Opening Doors to Opportunity for Refugees

Addressing Toxic Stress and Child and Family Well-Being for Refugee Children and Adults

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Setting the Stage

Toxic Stress

- What is it?
- How does it affect children?
- What negative child and eventual adult outcomes are associated with toxic stress exposure?

Stressor: A stressor is an experience or action that causes an individual to experience stress – it is subjective

Stress: Stress is an individual's response to a stressor; it can be physiological, mental, or emotional and is NOT ALWAYS bad.

STRESS IN CHILDHOOD
Three Types

Stress is a mental, physical, or biochemical response to a perceived threat or demand. Stress is a natural and inevitable part of childhood. But the *type of stress* can make a difference in the impact on a child's brain and body, as well as potential effects that can last a lifetime.

POSITIVE STRESS
Normal, typical childhood experiences

Common Stressors
- Child care drop off and pick up
- Playground injuries
- Losing a game

Buffering
- No buffering support necessary

Brain & Body
- Temporary, mild elevation in stress hormones
- Brief increase in heart rate and blood pressure

Long-term
- Increased resiliency and confidence
- Coping skills development

TOLERABLE STRESS
More complicated, scary, challenging, and long-lasting

Common Stressors
- Natural or manmade tragedy
- Parents' divorce
- Poverty
- Death of a loved one

Buffering
- Caring adult buffers stress

Brain & Body
- More severe, continuing cardiovascular and hormonal response

Long-term
- Adaption and recovery likely, but potential for lasting physical or emotional damage

TOXIC STRESS
Severe, long-lasting, uncontrollable, and/or frequent stress

Common Stressors
- Physical, sexual, or mental abuse
- Neglect
- Exposure to violence
- Severe economic hardship

Buffering
- No adult buffers child from stress

Brain & Body
- Prolonged activation of stress response system
- Disrupted development of brain circuits
- Immune system depression

Long-term
- Possible lifelong changes, such as:
  - Heart disease
  - Alcoholism
  - Memory, learning, multitasking difficulties
  - Anxiety/depression
  - Cancer

Sources:
http://www.nimh.nih.gov/health/publications/stress/index.shtml
http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response
http://www.cdc.gov/ncipc/pub-res/pdf/childhood_stress.pdf
http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp3

HARVARD T.H. CHAN
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Shanbaro Community Association

Chelsea Collaborative

Addressing Health Disparities in the Mental Health of Refugee Children through Community Based Participatory Research: A Study in Two Communities

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Learning Objectives

- The refugee experience: implications for family functioning and child mental health
- Discuss importance of CBPR research with refugee communities
- Understand the application of shared data to addressing issues of policy and community concern

CBPR WITH REFUGEE COMMUNITIES

Community-Based Participatory Research (CBPR)

- Engages researchers and community members in equitable partnership; deconstruct power differentials (Minkler, 2010; Leung et al., 2004)
- Community members engaged in all aspects of research (Wallerstein & Duran, 2006)
- Well suited for research on and elimination of health disparities
- Shared access to study data and tools; all team members become representatives of the research

CBPR and mental health

- Limited application so far in mental health, particularly with refugees
- Promising approach, given stigma around mental health
- Understanding local context and language (i.e. around mental health problems) can improve community engagement and inform intervention development (Betancourt et al, 2010)

Refugee barriers to care

- Reluctance to seek out services
  - Stigma around mental health
  - Lack of resources
- Families overwhelmed by their own migration experiences
  - Services access is very poor; especially for children—families may not be able to recognize needs
  - Unaware of what services are available
- Limited referral networks from schools, pediatrics etc.

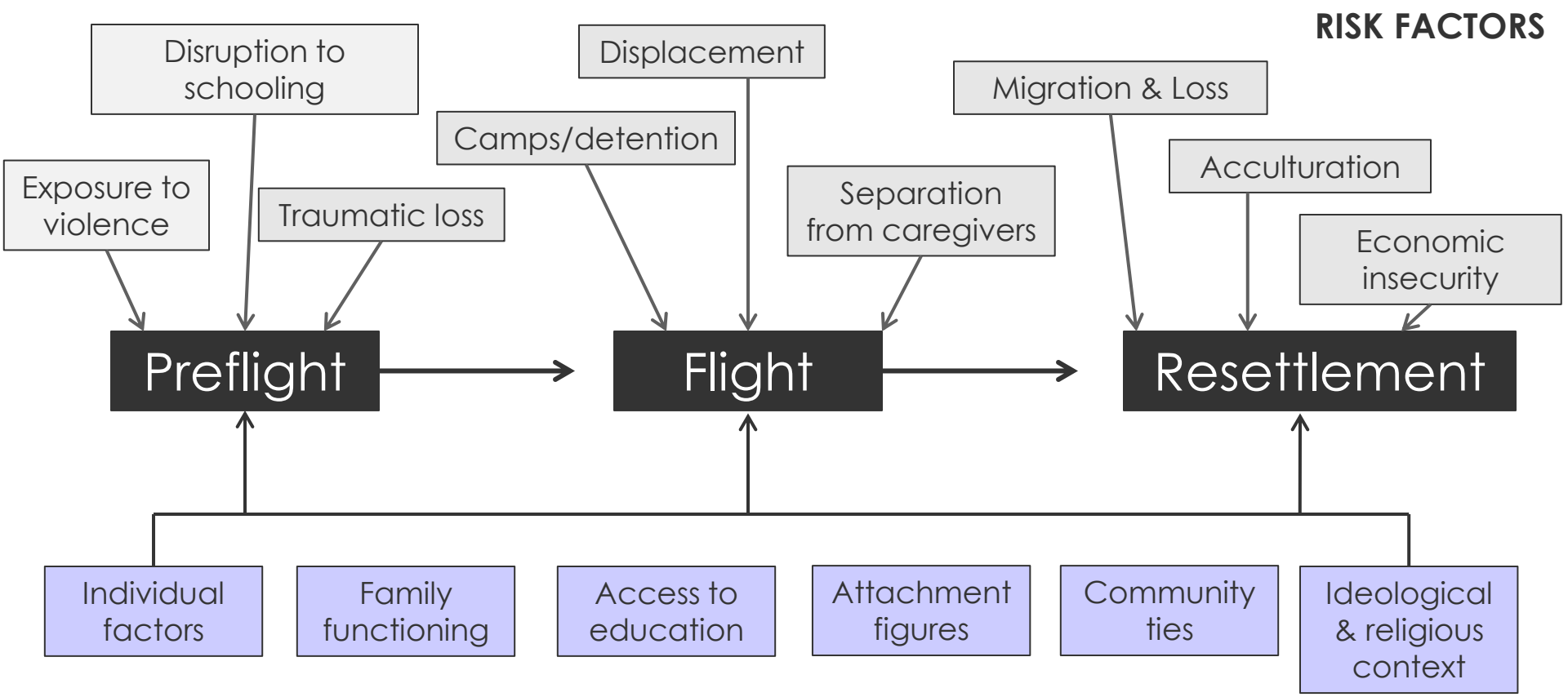
(Fazel et al., 2012; Edberg et al., 2010)

THE REFUGEE EXPERIENCE

Refugee children and mental health

- Globally, there are 15.4 million refugees; a third of these are children and youth (UNHCR, 2013)
- US admits about 70,000 refugees each year.
- Exposed to violence, loss (as well as acculturative and resettlement stressors) that increase risk of poor mental health outcomes.
- Depression(3-30%), PTSD (20-57%) - compared to 12% and 5% in general US population
- Children in US have poor access to mental health services; situation exacerbated in refugees (Betancourt et al., 2012; de Anstiss et al., 2009)

