Webinar: Addressing the Mental Health Needs of Unaccompanied Afghan Minors (UAMs)

September 24, 2024, 1:00 – 2:15 PM ET

Transcript

Introduction

Audrey Montgomery: Hello and good afternoon, everyone. It is an absolute privilege to be here with you all today. Today we will delve more into the insights and findings of a recent research project aimed at better understanding and now addressing the unique mental health needs of unaccompanied Afghan minors.

Today's Speakers

AM: Before we dive in, I have the honor of introducing my incredible colleagues joining me on our webinar today. First, we have Dr. Zaid Baha, who is an Afghan-American currently residing in Michigan. He is the Medical Director for Crisis Services through Genesee Health Systems. In addition, he has provided evaluations and follow-ups for unaccompanied Afghan minors in 2021 and in 2022. He treats all populations in every mental health condition.

Next, we have Farhad Sharifi, who is a recent Afghan evacuee and was initially at Camp Atterbury. He is a social worker, program advisor, and cultural expert at the Research Program on Children in Adversity, or the RPCA, at Boston College.

Next, we have Saeed Haseeb Arwal. Haseeb is currently pursuing a Master in Comparative Politics at Boston College, in addition to working as a Research Assistant and Cultural Advisor for the RPCA's Afghan Refugee-Based Projects.

Next, we have Dr. Ngozi Anolama, who is an Assistant Professor in the Department of Social Work at the University of New Hampshire. Her work promotes the adoption of culturally grounded approaches to address mental health disparities among immigrant and refugee children and youth.

Lastly, myself. Hi, everyone. My name is Audrey Montgomery. I also have a social work background, and I am a Research Associate at the RPCA and Program Coordinator at Boston Medical Center's Refugee Women's Health Clinic.

Learning Objectives

AM: As mentioned previously, this webinar will focus on the key research findings of a research project that aims to better understand the unique mental health needs of our unaccompanied Afghan minor population. This section will provide, to get us started, let's review our learning objectives. By the end of today, you will be able to, number one, explain the importance of equitable mental health services for unaccompanied Afghan minors and [number two] protective factors of unaccompanied Afghan minors and how they differ from the general unaccompanied refugee minor population. Number three, you will be able to name the culturally informed strategies that address the needs of unaccompanied Afghan minors at the caregiver, provider, and research levels. And then, lastly, you will be able to describe the implications of the research findings about unaccompanied Afghan minors for policymakers and practitioners. So let's get started.

1. The Importance of Equitable Mental Health Services for UAMs

Poll Question

What is your role in working with unaccompanied youth?

AM: By the end of this section, you will be able to provide some background, you will hear some background and additional context, both for unaccompanied Afghan minors, as well as the research that we have conducted itself, with hopes that you will also be able to identify and explain the importance of equitable mental health service provision for these youth. But first, I just introduced all of us and our respective roles to you, and now I want to hear from you all. So at this time, if you could, please take out your mobile device, or you can go to slido.com and enter the code listed on your screen. We will do this a few times throughout today's session to hear from you.

So if you can take the next minute or so and let us know, what is your role in working with unaccompanied youth? We have case manager, a foster parent, resettlement agency employee, folks provide post-release services, case manager, case manager, interns, practicum students. Exciting. Thank you all. Welcome. Welcome, welcome. Language access services, family support specialists, associate director, or case managers. Thank you. Yes. Welcome. We are all so, so, so excited to have you join us today. It is very clear from what I'm seeing here, medical coordinator, director of URM programs, that we have some experts in the room, our Zoom room today. So thank you. Thank you so much for joining us. Great. Great. Thank you. Yes. Okay. So that gives us a great idea of who we have joining us today. And with that, I'd like to hand it over to Farhad, who will get us started in section one today.

Who Are UAMs?

Farhad Sharifi: Thank you, Audrey. And thank you all for participating today and all your work for this community and for the URM in general. So let's talk a little bit about who are UAM or URM. So UNHCR defines unaccompanied child as a child separated from both parents and who are not being cared for by an adult who by law or custom has responsibility to do so. Common terms and language used to identify this population in the U.S. include unaccompanied minor UM or UAM, unaccompanied refugee minor URM, unaccompanied child UC, unaccompanied and separated child UASC, unaccompanied immigrant child UIC and or URY, unaccompanied refugee youth. So you'll hear about them in different acronyms. In the United States, unaccompanied children and unaccompanied refugee minors receive different identifications and different services through the unaccompanied refugee minor program and the unaccompanied children program. The Afghan children who entered into the United States without a biological parent but had a family member or USI were released to care coming to be referred as a attached Afghan minor. Those who didn't have a USI remained in the care and custody of the ORR or Office of Refugee Resettlement. Mostly in long term foster care or were released to the unaccompanied children program and then released to their sponsor. And the placement types are different. Placement types, specialized accommodations, access to support services, they all range significantly for this population. Given the unique vulnerabilities, there is a critical need for more knowledge about their experience to inform services and to reduce common mental health concerns and strengthen pathways for their success of course. Particularly for UAM, reunification of unaccompanied Afghan youth paroled in the United States with their families was and is and remains to be a top priority for the current US government administration. However, those who entered into the United States not as part of the formal relocation effort such as those who arrived in the country from the southern border and those who entered the United States through private means may not be eligible for relocation legal support. So that is important to differentiate. Next slide.

