reception, and the problem of a reception that makes the received refugees and migrants passive. These themes were further discussed in the second and third meetings. After finishing the data collection, we repeated the coding of the data and in this process three main themes emerged. Two themes overlapped with those discussed at the second and third meetings: the overlooked existential needs of refugees and migrants in the reception work (particularly the existential vulnerability and uncertainty of asylum seekers, the lack of meaningful everyday activities and existential life beliefs) and gender- and diversity-insensitive practices. A third theme was not discussed in the reference groups, nor in the individual interviews, but seems fundamental in the negotiation of a worthy reception, namely, ambivalences towards different groups of refugees and migrants in times of shifting migration policies.

The Swedish Reception of Refugees and Migrants

According to current legislation, the Swedish Migration Agency has the general responsibility not only for the asylum procedure but also for the reception of asylum seekers (SFS 1994:137). The latter is organized in collaboration with regional and municipal authorities. For unaccompanied children the legislation is different, and according to the Social Service Act (SFS 2001:453), municipalities have the responsibility for reception measures while the Migration Agency is responsible for administering the asylum procedure (Gustafsson, 2015).

After asylum seekers receive a residence permit, they also get a specific municipality placement and the responsibility concerning refugees' and migrants' resettlement is divided between different state and municipal agencies. Municipalities are responsible for housing (SFS 2016:38). According to a 2010 law about resettlement activities (SFS 2010:197), refugees and asylum seekers with a residence permit are entitled to a resettlement plan formed in consultation with the concerned individual and managed by the Public Employment Agency in collaboration with municipalities, authorities, companies, and civil society organizations. Before 2010, this was a municipal responsibility. However, municipalities are still responsible for providing Swedish-language training and social information about laws, regulations, and civic instructions. The National Social Security Agency is responsible for paying a resettlement benefit to the refugee or asylum seeker when he or she has been given a resettlement plan by the Public Employment Agency. Looking back on the Swedish Migration Agency's statistics, family reunification was the most common reason for migration to Sweden. Besides asylum-seeking and family reunification, Sweden has granted quota refugees permits registered by the UNHCR since the 1950s. Other bases for obtaining a residence permit include work or study in Sweden. Citizens of the European Union/European Economic Area EU/EEA-member countries are also eligible to relocate to Sweden and receive a residence permit (Migrationsverket, 2017).

In 2013 and 2014, Sweden experienced a major increase in the influx of refugees and migrants when around 54,000 people in 2013 and over 81,000 people in 2014 applied for asylum. However, in the fall of 2015, most municipalities were still quite unprepared for the more than 160,000 asylum seekers that entered Sweden within the space of a few months (Migrationsverket, 2017). In relation to Sweden's total population of around 10 million people, these were remarkable immigration figures.

The reception of people seeking asylum has also been an international and European matter of concern during the last decades (Europeiska Unionen, 2010). The European Union's directive of asylum reception from 2013 aimed to harmonize policies between member states and set up minimum standards about asylum reception. The directive states that the reception should be conducted with respect for human dignity (§35), but that the member states nonetheless have the right to treat asylum seekers less favourably than their own citizens (§24) (Europeiska Unionen, 2013). These contradictory objectives have created tensions and triggered conflicts between member states in the European Union, where some states have received large numbers of asylum seekers while other states have received very few. Furthermore, these contradictory objectives give nation states latitude to radically alter the terms and conditions of reception at short notice, for example, by reducing the standards of accommodation, language training, social activities, and other services offered to refugees and migrants.

As noted in the introduction, Sweden went through a shift in migration policy in 2016. Restrictive border controls in November 2015 and personal ID controls on trains, ferries, and buses were implemented in January 2016 followed by temporary changes in the migration law in July 2016. These changes in law and practice were implemented in order to restrict the increased influx of asylum seekers. Before July 2016, successful asylum seekers were offered permanent residence permits. Since the implementation of the new law, asylum seekers can only receive temporary residence permits from 13 months up to three years. Since July 2016, only those with refugee status according to the UN Refugee Convention have the right to family reunion (SFS 2016:752). Before

the new law was implemented family reunion was a fundamental social right for an immigrated person with a residence permit, regardless if the person was given a residence permit based on refugee status, subsidiary protection or labor market reasons. With increased legal restrictions, Sweden downsized its reception of asylum seekers to a minimum standard compared to European Union standards (Regeringens skrivelse, 2016). Due to changes in the law and agreements made between Turkey and the EU, the influx of asylum seekers has decreased in recent years. In 2016, Sweden received less than 29,000 applicants. Asylum seekers in the last few years have come from Syria, Afghanistan, Iraq, Somalia, Iran and Eritrea or were stateless. War and conflicts are the main reason for leaving these countries of origin. In 2016, 111,979 persons received a decision and 69,682 received a residence permit (77%), but only 17,000 were recognized as refugees. The rest were regarded eligible for subsidiary protection (Migrationsverket, 2017).

Results

Overlooked Existential Needs

The first central theme identified during the coding process of the interview data was that refugees' and migrants' existential needs were partly overlooked during their reception. We have structured the findings around this theme following three different perspectives discussed in the reference group meetings: the existential vulnerability and uncertainty of asylum seekers, the lack of meaningful everyday activities, and existential life beliefs.

One case worker at the Migration Agency told a story about her personal experiences of working in an asylum unit, where she encountered asylum seekers who felt frustrated about their situation and the long waiting time of more than one year for asylum applications. She described the atmosphere in the waiting hall of the asylum unit as characterized by despair and agony. The case worker's story was followed by a discussion about the poor situation of asylum seekers waiting for a decision. The process takes time and it is well-documented in research that such a waiting period can completely break down applicants' self-confidence and hope (Brekke, 2004; Valenta & Berg, 2010). The main problem is of course the time; it takes too long to receive a decision. But another problem is that the asylum seekers often become extremely passivized. Language training, workforce trainee programs, and other kinds of activities are not always offered or permitted before applicants have received a decision.

Actually, the right to education for children is the only welfare service that is offered that constitutes a "normal" everyday life situation for those awaiting a decision (Svensson, 2013). For adults there is no similar occupation offered although these circumstances have gradually changed since we did the reference-group interviews with professionals and volunteers in autumn 2016. From January 2017, the County Administrative Boards in Sweden are in charge of coordinating and funding early interventions for asylum seekers or persons with residence permits living in the Migration Agency's accommodations and waiting to be allocated a municipality placement. These early interventions aims to hasten the resettlement process and help to make the waiting time, when the asylum application is being processed, more meaningful. Supported by funding from the County Administrative Boards, civil society organizations then in practice often provide Swedish language training, social

information and social activities for asylum seekers in the local association sphere (Länsstyrelsen, 2017). Each person in the reference groups was asked about their contribution to the existential and normal everyday life of asylum seekers. The answers differed, of course, but a main difference was between actors working for public authorities and actors working for civil society organizations. Actors working for public authorities, such as social services, schools and the Migration Agency, had a mandate to receive asylum seekers and to give opportunities for a normal life by offering housing, basic economic assistance, and help with the procedures of the formalities of the asylum process (LMA card, address, filling in formulations, etc.). They stated that they did not really have a mandate to intervene in the existential quality of the refugees' lives. One social worker simply stated:

> *We should offer basic support according to legislation, but nothing more. Social life, integration and existential issues are things that the asylum seekers have to take care of themselves. We cannot do that.*

Still, despite this narrow view of social work, the same person was very critical of the passivizing situation most asylum seekers ended up in. He discussed how it takes too long to get the decision about acceptance or rejection regarding the asylum application, and during that time many asylum seekers are broken down. I wonder, he said, "what would happen if we said: here is your permit, now you have three months to establish yourself. People would manage, I am sure of it. Instead they have to wait, and wait and wait."

Professionals or volunteers working for civil society organizations answered differently. They saw it as their task to fulfill existential needs and create possibilities for normal social life. They also expressed criticism in line with the social worker above. Their main challenge was that they worked on a volunteer basis, had few resources and experienced difficulties in gaining access to the asylum seekers. One woman working locally for the Red Cross noted that it takes time to meet, talk and listen to people's existential problems, which is a demanding but extremely important task. Furthermore, she criticized the lack of information and communication from public authorities regarding the use of civil society organizations as a resource for meeting people's need for meaningful activities.

According to a priest from the Swedish Church, religious organizations naturally feel a responsibility to deal with people's existential needs. She expressed her view that is was healing to let people talk about their problems in front of a non-authority person, who does not share the same troublesome experiences, but who provides a sounding board for people's mental stress and worries. Her experience was also that the preconditions for taking care of people's existential needs at the Migration Agency's accommodations for asylum seekers were inadequate. The focus at these accommodations was instead, providing food and shelter.

In relation to the question put to participants in the reference groups about who is responsible for refugees' and migrants' existential needs, we have noticed a negotiation among the group participants as to whether this is actually an issue of significance. Actors in the reference groups working for public authorities such as the Migration Agency, the Public Employment Agency, the Police and social services said that these existential needs were not their professional responsibility. They took the stance that the individual refugee or migrant is more or less responsible for taking care of themselves in fulfilling these needs. One social worker's narrative quoted above, that

social services should offer basic support according to legislation, nothing more, is one illustration of these standpoints. The caseworker from the Migration Agency argued in the same direction, "The individual has to search for different activities by him- or herself. To show curiosity and a will to do something with his/her life." The same social worker quoted above declared, "we ought to put the largest responsibility where it belongs, on the individual, instead of giving state and municipal officials too much responsibility."

Most public actors felt that it was first and foremost the individual's responsibility to tackle any existential problems. They expressed a common feeling that public officials should treat all clients politely, objectively, and with the same kind of treatment and respect. However, in different ways they all expressed a lack of professional responsibility to involve themselves in people's existential worries or anxiety. Accordingly, these public officials claimed that their ability to involve themselves was restricted by the law (i. e., the migration law, the social services act, the regulation on labor market policy, etc.). The responsibility for engaging existential needs and problems was left to the individual refugee or migrant.

In contrast, the teachers working with introducing refugees and migrants into society as well as employees from civil society organizations such as the Swedish Church, the Red Cross and Fryshuset (the Freezer House) expressed a willingness to develop the existential support available to refugees and migrants. One male teacher working with social information courses at a local training center argued that by really seeing and listening to a person's life story, one becomes better prepared to understand and handle that person's feelings of misery and frustration. A Red Cross employee said that she meets people on a daily basis who are frustrated over their situation as asylum seekers, i.e., the new migration law preventing family reunion, the long waiting time, and being forced to live in uncertainty about whether they can stay in Sweden or will be deported. "We try to fulfill their existential needs, give support and we also work with different activities." One improvement of the reception which she desired was to introduce official information about the procedures in the asylum process and about residence permits as soon as people arrive in Sweden as asylum seekers. Such improvements could ease some of the stress and uncertainty of asylum seekers. She was critical of the fact that most official information is provided only after people have been given a residence permit and municipality placement.

In contrast to public actors, actors working for civil society organizations expressed a stronger willingness to engage themselves in people's existential needs and everyday social activities. Ironically, however, despite their willingness, their efforts are sometimes hampered by their organization's limited economic and staff resources or limited access to the target groups for which their social activities are intended. The limited access was the result of public regulations or weak multisectoral cooperation.

Negotiated Stereotypes on Gender

A second theme that became apparent in the analysis of the data was gender. In all groups and at every meeting the issue of "refugee and migrant women" was discussed. It is important to note that the notion of "refugee and migrant women" tend to be stereotyped and oversimplified in public debate and policymaking instead of recognizing the need for understanding migration as a gendered process involving different conditions for men and women in relation to other aspects, for instance

education, class, and so on (Akman, 2014). In order to analyze how the perceived problem of “refugee and migrant women” was negotiated, we will proceed from a discussion in one of the reference groups where the challenges of women came up when the theme of integration was discussed.

A private entrepreneur running a refugee accommodation said that she had noted that the refugee women living at her place always stayed in their rooms. They did not take part in activities at the center and did not even go out to buy groceries. She declared that females in their culture (vaguely defined as Arabic) stick to themselves and their goal is to become housewives. Several of them have a high level of education, she stated, but still education is only a hobby, not a means to become a professional but a rather talented housewife who is financially supported by her husband. The entrepreneur emphasized her experiences of cultural differences by adding a story about how men with migrant backgrounds “imported” a wife from their home country rather than marrying a Swede. She had witnessed this practice on several occasions and was disappointed about it. In her opinion these “marriage arrangements” were a loss for Swedish society; e.g., she could not imagine a better way to integrate than through mixed marriages. She added, “it is also a loss for these women, who often get extremely alienated when they arrive in Sweden.”

The private entrepreneur touched upon two well-established ideas in many European countries about the “flaws” of arranged marriages among migrants and the “strength” of integration through marriage between natives and migrants. These ideas have influenced laws and regulations concerning international marriages in several European countries. The most prominent example is probably the Danish legislation from 2002 on family reunification. The legislation was introduced to stop arranged international marriages, primarily among Pakistani migrants in Denmark, but in fact had a greater effect on stopping native Danes’ international marriages (Rytter, 2013).

One of the other participants, an activist who arranged meetings for women with migration experiences, added to the discussion of the private entrepreneur with further common (although equally simplified) ideas about “refugee and migrant women.” She stated that the combination of culture, patriarchal structures, and the Swedish reception of refugees and migrants was devastating for women. “Many women who have lived in Sweden for a long time are depressed, isolated and need medical treatment.” She thought that the reception of migrants and refugees in Sweden took away all sense of self-responsibility and made people passive. She added, “if it is a recognized problem that asylum seekers [as a total] get passive and depressed, the situation is even worse among women.” A third person then entered the conversation and declared that he found the previous statements about refugee and migrant women too generalized and stereotyped. The private entrepreneur immediately defended herself and received support from a representative of the Red Cross who said, “It is not so dramatic to talk about these things; we had the same situation in Sweden 100 years ago.”

The other participants in the reference group then declared their ambivalence towards the description of the situation of migrant women on one hand and towards the stereotyped image of “refugee and migrant women” on the other hand. They agreed that it is dangerous to be too stereotyped and general in their descriptions. At the same time, they concluded that they should not overdramatize this problem since they all recognized the description of the situation of refugee and migrant women as accurate and problematic.

In this reference group, as well as in the other groups, the perceived problem of "refugee and migrant women" was discussed from different perspectives. Firstly, the participants discussed gender in terms of culture. Several participants, as in the example above with the private entrepreneur, described the cultural differences they experienced in encounters with refugee and migrant men and women. An interesting finding, though, is that narratives about gender issues were almost the only topic that also led to cultural explanations for refugee and migrant behavior. The example above shows how the participants in the reference groups negotiated how to formulate the perceived problem of "refugee and migrant women" without being prejudiced. Some of them preferred to explain perceived differences in terms of culture. Others were more sensitive about the idea of culture. They balanced the conversations by interrupting those whom they found too stereotyped in their descriptions. In this way, several of the participants showed an awareness of the difficulties that are related to the concept of culture, for example the risk of culturalization, othering and essentialism (Eliassi, 2015; Gustafsson, 2015). In this sense they struggled with the dilemma of how to address perceived differences between themselves and the refugees and migrants that they meet in the reception.

Another example came up in relation to the courses on social information about Swedish society. These courses are offered to asylum seekers with a residence permit in Sweden and consist of at least 60 hours of information and education about Swedish society. The teacher of these courses, supported by a social worker working with families and children at a place called "Landningsbanan" ("the Landing Strip"), discussed the need to recognize differences in culture and fundamental values. The oppression of women or the value of equality between men and women were topics that were raised in the information courses. Both the teacher and the social worker in the group concluded that there is a huge need among refugees and migrants (course participants) to understand and reflect upon these topics, especially in their mother tongue. In that sense, they supported a gender- and diversity-sensitive approach in the reception of refugees and migrants. At the same time, their hope to understand cultural differences also reflected a more normative perspective. The aim of the information presented in the courses was to change the ideas among the refugees and migrants rather than creating dialogue and mutual understanding between different values.

This kind of normative perspective surfaced at almost all the meetings and in all of the reference groups. The perceived problem of women being too passive was mainly framed as a consequence of an oppressive (male) culture and the solution was that those women should be "forced" to take responsibility for their integration through education and finding a job. One of the social workers stated that the refugees and migrants must get to know that in Sweden "you have to work. Both partners in the family have to work in order to manage and support the family." Hence the demand to join labor market activities was also discussed in terms of gender equality.