Stages of Displacement



(Lustig et al, 2004)

SOMALI BANTU REFUGEE COMMUNITY

Somalia

- Somali Bantu have a history of slavery in Somalia – Likely from Mozambique, Tanzania, Rwanda, and other African Nations
- Limited access to education, healthcare in Somalia; jobs limited to farming
- 1991 Civil war erupted affecting all in Somalia
- Instability continues to date;
- Prolonged brutal fighting, disruption of basic food production and services

Kenya – Refugee Camps

- Massive population displacement; Dependence on UNHCR rations
- Somali Bantu in very insecure areas of the camps; Lootings from across the border at night
- No access to Kenyan society, citizenship, jobs, limited education; slow resettlement of both Somali Majority and Somali Bantu to host countries

Somali Bantu Refugees in the US

- Somalis are largest single group of resettled African refugees in U.S. history
- In 2004, an estimated 12,000 Somali Bantu were resettled in 50 communities across 38 states
- Resettlement in the Boston area began in February 2004 with two families; now over 400 in the greater Boston area

BHUTANESE REFUGEE COMMUNITY

- Bhutan- geographically and politically isolated kingdom
- Ethnic cleansing initiated by government in early 90's evicting over 100,000 ethnic Nepalese ((Lhotshampas)

- Settled in eastern part of Nepal in Refugee camps

Bhutanese Refugees in the US

- Third country resettlement began in 2007. over 49,000 resettled in US (CDC, 2012).
- Stigma around mental health in Bhutanese culture
- Exacerbating mental health problems once resettled in the US
- Increasing rate of suicide among Bhutanese in the US (21.5 per 100,000), higher than national average.

Research Partnership

- History
  - 2004, Lynn, MA Public Schools
  - Work on how to better support Somali Bantu refugee children in public schools
  - Evolving community partnership took time
- Result
  - Distinct collaboration to meet both community and research goals

Chelsea Collaborative and Shanbaro Community Association

Aim of Partnership

- Understand the community situation and its priorities
- Assessing the nature of problems and causes before developing solutions
- Improve communication through learning community language, concepts, and beliefs
- To improve screening and assessment; assist in planning interventions & programs

Value of Partnership

- Investing in refugee community
  - Employment, skill building, advocacy for services
- Refugee community has ownership of research and data – greater chance of sustainability
- Insider knowledge leads to higher quality of research

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Far From Home

Photograph courtesy of Theresa Betancourt

Zahara Haji (foreground) and Amina Abdullahi, research assistants in Betancourt's project with the Somali Bantu refugee community in Boston, during a presentation at Chelsea City Hall

The larger community learns about the Somali Bantu Research Project

Boston Bantu Girls

MIXED METHODS AND CROSS CULTURAL MENTAL HEALTH

Culture in Assessment/Measurement and Intervention Development

"Ethnographic studies demonstrate convincingly that concepts of emotions, self, and body, and general illness categories differ so significantly in different cultures that it can be said that each culture's beliefs about normal and abnormal behavior are distinctive"

(Kleinman 1988, p.49)

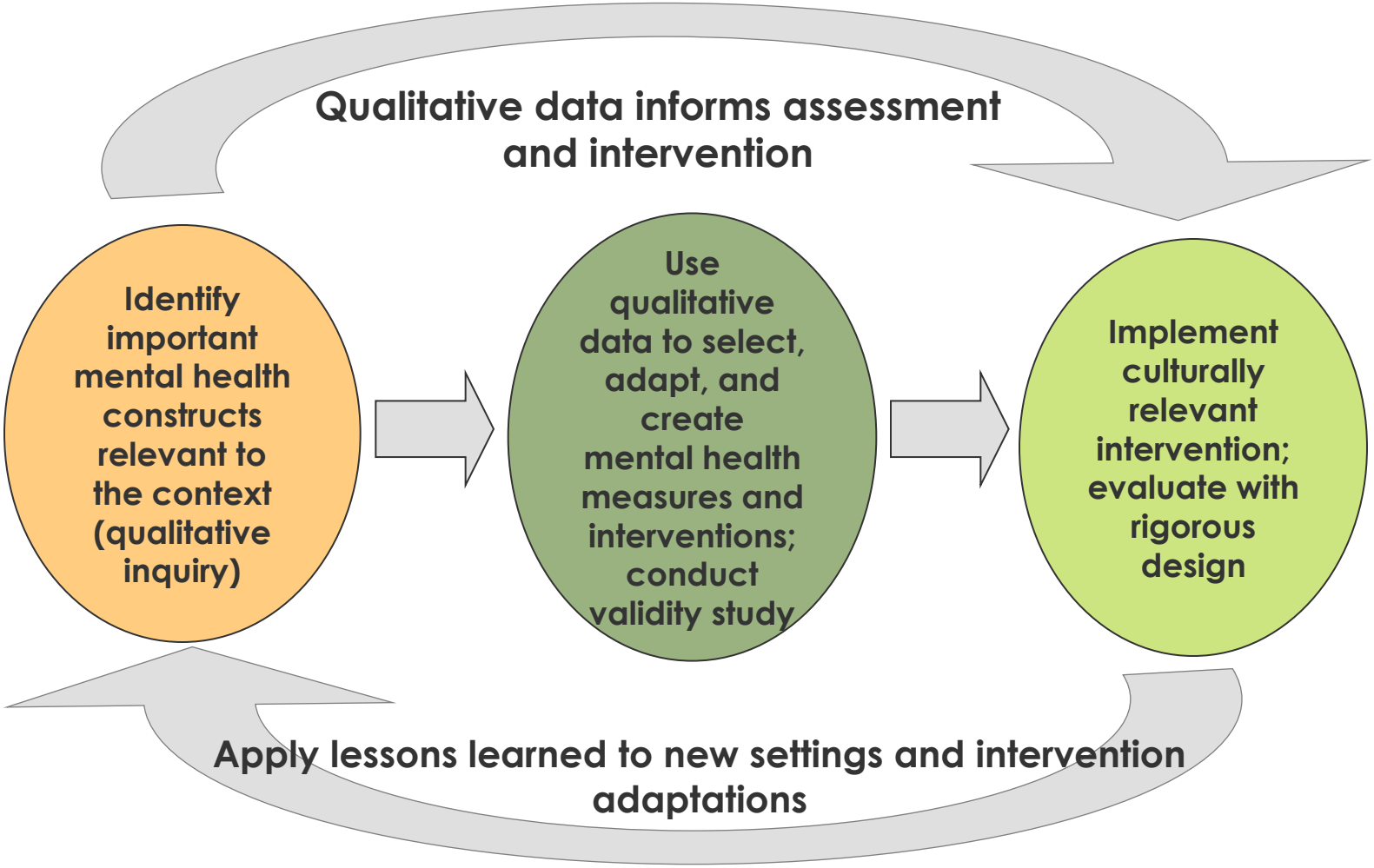
Typical Use of Questionnaires in Assessment

1. Select or create questionnaire/select standard measure to adapt
    - Usually developed *outside* the local culture/situation
2. Translate into local language (no validity tests)
3. Individual interviews with survey
4. Determine need based on frequency of responses
5. Choice of problem and therefore intervention is based on quantitative results
6. Repeat individual surveys before and after intervention to assess program impact

Problems with Relying on Western Measures in Cross-Cultural Research

- **Cultural validity:** How closely concepts in a questionnaire match local concepts; Western/outside concepts may not apply locally
- **Unknown local concepts:** Are there important local issues/concepts unknown to us? How to include questions we don't know we should be asking?
- **Translation problems:** Who translates? Translation- back translation methods inadequate, can result in semantic equivalence but real-world insignificance
- **RISK: Evaluations don't accurately measure impact**

A Model for Designing and Evaluating Mental Health Services in Diverse Cultural Settings



APPLYING THE MIXED METHODS PROCESS WITH REFUGEE COMMUNITIES IN BOSTON

American Journal of Public Health (AJPH), 2015

Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities

Theresa S. Betancourt, ScD, MA, Rochelle Frounfelker, MPH, MSSW, Tej Mishra, MPH, Aweis Hussein, and Rita Falzarano, BA

Objectives. We sought to understand the problems, strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees and determine local expressions of mental health problems among youths in both communities.