Common Adverse Outcomes for URMs

FS: I will talk a little bit about common adverse outcomes for UAMs. There is significant evidence on the prevalence of mental health concerns for the unaccompanied Afghan minors in general. Present literature

concludes that unaccompanied refugee minors have more severe mental health concern than accompanied refugee minors as well as general youth population. The most common diagnosis found among unaccompanied minors is PTSD or post-traumatic stress disorder, depression, and anxiety and of course as a result leading to behavioral challenges. So pre, during, and post-migration factors all contribute to the mental health of URM. The literature showcases the exposure to trauma, separation from family, of being unaccompanied, being female and older are all associated with poorer outcomes. Additionally, lack of access to mental health services or stigma around that and placement type are identified as key post-migration factors that can contribute to adverse outcomes for URMs. And consistent with literature broadly, studies suggest poorer mental health outcomes for Afghan youths, specifically who have exposure to multiple traumas. For example, witnessing violence or conflict prior to evacuation, the confusion and uncertainties during this evacuation and questions they have about the evacuation itself, separation from family, insecurity of living condition here in the U.S., the care arrangements, and many more similar challenges all contribute to their challenges. With this potential adverse outcomes in mind for URM in general and UAN's unique migration journey and visit them in the United States, it is critical to attempt to meet the needs of this community. Unfortunately, there is little published evidence-based research on the common adverse mental health outcomes for UAMs, which are not in the United States yet. However, our project goals or our research goals and results shared, which I will talk about in upcoming slides, will provide additional insight on potentially worse mental health outcomes for UAM. And we aim to capture the unique needs of this community that inform what equitable practice looks like for UAM.

Discussion Question

What are some signs of negatively impacted mental health you have experienced when working with UAMs?

FS: Next, just not to talk a lot and then have an engagement with you all, we have another Slido, which, again, as Audrey just mentioned, you can scan the QR code or go to a new browser and type slido.com with that Unicode to answer this question. And the question is, what are some signs of negatively impacted mental health concern you have experienced when working with UAMs? Hopelessness, cultural trauma, wanting to drop out of a school, being aggressive, anxiety, withdrawn, depression. This is exactly similar to what we also found out. Not going to school, depression, societal ideation, loneliness, isolation, and so on. Societal ideation, loneliness, isolation. Great answers. Not leaving bedroom. Trust building for all imaginable reasons, of course. Building that trust is really important and crucial. Okay. Thank you all for all your great responses.

Project Goals and Methods

FS: And next, I would like to talk a little bit about our research goals. So, as you know, following the arrival of nearly 1,500 UAMs in the U.S. and to contribute to a small evidence base for interventions with the UAMs, our team, in collaboration with Switchboard, began a project aimed to explore the current needs, family dynamics, challenges, and supportive needs, family dynamics, challenges, and supportive factors of this population, which is UAM. So, our research had the following goals. First one was, we wanted to assess the needs and strengths of the UAM and their adult caregivers, as well as the challenges that UAM are experiencing during their resettlement experience. The next aim was to summarize what is known about psychosocial consequences of this kind of forced migration facing UAM and evidence-based strategies for supporting this use. We also wanted to utilize from the results of this research for development of a mental health screening tool for the Afghan minors, particularly for this group. As you can see in this slide also, it highlights the methods we had for this research so that we get to our goals. We used what we call qualitative community-based participatory methods, or CBPR, and CBPR is a community-driven approach that involves community members, researchers, stakeholders, at all stages of the research process, to prioritize sharing of knowledge and expertise from all partners. One way in which we use CBPR is through what we call CAHPS, and CAHPS is short for Community Advisory Board, and CAHPS meetings is simply consulting the community members with whom we do the research. It is facilitated through our partner organization, and the CAHPS provide critical community insight on the research. They also help us with the project goals, with the implementation, and we

communicate with them before, while, and after the research, what we are going to do, how we share our findings, and we also listen to them specifically during the research if they have concerns and how things are developing. And toward the end of the research, we confirm with them, this is what we have found, and if this makes sense to them. So engaging community is essential and considered one of the best practices. Data collection that we had was through what we call free listening interview technique, which is a qualitative technique that involves asking people or the participant to list all of the problems and protective factors that they can think of relating to a specific topic. We also had what we call focus group, or focus group questions and discussions, and they were guided by the results of these free listening interviews. And the focus groups, we had three levels. We had focus group with the UAM themselves. We also had a separate focus group with their caregivers or sponsors, whoever were sponsoring or caring for this UAM, or not with their biological parents. And the third group was the service providers who worked directly alongside this population. A lot of you here in this, I think some of you at least were part of our focus group, hopefully. And of course, every research should be approved by the IRB, or Institutional Review Board, which we also have. And our research assistants who had the Afghan background, fluent in Darian Pashto and English, they were part of the research. They supported the recruitment, interpretation, data collection from the UAM themselves. And the interviews were also done through Zoom or in person, if applicable. The interviews with caregivers and the service providers were primarily interviewed in English. And we recruited the unaccompanied Afghan minors or UAMs and their caregivers to partner organizations across the country who work directly alongside this population. We were intentional to go through established agencies who have referral services, since that is in line with the following best practices like that of principle of no harm. And the selection criteria and the selection criteria for the UAM included those aged 10 to 22, who recently arrived in the United States after 2021, and are under the placement or supported by agencies designated by the ORR, or Office of Refugee Resettlement. Next, my colleague, I think Dr. Zaid Baha will talk about a case that you all can listen to him.

