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Parenting in a New Land: Specialized Services for Immigrant and Refugee Families in the USA

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Abstract This practice-based research study examines a US-based preventive services program tailored to immigrant and refugee families that have been subject to a Child Protective Services report. The model is the result of a collaboration between an immigrant serving community-based agency and a county department of child welfare services in a medium-sized city that has become a hub for refugee resettlement. A clinical data mining approach was used in an intensive examination of 15 families' case records. This paper identifies family characteristics, service needs, and strength-based practices that emerged, offering recommendations for child welfare agencies and practitioners in other jurisdictions seeking to design strategies to strengthen their services for immigrant and refugee communities.

Keywords Immigrants · Refugees · Parenting · Cultural orientation · Prevention

Recent increases in the numbers of immigrants, including refugees, along with their wide-ranging ethnic backgrounds have broadened the cultural and linguistic diversity of the USA, producing an impact on service delivery system across the nation. Refugees, defined as persons legally admitted to the USA who cannot return to his or her country because of a "well-founded fear of persecution," now comprise 7 %, or 2.5 million, of the immigrant population in 2003 (Capps and Passel 2004). Immigration is no longer confined to traditional destination states such as California, New York, Florida, Texas, and New Jersey, and immigrants and refugees are increasingly dispersed throughout the states in the Southeast, Midwest, and West of the USA (Fix and Capps 2002; Warner 2009). These trends indicate that child welfare service systems are likely to be called upon to address the unique needs of these families.

Immigrants and refugees are confronted with a host of psychosocial issues related to the migration experience and the ensuing demands placed on them by resettlement and adjustment in a new country. These have many implications for family functioning and contribute to additional stresses that can place such families at greater risk of child

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welfare involvement (Fontes 2005; Capps and Passel 2004; Bridging Refugee Youth and Children's Services 2003). An emerging concern is that lack of appropriate services not only undermines family stability and well-being, but also results in unnecessary and traumatic removals of children to foster care (Lincroft and Resner 2006; Committee for Hispanic Children and Families, Inc. 2001; Lee et al. 2001; Velasquez et al. 2006). In recent years, immigrant organizations, researchers, and practitioners have cited a need for strategies to improve the responsiveness of child welfare service systems to migrating children and their families, including collaborations between community-based agencies and child welfare services (Earner 2007; Lincroft and Detlaff 2010; Lincroft and Resner 2006; Torrico 2010). Nonetheless, scant information regarding actual programs for immigrant and refugee families continues to pose a barrier to safety permanency and well-being for them.

This practice-based research study used a clinical data mining approach (Epstein 2001) to examine a preventive services program based on collaboration between a county child welfare system and a community-based organization specializing in comprehensive services to immigrants and refugees. An intensive review of 15 families' case records provides an in-depth understanding of the program's operations and practices. Case reviews were enhanced through interviews with the program coordinator who provided additional insights regarding the program's operations. The study addresses the following questions: What circumstances bring immigrant and refugee families to the attention of child welfare services? What are their common service needs? What approaches and interventions are effective with this population? This paper disseminates lessons learned from a promising preventive service model with migrating children and their families that can guide the development of programs in other localities and form a foundation for further research and experimentation.

Background

Immigrant Families and Child Welfare Involvement

Limited data exists about the number of immigrant children and families under the care and custody of state or local child welfare agencies in the USA. Recent research from The National Survey of Child and Adolescent Well-Being (NSCAW) reports that children of immigrants represent 8.6 % of all children who come to the attention of the child welfare system. It is suggested that the lack of data masks a significant problem and that immigrant children are in fact underrepresented and underserved, possibly as a result of isolation from government systems and other service providers (Lincroft and Detlaff 2010; Earner 2007; Lincroft and Resner 2006). Immigrant families enter child welfare systems for many of the same reasons as native-born families, such as substance abuse, health, and mental health problems. However, other factors such as inappropriate child care and discipline techniques as well as domestic violence due to family stress have been identified as predominant reasons that immigrant families come to the attention of the child welfare system authorities (Lincroft and Resner 2006). Difference in cultural norms and child-rearing practices play a role in incidents of suspected child abuse and neglect. Many families do not intentionally abuse or neglect their children. For example, corporal punishment in many families is

accepted and Western parenting styles appear permissive (Fontes 2002; Lee et al. 2001; Fontes 2005; Lincroft and Resner 2006). Furthermore, state involvement in the private sphere of the family, especially with regard to the discipline of children, is an unfamiliar concept to many immigrants and refugees. Consequently, parents do not understand their rights and responsibilities within the US framework of child welfare laws and policies (Cervantes and Lincroft 2010).