Methods. We used qualitative research methods to develop community needs assessments and identify local terms for child mental health problems among Somali Bantu and Bhutanese refugees in Greater Boston and Springfield, Massachusetts, between 2011 and 2014. A total of 56 Somali Bantu and 93 Bhutanese refugees participated in free list and key informant interviews.

Results. Financial and language barriers impeded the abilities of families to assist youths who were struggling academically and socially. Participants identified resources both within and outside the refugee community to help with these problems. Both communities identified areas of distress corresponding to Western concepts of conduct disorders, depression, and anxiety.

Conclusions. There are numerous challenges faced by Somali Bantu and Bhutanese youths, as well as strengths and resources that promote resilience. Future steps include using culturally informed methods for identifying those in

There are disparities in the mental health of refugee children and adolescents resettled in the United States compared with youths in the general US population. For instance, the prevalence of posttraumatic stress disorder and depression among resettled refugee children is estimated to be as high as 54% and 30%,[1] respectively, compared with an estimated 5% (posttraumatic stress disorder) and 11% (depression) of youths with these disorders in the general population.[2] In addition to specific psychiatric disorders, refugee youths experience overall greater psychological distress than those in the general population.[3]

Research Aims

- ***Objectives***. To **understand the problems, strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees**
- Determine **local expressions of mental health problems among youth** in both communities
- *Methods.* Qualitative research methods were used to develop **community needs assessments** and identify **local terms for child mental health problems** among Somali Bantu and Bhutanese refugees.
- **N=56 Somali Bantu** and **93 Bhutanese refugees** in free list and key informant interviews
- Assist in planning interventions & in later evaluation of impact

Free List Exercise

- Respondents are asked a question designed to elicit responses in the form of a list
- Responses & short description recorded verbatim in the respondent's own language
- Trained local interviewers
- Topic: **Problems facing refugee children in the community**

Key Informant Interviews

- Prolonged, semi-structured interviews with local knowledgeable people
- Investigate selected free list issues in detail (nature, causes)
- What helps a child with these problems? (individual, family, community factors)?
- What do children and their parents do to get help with these problems? (help seeking)

TABLE 2—Problems and Protective Resources Among Somali Bantu and Bhutanese Refugees Living in the Greater Boston and Springfield, MA, Area Between 2011 and 2014

Variables	Youths, No. (%)	Adults, No. (%)	Total, No. (%)
Somali Bantu			
Problem			
Financial problems	10 (50)	11 (55)	21 (53)
Kids losing their religious education; no madrassa	10 (50)	6 (30)	16 (40)
Trouble with homework	7 (35)	9 (45)	16 (40)
Language difficulties for parents	8 (40)	6 (30)	14 (35)
Problems with housing	7 (35)	7 (35)	14 (35)
Children don't listen to parents, have bad friends	10 (50)	4 (20)	14 (35)
School work difficult; worried won't graduate	5 (25)	7 (35)	12 (30)
Need a job; lack of jobs; don't know how to get a job	5 (25)	5 (25)	10 (25)
Language difficulties for children	4 (20)	6 (30)	10 (25)
Young and old need education; no place to study	1 (5)	8 (40)	9 (23)
No one to watch kids or taking care of children	2 (10)	7 (35)	9 (23)
Protective resources			
Somali Bantu community organization or other local community organizations	6 (30)	10 (50)	16 (40)
Maay Maay translators	5 (25)	10 (50)	15 (38)
Somali Bantu community support and strength	9 (45)	4 (20)	13 (33)
Teachers, school counselor, principal, teacher–parent working together	5 (25)	5 (25)	10 (25)
Friends	1 (5)	9 (45)	10 (25)
Call others in the community with good English to translate and help with paperwork	7 (35)	2 (10)	9 (23)
Government benefits, welfare, food stamps, housing subsidies	2 (10)	6 (30)	8 (20)

	Bhutanese		
Problem			
Language difficulties	24 (80)	27 (84)	51 (82)
Financial problems	8 (27)	13 (41)	21 (34)
Bullying or teasing	12 (40)	6 (19)	18 (29)
Difficulty with homework	9 (30)	6 (19)	15 (24)
Distance to school or no school bus	7 (23)	7 (22)	14 (23)
Lack of friends	4 (13)	7 (21)	11 (18)
Fighting	6 (20)	4 (13)	10 (16)
Fear or scared	7 (23)	3 (9)	10 (16)
Loneliness	3 (10)	5 (16)	8 (13)
Depressed or sad	3 (10)	5 (16)	8 (13)
Protective resources			
Bhutanese community members	13 (43)	15 (47)	28 (45)
Parents or family—advise children, help with school work	13 (44)	12 (38)	28 (45)
Refugee or immigrant service organizations	10 (34)	13 (41)	23 (37)
Government programs—SSI, EBT, MassHealth	5 (17)	12 (38)	17 (27)
Friends—play with friends, share problems, help with homework	13 (44)	4 (13)	17 (27)
Relatives—financial help, help with homework, mediate conflicts	11 (37)	5 (16)	16 (26)
Neighbors—help with homework, financial help, give advice	4 (13)	8 (25)	12 (20)
Teachers—help with studies, language, resolve fights, encourage	4 (13)	5 (16)	9 (15)
Local hospital	6 (20)	2 (6)	8 (13)
Interpreters	. . .	5 (16)	5 (8)

Note. EBT = electronic benefit transfer; SSI = Supplemental Security Income.