In addition to this normative perspective on gender equality and the passion for work activation, the perceived problem of women and their situation was also discussed from a more existential perspective. In the reference-group discussion summarized above, the activist described how the existential situation is difficult for all refugees and migrants, but was worse for women than for men. She then touched upon the problem that in the daily debate in the media, politicians, professionals, and others tend to talk about asylum seekers as one homogeneous category without recognizing gender and diversity. The solution to this existentially poor situation and environment from

the perspective of the activist was the same as the one formulated above: to take part in education and work would lead to independence, self-responsibility and gender equality. But in order to do that, gender differences would have to be recognized in the reception structure.

This led to another aspect of the way the idea of a gender- and diversity-sensitive reception was discussed. Again, the teacher of the social information courses provided an example. He told the other participants about how he came to Sweden from Syria four years ago and received a residence permit within a few months. He began his university studies and has since finished a master's degree. At the time of the meeting, he was a full-time employee at the training center and he declared that:

> *I see myself in the line. I am not the one sitting behind the desk. I understand when someone comes forward and is angry, frustrated, and yells at me. When I came to Sweden, I knew English, so I could manage quite well. But imagine a 55-year-old Somali woman who only speaks (but does not read) Somali. It is not easy to learn Swedish and to understand a new language. People must have more patience. […] I was privileged and came from a well-educated family. And no, a 55-year-old Somali woman cannot manage as well as I could. The problem is that the system does not understand this. The system treats everybody the same and with the same expectations.*

In his narrative, reception work does not meet the needs of individuals and he reiterated the earlier idea that reception measures proceed from the needs of the host society, rather than the perspective of the migrant, leaving the latter in an ambivalent position of being both empowered and powerless (Andersson, 2014; Gibney, 2015; Gustafsson et al., 2012; Larsen, 2011). The teacher also presented another perspective on the perceived problem of "migrant women." His suggestion was that instead of viewing the 55-year-old Somali woman (or any migrant woman) as a problem, Swedish authorities must investigate problems inherent in their own systems and practices. He then argued in line with the aforementioned critique of minority model thinking as presented in research literature.

We identified a consensus in the reference groups' discussions concerning views about the problem of "refugee and migrant women." The main perceived problem was that they lived in culturally different contexts that expected them to stay at home and not pursue education or work. This, in turn, undermined the virtue of gender equality that was embraced among the participants, and was considered as a non-negotiable value in Swedish society and by Swedish authorities. This theme of negotiated stereotypes on gender is reflected in previous research and government inquiries where Swedish welfare benefits, such as paid parental leave, seem to cement migrant women's marginalization (Länsstyrelsen, 2017; SOU 2006:37; SOU 2012:9). Larsen explored how the Scandinavian welfare state intervenes in family lives in order to create "good citizens," sharing "Danish" values of gender equality and emancipation (Larsen, 2011). However, the strong focus on labor market activation and education in integration policies ignores the experiences of the women themselves as mothers and family members.

In contrast to these officially-sanctioned values of gender equality and labor market activation policies, a more critical discussion came up in the reference groups as they talked about the need to recognize cultural differences. Thus, according to the participants in the reference groups, reception in contemporary Sweden is not gender-

and diversity-sensitive. The current reception approach is not able to solve differences between men and women, nor between individual circumstances. Participants expressed a willingness to do more in this area. On the one hand, those active in reception work desire to uphold the normative idea of gender equality, promote labor market activation, and change the way they perceive that many refugee and migrant women live their lives. On the other hand, there is a willingness to be more open-minded, to find ways to talk about cultural differences in various languages, and to find ways to meet the individual needs of particular women or men instead of offering standardized support that is more in line with the officially proclaimed needs of society.

Ambivalences Towards Various Refugee Groups

The third theme encompasses the dilemma of receiving different categories of refugees and migrants and the present changes in the migration policies in Sweden. We will start out with a narrative which frames both of these dilemmas and how they intersect. At the first meeting, a police officer in one of the reference groups described his experiences of receiving refugees in a huge parking lot outside a shopping mall situated close to the Danish/Swedish border in November 2015.

> *There were hundreds of people waiting from all over the world. Buses came to pick them up and take them to municipalities all around Sweden that had prepared housing for them. Before they entered the buses, the caseworkers from the Migration Agency registered their names and nationality. Our job as police officers was to check that no person entered a bus without being registered. The first evening, the lights went out when the shopping mall closed. It was completely dark and I noted that many people never came forward and registered. We had absolutely no idea of who they were or where they went. It was completely out of control and people were desperate. […] I think we have to pay a high price for this today, both in relation to those who we received and are now waiting for residence permit, and those who were never registered at all. From my perspective, of course, Sweden should receive refugees, those who come from war zones in Syria. But we also received all other kinds of migrants and travelers, and many of them entered Sweden without permission and were never registered.*

In this narrative, the police officer frames the complex of different laws and values, and how human rights are challenged by the need for national security (Gibney, 2004). This negotiation has an effect on his everyday professional work, perhaps even more than the other participants in the reference groups, since his function as a police officer is to uphold the law, maintain order, and assure the security of the nation and its citizens. His views on whether Sweden should receive all kinds of people, categorized as "refugees from war zones" in contrast to "all kinds of other migrants and travelers," could be interpreted as representing a welfare-nationalistic position. This position stresses the importance of regulating the influx of refugees and migrants due to a fear of losing control of the national welfare state's resources, capabilities and its task to secure the order and well-being of its citizens (Gibney, 2004; Johansson, 2005; Johansson, 2008).

The narrative also opens up for negotiation over who is a worthy receiver. The police officer suggests that not everybody who arrived at the parking lot was worthy of reception in Sweden. His suggestions frame a current feature in studies about refugees

and migrants, namely, the dilemma of who is a true refugee and who is not. Gibney (2004) describes how the UN Refugee Convention, in combination with the national migration law, regulates the categorization of migrants and divides them into three main categories: asylum seekers, economic migrants, and family migrants. All three categories have different legally legitimate claims for entry into Sweden based on the reason for the migration. A legitimate claim for a refugee and an asylum seeker would be, "Grant me asylum for, if you do not, I will be persecuted or face life-threatening danger" while an economic migrant would claim "Take me, or I and my family shall be condemned to a life of great poverty" (Gibney, 2004, pp. 9-12). In his analysis, Gibney (2004) denies that states have a responsibility for economic migrants. The sociologist Sassen (2016), in contrast, concludes that most refugees of today have "economic claims" and she describes how they are victims of a complex mix of conditions, wars, dead land and expulsions. Her main point is that liberal democracies all over the world have to recognize these refugees and include their claims for asylum among other legitimate claims (Sassen, 2016). When it comes to family migrants, Gibney refers to a double claim. On one hand, the claim is universal, "Take me in because families should be together" and on the other hand particular, "You owe it to me as a citizen to allow my cousin, daughter or spouse to enter" (Gibney, 2004, p. 14). The legitimacy of the claims for asylum is not only crucial for receiving a positive decision about asylum, but also for subsequent reception measures, residency status, and the possibilities for a future residence permit, citizenship, and family reunification (Hedlund, 2016).

The ambivalence among the professionals and volunteers in the reference groups about the assessment of who is a true refugee and who is not led to negotiations about the Swedish society's ability and willingness to receive refugees and migrants and to provide a worthy reception. The changes in Swedish migration policies were also discussed and negotiated. For example, the social worker at the Landing Strip stated, "We have a fantastic and generous reception, but we cannot receive everybody." In contrast, a teacher at the social information courses declared:

> *To me, the restrictive legislation breaks my heart. I'd rather have a crisis situation and work hard under stress and receive everybody than close the borders and have this restrictive legislation.*

The social worker defended the changes in the migration policies while the teacher was critical. In another reference group, the participants shared their perspective on how the changes in legislation in 2016 had a direct impact on their work. An employee at the Red Cross described how friends had quit their jobs at the Migration Agency. They could not stand the changes in the legislation with temporary permits. They felt that human rights were set aside in favor of the security of the nation in a way that did not fit with their values and ethics. She also noticed that there was much less interest among people in general in offering their support or working as volunteers than a year ago. A public service officer at the Public Employment Agency explained:

> *The changes in the law in 2016 have led to changes in the openness among people and those who work with reception. In 2015 the politicians said that "we should open our hearts" and "Wir schaffen das" about the refugees crisis. In 2016 they said the opposite, and the crisis became the crisis of Swedish [and European] welfare institutions and welfare officers instead of a crisis for refugees and migrants. The government wanted to send a signal*

> *internationally and to countries that produce refugees and migrants, telling them that they are not welcome to Sweden. Instead, they have sent an internal signal to the nation of Sweden. I believe that the changes in legislation have had more impact on our willingness to receive refugees and migrants than on the willingness of refugees and migrants to come to Sweden. Now, we are used to not wanting to receive refugees and migrants.*

He gives an example from his own work. He is supposed to create a resettlement plan for those who have received a permit to stay. But since it is a temporary residence permit it is almost impossible to create such a plan. At the same time, to find a job and prove that you can support yourself is vital to obtaining a permanent permit.

The participants in the reference groups working for the Swedish Church and the Red Cross explained that they met more and more desperate former and denied asylum seekers who did not know how to survive. The priest from the Swedish church explained that they took care of and supported these people, or if we use the vocabulary above, these "false" refugees. She did not want to provide details about this support in the reference group since representatives from both the Migration Agency and social services were present. A problem she had encountered and wanted to discuss, though, was that various groups were placed in opposition to each other. She and her colleagues as well as the volunteers from the Red Cross had received much criticism from the surrounding society because of their support for denied asylum seekers. In the critique, various vulnerable groups were juxtaposed. A common idea was, for example, that homeless people and people suffering from mental illness were suffering more now when asylum seekers took most or all of the available resources. The priest concluded that the juxtaposition of disadvantaged groups exposed them to hate and feelings of xenophobia or racism that were difficult to handle.

One of the social workers added that he had met the same kind of argumentation among his colleagues at the social services. They had their own idea of a hierarchy of who was the most vulnerable and who was most in need. He argued that in this evaluation, it was too easy to rely on the idea discussed above, about "true" and "false" refugees and migrants. In short, volunteers and professionals could justify a less ambitious treatment of some groups with the argument that many among the group of refugees and migrants were not worthy of support and social services since they were not "true" refugees. In this way, the insiders and the outsiders of a worthy reception were defined, negotiated and discussed in the different reference groups.

Conclusions

Initially, we framed the reference groups as cultural encounters between representatives of different knowledge-producing groups working under different jurisdictions and conditions. In addition, by referring to the concept of concurrences, our ambition was to emphasize different voices and claims and how they were performed or narrated in relation to and in negotiation with each other. Negotiation became possible within the framework of the research design during the reference group meetings. The design with mixed reference groups made it possible to frame the reception of refugees and migrants as a joint responsibility with shared problems and challenges.

This kind of conversation and exchange of experiences is not taking place in the receiving actors' everyday work within the reception structure. As outlined above, the

Swedish reception of refugees and migrants is not a “system” governed by one general law or regulation, but a complex “reception structure” consisting of different sectors and agencies that act independently of each other and rarely collaborate. They all have an impact on the refugees’ and migrants’ lives, but how they operate and intersect, as well as the joint outcome of their work, is difficult to understand if their agency and professional practices are not analyzed together (Andersson, 2014; Gustafsson, 2015; Zetterqvist Nelson & Hagström, 2016).

The refugee situation in 2015 temporarily changed the “structure” of reception and for a few months during the autumn, collaboration became necessary in order to solve the emergent situation. The receiving actors participating in our reference group meetings told of their personal experiences from both the fall of 2015 and the impact of the subsequent restrictive policy changes in 2016. Different events and procedures were highlighted as examples of how the challenging situation in the fall of 2015 required multisectoral cooperation and new, flexible solutions. One female social worker said with reference to a representative from the Red Cross: “You did a fantastic job. But even different municipal administrations did a fantastic job. Everyone took part and adjusted. Everyone came together.”

One benefit of this research approach is that we can reach a comprehensive narrative of the reception of refugees and migrants in contemporary Sweden, but also highlight issues and challenges that the representatives of different knowledge-producing groups have in common – problems that could be better addressed through cooperation. This does not mean that different actors have the same relation to or solution to these issues. We have, for example, analyzed the difference between the ability and willingness to deal with existential needs, gender and diversity and ambivalences towards what are perceived as “true” and “false” refugees and towards changes in migration policy. The most obvious, but perhaps unsurprising, differences could be seen between those who work for public authorities and those who work for civil society organizations. The former are limited by the ability of their authorities which are regulated and financed in relation to specific mandates and assignments. The latter can work more in accordance with willingness but are limited by their ability in terms of time and resources.

In relation to the first theme, we found that no matter which organization they belonged to, reference group participants agreed on the problem of overlooking refugees’ and migrants’ existential needs. Those working for public authorities believed that it was not their problem to deal with. They claimed that it was foremost an individual responsibility for the refugee or migrant. Those working for civil society organizations were prepared to take on larger responsibility and to act as sounding boards for fellow humans. While the analysis showed that the actors taking part in the reception structure became aware of overlooked existential needs, who is best equipped to address the unmet needs has not yet been resolved. Reception work actors are confronted with the risk that if overlooked needs are not dealt with anywhere in the reception structure, it could lead to severe consequences for the physical and mental health of refugees and migrants, which also has consequences for their long-term resettlement in the new country (Valenta & Berg, 2010). For these reasons, the responsibility for taking care of existential needs must be communicated and undertaken by the receiving actors in a collaborative dialogue with each other and with refugee and migrant groups and individuals that require some kind of existential support (Beresford & Croft, 2004).

When it came to the second theme, negotiated stereotypes on gender, we saw in the analysis that all participants agreed upon the need for recognizing gender differences and especially the situation for women who migrate. There were, however, differences in how the "problem" was perceived and formulated. Those working for public authorities focused on the normative perspective of promoting gender equality through education and working activation for women. Those working in civil society organizations and in close relation to refugees and migrants through their position as grass-root social workers and teachers had a larger engagement in finding ways to promote mutual understanding of cultural differences. They also recognized the need for a gender- and diversity-sensitive reception. One lesson that can be learned is how the reference groups negotiate and formulate the problem of gender and diversity and how to avoid using a stereotypical and othering discourse.

In the third theme about ambivalences towards who are perceived as "worthy", "true" and "false" refugees, the main difference was that civil society organizations helped everyone who came to them regardless of legal status, while public authorities were only allowed to support those who were still asylum seekers or had received a permit to stay. This third theme highlights the impact of legislation and the conditions for those who work and are involved in the reception structure. Migration policy limits a country's ability to receive refugees and migrants, but also affects the willingness among those actors who receive. In times of shifting migration policies, the issue of who is a worthy receiver is negotiated. Hence, an ethical dilemma that affects the everyday work of social workers and other welfare state professional groups was raised and contested in the reference groups. As stated by one participant, the legal changes in Sweden in 2016 towards a European minimum standard sent signals to refugees and migrants not to come to Sweden. He suggested that they also sent internal signals to actors in the reception structure that they should not welcome refugees and migrants. His statement created a dialogue in the reference group about the direct impact of law and regulation on the participants' daily work. The statement and the resulting dialogue demonstrates how the ability to receive refugees and migrants is intertwined or sometimes supported by the willingness of reception actors. This has an impact on how social work responds to the needs of refugees and migrants in different political climates. The division that emerged in the interviews, between who was defined as a "true" refugee and who was not, was shaped by the participants' different knowledge-producing groups and different levels of authority. The division was supported by contemporary restrictive legislation that gives more authority to border controls, security issues, and police forces than to human rights and social work values (Jönsson & Heggem Kojan, 2017; Lundqvist & Mulinari, 2016). Such a focus on social control also affects contemporary debates about migration in Sweden and other European countries. An implication is that social workers need to be more actively involved in debates on migration so that the importance of responding to human suffering and inequality is not lost to the dominant perspective on control and security.

This conclusion about the dominance of control and security over human rights and social work values can also be situated in the wider context of contemporary Europe and Sweden's role in negotiating general standards for the asylum process and for receiving a "fair share" of refugees and migrants between countries in Europe (Gibney, 2015). The changes in Swedish migration policy sent signals to other European countries that a minimum standard was enough instead of higher demands on a "worthy reception." Where this will end we do not know, but lessons are to be learned from

listening to the different voices and claims among those involved in the reception structure.

