The Center for
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The George Washington University

Children of Immigrants and Refugees: What the research tells us

Background

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Recent immigration trends: In 2009, the foreign-born population in the United States (US) numbered 38.5 million, or 12.5% of the population. Between 2000 and 2009, the foreign-born population increased by 7.4 million or 24%.[1] Among all foreign-born residents, 59% entered the US during the last two decades and 21% entered the US prior to 1980.[2]

The US immigrant population represents every corner of the world, but the largest numbers, by far, come from Mexico. An estimated 11.5 million foreign-born individuals in the US are from Mexico, representing 30% of the total foreign-born population. Individuals born in Central American countries represent 37% of the total foreign-born population; 27.7% are from Asia and Pacific Islands; 12.7% are from Europe; 3.9% from Africa, and 2.7% from other regions of Oceania and Northern America.[2]

Racial/ethnic minorities will become the numerical majority in the US within a few decades.[3] Three-fourths of immigrant children live in just ten states—Arizona, California, Florida, Georgia, Illinois, Massachusetts, New Jersey, New York, Texas, and Washington. Nearly half of all immigrant children live in just three states (California, Texas and New York), and California alone is home to 28% of this group. California has not only the largest number of immigrant youth but also the highest concentration; roughly half of the children in the state are children of immigrants, more than twice the national share of 23%.[4] These trends are expected to continue.[5]

Children and immigration: In 2009, there were 74.5 million children ages 0–17 in the US, constituting nearly 24% of the population.[6] About 16.9 million children age 17 and under, or nearly 24% of this age cohort, had at least one immigrant parent.[7]

Immigrant youth—defined as those children under age 18 who are either foreign-born or US born to immigrant parents—now approximately account for one-fourth of the nation's 75 million children. By 2050, they are projected to make up one-third or more than 100 million US children. Demographers estimate that by 2050, when one-third of all US children will be Hispanic, non-Hispanic whites will make up 40 percent of the child population.[4]

Families and immigration: Official poverty rates for children in immigrant families are substantially higher than for children in native-born families (23% versus 18%).[4]

Immigrant families frequently lack health insurance and are much more likely to live in crowded housing. The Urban Institute's 1999 National Survey of America's Families (NSAF) reports that, compared with children in native-born families, children in immigrant families are generally poorer, in worse health, and more likely to experience food insecurity and crowded housing conditions.[8]

Younger immigrant children are both more likely to experience these circumstances, and to be negatively affected as a result. Younger children, rather than older children, are most likely to live in families that entered the United States after 1996, when welfare legislation was enacted that barred immigrants from receiving many public benefits. As a result, younger immigrant children are more likely to live under conditions of extreme hardship despite high workforce participation by their parents.[7]

However, foreign-born children may have certain protective factors that can help them withstand the severe adjustments that accompany migration to a new country. They tend to live in two-parent and multigenerational households with high levels of family support and other social supports that can mitigate stress, especially during the initial settlement period.[9,10]

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Background *continued*

Schools and immigration: Many "new destination communities," having no recent experience with immigrant populations, may be unprepared for an influx of students, who sometimes may comprise as much as 50% of the school enrollment.[5]

Six "gateway" states (California, New York, Texas, Florida, Illinois, and New Jersey) accounted for roughly 60 percent of the 5.6 million foreign-born who moved to the US from abroad between 1995 and 2000.[11] In 2000, almost 70 percent of school-age children of immigrants lived in the six states with the largest immigrant populations: California, Texas, New York, Florida, Illinois, and New Jersey. 47% of California's students in PreK to fifth grade were children of immigrants. Nine other states had percentages above the national average of 19%: Nevada, New York, Hawaii, Texas, Florida, Arizona, New Jersey, Rhode Island, and New Mexico. The highest growth in school enrollment of immigrant children was in new gateway states in the Southeast, Midwest, and interior West. Between 1990 and 2000, children of immigrants in PreK to fifth grade grew most rapidly in Nevada (206%), followed by North Carolina (153%), Georgia (148%), and Nebraska (125%).[12]

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.[13]

Mental Health, Language and Culture

Prevalence: Between 14-20% of young people in the US have one or more mental, emotional, and behavioral (MEB) disorders at any given time. Among adults, half of all MEB disorders were first diagnosed by age 14 and three-fourths were diagnosed by age 24.[14]

