Understanding Immigration Trauma and the Potential of Home Visiting Among Immigrant and Refugee Families

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Abstract
This article examines the outcomes of implementing a trauma-informed home visiting program in a refugee/immigrant-serving mental health program in Chicago, Illinois. The mental health program used the Baby TALK home visiting program model, an evidence-based relational approach to supporting pregnant mothers and families with children less than 3 years old. The authors share findings from a randomized controlled trial (RCT) examining the impact of the Baby TALK model on child and maternal outcomes among 200 refugee and immigrant participants. In addition, the authors share the story of a participant to demonstrate the ways in which home visiting programs can support developmental outcomes and mental well-being.

The world erupted in anger and sadness when images circulated of Alan Kurdi's lifeless body washed up on a beach in Turkey. He was 3 years old, a mere child who fled to Turkey after the conflicts in Syria escalated. It was in the early hours of September 2, 2015, when Alan and his family boarded an inflatable boat wearing what ended up being fake life jackets with 16 other people, even though the boat was designed to carry only 8 people. The boat capsized within just 5 minutes into the trip from Bodrum, Turkey, to the Greek island of Kos 30 minutes away. Alan, his brother, and mother died that day, in addition to several others who were on the ill-fated trip. While these refugees were not the first to travel to countries that could only serve as a temporary safe haven, Alan dying at such a tender age brought global awareness to the plight of forcibly displaced communities and the lengths people will go to if hope exists to rebuild their lives with dignity and safety abroad. Since that fateful day, individuals, families, and entire communities have taken the same risk that Alan's family took, despite the perils of traveling by sea or land.

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Impact of Immigration Trauma on Families With Young Children

The reasons that people flee their home countries are as diverse as the nationalities represented in these statistics. Failing economies, oppressive regimes, civil unrest, and even

climate change have contributed to the increased movement of people worldwide. For many, there is no choice but to move in order to survive. Those able to travel as a family experience a particular stress in their journey to safety. Refugees and immigrants face many challenges and are exposed to violent and traumatic events in their home countries that already greatly impact their mental and physical health (Hart, 2009; McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013).

There is an entire generation of displaced children and youth growing up in unpredictable and often dangerous circumstances that directly influence their physical and psychological development. They exist in environments with limited access to adequate health care, early childhood programming, and general resources that ensure these children are able to meet their developmental agendas. In addition, researchers have a clearer understanding that early exposure to trauma or untreated trauma in the early childhood years can have long-lasting effects on their physical, social, and emotional development due to the impact on brain function and development over the lifespan; this knowledge is well documented in the Adverse Childhood Experiences studies (Anda, 2006; Anda et al., 2006; Hart, 2009; Niaz, 2015).

Young children struggle when social–emotional development and competence (also referred to as infant-early childhood mental health [IECMH]) is underdeveloped. Consequently, their families struggle without appropriate services to support IECMH. Preschool expulsion rates have increased among young children due to behavioral issues, with risks to long-term academic achievement (Gilliam, 2005; Hoover, Kubicek, Rosenberg, Zundel, & Rosenberg, 2012). Children's social–emotional deficits may be expressed through challenging behavior that makes it difficult for them to navigate other environments such as school (Hughes, Spence, & Ostrosky, 2014). The challenges of supporting IECMH can be exponentially difficult for the parent who struggles with postpartum depression and anxiety (Coates, Schaefer, & Alexander, 2004), those with intellectual disabilities (Monsen, Sanders, Yu, Radosevich & Geppert, 2011), and those impacted by trauma (Gomby, 2005). In each circumstance, parents need to be supported in order to support themselves and the mental health of their children.