References

Ahmadi, N. (1998/2003). *Ungdom, kulturmöten och identitet*. Stockholm. [Youth, cultural encounters and identity]. Liber och SiS.

Akman, H. (Ed.). (2014). *Negotiating identity in Scandinavia: Women, migration, and the diaspora*. New York: Berghahn Books.

Andersson, H. E., Ascher, H., Björnberg, U., & Eastmond, M. (2010). *Mellan det förflutna och framtiden: Asylsökande barns välfärd, hälsa och välbefinnande .* [Between the past and the future: Asylum seeking children's welfare, health and well-being]. Göteborg: Centrum för Europaforskning.

Andersson, R. (2014). *Illegality, inc.: Clandestine migration and the business of bordering Europe.* Berkeley: University of California Press.

Beresford, P., & Croft, S. (2004). Service users and practioners reunited: The key component for social work reform. *British Journal of Social Work, 34*(1), 53-64. doi: https://doi.org/10.1093/bjsw/bch005

Brekke, J. P (2004). *While we are waiting: Uncertainty and empowerment among asylum- seekers in Sweden* (Report No. 2004:10). Institute for Social Research. Oslo. Retrieved from https://brage.bibsys.no/xmlui/bitstream/handle/11250/2440626/R_2004_10.pdf?sequence=3

Brydon, D., Forsgren, P., & Fur, G. (Eds). (2017). *Concurrent imaginaries, postcolonial worlds. Towards revised histories*. Amsterdam: Brill.

Bunar, N. (Ed.). (2015). *Nyanlända och lärande - mottagande och inkludering* [*Newly arrived and education – reception and inclusion*]. Stockholm: Natur & Kultur.

Castles, S., & Miller, M., J. (2011). *The age of migration. International population movements in the modern world*. Basingstoke: Palgrave.

Eliassi, B. (2015). Constructing cultural otherness within the Swedish welfare state: The case of social workers in Sweden. *Qualitative Social Work, 14*(4), 554-571. doi: https://doi.org/10.1177/1473325014559091

Esping-Andersen, G. (1990).*The three worlds of welfare capitalism*. Cambridge: Polity Press.

Europeiska Unionen. (2010). Europeiska Rådet[The European Council] 2010/C 115/01.

Europeiska Unionen. (2013). Mottagandedirektiv [The directive for reception] 2013/33/EU.

Fur, G. (2017). Concurrences as a methodology for discerning concurrent histories. In D. Brydon, P. Forsgren, & G. Fur (Eds.), *Concurrent imaginaries, postcolonial worlds: Towards revised histories* (pp. 33-58). Amsterdam: Brill. doi: https://doi.org/10.1163/9789004347601_003

Gibney, M. J. (2004). *The ethics and politics of asylum: Liberal democracy and the response to refugees.* Cambridge: Cambridge University Press. doi: https://doi.org/10.1017/CBO9780511490248

Gibney, M. J. (2015). Refugees and justice between the states. *European Journal of Political Theory, 14*(4), 448-463. doi: https://doi.org/10.1177/1474885115585325

Gustafsson, K. (2015). The reception of separated minors in Sweden: To receive with grace and knowledge. In E. Heikkilä, A. Kostiainen, J. Leinonen, & I. Söderling, I. (Eds.), *Participation, integration and recognition: Changing pathways to immigrant incorporation* (pp. 111-124). Turku: Institute of Migration.

Gustafsson, K., Fioretos, I., & Norström, E. (2012). Between empowerment and powerlessness: Separated minors in Sweden. *New Directions in Child and Adolescence Development, 2012*(136), 65-77. doi: https://doi.org/10.1002/cad.20011

Hall, S. (1997). *Representation: Cultural representations and signifying practices*. London: Sage Publications.

Hastrup, K. (2010). *Kultur. Den flexibla gemenskapen* [Culture: The flexible community]. Lund: Studentlitteratur.

Hedlund, D. (2016). *Drawing the limits: Unaccompanied minors in Swedish asylum policy and procedure.* Stockholm: Stockholm University Department of Child and Youth Studies.

Hessle, S. (1988). *Familjer i sönderfall: En rapport från samhällsvården* [Families and disintegration: A report from the social services]. Göteborg: Norstedts.

International Federation of Social Workers [IFSW]. (2012/2004). Statement of ethical principles, International Federation of Social Workers. Retrieved from http://ifsw.org/policies/statement-of-ethical-principles/

Johansson, C. (2005). *Välkomna till Sverige? Svenska migrationspolitiska diskurser under 1900-talets andra hälft* [*Welcome to Sweden? Swedish migration policy discourses during the second half of the 20th century*]. Malmö: Bokbox förlag.

Johansson, J. (2008). *"Så gör vi inte här i Sverige. Vi brukar göra så här." Retorik och praktik i LO:s invandrarpolitik 1945-1981* (Doctoral dissertation). [We do not do it like this in Sweden. We do like this: Rhetoric and practice in LO's immigration policy 1945-1981]. Växjö: Växjö University Press.

Jönsson, J. H., & Heggem Kojan, B. (2017). Social justice beyond neoliberal welfare nationalism. Challenges of increased immigration to Sweden and Norway. *Critical and Radical Social Work. An International Journal, 5*(3), 301-317. doi: https://doi.org/10.1332/204986017X15029696492785

Larsen, B. R. (2011). Becoming part of welfare Scandinavia: Integration through the spatial dispersal of newly arrived refugees in Denmark. *Journal of Ethnic and Migration Studies, 37*(2), 333-350. doi: https://doi.org/10.1080/1369183X.2011.521337

Lundqvist, Å., & Mulinari, D. (2016). Introduktion [Introduction]. *Socialvetenskaplig Tidskrift*, *23*(3-4), 187-191.

Länsstyrelsen. (2017). Tidiga insatser för asylsökande [Early interventions for asylum seekers]. Retrieved from http://extra.lansstyrelsen.se/integration/Sv/tidiga-insatser-asylsokande/Sidor/default.aspx

Migrationsverket. (2017). Översikter och statistik från tidigare år [Overview and time series]. Retrieved from https://www.migrationsverket.se/Om-Migrationsverket/Statistik/Oversikter-och-statistik-fran-tidigare-ar.html

Montesino, N., & Righard, E. (Eds). (2015). *Socialt arbete och migration* [*Social work and migration*]. Malmö: Gleerups.

Nilsson Folke, J. (2017). *Lived transitions: Experiences of learning and inclusion among newly arrived students.* Stockholms Universitet: Samhällsvetenskapliga fakulteten, Barn- och ungdomsvetenskapliga institutionen.

Ottosson, L., & Lundberg, A. (2013). 'People out of place'? Advocates' negotiations on children's participation in the asylum application process in Sweden. *International Journal of Law, Policy and the Family, 27*(2), 266-287. doi: https://doi.org/10.1093/lawfam/ebt003

Pripp, O. (2005). Den segregerande välviljan: Kultur som makt [*The segregating goodwill: Culture as power*].. In: M. Öhlander (Ed.), *Bruket av kultur: Hur kultur används och görs socialt verksamt* (pp. 73-98). Lund: Studentlitteratur.

Regeringens skrivelse. (2016). Verksamheten i Europeiska unionen under 2016 [Operations in the European Union in 2016, Skr. 2016/17:115]. Retrieved from https://www.regeringen.se/494698/contentassets/fd2216a175884446b203965e1dd45afd/verksamheten-i-europeiska-unionen-under-2016-skr.-201617115

Rytter, M. (2013). *Family upheaval: Generation, mobility and relatedness among Pakistani migrants in Denmark*. Copenhagen: Berghahn Books.

Sainsbury, D. (2012). *Welfare states and immigrant rights: The politics of inclusion and exclusion.* Oxford: Oxford University Press. doi: https://doi.org/10.1093/acprof:oso/9780199654772.001.0001

Safipour, J., Hadziabdic E., Hultsjö, S., & Bachrach-Lindström, M. (2017). Measuring nursing students' cultural awareness: A cross-sectional study among three universities in southern Sweden. *Journal of Nursing Education and Practice*, *7*(1), 107-113. doi: https://doi.org/10.5430/jnep.v7n1p107

Sassen, S. (2016). A massive loss of habitat: New drivers for migration. *Sociology of Development, 2*(2), 204-233. doi: https://doi.org/10.1525/sod.2016.2.2.204

Schierenbeck, I. (2003). *Bakom välfärdsstatens dörrar* [Behind the welfare state's doors]. Umeå: Borea.

SFS 1994:137. Lag om mottagande av asylsökande m.fl [Act on reception of asylum seekers et al.].

SFS 2001:453 Socialtjänstlagen [Act on social services].

SFS 2010:197. Lag om etableringsinsatser för vissa nyanlända invandrare [Act on resettlement activities for some newly arrived immigrants].

SFS 2016:38. Lag om mottagande av vissa nyanlända invandrare för bosättning [Act on reception of some newly arrived immigrants for residence].

SFS 2016:752. Lag om tillfälliga begränsningar av möjligheten att få uppehållstillstånd i Sverige [Act on temporary restrictions on the possibility of obtaining a residence permit in Sweden].

SOU 2006:37. *Om välfärdens gränser och det villkorade medborgarskapet*. [On the limits of the welfare and conditional citizenship]. Stockholm: Fritzes offentliga publikationer.

SOU 2012:9. *Förmån eller fälla: Nyanländas uttag av föräldrapenning*. [Benefit or Failure: Newly arriver's withdrawal of parental allowance]. Stockholm: Fritzes offentliga publikationer.

SOU 2017:12. *Att ta emot människor på flykt. Sverige hösten 2015* [To receive people on flight. Sweden autumn 2015]. Stockholm: Fritzes offentliga publikationer.

Soydan, H. (1995). *Försäkringskassan och invandrarna* [The social insurance agency and immigrants]. Malmö: Bokbox Förlag.

Svensson, M. (2013). Betwixt and between: Hope and the meaning of school for asylum-seeking children in Sweden. *Nordic Journal of Migration Research*, *3*(3), 162-170. doi: https://doi.org/10.2478/njmr-2013-0007

Svensson, M. (2017). *Hoppet om en framtidsplats. Asylsökande barn i den svenska skolan* [Hoping for a future home. Asylum-seeking children attending Swedish school, no. 402]. Göteborg: Gothenburg Studies in Educational Sciences.

Turunen, J., & Weinryb, N. (2017). Volontärer i välfärdsstaten – socialt arbete med transitflyktingar som politisk handling [Volunteers in the welfare state - Social work with trans-refugees as political action]. In S. Linde & R. Scaramuzzino (Eds.), *Socialt arbete i civilsamhället – Aktörer, former och funktioner* [Social work in civil society: Actors, shapes and functions] (pp. 175-200). Lund: Studentlitteratur.

Valenta, M., & Berg, B. (2010). User involvement and empowerment among asylum seekers in Norwegian reception centres. *European Journal of Social Work*, *13*(4), 483-501. doi: https://doi.org/10.1080/13691451003603406

Zetterqvist Nelson, K., & Hagström, M. (2016). *Nyanlända barn och den svenska mottagningsstrukturen. Röster om hösten 2015 och en* kunskapsöversikt [New arrivals and Swedish reception structure. Voices on autumn 2015 and a research overview]. Stockholm: FORTE (Forskningsrådet för hälsa, arbetsliv och välfärd).

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Seeking Refuge: An Exploration of Unaccompanied Minors and Women from Somalia and Pakistan Experiences of Services in Bangkok, Thailand

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Abstract: *The number of unprotected urban refugees in Bangkok has grown over the past few years with new migrations of young women, men and families from Somalia and Pakistan. An urban environment can mean opportunity for some but for many the environment can increase vulnerability to exploitation and detention. This study aimed to explore refugees' experiences in Bangkok, assess agencies' service delivery models, and strengthen their capabilities to address service gaps. Participants were recruited using purposeful sampling and snowball. Using CBPR, focus groups discussion with Somali and Pakistani refugees (n=63) and individual interviews (n=42) were conducted. Agencies' staff (n=23) were interviewed regarding challenges in providing services to refugees. Qualitative data analysis revealed four major themes: lack of basic need, problems with legal services, agencies revealed urgent need for shifting from emergency services towards long-term strategies given the protracted immigration status of urban refugees, and the need for a collaborative approach in service provision emerged as an urgent call. Implications to social work practice with urban refugees focusing on potentials for innovative service provision and collective agency responses are discussed.*

Keywords*: Refugees; urban refugees; asylum-seekers; refugee services; community-based research; partnerships*

While Bangkok has always been a well-known destination for refugees and asylum-seekers, something is different today. Over the past few years, Bangkok has experienced new waves of migration including women, children, and families from Somalia and Pakistan. With over 9,000 new refugees and asylum-seekers coming into the city from 1996 to 2015 the new migration phenomenon is challenging current resources and knowledge, putting into question the relevance of existing service delivery models and organizational policies (UN High Commissioner for Refugees [UNHCR], 2015b).

While an urban environment can mean opportunity for some, for many more this urban environment can increase vulnerability to being exploited, arrested, or detained (UNHCR, 2017b). Thailand is unique. The nation has not signed onto the 1951 UN Refugee Convention and does not have a legal framework in place to support asylum-seekers and

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refugees. With the emergence of the Syrian refugee crisis, and already scarce resources, crucial attention has been diverted away from Bangkok, even as the numbers of unprotected urban refugees has grown (Potter, 2014).

The Context: Seeking Refuge and Finding Fear

The United Nation's Convention Relating to the Status of Refugees, adopted in 1951, lays the foundation for international human rights relating to refugees and asylum-seekers. The Convention offers the widely accepted definition for the term "refugee" and creates the framework for states to recognize rights to protect refugees. Article 1(A)(2) of the 1951 Convention defines a refugee as a person who, "as a result of events occurring before 1 January 1951 and owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (UN, 2011, p. 16). Oftentimes, when there is an influx of migrants fleeing into a country, it is impossible to process every individual for formal refugee status. In these circumstances, people may be referred to as an asylum-seeker, or "someone whose request for sanctuary has yet to be processed" (UNHCR, 2017a).

Globally speaking, the UNHCR serves as the guardian for the 1951 Refugee Convention (UNHCR, 2011). This convention is an instrument for States to develop their legal framework and stemming from the UN Declaration of Human Rights, has a foundation in non-discrimination, non-penalization, and non-refoulement (UNHCR, 2011). Specifically, the Convention sets standards that give refugees access to education, work, and courts (UNHCR, 2011). Unfortunately, Thailand is not one of the states who has signed onto the 1951 Convention, leaving many asylum-seekers who have fled to this country in an extremely vulnerable situation (UNHCR, 2015b). The 145 nations that have signed onto the convention have made a commitment to significantly increase protections and overall well-being for refugees who flee to their homeland. Without signing onto the 1951 Convention and without a legal framework for handling refugees and asylum-seekers, Thailand is left with few options for handling an estimated 130,000 individuals who are asylum-seekers and refugees (UNHCR, 2016; Universal Periodic Review [UPR], 2015).

Moreover, according to UNHCR, by 2009 more than half of the world's refugees resided in cities and towns, compared to one third who live in camps. In recognition of the changes in the size and composition of the urban refugee population, as well as the protection risks facing these refugees, UNHCR released a comprehensively revised policy on refugees in urban areas in 2009. The policy has two principal objectives: (1) to ensure that cities are recognized as legitimate places for refugees to reside and exercise the rights to which they are entitled; and, (2) to maximize the protection space available to urban refugees and the humanitarian organizations that support them (UNHCR, 2009). This approach is a significant departure from the previous policy of giving primary attention to refugees in camps, and an acknowledgement that movement to urban areas can be a

legitimate response to lack of access to livelihoods, education, and even physical and material security in some camps" (UNHCR, 2009).

While Thailand has not signed onto the Convention, the state is bound to international human rights standards, which include basic human rights along with a non-refoulement policy that dissuades a state from sending asylum-seekers back to the country from which they have fled. This has created an anomalous life experience in Thai refugee camps and urban settings. The refugee camps are an organized response to asylum-seekers; however they are deeply confining. Thailand has responded to the influx of asylum-seekers in the creation and management of nine refugee camps along the Thai-Burma (Myanmar) border. These camps house approximately 106,321 refugees from Burma (Myanmar), with a large portion of assistance coming from non-governmental organizations such as Jesuit Refugee Services (JRS) and the International Rescue Committee (IRC) (UNHCR, 2016). While the camps meet basic needs (albeit in a volatile manner), without legal rights in the country, a refugee living in a camp is restricted in their ability to come and go from the camp as they please.

