



# Caring Across Communities: Addressing Mental Health Needs of Diverse Children and Youth

An RWJF national program

*Caring Across Communities: Addressing Mental Health Needs of Diverse Children and Youth* brought school-connected mental health services to immigrants and refugees in 15 communities in eight states. From 2007 to 2010, partnerships developed model mental health programs that engaged schools, families, students, mental health agencies, and other local organizations in building culturally appropriate, readily available services. Most sites also offered supportive services such as case management. The Robert Wood Johnson Foundation (RWJF) Board of Trustees authorized the program for up to \$7 million.

## CONTEXT

Immigrants and refugees are a growing part of the U.S. population. In 2009, the foreign-born population in the United States numbered 38.5 million, or 12.5 percent of the population. Between 2000 and 2009, the foreign-born population increased by 7.4 million or 24 percent.<sup>1</sup> Immigrant youth—defined as those children under age 18 who are either foreign born or born in the United States to immigrant parents—now account for approximately a quarter of the nation’s 75 million children.<sup>2</sup> “These are special populations of children with mental health needs that are both unique and substantial,” said RWJF Program Officer Wendy Yallowitz.

### Starting a New Life in the United States

Children from immigrant and refugee families often face economic, social, and personal hardships. These families tend to be poorer than native-born families (with a poverty rate

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<sup>1</sup> From *Children of Immigrants and Refugees: What the research tells us* (Updated May 2011). Washington: Center for Health and Health Care in Schools: George Washington University, 2011.

<sup>2</sup> Ibid.

of 23 percent versus 18 percent).<sup>3</sup> Many do not have health insurance. Children must adjust to new cultural norms, new schools, and a new language, without the support of extended family, friends, and neighbors from their home country.

### ***The Traumatic Experiences of Refugees***

Refugees, one type of immigrant, have left their native country because of persecution or fear of persecution owing to their race, religion, nationality, political views, or membership in a specific social group.<sup>4</sup> Most refugees have experienced traumatic events, such as wartime atrocities or other violence, and they may also have lived in multiple refugee camps, where violence, food shortages, and lack of schools are common.

### ***Barriers to Mental Health Care***

Children from immigrant and refugee families are at higher risk than other children for depression, anxiety, social isolation, lack of social integration, and undiagnosed mental health disorders. They have limited access to mental health care, and face cultural and linguistic barriers to getting help.

One of the most substantial barriers is that most recent immigrants and refugees come from cultures where getting help for mental health issues carries stigma. People with limited English proficiency are also less likely than others to seek and receive health care of any type.

### **Consequences of Unmet Mental Health Needs**

Children with unmet mental health needs may:

- Do poorly in school or drop out
- Have behavioral problems
- Grow up to have fewer job opportunities or have difficulty performing a job

### **RWJF's Interest in This Area**

Factors outside the health care system, such as how and where people live, learn, work, and play, influence whether people are healthy or unhealthy. RWJF's Vulnerable Populations portfolio supports promising new ideas that address challenges that reflect these social determinants of health.

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<sup>3</sup> Ibid.

<sup>4</sup> For another definition of refugee see the Call for Proposals, available [online](#).

## **Building on RWJF Work in School Health**

*Caring Across Communities* built on RWJF's work in school health, which began in 1972. Early efforts included funding several school health programs, setting up a health center for children from poor families in two Chicago neighborhoods, and funding a national conference on school health.

Other major programs in school health included:

- *School Health Services Program*, which brought nurse practitioners into elementary schools attended by 150,000 children in four states (1978–1982).
- *School-Based Adolescent Health Care Program*, in which 19 institutions set up adolescent health centers in 24 high schools in 14 cities (1986–1993).

Julia Graham Lear, PhD, a faculty member at George Washington University's School of Medicine and Health Sciences, co-directed the program, the first of several related to school health that she worked on for RWJF, including *Caring Across Communities*.

- *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers* helped fund nine states and their local partners to establish new school-based health centers and promote policies to sustain them (1994–2001). The program helped participating states expand the number of school-based health centers from 278 in 1994 to 442 in 2000.

Lear directed the program, which was based at George Washington University. (See the [Program Results Report](#) for more information.)

## **Starting a Center for Health and Health Care in Schools**

In 2001, RWJF established the Center for Health and Health Care in Schools at George Washington, with Lear as the director, to strengthen the well-being of children and youth through health programs and health care services in schools.

Through 2005, the center had:

- Established a resource center on school health services for school nurses, staff of school-based health centers, school administrators, teachers, researchers, parents, and students
- Managed *Caring for Kids: Expanding Dental and Mental Health Services through School-Based Health Centers*, which used such centers to expand dental services (17 schools in six states) and mental health services (17 schools in seven states)

For more information, see the [Program Results Report](#).

*Caring Across Communities*, which started in 2006, was part of the efforts of RWJF’s Vulnerable Populations team to help meet the emerging needs of vulnerable communities whose populations are changing—in this case, through immigration. “This was a new vulnerable population. The children were overly represented in a number of mental health concerns that we were reading about and seeing,” said Judith Stavisky, the initial RWJF program officer for *Caring Across Communities*.

## **THE PROGRAM**

*Caring Across Communities* brought school-connected mental health services to immigrants and refugees in 15 communities in eight states. From 2007 to 2010, the program’s sites developed model mental health projects that engaged schools, families, students, mental health agencies, and other local organizations in building culturally informed, linguistically accessible, and readily available services for children, youth, and their families. Most sites also offered supportive services such as case management to help families with basic needs such as winter clothing or housing.

With the encouragement of RWJF and the national program office at the Center for Health and Health Care in Schools, the sites developed different models and approaches. “We didn’t know enough to create a single model,” said Lear. But all the sites:

- Offered at least some mental health services in schools
- Provided families with interpretation and translation services
- Adapted their strategies to the cultural group(s) being served

### **Focusing on Communities with Many Immigrants and/or Refugees**

All the projects were located in communities with many immigrants and/or refugees, and were led by a public or not-for-profit institution. The projects ranged from two in Los Angeles with many Mexican and Central American immigrants, to Fargo, N.D., where refugees from Somalia, Sudan, Bosnia, Liberia, Iraq, and other countries were resettling.

A lead organization in each community received a three-year grant of up to \$300,000, which began in March 2007 and ended between February and August 2010. For a list of communities and lead organizations, see [Appendix 1](#).

