MPI
MIGRATION POLICY INSTITUTE

NATIONAL CENTER ON
IMMIGRANT INTEGRATION POLICY

Addressing Trauma in Young Children in Immigrant and Refugee Families through Early Childhood Programs

Webinar

April 3, 2019

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Maki Park, Senior Policy Analyst, Migration Policy Institute

Caitlin Katsiaficas, Associate Policy Analyst, Migration Policy Institute

Jessica Dym Bartlett, Co-Director, Early Childhood Research, Child Trends

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- Education and Training:
  - Early Childhood
  - K-16
  - Adult Education and Workforce Development
- Language Access and Other Benefits
- Governance of Integration Policy

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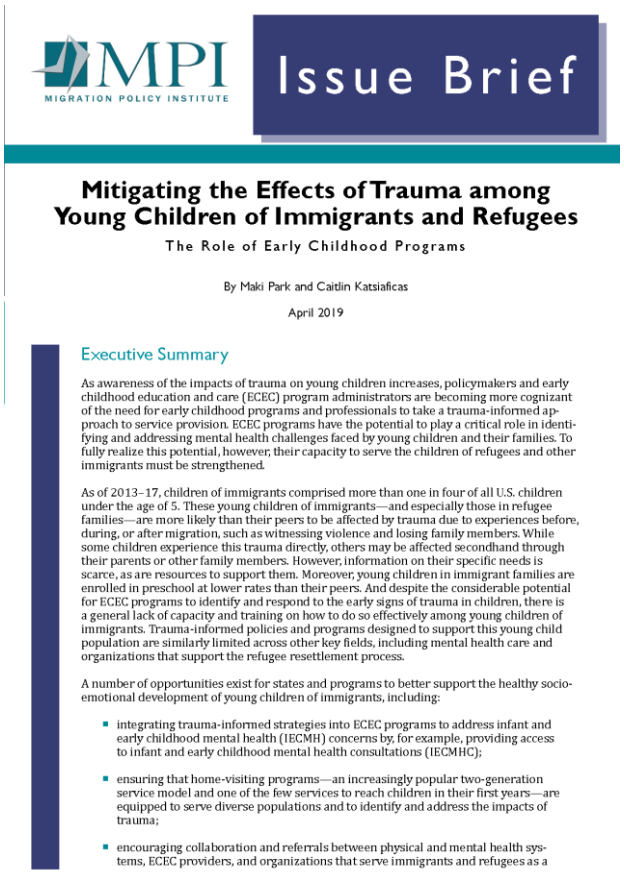
Today's Release



MPI MIGRATION POLICY INSTITUTE Issue Brief

Mitigating the Effects of Trauma among Young Children of Immigrants and Refugees

The Role of Early Childhood Programs

By Maki Park and Caitlin Katsiaficas

April 2019

Executive Summary

As awareness of the impacts of trauma on young children increases, policymakers and early childhood education and care (ECEC) program administrators are becoming more cognizant of the need for early childhood programs and professionals to take a trauma-informed approach to service provision. ECEC programs have the potential to play a critical role in identifying and addressing mental health challenges faced by young children and their families. To fully realize this potential, however, their capacity to serve the children of refugees and other immigrants must be strengthened.

As of 2013–17, children of immigrants comprised more than one in four of all U.S. children under the age of 5. These young children of immigrants—and especially those in refugee families—are more likely than their peers to be affected by trauma due to experiences before, during, or after migration, such as witnessing violence and losing family members. While some children experience this trauma directly, others may be affected secondhand through their parents or other family members. However, information on their specific needs is scarce, as are resources to support them. Moreover, young children in immigrant families are enrolled in preschool at lower rates than their peers. And despite the considerable potential for ECEC programs to identify and respond to the early signs of trauma in children, there is a general lack of capacity and training on how to do so effectively among young children of immigrants. Trauma-informed policies and programs designed to support this young child population are similarly limited across other key fields, including mental health care and organizations that support the refugee resettlement process.