Case Example: Zaki

Zaid Baha: Thank you. Thank you, Farhad. My name is Zaid Baha. Today, I will be presenting a brief case study regarding a teenage unaccompanied Afghan minor, who we will call Zaki. His real name and His real name and location will be hidden for confidentiality. He arrived to the Midwest from Afghanistan in late 2021. And this individual was under my care for about six months into 2022. Zaki suffered from PTSD prior to arriving to the States. He was living in a shelter with certain restrictions placed based on his level of risk. Zaki had been involved in many serious incidents prior to my involvement, requiring behavioral management with psychotropic medications. On one occasion, he had been denied access to certain staff at the shelter due to inappropriate behaviors exhibited at the shelter. He had developed a strong relationship with one of the female staff members and Zaki really wanted her to foster him. He began to call her mother and demanded access to her, leading to a no contact order with Zaki and the staff member. Zaki would break windows when he was denied access to her and his escalating behaviors led to Zaki eloping from the shelter on multiple occasions. The first time I met Zaki, we discussed his trouble sleeping at night, as well as his difficulties with self-regulating his emotions, which led to poor behavioral outcomes. He had difficulty sleeping due to constantly thinking about his 10 siblings and parents back at home who were poor and suffering bouts of malnutrition. He would also think about how he ended up in the U.S. all alone. He was only sleeping about two hours per night at that time. However, at the time, we discussed goals and his goals were to finish school and become a physician. I really had to press Zaki as he was minimizing many of his concerns on our initial visit. I needed to develop a level of trust between us. He had initially refused the medications I had prescribed him. Early at the treatment, Zaki began to exhibit more inappropriate behaviors, including being inappropriate with peers, acting out, being aggressive, obsessive, demanding, and a level of petulance that was difficult to redirect or de-escalate. He was endorsing racing dots at that time and a level of impulsivity and unpredictability could be exhibited that was also a major concern. Due to these compounding of recent serious events and incidents, it was recommended by the shelter to transfer Zaki to a higher level of care that was more secure with more resources available. He was rejected by all facilities the shelter reached out to. It was unclear why he could not get transferred to a more appropriate setting at that time, possibly because he was aging out soon into adulthood, his level of risk did not qualify him to be moved, a language or interpretation issue, or possibly some other reason that I was unaware of. At this point, I'll hand it off to Haseeb to discuss unique challenges and protective factors of unaccompanied Afghan minors and how they differ from the general URM population.

Thank you.

2. Unique Challenges and Protective Factors of UAMs

Discussion Question

What are the most significant concerns you have seen among UAMs that go beyond the challenges typically experienced by URMs?

Haseeb Arwal: Thank you, Dr. Baha. So now we are moving to unique challenges and protective factors of UAMs and how do they differ from the general URM, the unaccompanied refugee minors population. So before we discuss those unique challenges, we have a question for you all and let's see what we get in responses. The question is, what are the most significant concerns you have seen among UAMs that go beyond the challenges which are typically experienced by URMs? I think you all are familiar how to get responses by scanning the barcode. Language, self-destructive behavior, specific cultural barriers, language barriers, communication, isolation, trauma, societal behavior issues. Yes, that's great. These match our findings. The amount of trauma and stress about sending money home. That's correct. That's financial problems. Yes. Isolation, cultural norms, inability to communicate effectively. Yes. Language problems, feeling like they failed. Yes. Lack of interpreters. That matches our findings. That's great. That's great. Fair. Correct. Support groups, peer support group. Isolation. Mm-hmm. These are great responses. Thank you, everyone. Okay. So now, what are the most significant concerns? Okay. So after the question, we are going to the next slide.

UAM & URM vs. UAM

HA: Before we discuss the knowledge gained throughout our project, here on the left side of screen that you can see our common challenges faced by URMs, including UAMs. I want to mention that this list is not exhaustive. The challenges listed here represent only a portion of the difficulties faced by URMs. So the first one is unaccompanied. Being unaccompanied is a big challenge for these youths as this cuts the consistency for parental care and guidance and leads to mistrust with their caregiver and creates instability and lack of security for them. So reunification in U.S. is a lengthy process, as you all know. However, being said, it is a priority to the current U.S. administration. The second one is care placement or placement time. URMs require special care and accommodation to ensure their safety and well-being, such as foster care, where they are being cared temporarily and provided with a stable home environment. Kinship care, where they're living with extended family members or relatives. Semi-independent accommodation and independent accommodation, where they are living on their own but with minimal supervision. Or residential or group home, where they are cared by a trained staff and structured environment. Placement type can also include a detention facility, if they have the legal issues or they have safety problems. So for URM, this looks different. They are being placed in detention facilities, as they are families, or they are also placed with family members, as their uncles, elder brothers, cousins, or other close family members who lived here or who came out of the camps with them at the same time. Or they are placed with sponsor or group homes and so on. The other problem is integration. Adjusting to new cultural environment can be very challenging for URM overall, as they will be in process of navigating new cultural environment and looking around to familiarize themselves where they are going to see their whole life there in that environment. And integration can sometimes be disrupted due to the change in inconsistency in the care placement, like changing from the foster care to the kinship or to the detention facility. It can make it difficult for them to navigate the environment. And the other problem is education, such as language ability. So for the URM, the common problem among URMs in regard to the language was the barriers and limited access to Dari and Pashto interpretation, as some of you responded to the question, the limitation or the barriers of the Dari and Pashto interpretation. So because many schooling systems only provide Spanish language needs, it was difficult for the schools to provide them with Pashto and Dari interpretations. And overall, the new system and expectation, which all needs to be navigated through learning English, as we all know, this was also, you mentioned the English language problem. The other problem is at risk of adverse childhood experience or called ACES. They also carry this risk because they experience trauma

of losing or being separated from their families. The other problem is experience child poverty. So the poverty, they often live in poverty because they lack family support, which makes it harder for them to access basic needs like food, education, health care, or even emotional care from their parents' side. Risk of abuse. Without the protection of others, they are more likely to face abuse, exploitation, and neglect, as they may be taken advantage in an unsafe environment.

Challenges UAMs Experience

HA: So now we are going to move to address UAMs' unique challenges. The UAM identified challenges were found through both pre-listing interviews, where we asked the youth themselves and their caregivers individually. And we asked them generally, what kind of problems do UAM face? So from these findings, when findings of the problems, they provided their insights and their their insights and their experience. Then we explored further through these challenges through the focus group. In the focus group, we discussed this problem and other questions with the youth and caregivers, and also with UAM service providers. So the service providers were those who were working within UAM programs, legal service representatives, who were social workers, and also who were working for non-profit organizations. So we intentionally asked the service providers that what are the differences they have seen or noticed between URM and UAM, in order to obtain knowledge of how they see those differences. So here on the right side, you will notice that many problems identified among UAMs on the screen dive deeper into the previously identified UAM challenges.

