

# “Opening Doors to Opportunities for Refugees: Addressing Toxic Stress and Child and Family Well-Being for Refugee Children and Adults”

ORR Webinar – Transcript

Webinar Date: September 9, 2015

**Operator:** Please stand by, we are about to begin. Good day, and welcome to the ORR Opening Doors Conference Call. Today’s conference is being recorded. At this time I would like to turn the conference over to Ms. Allison Hyra. Please go ahead.

**Allison:** Thank you, Chanel. Good afternoon, or good morning to those of you farther west. I would like to welcome you to our Webinar today entitled Opening Doors to Opportunity for Refugees, Addressing Toxic Stress and Child and Family Well Being for Refugee Children and Adults. Our Webinar today is sponsored by the Office of Refugee Resettlement in the Administration for Children and Families.

We have a great panel of speakers today. First off is Dr. Theresa Betancourt. She is the director of Research Program on Children and Global Adversity at the Harvard School of Public Health, and an affiliated faculty member of the Harvard Center on the Developing Child. We next have Kathleen Cloutier, who is the Executive Director at Dorcas International Institute of Rhode Island. And finally Ardiana Halilaj, Clinical Supervisor, and Lacey Dean, Family Engagement Specialist of the Refugee and Immigrant Family Empowerment Center of IRCO. My name is Allison Hyra from ICF International, and I will be moderating the Webinar.

So a bit of housekeeping. This Webinar will have a discussion period where you can ask questions of any or all of our presenters. You can submit questions throughout the Webinar by clicking on the Q&A, typing your question, and then submitting. Also if you are having any problems with the technology or your audio, please press star 0 to get connected to an operator.

So before our speakers get started, I just wanted to set the stage for our discussion by providing a bit of a primer on toxic stress. What is it? How does it affect children? And what negative outcomes are associated with toxic stress exposure?

So to start, what is a stressor? A stressor is an experience or action that causes an individual to experience stress. It is subjective. So what that means is that what triggers a stress response in one person may not in another. So think of it this way- many people find public speaking stressful, but others enjoy the attention and experience of performing in front of others. What is stress? Stress is an individual’s response to a stressor. It can be physiological, mental, or emotional. And it is not always bad. That’s right, you heard me. Stress isn’t always bad.

This visual which ICF created for ACF’s Office of Family Assistance helps explain the three different kinds of stress that children experience. Positive stress on the left-hand column occurs during normal childhood experiences. For example, a child may experience stress on the first day of a new school or daycare. While their feelings may be uncomfortable, positive stress actually builds self-confidence, self-efficacy, and resilience. The child learns that he or she can adapt to a new environment, self soothe, and recover. The middle column is tolerable stress. Tolerable stress is a reaction to something that’s more

complicated, scary, challenging, or long lasting. Potential tolerable stressors include family dissolution, living through a natural disaster, or experiencing poverty. These experiences aren't "good," but through the guidance and support of a caring adult, children can recover from tolerable stress with minimal, long-lasting effects.

Without the presence of a caring adult however, tolerable stress can move to that far right-hand column. It can become toxic. Toxic stress is brought on when children undergo adverse childhood experiences such as physical abuse and don't have a trusted adult to help them navigate the situation.

Toxic stress is thought to affect children several ways, and one large way which is thought to affect children is by constantly revving up their hormonal stress response. Sort of like a car that you're constantly pressing the gas pedal on. Such revving can sort of burn out children's ability to respond to stressors appropriately. And think about it this way, when a child's body is in that sort of flight or fight response, it can't do all of the other things that it needs to do to grow and develop properly. The body is literally focused on staying alive, and not building connections in the brain.

So toxic stress is thought to affect growing brain architecture. That's why toxic stress only occurs in children because as adults our brains are largely formed while during development their brains are very malleable. So toxic stress is associated with childhood and adult challenges including difficulty learning, difficulty with memory, and challenges with displaying and managing appropriate emotions and stress. It's also associated with making high-risk behavioral decisions such as substance abuse. Finally, individuals who experience toxic stress have a higher likelihood of suffering from a variety of diseases and conditions, ranging from depression to heart disease to cancer. Now although what I laid out sounds very depressing and deterministic, the key point I want you to remember is that with toxic stress, it's possible that those negative outcomes can be prevented or reduced by the presence of a caring, trusting adult. Also these concepts are associations. They're not inevitabilities. So an individual that experienced toxic stress does not have 100% likelihood of developing a lifelong disease later on.

So with that I'd like to introduce our first speaker, Dr. Theresa Betancourt. Dr. Betancourt is an associate professor of Child Health and Human Rights in the Department of Global Health and Population, and Director of the Research Program on Child and Global Adversity at the Harvard T.H. Chan School of Public Health. Her central research interests include the consequences of concentrated adversity on children and families, resilience and protective processes in child and adolescent mental health, refugee families, and applied cross-cultural mental health research. She's been involved in the adaptation and testing of several mental health interventions for children and families facing adversity due to violence and chronic illness, including the development and evaluation of a family strengthening intervention for HIV-affected families in Rwanda. She is currently the principle investigator of an ongoing project to integrate an evidence-based behavioral intervention for war-affected youth into programs in Sierra Leone. One of her long-standing projects is a longitudinal, inter-generational study of war-affected youth in Sierra Leone. She has written extensively on mental health, child development, family functioning, and resilience in children facing adversity. Dr. Betancourt, the time is yours.

**Dr. Betancourt:** Thank you very much, Allison, for the kind introduction and for inviting me to participate in the Webinar. So I'll be speaking about addressing how disparities in the mental health of refugee children through community-based participatory research, and sharing with you an experience that we've been engaged with now for several years involving two different refugee communities in the Boston metropolitan area.

So I have to mention this isn't just my work, it's the work of a huge team of collaborators, both at the Harvard T.H. Chan School of Public Health, but also University of Michigan, (John Cresdahl), Children's Hospital with Bill Beardslee, (Heidi Ellis and (Syada Abdi). And then a really wonderful local team of refugee staff both from the Somali Bantu and from the Bhutanese Refugee community, and I have to also acknowledge members of our advisory board such as Brendan Courtner, our funding support from the National Institutes of Minority Health and Health Disparities.

So what I'd like to talk about today is the refugee experience and implications for family functioning and child mental health, and then discuss the importance of community-based participatory research with refugee communities in terms of the application of shared data to addressing issues of policy and community concerns as well.

So to say a little bit about community-based participatory research with refugee communities. This is a stance that engages researchers and community members in equitable partnerships. It's really meant to deconstruct the power differentials between those who are studied, and those who do the studying. And community-based participatory researcher (or CBPR) community members are engaged in all stages of the research, from conceptualizing the early research questions to developing and deciding on methods to implementation of data collection to data analysis, and then dissemination of the data afterwards. It's well suited for research on addressing health disparities, and an important feature of CBPR's shared access to study data and tools, and that all team members become representatives of the research.