Camps have been the most formalized response to asylum-seekers in Thailand, but a legal framework and response is lacking for the urban asylum-seekers and refugees arriving from nations other than Burma (Myanmar) (UNHCR, 2016; UPR, 2015). This urban population of Bangkok's refugees is changing with the emergence of Pakistani and Somali refugees in the past few year. These new populations have presented unique challenges for the agencies that serve urban refugees and are the focus of our article. Individuals seeking refuge arrive in Bangkok and initially link to services through informal networks and word-of-mouth referrals through peers. While a dense urban population makes the word-of-mouth referrals possible, this is not a sustainable or consistent mechanism for linking refugees to resources.

While struggling to obtain basic needs, individuals are simultaneously working with UNHCR to register, secure an interview, and receive determination on their migration status. While lack of a legal framework leads to a shaky foundation for these individuals seeking refuge, UNHCR continues to process these applications, perhaps in hopes that a refugee status determination will lead to increased access to resources, resettlement, or the adoption of a legal framework that will open up opportunities. With continued conflict in their countries of origin, repatriation is not an option for these individuals. At this point, however, refugee status determination simply leads to the very slim chance at resettlement. The initial interview and determination process takes time and while experience and expertise is high within UNHCR, with constrained resources towards refugee services, capacity to process asylum-seekers and refugee determination is limited. In Bangkok, individuals seeking refuge are currently waiting an average of 4 years before their refugee status claims are heard (UPR, 2015). During the course of the study, UNHCR increased the number of staff processing claims and progress was being made on the backlog of cases.

Due to the lack of national legal framework for integrating asylum-seekers and refugees, in conjunction with the lengthy wait time to begin the UNHCR determination process, asylum-seekers and refugees are vulnerable to many human rights violations. Without legal status, they are at risk for arbitrary arrest, detention, and exploitation. The

UPR (2015), a tool used by UN states to assess human rights, lists the top five human rights concerns in Thailand as arbitrary detention, lack of basic needs (e.g., shelter, food), education, refoulement, and healthcare. Lack of legal status puts asylum-seekers at risk of being stopped and arrested anywhere in Thailand, including in their homes but the dense population in Bangkok makes the risk of detention even higher. As people travel to and from their homes, via bus, long walks, or taxi, their risks for arrest increase.

Being arrested is a traumatic experience, leading to detention and division of families. The Bangkok detention center has received negative international attention for keeping people in foul, confined conditions (Global Detention Project, 2017). Many refugees and asylum-seekers fear leaving their home with the looming threat of detention at their doorstep. As a result, the unique urban context of Bangkok, Thailand has led to an isolating and dangerous life for urban asylum-seekers and refugees.

Bangkok Urban Asylum: The Journey to Limbo

Somali and Pakistani asylum-seekers are fleeing complicated and traumatic environments. Asylum-seekers from Somalia are fleeing decades-long civil war and sexual and gender-based violence (SGBV) (Pickering, 2011). In Bangkok, the majority of the asylum-seekers from Somalia tend to be women and men in their early 20's, many who arrived in Bangkok as unaccompanied minors and single mothers. The Pakistani community in Bangkok is made up of Christians and Hammadi Muslims fleeing religious persecution. They fled as families and are living together in Bangkok.

The journey to Thailand across the Somalis and Pakistanis varies; some are smuggled, others arrive by boat, travel by bus from Malaysia, all to seek refuge in the Thai capital, Bangkok. Consistent with the interviews in this study, Pickering (2011) describes the specific terror that many women face as they travel towards asylum. The violence towards women does not end after crossing state borders but continues along the journey. Upon arriving in crowded international bus terminals in Bangkok, some seem confused on where they are, having paid for travel to a transition country as asylum-seekers and then abandoned in Bangkok (Potter, 2014). Service providers have expressed concerns over increased risk of abuse of asylum-seekers because of misinformation regarding the migration process (UNHCR, 2015b).

The lack of formal infrastructure or response has led to significant misinformation, which may exacerbate migration to cities such as Thailand, without the resources to support the influx. Families move or push their children towards a perceived better life, but that is not the case for the Somalis and Pakistanis in Bangkok (Oppedal & Idsoe, 2015; Vervliet, Vanobbergen, Broekaert, & Derluyn, 2014). The realities of surviving in Bangkok lies in stark contrast to their hopes of a new life (Jesuit Refugee Services, 2015). Thailand does not have a formal asylum framework and receiving official refugee status is a long process with no assurances (UNHCR, 2015b). While people wait for a chance at refugee determination and the small chance of resettlement, there is the present-day reality in limbo. In countries without effective protection measures, such as Thailand, asylum-seekers are more susceptible to experience abuse from employers (Migration Policy Institute, 2015). As a result, many are unemployed or in illegal employment and risky

circumstances. Additionally, with no documentation or work papers, Bangkok's refugee community remains vulnerable to arrest and myriad forms of exploitation and abuse (Migration Policy Institute, 2015; UNHCR, 2015a). Without a job, within weeks, Somali and Pakistani refugees find their savings depleted, languishing in a small apartment with little food, let alone hope for employment (Steele, 2014).

An asylum seeker's journey is often leaden with trauma. Studies have uncovered the trauma that women with refugee status have witnessed or experienced in their journeys away from violence, although additional research is needed to continually assess the unique needs of women in Bangkok and develop culturally relevant treatment approaches (Holt, 2013; Robertson et al., 2006; Schmidt, Kravic, & Ehlert, 2008). Women may be survivors of rape, sexual and other forms of gender based violence (SGBV), or domestic violence and may not be initially equipped to cope with trauma (Jesuit Refugee Services, 2015).

Methods

In response to the drastic shift in the needs of asylum-seekers in Bangkok, Jesuit Refugee Services (JRS) in Thailand collaborated with faculty and students from the University of Utah, College of Social Work in the implementation of a community-based participatory research (CBPR) project. The focus was on the evaluation and improvement of the current service delivery model and examining the potential of a collective agency response to address challenges and gaps. The research team consists of staff from a local NGO, faculty, and students from the College of Social Work. Researchers conducted 42 interviews with 63 individuals representing refugee and asylum-seekers from Somalia and Pakistan The team began this project with two aims in mind:

(1) Exploring the experiences of Somalis and Pakistanis residing in Bangkok as urban refugees and/or asylum-seekers to assess and better understand formal and informal networks for accessing services, as well as gaps and challenges for obtaining services.
(2) Strengthening partners' capacity by providing trainings on case management and community practice based on local demands.

Jesuit Refugee Services and the University of Utah, College of Social Work have partnered on a variety of projects, including *Bridging Borders,* a community-university partnership with camp and migrant communities along the Thai/Burma (Myanmar) border since 2012. Both university and community partners expect the partnership to continue and evolve as a long-term applied research, teaching and practice collaborative with the aim of investigating and responding to refugee issues in urban settings in the Asia Pacific region.

Within a community-based participatory research (CBPR) framework, NGO partners identified the following goals for the research: a) to assess and better understand challenges accessing services; and b) to develop JRS's capacity to address service gaps. The long-term aim was to gather information that will increase case managers' understanding of diversity in the community and inform development of innovative treatment and practice aimed at working with asylum-seekers' strengths and needs.

Working to change the pervasive narrative of *refugees as needy* and *refugees as consumers of services* to *refugees as strong and co-creators of services*, a community development and asset-based approach were utilized in the development, implementation, and thematic analysis of the data. According to Community Development Exchange, "A community development approach's key purpose is to build communities based on justice, equality and mutual respect. Community development involves changing the relationships between ordinary people and people in positions of power, so that everyone can take part in the issues that affect their lives. It starts from the principle that within any community there is a wealth of knowledge and experience which, if used in creative ways, can be channeled into collective action to achieve the communities' desired goals" (2008).

Community Based Participatory Research (CBPR) is another way of collaborating with communities to explore and better understand social phenomena communities are experiencing. CBPR is a process of learning and knowing based on communities' own terms (Minkler & Wallerson, 2003; Strand, 2000). Communities identify, describe, assess and plan ways of addressing social issues of concern with research experts engaging as partners or collaborators (Anderson, 2006; Strand, 2000). One of the unique characteristics of CBPR as a methodology and method is that CBPR is based on the premise that communities' ways of knowing are central and equally legitimate as any other centered knowledge, in research and that CBPR is action oriented towards social transformation (Strand, 2000). Communities take charge of their own affairs in terms of design, implementation and follow-up, which ensures sustainability, together with mutual and equally shared partnerships with external partners. The goal of such an interpretive research was to better understand a phenomena for the researchers and those impacted by the social phenomenon so that both of them can explore alternatives or other possibilities (Yanow, 2000). Social work practice being inherently pedagogical (Freire, 1990), using CBPR and field observation to explore immigrants experiences in Bangkok was central as a co-learning process and building relationships during the study period. Utilizing these paradigms, the research team made up of lead individuals from JRS and the CSW co-developed the research topics and questions, research methods, and identified key community, agency, and community based organization stakeholders to be interviewed. The following sections include the interview, study participants and emerging themes from the study followed by discussion and future plans.

The Interviews

In order to develop a comprehensive service delivery and advocacy response supporting urban refugees and asylum-seekers from Somalia and Pakistan, interview guides gathered information on: the experiences in accessing services and the challenges of newly arriving communities to better understand existing gaps in services and inform practice.

As summarized in Table 1, 42 interviews were conducted with 23 NGOs and CBO's staff who served and advocated for the refugee communities, and with 63 refugees and asylum-seekers from Somalia and Pakistan. The research team included faculty (4), students (2) and community partners (2) who conducted the interviews. Through a purposeful sampling technique, service providing agencies identified refugees and asylum-

seekers and recruited those who were willing to participate in the study. A snowball method also occurred, sometimes with interviewees mentioning another person to interview and sometimes the translator. All of the interviews happened in the interviewees' apartments or a neighbor's apartment. Conversations with staff from JRS, other agencies and community based organizations happened at their respective places of work. Participants from agencies and CBOs were mainly staff selected randomly.

Table 1. *Number of Participants and Interviews*

Participants	**# of interviews**	**# of people interviewed**
Agency Staff	9	17
Community Based Organizations	4	6
Somali Community Members	21	23 (16 ♀, 7 ♂)
Pakistani Community Members	9	17 (13 ♀, 4 ♂)
Total	**42**	**63**

Jesuit Resettlement Services (JRS) provided Somali and Pakistani translators for the relevant interviews. The translators received training by College of Social Work (CSW) researcher team. The research team also included members with refugee and/or asylum seeking backgrounds now residing in the United States. For example, one researcher, a US citizen originally resettled from Somalia and was extremely valuable to the team in developing trust with the Somali community in Bangkok, as well as providing other team members with cultural context. It is important to mention that the interviews were conducted the week following a raid in the communities where some of the interviews took place. JRS and interviewees reported that between 40-65 asylum seekers and refugees were arrested including 25 children.

The partnership relied heavily on community-based interpreters of refugee background, not only to translate interviews but also serving as guides in the community, community liaisons, and connecting with potential participants. The research team came to develop important professional relationships with the translators, filled with trust and deep respect. The interviews took place in neighborhoods across Bangkok where the Somalis and Pakistanis were living, and at agencies' offices. An IRB application was approved by the University of Utah. It is important to note that the research team made explicit decision not to ask interviewees about the reasons for immigrating to Bangkok from Somalia and Pakistan, nor about their migration stories. This was to avoid re-traumatizing the individual, as well as to move away from the dominant, and disempowering, approaches to refugee narrative that focus mostly on trauma stories. However, participants shared their stories, which could be due to power differentials, or the possibility that comes with telling one's story, or simply the familiarity that comes with sharing one's life story with interviewers. The research team embraced the stories as potentially therapeutic and a natural opportunity of listening to support healing. Collected information was transcribed, reread and discussed by team members. Together with partners' contributions, shared identification of major themes revealed recurring events and experiences participants reiterated during the interview. The results section details what emerged from the conversations.

Results

With the exception of one female, Somali interviewee, individuals reported leaving Somalia when they were between the ages of 13 and 16, with age 15 as the most common. 68% interviewed had been in Bangkok since 2014 (2 years at the time of the research), 21% after 2014 (less than 2 years), and 11% before 2014 (more than 2 years). The next section presents three major themes from the findings of this study, (1) Services and support in Bangkok, (2) Legal services and (3) Shifting towards a collective response. Examples of each theme can be found in Table 2.

Themes

Table 2. *Major Themes*

Themes	Examples
Basic needs and referrals	"I went Agency 1, but they send me back to Agency 2. When I go to Agency 2 then they send me back again to Agency 1."
Legal services	"Agencies collaborate but refugees don't know"
Shifting to a collective response	"Scattered resource locations won't work"

Basic Needs and Referrals

While agencies who provide services to urban refugees provide information about their services, study participants shared that there is a lack of information regarding what services exist for asylum-seekers, how to access these services, and an understanding of how the systems work in Bangkok. UNHCR provides a booklet with information about all the NGOS and their services to individuals who visit their offices. Nevertheless, individuals who participated in the interviews indicated that the primary way to contact service providing agencies (Community-Based Organizations [CBOs], Faith-Based Institutions [FBIs] and Non-Governmental Organizations [NGOs] is through word of mouth from their respective communities, informal connections with other communities, and referral to these agencies. Many study participants shared a similar story of being lost and isolated when arriving in Bangkok, often not knowing where they were or who and how to connect to resources in the community. Resources are scattered around the city and transportation into the heart of the city felt like navigating a maze. A female, 17 years old participant recounts his arrival to Bangkok:

> *So the thing is, when I first arrived here, I took a cab to drive me to the town but I had no clue where to go or if there were some Somali people around this area, so I was taking the cab and I've been in the cab for a long time, but when I was passing here I have seen 2 Somali passing by and I recognized their face and their color and I told the cab driver to just stop and leave me. I get off the taxi and I talk to the guys and they ask me, 'Are you Somali too?' I said, 'Yes.' Then the 2 Somali men took me to where 3 Somali men were living in a room and they told them about my situation that I just got off the taxi and I don't know any person here so they told them that I should at least stay with them for a while until I know places.*

Representatives of participating agencies indicated that the process to gaining access to services ideally starts with the UNHCR. This process includes registration with the UNHCR to gain refugee status in Thailand based on the credibility of each case. When UNHCR legally validates asylum-seekers' cases for refugee status, they get a card from UNHCR implying that they have status as a refugee but not legal status in Thailand. Additionally, not all asylum-seekers obtain the UNHCR card because they do not meet the criteria or because of the prolonged waiting period to meet with UNHCR since arrival in Bangkok.

According to participants, the UNHCR's card facilitates access to services, but does not protect them from Thai immigration officers' random detentions. The acknowledgement of status from UNHCR allows asylum-seekers to follow-up on referrals to services provided by CBOs, FBIs and NGOs in Bangkok. The types of services CBOs, FBIs, and NGOs provide are primarily basic human needs including food, healthcare, education, and housing. The services vary in terms of quality and permanency. Asylum-seekers noted that they get confused regarding who is providing what type of services and for how long. The agencies keep on referring them from one agency to another. They may also roam around based on word-of-mouth and lose hope and trust in the agencies. Given the lack of a national legal framework, the access to referrals can be random and happenstance. Individuals resettle themselves around the city and find UNHCR, Asylum Access Thailand (AAT), or other international NGOs rather haphazardly.

