Addressing Trauma in Young Children in Immigrant and Refugee Families through Early Childhood Programs

Webinar

April 3, 2019
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Presenters

Maki Park, Senior Policy Analyst, Migration Policy Institute

Caitlin Katsiaficas, Associate Policy Analyst, Migration Policy Institute

Jessica Dym Bartlett, Co-Director, Early Childhood Research, Child Trends

Aimee Hilado, Wellness Program Senior Manager, RefugeeOne
Primary Areas of Work:

• Education and Training:
  - Early Childhood
  - K-16
  - Adult Education and Workforce Development

• Language Access and Other Benefits

• Governance of Integration Policy

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Today’s Release

Mitigating the Effects of Trauma among Young Children of Immigrants and Refugees: The Role of Early Childhood Programs

By Maki Park and Caitlin Katsiaficas

This issue brief explores the types of trauma that may affect young children in immigrant families, what the effects of those experiences may be, and what can be done to protect children against them. Among these opportunities: promoting the systematic use of mental health screening tools that are appropriate both for young children and for use across cultures, and boosting collaboration between early childhood education and care (ECEC) providers, health services, and organizations that work with immigrants to ensure that young children and their families are referred to needed services in a timely fashion.
Children of immigrants comprise 1 in 4 of all young children ages 0-5 in the United States

- Accounted for all net growth since 1990
- Majority of immigrant-origin children are U.S. citizens
- 27% live in households experiencing poverty
- More likely than peers to lack health insurance
- Less likely to be enrolled in pre-K
- Linguistically diverse families
643,000 refugees have resettled in the United States since FY 2009.

Their experiences may include:

• Violence or persecution
• Loss of or separation from family members
• Refugee camps or displaced in cities

➢ The federal government has decreased the number of refugees resettled and expanded security checks.
➢ USCIS recently announced plans to close international immigration offices.

Source: Refugee Processing Center
Asylum seekers submitted nearly 332,000 applications in 2017.

Their experiences may include:

• Dangerous journeys
• Months or years of waiting for an application decision

➢ Federal policies have aimed at narrowing grounds for asylum claims and decreasing the number of border crossings.

Source: UNHCR
There were 4.1 million U.S.-citizen children (under age 18) with unauthorized immigrant parents in 2009-13.

Their experiences may include:

- Psychological distress and economic instability
- Limited eligibility for and lower likelihood of accessing services

➢ Immigration enforcement has expanded under the Trump administration.

Source: MPI
The Role of Post-Migration Stressors

• More generally, settlement-related stressors are also important to consider when thinking about families’ migration experiences, including:
  – Adjusting to a new culture
  – Language barriers
  – Discrimination and racism

• The current situation in which families are living also plays an important role in their mental health and wellbeing.
Gaps in Services for Young Children of Immigrants

• **Under-identification:** ACE surveys, for example, may not capture many of the experiences that are likely to affect immigrant families

• **Gaps in services:**
  – ECEC capacity and under-participation
  – Lack of linguistic and cultural competence across services
  – Disparate access to mental health services
  – Refugee resettlement services are focused primarily on adults and school-aged children
Opportunities to Improve Services

• Integrating trauma-informed strategies into ECEC programs
  – Access to Infant and Early Childhood Mental Health Consultations (IECMHC)

• Leveraging home visiting programs

• Encouraging collaboration between ECEC providers, immigrant & refugee service providers (e.g. refugee resettlement agencies), and physical and mental health systems

• Promoting systematic use of standardized mental health screening instruments appropriate for use with young children and across cultures
Jessica Dym Bartlett conducts applied research with infants, young children, their parents, and the prevention and intervention programs with which they interact. Specifically, her interest is in the mental health, wellbeing, and care of young children who experience or who are at risk for experiencing trauma and adversity, with a focus on identifying individual, family, and contextual factors that contribute to resilience and the prevention of poor life outcomes.