TABLE 3—Somali Bantu Local Mental Health Syndrome Terms and Descriptors

Syndrome Term	Descriptor	
	Maay Maay	English
Aasiwaalidin (conduct problems)	*Sharaf laawe*	Disrespectful
	Edeb laan	Lack of "asluup" (respect)
	Dherif	Easily angered
	Makoroof	Disagrees, argues, talks back to parents
	Karawai	Does not obey parents
	Ded-mekaalmeyay	Does not assist others
	Rabshoole	Has conflict with peers
	Dhega adeeg	Poor follow through
	Dantiis gorod	Self-centered
	Shaqa diid/Hool beel	Does not like to work; does not engage with education
	Mas'uul dare	Does not take responsibility for actions
	Kerway	"Making trouble" or bullying other children
	Gardaresti	Engages in fighting
	Daroogiste	Engages in negative behaviors (e.g,. drinking alcohol, gambling, joining gangs)
Wel wel (worry)	*Was was*	Worries about current and future life stressors
	Absi	Fear
	Fulemimo	Overly scared about things
	Dhug-la'aan	Poor attention
	Damiin	Forgetful
	Siseeg	Poor follow through
	Tiirman	Engages in quiet, isolative behavior
	Is shuujin	Weight loss
	Mathy dhuury	Headaches
	Indhu-dhuuru	Visual disturbances
Dherif (anger)	*Amal*	Quick to anger
	Murug	Feel as though they are under pressure
	Amal low	Easily upset by small issues
	Kifle	Defensive (get angry when you joke with them)
	Kerway	"Making trouble"
	Isfilit	Anger without reason
	Hanaang	Anger
Takoor (persistent sadness)	*Takoor*	Sadness
	Ma'abos	Low mood, always unhappy
	Tiire/joogow maqane	Being absent; your mind is elsewhere; not paying attention
	Shaleen daak	Not comfortable with friends
	Qurb rabshoole	Thinking too much about their problems (rumination)
	Rabshoole	Difficulty getting along with others
	Damiin	Difficulty learning

TABLE 4—Bhutanese Local Mental Health Syndrome Terms and Descriptors

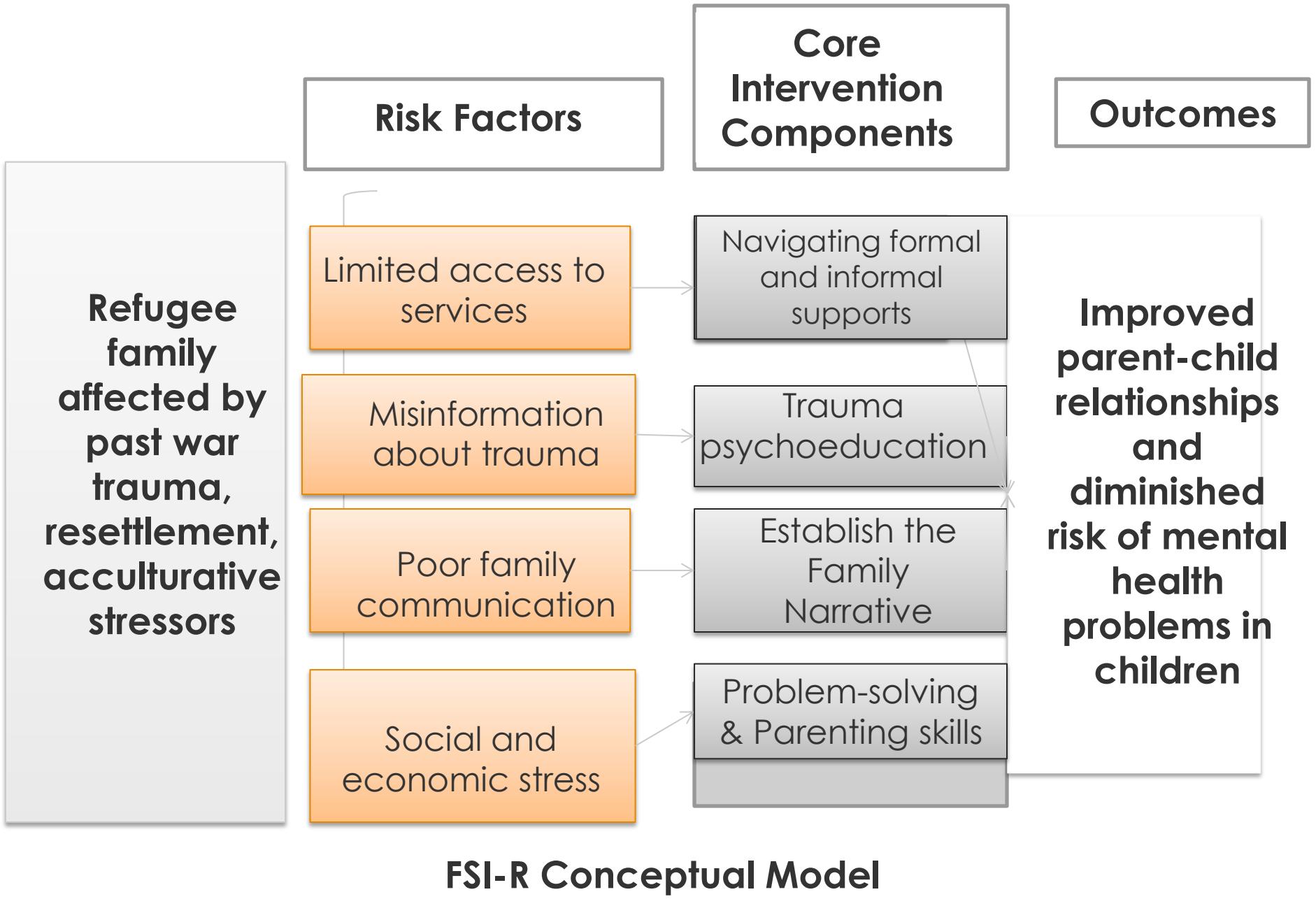
Syndrome Term	Descriptor	
	Nepali	English
Badmaas (conduct problems)	*Naterne*	Disobedient
	Jjhagadama saamel hune	Involved in fighting (fights, quarrels)
	Naramro bhasa/sabda bolne	Use bad language, words
	Lagu padarthako sewan	Use of addictive substances
	Dada-giri/chot (puryaune)	Bullying, wound verbally
	Fatah	Scoundrel, delinquent (vandalism, disobedient)
	Rish/rishaune	Anger, angry
	School ma aniyamit	Irregular school attendance
	Arulai kutne	Beats others
	Jharkine	Irritable
	Rakshi khane/piune	Drinks alcohol
	Churot/ganja khane	Smoking
	Ghamanda	Arrogant
	Awara	Roams aimlessly
	Padhaima kamjor	Weak in studies
	(Aruko)jijjat nagarne	Lack of respect (for others)
Chinteet (worry)	*Chintajanak/chinta*	Worry
	Rish	Anger
	Khulera nabolne	Does not talk openly
	Darr	Afraid
	Traseet	Scared
	Ekohorine	Fixates
	Aatmahatyako soch rakhne/ aafailai hani puryaune	Keeps suicidal thoughts; poses harm to oneself
	Dookhit	Sad
Dookhit (persistent sadness)	*Dukhi/dookhit*	Sad
	Jharkine/bolna jharko manne	Irritable
	Eklopan	Loneliness
	Ekohorine/tolaune	Fixate (rumination)

2015

REFUGEE FAMILY STRENGTHENING INTERVENTION

Harvard T H Chan School of Public Health

A family-based preventive mental health intervention for use with children and families with a refugee life experience



FSI-R Conceptual Model

10 Home-Visiting Modules (FSI)

1-2	Introduction	• Introduce intervention goals • **Create & discuss "Family Narrative"**	• Establish trusting relationship • **Understand family's circumstances**
3	Responsive Parenting & Caregiving	• Identify ways to build positive parent-child relationships • Build positive parenting skills	• Understand family dynamics • Introduce alternatives to harsh punishment; positive parent-child interactions
4	Engagement with the US Education System	• Discuss engagement in education system • Identify strategies to talk to children about school and health promotion	• Empower parents/caregivers to engage with their children's educators and health providers • Build strong relationships with teachers and health providers
5	Children & Family Relationships	• Create and discuss the "Family Narrative" from child's point of view • Build communication skills for family meeting	• Establish a trusting relationship • Understand family's circumstances from a child's point of view and parenting expectations in the U.S.
6-7	Communicating with Children and Caregivers	• Identify strategies for building communication skills, stronger families and ways to respond well to hard questions • Prepare for Family Meeting	• Prepare caregivers and children for the Family Meeting • Build skills related for improved child-parent communication
8	Uniting the Family	• Prepare agenda for family meeting • Create shared understanding of family strengths and challenges	• Promote positive communication between children and parents/caregivers • Develop parent and child perspectives
9	Promoting Health, Wellbeing & Safety	• Identify strategies for wellness • Learn self-regulation and stress reduction skills to promote resilience	• Promote health, wellbeing and safety • Promote mental health and stress management
10	Bringing it All Together	• Create a plan to apply what was learned going forward	• Empower family to practice and implement new strategies and skills