> *When I was first registering at the UNHCR, I've been told that there are some organizations that help the people and later on I also ask the Somali people to show me those places that I can ask help from.*

In addition to the location of organizations being scattered around the city, the provision of services was assorted. For example, some CBOs, FBIs and NGOs focus on provision of food, while others provide health care services, education, or shelter. Some agencies provide two or more types of services. FBIs, for instance, focus on providing food, more often than not based on those who register with them and attend church services and activities. Other well-established churches provide services to all asylum-seekers, asylees and refugees in Bangkok regardless of their membership in that specific church. For example, Calvary church conducts home visits to protect recipients from the risk of random detention in the streets. However, as time goes by and asylum-seekers do not hear from the UNHCR, they start losing hope. As one female participant shared,

> *We are here for long time and we still don't know really that we have the results, if they are going to reject us, if they are going to refuse us, or what they are going to do, we don't know. Every day is a different day and we don't know each day what is going to be happening.*

While there are several NGOs providing a variety of services, in our interviews, we found that there are three well-known agencies that seem to be focal points for providing for meeting basic human needs: JRS, Bangkok Refugee Center, and Yateem TV. JRS is an international Catholic non-profit organization established to serve and advocate for refugees and internally displaced populations worldwide. The organization has regional offices around the world, including South Asia. In Thailand, JRS typically provides

psychosocial counseling, financial assistance, and material resources for asylum-seekers. JRS provides basic services to newly arriving asylum-seekers for six months based on AAT referrals for psychosocial counseling and will then refer out for medical services. According to one of the representatives, the support is short-term due to lack of funding. In addition to short-term monetary support, JRS also provides training for parents and children, including English and Thai language courses, mainly to train people in skills that would serve them locally and when resettled in a third country. JRS also refers asylum-seekers and refugees to the Bangkok Refugee Center (BRC), an arm of UNHCR, for services they do not provide.

Bangkok Refugee Center (BRC) is the branch of UNHCR that provides on-the-ground assistance, including medical screening for newly arriving asylum-seekers. The BRC is located in a residential area of Bangkok and receives walk-ins, unlike the UNHCR office, which is closed to the public, requires an appointment, and includes extensive security clearance for entry. BRC, on the hand, is a setting where individuals can attend classes, receive assessments for other services, referrals to other agencies, and additional social services. BRC has a bridge school at the center where refugees' children learn Thai for six months to help them transfer to Thai public schools. This center also provides health services even though, according to representatives of the agencies, access to medical treatment is not guaranteed for asylum-seekers and refugees. The BRC and JRS are two agencies that provide resources and services to the urban asylum-seekers. One agency, Yateem TV, is unique, in that they are focused on providing actual housing for the urban asylum-seekers in addition to a variety of services.

Yateem TV is a Bangkok NGO led and run by a local Muslim addressed as Sheikh. The agency provides varied services not only to asylum-seekers but also to the poor and low income in Bangkok. Local Thai businessmen, leaders of the Muslim community appointed by the King, and the Thai Muslim Center support Yateem TV. At the center, there are faith-based services, large spaces for gathering, and space whereby volunteers cook food for anyone who cannot afford to feed him or herself in the city. Participants admitted that Yateem TV is a welcoming space for urban refugees and asylum seekers in Bangkok. Furthermore, the agency gives adults financial incentives to learn English and pays for school transportation for youth. Given the dispersed population of asylum-seekers and resources, access to transportation is of vital importance. Yateem TV is well-known for providing asylum-seekers and refugees with free of charge apartments and/or paying for their rent. According to Yateem TV representatives, bringing together asylum-seekers and refugees across various communities has been key to the communities' ability to support each other. Still, as important and accessible as this organization is for the Somali community, during our interviews we found some young women who did not know of Yateem and described a sense of fear about going outside of their apartment buildings, as there was no place for a Somali woman to hide from police and avoid the risk of detention. As a 16 years old female Somali participant shared,

> *I've been staying in the room without going to the UNHCR and registering myself in the UNHCR 14 days because I was afraid if I go out I will be arrested. But you know, I couldn't just keep myself in the room and I went out one day and I registered in the UNHCR but after a while, I, as I went to the BCP office and*

> *registered in that office as a minor an unaccompanied minor, I went to back to my home and when I arrived at my home, I entered the room, a knock at the door. I didn't know them, they just entered the room and we were captured and we have been taken to the IDC, to the prison.*

Asylum-seekers who migrated from Africa in particular, their skin color exposes them to racist attitudes they have to endure every day of their lives, and that would also make them easy targets of immigration officers who roam around their neighborhoods. Moreover, as service users, they have to take public transportation or a taxi to visit these agencies for services. The drive can take two hours to get to the agencies depending on the traffic. The financial resources they need to take a taxi or public transportation, and the long hours drive to go back and forth to visit the agencies, not to mention during emergency, puts them at great risk of being questioned and detained. Yet they have no other choice but to take the risk. When meeting with a family of four from Pakistan, the father said,

> *There is one church….. There is one Indian lady and she got care from the church. They are providing food for the people. Nobody help for the rent, only JRS they do help. JRS also have limited sources, they will help you in emergency cases. ... I have a son and he is not normal and he is not taking a normal food as well. What I have to give to him is always I have to spend money. He have a very heavy medicine and if I don't choose the milk, if I give him the medicine without milk, then he have starting to have motions, and we have to buy the pampers for him. There is not any organization that is helping to us that we can live here easily. Especially, the people like me, who have children for special needs or have some medical issues, it is really difficult for these type of people to stay here.*

In addition to security issues, nothing seems to be enough and/or there is no one to fill in the gaps when lack of basic needs is the main issue.

Legal Services

UNHCR and Asylum Access Thailand (AAT) are the primary agencies that provide legal services for urban refugees and asylum-seekers in Bangkok. IDC issues. In addition to processing status applications, UNHCR works with the government on system level issues and with the local Thai police. Their role is to educate local police about what the UNHCR card means and provide a context for migration and the people seeking refuge in Bangkok. In this way, UNHCR strives to assist the police with considering the priorities around crime in the city and to deter them from arresting people whose only violation is their status. UNHCR staff will go out into the community to meet with police and military groups to provide education about refugees and asylum-seekers and to discuss bailout programs for individuals who have been arrested and are in detention.

In addition to providing legal services, AAT also works with refugees and asylum-seekers to assist them "to organize and assert their rights." AAT works with identified community leaders and supports them in developing the capacity of the community to develop advocacy and action efforts. For example, in Bangkok, AAT is active in supporting

Somali and Pakistani communities with forming and running democratic collective action groups. These groups are initiated and run by the urban refugees. Another example is the community paralegal program. AAT has also developed formal public/private partnerships, such as partnering a private Law Firm with the International Refugee Assistance Project (IRAP). Additionally they have been successful in engaging a corporate law firm with providing pro bono legal aid and developing legal briefs for advocacy and policy work. These public/private partnerships have also supported the work of UNHCR. By working with community leaders, AAT learned that these direct connections to the community are the most beneficial way to get and share information and to support organizing efforts, as well as to get legal and human rights assistance directly to urban refugees.

However, the fears of one's apartment been raided, picked up from the streets and detained remains to be threatening refugees who hesitate between taking the risks or not even for the sake of feeding their children and/or going to clinics. One female Somali participant describes her sense of living in constant fear.

> *I'm always afraid if I am going out or if I am staying inside, if I accompany my daughter to the school, if I try to pick up her from the school, I always, I'm always afraid about it.*

As people travel to and from their homes, via bus, long walks, or taxi, their risks for arrest increase. As a young 16 years old Somali male shared,

> *When I came to Bangkok, I didn't have any information about it. I didn't know the name of the city. I didn't even know there were Somalis in Bangkok. But when I arrived here and I met Somali people they told me that the people are arrested for being illegal immigrants here. And they frightened me. I've been staying in the room without going to the UNHCR and registering myself in the UNHCR 14 days because I was afraid if I go out I will be arrested. But you know, I couldn't just keep myself in the room and I went out one day and I registered in the UNHCR but after a while, I, as I went to the BCP office and registered in that office as a minor an unaccompanied minor, I went to back to my home and when I arrived at my home, I entered the room, a knock at the door. I didn't know them, they just entered the room and we were captured and we have been taken to the IDC* [Immigration Detention Center]*, to the prison.*

Despite the efforts of legal experts, the lack of information about legal services, lack of transportation and fears of leaving their homes have left urban refugees in Bangkok isolated and insecure. Six of the Somali interviewees (three female and three male) had been in IDC themselves and 50% of those report having been beaten or tortured during their time there. The amount of time spent in IDC varied greatly—between 12 days and 2 years. Conditions were described as *"awful and difficult"*. Concerns within IDC include: cramped quarters (200 men in one room), the spread of disease (i.e. TB), lack of water, children being born inside and "being impossible to provide for", corruption and discrimination amongst IDC staff, unpredictable and inequitable system for getting out and bailout being open, etc. They also discussed how once someone is in IDC it is very hard to build their resources again.

> *Usually when they are arrested, all the work that we have done build them up and helping them achieve goals, sustainable, and mental health, and well-being, all of that just falls apart, so it is a constant challenge for us to help people in this environment where they are so subject to these risks of arrest....everything falls apart.*

As the agencies indicated, urban refugees' illegal status leaves them vulnerable to their employers and residential property owners. Hence, the need for coordinated and geographically accessible legal service sites essential for refugees.

Shifting to a Collective Response

Overall, while both service providers and asylum-seekers claim availability of varied services, the services are not enough in terms of quality, longevity, and types of services. For instance, according to a representative of an NGO, "UNHCR resources are draining due to the global focus on the Middle East, mainly the Syrians." Some agency representatives indicate that many of the NGOs do not have enough resources to provide services until asylum-seekers are resettled in a third country because of financial, human, and material resources. An NGO male staff member who has been working in the areas of case management with urban refugees explains the situation.

> *We are struggling in all the social sectors. There are not enough resources, basic needs are not met,,.nowhere for single people to live, and there are limited health services.*

While the agencies are dispersed around Bangkok and services are varied, there has been a growing trend to collaborate and work towards a collective response to the influx of urban asylum-seekers and refugees. Each agency may also be providing two or more types of services, which has led to the need for networking and coordination of services to maximize resources and have greater impact on the individuals and families they serve. For example, the Tzu Chi clinic (an Indian community-based clinic), has organized with BRC, UNHCR and Muslim communities to support Christian churches in emergency times. This community-based clinic provides free services including medical tests, x-rays, dental services, and medications at no cost. The clinic itself is a collective of pro-bono doctors and nurses providing free services for those seeking refuge in Bangkok. At the time, they reported serving 700 to 800 patients every month. Study participants repeatedly acknowledged the importance of these agencies for urban refugees in Bangkok. A 20-year-old Somali female stated it this way.

> *The country doesn't recognize the refugees and there's no one who helps the refugees so deep down in my heart, I believe that it's only the UNHCR, BRC, JRS and BCP that can help the refugees.*

There are a number of advocacy collectives that come together to assess and respond to the growing needs of refugees and asylum-seekers in Bangkok. The Core Urban Refugee Network meeting is an example of one of these collaborative efforts. They meet once every two months among the NGOs serving these communities. The Bangkok Asylum Seeker and Refugee Assistance Network (BASRAN) is another form of network holding open

meetings whereby UNHCR and the American Embassy staff can attend. The BASRAN group breaks up into interest groups (i.e., health, education, etc.) so that each one of the sub-groups can concentrate on their expertise.

During our interviews with agency representatives, we found strong desire across NGOs, Community Based Organizations (CBOs), Faith Based Institutions (FBIs) and UNHCR to increase their networking and coordination of services. Indeed, it was the desire on the part of JRS for an increase in understanding of the community networks, both formal and informal, that sparked this research. As the spectrum of organizations who support these communities are increasingly stretched with higher numbers and shrinking resources, they are searching for a collective response that can maximize the resources. University of Utah, CSW and JRS partners are using the information gained from this study to inform a process that will enable interested partners to shift from an emergency service provision model to sustainable, and long-term solutions. The partnership aims to strengthen JRS and University of Utah partnership for further research that will inform larger practice and advocacy frameworks related to refugee and immigrant services to address misperceptions, misinformation, and acts of exploitation of migrant communities, and formulate a plan for improving services through a collective response.

Discussion

Service-providing agencies for urban asylum-seekers and refugees in Bangkok are doing their best with available resources. Efforts to move beyond conventional approaches to service users and working independently despite the overlaps of the service demands has led agencies to engaging in dialogues around collaborations. Such collaborative efforts would not only maximize agencies' resources but also minimize service users' efforts to seek support.

Considerations of advocacy and systems level changes, as well as JRS' initiative of shifting their approach from an emergency to long-term and sustainable interventions, and expanding the initiative to other agencies, are underway. Such efforts would also address the main challenges asylum-seekers are facing including the lack of sufficient resources and information, length of time for interviews, and risk of arrest and detention. Investing in sustainable skills is strategic and will have long term effects that would also be reflected when asylees and refugees get resettled in a third country.

Asylum-seekers are often trapped and deserted in the poor sides of the city, with poor infrastructure and environmentally unhealthy neighborhoods. For those who migrated from Africa in particular, their skin color exposes them to racist attitudes they have to endure every day of their lives, and that would also make them easy targets to immigration officers who roam around their neighborhoods or the agencies they visit for services. There is a felt need for a national framework that would reconsider the basic rights of asylum-seekers, their immigration status, and access to basic social services including employment rights and security from random detentions so that they can sustain their life until decisions are made regarding their resettlement process.

Study Limitations

This study could have been stronger if study participants were identified through a random selection based on neighborhoods where asylum-seekers and urban refugees reside. Having research team members who could speak languages spoken by all study participants would also have strengthened the discussions. Moreover, since the translators were also urban refugees and/or asylum-seekers, safety concerns limited their mobility to interview sites. The team shared some incentives with study participants. However, the basic needs were beyond the incentives and created discomfort and uneasiness among team members. Bringing all study participants—refugees, asylum-seekers and staff from agencies and CBOs—to focus group discussions would have yielded powerful conversations around their basic needs, legal services, and the future.

Remarks for the future

The findings from this research are not meant to be conclusive of either all Somali and Pakistani urban refugees in Bangkok or the agencies and community-based organizations working with them. More so, it is meant to provide a snapshot, highlighting the voices of those interviewed. This study was a starting point to explore the experiences of urban refugees and asylum-seekers in countries whereby legalized protection does not exist. The findings have serious implications for social work practice with urban refugees and asylum-seekers in such contexts including cultural sensitivity during practice with diverse communities, having information regarding sources of resources easily available and in different languages, having systems in place rather than responding to emergency calls from newly arriving refugees and asylum seekers, and coming up with innovative approaches to service with communities in danger such as living and/or providing services within communities' apartment buildings and neighborhoods.

Overall, while service providing agencies' and CBOs' initiatives are hopeful there is a prerequisite for a political commitment and will of the agencies to ensure that a national framework is in place, and collaborative approaches to protect and serve asylum-seekers are strengthened and translated into action. Exploring formal and informal networks is essential to help asylum-seekers realize their potential to support themselves.

The research team is aware of the power differentials involved in outside researchers coming into communities for short periods and believe the role of the community translators was paramount in the success of the conversations. Our sincerest thanks is extended to them, both for the wisdom they offered as well as the risks that they took in creating access to their communities.

Finally, sharing and disseminating what partners have learned from this study at different venues and through varied means (publications, conferences, community events, etc.) is essential. Getting informed and learning from other models of working with asylum-seekers including University of Utah model of serving refugees in their residential areas, including inside apartment complexes, to meet unsecured asylum-seekers and refugees where they feel comfortable and safe is critical. An important aspect of the CBPR framework is the value of research findings as community owned. There is a commitment

to provide the findings directly to those who participated in the study and those most affected by the issues.

References

Anderson, D. K. (2006). Mucking through the swamp: Changing the pedagogy of a social welfare policy course. *Journal of Teaching in Social Work, 26*(1/2), 1-17. doi: https://doi.org/10.1300/J067v26n01_01

Friere, P. (1990). A critical understanding of social work. *Journal of Progressive Human Servies, 1*(1), 3-9. doi: https://doi.org/10.1300/J059v01n01_02

Global Detention Project. (2017). *Thailand.* Retrieved from https://www.globaldetentionproject.org/countries/asia-pacific/thailand

Holt, M. (2013). Violence against women in the context of war: Experiences of Shi'I women and Palestinian refugee women in Lebanon. *Violence Against Women, 19*(3), 316-337. doi: https://doi.org/10.1177/1077801213485550

Jesuit Refugee Services. (2015). *Psychosocial accompaniment for women and girls in Bangkok*. Retrieved from http://www.jrsap.org/campaign_detail?PTN=PROMO-20130613023023&TN=PROJECT-20150614105706

Migration Policy Institute. (2015). *The Asia-Pacific and women's labour migration* [Audio]. Retrieved from http://www.migrationpolicy.org/multimedia/asia-pacific-and-womens-labour-migration

Minkler, M., & Wallerson, N. (2003). *Community-based research for health.* San Francisco*:* Jossey Bass.