Researchers' growing understanding of the impact of immigration trauma on not just the child or her parents but the family as a whole makes it all the more concerning. Trauma has a dangerous ability to freeze the parent–child relationship and compromise parent availability, negatively impacting adult mental health and IECMH. While many who resettle in the United States are hopeful for new opportunities, there are many challenges that they face including adverse effects on trauma-exposed children who may experience emotional and behavioral difficulties in school and within their families (Goldfinch, 2009; Marans, 2013; Montgomery, 2011; Niaz, 2015). It is not only the experience from their home countries that impacts children and their families, but also the changes and having to adapt to a different environment (Hart, 2009; McMullen et al., 2013; Montgomery, 2011). Parents might try to hide what is going on from children with the goal of protecting them, yet this same secrecy limits the opportunities children have to talk about what they are feeling and ask about what is happening (Hart, 2009). In addition, the parents' own traumatic experiences (and the resultant mental and physical implications) may also affect the child; in some cases, parents may become inadequately attentive to the needs of their children (Montgomery, 2011; Van Ee, Kleber, & Mooren, 2012).

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There is an entire generation of displaced children and youth growing up in unpredictable and often dangerous circumstances that directly influence their physical and psychological development.

The reality is that "most potential mental health problems will not become mental health problems if we respond to them early" (Center on the Developing Child, 2015). As such, there has been a call for an increase in cross-disciplinary training and cross-discipline collaboration around IECMH (Division for Early Childhood, 2014). There has also been an increased interest in mental health consultation (Carlson, Mackrain, Van Egeren, Brophy-Herb, & Kirk, 2012; Kauffman, Perry, Hepburn, & Hunter, 2013; Meyers, 2007). Also, there have been more policy discussions, research, and federal/state funding directed at early intervention services, such as home visiting (Gomby, 2005; Oh & Bayer, 2015; Sharps, Campbell, Baty, Walker & Bair-Merritt, 2008), given the successful outcomes for both parent and child with such interventions. Oh and Bayer (2015) suggested that when professional support is available, parent help-seeking behaviors and their ability to recognize the young child's mental health needs increase, a very promising finding.

Supporting mental health and developmental outcomes are not completely separate agendas. For trauma-exposed refugee and immigrant families, the two are parallel. While there are many families considered as vulnerable or at-risk for poor child and parent/family outcomes, recent events have highlighted the unique needs of refugees and immigrants who need simultaneous attention to both development and health needs. This intergenerational impact of immigration trauma on families has potentially lifelong health, mental health, and adjustment implications. Consequently, there is a great need

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Parents receiving Baby TALK home visiting were experiencing less parental stress, and in the area of trauma symptoms, the treatment group was coping better as a result of the intervention.

for culturally sensitive interventions that are both accessible to new arrivals who may not be familiar with resources in the U.S. and the critical information that early prevention services can provide to ethnically and linguistically diverse refugee and immigrant families. To that end, we want to share impact stories from a mental health program that integrated one critical early prevention service—trauma-informed home visiting—to support pregnant mothers and families with children under 3 years old with refugee and immigrant status. The lessons learned have been increasingly gaining local and national attention and evidence as a promising intervention to support trauma-experienced immigrant and refugee populations.

RefugeeOne, the Wellness Program, and Supporting Mental Well-Being

RefugeeOne is the largest refugee resettlement agency in Chicago. Every year, the agency serves more than 2,500 refugees and immigrants of all ages, ethnic groups, faiths, and backgrounds. Its primary focus is to assist these resilient individuals in becoming an independent, self-supporting member of their new community by providing a wide variety of supportive services. The majority of service recipients are those individuals who fall under the definition of refugees by the United Nations High Commission for Refugees. Specifically, its definition of refugees are persons owing to a well-founded fear of persecution who must leave their home country and seek refugee outside of their country's border.

Since 1982, RefugeeOne has welcomed more than 17,500 refugees and supported refugees from the moment they land at O'Hare International Airport—welcoming them to Chicago and providing furnished apartments, English classes, job search support, mental health care, youth programming, and mentors to help them adjust to life in the U.S. Asylum-seekers and other immigrants groups can also find supports within the agency, as services under RefugeeOne have extended their reach in the current sociopolitical climate. As stated in the agency mission statement: *RefugeeOne creates opportunity for refugees fleeing war, terror, and persecution to build new lives of safety, dignity, and self-reliance.* The organization's full range of coordinated services equip newly arrived refugees with the support and skills necessary to rebuild their lives including: Resettlement Services (includes housing and accessing public benefits support), English Language Training Programs, Workforce Development, Youth Program, Immigration Assistance, Women's Programs, and mental health services through the Wellness Program. It is this final program—the RefugeeOne Wellness Program—that will be the focus of this article as it houses all mental health services from birth through adulthood, including the newest addition of trauma-informed home visiting services.