FSI Refugee Pilot

- FSI pilot wrapping up with high satisfaction

- Tremendous **opportunity** as the community health worker-delivered interventions expand under the Affordable Care Act (ACA)
- **Research questions:**
- what are the institutional, training and supervision needs to deliver via local refugee CHWs
- **impact** on **parenting**, **family functioning and mental health** in families with school-age children 7-17 years of age

Implications

- Tremendous disparities in mental health of refugee children
- CBPR is a promising approach for **engaging** refugee **communities** in research from the beginning
- Working with partners, it is vital to also **attend to primary concerns** of the community.
- **Shared data** and **mutual exchange** can assist in development of **acceptable**, **feasible** and ultimately more **sustainable** interventions

Thank you!

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Poll Question

DORCAS INTERNATIONAL
INSTITUTE OF RHODE ISLAND

Addressing Toxic Stress and Family Well-Being

Our Clients

- Refugees
- Immigrants
- TANF Participants
- 80% Live In Providence
- 95% Members of minority groups
- 70% Unemployed
- 74% Women

Our Services

- Refugee Resettlement
- Case Management
- Interpreting & Translation
- Immigration & Citizenship Legal Services
- Employment Training & Placement Services
- Adult Education & Career Academy
- Family Literacy

Refugee Programs

- Resettle ~170 Refugees; primarily from:
  - Iraq
  - Somalia
  - Democratic Republic of the Congo (DRC)
  - Colombia
  - Burma
  - Eritrea
  - Burundi
- $1.366 million Budget

Refugee Adult Programming

- Reception & Placement
- Cultural Orientation
- Health Assessment & Follow up
- Mental Health Assessment & 90 day Follow up
- English Language Learning
- Pre-Employment Training
- Employment Placement Assistance
- Employment Retention Support

Supports

- Intake Assessment
- Individual Service Plan Development
- Case Management
- Interpreting & Translating Services
- Immigration Legal Services
- Citizenship Services
- Housing & Basic Needs Services
- Childcare, Transportation & Work Supports
- Work Appropriate Attire

Refugee Family Programming

- School Orientation & Liaison Services
- In-school Newcomer Academies
- In-home Tutoring for Refugee Youth
- Refugee Youth Summer Learning Camp
- Refugee Youth Support Group
- Family Literacy Program
- Leadership Development & Service Learning

Partnerships

- **Providence Public Schools**
  - Approximately 24,000 students in district
  - Total Active ELLs – 5,604 -23% of students
  - Average 84% free & reduced lunch
- **Brown University Swearer Center (BRYTE)**
  - Provides 130 Tutors for Refugee youth
  - Summer Camp for 100 Refugee youth
- **Full Service Community School Partners:**
  - YMCA for site management & out of school time
  - Family Services for Care Coordination
  - Capital Good Fund for Financial Empowerment

Why Engage Parents?

Student achievement

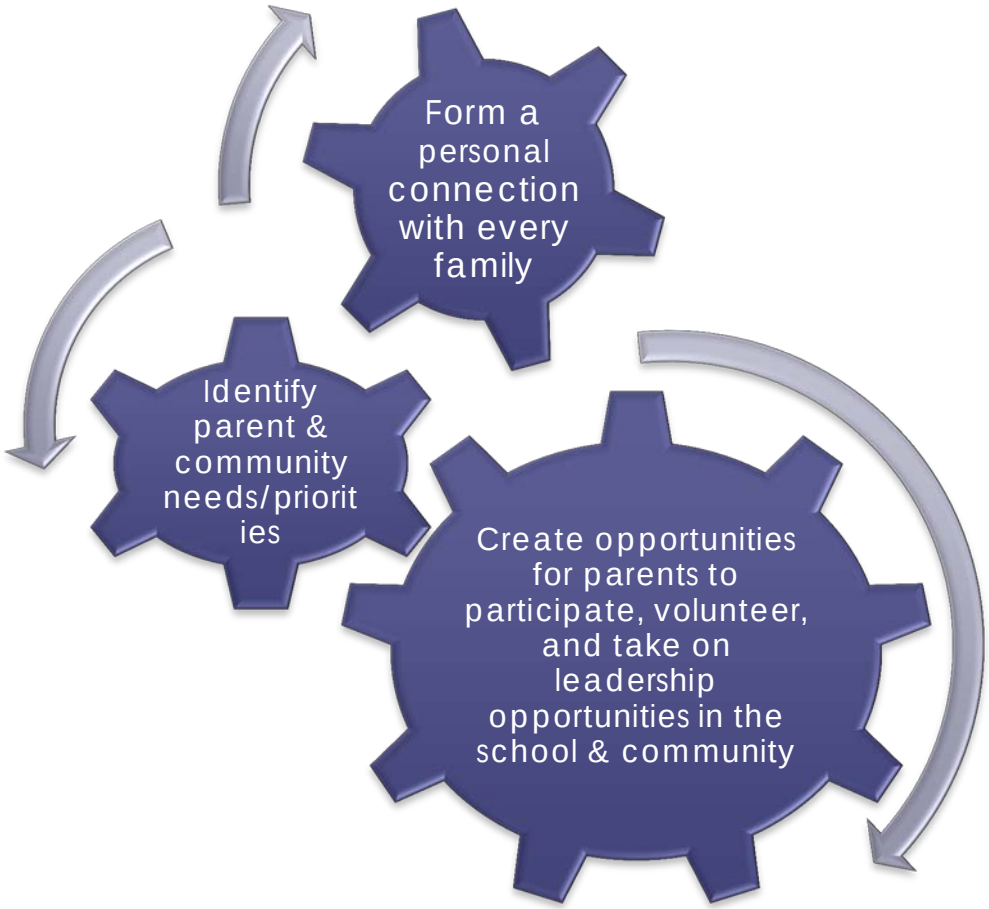
Student behavior

Benefits for the parents

Benefits for children's teachers

Benefits for school quality

Parent Engagement



Parent Education

- **Adult Education**
  - ESOL, ABE,
  - Family Literacy
- **Parent Time**
  - Financial Education
  - Technology
  - Parenting Education
  - Community Education
- **Parent and Child Together Time**
  - In school or at home models

Out of School Time

- **BRYTE One on One Tutoring/Mentoring**
  - 3-5 hours each week at home
  - Ongoing relationship for up to 4 years