Although immigrant families may face a number of risks due to their experiences with immigration and acculturation, recent findings from a study that analyzes data from the NSCAW compared the characteristics, risk factors, and incidence of maltreatment among children of immigrants with that of children in US-born families and found differences in the likelihood of certain risk factors associated with maltreatment among them. US-born parents are three times more likely to be actively abusing alcohol or drugs than immigrant parents and are significantly more likely to have recent histories of arrests. However, children of immigrants were more than twice as likely to be subjects of substantiated reports of emotional abuse, while children of US parents were more likely to be confirmed as victims of physical neglect (Detlaff and Earner 2012) investigation than children of US-born parents. However, considerable differences were found in the types of substantiated maltreatment, with children of immigrants more than twice as likely to experience emotional abuse. Interpretation of this finding is difficult due to variations in statutory definitions of emotional abuse across states and lack of data available on the behaviors associated with these allegations (Hamarman et al. 2002). It is speculated that cultural differences in parenting styles or expectations that may fall outside of the norms of US culture contribute to this finding (Detlaff and Earner 2012). For example, studies indicate that children in Mexican immigrant families have significant responsibilities, including conducting basic household tasks, caring for younger siblings, and providing financial support (Orellana 2001; Orellana et al. 2003), which may be assessed as emotionally harmful or as "parentification" by child welfare practitioners. Immigrant mothers are also significantly more likely than US-born mothers to be identified as having "inappropriate developmental expectations" of their children when rated on a measure normed on US-born adults to identify parents at risk for abuse or neglect (Jambunathan et al. 2000). Notably, this study did note a lack of significant differences in the prevalence of several risk factors often associated with immigrant families, including the use of excessive discipline, active domestic violence, low social support, and difficulty meeting basic needs which were attributed to strengths that are embedded within many immigrant families (Detlaff and Earner 2012).

Immigrant and Refugee Families: Issues with Child Welfare Implications

A host of issues related to the migration experience also have implications for child welfare interventions. Service providers are often unprepared to address them, which diminishes the helping nature of encounters with service systems (Earner 2007).

It is essential that assessments accurately identify a family's immigration status, country of origin, and native language in order to ascertain eligibility for various services and to develop an appropriate plan of intervention. While immigrants and refugees share many similar characteristics as persons who enter and become established in a country where they are non-natives, their modes of entry into the

USA differ. A refugee is defined as a person that is unable to return to their country of nationality because of a "well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion" (Martin and Hoeffer 2009). Asylum and refugee statuses are closely related; however, they differ depending on where a person applies for the status. Other types of immigrants tend to migrate in a more planned fashion.

Refugees and asylees are eligible for services that are not available to other types of lawful permanent residents. Initial certain core services are provided by resettlement agencies during the first 30 days after a refugee arrives in the USA, including locating appropriate housing, food, basic orientation, school registration for children, initial health screenings, and health care. Refugees also receive services that include 8 months of Refugee Cash Assistance and Refugee Medical Assistance, English as a Second Language (ESL) classes, employment services, and other specialized services. Services are geared to support reaching self-sufficiency as quickly as possible and essentially total about 180 days upon arrival (Bridging Refugee Youth and Children's Services 2003; Warner 2009). As humanitarian entrants, refugees are entitled to apply for legal permanent status 1 year after admittance and are eligible for benefits such as Temporary Assistance for Needy Families (TANF) without a waiting period.

This type of systematic governmental assistance is not available to other classifications of immigrants to assist them in the process of integration in the USA. Policies such as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (welfare reform) have limited immigrants' access to key federal income and employment supports such as food stamps, public health insurance, Supplemental Security Income, and TANF during their first 5 years as a legal immigrant (Dinan 2005). Consequently, in many cases, a lack of resources can also contribute to their child welfare involvement. For example, a lack of financial resources can force families to live in overcrowded homes or to leave their children unsupervised while they go to work (Torrico 2010). Poverty rates are higher among children of immigrants than their native peers; rates are even higher for young children of immigrant families (Capps, Fix, Ost, Reardon-Anderson, & Passel, 2004).

Service providers must also understand the migration process and its interplay of trauma, dislocation, and adjustment on family bonding, dynamics, and child well-being (Bridging Refugee Youth and Children's Services 2003). Migration is far from a one-time event. It is a multistage process consisting of a pre-migration or pre-flight stage, a migration or transit stage, and a post-migration or resettlement stage (Martin 1994; Pumariega et al. 2005). Each stage contains a number of potential stressors referred to as perimigration trauma (Perez-Foster 2005). These include pre-migration stressors such as traumatic exposure in the country of origin which are often compounded by the loss of extended family and kinship networks. The migration or transit stage often involves difficult journeys including hunger, fear, hiding, separations from loved ones, and death of traveling companions. For refugees, detention in refugee camps often takes place for prolonged periods with chronic deprivation of basic needs (Martin 1994).

