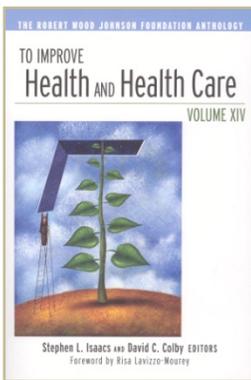


Caring Across Communities

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Editors' Introduction

If one were to conduct a search for the most vulnerable population in the United States, children with mental health problems born to refugees or immigrants would surely be near the top. For starters, immigrants and their children are not generally welcome in the medical care system. If undocumented, they are pretty much precluded from getting care except in public hospitals, free clinics, and, to a limited extent, community health centers. They are more likely to live in poverty, be poorly educated, and lack health insurance coverage—with all the attendant consequences to health.

Then there is the question of obtaining mental health services. Despite laws and regulations requiring parity in coverage of mental and physical health services under employer-sponsored health plans, such parity does not in fact exist. Not to mention the stigma associated with mental illness, which would discourage many people from seeking services for themselves and their children. Moreover, there are all of the cultural barriers, of which language is the most obvious and perhaps the easiest to resolve. In *The Spirit Catches You and You Fall Down*, Anne Fadiman writes poignantly about cultural misunderstanding between well-meaning American doctors and the equally well-meaning Hmong parents of an epileptic girl: “Many Hmong were overwhelmed. ‘In America, we are blind because even though we have eyes, we cannot see. We are deaf because even though we have ears, we cannot hear.’ Some newcomers wore pajamas as street clothes; poured water on electric stoves to extinguish them; lit charcoal fires in their living rooms; washed rice in their toilets [and] their clothes in swimming pools. . . . If the United States seemed incomprehensible to the Hmong, the Hmong seemed equally incomprehensible to the United States.”¹

In 2007, the Robert Wood Johnson Foundation launched a three-year program, Caring Across Communities, aimed at bringing school-connected mental health services to children of immigrants and refugees. Many refugees and their children have witnessed

horrors unimaginable to most Americans. As a result, they suffer from post-traumatic stress disorder and are in great need of mental health services. In this chapter, Will Bunch, a Pulitzer Prize-winning journalist with the *Philadelphia Daily News* and the author of the recent book, *The Backlash*, writes about Caring Across Communities. He describes the different approaches adopted by the grantees in fifteen communities and examines the lessons that have emerged from the program. With racial and ethnic minorities poised to become the majority of the population by 2042, programs such as Caring Across Communities will only increase in importance.

Notes

1. Fadiman, A. *The Spirit Catches You and You Fall Down*. New York: Noonday Press, 1997, p. 188.

There was no dramatic tipping point alerting public health officials in the United States of the need for specialized services for traumatized children of immigrants. However, by the late 1990s there was both an increase in, and a change in the nature of, new arrivals to America. In 2000, according to the Census Bureau, there were more than 31 million people in America who had been born somewhere else, a rise of 57 percent in just one decade, and many of those born elsewhere were schoolchildren.¹

The mass migration took place despite domestic political currents hostile to immigration, especially toward those from Mexico and elsewhere in Latin America. On the southern border of the United States, children often arrived with the help of smugglers, surviving lethal heat and other brutal conditions. Meanwhile, a new surge of warfare across the Third World, especially in poverty-wracked Africa—frequently involving young people as victim or as child soldier—created new and previously unseen small pockets of immigration by legally protected refugees. With little cultural connection to America, they arrived in towns like Portland, Maine, and Fargo, North Dakota.

Studies show that one out of every five school children in America is now either the child of an immigrant or an immigrant him or her self—and the nature of the migration to this country is changing rapidly.² During the last three decades, the United States has accepted more refugees than the world's other developed nations combined, and increasingly these newcomers have been exposed to brutal modern warfare in Africa and elsewhere; thousands of children were killed, and many more were left psychologically scarred. Even economic refugees from Mexico and Central and South America faced new, lingering types of trauma as families were smuggled across the border in degrading conditions.

By the early 2000s, some experts were beginning to study the challenges these new arrivals faced in the area of mental health. Much of the evidence remained anecdotal. Foreign-born students who arrived under less stressful circumstances seemed to have mental health issues at about the same rate as American-born children; roughly one in ten kids receives medication or therapy.³ But problems such as posttraumatic stress disorder (PTSD) appeared to be much more prevalent—closer to 20 percent—for those immigrants who experienced violence before arriving. School officials began to see the effects of PTSD in problems that ranged from rising individual disciplinary cases to a 25 percent high school dropout rate nationally for foreign-born pupils.⁴ But no one had yet worked to develop a comprehensive strategy for tackling stress or related mental health issues among these children who seemed so clearly in need.