### **Focusing on Schools**

RWJF focused *Caring Across Communities* on schools because they were the most obvious point of contact with immigrant and refugee children and their families. “We wanted to narrow it down to where we could make the biggest impact, and schools were where immigrant children were spending the majority of their time,” said RWJF’s Yallowitz.

Also, most immigrant and refugee parents understood the importance of a good education. “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 youth in school and help them achieve,” said Program Director Olga Acosta Price, PhD, MA.

Elementary, middle, and high schools served as the venue where children received mental health services, or as part of a network of care in each community. Although the services were geared to the needs of immigrants and refugees, they were available to all students in participating schools.

Along with schools, the lead organizations worked with families, community groups such as immigrant and refugee organizations, local mental health agencies, faith-based groups, and others.

## **Management**

### **National Program Office**

The Center for Health and Health Care in Schools at George Washington University, the national program office for *Caring Across Communities*, is nationally known as “a go-to source of information and analysis on school health services,” according to former RWJF Program Officer Stavisky.

Lear, one of the nation’s few authorities on health services in school settings, according to Stavisky, directed the program initially. After RWJF awarded the grants to the sites, Lear named Acosta Price, who had been deputy director, as director of *Caring Across Communities*. Lear also became a senior adviser to the Center for Health and Health Care in Schools, and Acosta Price became director of the center.

The center provided technical assistance and direction to the sites. The following are some of the methods employed:

- Annual conferences and a wrap-up meeting
- Site visits, which allowed program staff to develop a technical assistance plan for each site in conjunction with site staff
- An extranet through which the sites could share information about their work with each other and the center
- Webinars
- Web-based resources

To encourage partnerships between *Caring Across Communities* and *New Routes to Community Health*, another RWJF program focused on the health needs of immigrants and refugees, center staff facilitated three meetings for grantees of both programs.

In 2007, RWJF awarded the center a separate grant<sup>5</sup> to expand technical assistance to people and organizations working in health care or mental health for immigrant and refugee children and families. Staff responded by expanding the center’s website technology and content to create a community of e-learners.

Center staff also assessed opportunities to support mental health programming in Texas and Florida, two states with large immigrant and refugee populations that had submitted few proposals to *Caring Across Communities*. Based on eight key informant interviews, staff concluded that agency reorganization, attitudes toward mental health, immigrants and refugees, and funding for mental health services in those states would make it unproductive to invest time and resources there at that time.

In 2010, RWJF awarded the center a grant to disseminate program findings and promote a national discussion of them, and to communicate with a growing network of organizations working with immigrant and refugee communities. RWJF and the center have been holding webinars to disseminate information on the program.<sup>6</sup>

### National Advisory Committee

A national advisory committee helped select the *Caring Across Communities* sites. Individual members also spoke at the program’s annual meetings and participated in webinars and site visits. For a list of members, see [Appendix 2](#).

### The Evaluation

In 2009, RWJF awarded a grant to the Center for Health and Health Care in Schools to select and fund an evaluation of *Caring Across Communities*. RWJF and the center chose Clea McNeely, DrPH, assistant professor of public health at the University of Tennessee, Knoxville, and a researcher at the university’s Center for the Study of Youth and Political Violence and department of public health, to lead the evaluation.

The evaluation focused on identifying common elements of culturally appropriate and accessible mental health services, based on five projects that represented the age range and type of children the program served (immigrant, refugee, or both) and various regions:

- Bienestar, led by Duke University School of Medicine, Durham, N.C.
- Albany Park Refugee and Immigrant Youth Mental Health Project, led by World Relief–Chicago, Chicago
- Explorer’s Program, led by the Village Family Service Center, Fargo, N.D.

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<sup>5</sup> Grant ID# 61284.

<sup>6</sup> Grant ID# 66646.

- The 3 R’s Project: Building Relationships, Resiliency, and Recovery in Children, led by the Los Angeles Child Guidance Clinic
- Project SHIFA (Supporting the Health of Immigrant Families and Adolescents): School-Based Trauma Systems Therapy for Somali Adolescent Refugees, led by Children’s Hospital Boston

The evaluation explored these three questions:

- What are the challenges experienced by the children and families the *Caring Across Communities* programs serve?
- What are the necessary components of comprehensive mental health services for immigrant and refugee children?
- How can partnerships between schools and community agencies work most effectively to implement these components?

McNeely and colleagues investigated these questions through 83 in-depth interviews with site leaders and staff, school staff, staff from partner agencies, and parents of participating children. The evaluators also conducted a focus group with eight mental health providers at one site.

The evaluators developed findings across the five sites they studied.

## OVERALL PROGRAM RESULTS

National program staff and evaluators reported the following results to RWJF in an evaluation report<sup>7</sup> (available [online](#)), other reports and interviews, and on the *Caring Across Communities* website:

- ***Caring Across Communities* projects provided thousands of immigrant and refugee children and families with access to culturally responsive mental health prevention and treatment services.**

— *The projects supported more than 9,000 students (ages 3–18) in 36 schools (15 elementary schools, 10 middle schools, three K–8 schools, and eight high schools).* The projects served children who spoke 33 languages and were from 55 countries, and provided care in more than 20 languages.

*“When families are engaged, the students do better in school and their mental health outcomes improve. They are less depressed, less angry, less anxious. They are more able to focus and stay on track.”—a psychiatric social worker*

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<sup>7</sup> McNeely C et al.

Read about Delmar, a Somali refugee who learned how to make friends and focus on school, in [Appendix 3](#).

For example, in Portland, Maine, refugees from Africa and Iraq and immigrants from El Salvador, Guatemala, and other countries at 18 schools had access to mental health services to reduce emotional and behavioral problems.

Read more in a sidebar about *Caring Across Communities* in [Portland, Maine](#).

- *The projects engaged more than 4,600 parents/caregivers and partnered with more than 4,500 teachers, counselors, school health professionals, and others.*

For example, the School Outreach Program in Bucks County, Pa., worked with leaders in the Liberian community to understand the culture and needs of refugee families. Project staff then trained teachers, counselors, and principals in the participating school district on how to work with Liberian students and families.