The post-migration stage and survival in the host nation's social and economic structure presents further challenges. Immigrants may experience significant strains relating to changes in their socioeconomic status and their encounter with different customs and beliefs, and fewer emotional and social resources (Pumariega et al. 2005; Rogler et al. 1989; Pine and Drachman 2005). Additional risks to these families at this

stage stem from poverty. Lack of knowledge of and/or access to resources can inhibit their ability to meet the needs of their children. Immigrant families account for more than a third of low-income working families, yet they participate in public benefit programs at substantially lower rates than their native-born counterparts (Lincroft and Detlaff 2010; Capps et al. 2004).

Other challenges of family adaptation also emerge at this stage. Each family member begins the acculturation process, a complex transition whereby individuals learn and adopt the values, behaviors, lifestyles, and language of the new culture. Acculturative stress associated with this process is common (Williams and Berry 1991). The transition process is experienced in a variety of ways based upon individual difference as well as developmental stages (Pine and Drachman 2005). For example, children learn English and adapt to US systems more quickly than their parents (Delgado et al. 2005). The transition for people arriving from a rural or fishing village into a technological society is likely to be different from that of highly educated individuals (Porter and Haslam 2005). New family roles and patterns such as shifting power structures within the family, changes in gender role expectations, family roles and responsibilities, and the loss of status of family members are part of this adaptation (Pine and Drachman 2005; Delgado et al. 2005). The limited duration of services to assist refugee adaptation coupled with the lack of formal governmental programs to assist the integration of other types of immigrants leaves many families to struggle on their own. They often experience high levels of stress as they struggle to make ends meet and raise children in new work and home environments (Bridging Refugee Youth and Children's Services 2003). The interaction of these factors may create enough stress to bring the family to the attention of child welfare authorities (Pine and Drachman 2005; Earner 2005).

Method

Study Site

The study was conducted at an established nonsectarian social agency located in a medium-sized city in upstate New York that has seen a steady rise in refugee resettlement over the past decade. This particular organization has a long history of service to immigrant and refugee families, a population that is often underserved in traditional human services programs. It offers resettlement services, legal services, domestic violence advocacy, English as a Second Language program, interpretation and translation, employment services, and trafficking victim services. The program under study was initiated in 2007 in response to these changing local demographics. Local child welfare services were increasingly unable to adequately meet the needs presented by immigrants, in particular the growing numbers of resettled refugees, and contracted with this organization using Federal Title IVB Preventive Services funding. A unique feature of this program is the dual emphasis on supportive services designed to strengthen the family's parenting ability with assistance in cultural orientation to enhance successful adaptation to life in the USA, so that foster care placement can be prevented. It funds a full-time caseworker, part of a director's salary, a clinical consultant, and trained interpreters who work on a consultant basis. The county child welfare worker provides case oversight and approves additional resources when necessary.

The primary rationale for selection of this particular program for study was its rare and innovative nature. A search of the literature and of various national clearinghouses related to child welfare and immigrant services revealed a paucity of programs for this population with very few those geared to child welfare and family preservation (Bridging Refugee Youth and Children's Services 2010a, b; Child Welfare Information Gateway; Migration and Child Welfare National Network). Most existing service innovations rely on cross agency training or consultation to child welfare organizations. This program offers a unique blend of direct resettlement and child welfare services and appears to be one of the first programs of this nature. This study therefore offers an opportunity to acquire knowledge from their experiences that can aid in the development of additional programs for this underserved population.

Study Design

Practice-based research is an investigation that uses research-inspired principles, designs, and information gathering techniques within existing forms of practice to answer questions that emerge from practice in ways that inform practice (Epstein 2001, p. 17). Its goal is new knowledge that has operational significance for practice (Westfall et al. 2007). Clinical data mining is one practice-based research strategy that advocates for the use of available clinical information from case records, an untapped source of valuable data on practice (Epstein and Blumenfield 2001). In this study, 15 family case records were systematically examined or "mined." Case selection was based on an availability sample of all of the families who had participated in the preventive services program from its inception in 2007 until the mid-2009 when the study was conducted. Several interviews with the program coordinator supplemented the case review and provided clarity on questions that emerged from the data and greater detail about service delivery.

Data Collection and Analysis

Clinical data mining is an inductive, retrospective approach relying on instrumentation tailored to practice rather than externally standardized research measures (Epstein 2001). An instrument that gathered strategic quantitative and qualitative data was developed in collaboration with the program's coordinator to review the program records and structure the data collection. Key variables of interest related to child welfare risk assessment and services and the immigrant resettlement process were selected on the basis of combined practice experience, support from the literature, and existing agency practice. Since the organization has traditionally directed it services toward refugee resettlement, basic information about the family's migration history, language proficiency, and level of acculturation are routinely documented in the charts. Case recording procedures required by the child welfare system are standardized so that all case records contain data regarding child and family characteristics, risk factors for child abuse and/or foster care placement, service needs and family goals, services provided, and family progress toward case goals. In-depth clinical information regarding mental health status and family psychological dynamics was not available in the records and such variables were not included.