Now CBPR in terms of mental health research has limited applications [inaudible], especially with refugees, but it's quite promising given tremendous stigma often around mental health issues in these communities and it can also be a tremendous approach for understanding local context and starting to arrive at an understanding of local language that's less stigmatizing for talking about mental health problems, especially mental health problems with children. And when we have terminology like this especially gained through participatory community efforts, we can do a lot in terms of raising awareness of the importance of the issues, and also thinking about interventions that are a good fit to context.

In terms of why these issues matter, we know there are a number of barriers to children involved in mental health services overall and especially for refugee children. Often times in refugee families, there's a reluctance to seek out services. There is often times, as I mentioned stigma, or just a lack of resources. So it's not seen as a priority. Caregivers may be overwhelmed by their own migration experiences and not able to recognize the needs in their children, and they may also not even know what services are out there. Often times, in the neighborhoods and communities where refugees are resettled, we don't see enough in terms of referral networks from schools or pediatric programs as well. So there are a number of barriers to overcome in the policy environment and programmatically.

Now to talk just a bit globally about the refugee experience in the next slides, we know that there are 15.4 million refugees around the world, a third of these are children and youth. So this is a very important part of the refugee population. Now in the United States we admit about 70,000 refugees each year, and as we're seeing even today in the news with the tragedy of the Syria crisis and refugee flight to Europe that there's tremendous exposure to violence, to loss. And then also migration stresses along the journey as well as acculturative and resettlement stressors upon reaching places of resettlement that all contribute to increase risk of poor mental health outcomes in refugees.

So if we look at common mental health disorders in refugee populations compared to the general population we see disparities. Refugee studies document depression anywhere from 3% to 30% in refugees. PTSD 20% to 57% compared to about 12% and 5% of those disorders in the general U.S. population. As I mentioned before, children overall in the U.S. have poor access to mental health services and this is certainly exacerbated in child and adolescent refugees.

And now to go the next slide to talk about sort of the temporal experience of there, you know, the refugee stages of displacement, we have to think about these in terms of pre-flight, flight, and then the resettlement phase, and that mapped along each of these are risk factors as well as protective factors.

So starting first with risk factors, we knew, as we see even in the news today and so many different situations of refugee flight that often times there's exposure to violence, there's persecution, there's insecurity. Also there's disruption of basic services, access to medical care, schooling for many families that means that relocation and becoming a refugee is an important way of bettering the opportunities for your own children, or many families are motivated by that, and also just survival. And then traumatic loss in addition to the exposure to violence, a loss of loved ones, separation from social networks. Then in the process of flight, often times we see very harrowing flight experiences where there's further exposure to violence and other threats. Often times a period spent in a camp or detention center during displacement, and further separation from social networks and loved ones. And then upon resettlement, there are issues of just of adapting to the migration experience and to the loss of so many things, identity, home, loved ones, social connections. There's adjusting the new culture, and then often times situations of economic insecurity, and trying to find work, and support your family.

Now mapped along all of these are protective factors that we've seen documented in many studies of refugees from individual coping abilities or strengths to family functioning being very important especially in terms of how children fare. Being able to advance yourself through education or a job. For children the importance of intact attachment figures, and also social support and community ties. And also ideological and religious context being very important to shaping how refugees fare over time in terms of very important protective factors.

Now I'm going to talk about the two communities that we're working with in the Boston area, the first being the Somali Bantu refugee community. The Somali Bantu are a sub group within the overall Somali majority refugee community. The Somali Bantu have a history of slavery in Somalia. Often taken from other parts of Africa such as Mozambique, Tanzania, Rwanda, and other nations. Historically the Somali Bantu in Somalia had very limited access to education, to healthcare, to basic opportunities. Were often times involved in the agricultural sector, and when war broke out in Somalia in 1991 it affected all Somalis. It still continues to date, a situation of tremendous insecurity in Somalia, prolonged fighting, disruption of basic food production and services, and displacement into Kenyan refugee camps has been tremendous of both the Somali majority and the Somali Bantu.

These are populations that are really dependent on external aid, and the camps themselves, Kakuma, Dadaab are very insecure. The areas where the Somali Bantu are resettled within the camps are very insecure. There's tremendous additional violence going on that affects the camps, and it has no access to Kenyan citizenship.

There's been slow resettlement of the Somali Bantu and Somali majority over time, and more recently acceleration of Somali Bantu resettlement. Somalis overall are the 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 in the United States. In Boston resettlement began in February of 2004 with two families and it's now grown to over 400 families in the greater Boston metropolitan area.

Now I'd like to say a little bit on the next slide about the Bhutanese refugee community. As you may know Bhutan is a geographically and politically isolated kingdom sometimes called the Happiest Kingdom on Earth, but actually has a very difficult history of ethnic cleansing initiated by the government in the early 90s to evict over 100,000 ethnic Nepalese from the country. These are the called the Lhotshampas, or southerners. Upon eviction they settled in eastern parts of Nepal in refugee camps, and much like the Somali Bantu and Somali have a prolonged period of being in refugee camps of over 20 years. So many children are born into that experience before resettlement.

Third country resettlement of the Bhutanese began in 2007 with over 49,000 resettled in the United States. Again, issues of stigma around mental health issues have been common in this population, but there's also been tremendous concerns about mental health problems, and a very high rate of suicide that's been documented in Bhutanese refugees resettling in the U.S., much higher than the national average. It's 21.5 per 100,000. And there's been a recent Center for Disease Control report investigating what could be some of the drivers behind these very high rates. But there's tremendous concern about mental health and how to think more preventively.

So talking about our research partnership in the CBPR work, this collaboration began some time ago in 2004 when we were contacted by the Lynn public schools to come out and advise them on some challenges they were facing with refugee children in the schools of problems of fighting, not listening to teachers, parents being very disengaged. And so we went out to the schools and did some awareness raising to help teachers, and administrators, and school guidance counselors understand that some of the behaviors they were observing were not bad kids. But really kids who'd learned survival strategies in refugee camps and haven't really had the chance to understand how things work in the United States nor had their parents who saw it as very respectful to stay out of the hair of teachers and not get involved in the school.

So we did some real work around community awareness raising, and making those links between the community and the schools, and at that time met community leaders such as Oawas Hussein, who helped us to start this community-based participatory research project. And we set out on a collaboration that could meet those community and research goals to contribute to our understanding of child and adolescent refugee mental health, but also help advance some of the concerns that were facing the community and gather data that could be used for advocacy purposes.

