The Center for Health and Health Care in Schools
School of Public Health and Health Services
The George Washington University

Children of Immigrants and Refugees

What the research tells us

Background

Recent immigration trends

The foreign-born population of the US numbered 31.1 million in 2000, which amounts to 11.1% of the total population, an increase of 57% over 1990.[1]

The immigrant population represents every corner of the world, but the largest numbers, by far, come from Mexico (39% of immigrants). About 23% come from Asia and the Pacific Islands, 6% from Central America and the Caribbean, 11% from Europe, 5% from South America, 3% from Africa, and another 2% from Canada, Bermuda and Cape Verde.[2]

Racial/ethnic minorities, in the aggregate, are destined to become the numerical majority in the United States within the next few decades.[2] This dramatic shift in demographics is being driven by immigration and fertility trends, with the number of children in immigrant families growing rapidly in nearly every state across the country.[3] These trends are expected to continue.[4]

Children and immigration

According to the 2000 Census, 1 of every 5 children in the United States is a child of immigrants—that is, either a child who is an immigrant or who has at least one immigrant parent.[3]

In 2003, there were 73 million children ages 0–17 in the US, making up 25% of the population. The percentage of children who are Hispanic has increased faster than any other racial or ethnic group, up from 9% of the child population in 1980 to 19% in 2003. By 2020, it is projected that nearly 1 child in 4 in the US will be of Hispanic origin.[5]

Families and immigration

Official poverty rates for children in immigrant families are substantially higher than for children in native-born families (21% versus 14%). Nearly half have incomes below 200% of the poverty level, compared with 34% of native children.[2]

Immigrant families frequently lack health insurance and are much more likely to live in crowded housing. They're also less likely to receive public assistance. Most noncitizens are not eligible for TANF and Medicaid during their first 5 years in the US. Their children, when born in the US, are eligible for TANF and Medicaid but may not be enrolled because their parents are unfamiliar with the programs or may wish to avoid contact with public officials.[2]

Foreign-born children may have certain protective factors that can help them withstand the severe adjustments that accompany migration to a new country. They are likely to have two-parent families, with a strong commitment to the well-being of the family unit and a solid work ethic.[6] And they tend to be healthier than native-born children overall with fewer risky behaviors.[3]

Schools and immigration

The US settlement patterns of the foreign-born population have shifted to the west and south, up from 37.7% in 1970 to 65.5% in 2000.[1] Many "new destination communities," having no recent experience with immigrant populations, may be unprepared for the influx of students, who sometimes comprise as much as 50% of the school enrollment.[4]

Immigrant children—particularly recent immigrants—are less likely to receive necessary mental health services than their nonimmigrant peers. A shortage of bilingual/bicultural mental health professionals, unfamiliarity with US mental health services, lack of health insurance, and the stigma associated with treatment may prevent immigrant families from getting their children the help they need. Thus, a school-based approach seems especially promising.[7]

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Background

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Mental Health, Language and Culture

Prevalence

One young person in 10 suffers from mental illness severe enough to cause some level of impairment in their lives, yet nearly 75% of them do not get the care they need.[8]

While the rates of mental disorder are not sufficiently studied in many smaller ethnic groups to permit conclusions about overall prevalence, in general, incidence rates in the United States appear to be similar across minority and majority populations.[9]

Many things about the immigrant experience are stressful for children: They are often separated from family for extended periods of time;[10] some children come from rural or farming communities and are ill-equipped to cope with urban settings; others come from refugee camps, after witnessing or experiencing wartime atrocities or personal or family violence.[9] Many suffer from post-traumatic stress disorder.[11]

Of all US children ages 4–17, an estimated 16% had parents who talked to a health care provider or school personnel about their child's emotional or behavioral difficulties during the past 12 months.[12]

Access to care

Talking about difficulties does not necessarily indicate that the child receives treatment. Nearly 5% of US children 4–17 years were prescribed medication for emotional or behavioral difficulties. About 6% of all US children received some type of mental health treatment or help other than medication during the past year.[12]

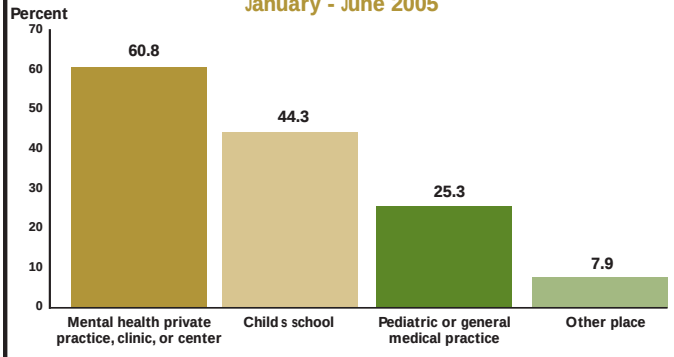
While access to mental health care is a problem for all children and adolescents, minority adolescents are at particular risk of not receiving care. Among suicidal adolescents, Latino, African American, and Asian American youth were less likely to receive psychological or emotional counseling than white adolescents. The lack of treatment was particularly acute for Asian American youth, who were less than half as likely to receive counseling as white youth.[6]