So we will start with Halal food. As you may all know, the Afghan population are 99% Muslims. So of course, the first thing they were looking was for Halal food. And also you can see down the list that they also mentioned the issue of finding prayer time and space for prayer. The other problem with UAMs were legal issues, reunification paperwork. So all of them were concerned about promises they were given that they will be reunified sooner, but they said the paperwork of their families took a long time.

And the other problem is family separation. Of course, whenever we were asking them about problems, they started directly with separation from family. They even said, we have never been separated from our family, and it's first time in our life. They were feeling sad and even said they couldn't focus on their routine life. Here, importantly, they said we can't focus on studies. That's very important.

The other problem was Dari and Pashto language interpretation access, as you all mentioned that. As I mentioned before, the lack of Pashto and Dari interpretation space in school was one of the language problem for UAMs. So in addition, UAMs also associated the language variants and challenges with social connections, such as finding friends and finding work. As they mentioned by their own words, that we cannot find friends soon enough because we don't understand English. Or they also said that they are not giving us the job because of the language. Or they also mentioned that it takes time to do schoolwork, such as homework, or the required paper activity from the school. So this is all the expectations that the school have from them. And I want to mention that the school may not, like not everywhere they go, that they may not understand them like the English problem with it. So they expect them a lot to do a lot. And this was a main challenge for them.

Lack of birth certificate. So the documentation problem, as they were all evacuated in a very crisis situation, so most of the UAMs were not able to bring their important documents such as birth certificate. Even one UAM said he was graduated from the school, but he wasn't able to bring his diploma from Afghanistan. So he struggled for months. Even he said that struggle like for more than seven months. And I wasn't able to find a college and to build my career and continue my education. So finally, after like seven months, eight months, he said that college accepted his enrollment.

The other problem for UAMs was financial responsibility for family back home. I think this was also mentioned by some of you in responses. So some UAMs are able to be able to work and could help their families back home, as they explained that their families are expecting them to help them financially due to the current economical situation, as you may all know from the news in Afghanistan. So the country, so UAMs themselves as well has the intention to support their families. So as you, I think I did one of the responses that was mentioned that they have the worry of like, how can we help our family back home financially? And so however,

some were not able to do also due to some reasons that I had there, some problems or restrictions from their caregivers. So those were and those led to worries, as you also mentioned.

So religion and prayer time. Earlier, I mentioned that the UAM struggled finding place for and practicing their religion and navigate prayer times. So for your information, for Muslim, it's five different times in a day to pray. So this was also an important issue for them beside halal food religiously.

Case management and service outside of URM. So the case management was also an initial problem to most of UAMs. They mentioned that their caseworker was not able to provide them food. Even they were promised with food, but the caseworker or could be said that the agency didn't bring them food. It could be one of the scenarios, but they mentioned this as well with finding a house when they were out of camps, because some of the UAMs were out of out directly with their extended family members or close family members, such as their elder brother or uncle or cousin. So it took them a while for the case manager or agency to find a proper living space for them.

The other problem, lack of establishment, established community in the United States. This problem was also mentioned by most of the UAMs, the lack of Afghan community in their city or state to help them navigate and adopt the new system and environment sooner by guidance of their own Afghans. Do not forget caregivers and service providers as well agreed on this problem, that UAMs need to be around their own people in order to feel safer and learn the new system faster. Can we move to the next slide?

Okay, so in here, the challenges UAM experience, so here we have some of the problems that they said in their own words. So first one is like halal food. So even they said like, if there is no halal food, I won't eat anything. So this is really a big problem for them. And the other they said is missing family. So missing family, their family and sad for them, feeling bored. But sometimes when they call in weekends, so they said that kind of they feel like relaxed, but overall they were sad and missing their families. The other problem is with the English or language, we can say that the problem with English speaking, their classmates couldn't understand what they say. So this was really frustrating for them. Like they said, we want to make friends, they couldn't understand what we are saying. And the other problem that they mentioned by their own words was like, everything is about their parents. So they want their parents to be here. If their parents here, they can focus, they can be relaxed, they can focus on their routine life and their studies. So this was very important for them, the reunification. Next slide. Okay, thank you. So now I will hand over this next slide to Mr. Farhad to continue. Thank you, everyone.

Protective Factors of URMs

FS: Thank you, Saeed. So yeah, protective factors. Among our protective factors, we have, of course, the social support, which primarily from peers, mentors, family in the U.S. and abroad. I mean, extended family for the Afghan. A family contact is considered another protective factor, family contact in the US, of course, as well as family and relatives abroad. The next one is placement type. Culturally sensitive placements is very important, namely foster care settings or settings where you are living with one or more family member, maybe associated with better mental health outcomes. It is believed that foster care as placement options for unaccompanied children is a more suitable option due to, ideally, it will be more supportive in accommodation and mirroring a nuclear family environment, if they happen to have that one. And another one, of course, is a stable and multiculturally affirming environment like a safe school environment has showcased to have a protective effect. The next one, which is gender identity, could be a tricky one. It can be a risk and a protective factor. As a protective factor, it can be good in many ways. For example, connecting with others who share their gender identity can create a sense of community and belonging for them. It is important also to understand the cultural context from which you are income, as gender norms and acceptance can vary significantly, and this is my understanding, just for the record. Gender identity intersects with other aspects of identity, such as race, ethnicity, sexual orientation, and religion, and these intersections can create unique challenges and strengths. Providing URMs with access to support services and resources that are affirming of their gender identity is crucial for their well-being. While gender identity can be a protective factor, it's important to recognize that URMs may also face discrimination and challenges related to their gender identity. Providing a safe and

supporting environment where they can explore and express their gender identity without fear of judgment or harm is essential.