Case progress was measured on a four-point scale (minimal, some, good, excellent) and determined by the number of treatment goals achieved in the most recent case

service plan review (1 or less=minimal progress, less than half=some progress, half or more=good progress, and most or all=excellent progress). All case record contents were read in their entirety including referral materials, intake information, correspondence and progress notes, and all Uniform Case Records (UCRs). UCRs are completed for all child welfare cases in New York State and include an assessment with child and family history, a family service plan that is periodically reviewed and updated to document family progress and risk factors, dates and descriptions of all services provided to the children and family, and documentation of judicial or administrative proceedings relating to the case. Confidence regarding the consistency of the case recordings and their validity is bolstered by the program's strict adherence to standardized reporting procedures and that the charting was completed by a solo worker because of the small program size. Qualitative data regarding significant aspects of the family history, worker's interventions, or the family's response were noted in the instrument and systematically reviewed in order to identify thematic elements to supplement the quantitative data. To ensure reliability, the records were reviewed by the researcher and the program coordinator. In a few cases where there was variance in the ratings, the file was re-reviewed and findings discussed with the coordinator to arrive at a determination. The quantitative data was analyzed with SPSS.

Study Limitations

There are a number of study limitations that stem from the small sample size and the reliance on case records without direct observation or interviews with the program consumers. The cost of interpretation services and the logistics involved made such a design impractical. Baseline data or pre- and posttest measurement of the families' abilities in areas such parenting or acculturation level is not routinely collected in order to gain a measure of progress. Therefore, this study makes no claim of presenting cause–effect evidence of the effectiveness of the interventions of the program. Furthermore, the study design and small sample make it difficult to generalize these findings. However, the strength of this idiographic research approach is that it offers a detailed case study, highlighting the variations and individualized features of a program in an emerging field where few promising practices have been documented or studied (Sydiaha 1971; Behi and Nolan 1996). Drawing upon rich data of the case records, it provides a close-up, historical understanding of such a program within its particular geographic location and context and identifies the characteristics and service needs of families likely to use this program and the strength-based practices that emerged. Such practice-based evidence can serve as an important tool to advance effective practice with this population and may be adapted by other organizations as deemed appropriate.

Findings

Family Profiles and Characteristics

All families were referred by the County Department of Social Services because of a report of suspected child abuse or neglect to the State Central Registry. The families were primarily refugees (13), 1 asylee family, and 1 family of legal permanent residents

(see Table 1). Seventy-nine percent of the families were new immigrants and had been in the USA for 5 years or less, with a median length of residence of 3.5 years. Some families had resided in the country as little as 3 months while two families had resided in the USA about 15 years. They originated from nine different countries, primarily located in Africa and Asia. All the parents and children had various experiences of displacement, loss, or violence. Both of the non-refugee families experienced serious domestic violence, which in one case had resulted in the death of the mother prior to the referral. Five of the families spent from 6 to 15 years waiting to be resettled and one family spent more than 15 years in a refugee camp. Major life events such as marriages, births to children, and deaths took place in the camps.

There was intracountry ethnic, language, and religious diversity among the participants. For example, three different ethnic, linguistic, and religious groups were encountered among the Burmese. Eight distinct primary languages were spoken. Eleven of the families were in need of interpreters to engage in services and ten homes contained no adult English speaker. In terms of family structure, eight were two parent families and seven were single parents. Family size ranged from as large as ten persons (single mother with nine children) to three persons, with a mean family size of six people. The number of children per family ranged from two to nine children with an average of five children per family. More than half of the families had six children or more. All of the families but one had low income and lived in the inner city area. Most of the families (ten) were engaged in some type of employment, mostly farm, manual, or factory labor and several were underemployed with part-time jobs. Nine families received TANF as a source of income, although three were working part-time and received TANF as a supplement. Most families obtained food stamps and Medicaid (13 and 14, respectively). At the time of the study, 11 cases were closed and 4 were active (see Table 1).

Reasons for Referral and Presenting Problems

Families experienced multiple problems, with an average of five areas of difficulty. More than a quarter of the families were experiencing at least seven problems that posed risk to family well-being at the time of referral. The most common reasons for the referral were an identified need for cultural orientation, lack of parenting skills, intergenerational family conflicts, inadequate finances, domestic violence, and inadequate living conditions (see Table 2). The program's assessments and service plans assess a wide range of psychosocial issues including migration and resettlement history, cultural practices, religious traditions, length of time in the USA, and cultural adaptation dimensions of each case. All of the families demonstrated or limited ability to avail of social services and/or education systems independently. Most family members had limited English language skills and interpretation needs in a wide range of uncommonly spoken languages.