Read more in a sidebar about *Caring Across Communities* in [Bucks County, Pa.](#)

- *The projects offered services that ranged from schoolwide mental health promotion (14 schools), to group counseling (11 schools), to individual counseling (10 schools), to home visits (10 schools).*

Examples of schoolwide mental health promotion are:

- Life skills coaching during breakfast and lunch in the cafeteria, and on the playground during recess, for students at an elementary school and a middle school in Fargo, N.D.
- Stress management groups at Norwood Elementary School in Los Angeles
- **The immigrants and refugees faced four types of challenges that caused emotional distress: economic, language, and academic challenges; stress adjusting to life in a new culture; challenges related to parenting and children’s behavior; and trauma.**

- *Almost all families faced daily challenges stemming from poverty, language barriers, and the fact that their children lagged behind U.S.-born students academically.*
- *The majority of immigrant and refugee children experienced stress from learning to navigate the U.S. culture.*
- *Some parents faced challenges related to their children’s behavior and how to be good parents in a new country.*

*“We had older children who didn’t know what school was about—they had never been in a school before.”—a mental health provider*

*“There was no connection between parents and teachers because we came from a community that has never been involved with any school system.”—a family liaison for refugee students*

— *Children and parents faced challenges related to traumatic or tragic events they had experienced, such as political violence or the loss of family members.* However, those concerns were not always foremost, according to evaluator McNeely. “If someone’s hungry and you want to help them with trauma that happened four years ago, they’re not that interested,” she said.

- **Four components of mental health services for immigrant and refugee children are essential:** engaging families, meeting basic needs, support for adapting to a new culture, and emotional and behavioral support. These components follow a hierarchy of needs, and must be seamlessly integrated so families can turn to one person to gain access to all services.

— *All services build from family engagement, which entails establishing relationships with families and identifying their unique needs and strengths.*

Home visits, especially, help build those relationships. “This seems to be the single most effective thing programs can do to engage families, establish trust, and accurately assess the needs of their children,” said McNeely.

Providing a consistent, helpful, and culturally comfortable presence in the community—such as by greeting families as parents dropped their children off at school every day—also helped engage families.

— *Comprehensive mental health interventions should start by responding to families’ basic needs, such as winter clothing or a mattress for a child to sleep on, academic supports for children, and language classes for children and adults.*

“You can’t just provide mental health services,” said Yallowitz. “You need to think about the whole picture and all the environmental factors that contribute to mental health issues.”

Addressing basic needs may be an efficient way to resolve mental and emotional distress for many immigrant and refugee families. “Lack of basic resources was universally stressful among the refugee and immigrant families,” said McNeely. “A lack of housing, medical care, transportation, and even food placed them at risk for stress-related problems (e.g., family conflict) and traumatic experiences (e.g., gang violence).”

Identifying basic needs and helping families meet them was also an effective way to build trust.

— *Nearly all refugees and some proportion of immigrants need support in adapting to a new culture.* Using cultural brokers who

*“If you’re not someone the family can go to when they have a concrete need, why are you someone they would go to for a really high-level, personal need, like ‘My child is breaking down at night and I’m worried about her killing herself.’” —Project Director*

understood the cultures of refugees and immigrants—and who may even have been immigrants or refugees—helped families integrate into American culture.

Successful cultural brokers are bilingual and bicultural, know the local refugee or immigrant community, and can spend time with families, conduct home visits, and respond to emergencies. Program staff who are not of the culture can assist with cultural adaptation as well, particularly if they understand the culture and are open to learning about it from the families.

- ***A significant minority of children need intensive emotional and behavioral supports.*** Such supports may include trauma-informed individual and group therapy, support groups, individual behavior plans, coaching in conflict resolution and relationship skills, mentoring, and nontraditional individual and group therapies, such as narrative methods, play therapy, and cinema therapy.

The evaluators referred to these services as emotional and behavioral supports rather than therapy or counseling for two reasons:

- Some cultures stigmatize therapy and counseling, and using those terms can inhibit the delivery of services. Four of the five projects avoided using the terms “mental health,” “counseling,” or “therapy” when they first contacted families.
- Not all stakeholders saw counseling or therapy as distinct from social and emotional supports. Some project leaders viewed mental health services as any service that reduced environmental triggers of emotional problems (e.g., help paying the rent, since a financial shortfall could trigger such problems).

Read the story of Lucy, a Mexican immigrant who becomes a happy little girl again in [Appendix 4](#).

Projects that effectively engaged parents and integrated all four components had mental health providers work hand in hand with bicultural family liaisons whom the families trusted. These liaisons helped families navigate a new culture, interpret a new language, understand a new academic setting, and gain access to economic resources.

- **Five actions maximized effective collaboration among community partners:**

- ***Focusing resources.*** Sites that served a single school could deliver all four components of comprehensive school-linked mental health services, and staff and partners expressed satisfaction with their work and could point to clear accomplishments.

Sites that spread staff across multiple schools or locations had higher staff turnover. Staff felt overwhelmed and expressed feelings of inadequacy. Parents had less contact with staff and perceived fewer benefits.

However, a focus on one school may make it harder to build a constituency across a school district to sustain a project.

— **Sharing resources.** Partners were more willing to collaborate when they perceived mutual benefit. For example, teachers who attributed a drop in behavior problems in their classrooms to the project were more likely to refer students to project services and share information about children’s families. And partner agencies committed more time to project activities—whether or not they were paid—when those activities helped them achieve their goals.

— **Developing a shared vision.** Such a vision entails a commitment to the program model along with constant cultural adaptation and flexibility, respect for each other’s point of view, the team itself, and, most importantly, the children and families.

— **Supporting teachers.** Many immigrant and refugee groups see teachers as a trusted resource. Projects therefore found that teachers were essential partners who needed support to help children adjust to a new culture, which in turn fosters academic achievement. Stakeholders, including teachers, identified two ways to support teachers:

- Provide training on working with immigrant and refugee students
- Provide day-to-day support with discipline, behavior management, and caring for students

— **Devoting resources to coordinating among partners.** Integrating all four components of mental health services for immigrant and refugee children required more coordination among partners than anticipated. Project directors at sites with the most coordination worked many more hours than those for which the grant compensated them.