Developing a Program to Address the Mental Health Needs of Refugees and Immigrants

Judith Stavisky, a former senior program officer for the Robert Wood Johnson Foundation who now heads the Philadelphia-based Friends of the Children, said that the Foundation began hearing reports in the early 2000s from grantees about difficulties they were facing in helping refugees and other immigrants make the transition to life in America. In 2003, she and Foundation program officer Wendy Yallowitz traveled the country to visit agencies on the front lines working with such refugees.

Stavisky said she was especially moved by the struggles of newcomers she met on a trip to Omaha, where many Sudanese, Somali, Burmese, Latino, and other refugees had come to work in the local meatpacking industry. She was also handed a book by a well-known local therapist, Mary Pipher, called *The Middle of Everywhere: Helping Refugees Enter the American Community*, which depicted in great and occasionally almost comic detail the problems that Sudanese and other refugees encountered in Nebraska. It described some of their underlying traumas and called for “cultural brokers” who would work full

time with refugees—as a practical nurse might—to help them adjust. The site visits and the timely book convinced Stavisky and her colleagues at the Foundation to devise a program to address the mental health needs of these immigrants.

“Some of these children had seen unthinkable things—they had seen torture, for example, and they had lived in these camps, or they had been homeless,” Stavisky said. “Then they come to school in America—and they’re not even wearing the right clothes. So a lot of this was: How do we overcome this, and make sure that this accumulation of hurt and losses that they have is recognized?”

Julia Graham Lear, the former director of and now senior advisor to the Center for Health and Health Care in Schools at George Washington University, who has worked with the Foundation on child health issues for more than two decades, was also intrigued by what the research was showing and by how little Americans knew about the issues that refugees encountered. Lear pointed to the little-understood ways that immigrating to America frequently ripped apart families—especially for those coming from war-torn Africa. “Here’s the deal—you get a visa to the United States when you’re in the refugee camp through a lottery system, but the child is not in the lottery, it’s the adult,” Lear explained. But when an adult was tapped for resettlement in the United States, she often would take as many children as she could, regardless of whether or not they were her own biological kids—a situation that might make kids physically safer but could be damaging psychologically.”

A new initiative seemed a logical step for the Foundation, which had recently created its Vulnerable Populations portfolio to address the areas in American life where health problems were exacerbated by social factors such as poverty, violence, and substandard living conditions. Yallowitz said a plan was created to reach immigrant children through the most obvious point of contact, the public schools. “We wanted to narrow it down to where we could make the biggest impact, and schools were where they were spending the majority of their time,” Yallowitz said.

The Foundation and Lear had already worked to establish the very first school-based health centers, primarily in underserved communities. The efforts began in the early 1970s with a pilot program, the School Health Services program, that placed nurse practitioners in elementary schools in four states; in 1986, the Foundation launched a more ambitious, seven-year nationwide program called the School-Based Adolescent Health Care program, which helped create a template for treatment that today is used in many of the nearly two thousand such school-based health centers in the United States. To build its mental health effort for refugees, the Foundation turned to Lear.

In 2006, the Foundation announced a first-of-its-kind initiative, Caring Across Communities, to target immigrant and refugee populations in fifteen communities. The goal was to develop different models and a variety of approaches—sharing information during the three-year life of the program; at the end of the thirty-six months, the Foundation could apply the knowledge developed through the pilot program to promulgate best practices and to develop working programs in immigrant communities across the United States.

The Foundation allocated \$4.5 million over three years for the Caring Across Communities program and selected Lear’s Center for Health and Health Care in schools to administer it. Each of the fifteen sites would receive up to \$100,000 a year over the three years. The roster of projects unveiled in March 2007 showcased a variety of approaches in locations ranging from the sun-baked, overwhelmingly Latino Imperial County, California, on the Mexican border, to the northern climes of Fargo, North Dakota—a destination for a surprising number of refugees from an array of nations.

The common thread throughout this variety of programs was the school. “That was because most refugee parents coming to America in pursuit of a better life for children understood the importance of a good education,” Olga Acosta Price, director of the Center for Health and Health Care in Schools, said. “Thus parents would be more willing to work with a program with a focus on mental health if it were framed and

explained as a way to keep kids in school and help them to achieve.”

A Variety of Approaches: Caring Across Communities in Practice

After the first two years of the Caring Across Communities program—a period of trial and error but also of encouraging stories—many of the fifteen programs had already become established fixtures in the communities they served. Here is the in-depth story of site visits to two of the local sites.