So this was done with the Shanbaro Community Association, which is a mutual assistance organization of Somali Bantu refugees in the Boston area. It's housed out of the Chelsea Collaborative which is a community organizing group which has really been building the skills of Shanbaro Association to really organize itself and develop leadership skills. And the aim of the partnership, or to understand the community situation and the priorities of people in the community and both refugee groups, assess the nature of problems, especially around child and adolescent behavioral issues before proposing solutions to improve communication and awareness raising by learning community language, learning local concepts, understanding belief systems. And to use this information to improve assessment and

screening tools, and also think about intervention models, and begin to plan those with the community involved.

Now another value of this partnership is that we're able to make investments in the refugee community, offering employment, offering capacity building, training, and with the data that we collect together having resources and information to advocate for further services. The refugee community has ownership of the research and data in this manner has a greater chance of really being effective in its goals and sustainability, and by having refugees intimately involved on the team and leadership roles in the research we arrive at insider knowledge which allows us to have greater understanding, and increase the quality of the research outputs overall.

So over time we've been involved in a lot of dissemination about the importance of child mental health issues in the community. These are pictures from our session at Chelsea City Hall, where we presented on the collaboration and the research. We also got a cover story at Harvard Magazine talking about our work, and have been able to do a lot around awareness raising. Also there've been some spin-off opportunities such as the Boston/Somali Bantu girls group which is really a girls' empowerment group that was started by a student of ours who worked on the project and it continues to this day.

Now to tell you a little bit about the actual methods and the research we've been doing, why we have to be concerned about culture, and assessment, and measurement, and also intervention development. I like this quote from Dr. Arthur Kleinman, who's a well-known medical anthropologist and a psychiatrist here at Harvard, and he says we know convincingly from ethnography that concepts of emotions, the self, the body, and general illness categories differ so significantly in different cultures that it can really be said that each culture's beliefs about what is normal and abnormal behavior are actually quite distinctive.

Now with that as the backdrop, how do we normally go about doing assessment or research when it comes to diverse cultural settings and child mental health? Well, often times we may create a questionnaire, or select the standard measure that we're familiar with that comes from outside the culture, translate this into the local language, often with no attention to its fit. Conduct individual interviews with these surveys to determine needs based on the frequency of responses on a survey, choose your problem and your intervention based on that and then we may do some intervention work, and repeat surveys before and after to look at our impact. Now this is a standard approach. It's one I've been involved with myself in a number of different settings earlier in my career, but there's some real problems with it.

First is the issue of culture validity on the next slide. So how closely do concepts in a questionnaire match local concepts? It may be that a standard questionnaire doesn't really fit the local culture, or language use, or how they think about certain problems. Also when we're thinking about child behavioral issues, and promoting resilience and strength in families there may be unknown local concepts, really important questions that we should be asking, and how do we have the space to ask those questions when we don't even know what we should be asking about .

And then there are issues of translation and interpretation just by nature of speaking the local language and speaking English. The type of people we often involve in translation or interpretation services have a different level of education, different word use than the beneficiaries who are more impoverished that we're often trying to serve in these programs. And the risk of all this is that our evaluations may not

accurately measure program impact and we may miss really important things that we need to learn about if we're working with certain communities.

So on the next slide we lay out a model for designing and evaluating mental health services in diverse cultural settings where when we come in in partnership with communities we recognize that we are outsiders and that we really need to start by learning from the ground up with locals involved in leadership roles about mental health, about resilience, about protective constructs, child development from the ground up.

And often we're starting with qualitative inquiry. From that data we can then use our findings to select, adapt, or create measures of important constructs as well as to think about what are intervention models that fit given what we've learned about what matters, and how people think about problems, and also strength and resources. If it at all possible we try to pay attention to the validity, and the cultural fit of our measures and intervention models. And then we can come back in this third part of the model and implement a culturally-informed model, and evaluate it using the most rigorous designs possible including even randomized control trials. And this is something, a model that we've iterated across multiple settings from Rwanda to Uganda to Sierra Leone to here in Boston working with different refugee groups.

So to tell you a little bit about that process here in Boston on the next slide, I'm going to be talking about this article we recently published in the American Journal of Public Health called Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-based Participatory Research. The objectives of the study were to understand the problems, strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees to determine local expressions of mental health problems amongst youth in both communities. And to use qualitative research methods to do a number of things. First to develop a community needs assessment so to understand broadly how people thought about the challenges facing children and adolescents in the community. And then also to understand local terms for child mental health problems, and also strength and protective resources in Somali Bantu and Bhutanese refugees.

So we're going to show you data that came from 56 Somali Bantu refugee community members and 93 Bhutanese refugees involving both free list and key informant data collection, and I'll tell you a bit about what that involves. And then we use this to later go on to think about an intervention model and have tools to evaluate it as we move into the next stages of the work.

So I talked about different qualitative research methods and a free list exercise which is described on the next slide. Respondents are asked a question designed to illicit responses in the form of a list. And the responses and short descriptions are recorded verbatim by a trained local refugee staff member who's a part of our research team in their own language. And what we do when we're talking about mental health is rather than use those terms, we find that a much less stigmatizing term is to talk about problems. You know, every culture has problems, people can understand that and relate to that. And this gives a sense to look at what are the problems that people see spontaneously from the perspective of children or from the perspective of adults, and then within those problems which of those relate to things that we would call psycho-social, that they are problems of thinking, of feeling, or of relationships.

And then we take that data to key informant interviews on the next slide. These are prolonged, semi-structured interviews with local people who are nominated as being particularly knowledgeable about these kinds of problems in children, and how to help children who have these problems. And this gives us a chance to look at the free list issues in greater detail to think about the nature of the problem, its causes. We can also probe on questions such as what helps a child who has these kinds of problems, what do children and their parents do to get help for these sorts of problems. So these are all really critical parts of the research.

I'm now going to show you a little bit of the data because we're tight on time, but on the next slide this is a display of problems of protective resources. I'm going to show you for Somali Bantu and then Bhutanese refugees living in the greater Boston area and Springfield, Mass., between 2011 and 2014.

So when you go out and you ask school-aged children and adults what are the problems of refugee children and adolescents out here in the Somali Bantu community, they talk immediately about financial problems, but also kids losing their religious education, the lack of madrasas for moral education. Other things you might expect, trouble with homework, language difficulties, problems with housing and security. But then some things that are more behavioral or relate to thinking, feeling relationships. Children not listening to parents, having bad influences in their life, poor monitoring of children.

And in terms of protective resources, strongly endorsed are the Somali Bantu Mutual Assistance Organizations, also people who help with the Maay Maay language translation and interpretation, but also the strength of the community just naturally itself, and then other extended parts of people's networks, teachers, friends, and formal government services that provide supports to refugees.

The next slide are similar free-list exercises done amongst the Bhutanese with a team of Bhutanese refugee researchers. We'll talk about language difficulties, financial problems. But then there's a lot more that immediately psycho-social that comes up in the free list for the Bhutanese, problems of kids experiencing bullying or teasing, feeling that they lack friends, getting into fights, being fearful or scared, loneliness, depression or sadness. So there's a lot there. Even though it's not at the top of the list, it's coming out spontaneously when you just ask what are the problems of kids in this community.