Interventions and Service Delivery

The length of service ranged from 1 to 18 months, with a median length of service of 10.5 months. An individualized family service plan with a series of goals is created within 30 days of the case initiation date and reviewed biannually. Each family had four to six designated service goals. Service goals were congruent with the referral

Table 1 Characteristics of study participants

N=15	Frequency
Country of origin	
Somalia	4
Burma	4
Liberia	2
Sudan	1
Central African Republic	1
Burundi	1
Jordan	1
Pakistan	1
Native language	
Burman	2
Karen	2
Arabic	2
Maymay	1
Grabo	1
Kirundi	1
Sango	1
Pidgeon English	2
Interpreter	
Yes	11
No	4
Families with no adult English speaker	10
Religion	
Muslim	7
Christian	7
Buddhist	1
Family and household structure	
Two parents	8
Single parent	7
Total number of children	70
Mean family size	6
Immigration history	
Time in the USA	
1 year or less	2
2 years or less	4
3 to 5 years	5
5 to 15 years	3
More than 15 years	1
Time in the refugee camp	
1 to 5 years	1
6 to 10 years	4

Table 1 (continued)

N=15	Frequency
11 to 15 years	1
More than 15 years	4
Unknown	2
Income/supports	
Employment FT	4
TANF	6
Employment PT	1
Employment PT with TANF	3
SSI	2
Medicaid	14
Food stamps	13
WIC	8

problems, reflecting a strong focus on cultural orientation and adaptation. Hence, the most common service goals were cultural orientation, followed by improving parenting skills, improving family relations, obtaining educational services for children, improving parental English language skills, and obtaining mental health counseling for children. Face-to-face contacts heavily concentrated on cultural orientation of various types. Other key services provided included parenting skills; concrete assistance with clothing, especially winter clothing and coats, furniture, cribs, mattresses, household supplies, and school supplies; interpreter services; transportation services; English as a Second Language; and obtaining medical services for parents and children health. The number of services per family ranged from 3 services to 16 with a mean number of 10 types of services per family (see Table 3).

Table 2 Reasons for referral

Reason	Frequency
Cultural orientation	14
Parenting issues	12
Intergenerational conflicts	8
Inadequate finances	8
Domestic violence	6
Inadequate living conditions	6
Inadequate supervision	4
Neglect	3
Truancy	2
Physical abuse	2
Sexual abuse	2
Pregnancy	2

Table 3 Service delivery (N=15)

	Frequency
Length of service	
1–3 months	3
4–6 months	1
9–12 months	7
1 year–18 months	2
More than 18 months	2
Major services provided	
Cultural orientation—family laws	14
Cultural orientation—childrearing	12
Cultural orientation—self-advocacy	12
Cultural orientation—education system	7
Parenting skills/education	11
English as a Second Language	11
Transportation	11
Concrete services	13
Advocacy—entitlements	10
Health services—child	8
Recreation	7
Domestic violence	6
Educational services	6
Childcare	5
Mental health—child	5
Family counseling	5
Child counseling	5
Mental health—parent	4
Housing assistance	5
Advocacy—other	15
Employment assistance	5

The most frequent location of casework contacts was the home, followed by the community and the program office. Community contacts in a variety of settings such as libraries, zoo, parks, and other recreational sites as well as courts, hospitals, and schools addressed multiple goals such as orienting the family to community resources, facilitating participation in community life, improving family relationships, and decreasing the family's social isolation. Casework contacts at family court and other institutions modeled self-advocacy skills and the exercise of citizen rights.

The number of casework contacts exceeded preventive services regulations that require biweekly casework contacts including a quarterly home visit. In most cases, the worker met with the family twice the required amount. Rural origins combined with prolonged periods of time in refugee camps left parents unfamiliar with urban living and household management skills that are taken for granted in America. Orientation

regarding housekeeping methods, assistance with budgeting, and financial management became necessary components of service.

Various therapeutic techniques such as family activities and bonding exercises with children and parents facilitated family communication. Art therapy and social work interns were also assigned to work individually with children who were referred due to emotional and behavioral problems. Parents commonly avoided interaction with schools. They required considerable support to engage with their children's schools and to understand expectations regarding parental involvement in children's education. Direct concrete assistance from the worker was required. For example, some families greeted the caseworker needing assistance with shopping bags full of unread mail and required help to negotiate basic transactions because of illiteracy and language barriers.

Case Outcomes

As a preventive service program, a key measure of success is preventing the placement of children in foster care. Of the 15 families with 69 children served, only one child was placed in foster care. One family was referred to the program to facilitate the discharge of three children from foster care. This was unsuccessful so the children remained in care.

Two thirds of the families were rated as having made either good or excellent progress (4 and 6, respectively), two families made some progress, and three families made minimal progress as measured by the attainment of the treatment goals in the family service plan. The majority of cases that had been closed (seven) were determined to have attained the case goals. Where concerns for child safety remained, the cases were taken over by the county child welfare department. Some barriers to progress continued, especially in the areas of language and transportation, making it difficult for families to engage in services outside of the prevention program or to obtain better employment.