Boston, Massachusetts

At 10:45 on a Tuesday morning, half a dozen boys from the seventh and eighth grades slowly file down a hallway inside Boston’s Lilla G. Frederick Pilot Middle School, their heels clicking on the glossy floor of their ultra-modern, Wi-Fi-enabled high-tech haven located amid the peeling multifamily homes of the city’s rugged Dorchester section. The boys have a lot in common and are wiry, dark-skinned, and bantering in accents of their homeland, Somalia. They file into a conference room, where for the next fifty minutes they’ll take a break from online algebra lessons and do something normally quite unremarkable for young teenagers—compete against each other or with two adults in board games like tic-tac-toe-inspired Connect 4 or Jenga, the block-stacking game.

The Somali-born boys are mostly quiet as they play, the squeaking of their chairs across the floor interrupted only by the collapse of a towering Jenga stack, accompanied by a “Ya!” or a self-satisfied declaration of victory. “Piece of cake, I win!” declares one of the boys after besting one of his friends at Connect 4, and there are good-natured smiles and murmurs around a big table. One of the two adult leaders, Saida Abdi, who is herself a native of Somalia, reminds the young immigrants about the importance of taking deep breaths to relax. At the end of the hour, she turns to Amanda Nisewaner—also a social worker in the novel refugee aid program called Project SHIFA (for Supporting the Health of Immigrant Families and Adolescents; *shifa* means “healing” in Arabic)—and declares, “I am very proud of them, Amanda. They played for a long time, and they did it by

themselves.”

When Abdi and other social workers started working with Boston’s Somali refugee community several years ago, such a placid hour of group play would have been impossible: The boys were prone to fights over minor slights, and several even found it difficult to sit still for such a long period. Their difficulties in adjusting to life in an American middle school should not have been a surprise; most of the youth were just a couple of years removed from a grim existence in Kenyan-based refugee camps for the thousands displaced by years of brutal warfare in their neighboring failed state on the Horn of Africa, and some had already seen brutal murders or abandoned corpses in the streets or felt the fear of a hasty flight at the point of a rifle. Resettlement in the United States was a step toward a better life, but in addition to the traditional burdens of learning a new language and culture, many of these young refugees from war had to also overcome PTSD, along with other mental-health issues.

It’s a vexing problem to the educators, social workers, and mental health professionals who are aware of it. But Project SHIFA—led by Children’s Hospital Boston, working closely with members of the local Somali community as well as schools and Somali community agencies, and funded by the Robert Wood Johnson Foundation—has made considerable headway in just a couple of years. Its efforts have been increasingly focused on raising awareness among parents, religious leaders, and other key figures in Boston’s still-growing Somali community about the importance of mental health, while breaking down considerable cultural stigmas surrounding mental health issues.

Since it was launched, in 2007, Project SHIFA has worked with dozens of Somali teens and pre-teens and their families in informal settings like the weekly discussion and play group at the Dorchester school; officials boast a hundred percent success rate in engaging once-reluctant parents to seek help when more intensive therapy is needed. Heidi Ellis, a clinical psychologist at Children’s Hospital and associate director of its Center for Refugee Trauma and Resilience, who launched the project to address the

growing Somali caseload, said that a key was cutting through taboos. “The idea of a kid having some problems or being a little stressed or distressed about something—most families would look at that and say, ‘Don’t call my child crazy,’” she said.

Ellis said the tide began to turn after a parent outreach director, Somali-born Naima Agalab, held a Ramadan tea for forty refugee mothers and convinced them that it was better to join the system of counseling in American schools than to resist it. “This is real, this is happening,” she recounted Agalab telling the immigrants, “and instead of just denying it and wishing that kids weren’t going to mental health professionals, we need to get involved in it—so that we are confident that the services that are happening can really help our kids and not hurt them.”

These struggles are hardly isolated to refugees from Somalia or Boston. In many ways, Project SHIFA—working amid a growing Somali community of about eight thousand people—is typical of the Caring Across Communities grantees.

The idea was hatched several years ago when a couple of cases from the Boston school district involving Somalis with disciplinary problems were referred to Ellis, who was then working through an immigrant-based psychology clinic at Boston Medical Center. Ellis said she quickly realized that these young refugees were coping with enormous trauma—not just from their war-torn past but now from adjusting to life in some of Boston’s rougher neighborhoods and public schools. In addition, the hurdles in connecting these refugees with the proper treatment were quite high, indeed. Although most of the children were quick to pick up English, their parents often didn’t speak the language, were unfamiliar with how things worked in an American school, and were reluctant to agree to the kind of intense aid that some of the children clearly required.

What’s more, the classroom teachers frequently didn’t have the time (or even the interest) to explore the deeper reasons for a student’s acting out in the classroom. There were few Somali teachers in the entire Boston school system, and not one mental health professional that Ellis could find in the entire state of Massachusetts who could speak

the Somali language or had any familiarity with the distinctive culture of the East African nation. It quickly became clear that a huge problem would be simply winning acceptance for Western ideas about mental health care.