A number of opportunities exist for states and programs to better support the healthy socio-emotional development of young children of immigrants, including:

- integrating trauma-informed strategies into ECEC programs to address infant and early childhood mental health (IECMH) concerns by, for example, providing access to infant and early childhood mental health consultations (IECMHC);
- ensuring that home-visiting programs—an increasingly popular two-generation service model and one of the few services to reach children in their first years—are equipped to serve diverse populations and to identify and address the impacts of trauma;
- encouraging collaboration and referrals between physical and mental health systems, ECEC providers, and organizations that serve immigrants and refugees as a

http://bit.ly/immrefchildren

Mitigating the Effects of Trauma among Young Children of Immigrants and Refugees: The Role of Early Childhood Programs

By Maki Park and Caitlin Katsiaficas

This issue brief explores the types of trauma that may affect young children in immigrant families, what the effects of those experiences may be, and what can be done to protect children against them. Among these opportunities: promoting the systematic use of mental health screening tools that are appropriate both for young children and for use across cultures, and boosting collaboration between early childhood education and care (ECEC) providers, health services, and organizations that work with immigrants to ensure that young children and their families are referred to needed services in a timely fashion.

Children in Immigrant & Refugee Families in the United States

Children of immigrants comprise 1 in 4 of all young children ages 0-5 in the United States

- Accounted for all net growth since 1990
- Majority of immigrant-origin children are U.S. citizens
- 27% live in households experiencing poverty
- More likely than peers to lack health insurance
- Less likely to be enrolled in pre-K
- Linguistically diverse families

Migration Experiences: Refugees

643,000 refugees have resettled in the United States since FY 2009.

Their experiences may include:

- Violence or persecution
- Loss of or separation from family members
- Refugee camps or displaced in cities

- ➢ The federal government has decreased the number of refugees resettled and expanded security checks.
- ➢ USCIS recently announced plans to close international immigration offices.

Source: Refugee Processing Center

Migration Experiences: Asylum Seekers

Asylum seekers submitted nearly 332,000 applications in 2017.

Their experiences may include:

- Dangerous journeys
- Months or years of waiting for an application decision

➢ Federal policies have aimed at narrowing grounds for asylum claims and decreasing the number of border crossings.

Source: UNHCR

Migration Experiences: Mixed-Status Families

There were 4.1 million U.S.-citizen children (under age 18) **with unauthorized immigrant parents in 2009-13.**

Their experiences may include:

- Psychological distress and economic instability
- Limited eligibility for and lower likelihood of accessing services

➢ Immigration enforcement has expanded under the Trump administration.

Source: MPI

The Role of Post-Migration Stressors

- More generally, settlement-related stressors are also important to consider when thinking about families' migration experiences, including:
  - Adjusting to a new culture
  - Language barriers
  - Discrimination and racism
- The current situation in which families are living also plays an important role in their mental health and wellbeing.

Gaps in Services for Young Children of Immigrants

- **Under-identification**: ACE surveys, for example, may not capture many of the experiences that are likely to affect immigrant families
- **Gaps in services:**
  - ECEC capacity and under-participation
  - Lack of linguistic and cultural competence across services
  - Disparate access to mental health services
  - Refugee resettlement services are focused primarily on adults and school-aged children

Opportunities to Improve Services

- **Integrating trauma-informed strategies into ECEC programs**
  - Access to Infant and Early Childhood Mental Health Consultations (IECMHC)
- **Leveraging home visiting programs**
- **Encouraging collaboration between ECEC providers, immigrant & refugee service providers (e.g. refugee resettlement agencies), and physical and mental health systems**
- **Promoting systematic use of standardized mental health screening instruments appropriate for use with young children and across cultures**

Jessica Dym Bartlett

Jessica Dym Bartlett conducts applied research with infants, young children, their parents, and the prevention and intervention programs with which they interact. Specifically, her interest is in the mental health, wellbeing, and care of young children who experience or who are at risk for experiencing trauma and adversity, with a focus on identifying individual, family, and contextual factors that contribute to resilience and the prevention of poor life outcomes.

Dr. Bartlett oversees Child Trends' Massachusetts office and is Co-Director of the Early Childhood program area. She has strong expertise in a range of research and evaluation methodologies. Her current work includes serving as principal investigator on a 15-state longitudinal randomized controlled trial (RCT) study of resilience to child abuse and neglect in Early Head Start, as well as an RCT examining the effects of the Newborn Behavioral Observations on parent-child relationships and parental mental health at Brigham and Women's Hospital, Harvard Medical School.