In June 2011, RefugeeOne established the Wellness Program in order to address the mental health needs of RefugeeOne clients under the direction of Dr. Aimee Hilado (author). The organization recognized the challenging circumstances refugees have endured prior to arriving in the U. S. and the limited community mental health programs with either sufficient language capacity or a deep understanding of the refugee experience. As a result, the Wellness Program was designed as a research-informed, evidence-based program that provides a range of services from prevention, to early intervention, and intensive treatment services to support clients with mental health needs. The program understands the ways in which experiences of fear, trauma, and loss can impact clients' ability to live full and productive lives. Many clients were enrolled in services due to symptoms of depression, post-traumatic stress disorder, adjustment disorders, and sometimes symptoms of severe mental illnesses. In response, the purpose of the Wellness Program is to identify any present mental health needs, implement the appropriate behavioral support services, and provide on-going resources to support overall health and mental well-being.

Early Prevention Services

As the program continued to flourish, Wellness Program administrators saw great need among pregnant mothers and families with children under 3 years old who were not directly benefiting from other clinical services offered in the program. The program encountered pregnant mothers who were still learning the U.S. health care system and had not received prenatal services; some were without prenatal care for the first 6–7 months of their pregnancy. There were also expectant mothers who witnessed a great deal of trauma prior to arriving in Chicago and already had symptoms of post-traumatic stress disorder. In addition, the program encountered families with very young children who had little knowledge of early child development; these families' infants and toddlers were also difficult to soothe and unpredictable, with the related stress and frustrations parents felt as a result.

Often times, these groups were not readily able to come to the agency or after-school programs due to the challenges

of having multiple responsibilities including young children in the home, navigating public transportation, and other circumstance that kept this specific group—pregnant mothers and caregivers with very young children—away from much-needed clinical services. The program had already seen the two-generational impact of trauma on families and sought innovative ways of delivering supportive services, education, and related mental health services to this group, in order to ensure needs presented in early life would not progress and become the issues staff members were seeing among the child and youth clients (4 years and older) being served.

The Illinois State Board of Education (ISBE) awarded a Prevention Initiative grant to the Wellness Program in November 2016 to provide supportive, intensive home visits to pregnant mothers and families with children from birth to 3 years old—this grant was a direct response to the staff's concerns regarding the mental health needs seen in the field. Strong mental health is vital across all ages and in partnership with ISBE, the Wellness Program could now support the mental health needs of the youngest citizens through intensive home visiting using the Baby TALK (Teaching Activities for Learning and Knowledge) model. Through this program, trained home visitors use the Baby TALK early childhood intervention curriculum to support expectant and new refugee mothers while supporting families in their adjustment to life in Chicago. Education around the importance of early development is shared, but there is also a strong bond formed between home visitor and parent–child dyad (and family) in which case management and emotional support is given to aid in the family's adjustment. This mode of engagement, while not direct therapy, afforded a therapeutic element that was culturally aligned to the clients served and yielded some of the benefits that would be seen in typical Western-based talk therapy.

In the short period of operation, the program provided home visiting services to more than 150 refugee and immigrants families from seven different countries and speaking 10 different languages. Several home visitors are bi-cultural and represent the cultures of the participants while others work in tandem with interpreters to deliver the same services. Anecdotally, participants reported feeling supported and were able to access more intensive clinical referrals for both adults and other children in the home through their home visitor, increasing direct access to additional supportive services and overall promoting healthy families. It is the findings from the RefugeeOne Wellness Program's home visiting program that are at the core of this piece; certainly, as a result of the intervention, there was a significant impact on both adult and early childhood mental health and development dimensions.