Dr. Bartlett oversees Child Trends’ Massachusetts office and is Co-Director of the Early Childhood program area. She has strong expertise in a range of research and evaluation methodologies. Her current work includes serving as principal investigator on a 15-state longitudinal randomized controlled trial (RCT) study of resilience to child abuse and neglect in Early Head Start, as well as an RCT examining the effects of the Newborn Behavioral Observations on parent-child relationships and parental mental health at Brigham and Women’s Hospital, Harvard Medical School.

Dr. Bartlett is the lead evaluator for the Child Trauma Training Center at the University of Massachusetts Medical School and serves as the co-chair of the Substance Abuse and Mental Health Services Administration’s National Child Traumatic Stress Network Evaluation Community of Practice. She also provides evaluation technical assistance and consulting to policymakers, programs, and federal grantees. Dr. Bartlett worked for more than a decade as a child and family psychotherapist, infant and early childhood mental health consultant, Early Intervention educator, and adoption placement worker for abused and neglected children. She completed her BA, master’s, and PhD in child study and human development at Tufts University, as well as a master’s degree in social work from Simmons School of Social Work.
How Early Childhood Programs Can Address Trauma in Young Children from Immigrant and Refugee Families

Jessica Dym Bartlett, MSW, PhD
Co-Director, Early Childhood Research
Objectives

1. Describe early childhood trauma and its prevalence

2. Discuss the impact of early childhood trauma among immigrant and refugee families

3. Offer information on and examples of how to meet the needs of young, traumatized immigrant and refugees children using trauma-informed care
1. EARLY CHILDHOOD TRAUMA
When a young child experiences an event that causes actual harm or poses a serious threat to the child’s emotional and physical well-being

- Different from regular life stressors, because it causes a sense of intense fear, terror, and helplessness beyond the normal range of typical childhood experiences

(National Child Traumatic Stress Network, nctsn.org)
Prevalence of Early Childhood Trauma

Affects almost half of U.S. children (35 million)

Disproportionately affects young children

(National Survey of Children’s Health (2011/12); APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008)
Common Types of Traumatic Experiences in Early Childhood

- Abuse and neglect
- Serious, untreated parent mental illness or substance abuse
- Witnessing domestic violence
- Parental incarceration
- Serious injuries or painful medical procedures
Additional Types of Trauma Among Young Immigrants and Refugees

- War and community violence
- Displacement from home and community
- Flight and migration
- Death of loved ones
- Extreme poverty
- Sexual assault
- Separation from family
- Living in refugee or detention camps

2. IMPACT OF EARLY CHILDHOOD TRAUMA
Myths About Early Childhood Trauma

Myth #1
- Young children do not remember traumatic events

Myth #2
- The younger the child, the less impact trauma has

Myth #3
- Children are resilient and always “bounce back” from trauma
Impact on Young Children’s Development

Impact of Childhood Trauma

Cognition
- Impaired readiness to learn
- Difficulty problem-solving
- Language delays
- Problems with concentration
- Poor academic achievement

Brain development
- Smaller brain size
- Less efficient processing
- Impaired stress response
- Changes in gene expression

Physical health
- Sleep disorders
- Eating disorders
- Poor immune system functioning
- Cardiovascular disease
- Shorter life span

Emotions
- Difficulty controlling emotions
- Trouble recognizing emotions
- Limited coping skills
- Increased sensitivity to stress
- Shame and guilt
- Excessive worry, hopelessness
- Feelings of helplessness/lack of self-efficacy

Behavior
- Poor self-regulation
- Social withdrawal
- Aggression
- Poor impulse control
- Risk-taking/illegal activity
- Sexual acting out
- Adolescent pregnancy
- Drug and alcohol misuse

Mental health
- Depression
- Anxiety
- Negative self-image/low self-esteem
- Posttraumatic Stress Disorder (PTSD)
- Suicidality

Relationships
- Attachment problems/disorders
- Poor understanding of social interactions
- Difficulty forming relationships with peers
- Problems in romantic relationships
- Intergenerational cycles of abuse and neglect
## Signs and Symptoms of Early Childhood Trauma