Several years later, half a dozen or so mothers of Somali-born Boston school students are sitting around a windowless conference room inside the city's Refugee and Immigrant Assistance Center, an old brewery building in the city's Jamaica Plain neighborhood. Dressed in blindingly bright *guntiinos* (full-length dresses), in head scarves, and munching on pastries as they speak in their native Somali tongue, the women are all members of a parent advisory board that has proved critical in helping Ellis and her small team of social workers gain acceptance and understanding.

"In our country, we do not have these terms like bipolar or manic-depressive," says one of the women through a translator, smiling at how much she had learned about the subject of mental health in just a couple of years. "In our country, you are not 'crazy' unless you are running around in the street with no clothes on!" The others in the group of refugee moms laugh heartily. The fact that the Boston-based Somalis can joke about such once-taboo topics is a sign of how far Project SHIFA has been able to reach into the community in just a couple of years.

How did this happen? Ellis and her growing team of psychologist colleagues and social workers broadened their strategy to go well beyond just therapy sessions for the most troubled kids: They added Somali natives like Abdi, who brought credibility and also did extensive outreach work to educate schoolteachers about the unique problems of refugee children; then they met with parents and with Islamic religious leaders in the immigrant community to boost awareness. In a sense, Project SHIFA created its own nomenclature as the social workers learned ways to get parents and kids to trust in its work initially without even using the phrase *mental health* or related terms, for fear of scaring would-be clients away. Now its team holds weekly meetings on the Children's Hospital campus to develop treatment strategies for Somali teens who once would have been lost deep in the

system.

On a Monday morning, roughly ten professionals sit around a large table to discuss the progress of some of their more intensely managed cases—allowing both the author and a visiting film crew to observe as long as names of the individual students are withheld. In addition to staff psychologists, the team includes Abdi, who has often visited the families in their homes, as well as caseworkers like Nisewaner, who spends a good portion of her time at the middle school in Dorchester when she is not studying toward her social work degree at Boston University through a Project SHIFA–related program. (Since this scene took place, Nisewaner completed her studies and was hired by the project.) Nisewaner spoke at length about a boy who was born in one of the Somali refugee camps in neighboring Kenya, the oldest of several siblings, who has had a tough time in school with fights and other temper flare-ups. As the oldest child, and because of the violence and squalor he witnessed in the camp, Nisewaner speculated, the student seemed constantly worried about protecting his mother.

“He felt like he should be at home,” Nisewaner said, explaining why he didn’t find pleasure in playing soccer with some of the other Somali boys after school. “He felt like he was too old to be out playing.” She described bumpy progress, but the young social worker said she believed that counseling had helped the boy avoid what could have been a violent confrontation with a group of kids in the neighborhood. The staff around the table agreed that the boy was not currently in need of crisis-level intervention, although Ellis asked, “Is there any way to get the school to give him some positive feedback?”

The case sums up much of what educators, psychologists, and social workers from the Los Angeles barrio to foggy Portland, Maine, have discovered during the three years of the Caring Across Communities experiment; regardless of culture, advocates for treatment can break down the barriers of social traditions and language and make a difference in the lives of at least some families—but the work is difficult and time-consuming. With the three-year pilot ending in 2010, leaders of most of the fifteen

Caring Across Communities projects were turning their attention toward the problem of finding a sustainable funding base in a rough economy, so that more kids like this struggling Somali boy in Dorchester could be helped in the future.

Bucks County, Pennsylvania

George Wion speaks slowly, in raspy, lilting tones of his native Liberia, frequently burying his bald head into his hands when asked about his family's life in the war-torn African nation or about his son—also named George—and some of the awful things that George Jr. and his siblings witnessed in Liberia, where civil war between 1999 and 2003 killed an estimated two hundred thousand people. Wion and his family, including three kids, immigrated to the United States in July 2005, but their new life in the working-class suburbs just north of Philadelphia also brought new problems.

When the younger George Wion was in seventh grade at the Franklin D. Roosevelt Middle School in Bristol Township, Pennsylvania, he fell in with some kids involved in gang activity. “He was getting along, but the problem was there were some kids here that used to take him along to all kinds of places,” the father said. “He was getting friendly with some bad boys, and every time he comes to school sometimes he didn't come home, and when he was home sometimes they would come over very late.”

The older George Wion was separated from his wife and wasn't around much himself. He worked long hours at a residential youth home in a different community in suburban Bucks County. But partly on the recommendation of a Liberian Christian minister who is well-known among Bristol Township's small, tight-knit refugee community, the senior Wion gave his permission for his son to work with a school-based Caring Across Communities project run by the Family Services Association of Bucks County. The program sought to go beyond traditional therapy, not only with more intensive one-on-one counseling in the schools but also through home visits, family counseling, and other forms of community outreach. In young George's case, working with a social worker, Allison Taite-Tarver, based at the middle school, and with a school psychologist helped

him improve both his grades and his self-esteem. Taite-Tarver made frequent visits to the family's home for additional counseling and even visited their church; she and a colleague then worked with them to prepare an application to transfer to a Christian boarding school in Indiana, a long way from urban gang activity. The application was successful.