- **Caring Across Communities made mental health services more accessible to immigrant and refugee youth, and bolstered the ability of staff to work with them.** Although the evaluation was not designed to assess the impact on immigrant and refugee well-being, participants spoke about it often enough that the evaluators suggested effects in three areas:

*“As a teacher, I see how these behaviors affect children in the actual classroom. Once the children got the counseling and guidance, I’ve seen them come around. We’ve set up a behavior plan for them, we’ve given the parents and children counseling...now they are able to focus on learning.”—a teacher*

*“I try to meet with parents as often as I can in homes. Lots of parents want to do that. Sometimes it’s actually better so I can see what’s going on in the homes, too.”—a mental health provider*

- ***Made mental health services more accessible to immigrant and refugee youth.*** Several stakeholders indicated that the *Caring Across Communities* grant had this effect.
- ***Improved child affect<sup>8</sup> and behavior.*** Parents, teachers, and mental health providers reported that children were better able to focus and learn, and were less disruptive in class.
- ***Greater ability among parents and children to advocate for themselves, at sites that worked the most intensively with parents.*** For example, some parents were better able to talk to teachers about what their children needed.
- ***Caring Across Communities created tools to guide the design and implementation of school-connected mental health services for immigrant and refugee students.***

Examples include:

- The Children’s Crisis Treatment Center in Philadelphia developed a [guidebook](#) for training school personnel in its West African Refugee Assistance Program, a trauma treatment program.
- Project staff from New York University School of Medicine created two training manuals (available [online](#)) based on the Bridges program in Brooklyn, to help immigrant students and families and teachers who work with them reduce the stress of learning to live in the United States.
- An [article](#) by project staff from Children’s Hospital Boston and others in the *Journal of Child & Adolescent Trauma* outlines why refugee communities rarely use mental health services even when in need, and how to overcome these barriers.<sup>9</sup>

## Site Themes

- **All the sites developed approaches to providing mental health services that were culturally appropriate for local immigrant and refugee families.** These approaches included:
  - Reframing mental health services as a way to help children do well in school, to combat the stigma of mental illness in the cultures of most immigrants and refugees.

*“Aside from speaking Spanish, I’m an immigrant myself. When I have disclosed that...it helps to establish the rapport quicker and kids can relate to me.”—a mental health provider*

<sup>8</sup> Affect is the expression of emotion through expressions, gestures, and voice tone.

<sup>9</sup> Ellis BH, Miller AB, Baldwin H, and Abdi S. “New Directions in Refugee Youth Mental Health Services: Overcoming Barriers to Engagement,” *Journal of Child & Adolescent Trauma*, 4: 69–85, 2011. Available [online](#).

- Hiring mental health providers (at some projects) and cultural brokers with a similar backgrounds as the immigrants and refugees. The brokers helped engage families and build relationships between them and mental health providers.
- Providing services in the native language of immigrant and refugee families

Examples of culturally appropriate approaches:

- A 14-week parenting class run by the Bridges program in Brooklyn, N.Y., began with parents teaching staff about Afro-Caribbean culture and how it relates to raising children. Program staff then modified the parenting strategies they taught to mesh with Afro-Caribbean culture.
- The Los Angeles Child Guidance Clinic provided all services, and even held project meetings, in Spanish.

Read more in a [sidebar](#) about how projects enhanced cultural competence in Brooklyn, Chicago, and Los Angeles.

- Staff from Project Tan Am in San Jose, Calif., had a 15-minute weekly slot on a local radio show, and ran ads in a Vietnamese newspaper, to tell refugee families about the project. The show, which featured conversations with parents and teens or mental health professionals, tried to dispel the notion that problems such as post-traumatic stress disorder were the result of “bad karma” and not treatable.
- **Most sites provided special services for children who had experienced trauma, such as living through a war, losing or being separated from family members, living in a refugee camp, or experiencing violence.**

Examples of special trauma services include:

- Project SHIFA (Supporting the Health of Immigrant Families and Adolescents) in Boston combined a weekly support group for Somali students at one middle school with Trauma Systems Therapy, to help students with significant trauma-related mental health issues.

The support group helps students learn how to become part of American culture while maintaining their sense of who they are. Trauma Systems Therapy considers a child’s social environment along with the trauma he or she has experienced. It includes home-based care, school-based therapy, and advocacy (e.g., helping families get better housing), and is customized to each child’s needs.

Read the story of Mustafa, a Somali refugee, who learns how to conquer his trauma in [Appendix 5](#).

- Minneapolis Public Schools helped rebuild connections between children and Latin American parents who had come to the United States years before their children. Project staff used Parenting Through Change, a group training program

that teaches parents effective, positive parenting practices related to limit-setting, monitoring, involvement, and encouragement.

Read more in the [sidebar](#) about special services for traumatized children in Boston and Minneapolis.

The Los Angeles Unified School District and partners provided Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) to traumatized students at Belmont High School. The intervention provides mental health screening and brief standardized therapy sessions to reduce children’s trauma-related symptoms and enhance skills for handling future stresses.

*“The children grew up as refugees, and they were even jumping on the table at first, so [the Caring Across Communities provider] helped us with the kids by talking to them about how to respect teachers and the school.”—a refugee parent*

- **Three sites—Chatham County and Durham in North Carolina, and Fargo, N.D.—developed systems to provide mental health services in areas that were new destinations for immigrants and refugees.** For example:

— *The Explorer’s Program in Fargo served refugees from Somalia, Sudan, Bosnia, Liberia, Iraq, and other countries at one middle school and one elementary school:*

- A mental health professional provided individual and group therapy.
- A youth skills coach helped all children build social skills.
- A cultural mentor, a recent refugee or immigrant, worked closely with students, the school, parents, and other partners to bridge the cultural gap and create stronger connections between the school, parents, and the Explorer’s Program.

Staff at the Village Family Service Center, which led the Explorer’s Program, also helped build a network of services for immigrants and refugees by participating in the new Inter-Agency Network for New Americans and the Multi-Cultural Parents and Teachers Association. The center also formed the Subcommittee for the Mental Health of New Americans.

*“A student talked to me about how he and his mom had walked for like eight days nonstop. And he was just really tired and he was really scared.”—a mental health care provider*

— *Building on Duke University’s health centers in three elementary schools in Durham, staff at the academic medical center, the public schools, a local Latino organization, and a mental health provider developed strategies to address the mental health needs of immigrant families.*

Duke hired a bilingual clinical social worker and a bilingual/bicultural health educator to run support groups on cultural orientation and child behavior management to help prevent problems for children, parents and families; and other groups to provide individual, family, and group counseling.

- **Most sites sustained at least some of the services provided during *Caring Across Communities*, and some sites sustained their entire program.** The keys to sustainability were tapping Medicaid or other third-party payments for services, and establishing strategic partnerships in which partners took ownership of aspects of the program, according to Project Director Acosta Price.

Examples of how sites sustained their work:

- The Family Service Association of Bucks County (Pa.) established outpatient behavioral health treatment sites licensed by the state at the two schools that participated in *Caring Across Communities*, enabling the agency to bill Medicaid for the services. The county Children and Youth Social Services Agency is funding home visits and case management, which are not covered by Medicaid. These services are now available to all students.