Oppedal, B., & Idsoe, T. (2015). The role of social support in the acculturation and mental health of unaccompanied minor asylum-seekers. *Scandinavian Journal of Psychology, 56*, 203-211. doi: https://doi.org/10.1111/sjop.12194

Pickering, S. (2011). *Women, borders, and violence: Current issues in asylum, forced migration, and trafficking.* New York: Springer. doi: https://doi.org/10.1007/978-1-4419-0271-9

Potter, M. (2014, November 14). Thailand refugees: Please tell the world we exist. *Toronto Star.* Retrieved from http://www.thestar.com/news/world/2014/11/14/for_thailands_migrants_a_life_in_limbo.html

Robertson, C., Halcon, L., Savik, K., Johnson, D., Spring, M., Butcher, J.,…Jaranson, J. (2006). Somali and Oromo refugee women: Trauma and associated factors. *Journal of Advanced Nursing, 56*(6), 577-587. doi: https://doi.org/10.1111/j.1365-2648.2006.04057.x

Schmidt, M., Kravic, N., & Ehlert, U. (2008). Adjustment to trauma exposure in refugee, displaced, and non-displaced Bosnian women. *Archives of Women's Mental Health, 11*(4), 269-276. doi: https://doi.org/10.1007/s00737-008-0018-5

Steele, S. (2014, May 5). Pakistan Catholics flee to seek refuge in Bangkok. *UCAnews.com.* Retrieved from http://www.ucanews.com/news/pakistan-catholics-flee-to-seek-refuge-in-bangkok/70855

Strand, K. J. (2000). Community-based research as pedagogy. *Michigan Journal of Community Service Learning,* 7(2000), 85-96.

United Nations High Commissioner for Refugees [UNHCR]. UNHCR Policy on Refugee Protection and Solutions in Urban Areas, September 2009. Retrieved from http://www.unhcr.org/refworld/docid/4ab8e7f72.html

UNHCR. (2011). *The 1951 convention relating to the status of refugees and its 1967 protocol.* Geneva, Switzerland.

UNHCR. (2015a). *Global appeal 2015: Thailand*. Retrieved from http://www.unhcr.org/5461e60b17.html

UNHCR. (2015b). *Thailand*. Retrieved from http://www.unhcr.org/pages/49e489646.html

UNHCR. (2016). *Thailand factsheet: January 2016.* Bangkok, Thailand.

UNHCR. (2017a). *Asylum- seekers.* Retrieved from http://www.unhcr.org/en-us/asylum-seekers.html

UNHCR. (2017b). *Urban refugees*. Retrieved from http://www.unhcr.org/en-us/urban-refugees.html

Universal Periodic Review. (2015). *Kingdom of Thailand: Universal periodic review-2nd Cycle.* Kingdom of Thailand. Submitted 21 September 2015 on behalf of Asia Pacific Refugee Rights, Asylum Access, Human Rights Development Foundation, Jesuit Refugee Services, Migrant Working Group, and People's Empowerment Foundation.

Unterhitzenberger, J., Eberle-Sejari, R., Rassenhofer, M., Sukale, T., Rosener, R., & Goldbeck, L. (2015). Trauma-focused cognitive behavioral therapy with unaccompanied refugee minors: A case series. *BMC Psychiatry, 15*, 260-273. doi: https://doi.org/10.1186/s12888-015-0645-0

Vervliet, M., Vanobbergen, B., Broekart, E., & Derluyn, I. (2014). The aspirations of Afghan unaccompanied refugee minors before departure and at arrival in the host country. *Childhood: A Global Journal of Child Research, 22*(3), 330-345. doi: https://doi.org/10.1177/0907568214533976

Yanow, D. (2000). Conducting interpretive policy analysis. Thousand Oaks, CA: Sage Publications. doi: https://doi.org/10.4135/9781412983747

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Environmental Migration: Social Work at the Nexus of Climate Change and Global Migration

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Abstract: *Environmental migrants are caught at the nexus of the climate crisis and the global migrant crisis. The problems of the migrant crisis are recognized globally as they are linked to the complex issues being addressed by the United Nations' Sustainable Development Goals. The complexity of the issues makes it difficult to grasp the breadth and depth of this crisis. As a result, it can be understood as one of the "wicked problems" requiring us to respond through a lens that recognizes the interconnections of humans and the broader ecosystems within the physical surroundings. When approaching the migrant crisis from this perspective, professionals are challenged to create transdisciplinary, community-based response systems which are holistic, multi-pronged, and inclusive of migrants' voices and strengths. Storytelling provides a venue for highlighting migrants' voices, engaging in change, and creating the space for individual and collective healing. Social workers are increasingly being called upon to become trained in this practice and to engage in complex change systems alongside other disciplines and community members. As they provide prevention, mitigation, resettlement, and relief efforts, social workers become a part of a global community of leaders engaged in transformative change. By working to address these challenges, they are securing a better world not only for environmental migrants, but also for our planet as a whole.*

Keywords: *Environmental migrants; climate crisis; indigenous biophilia framework*

Climate change and environmental degradation, significant factors of the climate crisis, precipitate deteriorating environmental, political, and economic systems that are creating a global migrant crisis (Besthorn & Meyer, 2010; Black et al., 2011; Brown, 2008; Drolet, 2017; United Nations High Commission on Refugees [UNHCR], 2009). In fact, climate change has been acknowledged as the most significant threat to present and future generations of the global community, creating unprecedented migration (UNHCR, 2009; UN Environment, 2016; UN Trust Fund for Human Security, n.d.). Such threats from natural occurrences include the slow onset of environmental degradation, as well as extreme weather patterns and correlating droughts, desertification, storms, volcanic eruptions, earthquakes, tsunamis, and rising sea levels. These threats are exacerbated by human behaviors in two ways: (a) in our contribution to global warming and toxic environments, and (b) in the way we create built environments in areas that are at risk for such threats and yet are unequipped for and/or biased in the way we address the devastation of such crises when they occur. Thus, the problem of the global migrant crisis lacks

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recognition of the interconnections of humans and the broader ecosystems. Approaching the migrant crisis in its complexity, challenges social workers and other professionals to create response systems which are inclusive of migrant voices, vulnerabilities, and strengths while validating the environmental crisis that precipitates this migration crisis. This requires tackling climate change and the resulting migration crisis simultaneously.

Estimates of the number of environmental migrants vary widely; ranging from 25 million to 1 billion, with the most widely accepted estimate of 200 million (Intergovernmental Panel on Climate Change [IPCC], 2015; International Organization for Migration [IOM], 2018b). As defined by the IOM, environmental migrants are those displaced and/or migrating as a result of natural and human-made disaster events, as well as ongoing, deteriorating environments that create conditions that are not sustainable for life (IOM, 2018a). They experience significant loss and trauma, but in many instances, are resilient and make remarkable recoveries (Weng & Lee, 2016).

Although all persons moving for environmental reasons are protected by international human rights law, these rights are often not easily upheld, in transit or in relocation. Persons displaced within their country of origin due to natural or human made disasters, are covered by provisions laid out in the Guiding Principles on Internal Displacement (IOM, 2015). Environmental migrants are further recognized officially by the IOM as:

> ...persons or groups of persons who, for reasons of sudden or progressive changes in the environment that adversely affect their lives or living conditions, are obliged to have to leave their habitual homes, or choose to do so, either temporarily or permanently, and who move either within their territory or abroad. (IOM, 2018a, para. 1)

This definition acknowledges that environmental migrants are forced to leave, or decide by choice to migrate, due to deteriorating environmental conditions and extreme environmental events; this may occur within and/or across international borders for brief, prolonged, or permanent periods of time (IOM, 2015). Thus, while the term environmental refugee continues to be a matter of debate, for purposes of this article, we will use the term environmental migrants to refer to those who migrate due to environmental perils, regardless of their legal status as refugees.

Environmental migrants are a diverse group and some are eligible to receive legal refugee status due to other displacement criteria. Current international policies, however, do not include climate change and environmental hazards as the basis of becoming a refugee, and the term environmental refugee is not a legal term or status (UNHCR, 2016). The way in which some migrants' hardships are legally recognized and thus provided with aid and resources, while others are excluded (e.g., environmental hardships), is one aspect of the complexity.

Social workers play instrumental roles in helping environmental migrants overcome the challenges faced at each stage of their journeys, from working to mitigate climate change issues that cause displacement, to helping rebuild and reestablish people in their homes of origin, to assisting with resettlement and building new lives, and to being advocates to change the policies and laws to include environmental refugees (Powers &

Nsonwu, in press; Drolet, 2017). While addressing issues faced by environmental migrants, social workers not only collaborate with professionals in the social and natural sciences, but also with communities around the globe to address the United Nations' Sustainable Development Goals (IFSW, 2017).

According to the Global Agenda for Social Work and Social Development, professional social workers are to promote community and environmental sustainability while also advocating for social and economic equality, the dignity and worth of all peoples, and attending to the importance of human relationships (International Association of Schools of Social Work, International Council on Social Welfare, and International Federation of Social Workers [IASSW, ICSW, & IFSW], 2012). Social workers, as interdisciplinary partners, are able to address these four interwoven agenda items in addition to the United Nations' Sustainable Development Goals through providing leadership on climate advocacy and action, and by working with environmental migrants to rebuild their lives.

The Interwoven Complexity of the Global Climate and Migrant Crises

Environmental migration occurs at the nexus of complex and interwoven concerns: the global climate crisis and the global migrant crisis. These problems are so large, complex, and interconnected that they cannot be solved, but due to their nature we have to intervene; these crises therefore fit Kolko's (2012) definition of a *wicked problem*. They have many causes, ongoing processes of spiraling change, complex social interactions, multiple interpretations, conflicting goals, and an interdependency further complicated by the transnational nature of the issues. In attempting change, it is necessary to recognize that there is no one solution and there is great potential for unforeseen consequences (Brown, 2010). Although the climate crisis and the migrant crisis are interwoven, environmental migrants have little recognition globally of their status as migrants with legitimate human rights claims for permanent resettlement because the intersection is not validated.

This century, the world is facing a global climate crisis with issues of sustainability due to overpopulation, overcrowded cities, the depletion of environmental resources, limited food supplies, and pollution of air, water, and land (Brown, Deane, Harris, & Russell, 2010). Climate science has established the contributing role of human behavior in global warming; 97% of climate scientists are in agreement (Cook et al., 2016). Further, humans have been frustrated as they have struggled to increase food and energy production (Brown et al., 2010). "It is the sum of the local issues that has generated the global issues in the first place. Thus, we can appear to be locked in an endless spiral from which there is no escape" (Brown et al., 2010, p. 3). These social-environmental problems cannot be solved with the tools of the last century These are not individual issues, but rather have implications inclusive of communities, regions, and countries devastated by environmental change. While there are no final solutions, transformative change will require validation of the degradation and an understanding of the collective impact and context for change.

Experts warn that the climate crisis will exacerbate environmental migration well beyond what we have previously seen (Taylor, 2017). The migrant crisis as enmeshed with the climate crisis is further aggravated by conflicts that erupt due to depleted resources

along with related economic, social, and environmental injustices (IPCC, 2015). "Environmental justice occurs when all people equally experience high levels of environmental protection and no group or community is excluded from the environmental policy decision-making process, nor is affected by a disproportionate impact from environmental hazards" (Council on Social Work Education [CSWE], 2015, p. 20). The impact of the climate crisis is further intertwined with issues of violent conflict; cultural, economic, and environmental injustice; and displacement. In a study conducted in 2015, evidence showed that the effects of global climate change have sparked armed conflict; it has significantly contributed to the armed conflict and eventual civil war in Syria (Kelley, Mohtadi, Cane, Seager, & Kushnir, 2015; Welch, 2015). This evidence points to the spiraling nature of the issues and to the concepts many scholars have theorized for years, that the scarcity of resources (i.e., food, shelter, water) lead to major violent conflicts as the effects of climate change worsened.

Environmental migrants often flee their homes of origin due to violent conflict and/or because they face hardships (e.g., starvation) that result from climate change and prolonged conflict. Their experience of loss is multi-layered, including the loss of family, friends, and home as well as the general comfort of the familiar, including culture and language, which impact whole communities. The sights, sounds, relationship patterns, interactions, structures, language, and communication patterns of their new surroundings are unfamiliar (Deepak, 2018; Powers & Nsonwu, in press).

Demographic factors influence the need for and path of migration. "It is incumbent upon professionals committed to social and economic justice, to comprehensively understand the range of obstacles facing immigrants and refugees and empower them in their struggle to make a healthy adjustment" (Schmitz, Vazquez Jacobus, Stakeman, Valenzuela, & Sprankel, 2003, p. 135). Vulnerable populations are more burdened by environmental degradation and climate change; as a consequence, these influences are more prevalent in the migrant crisis. An expanded analysis thus considers how demographics not only influence who migrates, but also explores more deeply why they are at higher risk and consequently more likely to migrate. Populations at highest risk and most heavily impacted include populations of color, those in the Global South, low economic status, and women and children (Alston, 2013; Parry, Canziani, Palutikof, Linden, & Hanson, 2007; United Nations Women Watch, 2009). Gender, race, economic status, and religion are closely linked to the discrimination faced by migrants before, during, and after migration (Soylu & Buchanon, 2013). The history of displacements and fear that compound the transitions faced by migrants (Devore & Schlesinger, 1998; Schmitz et al., 2003) is further aggravated for women and girls, especially women and girls of color (Lie & Lowery, 2003).

In order to address the complexity, the analysis needs to be expanded to include the multiple, intersecting issues. As migrant communities share their stories, our understanding of their experience of loss and trauma takes shape; the claiming of collective agency has a role in framing the healing process. Environmental migrants have too often been subjected to chronic injustices, which are then exacerbated by environmental disasters. For example, in Sri Lanka people who were fighting against waste being dumped in their communities then endured a massive landslide, which wiped out over 100 homes in the area and resulted

in many losing their lives (Reuters and The Associated Press, 2017). Another tragic example includes the hurricanes that devastated families' homes and livelihoods in Puerto Rico creating displacements and environmental migrations. These communities were already vulnerable socially, politically, and economically due to extreme environmental injustices from the hazards of 23 Superfund sites, former US military bomb test sites, and local corporate waste of coal ash; these hazards were exacerbated by the hurricane damage (Atkin, 2017).

Kenya is a country that has faced significant hardships including climate change, environmental migration, political violence, and loss of the ecology for supporting food production and a clean water supply (Opido, Odwe, Oulu, & Omollo, 2017). Because wicked problems, as they overlap, have no single answer, we must therefore embrace multi-pronged processes and systems for change that are inclusive of the local community (Balint, Stewart, Desai, & Walters, 2011). Wangari Maathai modeled the multi-pronged approach to change as she addressed the interconnection of environmental, social, and political problems. It was in her community that she began her path as an activist and change agent to rebuild the ecosystem, repair the fundamental connections of people to their environment, and overcome political violence. She began the process by working locally on very practical issues and building community and collective change in the process. This served to mitigate the need to migrate. She was able to see beyond the immediate presenting problems in the community to address them holistically, taking into account all of their complexity. As the ecosystem healed, so did the community. She poignantly stated,

> Recognizing that sustainable development, democracy and peace are indivisible is an idea whose time has come… Today we are faced with a challenge that calls for a shift in our thinking, so that humanity stops threatening its life-support system. We are called to assist the Earth to heal her wounds and in the process heal our own - indeed to embrace the whole of creation in all its diversity, beauty and wonder. (Maathai, 2004, para. 7, 22)

Wangari Maathai grew up in a village in Kenya that had a vibrant and self-sustaining ecosystem. When she returned home after completing bachelor's and master's degrees in biology in the United States, she found an ecosystem that had collapsed. In Kenya, she completed her Ph.D., becoming the first woman in East Africa to earn a doctorate. She engaged the women of the community in germinating, growing, and planting trees. Because she was only organizing women, she was ignored by the repressive, patriarchal government. This project blossomed into the very successful Green Belt Movement (Maathai, 2003; Merton & Dater, 2008); at the point that it was apparent that an effective movement was taking root, she (and the movement) became a threat, engendering a violent response. The movement occurred at the nexus of multiple struggles, including climate change, environmental degradation, gender oppression, and violent conflict with governmental oppression (Strides in Development, 2010). The women stood boldly in the face of violence, and engaged the community to challenge the repression; through her work, Maathai was the first woman in Africa to win the Nobel Peace Prize in 2004. Maathai created a movement with multiple threads that promoted processes engaging civic

dialogue, critical assessment, and mechanisms that facilitated the empowerment of the community toward transformative change (Strides in Development, 2010).