Next slide, I will discuss a little bit about cultural protective factors. The top protective factors found when asking the question, what helps from the Afghan community with the problems that we identified? Many of them said community, connection to family, in particular, that's protective factors for them. It helps gatherings, many forms of gatherings, and as you might have understood, connecting with the URMs that the Afghan culture, within Afghan culture, there is diversity, and they have different forms of gatherings among each ethnic group, for example, or social group. So, those gatherings also help them. Religion, for some. Afghan food, as John said, Halal-friendly Afghan food. And some of them also said patience, just to be patient. That's another way of just coping with the situation that they are in now. And some others also said about activities such as sports, attending to those kind of activities is helpful. Having a job is important, and as some of them mentioned.

Sources of Support

FS: So, next slide, I will talk a little bit about the sources of support. Most UAM identified avenues through which they have received what we call outside support, out of the community, or the groups that they were. What are those kind of support? So, they said that the Afghan community who are in the U.S., that can be a source of support. Religious institutions, such as mosques, the benefits they get from the government, for example, welcome money, financial aid, social services, schools, of course, universities, agencies, non-profits, churches. And some of them mentioned about the volunteers, the support they get from some of the volunteers who support them, that has a huge impact. And they were appreciative. Lawyers, and they were talking about the pro bono services that are offered, that's helpful. And even some said that your research is also important for us. Personal doctors, of course, employment. And I don't know if the slide that you can see there, some of them are highlighted in black, and those highlighted or written in black ink, I guess, they are more particular to the Afghan UAM.

Strength and Resilience of UAMs

FS: Next slide, I will talk a little bit about the strength of the UAM. Through all of the questions that we asked in our free listening exercise, and the focus groups, the following were some of the expressions of the strength that they have. So, of course, we heard a lot of expressions of resilience, despite the challenges and the trauma and the challenges of the displacement. Some of them talked about what they have learned, and they have adapted and found some coping mechanism to face the challenges they have. We had the growth and self-efficacy. Some described how they have improved in their English, for example. They got some part-time jobs. And some others also actively support others, the other UAM, because they were saying, we understand how tough it is, and they were trying to support other UAMs. Even some also described about their efforts to just make halal food for themselves. That showcased their resourcefulness and their determination. Staying positive and optimistic, that was another strength as they go through their challenges. And acknowledging the positive aspects, and my lessons also was among the positive aspects and their strengths. Even some were doing self-advocacy, and that's another aspect which showcases how they are trying their best to cope. And the next slide, there is resilience of the UAM in their own words. Shortly, I will just read the highlights. I'm trying my best. Yes, we are preparing food by ourselves now. Step-by-step, I made it, which was heartwarming for us to hear that. And some said after that, I slowly continued my life. So these are some of the ways they mentioned in the face of the challenges. Next, Dr. Baha will continue with the case.

Case Example: Zaki [continued]

ZB: Thank you, everyone. Thank you, Farhad. Let's get back to the story about Zaki. About two months into treatment, I developed considerable rapport with Zaki. He began to take his medications, and there was a marked improvement in his behavior and mood. Zaki made encouraging statements reflecting on his past behaviors. He actually had stated in that, I promise I will behave myself and I will do whatever it takes. He was

sleeping better, became less reactive in triggering situations. He became less threatening to others and was given more freedom, including the ability to go outside. We can go to the next slide. The next slide is a slido.

Poll Question

What are some unique protective factors that you seek to put in place for UAM clients?

ZB: Before we move on to the slide after this, which is advancing culturally informed approaches to address UAM needs, let's get some audience participation with this next question. What are some unique protective factors that you would seek out, that you would seek to put into place for your unaccompanied Afghan minors? And I'll also hand the slides over to Ngozi.

Ngozi Anolama: I see the responses coming in. Thank you, Dr. Baha. Youth gatherings and events, guidance to support other UAM connection to religious community, foster parents learning about Islam to help the youth, provider with same language and culture, mentoring, mosque connection, school support, age and culturally appropriate support groups, language access, guidance, explanations. Fantastic. Connect and introduce resources, guidance to increase communication according to the minor's age. Guidance, which they've asked for, which they asked for. Yes. Social activities. Thank you very much. Thank you. Thank you.

3. Advancing Culturally Informed Approaches to Address UAM Needs

Culturally Informed Approaches

NA: So in this next section, we're going to discuss some culturally informed approaches to address UAM, just like what you've all listed there. How do we ensure that we're aligning our support to a way that is a separate to their culture and to who they are? Next. In summary, we want to ensure that our approaches respect the culture and diversity of the UAM population. As we've noted, I may have read about Afghanistan has so many ethnic groups and even what they've come into the country as one body. There are different ethnicities and tribes with different languages and cultural expressions. So it's not a one cooker, one size fits all approach. We want to ensure that we respect that diversity and we want to align our strategies, you know, true strength based approaches with our family goals. So here we're focusing on their strengths, their abilities, and what they already know, rather than emphasizing their weaknesses or their deficiencies, be positive and strengthening and affirming in your support for them. We want to ensure that we are providing or communicating in culturally aware and trauma informed ways, knowing that they have been through a lot, but as a country and as individuals here alone without their parents or the supportive adults that they know. So we want to be aware of that trauma and communicate in such a way.