And then in terms of protective resources, we see again the indigenous community supports being very important, parents advising children, helping with schoolwork, and then more formal government services, refugee and immigrant services, government programs, Mass health, and then extended friends, relatives, neighbors, and teachers.

On the next slide, you see the results of some of the in depth key informant interviews about clusters of problems and what their cover terms are, and these are now how we can start to have less stigmatizing language that comes from the local language to talk about mental health problems that everyone can recognize. So you see here *aasiwaalidin*, which is a Maay Maay term in the Somali Bantu language for conduct problems and what its indicators are. And you see the indicators across multiple (in) every use that we found were commonly described for *aasiwallidin* are lack of respect. This, engaging in disrespectful behavior, being easily angered, being argumentative, and talking back to parents, not obeying, not helping others when you're expected to, having conflicts with peers.

So you start to see ways in which we can actually develop assessments to see if kids are having high levels of these sorts of problems, or lower levels, or if our interventions are having affects. And we have



syndrome terms also for *wel wel*, the local anxiety like problem, problems anger- *dherif*, and *takoor*-persistent sadness in the Somali Bantu.

It'd like to go to the next slide to show you some of the data from the Bhutanese doing also similar work around cover terms and what their indicators are from the key informant interviews. So you see here the Bhutanese version of *badmaas*, or conduct problems, the indicators that matter, problems with irritability, also lots more about use of substances, drinking and smoking, using addictive substances, using bad words, getting in fights. And then the more anxiety like and depression like problems. *Chinteet*, problems of worry, being afraid, scared, fixating on things, having suicidal thoughts; *Dookhit* or persistent sadness, problems with irritability and loneliness, rumination. So again, we get at these ways that we can talk about mental health problems in kids in local language, and ways that are much more readily recognized, and people can talk about also prevention of these kinds of problems and what helps.

So talking about prevention, what we've been working on together is a family-based preventative mental health intervention for use with refugee children and families, and we call this the Family Strengthening Intervention. It actually builds off the work of Dr. Bill Beardslee, who developed the family-based preventive intervention for the prevention of depression in the offspring of depressed caregivers, which we know is a major risk factor for depression in children. We've adapted this model successfully and used it for families facing adversity in Rwanda due to HIV, and this is now our first adaptation back for refugees in the United States.

The next slide shows a conceptual model and the core components of the Family Strengthening Intervention that we know about the stressors that we talked about earlier related to resettlement, and a culture of stressors, and past trauma. Some of the big risk factors are just poor access to services, or poor navigation of life experience in the United States such as working with schools, misinformation about trauma and its effects on family functioning, poor communication, and conflict in families, sometimes use of harsh punishment, a sense of hopelessness, and then social and economic stressors.

And so core intervention components include helping families navigate those services systems, schools, health systems, in relationships in the community. Also helping them normalize the experience of trauma and loss, and get a psycho-education about trauma, and also beginning to think in a more hopeful way, and establish a family narrative that points out the many strengths in the family and the resilience they've shown to even be here today as resettled refugees. And then addressing some of the social and economic stressors. Really building up those parenting skills, improving parent-child communication, and improving problem solving skills. With the idea of being of diminishing risk of mental health problems in children, and improving the parent-child relationship.

So on the next slide, the intervention involves ten home visiting modules that are early modules of assessment and working with the caregivers so we have child sessions. And then we're moving eventually towards the family meeting, and it's about getting the parent back in the driver's seat, and feeling that they have the capacity to really help provide the reassurance and the guidance to their kids, and that they get support in taking that helm in the household.

Moving onto the next slide, we've just finished an initial pre-pilot and it found very high satisfaction in using the intervention with refugee families in the community. We're now moving into a next phase where we'll actually be working with a small, randomized design to look at program impact, and having

the intervention delivered by community health workers who are themselves refugees from the affected communities. And this is a tremendous opportunity to think about models delivered in this way as community health worker delivered interventions are really being expanded under the Affordable Care Act, and become billable, and possible in many different parts of the United States. Also in doing this sort of pilot research we're considering what are the institutional training and supervision needs to deliver an intervention like this with local refugee community health workers, and also what are its initial facts on parenting, family functioning, and child mental health in families who have school-aged children ages 7 to 17.

So just to wrap up, the take away messages here that are most important is that there are tremendous disparities in the mental health of refugee children and adolescents. Community-based participatory research is a promising approach really for engaging refugee communities in research from the very beginning. And by working with partners in this way, we can attend to primary community concerns, help share data that can be used both for advocacy, but also engagement of refugee communities in services, and to help develop and evaluate a service models that are ultimately more feasible and a good fit to the local context. So with that I'll wrap up and thank you very much.

**Allison:** Thank you, Dr. Betancourt. Looks like we got a couple of reference slides. All right. So now we want to turn on our poll question if we can pull it up.

Thinking about the work that you do, what would you say is the single most common toxic stressor that is present in your clients' children's lives? Is it divorce, a separation? Death of a caretaker? War or violence? Discrimination? Poverty or homelessness? Different levels of abuse or home and domestic violence? Or substance abuse, parental substance abuse? I'll give you all just a little bit longer to vote.

And like we said before, you know, any of these could not be toxic if there is a caring individual in their lives helping them to navigate these situations, and there can be other stressors that do end up being toxic that aren't some of the ones we initially think about.

Great. So it looks like according to the poll, folks are saying that the biggest challenge that children are facing that could lead to toxic stress seems to be severe poverty or homelessness.

Great. Okay, so moving to the next slide, we are now going to listen to our second speaker, Kathleen Cloutier. Kathy has over 30 years' experience in non-profit management, most recently as the executive director of Dorcas International Institute of Rhode Island, where she has worked since November of 2013. She's responsible for leading an agency that has become a vital part of the community, and it's recognized as the place in Rhode Island where immigrants, refugees, newcomers, and low-income families receive the education, employment, in a wrap-around services they need as they journey towards attaining economic self-sufficiency. She has an international master's degree in management from the Krannert School of Management at Purdue University, and is also a nationally certified results-oriented management and accountability trainer. I'll turn it over to you, Kathy.

**Kathy:** Thank you, and thank you for having me. As said in the introduction, our Dorcas International Institute is a multi-service, human service organization. So we provide a full range of services. Among them we're a recognized resettlement agency for refugees, and then we provide wrap-around services including case management, education, immigration services, interpreting, translating, and we have a

range of school-based programs which I'll emphasize in this presentation as we talk about addressing toxic stress.