The Bucks County Behavioral Health System (the county Medicaid agency) has adopted the model, establishing treatment sites at 17 schools (as of August 2011). The Family Service Association runs 11 of these sites.

- Under a contract from Imperial County Behavioral Health (Calif.), a partner in *Caring Across Communities*, the county Office of Education is running the Nurturing Parenting Program. The primarily school-based program focuses on preventing mental health problems.
- In Chatham County, N.C., a clinical social worker at the middle school that participated in *Caring Across Communities* sees students at the school two days a week, and at her agency two days per week. Medicaid and Chatham County cover most of her services.

Read the [sidebar](#) for more about sustaining the work done during *Caring Across Communities* in Imperial County, Chatham County and Minneapolis.

Communities that used a more traditional clinical model sustained their efforts more easily than those that tried to “follow the spirit of what RWJF was trying to accomplish,” according to evaluator McNeely: comprehensive, original models to restructure mental health services to make them truly accessible to immigrants and refugees.

Sites that used the traditional clinical model, however, were less successful in expanding access to care, and did not have case management support to help families meet basic needs, leading to a lot of stress for staff.

More traditional sites “were the ones who carried on, because they had either billable hours or access to other funds. It was an existing service, they tweaked it to make it fit the grant, but they didn’t really change the system. The ones that really took to heart the mission of RWJF and were really implementing the essential services weren’t able to carry on,” said evaluator McNeely.

## Conclusions

“We have growing evidence about which practices in school-based mental health are effective,” said Program Director Acosta Price. “However, we lacked information on which interventions and engagement strategies are respectful and a good match for various cultural and ethnic groups. *Caring Across Communities* helped us begin to understand which innovative strategies and creative approaches can draw on the strengths of these communities to ensure higher-quality care and good outcomes.”

Overall, this program “challenged the dominant model” for viewing immigrant and refugee families, which emphasized the trauma they had endured, evaluator McNeely noted. Participating communities found that “the chronic stresses of ‘how to do life in America’ are much more challenging on a day-to-day level for immigrant and refugee children than the fact that they may have been held at gunpoint crossing a border. We need to look much more holistically at the challenges these children face.”

“On a macro level, this program showed us what needs to be done: to coordinate the fields of mental health and education, and to make a stronger case for this kind of work,” said RWJF Program Officer Yallowitz.

## Communications Results

The Center for Health and Health Care in Schools created a [website](#) for *Caring Across Communities*, using another RWJF grant<sup>10</sup> to add resources and continue dissemination of activities after the program ended. Key online resources included:

- Website pages on each site
- The evaluation report, *Comparative Case Study of Caring Across Communities: Identifying Essential Components of Comprehensive School-Linked Mental Health Services for Refugee and Immigrant Children*<sup>11</sup>
- Webinars on mental health screening in schools, attracting and sustaining support for children of immigrants and refugees, and other topics— some accessible from the [home page](#) (under *Caring Across Communities* webinars)

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<sup>10</sup> Grant ID# 66646.

<sup>11</sup> McNeely C et al.

Center staff also disseminated program results and resources through:

- Several Listservs with 3,105 subscribers
- Presentations at 22 national conferences and exhibits at 19 conferences
- Meetings with national partners in education, mental health, and immigrant/refugee advocacy organizations to discuss findings from the program

## LESSONS LEARNED

1. **Parental involvement is critical to the effective delivery of mental health services, especially to families new to the United States.** Parental engagement was a key strategy in *Caring Across Communities*. “Engaging families in any services for their children will improve outcomes,” said Acosta Price.
2. **Address children’s and families’ needs for safety, shelter, and food before tackling their mental health needs.** The most successful programs were those that addressed these basic needs early on by providing case management services. (National Program Director/Lear)
3. **When communities integrate mental health services for immigrants and refugees with other social services and case management, the acceptance of mental health services is high, even when stigma is pervasive.** In sites that completely integrated those supports into other services, acceptance of intensive mental health services was high. In sites where mental health providers made cold contact with families to offer therapy, gaining parental trust to help a child was more difficult. (Report to RWJF)
4. **When mental health providers work closely with cultural brokers who help families navigate complex systems, they are much more likely to engage families in services and find that they comply with treatment.** “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.” (Report to RWJF; RWJF anthology chapter on the program<sup>12</sup>)
5. **Helping immigrants and refugees deal with everyday stresses is a higher priority than helping them deal with trauma that happened years ago.** Experiencing traumatic or tragic events, such as violence or the loss of a parent, was a challenge for the immigrants and refugees served by *Caring Across Communities*, but its importance was overemphasized, according to evaluator McNeely.

“If someone’s hungry and you want to help them with trauma that happened four years ago, they’re not that interested,” she said. The everyday stresses of living in

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<sup>12</sup> “Caring Across Communities,” in *To Improve Health and Health Care*, Volume XIV, Robert Wood Johnson Foundation, 2011.

poverty and in poor neighborhoods, and having limited economic, social, and cultural resources, were of much more immediate concern to children and parents.

6. **Use home visits to assess mental health issues and build trust with families.** Home visits were a key component of comprehensive mental health services for immigrants and refugees at many sites. “The single best way to assess what’s going on with the family and establish trust and engagement with the parents is a home visit. The programs that didn’t do it really struggled,” said evaluator McNeely.
7. **Schools are effective sites for delivering prevention, early intervention, and treatment services, especially if they are treated as equal partners.** Schools were a key partner for every site, and offered at least some services. They were “clearly a focal point for immigrant and refugee families.” Many refugees regard their children’s education as very important, so doing well in school is “likely to be a trigger for accepting aid, especially mental health counseling.” (Report to RWJF. RWJF anthology chapter<sup>13</sup>)
8. **Support from school administrators is critical.** “The top concern of administrators is often test scores and academic success,” RWJF Program Officer Yallowitz noted. “To get buy-in, we need to educate administrators about how emotional, social, and behavioral health affects academic performance.”
9. **Train teachers and other school staff on the experiences and challenges of immigrant and refugee families.** Sites that trained and worked with school staff one-on-one reported improvements in their cultural competence, as well as their understanding of mental health and the importance of fostering positive ethnic identity among their students.