The Baby TALK Home Visiting Model

Home visiting programs have gained attention as a positive force in supporting IECMH and buffering against the negative impact of trauma, and this type of program has a long history in the field. Documentation of home visiting programs can be found as early as the 1880s (Charity Organization Society of the City of New York, 1883) and it continues to play a key role in early childhood intervention systems today (Duggan et al., 2013). Within home visiting, greater focus has been placed on relational approaches to engaging families, particularly culturally diverse families in the field (Astuto & Allen, 2009; Birth and Beyond, 2007; Brookes, Summer, Thornburg, Ispa, & Lane, 2006).

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It is the relationship developed between Baby TALK-trained home visitors and their families, and their unique understanding of trauma and mental health terminology, that serves as the vehicle for change.

The Baby TALK model has placed the parent–child and family–home visitor relationship at the center of its home visiting approach and has developed its reputation of effectiveness when used with families with high-risk qualities. Established in 1986, the Baby TALK model has been recognized as a promising practice in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices and approved as an evidence-based model for use in ISBE-funded programs serving birth to 3 families and pregnant mothers across Illinois. Furthermore, Baby TALK has professionals represented in 32 states and Canada. More recently, the home visiting protocol of the Baby TALK model has been successfully employed with refugee families and families of mixed and undocumented status. It was this model that was implemented in the RefugeeOne Wellness Program to guide home visiting services.

The mission of Baby TALK is to positively impact child development and nurture healthy parent–child relationships during the critical early years. Baby TALK carries out this mission through less intensive group services for families with fewer risk factors, plus through more intensive home visiting and case management for families whose needs are greater. Since it was established, the training faculty at Baby TALK has provided early childhood professionals from across the country with training, consultation, curriculum, and parent materials on its unique approach to working with high-risk families.

"Like many states, Illinois has placed a great deal of emphasis on using research-based intervention models to target

high-risk children who are at greater risk for developmental delays, mental health needs, and/or school failure" (Hilado, Leow, & Hornstein, 2012, p. 4). In Illinois, the Baby TALK model has been used extensively in birth-to-3 programs overseen by the Illinois State Board of Education, Early Head Start, and the Chicago Public Schools, and Chicago Department of Family Support Services because of its evidence-based approach to serving young children up to 3 years old. The priorities of these government-approved entities are in line with federal- and state-level priorities as each focuses on the health and well-being of the youngest members of society and their families.

The home visiting protocol includes extensive early childhood materials, and Baby TALK trained professionals who complete the 4-day core training are eligible for implementing the engagement strategies and materials in their respective early childhood programs. In addition, the methods of engagement in Baby TALK's home visiting program model embody the critical concepts of engaging families through a relational process; this process affirms parent competence and allows the parent to help guide and develop the quality of the parent–child relationships. Moreover, the Baby TALK home visiting approach emphasizes the critical nature of building a "trustworthy system of support" through linkages to services and resources that help parents help themselves by fully integrating families into their community.

The mission of Baby TALK is to positively impact child development and nurture healthy parent–child relationships during the critical early years.

Accordingly, the Baby TALK home visiting model is ideal in its approach to engaging trauma-exposed families—particularly those of refugee or immigrant status—because its core design emphasizes a relational approach since the model's beginnings. The core concepts and framework of the model emphasize the importance of meeting families where they are, using effective communication strategies that honor culture, promote parent confidence and self-efficacy, and ensuring families are engaged from a place of respect and curiosity. When considering the importance of aiding at-risk families with young children, early identification and the delivery of home visiting services can be incredibly valuable. For culturally diverse, trauma-experienced refugee and immigrant families, home visiting approaches that use a relational approach truly matter because this method influences the ongoing level of engagement and, ultimately, to what extent the gains of home visiting can be realized for the family.