Brief Case Examples

Two brief cases studies are presented that illustrate the elemental predominant psychosocial challenges that emerged among the families served by the program. They also compare and contrast examples of successful and unsuccessful outcomes, respectively. The vignettes underscore the distinct assessment and treatment challenges presented by the families. The first case details the pervasive impact of migration stress on the entire family as well as the multiple psychosocial needs among families that must be addressed in order to strengthen the family functioning.

Case #1: Perimigration Stress and Family Adaptation Issues

A family from Burundi with six children was referred because of the behavior of a 14-year-old boy who was acting out and caught destroying property in the community. The parents were experiencing difficulty meeting financial, educational, and housing needs of the family. The family escaped a brutal civil war and had to relocate to multiple refugee camps in Tanzania before resettlement in the USA. All the children, except the baby, were born in a refugee camp. The parents were unable to communicate in English

and an interpreter had to be arranged for all contacts. Contact with schools was minimal and the son's behavior created additional stress. The father is currently unemployed, has a possible sleep disorder, and voiced his frustration with the discrepancies between what he expected in the USA and what the actual experiences have been. The parents were referred to English as a Second Language (ESL), childcare was obtained for the baby, the father referred to the employment assistance program, and the family provided with household items. Extensive cultural orientation regarding parenting norms in the USA, family laws, working with the educational system, self-advocacy, and help with basic skills such as paying bills, using the bank, and budgeting were provided. Parenting education focused on establishing rules to manage behavior and communicating with the school. An MSW intern was assigned to work individually since referrals for traditional counseling were not successful. Tools such as a daily feelings diary and other written and art-based exercises helped him verbalize about his past life in contrast with his current one, his self-image, and what he wished parents, teachers, and friends knew about him ("Sometimes my life was hard, sometimes we had no food, no place to live, no job"; "I want them to see that I am good"). These enabled him to talk about being picked on in school and the difficulties communicating with his parents about his problems. He now demonstrates improved coping and communication skills and requests help with problems instead of fighting, has improved academically, and is learning to avoid negative peer influences. The family continues to work with the caseworker addressing family needs.

This vignette highlights the interplay of the pre-migration, transit, and resettlement stresses of the family that impacted on each family member. The stress of adjustment on the family diminished their ability to attend to their son's adjustment issues. Extensive concrete assistance, cultural orientation, and nontraditional counseling support were necessary to address the wide range of needs presented by the family.

This second case illustrates how limited access to culturally informed and competent resources may impede effective work within newcomer communities and add additional challenges to risk assessment. Lack of access to culturally and linguistically competent health and mental health providers made assessment of the presenting problems difficult and hampered the formulation of a sound and timely treatment plan before the risks to the child escalated.

Case # 2: Culturally Competent Assessment Challenges: Balancing Regard for Cultural Rights While Safeguarding Children

The family consists of a mother and five children referred due to medical neglect of a 2-year-old child who has leukemia. The family had no income and no furnishings and the children were truant from school. The family is Burmese and of Rohingya ethnicity, a minority group from a remote region that has been displaced by the military government and brutally oppressed. The family lived in a refugee camp in Malaysia and the mother gave birth to her first child at age 14. The family has lived in the USA since 1991 and the younger children were born in the USA. The parents are separated and live in different cities. The mother speaks little English and needs a translator at all times. Extensive efforts were made to provide cultural orientation about medical, educational, and child welfare systems. Referrals were made to the agency's ESL program and she was helped to obtain TANF and SSI for the ill child. Pediatric home

care with instruction on administering the child's treatment was arranged. The mother failed to sustain the treatment and maintained that the child was ill as "punishment for the sins of his parents." The caseworker continued efforts to engage the mother and sought information about Burmese cultural beliefs and traditional medicine, but the lack of follow through continued. The child relapsed, resulting in the child's placement in foster care. At the close of services, the county was attempting to obtain a mental health evaluation of the mother and was closely monitoring the other children.

This case demonstrates some of the most challenging aspects of work with this population. Cross-cultural mental health assessments were difficult to difficult to obtain. There is a lack of service providers fluent in the necessary languages or knowledgeable about the clients' cultural background in this community. The worker sought to preserve the family and accurately assess the role of culture in the presenting problems, but the need to assure the child's well-being assumed priority. It was difficult to ascertain the basis of the mother's rejection of treatment for her child. Was it based on traditional belief system, a manifestation of mental illness, a product of perimigration trauma, or a combination of these factors? It may have been beneficial to employ further creative strategies to identify cultural experts to accurately assess these circumstances earlier in the case before this crisis ensued. Access to culturally relevant and linguistically competent services are likely to exist within communities outside of large, cosmopolitan areas that have experienced recent arrivals of immigrants and refugees from diverse countries, with no base of established practitioners from the cultural groups represented.