<table>
<thead>
<tr>
<th>Stomach aches, headaches</th>
<th>Pains in the body that don't seem to have a physical cause</th>
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</thead>
<tbody>
<tr>
<td>Crying a lot</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>Fear or anxiety</td>
<td>Nightmares</td>
</tr>
<tr>
<td>Sadness or irritability</td>
<td>Trouble paying attention</td>
</tr>
<tr>
<td>Thoughts about the traumatic event that won't go away</td>
<td>Trouble falling asleep, or sleeping too much</td>
</tr>
<tr>
<td>Avoiding thinking or talking about the traumatic event</td>
<td>Getting upset at reminders of the traumatic event</td>
</tr>
<tr>
<td>Acting as if the event is happening right now</td>
<td>Lack of desire to play with others or take part in activities that used to be enjoyable</td>
</tr>
<tr>
<td>Trouble managing behavior or emotions</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from the National Child Traumatic Stress Network, https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/effects)
Parenting a trauma-exposed child is stressful
  - Stress may lead to insensitive caregiving

Stress is exacerbated when parents also experience trauma
  - Reactions in parent or child may intensify the other’s symptoms

Challenges related to child trauma may lead to family conflict
3. MEETING THE NEEDS OF YOUNG CHILDREN WHO EXPERIENCE TRAUMA
What Young Children Who Experience Trauma Need

- Presence and continuity of a nurturing caregiver (or caregivers)

- Environments that promote:
  - safety and trust
  - self-regulation and social-emotional skills
  - other early skills needed to succeed in school

- Early childhood programs and systems that provide trauma-informed care
Trauma-Informed Care (TIC)

- **Realize**
  - the widespread impact of trauma and understand potential paths for recovery

- **Recognize**
  - the signs and symptoms of trauma in clients, families, staff, and others involved with the system

- **Respond**
  - by fully integrating knowledge about trauma into policies, procedures, and practices

- **Resist re-traumatization**
  - of children as well as the adults who care for them

The Role of Early Childhood Programs

- Learn more about child trauma
  - Increase awareness of ALL staff on the impact of trauma on children and families and talk to each other about what works

- Create warm, inviting, nurturing, safe spaces
  - Use carpets, pillows, soft colors, low lights
  - Notice and remove or avoid trauma “triggers”
The Role of Early Childhood Programs

- Create a regular routine so children and families know what to expect
  - Establish a place to meet for each activity; during transitions
  - Use carpet squares, rugs to show where to sit without words
  - Sing the same welcome/goodbye songs
  - Use the same hand gestures to accompany words so children who speak other languages can understand

- Understand that general distrust of power, authority, programs, and government assistance is natural and even an adaptive response
The Role of Early Childhood Programs

- Create an inclusive environment—Include resources, décor, materials that reflect the diversity of all children and families

- Offer information in different languages
  - Display community resources available in different language

- Make books and materials available that speak to the immigrant and refugee experience
Examples of TIC in Early Childhood Programs

• Early Care and Education
  • Trauma Smart
  • Let’s Connect
  • Safe Start
  • Infant/Early Childhood Mental Health Consultation

• Home visiting
  • Baby TALK Model

• Professional Development and Training
  • National Child Traumatic Stress Network training centers
  • Michigan Association of Infant Mental Health Competency Guidelines and Endorsement
Examples of TIC in Early Childhood Programs

- Partnering with Community Providers
  - Child Trauma Training Center’s Centralized Referral System
  - Mental health centers using evidence-based treatment
    - Child-Parent Psychotherapy
    - Parent-Child Interaction Therapy
    - Trauma-Focused Cognitive Behavioral Therapy
    - Attachment and Biobehavioral Catch-up
    - Culturally Modified Trauma-Focused Treatment
- Help Me Grow
- Safe Babies Court Teams
Resources for Working with Young Immigrants and Refugees Affected by Trauma


- Refugee Health Technical Assistance Center [https://refugeehealthta.org/](https://refugeehealthta.org/)

Thank you!

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Acknowledgement: Thank you to the Alliance for Early Success for support of this webinar
Aimee Hilado is an academic, researcher, and clinician specializing in immigration trauma and refugee/immigrant mental health. She is an Assistant Professor of Social Work at Northeastern Illinois University where she serves as the Curriculum Specialist in Human Behavior in the Social Environment and teaches undergraduate and graduate courses on practice with immigrants and refugees and practice with children and families. 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 age 3 of refugee/immigrant status.