Jessica
Dym Bartlett
Co-Director,
Early Childhood
Research,
Child Trends

Dr. Bartlett is the lead evaluator for the Child Trauma Training Center at the University of Massachusetts Medical School and serves as the co-chair of the Substance Abuse and Mental Health Services Administration's National Child Traumatic Stress Network Evaluation Community of Practice. She also provides evaluation technical assistance and consulting to policymakers, programs, and federal grantees. Dr. Bartlett worked for more than a decade as a child and family psychotherapist, infant and early childhood mental health consultant, Early Intervention educator, and adoption placement worker for abused and neglected children. She completed her BA, master's, and PhD in child study and human development at Tufts University, as well as a master's degree in social work from Simmons School of Social Work.



How Early Childhood Programs Can Address Trauma in Young Children from Immigrant and Refugee Families

Jessica Dym Bartlett, MSW, PhD
Co-Director, Early Childhood Research

Child Trends

Objectives

Photo by Antonio Masiello/Nurphoto via Zuma Press

1. Describe early childhood trauma and its prevalence

2. Discuss the impact of early childhood trauma among immigrant and refugee families

3. Offer information on and examples of how to meet the needs of young, traumatized immigrant and refugees children using trauma-informed care

Child TRENDS

1.

EARLY CHILDHOOD TRAUMA

Child TRENDS

Definition of Early Childhood Trauma

When a young child experiences an event that causes actual harm or poses a serious threat to the child's emotional and physical well-being

- Different from regular life stressors, because it causes a sense of intense fear, terror, and helplessness beyond the normal range of typical childhood experiences

(National Child Traumatic Stress Network, nctsn.org)

Prevalence of Early Childhood Trauma

Affects almost half of U.S. children (35 million)

Disproportionately affects young children

(National Survey of Children's Health (2011/12); APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008)

Child TRENDS

Common Types of Traumatic Experiences in Early Childhood

- Abuse and neglect
- Serious, untreated parent mental illness or substance abuse
- Witnessing domestic violence
- Parental incarceration
- Serious injuries or painful medical procedures

Additional Types of Trauma Among Young Immigrants and Refugees

(National Child Traumatic Stress Network, https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/about-refugees)

Child TRENDS

2.