This slide just represents our clients, basically who they are and what they are. And our services, as I just kind of rattled off quickly, full range of services. And we resettle about 170 refugees each year, in - Providence, we resettle most of our refugees in Providence because this is where the services are, largest city in the smallest state so everything's kind of consolidated here in Rhode Island. It's a very diverse community, and so we do resettle refugees from all over. We're one of the few organizations resettling our refugees from Columbia in the last couple years, primarily because we have a large Columbian population already. And so that provides a lot of benefits in terms of refugees aren't really recognized as refugees initially, but at the same time, we're dealing with a lot of different cultures and contacts when we're working with our clients.

And our refugee program budget is \$1.3 million, but it's a compilation of a lot of different small sources of funding including Office of Refugee Resettlement funds, Department of Education, TANF, as well as United Way, and public school district support. So we patch of a lot of small funding together to try to offer a full range of services for refugees. And our adult programming which we separate from the family programming is more of the traditional refugee resettlement support. The reception and placement, cultural orientation, those kinds of things.

We have just in the last year or so really shifted our paradigm. Refugee resettlement programming was meant to be, or was designed as a short term, kind of rapid community integration solution for refugees, right? Okay. Here you go, here's your money, we'll set you up with some services, and you're on your own kind of thing. I'm exaggerating obviously. But we've recently changed our paradigm within which we work, and are recognizing, or designing our programming, to be client-centered and strength-based case management focus where we'll invest much more resources in the front end to mitigate the crises afterwards.

So we say we work with refugees for five years, and we are used to, our staff are used to work in crisis mode all the time, and we would have folks come back two, three, four years later not dealing with their family crises much more readily than they did when they first arrived.

So we've kind of switched how we do things, and start to put some focus on beefing up the initial first year of services and expanding that to the extent we can with the funding that we do have. So, you know, we have in-house English language learning, employment training. We do the whole employment placement assistance but then we're adding on some employment retention supports afterwards. We're doing behavioral health assessment initially and 90 days later for the adults. We've created a whole healthcare model that our refugee clinic has become primary care or the medical home for most all of our refugees. So it's -- you go to the same place. And I'll talk a little bit about our partnership with Hasbro Children's Hospital in a little, (but) that's basically how we've structured our services for refugee adults.

Again, as I mentioned earlier, we have the full range of wrap-around services as well to basically try to meet clients where they are and provide what they need when they need it within the same context, within the same service that we can offer. We also, these are our in house supports, but we also rely very heavily on our community partners. Again, most of the services, service providers are located in Providence and so that's one of the reasons we resettle our refugees here, but then we also make use of

the additional services that are so close and available to most of our folks. But my focus of the presentation today is really on our two generational approach to working with refugees, and other immigrants, and newcomers. And so here are our list of our family programming.

And we through various sources of funding actually have a position in our organization that's responsible for school orientation and acts as a liaison between refugee families and the Providence School District which is a very strong partner. They're very committed to supporting English language learners and newcomers to the community. So they've created, as some of other districts I understand have created newcomer academies where refugee children are initially placed to, so that they're not, so they have the ability to catch up if you will to grade-level learning in their appropriate grade before they're transferred into the mainstream grade levels. We have a whole in-home tutoring program which I'll go into a little bit as well as a summer learning camp.

And we also, one of our, a local immigrant, a therapist, youth counselor actually has, volunteers her time to run a youth support group on Saturdays for refugee youth, both newly arrived refugees and refugee youth who are experiencing issues and could benefit from attending a youth support group. We have a family literacy program and some leadership development for parents and parent engagement, and I'll go into some more detail about these types of programs and how they work together.

Our major partners are the Providence Public Schools as I mentioned, a really strong partner. They have a, as you can see, 24,000 students in the district with almost, about 23% of the students as active English language learners, 84% of their students are in poverty, (who are) receiving free and reduced lunches. So it gives you an indication it's a traditional, urban school setting if you will. The Brown University Swearer Center, the Swearer Center is their community service organization, provides 130 Brown students to tutor refugee youth after school, and they also created the summer camp, we call it the (Bright) Summer Camp for refugee youth which I'll, again, go into some detail in terms of how that works. Others of our partners, we are operating, Providence District operates several full service community schools, and these are our full-service partners. The YMCA, a family services provides some care coordination and social work services. And the Capital Good fund provides some financial empowerment services. So together we work within the schools to offer a range of school-based programming both for refugee youth, unaccompanied youth, and other new coming immigrant youth as well.

Some of our other partnerships are the Hasbro Children's Hospital as I mentioned earlier, and basically we've created a model, a primary healthcare model that's been very successful in that the refugee clinic becomes the, it's the refugee pediatric clinic, becomes the primary care clinic for refugee children. And so as they're introduced to their initial pediatrician, that pediatrician remains their pediatrician throughout their healthcare in Providence. In addition there's an on-site child psychiatrist available so referrals happen directly between the pediatrician and the psychiatrist so that in terms of stigma or whatever, the child is just going to the clinic to see the doctor. It's just another doctor that they're seeing when there's, issues arise regarding mental health or other behaviors that would indicate that something else is going on.

And we have been working very closely. We've, as part of our change in provision of services, we do have a clinical supervisor, a licensed social worker who's supervising our case managers. And she's working very closely with the behavioral health providers to identify what the barriers are to providing mental health services to refugees and immigrants who don't speak English well, and have issues

possibly with interpreters and providing services to those who don't have a full comprehension. Following Theresa's presentation, we've got a lot of great ideas in terms (of carry) to Providence, and we're really excited about that. But those are some of the work that we're doing with the Hasbro Children's Hospital and the support that they're also providing.

There was a specific example working with the schools in terms of acting as liaison in terms of helping the school staff really understand what some of the issues are. We had an example of one of the Columbian children was having frequent outbursts of aggression in the classroom, and the school staff thought he was just acting up and being difficult in the classroom. But once we were able to communicate both to the administrator and the social worker about some of the background of the child and that the child may be exhibiting symptoms of PTSD, the child received proper support in the classroom, and then was referred to mental health services that he needed outside the classroom.

So this whole wraparound model has really grown into quite successful for the refugee clients that we have. And one of the things that we've found in resettling our refugees is a common experience of refugee parents integrating into the American school system is a sense of helplessness and disempowerment that results from their inability to be connected to their children's lives while they're in school.

And so in addition to the normal reasons why schools and people feel they need to engage parents in the schools which you see on this slide, we recognize that there's an even more important reason from the perspective of the refugee parents being able to support their children as the children are integrating into American school system.

So I love the distinction between parent involvement and parent engagement that Larry Fliaso and Lori Hammond have brought. A parent involvement begins with the school. So see, the school staff in public institutions feel that they know what the problems are and how to fix them, and so they start determining what the criteria is to use to evaluate success, where parent engagement really begins with parents. And so we've incorporated into our model a full parent engagement model where ideas are elicited from parents by school staff in the context of developing the relationships, and they emerge from the community needs and priorities, and parents are, when engaged, really drive the efforts. And that I think is one of the successes of what we've been able to accomplish in Providence.