Lens for Critical Exploration and Engagement

The migrant crisis, approached as a communal problem, can be more deeply understood by including the broader social, political, and biophysical context into our analysis. Like all such complex struggles, intervention failures often result because the nature of the problem is not understood and therefore responses are off target (Watkins & Wilber, 2015). Problems cannot be solved "with the same level of thinking that created the problems—we need a new level of thinking. The first step to bringing a new level of understanding to the nature of these complex issues is to dissect the features of extremely complex, difficult, or 'wicked problems'" (Watkins & Wilber, 2015, p. 4). Engaging holistic, collective, and complex frameworks for action supports the potential for creating systems and processes for change within communities. Life on earth is not just composed of interactions between humans, but also includes the interconnectedness of humans, entire ecosystems, and the physical environment. Life here denotes countless species of flora and fauna that live on the planet; all things, living and non-living, human and *other than human*, are connected in the large matrix of life on earth (Canty, 2017).

It is this interactive relationship of life within a physical space/place that forms the backdrop for the development of the biophilia framework. The term "biophilia" was first used by Harvard Zoologist E. O. Wilson (1984) to describe "the innate human urge to affiliate with other forms of life" (p. 85). Use of the biophilia framework expands the depth of analysis for the migrant crisis by helping us to recognize the interconnectedness of species with each other and with the ecosystem/environment (Lysack, 2010; Rabb, 2017). Destruction of the ecological environment, negatively impacts the quality of human life materially, psychologically, and spiritually (Kellert & Wilson, 1995).

Biophilia involves an awareness of the interconnectedness of nature and understands the role of humans as only one aspect in nature. Dr. Maathai's work exemplifies the application of this framework. Analytic assessment with a biophilia framework involves not just accounting for a physical place inclusive of sun, wind, rain, land, lakes, rivers, and oceans, but also the components of spiritual relationship to a place, a sense of belonging to the local components of nature and understanding their importance and striving to respect these aspects (Lysack, 2010; Rabb, 2017). It is the well-being of these relationships that creates and sustains life on this planet. Environmental degradation and climate change is resulting in a loss of a species and altered landscapes, and thus is a pivotal, precipitating factor in the migrant crisis. Understanding these connections and trying to address aspects of the biophysical context through a biophilia framework allows us to more critically analyze and mitigate the migrant crisis.

As a prime example, water is often referred to biologically as an inanimate aspect, yet, water is life. Humans rely on water for our personal consumption, and without it would surely die within a few days (Packer, 2002). Communities rely on water for our agriculture, household needs, and countless other purposes. In addition, water provides a context for life for many species, and water in many forms of weather slowly and dramatically shapes

and reshapes landscapes. Global changes to the environment severely affect seawater and air temperatures, creating glacial melting and creating a significant sea level rise over the past century (Garner, 2015). Shifts in ocean currents and large weather events off continental coastlines have major impacts including hurricanes, cyclones, and typhoons. These storms can have a dramatic impact from heavy rainfall, flooding, storm water surges, and high winds, even if they do not make landfall. Such events not only harm human and other forms of life, but also alter the entire ecosystem and physical space, many times creating the need for environmental migration.

Humans have always oriented themselves by establishing a direct, personal, and communal relationships to places in the landscapes with which they have interacted (Cajete, 1999). It is the well-being of these relationships that can sustain or denigrate life on this planet. While the biophilia framework embraces the connection of people to place and the nature, inclusive of all life (Besthorn & Saleeby, 2003), indigenous biophilia, further explicates and emphasizes these links while also adding the additional layers of oppression and power dynamics across culture, place, and nature (Cajete, 1999). Through an indigenous biophilia lens, complex change systems can be embraced. For example, indigenous biophilia knowledge is increasingly acknowledged "as valuable for adaptation to climate change" (Williams & Hardison, 2013, p. 531); there is some concern, however, about humankind's ability to adapt are strained given how rapid the changes are occurring (McLean, 2010).

Indigenous biophilia knowledge, in recognizing the link of people with place, nature, community, and tradition (Cajete, 1999), promotes respect for human and other than human and mindfulness when creating change, even small changes, as they can have drastic consequences for the entire ecosystem. The cultural activities, traditions, and stories of one's own community reflect the context for social and environmental relationships (Cajete, 1999). The specifics are understood in relation to the whole, and the principles are experienced within everyday circumstances (Kawagley & Barnhart, 1999). Indigenous biophilia sets the framework for ecological transformation (Cajete, 1999) as well as a context for exploring tribal oppression and engaging resistance (Norgaard & Reed, 2017). Decline in the natural world is related to social and political disruptions (Colomeda, 1999; Norgaard & Reed, 2017), in turn creating more environmental migrants.

Engaging Complex Change Systems

Approaching environmental migration, and the overarching global migrant crisis as a wicked problem highlights the complexity of the issues, challenging us to think beyond simplistic uni-dimensional interventions. Without embracing a holistic overview, the need to engage in complex, transformative processes and systems of change can be glanced over (Bradshaw, 2009). Vulnerable and marginalized prior to migration, individuals, families, and communities seeking refuge too often face additional struggles as their safety and status is further marginalized on the journey. Thus, the global migrant crisis requires multi-pronged systems of response that are inclusive of the collective and individual voice of the migrants. While environmental migrants confront unique risks as historically marginalized groups, they also present individual and collective strengths such as agency, resilience, and the potential for healing (Weng & Lee, 2016).

The power for collective healing should not be overlooked in developing systems of response to the migrant crisis. Social healing and resilience can be built in communities experiencing sustained violence (Lederach & Lederach, 2010). The building of resilience is linked to strengths, temperament, and environmental context (Hutchinson, Stuart, & Pretorius, 2010) with studies highlighting the importance of social connection for building community resilience (Ellis & Abdi, 2017). The agency and power of environmental migrants is recognized and becomes a base for empowerment thru policy action: "The meaningful participation of immigrants and refugees in challenging immigration and labor policies is in itself a path toward healing" (Deepak, 2018, p. 120).

Gendered risk factors and the promotion of healing through the empowering quality of collective resistance can be analyzed through the lens of postcolonial feminism (Deepak, 2018), which is inclusive of the voices of indigenous women and critical reflection of racial domination (Spurlin, 2010). The postcolonial feminist perspective provides a framework for rethinking “the risk factors for poor mental health as embedded in oppressive structural, historical, and political factors rather than solely in individual experiences" (Deepak, 2018, p. 120). Response processes and systems with environmental migrants that focus on deficits, dependency, and models of helplessness negate the potential impact of collective agency in the change process (Weng & Lee, 2016). The experiences and transnational context facing immigrants impact health and mental health promoting or compromising mental health (Deepak, 2018). These factors impact the individual and collective resilience reinforcing the need for community leadership.

Community Embedded Healing

Communities are sites for collective action, holding the potential to function as spaces for transformative change. Through collaborative community development, individual and communal issues can be interconnected creating the potential to support holistic models of sustainable change (Orr, 2004). While the meaning of community varies widely at the local and global levels, community remains the context for organizing, developing, and changing social, economic, and political systems (Gamble & Weil, 2010). "Neighborhood and community organizing takes place when people have face-to-face contact with each other, allowing them to feel connected to a place" (Gamble & Weil, 2010, p. 122). Communities are rich in the resources necessary for healing and recreating home, offering with the possibility for supporting sustainable development and addressing climate change. The impact of the Greenbelt Movement (Merton & Dater, 2008) as the beginning process for community development provides lessons on community and environmental healing. Within the indigenous biophilia framework, it is understood that community and environmental healing and sustainability, at the local and global levels, depends on respect for and maintenance of the Earth’s ecosystems, which forms the basis for the wellbeing of current and future generations (Cajete, 1999; Kellert & Wilson, 1995; Lysack, 2010; Rabb, 2017; Sustainable Human, 2014).

Healing is facilitated when collective narratives are explored and respected. Storytelling can be used at the community level to develop and redevelop narrative. The voice of environmental migrants can be recognized and empowered through storytelling and narrative. Through storytelling, processes of change are envisioned and supported

(Senehi, 2002). With the rise in nationalism across the globe, engaging the narrative becomes even more important. Anti-immigrant sentiments set the stage for the development of a negative context, increasing the risk of trauma in adjustment. Through story and empowering, strength-focused narrative can be highlighted while negative messages are contextualized and deflated.

> Connecting with our own or others' stories of strength and resilience in the face of social upheaval, war, and trauma can be an antidote to what might otherwise be the internalization of a sense of powerlessness, depression, fear, or even shame. (Senehi et al., 2009, p. 90)

Storytelling gives voice to the unique experience of intergroup and cross group conflict. It can also give voice to processes and pathways to change toward a place of peace (Senehi, 2002), and transformative change based in community narrative. The transformative change required to create sustainable communities that engage social, economic, political, and environmental justice requires a shift. Remediation and the building of resilience requires identifying strengths in individuals, families, and communities and mobilizing collective action through policy, advocacy, and/or community organizing.

The intersection of human systems, the ecology and physical space, and other wildlife creates a juncture for healing. As bell hooks (2008) reminds us through her storytelling, there is healing power through connection to the earth. In *Belonging: A Culture of Place*, hooks (2008) visualizes the mountains as the context of a sustainable and lush ecology, creating a love and warmth for deep connection to natural surroundings. She highlights a sense of belonging embedded in the natural ecology, and a deep connection with place--the "culture of place". hooks (2008) demonstrates a biophilia framework as she points out how nature becomes a teacher and healer if we listen. Through such a biophilia framework, we reconnect to the true position of human life within the context of nature, and thus are able to explore and engage in related healing processes that have been lost in modern life.

For example, when Muslim refugees from Somalia came to Lewiston, Maine in 2001, they were welcomed by some residents and feared by others because of their race and religion (Ellison, 2009). Lewiston was a decaying former mill town with large homes, low crime, and decent schools. Initially the level of hostility toward this new population rose. The new members of the community along with their allies stood non-violently in the face of violence. Over the years, they have built community businesses, rejuvenated the economy and the community, and connected to the land through farming. Their connection to the land and skills for farming have been shared as they build a new community embedded in place highlighting the link across community, biophilia, and identity. Similarly, Litfin (2014) underscores the link between community and sustainability as she explores the power of ecovillages across the globe. These communities create healing and sustainability as they operate at the juncture of the economic, ecological, and political context, particularly accounting for the significance of local control.

The value of regaining the lost connection with nature has the potential to help create a better life (hooks, 2008). We are challenged by hooks to consider the ways it is possible to live in a sustainable manner.

> Making peace with the earth we make the world a place where we can be one with nature. We create and sustain environments where we can come back to ourselves, where we can return home, stand on solid ground, and be a true witness. (hooks, 2008, pp. 25-26)

When she gives voice to a type of healing and peace that stops the exploitation of our earth, she pays tribute to the flora and fauna and the way all our lives are interconnected.

Social Work: Interdisciplinary Partner

As social work looks to address the global migrant crisis and mitigate environmental migration, we can be leaders in addressing the root problems of climate change and environmental degradation. If we are to promote sustainable communities and environments and support the resettlement of environmental migrants who have no hope of returning to their home, then it is critical that social workers who have not yet joined the professional agenda, be trained to work alongside those social workers who have taken up the fight to address the climate crisis. Social workers seeking to address the migrant crisis, by working as partners who engage in response systems alongside other professional disciplines and community members can help highlight the interconnections to the climate crisis.

Social work is a profession that operates in the nexus of multiple systems and disciplines, making it particularly well poised to address environmental migration as one piece of the complex migrant crisis. Social workers, trained to work across disciplines and within a collaboratively global context, bring a unique lens to practice in communities struggling with climate change and inadequate resources, such as those touched by the migrant crisis. These response systems can range from prevention and mitigation to resettlement and relief efforts to address climate change and environmental degradation. Social workers can also bring critical questions to the dialogue, such as: How does climate change and environmental degradation compound factors faced by vulnerable/marginalized people and communities? What ripple effects have been created by environmental migrants on their families, communities of origin, communities of resettlement, the ecosystem as a whole?

Social workers also have the knowledge and training for building the relationships needed to support environmental migrants in the building of capacity for empowerment, action, the forging of new links, and the establishing of working within relationships with a respect for differences. The profession has a rich history of working with communities as they form and re-form. Social work professionals can be a part of the capacity building that develops as groups move beyond intergroup and intragroup conflict to dialogue that explores multiple perspectives. As part of a multi-pronged response system for the migrant crisis and the related climate crisis, university-community collaborations can enrich the development by bringing together resources for the benefit of all. In addition, social workers enrich community/university coalitions (Schmitz, Matyók, Sloan, & James, 2012), bringing resources to the work in community.

The biological and physical sciences have an extensive base of knowledge in the environmental sciences that focus on climate change; the social and human sciences have

tended to lag behind (Schmitz, Stinson, & James, 2010). This is shifting as the need for integrated responses to address the impact of climate change and environmental degradation on human communities and their social, economic, and political systems is being recognized. Besthorn and Saleeby (2003) underscore the alignment of social work with the biophilia framework. The indigenous biophilic framework is even more closely aligned with social work as it incorporates not only nature and place, but also community, oppression, and power dynamics (Cajete, 1999). Social workers and social work education are increasingly turning a focus toward recognizing climate change and environmental degradation and the related environmental injustices as having a major impact on human communities. Expanding to take an ecosystems perspective provides a framework for students to engage in practice the recognizes the adverse impact of climate change and environmental degradation (Schmitz et al., 2010) and the connections to the migrant crisis. Further complicating the issues is the tendency for professional disciplines to educate students in silos, poorly prepared for interdisciplinary responses (Orr, 2011). New methods are called for as we delve into problems which are multi-faceted by definition (Brown et al., 2010)

The complex and multilayered concerns of the migrant crisis cut across disciplines requiring education inclusive of the social and natural sciences, as well as indigenous knowledge. While Western science and education tend to emphasize compartmentalized, decontextualized knowledge, indigenous peoples have traditionally acquired knowledge through direct experience with the natural environment (Kawagley & Barnhart, 1999). Williams and Hardison (2013) call for bringing scientists and indigenous peoples together to collaborate and exchange knowledge" (p. 531). “Our incapacity to deal with wicked problems...is related to their complexity, to the compartmentalization of scientific and professional knowledge” (Lawrence, 2010, p, 16). In addressing this shortcoming, it is important to integrate “the work of the academic disciplines with other forms of knowledge” (Lawrence, 2010, p. 17) through transdisciplinary inquiry and response, which we will use here as synonymous with interdisciplinary. Trandisciplinarity "is taken here to be the collective understanding of an issue; it is created by including the personal, the local and the strategic; as well as specialized contributions to knowledge" (Brown et al., 2010, p. 4). Thus, social workers operating with interdisciplinary partners have the experience and knowledge to be leaders in addressing the push toward and consequences of environmental migration at home, in transition, and upon resettlement.

Conclusion

As a profession, social work is mandated by our Global Agenda to promote community and environmental sustainability while also advocating for social and economic equality, the dignity and worth of all peoples, and attending to the importance of human relationships (IASSW, ICSW, & IFSW, 2012). We are increasingly recognizing our interdisciplinary partnership role to become leaders in addressing the wicked problems of the climate crisis and the migrant crisis. Although we acknowledge that social work is addressing these issues of the migrant crisis, it is often done separately from addressing the intersecting issues of the climate crisis. Caught at the nexus of climate change and environmental deterioration, environmental migrants lack adequate support because the intersection is not

recognized and validated. There are increasing numbers of social workers who do embrace the urgent need to address the climate crisis in their work, we are calling attention to the need to further train and encourage social workers to highlight the voices and needs of environmental migrants experiencing the impact of the climate crisis (Powers, 2016); climate change is the precipitating and compounding factor for the migration crisis.

In addition to working to mitigate climate change issues that cause displacement, helping rebuild and reestablish people in their homes of origin, promoting individual and community healing, and assisting with resettlement and building new lives, social workers can also be advocates to change the policies and laws to include environmental issues as justification for refugee status and thus increased aid. The United Nations' Sustainable Development Goals provides a framework through which we can increase our interdisciplinary responses as we work on climate advocacy and action, and address environmental migration. For example, social workers can help to mitigate environmental degradation and climate change by working to reduce toxins and promote clean water and sanitation, or working with urban planners to mitigate risks for vulnerable populations in case of disaster. In order to address environmental migration, social workers must engage in complex change systems which are holistic, multi-pronged, and inclusive of the biophysical environment and an indigenous biophilia framework and environmental migrants' voices and strengths. Understanding these connections and trying to address aspects of the biophysical context through an indigenous biophilia framework allows us to more critically analyze and mitigate the migrant crisis. Only then, can we hope to move forward, and address environmental migration.