Dr. Hilado presents nationally and has published in the areas of mental health, home visiting, and culturally sensitive clinical practice; her most recent edited book is *Models for Practice with Immigrants and Refugees: Collaboration, Cultural Awareness, and Integrative Theory*. She has played key roles in community organizing and advocacy, co-founding 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 PhD in social work, with distinction, at Loyola University Chicago and a dual-degree master’s program in social work and in science in applied child development at Loyola University Chicago and Erikson Institute, respectively.
Supporting Immigrant and Refugee Mental Health through Home Visiting

Aimee Hilado, Ph.D., LCSW
ZERO TO THREE Fellow
Assistant Professor, Northeastern Illinois University
Founding Manager, RefugeeOne Wellness Program
The impact of immigration trauma on families
The common denominators of immigration trauma

Refugees and immigrants come with their unique and collective trauma narrative

1. History of fear and uncertainty
2. Need for safety with worry about the future
3. Loss of homeland, loved ones, and cultural underpinnings exacerbates feelings of loneliness, homesickness, & isolation
4. Feelings of guilt for families left behind or for personal safety
5. Cumulative impact of migration experiences on mental health
Prevalence of adverse mental health symptoms for adults

Common symptoms:

• Prolonged sadness with poor coping skills
• Increased anxiety and frustration levels
• Poor sleep patterns and appetite
• Difficulty concentrating
• Somatic symptoms
• Suicide risk
• Substance abuse
• Severe mental illness: Schizophrenia, Bipolar I, Major Depressive Disorder, PTSD
How do immigrants and refugees define mental health?

• The term “mental health” has a negative connotation in many cultures.

• Mental health is sometimes correlated with “being crazy” or a product of moral failing.

• It is only understood through physical health symptoms.

• Many cultures see mental health as a private matter that is not to be discussed.

• Some cultures do not realize that poor mental health symptoms are a problem; it is part of the collective group experience and seen as normal.
The intergenerational model of trauma

Trauma has the ability to freeze the relationship between parent and child.

Parent availability is compromised.

Leads to additional stress that disrupts the architecture of the brain in a young child.
Supporting refugee and immigrant mental health: What do we know?

- Immigration trauma can have a **cumulative** effect on mental health.
- Unaddressed I-ECMH and adult needs **influences adjustment and overall health outcomes** for all family members. Family-centered approaches are valuable.
- New arrivals are **less likely to seek formal mental health services** due to the priority of other needs, misinformation about mental health, Western treatment models being inappropriate, and the lack of knowledge of general resources available.
- The current **sociopolitical climate** increases reluctance to seek services and engage with unfamiliar programs/professionals.
Supporting refugee and immigrant mental health: Why home visiting could be an answer

First, the delivery mechanism – services in the home – matters.

- Removes the barriers of families having to find services, navigate transportation needs, and families are generally more comfortable.
- We see the true needs of a family when we are in their home.
- Reduces fears of families encountering ICE or other federal agents who may threaten their sense of safety.
- Provides an opportunity to identify needs and refer for additional clinical & non-clinical services.

Second, the nature of engagement builds a relationship within which promotes positive home visiting and mental health outcomes.
The RefugeeOne Wellness Program: Our home visiting goals

- The RefugeeOne Wellness program is the first mental health program in the state to have received a ISBE home visiting grant to deliver home visiting services using the Baby TALK Model.
- We have four clinicians, five refugee home visitors, psychiatrist, and a team of interpreters who provide services.
Quick Facts about the Baby TALK Model:

- Since 1986 the Baby TALK Model has trained professionals in **32 states** across the country and in Canada.
- Over **1,400 professionals** trained through Baby TALK’s National Learning Institute.
- In Illinois, more than **100 publicly-funded** programs use Baby TALK as their model for working with families.
- As of FY17, **6,781 of 13,330 children (51%)** served by state funded (ISBE) Prevention Initiative program were served using the Baby TALK Model in Illinois.