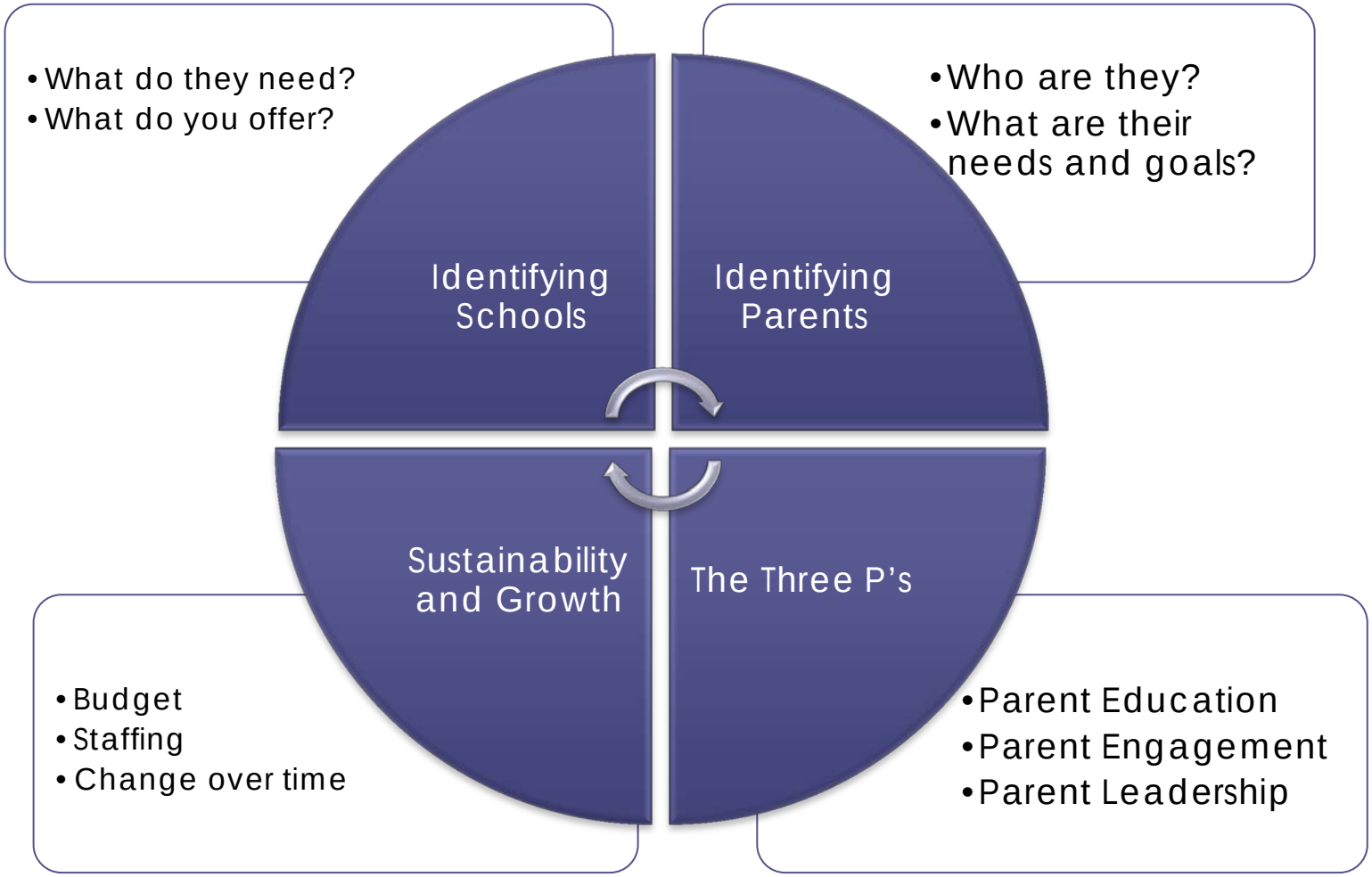
- **In-School BRYTE Summer Learning Camp**
  - Holistic family approach
  - District Teachers, Nurse & Social Worker
  - Brown Student Camp Counselors
  - Adult Literacy Classes on site

- **YMCA in school program**
  - Access to full range of services through community school model

Leadership Development

- Family Mentoring
- Family Service Learning
- Parent Leadership Council
- BRTYE Leadership Institute

Lessons Learned



FAMILY EMPOWERMENT (RIFE) PROGRAM

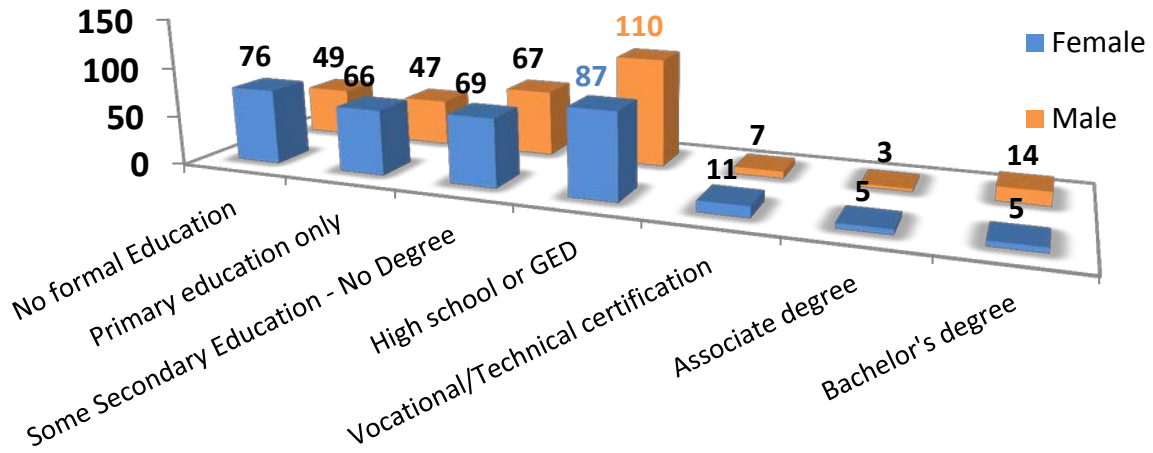
RIFE INTRO

- Funded through Office of Family Assistance
- Federal Grant called "Healthy Marriages"
  - *"The Healthy Marriage Program funds organizations that combine marriage and relationship education efforts with a robust effort to address participation barriers and the economic stability needs of their participants."*
- Currently in 5th year; have responded the to new RFP for funding after September.

FAMILY EMPOWERMENT (RIFE) PROGRAM

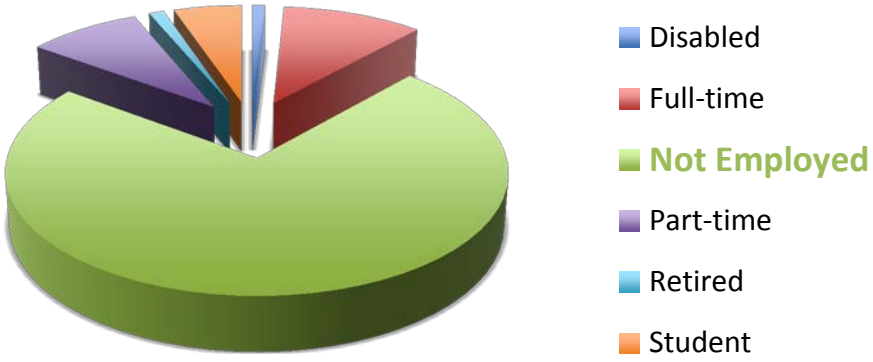
Demographics

Client Education Status

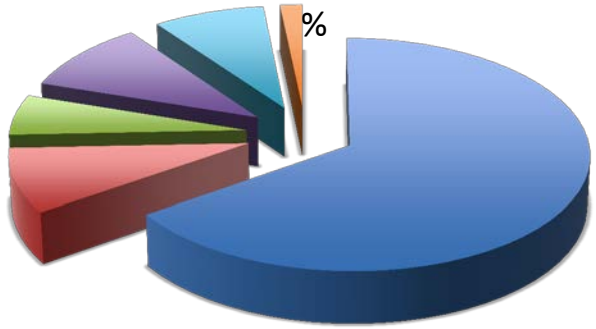


Majority of our clients are
- Poorly educated
- Unemployed
- With no income sources

Employment Status



Income At Enrollment



Refugee and Immigrant Family Empowerment Program (RIFE)

319

297

Marital Status

51% Married
33% Single/Never Married
8% Widowed
4% Divorced
4% Committed Relationship

Average Family Size
5.2

DEMOGRAPHICS

YEAR 3 N=619

CLIENTS FROM 36 COUNTRIES

SPEAKING 34 LANGUAGES

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FAMILY EMPOWERMENT (RIFE) PROGRAM

PROGRAM MODEL

ELIGIBILITY: Foreign Born, in Portland area.