The Impact of Home Visiting on Refugee and Immigrant Families

There is shared agreement on the need for interventions to help immigrants and refugees who are in psychological distress and have been affected by war (Willimson, Knox, Guerra, & Williams, 2014) but there is limited research on home visiting for this group. What is available is ancillary, showing that home visiting is effective and can greatly support families to progress in parenting skills, family functioning, and child's readiness for preschool (Knox, 1996; Willimson et al., 2014). In addition, home visiting was shown to improve connections with the community and resources available to them, the positive impact on parent-child interaction, home safety, and the reduction of social isolation (Knox, 1996), all critical factors relevant to the effort of supporting new refugees and immigrants who are adjusting to life in a new country.

The RefugeeOne Wellness Program and its integration of the Baby TALK home visiting model was innovative as it embedded home visiting (a nonclinical, early prevention service) in a mental health/clinical program that was nested within a refugee resettlement program. RefugeeOne could identify at-risk refugee families immediately upon arrival in the U. S., given the embedded setting. As a well-known immigrant-serving institution, it was also a convenient hub for immigrants across statuses to access services. Furthermore, the provision of culturally and linguistically sensitive mental health services provided at no cost to clients means it could grow as an asset within the community; at the same time, the added focus on the birth to 3 period was a great opportunity to understand the impact of early prevention services on future child and family outcomes.

Contributing to the Home Visiting Research

We knew that it was important to study home visiting within this setting because it hadn't been done before. The researchers charged with this project sought to address the gap in knowledge while exploring the experiences of refugee and immigrant families receiving Baby TALK home visiting services. To that end, a randomized controlled trial (RCT) was completed with a sample of 200 parents—refugee and immigrants of undocumented status—with children between ages 3 and 36 months old recruited from the RefugeeOne Wellness Program in Chicago, Illinois. From this sample, 101 parents were randomly assigned to the treatment group and received Baby TALK home visiting services (intervention), and 99 parents were randomly assigned to the control group and did not receive home visiting services.

In the study, all home visits were completed in the participant's home. Treatment families received the standard dosage of services outlined in the program model (i.e., 60-minute sessions twice a month for 12 months) and the visits involved both parent and child simultaneously. Those in the control condition received no home visits for the study duration, but did receive one visit every 3 months with the delivery of one package of diapers to help ensure that participants remained in the study. The impact was studied after 12 months from baseline data collection and is being discussed in publications and conferences nationally.

Research Questions

The RCT was designed specifically to understand the impact of the Baby TALK home visiting program model between randomly assigned treatment and control groups on the following outcomes that were relevant across child, parent, and family dimensions:

- Child's social–emotional development (as measured by Ages and Stages Questionnaire, Social Emotional, ASQ: SE2; Squires, Bricker, & Twombly, 2019)
- Child's language development (as measured by Preschool Language Scales, PLS-5; Zimmerman, Steiner, & Pond, 2019)
- Parental Stress Level (as measured by Parenting Stress Index, Fourth Edition, Short Form, PSI-4-SF; Abidin, 2019)
- Parental Trauma Symptoms (as measured by Refugee Health Screener-15, RHS-15; Pathways to Wellness, 2011)
- Economic Self-Sufficiency (as measured by levels of employment on a study-developed questionnaire)
- Referral Coordination (as measured by study-developed questionnaire)
- Positive parenting strategies (as measured by Baby TALK home visiting Personal Encounter Documentation Form) within the treatment group between baseline and 12 months after baseline

Sample Characteristics

Participants were purposefully recruited across ten different ethnic groups and across four different global regions designated by the U.S. Department of State, Bureau of Population, Refugees, and Migration (PRM). Participants were represented from the following PRM regions and their respective countries (in parentheses) included: Africa (Democratic Republic of Congo), East Asia (Burma, including Rohingya Burmese), Latin America/Caribbean (Columbia, Cuba, Ecuador, and Mexico), and Near East/South Asia (Iran, Iraq, and Syria). These ethnic groups were targeted to reflect the diversity of the refugees as well as immigrants with undocumented status who were accessing services at RefugeeOne.

In addition, the study involved a universal screening of parents of diverse demographics, which included a particular search for families with risk factors, paralleling studies conducted by Maternal, Infant, and Early Childhood Home Visiting/Mother and Infant Home Visiting Program Evaluation and the risk qualities that include: low-income, young mother, single parent, low social support, parent with physical or mental health needs, history of domestic violence, history of substance abuse, child with special need/disability, adult with disability, refugee or undocumented immigrant status (i.e., the primary risk factor in this study).