IMPACT OF EARLY CHILDHOOD TRAUMA

Child TRENDS

Myths About Early Childhood Trauma

Myth #1

- **Young children do not remember traumatic events**

Myth #2

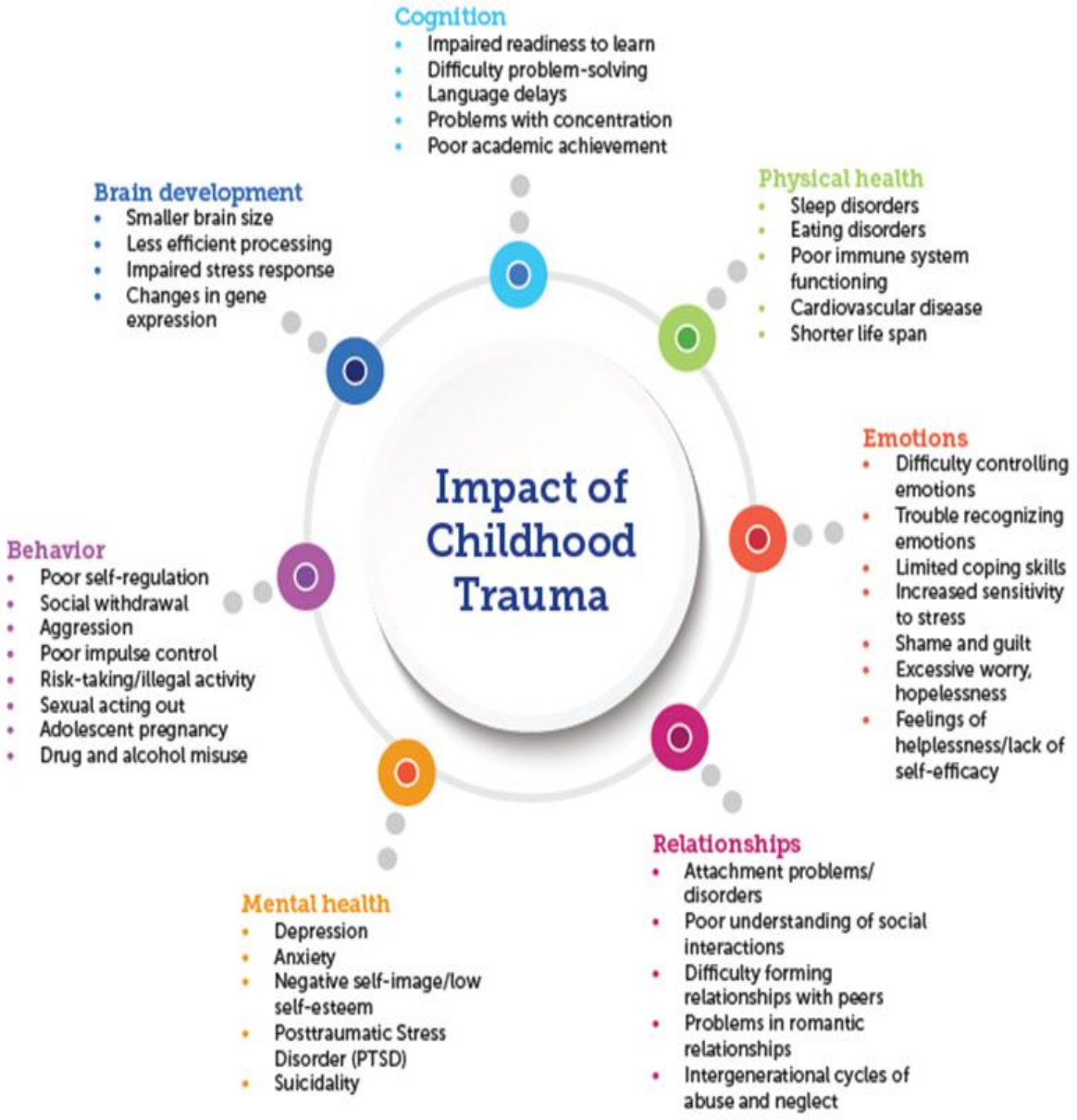
- **The younger the child, the less impact trauma has**

Myth #3

- **Children are resilient and always "bounce back" from trauma**

Child TRENDS

Impact on Young Children's Development



Child TRENDS

Signs and Symptoms of Early Childhood Trauma

- Stomach aches, headaches
- Crying a lot
- Fear or anxiety
- Sadness or irritability
- Thoughts about the traumatic event that won't go away
- Avoiding thinking or talking about the traumatic event
- Acting as if the event is happening right now
- Trouble managing behavior or emotions
- Pains in the body that don't seem to have a physical cause
- Hopelessness
- Nightmares
- Trouble paying attention
- Trouble falling asleep, or sleeping too much
- Getting upset at reminders of the traumatic event
- Lack of desire to play with others or take part in activities that used to be enjoyable

(Adapted from the National Child Traumatic Stress Network, https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/effects)