Discussion

Foremost of the beneficial program components was the organization's accessibility and capacity to provide essential wraparound services such as ESL, specialized domestic violence services, and employment services. Exhaustive knowledge of the migration and acculturation process, access to interpreters, and in-depth knowledge of laws and entitlement programs for immigrants and refugees enabled a comprehensive approach to an extremely diverse population with tremendous concrete needs. The findings emphasize the critical importance of concrete assistance and more intensive cultural orientation to these newly arrived families in order to reduce risk of child welfare involvement.

This collaborative model may be particularly useful for localities that have diverse groups of newly arrived immigrants without a concentrated density of any ethnic group, which is a common scenario in small to medium size cities across the USA. One difficulty encountered was the high cost of interpreter services which exceed the allotted budget. Dedication of sufficient funds for interpreter services although costly is essential for the program's success.

Another positive feature of the program was the small caseload size (eight families) that allowed for frequent face-to-face contact. This was critical because of the number of and complexity of family service needs of the families, the time involved in coordination of all service provision with interpreters, and the large family size. It is notable that most of the families were referred for problems stemming from domestic violence and by acculturation stresses such as intergenerational conflict, problems

related to low income, and social disadvantage rather than serious physical abuse of children. No differences in outcome were observed as being related to family size, language acquisition, or country of origin. Families with better outcomes tended to have more face-to-face contacts with program staff and to have been characterized as "engaged or highly engaged" with the program. With supportive case management coupled with a strong focus on cultural orientation, most of the families experienced improvement of their presenting problems and reduction of risk factors to children so that foster care placement was averted.

In contrast, the small minority of families that did not benefit from the program were characterized by greater risk factors and chronic problems than the other families such as child sexual abuse, mental illness, and previous histories of involvement with child protective authorities. These findings were somewhat consistent with previous studies that have found risk factors related to acculturation and lack of awareness of US parenting norms, rather than risk factors such as alcohol and drug abuse or physical neglect. However, it was apparent that most families experienced financial challenges and required ongoing assistance in order to meet basic family needs.

The key lessons learned and specific recommendations that emerged from the experiences of this program serving immigrants and refugee families are as follows:

Centrality of Cultural and Linguistic Competence: These competencies are indispensable for a successful program and without which all other services, however well-intentioned, cannot succeed. This point is underscored by the diversity of national origins, intracountry diversity, ethnicities, languages and dialects, and stages of acculturation among the families referred for service. Cultural and linguistic competence extends beyond the hiring staff of and is an integral part of the organization's values and philosophy. The organization also serves as a meeting place for ethnic communities and sponsors many cultural events such as dance performances, fairs, and dinners, thus enabling families to maintain connection to their cultures. This promotes resilience and helps them cope with stress (Servan-Schreiber et al. 1998).

Time for Relationship Building: Successful work with families rests upon the engagement process and building rapport, conveying respect and exhibiting a warm demeanor (Fontes 2009). Visiting, a cultural tradition in many cultures represented, was viewed positively by the families and home visits by the caseworker alleviated some of the isolation experienced by families. Respect for the family's culture was demonstrated through efforts to learn as much as possible through reading and, more importantly, directly talking with the family about it, especially the differences between their former and present lives. The worker joined with the families by sitting on the floor in the Somali style, learning greeting protocols, and acknowledging Eid, a major Muslim holiday.

Support Parenting Efforts/Enhance Family Resources: The families experienced stressors common to immigrant families including poverty and low wage work, language barriers, and low educational attainment and illiteracy (Shields and Behrman 2005). A critical aspect of their approach was the immediate attention to issues of safety and survival that was provided to help families feel secure in the new environment in order to enable them to focus on counseling issues (Geltman et al. 2000). Parental well-being is bolstered by economic opportunity and social

support which has been found to serve as a protective factor for children (Ajdukovic and Ajdukovic 1993; Almqvist and Broberg 1999; Porter and Haslam 2005). Facilitation of parental involvement in schools is an important factor in reducing the acculturative gap that often develops between parents and children (Gaitan 1991).

Parenting education with immigrant families is fraught with challenges considering the wide variation in child-rearing beliefs and behaviors across cultures. In this program, families were from traditional, primarily rural, and in some cases nomadic cultures. Corporal punishment is much more accepted in many of these societies and families may be more hierarchical with less emphasis on open communication between parents and children (Fontes 2005; Lee et al. 2001). It is also important to note that approaches to parenting and child development common in the USA are based upon western, middle class constructions of childhood and behavior so that immigrant families may not immediately relate to "time-out" or other behavioral approaches (National Child Traumatic Stress Network 2003). Efforts were made to make parenting and disciplinary concepts accessible to the families and to engage the parents and youth in the process of setting realistic goals.