So as part of our family literacy model, what we do is not only are we working with school staff but we're also inviting parents into the schools to provide their adult education within the same school that their child is attending. So we offer English language learning, or adult basic education, you know, nearby to where their child is studying. And at the same time we're providing workshops and, around financial education or parenting education, whatever topics the parents themselves have identified is something what they learn more about.

And then in addition to these two pieces of our programming, we also have a parent/child together time, a (PaCT) time in which the parent will spend a couple of hours a week in the child's classroom volunteering, quote/unquote, volunteering in the classroom where they're able to actually get to know their child's teacher better as well as really learn what their child is learning so they can better assist them when they're home. For adults who are attending our evening classes, so for working adults, again, they're having their adult education in the schools where their children attend. However, they

don't have access to their child's classroom. So we provide activities where we invite parent and child, and introduce them to the activities that they can take home with them.

And in addition to this family literacy model that we've identified, we offer some leadership on development which I'll talk a little more about as well. And so while all of this is happening in the school, we've partnered with Brown University as I said to do this one-on-one tutoring, mentoring program. So each child even if it's a family with, you know, six or more children, each child is given a tutor to tutor individually. So the tutor spends three to five hours a week in the child's home working on homework assignments, or doing some remedial catchup, English literacy working, whatever is seen as needed by the child's teachers. And often the relationship can continue for the whole period of the Brown student's college years, up to four or five years, and that's been very, very successful. The Brown tutors are able to also communicate with our case managers when there are concerns either within the home or other types of family concerns that they act as a liaison as well in terms of communicating.

The Brown students came up with this great idea of a summer learning camp that's both a fun camp for refugee youth as well as academics to prevent a summer learning loss, or to prepare newly arrived refugees for school who have maybe had some interrupted education if not a lack of education all together. What's happened over the years, the Brown students started this camp about six years ago, and what's happened over the years is we've brought in various partners and funding to beef up this, and so this last summer's experience was phenomenal. We had the Providence Public School District provided certified teachers, district teachers, to operate the classroom in the morning, and provide all the English literacy programming in the morning along with bright Brown students who acted as teacher assistants. And some of our former camp members acting as junior counselors. So they were really in addition to the district teachers, the district provided a school administrator, a nurse, and a social worker who were there the whole time.

The camp ran Monday through Friday, full days, nine to three for about six weeks. We pretest, post-test, and the numbers, the learning of the children was actually really exciting to watch. It was a really successful program this year. And in addition we provided the adult literacy classes, the adult learning classes right on site so parents were learning in the next room where their children with learning and having fun as well. So that's been really exciting to see that develop over the years.

And we have, the YMCA provides out of school time which again offers a full range of services through the full-service community schools. So out of school time before and after school, reading help, homework help, those kinds of things. They've been a great partner too in terms of improving the academics of the kids in school so. As I mentioned earlier as part of this whole family literacy, family engagement model in the schools is really, again as we said, to really help parents feel comfortable supporting their children in this new school environment.

So we've been fortunate enough to have a Toyota Family Learning Grant that offers a whole leadership development module to our Family Literacy where each refugee family is partnered with a family mentor who is another family within the same school who can assist the refugee family in terms of navigating school events, or school issues, and all those kind of day to day issues that parents of school-aged children have to deal with.

In addition there's a whole service learning model. So the refugee parents and their mentors work together to identify community service activities that they want to participate in. So it really allows

refugee parents and children to fully participate in their communities and helping other communities more quickly than they may otherwise have been, had opportunity to do. There's a parent leadership council that family, parents can join, and there's the, as I mentioned earlier, a Brown University Bright Program offers a leadership institute to develop leadership opportunities for older refugee youth, high school age refugee youth. And pair them with a tutor/mentor that really relates to them on a more peer level to offer opportunities for the older refugee youth to start to take owner and leader, and learn some leadership activities.

So our holistic model really empowers extremely vulnerable refugees to gain confidence and some self-reliance, and also assist other refugees who come after them. The model not only strengthens the refugee community but also empowers refugees who have been isolated for many years, really become leaders in their communities. And with strong family as basically as we try to address the toxic stress that's, that we see so often among the refugee youth.

So really this slide here talks about kind of what we've learned in terms of as this programming, this is a really an integration of a lot of different programs and funding, and really trying to put together a much more holistic continuum of support for parents and children as they navigate school systems and education. So we've identified some questions that you want to ask as you think about possibly replicating this type of a program in your communities. And again, it's really trying to identify, you know, what the schools need and how you can position yourself as filling some gaps in terms of the, what the school - schools are under a lot of pressure to meet outcomes, and to engage parents, and do to all of these things. And so if you can indicate to your school leaders how you and your organizations can support them in meeting their outcomes, at the same time they'll give you access and support to do the work that you do well. So, and that seems to be the end of my presentation, but I appreciate you giving me the time, and thank you very much.

**Allison:** Thank you, Kathy. All right. We will now turn to our final speaker, Ardiana Halilaj. Ardiana Halilaj is the clinical Supervisor for Child Welfare, Contracted Programs, and Federally Funded RIFE Program serving refugee families and individuals of multiple ethnic and cultural backgrounds at IRCO. A native of Albania, she has lived in the U.S. for the last 16 years where she trained in social work, and marriage and family therapy. Her first experience working with people who suffered from trauma was in 1999 in refugee camps in Albania during the Kosovo-Serbian war. She's also an individual, child, family, and relationship therapist practicing at Western Conexiones Center for Multi-cultural Counseling and Trauma Recovery. She has worked in various community mental health programs serving underserved and marginalized families and children. Currently she works with individuals and families from a multicultural background addressing issues of complex and developmental trauma as presented by symptoms of depression, anxiety, acculturation and adjustment challenges, domestic violence as well as relationship issues. Ms. Halilaj, I'll turn the presentation over to you.

**Ardiana:** Thank you very much. Thanks. So I just wanted to say that I will be here by myself today. Unfortunately both my colleagues Megan and Lacey are not present, and I, so I will speak on their behalf and other members of the staff here, but I just wanted to really thank you all for having us on.

Even though it's not the slides, I will just mention briefly our organization, and then focus on just the refugee and immigrant family empowerment program (that) because that is most likely one of the programs that really offers the case management services.

But IRCO, Immigrant and Refugee Community Organization, has been around since 1976 and we have provided a variety of services. At any given year, a 100 different kinds of programs are funded through various sources to serve a variety of communities, refugee and immigrant communities in the Portland area. And we have many different kinds of services offered to children and families, senior services, youth academics, employment and training, and other community development programs. But my presentation will be mainly on the family empowerment or RIFE program. RIFE is funded through the Office of Family Assistance. It's a federal grant called Healthy Marriages, and we are currently in our fifth year, but they have responded to the new RFP for funding after September of 2015.