Upon receiving informed consent, the baseline instruments were administered and then those participants were given their randomized assignments described fully in the next section. The randomization was conducted separately for different ethnic groups (by PRM region) to ensure the balance of the participants within each group. All the participants had the same chance of being assigned to the treatment or the control group.

Baseline and Analytic Summary: Participant Characteristics

Table 1 shows the racial composition of the sample at baseline during recruitment while Tables 2 and 3 summarize the characteristics of the full sample (N = 200) as well as the final sample (N = 167) used in the analysis. As shown in the tables, none of the outcome measures were significantly different between the treatment group and the control group, for neither the full sample nor the final analytic sample at baseline. Attrition was only 16.5%, which is within the acceptable range; consequently, we are presenting the analytic sample from here onward.

All participants were mothers, except for one grandmother who served as the primary caretaker in the family in the control group. Overall, the participants were predominantly low-income families with more than 90% receiving some form of public benefits (e.g., food stamps, Medicaid, refugee cash assistance). Of participants, 64% had less than a high school degree, and roughly 88% of the sample were English language learners. Moreover, the average length of time displaced from their countries of origin was 9 years before resettlement in the United States. For many, years displaced were upwards of 15+ years, reflecting protracted periods of uncertainty and exposure to trauma that could impact developmental outcomes and mental well-being among the families adjusting to life in a new country.

Lessons Learned: The RCT Findings

When comparing control and treatment groups at 12 months after baseline data collection, we learned of the following outcomes tied to the Baby TALK home visiting program model (hereafter Baby TALK). Because baseline equivalence was

Table 1. Racial/Ethnic Composition of the Sample at Baseline

Region	Treatment Group (n = 101)	Control Group (n = 99)
Africa (Democratic Republic of Congo)	15	13
East Asia (Burma)	55	56
Near East/South Asia (Iraq, Iran, Syria)	24	23
Latin America/Caribbean Islands (Columbia, Cuba, Ecuador, Mexico)	7	7

Table 2. Participant Characteristics by Assignment: Baseline

Characteristic	Treatment Group (*n* = 101)	Control Group (*n* = 99)
	Number of families (%)	Number of families (%)
Immigration status: Refugee	94.0	92.9
Immigration status: Immigrant	6.9	7.0
Public benefit recipients	95.0	92.9
Maternal education levels (high school/ GED or higher)	34.7	31.3
English language learners	88.1	86.9
Marital status (married vs. other)	91.1	86.9
Female child	41.6	52.5
	Average	Average
Parental age	29.9	30.3
Family size	4.8	4.7
Years displaced	9.3	9.0

Note: No significant differences were found in any of the characteristics between the full treatment sample and the full control sample at baseline.

Table 3. Participant Characteristics by Assignment: Analytical Sample

Characteristic	Treatment Group (*n* = 86)	Control Group (*n* = 81)
	Number of families (%)	Number of families (%)
Immigration status: Refugee	94.0	92.9
Immigration status: Immigrant	6.9	7.0
Public benefit recipients	96.4	96.3
Maternal education levels (high school/ GED or higher)	34.7	31.3
English language learners	88.1	86.9
Marital status (married vs. other)	91.1	86.9
Female child	41.6	52.5
	Average	Average
Parental age	29.9	30.3
Family size	4.8	4.7
Years displaced	9.3	9.0

Note: No significant differences were found in any of the characteristics between the final treatment analytic sample and the final control analytic sample at 12-month.

established between the treatment group and the control group, standardized differences between the two groups were determined, and these effect sizes show the magnitude of the impact of Baby TALK.