Compared with proficient English speakers, people with limited English proficiency (LEP) are less likely to seek care and to receive needed services. They have fewer physician visits and receive fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators, or ethnicity are accounted for.[13]

Mental health and culture

In the mental health care setting, culture affects how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and respond to treatment.[14]

Figure 1. Providers of treatment for children 4-17 years of age who received treatment, other than medication, for emotional or behavioral difficulties in the past 12 months: United States, January - June 2005



NOTES: Percentages do not add up to 100% because children may have more than one provider of treatment. The denominator is based on 267 children in the sample who received mental health treatment other than medication in the past 12 months.
DATA SOURCE: Sample child component of the 2005 National Health Interview Survey. The estimates for 2005 were based on data collected from January through June 2005. Data are based on the household interviews of a sample of the civilian noninstitutionalized population.

Cultures vary with respect to the meaning they impart to illness, their way of making sense of the subjective experience of illness and distress.[9]

Cultural meanings of illness have real consequences. "Meanings" influence whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help (mental health specialist, primary care provider, clergy, and/or traditional healer), the pathways they take to get services, and how well they fare in treatment.[9] Immigrant children who have experienced stressful events in their home country, during migration, or while living in the US show high levels of psychological distress.[7]

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Build Cultural Competence

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Build Cultural Competence—Advice from the Experts

Understand why cultural competence is important

In mental health care, key elements of therapeutic success depend on rapport, and upon the clinician's understanding of the patient's cultural identity, social supports, self-esteem, and reticence about treatment due to societal stigma.[9]

Americans find it respectful and direct to look someone in the eye when speaking, and to respond with feedback in conversation. This may seem aggressive or dominating to immigrants whose culture may customarily show respect by looking away or remaining passive in conversation with strangers or persons of authority.

Strive for competence

Work to build rapport, a critical component of competency development. Knowing whom the person perceives as a "natural" helper or as a traditional helper (such as elders or the church) can facilitate the development of trust and continued participation in treatment.[15] Assess possible school problems in light of other factors, such as the family income, jobs, work schedules, the need for food or shelter, the presence of many other people in the home, or concerns about becoming involved with authorities.[15]

Facilitate language access

Language barriers create problems for both providers and recipients of care. For immigrant families with low English proficiency (LEP), language and communications influence not only how but if they access and experience health care.[16] Language barriers have a demonstrable negative impact on health care access, quality, patient satisfaction, and sometimes cost.[13]

Start with communication

According to the US Department of Health and Human Services, 19% of children 5–17 speak a foreign language in the home. Five percent of all children also have difficulty speaking English.[5] The size of a language community may drive the demand for language services.[17] Often, resources can be allocated only to accommodate the most prevalent foreign language, even though several others may be present in sizeable numbers.

Encourage adaptation

The cohesiveness and commitment that make families such strong survival units can also be barriers to adaptation.[3] Adaptation to the new country, language, and culture can be viewed as a betrayal of traditional values and the country of origin.[18]

Hiring staff from a language community can be fostered by placing ads in ethnic-specific newspapers, thus increasing the diversity of staff and building community trust.[19]

Develop outreach materials—booklets, fotonovelas, video programs—on how to use school or health care resources, and translate them into the languages used in the community.

Keep in mind that "staff diversity" does not equal cultural competence or language access. It helps to have various cultures represented on the staff but competence and language access require a more active, comprehensive approach. In health care, specific training in medical translation is considered essential for good quality care.[17]

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

Caring Across Communities, a Robert Wood Johnson Foundation (RWJF) grant initiative, will address the mental health needs of underserved children and youth by supporting school-connected mental health services for students who require them. Special emphasis will be given to projects that help children of immigrant and refugee families overcome the cultural and language barriers to mental health services. All grant applications must be submitted by **July 28, 2006**, through the RWJF Grantmaking Online system at http://grantmaking.rwjf.org/cac.

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What Can Schools Do?

Schools are already responding to the mental health needs of their students. In addition to hiring school psychologists, social workers, and counselors, nearly half of all schools contract or make other arrangements with a community-based organization to provide mental health or social services to students.[21]

Keep in mind that school-based mental health interventions may be more acceptable to immigrant families because they may carry less stigma for the child and the family than service through a mental health agency.[11]

Cultural Competency is the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations.[15] Cultural competence is not an endpoint but a continuous process of assessing people's needs and incorporating what is learned into the provision of services.[14]

Work from the top down; involve the whole school

Success begins with the principal, whose attitude and commitment set the tone for the entire staff, the student body, and the community.[4] Remain alert to the needs of all students. Beware of assuming that smaller groups don't need as much support, or that a certain group is doing well enough without help.[22]

Language Access is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. The linguistically accessible organization should provide the policy, structure, practices, procedures, and resources to support this communication.[20]

Be aware of federal law

No Child Left Behind (NCLB) requires schools to assess student performance in reading and math, beginning in the third grade, and report student performance in "major racial and ethnic groups." NCLB also requires schools to measure and improve LEP students' English proficiency.[23]

NCLB poses particular challenges for children of immigrants, LEP students, and the schools that serve them. LEP students tend to cluster in some schools while English-proficient students are clustered in others. Schools serving large numbers of LEP students are expected to meet general performance standards or face interventions required by NCLB.[23] The extra staff and services required to help LEP students attain required English levels strain limited school budgets and busy calendars.