Taite-Tarver concedes that in helping young George Wion adjust to—and then leave—Bucks County, the program barely scratched the surface of the teen's experiences in Liberia, where the family frequently moved around at the barrel of a gun. In an interview, the father filled in some of the blanks. "We were going from place to place, looking for food for the kids, and we had to go through all kinds of stuff," he said. "They would kill people, and they would be lying there dead in the street. But the kids were still little. . . ."

Ironically, the now famous phrase that "it takes a village to raise a child" is an African proverb, but it is here in Bucks County that the phrase came to life for George Wion Jr. and also for some of the other adolescent children among the estimated two hundred or so Liberians who resettled in Bucks County.

That's because the program in Bucks County came together through the efforts of a diverse team, including an enthusiastic principal at the FDR Middle School eager for outside help with its new Liberian students and other nontraditional immigrants. She was aided by staff members at the county mental health agency and at the Family Service Association, a nonprofit mental health and counseling agency. A suburban county such as Pennsylvania's Bucks has more resources than some cash-strapped locales, but officials still had a hard time delivering social services to the small number of Liberians who began trickling in roughly a decade ago, at the height of the civil war. Even though Liberians arrived speaking English, removing one barrier, officials said, early relief efforts by Catholic Social Services faltered. County mental health services were geared to interventions that could be billed to the federal Medicaid program. They did not provide

for the more broadly based family and school outreach envisioned by the Caring Across Communities grant—especially the community work, home visits, and family therapy efforts that were not covered by insurance—and the services that were available were difficult to access, especially by people who were working.

The program’s most enthusiastic booster is the school’s principal, Ruth Geissel, who began in 2006 and saw a few Liberian-born students involved in an alarming number of fights, especially with a much larger and entrenched group of African Americans. “The students coming in were used to fighting,” Geissel said, referring to Liberian teens who had spent their formative years in a refugee camp. “So it was much easier for them to fight than to work things out.” Officials with the refugee-counseling partnership that came together in Bucks County agree that the interest that Geissel and other school officials showed in a full-time social worker inside the school and in outreach to the community on the outside (in some other locales there has been resistance to these kind of programs) has been critical to the success of the effort; the principal even donated her own conference room so Taite-Tarver could work with students.

Another beneficial move was hiring a Liberian native named Abraham Kamara Jr., who first came to the United States in the 1970s with his single mother and was educated in American schools. Kamara has kept one foot planted in Liberian culture; he had already been working closely with the refugee community in Bucks County as a caseworker for Planned Parenthood when he was brought on to help the Family Service Association promote its efforts.

“I went into the churches, because you have to do it outside the box,” Kamara said. In many ways, he has been the kind of cultural broker the Nebraska writer Pipher had envisioned. In his part-time role, he not only went to religious services and soccer games but spent considerable time on aid that was tangential to mental health, such as housing, medical referrals, immigration-law problems, and connecting Liberians with food pantries. “You have to come at them with respect—you have to engage in a conversation

[about] being in this country and the opportunities that are given here, compared to being in Liberia,” said Kamara, who splits his time between the middle school and home and church visits. He said he understood the complexities of Liberian family life, including male dominance in household affairs, and often swept-under-the-rug problems caused by children coming to America with adults who are not their biological parents. Having an educated Liberian-American to talk to “just raises their self-esteem, makes them feel good about themselves,” Kamara said.

Diverse Approaches from Coast to Coast

Some communities used Robert Wood Johnson Foundation funding to develop a strategy different than those employed in Boston and Bucks County, where programs targeted a specific refugee group. In Portland, Maine, school officials found that their midsized New England city (population sixty-five thousand) was flooded with new arrivals from all over the globe—Cambodia, Somalia, Serbia, Vietnam, and Latin America, among other places—and that the existing network of social services was ill-equipped to meet refugees’ needs. About sixteen hundred of the seven thousand public school students in Portland were taking English as a second language (ESL) classes.

Grace Valenzuela, who directs the Portland Caring Across Communities project and is also assistant for multicultural affairs to the schools superintendent, said that “we were in silos”—with too little to bridge steep walls between the teachers, the guidance counselors, the social workers who worked with local immigrant groups, and the public mental health staffers who could treat the most trauma-stricken students. Although the resources to work with refugees with PTSD were largely in place, the missing pieces of the puzzle in Portland were largely twofold: (1) upgrading the cultural competence of the key players within the schools and social services, and (2) building trust with the immigrant parents to convince them to avail themselves of these services.