We also have to recognize that the Afghan culture is very family oriented, very communal, and there's a lot of respect for the elders and the authority figures in the family. We want to ensure that we are supportive of that, their cultural background, recognizing the place and role of their elders as we support the decision making, as we plan for their future. Of course, most important, you have to build connection and trust. Most of you have listed some of the challenges that you experienced working with the UAMs, the lack of trust, the inability to build that connection, the fear, lack of engagement with the system. That only happens when they know that you care, when there's honesty, when there's selflessness and a sensitivity to their culture in when you're providing services. So overall, these are the culturally informed approaches that we want to advance. We want to push forward for the UAMs shown both from this current research and other past studies and research. So we'll go into this deeper in the forthcoming slides.

Culturally Informed Strategies

NA: So these culturally informed strategies work both for the research, if you're conducting research among

UAM, or if you're caring for them either in school or as a caregiver, or if you're providing services or you're advocating for them, legal system, whatever way you're interacting, you're a stakeholder in the issues of UAM. You want to, first of all, understand that there are gestures in the culture, how they greet, standing to greet or with hand over the heart. And if there are family or other communist members in that meeting, you want to acknowledge or rather than focus just on that child, you want to acknowledge all who have come together. And also know that, whereas in an American culture, you want someone to look you in the eye and shake your hand, the culture may be more indirect where someone is not looking at you in the eye or being more standing away from you. That does not mean lack of engagement. It would just be the cultural gesture. And again, if there are families or if Afghan youth is culturally or ethnically placed, and you're having these meetings, be kind to use the titles. It could be Jan or whatever title. Ask what would you like to be called and respects for that elder. We also want to protect our children from the stress that comes from being used as interpreters or translators. So when you have kids or children who understand the English language, you don't want to give them that additional burden of being translators or interpreters. Another aspect of the culturally aware speech is what we've discussed before about the multiple ethnicities and languages, the Dari, the Pashto, the Persian, Farsi, there are quite a number. So you want to be mindful that the interpreters or translators that we're working with are open, they're being trained, they understand that there are variations and that they're not discriminating against or toward any particular ethnic group. Again, respect for the individual, paying attention, being patient. If your UAM or the people working with them are slow in forthcoming, you want to listen actively and guide them slowly to come to the, understand what they're really trying to drive at, because there may be indirect communication, indirect languages. And so that ties also to building trust in the sense of observing body cues, body language, indirect speech, and also respecting their personal space. Next slide.

So in this next slide, again, also ties to acknowledging the family and the cultures and ensuring that the elders are involved, particularly if they're becoming unified or they're living with an Afghan family, again, consider the adult-child relationship in making your decisions. And you want to be able to normalize challenges. For instance, you can say, hey, I know things are different here, things are difficult, but we want to support you, want to show you how you can walk through this path. So you're also equipping the caregiver to be able to support that adjustment, because that was one of the biggest challenges that the caregivers observed in working with UAM, caring for them, adjusting to the American culture. The difference was a lot, what they have to come to terms with was quite a lot. Again, we emphasize the strengths-based approaches where we emphasize strengths, where we acknowledge their optimism, their resilience, ask them what they already know, how have they solved this kind of problem before back home? And you help them to draw from their strengths. And that way they're actually engaged with you in providing the solution and they are strengthened in the process rather than reduced. So that actually also strengthens their commitment to adjust, integrate, and have a successful life. Again, we also want to frame whatever support or actions we're giving to them towards a life goal, because they are more goal-oriented, focused on one activity for a time, not like having too many multiple things to do. This is your education, maybe this is around employment, and then your actions or what you're providing or recommending is towards those goals. Again, we talked about developing essential tasks based on their needs and link activities to goals. For instance, if this child has a lot of mental health issues or challenges or problem, and then you want to have an educational approach, you want to help them increase their language. What are some ways that the mental health service can tie to the educational goal? Maybe the words that I use, your learning, the repetitions, the things that you're using to promote a mental health aspect of their life, the art therapy is also improving their mental health. So education tied to mental health or to goals or learning new skills, maybe for jobs and all of that.

In the next slide, we look at the skills. We noticed that most of our UAM and the service providers mentioned that they didn't have a lot of skills to address the need of UAM. We want to make sure that at the organizational level, at the agency level that we advocate or we ask for training so that we can identify trauma and grief and their symptoms, even when the child is internalizing it, when even they come with a facade, you can't tell what's on their mind. What skills do you need to be able to identify hidden trauma that has been there for a while? Individually as providers, as researchers, we want to ensure that we've identified and addressed our own bias, our own stereotype, because this oftentimes becomes a barrier to our providing effective service, to our building a therapeutic alliance with the UAM, because as human, they can sense, even if they cannot communicate, they sense where you're coming from. So you don't want to deal with each anyone with a bias or

a stereotype that you have around the population or around immigrants or around refugees. You don't want this to be a barrier. So at the organizational level and individual level, we want to see what are the steps, what are the biases that we may have? How do we ensure that these do not come up as we're providing service to our UAM? Again, Fahad talked about gender sensitivity and gender roles, and this can come in so many ways in terms of being sensitive to Afghan gender roles from their culture, and also in terms of when you're providing services, how do you match the gender of those who are serving the UAM, whether they're female, male, however they choose to identify. We cannot overemphasize the need for trauma-informed care, because we know that even pre-migration, during the journey, and now in resettlement, there's a lot of trauma that is going on. We don't want to also re-traumatize them. We want to be sensitive so that our care is trauma-informed, and we want to be prepared for longer term support, because it's not a one-day solution. It's not the 90-day, we have resettled you, we're putting you in a home, we're putting you in school, and you're fine. No, we must be prepared to work with them a longer term, and these all have implications both for funding, for policy, and we'll go into that as we go on. Again, very important is do no harm. As we uphold the UAM, they are vulnerable, they are children. We want to be sure that we're not asking them questions or expecting things from them that an average teenager or young child in America would not be. That is tantamount to abuse. We want to protect them because they are vulnerable. Again, during the interpretations or sessions we have with them, we prefer to use impartial or official interpreters, not family members, not people that know you, because even from our study, you find out that someone that knows you or family, you're living with a culturally aligned caregiver, they might be minimizing your symptoms. They might say, you're fine, you have food to eat, you have a roof over your head, what are you worrying about? Whereas someone who is an impartial, who is not connected to that UAM, may be able to express what they're saying better. You want to ensure that you have put all of this in place while serving this community. Right. Next slide. Thank you.