These professional development activities were a relatively cost-effective method of reaching many more students and families than providing direct services. (National Program Director/Acosta Price)

10. **Identify key community partners and build strong relationships with them.** Sites that nurtured relationships with key partners and invited them to help develop, implement, and evaluate a project made significant progress.

Sites that held regular meetings with partners and developed a shared agenda and goals, and where partners respected each other, drew on each other’s strengths, understood their roles, and shared grant resources, were able to sustain and expand their services. (National Program Director/Acosta Price)

11. **The stability of local leaders, the commitment of participating agencies, linking to school priorities, and diversifying funding influences the speed and depth of a community’s progress.** For example, when a project director or supportive superintendent left, progress stalled. (National Program Director/Acosta Price)

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<sup>13</sup> Ibid.

**12. Look for leaders who can improve the visibility and acceptance of mental health programs for immigrant and refugee families.** Such leaders were charismatic, connected to key decision-makers, committed to addressing the mental health needs of vulnerable youth and families, credible with the community, and consistent in their messaging. (Report to RWJF)

**13. Foster innovation by allowing flexibility.** Flexibility allowed providers to adapt evidence-based practices to each culture and pay attention to the complex needs of immigrants and refugees. “It was an iterative learning process where they could try something and get feedback from all stakeholders and make adjustments. The flexibility was important in articulating best practices,” said Acosta Price.

For lessons from the sites, see [Appendix 6](#).

## AFTERWARD

### Expanding School-Based Mental Health Programs

*Caring Across Communities* revealed the need to build capacity for school-based mental health services, and led RWJF to expand such work to all children who are part of vulnerable populations, according to Yallowitz.<sup>14</sup>

RWJF provided two grants to the Center for Health and Health Care in Schools to build capacity for such programs and “make a bigger case for this kind of work going forward,” said Yallowitz. “We want to translate policy into practice, and create tools for people to implement programs and sustain them.”

### Research on School-Based Mental Health Programs

The first grant,<sup>15</sup> awarded in August 2010, allowed the center to conduct research on school-based mental health programs. Center staff:

- Conducted interviews, focus groups, and surveys with thought leaders, foundation staff, and school personnel
- Analyzed public policies and federally funded grant programs related to mental health
- Analyzed lessons learned from *Caring Across Communities* and other RWJF national programs managed by the center

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<sup>14</sup> The Foundation considers as vulnerable those people who do not have the same kinds of opportunities to make healthy decisions as others, and who have compromised opportunities for good health owing to insufficient education, inadequate housing, racism, or low income.

<sup>15</sup> Grant ID# 67762.

This work informed RWJF's online [School Based Mental Health Forum](#), which examined laws, regulations, and policies that affect the organization and funding of school-connected mental health (March 28 through April 22, 2011).

### ***Policy Opportunities in School Mental Health***

The second grant,<sup>16</sup> awarded in January 2011 and scheduled to end in March 2012, is allowing the center to:

- Analyze school-connected mental health programs across a number of states
- Explore strategies to increase the number, quality, and sustainability of school-connected mental health interventions
- Identify opportunities to institutionalize school-connected mental health services and programs in school districts, state education agencies, and federal agencies

The goal of the project is to help ensure maximum uptake of federal and state policy opportunities supporting school mental health.

The center co-hosted a meeting of mental health and education researchers with the federally funded Center for School Mental Health in September 2011 to discuss integrating mental health and education research and to support the application of scientific knowledge to educational practices. This effort, based partly on work with [MissionWise](#) from 2009 to 2010, prompted the center to focus even more strongly on school-based mental health programs and start a business plan for its operations.<sup>17</sup>

The center also continues to act as a clearinghouse for resources and tools on school-connected mental health services. To build on *Caring Across Communities*, the center is strengthening its partnerships with national organizations, professional associations, other technical assistance centers, federal agencies, experts in immigrant/refugee mental health, state refugee coordinators, and other state officials.

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#### **Prepared by: Lori De Milto**

Reviewed by: Sandra Hackman and Molly McKaughan

Program officers: Wendy L. Yallowitz and Jane Isaacs Lowe

Grant ID # CAC

Program area: [Vulnerable Populations](#)

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<sup>16</sup> Grant ID# 68467.

<sup>17</sup> RWJF provided a grant (ID# 63411) to MissionWise, a division of the Comprehensive Health Education Foundation, to help the center and other organizations funded through the Vulnerable Populations portfolio expand their impact and sustainability by improving their business capacity.

## APPENDIX 1

### *Caring Across Communities Projects*

#### **Boston, Mass.: Children’s Hospital Corporation**

Project Name: Project SHIFA: Supporting the Health of Immigrant Families and Adolescents

Focus: School-based Trauma Systems Therapy for Somali youth and their families

ID# 61056 (March 2007–August 2010) \$296,087

**Project Director:**

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#### **Brooklyn, N.Y.: New York University School of Medicine (New York, N.Y.)**

Project Name: Bridges Program

Focus: Afro-Caribbean immigrants

ID# 61050 (March 2007–July 2010) \$298,520

**Project Director:**

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#### **Chatham County, N.C.: University of North Carolina at Chapel Hill (Chapel Hill, N.C.)**

Project Name: Creating Confianza

Focus: Latino immigrants

ID# 61052 (March 2007–July 2010) \$296,769

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**Chicago, Ill.: World Relief-Chicago**

Project Name: Albany Park Refugee and Immigrant Youth Mental Health Project

Focus: Refugee and immigrant children in Albany Park

ID# 61058 (March 2007–February 2010) \$300,000

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**Durham, N.C.: Duke University School of Medicine**

Project Name: Bienestar

Focus: Newly arrived Latino parents and their children

ID# 61053 (March 2007–May 2010) \$299,390

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**El Centro, Calif.: Imperial County Office of Education**

Project Name: Proyecto Puentes/Bridges Program

Focus: Mexican immigrants

ID# 61073 (March 2007–May 2010) \$300,000

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**Fargo, N.D.: Village Family Service Center**

Project Name: Explorer's Program

Focus: Refugees from Somalia, Sudan, Bosnia, Liberia, Iraq, and other countries

ID# 61060 (March 2007–May 2010) \$299,584

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**Langhorne, Pa.: Family Service Association of Bucks County**

Project Name: School Outreach Program

Focus: Liberian refugees

ID# 61057 (March 2007–February 2010) \$300,000

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**Los Angeles, Calif.: Los Angeles Child Guidance Clinic**

Project Name: The 3 R's Project: Building Relationships, Resiliency, and Recovery in Children