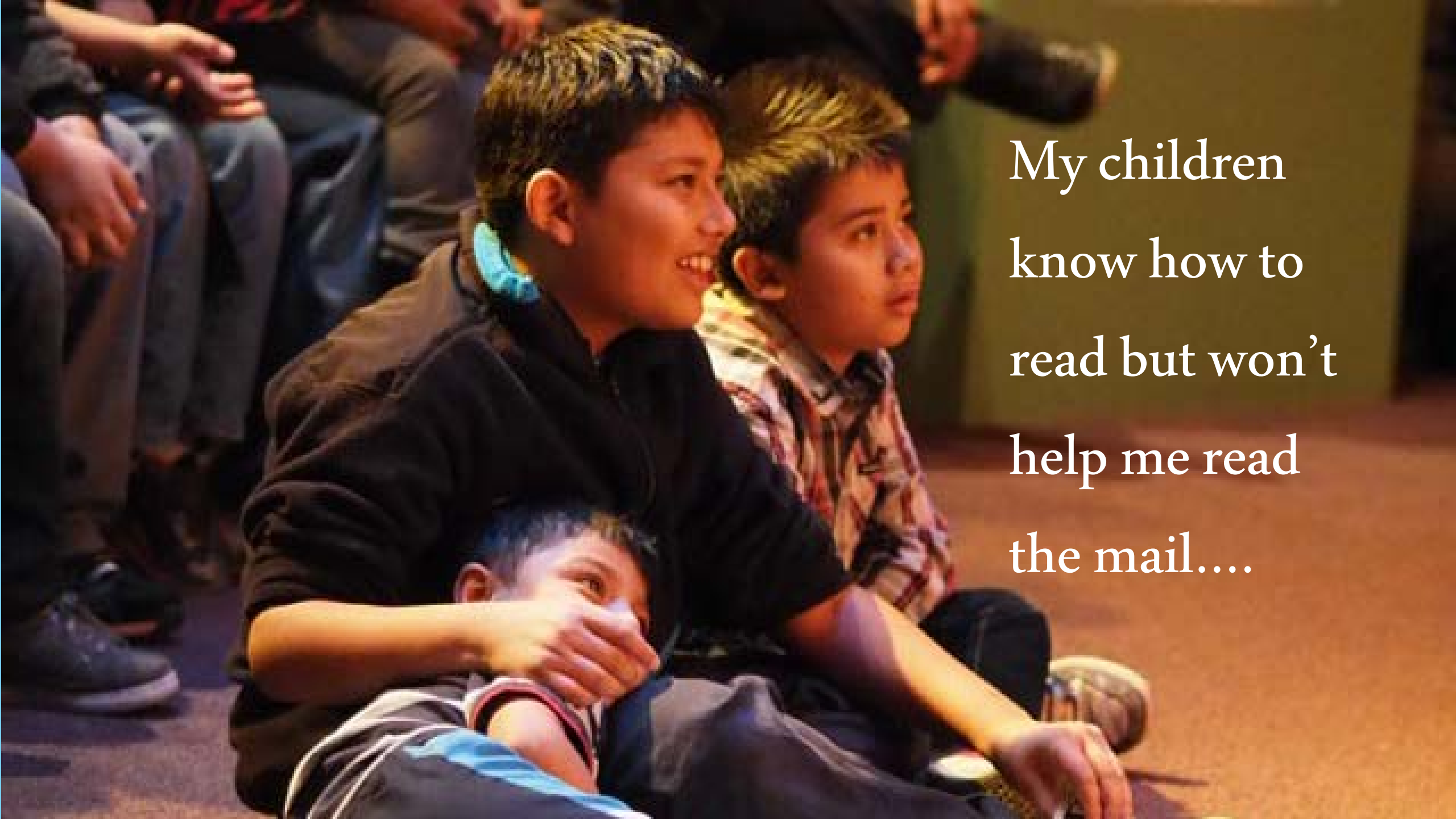
→ Culturally and linguistically specific workshops are offered to members of the community.
→ After the workshop, a potential client (family and/or individual) needing more support meets with a Family Engagement Specialist (FES) for screening.
→ FES determines eligibility, and may complete an intake (only about 1/3 of workshop participants are enrolled in case management in a given year).