Impact on Parents and Families

Parenting a trauma-exposed child is stressful

- Stress may lead to insensitive caregiving

Stress is exacerbated when parents also experience trauma

- Reactions in parent or child may intensify the other's symptoms

Challenges related to child trauma may lead to family conflict

Child TRENDS

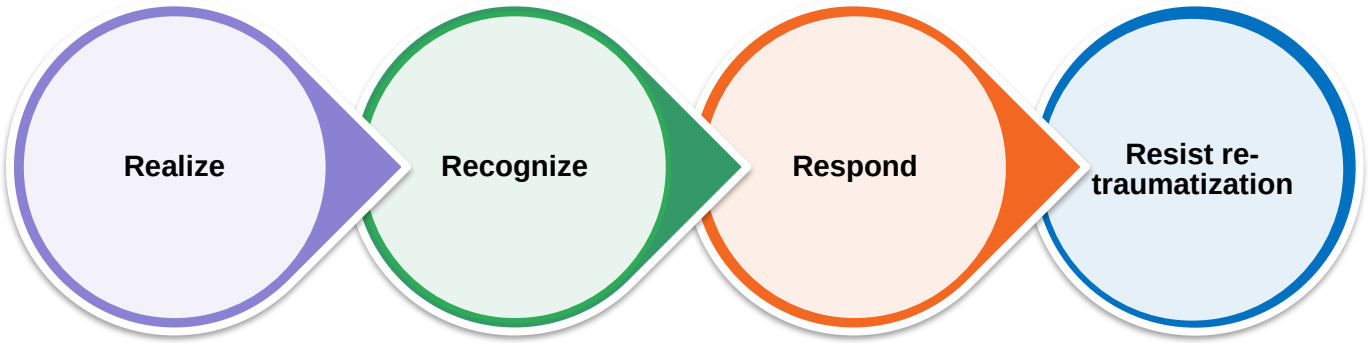
3.
MEETING THE NEEDS OF YOUNG CHILDREN WHO EXPERIENCE TRAUMA

What Young Children Who Experience Trauma Need

- Presence and continuity of a nurturing caregiver (or caregivers)
- Environments that promote:
  - safety and trust
  - self-regulation and social-emotional skills
  - other early skills needed to succeed in school
- Early childhood programs and systems that provide trauma-informed care

Child Trends

Trauma-Informed Care (TIC)



Realize
the widespread impact of trauma and understand potential paths for recovery

Recognize
the signs and symptoms of trauma in clients, families, staff, and others involved with the system

Respond
by fully integrating knowledge about trauma into policies, procedures, and practices

Resist
re-traumatization of children, as well as the adults who care for them

(Substance Abuse and Mental Health Services Administration, 2014, https://store.samhsa.gov/system/files/sma14-4884.pdf)

Child TRENDS

The Role of Early Childhood Programs

- Learn more about child trauma
  - *Increase awareness of ALL staff on the impact of trauma on children and families and talk to each other about what works*
- Create warm, inviting, nurturing, safe spaces
  - *Use carpets, pillows, soft colors, low lights*
  - *Notice and remove or avoid trauma "triggers"*

The Role of Early Childhood Programs

- Create a regular routine so children and families know what to expect
  - *Establish a place to meet for each activity; during transitions*
  - *Use carpet squares, rugs to show where to sit without words*
  - *Sing the same welcome/goodbye songs*
  - *Use the same hand gestures to accompany words so children who speak other languages can understand*
- Understand that general distrust of power, authority, programs, and government assistance is natural and even an adaptive response

The Role of Early Childhood Programs

- Create an inclusive environment—Include resources, décor, materials that reflect the diversity of all children and families
- Offer information in different languages
  - *Display community resources available in different language*
- Make books and materials available that speak to the immigrant and refugee experience

Examples of TIC in Early Childhood Programs

- Early Care and Education
  - Trauma Smart
  - Let's Connect
  - Safe Start
  - Infant/Early Childhood Mental Health Consultation
- Home visiting
  - Baby TALK Model
- Professional Development and Training
  - National Child Traumatic Stress Network training centers
  - Michigan Association of Infant Mental Health Competency Guidelines and Endorsement

Examples of TIC in Early Childhood Programs

- Partnering with Community Providers
  - Child Trauma Training Center's Centralized Referral System
  - Mental health centers using evidence-based treatment
    - Child-Parent Psychotherapy
    - Parent-Child Interaction Therapy
    - Trauma-Focused Cognitive Behavioral Therapy
    - Attachment and Biobehavioral Catch-up
    - Culturally Modified Trauma-Focused Treatment
  - Help Me Grow
  - Safe Babies Court Teams

Resources for Working with Young Immigrants and Refugees Affected by Trauma

- *Bartlett & Ramos-Olazagasti (2018). Supporting Children and Parents Affected by the Trauma of Separation*. https://www.childtrends.org/publications/supporting-children-parents-affected-trauma-separation

- Bartlett, Smith, & Bringewatt (2017). *Helping Young Children Who Have Experienced Trauma: Policies and Strategies for Early Care and Education* https://www.childtrends.org/publications/ecetrauma/

- Harden, B. J. (2015, January). *Services for Families of Infants and Toddlers Experiencing Trauma: A Research-to-Practice Brief*. https://www.acf.hhs.gov/sites/default/files/opre/opre_nitr_brief_v07_508_2.pdf

- National Child Traumatic Stress Network (n.d.). *Refugee Trauma*. https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma

- Refugee Health Technical Assistance Center https://refugeehealthta.org/

- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* https://store.samhsa.gov/system/files/sma14-4884.pdf

Child TRENDS

Thank you!