At the launch of the Portland program, its organizers worked with so-called consultants—community members who might receive gift certificates or other minimal compensation

for their efforts—to understand what the needs of the city’s different immigrant communities were. From that, a series of roughly thirty workshops for Portland’s professionals were held over the next three years on topics ranging from resettlement issues and immigration law to working with interpreters and notions of family and kinship. In addition to the knowledge that was shared, these sessions led to better communication between the once- isolated agencies. There were even one-on-one sessions between social workers and various healers within the refugee communities—all with the goal of improving cultural competence.

“We’ve learned that we have to shift the paradigm for healing as it exists—that we’re in a box and it’s been arbitrarily created for us by a system that really doesn’t do the work: they do things like insurance coverage,” said Lisa Belanger, the city of Portland’s family health program manager. She said the goal of the program in Portland and many of the other projects in Caring Across Communities was nothing less than “a revolution” in health care for refugees, centered less on top-down mandates about coverage and American notions of mental health best practices and more on the bottom-up cultural needs and related issues surrounding migrants. Growth of the Caring Across Communities program was analogous to the hospice movement, which arose from the failure of the health care and insurance industries to develop a system of care for the dying much as schools and some government agencies were oblivious to mental health problems among refugees. In three years, project leaders said the Portland program was able to offer counseling services to 153 students, often working closely with their families.

Despite obstacles, the program in Maine had an advantage that was not shared by some of the other Caring Across Communities projects. The Maine program had a supportive political climate, including many non-immigrant parents who cherished the diversity the public schools in Maine had to offer. But that was not the case in every locale where the Caring Across Communities projects operated. The 2000s were defined in much of the United States by a political climate of increasing resentment from native-born American

citizens toward immigrants who did not speak English or who lacked proper documentation, or both. In search of a decent wage, many refugees flooded rural Sunbelt communities that were not used to handling students from non-English-speaking homes, let alone to offering special services for trauma. Political resentment flourished in these communities.

Chatham County, North Carolina, a rural area south of the university town of Chapel Hill, is such a place; its town of Siler City was considered a model for television's Mayberry, the iconic fictional small southern town depicted on *The Andy Griffith Show* in the 1960s. Today, roughly half of this small town is made up of immigrants, mostly Spanish-speaking families from Mexico or Central America who were lured by work in a chicken processing plant that closed in 2008. The influx has not always been welcome; the notorious ex-Klan leader David Duke even held a rally in Siler City where he asked several hundred people, "To get a few chickens plucked—is it worth losing your heritage?"

In the county schools, officials report that about fifteen hundred of the seven thousand students are either Hispanic immigrants or the children of immigrants. As with refugee children from war zones, preliminary studies indicate high rates of mental health problems: Some 59 percent of the immigrant children are suffering from symptoms of anxiety, about one-third are dealing with PTSD, and 9 percent have had thoughts of suicide—and yet rates of treatment are appallingly low. When Caring Across Communities was launched in 2007, Mimi Chapman, an associate professor in the School of Social Work at the University of North Carolina, seized the opportunity to partner with the county school system and with El Futuro, a program that aggressively promotes and offers mental health programs for local immigrants, and with the county school system. The new partnership would be named Creating Confianza.

"A lot of these kids have problems because they were exposed to violence or to other traumatic life experiences," said Chapman. She said that many of the Latino immigrant

children experienced harrowing journeys from Mexico or elsewhere in Latin America with their parents who were in search of work. “I don’t think their teachers realize what they went through,” she said. “They have no idea that they saw people dying in the desert, or that they were kept alive on boxes of rice.”

Unlike some of its northern counterparts in the Caring Across Communities network, the district in Chatham County did not have a history of offering school-based mental health services to students. In launching *Creating Confianza* for the immigrant student population, Chapman and her partners were forced to create that foundation from scratch, working with parents and others to create a mental health advisory board. Although a cornerstone of the program was hiring a full-time, Spanish-speaking social worker—called a school-family liaison—based in the county’s middle and high schools, *Creating Confianza* learned that some of its most successful work was simply raising the awareness level of teachers about some of the issues their new students faced as immigrants. In one typical case, the liaison interceded on behalf of a Mexican-born, Spanish-speaking new arrival at his middle school who was uncommunicative and sometimes failed to show up at all. The liaison learned that the youth had developed poor attendance habits in Mexico, where he was often unable to attend his school because of local flooding. Simply learning the student’s troubled background and explaining his story to his teachers, Chapman reported, created a climate of improved compassion.