References

Alston, M. (2013). Environmental social work: Accounting for gender in climate disasters. Au*stralian Social Work, 66*(2), 218-233. doi: https://doi.org/10.1080/0312407X.2012.738366

Atkin, E. (2017, September 20). *Even before Hurricane Maria, Puerto Rico was already in environmental despair: A public health crisis looms*. Retrieved October 07, 2017, from https://www.motherjones.com/environment/2017/09/climatedesk-now-hammered-by-hurricane-maria-puerto-rico-was-already-in-environmental-despair/

Balint, P. J., Stewart, R. E., Desai, A., & Walters, L.C. (2011). *Wicked environmental problems: Managing uncertainty and conflict*. DC: Island Press. doi: https://doi.org/10.5822/978-1-61091-047-7

Besthorn, F. H., & Meyer, E. (2010). Environmentally displaced persons: Broadening social work's helping imperative. *Critical Social Work, 11*(3), 123-138. Retrieved from http://www1.uwindsor.ca/criticalsocialwork/sites/uwindsor.ca.criticalsocialwork/files/coates_8_pdf.pdf

Besthorn, F. H., & Saleeby, D. (2003). Nature, genetics, and the biophilia connection: Exploring linkages with social work values and practice. *Advances in Social Work, 4*(1), 1-18.

Black, R., Adger, W., Arnell, N. W., Dercon, S., Geddes, A., & Thomas, D. (2011). The effect of environmental change on human migration. *Global Environmental Change, 21*(1), S3-S11. doi: https://doi.org/10.1016/j.gloenvcha.2011.10.001

Bradshaw, T. K. (2009). Theories of poverty and anti-poverty programs in community development. *Community Development, 38*(1), 7-25. doi: https://doi.org/10.1080/15575330709490182

Brown, O. (2008). Climate change and forced migration: Observations, projections and implications. *Human Development Report 2007/2008, Fighting climate change: Human solidarity in a divided world*. Retrieved October 22, 2016, from https://www.iisd.org/pdf/2008/climate_forced_migration.pdf

Brown, V. A. (2010). Collective inquiry and its wicked problems. In V. A. Brown, J. A. Harris, & J. Y. Russell (Eds.), *Tackling wicked problems: Through the transdisciplinary imagination* (pp. 61-83). New York: Earthscan.

Brown, V. A., Deane, P. M., Harris, J. A., & Russell, J. Y. (2010). In V. A. Brown, J. A. Harris, & J. Y. Russell (Eds.), *Tackling wicked problems: Through the transdisciplinary imagination* (pp. 3-15). New York: Earthscan.

Cajete, G. (1999). Reclaiming biophilia: Lessons from Indigenous people. In G. A. Smith & D. R. Williams (Eds.), *Ecological education in action: On weaving education, culture, and the environment* (pp. 189-206). Albany, NY: State University of New York Press.

Canty, J. M. (Ed.). (2017). *Ecological and social healing: Multicultural women's voices*. New York: Routledge.

Colomeda, L.A.L. (1999). *Keepers of the central fire: Issues of ecology for Indigenous people*. Sudsbury, MA: Jones and Bartlett.

Cook, J., Oreskes, N., Doran, P. T., Anderegg, W. R. L., Verheggen, B., Maibach, E. W….Rice, K. (2016). Consensus on consensus: A synthesis of consensus estimates on human-caused global warming. *Environmental Research Letters, 11*(4), 1-7. doi: https://doi.org/10.1088/1748-9326/11/4/048002

Council on Social Work Education [CSWE]. (2015). *Educational Policy and Accreditation Standards and Glossary.* Alexandria, VA: Author. Retrieved from https://www.cswe.org/getattachment/Accreditation/Standards-and-Policies/2015-EPAS/2015EPASandGlossary.pdf.aspx

Deepak, A. C. (2018). Postcolonial feminist social work perspective: Additional considerations for immigrant and refugee populations. In A. Hilado & M. Lundy (Eds.), *Models for practice with immigrants and refugees: Collaboration, cultural awareness, and integrative theory* (pp. 113-124). Los Angeles, CA: Sage.

Devore, W., & Schlesinger, E. G. (1998). *Ethnic-sensitive social work practice* (5th ed.). Boston, MA: Allyn & Bacon.

Drolet, J. (2017). Forced migration and the lived experiences of refugees. In M. Rinkel & M. Powers (Eds.), *Social work promoting community and environmental sustainability: A workbook for social work practitioners and educators* (pp.192-201). Switzerland: International Federation of Social Work [IFSW]. Retrieved from http://ifsw.org/product/books/social-work-promoting-community-and-environmental-sustainability-free-pdf/

Ellis, H. B., & Abdi, S. (2017). Building community resilience to violent extremism through genuine partnerships. *American Psychologist, 72*(3), 289-300. doi: https://doi.org/10.1037/amp0000065

Ellison, J. (2009, January 16). The refugees who saved Lewiston. *Newsweek Magazine*. Retrieved from https://www.newsweek.com/lewiston-maine-revived-somali-immigrants-78475.

Gamble, D. N., & Weil, M. (2010). *Community practice skills: Local to global.* New York: Columbia University Press.

Garner, R. (2015, August 26). *Warming seas, melting ice sheets*. Retrieved October 04, 2017, from https://www.nasa.gov/feature/goddard/warming-seas-and-melting-ice-sheets

hooks, b. (2008). *Belonging: A culture of place*. Hoboken: Taylor & Francis.

Hutchinson, A-M. K., Stuart, A. D., & Pretorius, H. G. (2010). Biological contributions to well-being: The relationships amongst temperament, character strengths and resilience. *South African Journal of Industrial Psychology, 36*(2), 1-10. doi: https://doi.org/10.4102/sajip.v36i2.844

International Association of Schools of Social Work, International Council on Social Welfare, and International Federation of Social Workers [IASSW, ICSW, & IFSW]. (2012). *The global agenda for social work and social development: Commitment to action*. Retrieved November 17, 2015, http://cdn.ifsw.org/assets/globalagenda2012.pdf

IFSW. (2017). *High level political forum 2017, United Nations, New York Workshop to promote Social Workers Role for reaching the Sustainable Development Goals (SDGs)*. Retrieved September 4, 2017, from http://ifsw.org/news/high-level-political-forum-2017-united-nations-new-york-workshop-to-promote-social-workers-role-for-reaching-the-sustainable-development-goals-sdgs/

Intergovernmental Panel on Climate Change [IPCC]. (2015). *Climate change 2014: Mitigation of climate change: Summary for policymakers.* Retrieved from https://www.ipcc.ch/pdf/assessment-report/ar5/wg3/WGIIIAR5_SPM_TS_Volume.pdf

International Organization for Migration [IOM]. (2015). Terminology on migration, environment and climate change. In *IOM outlook on migration, environment and climate change* (pp. 21-24). NY: UN Publications. doi: https://doi.org/10.18356/14b2ac9d-en

IOM. (2018a). *Definitional issues.* Retrieved June 15, 2017, from https://www.iom.int/definitional-issues

IOM. (2018b.). *Migration and climate change: What are the estimates?* Retrieved from https://www.iom.int/migration-and-climate-change-0

Kawagley, A., & Barnhart, R. (1999). Education indigenous to place: Western science meets Native reality. In G. A. Smith & R. W. Dilafruz (Eds.), *Ecological education in action: On weaving education, culture, and the environment* (pp. 117-140). Albany, NY: State University of New York Press.

Kellert, S. R., & Wilson, E. O. (Eds.). (1995). *The biophilia hypothesis* (reissue ed.). DC: Shearwater/Island Press.

Kelley, C. P., Mohtadi, S., Cane, M. A., Seager, R., & Kushnir, Y. (2015). Climate change in the Fertile Crescent and implications of the recent Syrian drought. *Proceedings of the National Academy of Sciences, 112*(11), 3241-3246. doi: https://doi.org/10.1073/pnas.1421533112

Kolko, J. (2012). *Wicked problems: Problems worth solving*. Austin, TX: Austin Center for Design.

Lawrence, R. J. (2010). Beyond disciplinary confinement to imaginative transdisciplinarity. In V.A. Brown, J.A. Harris, & J.Y. Russell. *Tackling wicked problems: Through the transdisciplinary imagination* (pp. 16-30). New York: Earthscan.

Lederach, J. P., & Lederach, A. J. (2010). *When blood and bones cry out: Journeys through the soundscape of healing and reconciliation.* Oxford, NY: Oxford University Press.

Lie, G.-Y., & Lowery, C. T. (2003). Cultural competence with women of color. In D. Lum (Ed.), *Culturally competent practice: A framework for understanding diverse groups and justice issues* (2nd ed., pp. 282-309). Pacific Grove, CA: Brooks/Cole.

Litfin, K. T. (2014). *Ecovillages: Lessons for sustainable community*. United Kingdom: Polity Press.

Lysack, M. (2010). Environmental decline, loss, and biophilia: Fostering commitment in environmental citizenship. *Critical Social Work, 11*(3), 48-66.

Maathai, W. (2003). *The Green belt movement: Sharing the approach and the experience.* New York, NY: Lantern Books.

Maathai, W. (2004). Wangari Maathai - Nobel Lecture. Retrieved from www.nobelprize.org/nobel_prizes/peace/laureates/2004/maathai-lecture-text.html

McLean, K. G. (2010). *Advance guard: Climate change impacts, adaptation. Mitigation and Indigenous Peoples*. NY: United Nations University.

Merton, L., & Dater, A. (Producers and Directors). (2008). *Taking root: The vision of Wangari Maathai* [DVD]. United States: Marlboro Productions.

Norgaard, K.M., & Reed, R. (2017). Emotional impacts of environmental decline: What can Native cosmologies teach sociology about emotions and environmental justice. *Theory and Society, 46*, 463-495. doi: https://doi.org/10.1007/s11186-017-9302-6

Opido, G., Odwe, G., Oulu, M., & Omollo, E. (2017). *Migration as adaptation to environmental and climate change: The case of Kenya*. Kenya: IOM.

Orr, D. W. (2004). *Earth in mind: On education, environment, and the human prospect*. DC: Island Press.

Orr, D. W. (2011). *Down to the wire: Confronting climate collapse*. Washington, D.C.: Island Press.

Packer, R. K. (2002). *How long can the average person survive without water?* Retrieved October 04, 2017, from https://www.scientificamerican.com/article/how-long-can-the-average/

Parry, M., Canziani, O., Palutikof, J., Linden, P. V., & Hanson, C. (2007). *Climate change 2007 - impacts, adaptations and vulnerability.* Cambridge: Cambridge University Press. Retrieved from https://www.ipcc.ch/pdf/assessment-report/ar4/wg2/ar4_wg2_full_report.pdf

Powers, M. C. F. (2016). Transforming the profession: Social workers' expanding response to the environmental crisis. In A.-L. Matthies & K. Narhi (Eds.), *Ecosocial transition of societies: Contribution of social work and social policy*. New York: Routledge.

Powers, M. C. F., & Nsonwu, C. (in press). Environmental injustices faced by resettled refugees: Housing policies and community development. In R. Hugman, J. R. Drolet, J. & S. Todd (Eds.) *Community practice and social development in social work: Major research works*. NSW, AUS: Springer Nature.

Rabb, H. (2017). Sustainable wellbeing and social work with children: Promoting our connectedness with nature through Nature- Assisted interventions. In M. Rinkel & M. Powers (Eds.), *Social work promoting community and environmental sustainability: A workbook for social work practitioners and educators* (pp. 133-145). Switzerland: IFSW. Retrieved from http://ifsw.org/product/books/social-work-promoting-community-and-environmental-sustainability-free-pdf/

Reuters and The Associated Press. (2017, April 16). *Hundreds feared buried in Sri Lanka rubbish dump landslide*. Retrieved October 06, 2017, from https://www.theguardian.com/world/2017/apr/16/hundreds-feared-buried-in-sri-lanka-rubbish-dump-landslide

Schmitz, C. L., Matyók, T., Sloan, L., & James, C. D. (2012). The relationship between social work and environmental sustainability: Implications for interdisciplinary practice. *International Journal of Social Work, 21*(3), 278-286. doi: https://doi.org/10.1111/j.1468-2397.2011.00855.x

Schmitz, C. L., Stinson, C. H., & James, C. D. (2010). Community and environmental sustainability: Collaboration and interdisciplinary education. *Critical Social Work, 11*(3), 83-100.

Schmitz, C. L., Vazquez Jacobus, M., Stakeman, C., Valenzuela, G., & Sprankel, J. (2003). Immigrant and refugee communities: Resiliency, trauma, and social work practice. *Social Thought, 22*(2/3), 135-158. doi: https://doi.org/10.1300/J131v22n02_10

Senehi, J. (2002). Constructive storytelling: A peace process. *Peace and Conflict Studies, 9*(2), 41-63.

Senehi, J., Flaherty, M., Kirupakaran, C. S., Kornelsen, L., Matenge, M., & Skarlato, O. (2009). Dreams of our grandmothers: Discovering the call for social justice through storytelling. *Storytelling, self, society: An interdisciplinary journal of storytelling studies, 5*(2), 90-106.

Soylu, A., & Buchanon, T. A. (2013). Ethnic and racial discrimination against immigrants. *Journal of Business and Economics, 4*(9), 8548-858l.

Spurlin, W. J. (2010). Resisting heteronormativity/resisting recolonisation: Affective bonds between indigenous women in southern Africa and the difference(s) of postcolonial feminist history. *Feminist Review*, *95*(95), 10-26. doi: https://doi.org/10.1057/fr.2009.56

Strides in Development. (2010, July 9). *Wangari Maathai & the green belt movement*. [Video file]. Retrieved from https://m.youtube.com/watch?v=BQU7JoxkGvo

Sustainable Human. (2014, February 13). *How wolves change rivers*. Retrieved October 07, 2017, from https://www.youtube.com/watch?v=ysa5OBhXz-Q

Taylor, M. (2017, November 2). Climate change 'will create world's biggest refugee crisis. *The Guardian.* Retrieved February 1, 2018, from https://www.theguardian.com/environment/2017/nov/02/climate-change-will-create-worlds-biggest-refugee-crisis

UN Environment. (2016). *Annual report 2016: Engaging people to protect the planet.* Retrieved from https://www.unenvironment.org/annualreport/2016/?page=0&lang=en

United Nations High Commission on Refugees [UNHCR]. (2009). *Climate change, natural disasters and human displacement: a UNHCR perspective*. Retrieved from www.unhcr.org/4901e81a4.html

UNHCR. (2016, November 6). *Frequently asked questions on climate change and disaster displacement*. Retrieved June 15, 2017, from http://www.unhcr.org/en-us/news/latest/2016/11/581f52dc4/frequently-asked-questions-climate-change-disaster-displacement.html)

UN Trust Fund for Human Security. (n.d.). *Human security: Building resilience to climate threats.* Retrieved October 4, 2017, from

https://www.un.org/humansecurity/wp-content/uploads/2017/10/Human-Security-and-Climate-Change-Policy-Brief-1.pdf

United Nations Women Watch. (2009). *Women, gender equality and climate change.* Retrieved October 4, 2017, from http://www.un.org/womenwatch/feature/climate_change/downloads/Women_and_Climate_Change_Factsheet.pdf

Watkins, A., & Wilber, K. (2015). *Wicken & wise: How to solve the world's toughest problems*. Great Britain: Urbane Publications.

Welch, C. (2015, March 02). *Climate change helped spark Syrian War, study says*. Retrieved September 28, 2017, from http://news.nationalgeographic.com/news/2015/03/150302-syria-war-climate-change-drought/

Weng, S. S., & Lee, J. S. (2016). Why do immigrants and refugees give back to their communities and what can we learn from their civic engagement? *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations, 27*(2), 509-524. doi: https://doi.org/10.1007/s11266-015-9636-5

Williams, T., & Hardison, P. (2013). *Culture, law, risk and governance: Contexts of traditional knowledge in climate change, 120*(3), 531-544.

Wilson, E. O. (1984). *Biophilia*. Cambridge, Mass: Harvard University Press.

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