What Works

NA: What works? During the study, we asked the UAM, what works? What works in African culture? What works while you're in the U.S. here? They were very vocal. They shared with us some of the things that they feel make them adjust and do better. They love the opportunities to celebrate Eid and other Muslim festivals, just as Hasib has talked about. They even suggested if there could be Islamic schools or sections in schools that focus on Islamic studies. They also want to go on vacations to see something different. Most of them have been in from shelter to a caregiver and then just straight to school or in the camp. They want to see the culture they've come into. They also do mention that they want to be involved. Ask us, what can we do for you? Rather than just drop already, this is a program we have, youth development program. Whatever it is, we've already packaged this for all our refugee minors, then give it to them. No, you want to ask them, what can we do for you? What are you interested in right now? Of course, some of them have looked out for resources to focus on them. We had minors who, when they came in, were of college age and got into school and they didn't have resources. Thankfully, some of them got scholarship. But other than that, they had to work to pay their rent. They have to provide for themselves because they had the option. They had to choose, are you going to be a student or are you going to live with a caregiver? But they were at the age where they could go to college because they had a little bit of background. They chose education. Because of that, they got an F1 visa and were no longer being on the payroll, on the pipeline for reunification and all of that. Having the children to choose between that was quite challenging because that meant they couldn't get any of the support that other UAM were getting. So how can we increase resources that focus on these minors? Next slide, please.

This is just their quotes. According to them, someone to show them the way that we've talked about. And you've also mentioned that these are some protective factors that you will put in place for them, more guidance, more English classes. Next slide. You also ask caregivers, you've lived with this UAM, they've been in your care. What have you observed? What do you think they need? What will work for them? Primarily, they all mentioned patients. We need to have patients with them. They're just young people. They're learning. There's a lot happening in their lives at the same time. They're not the typical URM that intentionally came into the country or were planning to join a relative here. They were thrust into this. So patients with them, they need religious activities. They observe that during the festivals like Eid or the Ramadan, most of the UAM in their care were calmer. It had a positive effect on them. So encouraging and promoting that for the UAM would be very helpful. They also mentioned promoting connections. Some UAM talked about being isolated in classes on their own,

maybe because of language or being alone or even in their living arrangements. And that social isolation actually compounds mental health issues for them. So promoting connections, having welcoming communities where we as a whole community, as a whole organization, we promote their connection with other members of the community, other youth their age. Of course, we've mentioned this over and over, halal food. And of course, that sense of belonging and connection, they go together. Next slide. Yes, this is what the caregivers said, exactly the religion, being patient with them. Next slide. And this was really a summary from one of the UAM that said providing that sense of belonging, taking them to places, shopping, whatever you can do, their favorite sports, playing with them, and mostly talking to them and having their parents speak with them and talk to them on a regular basis that these help the children. Next slide. Yes. I'm going to invite Dr. Baha to take country from here. Thank you very much.

ZB: Thank you, Ngozi. We also reached out to service providers as well to achieve some of their responses and recommendations that could help this community. Some of their recommendations are listed on this slide. Their advice revolves around approaching persons served through a lens of cultural humility and to provide culturally informed services, collaborating with community partners on emphasis on a holistic approach, providing mentorship and role models, ideally from the Afghan community and hiring more Afghan staff and also, lastly, involving youth in the conversations. Next slide. And so to elaborate further on what the service providers' recommendations were, here's what some of the service providers specifically stated. I'll focus on a few of them. Building out partnerships because no agency and no one person can do it all on their own. Emphasis on focus on individuality as opposed to a general sense of, well, let's give all these kids the same thing. And lastly, the importance of culturally sensitive and or faith-based approaches for Afghan youth. Next slide.

Case Example: Zaki [continued]

ZB: Okay. Let's go back to Zaki again. The improvements in well-being observed with Zaki lasted for about a month before he began to regress. He began to have issues with compliance with activities, therapy, and treatment. He stopped attending school. Not compliance coincided with his worsening behaviors. He stated to me at that time, indicting, I'm not going to take the medications anymore. I don't need them. I fix my behaviors on my own without the help of the medicine. He was engaging himself in various behaviors. He had cutting and would stay here. He was cutting himself superficially because he was, in quotes, bored, close quotes. And regarding the last bullet point that's on this slide, behaviors, barriers to treatment, and aging out were my assumptions with regards to issues of disposition. These are not shared to me likely due to confidentiality concerns, which I wholeheartedly agree with. But yeah, those are the last bullet point is just my opinions on what I thought were the reasons why they were unable to transfer him to a higher level of care. Next slide.

Discussion Question

What strategies at the caregiver level and the provider level might benefit Zaki?

ZB: So we're now at a Slido. So let's, let me, let me say the question. What is it? Okay. What strategies at the caregiver and provider level might benefit or might not benefit itself? Okay. So I'll go through these answers. So they would benefit from EMDR and working on statements like I am not in, like I am not in control, helping with their internal locus of control, providing mentorship, support in his own language, connections to an adult community, peer consultation and support groups. Perfect. So we can now go on to the next slide.