Creating Confianza workers found the bulk of their work involved achieving what it called “climate change” in the Chatham schools—for example, making sure a simultaneous translation machine was hooked up and working for parent-teacher meetings; the expensive device had been sitting idle, remarkably, for six years. Chapman and her team also went to great lengths to design two-hour sessions for parents. To encourage attendance, dinner and childcare were provided. At these sessions, the adults were asked to react to certain vignettes, told in such a way as to de-emphasize that the cases were mental health problems. *Creating Confianza* later reported that nine families

asked El Futuro for counseling after these meetings. Chapman said that “ninety-five percent of the parents tell us, ‘Yes, these problems are important—but I wouldn’t know where to go for help.’ Only three percent have sought mental health services. That’s a good indication that we need parents who are willing to participate.”

Rural Imperial County, California, which borders Mexico and Arizona, lies to the east of the San Diego metropolitan area. The mostly agricultural county’s population is roughly 75 percent Hispanic, mixing Mexican-American families who have been there for three or four generations with newly arrived immigrant families. Nearly a third of the county’s current population was born in Mexico. Here, Caring Across Communities financed a project that grew out of a longstanding project, Proyecto Puentes (the Bridges Program), which targeted mental health issues for students in two communities: Calexico, just across the border from the sprawling city of Mexicali, and Heber, an unincorporated community nearby with high poverty levels.

George Miranda, the longtime administrator of family services and student well-being in Imperial County, said social workers in the Bridges Program learned that some families who had been on the U.S. side of the border for a number of years continued to struggle with acculturation, language issues, and poverty. The Robert Wood Johnson Foundation grant allowed Proyecto Puentes to hire two bilingual *promotoras*, who worked with school staff, held weekly sessions with small groups of students in two junior high schools, and launched outreach efforts to parents. “They know the culture, they’ve grown up in the Valley, and they make personal contact with follow-up visits to the homes,” Miranda said of the *promotoras*. “They [have] also mastered the art of avoiding cultural stigmas by discussing mental health issues with families in terms of everyday stress.”

By the end of the second full year, more than three hundred students at the two schools had been connected to outside support services, and some thirty-four of these—kids who otherwise most likely would have fallen through the cracks—had received mental health services. “You need a lot of people to just get out there and talk to them and connect

with them,” Miranda said. Still, as the Caring Across Communities funding neared its end, Miranda seemed overwhelmed at trying to tackle these issues with only two full-time people. “It’s not a lot of resources, really—we need more support,” Miranda said.

Taking Stock

Miranda’s comments summed up the broader mood of those who had participated in Caring Across Communities as the three-year funding window was about to shut. There was optimism that the projects could make a difference for immigrant students and their families, tempered by the realization that models for a successful program are expensive, and options for future funding are limited.

Yet despite the limited time frame of the Caring Across Communities program and the uncertain funding prospects, those involved with Caring Across Communities said that in three years these pilot projects had accumulated a number of lessons to offer to others contemplating programs to improve mental health for immigrant and refugee children and their families. These lessons include the following:

1. *Cultural competence is key.* Many of the individual Caring Across Communities projects reported that their greatest progress came when they were able to identify and hire individuals or mental health professionals who came from the same country or ethnic background as the refugee population they were trying to serve. Most leaders said that these cultural brokers—who not only spoke the language but also understood taboos and culturally based selling points for wary refugee families—were the missing link that led to surprisingly high rates of parental participation.

Lear, the founder of the Center for Health and Health Care in Schools, said that working with community groups or social workers from the same culture as the refugees was important because immigrants might have been scared away by an imposing expert-heavy, mental health-only oriented approach. “As a culture, America really values expertise—and that is not a bad thing,” Lear said. “However, if the expertise is not going

to be a source of enlightenment, it can be a barrier.”

2. *The notion of building programs around the schools is a good one.* The public schools are clearly a focal point for immigrant and refugee families; that is especially true for programs such as the Caring Across Communities efforts in California and North Carolina, which targeted students born in Mexico or Central America where many parents lacked documentation and had few other contact points with official institutions. Likewise, many refugees—both political and economic—have placed many of their hopes for life in the United States on the education of their children, which is why school achievement is more likely to be a trigger for accepting aid, especially mental health counseling. “If you don’t have the commitment from the schools, then the program doesn’t work,” said Yallowitz, the program officer with the Robert Wood Johnson Foundation.
3. *Effective programs involve a wide partnership of school, community, and governmental groups.* The staff members who planned and organized the Caring Across Communities program said they felt vindicated in their original idea of a partnership model that connected existing community groups with school and mental health professionals. In communities with sophisticated social services infrastructures—such as those in Portland, Maine, and Boston—project organizers saw that all the key elements were in place. However, before the Caring Across Communities involvement, organizers were not communicating with one another. In more isolated or more poverty-stricken areas, the challenge instead was to take an existing asset—the in-school social services that already existed in Imperial County, California, for example—and use that as a base for building a new project.
4. *Parents must become stakeholders in the program.* Many of the programs put considerable resources into outreach programs aimed not only at telling families about the existence of the project but also convincing them of its merits. One of the more ambitious efforts was created by the Caring Across Communities program in San Jose, California and was named Project Tam An. Project Tam An was an Asian American Recovery Services program that targeted Vietnamese refugees. The project