We do not provide mental health services to our communities through this program at all, however we definitely see those lines blurred a little bit when we engage with families in a variety of interactions as you will see later.

A little bit about demographics who are communities that we work with are. So up there there's client education status and also divided by gender, and what we see are all of the communities that we serve together so it's not divided by different ethnicities. The employment status, and you can see there's 78% there being unemployed. That seems to be one of the main stressors that our clients come in with. And then a little bit about the financial situation, and 58% having no income. We have found that majority of our clients that we have been serving in the five year period have been poorly educated in their own countries due to various displacement and not having a set place for long periods of time, sometimes inter-generationally. They are unemployed and they have very little or no income sources.

As far as family makeup, this is the demographics and these are coming from year three, so I apologize that we don't have later data gathered yet, but what we're finding is that 51% are married, 33% single or never married, 8% widowed, 4% divorced, and 4% are in committed relationships. And the family average size would be around five to six people, and these are all, the number of individuals that, in families that we have served over the years.

The program model is to be eligible, to participate in our program is to be foreign born, this is the one or the only program I believe at IRCO that does not have any kind of stipulation to be served by the program as far as how many years you've been in the country. Most of the programs beyond year five will not be able to really serve our communities, and RIFE, and I think actually there are a couple of other programs who, open that to, or their services to immigrants and refugees beyond five years of their resettlement.

We offer culturally and linguistically specific workshops to the members of the community and that is how we first reach the communities, and then after the workshop a potential client or a family needing more support meets with the family engagement specialist. And then through a process, a short process, then, the FES, or the family engagement specialist, would determine eligibility and then we'll start enrollment in the program.

Usually the way that our clients enter our program is if we, these are the kinds of things that they come to, to the case managers or to staff with the kinds of problems, and they might say things like:

- "My children don't listen to me." So there's some kind of parent child conflict going on due to various reasons.



- “I don’t feel respected in this country.” This speaks a lot to the alienation of parents. A lot of time they feel just not their cultural norms, not fitting quite well with the larger individualistic cultural norms in the U.S.
- “I work all the time but don’t know where the money goes.” So that is the financial stress that most of our families feel as soon as they arrive.
- “My children know how to read but don’t help me to read the mail.” That is one of the things which just kind of speaks to the generational divide, or starting to, the division where kids are really engrossed in their development of integration into the main society and parents feeling like they’re being left behind.
- This speaks more to sometimes gender issues that come up. “I’m afraid my wife and daughters will become Americanized.” The fear of losing traditional and cultural norms.
- “I’m tired and wish my husband would help me with the dishes and children.” I think this speaks to, a lot of the times speaks to the, just the change in gender roles because both, a lot of times, both parents are required and need to work, and that just creates a lot of conflict between parents, and how to manage the stressors as day to day life.

Our workshop series focuses on building strong families and this is a 12-hour workshop where communication skills in general are just delivered to the community. There’s the Effective Parenting Workshop, Money Matters, which is just focusing on budgets and financing, and just understanding the system in the U.S., financial system a little bit, and how to save, and how to be financially responsible, and then also we try to target youth with a six-hour workshop where various issues of integration and inter-generational conflict are addressed with the youth who are participating.

Our employment services which are part of our program as well try to address the unemployment rates, and the unique thing that we do is that really kind of walk our clients through the whole process of preparing for the interview. Or starting actually with skills. How to put together a resume, preparing for the interview, bridging the local employers to the communities. So being that person who links and who makes those links actually. And then going through the whole process of interviewing with our clients so they know for the first time what that feels like. And a lot of times, you know, they come back because that didn’t work, and so that is part of our, or employment staff really helping to continue the search for a better job and some (inaudible) our clients when possible.

We really couldn’t do it without our partners because the community is, that is part of what we try to do is to really have the communities, or ethnic communities, link to a larger community. So all of these partners, we do different kinds of events throughout the year, and that has been really successful, and the participation has been really amazing from everybody.

And our wrap-around case management, we really try to focus on increasing the healthy communication skills between all family members, looking at developing and building on the resiliency that already exists within the family and each individual, and then just really work on stress management skills with, when we can. Increase access to resources and build financial stability that is (what), so we can reduce that stress on the family. And then continue to grow positive relationships, and heal from trauma, and

increase peace and equity in homes between parents and children, and parents themselves. And also try to teach them self-sufficiency skills as we walk families through a variety of services.

This is what, typically what we say, and this is not getting into the more high-need families, but what we have found these are mainly the challenges that families come in with, and then the interventions that we try to engage the families, and then the goal becomes - or on the farther side of those are the goals that we try to achieve with the family. Conflict and arguments between parents that's one of the things that, actually that's after financial stress and unemployment, and then that's the next thing that families start to talk about. And then parental stress resulting in parent-child conflicts a lot of the time. The budgeting and understanding of the U.S. system. We find that parental involvement in the educational system is quite minimal at first because they, it's so complicated, and then a lot of stigma around behavioral and emotional needs, and just like those previous two presenters mentioned that, you know, finding that community language around those kinds of issues have been a challenge for us. Unemployment is definitely another issue that our families come in with, and then a lot of struggles navigating the systems including healthcare. And the interventions that we try to focus on is just starting where, and there will be another slide there, where, how we engage the family is wherever they come in and that's where we start with them, and that is part of building trust with them, and really attending to their immediate need as we continue to assess what other needs there are.

What we have found makes the difference in working with our communities is that we really have tried to be as culturally competent as we can. We try to be in trauma informed in our service delivery, and then building trust, and continuing to empower the individuals and families as we continue to help them for as long as they are engaged in our family, in our program.

So IRCO as a whole, and definitely RIFE, trains and hires staff from the communities that we serve. And we understand that language is not the only aspect of cultural competency, however, it does start with that because it does eliminate the language barriers and reducing the stress when clients are seeking help. And then the process of engagement really is facilitated by the bi-cultural staff. If you, do connect really well in that dimension of their experience as a refugee. They speak the community language in terms of, you know, what the issue is. And then they're able to really respect a client's personal story and journey, and try to separate that from theirs. And the process of cultural competency we have found can, it's ongoing. So with each community really we do try to engage that particular community leadership, and so we can have as much information as we can upfront with what the needs are and how do we engage the community as a whole.

IRCO staff really, I just want to say something which is I think it's really unique for IRCO, we do represent over 40 ethnicities, and then we all, you know, as staff speak 75 different languages. 80% of staff are former immigrants and refugees. RIFE, so my program mainly serves Burmese, Karen, Somali, Nepali speaking Bhutanese, and Zomi communities. We also are reaching out to Arabic speaking communities, and Farsi, and a little bit of Spanish-speaking communities.