4. Implications

NA: Thank you very much, Dr. Baha. This next slide would address some implications of this study for policymakers, for practitioners and researchers. Before I hand over to my colleague, Audrey, I'm just going to, this is just a summary of some of the implications that we have seen, or we, we, we pulled up. For instance, for policymakers in terms of migrant policies, funding, capacity building, promoting integration, addressing social

determinants of health. At the service providers level, we're looking at culturally, culturally sensitive service, trauma-informed care, Afghan staff or training, engaging to build a therapeutic alliance and strength-based or empowerment approaches. At the research level, we want to promote community engaged and empowerment methods, culturally validated measures and tools, capacity building of the community themselves, adequate compensation for use of cultural and adequate compensation for use of cultural expertise and ensure that do no harm principles are upheld at all levels. Audrey.

Implications for Policy

AM: Thank you so much, Dr. Anolama. To break down a little bit more of what she mentioned of each of the study implications by area, even a bit further, we're going to provide some, some specifics here. So on the next slide, we're going to focus on policy. So you'll see detailed here, a couple of recommendations based on what we've learned in this study so far. So for our policymakers and advocates, we have a call to update and improve policies to support reunification, resettlement, language, and access to care overall. Promote and build capacity for community participation, integration, and welcoming practices. Next to address and prioritize social determinants, so non-medical factors such as housing, food, education, and employment. Next, we have ensure diverse choices for access or delivery of care. And then lastly, to increase funding and resources for programs, health workers, training, and services.

Implications for Research

AM: As you'll see detailed here on this slide, these are some implications for our researchers in the room. So the first is to increase Dari and Pashto language, mental health screening tools, and interventions for unaccompanied Afghan minors, which is a key goal of this project in particular. Next is to use empowerment or community engaged slash participatory research message methods as Farhad detailed out earlier. Next, we have to apply strategies that recognize vulnerability and past trauma, avoid triggers, and ensure referral for care if needed. So those do no harm methods that my colleagues have mentioned throughout today's session. Next, apply culturally sensitive sensitivity and communication approach and data collection. And then lastly, for our researchers to recognize and build an adequate compensation for cultural expertise.

Implications for Service and Practice

AM: And then lastly, I want to highlight some implications for our service and practice. So for all my service providers in the room, we call on, or we found through this study, it's important to engage in culturally sensitive service. So when possible, using Dari or Pashto language, mental health screening tools, and interventions. We promote advocacy for culturally matched care arrangements and support services, again, when possible. And then next to prioritize funding and training on trauma informed care, empowerment, and strength based approaches. And then lastly, something we've mentioned a few times throughout is to employ Afghan staff and invest in training when possible. All right. And then lastly, I'll hand it off to Dr. Baha, who will conclude our story with Zaki today.

Case Example: Zaki [conclusion]

ZB: All right. So Zaki's regression lasted for about a month before his presentation began to improve again. He was becoming more compliant with treatment and therapy. He began to follow the rules and exhibited improved coping skills and a sense of level-headedness indicating an increased level of maturity, as well as insight. Zaki's wounds were healing from a month ago when he had engaged in cutting himself superficially on both arms. He was less irritable and exhibited improved tolerance to frustration. In one event, Zaki was actually slapped in the face by another peer at this time, and it was reported that Zaki did not retaliate. He was still getting in trouble, typical of a teenage boy his age. However, Zaki was now making statements indicating absorption of self-regulating concepts. He was learning through consistent therapy. On another occasion, Zaki had stated in that he, I'm trying hard not to be confrontational with other people. I know what it was I was doing wrong in the past, and now I understand I was making mistakes that I needed to work on my own. He was also

getting closer to aging out as a minor and would have to depend on more community resources once he was an adult. And so, on our last visit before he was eventually transferred out of this shelter, he had stated to me, and Daddy, I understand that when I react to something in a bad way, nothing good comes out of it. I'm going to keep trying to do my best. For confidentiality reasons, I will not be able to disclose the location or level of care Zaki was transferred to. Now, we can actually go on to the next slide. And we can get on. So, before I hand it back to Audrey, I'd like to read a quote from a current EOM. Actually, is that the Slido or is that the quote next? Okay, yeah, I'll do the Slido first. Sorry about that.

Discussion Question

Based on what you learned today, what additional strategies might you use with Zaki following his transfer of care?

ZB: Based on what you learned today, what additional strategies might you use with Zaki following his transfer of care? And I'll try to get through four or five of the responses of the participants who are typing. So, one person said more support groups, providing a mentor, and connecting with another peer, the importance of a change of scenery, community engagements, provide more resources, getting him connected again with his community, again, mosque connections, post 18 years old planning and goals for education and work, and also opportunities for self-reflection with a mentor on his progress. We can go on to the next slide. Okay, so last slide is, this is a quote from a current EOM caregiver, because at the end of the day, they all act like teenagers. I hear horse playing, joking all the time, you know, doing something they're not supposed to do. So, it is, they're all teenagers. And once you understand it all, they're just like any teenager here. They just probably have a different culture, maybe speak a different language. And, you know, really, that's about it. So, now I'm going to turn it over to Audrey to discuss the project's next steps.

Conclusion

Project Next Steps

AM: Thank you. All right. Thank you so much, Dr. Baha, and thank you, everyone, for joining us today. As I mentioned in the chat, we recognize that we are a little beyond time, and so completely understand if you need to exit. We will certainly follow up via email with today's webinar, as well as some additional resources. And then what you'll see here on this slide is just some project next steps that detail out the strategies, the support strategies that we, myself and the team, have put together and have, is currently published on Switchboard's website regarding some support strategies for the mental health of unaccompanied refugee minors. We have a forthcoming adapted mental health screening tool coming and a forthcoming publication regarding today's information.

Stay Connected

AM: And then you'll see here, if you could, again, take out your mobile devices and scan the QR code or click the link in the chat to access our feedback survey, which is just a couple of questions. It'll take 60 seconds, max, if you could fill that out and let us know your thoughts regarding today's webinar. Again, we so, so appreciate your time, and thank you so much for all that you do. Thank you.

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