Overall, there were significant findings in child outcomes, which is one of the main domains that Baby TALK targets for intervention (Hilado, Leow, & Yang, 2018). In particular, there was a significant effect size for language development, while there was a significant gain in socio-emotional development. In addition, all the other effect sizes in the maternal health, referral, and economic self-sufficiency domains were in the desired direction. Overall, parents receiving Baby TALK home visiting were experiencing less parental stress. Also, in the area of trauma symptoms, the treatment group was coping better as a result of the intervention after we consider their baseline in trauma stress. This finding is worth noting given this is one of the few home visiting studies to specifically examine trauma symptoms among refugee and immigrant populations.

Parents receiving home visiting were also more proactive in seeking community resources than those without the service; they were also more likely to be employed. Preliminary evidence also showed a significant improvement in positive parenting practices for the treatment group. In instances when there was a lack of significance in the effect size estimation, possibly due to the relatively small sample size for this study, a within-group analysis was conducted allowing us to detect difference more readily than a direct treatment-and-control comparison (Hilado et al., 2018).

Moreover, it is the relationship developed between Baby TALK-trained home visitors and their families—namely, the home visitors' unique understanding of trauma and mental health terminology—that serves as the vehicle for change in their work with families. This is the hallmark quality of the Baby TALK model. A qualitative sub-study involving interviews with 21 mothers from five countries (Burma, Democratic Republic of Congo, Iraq, Mexico, and Syria) who participated in the RCT helped us understand why the relationship was critical. We learned that emotional support was critical for parents and children with high needs and that positive parenting skills and parent goals could be realized through the engagement (Hilado, 2018). Moreover, strong home visiting–parent relationships led to strong parent–child relationships, and even families with low levels of need experienced universal gains in meeting child and parent goals (Hilado, 2018).

Lessons Learned: Stories From the Field

Beyond the numbers, we saw the importance and benefits of the home visitor–family relationship and the direct impact across refugee and immigrant families receiving Baby TALK home visiting services. One story in particular stands out. Manar is a Baby TALK home visitor in the RefugeeOne Wellness Program who was herself a former refugee from Iraq and had lived in the U.S. for 10 years prior to joining our team. Fluent in Arabic, Assyrian, and English, Manar was assigned to work with our Iraqi and Syrian refugee families. One Syrian refugee family in particular had a 27-month old son whose parents were

concerned because he had little appetite and continued to rely on only formula for nutrients. His mom reported her concerns weekly about his eating habits and lack of self-help skills for a child his age. Mom further reported her child's consistent bad mood and that he was agitated easily—issues believed to be tied to his feeding problems—but this mother felt at a loss because her son's pediatrician repeatedly stated that he would eventually eat and that he was "doing fine."

Manar supported this family by helping them find referrals, practicing ways of articulating the son's needs, and learning more about typical development milestones and skills for this age. Manar connected with the Illinois Child and Family Connections hotline and was able to secure an in-home assessment. The family simultaneously felt empowered by the collaboration to understand the true needs of the son and they found another pediatrician who was willing to listen and work with them around their concerns. With bloodwork, the family learned that their son was both anemic and had vitamin deficiencies. The child assessment also confirmed that the son needed and was eligible for feeding support and would begin receiving weekly support to get him back on track.

The relationship that developed allowed the family, especially the mother, to feel heard and empowered to help their son in concrete ways. "Coming Alongside" is a key critical concept of the Baby TALK model in which the home visitor joins the parent in their role of parenting. Rather than pushing or pulling parents in any one direction, Manar was a thoughtful and intentional observer with the mom while reflecting back the mom's concerns for her son, providing information, and providing empowering support to seek solutions that are identified by the family. With the support of the home visitor, this family had the courage to get a second opinion and found another doctor who did confirm a need, thereby supporting the family in getting appropriate services. In the process, the family became closer and gained confidence in navigating community resources. This movement supported the child as well as the family's ongoing adjustment to life in a new country. As Manar continued her visits, the son was getting services, his mom's stress levels went down, and the family was thriving.