Visit [www.babytalk.org](http://www.babytalk.org) for more information on the Model.
Home visiting goals include....

- Using a developmental parenting approach; focusing on the parent-child dyad
- Supporting parent mastery through:
  - Facilitating parent-child interactions
  - Observation, Narrating behavior
  - Listening and engaging to understand the meaning the parent is making
- Sharing information and reflecting
- Further supporting parent confidence and competence through meaningful goal-setting in support of the parent/family, the child’s development, and the parent/child relationship
- Ongoing case management to support overall family wellbeing

An attuned relationships is the **vehicle** for achieving these goals!
Trauma-informed home visiting as a pathway to supporting mental health and child outcomes

- In addition to the Baby TALK Model curriculum, all home visitors were trained on topics related to:
  - mental health terminology,
  - trauma-informed practice, and
  - how to look for common mental health symptoms that warrant referrals.
Home Visiting is NOT therapy but…

- Home visiting is culturally-sensitive approach to engaging families and supporting them in a therapeutic way.
- The goals of home visiting can be realized in addition to supporting adjustment to life in a new country.
- Trauma-informed home visiting creates a pathway to talking about mental health and getting families to appropriate clinical services more effectively.

- We saw greater success in identification of need and engagement from participants who came through the home visiting program.
- Some families didn’t want services but said they felt better knowing they had a consistent source of support in their home visitor.
The Baby TALK – RefugeeOne Study: A randomized controlled trial examining home visiting services with refugees and immigrants

Study Components
- **Type:** Randomized Controlled Trial
- **Intervention:** Home Visitation twice per month for 12 months
- **Measures:** Baseline at 12-months from baseline

Research Team
- 5 Researchers
- 3 Research Assistants
- 8 Home Visitors including 5 home visitors who were former refugees

200 Families Recruited
186 refugee families and 14 families of undocumented immigrant status

12 Nationalities Represented
- Iraq, Syria, Iran, Afghanistan, Sudan, DR Congo, Ethiopia, Burma, Ecuador, Cuba, Mexico, Columbia

9 Languages Spoken
- Arabic, Burmese, Farsi, Kinyarwanda, Malay, Rohingya, Spanish, Swahili, Tigrinya

Principal Investigators: Aimee Hilado, Ph.D., LCSW and Christine Leow, Ph.D.
Study Instruments

CHILD OUTCOMES (2 measures)
1. Ages and Stages Questionnaire, 3rd Edition (ASQ3)

PARENT OUTCOMES (2 measures)
1. Parental Stress Index, 4th Edition, Short Form (PSI-4-SF)
2. Refugee Health Screener 15, Mental Health/Trauma (RHS-15)

FAMILY OUTCOMES (3 measures)
1. Demographic Form to measure 1. Economic Self-Sufficiency and 2. Coordination/Access to Community Referrals
2. Home Visiting Documentation Form to measure 1. Positive Parenting Skills
### RCT Participants

#### Main Ethnicity Grouping

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<th>Treatment</th>
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<tr>
<td>East Asia</td>
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<td>56</td>
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<td>Central/Latin America</td>
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<thead>
<tr>
<th>Percent</th>
<th>97.0%</th>
<th>95.8%</th>
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RCT Findings: Among refugee and immigrants, the Baby TALK Home Visiting Protocol…

• …has a statistically significant impact on social-emotional development ($p=0.00$) and language development ($p=0.02$).
• …has a positive impact on parental stress and trauma symptoms (maternal health).
• …has a positive impact on access to linkages and referrals.
• …has an impact on economic self-sufficiency.
• Preliminary evidence shows the protocol has an impact on positive parenting practices.
Lessons Learned

- Understanding **immigration trauma** is critical to understanding the experiences of refugees and immigrants.

- Home visiting can produce significant effects on **developmental outcomes** among refugee and immigrant children.

- Frontline providers, including home visitors, can also be effective in **supporting mental health** among this group.
Contacts

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Q & A

➢ Use Q&A chat function to write questions
➢ Or email events@migrationpolicy.org with your questions
➢ Or tweet questions to @MigrationPolicy #MPIdiscuss
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