Clients could be a good fit for our program if they say things like…

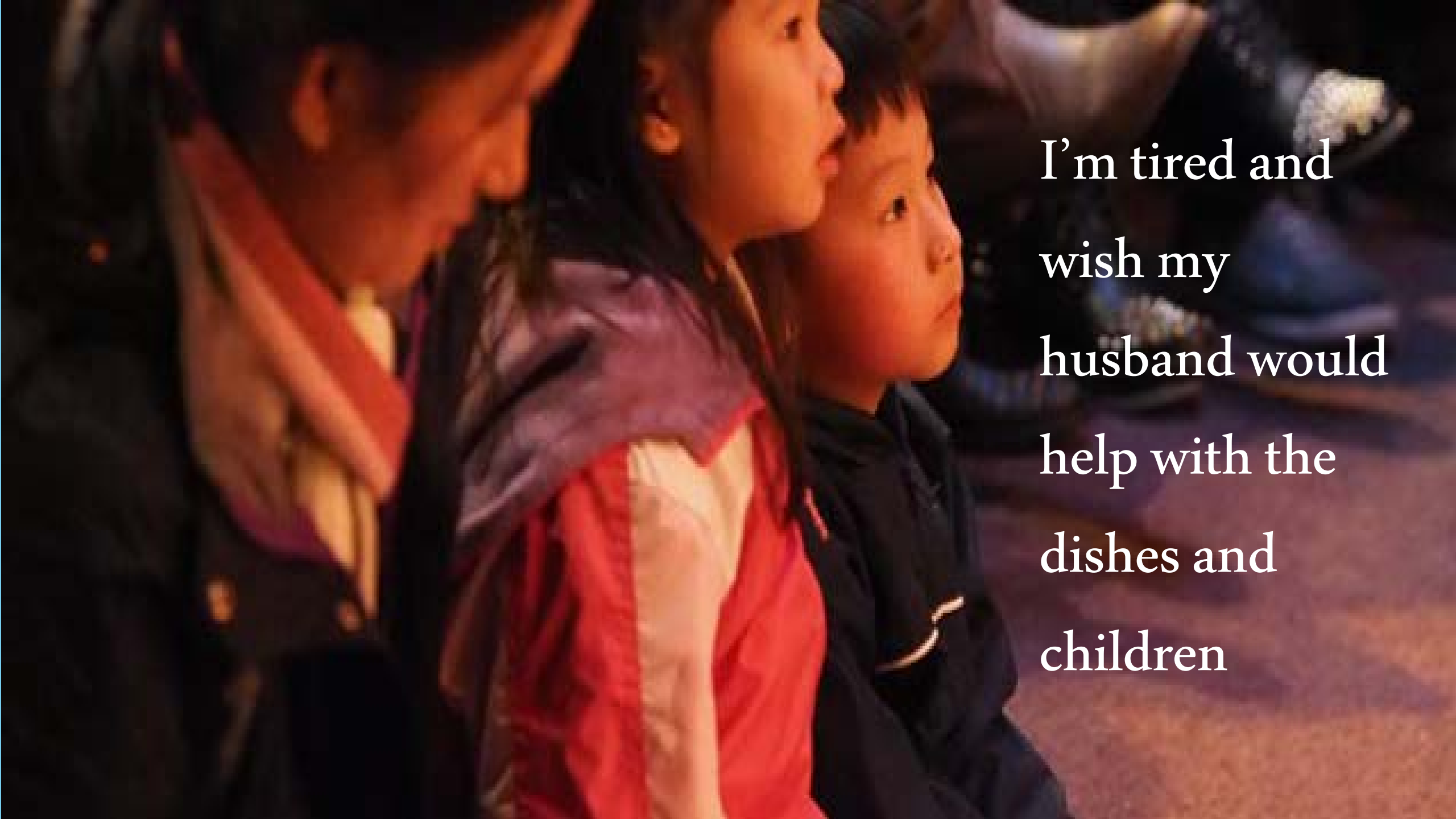

My children
don’t listen
to me


I don’t feel
respected in
this country


I work all the
time but don't
know where
the money
goes


My children
know how to
read but won't
help me read
the mail.....


I’m afraid my
wife and
daughters will
become
Americanized


I’m tired and
wish my
husband would
help with the
dishes and
children

WORKSHOP SERIES

- Building Strong Families (12-hour Workshop)
- Effective Parenting (12-hour Workshop)
- Money Matters (6-hour Workshop)
- Empowering Youth (6-hour Workshop)

FAMILY EMPOWERMENT (RIFE) PROGRAM

Our Employment Services

Employment Services and Job Placement

We equip families to overcome poverty by placing clients in jobs and teaching them job search and retention skills

Networking with employers

- Place clients with different employers
- Place clients in training programs
- Hold employer hiring events at IRCO

Preparation for Employment

- Assist clients through interviews
- Prepare resumes and applications

Job Placement

- Clients are placed in F/T and P/T jobs
- Case management and advocacy after placement

irco

Our Partners Help Us Connect Families to the Larger Community

Community Partnerships and Volunteers

We increase equity and empower social and emotional development by linking families with community resources.

Community volunteers and service organizations offer opportunities to integrate, learn, play, and heal.

Portland Children's Museum

Portland Police Bureau

Multnomah & Washington County Library Systems

Outgrowing Hunger

Girls Inc. of the Pacific Northwest

Summer Camp Program

Wrap Around Case Management

- Focus on increasing healthy communication skills between all family members
- Develop resiliency and stress management skills
- Increase access to resources and build financial stability
- Grow positive relationships and heal from trauma
- Increase peace and equity in homes
- Teach self sufficiency skills

FAMILY EMPOWERMENT (RIFE) PROGRAM

rco

Building Family Capabilities through Case Management

Problem

- Conflict and arguments between parents
- Parental stress resulting in parent – child conflict
- No budget or understanding of US banking system
- Minimal parental involvement in educational system
- Stigma around behavioral and emotional needs
- Unemployment
- Struggles navigating bureaucratic systems including health care

Case Plan Goals

- Learn communication and conflict skills
- Facilitate family discussions between parents and children
- Financial Literacy Education, connect clients with banking services
- Develop capacity for parents to get involved in children's education through advocacy
- Connect family to more specialized resources such as individual and family therapy
- Job placement and vocational education services
- Coaching clients to navigate system, respond to notices, make appointments, etc.

Outcome

- Reduced conflict between parents and increase in positive relationship modeling
- Increased parenting skills and bonding, reduced likelihood of system involvement
- Parental involvement with children's schools bridging family to the community at large
- Families receive much-needed services; communities receive education on emotional health
- Parental employment, reduced reliance on state support
- Reduced stress and increased stability as basic needs are met

Problem → Case Plan Goals → Outcome

rco

WHAT MAKES A DIFFERENCE IS….

Cultural Competency

Trauma Informed Service Delivery

Building Trust

Empowering Individuals and Families

CULTURAL COMPETENCY

- IRCO, and consequently RIFE, trains and hires staff from the communities we serve
- Most services are delivered in clients' own languages, eliminating language barriers and reducing stress in clients seeking help
- The process of engagement is facilitated by bi-cultural staff who are able to connect with clients in the dimension of their experience as a refugee/immigrant AND are able to respect their clients' personal stories and journeys
- The process of cultural competency development is on-going

TRAUMA INFORMED

- Every engagement/interaction that RIFE staff have with clients is informed by the impact of the trauma story of that particular client/family/community
- Staff is respectful and sensitive to clients' individual and collective trauma stories: Do No Harm Policy- we don't ask a question if we are not prepared for the answer
- New information is given in increments with enough time set aside to absorb; practice is allowed
- Validation of refugee experience as being challenging is the basis for a trusting relationship with CM
- We normalize our clients' responses as the best they can do under the circumstances
- Educate/train staff on issues of interconnection of own experiences/trauma/toxic stress with those of our clients'.

WE BUILD AND EARN THE COMMUNITIES' TRUST BY:

- Meeting the client and the family where they are
- Attending to ***their*** identified need: fill out paperwork/attend meetings at DHS/connect them to resources in the community
- Consistent contact with clients in office/home/community
- Creating structure each meeting: predictability
- Transparency: clarification of each intervention and why we do it
- Focus on safety (physical and emotional) by helping them prioritize and structure their needs.

WE EMPOWER BY:

- Asking questions of community leaders about the needs of that particular community
- Educating the families and the community about various systems (legal, social, medical, educational).
- Organize community events with healing purposes (vigils).
- Organize community events bridging local agencies and entities to the refugee communities (police force events, library events, museum events).
- Teach self-sufficiency skills to the individuals and families we are working with.
- Help client advocate for self, while case manager walks along them.

CHALLENGES WE CONTINUE TO FACE.....

- Our clients and communities come from strenuous circumstances that have produced chronic and complex toxic stress
- Foundational problems (e.g. toxic stress, communication breakdown in family, etc) on case plan often delivered indirectly while addressing constant "symptomatic" challenges
- Ongoing challenges with understanding and discerning what is a crisis in a person's/family's life
- Ongoing challenges to maintain a consistent helping relationship with clients/families that engage through crisis situations only
- Ongoing challenges with unreliable funding, and negotiation between clients' needs and funder's requirements
- Ongoing challenges with educating the system at large about refugee and immigrant communities needs (educational, health care, criminal and judicial).

IN CONCLUSION….

- IRCO and RIFE strive to enrich each person's life (client and staff alike) through relationship and community building
- We recognize that our communities are resilient and want to do better when given opportunities, and we help build on those strengths
- We become the bridge that different communities need to connect to the society at large


Q & A