Focus: Mexican and Central American immigrants

ID# 61068 (March 2007–July 2010) \$288,828

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**Los Angeles, Calif.: Los Angeles Unified School District**

Project Name: Bienestar: A High School Program for Traumatized Immigrant Adolescents

Focus: Mexican and Central American immigrants

ID# 61055 (March 2007–June 2010) \$300,000

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**Minneapolis, Minn.: Minneapolis Public Schools**

Project Name: School Based Mental Health–Building Cultural Connections and Competence

Focus: Somali, Oromo, Liberian and Latino immigrants and refugees

ID# 61064 (March 2007–August 2010) \$299,945

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**Philadelphia, Pa.: Children’s Crisis Treatment Center**

Project Name: West African Refugee Assistance Program (Tamaa) School Training

Focus: West African refugee children and their families

ID# 61051 (March 2007–February 2010) \$289,661

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**Portland, Maine: Portland Public Schools**

Project Name: Empowerment Across Communities

Focus: A diverse group of refugee and immigrant students

ID# 61061 (March 2007–June 2010) \$300,000

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**San Jose, Calif.: Asian American Recovery Services (South San Francisco, Calif.)**

Project Name: Tam An (Inner Peace) Project

Focus: Vietnamese children and their families

ID# 61049 (March 2007–February 2010) \$300,000

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**Watsonville, Calif.: Santa Cruz Community Counseling Center (Santa Cruz, Calif. )**

Project Name: Nuestro Futuro

Focus: Predominantly Mexican migrant and immigrant students

ID# 61048 (March 2007–May 2010) \$300,000

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## APPENDIX 2

### National Advisory Committee

*(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)*

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Shanti K. Khinduka Distinguished Professor of Social Work and Professor of Psychiatry  
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## **APPENDIX 3**

### **Delmar, a Somali Refugee Learns How to Make Friends and Focus on School**

Dalmar and his family came to Boston from war-torn Somalia. When the 14-year-old started high school, he was intimidated by his classmates. To hide this, he acted tough. Soon, the other students stayed away from him. Even his teachers seemed unfriendly and unhelpful.

After two years in school, Dalmar had earned just half a credit. He was often suspended for fighting and talking back to teachers. He began picking on other kids and was disruptive in class.

Then a school counselor turned to Project SHIFA (Supporting the Health of Immigrant Families and Adolescents), the *Caring Across Communities* project in Boston led by Children's Hospital Boston. Naima, a social work student at Boston University who was also from Somalia, worked with Dalmar, teachers, administrators and staff. She had been trained to provide mental health services under *Caring Across Communities*.

Naima learned about rumors that Dalmar was a child soldier in Somalia who had killed people and was still dangerous. She helped teachers, administrators and staff understand that the rumors were not true. She also taught staff and Dalmar's classmates what life had been like in Somalia for Dalmar and his family.

Dalmar also began counseling. With new understanding, teachers began to engage Dalmar in class. And he began to make friends and focus on his studies.

## APPENDIX 4

### **Lucy, a Mexican Immigrant Becomes a Happy Little Girl Again**

After moving to Los Angeles with her family, Lucy stopped smiling or playing. She cried a lot, was losing weight, and had headaches. The little girl, who had been happy, eager to please and eager to learn, stopped listening to her parents and did so poorly in the first grade that she had to repeat it. She wanted to go back to Mexico.

Lucy's teacher referred her to the Los Angeles Child Guidance Clinic's 3R's Project at Norwood Street Elementary School, a *Caring Across Communities* project in Los Angeles. A counselor worked with Lucy for nine months to learn more about her thoughts and feelings and find ways to help her. She learned that Lucy missed her brother, who had been sent back to Mexico after being threatened by local gang members. Lucy also missed her friends and the foods and customs of Mexico.

The counselor spoke to Lucy in Spanish and used art therapy to encourage her to express her feelings. As Lucy began to talk more, the counselor helped her work through her grief about living in the United States without her brother, and suggested she write to him.

During that school year, Lucy became more confident, tried new things, and gradually began to feel better. Before long, Lucy was making new friends and doing better in school. At home, Lucy's behavior problems disappeared and she was a happy little girl again. And she wanted to stay in this country.

## APPENDIX 5

### **Mustafa, a Somali Refugee Learns How to Conquer His Trauma**

For Mustafa, a sixth-grader from Somalia, the challenge of adapting to life in Boston was almost too much. Mustafa and his family had lived through Somalia's civil war. In the chaos of the war, Mustafa was separated from his parents and placed with relatives he barely knew. When Mustafa's relatives won refugee status in the United States and moved to Boston, he was suddenly expected to adapt to American schools, culture and norms with little support and almost no recognition that he had post-traumatic stress disorder.

By the time staff members from Project SHIFA (Supporting the Health of Immigrant Families and Adolescents) at Children's Hospital Boston heard about Mustafa, he had already been labeled a "bad kid." His teachers reported fighting and other behavioral problems, and he was hanging around with other students who had behavioral problems. He was doing poorly in school.

Mustafa began attending a weekly school-based support group for Somali students and working with a therapist. The group work helped him learn how to become part of American culture while maintaining his sense of his own culture. Through the group, he met other students who could help him make good decisions and began to make friends.

The therapy, called Trauma Systems Therapy, focused on making Mustafa's social environment more stable and teaching him how to deal with the trauma he had experienced. It included home-based care, school-based therapy and advocacy for necessary services, such as more appropriate school placement or better housing.

Within a few months, Mustafa's grades began to improve. He entered the seventh grade and started to become a model student. Mustafa also began to talk about the future in a positive way.

## APPENDIX 6

### Lessons from the Sites

#### *Lessons From Partnerships*

14. **Solid partnerships are instrumental to sustaining school-connected mental health programs.** World Relief-Chicago found its partnership crucial both in times of crisis and in times of growth. For example, partners' strong advocacy during a state fiscal crisis enabled the project to maintain and increase funding. Partners also helped the project win funding after *Caring Across Communities* ended. (Report from World Relief-Chicago to RWJF)
15. **In effective partnerships, each partner learns about the other partners, including how their "business" works and their challenges.** For example, community agencies and schools often have different budget years, which has significant implications for funding a joint project. (Report from Minneapolis Public Schools to RWJF)

#### *Lessons From Working with Immigrants and Refugees*

16. **Establishing trust with immigrant parents takes time and patience.** "As staff provided services, the children and parents felt understood and cared for, gained greater confidence in the relationship, divulged more, and asked for more help and information," according to a report from the Los Angeles Child Guidance Center to RWJF.
17. **Expect immigrant and refugee families to have difficulty understanding the importance of mental health services.** The Proyecto Puentes project in Imperial County, Calif., found that families did not understand how mental health services could help them, and that attitude deterred them from using these services.