secured a fifteen-minute weekly slot on a community radio show and ran ads in the ethnic newspaper for the region's Vietnamese. The radio show featured conversations with parents and teens (or with mental health professionals) and was aimed at combating the notion among parents that problems like PTSD were not treatable but were simply the result of "bad karma." Many of the Caring Across Communities projects also invested considerable resources in high-quality brochures or in sponsoring community breakfasts, all aimed at raising parent awareness and fighting stigmas and other fears.

Some of the directors of the fifteen individual Caring Across Communities projects came to learn that parents—perhaps intimidated by the American school systems—didn't think it was their role to get involved in such matters at first, but responded positively when they were sought out. "These refugee parents resettled here for their children," said Kristen Huffman-Gottschling of the Caring Across Communities project called World Relief-Chicago, which works with a polyglot of immigrant and refugee groups. "They [parents] are fully invested in their children's future."

To reach those parents, however, it was critical for the project leaders to also forge close working relationships with already existing social service agencies that had strong roots and had built trust within a particular immigrant community; trusted agency staff could serve as cultural guides and interpreters.

As the program began winding down in late 2009, the Robert Wood Johnson Foundation hired an evaluator, Clea McNeely, assistant professor in the department of public health at the University of Tennessee and an expert in adolescent mental health issues, to study five Caring Across Communities projects in depth to identify lessons that could guide similar programs in the future. Speaking in general terms about the programs, before her findings were published in 2010, McNeely noted that Caring Across Communities projects often found they had to deal with other barriers of poverty, cultural divides, and the day-to-day needs of employment or food before they

could even reach the point where intensive mental health treatment made sense.

McNeely said that the stronger projects she witnessed were moving away from a narrow focus on placing some refugee and immigrant kids into mental health counseling programs and were instead taking a more holistic approach to the range of problems that refugees face. “What is stress?” McNeely asked. “It’s moving to a neighborhood where’s there is crime and no jobs, where you are unable to get a driver’s license.” She joined program officials in noting that refugee families experience certain kinds of problems not typically addressed by traditional American treatment models, including the language barriers that often cause teens to assume adult roles in the family as well as a frequently voiced fear by parents that an angry child could report them for abuse and they could lose custody as a result.

McNeely said she would advise projects not to adhere too closely to what she called “the trauma model” of seeking to cull the most serious cases of PTSD or other severe mental health crises, but to instead move toward offering a much more broadly based set of services.

McNeely also noted that programs such as Caring Across Communities placed a heavy load on teachers, whose workday was already full. “The teachers need to teach,” she said, “and they’re being asked to do a lot more”—while often lacking both resources and the time to communicate with project staff members about individual students. “The stronger programs actually took the burden off the teachers’ shoulders,” McNeely continued. “The teachers loved it, and it helped them deal with problems that they were unequipped to handle or didn’t have time for.”

Indeed, McNeely said her evaluation research found that the Caring Across Communities projects were fighting what she believed to be an uphill battle against inadequate support for resettled refugees in general: the federal law on assistance for refugees, which had not been updated since 1980, was finally amended in 2009. McNeely notes that refugees receive only \$1,100, which must last them for four months

and out of which they typically have to pay rent, purchase food and transportation, buy clothes, and take care of their basic necessities. Immigrants, McNeely noted, often face economic challenges even more severe than those faced by refugees.

The annual fall gathering of the Caring Across Communities partners held in Washington, D.C., in the fall of 2009 centered on what was now the most critical issue: program sustainability.

At that conference, there was considerable sharing of information about which services could be billed for reimbursement for the Medicaid program, which typically covers resettled refugees and identifies regional grant makers who might consider supporting the more broadly based immigrant services. Despite the lingering effects of the American economic slowdown and disappointment about having lost support from the Robert Wood Johnson Foundation, many of the Caring Across Communities program leaders felt that the breakthroughs they had seen in just three years should bring new attention and sources of support—especially when so much more remains to be learned about refugees and their mental health issues.

The program’s leaders take pride in the individual children they have helped, including a case that Lear witnessed on a visit to Boston, where a Somali teen in the middle school was observed by teachers as isolated, angry, and acting out. “It turned out,” Lear recalled, “that the rumor had gone around the school that this boy was a boy soldier. The teachers were able to sit down with both the refugee community and with people who know something about treatment, and ask, ‘How do we deal with a situation like this?’” It was another case that showed that, regardless of whether the setting is Africa or America, quite often it can still take a village to save a child.

Notes

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