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Acknowledgement: Thank you to the Alliance for Early Success for support of this webinar

Aimee Hilado

Aimee Hilado
Wellness Program Senior Manager, RefugeeOne

Aimee Hilado is an academic, researcher, and clinician specializing in immigration trauma and refugee/immigrant mental health. She is an Assistant Professor of Social Work at Northeastern Illinois University where she serves as the Curriculum Specialist in Human Behavior in the Social Environment and teaches undergraduate and graduate courses on practice with immigrants and refugees and practice with children and families. Dr. Hilado is also the Founding Manager of the RefugeeOne Wellness Program, a mental health program established in 2011 for refugees, asylum seekers, and immigrants in one of the largest resettlement agencies in Illinois. It is the first mental health program in the state that has integrated a home visiting program for trauma-exposed pregnant mothers and families with children under age 3 of refugee/immigrant status.

Dr. Hilado presents nationally and has published in the areas of mental health, home visiting, and culturally sensitive clinical practice; her most recent edited book is *Models for Practice with Immigrants and Refugees: Collaboration, Cultural Awareness, and Integrative Theory*. She has played key roles in community organizing and advocacy, co-founding the Illinois Refugee Mental Health Task Force; serving as co-chair of the Illinois Childhood Trauma Coalition, Refugee and Immigrant Policy Workgroup; and training Mental Health First Responders as part of the citywide Chicago Is With You Task Force.

Dr. Hilado completed her PhD in social work, with distinction, at Loyola University Chicago and a dual-degree master's program in social Work and in science in applied child development at Loyola University Chicago and Erikson Institute, respectively.

Supporting Immigrant and Refugee Mental Health through Home Visiting

Aimee Hilado, Ph.D., LCSW
ZERO TO THREE Fellow
Assistant Professor, Northeastern Illinois University
Founding Manager, RefugeeOne Wellness Program

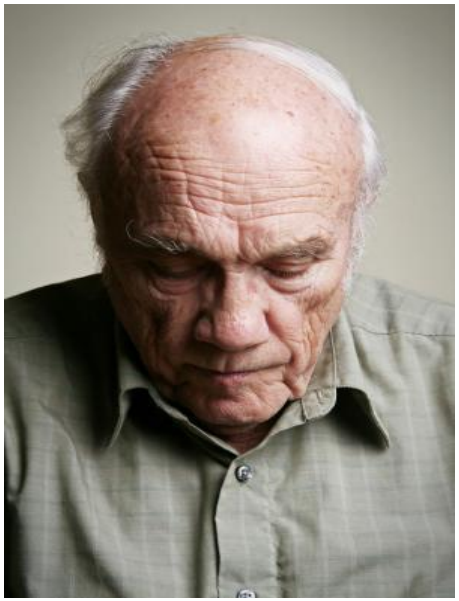
The impact of immigration trauma on families

The common denominators of immigration trauma

Refugees and immigrants come with their unique and collective trauma narrative

1. History of fear and uncertainty
2. Need for safety with worry about the future
3. Loss of homeland, loved ones, and cultural underpinnings exacerbates feelings of loneliness, homesickness, & isolation
4. Feelings of guilt for families left behind or for personal safety
5. Cumulative impact of migration experiences on mental health

Prevalence of adverse mental health symptoms for adults



Common symptoms:

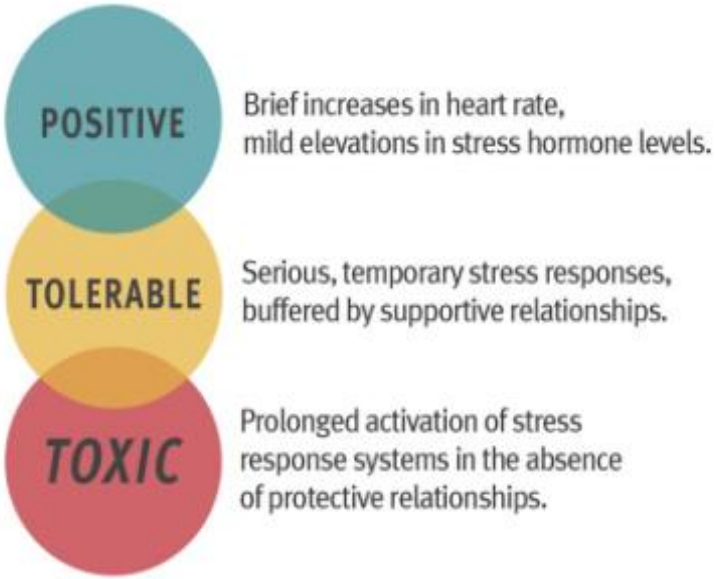
- Prolonged sadness with poor coping skills
- Increased anxiety and frustration levels
- Poor sleep patterns and appetite
- Difficulty concentrating
- Somatic symptoms
- Suicide risk
- Substance abuse
- Severe mental illness: Schizophrenia, Bipolar I, Major Depressive Disorder, PTSD

How do immigrants and refugees define mental health?

- The term "mental health" has a negative connotation in many cultures.
- Mental health is sometimes correlated with "being crazy" or a product of moral failing.
- It is only understood through physical health symptoms.
- Many cultures see mental health as a private matter that is not to be discussed.
- Some cultures do not realize that poor mental health symptoms are a problem; it is part of the collective group experience and seen as normal.

The intergenerational model of trauma

Trauma has the ability to freeze the relationship between parent and child.



Parent availability is compromised.

Leads to additional stress that disrupts the architecture of the brain in a young child.

Supporting refugee and immigrant mental health: What do we know?

- Immigration trauma can have a cumulative effect on mental health.
- Unaddressed I-ECMH and adult needs influences adjustment and overall health outcomes for all family members. Family-centered approaches are valuable.
- New arrivals are less likely to seek formal mental health services due to the priority of other needs, misinformation about mental health, Western treatment models being inappropriate, and the lack of knowledge of general resources available.
- The current sociopolitical climate increases reluctance to seek services and engage with unfamiliar programs/professionals.

Supporting refugee and immigrant mental health: Why home visiting could be an answer

First, the delivery mechanism – services in the ***home*** – matters.

- Removes the barriers of families having to find services, navigate transportation needs, and families are generally more comfortable.
- We see the true needs of a family when we are in their home.
- Reduces fears of families encountering ICE or other federal agents who may threaten their sense of safety.
- Provides an opportunity to identify needs and refer for additional clinical & non-clinical services.

Second, the nature of engagement builds a relationship within which promotes positive home visiting and mental health outcomes.

The RefugeeOne Wellness Program: Our home visiting goals

- The RefugeeOne Wellness program is the first mental health program in the state to have received a ISBE home visiting grant to deliver home visiting services using the Baby TALK Model.
- We have four clinicians, five refugee home visitors, psychiatrist, and a team of interpreters who provide services.

The Baby TALK Model: Relational approaches to engaging trauma-experienced, culturally-diverse families

Quick Facts about the Baby TALK Model:

- Since 1986 the Baby TALK Model has trained professionals in **32 states** across the country and in Canada.
- Over **1,400 professionals** trained through Baby TALK's National Learning Institute.
- In Illinois, more than **100 publicly-funded** programs use Baby TALK as their model for working with families.
- As of FY17, **6,781 of 13,330 children (51%)** served by state funded (ISBE) Prevention Initiative program were served using the Baby TALK Model in Illinois.

Visit www.babytalk.org for more information on the Model.

Home visiting goals include….

- Using a developmental parenting approach; focusing on the parent-child dyad
- Supporting parent mastery through:
  - Facilitating parent-child interactions
  - Observation, Narrating behavior
  - Listening and engaging to understand the meaning the parent is making
- Sharing information and reflecting
- Further supporting parent confidence and competence through meaningful goal-setting in support of the parent/family, the child's development, and the parent/child relationship
- Ongoing case management to support overall family wellbeing

An attuned relationships is the **vehicle** for achieving these goals!

Trauma-informed home visiting as a pathway to supporting mental health and child outcomes

- In addition to the Baby TALK Model curriculum, all home visitors were trained on topics related to:
  - mental health terminology,
  - trauma-informed practice, and
  - how to look for common mental health symptoms that warrant referrals.