Mental, emotional, and behavioral disorders—such as depression, conduct disorder and substance abuse—among children, youth, and young adults create an enormous burden for them, their families, and the nation. They threaten the future health and well being of young people.[14]

While the rates of mental disorder are not sufficiently studied in many specific 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.[15]

Many things about the immigrant experience are stressful for children: They are often separated from family for extended periods of time.[16] 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.[15] Many suffer from post-traumatic stress disorder.[17]

Access to care: In 2005, nearly 5% of all US children 4–17 years were prescribed medication for emotional or behavioral difficulties. About 6% of these children received some type of mental health treatment or help other than medication during the past year.[18]

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.[9]

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

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Mental Health, Language and Culture *continued*

fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators, or ethnicity are accounted for.[19]

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.[20]

Cultures vary with respect to the meaning they impart to illness, their way of making sense of the subjective experience of illness and distress.[15] 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.[15] 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.[13]

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.[15] 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 customarily shows 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.[21] 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.[21]

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.[22] Language barriers have a demonstrable negative impact on health care access, quality, patient satisfaction, and sometimes cost.[19]

Start with communication: Children who have difficulty speaking English may face greater challenges progressing in school and in the labor market. In 2008, 21% of children ages 5–17 spoke a language other than English at home. Sixteen percent of school-age Asian children and 17% of Hispanic children spoke a language other than English at home and had difficulty speaking English.[23] Court decisions and other federal actions have established that Title VI of the Civil Rights Act of 1964 requires all recipients of federal aid to provide limited English proficient (LEP) individuals with "meaningful access" to their federally subsidized services.[24] If an organization receives any federal aid, effective language assistance to the limited English proficient individuals must be provided.[25]

Encourage adaptation: The cohesiveness and commitment that make families such strong survival units can also be barriers to adaptation. Adaptation to the new country, language, and culture can be viewed as a betrayal of traditional values and the country of origin.[26] About two-thirds of English-language learners (ELL) students are second or third generation immigrants, some of whom are from families that have remained linguistically and culturally isolated.[27]

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Build Cultural Competence—Advice from the Experts *continued*

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.[28]

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.[29]

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 community-based organizations to provide mental health or social services to students.[30]

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.[17]

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.[21] 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.[20]

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.[5] 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.[31]

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.[32]

Be aware of federal law: The federal Elementary and Secondary Education Act (ESEA), formerly known as the No Child Left Behind Act (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." ESEA also requires schools to measure and improve LEP students' English proficiency.[33]

ESEA 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

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What Can Schools Do? *continued*

clustered in others. Schools serving large numbers of LEP students are expected to meet general performance standards or face interventions required by ESEA.[33] 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.[5]

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.[5]

10 Tips for Schools

1. Embrace diversity and accept the challenges.
2. Be flexible and creative—explore other ways of communicating.[5]
3. Communicate clearly, use simple language, and highlight important points.[21]
4. Utilize community resources and cultural intermediaries.[9]
5. Reach out to parents, families—offer educational support, English classes, computers, introduction to resources.
6. Send staff to community meetings, create liaisons with cultural community leaders and organizations.[28]
7. Foster community partnerships by including community organizations in 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.[28]

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.[9]

Regardless of race/ethnicity or immigrant origin, the family feature most relevant to overall child well-being and development is parental education.[3] 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/

BRYCS Bridging Refugee Youth & Children's Services
US Conference of Catholic Bishops
http://www.brycs.org

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
Cultural competence and medical interpretation trainings
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://news.harvard.edu/gazette/2004/12.09/11-louie.html

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

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http://futureofchildren.org/futureofchildren/publications/journals/journal_details/index.xml?journalid=74

Migration Policy Institute
http://www.migrationpolicy.org

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.healthfinder.gov/orgs/HR2873.htm

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

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

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

NICHQ-National Initiative for Children's Healthcare Quality
http://www.nichq.org/areas_of_focus/cultural_competency_topic.html

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

Pew Hispanic Center
http://www.pewhispanic.org

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

Urban Institute
http://www.urban.org/immigrants/index.cfm

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School of Public Health and Health Services
The George Washington University

2121 K Street, NW, Suite 250, Washington, DC 20037
202-466-3396 fax: 202-466-3467 email: chhcs@gwu.edu

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