Some families were also afraid that authorities would ask too many questions. Project staff used personal interactions to help families feel comfortable. (Report from Imperial County Board of Education to RWJF)

18. **Incorporate case management services into mental health programs for immigrant families.** Staff at the School Outreach Program in Bucks County, Pennsylvania found that families responded positively to mental health services when offered along with help in gaining access to other essential resources. “Families felt that this combined approach conveyed care and concern for their overall well-being,” said Project Director Audrey Tucker, MSW. She added, “The ability to share resources with families and students that will help improve their lives is key to building trust and establishing rapport.”
19. **Engage stakeholders by using their native language.** The Los Angeles Child Guidance Clinic conducted meetings in Spanish, “not only as a mechanism to engage parents but out of our respect for their central importance.” As a result, parents became very engaged, influencing services and encouraging other families to use them. Parents also provided practical help, such as distributing flyers to publicize events and services. (Report from Los Angeles Child Guidance Clinic to RWJF)
20. **New immigrant Latino youth and parents will use mental health services if they already have a relationship with project staff.** The Creating Confianza project in Chatham County, N.C., built relationships with families before problems occurred by basing a clinical social worker at participating schools. (Project Director/Mimi Chapman, MSW, PhD)
21. **Avoid lumping refugees and immigrants together, as their needs differ.** Project staff in Portland, Maine, worked with both groups, and found that their experiences diverged. For example, immigrants choose to come to the United States, whereas refugees are often assigned to a country. Providers must tweak service delivery to meet the needs of each group. (Report from Portland Public Schools to RWJF)

### ***Lessons From Mental Health Projects***

22. **Use support groups to avoid any stigma associated with mental health problems.** Project staff in Boston used a support group to get to know students and their parents, giving staff a reputation as helpful and supportive. That made it easier to engage parents and students in more intensive mental health services. (Report from Children’s Hospital Boston to RWJF)
23. **Providing school-based mental health services is intensive work that requires adequate resources, particularly staff.** New York University’s Bridges program in Brooklyn, N.Y., found that school staff did not have time to provide the intensive support needed to address students’ mental health concerns. Project leaders revised the program to allow Bridges staff to spend more time in each school, to provide some of the needed support. (Report from New York University to RWJF)

## **Other Lessons**

24. **Work intensively with school administrators before implementing a program.** Staff with the Bridges program in Brooklyn, N.Y., had won broad buy-in from school administrators, but did not discuss needed resources or ask them to be part of the project. “If we had started by meeting with principals regularly to review goals and needed resources, that would have given us opportunities, such as a guarantee that teachers and space for programs would be available,” said Project Director Esther J. Calzada, PhD.
25. **Include family members in every stage of a project, from conception and design to implementation and evaluation.** For example, the *Caring Across Community* project in Portland, Maine, held focus groups with immigrant and refugee families to learn about their needs. (Report from Portland Public Schools to RWJF)

## BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

### Articles

#### Journal Articles

Lear JG, Barnwell EA, and Behrens D. “Health-Care Reform and School-Based Health Care.” *Public Health Reports*, 123(6): 704–709, 2008. Available [online](#).

Lear JG. “Health At School: A Hidden Health Care System Emerges From The Shadows.” *Health Affairs*, 26(2): 409–419, 2007. Available [online](#).

#### Non Journal Articles

Kugler EG and Acosta Price O. “Go Beyond the Classroom to Help Immigrant and Refugee Students Succeed.” *Kappan Magazine*, 91(3): 44–52, 2009. Abstract available [online](#).

### Reports

#### Evaluation Report

McNeely C, Sprecher K, and Bates D. *Comparative Case Study of Caring Across Communities: Identifying Essential Components of Comprehensive School-Linked Mental Health Services for Refugee and Immigrant Children*. Knoxville, TN: University of Tennessee, Knoxville, 2010. Available [online](#).

#### Issue Briefs

*Issue Brief #1: Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs*. Washington: Center for Health and Health Care in Schools, 2008. Available [online](#).

*Issue Brief #2: Partnering with Parents and Families to Support Immigrant and Refugee Children at School*. Washington: Center for Health and Health Care in Schools, 2009. Available [online](#).

#### Fact Sheet

*Children of Immigrants and Refugees: What the research tells us*. Washington Center for Health and Health Care in Schools, 2006 (Updated 2011). Available [online](#).

## Reports

*Mental Health Interpreter Training Table: Where to Find Training? What Type? What's the Cost?* 2007. Washington: Center for Health and Health Care in Schools. Available [online](#).

*Tips for Mental Health Interpretation.* Washington: Center for Health and Health Care in Schools, 2007. Available [online](#).

## Communications or Promotions

### Grantee Website

[www.healthinschools.org/Immigrant-and-Refugee-Children/Caring-Across-Communities.aspx](http://www.healthinschools.org/Immigrant-and-Refugee-Children/Caring-Across-Communities.aspx). Provides an overview of *Caring Across Communities*, describes the sites and offers publications and other resources. Washington: Center for Health and Health Care in Schools.

## PROFILE LIST

### Site Profiles

- **Increasing Understanding of Immigrant and Refugee Families: Caring Across Communities project in Portland, Maine** (Grantee: Portland Public Schools, Portland, Maine)
- **Helping Students Do Well in School: Caring Across Communities project in Bucks County, Pa.** (Grantee: Family Service Association of Bucks County, Langhorne, Pa.)

### Theme Profiles

- **Enhancing Cultural Competence: Caring Across Communities projects in Brooklyn, N.Y., Chicago and Los Angeles** (Grantees: New York University School of Medicine; Los Angeles Child Guidance Center; and World Relief-Chicago)
- **Helping Traumatized Refugees and Immigrants Start New Lives: Caring Across Communities projects in Boston and Minneapolis** (Grantees: Children's Hospital Corporation, Boston; and Minneapolis Public Schools)
- **Continuing School-Connected Mental Health Services: Caring Across Communities projects in Minneapolis, Imperial County and Chatham County, N.C.** (Grantees: Minneapolis Public Schools; Imperial County Office of Education; University of North Carolina at Chapel Hill)