Invite innovation

Invite students to teach their language to others. Reversing the roles—especially of students and parents who are usually the linguistic outsiders—can boost the self-esteem of the new "teachers" and raise the parents' status in the eyes of their children.[4]

Partner with existing groups. Neighborhood cultural associations in one town are housed in a school-sponsored Resource Center, providing easy access to support both academic and family needs.[4]

10 Tips for Schools

1. Embrace diversity and accept the challenges.
2. Be flexible and creative—explore other ways of communicating.[4]
3. Communicate clearly, use simple language, and highlight important points.[15]
4. Utilize community resources and cultural intermediaries.[6]
5. Reach out to parents, families—offer educational support, English, computers, introduction to resources.
6. Send staff to community meetings, create liaisons with cultural community leaders and organizations.[19]
7. Foster community partnerships with school activities.
8. Ask yourself about your own cultural viewpoint—review and update your own information.
9. Develop and "bank" resources—language help, cultural resources, community elders, outreach opportunities.
10. Make services available to all students; emphasize strategies that meet the unique needs of children from immigrant or refugee families.[19]

Support families

Make programs, materials, and personal communications available in parents' native languages, to make families comfortable and ensure that the correct information is being delivered.[6]

Regardless of race/ethnicity or immigrant origin, the family feature most relevant to overall child well-being and development is parental education.[2] Providing after-work educational and English language programs for parents can improve their job potential, increase their self-esteem, and enhance their ability to relate to and support their children's schoolwork.

Review and renew programs regularly

Frequent change is a major part of the immigrant experience. It is important for school faculty and staff to constantly update their information on shifting community demographics, and changes in family status and income. This information should be added to faculty and staff training and considered in outreach to the school community.

- Expect patterns to keep changing as the population changes.
- Take advantage of technology.
- Keep an open mind.

Additional Information and Resources

African American Mental Health Research Center
Institute for Social Research
University of Michigan
http://www.psc.isr.umich.edu/research/project-detail.html?ID=32965

American Community Survey US Census Bureau
http://www.census.gov/acs/www/

Center for Healthy Families and Cultural Diversity University of Medicine and Dentistry of New Jersey
Robert Wood Johnson Medical School, Department of Family Medicine
http://www2.umdnj.edu/fmedweb/chfcd/index.htm

Child and Adolescent Mental Health
Substance Abuse and Mental Health Services Administration
http://www.mentalhealth.samhsa.gov/child/childhealth.asp

Cross Cultural Health Care Program
http://www.xculture.org

Hablamos Juntos
UCSF Fresno Center for Medical Education and Research
http://www.hablamosjuntos.org

Harvard Immigration Project
Graduate School of Education
Harvard University
http://www.researchmatters.harvard.edu/program.php?program_id=619

Hogg Foundation for Mental Health at the University of Texas at Austin
http://www.hogg.utexas.edu

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http://www.futureofchildren.org/pubs-info2825/pubs-info_show.htm?doc_id=240166

Minority Links
Facts on various segments of the population from the 2000 US Census.
http://www.census.gov/pubinfo/www/hotlinks.html

National Alliance for Hispanic Health (formerly COSSMHO)
http://www.hispanichealth.org

National Asian American and Pacific Islander Mental Health Association
http://www.naapimha.org

National Center for American Indian and Alaska Native Mental Health Research
University of Colorado Health Sciences Center
http://www.uchsc.edu/ai/ncaianmhr/ncaiainmhr_index.htm

National Center for Cultural Competence
Georgetown University
http://gucchd.georgetown.edu/nccc/pa.html

National Center on Minority Health and Health Disparities
National Institutes of Health
http://www.ncmhd.nih.gov

The National Multicultural Institute
Organizational training, consulting, conferences, publications and resource materials
http://www.11.georgetown.edu/research/gucchd/nccc

NHeLP-National Health Law Program
http://www.healthlaw.org

NICHQ-National Initiative for Children's Healthcare Quality
http://www.nichq.org/NICHQ/Topics/SocialBehavioral/DisparitiesCulturalCompetency

Office of Minority Health Resource Center
US Department of Health and Human Services, http://www.omhrc.gov

Refugee Health Issues Center
American Refugee Committee
http://www.archq.org

Refugee Mental Health Links
National Mental Health Information Center
Child and Adolescent Mental Health
Substance Abuse and Mental Health Services Administration
http://www.mentalhealth.samhsa.gov/CMHS/SpecialPopulations/refugeelinks.asp

School of the 21st Century
Center for Child Development and Social Policy, Yale University
"Portraits of Four Schools: Meeting the Needs of Immigrant Students and Their Families," available at
http://www.yale.edu/21C

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