We tend to be trauma-informed in our work with clients and when we're delivering these services, and so staff is aware and continues to develop that awareness around the impact of the trauma story as that particular client, and family, and community. So they are really sensitive and very respectful of that collective story that they come with, and our policy is "do no harm". So if we're not able to really attend to what the answer might be, we don't ask that question, and, but which, then that's where, represents a lot of challenges when we try to serve the family because on the course of our services, you know,

these things will start to come up. And so then it becomes our task to really try and link the family with the needed resources, but we're very slow in getting that information right up front because we do not have those services in house.

New information, you know, whether it is without something, you know, a new resource, or an employment opportunity, or whether we're working on communication skills really is given in small increments, I mean short increments, and not really a lot of information given at the first time, and then allow a lot of time for practicing.

Validation as the refugee experience has been really challenging. We have found that it just really helps create trust and relationship with case manager and the client, and then we really normalize our client's responses as best, they can do under the circumstances. And continue to educate staff on the issues of this interconnection of their own experiences with both of their clients. And that trust continues to be rebuilt and it's an ongoing relationship. Building by meeting the client and the family where they are, and that means it's their identified need once they enter the program that we really try to attend to initially, and whether that's filling out some paperwork, or attend a meeting at DHS, local DHS, or connect them to resources in the community. And then once that trust continues to be established, then we really have, or try to have consistent contact with clients in the office, at home, in the community, or wherever it's possible for them. So our staff has that flexibility. Try to create some kind of structure at each meeting so that gives predictability, and that tends to reduce the stress as the families continue to engage and focus on what they need. And then really attempt to be very transparent with clarification, or, of any interaction and the intervention that we do with them. So they understand the context as a whole. And then focus on safety, physical and emotional, by helping them prioritize, and then structure their needs as we go along. A lot of the time that can be challenging however.

And we continue to empower along the way by asking questions of the community leaders, about the needs of that particular community so that is an IRCO policy as a whole, and RIFE really follows in those footsteps. We continue to educate the families and the community about various systems here in the Portland area. Organize community events with healing purposes such as vigils. It's happened a couple of times and we've had a wonderful turnout of community. Organize community events, bridging local agencies and entities to the refugee communities such as police force events, library events, museum events, and then continue to teach those self-sufficiency skills to the families. And also start to, this is done more, or through modeling and showing, and how do you advocate for oneself, and while the case manager really is present as this happens.

We definitely continue to face the challenges that I think most of us do when we're engaging such diverse communities and with diverse needs. And our, as we know, clients and communities, they do come from strenuous circumstances and that's been an ongoing stressor for them, and sometimes inter-generationally, foundational problems. Really when we're engaging with a family, they end up being delivered indirectly, and while we're constantly engaging in what the crisis of the moment is which is, you know, a DHS meeting, or ending assistance, or something like that that we, so we're trying to relieve that need for them while trying to address how do we teach some stress management skills along the way. We definitely have ongoing challenges with understanding and discerning what a crisis is in a person's and a family's life. A lot of the time just as something that's very small can throw the family in a chaotic situation, and then it's just holding that space for them so they're learning how to deal with it. Ongoing challenges to maintain a consistent helping relationship with clients and families and engage through crisis situations only. We just lose track of a lot of families and then come back when their next

crisis hits. Ongoing challenges with unreliable funding, and negotiation between what a client needs, and the community need, and what the funder's requirements are. And then ongoing challenges with educating the system at large about refugee and immigrant experience and communities that needs of as a whole so, whether it's an educational, healthcare, criminal and judicial system.

And in conclusion, we really believe and want to enrich each person's life, client and staff alike because we do recognize that staff are such a huge part of a client's success through relationship and community building. We recognize that our communities are resilient, and want to do better when given opportunities and we want to help build on those strengths and protective factors. And we become the bridge that a lot of the time we become the bridge that different communities need to connect to the society at large when resettled here. And this concludes my presentation, and thank you so much for giving me the time.

**Allison:** Thank you, Ardiana. In the interest of time, I wanted to put out one question and offer it to each of the speakers in order. So the question that I have is that, you know, when you're using a trauma-informed approach and you're talking about these concepts of trauma and toxic stress in a way to educate and empower your participants. How do you describe them from a viewpoint of resiliency and agency in a way that doesn't further traumatize your participants? What tips do you have for talking about those concepts in an effective manner? And I'll send it to Theresa first.

**Dr. Betancourt:** Thanks for the question, and thanks for all of my fellow speakers for the great presentations they gave. So when talking about trauma at least in our intervention work and also just our community outreach, we really try to take the stance of normalizing the experience, making people feel not isolated or shameful, or alone in it. That many people around the world go through difficult events and go on to thrive and do well. In fact, you know, the story of so many refugees is that of survivors who've been through all sorts of life disruption and violence, but are here today starting new lives. And so we normalize it, we recognize it, we don't try to minimize it, but we also pair that discussion with the discussion of strengths and resilience.

**Allison:** Thank you. Kathy?

**Kathleen:** That was a great response, Theresa. And I was going to say similarly, we really do focus on the strengths and all the things that are working, and don't approach issues as deficits, but rather situations to grow from and learn from. One of the things I think we found useful is in, you know, creating support groups and pairing cohorts together that folks when they're sharing their stories together, again, shares that, you know, that this is happening all over and different things are happening to different people. And yet there are some phenomenal successes that they see. So it frames it in a positive, you know, through adversity comes, you know, growth and better kind of thing.

**Allison:** Ardiana, what are your thoughts?

**Ardiana:** I don't think I can add much to what Theresa and Kathleen were saying, and like I said we're really, two things are real important that we try to hold for our clients is we really want to honor their experience as being unique to them on some level. So we're honoring, you know, their struggles, but at the same time the message of being, you know, in a place with others and then looking at what brought them so far is very important. And so it's a very delicate balance to hold. And my staff, you know, we are in our supervisory discussions we really, you know, struggle with finding that message of hope

sometimes, but it's, when you look at it from a strength based really you can find that resiliency. So it, and then how to deliver that in a way that makes sense to the client and to the families so they continue to build on it. It really it is about finding that common language and to let them know that what we see is real, you know, because it's in them so.

**Allison:** Great. Thank you for that. This has been a wonderful Webinar, and I want to thank all of you listening for taking the time to listen to and engage with our Webinar. I also want to thank all of our presenters for taking the time to put their thoughts on PowerPoint, and spend the time with us, and providing the insightful evidence and practice-based advice, case studies, and guidance.

We will be sending an e-mail shortly in the next couple weeks with a Web link to the slides. So everyone that has signed up for the Webinar will be able to see the slides. And I want to thank you all again and please enjoy the rest of your day and this concludes our Webinar.

**Operator:** That does conclude today's conference. We thank you for participation.