Home Visiting is NOT therapy but…

- ✓ Home visiting is culturally-sensitive approach to engaging families and supporting them in a therapeutic way.
- ✓ The goals of home visiting can be realized in addition to supporting adjustment to life in a new country.
- ✓ Trauma-informed home visiting creates a pathway to talking about mental health and getting families to appropriate clinical services more effectively.
  - *We saw greater success in identification of need and engagement from participants who came through the home visiting program.*
  - *Some families didn't want services but said they felt better knowing they had a consistent source of support in their home visitor.*

The Baby TALK – RefugeeOne Study: A randomized controlled trial examining home visiting services with refugees and immigrants

Study Components

Type: Randomized Controlled Trial
Intervention: Home Visitation twice per month for 12 months
Measures: Baseline at 12-months from baseline

Research Team

5 Researchers
3 Research Assistants
8 Home Visitors including 5 home visitors who were former refugees

200 Families Recruited

186 refugee families and 14 families of undocumented immigrant status

12 Nationalities Represented

Iraq, Syria, Iran, Afghanistan, Sudan, DR Congo, Ethiopia, Burma, Ecuador, Cuba, Mexico, Columbia

9 Languages Spoken

Arabic, Burmese, Farsi, Kinyarwanda, Malay, Rohingya, Spanish, Swahili, Tigrinya

Principal Investigators: Aimee Hilado, Ph.D., LCSW and Christine Leow, Ph.D.

Study Instruments

CHILD OUTCOMES (2 measures)

1. Ages and Stages Questionnaire, 3rd Edition (ASQ3)
2. Preschool Language Scales, 5th Edition (PLS-5)

PARENT OUTCOMES (2 measures)

1. Parental Stress Index, 4th Edition, Short Form (PSI-4-SF)
2. Refugee Health Screener 15, Mental Health/Trauma (RHS-15)

FAMILY OUTCOMES (3 measures)

1. Demographic Form to measure 1. Economic Self-Sufficiency and 2. Coordination/Access to Community Referrals
2. Home Visiting Documentation Form to measure 1. Positive Parenting Skills

RCT Participants

Main Ethnicity Grouping	Treatment	Control	Total
Africa	15	13	28
East Asia	55	56	111
Central/Latin America	7	7	14
Near East/South Asia	24	23	47
Total	101	99	200

Immigration Status	Treatment	Control	Total
Refugee Status	94	92	186
Undocumented Immigrant Status	7	7	14
Total	101	99	200

Years Displaced	Treatment	Control	Total
Less than 5 years	36	34	70
5 to 10 years	18	18	36
10 to 20 years	30	28	58
more than 20 years	14	15	29
Missing	3	4	7
Total	101	99	200

Maternal Education Level	Treatment	Control	Total
None	32	18	50
Elementary	19	31	50
Middle	8	7	15
HS/GED	27	22	49
BA or above	8	9	17
Missing	7	12	19
Total	101	99	200

English Proficient	Treatment	Control	Total
No	89	86	175
Yes	12	13	25
Total	101	99	200

Received Public Benefits	Treatment	Control	Total
No	3	4	7
Yes	96	92	188
Total	99	96	195
Percent	97.0%	95.8%	96.4%

RCT Findings: Among refugee and immigrants, the Baby TALK Home Visiting Protocol…

- …has a statistically significant impact on social-emotional development (p=0.00) and language development (p=0.02).
- …has a positive impact on parental stress and trauma symptoms (maternal health).
- …has a positive impact on access to linkages and referrals.
- …has an impact on economic self-sufficiency.
- Preliminary evidence shows the protocol has an impact on positive parenting practices.

Lessons Learned

- Understanding immigration trauma is critical to understanding the experiences of refugees and immigrants.
- Home visiting can produce significant effects on developmental outcomes among refugee and immigrant children.
- Frontline providers, including home visitors, can also be effective in supporting mental health among this group.

Contacts

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Q & A

- Use Q&A chat function to write questions
- Or email events@migrationpolicy.org with your questions
- Or tweet questions to @MigrationPolicy #MPIdiscuss
- Slides and audio will be available at: http://www.migrationpolicy.org/events

Thank You for Joining Us!

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