This program's interventions sought a balance between respect for the cultural perspectives of parents and the obligation to safeguard children, as seen in the second case example. Not all cases encountered are as unambiguous. The US Constitution protects the rights of all parents to raise their children as they see fit, as long as they cannot be described as "abusive" or "neglectful" as well as the right to refuse orthodox medical treatment as long this refusal does not seriously jeopardize the health of the child (Coleman 2007). A guiding program principle is to preserve continuity of family relationships with a belief that children should be removed only to protect them from greater harm. Staff did not assume that there was intentional mistreatment of children. A focus centered on the need for educational and cultural orientation, taking into account each family's unique history and culture. For many families, the ability to provide food, shelter, and have accessible education for their children is a significant improvement from their past lives. It must be kept in mind that some families, particularly refugees, have survived some of the most unspeakable acts of humankind and managed to protect and preserve family. Parents may find it difficult to accept that their parenting abilities are now questioned. Acknowledgment of the family's strengths and sacrifices can help diffuse resistance and facilitate an open discussion of parenting issues in the US context.

Address Acculturation Issues and Migration Stress: Families exhibit diverse responses to the migration experience as well as a variety of strengths that can be drawn upon (Shields and Behrman 2005). Assessments incorporate a trauma-informed approach that is attentive to the acculturation and perimigration stresses of families and evaluates migration issues that may contribute to the presenting problems (National Child Traumatic Stress Network 2003). In this program, migration history, acculturation and language acquisition differences within the family, and ability to navigate the community were all part of the standard assessment protocol. Service plans also incorporated goals regarding acculturation and mastery of new adaptation skills in addition to the general child welfare

concerns. Discussion of previous trauma and losses was gently broached by staff with sensitivity to the fact that many of the families may not perceive themselves as traumatized or may not feel comfortable with the concept.

Use Alternative Approaches to Address Mental Health Needs: Immigrants and refugees tend to underutilize mental health services because of stigma associated with mental illness, few clinicians who speak their languages, and low priority given to mental health because of other overwhelming needs of newly immigrated families (Geltman et al. 2000; Williams and Westermeyer 1986). Talking about painful events may not be experienced as valuable or therapeutic and cultural values about discussion of personal matters to strangers taboo (National Child Traumatic Stress Network 2003). Thus, most parents did not follow through on formal therapy for their children in spite of psychoeducation regarding the process and they rarely engaged themselves in it. Alternatives to traditional talk therapy such as play therapy, art therapy, journaling, and expressive exercises were used with positive results. Other recommended techniques include testimonials, drama, dance, and music to help individuals make sense of their experiences (Davies and Webb 2000).

Conclusions

Several policy and practice implications emerge from this study. Intensified efforts to assist newcomer families integrate into the U.S. are indicated. This would include child welfare services that are equipped to recognize their unique characteristics and needs. Despite the vast amount of immigration to the USA and decades of resettling refugees, there is a very limited range of service available to assist this population. For example, funding for resettlement service to assist refugees is targeted in the first 30–90 days post-entry to the USA and focuses primarily on early employment and economic self-sufficiency, not on full and meaningful services that can help families adjust to their new environment. There is insufficient time and inadequate resources available to provide for these services in a manner that allows for sufficient cultural orientation (Church World Services 2010; Fix et al. 2005). Immigrants and refugees entering the USA come from many different countries and possessing multiple and varied social, cultural, educational, and language backgrounds so that communities face a variety of challenges that heighten the potential for attention from the child welfare system. Many communities such as the one where the program under study is located that are characterized by smaller and more heterogeneous groups of immigrants and refugees lack resources to adequately address the scope of needs (Martin 2005; Gilbert et al. 2010). The integration of these diverse groups requires more targeted and individualized approaches rather than a one-size-fits-all approach (Church World Services 2010; Gilbert et al. 2010). Expansion of services to this population is recommended. This would include added services to provide cultural orientation as well as funding to pilot new programs or replicate other successful program models (Bridging Refugee Youth and Children's Services 2010a, b; Church World Services 2010).

Interventions specifically targeted to immigrant and refugee families who are struggling with parenting in the context of acculturation reduce family stress or family breakup. Such interventions would bridge an appreciable gap in services for migrating

families. The model presented here is replicable in other localities using child welfare preventive services funding and/or refugee resettlement funds. Child welfare agencies should consider formal contracts with community-based agencies or establish specialized immigration units either within the agency. Child welfare agencies can also develop participatory, collaborative partnerships with community-based agencies and ethnic organizations to provide critical outreach to the immigrant community to educate them about the child welfare system (Cervantes and Lincroft 2010). Proactive programs that enhance immigrant families' integration minimize more costly future interventions. In a nation increasingly comprised of immigrants, programs that protect the unity and well-being of these families and children are clearly a valuable investment.

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