Conclusion

The staff at RefugeeOne have a responsibility to ensure our leaders do not ignore the unprecedented needs of forcibly displaced persons worldwide while ensuring trauma-experienced refugees and immigrants have access to programs that promote health and well-being. Thoughtful, multidisciplinary efforts within the early childhood field are needed to adequately address the broad and varying impact of immigration trauma and the complex ties to addressing mental health within culturally diverse populations. As reflected in this article, there is no one way to address the adverse effects of immigration trauma in families, particularly trauma that impacts ethnically diverse families who may not understand or recognize the importance of mental health for adults and especially the importance of IECMH. There is also recognition around the lack of understanding when seeking to access mental health services among immigrant and refugee populations who may avoid services because of the stigma or who simply are not aware these services exist. The current sociopolitical climate creates further barriers to seeking services, as there are real fears and consequences of identification in the community.

This article offers one viable response to address these challenges among immigrant and refugee families with very young children. The solution is to equip frontline providers such as home visitors with mental health knowledge and deliver developmental, trauma-informed, and culturally sensitive services in the home. Home visiting programs, especially those grounded in relational approaches to serving families that focus on the two-generation (parent–child dyad) approach to services, offer concrete strategies to overcome barriers to service access. At the same time, home visiting promotes child developmental outcomes, encourages parent mastery in their role of raising their children, and supports families in navigating social supports in the community. Home visiting also provides a pathway to talking about immigration trauma, mental health, and its importance for lifelong health and well-being. Lastly, the service promotes adjustment through information-sharing and connections to the community that are critical for immigrants and refugees in a new country. Such holistic efforts build stronger families and communities, equipping these populations with the resources to succeed and thrive rather than simply survive.

Our work documents an opportunity to support the positive trajectory of immigrant and refugee families when trauma-informed home visiting services are provided. While more research is needed within this population, the findings of the Baby TALK model and its use in community-based, immigrant/refugee-serving mental health programs is a contribution illustrating what can be done—and how to effectively promote—child development and early childhood and adult mental health among trauma-exposed populations.

Aimee Hilado, PhD, LCSW, is a ZERO TO THREE Fellow, an academic, researcher, and clinician specializing in immigration trauma and refugee/immigrant mental health. She is an associate professor of social work at Northeastern Illinois University. Dr. Hilado is also the founding manager of the RefugeeOne Wellness Program, a mental health program established in 2011 for refugees, asylum seekers, and immigrants in one of the largest resettlement agencies in Illinois. It is the first mental health program in the state that has integrated a home visiting program for trauma-exposed pregnant mothers and families with children under 3 years old of refugee/immigrant status. In addition, Dr. Hilado continues to present nationally and publish in the areas of mental health, home visiting, and culturally sensitive clinical practice and continues to play key roles in community organizing and advocacy, cofounding the Illinois Refugee Mental Health Task

Force; serving as co-chair of the Illinois Childhood Trauma Coalition, Refugee and Immigrant Policy Workgroup; and training Mental Health First Responders as part of the citywide Chicago Is With You Task Force. Dr. Hilado completed her doctorate in social work, with distinction, at Loyola University Chicago and a dual-degree master's program in social work and applied child development at Loyola University Chicago and Erikson Institute, respectively.

Christine Leow, PhD, has extensive experience in evaluation, research design, and quantitative statistical methods. In addition to supporting research efforts at Baby TALK Inc., she is a principal research scientist and technical advisor at Pearson Research and Efficacy where she establishes research standards that position Pearson as the leader within the education technology industry in conducting efficacy research and spearheading the company's data privacy, security, and ethics practices related to platform data. Her past affiliations include American Institutes for Research in Washington, DC, and the Herr Research Center at Erikson Institute, where she held lead roles in project evaluation and design. Dr. Leow received her bachelor's degree in psychology and statistics from the National University of Singapore and her doctorate in policy research, evaluation, and measurement from the Graduate School of Education at the University of Pennsylvania. Her research interests focus on addressing selection bias and using rigorous evidence-based research to inform policy.

Yinmei Yang, MA, has a background in data management, statistical analysis, and quantitative research. She received a bachelor's degree in economics and a master's degree in applied statistics at West Chester University of Pennsylvania. Yang has broad research and data analysis experience in a number of areas, including marketing, pharmaceuticals, and education.

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